Draft Generic Competencies for Public Health Practitioners in Aotearoa-New Zealand

A report on feedback from the 2006 consultations

February 2007

INTRODUCTION

In 2005 a coalition of public health disciplines guided by the Public Health Association began work on a set of generic competencies for public health practitioners in New Zealand. The Generic Competencies Project is part of the wider body of work that is the Public Health Workforce Development Plan (PH WDP).

The PH WDP has two overarching goals.

Goal 1: Develop an effective and sustainable public health workforce.
Priority areas for this objective are:

- Education and training
- Māori public health workforce development
- Pacific public health workforce development
- Public health sector professional development.

Goal 2: Support public health environments to grow and develop the public health workforce.
Priority areas for this objective are:

- Workforce planning
- Information, policy and research
- Supportive workplace cultures
- Public health careers.

Whilst developing public health generic competencies is a priority action under Objective 1: Education and training, development and implementation of the generic competencies will also contribute to other objectives.

GENERIC COMPETENCIES

Generic competencies are the minimum baseline set of competencies that are common to all public health roles across all public health sectors and disciplines and that are necessary for the delivery of essential public health services. They are what all public health practitioners are expected to be capable of doing in order to work effectively in the field.

Generic public health competencies sit alongside other sets of competencies that guide the practice and functions of the many disciplinary fields that exist within public health.

CONSULTATION

A draft 'Discussion Document' was developed by the working group and the '*Draft Generic Competencies for Public Health Practitioners in Aotearoa-New Zealand'* were circulated for consultation in the second half of 2006.

Consultation formats ranged from one-on-one interviews, existing sector meetings, PHA-sponsored meetings and presentations at conferences and other gatherings. Responses were collated from meeting notes, hard copy feedback forms, and online responses from the PHA web site.

Views were collated from the Public Health Directorate (Ministry of Health,) District Health Boards New Zealand and public health service providers including public health units, non government organisations, primary health organisations, Pacific health providers, Māori health services, and the tertiary sector.

Meetings were with national, regional and local organisations; venues spanned from Tamaki Makaurau Auckland to Otepoti Dunedin. Meetings were held, or presentations made, in Auckland (8), Christchurch (4), Dunedin, Hutt Valley, Napier (3), Ngaruawahia, Palmerston North (3), Ratana, Rotorua, Tolaga Bay, Tauranga, and Wellington (15).

RESPONDENTS

Whilst some responses expressed individual opinion, others reflected views from a group or service.

The range of occupations and disciplines reflected in the development process includes policy makers and policy analysts, service managers, public health nurses, academics, epidemiologists, lecturers, Māori community health workers, the Pacific Public Health Workforce Working Group health promoters, health protectors, medical officers of health, researchers, cervical screeners, dieticians, kaimahi Māori, public health physicians and others who were part of group consultations and responses.

REVIEW PROCESS

All comments and responses were reviewed by a sub committee of the working group. Whilst most comments related to a specific competency or issue, each suggestion was evaluated in view of the set of competencies as a whole.

Changes were made as a result of:
- expertise from specific disciplines that lead to corrections or additions
- thought provoking comments that lead to reconsideration of some aspects
- strength of feedback on some issues which emerged as common themes.

Significant or unresolved (by the sub-committee) issues were taken back to the Working Team for further debate and consideration.

In response to feedback, two representatives from the Pacific Public Health Workforce Working Group were invited to join the Working Team.

WHAT PEOPLE SAID

Differing perspectives from the multidisciplinary workforce that comprises the public health sector were reflected in the feedback but overall very strong support was expressed for the concept, typified in this quote "Congratulations on the draft competencies as a starting point." However, in many instances this support was accompanied by the proviso that care must be taken to ensure the use of generic competencies increases rather than decreases equity. This is seen as being of particular importance for those sections of the workforce that currently have less developed training and career pathways (health promotion, community health work, Māori and Pacific workforce, rural workforce).

Feedback identified numerous positives and many details that stimulated vigorous discussion in the working group and resulted in improvements to the document. Several important issues were raised but considered too advanced for a generic framework and might fit better in discipline-specific competencies.

1 Number and pitch

Overall, there was support for the selection of competency topics and their content, but the number of competencies and the level they are pitched at elicited much debate. In general, people felt that there were too many competencies at too high a level, but equally that little could be removed from their own disciplinary areas.

Response
- The number of competencies has been adjusted and some have been re-ordered or re-titled.
- It is anticipated that inclusion of scope statements and the future development of assessment guidelines will clarify levels of performance expected for compliance.

2 Language

A number of responses related to the use of language within the competencies. Concerns were expressed about the clarity of language used in specific competency statements and performance criteria, the definitions of terms such as culture and the need for an expanded glossary.

Response

A number of changes were made to simplify the language and clarify intent:

- some competency statements and performance requirements were reworded to make them clearer
- scope statements were shifted or added to clarify performance criteria
- the glossary was expanded to include definitions of commonly used terms such as culture
- definitions were included in scope statements.

3 Te Tiriti o Waitangi

While comment relating to Te Tiriti of Waitangi competencies was largely positive, language used was seen to reinforce the voice of the dominant culture. Māori core health competencies for practitioners who are working with Māori communities and their relationship to the generic public health competencies was also raised. Increasing equity between Māori and non-Māori in the workforce was seen as being of primary importance and a key factor in improving health outcomes for Māori.

Response

- A number of changes were made in the document to strengthen integration of tikanga, kaupapa Māori, Māori health models and to better reflect partnership.
- A recommendation is being made to the Ministry of Health for the development of a dedicated set of Māori cultural competencies that provides additional, more advanced competencies for both Māori and non-Māori practitioners who work with Māori communities.
- Equity issues for the Maori workforce have been a primary consideration in developing recommendations for the Ministry of Health regarding education and training pathways.

4 Cultural issues

Among the challenges for the working group was how to include Pacific peoples and other cultures. Presuming everyone is included in the same competencies risks specific groups with specific attributes and needs becoming invisible within the dominant culture. Identifying specific groups and developing separate competencies risks these groups being seen as separate so dominant services may absolve responsibility for including them.

Submissions pointed out “The words ’culture’ and ‘cultural’ are used very frequently in the competencies. In common usage in New Zealand these words have become synonymous with ethnicity……. “

Response

- The position of Pacific peoples and their relationship with public health has been made more visible and strengthened.
- Scoping statements have been added to performance requirements to clarify intent and terminology.
- The glossary and the competencies were expanded with special attention to culture, cultural awareness, cultural competence and cultural safety.
- Culture is now defined in the glossary as; "includes but is not limited to ethnicity, age, disability, gender, sexual orientation, religious or spiritual belief, socio economic status, occupation and organisational background".
- A recommendation is being made to the Ministry of Health that a dedicated set of Pacific cultural competencies that provides additional more advanced competencies for both Pacific and non-Pacific practitioners who work with Pacific communities be developed.
- Competencies relating to addressing inequalities were strengthened and made more visible.

5 Discipline specific knowledge and tools

Due to the multidisciplinary nature of the public health workforce several groups requested the addition of discipline-specific knowledge and/or tools, e.g. health impact assessment, emergency preparedness and health equity assessment tool (HEAT), Pacific knowledge, occupational health, and basic biology/ psychology.

Response

- A set of competencies for emergency preparedness has been added.
- Scope statements have been used to include other identified gaps such as occupational health and health impact assessment.
- Other areas were judged to be outside the scope of generic public health competencies, although clearly essential for some disciplines.

6 Fit with discipline specific competencies

Whilst supporting the unifying concept, many expressed concern about how well generic competencies will fit alongside discipline-specific competencies. It is a challenge for the sector to maintain and accommodate the diversity of disciplines, roles, functions, practices and educational status within the public health workforce. Generic competencies are complementary to those of other disciplines, are a first step and will not require practitioners to duplicate training.

Response

- The report to the Ministry will recommend that provision be made for cross crediting, recognition of prior learning, recognition of current competency, and that credits and qualifications should be transferable to other employers, disciplines and training institutions.
- The working group recommends that public health disciplines revise their competencies to include the generic public health competencies.

7 Implementation

Major concerns centre on implementation pathways and assessment processes. The potential for national consistency was mentioned as a strength but there was uncertainty about how this might be achieved. Concern was expressed that people who have strong practice-based community skills but no formal academic education or qualifications may be disadvantaged. Equity of access to training across geographical regions is seen as being of critical importance. Requirements for minimum education and qualifications must embrace the diversity within the public health workforce and ensure everyone has an opportunity to be included. The availability of funding and resources to support implementation and training was viewed as essential for the on-going success of the competencies.

Response
The report to the Ministry will make recommendations on:
- how the competencies can be supported
- how providers can adopt and commit to an implementation programme
- clear implementation pathways that are expected to emerge as work on these issues progresses
- the need for adequate funding and resources.

8 Accessibility of training

An integral part of competency implementation is a training programme to facilitate qualifications and education to up-skill the public health workforce.

During consultation many questions arose that will need to be addressed in future to ensure sustainability of the competencies. The following questions were asked about the accessibility and resourcing of training:
- is there enough capacity in the education sector to meet the need?
- who will ensure funding for both training provision and training uptake in an environment of shrinking training budgets?
- who will fund mentoring development?
- will the process help rationalise resources and address inequalities in the workforce?

Response
- The report to the Ministry will make recommendations on how these issues might be addressed.
- An analysis of the likely costs of implementing the competencies has been made.
- Accessibility of training has been a key consideration in developing recommendations for education and training pathways.

9 Scope of the workforce

Public health expertise is already spread through a multidisciplinary workforce and many submissions reflected concerns that the critical mass of public health expertise will be further dispersed should funding be devolved to the 21 district health boards.

Response

- The working group acknowledges that it will be will be a challenge for the recognised public health sector to strengthen intersectoral links and develop strategies to engage and support other sectors who are doing or contributing to public health outcomes but do not identify as part of the sector e.g. local authorities.

10 Public health competencies in organisations

The need for organisations to commit to and measure up to the competencies was raised by several voices. Queries arose around the relationship between individual standards and organisational competencies. The need for public health organisations to be culturally competent was a particular concern.

Response

- The working group acknowledges the importance of competencies for organisations but it is outside the brief of the current project to explore or develop these.

NEXT STEPS

Now that the consultation process has been completed, a report will be submitted to the Ministry of Health on a set of generic competencies for all public health practitioners. The report will include recommendations on ways to support the use of the competencies, mechanisms for implementing and maintaining the competencies, and advice on training and relationships with national frameworks. It will consider the implications of such an approach for practitioners, professions, employers, trainers, and funders, and identify possible next steps.

CONCLUSION

The Generic Competency Project thanks everyone who participated in the consultation process. Thoughtfulness and helpful solutions were features of the feedback and submissions. As a result many changes were made to the document whilst additional issues have been noted for use in later developments. These competencies are not definitive but should be considered as a working set that is open to ongoing review, evaluation and refinement as they are used in work and training environments.

As one respondent commented, the Draft Generic Competencies for Public Health Practitioners in Aotearoa-New Zealand are seen as a “significant concept that offers some cohesion and will help to unify and bring recognition to what is now a somewhat disparate sector”.