

Creating a Sustainable Health Promotion Workforce

Discussion Paper - Part 1

Project Deliverable 1

On behalf of



With the kind support of:



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Table of Contents

Important Definitions.....	4
Background.....	5
Purpose	5
Summary of Findings	8
The Case for Change.....	10
The Environmental Context.....	15
The State of the Health Promotion Industry	18
Understanding the Options.....	23
Informant Interviews.....	39
A Proposed Plan of Action.....	54
Recommended Regulatory Options for AHPA	57
Appendix 1: Project Plan.....	73
Appendix 2: List of Key Informants	74

Table of Figures

Table 1: Defining the Health Promotion Workforce	20
Table 2: Types of Regulation	25
Table 3: Benefits of Regulation	26
Table 4: Costs of Regulation.....	27
Table 5: Focus Group Responses (Six Hats)	49
Table 6: A Proposed Plan of Action	54
Table 7: Comparing the effect of regulatory models	59

Important Definitions

Workforce development

A process initiated within an industry or organisation to respond to the strategic priorities of the system and to help ensure that the people working within these systems have the knowledge, skills, capabilities and commitment to contribute to these priorities.

Workforce development strategies

Workforce development strategies aim to enhance the efficiency, effectiveness, career progression and satisfaction of a workforce. These may include education, professional development, reward and recognition, role delineation, professional regulation, human resource management and leadership.

Not-for-profit definitions

There are three types of not-for-profit organisations in Australia; a charity, a professional association and an industry group. AHPA is currently defined as an industry group, but may aspire to operate as a professional association or as both.

Health Promotion Industry

The health promotion industry refers to all of the key stakeholders in the health promotion field including the industry association (AHPA), health promotion professionals, educational providers, employers and government.

Discipline

Is where instruction is given systematically to a group of individuals to train them in a particular craft or trade. Health Promotion could currently be referred to as a 'discipline'.

Profession

A profession arises when a trade or occupation transforms itself through alignment with formal qualifications, but also where regulatory bodies emerge with powers to admit and discipline members, and confer some degree of monopoly rights over the market¹.

¹ Alan Bullock and Stephen Thromley, The New Fontana Dictionary of Modern Thought, London: Harper Collins, 1999 pg 689

Background

The Australian Health Promotion Association (AHPA) is Australia's peak health promotion association. In recent years AHPA has been focussed on initiatives to improve career opportunities and professional standards in the health promotion industry. This work culminated in the successful inclusion of health promotion as a recognised health profession in the QLD Health practitioners award. This resulted in a number of benefits being realised for health promotion officers in Queensland, including parity of wages being achieved with other allied health professions, clearer pathways for career entry and advancement, and more consistent training and development standards.

AHPA recently commissioned a body of work, the first element of which is this discussion paper, to evaluate whether the current structure of the health promotion industry in Australia is adequate to support the growth and development of the industry into the future.

Purpose

The purpose of this paper is to inform discussion on the most appropriate workforce development strategies available to the Australian Health Promotion Association (AHPA) to support the sustainability of the health promotion industry. This discussion paper represents the first deliverable of the project; it explores all of the regulatory and non-regulatory options available, provides an environmental scan of the health industry market, summarises the views from stakeholders, and proposes a way forward to achieve the objectives of the industry.

What question are we are aiming to answer in this paper?

- 1) What are the best workforce development strategies available to AHPA to support the sustainability of the health promotion workforce?

Essentially we are aiming to look at workforce development from the perspective of AHPA.

Who is this paper for?

As this paper explores high level industry level drivers such as legislation, regulation, governance, and standards, the primary audience is the AHPA Board, however all AHPA members and industry stakeholders are encouraged to read this paper.

This paper also describes a methodology for matching industry development options to the objectives of a health association. Other health associations may find this methodology useful.

AHPA's objectives for creating a sustainable health promotion workforce

Primary objective:

1. To enhance the quality and effectiveness of health promotion service delivery by implementing improved standards and quality controls.

Secondary objectives:

1. To enhance supply chain management to meet the growing demand for the health promotion workforce.
2. To improve the relative employment conditions and wages for health promotion professionals to be a more competitive career choice.
3. To secure the resources and financing required to maintain a sustainable workforce.
4. To demonstrate leadership of the health promotion industry as a whole.

Project Deliverables

The project has four deliverables:

Deliverable 1: Discussion paper – Part 1 (this paper)

- outline the regulatory and non-regulatory options available
- conduct a literature scan
- reconcile the recent regulatory reforms in Australia
- conduct interviews of key stakeholders
- develop a project plan
- make recommendations for a way forward

Deliverable 2: Discussion Paper – Part 2

- develop an impact statement
- evaluate the effectiveness, efficiency and appropriateness of the recommended option/s
- explore the strategic, operational, governance, resource and funding implications
- evaluate the benefits and costs to AHPA, as well as other key stakeholders such as the tertiary sector, employers and government

Deliverable 3: To communicate and consult with key stakeholders

- To seek the input and feedback of key stakeholders and members throughout the process

Deliverable 4: To develop an implementation strategy

- Provide advice, support and training to implement approved strategies

What is not looked at in this review?

- A review of the health promotion competencies.
- A study of the demographics and needs of the health promotion workforce.

Note: These are not being covered in this review because they are being addressed elsewhere. AHPA has already conducted a major body of work to establish a national set of health promotion competencies and is committed to their continual review and development. There are also other bodies of work being undertaken by the Australian National Preventive Health Agency and Health Workforce Australia to look at the needs of the health promotion workforce.

Summary of Findings

Our analysis found that the best option available to AHPA would be to use a combination of the following four strategies:

- 1) The introduction of a three tiered certification program designed to be inclusive and relevant to the broader health promotion workforce.

Certification Level 1 (e.g. Certified Health Promotion Officer -CHPO)

Certification Level 2 (for non-specialised health promotion professionals)

Level 3: Health Promotion Advocate (HPA)

Level one could be targeted at those with a relevant degree and/or demonstrable experience in health promotion. Level two could be targeted at other health professionals and/or the Vocational Education and Training sector as either a transition to further study, or as a pathway to less specialised career outcomes. Level three could be aimed at recognising and valuing those in the broader workforce who would not normally identify as part of the health promotion industry.

A certification model was preferred to a university accreditation model due to the increased flexibility and control it can provide for AHPA during a period of rapid change in the market.

- 2) The inclusion of Certified Health Promotion Officers in the list of 'Common Health Professions' in the Health Professionals and Support Services Award 2010, and then ensure this takes effect in all related state awards.
- 3) The introduction of a continuing professional development (CPD) requirement to maintain currency of knowledge against key criteria (for Level 1 and 2 certifications).
- 4) The targeting of a number of key economic incentives that have the potential to significantly enhance the sustainability of the health promotion workforce. These include:
 - a. A grant to support AHPA to develop workforce initiatives that will support the sustainability of the health promotion workforce. Such a grant might be supported by Australian National Preventive Health Agency (ANPHA), or alternatively the Department of Health and Ageing (DoHA) or Health Workforce Australia (HWA). (The quantum of funding needed will be determined in deliverable 2 of this project).
 - b. Advocating to the Department of Education, Employment and Workplace Relations (DEEWR), or HWA, that funding for health promotion places in universities needs to be equivalent to, or exceed that of other health disciplines. This is needed to create an incentive for universities to shift their investments towards producing more graduates

in specific workforces, such as health promotion, who have the potential to improve the sustainability of the health system.

- c. Encouraging more grants that stimulate jobs in the health promotion workforce. However to ensure the integrity of workforce development initiatives, future grants should specify minimum standards for employment, such as '*must be eligible to be certified as a Health Promotion Officer or Practitioner with the Australian Health Promotion Association*'.

Target Workforce

The intent of these recommendations is to be inclusive of the entire health promotion workforce with a focus on defining and growing both the tertiary and non-tertiary qualified segments of the workforce.

Other recommendations

It is recommended that an organisational impact assessment be conducted to compare and test the effectiveness, efficiency and appropriateness of the recommended options.

The Case for Change

The regulation and development of health workforces in Australia has reached a critical point. As the Australian population live longer with a growing burden of chronic disease and the number of people requiring long term care escalates, health expenditure (as a percentage of GDP) is forecast to rise at an unsustainable rate². Conservative projections suggest that healthcare demand over the next 20 years will at least double, with some projections suggesting demand will quadruple³.

The size of the Australian health workforce is currently larger than ever and yet in order to maintain the health services we have now into the future, workforce numbers will need to treble². The scale of the workforce challenge facing our nation is so large, that it has been estimated that even if every baby born in Australia over the last 20 years became a nurse, nursing shortages over the next 30 years would still not be addressed³.

The reality is that the Australian health workforce is heading towards a market failure. Although Australia is recognised as having one of the most advanced health professional training, regulation and industry development frameworks in the world, it is simply not sustainable to continue using current workforce planning and development approaches if we are to maintain the integrity of our healthcare system. What is needed is a transformational shift in the way we train, retain, develop and deploy health workforces in Australia. In recognition of this, the Australian government has intervened. Health Workforce Australia (HWA) has called for a major overhaul in the way we plan, train and develop our health workforces to ensure that future healthcare challenges are addressed in a sustainable manner³. HWA proposes that future workforce development requires tertiary training providers, health services, researchers, governments, and professional associations to collaborate more closely than ever before to plan, implement and evaluate health workforce initiatives.

The impact on the health promotion industry will likely be significant. Health promotion is projected to experience significant market growth many orders of magnitude greater than other occupations over the next decade. A recent ABS Labour Force Survey projects a “very strong growth” of the Health Promotion occupation over the next 10 years of 149%, which contrasts the projected growth of all other occupations at 9%⁴. These projections are partly attributed to the maturation of the health promotion and preventive health market, and compounded by the broader health industry trends noted above.

These projected trends for growth in Health Promotion are being reinforced by strong commitments and investments from key government agencies aiming to ‘refocus’ health service delivery towards prevention. There is an increasingly widespread realisation that such shifts are needed if the Australian healthcare system is to

² Health Workforce Australia Innovation and Reform Strategic Framework for Action <http://www.hwa.gov.au/work-programs/workforce-innovation-and-reform/strategic-framework-for-action>

³ Health Workforce 2025 volume 1 <http://www.hwa.gov.au/health-workforce-2025>.

⁴ ABS Labour Force Survey, DEEWR trend data to Nov 2010
<http://joboutlook.gov.au/pages/occupation.aspx?code=2519>

become sustainable. In the last 12 months alone there has been a record commitment of \$1 billion worth of investments allocated to prevention over the next three years (through the ANPHA and the states), with much more expected if key targets can be achieved - and if the preventive health market can meet expectations.

In 2011 HWA identified Health Promotion as a non-clinical workforce requiring capacity development². The ANPHAs strategic plan similarly identifies *capacity building in health promotion* as a key strategic goal and the Australian General Practice Network (AGPN) identified *building capacity in health promotion and prevention* as one of its key functions⁵. This is the first time there has been such specific and widespread commitment from key government agencies to building capacity in the health promotion workforce.

It appears that such commitment and investment is already translating into tangible effects on the health promotion workforce. In the two years leading up to November 2010 (which was just prior to these major commitments being made), the Health Promotion workforce experienced 68.5% job growth, in contrast to 4.3% growth in all occupations⁶. But it is in the period since November 2010 the private sector and local governments have injected hundreds of millions of dollars into employing health promotion professionals across the country, which is expected to contribute to a substantial increase in jobs growth in the current year.

These are certainly promising developments which represent enormous opportunity to the Health Promotion industry, however with such great opportunity comes great risk. Not unlike many disciplines, the Health Promotion industry has primarily invested in understanding the causes and consequences of health issues (and to a lesser extent the effectiveness of interventions), but has not adequately investigated the best way to organise, lead, govern or finance the macro-level drivers of the effectiveness and efficiency of the occupation as a whole. As Catford⁷ describes, 'the science of discovery' has tended to dominate 'the science of delivery'.

If not managed properly there is a strong likelihood that rapid industry growth could lead to a loss of control of quality and very quickly disenfranchise the market, potentially causing irreparable damage to the industry's brand. However, the risk of *not* capitalising on such opportunity might lead to marginalisation by more aggressive competitors, or potentially erosion of the industry as a whole. The negative implications of complacency in industry development are evidenced in the experience of other health promotion industries around the world. In England and Wales for example, the lack of action on workforce development has led to the erosion of the health promotion workforce⁸ with key government reports⁹ indicating that lack of organised advocacy and professional definition and standards

⁵Australian General Practice Network response to Medicare Locals discussion paper on governance and function <http://bit.ly/ae9vxt>

⁶ ABS Labour Force Survey, DEEWR trend data to Nov 2010 <http://joboutlook.gov.au/pages/occupation.aspx?code=2519>

⁷ Catford et. al. Health Promotion International, Vol 24. No 1.

⁸ Dark P, Griffiths J. Shaping the future of public health: promoting health in the NHS. London: Department of Health, 2005

⁹ Wise M. Health promotion in Australia: Reviewing the past and looking to the future. Critical Public Health 2008;18(4):497-508.

inevitably led to the health promotion workforce becoming invisible, irrelevant, and obsolete over time¹⁰.

In regards to the Australian setting, Schirmer¹¹observed that health promotion professionals already experience a lack of role clarity in their work and are uncertain about their future careers in health promotion. Coen and Wills¹²described a similar phenomenon in the UK before the profession was absorbed and eventually eliminated from UK policy documents¹³. Wills, Evans and Scott Samuel describe the health promotion movement as being increasingly marginalised within a public health paradigm which is itself being marginalised.

However establishing workforce development initiatives at the same time as managing significant industry growth is not easy. It requires a collaborative approach between the association, government, employers and training providers. In regards to managing growth, the literature identifies a number of common mistakes made in workforce development:

- a) a lack of clarity in the skills, competencies and expectations of professionals
- b) poor quality controls
- c) diversifying into new scopes of practice that are poorly understood (or not evidence based)
- d) a lack of data to support workforce planning
- e) supply chain issues for producing enough graduates to meet demand
- f) poor marketing, promotion and branding
- g) over committing
- h) poor collaborative working relationships with suppliers (training institutions) and customers (employers and industry)
- i) a lack of capital and cash flow to support growth
- j) a lack of infrastructure and support at both the individual and organisational level to deal with issues in a timely way

In respect to these risks, the health promotion industry as a whole is quite exposed. Points a) to d) relate to the need to have a clear understanding of the product, and having the appropriate controls in place to maintain quality and consistency

¹⁰Wills J, Evans D, Scott Samuel A. Politics and prospects for health promotion in England: mainstream or marginalised? *Critical Public Health* 2008;18(4):521-31

¹¹Schirmer. The health promotion workforce: pathways and challenges. A report prepared for AHPA, SA Branch 2010

¹²Coen C, Wills J. Specialist health promotion as a career choice in public health. *The Journal of the Royal Society of the Promotion of Health* 2007;127(5):231-8.

¹³Scriven A. Guest editorial: Shaping the future has become the rallying cry for health promoters in the first decade of the 21st century. *The Journal of the Royal Society for the Promotion of Health* 2007;127(5):206.

throughout the growth curve. The industry does have a core competencies document produced by AHPA, however it is not mandatory for training providers to use it. In regards to quality controls, beyond graduation there are currently no quality controls or standards applied consistently across the industry (such as mandated CPD requirements, or intermittent assessments of competence).

The remaining points from e) to j) relate to having the right growth strategy as well as the financial, human and operational resources required to maintain the integrity of service provision during the growth phase. Probably the key risk during this phase is cash flow problems. This essentially means there is more money going out of the business than into it, and therefore leaving the business unable to meet its operating costs. This may occur as the need to invest in things like additional human resources, technology, and larger office space are incurred well before the receipt of revenue from membership, professional development, or sponsorship could recoup these expenses. Negative cash flow can even occur when the business is highly profitable.

We expect that the health promotion industry will most likely require unqualified capital (government or industry grants) to establish the required standards, controls and resources to support growth. Depending on the scale of growth, some additional funds may be required to sustain liquidity (again from grants, debt financing, or the sale of shares or assets). AHPAs role would probably be to assume most or all of the subsequent operational risks of implementing the growth strategy. Deliverable two of the project will explore the options available, the estimated quantum required, and develop a case for return on investment from potential funding agencies.

To assert itself as a dominant force in a rapidly growing preventive health market, urgent action needs to be taken by the health promotion industry to establish the levers necessary to develop a sustainable industry framework capable of managing a rapidly changing market. As Mike Daube, Deputy Chair of the National Preventative Health Taskforce stated, "Prevention practitioners are an endangered species and will be even more so as Treasury comes harvesting in these hard economic times"¹⁴. The industry needs a sustainable regulatory framework that recognises and values education in health promotion, embraces the use of quality controls, and encourages ongoing professional development. The challenge here is to ensure that the regulations are both effective and efficient: effective in that they resolve the problem they were intended to address, and efficient in that they minimise both the direct compliance costs borne by those subject to the regulation and other indirect costs which may be imposed on the public. To achieve this will require a collaborative effort from governments, employers and AHPA who will need to work closely together to lead, govern and finance these workforce development strategies.

It is clear from the experience of other Australian health professions that a traditional approach is unlikely to work. Our current systems are leading to an impending market failure in the health workforce, and now radical reforms have had to be employed to mitigate the risks. Even where the majority of action has taken place in

¹⁴Daube M. Debate: Prevention on a broader canvas: is moving beyond risk factors necessary, desirable or possible? Public Health Bulletin SA 2009;6(1):4.

the registered professions, grave concerns still exist that the response may be 'too little too late'. It would be fair to say that the self-regulating and deregulated health professions are yet to respond at all. The health promotion industry needs an innovative approach that will deliver a more flexible and responsive workforce while maintaining some of the core values and objectives of health promotion such as inclusion and equity.

The question then becomes, what options are there? And, what will work best for the health promotion industry? Essentially the purpose of this paper is to propose answers to these questions and a plan for the industry to move forward. In seeking these answers we have not limited ourselves to evaluating only the common or traditional options available, instead we have chosen to undertake a detailed evaluation of all of the potential regulatory and non-regulatory options available, and apply a logical methodology to select the most appropriate option/s for the health promotion industry. Although using this type of approach may seem obvious, we are not aware of any similar review that has taken place in the Australian health industry.

We believe the time to act is now. There are strong indicators that both the health promotion industry (and the health industry as a whole) are experiencing significant workforce challenges. Key government agencies have made strong commitments and investments that are already translating into measurable effects on the health promotion workforce. Future workforce projections predict unprecedented increases in health workforce demand and it is clear that 'maintaining the status quo' is unlikely to address the industry's objectives, and may in fact compromise the sustainability of the industry. We believe these indicators represent a strong case for change, and that action should be taken to develop an industry development framework that will prepare the health promotion industry for the challenging times ahead and ensure the occupation of health promotion is not only sustainable, but can realise its true potential.

The Environmental Context

There are several key regulatory reforms that have taken place over the last three years that are relevant to the development of a more sustainable health promotion workforce;

- 1) The national registration of health professions
- 2) The introduction of modern awards
- 3) The recognition of Health Promotion Officers within the Queensland Health Practitioners Award
- 4) The establishment of the Australian National Preventive Health Agency (ANPHA)
- 5) The establishment of Health Workforce Australia (HWA)
- 6) The definition of Standards for Credentialing and Defining Scopes of Practice

The National Registration of Health Professions

From the second half of 2010 a uniform regime for registration of 13 health professions was introduced in Australia. Health promotion was not included in this tranche, (and may never be eligible to do so), however the standards that have been developed in this process are likely to flow on to the non-registered health professions.

The introduction of Modern Awards

Modern awards were created to establish one set of minimum conditions for employers and employees across Australia who work in the same industries or occupations. Modern awards, together with the National Employment Standards (NES) and the national minimum wage orders made by Fair Work Australia, create a new nationally driven workplace relations system. This scheme will bring together the disparate state awards, and provide an opportunity for occupations, like health promotion, to establish greater uniformity and consistency in pay and conditions across the country.

Queensland Health Practitioners Award

In 2007 the Queensland commissioner agreed that a number of employees in Administration Officer (AO) classified positions in QLD Health were primarily performing 'professional' responsibilities as Health Promotion Officers and Public Health Officers. These professional officer roles were identified to be within the scope of positions to be classified as 'Health Practitioners'. To maintain consistency with other health practitioners, a mandatory qualification (entry) requirement was also introduced and was assessed on a case by case basis.

The recognition of Health Promotion Officers within the Health Practitioner Awards realised a number of important benefits for the health promotion industry in QLD. It was hoped this reclassification of Health Promotion Officers might create a precedence for other jurisdictions.

However we found that most of the other jurisdictions require the profession to demonstrate;

1. consistent minimum entry standards to the profession
2. systems to ensure currency of practice
3. the existence of a single peak professional body (AHPA) and
4. standards for the ethical conduct and behaviour of professionals.

The establishment of the Australian National Preventive Health Agency (ANPHA)

ANPHA was established on January 1, 2011 to be a catalyst for strategic partnerships, including the provision of technical advice and assistance to all levels of government, to promote health and reduce risk and inequalities. ANPHA is likely to be a key strategic partner, and potentially funder, for developing capacity and sustainability of the health promotion workforce.

The establishment of Health Workforce Australia (HWA)

Health Workforce Australia was established by the Council of Australian Governments (COAG) to meet the future challenges of providing a health workforce that responds to the needs of the Australian community. HWA will also be a key strategic partner, funder and advisor for developing workforce development strategies for health promotion.

Standards for Credentialing and Defining Scopes of Practice

The Australian Commission of Quality and Safety in Healthcare has identified 'Accreditation, Registration and Credentialing' as a national priority area, as do most of the jurisdictional Safety and Quality Frameworks and Strategies. Workforce competence and development is integral to achieving high quality and safe care.

The principles of the ACSQHC Standard for Credentialing and Defining the Scope of Professional Practice (2004) are:

- Organisational governance must maintain and improve the safety and quality of health care services
- Professional registration requirements and individual professional responsibilities help to protect the community
- Effective processes benefit patients, communities, health care organisations and professionals
- Credentialing and defining the scope of professional practice are essential components for a system of organisational management of relationships with professionals
- Reviewing the credentials should be a non-punitive process

- Strong partnerships should exist between health care organisations and professional colleges, associations and societies
- Processes must be fair, transparent and legally robust.

The State of the Health Promotion Industry

Over the last 20 years the health promotion discipline has experienced significant industry advancements. A strong evidence base emerged which has established both the efficacy and cost benefit of health promotion approaches.^{15,16} In 1986 a landmark agreement, the Ottawa Charter,¹⁷ created a momentum for health professionals from many disciplines to gravitate towards this exciting new discipline. A national professional body (AHPA) was created in 1989 and since then a number of tertiary health promotion programs have been established around the country.

The last five years in particular, has been a time of rapid growth and development. Several international consensus statements^{18,19,20,21} have called for global action to address the social determinants of health and encourage new models of care, with a key driver being the need to develop the health promotion workforce. In 2009 a set of core competencies was established in Australia which clearly defines the entry level knowledge, skills and behaviours required to be an effective Health Promotion Officer²². Following this a range of professional development opportunities based on these standards emerged.

Today there are approximately 1100 members of AHPA. The best estimate we have for the total size of the health promotion market is around 5000.³ Due to the lack of available data and the inconsistent classification of health promotion workers, we do not have an accurate picture of the size or demographics of the workforce.

Each Australian state and territory currently employs health promotion professionals under a range of different titles and awards. Health promotion professionals are usually employed under titles like 'Health Education Officer', 'Project Officer' or 'Administrative Officer' which are very generic employment titles. The salary and conditions for these positions are typically below that of allied health awards, therefore discouraging health professionals who hold other health qualifications to move into health promotion.

There is no current industry requirement for health promotion professionals to maintain continuing professional development following completion of a health

¹⁵Abelson P. 2003. Returns on investment in Public Health. Department of Health and Ageing, Canberra.

¹⁶ Murphy, J. 2005. Health Promotion. Economic Roundup Winter 2005. The Treasury, Australian Government. <http://www.treasury.gov.au/contentitem.asp?NavId=035&ContentID=1009>

¹⁷World Health Organisation & Health and Welfare Canada. Ottawa Charter for Health Promotion. Geneva: WHO; 1986.

¹⁸World Health Organisation. Jakarta Declaration on Leading Health Promotion into the 21st Century. Fourth International Conference on Health Promotion, Jakarta. 1997

¹⁹World Health Organisation. Mexico Ministerial Statement for the Promotion of Health. The Fifth Global Conference on Health

Promotion. Bridging the Equity Gap. 5-9 June Mexico City.

²⁰World Health Organisation. Sundsvall Statement on Supportive Environments for Health. Third International Conference on Health Promotion, Sundsvall, Sweden 9-15 June.

<http://www.who.int/healthpromotion/conferences/previous/sundsvall/en/index.html>

²¹World Health Organisation. The Bangkok Charter for Health Promotion in a Globalized World. 6th Global Conference on Health Promotion, Bangkok, Thailand, 11 August 2005.

http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/

²² AHPA Core Competencies 2009

<http://www.healthpromotion.org.au/images/stories/pdf/core%20competencies%20for%20hp%20practitioners.pdf>

promotion qualification. Career paths are poorly defined and because of fairly 'flat' organisational structures, the only real opportunity for career advancement is into management.

A key milestone for the industry in Australia was the formal recognition (and confirmation in statutory legislation) of 'Health Promotion Officers' as recognised 'Health Practitioners' in Queensland alongside other allied health and medical professions. This resulted in a number of benefits being realised for Health Promotion Officers in QLD, including parity of wages being achieved with other allied health professions, more clearly defined pathways for career entry and advancement, and more consistent training and development standards. This achievement represents a major step towards addressing some of the key disincentives in the health promotion workforce.

Building on these advancements, the Queensland and South Australian governments have provided support to AHPA to explore workforce development strategies for the health promotion workforce. The objective is to provide a more sustainable framework for developing and maintaining the competence of the health promotion workforce. In turn this will reduce the burden and costs on employers.

Before the industry can explore new models for developing the workforce, some key questions need to be answered. As Wise (2003) pointed out in an editorial on workforce development in health promotion²³ "*Questions such as who is the health promotion workforce, what kinds of knowledge and skills do they need, and what policy and organisation support do they require?*" require further attention. Since 2003 there has been much work done to better define the workforce, and a national set of core competencies have been established. However in regards to determining what policy and organisational support is required to create a sustainable health promotion workforce, this has attracted much less attention, and is hence the focus of this project.

Who is the health promotion workforce?

Before we can build capacity in the health promotion workforce, we must first define who the health promotion workforce is. A number of definitions of the health promotion workforce have been proposed.^{24,25,26,27} For the purpose of this review, a three tiered definition of the health promotion workforce has been proposed, and is similar to that described by Barry²⁴ and Schirmer¹¹.

The first tier refers to the Health Promotion Officer. This is the group most likely to have a relevant degree, would most likely identify themselves as being a part of the

²³ Wise M. The health promotion workforce and workforce development. Health Promotion Journal of Australia 2003;14(1):3-4.

²⁴ Barry M. Capacity building for the future of health promotion. Promotion & Education 2008;15(4):56-8

²⁵ O'Connor Fleming ML, Parker E, Oldenburg B. Health promotion workforce development in Australia: findings of a national study. Health Promotion Journal of Australia 2000;10(2):140-7.

²⁶ Swerissen H, Tilgner L. A workforce survey of health promotion education and training needs in the State of Victoria. Australian and New Zealand Journal of Public Health 2000;24(4):407-12.

²⁷ Taub A, Algrante JP, Barry MM, Sakagami K. Perspectives on terminology and conceptual and professional issues in health education and promotion credentialing. Health Education & Behaviour 2009;36(3):439-50.

health promotion workforce, and hold membership of a professional association.¹¹ The second tier refers to General 'Allied' Health Workers who work in the health sector, most likely as a clinician, and whose role includes some elements of health promotion.

The third tier refers to the broader workforces who do not necessarily work in the health sector, but their role has the capacity to influence the objectives of health promotion. This group consists of a wider workforce from different sectors and professional backgrounds including education, the community sector, the built environment and transport²⁴. It is acknowledged that these sectors have a large influence in shaping health²⁸.

Table 1: Defining the Health Promotion Workforce

Health Promotion Officers	This segment of the workforce would hold a relevant degree and have demonstrable experience working in the field of health promotion.	This segment would typically identify themselves as part of the health promotion workforce.
Health Promotion Practitioners	General health workers whose role includes some health promotion activities.	May not currently identify themselves as part of the health promotion workforce.
Health Promotion Advocates	Broader workforce who generally work outside of the health sector, but whose role has the potential to influence health promotion objectives.	Would generally not identify themselves as part of the health, or health promotion workforce.

The Core Competencies

Although there has been little work undertaken to map the needs of the health promotion workforce in Australia, there has been considerable work undertaken, both nationally and internationally, in identifying the knowledge skills and competencies required for health promotion professionals. In 2008 AHPA launched a national set of core competencies for Health Promotion Practitioners, organisations, employers and educators.²² The above document was based on extensive national and international research^{29,30,31} and has gone a long way to better defining the

²⁸ Keleher H. The drivers for health lie outside the health sector. In: Keleher H, MacDougall C, Murphy B, editors. Understanding health promotion. Melbourne: Oxford University Press, 2007:47-60.

²⁹ Barry MM, Allegrante JP, Lamarre MC, Auld ME, Taub A. The Galway Consensus Conference: international collaboration on the development of core competencies for health promotion and health education. *Global Health Promotion* 2009;16(2):5-11

³⁰ Battel-Kirk B, Barry MM, Taub A, Lysoby L. A review of the international literature on health promotion

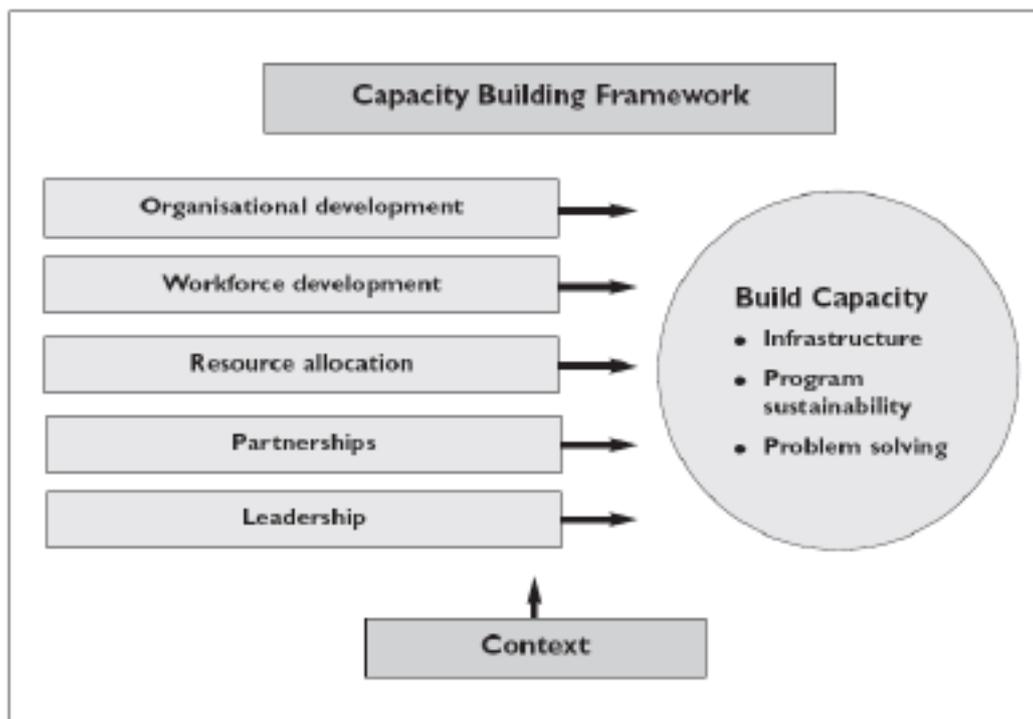
discipline, the key graduate outcomes of a 'Health Promotion Officer', and the knowledge and skills required to be an effective practitioner.

What Policy and Organisational Support is required to Build Capacity?

As Shirmer¹¹ describes in her thesis, a clearly articulated definition of the health promotion workforce, together with the implementation of clear competencies alone is not enough to deliver health promotion policy and action.

She refers to the Framework for Building Capacity to Promote Health³², developed by NSW Health, which describes workforce development as one of five action areas to enhance the capability of the system to improve health. The five action areas of capacity building are: infrastructure and organisational development; workforce development; resource allocation; leadership; and partnerships (see Figure 1). Adoption of each of these action areas is encouraged to maximise opportunities for health gains.

Figure 1



None of these elements is likely to be successful in isolation. Schirmer suggests that there is a profound co-dependency and feedback between these areas whereby one cannot exist or reach its peak without the other¹¹. Although initial scope of this project was to review only workforce development initiatives, the focus has since been broadened to include elements of all of these areas.

competencies: identifying frameworks and core competencies. *Global Health Promotion* 2009;16(2):12-20.

³¹ Santa-Maria Morales A, Battel-Kirk B, Barry MM, Bosker L, Kasmel A, Griffiths J. Perspectives on health promotion competencies and accreditation in Europe. *Global Health Promotion* 2009;16(2):21-31.

³² NSW Health. The framework for building capacity to promote health. NSW Health Department, 2001

Schirmer also points out that leadership is a particularly important component of building workforce capacity. Leadership creates the vision, the aspiration and the environment for change. Good leadership creates opportunities, manages obstacles and can turn problems into opportunities. The health promotion industry has never needed good leadership more so than now.

When considering the importance of partnerships it is important to acknowledge the key institutions that shape the health promotion workforce such as tertiary education providers, governments, employers, and professional associations. These institutions can either strengthen or weaken a discipline depending on their inputs towards the partnership and their commitment to workforce development. These partners each have a stake in the quality of the workforce and must work in cooperation to plan and implement workforce development strategies.³³

Although the aim of this project is to look at workforce development from the perspective of AHPA, we will also consider the benefits, impacts and potential opportunities for other stakeholders.

Values of Health Promotion

AHPA's values are those enshrined in the Ottawa Charter for Health Promotion⁹. They include equity, social justice, and shared responsibility for health. These values have underpinned the approach taken in this review.

³³ Allegrante JP, Moon RW, Auld E, Gebbie KM. Continuing-education needs of the currently employed public health education workforce. *American Journal of Public Health* 2001;91(8):1230-4.

Understanding the Options

What is regulation?

Regulation provides a mechanism to protect community and industry interests by ensuring that professionals have met minimum qualifications and can demonstrate their ongoing fitness to practice.

Regulation of professions asserts that quality-assured professionals provide a more skilled, safe and effective level of service. Without signals provided by regulation the general public and employers have more difficulty in the selection and performance monitoring of providers.

The trade off between granting professions exclusive or protected rights in return for achieving more effective, efficient and equitable services for the community, has both costs and benefits³⁴. Some of the costs include the cost of administering the framework, potentially higher membership costs, higher wages, and market restrictions such as reduced competition. However the benefits can include higher quality health services, greater reliability, increased industry participation, and higher professional influence.

Regulation essentially operates to counter market failure. That is, failure of the open market to provide the right quality of services at the right price, without undue risk of loss to consumers or employers³⁴. A 'loss' could include costs incurred in locating a competent service provider (transaction costs), costs to parties not involved in a service transaction (negative spillovers), or loss as a result of incomplete information upon which to base decisions and actions (information asymmetry).

Why Regulate?

There is a long history of government and industry regulation 'in the public interest', that is, regulation essential for the functioning of society and the economy. At a basic level, laws define and enforce property rights, which are essential underpinnings for the operation of markets. The public interest requires that governments intervene in areas of health and safety, the environment, social policy and the economy, and it is through this that governments meet societal demands and desires, and maintain frameworks for markets.

There has been a move away from direct government provision of goods and services towards a greater reliance on the market to meet the needs of the population and ensure economic growth. But because markets do not operate in a vacuum, there are circumstances when markets may not generate optimal economic outcomes. These cases of 'market failure' provide a rationale for regulators to intervene and correct the perceived failure. Typical examples of market failure which have led to regulation and intervention include:

- 1) The existence and abuse of market power(monopoly);

³⁴ ACT Department of Health & Community Care, National Competition Policy Review of ACT Health Professional Regulation. Sep 2009.

- 2) Information asymmetries or deficiencies (that is, where one or more of the parties involved in a transaction have incomplete information upon which to base their decisions and actions); or
- 3) Externalities and spillovers (that is, when one or more of the parties involved in a transaction do not take into account the full effects of their decisions on others).

In addition, regulators may also intervene in the operation of markets to achieve objectives other than economic efficiency. For example, regulation to achieve social, environmental and cultural objectives. Such objectives could include: a more equal distribution of income and wealth; and ensuring equal access to health and other essential services.

Types of Regulation

There are five key types of professional regulation. They are:

- 1) Registration
- 2) Self Regulation
- 3) Negative Licensing
- 4) Incentives and market based instruments, and
- 5) Deregulation

Table 2 below summarises the different types of regulation, their mechanisms and some examples.

Table 2: Types of Regulation

Registration		Example
Protection of title	Legislation provides exclusive use of title on persons who have been accepted as meeting the entry requirements	Doctor, Nurse, Physiotherapist
Protection of practice	Legislation prohibits unregistered people from practicing certain procedures or practices.	Dispense of prescription lenses
Self Regulation		
Certification	Voluntary time-limited recognition and use of a credential after meeting predetermined criteria	Certified Practicing Accountant
Accreditation	Approval of an educational program according to defined standards	University Course Accreditation
Licensure	Mandatory time limited permission to engage in a given occupation or practice after meeting pre-determined standards.	Builders
Continuing Professional Development	The requirement to maintain currency of practice through ongoing learning and development	Dietitians CPD Standards
Negative Licensing		
No entry requirement	Professionals are not typically screened before starting to practice	Insolvency Practitioners, financial advisors, casino dealers
Sanctions	Legislation that details what is not acceptable in the operation and activities of an occupation, and providing sanctions or de-licensing for unsatisfactory conduct	De-licensing of Insolvency Practitioners
Incentives and market based instruments		
Economic incentives	Changing relative pricing or making trading opportunities available where they did not previously exist.	Solar panel installation incentives
Trading schemes	Market schemes with clearly defined targets or objectives.	Emissions Trading Scheme
Fiscal measures	Taxes and subsidies	Taxes on cigarettes and alcohol
Deregulation		
Market forces	Market forces to select out providers who have the right price and quality mix of services.	Sale of petroleum
General legislation and common law	The use of general legislation and common law to impose market restrictions	Fair Trading legislation, compensation for damages, health complaints legislation, Employment awards
Private information market	Consumer advocate groups and media systems targeting information and other power imbalances between consumers and health providers	Restrictions on pharmaceutical advertising
Independent credentialing	i.e. Health insurance schemes, workers compensation schemes etc certifying health providers	Health Insurance Act

Table 3: Benefits of Regulation

Table 3 and **Table 4** summarise the key benefits and costs of regulation for key stakeholders

Benefits of Regulation				
HP Professional	AHPA	University	Industry	Consumer
Improved career opportunities	Enhanced ability to market profession	Branding	Reduced recruitment costs	Increased access to higher quality practitioners
Improved pay	Increased membership	Increased student numbers	Quality assurance	Assurance that minimum competence and quality standards have been met
Enhanced professional recognition	Improved industry credibility	Improved credibility of school	Economic benefits from improved effectiveness of healthcare	Reduced costs from inappropriate treatment choice
Less competition	Competitive advantage	Competitive advantage to universities not producing accredited/ registered grads	Reduced workforce turnover	Assurance that those who are not competent or fit to practice have been restricted or prohibited from practice
Branding opportunities	Enhanced revenue from related products and services.	Increased funding (DEEWR)	Improved employee satisfaction	Reduced risk from information imbalance (i.e. misrepresenting benefits or competence)
Less price competition	Provide transparent benefits for members	Ability to leverage internal resources	Reduced costs associated with malpractice	Provides complaints and appeals processes
Less promotion costs	Support learning and development or workforce	Enhanced relationship with industry	Low cost for maintaining and oversighting standards	Protects from substandard treatment
Maintains reputation and confidence in profession		Enhanced research funding	Standards for good health practice administered in the public interest	Professional indemnity insurance requirements protect in the case of claim
Peer level understanding and judgement in relation to the interpretation of standards and codes of practice		Reduced marketing costs	Improved opportunities to access funded HP placements	Costs of regulation mostly met by practitioners and industry
Improved role clarity				

Table 4: Costs of Regulation

Costs of Regulation				
HP Professional	AHPA	University	Industry	Consumer
Cost of obtaining qualifications	Administration and resource costs of maintaining regulatory structures	Cost of accreditation schemes	Higher wages cost due to award	Reduced access to an unrestricted range of providers
Increase in membership fees	Potential for legal costs and risk of standards being challenged.	Resource and cost of maintaining compliance	Potential to reduce competition for roles	Inability to access services due to higher price
Reduced incentive to innovate and improve efficiency	Costs of supporting a complaints infrastructure	Lack of evidence that regulation instruments contribute directly to the intent of self regulation	Increased costs related to professional development	Reduced equity due to reduced providers and their distribution
Cost of contribution to disciplinary processes through fee levels	Need to manage a larger group of stakeholders	Potential to restrict or limit innovation in educational program delivery	Potential to restrict innovation and substitution within provider services	Slightly higher cost of service as providers and employers recoup training, recruitment and fee costs.
Possible restrictions on practice/ removal from practice as a result of breaches.	Potential that increased standards might restrict the market	Need for increased resources		Restricted competition
Conservative professional conduct due to fear of sanctions	Potential for competitor to establish in the same market	Potential need to review program structure and content		Lack of participation in standard setting and enforcement
Costs of maintaining professional indemnity insurance				Risks that standards enforcement could be used to reduce competitive conduct
Cost of professional development to maintain standards				Lack of information to differentiate on the basis of price or quality
				Disciplinary action may be perceived to minimise impact on profession rather than public

What is Registration?

Registration is a regulatory instrument that empowers a regulatory authority to set standards for registration, to investigate complaints, and to impose sanctions on a practitioner, including deregistration. The effect of registration is to create an enforceable barrier to entry, to regulate the standards of practice and the conduct of registered professionals.

Although registration of health professions in Australia claims to improve both the quality and safety of health services, the model is primarily geared towards improving safety, with little emphasis on quality, and almost no emphasis on whether it contributes to effective health outcomes. Therefore it would be fair to say that registration is about protecting the public from loss in their transactions with health professionals, with a particular emphasis on ensuring that services are safe.

Registration schemes aim to mitigate the potential for loss by applying the following restrictions.

- *Entry standards* - restriction on who may practice in the profession by setting a barrier to entry. These include minimum qualification requirements, criminal history checks, English language skills, fitness to practice, recency of practice requirements, and the obligation to contribute to the maintenance of the model by paying appropriate fees. Many professions also require that professionals hold appropriate professional indemnity insurance.
- *Conduct standards* - restrictions on how professionals or businesses behave and conduct their activities. These include grounds for taking disciplinary action for fraud or misrepresentation, convicting an offence, habitual drug use, failure to exercise adequate judgement, unethical conduct, or bringing the profession into disrepute.
- *Regulatory Boards* - the provision of powers to regulatory Boards to influence the practice and business conduct of health professions. Boards have a central role in the administration and enforcement of the framework established within the *Health Practitioner National Law Acts*.

The effect of entry standards

Entry standards have the effect of restricting market supply, and preserve the economic benefits of being a registered health professional within a specific discipline³⁴.

Where statutory restrictions are applied in the market place there is a risk that services may be provided inefficiently, competition is reduced, incentives to innovate are diminished, and artificially high prices and wages can be experienced.

However in a market where no restrictions are applied people with and without training would compete for the same market share. Theoretically survival in the market would be determined simply by consumer or employer acceptance of the price and quality offered by the provider. However, it is difficult for consumers and employers to make appropriate decisions on these factors alone without being very well informed on how to distinguish one provider from another. Furthermore in

complex services such as medicine, this type of information is extremely difficult to communicate, and can be difficult to interpret.

This highlights the need for statutory requirements and standards that have been determined by well-informed people, in the interests of the community. The challenge is getting the balance right between protecting the community from undue loss, without creating consequences that are disproportionate to the benefits achieved.

The effect of conduct standards

Conduct standards act to restrict competitive conduct of health professionals and therefore reduce economic outcomes for both health professionals and consumers alike. Those acting outside the conduct requirements are liable to face disciplinary action and potentially to have their capacity to work in their profession restricted and in some cases removed. The anti-competitive effect of conduct standards usually arises from their observance rather than their enforcement (i.e. the fear of sanctions is generally sufficient to moderate conduct).

These restrictions tend to lead to conservative business conduct out of concerns for breaching conduct standards. The outcome of such standards can therefore preclude innovation and dynamism, encourage inefficient operations and generally further the status quo.

Without disciplinary conduct standards health professionals would be free to conduct and market their services in the same way as any other business. Therefore survival in the market would primarily be linked to competitiveness and consumer choice. The benefit of this would be that consumers may be better able to exercise control of their health care treatment. However the risk of not regulating health professional conduct is that health consumers and employers, particularly the most vulnerable elements of the market, may be subject to abuse or misrepresentation from unprincipled health providers.

A market driven health workforce may also be more prone to manipulate demand, particularly through promoting unfounded expectations and consumer anxiety such as that commonly seen in weight loss and cosmetic products' industry. For that reason conduct standards are useful to reduce the prevalence of unscrupulous behaviour and business practices.

The effect of regulatory boards

Boards have powers conferred by statute to determine qualifications and other requirements for registration and to maintain a publically accessible register of qualified persons.

Regulatory boards are empowered by the Acts to:

- recognise appropriate qualifications and fitness for registration,
- to maintain a register of health professionals,
- to scrutinise the conduct of registered professionals, and

- inquire and adjudicate on complaints

The membership of Boards, as stated in the new National Legislation for Health Practitioners, state that at least half, but not more than 2/3rds, of the members of a national board must be practitioners, at least two members must be community representatives, and at least one member of the board must be from a rural or remote area³⁵.

The role of Boards is essentially to oversee the regulation of the profession using powers conferred by statutory law. (As discussed previously) Boards have powers to set entry standards, investigate complaints, discipline poor conduct, and restrict or prohibit participation in the market.

In recent years some Boards have been criticised for a lack of transparency and innovation, particularly in relation to the handling of complaints and acting decisively to meet future workforce demands. One of the underpinning criticisms is the perception of, and potential for, conflicts of interest to arise with board members who themselves compete in the market. There is also a risk that boards will actively guard the scope of practice of their profession and launch action where another profession seeks to participate in their market domain.

Eligibility criteria for registration

The first criteria for professional registration, is that the profession must pose 'a significant risk of harm to the public'. As mentioned earlier, one of the core functions of registration is the need to protect the safety of the community. Professions such as medicine perform a number of high risk activities including invasive, infectious, pharmacological and psychological practices that have the potential to maim or kill, and for this reason a comprehensive regulatory model is appropriate.

However health promotion, by comparison, is considered quite safe. We found that there have been no deaths in Australia attributed to the actions or behaviours of a Health Promotion Officer or member of AHPA. AHPA has not instigated disciplinary action in relation to inappropriate conduct of any member since the organisation's inception, nor have there been any complaints made to any of the state healthcare complaints commissions (or equivalent) relating to a Health Promotion Officer.

The practice of Health Promotion inherently safer as it involves a high proportion of indirect service delivery (such as education and policy development) which is usually implemented in a team based environment after being reviewed and signed off by other professionals. This type of practice significantly reduces the likelihood that the action or inaction of an individual practitioner would lead to unacceptable risk of harm to the public. That is not to say that it is not conceivable that the actions of a Health Promotion Officer could present a risk to the public, but in the context of regulation the risks are mitigated and would not be considered to be 'significant'.

On this basis Health Promotion would be ineligible to apply for Registration. Furthermore our analysis concludes that even if it was eligible, registration would not

³⁵ National Health Practitioner Regulation Law Act 2009.

be an appropriate workforce development strategy for the health promotion workforce.

What is Self Regulation?

Self-regulation typically involves an industry or professional group voluntarily developing rules or codes of conduct that regulate or guide the behaviour, actions and standards of its members. The professional group is responsible for developing self-regulatory instruments, monitoring compliance and ensuring enforcement. Examples of self-regulation include: codes of practice; certification; university accreditation; and voluntary adoption of competency or practice standards.

The specific types of instruments or mechanisms that may be created under a self-regulatory regime are similar under a co-regulatory framework, but co-regulation entails explicit government involvement. It is the degree of government involvement and legislative backing that determines the difference between the two. Self- and co-regulatory approaches are frequently used in the professions and by industry associations where detailed technical knowledge is likely to be important.

When used in the right circumstances these instruments can offer significant advantages over traditional 'command and control' regulation models like registration, including: greater flexibility and adaptability; potentially lower compliance and administrative costs; an ability to address industry-specific and consumer needs more directly; and quick and low-cost complaints handling and dispute resolution mechanisms.

Self regulation has the potential to be a very efficient policy instrument because of its flexibility. It can be more readily tailored to the specific issues it is designed to address, and can be changed relatively quickly in response to changing circumstances. However, there can also be negative consequences: as there are no legislative frameworks that underpin the model, there must be adequate protection in place to ensure that the regime is not captured by regulated stakeholders such as (universities or factions of health promotion professionals), and so promote narrow interests rather than the wider community interest.

Self-regulation has been a common way in many countries to help overcome the information deficiencies faced by consumers and employers in accessing professional services. A common form of self-regulation in professions occurs when the profession creates a 'barrier to entry' which may require candidates to meet minimum qualification levels and adhere to a code of conduct to become a qualified professional. Recognition as a 'qualified professional', usually through an accreditation, certification or qualification of some type, provides quality assurance signals to the potential consumer, or employer, as to the professional status of the person and their competency to undertake the required role.

Self regulation of the health professions has developed quite rapidly in Australia in the last 10 years, not the least within the allied health professions. A National Alliance of Self Regulating Health Professions was even established within the last 12 months and currently has 8 members, representing over 50,000 health professionals.

Of all of the regulatory and non-regulatory models being reviewed (as listed in Table 2), self regulation is likely to be most appropriate to the health promotion workforce. The potential for flexibility, inclusiveness and the ability to change quickly in a rapidly changing environment are clearly aligned with AHPA's industry development objectives.

Concerns about the peer review model of regulation

The peer review models of regulation (including self regulation and to an extent registration) enshrines the principle that peers from the health profession are in the best position to judge what constitutes appropriate professional and unprofessional conduct, and also to know what is in the best interests of the public.³⁶

The new regulatory boards in the National Registration Scheme do make provision for community and independent members, however there are questions about the extent of influence these members can have on the boards. Practitioner members bring essential professional and clinical expertise, but may be ill prepared for a role that requires an understanding of the principles of natural justice and procedural fairness, and they may, at times, lack insight where professional interests conflict with the broader public interest³⁶.

Of course the reality is that no model is perfect. However in determining the most appropriate governance model for any regulatory framework the aim is to ensure that a proper and reasonable balance is struck between the rights and interests of consumers, employers, and the practitioners who deliver the services. Whatever framework is chosen it is important to always keep the potential for conflicts of interest and power imbalances at the heart of any process that involves peer review.

What is Negative Licensing?

Negative licensing schemes are characterised by having minimal or no barriers to entry. Although it is still possible to have conduct standards and requirements for undertaking professional development, there would be no stringent or prescriptive entry standards (such as having to complete an appropriate degree). The key regulatory lever is the ability to withdraw the right to practise if the person subsequently fails to meet professional or conduct standards.

The benefits of a negative licensing scheme are:

- *Low cost.* The cost of administering the scheme would be lower than all other schemes (with the exception of deregulation), and has very low resource requirements.
- *Reduced conflicts.* Reduced industry and professional conflicts of interest which can act to protect dominant industry players and assert coercive control over barriers to entry to restrict competition;
- *Increased workforce participation.* Health professionals may be more likely to enter the market with no entry requirements, lower compliance costs,

³⁶ Louise-Carlton. National Models for the Regulation of the Health Professions pg 21-44.

reduced membership fees and more flexibility to offer competitive pricing and innovative service delivery.

- *Poorly performing health professionals can be removed* from the market, the threat of which is usually enough to maintain service quality and compliance.

The potential disadvantages of a negative licensing scheme are:

- The absence of an initial screening system may permit people to provide health services that are unsatisfactory and this may result in loss to consumers;
- There is not typically a register of all practising professionals.
- Some health professionals may be able to operate undetected in the market place and cause considerable damage;
- Such schemes are not seen to be proactive and lack of opportunities for early intervention or to remedy poor performance or behaviour;
- Alternate enforcement and monitoring activities may need to be established and supported.

While negative licensing offers a low cost system with a relatively low burden on all stakeholders, the major deficit of traditional negative licensing schemes is the inability to intervene on matters regarding the competence or conduct of a professional until after a complaint has been made.

The other key challenge for health promotion using this model would be that it is completely different from all other health professional regulation schemes in the market. By deviating from the generally accepted regulatory models (such as self regulation), it may cause anxiety in the market (and in the profession), and initially incur additional costs for some stakeholders to be convinced to adapt the model. There is also a risk that the model might not be compatible with existing legislation and practices. These include health care payment systems, employment awards, and drugs and poisons law which all refer to the need for both initial and ongoing certification standards.

That being said, negative licensing does provide a viable regulatory option for professions that are deemed safe. The model might be 'different', but it may be entirely appropriate for some health occupations. As long as there was a requirement to register, and appropriate conduct and behaviour standards could be enforced, the model could be a very efficient and effective model in certain conditions.

Suitability for Health Promotion

Many elements of a negative licensing system are appealing and probably well suited to a profession like health promotion (where safety is not a primary concern). However in the current environment negative licensing would not adequately solve the problem of having to manage rapid change in the market, nor would it act to establish consistency and quality in the market in a timely way. The punitive approach to managing quality is also in conflict with the values of health promotion. Nevertheless negative licensing should be looked at more carefully by regulating bodies and governments as a potentially viable way of regulating safe health professions in future. Most of the current barriers to negative licensing could be

overcome, if the regulatory environment in the health sector was more forgiving and accepting of such a model.

What are incentives and market based instruments?

Market-based regulatory instruments act to change or modify behaviour through the economic incentives facing citizens and businesses, to ensure that they correspond more closely with society's objectives. They primarily operate through changing relative prices or making trading opportunities available where they did not previously exist.

Trading schemes are a common form of market-based instrument. Such instruments can involve the government setting an allowed level of an activity, such as the production of carbon dioxide (i.e. an emissions trading scheme), and allocating emission permits to firms. But the firms are then free to trade these permits amongst themselves. In this way the government is able to specify the total level of emissions but not impose limits on individual firms.

Fiscal measures – such as the use of taxes and subsidies – are also commonly used market-based instruments. Taxes are often imposed on harmful activities to make them relatively more expensive. For example, in many countries high tax rates are imposed on tobacco products to discourage their consumption. Alternatively, grants and subsidies can be used to encourage production or consumption of activities or products which are considered desirable.

The key problem with market based instruments is their potential lack of precision in achieving an objective. For example the introduction of a tax to reduce emissions or lower the prevalence of obesity is a clear objective, but it can lack precision in terms of the quantifiable change required for the instrument to be considered successful. Other issues include the fact that market based instruments can have multiple and often conflicting outcomes. Even when they are very successful at achieving one specific outcome, when the overall effect is taken into account, the result can be negligible or even contradictory to the desired objectives.

Market based instruments are also difficult to operate across jurisdictional borders, and across various levels of government. This is due to the fact that the rates of taxes and subsidies may need to be approved or adjusted by different levels of government.

More positively, compliance with market-based instruments is likely to be high given that these instruments act through the economic incentives facing businesses and users. However, avoidance or evasion can weaken their effectiveness. The complexity of the tax or subsidy arrangements is also an issue. If the arrangement is very complex, there will be stronger incentives not to comply. Effective monitoring by governments or regulators is therefore necessary to prevent abuse and manipulation of market-based schemes.

The key advantage of market-based instruments is that they reflect decisions made by the general public and businesses in response to the incentives they face. The decisions taken will reflect the preferences of the individuals involved, market-based schemes are therefore able to draw on information that is unlikely to be known by

governments and regulators. Market-based instruments are, therefore, generally very flexible instruments.

Consideration of compliance costs should take account of the costs borne by both the regulated entity and the government or regulator itself. The extent of these costs will depend on the type of economic instrument being used, and the distribution of these costs between the regulator and the regulated, which will differ widely between fiscal instruments (taxes and subsidies) and trading instruments. In the case of fiscal instruments, the regulated are likely to bear most of the cost, and will have little scope to reduce direct compliance costs. However, they will have some flexibility to change production processes or to take other steps to minimise the costs of compliance, providing the tax or subsidy rates involved are not changed frequently. In the case of trading mechanisms, the costs involved are likely to be more evenly distributed between the regulator and the regulated.

Suitability for Health Promotion

Incentives and market based instruments could be suitable to support the health promotion industry. Specifically grants and subsidies which might be used to encourage training of more health promotion professionals, and those that increase the consumption of health promotion services. As stated earlier there is an urgent need to shift to new models of healthcare delivery if our health system is to remain sustainable. Health Promotion represents the ideal type of health service to incentivise primarily for its cost effectiveness, and large scale community and population-level effects.

Four key opportunities for grants or subsidies to support health promotion workforce development include those that:

- 1) make health promotion education more attractive
- 2) stimulate employment in health promotion
- 3) establish quality management strategies in the industry
- 4) increase workforce retention

What is Deregulation?

A deregulated health professional workforce leaves market forces to select out providers who have the right price and quality mix of services to meet consumer needs. Providers support market forces by promoting themselves better and developing innovative product or service models to attract market share. Where unsatisfactory or unsafe health services occur, the community still has recourse to redress the professionals through general legislation, common law, and the private information market.

These include access to or support provided by;

- health complaints law and related conciliation services;
- advertising and unsafe goods/fair trading legislation, allowing prosecution of persons who falsely describe, misrepresent or promote goods or competence;

- consumer action through courts in relation to compensation for damages or injury suffered as a result of unsatisfactory services by a health professional;
- Consumer advocate groups and media systems targeting information and other power imbalances between consumers and health providers; and
- Health insurance schemes accrediting or otherwise certifying the competence of health providers.

There are however a number of factors that suggest that complete deregulation is not ideal in the current market system. Such factors include;

- unsatisfactory transactions with a health professional do not only place the consumer or employer at risk of direct economic loss but also at risk of causing injury, disability or even loss of life;
- consumer protection legislation may be unresponsive to emergency situations where action to prohibit unsafe practices requires confirmation through a judicial process;
- health complaints legislation relies on access to health professional regulatory systems to intercede in questions of health professional conduct and competence;
- the interests of the consumers, employers and health providers may not always be the same;
- providers with unsatisfactory skills may remain in the marketplace and target their services, in particular, towards disadvantaged groups;

Private Information Market

The Private Information Market uses education and persuasion to achieve the community's objectives. Strategies which attempt to address perceived problems by providing more information, or changing the distribution of information can improve market functioning by enabling people to make better informed decisions.

Examples of these instruments include: information and education campaigns, labelling requirements, or requirements to disclose information to the market (such as being required to display kilojoule content on fast foods). Labelling requirements also provide information to consumers. Practical examples of labelling campaigns include, for example, energy efficiency labels on electrical appliances of environmentally friendly products; and labelling of clothing to show that workers have not been exploited in its production.

This type of instrument is often characterised as being 'light-handed' because the degree of direct government involvement in decision making or directing behaviour is more limited than with other instruments. They do not directly impose legally binding rules on the behaviour of consumers or businesses. They may, however, impose quite stringent requirements on businesses to collect and disseminate information that they may not otherwise have chosen to disclose, and this may also impose compliance costs on the producer.

In terms of their effectiveness, information and education campaigns often address clearly specified objectives and can be well integrated with other regulations. However in many cases there is no attempt to monitor compliance with the

campaign nor to impose penalties or sanctions for non-compliance, because the objective is to provide information that should lead to a change in behaviour as consumers and businesses make better informed decisions. The benefits of this type of instrument will only be realised if the appropriate information is made available to those who need it. It is therefore necessary to ensure that these instruments are well targeted, which will also help to minimise costs.

Information and education approaches are very flexible instruments in the sense that they do not impose or require certain actions to achieve their objectives. But the flexibility to 'fine tune' them may be limited because of the time taken for them to influence people's behaviour. It may also be difficult to determine, when designing the instrument, how people will change their behaviour given the information provided. This means that these instruments may not be appropriate in circumstances where policy objectives or the policy environment are changing rapidly. Such instruments may lack the flexibility to be able to change behaviour quickly and precisely in changing circumstances.

Independent Credentialing

Independent Credentialing is the process by which a regulator or funder who has some control over a particular market recognises a particular profession, or practice, as eligible to operate in a particular market and in turn provides access to funding. Some examples of regulators or funders who provide independent credentialing include health insurers, workers compensation schemes and traffic accident schemes.

Most of these models are primarily geared towards individual fee-for-service models, which are not suitable for Health Promotion Officers, the only exception to this would be broader health cover legislation offered by some health insurers. This initiative provides insurers the opportunity to fund preventative, out-of-hospital or hospital substitute programs and services which health promotion officers could potentially seek independent credentialing to access.

In summary, deregulation manages the control of market quality by relying on a complex framework of non-specific and largely unresponsive legal and trading mechanisms which operate in disparate silos. In general deregulation is unlikely to provide sufficient protection for the community or employers.

Suitability for Health Promotion

We contend that although deregulation may have supported the health promotion industry to this point, it is unlikely to serve the industry well into the future. With the prospect of rapid growth, an increasingly competitive market environment, and quality and supply-chain controls, a fully deregulated market presents major risks to the sustainability and financial viability of the industry in the next 5- 10 years.

Although the effect of changes to general legislation, through employment awards, has been shown to have a profound effect on a deregulated health promotion workforce in QLD, most other jurisdictions have indicated they are not likely to consider such changes in the absence of consistent entry standards and a mandatory mechanism for ensuring ongoing competence (generally because of state based legislation that requires these criteria are met in all self regulating

professions). If this position was to change, deregulation would be a much more viable option.

Informant Interviews

Methodology

Participants

Based on the literature and environmental scan and after consultation with the AHPA Career Structure and Development Working Group, a sample of 51 recognised health promotion leaders, expert commentators, stakeholder representatives, and experts in workforce development were approached for interview or participation in focus groups (see full list in Appendix). They represented all the key stakeholder groups including AHPA members, the tertiary sector, professional and industry associations, Fair Work Australia and other key health reform agencies. Of the 51 people invited to participate, 1 did not reply to the invitation (on leave), none declined, 49 accepted and 42 were available to be interviewed in the available time period (a response rate of 82%).

Of those interviewed very few (<6) had experience in workforce development at an industry-level.

Focus

The focus of the consultation was to explore the perceived needs, objectives and potential solutions available to the health promotion industry to support a sustainable workforce. As the health promotion industry currently operates in a deregulated environment, the interviewees were challenged with the scenario of exploring a regulatory option. Stakeholders were asked to give feedback on the objectives and direction of the project, clarify the perceived benefits and risks of change, and contribute ideas and suggestions on the direction of the project.

Design

There were three approaches used in this consultation process;

1. Interviews with key stakeholders
2. Interviews of comparable professional associations
3. Focus groups

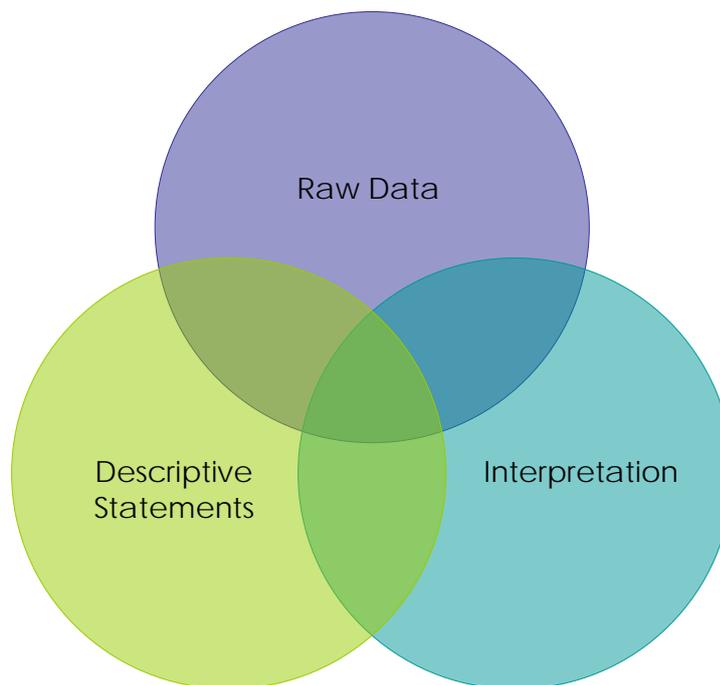
In the stakeholder and professional association interviews the questions posed were tailored to the interviewees on the basis of their capacity to answer (for example, those without detailed knowledge of regulation were not asked about the mechanisms of other regulatory options).

The interviews were conducted from late December 2011 to late February 2012 and the results were subjected to a 'framework analysis' approach following Krueger's

(1994)^{37,38} method, which draws heavily on the framework analysis procedure first described by Ritchie and Spencer (1994).³⁹ See Figure 2.

Framework analysis can be thought of as a continuum of analysis ranging from the mere accumulation of raw data to the interpretation of data, although it is not a linear process, and each step overlaps the next:

Figure 2



The five key stages outlined by Krueger are familiarisation; identifying a thematic framework; indexing; charting; and mapping and interpretation. The other distinctive aspect of framework analysis is that, although it uses a thematic approach, it allows themes to develop both from the research questions and from the narratives of participants. Qualitative research generates large amounts of data, and it is

³⁷ Krueger RA (1994) Focus Groups: A Practical Guide for Applied Research. Thousand Oaks, CA: Sage Publications

³⁸ Krueger RA & Casey MA (2000) Focus Groups: A Practical Guide for Applied Research, 3rd ed. Thousand Oaks, CA: Sage Publications.

³⁹ Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In Bryman A, Burgess RG (eds). Analysing Qualitative Research. London: Routledge, 1994: 173–194.

important that the purpose of the study drives the analysis. At the same time, it is important to capture emerging themes from interviews that will further inform the project.

The findings documented in the following section of this report are the result of a thematic analysis of the views of the respondents, not of the consultant. These findings have been synthesised with the findings from the literature scan and environmental context to provide advice to AHPA on the future directions of the project and its role in supporting the sustainability of the health promotion workforce.

Interviews with Key Stakeholders

In a semi-structured interview the interviewer provided background information, tables including a summary of the key benefits and costs of regulation, and the draft objectives for the project in an invitation letter. The interviewer then used information from the literature scan and the background information provided to prompt discussion, clarify aspects of the draft objectives the interviewee had direct knowledge of, and seek more detailed reflection. The eight areas for discussion were these:

1. Do you agree with the draft objectives for the project?
2. Do you believe that the potential benefits of regulation are adequately summarised in (Table 3)?
3. Do you believe that the potential costs of regulation are adequately summarised in (Table 4)?
4. How would regulation affect you in your current role?
5. Do you believe the benefits of regulation in the health promotion Industry are likely to outweigh the costs?
6. If the industry decides to go ahead with regulation, what do you believe would need to happen to make this work? What are the key success factors?
7. What are the key risks and issues the project should look out for?
8. Do you have any other comments or suggestions to inform the project?

Results

Do you agree with the draft objectives for the project?

In general, respondents were in agreement with the draft objectives of the project.

Those respondents who worked as a health promotion practitioner rated the importance of those objectives related to employers, funding, and workforce development as least important, and the objective related to increasing salaries of health promotion professionals as most important. They also challenged the scope of the project as potentially too broad, i.e. regulation of industry vs. focussing on the professional practice of health promotion. Others felt strongly that the focus may be

too narrow and that the objectives did not adequately capture the importance of strategies such as organisational development, resource requirements and leadership which were felt to be critical.

Employer representatives generally believed that the objectives related to reducing employer costs and improving productivity were most important.

The tertiary sector representatives were probably the strongest advocates for change, and were in general agreement with the objectives. They spoke of the importance of conducting a workforce study, and cautioned against the use of a 'competency based' approach, if an accreditation or certification scheme is to be introduced in future.

AHPA branch council members spoke primarily of concerns relating to the limited availability of funding and resources to support implementation.

Those in early career stages said they were strongly supportive of the objectives, and of going even further proposing that AHPA focus on attracting more students into health promotion courses, improve graduate pathways for career advancement, establish greater recognition of the health promotion industry, and seek recognition of health professional in employment awards.

Senior practitioners cautioned against the potential narrowing of the definition of the health promotion discipline, and although supportive of the rationale, favoured the more inclusive approaches. There was some resistance to the use of the word regulation. There were some reservations as to AHPA's capacity to regulate the 'industry' vs. its ability to regulate the membership, however others felt this view was based on past paradigms rather than future or aspirational ones. There was a strong consensus that the reference to 'make health promotion everyone's business' should be removed from the objectives as there was a sense that this statement had been a contributing factor to the poor delineation and lack of appreciation of the health promotion discipline.

Representatives from key reform agencies were in support of the objectives and emphasised the importance of the intersections and relationships with other bodies of work being undertaken. The ANPHA reinforced the strong relationship of this project with their strategic plan as well as a number of other projects underway, such as a workforce audit of the health promotion industry.

A respondent with significant experience in workforce development highlighted that regulation can be very effective in some situations, but not in others. This respondent suggested that a more tailored approach may be more likely to be effective, rather than a 'one size fits all' approach.

Do you believe that the potential benefits of regulation are adequately summarised in Table 3?

Due to the small number of stakeholders with a deep understanding of regulation, there were very few substantive amendments to this table.

Tertiary sector representatives felt that the benefits were well captured. They also raised a potential benefit as reducing potential costs and wastage in the

development of, and participation in, substandard courses and training which are not aligned with broader industry and government objectives.

Do you believe that the potential costs of regulation are adequately summarised in Table 4?

Due to the lack of stakeholders with a deep understanding of regulation, there were no substantive amendments suggested to this table.

How would regulation affect you in your current role?

Early career professionals felt it would improve role definition, career opportunities, salary levels and retention in the workforce.

Senior professionals felt it probably wouldn't impact on their role much, but were 'cautiously optimistic' about the implementation of any regulations. The main reason for caution was the perception that some regulatory models can be exclusionary in nature, particularly if the standards might exclude them.

Tertiary sector representatives felt that it might increase student numbers, create internal levers for funding and resource allocation in their courses, and improve graduate outcomes. They also noted benefits including branding, and identity. However they also felt the proposed objectives might increase costs and demands on universities. Nevertheless they felt these impacts would be worthwhile. All of the tertiary representatives were supportive of universities contributing some funds towards the cause if required. One representative suggested clarity in the definition of the terms *occupation*, *discipline* and *profession*.

Do you believe the benefits of regulation in the health promotion Industry are likely to outweigh the costs?

All respondents felt that the benefits were likely to outweigh the costs. Many respondents were aware and accepting of the fact that some sacrifices may need to be made in the best interests of the industry as a whole. There was an appreciation of the fact that no model is perfect. Respondents seemed to have a good understanding that the purpose of this project was to find the option that was the most effective, efficient and appropriate to the health promotion workforce.

If the industry decides to go ahead with regulation, what do you believe would need to happen to make this work? What are the key success factors?

Tertiary sector representatives felt the objectives must to be clear, adequate time for consultation, a focus on attracting funding, and the importance of maintaining regular communication with members.

There was some support in senior professionals for aligning the profession more closely with the preventive health movement, even suggesting the title of the profession be 'Prevention Specialists' or 'Prevention Managers', however others felt strongly that the title should be 'health promotion specialist, officer or practitioner' as it has a broader remit to also promote wellness and resilience. There was a suggestion that management and leadership skills were lacking in senior ranks and that there may be some value in integrating management or leadership skills into

the advanced certification level (maybe even calling them 'Health Promotion Managers', or 'Health Promotion Leaders').

Respondents who worked in health promotion felt there was a need for more consistency in employment awards, job titles, salary scales and employment conditions.

ANPHA suggested that the legislation underpinning their creation may be a useful tool to support these objectives, however they hadn't yet explored how this might work.

What are the key risks and issues the project should look out for?

Tertiary sector respondents felt the major risk was not achieving widespread support and consensus for change.

Senior professionals felt that the major risk was disenfranchising segments of the current AHPA membership. They felt it was very important to ensure the membership were kept well informed and given the opportunity to contribute.

AHPA branch council members were most concerned about aspects such as the financial and resource capacity of AHPA to implement the proposed reforms.

Do you have any other comments or suggestions to inform the project?

The tertiary sector reinforced the importance of the model being flexible and not too restrictive. They also suggested looking at other examples of self regulatory models such as social work and occupational therapy.

Interviews of comparable associations

The five comparable professions identified for this initial consultation were;

- 1) The Public Health Association of Australia (PHAA)
- 2) Exercise and Sport Science Australia (ESSA)
- 3) Environmental Health Australia (EHA)
- 4) Dietitians Association of Australia (DAA)
- 5) Australian College of Social Work (ACSW)

PHAA was the only association that was unable to be interviewed within the timeframes. However PHAA and other associations will be captured in later consultation processes.

Interviews

In a semi-structured interview the interviewer provided background information, tables including a summary of the key benefits and costs of regulation, and the draft objectives for the project in an invitation letter. The interviewer then used information from the literature scan and the background information provided to prompt discussion, clarify aspects of the draft objectives the interviewee had direct

knowledge of, and seek more detailed reflection. The six areas for discussion were these:

- 1) What year did your association introduce self-regulation?
- 2) In your opinion, did the benefits of self-regulation outweigh the costs?
- 3) What have been the key benefits to your industry?
- 4) What were the problems or sacrifices your organisation experienced?
- 5) Roughly what costs/s did you incur in introducing self-regulation?
- 6) What ongoing costs and resources are experienced to maintain your self-regulatory measures?

Results

What year did your association introduce self-regulation?

ESSA: early 1990s introduced individual certification, a national university accreditation program was introduced in 2005, a revision of the individual certification standards for Accredited Exercise Physiologists was implemented in 2008.

DAA: 1970s. 1980 introduced university course accreditation, 1994 introduced the Accredited Practicing Dietitian standards.

EHA: has been accrediting university programs for > 20 years. Regulation was driven largely by employers who requested the industry set standards and regulate. EHA has quite a prescriptive regulatory model. EHA has applied for National Registration.

ACSW: accredits all 26 universities that provide social work courses. Social workers are Medicare registered. ACSW has a comprehensive self regulatory model with robust complaints handling and disciplinary review processes. ACSW has applied for National Registration.

In your opinion, did the benefits of self-regulation outweigh the costs?

ESSA: Absolutely

DAA: Yes. However requires continuous promotion and support.

EHA: Yes.

ACSW: No. The current self-regulatory framework means that the association is a bit of a 'toothless tiger'. Since the emphasis of the ACSW model is on complaints handling, not having a legislative operating environment limits the associations powers to act (hence why applying for registration). Also ACSW feels they can't currently get good workforce data.

What have been the key benefits to your industry?

ESSA: Increase in Accredited Exercise Physiology (AEP) members from 250 to 2800 in 5 years. Total membership has grown from 650 to 3400. Previously 20% of members were certified as AEPs, has now grown to 80%. Other benefits include credibility,

recognition, policy and advocacy engagement, has increased the quality of tertiary courses, improved brand. Consumers do not perceive they pay extra for regulated services. Model has proven to be a flexible and responsive workforce development strategy.

DAA: Funding for practitioners (i.e. Medicare, DVA, PHI recognition). Significant increases in membership (current growth 8% per year). Total impact is an increase of approx. 2000 members. The number of tertiary courses offering Dietetics has doubled. Also has provided significant credibility and recognition, and the ability to engage in policy and advocacy activities.

EHA: Key benefits have been benefits to the community with respect to the expectation of competence, improved profession controls and levers.

ACSW: Increased membership, although market share is only ~40% (market size 20,000, membership 6,500). Has been important in recognition and credibility.

What were the problems or sacrifices your organisation has experienced?

ESSA: Administrative burden, growth pains, structural inefficiencies, long periods to assess applications. Universities have complained about the complexity of uni accreditation process, significant cost to implement and maintain, ongoing resources required.

DAA: Primary problem was cost. Uni accreditation is self-funding (by universities), any additional costs absorbed through membership fees. The assessment of overseas applications are also based on a cost recovery model.

EHA: Reduced membership. In their experience governance issues limited their inability to realise membership and industry benefits (in particular not having the appropriate skills mix on the board and branches was seen to limit potential. EHA may have benefited from enhanced business and commercial acumen and marketing skills). EHA have also experienced difficulties with managing inconsistent legislation and standards in each state.

ACSW: Being overwhelmed with managing regulatory requirements. Inability to regulate character, recency of practice, or scope of practice without a legislative framework. Very costly to implement, increased the risk profile to the board (legal implications). A declined member sued the College for natural justice at significant expense to the College.

Roughly what costs/s did you incur in introducing self-regulation?

ESSA: Received an Australian Learning and Teaching Council (ALTC) grant of ~\$500,000 over 5 years supported the research, consultation and implementation of their regulatory model. Universities provided 'in-kind' support by essentially lending academics to support the project. Indirect costs hard to estimate.

DAA: In 1992 DAA was provided \$150,000 by NT and VIC governments to move from registered to self regulated model (as Dietetics was not considered 'dangerous enough' for registration).

EHA: Unsure. Government funded.

What ongoing costs and resources are experienced to maintain your self-regulatory measures?

ESSA: 1 research assistant for 2 days pw, 1 university accreditation manager (all resources are recovered through uni accreditation fees and membership fees). Course accreditation costs universities \$22,000 for one course, two or more increases cost efficiencies therefore ~\$1200 per additional course (5 year accreditation). Membership fees are \$550 (ex GST).

DAA: Full time accreditation manager and F/T registrar. F/T APD manager, F/T APD registrar, and 0.5FTE professional services manager. Uni accreditation fees are \$25,000 for full accreditation for 5 years (+ \$5000 fee for late paperwork). There are 17 accredited courses. APD membership fee is \$590 (ex GST). As a result of the trade practices act it is not a requirement to be a member of a professional association to seek accreditation/ certification, however the DAA charge the same fee as the membership fee for non-members to be individually accredited.

EHA: 0.2FTE of the EO, volunteers do the rest. The EHA funds an annual national meeting of course providers and the costs related to the ongoing review of the accreditation model. Uni accreditation fees are \$10K, 12 accredited universities (accreditation is for 5 years).

ACSW: 4-5 professional officers directly involved in regulatory management and oversight. Recouped through membership and accreditation fees. They pay nominal fees for volunteers on accreditation panels.

What might be important for the health promotion industry to consider if they decide to consider self regulation?

ESSA: Marketing, promotion and strong relationships with universities.

DAA: Clarity in the definition of the profession is very important. Safety is more important in clinical professions, but possibly not as important in health promotion. DAA questioned need for comprehensive self-regulation in health promotion, recommended less intensive approaches. A submission is being prepared by the Association of Self Regulating professions to government (Note: may be an opportunity to be involved?). DAA advised that several professions that were accepted into the national registration scheme (Physio, osteo, and psych) are now trying to get out in favour of a more flexible self-regulatory model.

EHA: Has the potential to limit the size of the market if not implemented carefully. Needs to be flexible and not too prescriptive. Good governance is important.

ACSW: Must undertake a cost benefit analysis.

Focus groups

Participants

A total of two focus groups were held with stakeholders from the following locations:

- 1) Adelaide, South Australia
- 2) Perth, Western Australia

Forums were typically 2-3 hours in length and were recruited by an email sent from the AHPA branches to key stakeholder and member representatives.

Approach

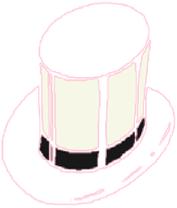
The approach used for the forums was based on De Bono's six thinking hats⁴⁰. The premise of the method is that the human brain thinks in a number of distinct ways which can be identified, deliberately accessed, and planned for use in a structured way allowing one to think more clearly about particular issues⁴¹. De Bono identifies six distinct modes in which the brain can be "sensitised". In each of these modes the brain will identify and bring into conscious thought certain aspects of issues being considered (e.g. gut instinct, pessimistic judgment, neutral facts). Coloured hats are used as metaphors for each mode. Switching to a mode is symbolised by the act of putting on a coloured hat, either literally or metaphorically. These metaphors allow for a more complete and elaborate segregation of the thinking modes.

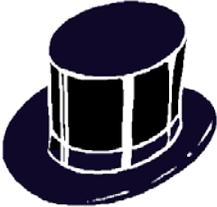
A semi-structured group discussion was conducted using De Bono's six thinking hats. Prior to the discussion the interviewer provided background information, and in one case a researcher also provided a presentation, as well as tables including a summary of the key benefits and costs of regulation, and the draft objectives for the project which were provided in an invitation letter approximately one week in advance of the meeting. The interviewer then used information from the literature scan and the background information provided to prompt discussion, clarify aspects of the draft objectives the interviewee had direct knowledge of, and seek more detailed reflection. The discussion areas and responses are outlined in the table below:

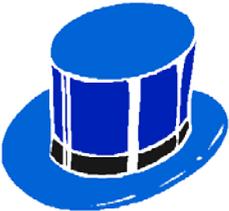
⁴⁰ De Bono, Edward (1985). *Six Thinking Hats: An Essential Approach to Business Management*. Little, Brown, & Company. [ISBN 0316177911](https://www.amazon.com/Six-Thinking-Hats-Edward-De-Bono/dp/0316177911)

⁴¹De Bono's six Thinking hats. Wikipedia http://en.wikipedia.org/wiki/De_Bono_Hats

Table 5: Focus Group Responses (Six Hats)

Coloured Hat	Detailed Description	Responses
<p>WHITE</p> 	<p>Represents neutral and objective thinking</p> <ul style="list-style-type: none"> • Facts and figures • What do we know? • What do we need to know? • How will this information be obtained? 	<ul style="list-style-type: none"> • Background information included info on regulation, benefits and costs, draft objectives of the project, and objectives for the project. • We need a more detailed profile of the health promotion workforce, including how many students are studying HP degrees. • Regional and rural areas need alternative pathways to enter the profession, other than tertiary training. We need to be able to develop the HP workforce from within the current workforce. • Many health promotion positions are being filled by non-qualified professionals • Many health promotion professionals perform multiple/ dual roles (i.e. HP + nurse or youth worker etc) • The part time workforce is growing • Funding constraints and short term contracts are putting more downward pressure on the attractiveness of health promotion careers. • There is currently enormous variation in the quality and content of health promotion degrees.
<p>RED</p> 	<p>Represents feelings and emotions.</p> <ul style="list-style-type: none"> • Non-rational aspects of thinking. • No need to give reasons or justify. • What is my gut feeling? 	<ul style="list-style-type: none"> • The general feeling within the groups was one of 'cautious optimism'. • On one hand the groups were excited by the prospect to improve the professionalism of the health promotion discipline, improve recognition, career opportunities, and also to leave a legacy for the young ones. On the other hand there was also some hesitancy and reservation at the risk of excluding or disenfranchising segments of the industry. • One specific segment which stakeholders were concerned about was

	<ul style="list-style-type: none"> • What does my intuition say? 	<p>Aboriginal Health Workers, who also perform a dual health promotion role. Need to consider how to nurture and protect this workforce.</p> <ul style="list-style-type: none"> • Despite the reservations described, there was an acceptance that the risk of not changing may have dire consequences.
<p>BLACK</p> 	<p>Represents the logical negative response.</p> <ul style="list-style-type: none"> • Negative, but not emotional. • Critical judgements/ pessimistic. • What are the difficulties? • What are the weaknesses? 	<ul style="list-style-type: none"> • Concerns about the definition of the health promotion workforce. Who will this be targeting? • Equity and inclusivity are fundamental beliefs of health promotion; will these plans compromise these values? • Are the objectives too individually focussed? • Not sure how the model fits with the PHAA? • Need to start by defining clear outcomes, and then work backwards. • Regulation alone won't assist AHPA with marketing, strategy, operations, funding. There is much more to it than just implementing a regulatory model.
<p>YELLOW</p> 	<p>Represents the positive view.</p> <ul style="list-style-type: none"> • The best possible scenario. • Bright, optimistic and positive views. • Ways to make things happen. • What are the strengths? • What are the opportunities? 	<ul style="list-style-type: none"> • The groups were overwhelmingly positive about the project. • May assist with the establishment of clearer career pathways • May raise the profile of the industry • A number of other professions have experienced great success with self regulation • AHPA and universities need to start talking to high school students about the health promotion career choice. • Strategic alliances may support the implementation process

<p>GREEN</p> 	<p>Represents new ideas, new concepts and new perceptions.</p> <ul style="list-style-type: none"> • Creation of new ideas. • New approaches to problems. • Humour, lateral thinking, creativity • Are there new opportunities? • Are there alternatives? 	<ul style="list-style-type: none"> • Another approach could be to embed health promotion across all other discipline tertiary courses.
<p>BLUE</p> 	<p>Represents thinking about thinking.</p> <ul style="list-style-type: none"> • Defining the problem. • Organisation, control and regulation. • Asking the right questions. • Observing and giving overviews. • Summaries and conclusions. 	<ul style="list-style-type: none"> • Very positive about plans to professionalise health promotion • The only hesitation is regarding the potential to be too restrictive or exclusive, prefer a more inclusive and flexible approach. • There is already momentum in several states to regulate the health promotion profession. AHPA should take a leadership role; otherwise others will do it for us. • This next step for the industry is desperately needed, but must craft the best way forward. • Need to use a staged approach to implementation and bring members along.

Summary of Informant Interviews

Key themes from the informant interviews:

- Health promotion needs to explore options to 'professionalise' the industry using a flexible and inclusive approach.
- There is a need to enhance credibility and confidence of health promotion services in the market.
- There is a need to improve the consistency and availability of pre and post vocational training for health promotion professionals.
- It is important to define the health promotion industry. What segments will be affected and how? And what support will be provided to those that are excluded?
- The objectives of the project need to be broadened to encompass more than just a plan for regulation, but also a plan for organisational development, partnerships, and leadership initiatives within AHPA.
- There is a need for a workforce study to be conducted on the health promotion industry to define current and project future needs.
- Some stakeholders are concerned that AHPA may lack the current financial and human resource capacity to lead such an initiative. A focus on securing this capacity will be a critical success factor.
- There was a suggestion that management and leadership skills were lacking in senior ranks and that there may be some value in integrating management or leadership skills into the advanced certification level (maybe even calling them 'Health Promotion Managers', or 'Health Promotion Leaders').
- Strategic partnerships will be critical. ANPHA and PHAA are two key partnerships that should be explored.
- Stakeholders overwhelmingly believed that the benefits of implementing an enhanced regulatory model would outweigh the costs, but accepted that some sacrifices may need to be made in the best interests of the industry as a whole.
- Respondents feel that AHPA should be playing a more active role in making health promotion a more attractive career choice.
- The implementation process for this project should be characterised by good communication to members, adequate time for consultation, and managing risks along the way.
- Other professional group consulted received unqualified grants to establish their regulatory frameworks of between \$200-\$500K (in today's dollar terms).

- The recurrent operational costs of maintaining self-regulatory frameworks in other comparable associations ranged from ~\$150-\$350K per annum, which was typically recouped in a cost recovery model through accreditation and membership fees.
- Most other professional groups interviewed experienced significant benefits from introducing self-regulation. The one respondent that didn't feel they may have benefited from improved business and commercial acumen on their governing councils to realise benefits.
- The key success factor for other professional groups was the clear link between the need to introduce regulation, and the ability to attract direct funding or improved salaries for their members.
- Although there is a sense of hesitation in the prospect of change, there is general acceptance that the risk of not changing is greater.
- There is general support for AHPA playing a more prominent leadership role in creating a sustainable health promotion workforce, as long as it can demonstrate its capability to do so.

A Proposed Plan of Action

The following table provides an outline of the key goals and actions AHPA will be required to progress in order to develop and implement a model.

Table 6: A Proposed Plan of Action

AHPA Industry Development Objective	Plan of Action
<i>Primary objective:</i>	
1. To enhance the quality and effectiveness of health promotion service delivery by implementing improved standards and quality controls.	1. Promote evidence informed practice
	2. Establish requirements for entry to the profession
	3. Establish standards for maintaining currency of knowledge throughout the career journey
	4. Consider establishing enforceable standards for ethical conduct and acceptable behaviour
	5. Make criteria available to employers for the recruitment of health promotion professionals
	6. Make criteria available to employers to assist with performance management & career advancement
<i>Secondary objectives:</i>	
1. To enhance supply chain management to meet the growing demand for the Health Promotion workforce	1. Improve the attraction of prospective students to health promotion education
	2. Enhance the capacity of universities to increase health promotion places (e.g. support universities to secure commonwealth supported places in health promotion courses)
	3. Establish more pathways for entry into the profession i.e. more post grad bridging courses to attract health and other related professionals,
	4. Explore options for expanding the VET level workforce by identifying career ⁵⁴

	<p>outcomes, establishing a competency framework, and promoting employment opportunities</p>
	<p>5. Enhance the conversion of eligible graduates to employment in the sector</p>
	<p>6. Contribute to improving the retention of health promotion professionals within the workforce (i.e. Improve graduate pathways for career advancement)</p>
	<p>7. Create incentives to attract qualified professionals from comparable countries (Canada, UK, USA, Europe) i.e. streamline recognition processes, advertise jobs internationally, create immigration incentives</p>
	<p>8. Ensure supply chain mechanisms are flexible and responsive (i.e. Data to monitor trends, ability to influence the different inputs)</p>
<p>2. To improve the relative employment conditions and wages for Health Promotion Professionals to be a more competitive career choice.</p>	<p>1. Lobby for health promotion to be included in Health Practitioner employment awards</p>
	<p>2. Align or exceed wages and conditions for Health Promotion Officers with other comparable allied health professions</p>
	<p>3. Market and promote health promotion as a career of choice</p>
<p>3. To secure the resources and financing required to maintain a sustainable workforce</p>	<p>1. Undertake financial modelling to establish budget scenarios, cash flow projections and funding requirements</p>
	<p>2. Establish a business case for investment to potential funders</p>
	<p>3. Establish an industry development strategy with clear governance roles and responsibilities</p>
	<p>4. Develop an operational plan</p>
	<p>5. Identify opportunities to enhance</p>

	current revenue sources (membership, PD, sponsorship etc)
4. To demonstrate leadership of the health promotion industry as a whole.	1. Refocus leadership in AHPA away from only the board, branches and committees to leading initiatives that support the career journey of health promotion professionals
	2. Foster and support the development of leadership skills within AHPA
	3. Provide support for AHPA officers and leaders to develop the level of business acumen necessary to meet growing operational and fiduciary responsibilities
	4. Establish more collaborative working relationships with training providers, employers, and key health reform agencies
	5. Foster a culture of innovation, creativity and change (create innovation teams, reward innovative behaviour, systematically manage ideas from all stakeholders)
	6. Facilitate the widespread uptake of health promoting approaches in all professions and settings
	7. Develop a brand strategy

Recommended Regulatory Options for AHPA

Determining the best regulatory options

To determine the best regulatory options to support the achievement of AHPA's industry development objectives, a simple matrix was used (see Table 7 below).

- The five key regulatory options are presented along the top row of Table 7
- AHPA's industry development objectives are shown along the left hand column.
- A simple 'Y' for Yes, and 'M' for Maybe are used to indicate whether the regulatory options would achieve each respective objective. There is no entry if the answer is no.
- Two points have been awarded to a 'Yes', one point for 'Maybe' and no points for 'No', a tally of the scores is shown at the base of the table. Higher scores indicate a higher likelihood that the model would achieve the stated objectives.
- A process to 'weight' the objectives was also explored. A survey was conducted whereby the AHPA board was asked to rate the objectives from most important to least important, however even after these weightings were applied to the table; the outcome did not change, and so for simplicity, weightings have been removed.

The regulatory models being compared in this review include:

1. Registration

- a. Protection of title (Title)
- b. Protection of practice (Pract)

2. Self Regulation

- a. Certification (Cert)
- b. Accreditation (Accred)
- c. Licensure (Licen)
- d. Continuing professional development (CPD)

3. Negative Licensing

- a. No entry requirement (No ent.)
- b. Sanctions (Sanc)

4. Incentives and Market Based Instruments

- a. Economic incentives (Eco)
- b. Trading schemes (Trad)
- c. Fiscal measures (Fisc)

5. Deregulation

- a. Market forces (Mark)
- b. General legislation and common law (Gen)
- c. Private information market (Priv)
- d. Independent credentialing (Ind)

See over page

Table 7: Comparing the effect of regulatory models

Model/ Objective	Registration		Self Regulation				Negative Lic.		Incentives & Market			Deregulation						
	Title	Prac	Cert	Accred	Licen	CPD	Noent	Sanc	Eco	Trad	Fisc	Mark	Gen	Priv	Ind			
Promote evidence informed practice	N/A	N/A	Y	Y	N/A	Y				N/A			M		M			
Create entry standards to the profession			Y	Y								Y						M
Maintain currency of knowledge			M	M					Y			M				M		M
Ethical conduct & behaviour standards			Y						M			Y				Y		
Attract students to HP education			Y	Y									Y	Y		Y		Y
Increase HP uni places													Y	Y				
Create more pathways to entry (dual qual)			Y	Y					Y		Y					Y		
Define and expand the VET level workforce													Y					
Convert more HP grads to employment			Y	Y									Y			Y		Y
Improve retention			Y	M					Y				Y			M		M
Attract qualified international HPPs			Y						Y		Y		Y			M		M
Ensure supply chain is flexible + responsive			Y	Y					Y		Y					M		
Establish HP within employment awards			Y	Y					Y							Y		
Align/ exceed wages with AHPs			M	M				N/A	M					N/A		Y		
Market HP as a career of choice															Y		Y	
Undertake financial modelling																		
Establish a business case for investment																		
Establish roles and responsibilities																		
Develop an operational plan																		
Enhance current revenue sources																		
Lead initiatives on the HP career journey																		
Foster leadership skills development																		
Ensure business acumen and skills on board																		
Strengthen collaboration with stakeholders																		
Foster a culture of innovation																		
Facilitate HP in all professions & settings																		
Develop a brand strategy																		
Total Score			22	17		16	6	3	12		4	2	19	2	9			

The objectives which have not been addressed by the regulatory models above will be addressed through the organisational and operational mechanisms to be reviewed in deliverable 2. They are:

1. Leadership
2. Strategy
3. Governance
4. Operations &
5. Funding

From the assessment conducted in Table 7, the five best performing options were:

1. Certification (22 points)
2. General legislation and common law (19 points)
3. Accreditation (17 points)
4. CPD (16 points) and
5. Economic incentives (12 points)

Also note that the AHPA's current form of regulation (a deregulated model based on market forces), scored only 2 points, which certainly supports the need for change. However, a deregulated model may still be a viable option if general legislation and common law strategies can be implemented such as the inclusion of health promotion in health professional employment awards, although this is only likely to be possible with some sort of minimum standards for entry (i.e. certification or accreditation).

These five discrete models are not entirely mutually exclusive and can in fact be implemented in various combinations with each other to strengthen their effect. For example, certification could be combined with general legislation and common law (which would achieve 23 points); adding CPD would increase the score further (to 25 points); and using economic incentives would increase the effect again (27 points).

Below three recommended options have been outlined, and include a detailed analysis of how and why they would work to support AHPA's objectives.

Option 1: Certification

This option proposes to improve the sustainability of the health promotion workforce by introducing the following workforce development strategies:

1. Certification
2. General legislation and common law
3. Continuing Professional Development and
4. Economic incentives

What would this involve?

1. *Certification* – A certification program is an individual, voluntary, time-limited issuing of a credential after meeting predetermined criteria; it is essentially a process to assess individuals for entry to the profession and to recognise career progression. A certification could be introduced by developing more specific membership criteria or new types of membership, or by developing an independent certification program.

To ensure the model is inclusive and relevant to the broader health promotion workforce (while at the same time maintaining the integrity of, and incentive to undertake education in health promotion), the certification program could have multiple tiers. For example:

Certification Level 1 (e.g. Certified Health Promotion Officer -CHPO)

Certification Level 2 (for non-specialised health promotion professionals)

Level 3: Health Promotion Advocate (HPA)

Level one could be targeted at those with a relevant degree and/or experience in health promotion.

Level two could target other health professionals and/or the VET and non-tertiary qualified segment of the market, and be used either as a transition to further study, or as a pathway to less specialised career outcomes.

Level three be targeted at the broader workforce who would not normally identify themselves as part of health promotion workforce.

Examples of certification programs include the Chartered Practising Accountants Certification, Chartered Secretaries Certification, Accredited Practising Dietitian and Accredited Exercise Physiologist (although the latter two are also supported by university course accreditation programs). Both the APD and AEP certifications are part of multi-tiered certification models which also include nutritionists and exercise scientists, respectively. It is recommended that certification initially relies on a qualifications-based approach to assessing eligibility, as opposed to a more prescriptive standards or competency based approach.

2. *General legislation and common law* – The primary strategy here would be to seek recognition of Certified Health Promotion Officers in the Health Professionals and Support Services Award 2010, and more specifically being included in the list of ‘Common Health Professions’ in Schedule C. Integral to this strategy would be to ensure that this amendment in the national award flows onto all other related state awards. However, other legislative strategies might be possible through the Health Workforce Act 2009, the Health Practitioner Regulation National Law Act 2009, or the Australian National Preventive Health Agency Act 2010, although further investigation would need to be undertaken determine how these pieces of legislation could be used.
3. *Continuing professional development* –This involves introducing a mandatory continuing professional development process required to maintain certification. Each member wishing to maintain certification would be required to make a submission for re-certification (on an annual or biannual basis) by providing evidence that they have maintained their currency of knowledge and practice against key criteria. Criteria might include participation in ongoing professional development, requirements to keep up to date with research, or engaging in industry development activities. To minimise the administrative burden (and cost) to the association of assessing every individual CPD submission on an annual or biannual basis, a random annual audit of 5% of submissions is considered to be an accepted industry practice.
4. *Economic incentives* – A number of economic incentives could be provided to enhance the sustainability of the health promotion workforce. Some of these might include:
 - a. A direct grant to AHPA to support the development of sustainable workforce initiatives in the health promotion workforce. Such a grant might be supported by ANPHA, or alternatively DoHA or HWA.
 - b. Adjusting health promotion wages and conditions to align with or exceed other allied health disciplines through the employment awards. The cost of this would be borne by employers, although would be negligible.
 - c. Providing grants or funding to stimulate jobs in the health promotion and preventive health workforce such as the Healthy Children’s Initiative, the Health Promotion in Local Government initiative in VIC, as well as the VIC WorkHealth program. To improve the quality and sustainability of the workforce, the grants should specify minimum standards for employment, such as ‘*must be eligible to be certified as a Health Promotion Officer or Practitioner with the Australian Health Promotion Association*’.
 - d. DEEWR funding for health promotion places, which should be equivalent to that of other health disciplines to increase the capacity of universities to increase student numbers.

Note: In this option 'certification' could be substituted with a university accreditation program (as outlined in option 2), however the preference is to use a certification model due to the increased flexibility and control it provides during a period of change in the market. Certification can also be introduced much faster than course accreditation. An accreditation program could be added once the market stabilises.

Target Workforce

The intent of Option 1 is to be inclusive of the entire health promotion workforce. This approach is the best available option for defining and growing the segments of the workforce who do not have specialist health promotion qualifications or experience.

This approach would act to 'professionalise' one or more segments of the market. It would not restrict membership of AHPA for people outside of these segments, nor would it limit AHPA's ability to develop new professional or non-professional segments of the market (e.g. health promotion researchers).

Advantages of Option 1:

- It is inclusive of all segments of the market.
- It would improve the definition of the relevant health promotion workforces which would enhance marketability, credibility and confidence in the market.
- Only modest capital investment is required to establish the model.
- Ongoing administration costs are shared fairly between the parties who have the greatest vested interests in the transaction i.e. Health Promotion Practitioners, AHPA and employers.
- It provides the flexibility to easily adapt to a competency-based approach in future or to add a university course accreditation when it is desired.
- It is mutually beneficial for AHPA, the HP workforce and employers. Tertiary providers would also benefit greatly although they would not bear the cost.
- Certification provides greater control to the association, but also inherently requires a greater responsibility to create, monitor and manage the standards.
- Will encourage a shift to more cost effective models of healthcare delivery.
- This model could increase student demand for health promotion tertiary programs, and if the criteria provided for it, also establish a new market for alternative entry pathways such as post graduate short courses (including certificates and diplomas), double degrees, and CPD courses.
- This model would provide assurance to consumers and employers that minimum competence and quality standards are being met and maintained.
- It has the potential to dramatically grow the size of the competent workforce (with an order of magnitude between 2 and 10 within 5 years), therefore increasing the size of the available market to employers and customers.
- A qualifications-based approach to certification is less prescriptive than a standards or competency based approach therefore requires reduced resourcing and cost to administer.

- The alignment of the 'Health Promotion Officer' segment with health professional employment awards would provide a clear link between the need to introduce regulation, and the ability to provide a direct financial benefit to practitioners.
- This model would increase the potential size of the membership market for AHPA.

Disadvantages of this option

- Some of the cost of this approach will be borne by those who are most price sensitive, i.e. individual members (however this might be mitigated if they receive an increase in their pay and conditions) and AHPA (who may need to leverage new revenue opportunities from these changes).
- This option will not provide branding and marketing opportunities for universities as compared with a course accreditation program.
- Employers will experience slightly higher wage costs due to award increases. However, significant cost savings could be expected from shifting to less expensive models of care.
- A certification-based approach administered by the association does not provide a direct influence over tertiary program content, structure or delivery (as compared to a course accreditation program).
- A significant proportion of applications for certification would need to be assessed by AHPA on an individual case by case basis.
- AHPA may find that after investing in the development required to support this approach, external regulators do not support it.

Enablers

- A commitment from key potential funding bodies such as the ANPHA to provide a grant and ongoing strategic support to develop the sustainability of the health promotion workforce.
- AHPA should seek an amendment to the *Health Professional and Support Worker National Award 2010* to include Health Promotion within the 'list of common professions' in Schedule C. It is likely that all state awards would then follow.
- Engagement and support of the relevant unions will be important to establish health promotion officers in health professional awards. Unions are key in negotiations related to employment awards and EBAs. If health promotion employees are not usually union members, it may be advantageous for AHPA to advocate for members to join for this purpose.
- A submission should be made to DEEWR to ensure funding for health Promotion University places are aligned with other allied health disciplines. It will be critical that health promotion courses are not disadvantaged in an increasingly competitive market.
- Universities could indicate their willingness to collaborate with AHPA in working towards the development of health promotion course 'guidelines'

and an associated self-assessment tool for mapping their courses against the AHPA core competencies. This would act as an alternative to a comprehensive course accreditation scheme. The mapping of courses would also simplify and streamline the assessment processes in the certification administered by AHPA.

- It is recommended that the core competencies be reviewed to better define the various segments of the market (i.e. Officer, Practitioner, Advocate). Action also needs to take place to align these segments with specific graduate outcomes, and work towards generating a critical mass of people in these segments.
- The ANPHA may have the strongest vested interest in supporting these initiatives. These types of workforce reforms in the non-clinical and preventative health workforces are greatly needed to encourage new paradigms of healthcare delivery. These initiatives are strongly aligned to ANPHA's strategic goals.

Barriers

- This option is somewhat reliant on the receipt of a grant to support the implementation of workforce initiatives. Recognition of health promotion officers within the employment awards would also be a key success factor.
- Additional work needs to be undertaken to determine the core competencies, graduate outcomes and incentives for entry into the Advocate and Practitioner workforce segments before these certifications are likely to be effective.
- AHPA may need to review any constitutional barriers to these initiatives.

What objectives will this combined model address?

	Cert.	CPD	Economic Incentives	General Legislation	Combined Effect
Promote evidence informed practice	Y	Y		M	Y
Create entry standards to the profession	Y			Y	Y
Maintain currency of knowledge	M	Y		M	Y
Ethical conduct & behaviour standards	Y	M		Y	Y
Attract students to HP education	Y		Y	Y	Y
Increase HP uni places			Y		Y
Create more pathways to entry (dual qual)	Y	Y		Y	Y
Define and expand the VET level workforce			Y		Y
Convert more HP grads to employment	Y		Y	Y	Y
Improve retention	Y	Y	Y	M	Y
Attract qualified international HPP's	Y	Y	Y	M	Y
Ensure supply chain is flexible + responsive	Y	Y		M	Y
Establish HP within employment awards	Y	Y		Y	Y
Align/ exceed wages with AHP's	M	M		Y	Y
Market HP as a career of choice					
Undertake financial modelling					
Establish a business case for investment					
Establish roles and responsibilities					
Develop an operational plan					
Enhance current revenue sources					
Lead initiatives on the HP career journey					

Foster leadership skills development					
Ensure business acumen and skills on board					
Strengthen collaboration with stakeholders					
Foster a culture of innovation					
Facilitate HP in all professions & settings					
Develop a brand strategy					
Total Score	22	16	12	19	28

Option 2: Accreditation of University Courses

Improving the sustainability of the health promotion workforce by introducing:

1. University Course Accreditation

This option could be combined with CPD, economic incentives and general legislation in the same way as was outlined in Option 1. Rather than repeat the advantages and disadvantages of these models here, the focus of this section will be on the difference between certification and university accreditation.

What would this involve?

1. *University Course Accreditation* – A course accreditation program is an approval of an educational program according to defined standards. The key difference between accreditation and certification is that course accreditation can qualify large numbers of graduates as a group, rather than assessing each applicant on a case by case basis.

Course assessments can either be conducted through site visits to the universities (more expensive), or by desk-top assessments and video conferencing (less expensive). Developing a university course accreditation program is generally a lengthy and resource intensive process, although it can result in a very robust and sustainable model for growing the competent workforce, and may have slightly lower recurrent administrative costs than certification.

Target Workforce

One of the key differentiating factors between using a certification and university course accreditation approach, is that university accreditation would only benefit the segments of the market who complete a degree in an accredited university course. In contrast, certification is flexible enough to be adapted to all educational levels.

Although it is conceivable that a course accreditation or mapping process could be developed for other types of educational courses, the reality is that the cost, complexity and difficulty to administer multiple types of course accreditation, maybe untenable.

University course accreditation may be the best option in the following conditions:

- a. If AHPA is unable to attract adequate investment to establish a certification program as university accreditation costs are shared between the tertiary sector and AHPA.
- b. If AHPA wishes to narrow its strategic focus to the Health Promotion Officer 'niche' of the market. This would allow the profession to more easily align with the other self-regulating health professions, as well as open up the market up to other associations who might wish to focus on other segments of the workforce.

- c. If there is a sense that Health Promotion Officers are the only segment likely to benefit from regulation. In this case, it may be in the best interest of other segments to not be 'regulated' and for a university course accreditation approach to be considered.

Advantages of this option:

- It may provide a more robust and sustainable quality assurance framework.
- Slightly lower recurrent costs to administer.
- It may be easier to establish credibility and trust in a university course accreditation program, as this is an accepted industry model in the health sector.
- This model is mutually beneficial for AHPA, the health promotion workforce and employers. Employers would benefit greatly without having to bear the cost.
- The potential to strengthen collaborative working relationships with the tertiary sector.
- It will provide significant branding and marketing opportunities for universities.
- This option shifts the responsibility of education and assessment away from AHPA and to the tertiary sector, which may be better resourced to do this.
- University accreditation directly influences tertiary program content, structure or delivery (certification does not).
- This model would provide assurance to consumers and employers that minimum competence and quality standards are being met and maintained.
- It has the potential to dramatically grow the size of the competent workforce (with an order of magnitude between 2 and 10 within 5 years), therefore increasing the size of the available market for employers and customers (although may take 2-3 years longer to establish compared to certification).
- A standards-based approach to course accreditation is less prescriptive than a competency based approach, and therefore may reduce the cost to administer.
- By narrowing the strategic and industry development focus to only the health promotion officer 'niche' of the market, AHPA may be more effective at utilising its limited resources.

Disadvantages of this option

- More expensive to establish than certification.
- This option is not as flexible as certification. Longer lead times are required to establish and review standards, and therefore there is less ability to adapt to rapid market changes.
- A greater proportion of the cost is borne by the tertiary sector and AHPA.

Enablers

- Widespread support from the tertiary sector is a key success factor.

- A commitment from key potential funding bodies such as ANPHA to provide seed capital and ongoing strategic support to develop the sustainability of the health promotion workforce.
- ANPHA may have the strongest vested interest in supporting these initiatives. These types of workforce reforms in the non-clinical and preventative health workforces are greatly needed to encourage new paradigms of healthcare delivery. These initiatives are strongly aligned to ANPHA's strategic goals.

Barriers

- This option is reliant on the receipt of funds to establish the accreditation program, and strong support from the tertiary sector.
- Additional work would need to be undertaken to determine how AHPA will meet the needs of other segments of the market.

What objectives will a combined model using Accreditation address?

	Accred	CPD	Economic Incentives	General Legislation	Combined Effect
Promote evidence informed practice	Y	Y		M	Y
Create entry standards to the profession	Y			Y	Y
Maintain currency of knowledge	M	Y		M	Y
Ethical conduct & behaviour standards		M		Y	Y
Attract students to HP education	Y		Y	Y	Y
Increase HP uni places			Y		Y
Create more pathways to entry (dual qual)	Y	Y		Y	Y
Define and expand the VET level workforce			Y		Y
Convert more HP grads to employment	Y		Y	Y	Y
Improve retention	M	Y	Y	M	Y
Attract qualified international HPP's		Y	Y	M	Y
Ensure supply chain is flexible + responsive	Y	Y		M	Y
Establish HP within employment awards	Y	Y		Y	Y
Align/ exceed wages with AHP's	M	M		Y	Y
Market HP as a career of choice					
Undertake financial modelling					
Establish a business case for investment					
Establish roles and responsibilities					
Develop an operational plan					
Enhance current revenue sources					
Lead initiatives on the HP career journey					
Foster leadership skills development					
Ensure business acumen and skills on board					
Strengthen collaboration with stakeholders					
Foster a culture of innovation					
Facilitate HP in all professions & settings					
Develop a brand strategy					
Total Score	17	16	12	19	28

Option 3: A Deregulated Workforce

Maintain the status quo;

1. A deregulated market driven by market forces.

What would this involve?

1. This would involve maintaining a deregulated market environment (as is the current situation), and focussing on strengthening the operational capability and effectiveness of the association.

Target Workforce

One of the advantages of a deregulated market environment is the ability to aspire to be fully inclusive, however unfortunately this is rarely achieved.

A deregulated environment driven by market forces may be the best option in the following conditions:

- a. If AHPA is unable to attract adequate investment from government or the tertiary sector.
- b. AHPA and its stakeholders wish to delay the decision to take action, until more information is available (i.e. the completion of a workforce study of the health promotion workforce).
- c. The findings from the project deliverable 2 determine that there is a need to develop more operational capacity to support change (e.g. staffing, funding, systems or policies)
- d. After conducting a risk assessment, the risks of change are beyond the capacity or appetite of the association and/or the industry.
- e. If the association is preparing to be absorbed or acquired by another organisation.

Advantages of this option:

- Deregulation can promote greater competition between providers, therefore stimulating innovative products, servicing and pricing.
- Recent indications of jobs growth and an increased focus on building capacity in health promotion workforce may indicate that it is possible to continue growing the industry in the current environment.
- There are no restrictions to enter the industry, or requirements to maintain currency (other than paying dues for members of AHPA). This tends to be preferred by those in stable employment.
- Although the industry has access to a very robust set of core competencies, which include ethical standards, adherence to them is not required.
- Deregulation offers the opportunity for market forces to select appropriate providers (employers and consumers can choose who they feel is fit to do on a case by case basis).

Disadvantages of this option

- There are a number of factors that suggest that complete deregulation is not ideal in the current market environment (e.g. rapid change, poor quality controls in place, and a trend towards marginalisation of health promotion in other comparable countries).
- There is a lack of clarity in the skills, competencies and expectations of professionals, and therefore what outcomes they can achieve.
- The industry is at a competitive disadvantage for attracting and retaining people, particularly in a highly competitive and rapidly growing health market where career opportunities and incentives are plentiful.
- Due to a lack of knowledge or currency, professionals frequently practice non-evidence based services and diversify into new poorly understood scopes of practice.
- There tends to be less data available to support workforce planning.
- Poor supply chain controls to manage rapid changes in supply and demand.
- There is less incentive to strengthen collaborative relationships with suppliers (training institutions) and customers (employers and industry).
- Employers are often disadvantaged in negotiations with HP professionals, due to their lack of equivalent knowledge or access to credible standards about what the qualities and performance expectations for health promotion services should be.
- With poorly defined standards, and no requirement to adhere to them, it is very difficult for AHPA to market or promote the industry.
- Evidence suggests that health promotion professionals already experience a lack of role clarity in their work and are uncertain about their future careers in health promotion.
- Providers with unsatisfactory skills may remain in the marketplace and intentionally target their services, in particular, towards disadvantaged groups.
- The health and financial costs of poor practice are borne not only by the individual practitioner, but by the community at large, and these costs could be expected to increase significantly if the market is flooded with inadequately trained and experienced health promotion practitioners.
- Deregulation can encourage a market that is too disparate, sometimes characterised by strong self-interest and unresponsiveness.
- If not managed properly there is a strong likelihood that rapid industry growth could lead to a loss of control of quality and very quickly disenfranchise the market, potentially causing irreparable damage to the industry's brand.

- There is a risk that due to inadequate levers to maintain quality or compete in the market, AHPA risks being marginalised by more aggressive competitors, or the industry as a whole being eroded.
- Full deregulation is unlikely to ever provide sufficient assurance of quality for the community or employers.

What objectives will be achieved in a deregulated market environment?

	Market Forces	Combined Effect
Promote evidence informed practice		
Create entry standards to the profession		
Maintain currency of knowledge		
Ethical conduct & behaviour standards		
Attract students to HP education		
Increase HP uni places		
Create more pathways to entry (dual qual)		
Define and expand the VET level workforce		
Convert more HP grads to employment		
Improve retention		
Attract qualified international HPP's		
Ensure supply chain is flexible + responsive		
Establish HP within employment awards		
Align/ exceed wages with AHP's		
Market HP as a career of choice	Y	Y
Undertake financial modelling		
Establish a business case for investment		
Establish roles and responsibilities		
Develop an operational plan		
Enhance current revenue sources		
Lead initiatives on the HP career journey		
Foster leadership skills development		
Ensure business acumen and skills on board		
Strengthen collaboration with stakeholders		
Foster a culture of innovation		
Facilitate HP in all professions & settings		
Develop a brand strategy		
Total Score	2	2

Recommendations

It is recommended that in Deliverable 2 of this review:

1. an organisational impact assessment be undertaken to determine and compare the effectiveness, efficiency and appropriateness of all three recommended options noted above.
2. the leadership, strategic, operational, governance, and funding implications of implementing the recommended options are explored.
3. the needs, interests and opportunities for other key stakeholders such as the tertiary sector, employers and government are considered.
4. broad consultation and feedback is sought from members and stakeholders.

Appendix 1: Project Plan



Project Plan

Appendix 2: List of Key Informants

AHPA					
Complete	Mr	Andrew	Jones-Roberts	Chair	Accreditation Project Steering Committee
Complete	Mrs	Janine	Phillips	Member	Accreditation Project Steering Committee
Complete	Mrs	Kirsty	Tinsley	Member	Accreditation Project Steering Committee
Accepted - Not complete	Mrs	Suzanne	Gleeson	Member	Career Structure and Development Committee
Employers					
Accepted - Not complete	Ms	Robyn	Clark	Director Planning, Reporting and Development Unit	QLD Health
Complete	Mrs	Catherine	Turnbull	Chief Allied & Scientific Health Advisor	SA Health
Tertiary Sector					
On leave	Prof	Catherine	Bennett		Deakin University
Complete		Denise	Fry		Sydney University
Accepted - Not complete	Assoc Prof.	Marilyn	Wise		University of NSW
Complete	Mr	Ben	Smith		Monash University, Health Sciences
Industry and Professional Associations					
Accepted - Not complete	Dr	Mike	Moore	CEO	Public Health Association of Australia
Accepted - Not complete	Prof	Helen	Keleher	President	Public Health Association of Australia
Complete	Mrs	Clair	Hewitt	CEO	Dietitians Association of Australia
Complete	Prof	Steve	Selig	Director of Accreditation	Exercise and Sport Science Australia
Complete	Mrs	Keran	Purnell	Accreditation Officer	Australian College of Social Work
Complete	Mr	Bruce	Morton	EHA Board Director	Environmental Health Australia
Fair Work Australia					
Complete	Mr	Andrew	Wilson	Advisor	Fair Work Australia
Key Reform Groups					
Complete	Mrs	Cheryl	Hutchins		Preventative Health Agency
Complete	Mrs	Vicki	Shaw		Preventative Health Agency

SA Forum					
Complete		Michelle	Herriot	Director Health Promotion	SA Health
Complete	Mrs	Jenny	Phillip-Harbutt	Director	AHPA Board
Complete		Della	Rowley		DASSA Tobacco
Complete		Susan	Cameron		Royal Adelaide Hospital
Complete		Kristy	Shirmer		
Complete		Eva	Mariano		
Complete		Jane	Barnett		AHPA SA
Complete		Deb	Shultz		
Complete		Richard	McGrath		Uni SA
Complete		Georgina	Bickley		County Health
Complete		Annabel	Axford		
Complete		David	Edwards		Cancer Council
Complete		Kirsty	Hammet	A/Manager Integration HP Branch	SA Health
Complete		Angela	Thiel	Chief Project Officer	SA Health, Health Promotion Branch
Accepted - Not complete		Kylie	Williams		
Accepted - Not complete		Rae	Plush		
Accepted - Not complete		Tanya	Lehmann	Principle Consultant, Allied Health	Country Health SA
WA Forum					
Complete	A/Prof	Trevor	Shilton	Director Cardiovascular Health Programs	CompHP/ Heart Foundation
Complete	Mrs	Tia	Lockwood	Member	Career Structure and Development Committee
Complete	Dr	Sharyn	Burns	Assoc Professor Dir Health Promotion and Sexology	Curtin University
Complete	Mrs	Suzanne	Taylor	Senior Development Officer	Dept of Health WA
Complete	Mrs	Gemma	Crawford	Director	AHPA Board
Complete	Mrs	Ruth	Wernham	Safe System Coordinator	WA Local Government Association
NT Forum					
Complete	Mr	Alex	Kopczynski	Member	Career Structure and Development Committee
Complete	Miss	Emily	Raso	Member	Department of Education and Training

Complete	Miss	Talia	Hoskin	Member	Department of Children and Families
Complete	Mrs	Dagmar	Schmitt	Member	Department of Health
Complete	Ms	Trish	Slocum	Member	Department of Health
Complete	Mrs	Alison	Rogers	Member	Fred Hollows Foundation
Complete	Miss	Ayrlie	Williams	Member	Palmerston City Council
Complete	Ms	Kirsten	Green	Member	Congress
Complete	Mr	James	Smith	Member	Department of Education and Training