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Health promotion in Australian general practice

A gap in GP training

Background

General practitioners are well placed to provide health promotion, both at the individual level and more broadly by addressing socioenvironmental determinants of health. However, important barriers exist which need to be tackled.

Objective

This article describes the current approach to health promotion by Australian GPs and identifies a gap in GP training and education as an important barrier to health promotion.

Discussion

Health promotion by Australian GPs is currently focused on the individual behaviour of patients. To improve the health of individuals, however, it is also vital to tackle the broader socioenvironmental determinants of health. One of the important barriers to a more holistic approach is a lack of understanding about the principles of health promotion among GPs, suggesting a significant gap in their training. Future research should focus on integrating health promotion into the medical curricula at the undergraduate, graduate and continuing medical education levels.

■ In 1986, the World Health Organization (WHO) provided the framework for effective health promotion practice in its **Ottawa Charter for Health Promotion (OC)** (*Table 1*).^{1,2} The central theme of the charter is that health promotion should not just be restricted to modifying individual behaviour, but should also focus on other aspects such as socioenvironmental factors that determine health, thereby empowering people to achieve better control of the determinants of health.

Subsequent charters developed by WHO, such as the Bangkok Charter, essentially built on the principles of the OC (*Table 1*).³ The important role of health professionals such as general practitioners in achieving health promotion is promoted by WHO and supported by the Australian government and The Royal Australian College of General Practitioners (RACGP).^{4,5} In addition, GPs are seen as an important source of health information by patients and the community.⁶

Current approaches to health promotion by Australian GPs

The smoking, nutrition, alcohol and physical activity (SNAP) framework was originally developed by the Joint Advisory Group on General Practice and Population Health.⁷ It has been adopted by the RACGP in all of their guidelines as the main framework for health promotion in general practice for preventive care.⁸⁻¹¹ Subsequently, the divisions network developed Lifescripts to promote the uptake of the SNAP framework by GPs.¹² Lifescripts promotes the use of waiting room materials, flyers, posters, prescriptions and manuals for promoting healthy behaviour. The SNAP framework and Lifescripts have emerged as the core guidelines for health promotion for the significant majority of GPs who are members of divisions or the RACGP or both.¹³

The focus of SNAP/Lifescripts is on changing individuals' high risk behaviours through the use of individual behaviour change models and motivational interviewing.⁸ However, this only addresses one of the five core components of the OC (*Table 1*). 'Health inequality' is identified as

a risk factor by SNAP and other preventive guidelines published by the RACGP;^{8–10} however, current strategies to address this are insufficient.

Importantly, the uptake of SNAP and Lifescripts is incomplete and not uniform. For example, the Bettering the Evaluation and Care of Health (BEACH) report of 2007–2008 identified that at least one ‘advice/education’ session was provided in only 7.2 per 100 GP encounters, with nutrition/weight management counselling (4.2/100 encounters); psychological counselling (3.2/100); and counselling/advice for exercise (1.3/100), smoking (0.6/100) and lifestyle and alcohol (0.4/100 for each).¹⁴ It is important to note however, that BEACH data is collected on the primary cause of patient presentation and that counselling activities are measured only as a secondary activity. Due to this methodology, BEACH data may underestimate the total presentations and, therefore, the accompanying level of advice/counselling.¹⁴

Amoroso et al⁷ reported incomplete uptake of SNAP by GPs, with a majority of GPs failing to fully implement SNAP guidelines. The Report of the 2006–2007 Annual Survey of Divisions of General Practice¹⁵ revealed that 85% of divisions indicated use of the Lifescripts; however in practice, most preventive activities were restricted to immunisation, suggesting an incomplete uptake of the program by GPs in general. While the report indicated a rise in ‘health promotion activities’ by the divisions, the term ‘health promotion’ is not clearly defined.

Effective health promotion activities based on the multiple strategies of the OC have been undertaken in Australia,¹⁶ including:

- the Improving Youth Mental Health and Suicide Prevention Program¹⁷
- the South Australian Farm Injury Project,¹⁸ and
- the ‘Yarning for better health’ program (Table 2).¹⁹

These programs involved both behavioural and environmental

approaches, encouraged GPs’ active community involvement, and focused on community empowerment and capacity building. They addressed the core activities of the OC and were therefore more likely to produce sustainable outcomes in terms of the community’s health. They highlight the important role that GP organisations such as divisions of general practice could play in advocating for healthy communities, encouraging GPs to take on broader health promotion roles. However, such programs are infrequent, and clearly there is room for expanding health promotion in Australian general practice toward a more holistic approach.

Barriers to health promotion

Several barriers exist to health promotion by GPs. These include:

- lack of time and incentives
- inadequate infrastructure²⁰
- lack of integration at the policy level¹⁸
- patient compliance and attitudes,⁷ and
- attitudes of GPs toward health promotion and a lack of a clear understanding of the principles of health promotion among GPs, reflecting a gap in their training.^{7,18}

Knowledge gaps

A study by McKinlay et al²¹ explored New Zealand GPs’ knowledge of health promotion. It reported that most GPs were unsure about the definition of health promotion; some equated it to ‘checking blood pressure’ and ‘screening for cancer’. None of the GPs in this study expressed an understanding of the OC, many were sceptical about the utility and efficacy of health promotion by GPs and some questioned the value of health promotion in GP consultations.

Table 1. The Ottawa Charter for Health Promotion²

The Ottawa Charter for Health Promotion, developed by WHO in 1986, described the core activities of health promotion as follows:

- Advocating for health to make environmental, socioeconomic, cultural, political, and behavioural conditions favourable for health
- Enabling people to achieve their fullest health potential by providing them with a supportive environment, access to information, and life skills, as well as opportunities for making healthy choices, thereby reducing health inequalities
- Mediating with government and nongovernment agencies, industry and media to achieve coordinated action. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health

The five principles/strategies of the Ottawa charter are to:

1. Build healthy public policy: health promotion must put health on the agenda of policymakers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions
2. Create supportive environments: health promotion must aim to develop environments conducive to health. Developing personal skills only improves people’s health if they live in an environment conducive to the desired behaviour
3. Strengthen community actions: health promotion must encourage the empowerment of communities – their ownership and control of their own endeavours and destinies
4. Develop personal skills: health promotion must develop people’s personal skills by providing information and education for health, and by enhancing life skills
5. Reorient health services: the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. This requires not only encouraging behaviour change but also empowering people and communities to gain better control of determinants of health

The Bangkok Charter for Health Promotion in a Globalized World 2005 built on the principles of the OC and went on to acknowledge the effects of factors such as increasing inequalities, commercialisation, urbanisation and environmental changes²

Sims et al²² noted that Australian GPs did not view the health promotion programs as worthwhile, were slow to adopt the new ideas, and found difficulty in adopting a social model of health. Lack of clear conceptualisation of this issue among GPs is also reported by other researchers.^{18,23,24} General practitioners are uncertain and ambivalent about the concepts of health promotion, and this reflects the lack of adequate skills and training given to them. This gap in GP training has also been identified by others.^{7,22,24}

To address the gap, two areas of GP training need significant amendments: the undergraduate curriculum for MBBS students and continuing medical education (CME) for graduates and established GPs.

Undergraduate medical curriculum

McClary et al²⁴ and others²⁵ highlight the need for expansion of training and teaching in health promotion in the medical curricula. Raupach et al¹⁸ noted that the undergraduate medical curriculum in Australia has an uneven approach to health promotion and disease prevention. Current Australian curricula focus on SNAP risk factors, immunisation and screening in terms of disease prevention.²⁶ Research overseas has identified that physicians who received undergraduate training in the community domain, with rural rotations and community activities, were significantly more likely to be involved with community activities after graduation.²⁷ There is scope in Australia for expanding a population health perspective by teaching the importance of community needs and community empowerment to future GPs.

A recent review of the University of Sydney's medical program advised further enhancement of community oriented teaching; for example, projects in, and special rewards for, community oriented service.²⁸ The review recommended that the medical faculty should be perceived by students to have a 'strong public voice in contemporary issues'. Some universities are making an effort to incorporate health promotion in medical curricula; for example the project oriented health promotion unit at Monash University²⁹ and the self directed learning approach at the University of Sydney.³⁰ Consideration of attitudes of medical students toward population health is important; a recent Queensland University study suggested that most students viewed the application of health promotion as 'commonsense' and as less important than clinical sciences.³¹

Further research in this area is warranted. As Australian universities have individual programs, a systematic review of the curricula of all universities would be particularly worthwhile.

Continuing medical education

Ploeg et al³² reported that GPs who attended a seminar or workshop on health promotion (eg. physical activity promotion programs) scored better relative to knowledge and confidence about health promotion and were more likely to undertake health promotion activities. The RACGP and general practice networks conduct training programs in Lifescripts for GPs; however their uptake still needs to be evaluated. Of the GPs studied by Ploeg et al, 35–44% reported attending CME related to health promotion.³² Another survey reported this figure to be 22.6–39.3%.⁷ Both

Table 2. Examples of health promotion programs in Australia

- The Improving Youth Mental Health and Suicide Prevention Program, designed and implemented by the Central Highlands Division of General Practice, was a needs based program that trained participating GPs, who then provided training to peer educators and teachers. Networks were formed involving GPs, young people, schools and youth service providers who could sustain the program
- The South Australian Farm Injury Project, developed by five South Australian divisions of general practice, was a needs based project aimed at reducing farm injury. General practitioners received specific training and became involved in a range of activities such as school visits, community education and presentations, attendance at field days and participation in research
- The Yarning for better health program, run by Brisbane South Division of General Practice, involved specific training for GPs in local indigenous health issues, and GP community involvement in the form of education sessions and other activities based on community needs. Evaluation revealed that the community valued the involvement of GPs, that GPs felt more informed about indigenous community issues, and that the program was likely to produce sustainable results

surveys were however, restricted to a sample of GPs and the results may not be generalisable to nonmember GPs. Continuing medical education activities on health promotion topics other than SNAP and Lifescripts need to be developed and evaluated.

Postgraduate training in public health, such as a Masters or Graduate Diploma in Public Health, can increase GP understanding of, and confidence in, health promotion, and help them make informed decisions about their role relative to health promotion. A recent study³³ identified that only 14% of GPs had a Masters degree, graduate diploma (most commonly in obstetrics) or PhD. The proportion of GPs who had a Masters degree was only 5%, indicating that fewer than 5% had public health qualifications. These courses can be expensive; GPs desiring advanced training in public health should be strongly encouraged and specially funded. Also, universities could offer a combined MBBS/MPH (Master of Public Health) program (equivalent to the joint MD/MPH program widely offered by North American universities).

Not all GPs will be able or interested to undertake postgraduate training to the level of a Masters. However, targeted short duration training in population health for general practice registrars has been found to be effective³⁴ and feasible,³⁵ and should be considered for wider implementation. Similar principles could be applied to CME activities for established GPs.

Conclusion

Health promotion in Australian general practice is slowly evolving. However, there remains enormous scope for GPs to broaden their health promotion activities by focusing on the multiple aspects of the OC framework. To date, one of the major barriers to effective health promotion by Australian GPs has been their lack of knowledge, understanding and confidence with regard to health promotion principles and practices. This gap could be addressed, in part, by modifying the undergraduate medical curriculum to include health promotion education

and by encouraging practising GPs to undertake further CME and/or postgraduate qualifications in public health or health promotion. Future research should aim to further explore these gaps and evaluate the effectiveness of educational and other interventions to fill them.

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