Building on a foundation: strategies, processes and outcomes of health promotion in primary health care settings

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Jurisdictions around the world have articulated the need for the development of an integrated health care system with an increased emphasis on primary health care that incorporates the principles/practices of health promotion. Over the past century, the medical model has been the default model of care in many countries, and yet treatment alone is unlikely to have marked effects on health inequities or health status. This article presents and discusses three fundamental dimensions (strategies, processes and outcomes) of health promotion in primary health care (HP in PHC) settings. We argue that the three dimensions are founded on the values and structures of health promotion (Frankish *et al.*, 2006). Our work is based on a comprehensive literature review, validation by key informants and a national survey of Canadian primary health care settings. We suggest that the strategies (types of interventions), processes (client and community centred care), and desired health promotion outcomes (intended or unintended results) need to be better articulated and understood. Identification and discussion of the domains of HP in PHC settings is a crucial first step. It is a step toward the subsequent identification of related indicators and measures of health promotion that can be used for planning, implementation and evaluation of important health promotion initiatives.

Key words: health care reform; health inequities; health promotion; indicators; population health; primary health care; standards

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Introduction

This article represents the second of two (see Frankish *et al.*, 2006) articles that present a conceptual framework of health promotion in primary health care (HP in PHC) settings. The framework has five domains (values, structures, strategies, processes and outcomes). Frankish *et al.* (2006) present the foundational values and structures that serve to create a supportive environment for health promotion. The latter three domains are the focus of the present article.

We argue that health promotion deserves greater attention in primary health care settings. Treatment alone is unlikely to have marked effects on health inequities that underlie many health conditions. Many jurisdictions and health professionals now recognize that a reduction in health inequalities and a closing of the gap in health status requires greater integration of HP in PHC (Keleher, 2001; Ministry of Health, New Zealand, 2003).

Health promotion research in primary health care often focuses on only one or two of many components. This further contributes to the maintenance of diverse and fragmented perspectives. It is critical to identify/define the terms/concepts underpinning

HP in PHC. We do so by differentiating it from the more predominant disease focused model. By operationalizing the breadth, depth and diversity of HP in PHC, settings may be able to develop and sustain it. This change requires a philosophical paradigm shift and practical implementation. For definitions of primary health care and health promotion, readers are referred to Frankish *et al.* (2006).

Research design

This research project consulted broadly, using qualitative and quantitative methods, to construct a conceptual framework for HP in PHC that distils the most salient characteristics from dozens of possibilities. It included an extensive review of the published literature in scholarly journals, and grey literature, including policy documents and reports. We employed a Delphi technique by convening experts to seek input on relevant characteristics of HP in PHC. We also sought input from focus groups held in four Canadian cities. Finally, we undertook a national survey of primary health care settings to examine the perceived level of importance and reported activity that professionals and administrators attributed to the characteristics of our conceptual framework. Our conceptual framework was refined with each successive research phase. The characteristics within the five domains (values, structures, strategies, processes, and outcomes) were modified until no other aspects of health promotion could be identified for inclusion. Complete details on our research design is provided in Frankish *et al.* (2006).

Key domains and characteristics of HP in PHC

Health promotion comprises multiple, interconnected concepts that can be incorporated into the practice of primary health care settings.

Frankish *et al.* (2006) describes the philosophical *values* that provide the foundation for health promotion. They also highlight how these values should manifest in *structures* that create a supportive environment for health promotion. Our focus is to build on Frankish *et al.* (2006) by presenting the remaining three domains (strategies, processes, outcomes).

The strategies (types of interventions) and processes (client and community centred care) are important to the outcomes that health promotion initiatives may achieve in primary health care settings. *Strategies* are specific types of interventions. *Processes* describes aspects of providing client-centred care through interpersonal relationships. Finally, *outcomes* are the intended or unintended results of the strategies, processes and structures. The synergy between the first four components leads to desired health promotion outcomes.

None of the dimensions within the five domains are unique to health promotion *per se*. Health promotion is unique precisely because it is an *amalgam* of values and practices that enhance health. The information provided exemplifies the breadth of the subject area. Practitioners and decision makers may require additional information to acquire sufficient depth of knowledge.

This article builds on these values and structures. Below, we outline the strategies, processes and outcomes that may be expected to arise out of these foundational values and structures.

Strategies

Multifactoral causes of illness and disease necessitate a multifactoral approach to health promotion. We see three complimentary approaches to health promotion (Birse, 1998). The first is the medical or preventive medicine approach that is directed at improving physiological risk factors. Next, the behavioural or lifestyle approach is directed at improving behavioural risk factors, such as smoking and physical inactivity. Finally, the socio-environmental approach is concerned with the totality of health experiences and the factors that help to maintain or improve health (including risk conditions and psychological risk factors). This approach targets the determinants of health in one's physical and social environment.

These approaches differ in how health is viewed, how health problems are defined, what interventions are implemented, and how effectiveness is measured. They are most effective in terms of long-term outcomes when a combination of such strategies is used concurrently, and at several levels within a setting and with external partners (Swaby and Biesot, 2001).

Despite the apparent widespread acceptance of a socio-environmental (eg, population health)

perspective held by many working in health promotion, most health promotion activity continues to be preventive and lifestyle oriented through the provision of health information/education, screening and early intervention. These are valid strategies. But, they are insufficient and ineffective on their own and they do not harness the full potential of health promotion to positively affect individual and community health.

A health promotion approach seeks to expand the focus of attention beyond the individual. Clients of primary health care may be individuals, families, groups, communities and populations. Health promotion is more than a specific programme (add-on to existing health services) or a single strategy or aggregate of individual strategies. It demands a multifaceted reorientation and incorporation of a range of services and intervention strategies that meet people's immediate needs and also address social and economic conditions. Group and community strategies are fundamental to health promotion.

Empowerment is a fundamental value of health promotion and in keeping with health promotion's focus of enabling individuals. If the strategies employed are not enabling or empowering to individuals and communities, then it is not health promotion. Community empowerment involves individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community. Health professionals generally have more power (status, legitimacy, access to or control over resources) than their clients (Labonte, 1994). It is important that health professionals do not remain the locus of control, but rather are an enabling agent. Empowering individuals or groups requires access to decision making, skills and knowledge to effect change. People cannot achieve their fullest health potential unless they are able to take control of those things that determine their health.

Individual strategies

The individual level of care is fundamental to our health system. Primary care interventions are generally episodic and brief. They occur between an individual and a health care provider, typically a physician, and health promotion strategies are consequently short term, such as giving advice for smoking cessation or distributing health education pamphlets. Some practitioners see this as the full extent of health promotion (Swaby and Biesot, 2001). The individual is targeted for change rather than the social or environmental conditions that underlie the illness or disease. Individual focused strategies are not unique to health promotion. A health promotion approach, however, focuses on the individual in the context of their community, such as vaccinations targeted towards hard to reach populations, and includes the provision of ancillary services. Individual oriented health promotion strategies include personal life skills, psychological counseling, health education (and information), self care, referrals, home visits, and preventive interventions (eg, screening), individual risk assessments (for body weight, diet, activity levels), and immunizations (for tetanus, measles, polio and influenza).

Individual oriented strategies have not been successful in meeting the needs of the most vulnerable in society. Health promotion seeks to redress inequalities in health status. Need and demand for primary care are clearly divergent, with those in greatest need of an intervention being the least likely to receive it. The inequality of provision has led to inequity of uptake, and should be remedied by appropriate targeting and tailoring of programmes (Davis *et al.*, 1996).

Group strategies

Group strategies typically refer to groups small in number, generally fewer than 20 participants. These groups generally focus on life conditions of their members. They are where people begin to forge new identities in supportive relationships. Group strategies include group counseling, capacity building, outreach, self-help/mutual aid, and social support. Issues addressed may include drug and alcohol dependency, adolescent health, or mental health.

Community strategies

Community strategies are those that will affect the broad community and population (whether or not they directly participate) through social and environmental change. The groups that benefit the most from community level strategies are the ones at greatest risk of ill health, and often, the most difficult to reach through conventional approaches. Community strategies include community development/community economic development, healthy public policy (eg, economic and regulatory activities

involving financial and legislative incentives or disincentives focusing on price, availability, restrictions and enforcement, such as modifying consumption of tobacco and alcohol through increased taxation, and restrictions on advertising), health communication (eg, health fairs, social marketing, mass media strategies), coalition building, advocacy (eg, direct political lobbying, media advocacy), and supportive environments.

Organizational strategies

Organizational strategies are targeted at the health setting itself, and its practitioners (see structure section).

The range and *content* of the various strategies is vast. It can include any combination of medical conditions, determinants of health, lifestyle/behavioural issues and/or population groups (eg, age, gender, ethnicity). Strategies implemented in a primary health care setting will differ based on the needs of the population. In an inner city area, the strategies for community members may address poverty, homelessness, addictions problems, while in a rural area, services may include farming or fishing safety and addressing the needs of an aging population. Formulating health promotion strategies involves selection and prioritization since intervening on a multitude of problems while continuing to provide high quality primary health care services is challenging. It is possible, however, to pursue a strategy collectively, with shared initiatives, while also pursuing individual professional objectives.

Process

Health promotion is a process with the aim of enabling people to take action to improve their health. Health promotion is not something that is done *on or to* individuals; it is done *with and by* people, either as individuals or groups. Process characteristics are related to the client centred delivery of health promotion and address interpersonal issues between clients and practitioners. Below, we identify the process related characteristics in our conceptual framework.

Proactive approach

In addition to addressing the 'presenting symptoms' and immediate health needs of clients, health promotion practice requires organizations and staff to be proactive (rather than simply reactive) in service delivery by addressing underlying health issues of individuals and their community (eg, housing, social support, economic status). The most vulnerable members of a community have the greatest need for health promotion and the most limited capacity, thus the need to be proactive.

Individualization and choice

People have the right and responsibility to be active partners in making decisions about their own health. Health promotion services are offered in a manner that enables individuals to take more control of their health. However, people cannot be reliant upon resources they do not have. Providers need to assess participants' readiness to change, lived reality, and cultural traditions. The provider may advocate for the client if necessary or liaise with other professionals and agencies as needed.

Mutual learning

Health promotion encourages clients to be involved in planning and making decisions about their own health care. There is a sharing of information and options on a variety of health related issues and a reduction of power differentials between providers and clients. Both the *process* and *outcomes* of health promotion should be educational and capacity building for both clients and providers.

Respectful communication

Good rapport between clients and health professionals must meet expectations and standards of privacy, confidentiality, informed choice, empathy, honesty, sensitivity, accountability, transparency, openness, integrity, and equity (Howard Research and Instructional Systems, 2000). Interpersonal processes ensure the client has sufficient time in meeting with health professionals, and the practitioner is skilled, informed, credible and non-judgmental.

Meaningful participation

Health promotion involves clients and community members in meaningful ways in the planning, implementation and evaluation of health-related activities or services. It is not feasible or practical to seek public involvement in every decision. However, the active participation of clients and the wider community remains central to health

promotion and the related social model of health. The intent is to increase capacity at the personal and community levels, to strengthen social connectedness, trust and competence and to thereby address health problems. Community participation extends from professionally driven, top-down models seeking to respond to community input via surveys or a community representative on an institutional board, to bottom-up approaches with full community ownership of health programmes, including decisionmaking and programme implementation. Specific tasks and priority issues must be approached in a genuine planning and mutual identification process.

Outcomes

The final domain of our framework pertains to the *outcomes* of health promotion. We define a health outcome as a change in the health of an individual, group or population that is attributable to an intervention or series of interventions. It demonstrates to funders and policymakers that the programme had an impact. Assumptions around what interventions will impact the health of populations are reasonably easy to generate, however, the paths of causation to (ill) health are highly complex and not easily measurable. Proving a causal connection between activities and improved health is even more difficult. A health promotion approach is not part of a simple linear process in which there is a direct causal relationship between an intervention(s) and an outcome. This lack of obvious causality wrongly results in uncertainty and doubt about health promotion's effectiveness.

There are numerous, practical challenges to attributing health outcomes to health promotion interventions. Therefore, evaluation and outcomes are often difficult to address at the practice level (Adams *et al.*, 2001). In order to measure changes, baseline information (ie, benchmarks) and appropriate measurement tools are needed, but most systems are not readily available for tracking evaluative data. Regional reports may be published on some indicators, or pre-post data may have to be collected. Tracking high risk populations presents even more difficulties. There is also a lack of resources for undertaking sufficient and appropriate evaluations. Some managers and health professionals are also unrealistic about what can be achieved over the life of a relatively short-term project. Others often do not (believe they) have the capacity to carry out such functions, nor do they believe it is their responsibility to measure health outcomes of a particular health promotion intervention any more than they should be expected to measure the effectiveness of drugs they prescribe.

Outcomes require considerable time to accrue, and short timelines create significant challenges in assessing quality in a definitive way. Three years or less is too short for establishing new programmes in community health, especially health promotion programmes. It may be as long as five to ten years before the full impact of an intervention is realized and there is a measurable impact (Howard Research and Instructional Systems, 2000). It is also difficult to track all costs associated with programmes, especially if more than one organization is involved.

There is an unrealistic expectation that health promotion initiatives will adopt experimental research designs that have been developed for medical research. Such designs are deficient as an evaluation tool for complex and multidimensional activities. Randomized control trials are best suited for simple interventions, and are not appropriate for evaluating many health promotion strategies, such as working for policy change or community action, when outcomes may not be amenable to statistical analysis (Victorian Department of Human Services, 2000).

Often, governments and funding bodies expect health promotion to be evaluated to a much greater extent than is expected of the rest of the health system. Some concern has been expressed that health promotion is being set up to fail by being required to demonstrate its impact on people's health over a short period of time and after relatively minor interventions. If outcome criteria revolve around whether or not a project is easily measurable, specific and achievable within a short funding cycle, it may do little in the long term to improve health by reducing health inequalities or addressing causes of poor health. The more easily it can be measured the more insignificant it may be in improving the health of communities.

The conundrum is that the most powerful forms of health promotion action are those that are long term, and the least easily controlled or measured by conventional means. If health is broadly defined to include psychosocial dimensions, then outcomes should also include these aspects. However, the

search for outcomes may narrow the definition of what constitutes health promotion.

Both qualitative and quantitative research, and evaluation play a crucial role in improving quality and accountability in primary health care. Clearly defined programme goals and objectives, from which the evaluation flows, are critical. These goals and objectives must be prioritized so that the evaluation resources can be tailored to the identified priorities. The measurement of outcomes should be slowly integrated, and commensurate with requisite resources.

For HP in PHC we may have to be satisfied that 'quality' can only be approximated, not quantified. A template of possible outcomes is listed in Table 1. The outcomes are categorized at the individual, organizational and community levels. These outcomes may be distal, intermediate or immediate. The measurement of intermediate or immediate outcomes may be more realistic than measuring distal outcomes for most settings.

Discussion

Despite the call for health promotion and disease prevention in the *Declaration of Alma-Ata* and the appeal for the reorientation of health services in the *Ottawa Charter*, the prevailing models of health care throughout the world are still primarily curative. Curative care still predominates over preventive and developmental activities, such as health promotion. In most countries, primary care tends to be limited to the most basic provision of curative and preventive services (eg, diagnoses of illnesses, referrals, and vaccinations) (Anderson *et al.*, 2001). Most health care systems are in fact illness care systems. The role of health promotion in health care reform has been minor or insignificant in many jurisdictions (Ziglio *et al.*, 2000). Reform of primary care in many countries has involved more refinement (ie, tinkering) and rhetoric than substantive changes (Marriott and Mable, 2000). For instance, Canada's primary care system has been described as 'so much innovation, so little change' (Hutchison *et al.*, 2001).

The underlying values and strategies of HP in PHC remain as valid today as when they were alluded to in the *Alma-Ata Declaration* and the *Ottawa Charter*, and many of the burdens that gave rise to these seminal documents have yet to be overcome. There is still tremendous potential

for primary health care to tackle present day, worldwide challenges through the incorporation of health promotion. Political, social and economic crises have reduced the access of many people to health care. Demographical trends that have primary health care implications include urbanization, aging populations, population growth, the prevalence of chronic diseases, sedentary behaviour, drug resistance (eg, antibiotics), drug abuse, civil violence, AIDS and other emerging diseases, and environmental disasters. These problems threaten the health and well being of hundreds of millions of people throughout the world.

Implementation of a health promotion approach in primary health care has been characterized by heterogeneity and discontinuities. At the conceptual level, health promotion and primary health care have been subject to interpretations that reflect divergent political and health perspectives. While principles of primary health care and health promotion have been included in many strategic planning documents, there remains considerable diversity in the models of primary health care being used. Where the implementation of primary health care is incomplete or is not delivering expected results, shortcomings are attributed to a lack of practical guidance on implementation, poor leadership, insufficient political commitment, inadequate resources, and unrealistic expectations placed on this model of care (World Health Organization, 2003). In some countries, financing constraints have also impacted on the level of technical support to peripheral staff and on the development of referral and communication systems. Failure of primary health care to reach priority populations, such as the poor and other disadvantaged groups, also stems from complex socioeconomic and political factors. Most national health systems are coming under increasing scrutiny with a concern for containing costs, improving quality, and encouraging cooperation and balance between the private and public sectors. Taken together, the above issues and the economic and social pressures on primary care have resulted in missed opportunities for cumulative, incremental change involving health promotion. While sudden and major changes in primary health care delivery are unlikely (and undesirable), significant incremental change around health promotion is possible.

Some 25 years after the *Alma-Ata Declaration*, health ministers in many countries have called for

Table 1 Health promotion outcomes in primary health care (and examples of suggested measures)

Individual Level (Client/Community)	Organizational Level	Community Level
Health Status ↓ mortality ↓ illness and injury ↑ self-rated health status ↓ health inequity	*Health service effectiveness* ↑ appropriate utilization ↑ accessibility (geographic, financial, cultural, functional) ↑ availability of services ↑ appropriateness ↑ continuity of care ↑ comprehensiveness (biomedical, behavioural and socio-environmental) ↑ satisfaction with quality of service ↑ reallocation of resources ↑ co-ordination and communication (eg, information exchange)	*Collaboration* ↑ partnerships among individuals and organizations in the community ↑ advisory committees, community-based board of directors ↑ community participation in planning, implementation and evaluation of services and programs
Lifestyle and/or health behaviours ↑ positive health behaviours (eg, tobacco/illicit drug cessation, food choices, physical activity) ↑ self-responsibility for health capacity and skills (individual and group)		*Healthy public policy* ↑ health promoting regulations, legislation and policy statements
Health literacy ↑ clients' health knowledge ↑ clients' seeking/receiving health information ↑ clients' understanding/using health information ↑ clients' education (individual and group)	*Work environment* ↑ professional education and training ↑ practitioners with appropriate knowledge, attitudes and skills ↑ job satisfaction ↑ multidisciplinarity/interdisciplinarity	*Healthy environments (physical, economic and social)* ↑ safety ↓ pollution
Quality of life and well being ↑ positive life circumstances ↓ adverse life circumstances		*Social action* ↑ community development ↑ advocacy (eg, lobbying/political action) ↑ public awareness and involvement of health issues media communication

a renewed commitment to the goal of 'health for all' and endorsed the adoption of a health promotion approach in primary health care as a strategy for reducing the world's persisting inequities in health (PAHO, 2003). All countries need to identify ways to better incorporate a health promotion perspective within existing infrastructures and to make appropriate adaptations. A renewed commitment to health promotion and primary health care has great potential to guarantee the right to health for all citizens, while giving priority to the health of the least privileged groups and to reducing inequalities in health. A continued reliance on hospitals and advanced technologies does little to address health inequities or to improve population health. When compared to secondary and tertiary care, primary care is less intensive in its demand for both capital and labour and is less hierarchical in organization. Therefore, it is inherently more adaptable and capable of responding to changing societal needs.

Several countries have launched efforts to reorganize their primary health care, including increased reliance on regional health systems and strengthening human resources. Primary health care has contributed to greater social participation, introduction of new providers, such as community health workers, integration of services provided by different sectors, and extension of community outreach and intersectoral activities. Efforts are being made in some countries to enhance participation of rural communities and a sense of ownership.

The next set of challenges pertains to defining whose role and responsibility improved implementation of HP in PHC is, and enhancing the capacity the health system to address it. There are continuing issues to further develop the evidence base for primary health care, and the creation of relevant measurements and indicators need to be addressed in policy, practice and research.

Taken together, the two articles (Frankish *et al.*, 2006; Moulton *et al.*, 2006) provide a theoretically and empirically grounded conceptual framework for HP in PHC. Their five domains (values, structures, strategies, processes, outcomes) have high levels of both *face* and *construct* validity. There is a need to build on this work by creating consensus *indicators* or ways of measuring each characteristic. Equally, there is an urgent need to establish *standards* or *definitions of success* for each indicator of a given characteristic. Judd *et al.* (2001) provide

examples of nine approaches to setting standards in the evaluation of community based health promotion programmes. It remains to be determined whether such measures and standards would have *predictive* validity and utility in terms of predicting improvements in health status, health behaviours and use of health/social services.

The mechanisms by which people come together, interact and take action to promote their health should also be strengthened. There is a need to give added emphasis to locally integrated approaches to community development and to concentrate on the needs of disadvantaged populations. Policy and design interventions that promote rights to access, social justice and equity need to be improved. Primary care has inherent barriers that prevent providers from incorporating a more comprehensive approach. Building capacity for providers, organizations and bureaucrats to develop HP in PHC is crucial. Health promotion action also requires the involvement of people outside the health sector, beyond individuals that describe themselves as 'health' workers.

Conclusion

For settings and jurisdictions seeking to incorporate HP in PHC, we offer the present conceptual framework to assist them. We argue that in order for health promotion to come to fruition, its characteristics must be clear and broadly understood. More importantly, we must be able to identify clear measures that can be implemented on a sustained and comprehensive basis. We argue for the creation of a *vision* that makes the values, structures, strategies, processes and outcomes of health promotion more explicit. This *vision* may contribute to better dialogue among stakeholders and the negotiation of a new set of shared norms and standards, and broader engagement in health promotion initiatives.

Our overall goal is to improve the health of individuals and communities by improving the quality and quantity of health promotion that occurs. This goal can only be achieved through clear criteria for HP in PHC settings and the rigorous collection and evaluation of data associated with such criteria. Only then will health promotion achieve greater prominence in primary health care. We believe that health promotion reflects widely held community

values. Further, evidence suggests that many citizens would endorse a movement toward more collaborative structures, strategies, and processes in our health care system. The outcomes of health promotion also highlight the need to balance the great strengths of our '*illness care system*' with the strengthening of a parallel, integrated *health promotion system* that would maximize individual and community health, now and in the future.

Acknowledgements

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