Resources for Health Promotion

Rhetoric, Research and Reality

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ABSTRACT

Background: Canadian political discourse supports the importance of health promotion and advocates the allocation of health resources to health promotion. Furthermore, the current literature frequently identifies financial and human resources as important elements of organizational capacity for health promotion. In the Alberta Heart Health Project (AHHP), we sought to learn if the allocation of health resources in a regionalized health system was congruent with the espoused support for health promotion in Alberta, Canada.

Methods: The AHHP used a mixed method approach in a time series design. Participants were drawn from multiple organizational levels (i.e., service providers, managers, board members) across all Regional Health Authorities (RHAs). Data were triangulated through multiple collection methods, primarily an organizational capacity survey, analysis of organizational documents, focus groups, and personal interviews. Analysis techniques were drawn from quantitative (i.e., frequency distributions, ANOVAs) and qualitative (i.e., content and thematic analysis) approaches.

Results: In most cases, small amounts (<5%) of financial resources were allocated to health promotion in RHAs' core budgets. Respondents reported seeking multiple sources of public health financing to support their health promotion initiatives. Human resources for health promotion were characterized by fragmented responsibilities and short-term work. Furthermore, valuable human resources were consumed in ongoing searches for funding that typically covered short time periods.

Conclusions: Resource allocations to health promotion in Alberta RHAs are inconsistent with the current emphasis on health promotion as an organizational priority. Inadequate and unstable funding erodes the RHAs' capacity for health promotion. Sustainable health promotion calls for the assured allocation of adequate, sustainable financial resources.

MeSH terms: Public health; health promotion; health organizations; funding; health resources

La traduction du résumé se trouve à la fin de l'article.

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Provincial and federal political discourse on the health of Canadians has called for increased emphasis on public health and health promotion for more than three decades. Pivotal reports, such as *A New Perspective on the Health of Canadians*,¹ *Achieving Health for All: A Framework for Health Promotion*,² *A Framework for Reform: Report of the Premier's Advisory Council on Health (Mazankowski Report)*,³ *The Health of Canadians – The Federal Role (Kirby Report)*,⁴ have consistently linked a health promotion approach with improved long-term population health outcomes and decreased burden on the health care system.

Operationalizing the promise of health promotion calls for available and sufficient resources to sustain public health capacity building and organizational change.⁵ Financial and human resources are commonly described as leading facilitators of health promotion capacity when present in sufficient amounts, or conversely, barriers to health promotion when absent or inadequate.^{6,7} Health promotion funding determines the number of health promotion practitioners in an organization, their job priorities, and the availability of professional development opportunities.⁶ Inadequate or short-term funding has been linked with the loss of skilled health promotion practitioners in health organizations, as well as increasingly divergent job descriptions in which health promotion is not a priority. This contributes to less leadership for health promotion within a health organization⁶ and ultimately decreased advocacy for health promotion financing.

The purpose of this paper is to describe organizational resources available for health promotion in Alberta's Regional Health Authorities (RHAs) and the impact of resources on health promotion practice from the perspective of RHA management, front-line staff and board members within the context of how resources for health promotion are represented in public documents.

The Alberta Heart Health Project

The Dissemination Phase of the Alberta Heart Health Project (AHHP) studied the development of organizational capacity for (heart) health promotion within the context of Alberta's RHAs. Capacity, the capa-

TABLE I

Frequency Distribution of RHA Budget Allocations to Prevention, Promotion and Protection by Capacity Level (n=16*)

Range of Core Funding Allocated to PPP	Frequency of RHAs n %	# RHAs by Capacity Level
Less than three percent (<3.0%) Medium, urban, 2.5	1 (6.3%)	1/1 (100%) Medium Capacity
Between three to five percent (3.1-5.0%) Low, 4.5; Low, 4.7; Medium, 3.8; Medium, 4.0; Medium, 4.0; High, 3.2; High, 3.0; High, 5.0; High, 3.81	9 (56.3%)	4/9 (44%) High 3/9 (33%) Medium 2/9 (27%) Low
Between five to seven percent (5.1-7.0%) High, 5.5; High, 5.14; Medium, 7.0	3 (18.8%)	2/3 (67%) High 1/3 (33%) Medium
Greater than seven percent (>7.0%) Low, 7.4; Medium, 7.5; Medium, 7.27	3 (18.8%)	1/3 (33%) Low 2/3 (67%) Medium

* Budget allocations not reported by 1 RHA

bility of an organization to promote health, was defined as formed through the interaction of organizational leadership (e.g., champions), political will to act (e.g., priority setting) and infrastructure (e.g., resources).^{8,9}

Alberta's health system experienced dramatic restructuring in the 1990s when acute care, long-term care and public health services were amalgamated into 17 geographically defined health organizations, named RHAs. Re-regionalization in 2003 further reduced their number to nine. The continued dominance of biomedical values within the RHAs has contributed to paradigmatic tension between acute care and health promotion.^{10,11}

We defined health promotion as "a process for enabling people to take control over and to improve their health".¹² Our working definition encompassed principles of addressing broad determinants of health¹³ through Ottawa Charter action strategies (developing healthy public policy, creating supportive environments, strengthening community action, developing personal skills, reorienting health systems)¹² within a context of equity and empowerment. Although our initial focus was specific to heart health promotion, RHA participants informed us early in the research that most "heart" health promotion was integrated with other chronic disease prevention activities, therefore, we used (heart) health promotion throughout the research to imply health promotion within a context of chronic disease prevention activities.

METHODS

Organizational capacity for (heart) health promotion was studied with a time series research design and a mixed method

approach to data collection. Approval was obtained from the University's Health Research Ethics Board.

A validated instrument¹⁴⁻¹⁷ that assessed organizational capacity for health promotion was administered annually (4 times total) in each RHA between 2000 and 2004, except for 2003 when re-regionalization occurred. Annual intensive assessments (i.e., focus groups and interviews) occurred in three RHAs of varied capacity levels (i.e., low, medium and high) starting in 2001. Qualitative analyses of RHAs' organizational documents and strategic plans published in 2002/2003 further contributed to our understanding of health promotion capacity in the RHAs.

All Alberta RHAs (n=17) participated in the AHHP. Site coordinators in each RHA purposively recruited survey respondents from multiple organizational levels (i.e., service providers, management and board members) based upon their knowledge of or responsibility for health promotion within the RHA (see Smith et al.¹¹ for an overview of the project). A convenience sample of survey respondents identified as key informants were also involved in the focus groups and/or interviews conducted as part of the intensive assessments. This paper extracts a cross-section of these multiple sources of data to describe the context and impact of RHAs' resource allocations to health promotion. The following section details the methodological procedures.

Document review

A review of RHAs' business and strategic plans from 2001/2002 revealed information about organizational support for health promotion, such as the amount of core funding allocated to the budget category 'Protection, Promotion and Prevention' (PPP) (Table I). While the

RHAs are responsible for allocating funding according to regional variables (i.e., population age, socio-economic characteristics), this budget category encompasses a broad spectrum of public health activities (i.e., immunization, chronic disease control, community health nursing, and health education).¹⁸ This funding pool, and the public health activities within, is defined by the Alberta government (see http://www.health.gov.ab.ca/regions/RHA_Fund04.pdf). Consequently, it was not possible to determine the precise amount of funding specifically allocated to (heart) health promotion.

Organizational Capacity Survey

Development of the *Health Promotion Organizational Capacity Survey* was informed by current research literature and other capacity tools in the Canadian Heart Health Initiative (CHHI) (i.e., Saskatchewan, British Columbia, Ontario, Manitoba). Initial drafts of the questionnaire were validated through expert focus groups, pilot tests and review by other CHHI researchers. Validation characteristics and psychometrics of measures are published elsewhere.¹⁴⁻¹⁷ The questionnaire is downloadable from: <http://www.chps.ualberta.ca/ahhp.cfm>.

Survey respondents from across the 17 RHAs were asked for their perceptions about the availability of health promotion resources in their RHA. Three closed-ended questions specifically inquired about the availability of permanent and temporary financial resources for health promotion (Table II). With respect to human resources, respondents answered three questions relating to how much of their work time was spent in various health promotion and non-health promotion activities (Table III). Respondents were also asked their perceptions regarding sufficien-

TABLE II
Respondents' Perceptions of the Availability of Financial Resources for Health Promotion in Alberta RHAs – According to Year and Level of Capacity

Survey Question	Low						Medium						High						ALL							
	2000		2001		2002		2000		2001		2002		2000		2001		2002		2000		2001		2002		2004	
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	
Is the health promotion funding source permanent?	n=24	n=28	n=18	n=9	n=59	n=50	n=38	n=49	n=24	n=23	n=19	n=8	n=129	n=104	n=76	n=66										
	10 (41.7)	11 (39.3)	11 (61.1)	4 (44.4)	3 (50.8)	33 (66)	21 (55.3)	29 (59.2)	14 (58.3)	16 (69.6)	11 (57.9)	4 (50)	54 (50.5)	63 (60.6)	43 (60.6)	37 (56.1)										
	1 (4.2)	5 (17.9)	- (0)	- (0)	5 (8.5)	2 (4)	2 (5.3)	4 (8.2)	1 (4.2)	1 (4.3)	3 (15.8)	-	7 (6.5)	8 (7.7)	5 (7.0)	4 (6.1)										
	13 (54.2)	12 (42.9)	7 (38.9)	5 (55.6)	24 (40.7)	15 (30)	15 (39.5)	16 (32.7)	9 (37.5)	6 (26.1)	5 (26.3)	4 (50)	46 (43.0)	33 (31.7)	23 (32.4)	25 (37.9)										
Has your organization applied for funds from other sources to support (heart) health promotion activities?	n=27	n=28	n=20	n=10	n=63	n=55	n=40	n=49	n=27	n=23	n=20	n=8	n=117	n=109	n=77	n=67										
	6 (22.2)	5 (17.9)	8 (40)	6 (60)	20 (31.7)	18 (32.7)	16 (40)	23 (46.9)	5 (18.5)	6 (26.1)	7 (35)	1 (12.5)	31 (26.5)	31 (28.4)	30 (39.0)	30 (44.8)										
	6 (22.2)	7 (42.9)	3 (15)	1 (10)	14 (22.2)	14 (25.5)	8 (20)	6 (12.2)	7 (25.9)	6 (26.1)	4 (20)	1 (12.5)	27 (23.1)	28 (25.7)	13 (16.9)	8 (11.9)										
	15 (55.6)	16 (57.1)	9 (45)	3 (30)	29 (46.0)	23 (41.8)	16 (40)	20 (40.8)	15 (55.6)	11 (47.8)	9 (45)	6 (75)	59 (50.4)	50 (45.9)	34 (44.2)	29 (43.3)										
Has your organization acquired funds from any other sources to support (heart) health promotion?	n=30	n=27	n=20	n=10	n=67	n=53	n=40	n=48	n=33	n=23	N=19	n=8	n=130	n=107	n=75	n=66										
	6 (20.0)	4 (14.3)	4 (20)	5 (50)	16 (23.9)	16 (30.2)	12 (30)	21 (43.8)	4 (12.1)	2 (8.7)	8 (42.1)	1 (12.5)	26 (20.0)	24 (22.4)	20 (26.7)	27 (40.9)										
	8 (26.7)	8 (28.6)	5 (25)	1 (10)	15 (22.4)	15 (28.3)	12 (30)	10 (20.8)	10 (30.3)	9 (39.1)	2 (10.5)	1 (12.5)	33 (25.4)	33 (30.8)	20 (26.7)	12 (18.2)										
	16 (53.3)	16 (57.1)	11 (55)	4 (40)	36 (53.7)	22 (41.5)	16 (40)	17 (35.4)	19 (57.6)	12 (52.2)	9 (47.4)	6 (75)	71 (54.6)	50 (46.7)	35 (46.7)	27 (40.9)										

cy of resources allocated to health promotion internally and externally, and personnel assigned to health promotion, with response options ranging from 'not at all' sufficient (=1) to 'very sufficient' (=5) (Table IV). Finally, an open-ended question provided an opportunity for respondents to prioritize what they needed most to strengthen and support their health promotion work.

Intensive assessments

Descriptive statistics were performed on the RHAs' baseline data to determine a global score of organizational capacity for health promotion. A frequency distribution was created for the 17 RHAs, and then divided into tertiles representing high (n=5 RHAs), medium (n=8 RHAs) and low capacity (n=4 RHAs). Finally, one RHA from each capacity category was selected for intensive assessment (e.g., focus groups and interviews) based upon their willingness to participate and geographical variation.

The focus groups and interviews in the low-, medium- and high-capacity RHAs in 2002/2003 provided greater insight into the financial and human resources allocated to health promotion, as well as their resource needs. In each of the three RHAs, the focus groups were attended by between five and seven participants. We also conducted two semi-structured interviews in each RHA with senior management representatives. Questions prompted participants to consider facilitators and barriers to health promotion in their RHA, as well as incentives for capacity building. Focus group and interview proceedings were recorded and transcribed verbatim.

Data analysis procedures

Analysis of our multiple data sources required a combination of quantitative and qualitative methods. Descriptive statistics (i.e., frequencies) were used to analyze the Organizational Capacity Survey results for each of the low-, medium- and high-capacity RHAs.* One-way ANOVAs on the total sample were performed for each of the three questions pertaining to perceptions of health promotion resources (Table IV) to examine any changes in resource allocation over the duration of the study. Qualitative data (i.e., open-ended survey questions, focus groups and interviews) were analyzed with content and thematic procedures, as described by Miles & Huberman.¹⁹ Finally, data interpretation occurred through an integrative approach, whereby the quantitative and qualitative results deepened the meaning of each other.

RESULTS

Rhetoric: Public commitment to health promotion

In their 2001/2002 business and strategic plans, 10 of the 17 RHAs (58.8%) explicitly identified promoting population/community health as an organizational aim in their mission statements. A health promotion focus was also implicit in the mission statements of 2 other RHAs, as indicated by their intent to "promote healthy environments and lifestyles". In summary, just over 70% of Alberta RHAs clearly identified health promotion as an organizational priority (n=12, 71.0%).

Reality: Financial commitment to health promotion

Analysis of the business and strategic plans also revealed that nearly all of the RHAs (n=16) allocated core funding to PPP. More than half of these

* Due to the fact that several of the response options for the Board Group were zero, statistical testing (e.g., Chi-square analyses) could not be conducted, as statistical assumptions would be violated.

TABLE III
Respondents' Perceptions of the Availability of Human Resources for Health Promotion Activities in Alberta RHAs – According to Year and Respondent Type

Survey Question (HP = health promotion)	Service Provider				Senior/ Middle Management				Board			
	2000 n (%)	2001 n (%)	2002 n (%)	2004 n (%)	2000 n (%)	2001 n (%)	2002 n (%)	2004 n (%)	2000 n (%)	2001 n (%)	2002 n (%)	2004 n (%)
HP management, coordination & admin.												
None of the time	n=55 12 (21.4)	n=48 12 (25.0)	n=38 6 (15.8)	n=31 3 (9.7)	n=58 10 (17.2)	n=52 9 (17.3)	n=33 7 (21.2)	n=34 3 (8.8)	n=20 7 (35.0)	n=13 8 (61.5)	n=13 5 (38.5)	n=5 2 (40.0)
Some	29 (51.8)	25 (52.1)	23 (60.5)	19 (61.3)	26 (44.8)	26 (50.0)	15 (45.5)	19 (55.9)	12 (60.0)	3 (23.1)	7 (53.8)	2 (40.0)
Half	6 (10.7)	4 (8.3)	3 (7.9)	5 (16.1)	9 (15.5)	6 (11.5)	3 (9.1)	5 (14.7)	—	1 (7.7)	1 (7.7)	1 (20.0)
Most	7 (12.5)	4 (8.3)	4 (10.5)	2 (6.5)	12 (20.7)	7 (13.5)	7 (21.2)	6 (17.6)	1 (5.0)	—	—	—
All	1 (1.8)	3 (6.3)	2 (5.3)	2 (6.5)	1 (1.7)	4 (7.7)	1 (3.0)	1 (2.9)	—	—	—	—
HP implementation	n=55 4 (7.3)	n=49 2 (4.1)	n=39 2 (5.1)	n=29 2 (6.9)	n=57 12 (21.1)	n=51 11 (21.6)	n=33 5 (15.2)	n=34 12 (35.3)	n=19 6 (31.6)	n=13 8 (57.1)	n=12 4 (33.3)	n=5 4 (80.0)
None	29 (52.7)	30 (61.2)	21 (53.8)	15 (51.7)	41 (71.9)	33 (64.7)	23 (69.7)	18 (52.9)	9 (47.4)	5 (35.7)	8 (66.7)	1 (20.0)
Some	6 (10.9)	6 (12.2)	6 (15.4)	4 (13.8)	3 (5.3)	4 (7.8)	1 (3.0)	2 (5.9)	2 (10.5)	1 (7.1)	—	—
Half	15 (27.3)	8 (16.3)	8 (20.5)	7 (24.1)	1 (1.8)	2 (3.9)	3 (9.1)	1 (2.9)	2 (10.5)	—	—	—
Most	1 (1.8)	3 (6.1)	2 (5.1)	1 (3.4)	—	1 (2.0)	1 (3.0)	1 (2.9)	—	—	—	—
All	n=55 3 (5.4)	n=49 6 (12.2)	n=39 3 (7.7)	n=28 —	n=57 2 (3.5)	n=52 2 (3.8)	n=33 —	n=—	n=20 2 (10.0)	n=13 4 (30.8)	n=11 —	n=5 —
Duties other than HP	21 (37.5)	17 (34.7)	14 (35.9)	5 (39.3)	14 (24.6)	13 (25.0)	8 (24.2)	7 (20.6)	7 (35.0)	2 (15.4)	4 (36.4)	1 (20.0)
None	7 (12.5)	8 (16.3)	5 (12.8)	10 (17.9)	5 (8.8)	9 (17.3)	4 (12.1)	5 (14.7)	1 (5.0)	—	—	—
Some	22 (39.3)	17 (34.7)	14 (35.9)	2 (35.7)	31 (54.4)	23 (44.2)	17 (51.5)	17 (50.0)	8 (40.0)	5 (38.5)	7 (63.6)	3 (60.0)
Half	2 (3.6)	1 (2.0)	3 (7.7)	11 (7.1)	5 (8.8)	5 (9.6)	4 (12.1)	3 (8.8)	2 (10.0)	2 (15.4)	—	1 (20.0)
Most	—	—	—	—	—	—	—	—	—	—	—	—
All	—	—	—	—	—	—	—	—	—	—	—	—

RHAs (n=10, 62.5%) directed less than 5% of their total budget to PPP in the 2001/2002 fiscal year (Table I). Only 3/16 (18.8%) of RHAs allocated more than 7% of their core budget to PPP. Interestingly, there was no correlation between organizational capacity for health promotion and allocation of resources to PPP, with high-capacity regions allocating anywhere from 3.0-5.5% of budgets, medium-capacity regions contributing from 2.5-7.5%, and low-capacity regions allocating from 4.5-7.4% of their health budgets. Given that PPP is a broad budget category incorporating public health practices unrelated to health promotion or chronic disease prevention, it is likely a small fraction of this amount actually reached (heart) health promotion initiatives.

Rhetoric and reality: Insiders' perspectives on commitment to health promotion

Throughout the study, approximately half of the survey respondents from each capacity level reported that permanent (i.e., core) funding reached health promotion in their organization (Table II). Focus group participants supported the impression that organizational commitment was not sufficient to adequately fund health promotion.

"I think the main challenge is one of resources.... So if we could get a strong commitment from the organization that health promotion is a priority, and that the dollars that go into health promotion are protected, that would be the ideal." (Senior Manager, personal interview, medium-capacity region, 2002)

In order to obtain financial support for health promotion initiatives, survey respondents reported seeking funding from multiple sources external to the RHA (i.e., short-term grants from provincial government departments, non-governmental organizations, community agencies and businesses). Across capacity levels, the frequency of respondents who reported seeking and securing external funding increased over the study time periods. Furthermore, more respondents reported seeking funding than obtaining funding from outside sources (Table II). Focus group participants confirmed the need to secure external funding for health promotion.

"... V and I have filled out so many proposals in the past couple of years; many of them have fallen into never-never land." (Focus group, high-capacity region, 2003)

Low levels of core funding for health promotion affected the RHAs' human resources. Throughout the study, a trend of few human resources exclusively dedicated to health promotion was apparent. Regardless of the type of role they held (e.g., service provider, manager or board member), health promotion activities were rarely respondents' sole job responsibilities. (See Table III for a full account of the results by capacity level and membership level over the four years.) Focus group participants extended the meaning of these trends by identifying the stress related to fragmented roles and multiple responsibilities.

"But I think the, the problems continue to be, ah, that we often have people who are just overloaded." (Personal interview, low-capacity region, 2001)

Low levels of financial resources were also linked with a lack of permanent staff positions devoted to health promotion. The external funding sources previously described (i.e., grants) were often used to finance short-term positions for health promotion initiatives.

"You never know whether it's [the funding] going to come back next year, you know, what should we do with this bit of money to get the most out of it. And sometimes the decisions end up being kind of quick and dirty..." (Personal interview, low-capacity region, 2001)

Furthermore, scarce human resources were diverted from health promotion activities to continue the search for funding.

"... I think it's this lack of ongoing funding and such that puts us in a position to pursue something like this, where we just feel it's just consuming us instead of helping." (Focus group, medium-capacity region, 2003)

TABLE IV
Respondents' Perceptions re How Sufficient Resources Are in Helping Their RHA Conduct Health Promotion Activities – According to Year and Capacity Level

Survey Item	Low				Medium				High				ALL*			
	2000	2001	2002	2004	2000	2001	2002	2004	2000	2001	2002	2004	2000	2001	2002	2004
	(n=31)	(n=36)	(n=23)	(n=10)	(n=78)	(n=60)	(n=43)	(n=54)	(n=35)	(n=30)	(n=21)	(n=9)	(n=144)	(n=126)	(n=87)	(n=73)
	mean	mean	mean	mean	mean	mean	mean	mean	mean	mean	mean	mean	mean	mean	mean	mean
	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)	(SD)
Funds allocated to health promotion internally	2.14 (1.09)	1.91 (.78)	2.55 (.89)	1.70 (1.05)	2.44 (.91)	2.35 (.80)	2.53 (1.11)	2.29 (.76)	2.61 (.97)	2.73 (.98)	2.31 (1.05)	2.91 (1.17)	2.41 (.97)	2.31 (.89)	2.48 (1.03)	2.29 (.90)
Funds allocated to health promotion externally	2.27 (.89)	2.32 (.95)	2.69 (.92)	2.50 (1.17)	2.53 (.88)	2.56 (.73)	2.67 (.97)	2.50 (.78)	2.73 (.85)	2.32 (.85)	2.54 (.92)	3.00 (1.22)	2.52 (.87)	2.44 (.83)	2.64 (.94)	2.56 (.90)
Number of personnel assigned to health promotion	2.12 (.95)	2.07 (.83)	2.35 (.88)	1.70 (.67)	2.26 (.85)	2.30 (.85)	2.47 (1.12)	2.40 (.80)	2.55 (1.00)	2.62 (1.14)	2.26 (.91)	2.77 (1.09)	2.30 (.92)	2.31 (.94)	2.39 (1.01)	2.35 (.86)

Note: response options ranged from 'not at all sufficient' (=1) to 'very sufficient' (=5)

* One-way ANOVAs on the total sample for all three items revealed no statistically significant differences (p-values were >0.05) between years

Throughout the study, organizational survey respondents consistently identified “Financial resources to support improved staffing” as a top priority for health promotion in the RHAs. This need was supported in the focus group and interview data, as well, where participants described how adequate, sustainable financial and human resources are needed for health promotion action.

“The big problem is money. We don’t have enough money to hire additional staff...on that basis, we haven’t got much maneuvering room to do health promotion...It’s going to be a difficult procedure to increase health promotion in the current conditions.” (Focus group, high-capacity region, 2003)

Over the course of the study, respondents (regardless of capacity level or respondent type) consistently indicated that the level of funds and personnel allocated to health promotion was in most cases ‘not very sufficient’ to ‘somewhat sufficient’ in helping their RHA conduct health promotion activities. Further, one-way ANOVAs did not reveal significant changes in respondents’ perceptions of these resource allocations over the four years of the study (Table IV).

DISCUSSION

Provincial and federal reports have recommended reorientation of the health care system to increase emphasis on health promotion,¹⁻⁴ the Alberta government mandates health promotion in the RHAs,²⁰ and RHAs espouse commitment to health promotion. We found, however, the actual financial and human resources allocated to health promotion in Alberta are incongruent with this rhetoric.

Over the course of this study, the data consistently revealed inadequate funding for health promotion. Insufficient financial resources are frequently identified in the literature as a barrier to health promotion practice (e.g., Joffres et al.,⁶ Schwartz et al.²¹). In Alberta, health promotion financing may be further undermined by the invisibility of the Prevention Promotion Protection budget category. Since the allocations within this category are not specified, RHAs could avoid dedicating any resources to health promotion for preventing chronic diseases.

When successful, the search for supplemental health promotion funding resulted

in multiple funding sources that each provided small, short-term project-based allocations. Inadequate and fragmented financing, however, may contribute to the “poverty cycle of intervention programs”²¹ (p. 489) by compromising the implementation integrity of the intervention. Evaluation of a diffuse intervention may yield inconclusive or questionable results which suggest the intervention did not meet its stated outcomes. Such results lessen support for the intervention, impair opportunities for future funding, and ultimately erode the sustainability of health promotion.^{5,21}

The data also supported the link between inadequate financial resources and insufficient human resources for health promotion in the RHAs. Health promotion positions often consisted of fragmented roles or were short-term contracts. Unstable work related to short-term project funding may contribute to the loss of skilled health promotion practitioners.⁶ These factors risk undermining the development of multiple health promotion champions at multiple organizational levels, particularly higher organizational levels. Compromised leadership for health promotion within the organization means that health promotion is less visible and less influential within the organization.⁶ Ultimately, the interplay of insufficient financial resources (infrastructure), few health promotion champions (leadership), and little organizational influence (political will) will threaten public health organizational capacity for health promotion.

Our research findings were limited by a number of methodological factors. First, although the sample characteristics of the Organizational Capacity Survey were reflective of the organizations, they were nevertheless modest, potentially reducing the generalizability of our findings. Second, the sample proportions of the front-line service providers, managers and board members changed between the data collection points, perhaps reflective of the instability of health promotion within the RHAs. Third, the upheaval of re-regionalization in 2003 may have contributed to participant turnover and respondent fatigue resulting in sample attrition. Finally, many participants reported a low level of familiarity with organizational budgets and priorities, further limit-

ing the generalizability of our findings, but perhaps reflecting a reality of health promotion practice within a complex, predominantly treatment-oriented health organization.

CONCLUSION

Although Alberta is rich in resources, and Canada's only debt-free province, our research suggests a disconnect between political rhetoric supporting health promotion and the reality of resource allocations to health promotion. The inadequate financial and human resources reported herein may hinder the development of public health organizational capacity for health promotion. Accordingly, there is a need for sustainable and adequate financial resources specifically dedicated to health promotion in order to build RHAs' capacity for health promotion. Local advocacy efforts have invoked the adage, "an ounce of prevention is worth a pound of cure", to urge investment of at least one-sixteenth (6.25%) of Alberta's health budget in health promotion. Alberta may be the province with the financial infrastructure to make such an investment. Time will tell if the leadership and political will are present to stimulate such investment in building capacity for health promotion.

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RÉSUMÉ

Contexte : Le discours politique canadien convient de l'importance de promouvoir la santé en y affectant les ressources sanitaires nécessaires. De plus, dans les articles d'actualité, les ressources humaines et financières sont souvent considérées comme d'importants éléments des capacités organisationnelles de promotion de la santé. Dans le cadre d'un projet albertain sur la santé cardiovasculaire (AHHP), nous avons cherché à déterminer si l'affectation des ressources au sein d'un réseau de santé régionalisé en Alberta, au Canada, était conforme aux prises de position sur la promotion de la santé.

Méthode : Le projet AHHP faisait appel à une démarche plurielle inscrite dans un modèle en séries chronologiques. Les participants provenaient des trois paliers organisationnels (fournisseurs de services, gestionnaires, administrateurs) de toutes les régions régionales de la santé (RRS). Les données ont été recueillies selon plusieurs méthodes (une étude de la capacité organisationnelle, l'analyse de documents organisationnels et la tenue de groupes de discussion et d'entretiens en personne) pour faciliter les croisements. Nous avons choisi des techniques d'analyse quantitatives (distribution de fréquences, analyse de la variance) et qualitatives (analyse du contenu, analyse thématique).

Résultats : Dans la plupart des cas, les ressources financières affectées à la promotion de la santé dans les budgets centraux des RRS étaient minimales (<5 %). Les répondants se sont dits obligés de recourir à plusieurs sources de financement pour leurs projets de promotion de la santé. Les ressources humaines affectées à la promotion de la santé avaient des mandats fragmentés et de courte durée. De plus, il fallait consacrer de précieuses ressources humaines à la recherche constante de budgets ne couvrant le plus souvent que de brèves périodes.

Conclusion : Les enveloppes budgétaires de promotion de la santé dans les RRS de l'Alberta ne correspondent pas à la priorité que l'on dit accorder à cet outil. Le financement irrégulier et insuffisant érode les capacités des RRS en matière de promotion de la santé. Pour être durable, la promotion de la santé exige l'affectation assurée de ressources financières suffisantes à long terme.