

THE NATURE OF PUBLIC HEALTH NURSING PRACTICE:  
FINDING COHERENCE IN COMPLEXITY

by

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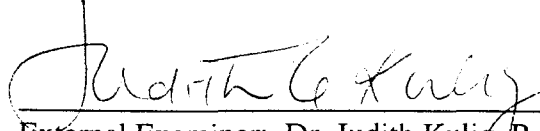
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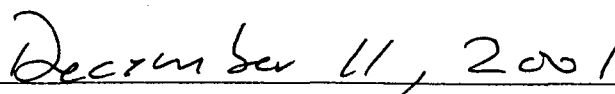


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## ABSTRACT

The nature of public health nursing practice is not well understood, as revealed in the persistent questions public health nurses face about their role and function within the health care system. Thus, it is the purpose of this study to explore the relationship between public health nursing practice and the practice context in order to better understand how nurses work out their practice within a complex environment to produce what is commonly accepted to be the content of public health nurses' work.

Literature, practice documents, and an injury prevention exemplar were explored through an interpretative process of analysis. Three contextual forces and three practice tensions were found to constitute the public health nursing practice environment. These contextual forces are historical influences, changing organizational structures, and public health policy developments. The practice tensions include: the individual versus the population as the focus of practice; the individual autonomy of the public health nurse versus the combined public health nursing effort necessary to improve health; and the public health nurses' ownership of particular roles and responsibilities versus their contribution to a larger societal endeavour to improve health. The practice environment is revealed to be complex and multi-faceted.

The way in which the public health nurse comes to understand and embrace these complexities shapes the nurse's practice. Emerging into view is the taken-for-granted way in which the nurse-in-practice configures her or his practice within the dynamic and complex nature of the practice environment.

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## CHAPTER ONE

### Introduction

An overlooked phenomenon in the world of public health nursing practice is how public health nurses come to understand and sort out their practice within a practice environment replete with constant change and competing interests. This sorting out of practice occurs in the face of ongoing questions about the role and function of public health nurses within the formal health care system. These questions come from those external to public health nursing practice such as managers, bureaucrats, and politicians, other organizations and agencies interested in health and social issues, and the general public. The recent regionalization of health services in British Columbia has increased the significance of these questions as they are frequently raised by the health care organizations within which public health nurses work. Public health nurses, themselves, spend time discussing and contemplating their role in an attempt to clarify their contribution within the health care system (Ministry of Health and Ministry Responsible for Seniors, 1995; Manitoba Health, 1998).

This persistent focus on the public health nurse's role and the associated lack of clarity about that role is echoed in the literature. In Ontario, public health nursing practice has been subject to the competing influences of health promotion and public health medicine paradigms. The result has been role confusion and a perception among public health nurses that their work is undervalued and invisible to others (Rafael, 1998, 1999a, 1999b). Some of the public health nursing literature contends that the lack of public health nursing role clarity and group identity contributes to the invisibility of the profession (Kuss, Proulx-Girouard, Lovitt, & Kennelly, 1997; Leipert, 1996; Zerwekh, 1992, 1993). Further, this lack of role

clarity is thought to impede understanding about the way in which public health nurses' roles and responsibilities are actually carried out (Laffrey & Craig, 2000). The resulting sense of invisibility, in turn, hampers the ability of public health nurses to promote their roles to others.

There are many factors at play within the practice environment that may be responsible for the sense among public health nurses that their work is undervalued and invisible to others. This study does not attempt to illuminate these factors nor does it strive to resolve the situation. Rather, if we accept that issues of role clarity, visibility, and a sense of value exist for public health nursing practice, we are acknowledging that there must be a relationship in place between the public health nurse's role and the larger context within which that role is carried out. If no relationship exists, it begs the question of why public health nurses see it as important work to clarify and promote their role to others.

Therefore, the need for role clarity, visibility, and a sense of value are perhaps symptoms rather than causes of the state of the relationship between public health nurses and the forces external to public health nursing practice. If this is true, we are led to ask questions and search for understandings about this relationship rather than only about the issues of role clarity, visibility, and a sense of value. This study explores the question: How does the relationship between public health nursing practice and the context of that practice shape public health nurses' work? Thus, the purpose of this study is to better understand how public health nurses work out their practice within a complex environment to produce what is commonly accepted to be the content of public health nurses' work.

An interpretative process of analysis is used throughout this study, beginning with an exploration of the research and practice literature. This analysis of the literature reveals three

contextual forces that contribute to the complexity of the public health nursing practice environment. The contextual forces included in this analysis are the history of public health nursing, the health and social services reform processes of the 1990s, and the public health policy developments of the later 20<sup>th</sup> Century. Emerging from this analysis are three tensions, shown to be inherent in the public health nursing practice environment. Finally, the relationship between public health nursing practice and the contextual forces and practice tensions are examined in light of a case study of public health nursing practice within an injury prevention initiative.

Contemplation of the relationship between public health nurses and the context of practice leads to questions about how much public health nurses really understand about the nature of the contextual forces surrounding the public health nursing practice environment and further, how these contextual forces come to shape practice. Throughout this analysis, I will argue that the public health nursing practice environment is revealed to be complex and messy and that these complexities are largely hidden from the view of both public health nurses and those external to their practice. Further, I will argue that sorting out practice within what is revealed within the practice environment is the substance of public health nursing practice. Thus, this analysis essentially has become about the taken-for-granted way in which public health nurses configure their practice given the complexities inherent within the practice environment.

The taken-for-granted way in which public health nurses configure practice becomes visible only as we view the public health nursing practice environment from the perspective of public health nurses engaged in that practice. My own public health nursing practice experience has served as the platform from which this analysis was initiated and

subsequently progressed. My practice experience began in 1982 in Manitoba. Since then, I have worked primarily in the public health sector of the Manitoba and British Columbia health care systems in public health nursing, public health nursing management, and as a senior manager with responsibility for public health programs. As a result, this analysis is focused on public health nursing practice within the public health sector of the health care system that is directly funded by government.

Over the last decade, my work within public health and public health nursing has been carried out in an organizational environment of turmoil and change, producing many questions regarding public health, public health nursing, and its contribution to the health care system. Thus, this analysis has become both a personal and professional journey of reflection on my own practice experiences in order to critically examine, explicate, and articulate what I have come to understand about the practice environment and the way in which practice is worked out in light of this environment.

The relationship between public health nursing practice and the external environment merits in-depth analysis for two reasons. First, there is little formal knowledge available about how public health nurses work out their practice within a complex practice environment. This study identifies three practice tensions and three contextual forces at play within the public health nursing practice environment. The literature does explore to some extent the content of public health nurses' work, the historical, organizational, and public health policy forces evident within the public health nursing context, and the practice tensions inherent in the practice environment. However, the relationship between practice and the context of practice has not been thoroughly explored. The literature also fails to examine these contextual forces, practice tensions and their interactions from the perspective

of the nurse-in-practice. I will suggest later in this analysis that an understanding of the nature of the relationship between the nurse-in-practice and the complex practice environment is critical if nurses are to successfully and intentionally navigate the choices, opportunities, and challenges confronting them in their day-to-day work.

The second reason for a comprehensive examination of this topic concerns the persistent questions about what public health and public health nursing are all about. In 2000, the Public Health Association of British Columbia [PHABC] embarked on a preliminary analysis of how the changing governance structures within the health care system have affected public health practice. This analysis was conducted through 27 key informant interviews with public health professionals, regional health authority board members, senior managers, and Ministry of Health officials. Interestingly, one of the key issues identified was a need to clarify what public health is and what contribution it makes to the health care system.

The regionalization process that began in British Columbia in 1992 has raised the profile of the question, “What is public health?”, as public health services are now situated in closer proximity to other health care service sectors. Prior to regionalization, public health services were often governed and managed by separate organizational structures or by divisions of the Ministry of Health, sheltering public health from the necessity of responding to the uncertainties about its particular role within the larger system. The establishment of regional health authorities has brought to the forefront the questions asked by service providers from other sectors, senior managers, and board members. The need to respond with clarity to, “What is public health?” has become more pressing as those with the power and control over the organization and delivery of health services seek answers to the questions.

Throughout history, nursing has been an integral part of the public health system and its evolution (Allemang, 2000). Thus, the challenging task of explaining public health is mirrored in attempts to clarify public health nursing practice. In the final chapter of this study, I will be arguing that public health nurses, who understand the nature of the practice environment and choose to embrace its complexities, can more successfully engage in an intentional process of configuring their practice. Public health nurses who are deliberately involved in sorting out their practice in light of what is known within the practice environment have a better chance of producing a practice that is relevant to the larger organization. It will also be more likely that these nurses will be equipped to explain their practice to others.

Before we can proceed with examining the relationship between public health nursing practice and the forces evident within the context of practice, it is necessary to lay some groundwork for this study. First, it will be helpful to look at how the practice of public health nursing is most often described. Second, it is necessary to outline three tensions that are revealed in the research and practice literature to be inherent in public health nursing practice. The content of practice and the practice tensions are critical to understanding the way in which public health nurses configure their practice and will be returned to in the analysis presented in the final chapter.

### *Content of Public Health Nursing Practice*

Efforts to describe public health nursing practice in the literature have centred on three basic approaches. In my role as a public health manager, I am often called upon to describe public health nursing practice for others in the health and social science professions. I have usually resorted to using these same three approaches. They include: outlining the

roles and functions evident in public health nursing practice; delineating the differences between public health nursing practice and other types of nursing practice most often accomplished by describing the target populations for public health nurses' attention; and explicating public health nursing practice through conceptual models and frameworks designed to capture the various facets of practice. All three approaches effectively assist in increasing our understanding by summarizing and portraying the content of public health nursing practice.

The first approach is perhaps the most common, whereby roles, functions and purpose statements are presented. Sometimes, descriptions of public health overall are used to clarify public health nursing practice. For example, the Canadian Public Health Association [CPHA] (1996a) produced a document with the purpose of positioning public health as a partner in the process of health system reconfiguration. CPHA hoped to challenge decision makers in the reform process to incorporate and integrate health promotion, disease prevention, health protection, and healthy public policy as primary components of the health care system. This document outlines eight contributions that are thought, when viewed collectively, to explain the uniqueness of public health (CPHA, 1996a). These contributions in sum are: focusing on individuals and communities in a societal and global context; building capacity in individuals and communities to improve health; facilitating community mobilization through community participation; embracing promotion, prevention, and protection; providing disease surveillance and control; influencing the orientation of the health system toward health outcomes; building partnerships among sectors at the local level; and advocating for the health of the public (p. I-8 – I-9). During the early stages of health reform in British



Columbia, academics, managers, and practitioners used this document to discuss the potential functions and roles of public health nurses.

Another document produced by CPHA (1990), *Community Health – Public Health Nursing in Canada: Preparation and Practice*, has been widely used in the practice environment to clarify the roles and functions of public health nurses. This document describes public health nursing as:

...an art and a science that synthesizes knowledge from the public health sciences and professional nursing theories. Its goal is to promote and preserve the health of populations, and it is directed to communities, groups, families, and individuals across their lifespan, in a continuous rather than an episodic process.

Community health/public health nurses play a pivotal role in identifying, assessing, and responding to the health needs of given populations. They work in collaboration with, among others, communities, families, individuals, other professionals, voluntary organizations, self-help groups, informal health care providers, governments, and the private sector. (p. 3)

The CPHA document goes on to list roles of public health nurses in health promotion and disease prevention as consultant, educator, community developer, facilitator, advocate, counsellor, communicator, coordinator, collaborator, researcher and evaluator, social marketer, and policy formulator (CPHA, 1990). This document presents a comprehensive and accurate outline of the content that makes up public health nursing practice, but it falls short of illuminating how public health nursing practice happens.

Others define the role of the public health nurse by focusing on the interventions carried out in practice (Keller, Strohschein, Lia-Hoagberg, & Schaffer, 1998). These interventions are described as advocacy, case management, coalition building, collaboration, disease investigation, health teaching, screening, surveillance and so on. Other literature outlines public health nursing services according to the approaches or strategies used in the delivery of services. The strategies most repeatedly discussed include health promotion,

health education, disease prevention, and health protection (CPHA, 1990, 1996a; Manitoba Health, 1998; Ministry of Health and Ministry Responsible for Seniors, 1995).

A second approach to clarifying the role of the public health nurse concentrates on distinguishing between the role and functions of public health nurses and other kinds of nurses. This generally takes the form of describing who constitutes the target of public health nurses' work. Laffrey and Craig (2000) state that public health nurses "have broad responsibilities for providing illness prevention and health promotion for all levels of individual, family, aggregate, and community" (p. 106).

The target population for public health nurses' work often leads to debate about the practice titles used to describe public health nursing. For example, some of the literature recommends that public health nursing practice be called population-focused or population health nursing to differentiate it from community-based nursing. This literature suggests that population health nursing concentrates on health promotion and disease prevention targeted to specific groupings of people. In contrast, the title, community-based nursing, is used to describe nurses providing individualized illness care in community settings (Baldwin, O'Neill Conger, Abegglen, & Hill, 1998; Zotti, Brown, & Stotts, 1996). Similarly, Kuss et al. (1997), in outlining their public health nursing model, advocate for a distinction between the professional practice titles of public health nursing and community health nursing. They emphasize the importance of this distinction in order to clarify the public health nurse's role and to obtain recognition as a unique field of professional practice.

The third and most comprehensive efforts to describe public health nursing are evident in the development of conceptual models or paradigms for public health nursing practice (Clarke, Beddome, & Whyte, 1993; Kuss et al., 1997; Laffrey & Craig, 2000). These

models vary in depth and breadth, but generally attempt to integrate components of the underlying concepts, activities, and target populations characteristic of public health nurses' work.

Kulig (2000) contends that public health nursing theoretical development is deficient, particularly in relation to public health nurses' role with the community as a whole. Kulig further argues that the inability to establish a clear and unified direction for public health nursing theory development is, in part, due to the absence of an in-depth clarification of public health nursing concepts.

Similarly, Stewart & Leipert (2000) recently reviewed the variety of nursing models, family theories, community theories, and primary health care theories that have been used in public health nursing practice and have found them lacking. The nursing models developed to date tend to be limited to public health nurses' work with individuals and, at most, families who are often viewed to be in a dependent relationship with the nurse. The socio-environmental determinants of health and the population context are frequently missing. Family theories, while integral to public health nurses' work with families, do not capture the full extent of public health nursing practice. Community theories and primary health care theories are seen as having the potential to contribute to a comprehensive public health nursing practice model, but this work has yet to be done.

Thus, it is evident that researchers, theorists, and practitioners alike have used a variety of approaches to describe and explicate the roles and functions seen to constitute public health nurses' work. While much work remains to be done, particularly in relation to theoretical development, the literature captures what is generally accepted to be the content of public health nursing practice but fails to clarify how public health nursing work happens.

### *Tensions Inherent in Public Health Nursing Practice*

The exploration of the contextual forces influencing public health nursing practice has led to the identification of three tensions inherent in the public health nursing practice environment. The first tension relates to whether the individual's health or the population's health is the focus of public health nursing service. The second tension arises from the interaction between the public health nurse's individual autonomous practice and the need for a combined public health nursing effort if improvements in population health are to be realized. The third tension is evident when the roles and responsibilities accepted to be within the purview of public health nursing practice are juxtaposed to the organizational and societal involvement in public health that is largely external to the directly funded public health system. These tensions are shaped by the historical, theoretical, and organizational context within which public health nursing practice occurs.

These tensions are only recently emerging in the analyses of public health nursing practice in the literature. The individual versus population focus of public health nursing practice is most frequently examined. There is scant attention in the literature focusing on the interaction between the individual public health nurse's practice and the collective activity of public health nurses or the collaborative relationship between public health nurses and the health promoting initiatives external to the formal public health system. We now turn our attention to a brief analysis of these three tensions.

*The public health nurse's focus of work.* Is public health nursing practice about the work that is done to improve an individual's health or is it about improving the health of the population? This question reflects the foremost tension evident in public health nursing practice, the tension between the individual versus the population as the focus of practice.

Public health nursing practice involves a public health nurse in the lives of individual community members not solely for the purpose of improving the health of a person but for the overall health of the population. This inevitably leads the public health nurse to processes and strategies targeted beyond that of the person (Laffrey & Craig, 2000).

For example, the nurse involved in an immunization program is not simply immunizing individuals who present at a clinic, but seeks approaches that ensure maximum uptake of the vaccine in the overall population. This includes activities such as regular immunization record reviews, reminder processes, awareness programs both of a general and targeted nature, and the collection, analysis, and monitoring of immunization rates. In this way, the focus of the public health nurse is both the individual and the population as a whole.

Two recent studies reveal the fundamental nature of this tension in public health nursing practice. Diekemper, SmithBattle, and Drake (1999a, 1999b) conducted research in a midwestern city in the United States using an interpretive phenomenological methodology to examine the expert nursing practice of 25 community health nurses. Their research identified that a population focus is innate in public health nursing practice. This population focus is both an intentional endeavour and a natural evolution of work that is targeted to individuals and families.

Rafael (1998) conducted a study of the oral history of public health nurses in Southern Ontario from 1980 to 1996 in order to “make visible the work and struggles of public health nurses during a time of rapid change and considerable turmoil” (p. 31). The findings of this study reveal how the development of the health promotion movement in the 1980s created an artificial dichotomy between the public health nurses’ work with individuals versus the population. Public health nurses were compelled to incorporate

community development, partnerships, and the determinants of health into their practice at the expense of their work with individuals. Rafael contends that these ‘new’ ideas had actually been “a central part of nursing’s legacy since the time of Nightingale” (p. 36). Paradoxically, these nurses were asked to engage in community development work while they were distanced from their communities through the elimination of their individualized interactions. In essence, these nurses experienced role confusion as they were deprived of the very tools that they would have turned to in order to move forward with work at the community or population level (Rafael, 1999a, 1999b).

Of necessity, public health nursing practice encompasses a dual focus on the individual and the population (Chambers, Underwood, & Halbert, 1989). The simple and somewhat obvious immunization example highlights the essentiality of the tension that nurses find themselves dealing with as they work with individuals on specific issues while simultaneously seeking population level outcomes.

*The combined public health nursing effort to improve health.* Is public health nursing practice about the nurse’s independent, autonomous practice and thus, best viewed from the perspective of the individual nurse’s contribution to improving health outcomes? Or is it about the combined effort public health nursing practice makes to these outcomes? Herein lies the second tension. In order to impact the population’s health, public health nursing practice must be a combined effort but the effectiveness of this effort is dependent upon the specific nurse’s work.

As discussed earlier, CPHA produced a document that described the roles and functions of public health nurses (CPHA, 1990). Subsequently, a survey of Ontario public health nurses was conducted to determine if their role perceptions were consistent with the

roles outlined in the CPHA document (Chambers, Underwood, Halbert, Woodward, Heale, & Isaacs, 1994). An analysis of the survey results demonstrated that as individuals, nurses were not necessarily involved in all the activities outlined in the CPHA document. However, as a whole, their work encompassed the entire list of roles.

An example from my own practice may assist in illuminating this tension. Public health nurses in one of the health units I worked in became involved in a prevention strategy to improve the health of women in mid-life. The outcomes achieved in relation to this goal relied upon work that individual nurses performed. For example, nurses in each community involved in this initiative organized educational events tailored to the specific needs identified by women in that community. In one community, a day-long symposium was organized that focused on issues of heart health and menopause. In another community, 15 health and wellness workshops were held and in another, a weekly drop-in time was established for women seeking information and consultation (Northern Interior Regional Health Board [NIRHB], 2000).

At the same time as each public health nurse was pursuing these specific initiatives, the nurse was working within the context of a combined public health nursing effort to improve health. In the example of a public health nurse participating in a women's health project, the work that the individual nurse chose to perform in relation to the goal of improving women's health in mid-life was dictated and constrained in large part by the goal itself. For example, in order for progress to be made in improving the health and well-being of mid-life women overall, the public health nurses had to collectively understand the issues related to women's health, the strategies required to achieve the goal, and be able to incorporate these strategies into their own day-to-day work. Further, the connections the

nurse chose to make in the community, the types of resources that were compiled, and the nature of discussions that were initiated in client contacts were shaped by the goal of improving health.

In this way, the outcomes of public health nursing practice are dependent upon the individual nurse's work. This nurse's work, in turn, is fashioned by the outcomes public health nurses are collectively striving towards. The tension is revealed in the push-and-pull between the activities the public health nurse chooses to engage in versus those activities required by the overall effort to improve health.

*The public health nurse's work as part of the societal effort to improve health.*

Finally, the question arises, how much is public health nursing practice only about the work that occurs within the public health sector of the formal health care system or how much is it also part of something larger that includes efforts to improve the population's health external to the public health delivery system? This tension is revealed as public health nurses work out partnerships with those external to the public health sector. The result can be a collaborative endeavour that is greater than the sum of its parts with the mutual goal of improving health. At worst, when this tension cannot be reconciled, the relationships between public health nurses and external partners will be fraught with turfism, territorialism, and miscommunication leading to an undermining of any effort to work in partnership towards a greater purpose.

The public health nursing literature has begun to articulate the importance of partnerships to public health nursing practice. In the Canadian public health nursing textbook edited by Stewart (2000), intersectoral collaboration has been identified as a key component of Primary Health Care and thus, public health nursing practice. Many of the determinants of



health reside outside the direct influence of the health care system, making these intersectoral linkages and partnerships critical to improving the population's health. Bolton, Georges, Hunter, Long, & Wray (1998) contend that health professionals must recognize that the improvement of the population's health is reliant upon collaborative partnerships rather than existing as the exclusive purview of a particular health profession like public health nursing.

Reutter & Ford (1998) explored the perceptions of changes in public health nursing practice in six Alberta health units. The nurses identified that their practice has changed as a result of the increasing number of service providers who are involved in community based health promotion activities. These nurses perceived the creation of working partnerships with other professionals, community agencies, and volunteers as critical to achieving mutual goals.

The health promotion literature corroborates the importance of partnerships in influencing the health of the population. Gillies (1998) reviewed the international literature regarding alliances or partnerships in health promotion published since 1986 and identified case study accounts of best practices from around the world. This comprehensive review validates the effectiveness of alliances and partnerships in promoting health, both at the individual health level and in addressing the determinants of health in populations.

Kuhn, Doucet, & Edwards (1999) undertook a systematic review of the literature from 1990 to 1998 in relation to the effectiveness of coalitions in heart health promotion, tobacco use reduction, and injury prevention. Coalitions were defined as "a group of individuals from at least three organizations or constituencies who agreed to work together to achieve a common goal" (p. 2). Although the review found limitations in the data available,

the findings generally supported the notion that community based coalitions were an effective public health strategy.

Public health nurses can assume a variety of roles and responsibilities within such partnerships as revealed in the following three examples. Public health nurses may function as leaders in establishing a partnership or collaborative relationship. For example, public health nurses working in the school system may be involved in health education related to decision-making and self esteem. As part of this work, they may involve students in identifying their own health issues and in planning strategies to deal with these issues. The nurse may also be involved in directly supporting an adolescent struggling with body image issues. These public health nurses are not only performing public health nursing work within a school setting to improve the health of the school population. They also could be viewed as sharing responsibility for improving the health of the school population with students, parents, and school district staff.

In other situations, the public health nurse may share responsibility for collaborative planning with representatives from other agencies and organizations. Recently in the Northern Interior Health Region, public health nurses have been instrumental in developing a collaborative network of agency representatives and individuals interested in the prevention of HIV/AIDS. This group developed a three-year HIV/AIDS plan with the following stated goals:

...(a) to build self care capacity and action among those in the region at risk for HIV, and those infected and affected by HIV/AIDS; (b) to build collective capacity and action among service providers across the region in agencies, organizations, and services relevant to HIV/AIDS; and (c) to create a supportive environment in communities throughout the region for those at risk for HIV, and those infected and affected by HIV/AIDS” (NIRHB, 1999, p. 6).

The collaborative effort of both public health nurses and other organizational representatives are mutually focused on the desired public health outcome of reducing the incidence and impact of HIV/AIDS in the population.

In other instances, the public health nurse is a participant in a process that is led by a community based organization or another discipline. For example, the Pregnancy Outreach Program in Prince George has created a Fetal Alcohol Syndrome (FAS) Collaborative Network consisting of a broad cross section of community agency representatives. This collaborative network has the goal of increasing the community's awareness about the prevention of Fetal Alcohol Syndrome (Prince George FAS Community Collaborative Network, 1999). Public health nurses are participants in rather than leaders of this process.

This practice tension is produced as public health nurses attempt to determine their particular contribution to improving health while simultaneously seeking opportunities to collaborate with other organizational and community members in an overall endeavour to improve health. A delicate balance is required between public health nurses' ownership of particular roles and responsibilities and the give-and-take required by collaborative relationships. As this balance is achieved, health can be influenced significantly beyond that attainable by public health nurses alone. At one extreme of this practice tension, the public health nurses are forced to sacrifice their voice and any acknowledgement of their contribution to the collaborative process. At the other end, the public health nurses carry out their roles and responsibilities with a view to protecting their perceived territory isolating themselves from collaborative processes. At both ends of the spectrum, the collaborative process and public health nurses' role within that process often are rendered less effective as a result.

### *Study Approach*

Before moving to an overview of the chapters in this thesis, it is important to discuss the overall design that was used throughout this study. An interpretative process of analysis was used to illuminate the nature of public health nursing practice. The approach used in this study draws on the philosophical hermeneutics of Martin Heidegger and Hans-Georg Gadamer. This philosophical stance places emphasis on ‘how people are’ rather than ‘how people know’ in the everyday world. Existence, then, is about being-in-the-world or inhabiting the world. This experiencing of the world leads to a familiarity with the everyday, causing the commonalities of living to be taken for granted. For the purposes of this study, everyday experience must be interpreted and explicated in order to understand the nature of public health nursing practice (Koch, 1996; MacLeod, 1996; Palmer, 1969; Reeder, 1988; Thompson, 1990).

Interpretative or hermeneutic phenomenological studies often draw on philosophical hermeneutics (e.g. Benner, 1994; MacLeod, 1996; Palmer, 1969; Van Manen 1990). Research undertaken within this approach seeks to reveal what is taken for granted with the goal of understanding more fully. Throughout the course of this study, I have stayed true to the central principles or concepts underlying a hermeneutic or interpretive analysis, namely, historicity and temporality of understanding, the hermeneutic circle, the fusion of horizons, attention to language, and commitment to rigour.

Interpretative analysis is a qualitative methodology that assumes that no dichotomy exists between the researcher and the subject of analysis. In other words, the researcher is engaged or situated in the subject of study. Further, the subject of analysis is situated in the present at a particular place and time in history. The researcher approaches the subject matter

with presuppositions derived from past experience and projections of a future, connecting the present to both the past and the future. Thus, the interpretation of the subject of analysis has both a historical and temporal character (MacLeod, 1996; Palmer, 1969). My familiarity with public health nursing practice both revealed and concealed aspects of public health nursing practice. In order to interpret and explicate public health nursing practice, I had to continually keep my own understandings in question throughout the course of this study.

The concept of the hermeneutic circle is at the heart of interpretative analysis. It assumes that the act of understanding is achieved as we make sense of something in relation to what we already understand given our presuppositions. Understanding and meaning emerge as individual parts come together into a whole through a dialectic process between the whole and the parts. The individual parts gain meaning as the whole is formed, while the whole and its meaning is dependent on the meaning of the individual parts. It is a circular, reflexive process of moving back and forth from the constituent parts to the whole, enlarging our understanding (Koch, 1996; MacLeod, 1996; Palmer, 1969; Steeves & Kahn, 1995).

Language is fundamental to gaining understanding within the concepts of the hermeneutic circle and the fusion of horizons. Through a dialectic process of questioning and answering, what Gadamer calls a “fusion of horizons” occurs. In other words, the horizon of the interpreter is broadened in order to fuse with the horizon of the subject of interpretation. A common horizon of meaning and understanding emerges and is made possible through language (Koch, 1996; Palmer, 1969). Language is the medium that enables the interpretation of that which is taken for granted and hidden from view (Koch, 1996; MacLeod, 1996; Palmer, 1969; Thompson, 1990; Van Manen, 1990). Throughout this study, I paid particular attention to the language in the documents and research and practice

literature that were reviewed and analyzed. For example, careful attention was paid to the meaning underlying the use of the words “health promotion” in the literature related to the lifestyle approach versus the socio-environmental approach. Differentiating the meaning ascribed to these words proved critical to understanding the impact of each approach upon public health nurses’ practice.

Rigour requires attention in studies where qualitative approaches are used. Rigour can be best established through the systematic use of multiple sources of data and through constantly comparing data. Rigour is evident to others through the documentation of the way in which a study is carried out (Koch, 1996; MacLeod, 1996). In this study, rigour was attended to through the use of data sources such as research and practice literature, government reports, press releases, and a case study from practice. As I proceeded through the study, I held my own perceptions in question, proceeding through multiple stages of interpretative analysis as further understandings emerged. The following discussion attempts to outline the course of this study.

At the outset of this study, I began with a rather vague intent to gain understanding about the nature of public health nursing practice. I initially approached this study with the background knowledge derived from my experiences as a public health nurse and a manager responsible for public health nursing practice through the development of a case study about an injury prevention initiative (Benner, 1994; MacLeod, 1996). This case study was first verbally discussed with colleagues in public health nursing practice and with nursing academics within the university setting. The case study proved to be helpful in increasing understanding about public health nursing practice with both practicing public health nurses and nurses from other sectors of health care. This led to the documentation of this case study

in writing and my decision to use it as the public health nursing practice touchstone for this thesis. This case study enabled my initial entrance into the hermeneutic circle (Koch, 1996).

This led to an examination of the role and function of public health nursing practice through a systematic review of research and practice literature, as well as professional practice discussion papers and reports. I analyzed these in light of my own public health nursing practice experience with its associated presuppositions and in light of the case study. As I reviewed the literature and developed the case study, three practice tensions were revealed that resonated with my own experience. My understanding of public health nursing practice as a whole expanded and shifted based on the examination of these parts of practice, leading, in turn, to the identification and analysis of three contextual forces or issues influencing practice.

The contextual forces identified included the historical influences, the organizational structure shaping practice, and the shifting public health policy developments. I proceeded systematically in examining each of these issues. The history of public health nursing was researched by reviewing and comparing descriptive and analytical accounts of both public health and public health nursing historical events. I chose to focus the study of organizational structure on the recent health and social service reform processes in British Columbia, as they are immediately relevant to understanding public health nursing practice today. This was done through a comprehensive review of governmental commissions, reports, discussion papers, and policy papers as well as press releases, correspondence, and reports of debates of the legislative assembly. Finally, the analysis of public health policy developments was conducted through an examination of books, practice and research literature, policy papers, and governmental and professional association documents. Once again, what was uncovered

in the analysis of contextual forces led to a closer look at the whole of public health nursing practice revealing the interaction between the contextual forces and between the contextual forces and the practice tensions within the public health nursing practice environment. The back and forth process of looking at the whole and then the parts enabled a fuller understanding of the complex interconnections within the public health nursing practice environment. Throughout I paid attention to language.

Next, I began to analyze what was discovered about the public health nursing practice environment in light of the case study. This enabled an interpretation of the way in which public health nurses sort out their practice given the complexity of the context of practice. Emerging was a better understanding of the relationship between public health nursing practice and the contextual forces, the content of practice, and the practice tensions. The interpretation presented here has been repeatedly revisited and changed as understanding of this relationship deepened and the taken for granted was made visible.

Finally, I tested the interpretation of how the relationship between public health nursing practice and the context of that practice shapes public health nurses' work. A discussion of the interpretation found within this study was held with a group of public health nursing leaders prior to the development of the final draft. They supported the interpretation as presented and expressed excitement about its meaning for the practice of public health nursing.

### *Chapter Preview*

The structure of this thesis will proceed as follows. In Chapters 2, 3, and 4, the contextual forces and practice tensions influencing the public health nursing practice environment are explored in-depth. Chapter 2 traces the historical roots of public health



nursing practice in Canada with a particular emphasis on British Columbia experience. This chapter reveals how historical events and decisions have influenced the organizational structures and public health policy developments shaping public health nursing practice environments. The historical roots of each practice tension are also discussed in this chapter.

Chapter 3 provides insight into how changing organizational structures influence the practice environment. It reviews two significant health and social services reform processes in British Columbia that have occurred over the last decade. They serve as examples of the impact organizational structure has had on practice over time. Of particular importance to this chapter is the identification of public health nursing practice issues that emerged from these most recent organizational reform processes. The interconnection between changing organizational structures, public policy developments, and the practice tensions is explored.

In Chapter 4, I analyze the public health policy developments and the associated conceptualizations of health that have pervaded the context of public health nursing practice throughout the later half of the 20<sup>th</sup> Century. The medical model, lifestyle or behavioural approach, socio-environmental approach, and population health approach and their associated conceptualizations of health are examined in relation to how they have shaped public health nursing practice. This chapter reveals the influence public health policy developments have had on organizational structure. The relationship between public health policy developments and the practice tensions is also explored.

Chapter 5 describes a case example from my public health nursing experience involving the implementation of an injury prevention project in northwestern British Columbia. This case study serves as a touchstone for the analysis of the contextual forces and practice tensions revealed in Chapters 2, 3, and 4.

In the final chapter, we return to the content of public health nursing practice, but from the perspective of the nurse-in-practice. The convergence and interaction between the contextual forces and practice tensions are explicated revealing the complex nature of the practice environment. This leads into an exploration of the taken-for-granted way in which public health nurses configure their practice in light of what has been revealed about the practice environment. The chapter ends with a discussion of the implications for practicing public health nurses, managers with responsibility for public health nursing practice, nursing educators, and nursing researchers.

## CHAPTER TWO

### Historical Influences on Public Health Nursing Practice

Public health nursing can be traced to the earliest forms of nursing in Canada, back as far as the 1600s. A review of history serves a threefold purpose in relation to explicating the contextual forces and practice tensions that influence public health nursing practice environments. First, a journey back in time enables us to more fully understand how the organizational structure of the Canadian health care system has evolved and, in turn, shaped public health and public health nursing services. Second, this historical review reveals a persistent and politically problematic philosophical struggle that emerged early in Canada's history. The struggle confronting politicians and policy-makers in times past was about whether individuals should be solely responsible for their own health or whether there should be a societal and governmental collective responsibility for health. Over time, this struggle evolved into the discourse and debate that eventually would establish Canada as a leader in public health policy development. Finally, an examination of public health nurses' historical roots reveals how the practice tensions that contribute to the complexity of public health nursing practice environments have emerged throughout the course of history.

Thus, this chapter will take us on a historical journey, from the rudimentary nursing practiced by lay nurses and religious nursing orders of the 1600s to the formally organized system of public health nursing services of the 1900s. Although obtaining understanding from history is complex as we inevitably interpret historical events within the context of contemporary thought, the nature of public health nursing practice today is inextricably linked to its history (Allemang, 2000). This chapter will describe the history of public health

nursing to fulfill the first and second purposes of this historical review. An analysis of the practice tensions will be discussed at the conclusion of this chapter. We will begin with the earliest forms of nursing in Canada.

### *1600s to 1700s: The Heredity of Public Health Nursing*

The first nurses of the 17<sup>th</sup> and 18<sup>th</sup> Centuries practiced a rudimentary form of nursing that resembles a type of public health nursing practice. Simultaneously, communicable disease epidemics stimulated a fledgling, albeit reluctant, interest in societal and governmental measures to support the public's health. It would be many years later before the two functions would merge into a public health delivery system with interest in collective action to improve population health. Nevertheless, these early forms of nursing and public health would prove to influence the organization of the Canadian health care system and pave the way for nurses' role in public health.

*Early approaches to nursing.* In 1534, King Henry VIII dissociated England from the Roman Catholic Church in order that he might marry Anne Boleyn, removing the sisterhoods from service in England's major hospitals. Nursing care in England was taken over by secular groups and remained an afterthought until the time of Florence Nightingale. In contrast, the sisterhoods provided exemplary nursing care in French hospitals. Fortunately, it is this French tradition that shaped nursing in Canada (Gibbon & Mathewson, 1947).

Early nursing in Canada was first recognized in the work of such religious orders as the Jesuits of New France who provided holistic physical and spiritual care. They had charitable intentions and hoped to convert First Nations people to Christianity. The Augustinian Hospitallers established the first hospital, Hôtel Dieu de Québec, in New France in 1639 with funding from wealthy philanthropists in France and New France. Subsequently,

Jeanne Mance came to Montreal from France to co-found and administer the Hôtel Dieu de Ville Marie. These early nurses belonged to cloistered orders and were not able to leave the hospital to provide nursing care. Overall, work in these hospitals was difficult with impoverished living conditions causing many of the Hospitallers to succumb to illnesses or return to France (Allemang, 2000; Duncan et al., 1999; Gibbon & Mathewson, 1947; Ross Kerr, 1996a, 1998).

The first uncloistered order of nuns was established in New France in 1738 by Marguerite D'Youville for the sole purpose of caring for the poor and sick in their homes. These nuns provided unconditional nursing care, treatment, and teaching and established homes for the elderly and chronically ill and hospitals for those acutely ill (Allemang, 2000; Ross Kerr, 1996a). This order of nuns became known as the Grey Nuns because of the greyish-brown habit they wore. The home visitation they provided was highly unusual at the time, resulting in accusations that they were selling liquor to the Iroquois. Gibbon and Mathewson (1947) state that the Grey Nuns were nicknamed the "Tippling Sisters" as a result. Nevertheless, over time both the French and British came to respect their work. These Grey Nuns are recognized as the first visiting nurses in Canada and perhaps laid the foundation for working with people within the context of their environment.

Religious groups predominated in the care of the ill until British benevolent groups began assisting destitute and often ill immigrants. These benevolent groups initiated soup kitchens and small hospitals and staffed them with lay nurses and physicians. The introduction of lay nurses proved to be controversial as many people thought that nursing services should be provided exclusively by religious orders (Gibbon & Mathewson, 1947).

*Role of communicable disease epidemics.* The development of both public health and nursing in Canada is also about the uncontrollable spread of communicable diseases. With the exception of tuberculosis, communicable diseases were virtually unknown to First Nations people prior to the arrival of Europeans to North America. There is preliminary evidence that mycobacterial diseases resembling tuberculosis may have pre-existed in North America. However, tuberculosis epidemics among First Nations people seem to have emerged following contact with Europeans infected with the disease (Grzybowski & Allen, 1999). Epidemics of smallpox were first identified in 1635 and spread rapidly and repeatedly and equally devastated the French and English colonies as well as First Nations people (Heagerty, 1940; Young, 1994). Heagerty suggests that these epidemics contributed to the surrender of New France to British rule in 1763 resulting in Canada becoming a British rather than French country.

The shift to British rule led to increasing numbers of British immigrants, bringing communicable diseases such as cholera, typhus, smallpox, measles, scarlet fever, and influenza (Allemang, 2000; Gibbon & Mathewson, 1947; Ross Kerr, 1996b). Initially, the health of both the settlers and First Nations people was not seen as important to government. The intent of colonization was to provide a new locale for economic development and it was to that end that attention was directed (Graham-Cummings, 1967). Until confederation in 1867, the government took very limited responsibility for health care. These duties were left to the religious orders and lay nurses well into the 1800s.

Despite a lack of awareness that the spread of communicable disease was preventable, some basic public health measures were put in place in New France. The control of the sale of meat and measures to ensure adequate care for homeless children are examples

of some of the public health oriented decisions made by government during this time.

Additionally, the first official quarantine regulations were passed in 1721 to deal with French ships infected with plague (Heagerty, 1940). Finally, a basic precursor to a vital statistics system was established by priests, whose meticulous recording of births and deaths resulted in a law requiring such record keeping to be passed in 1678.

### *1800s: The Shaping of Public Health Nursing's Foundation*

During the 19<sup>th</sup> Century, the foundations necessary for the organization of health care and public health in Canada began to solidify. Political processes and governmental institutions were created, hospitals were established, and physician and nursing educational programs were formed. As western society expanded, industrialization occurred and scientific knowledge advanced rapidly. Different philosophical approaches to addressing societal health and social problems surfaced. There was an underlying resistance to collective action to resolve health and social issues and many thought health matters should be the individual's responsibility. Reconciliation of these differences was difficult. Thus, the historical events of the 1800s would prove to shape and influence the organizational structure of health care and the ongoing philosophical debate about who was responsible for health care.

*Emergence of hospitals and public health action.* The provision of nursing care continued to be dependent upon religious orders well into the 19<sup>th</sup> Century. In 1844, four Grey Nuns left Lower Canada for the Red River Settlement. As they made their way across Canada, their work commonly consisted of caring for those afflicted by communicable diseases (Gibbon & Mathewson, 1947; Ross-Kerr, 1998). This work expanded to what is now Saskatchewan and Alberta over the next few decades. By the late 1800s, hospitals were

established in many communities due to the work of religious organizations and other charitable organizations, physicians, and local governments (Allemang, 2000; Ross Kerr, 1996b).

During these years, communicable disease epidemics had an increasing and devastating impact as immigrants settled the west, bringing communicable diseases with them. This created a demand for both nursing care and a public health response. The effectiveness of the public health response was limited by a lack of centralized action arising from inadequate municipal infrastructure and the prevailing view that health matters were best left to the individual's responsibility (Duncan et al., 1999).

Initially, public health action associated with communicable disease epidemics was restricted to dealing with each epidemic as a crisis. This occurred with the cholera epidemics of 1832 and 1849 where death rates reached epic proportions (Duncan et al., 1999; Heagerty, 1940). Heagerty records the mortality due to cholera epidemics to be 37-50/1,000 population. It is estimated that prior to contact with European settlers, approximately 210,000 First Nations people resided in what is now Canada. By 1870, the overall population dropped to about 80,000 due to these epidemics (O'Neil, 1993).

More aggressive action was taken in 1831, when the British Colonial Office notified Quebec that newly arriving immigrants were possibly infected with cholera. This stimulated the formation of the first Sanitary Commission and the appointment of a temporary Board of Health. The Act of 1831 was passed to provide directives regarding "personal and environmental cleanliness; quarantine of infected persons; attention to contaminated clothing by boiling, baking, or burning, and private and immediate burial of the dead" (Allemang, 2000, p. 11). This Act was revised in 1849 to apply to Canada West as well as Canada East.



As settlements were established, sanitation became a major issue due to the disposal of garbage, human and animal waste close to water supplies or near living quarters.

Regulations were put in place to deal with these issues (Ross-Kerr, 1998). Although, cholera was brought under control, other communicable diseases such as smallpox, typhoid fever, diphtheria, scarlet fever, measles, and influenza overwhelmed communities. Tuberculosis, mental illnesses, and high maternal mortality were additional health issues that were prevalent throughout the 1800s (Allemang, 2000).

*Influence of political processes on the organization of health care.* Although the individualistic perspective of this period in history limited government's role in health care, political processes were underway that set in motion the framework for the Canadian health care system. In 1867, the British North America Act established Canada as a nation, driven in large part by economic issues, difficult relationships between regional political entities, and the need for a system of defence (Allemang, 2000). The next major step in establishing Canada as a nation occurred in 1870 when the federal government purchased land from the Hudson's Bay Company fur trading empire. The government then proceeded with construction of a railway linking eastern Canada with the west. The Dominion Land Act of 1872 provided free homesteads as a mechanism to encourage settlers to move west. Throughout the late 1800s, predominately Anglo-Saxon people moved west but by the early 1900s major campaigns were underway to encourage immigration from Eastern European nations to the western prairies. These immigrants came to difficult economic and living conditions (Bramadat & Saydak, 1993).

The perspective that health care was an individual responsibility rather than a public or collective responsibility persisted throughout the 19<sup>th</sup> Century, relegating health and social

issues to a place of limited interest to the federal government. As a result, health and social issues were left to provincial governments and any health initiatives the federal government undertook were fragmented across many different departments (Allemang, 2000; Heagerty, 1940; Ross-Kerr, 1998).

In the absence of federal leadership, provincial legislation regarding public health issues began to be put in place. A particularly significant piece of provincial public health legislation was passed in 1882 in Ontario, stimulated by a Public Health Act passed in Great Britain in 1875. This legislation established the first permanent, provincial Board of Health with the purpose of advising municipal councils on health matters. Subsequently, the Public Health Act, passed in 1884 in Ontario, required that municipalities establish their own boards of health (Allemang, 2000; Heagerty, 1940). These boards were to be responsible for reporting communicable diseases, enforcing quarantine measures, controlling nuisances and the sale of meat and foods, and submitting all sewage and water system plans to the provincial board. They oversaw the administration of smallpox immunization programs and began milk inspection (Phair, 1940). Similar provincial legislation followed across Canada. The foundation for a formalized and organized provincial system of public health was now in place.

*Influence of scientific advances on the organization of health care.* The 1800s brought scientific advances that were capable of controlling communicable diseases. Although the perspective that health was best left to the individual thwarted the use of these scientific advances, they would prove to have far-reaching effects on the health care system. For example, Pasteur confirmed the germ theory in 1870 and Lister applied this theory to

antiseptic surgery. Koch further developed this theory for the prevention of communicable diseases and infection through the study of micro-organisms (Allemang, 2000).

During this period, scientific discoveries were stimulating the progress of industrialization. Simultaneously, methods of collecting epidemiological information became more sophisticated. Both government and industry began to appreciate the benefit of this information to planning and decision-making. The government of the day was interested in increasing defence capacity and industry was seeking ways to ensure profitability. Both were threatened as industrialization brought urban overcrowding and a concomitant transmission of communicable disease. As the century progressed, the government's economic interests forced consideration of an increased governmental role in preventing disease and improving living conditions (Rafael, 1999b; Ross-Kerr, 1998).

The advance of scientific knowledge and the consequent technological solutions to health issues fostered a dominant role for medicine in both health care and public health service delivery (Allemang, 2000). Specialty training for physicians became critical, leading to increasing numbers of medical schools. Nursing practice initially functioned outside of medicine's control, enabling a holistic approach to the provision of nursing care that persisted longer for nurses engaged in community work than for nurses working within a hospital context. Nevertheless, by the turn of the century, physicians were in positions of control in hospital settings and to some extent in the public health field (Rafael, 1999b; Ross-Kerr, 1998).

*Influence of Florence Nightingale on the organization of health care institutions.*

Despite the emerging dominance of medicine associated with scientific advancements, the impact of Florence Nightingale's approach to nursing education and practice cannot be

overlooked. By the mid-1800s, Florence Nightingale was stimulating a worldwide examination of nursing care.

In 1854, Florence Nightingale moved the cause of nursing forward when she obtained permission to provide care to British soldiers during the Crimean War. Previously, male orderlies had provided nursing care in the military hospitals. She was outspoken in condemning the poor care provided to British soldiers as compared to the excellent care provided by religious orders in French hospitals. During the war, Nightingale was successful in improving care through her administration skills and commitment to quality nursing care (Gibbon & Mathewson, 1947; Rafael, 1999b; Ross Kerr, 1996b). She was one of the first promoters of the value of social statistics and systematically and often successfully incorporated uniform record keeping and the collection and analysis of statistics in her endeavours to reform health care (Cohen, 1984; Nuttall, 1984).

Following the Crimean War, she focused her work on the disadvantaged and impoverished members of society. She had a tremendous impact on such public policy issues as the living conditions in British workhouses. Rafael (1999b) states “the focus of Nightingale’s activities to promote health extended from individuals to communities and their nature ranged from personal care to political activism” (p. 26).

Her influence reached North America during the American Civil War and led to the incorporation of her standards into nursing practice. Her philosophy of nursing practice was integral to establishing formal nursing education systems in North America. Nightingale advocated that nursing education was “the best method of raising the status of the nursing profession” (Gibbon & Mathewson, 1947, p. 110). Soon physicians began establishing nursing schools emulating Florence Nightingale’s philosophy of nursing. The first such

school of nursing in Canada was founded in 1874 in St Catharines, Ontario. Education programs using Nightingale's philosophy included a year dedicated to district nursing where the nurse's role in promoting self-care and in pressing for social and health reforms was taught (Rafael, 1999b; Ross Kerr, 1996b).

*Turn of the Century to end of World War II: Public Health Nursing Organized*

The turn of the century to the end of World War II marked the further organization of health care services in Canada. Structures supporting public health nurses' roles were emerging. These structures, together with scientific advances and an increased public and governmental receptivity to a collective versus individual responsibility for health enabled the creation of a rudimentary public health system in Canada. Governments had an increasing interest in improving the health and well-being of the population leading to the implementation of social reform strategies. Public health nurses were willing and capable participants in promoting social reform.

*Organization of public health nursing structures.* The early 1900s brought the advent of community nursing agencies, a national organization of nursing practice including the registration and setting of nursing practice standards, and the recognition of the need for advanced practice preparation for public health nurses. Such community nursing programs as Winnipeg's Margaret Scott Nursing Mission, Montreal's Soeurs de l'Espérance and Les Gouttes de lait and Assistance maternelle, and Halifax's Massachusetts-Halifax Health Commission were established with government funding (McPherson, 1996).

One of the most notable programs was stimulated by Lady Aberdeen, wife of the Governor General of Canada and President of the National Council of Women, when she travelled across Canada and learned about health care needs in remote and isolated

jurisdictions. As a result, the Victorian Order of Nurses for Canada (VON) was created in 1897, despite opposition from physicians who feared a return to unqualified nurses functioning independent of physicians. These fears were unfounded as the nurses employed were always graduates of a school of nursing and had an additional six months of district nursing training. Once accepted by the VON, these nurses agreed to work anywhere in Canada for a two year period. The VON quickly demonstrated the value of disease prevention, health promotion, and primary care to improving health (Allemang, 2000; Duncan et al., 1999; Gibbon & Mathewson, 1947; Rafael, 1999).

Another agency with interests in public health was the Canadian Red Cross Society, which was organized in 1896. Prior to World War I, the Red Cross provided services during disasters or in times of war. After World War I, Red Cross Societies internationally formed the League of Red Cross Societies to build on successful partnerships established during the war. Their mandate expanded to become “the promotion of health, the prevention of disease and the mitigation of suffering throughout the world” (Gibbon & Mathewson, 1947, p. 342). As a result, the Canadian Red Cross provided funding to rural communities wishing to employ public health nurses and set up outpost hospitals and nursing stations in remote locations. The Red Cross supplied communities with equipment, one or two nurses, and two years of operating costs for these outpost hospitals. After two years, the outpost was given to the community to operate. The nurses in these outposts developed a critical role in health education, particularly to mothers with new babies.

In addition, a Junior Red Cross was established to bring young people into disease prevention and health education work. These young people were expected to practice healthy living both to improve their own well-being and that of others. Other Red Cross activities

included home nursing classes, visiting housekeepers, nutrition classes, and seaport nurseries for returning soldiers and their families (Gibbon & Mathewson, 1947).

The creation of national and provincial nursing associations was a critical step in establishing nursing as a credible profession in Canada. In 1907, the first Canadian national organization of nurses was formed. Known originally as the Canadian Society of Superintendents of Training Schools for Nurses, it became the Provisional Society of the Canadian National Association of Trained Nurses in 1908 and then the Canadian Nurses Association in 1924. The national nursing publication, the Canadian Nurse was launched in 1905 (Ross Kerr, 1996b).

In 1920, motivated by a desire to establish national leadership for public health nursing practice, a public health section of the Canadian National Association of Trained Nurses was formed (Duncan et al., 1999). This section continues to exist today as the Community Health Nursing Group at both the national and provincial level. The development of the Canadian Nurses Association further progressed when it became a federation of provincial nurses associations in 1930, formalizing the provincial organizations' responsibility for the registration of nurses. Nursing was now considered an established profession with registration requirements ensuring a minimum standard of practice (Ross Kerr, 1996b).

By the 1920s, Toronto's Department of Health required public health nurses in their first year of employment to take a course in Medical Social Work, acknowledging the need for advanced preparation of public health nurses. Growing dissatisfaction with hospital-oriented nursing education led to the development of post basic nursing education for public health nurses with an emphasis on health promotion and disease prevention. The Canadian

Red Cross Society funded this post basic certificate program at six universities in 1920-21 and the VON provided students with bursaries. In 1919, the first baccalaureate degree program was established at the University of British Columbia (Allemang, 2000; Duncan et al., 1999; Gibbon & Mathewson, 1947; Ross Kerr, 1996b).

In 1932, a national study on nursing education, the Weir Report, was released making significant recommendations for the education and practice of public health nurses. This report recommended that public health nursing be recognized as a nursing specialty requiring advanced education. Other recommendations included doubling the number of public health nurses over the next five to ten years through a cost sharing agreement between provincial governments and municipalities and ensuring equivalency in salary between public health nurses and nurses working in institutional settings (Allemang, 2000; Duncan et al., 1999; Gibbon & Mathewson, 1947).

*Formation of a public health infrastructure within government.* Concurrently, a public health infrastructure was being created that would further formalize the public health nurse's role within the Canadian health care system. Communicable disease epidemics predictably stimulated government to take a more active role in public health. In 1901, tuberculosis was the leading cause of mortality in urban centres. The Spanish influenza epidemic of 1918 resulted in the death of about 30,000 people. These epidemics revealed the uncoordinated and limited nature of Canada's health care system (Allemang, 2000; Heagerty, 1940).

Simultaneously, scientific advances related to the control of communicable and nutritional diseases continued throughout the early 1900s. Although Edward Jenner had discovered the vaccine for smallpox in 1796, it wasn't until the late 1800s that the vaccine



began to be universally used, reducing the incidence of smallpox (Ross-Kerr, 1998). A diphtheria vaccine, improved methods to control tuberculosis, and the Wasserman test for syphilis are other examples of scientific discoveries that enabled disease prevention and control. Increased knowledge about the relationship between nutrition and health resulted in effective means to prevent diseases such as rickets. (Allemang, 2000). Gradually, as the means to control and prevent disease were becoming more readily available, governments were forced to acknowledge the need for a public health structure to deal with communicable disease control and sanitation issues.

Governmental organizations began implementing a variety of public health strategies. For example, the federal government provided matching grants to provinces engaged in sexually transmitted disease prevention work. The chlorination and filtration of water was initiated in Montreal in the early 1900s based on evidence that this would prevent typhoid. In 1905, the first tuberculosis clinic was started in Toronto with public health nurses providing follow up in people's homes. The remaining provinces started tuberculosis programs soon thereafter (Gibbon & Mathewson, 1947; Pelletier, 1940). Similarly, mandatory smallpox immunization campaigns were initiated in most provinces (Ross-Kerr, 1998).

Thus, both governmental and voluntary organizations were involved in organizing public health nursing services by the end of World War I (Duncan et al., 1999). A strong and persistent lobby from groups such as the Women's Institutes and the United Farm Women's Association resulted in the formation of national and provincial departments of health that would amalgamate the various forms of public health nursing. These women's lobby groups were interested in improving the health of mothers and children in remote parts of the

country. They maintained that access to health care was a right that the government had a duty to ensure (Ross-Kerr, 1998).

This lobby, together with ongoing work by the Canadian Medical Association to create a committee on vital statistics and public health, successfully persuaded the politicians that health services should be of interest to government and laid the groundwork for the creation of a national department of health in 1919. A Dominion Council of Health, consisting of provincial medical officers of health, a scientific advisor, and four lay representatives from labour, agriculture, and rural and urban women's organizations, was formed to advise the department of health (Allemang, 2000; Heagerty, 1940).

At the same time, the provincial governments developed public health nursing service delivery systems with public funds. Manitoba was the first province to directly fund and hire public health nurses. Five nurses, hired in 1916, were placed in interested municipalities for one month with a focus on preventing infant mortality. After this trial period, the municipality was required to pay one third of the operating costs if they wished to retain the service. By 1922 there were 52 nurses in Manitoba (Gibbon & Mathewson, 1947). Alberta developed a district nursing service in 1919, Saskatchewan launched their services in the 1920s and in 1921, Nova Scotia and New Brunswick embarked on public health nursing demonstration projects funded by the Red Cross (Allemang, 2000; Green, 1983; McHutchion, 1993; Ross-Kerr, 1998). In Quebec, the establishment of health units composed of a Medical Health Officer, public health nurses, and a sanitary inspector occurred in 1926. These health units are credited with the remarkable reduction in infant mortality and communicable disease rates that occurred in that province from 1926 to 1938 (Pelletier, 1940).

The formal development of public health services in British Columbia followed a course similar to other provinces. British Columbia became a province in 1871 with a small population of 36,247. The province had the legislative power to appoint a provincial board of health to deal with emergencies but it wasn't until a smallpox outbreak in 1892 that such action was required. As a result of this epidemic, the province passed a Public Health Act in 1893, later revised to become the Health Act of 1899. The Health Act was amended frequently during the early 1900s to include regulations concerning ventilation and plumbing in public buildings, immunizations, sanitary conditions in lumber, mining, and railway camps, water and sewage control, and the control of communicable diseases. British Columbia enacted two other pieces of public health legislation related to vital statistics collection in 1872 and venereal disease control in 1919 (Marshall, 1940).

Following the passing of the Health Act of 1899, the first permanent provincial medical health officer, Dr. Esson Young, was appointed as secretary to British Columbia's board of health (Marshall, 1940). He served in this capacity from 1916 to 1939 and was highly influential in shaping the public health system (Green, 1983; Riddell, 1991). The Vancouver School Board appointed the first school nurse in 1910. School health services were important to Dr. Young and as a result the School Medical Inspection Act of 1911 was passed, ensuring that every child had an annual medical examination paid for by the municipality. The need for follow up of the medical examination results prompted the appointment of the first provincial school nurse in 1913. This, in turn, led to an amendment of the Public School Act in 1921, enabling school boards to hire nurses as they did teachers (Gibbon & Mathewson, 1947; Green, 1983).

The first public health nurse in British Columbia was appointed in 1917 in Saanich. By 1921, five more nurses were appointed to Saanich and Duncan and the first health unit was opened, marking the beginning of a provincial public health nursing service. Over the next decade, three other health units were established around the province, with one in Kelowna (1929), one in North Vancouver (1930) and one in the Peace River district (1935) (Phair, 1940).

As health units developed, public health “became increasingly defined as promotion of health and prevention of illness and was a domain in which nurses were front line professionals.” (Ross-Kerr, 1998, p. 69). The duties of the first public health nurses employed in health units included school health services, inspection of children for communicable diseases, and health education through new baby visits and infant well baby clinics. Maternal-child health strategies gained importance during World War I. Well baby clinics expanded to all larger communities, with nurses traveling out to rural communities. Maternal health services expanded to include prenatal, postnatal care, health assessment, immunization and health education regarding nutrition and sanitation. The public health nurse’s activities also encompassed communicable disease control and often direct nursing care in the home (Green, 1983; McHutchion, 1993; Riddell, 1991; Ross-Kerr, 1998).

*Lillian Wald’s vision for public health nursing.* Public health nurses’ role and function in Canadian society was influenced by an American nurse, Lillian Wald, who practiced at the turn of the century in the New York City area. She is credited with ascribing the name public health nursing to her vision of nursing in the community. She advocated that illness should be considered within the social and economic context. Buhler-Wilkerson (1993) notes that “Wald’s paradigm for nursing practice was based on knowledge gained

during two decades of experience in visiting nursing and owed much to the progressive reform and public health movements at the turn of the century” (p. 1778). As the American system of health care developed, Wald’s vision of public health nursing would not be realized. However, her approaches would be incorporated into the work of public health nurses in Canada.

Lillian Wald entered nursing during a time when American cities were experiencing crowding, poverty, and unhealthy living conditions. In 1893, she agreed to teach a course in home nursing and was asked to visit the homes of some of her students. She was appalled at the living conditions and at the kind of society that would allow such circumstances to exist. She decided to live in the neighbourhood with another nurse with whom she established the Henry Street Nurses’ Settlement (Buhler-Wilkerson, 1993).

Wald modeled her nursing practice after Florence Nightingale’s plan for health visitors in England. She was a strong advocate for a combined curative and preventive role for public health nurses. Her vision included “providing care from the patient’s point of view; encouraging personal and public responsibility, and providing a unifying structure for the delivery of comprehensive, equally available health care” (Buhler-Wilkerson, 1993, p. 1785). Her nurses were unique in their advocacy for social and economic reform while continuing to participate as esteemed members of middle and upper class society. This credibility enabled the nurses to influence “reform in health, industry, education, recreation, and housing” (Buhler-Wilkerson, 1993, p. 1780). By 1910, there was a group of 54 nurses working in the settlement overseeing a variety of social and health programs (Buhler-Wilkerson, 1993).

*Social reform and the public health nursing role.* The kind of social reform advocated by Lillian Wald gained momentum during the early part of the 20<sup>th</sup> Century. The social reform agenda was partially driven by altruistic intentions related to improving sanitation, hygiene, and maternal and infant mortality as well as the ongoing need to have a healthy population for industrial expansion and defence reasons. More significantly, the social reform agenda was driven by the pervasive view that assimilation was required to create a healthy and strong nation (Bramadat & Saydak, 1993; McPherson, 1996).

The Anglo-Saxon population monopolized the middle class, particularly in the west, and their value system was inevitably imposed upon the remainder of society. Public health nurses were often the agents of both governmental and philanthropic organizations in promoting the middle class Anglo-Saxon values seen to be necessary to ‘Canadianize’ the Eastern European immigrants and First Nations people. As a result, early public health nurses were described as using health evangelism approaches and exhibiting a missionary zeal in promoting the ‘gospel of health’ in the interests of the public good (Bramadat & Saydak, 1993; Duncan et. al., 1999; Gibbon & Mathewson, 1947; McPherson, 1996; Riddell, 1991).

It would do a disservice to these early nurses to assume that they were entirely driven by a desire to impose middle class, Anglo-Saxon values on society. These first public health nurses were well educated, highly competent women who wanted to improve health and living conditions and in the context of the time, assumed that this required the adoption of middle class values. They had access to scientific knowledge that could make a difference to the health of those they served. In retrospect, these first public health nurses made an excellent contribution to improving health conditions in the communities they worked within. They recognized that the determinants of health contributed to health status and worked

diligently to influence such issues as poverty (Bramadat & Saydak, 1993; Duncan et. al., 1999; Riddell, 1991).

In their efforts to improve health and well-being, the public health nurses often confronted hardship and overwork. They worked in isolated circumstances and were challenged by uncooperative communities and physicians. These nurses dealt with gender issues during a time when women's role in the work force was limited and undervalued. Although these nurses often faced frustration and disillusionment, they remained committed to the larger purpose of creating a better world (Duncan et. al., 1999; McPherson, 1996; Riddell, 1991).

Unfortunately, separating the health promotion approaches necessary to improve health from the prejudices of a middle class value system was difficult for these public health nurses given the societal norms. Nevertheless, these nurses laid the foundation for health promotion work as it is understood today. It is only in retrospect that we are able to acknowledge the folly of the assimilation policies that became part of early public health nursing work (Bramadat & Saydak, 1993; Duncan et. al., 1999).

#### *Post War Era: Public Health Nursing Within the Evolving Canadian Health Care System*

The post war era facilitated a rapid expansion of public health services and established a Canadian health care system that would become primarily focused on hospital and physician services. The two decades following World War II were marked by rapid population growth and a dramatic increase in the birth rate creating what is now known as the "baby boom" phenomenon. This was particularly true in British Columbia as the population grew from 818,000 in 1941 to 2 million by the end of the sixties. British Columbia experienced rapid economic growth and prosperity as agricultural, mining and forestry

industries expanded. The social milieu in the 1940s and 50s promoted strong family values and a work ethic, resulting in increased family size, a more restricted role for women, and the development of suburban communities. These societal norms fostered the further expansion of public health services and the development of a unique health care system.

*Expansion of public health services in British Columbia.* Following World War II, a clearly defined infrastructure for public health nursing services in British Columbia emerged. The provincial government formed a Division of Public Health Nursing in 1939 and appointed a director in 1940. Between 1940 and 1949, the number of public health nurses grew from 44 to 111. Throughout the 1940s, the Division of Public Health Nursing organized and established public health nursing in British Columbia by producing a public health nursing newsletter, organizing regular provincial nursing meetings, creating a salary scale for public health nurses, and developing policy and procedure manuals (Green, 1983; Whyte, 1988).

When the Department of Health and Welfare Act was passed in 1946, the previous provincial board of health gained departmental status. The concept of a health unit emerged in the 1940s and typically included a main office with services distributed across several sub-offices in a geographically defined area. Health unit staff usually consisted of a medical officer of health, a sanitary inspector, public health nurses, and clerical staff. In some jurisdictions dental health consultants and nutritionists were available (Whyte, 1988).

The number of health units grew rapidly throughout the 1950s, creating the need for local supervisory staff and new facilities. The National Health Grants program assisted communities to construct community health centres designed specifically for the delivery of public health services. By 1959, British Columbia had 16 health units, two metropolitan units



and 191 public health nurses. The operation of these health units was funded by an annual levy of \$0.30 per capita supplemented by a grant from the provincial Department of Health and Welfare. When the Department of Health and Welfare was separated into two departments in 1959, the Department of Health Services and Hospital Insurance assumed responsibility for public health services (Green, 1983; Whyte, 1988).

Generally, the public health nurse served a population of about 5,000 in a geographic area covering 20-50 miles from the health unit office. The kinds of services provided were an expansion of those developed during the interwar years and included school health, communicable disease control, and maternal-infant care. School nursing activities included such initiatives as screening for health related problems, follow up of annual medical examinations and the provision of consultation services to teachers. Communicable disease control activities continued to be a significant component of public health nurses' work with a particular emphasis on tuberculosis and venereal disease. By the 1950s polio outbreaks and the administration of Salk vaccine, available in 1955, occupied much of public health nursing time. Public health nursing delivered immunization programs increased in significance as a consequence of the physician shortage created by World War II. Maternal-infant care, such as individual prenatal teaching, new baby visits, and child health conferences (well baby visits), remained a high priority for public health nurses. Public health nurses continued to be involved to varying extents in bedside nursing services until the formation of the provincial home nursing care program occurred in 1974 (Green, 1983; Whyte, 1988).

In 1950, the CPHA released a report on public health practice in Canada. This report, known as the Baillie-Creelman Report, made several recommendations that changed aspects of public health nursing practice. Some of the changes included the development of prenatal

classes as the forum for prenatal education, the development of a mental “hygiene” program, and the involvement of nurses in disaster planning and community education related to civil defence (Green, 1983; Whyte, 1988).

*Development of Canada’s health care system.* Although public health expansion occurred rapidly following the war, national and provincial attention was turning to the construction of hospitals and the development of a health insurance system. The post war period set the stage for the formation of Canada’s publicly funded health care system. The World Wars and years of depression in the 1930s created a growing need for and receptivity to government involvement in health and social issues. The lack of clarity about federal and provincial governmental powers on health and social matters was proving to be a barrier to responsive and comprehensive action. Nevertheless, there were attempts to deal with social issues through federal-provincial cost sharing initiatives.

The first such initiative occurred in 1927 with the passing of the Old Age Pensions Act. Similarly, issues of high unemployment during the depression brought forward an Employment and Social Insurance Act, passed in 1935, but declared unconstitutional in 1937 because of jurisdictional issues. It would take an addition to the British North America Act in 1940 to enable the federal government to take responsibility for an unemployment insurance scheme (Storch & Meilicke, 1994).

In 1943, the federal government commissioned two reports, the Marsh Report and the Heagerty Report, in an effort to clarify the federal and provincial roles in issues of social security. The need for federal and provincial cooperation in developing national social and health insurance plans was further recognized at a Dominion-Provincial Conference on Reconstruction held in 1945. Significant strides were made in addressing social issues

through such initiatives as the Family Allowance Act of 1944, providing families with an allowance for each child under age 16, but these actions were ad hoc rather than strategic in nature (Storch & Meilicke, 1994; Taylor, 1987).

The ensuing debate about jurisdictional issues raised both the political and social consciousness of the pressing need for a solution. The lack of resolution to this issue opened the door for provincial governments to proceed independently of the federal government. Tommy Douglas' newly elected Cooperative Commonwealth Federation (CCF) party in Saskatchewan passed the Hospital Services Plan in 1947, providing residents with compulsory and comprehensive hospital insurance. Several other provinces passed similar legislation, leading to negotiations with the federal government for a cost shared approach. In 1957, the federal government passed the Hospital Insurance and Diagnostic Services Act whereby the federal government paid fifty percent of insured hospital services to provinces that complied with federal conditions. To meet these conditions, provincial hospital insurance programs had to demonstrate comprehensiveness, accessibility, universality of coverage, public administration, and portability of benefits (Rachlis & Kushner, 1994; Storch & Meilicke, 1994; Taylor, 1987).

About the same time that Saskatchewan's hospital insurance act was passed, the federal government established the National Health Grants program to assist provinces with hospital and medical insurance planning processes, the provision of public health services, hospital construction, education of health care professionals, public health research and health surveys. The availability of these grants stimulated aggressive hospital construction across the nation that continued for several decades (Storch & Meilicke, 1994; Taylor, 1987). Both the National Health Grants program and the guaranteed coverage of hospital care costs

through the hospital insurance programs inevitably produced a reliance on hospitals and physicians that persists to this day (Rachlis & Kushner, 1994).

Once again, Saskatchewan led the way in 1962 when the CCF government implemented a Medical Insurance Plan despite massive opposition by physicians. At the national level, a Royal Commission on Health Services led by Chief Justice Emmett Hall was underway. This Commission, completed in 1964, recommended that a federal/provincial agreement be reached to develop a universal and comprehensive health insurance program. As a result the National Medical Care Insurance (Medicare) Act was passed in 1966 and implemented in 1968 enabling fifty percent of medical costs to be covered by the federal government for provinces who were in compliance with the same principles outlined in the Hospital Insurance and Diagnostic Services Act. By 1971, all provinces had agreed to participate in the national plan. The Canada Health Act was passed in 1984, entrenching the principles of medicare into legislation with the hope that this would prevent any breaching of these principles. Throughout the development of these new funding and insurance arrangements, the focus of policy makers remained on hospital and physician health care with public health and home care oriented services receiving limited consideration (Rachlis & Kushner, 1994; Storch & Meilicke, 1994; Taylor, 1987).

Throughout the 1960s and 1970s, health care costs began to escalate producing a number of health services commissions and reviews at both the provincial and federal level. At the provincial level the Castonguay-Nepveu Commission of Inquiry on Health and Social Welfare was completed in Quebec (1971), the Royal Commission on the Healing Arts was undertaken in Ontario (1970), the White Paper on Health Policy was produced in Manitoba (1972), and the Health Security for British Columbians Report was completed in British

Columbia (1973). At the federal level, a report from “The Community Health Centre in Canada Project” was produced in 1972 and Marc Lalonde’s report, “A New Perspective on the Health of Canadians: A Working Document”, was released in 1974. Although these reports identified issues in the health care delivery system and made recommendations for changes and improvements, governments took limited action. For example, the Community Health Centre in Canada Project suggested that the development of community health centres would increase consumer involvement, improve coordination and integration of health and social service professionals, and improve the system’s organization. Unfortunately, the changes suggested were never implemented due to both physician and hospital resistance (Government of Canada, 1973). The federal government’s attention remained focused on federal/provincial cost sharing arrangements (Storch & Meilicke, 1994).

By 1977, a new funding arrangement was agreed to by the federal and provincial governments. The Established Programs Financing Act abolished the fifty percent contribution by the federal government for health insurance programs in favour of a block grant system. The federal grant was no longer dependent on provincial spending but determined by such factors as population and economic growth. This enabled the federal government to better predict and control its health care expenditures and gave provinces increased flexibility in spending. Over the next couple of decades, further adjustments were made in transfer payments forcing increased provincial responsibility for health care and inevitable cost control measures (Rachlis & Kushner, 1994; Storch & Meilicke, 1994; Taylor, 1987).

From the 1960s to the 1980s, the organization of public health nursing services in British Columbia remained relatively static. The social unrest of the 1960s and the economic

downturn of the 1970s led to increasing concerns about escalating health care costs. Most provinces began re-examining the organization and delivery of health care services. Health reform and regionalization processes followed that would fundamentally change the organization and structure of public health nursing services.

### *Summary*

In this chapter, we have examined the role that historical influences played in establishing the roles and functions of public health nurses. Early on, public health nurses became actively involved in communicable disease control activities, maternal-child health initiatives, and school health endeavours. Variations of these roles persist to this day. This historical journey has also shown how such competing interests as the uncertainties about federal/provincial jurisdiction, societal biases that individuals rather than government should hold responsibility for health, the pressing need to deal with communicable disease epidemics, and the advent of voluntary nursing service organizations contributed to the complexity and messiness of the historical context. This chapter shows how this complex set of political and bureaucratic issues and events contributed to the initial development of public health organizational structures within the Canadian health care system. This chapter also provides the background necessary to understand the relationship between historical events and decisions and the development of public health related policy in Canada. Finally, this chapter has revealed the origins of the three practice tensions present in the public health nursing practice environment.

### *Relationship between historical influences and changing organizational structures.*

Decisions made early on in the development of the health care system shaped and will continue to shape the evolution and change of organizational structures affecting public

health nursing practice. Perhaps due more to default than design, a structured public health service delivery system managed to emerge, starting with the formation of provincial boards of health in the late 1900s, followed by the development of boards of education and municipalities as employers of public health nurses, and the establishment of national and provincial departments of health. The formation of health units ensued and variations of this structure persisted across the country until health reform action began in the late 1980s.

The pre-eminent position enjoyed historically by public health, diminished as the evolving acute care system shifted the focus of health care from the preventive, social reform agenda of the First and Second World War period to the curative, highly technological service delivery system of the 1960s and 70s. The relationship between public health nurses and this primarily acute care oriented system has often been uneasy. The system that emerged was designed to respond to curing and treating illness and disease. It was not designed to recognize the importance of public health nurses' efforts to create conditions conducive to health.

*Relationship between historical influences and shifting public health policy developments.* This chapter provides some insight into how historical influences set the stage for the leadership role Canada has taken in international public health policy development from the 1970s to this day. Governments were faced, early on in Canadian history, with a difficult and controversial struggle to determine whether the individual or society collectively held responsibility for health and health care. It was the devastation of the communicable disease epidemics and the solutions offered by scientific advancements that shifted thinking away from individual responsibility for health toward a more active but ad hoc role for government. It was only as industrialization and military defence needs demanded a healthier

population that government truly responded, perhaps motivated by economic and political concerns.

The growing societal opinion that health and social issues were important and that health care needed better organization eventually outweighed reservations about an interventionist role for government. This thinking led to the social reform agenda of the early 1900s. By the 1950's, as curative and technological solutions expanded, opinion shifted again to focus on an individualistic approach to health. Paradoxically, this shift set the stage for an active governmental role in national funding and insurance schemes for physician and hospital care. These activities, while important to the Canadian health care system, ensured that attention remained focused on institutional health care.

The changing social climate of the 1960s and 70s created dissatisfaction with the medical model and, together with concerns about escalating costs, provided the impetus for consideration of new ways of conceptualizing health and health care. The way was paved for the release of the Lalonde Report in 1974. This landmark document advocated a shift in thinking back to a more inclusive view of health, and would prove to position Canada as a leader in public health policy development throughout the remainder of the Century.

*Relationship between historical influences and the public health nursing practice tensions.* This chapter reveals the historical roots of the three public health nursing practice tensions outlined in Chapter 1. The first tension, described as the tension between the individual versus the population as the focus of public health nursing practice, can be likened to a pendulum swinging from an individual focus to a population focus. This tension has its roots in the communicable disease epidemics. It became increasingly evident that action at a population level was required to control communicable disease but the prevailing view that



health was purely a matter of individual responsibility created resistance to these actions. The role of nurses in managing these epidemics was thus challenged, forcing a primarily individualistic approach to practice.

This tension is evident again as Florence Nightingale, and others who emulated her approach, worked to redefine nursing practice in the mid-1800s. Her approach to community nursing practice recognized and profiled a duality of focus. Nurses were encouraged to provide quality individually oriented care while simultaneously engaging in action at the public policy and population level. Population-level action led to a process of community organizing and ultimately, contributed to the creation of an infrastructure for public health nursing practice. As formal infrastructures began to materialize, the dual focus of the public health nurse could be articulated, delineated in roles and responsibilities, and validated.

The 20<sup>th</sup> Century would prove to swing this first practice tension to the individual as the focus of practice. As the health care system shifted its attention to science, technology and curative functions, care providers were forced to concentrate on the needs of individuals. Conversely, the social reform agenda of the First and Second World War years had clearly positioned public health nurses' focus on improving the overall health of the population. These approaches were not well understood by a system designed to work at the individual level.

The second practice tension, described as the individual autonomy of the nurse-in-practice versus the combined public health nursing effort necessary to affect improvements in population health, also had roots in the work of Florence Nightingale. She recognized the importance of establishing a consistent approach to nursing practice and moved to formalize and standardize nursing education programs to accomplish these ends.

This tension came into view again with the advent of the social reform agenda in the early 1900s, when it became evident that a combined public health nursing effort would realize more significant gains than what a nurse could achieve as an individual practitioner. Community based women's organizations came to value this combined public health nursing effort and lobbied successfully for a formalized system of service. This encouraged governments and other organizations to foster the development and expansion of public health nursing. As the individual public health nurse's work came to be viewed as part of a combined effort, the public health nurse's choices about that work were by default constrained. The public health nurse could no longer function from an isolated practice perspective as the community came to value and expect certain kinds of nursing work. Thus, the individual public health nurse's practice became dependent upon the combined public health nursing endeavour.

History reveals an ongoing struggle to clarify society's collective responsibility for health. This could be considered the precursor to the third practice tension evident today as public health nurses seek to work out their contribution to the societal endeavour to improve the population's health. As previously mentioned, the social reform agenda of the first part of the 20<sup>th</sup> Century positioned public health nurses as an important part of a societal effort to improve health, albeit from the perspective of the predominant white, middle class.

By the early 20<sup>th</sup> Century, the causes important to public health nurses were also being advanced, purposefully or incidentally, by such groups and organizations as the Red Cross, the Victorian Order of Nurses, school districts, municipalities, and women's organizations. It behoved public health nurses to choose to work in partnership with the larger societal and organizational agenda to improve health rather than to separate or isolate

themselves from these endeavours. These partnerships would enable public health nurses to become an established part of the health care system but would also prove to constrain and often drive public health nursing practice.

This historical journey has revealed the underpinnings of the relationship between public health nursing practice, the practice tensions, and the contextual forces shaping that practice. We will now turn our attention to an examination of the health reform and regionalization process in British Columbia and its influence on the public health nursing practice environment.

## CHAPTER THREE

### Changing Organizational Structures: Health and Social Services

#### Reform in British Columbia

Organizational structures are a significant contextual force affecting the practice of public health nurses. Public health nurses generally work within organizational structures that are directly or indirectly formed and funded by government, such as Departments or Ministries of Health or Social Services and regional or local health authorities. The formation of these structures occurs largely external to the immediate practice environment of public health nurses. However, as these organizational structures shift and change, they inevitably influence and shape the public health nursing practice environment.

This chapter will focus on two organizational change processes that have occurred over the last decade. They are examples of the kinds of change that have been evident in the practice environment throughout history and can be anticipated to occur into the future. I have chosen these two organizational change processes because they have occurred concurrently and the impact on the public health nursing practice environment has been significant.

The first organizational change focused on in this chapter is the health reform process started in the early 1990s in British Columbia. From the 1960s onward, economic concerns have beleaguered the health care system across the nation, setting the stage for numerous provincial and federal studies, commissions, and reviews. Many of the reviews recommended a restructuring of the health care system to foster better integration of health and social services. Action on these recommendations did not occur until the late 1980s and 1990s

when health reform initiatives such as regionalization and decentralization became a national trend. In British Columbia, the process to regionalize health care began with the release of “Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs” in 1992 and continues to evolve today (Province of British Columbia, 1992).

The second organizational change of relevance to public health nursing practice is the reform of the social services system in British Columbia. This reform process was stimulated by the “Commission of Inquiry into Child Protection Services, Policies and Practices of the Social Services Ministry” undertaken by Judge Gove in 1994 following the death of a child who was in the care of the Ministry (Province of British Columbia, 1995). This inquiry eventually resulted in the formation of the Ministry for Children and Families in 1996.

Before turning to a description of how the health reform process and the formation of the Ministry for Children and Families influenced the organization and structure of public health nursing practice environments, it is useful to identify and discuss the issues they created for public health nursing practice. These issues arise from the integration of public health nursing services into systems primarily focused on acute care and child protection and the limited significance health promotion and prevention philosophies hold in these systems.

#### *Issues for the Public Health Nursing Practice Environment*

One of the key purposes of health reform and the decentralization of health services to regional health authorities was the integration of health services (New Directions Development Division, 1995). Similarly, the formation of the Ministry for Children and Families was driven, in part, by a desire to achieve an integrated and comprehensive system (Province of British Columbia, 1996). Both systems hoped to increase emphasis on health promotion and prevention and looked to public health to assist in attaining this shift in focus.

The agenda underlying this shift in emphasis was not entirely altruistic as both systems faced cost containment issues in the tertiary level services provided within the acute care and child protection sectors.

Ironically, both systems were seeking a shift in philosophy from intervention to health promotion and prevention but seemed unable to fundamentally change the design of acute care and child protection services. Thus, public health was to be incorporated into two systems that were not designed to understand the way in which public health needed to work while simultaneously expecting public health to influence these same systems to embrace health promotion and prevention philosophies.

*Philosophies of health promotion and prevention.* Health and social services reform offered the opportunity to incorporate philosophies of health promotion and prevention into the broader health and social service system. Although the importance of health promotion and prevention approaches were the rhetoric of health reform, community attention remained highly focused on the existing acute care and child protection systems and their preservation.

As acute care facilities throughout the province are confronted with budget issues and nursing, physician, and other health professional shortages, the media and general public are expressing increased concern. Two recent examples include the rural physicians dispute in 1998 and the withdrawal of physician services in Prince George in 2000. Both received extensive media coverage and occupied considerable time from the regional health board and management team in the Northern Interior Health Region (Ministry of Health and Ministry Responsible for Seniors, 1998a, 1998b, 1998c, 2000a, 2000b, 2000c). In general, the acute care sector consumes a large proportion of the health care budget and in turn demands extensive health board and management attention.

Similarly, the child protection system has faced increased public and political scrutiny regarding the Ministry for Children and Families' management of the abuse, neglect, and death of children known to the Ministry (Ministry for Children and Families, 2000). In addition, the Ministry's system is struggling with ongoing and severe staffing shortages and staff morale issues at both the practitioner and management levels (Ministry for Children and Families, 2001; KPMG, 2001).

These competing interests undermine the ability of the system to demonstrate commitment to philosophies of health promotion and prevention. Although there is an increasing interest and growing understanding of these philosophies' importance to the effectiveness of the health care and social services systems, there is an inherent inertia in the system which results in the maintenance of the traditional interventionist models of service delivery and challenges meaningful integration of public health services into these systems.

*Integration.* The struggle to integrate public health nurses into regional health authority organizational structures and into the Ministry for Children and Families multi-disciplinary team structures has had a major influence on the public health nursing practice environment over the last decade. Both health authorities and the Ministry for Children and Families view public health nurses as critical to achieving an integrated system focused on health and well-being. Both systems have sought opportunities to incorporate public health nursing services into multidisciplinary teams and integrated service structures. There has been active and passive resistance from public health nursing practitioners and managers to these proposed structures and processes.

The provincial public health system that evolved over the course of the 20<sup>th</sup> Century had enabled public health nurses to design services with a focus on improving individual

health in order to improve the overall health of the population. In contrast, the acute care and child protection sectors became elaborate systems entrenched in an individualistic approach. Integration into systems centred on resolving individual issues at a curative or intervention level threatened to unbalance the equilibrium attained under the old public health structures. The unfamiliarity of these environments made it difficult for public health nurses to effectively resist succumbing to an individualistic focus. For example, in some regions, public health nurses have shifted some of their work to support child protection social workers as they deal with the health issues of families in the child protection system. While this may be meaningful and necessary work, it has taken a scarce resource and shifted it from primary prevention, population level work to intervention activities (Roberta Hamilton, personal communication, 2000).

It is instructive to the process of clarifying the contextual forces influencing public health nursing practice to review the recommendations regarding the organization of the health care system that were made by the Royal Commission in 1992 and how the Ministry of Health proceeded to implement these recommendations. Next, the formation of the Ministry for Children and Families and its relationship to public health nursing will be discussed. I will return to a further examination of the issues these two organizational changes have created in the public health nursing practice environment and thus for practicing public health nurses in the summary of this chapter. We will start with the health reform process of the 1990s.

#### *Closer to Home Recommendations on the Reorganization of the Health System*

In 1992, “Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs” was released (Province of British Columbia, 1992). Part of the



mandate of the Royal Commission was to “examine the structure, organization, management, and mandate of the current health care system to ensure continued high quality, access, and affordability throughout the 1990s and into the twenty-first century” (Province of British Columbia, 1992, p. iii). The Commission developed four principles to assist the Ministry of Health in improving the management of the health care system. These four principles were decentralization, regional funding envelopes, a matrix organization, and the development of goals and objectives (Province of British Columbia, 1992).

The Commission’s vision of a decentralized system consisted of regional authorities with regional general managers who reported to a senior assistant deputy minister. The regions were to be responsible for cooperative community planning, resource allocation, and program support. A regional advisory board was seen as advising the regional general manager with the province retaining responsibility for the development of goals, objectives, policies and standards, broad action plans, regional resource allocation, and the monitoring and evaluation of the system (Province of British Columbia, 1992).

All health program funding, including the Medical Services Plan funds, was to be contained in a regional funding envelope. These funds were to be provided to the regions in a global budget with responsibility for the allocation of funds delegated to the regional general manager. The funding formula used to allocate regional funding would take into consideration the population health risk indicators (Province of British Columbia, 1992).

A matrix organization was envisioned where cross-program and cross-ministerial regional teams would be established to integrate health services. The regional general manager would assume responsibility for ensuring that integration occurred. Program

managers would have both vertical and horizontal reporting relationships (Province of British Columbia, 1992).

Following the release of the Closer to Home report, the Ministry of Health established several working groups. These working groups were to formulate the Ministry's response to the recommendations of the Closer to Home report. One of the working groups dealt with the recommendations about regionalization and decentralization. Decentralization would prove to be a key recommendation that would drive provincial planning and fundamentally change the way in which public health nursing services were organized.

*Ministry of Health's response to regionalization and decentralization.* The Ministry of Health's working group dealing with regionalization and decentralization agreed with the Commission's recommendations that a shift from a centralized system to a regional system was necessary. However, they did not support the model proposed by the Commission. Instead, they made three key recommendations. First, the Ministry of Health should devolve the health system to new regional and local authorities responsible for health planning, resource allocation, and management functions. Second, decentralization should include both the development of a framework outlining the roles and responsibilities of communities, regions, and the Ministry and the development of local and regional governance structures designed through community development processes. Third, the Ministry of Health should retain its legislative authority and policy setting functions and should reorganize to ensure integration. The Ministry was seen as continuing its responsibility for tertiary care, British Columbia Centre for Disease Control, Ambulance Services, Medical Services Plan, Pharmacare, forensic services, and vital statistics. In addition, the Ministry would continue to

be the funding body for the health system (Ministry of Health and Ministry Responsible for Seniors, 1992).

The working group process led to the production of a document, “New Directions for a Healthy British Columbia”, released in 1993. This document was based on the responses developed by the working groups and on ten months of consultation with professionals and members of the public. There were five new directions discussed in this document: better health, greater public participation and responsibility, bringing health closer to home, respecting the care provider, and effective management of the new health system (Ministry of Health and Ministry Responsible for Seniors, 1993).

*Creation of community health councils and regional health boards.* Bringing health closer to home was thought to mean a decentralized health system. Decentralization would require three major reforms, the first of which would be the creation of community health councils. These councils were to consist of elected and appointed representatives and were to be responsible for planning and coordinating all health services at the local level. It was thought that this would promote integration and prevent duplication of health services. The document then proposed the development of regional health boards consisting of representatives from community health councils and other appointed individuals. Their functions were to include regional health planning, coordination, and allocation of a global budget. Eventually, medical services funding would be included in this global budget. Finally, restructuring of the Ministry of Health would be needed to support the decentralization process (Ministry of Health and Ministry Responsible for Seniors, 1993).

The release of the “New Directions for a Healthy British Columbia” document produced a flurry of community organizing and consultation with community and

professional representatives through community forums and public surveys. Steering committees were established in many communities. Public health nurses were often actively involved on these steering committees and frequently had a direct role in assisting in the community organization process (Tim Rowe, personal communication, 2001).

Once the community health councils and regional health boards were officially recognized by the Ministry of Health, the health and management planning process began. The health and management plans included health status information for the region, identification and prioritization of health issues, an inventory of services, formation of advisory committees, and a description of how services were to be governed and managed. Regions were to reach agreement regarding what services were to be governed and managed at the local level and which should be governed and managed at the regional level.

As regions began grappling with the division of responsibilities between community health councils and regional health boards, the Ministry of Health developed a paper proposing four models for dividing these roles and responsibilities (New Directions Development Division, 1995). In the first model, governance and management would occur at the regional level with the community health council assuming an advisory role to the regional health board to ensure responsiveness to local needs. The second model suggested that the regional health board would serve as the governing body while most services would be delivered and managed locally. In the third model, governance and management were to be the responsibility of both the regional health board and the community health councils. The division of governance and management functions could differ from community to community and from service to service. The last model gave the majority of governance and management responsibilities to the community health councils. The regional health board

would allocate resources to the community health councils, set broad policies, and monitor the performance of the community health councils.

Following the release of these suggested models, public health nursing managers from health units around the province analyzed the impact each model would have on public health nursing practice. Two discussion papers were developed to address the issues identified (Health Officers Council, 1994; Public Health Nursing Administrators Council, 1995). The Health Officers Council paper dealt with the issue of the organization of public health nursing services in a decentralized system. The paper recommended that public health nursing services remain organized at the regional level reporting to a regional health board structure rather than a community health council structure. A regional structure was thought to retain the best components of the regionally based health unit structure that had been in place for most of the 20th Century.

A second paper was written to assist regional health boards and community health councils as they developed their health and management plans (Public Health Nursing Administrators Council, 1995). The paper outlined the criteria that public health nursing managers identified as critical to defining the future management structure for public health nursing services. There were significant concerns among public health nursing leaders that public health nursing services would be allocated locally to community health councils, undermining and fragmenting the regional system of public health service delivery that existed across the province.

By the summer of 1996, it was evident that communities and regions were struggling to define their management structure and governance functions. It was proving difficult for community health councils and regional health boards to come to consensus. The Ministry of

Health appointed a team of three Members of the Legislative Assembly (MLA's) "to assess B.C.'s health regionalization process, known as New Directions, to ensure it was meeting people's expectations as a way to manage the health system better" (Ministry of Health and Ministry Responsible for Seniors, 1997e, p.1).

*Streamlining regionalization.* This committee of three MLA's embarked on their review of the regionalization process by travelling around the province consulting with existing regional health boards, community health councils and community groups. The discussion papers outlining the recommendation and rationale for organizing public health nursing services at the regional level were provided to this team as part of their review.

The consultation process resulted in the abandonment of the "New Directions for A Healthy British Columbia" (Ministry of Health and Ministry Responsible for Seniors, 1993) approach for a new strategy called "Better Teamwork, Better Care" (Ministry of Health and Ministry Responsible for Seniors, 1997e). This more streamlined approach to regionalization and decentralization was announced in November 1996 and proposed that only one governance structure should exist in each regional health authority area thus reducing the number of boards and councils from 102 to 45.

In regions where there was a hospital that received funding for regional services, a regional health board was to be appointed and all community health councils were to be disbanded. The Ministry of Health would appoint members representative of communities across the region to these regional health boards. In all other regions, the regional health board would no longer exist and governance would be the responsibility of community health councils. In these regions, each community health council would appoint representatives to a new structure that would govern and manage the regional public health, continuing care, and

mental health services that were previously the direct responsibility of the Ministry of Health. This new structure was called a community health services society [CHSS] (Ministry of Health and Ministry Responsible for Seniors, 1997d). Public health nurses across the province were hopeful that the streamlining process meant that public health nursing services would consistently be organized at the regional level under either a regional health board or community health services society structure.

With the adoption of “Better Teamwork, Better Care”, the government proceeded to accelerate the transfer of authority for health care to the governance structures. By April 1, 1997, many of the new governance structures were finalized and the Ministry appointees to the eleven regional health boards and eight of the community health councils were confirmed allowing for the transfer of authority from the Ministry of Health to these boards (Ministry of Health and Ministry Responsible for Seniors, 1997b). The remaining 26 community health councils were put in place over the following six months.

Previously existing governance structures were amalgamated into the newly defined boards and councils with the goal of achieving efficiencies and providing a comprehensive continuum of services (Tim Rowe, personal communication, 2001). This occurred through either a collaborative planning process or by replacing the existing board or society with a public administrator to expedite the amalgamation process (Ministry of Health and Ministry Responsible for Seniors, 1997a, 1997c). For example, in 1997, the Northern Interior Union Board of Health, responsible for public health services in the region, amalgamated with the newly appointed regional health board. Conversely, in April 1997, four of the hospital boards in the Northern Interior Region had to be replaced by a public administrator to enable the amalgamation process to occur (Ministry of Health and Ministry Responsible for Seniors,

1997e). By May 1997, the Northern Interior Regional Health Board had hired a Chief Executive Officer and under his direction began the development of a regional management structure and the health services planning process (Tim Rowe, personal communication, 2001).

The regionalization of public health services was further complicated by the precipitous announcement of a new Ministry for Children and Families in November 1996. This announcement had been preceded by the “Commission of Inquiry into Child Protection Services, Policies and Practices of the Social Services Ministry” following the death of a child who was known to the then Ministry of Social Services (Province of British Columbia, 1995).

#### *Formation of the Ministry for Children and Families*

Judge Gove led the inquiry into the death of Matthew Vaudreuil from May 1994 to November 1995. This inquiry led to a report outlining 118 recommendations for change to the system responsible for child protection (Province of British Columbia, 1995). Over the next year, the government began work on these recommendations. One of the key recommendations was to appoint a “Transition Commissioner” with responsibility for designing and implementing a new child and youth service delivery system (Province of British Columbia, 1996, 1998).

*Office of the Transition Commissioner.* On February 1, 1996, an Office of the Transition Commissioner for Child and Youth Services was established and Cynthia Morton was appointed to the Transition Commissioner position for a period of three years (Province of British Columbia, 1996). In August 1996, the Ministry for Social Services released a report on the review of 19 deaths of children and youth known to the Ministry. The release of



this report stimulated an acceleration of the work being done by the Office of the Transition Commissioner.

Upon the request of Premier Glen Clark, the Transition Commissioner moved quickly to complete and present a report, “British Columbia’s Child, Youth and Family Serving System: Recommendations for Change” by September 17, 1996. The report made several major recommendations for immediate change including: establishing a Children’s Commissioner position to review unusual or suspicious deaths of children; dismantling the existing Ministry of Social Services and separating the financial support aspect from the service delivery components; transferring all child, youth, and family services held in the Ministries of Health, Women’s Equality, Education, Attorney General, and Social Services to a new Ministry for Children and Families (Province of British Columbia, 1996). These recommendations were rapidly acted upon.

On September 23, 1996, Premier Glen Clark announced the formation of a new Ministry for Children and Families in an effort to overhaul the child protection system and improve the safety of British Columbia’s children. He appointed Penny Priddy, MLA for Surrey-Newton as the new Minister and someone from outside government, Robert Plecas, as the new deputy minister. The Ministry was to assume responsibility from the Office of the Transition Commissioner for the implementation of the recommended changes including the amalgamation of child and youth services from five ministries into the new Ministry for Children and Families. At the same time, the Premier appointed Cynthia Morton to be the first Children’s Commissioner, reporting directly to the Attorney General. He also dissolved the Office of the Transition Commissioner ahead of the planned three-year schedule (Government of British Columbia, 1996).

*Public health services in relation to the Ministry for Children and Families.* The key aspect of the Transition Commissioner's recommendation that affected public health was the proposed amalgamation of child and family services from the Ministry of Health into the newly formed Ministry for Children and Families. The intent was to develop a "comprehensive child, youth and family serving ministry" that would "ensure that children, youth, and families have access to a continuum of services and programs, from the voluntary and preventive to the required and treatment oriented" (Province of British Columbia, 1996, p. 17). Public health's contribution was particularly relevant to one of the key mandates of the new Ministry, to "ensure healthy early childhood development through the application of a provincial early intervention and prevention program (including the provision or coordination of quality early childhood programs, and support and training programs for parents)" (Province of British Columbia, 1996, p. 18).

The Office of the Transition Commissioner's report recommended that the Ministry of Health programs should be transferred in the third month of the operation of the new Ministry (Province of British Columbia, 1996). The programs to be transferred were consistent with recommendation 107 of the Gove Inquiry and included:

...alcohol and drug treatment services for children and youth; public health nursing services relating to children and youth; forensic psychiatric services related to children and youth (i.e., Maples, Family Court Centre, Youth Court services); child and youth mental health services; infant and child development programs" (Province of British Columbia, 1995, p. 278).

The report from the Office of the Transition Commissioner was more specific and recommended that "Public Health Nursing – School Health and Family programs, audiology, speech, pregnancy outreach, dental, community care facilities licensing, public health – health unit support, medical health officers, public health engineer, community-based

services, Nobody's Perfect, prenatal access education grants, nutrition" be considered for transfer to the new Ministry with further discussion with the regional health boards (Province of British Columbia, 1996, p. A-40).

This recommendation came in the midst of the final stages of the regionalization streamlining process and a lengthy debate ensued between the Ministry of Health and the Ministry for Children and Families about which programs belonged in which Ministry. In the end, the programs actually transferred from the Ministry of Health varied somewhat from the recommendation. For example, alcohol and drug programs and many mental health services where it was difficult to separate the adult services from the children and youth focused services were transferred in their entirety. By April 1, 1997, it was decided that all public health services would remain with the Ministry of Health and be regionalized. However, the Ministry for Children and Families would provide 80% of the funding for public health nursing, dental, audiology, speech and language pathology, and nutrition services to the Ministry of Health through a protocol agreement (Hansard, 1997; Ministry of Health and Ministry Responsible for Seniors, 1997f).

In the early stages of the new Ministry for Children and Families, a decentralized approach was taken to organizational development and decision-making. The Ministry for Children and Families regions were coterminous with those of the Ministry of Health and were called Regional Operating Agencies. The bureaucracy in Victoria was called the Central Operating Agency. Given this decentralized approach, the health regions and Regional Operating Agencies were expected to work out local arrangements for public health service delivery (Northern Interior Region, 1997; Ministry of Health and Ministry Responsible for Seniors, 1997f).

*Prevention strategy of the Ministry for Children and Families.* At the outset of the development of the Ministry, there was an expressed desire to include prevention strategies into the continuum of services to be delivered. A provincial “Healthy Beginnings, Healthy Lives” task force brought together regional staff and Ministry staff from each of the five ministries to develop a promotion, prevention, and early support strategy. Each regional plan was to include a section outlining prevention initiatives to be undertaken in the region. Typically, the development of this section of the plan was led by a public health nursing management representative from the health authority (Northern Interior Region, 1997; Ministry for Children and Families, 1997a).

The provincial strategy consisted of two major components. First, regions were expected to embark on the development of three year ‘Healthy Beginnings, Healthy Lives’ plans for each region. Health authorities were asked to dedicate three percent of the public health budget received from the Ministry for Children and Families for “new or improved public health supports and services before birth to age five years” (Ministry for Children and Families, 1997b). Second, 10 pilot initiatives were announced throughout the province to support healthy child development with a focus on the prevention of Fetal Alcohol Syndrome and Fetal Alcohol Effects, enhancing child care, and lay home visiting. Regions were selected for pilot initiatives based on a range of socio-economic and health status indicators. In many regions, a multi-disciplinary planning process was led through collaboration between a community services manager from the Ministry for Children and Families and a public health manager from the regional health authority. In 1997, this strategy was renamed ‘Building Blocks’ by Penny Priddy, Minister of the Ministry for Children and Families.

*Centralization of the Ministry for Children and Families.* In 1998, Lois Boone, MLA for Prince George replaced Penny Priddy as the Minister responsible for the Ministry for Children and Families and Michael Corbeil was appointed as Deputy Minister, replacing Robert Plecas. With these changes, a more centralized, traditional Ministry began to emerge. The number of regions was reduced from 20 to 11 with many regions now encompassing several health regions (Ministry for Children and Families, 1999). Relationships between the regional health authorities and the Ministry for Children and Families became complicated and often difficult, particularly in relation to the delivery of public health services. The change in regional boundaries added to the frustrations many health authorities were experiencing in establishing meaningful partnerships with the relevant Ministry for Children and Families region.

### *Summary*

The organizational changes that have occurred over the last decade provide a snapshot of the impact that changing organizational structures exert on the public health nursing practice environment. Interestingly, the changes described in this chapter are continuing to shift and evolve as the Liberal government in British Columbia, newly elected in May 2001, examines both the health and social services systems. New Ministries have been recently established with changed responsibilities. For example, there is now a Ministry of Health Planning, a Ministry of Health Services, and a Ministry of Children and Family Development (Government of British Columbia, 2001). Throughout 2001/2002, programs are expected to shift from one Ministry to another and a modification of health authority structures is expected (John Phillips, personal communication, 2001).

Additionally, there are mounting concerns at the federal level about the future of health care. In April 2001, the federal Minister of Health, Allan Rock, announced the creation of a Commission on the Future of Health Care in Canada (Health Canada, 2001; Government of Canada, 2001). This Commission, chaired by the former premier of Saskatchewan Roy Romanow, is to:

...undertake a dialogue with Canadians on the future of Canada's public health care system; and recommend policies and measures, respectful of the jurisdictions and powers in Canada, required to ensure over the long term the sustainability of a universally accessible, publicly funded health system – one that offers quality services to Canadians, and that strikes an appropriate balance between investments in prevention and health maintenance, and those directed to care and treatment. (Government of Canada, 2001, p.1)

This initiative will inevitably create further changes in the structures and functions of the formally funded health care system.

Thus, this chapter has shown that the public health nursing practice environment is situated within complex political and bureaucratic structures and processes, both of which subject the nursing practice environment to repeated organizational change over time. These changes are always more or less chaotic for the practice environments they involve. This chapter has also revealed the interplay between changing organizational structures and public health policy developments. Finally, in this chapter we have also discovered how the public health nursing practice tensions are influenced by changing organizational structures.

*Relationship between changing organizational structures and public health policy developments.* This chapter highlighted two major organizational changes that have influenced the public health nursing practice environment over the last decade in British Columbia. The health care reform agenda had roots primarily in economic concerns. Although cost containment was also an issue for the social services reform agenda, it was

less about economic issues and more about the inefficiency and fragmentation of the system. The politicians and bureaucrats leading the organizational change processes looked to public health policy developments for guidance about how organizations should be structured to counteract such underlying issues as the long-term financial and functional viability of the health care and social services systems. The resulting rhetoric of both reform processes emphasized the importance of prevention and health promotion strategies with a focus on improving the population's health. Ironically, in British Columbia, the preservation of existing acute care and child protection services has become of paramount concern in recent years, rendering the creation of an organizational structure focused on improving health and well-being difficult at best.

Nevertheless, the interplay between the changing organizational structure and public health policy developments created expectations about the role public health nurses would play in both systems, further complicating the public health nursing practice environment. For example, integrated service delivery structures were created as a consequence of both reform processes, often without fundamental change to the purpose and function of these structures.

*Relationship between changing organizational structures and the public health nursing practice tensions.* Theoretically, the emphasis of health and social services reform on health promotion and population health, should have shifted the first practice tension away from an individual focus toward a population focus. However, the dual focus of public health nurses on both the individual and the population has proved to be difficult to clearly articulate to intervention-oriented systems designed philosophically and functionally to focus on interventions to individuals. Ultimately, the pull of these systems has often proved to be in

the direction of the individual despite rhetoric about improving the health of the population. This has been demonstrated in some regions as public health nurses have shifted some of their services to support children already in the child protection system.

The working out of the second practice tension, described as the individual autonomy of the nurse-in-practice versus the combined public health nursing effort necessary to improve health, is also influenced by organizational changes. For example, the recent development of integrated service delivery structures places public health nurses within multidisciplinary teams responsible for the continuum of services from promotion to intervention. Public health nurses find themselves reporting to managers with primary responsibility for acute care and institutional services. These managers often do not comprehend the importance of connecting local public health nursing endeavours with the outcomes public health is collectively striving to achieve at regional, provincial, and even national levels. This can serve to separate and isolate public health nurses from each other, pulling their practice away from a consciousness of these broader outcomes.

Health and social services reform has had an interesting effect on the third practice tension or the tension between public health nurses' ownership of roles and responsibilities versus their collaboration with the larger societal endeavour to improve health. The locally integrated service delivery system that has developed as a result of health and social service reform in British Columbia pulls public health nurses more readily into collaborative partnerships with community members and organizations. Locally integrated service delivery structures are designed to be more responsive to community needs than are large bureaucratic organizations. These structures have the potential to enhance public health nurses' contribution to the larger organizational and societal effort to improve health by removing



bureaucratic constraints and placing public health nurses' knowledge and skills where they can be readily shared. For example, since the advent of regionalization, public health nurses in the Northern Interior Health Region have become involved in local and regional coalitions related to heart health, women's health, tobacco reduction, injury prevention, child health, HIV/AIDS prevention and so on.

An examination of the shifts in public health policy development that have occurred over the later half of the 20<sup>th</sup> Century will serve to illuminate another important contextual force impacting the practice environment. The next chapter will review the foremost policy developments that have shaped public health nursing practice.

## CHAPTER FOUR

### Shifting Public Health Policy Developments: Impact on Public Health Nursing Practice

Throughout the later half of the 20<sup>th</sup> Century shifts in public health policy development have influenced the approaches used to improve the health of the population. Since public health nursing practice is patently about improving the population's health, it has been particularly susceptible to these shifts in thinking. It is from this world of public health nursing practice that I wish to focus this analysis of shifting public health policy developments. To this end, this chapter will include a description of each public health policy development, the context that enabled the thinking to gain prominence and subsequently fade into the background as another development superseded it.

Public health policy development is often separated into four categories (Glouberman, 2001; Labonte, 1993; Registered Nurses Association of British Columbia [RNABC], 1992). Each category is characterized by a particular conceptualization about health, beginning with the medical approach predominant in the 1960s, the behavioural or lifestyle approach that emerged in the mid-1970s, the socio-environmental approach of the 1980s, and the population health approach that increased in significance throughout the 1990s. Each public health policy development has held in common an expressed interest in improving health. Each has identifiable historical roots and has retained a unique identity over time. Each differs fundamentally in its philosophical or theoretical underpinnings and has inevitably pointed to divergent and often contradictory practice directions. Although there remains little philosophical convergence among the approaches, the contributions each

has made to health and health care has informed, and perhaps ironically, enabled the next wave of thought to achieve recognition and influence.

The categorization of public health policy development creates the impression of a deliberate evolution of ideas, expanding society's understanding of health and resulting in a concurrent progression in approaches to health and health care. It denotes a deductive process taking us forward to the 'right' approach to health and health care. Instead a more inductive, iterative process seems to be at work in determining which public health policies come to the forefront to influence public health practice.

Public health policy and the underlying conceptualizations of health seem to first find voice within the world of health policy, largely external to the public health nursing practice environment. The discourse and debate within the health policy world has been generally about reconciling philosophical and theoretical tensions in light of perceived societal issues rather than about how public health practitioners will incorporate policy into practice. As the debate and discourse has ensued, each public health policy has managed to gain prominence within a social, political, and economic context favourable to the further advancement of that particular policy development. This, in turn, has caused each public health policy to achieve credibility in mainstream thinking and to exert influence upon the societal view of health and health care and subsequently the way in which public health nursing practice occurs. We will begin this overview about the shifts in public health policy developments with an examination of the medical model.

### *Medical Model*

The medical approach to health has driven much of our modern conceptualization of health and health care and was particularly prevalent in the 1950s to the early 1970s. The

medical model developed concurrently with the rapid advancement of scientific knowledge that occurred in the late 1800s. Medicine gained a dominant role in society as trust grew in the curative solutions to illness and disease that science and technology offered. Medicine's approach to health care has been supported by a society that placed emphasis on the individual's responsibility for health (Allemang, 2000; Heagerty, 1940; Rafael, 1999b; Ross-Kerr, 1998).

A number of key decisions made in the early years of Canada's publicly funded health care system focused attention on medical care, hospitals, and their construction through much of the post war era (Badgley, 1994; Pinder, 1994). The prevailing definition of health as the "absence of disease or infirmity" further served to situate health in biomedical science (Labonte, 1993).

The question posed by a medical approach to health is: "How do we diagnose and treat people?" (Hayes & Glouberman, 1999, p. 4). Biomedicine promotes the view that the body is a complicated machine requiring 'fixing' when it experiences a breakdown. Risk factors for disease and illness are understood to be physiological in nature and can be addressed by interventionist strategies such as surgery, medications, risk factor screening procedures, and medical management of lifestyle changes. Prevention efforts are focused on repairing damage to the body in hopes of preventing disease (Labonte, 1993).

The medical model remains a significant part of the health care system today and has an ongoing influence on public health practice. Many of the disease prevention strategies evident in public health practice are based in a medical model where success is measured in the reduction of disease, disability, and death (Hancock, 1994). Indeed, the medical model has successfully enabled a sophisticated understanding of biological functioning, increased

our knowledge of the genetic determinants of health, and facilitated the development of a health care delivery system that, although expensive, is capable of treating disease and injury. However, there is convincing evidence that the contribution that the medical approach makes to health is limited and constrained by broader socio-environmental factors (Glouberman, 2001). By the early 1970s, the fiscal situation threatening the Canadian health care system opened the door to a broader view of health.

### *Behavioural or Lifestyle Approach*

Throughout the 1970s and 80s, two public health policy developments emerged. The first was a behavioural or lifestyle approach stimulated by the release of “A New Perspective on the Health of Canadians: A Working Document” (Lalonde, 1974). The second was the socio-environmental approach, articulated in “Achieving Health for All: A Framework for Health Promotion” (Epp, 1986) and the “Ottawa Charter for Health Promotion” (World Health Organization [WHO], 1986b). Some of the literature has chosen to merge the lifestyle and socio-environmental approaches into a health promotion category for the purpose of analysis. These authors describe the Lalonde Report as opening the door to health promotion and view the Epp Report and the Ottawa Charter as a maturation or expansion of health promotion thought shifting the emphasis from the lifestyle of individuals to the socio-environmental context (Glouberman, 2001; Legowski & McKay, 2000).

Other literature identifies distinct differences between the lifestyle and socio-environmental approaches (Hancock, 1994; Labonte, 1993, 1994). These authors argue that the discourse surrounding a socio-environmental approach to health promotion was more than a maturation of thought from a lifestyle-oriented definition of health promotion. Rather, the discourse stimulated a rethinking of beliefs and their application within society and as

such represented a transformation in understanding. From a public health nursing practice perspective, each approach has led in distinct practice directions. Thus, the separation of the two approaches for the purpose of analysis is useful. We will begin with the behavioural or lifestyle approach.

The behavioural or lifestyle approach to health has roots in the late 1800s as the public health infrastructure was evolving in response to the spread of communicable disease, sanitary issues, and maternal-child welfare. These issues were dealt with primarily through health education (Green, 1983; Riddell, 1991, Ross-Kerr, 1998). Both federal and provincial funds were invested in supporting many of these endeavours through brochures, educational sessions, and home visiting services. Although health education and marketing strategies continue to be a significant component of public health practice to this day, their emphasis within the overall health care system diminished as the focus of attention turned to the creation of a national medicare and hospital care system (Badgley, 1994; Labonte, 1994).

By the 1970s, dramatic social change was underway. The emphasis on family values and the work ethic of the 1950s had given way to such social movements as feminism, environmentalism, the peace movement, and the civil rights movement. At the same time, concern about the escalating cost of the health care system was mounting and medical approaches were proving unsuccessful in dealing with chronic conditions such as heart disease and cancer (Labonte, 1994; Pinder, 1994). The fiscal concerns ultimately led to a significant change in the funding of the Canadian health care system when the Established Program Financing (EPF) Act was passed in 1977. This effectively shifted health care financing arrangements from federal/provincial cost sharing to block funding, making cost containment issues a matter of provincial concern (Legowski & McKay, 2000; Taylor, 1987).

The convergence of major social change with the increasing concerns about health care costs set the stage for a shift in thinking within the mainstream health care system (Labonte, 1994).

The environment was thus receptive to a document entitled, “A New Perspective on the Health of Canadians: A Working Document”, produced by the Long Range Health Planning Branch, a ‘think tank’ of National Health and Welfare. This document was released in 1974 and came to be known as the Lalonde Report, in recognition of Marc Lalonde, then Minister of National Health and Welfare. When the Lalonde Report was first released, it was virtually dismissed by federal politicians. However, as it gradually filtered out to health professionals, agencies and organizations, and politicians, interest grew. Inadvertently, the Lalonde Report offered the overwhelmed health care system of the 1970s an optimistic solution to improving health and led to the development of a Health Promotion Directorate within National Health and Welfare. By 1984, it was internationally recognized as a landmark document that had shifted conventional thinking to the idea that health was more than health care (McKay, 2000; McKay, 2001; Pinder, 1994).

The Lalonde Report initially drew on work done by Dr. Thomas McKeown, who concluded, through an examination of historical influences on health, that things outside the traditional health care system had a significant impact on health (Lalonde, 1974). This represented a revolutionary change in thinking and stimulated a comprehensive analysis of mortality and hospital morbidity statistics in Canada, confirming that premature death and illness were likely the result of self-imposed risks rather than due to a lack of access to medical care. Consequently, the Long Range Health Planning Branch of Health and Welfare Canada began investigating the underlying causes of health and what needed to be done to improve health status (McKay, 2000; Glouberman, 2001). This analysis led to the

development of a new model that explained health through a Health Field Concept, which named four essential elements, human biology, the environment, lifestyle factors, and the health care organization, as contributing to health (Lalonde, 1974).

Human biology was thought to encompass “the genetic inheritance of the individual, processes of maturation and aging, and the many complex internal systems in the body” (Lalonde, 1974, p. 31). The environment included those things that are external to human biology and thus outside of the individual’s direct control. Lifestyle factors dealt with the decisions and choices individuals make that influence their health. Finally, the health care organization was described as the traditional health care delivery system (Lalonde, 1974).

The Health Field Concept attempted to draw attention to the factors underlying health, albeit at the individual level. It focused attention on a broad question about health: “How do we improve the health of the population?” (Hayes & Glouberman, 1999, p. 4). It recommended that more attention should be focused on the first three elements of the concept since the formal health care delivery system’s contribution to health status improvements had reached a plateau. The Health Field Concept remained silent about the potential interactions between the concept’s four elements (Glouberman, 2001).

The Lalonde Report made suggestions for health promotion action focused on ameliorating self-imposed risks that led to illness, disease, and eventually death and emphasized the identification and follow up of populations at high-risk for lifestyle related disease and illness. Health promotion action was defined as “informing, influencing and assisting both individuals and organizations so that they will accept more responsibility and be more active in matters affecting mental and physical health” (Lalonde, 1974, p. 66). The



Health Field Concept maintained that health was not simply a matter of fate but one significantly influenced by personal choice and self-determination (McKay, 2001).

Thus, the ensuing policy and fiscal response to the Lalonde Report was primarily oriented to a lifestyle approach focused on changing individual behaviours, despite the potential for more far-reaching action in the document's recommendations. For example, initial priorities selected for action included traffic accidents, occupational health, and alcohol abuse (Legowski & McKay, 2000). The contribution of the environment to health was given only perfunctory attention in comparison to the development of the lifestyle component of the report. For instance, although environmental risks such as the contamination of drinking water, air pollution, urbanization, working conditions, rapid social change, and economic deprivation were mentioned as contributing to health, the suggestions for action related to these issues were limited and narrow in scope (Labonte, 1994; Lalonde, 1974; McKay, 2000; Rootman & Raeburn, 1994). Additionally, the influence that such social contexts as the family unit, peer groups, and the community had on health and well-being were neglected in the analysis.

In summary, the Lalonde Report marked the first attempt since the Canadian health care system had been formally established, to shift the system to considering the underlying causes of health. The Lalonde Report can be credited with revealing possible underlying causes of mortality and morbidity and linking these causes with methods of intervention. It forced recognition that health was more than health care and thus channelled Canadian health policy into a new direction (McKay, 2000; Glouberman, 2001).

The Lalonde Report successfully popularized health education and social marketing strategies and promoted prevention initiatives aimed at helping people change unhealthy

behaviours (Hancock, 1994; Labonte, 1993). This represented a movement away from the medical model to inclusion of non-medical approaches to health within mainstream health care programs. To this day, public health accepts, as part of its responsibility, the use of health education strategies to support individuals in making behavioural changes in order to improve their health.

By the early 1980s, the lifestyle or behavioural approach came to be criticized as leading to a 'blame the victim' mentality in preventative endeavours and for failing to realize the social and institutional change thought to be necessary to achieve health and well-being (Labonte, 1993, 1994; O'Neill & Pederson, 1994; Robertson, 1998). The conceptualization of health promotion action as social marketing and persuasion and the notions of self-determination and personal choice as integral to behavioural change were about to be challenged by the socio-environmental approach to health and health promotion. It is interesting to note that, without the Lalonde Report's supposition that health is more than health care, the socio-environmental perspective would have struggled to attain the credibility and acceptance that were realized in the 1980s (Glouberman, 2001).

#### *Socio-Environmental Approach*

The emergence of the socio-environmental approach to health in the 1980s challenged much of the thinking and direction stimulated by the Lalonde Report. Although the socio-environmental approach to health came to be known as the "new public health" (Pederson, O'Neill, & Rootman, 1994), it is reminiscent of the social reformist activity of public health nurses who practiced at the turn of the 20<sup>th</sup> Century. The issues and strategies differ but the agenda is similar. Both were seeking ways to create a healthy population in the broadest sense (Bramadat & Saydak, 1993; McPherson, 1996; Robertson, 1998).

The 1980s were marked by a maturation of the social movements of the 1960s and 70s as the activists from this era moved into professional positions, advocating for their issues from within traditional systems (Labonte, 1993). The transfer of fiscal responsibility for health care to the provinces was accompanied by decreased federal transfer payments, further aggravating already difficult federal/provincial relationships. This led to numerous provincial reviews and Royal Commissions on health care starting in the late 1980s through to the mid-1990s. The combination of increased frustration with the fiscal issues of the existing system, the navel gazing stimulated by the provincial reviews and Royal Commissions, and the internal advocacy for social justice and environmental sustainability, cleared the way for a more radical conceptualization of health and health promotion to move to the forefront.

There was a firm belief in many health policy circles that the ecological and sociological aspects of health were important contributors to health and that medical and lifestyle approaches were narrow and paternalistic. Criticism was increasing that the strategies used to change behaviour were only realizing success within population groupings of higher socio-economic status. People who had difficult life issues to contend with were unable to manage the lifestyle changes (Labonte, 1993; Glouberman, 2001; Robertson & Minkler, 1994; Robertson, 1998).

Questions about the definition of health promotion espoused in the Lalonde Report were raised. The notion that behavioural change was purely subject to self-determination and personal choice was thought to ignore the social and cultural structures that conditioned and constrained lifestyle choices. Most significantly, the persuasion and social marketing

strategies that the lifestyle approach had led to were characterized as ‘victim-blaming’ (Labonte, 1993, 1994; Robertson, 1998).

Labonte (1994) suggests four reasons that a behavioural or lifestyle orientation to health did not fully achieve a new perspective on health. First, the behavioural approach tended to focus on the work that an individual practitioner did. The power structure of the institutions these practitioners worked within was left unchallenged. Second, the lifestyle approach led to a disease prevention model where behavioural change is sought for the purpose of decreasing the risk of disease or illness. Further, intrinsic to the lifestyle approach is the perspective that individuals make choices that affect their health independent of the influences of socio-economic circumstances or societal structure. Third, social marketing or persuasion was considered to be the primary mechanism to influence behavioural change, neglecting the role of social or community level action. Finally, health education strategies remained entrenched within the traditional health care delivery system. Opportunities to include such approaches as self-help and mutual aid were not contemplated.

A reworked definition of health promotion was legitimized in 1986 through the development and release of the “Ottawa Charter for Health Promotion” (WHO, 1986b) at the First International Conference on Health Promotion held in Ottawa (Legowski & McKay, 2000; O’Neill & Pederson, 1994). Embedded within this definition of health promotion was a new conceptualization of health. Health promotion and health were now defined as:

...the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize their aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. (WHO, 1986b, p. 2).

The Ottawa Charter proceeded to outline broad prerequisites or foundations for health including peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. It described health promotion action as building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services (WHO, 1986b).

Concurrently, a federal document, “Achieving Health for All: A Framework for Health Promotion” attributed to Jake Epp, then Minister of Health and Welfare was released at the same conference (Epp, 1986). This framework was in synchrony with international thought and demonstrated that the health care system in Canada was willing to embrace a broader view of health promotion (Legowski & McKay, 2000; Pinder, 1994). The framework emphasized the social determinants of health and the relationship between social inequities and health. It recognized that health promotion action would require partnerships between a broad cross section of society. Ten years later, the Jakarta Declaration on health promotion reaffirmed and expanded upon the statements made in the Ottawa Charter confirming their ongoing relevancy to health and health care (WHO, 1997).

The WHO outlined the newly conceived concept of health promotion and its principles in a 1986 discussion document (WHO, 1986a). Five principles of health promotion were articulated in this document and served to clarify the distinction between a socio-environmental approach focused on health promotion action and the lifestyle-oriented approach advocated in the Lalonde Report. First, health promotion was seen as involving the population overall versus targeting people at risk for disease. Second, health promotion action is directed to the determinants of health, beyond those under the purview of the traditional health care system. Third, health promotion action encompasses diverse methods

and approaches including education, public policy, reorientation of services, community development and so on. Fourth, public participation is critical to successful health promotion action. Finally, health professionals were thought to “have an important role in nurturing and enabling health promotion”, although it could not purely become their jurisdiction (p. 74).

Inherent in this new definition of health promotion were highly political issues of poverty, unemployment, powerlessness, isolation, and social justice. The preferred strategies included empowerment, community development, coalition building, and advocacy, and were likewise political in character (Labonte, 1994; Robertson & Minkler, 1994). The initial debate about these issues and strategies had been conducted external to the conventional health care system, enabling the disempowering nature of the system to be challenged by people who were unencumbered by bureaucratic or political obligations.

The mainstreaming of health promotion into the health care system was brought about in 1986 with the release of the Ottawa Charter and the Epp Framework. The general acceptance of these new ideas created some discomfiture for the proponents of health promotion as they reconciled the need to effect social change with the legitimacy that governmental and bureaucratic acceptance of their ideas offered. Further, the acceptance of the socio-environmental approach stimulated an ongoing debate as to whether health promotion was becoming a social movement in its own right or simply a professional movement informed by social and political movements such as environmentalism and feminism (Labonte, 1993, 1994; O'Neill, Rootman, & Pederson, 1994; Stevenson & Burke, 1992).

The mainstreaming of the health promotion movement produced a response that is interesting in both its inertia and its innovation. Within government, it proved difficult to

garner funds for process-based strategies such as community development and empowerment that seemed vague, difficult to describe and measure. Given the lack of interest in funding these process-based strategies, the federal Health Promotion Directorate maintained its previous agenda and forged ahead throughout the 1980s and 90s with lifestyle-oriented approaches focused on issues of concern to government. There was little motivation to reorient government's strategic planning to mesh with socio-environmental philosophies. At best, there were attempts to incorporate the principles of health promotion into issue specific strategies such as Canada's Drug Strategy and the Heart Health Initiative (Legowski & McKay, 2000; Pinder, 1994).

A more innovative health promotion response was the healthy communities project. This project was started at the federal level and supported in many provinces. It was modeled after the European "Healthy Cities" movement. In Canada, this initiative was jointly spearheaded by the CPHA, the Federation of Canadian Municipalities, and the Canadian Institute of Planners. It focused on involving municipalities and community members in developing community based plans that would address health issues, particularly in light of the social determinants of health (Manson-Singer, 1994; Stern, 1990).

In British Columbia, this project stimulated the formation of the B.C. Healthy Communities Network with representation from a broad range of organizations and sectors. This network, although funded by government, functioned primarily outside of its jurisdiction. It organized a couple of provincial workshops where community leaders from around the province were exposed to the concept of health promotion. These participants, in turn, organized workshops in their own regions. In some parts of the province, these

workshops evolved into full-fledged healthy communities processes (Altman & Martin, 1994; Ministry of Health and Ministry Responsible for Seniors, 1994; Stern, 1990).

In 1989, the creation of an Office of Health Promotion within the B.C. Ministry of Health helped communities to establish their community development activities. Resource people and funding were made available through this office to assist communities with Senior's Wellness, Healthy Schools, and Healthy Communities processes. This office functioned in parallel to the branch that operated public health programs and as such, produced some frustration among public health nurses about how its work related to traditional public health priorities. Nevertheless, it successfully facilitated the incorporation of health promotion approaches into public health work and many public health nurses became actively involved in local healthy communities committees and facilitated healthy schools processes (Altman & Martin, 1994).

Ultimately, the progression of health promotion within the mainstream system was dependent on the time needed for grassroots social change to occur. The progression of health promotion was also dependent upon buy-in from key participants to a particular political and social agenda. In the absence of fundamental social change and in the presence of a global economy, this agenda tended to alienate the very partners that were needed to foster the institutional level changes required if empowerment, social justice and equity were to occur. Thus, community processes were largely unsuccessful in engaging essential, but non-traditional partners from business, industry, and municipal governments. It was also proving difficult to bring these partners together with disenfranchised groups and where this was done, the partnership was uneasy at best. For example, healthy communities networks often included health and social service agency representatives and community participants



but had difficulty bringing business and municipal government representatives to the table. As a consequence, healthy communities-type activities were beneficial but remained small projects that influenced life for a few people or around the edges of a system that did not itself significantly change (Northwest Connections, 1994, 1996).

The 1980s and early 1990s were a challenging time for public health nurses working within the traditional system. They were asked to learn new skills such as facilitation, community development, and partnership building with no recognition of public health nurses' long history of successful community level work. Leadership for health promotion action was expected to come from outside the system, requiring public health nurses to form closer working relationships with non-traditional partners. At times public health nurses were confused as to whether they were in competition for resources, duplicating work, or collaborating around issues. Consequently, they faced unabashed criticism of their role and the systems they worked within. Communities were encouraged to identify barriers to health promotion such as turfism or territoriality, resistance to change, and professionals who saw themselves as experts. Public health nurses were often the only representatives of the traditional health care delivery system in health promotion processes. As a result, they were frequently caught between attempting to facilitate community processes and defending their legitimacy as participants despite the organizations they represented. A supportive work environment with sensitive and proactive leadership was required in order to enable these nurses to flourish in these new roles (Altman & Martin, 1994; Rafael, 1999a, 1999b).

In summary, the legacy of health promotion to public policy development is in the discourse it produced, both internal and external to the formal health care system (Labonte, 1994; Legowski & McKay, 2000). The socio-environmental era did, indeed, establish health

promotion as an important idea with associated principles for action. To some extent, it also stimulated social consciousness where none previously existed.

However, the fundamental social and political change sought by health promotion advocates would not be realized before interest waned (Hancock, 1994). The exclusive emphasis on the social determinants of health and the socio-environmental context became a 'bandwagon' response leading to a virtual rejection of individually focused work and a disregard of other determinants of health in some circles. Missing was an analysis of the interaction between the determinants of health and between the individual and the social context (Glouberman, 2001).

By the mid 1990s, governments and bureaucrats were changing and health reform agendas were marching forward. A system increasingly focused on cost containment and outcome measures made sustaining pure health promotion strategies difficult (Legowski & McKay, 2000). New ideas began their persuasive work and by the early 1990s, the language of a new approach to health, population health, was moving to the forefront.

#### *Population Health Approach*

The context of the 1990s surfaced fiscal concerns, this time focused on debt reduction in the face of an increasingly global economy. This issue became a governmental priority, leading to major federal cutbacks and restraint programs. For example, in 1995, a number of federal/provincial cost-sharing programs were amalgamated into a block funding transfer payment to provinces called the Canadian Health and Social Transfer. Although, provinces were given control of how these funds were expended until recently, they were subjected to steadily decreasing amounts (Legowski & McKay, 2000).

The environment of fiscal restraint was also producing a growing demand for outcome-based measures to justify program existence. As a consequence, process based initiatives such as the federal Healthy Communities Project were sacrificed early into these cutbacks leading to a disappearance of health promotion action from the policy scene within government. Health promotion research, thinking, and action continued to move forward within practice and academic environments. For example, the CPHA engaged in a two-year consultation process with the production of a document that identified key health promotion priorities (CPHA, 1996b; Legowski & McKay, 2000).

This context stimulated a growing interest in a new stream of thought that was emerging from research conducted primarily by the Canadian Institute of Advanced Research [CIAR] under the leadership of Dr. Fraser Mustard. Their research was epidemiologically based and thus able to produce the quantitative, empirical evidence that was relevant to the issues policy makers were grappling with. Their message was familiar and harkened back to the underlying premise of the Lalonde Report and to the ideology of health promotion, that social and economic factors outside of traditional health care were significant influencers of the population's health (Hayes, 1999; Hayes & Glouberman, 1999; Legowski & McKay, 2000).

The CIAR used empirical evidence to demonstrate the correlation between inequalities in health status and the socio-economic determinants of health. It was also able to show the relative importance of the determinants of health, indicating that the socio-economic determinants are most significant to improving population health. It provided answers to the question: "Why are some people healthy and others not?" (Glouberman, 2001, p. 20). The CIAR integrated this knowledge together into a population health framework that

identified the determinants of health and showed their interactions (Evans & Stoddart, 1994; Hayes & Glouberman, 1999; Mustard & Frank, 1994).

As the population health evidence was compiled and analyzed, four key focuses for research emerged. The first area focused on early childhood experiences and the notion of “biological embedding” whereby these experiences are shown to affect future health and well-being. Specifically, there was convincing evidence that children who have a good start in life, do better later on. Second, there was a realization that social and economic gradients directly impact the overall health of the population. This finding was discovered through statistical analysis of socio-economic indicators in relationship to mortality and morbidity rates in countries around the world (Keating & Hertzman, 1999; Mustard & Frank, 1994).

The third area of interest was about the contribution that work and working conditions made to health. This focus arose out of the Whitehall studies of civil servants in Britain where risk behaviours had different outcomes dependent upon the perception of control over life circumstances. The final focus was on the role of social networks and supports to improving health (Hayes & Glouberman, 1999; Mustard & Frank, 1994).

The federal response to these new ideas first occurred in 1995 with the release of federal/provincial/territorial document entitled, “Strategies for Population Health: Investing in the Health of Canadians” (Federal/Provincial/Territorial Advisory Committee on Population Health, 1994). This document summarized population health, the determinants of health and proposed three strategic directions for action. These included strengthening public understanding about the determinants of health, building the understanding of governmental partners outside of health, and developing comprehensive intersectoral population health initiatives (Federal/ Provincial/Territorial Advisory Committee on Population Health, 1994,

p. 6-7). This document represented the formal acceptance of population health as the framework to guide health policy development. Subsequently, two documents reporting on the health of Canadians have been released (Federal/Provincial/Territorial Advisory Committee on Population Health, 1996, 1999).

In the 1999 report, the Advisory Committee on Population Health defined population health as follows:

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic, and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services.

As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations (p. 7).

Population health's emphasis upon economic as well as social determinants of health enabled proponents of both right-wing and left-wing politics to be receptive to its ideas. Population health contends that sustained economic growth is a predictor of the population's health. The right were drawn to the idea that the accumulation of wealth made a difference to health status. The left found resonance in the message that it was the distribution of wealth or issues of equity that made a difference.

The acceptance of population health as the framework for health policy was disconcerting for proponents of health promotion. Population health is based in epidemiology, a positivist scientific methodology. Health promotion is situated in a critical social science perspective more in line with naturalistic inquiry methodologies. These philosophical differences mattered and created wariness and misgivings about the other's position on how to approach health. Health promotion advocates viewed population health as

focusing on economics to the disregard of the human faces and power relations behind much of the epidemiological data (Hayes, 1994, 1999; Labonte, 1995; Legowski & McKay, 2000; Robertson, 1998).

In turn, population health did not recognize the contribution to the social determinants of health that had been made through the community development initiatives and broad based community action mounted by health promotion activists (Legowski & McKay, 2000; Robertson, 1998). More recently, some of the population health literature has begun to emphasize both the empirical data available through epidemiological analyses and the understandings gained through qualitative approaches to analyzing the meaning of the social circumstances people find themselves in (Dunn & Hayes, 1999; Hayes, 1999).

Hamilton and Bhatti (1996) attempted to bring these two concepts together in a document, "Population Health Promotion: An Integrated Model of Population Health and Health Promotion". This document sought to reconcile the determinants of health with the health promotion strategies recommended within the Ottawa Charter. While useful in demonstrating that population health and health promotion can be complementary, it did not directly address or ameliorate the fundamental philosophical differences inherent in each approach.

In sum, the contribution of population health so far has been to produce empirical evidence supporting the notion that social and economic factors are significant contributors to health. Population health proposes economically and, more recently, socially based solutions at a societal level such as reducing the discrepancy between the rich and the poor, increasing the opportunities for a child to do well in society through such strategies as universal child care and extended maternity leaves, and the creation of a 'civic' society.

However, population health has not yet provided answers as to how communities might get to these solutions. In contrast, health promotion focuses on community processes, proposing how society can make the fundamental changes necessary to change power structures, enabling people to control their circumstances. It remains to be seen how population health and health promotion approaches will complement one another in achieving their mutual purpose of improving the health and well-being of all people (Butler-Jones, 1999; Dunn & Hayes, 1999; Hayes, 1999).

### *Summary*

This chapter has sought to shed light on another of the contextual forces at play in the context of public health nursing practice. Shifting public health policy developments together with their associated conceptualizations of health have been shown to have a direct impact on the nature of public health nursing practice. This chapter has also revealed the interconnection between organizational structure and public health policy development. Chapter 3 showed how the organizational changes of the 1990s were shaped by the developments in public health policy related to health promotion and population health. In turn, the underlying concerns driving changes in the organizational structure of health care over time have influenced which public health policy perspective was given voice at the forefront of the health care system. Finally, this chapter has illuminated the interaction between the practice tensions and the shifts in public health policy.

### *Relationship between public health policy developments and organizational structure.*

Public health policy development in the later half of the 1990s has centred on the medical model, the lifestyle oriented approach, the socio-environmental approach and the population health model. Each approach moved to the foreground of acceptance by the mainstream

health care system during periods when bureaucrats and politicians were seeking fundamental change. Similarly, each approach faded to the background as the context shifted and changed. Much of this movement has been stimulated by a search on the part of health care system policy-makers for ways to improve the population's health in order to reduce the escalating costs of the health care system.

For example, the emphasis of the health care system on curative, technological solutions to health care issues ensured that the medical model was predominant from the 1950s to 1970s. Although disease prevention activities based in the medical model persist to this day, the fiscal concerns emerging within the health care system during the 1970s produced a climate that was open to a new way of conceptualizing health. The new way of conceptualizing health was known as the lifestyle approach and suggested that health was more than health care. It encouraged health education and behaviour change as primary strategies for improving health.

The receptivity of the health care system to this approach, in turn, opened the door to the socio-environmental approach to health. This approach focused on the socio-environmental determinants of health and was articulated in such documents as the "Ottawa Charter for Health Promotion" (WHO, 1986b) and the federal document, "Achieving Health for All: A Framework for Health Promotion" (Epp, 1986). It emphasized work focused at the societal and political levels, but neglected work centred on the interaction between the individual and their social context.

In the 1990s, fiscal concerns about the organization and financing of health care would once again influence the system to move on to another approach to health. The socio-environmental approach was not designed to produce the outcome measures that a system



overwhelmingly concerned with its financial viability was coming to expect. Thus, attention turned to the population health approach, which came equipped with the empirical evidence policy-makers were looking for. At the same time, the population health approach was less well equipped to suggest what action was needed at the grassroots levels and how that action could be stimulated. The literature has begun to point out this shortcoming and some authors suggest that health promotion and population health can complement one another in this regard, to ultimately accomplish improvements in the population's health (Hamilton & Bhatti, 1996; Labonte, 1996).

*Relationship between shifting public health policy developments and the public health nursing practice tensions.* As shifts have occurred in public health policy developments, the first practice tension, referred to as the individual versus the population as the focus of practice, has been pulled in opposing directions. The medical model and the lifestyle approach have created a pull toward the individual as the most significant focus of practice. Both clearly place emphasis on the individual, with improvements in the health of the population occurring by default. For example, the medical model has led to activities such as child development screening and vision and hearing screening, carried out with individuals to prevent disease. Similarly, the lifestyle-oriented approach to health promotion has encouraged individual practitioners to focus their work on assisting at-risk individuals to change their lifestyle choices with little attention to the social context of their lives.

The rethinking of health promotion in light of the social determinants of health has pulled this tension back to a population focus with the challenge to achieve health for all by the year 2000. Only seeing the individual within the context of their social environment, has led to strategies focused on changing social structures such as employment and housing. This

has precipitated a critical analysis of whether public health nursing work could impact the socio-economic determinants of health, thought to be the most important contributor of population health. In some jurisdictions, this tension has played out in the complete separation and discontinuation of work that public health nurses did with individuals versus work they did with groups and populations (e.g. Rafael, 1999a, 1999b). This tension remains significant today as public health nursing is dominated by population health thinking, requiring a renewed consciousness of a balanced focus on the individual and the population.

The development of public health policy has served to further intensify the second practice tension, described as the individual autonomy of the public health nurse versus the combined public health nursing effort necessary to improve health. Typically, programs designed using the medical model or lifestyle approach have used top-down, hierarchical methods to organize public health nursing services. Programs are often dictated through organizationally driven policy, procedure and practice standards, thus ensuring consistency of approach and endeavour in public health nurses' work. For example, in British Columbia, priorities for communicable disease prevention action are usually determined at the governmental level and include clearly outlined policy and procedure. These provincial priorities thus structure the everyday work of public health nurses.

In contrast, the socio-environmental approach to health is about such issues as powerlessness, poverty, unemployment, isolation, and social justice. The strategies have included community development and empowerment. Inherent in these strategies is relationship building and a belief in 'power with' rather than 'power to' or 'power over', leading public health nurses to focus on community-identified priorities (Labonte, 1993; Wallerstein, 1992). Hierarchical, centralized methods of working out the relationship

between an individual's practice and the combined public health nursing effort were ineffective within this context. For example, health promotion required public health nurses to work with community groups to develop action plans around community-identified issues. The activities the nurse engaged in could not be dictated hierarchically, rather they of necessity flowed from the relationships established with community groups. Therefore, a socio-environmental approach required that, in the course of working out this tension, public health nurses challenge the systems they practiced within in order to create new ways of working. Networking, skill development, teamwork, consensus decision-making, and group facilitation have emerged from this struggle.

It is not yet clear how population health approaches will influence this practice tension, particularly because population health policy makers are just beginning to contemplate how practice should occur to improve the population's health (Butler-Jones, 1999). Experience with health promotion approaches demonstrates that a combined practice effort is necessary to influence improvements in population health. It remains to be seen whether population health's pull will be in a similar direction. If we presuppose that the pull of population health is toward a combined public health nursing effort, the need to work out this practice tension within a context of teamwork, networking, diffusion of knowledge and skill will persist into the near future.

The third practice tension, described as the tension between public health nurses' ownership of particular roles and responsibilities versus their contribution to an overall societal endeavour to improve health, also experiences the push and pull of public health policy developments. The social marketing and popular education strategies of the lifestyle orientation to health marked the first attempts to break away from the medical model in order

to work at a societal level to improve health. Public health nurses had to work out where they fit into and complemented such national campaigns as 'Participation'.

The complexity of this tension for public health nurses has increased with the advent of health promotion in the 1980s and its emphasis on the socio-environmental determinants of health. There was little clarity about how public health nurses could contribute to this agenda. Proponents of health promotion strategies were sceptical about the contribution public health nurses could make as they came from a system considered to be paternalistic and entrenched in the medical model. The working out of this tension became about the struggle to achieve recognition of public health nurses' legacy in health promotion work. It also was about proving that public health nurses did indeed have a valuable contribution to make to health promotion efforts. In some situations, the working out of this tension has meant working to overcome the power structures of the organizations public health nurses worked within so that they could contribute in meaningful ways to health promotion action.

This tension remains important to public health nursing practice as population health has shifted the focus of the health system's attention to the question, "Why are some people healthy and others not?" (Glouberman, 2001, p. 20), leading to an examination of the determinants of health and their interactions. The emerging policy and action directions are primarily targeted to political, economic, and societal levels and seemingly have little to do with public health nursing practice. Thus, public health nurses will continue to be faced with the need to work out their contribution to these broader efforts to improve the population's health.

Emerging from Chapters 2, 3, and 4 is a picture of a complex web of interactions between the historical influences, the changing organizational structures, and the shifting

public health policy developments, pushing and pulling each practice tension. The way in which the complexity of the public health nursing practice environment shapes the nature of public health nursing practice will be discussed in the final two chapters. We will now turn to an exemplar from my public health nursing experience.

## CHAPTER FIVE

### An Injury Prevention Case Example

In order to illustrate the contextual forces and practice tensions inherent in the practice environment and the way in which public health nurses configure their practice within this practice environment, I have chosen to describe an example from my experience as a manager in the Northwest Health Region, then known as Skeena Health Unit. This example is about an injury prevention program that was initiated by the public health nursing program in Skeena Health Unit. I was involved with this program for four years from its inception in 1992 as the senior public health nursing program manager. The injury prevention case example serves as a microcosm of public health nursing practice and as such, is a useful touchstone for this study.

I have chosen to use this particular example because it has been instrumental in clarifying my own perspective about the nature of public health nursing practice. It is a story I frequently reflect back on as an exemplar against which to critically analyze public health nursing practice. It has also served as a useful tool in explaining to others the meaning of public health nursing practice. The story unfolds in the northwestern reaches of British Columbia.

#### *The Setting*

The Northwest Health Region encompasses a large geographic area bounded by the Queen Charlotte Islands to the west, the Bulkley Valley to the east, the Yukon border to the north, and the city of Kemano to the south. Public health services are centred in Terrace with

service delivery based in nine other communities spread throughout the region. The population of the northwest at the time was about 78,000 (Skeena Health Unit, 1989).

In the early 1990s, public health in the northwest consisted of services focused on five program areas: communicable disease control, children and youth, environmental health, community care facilities licensing, and adults and seniors. The health professionals working in the region included public health nurses, speech and language pathologists, environmental health officers, community care facilities licensing officers, an audiologist, a dental hygienist, a dental assistant, nutritionists, and a medical health officer (Skeena Health Unit, 1989).

This team of health professionals had established their mission statement as “we are here to promote the active development of health and well-being for individuals, families, and communities of Northwestern British Columbia” (Skeena Health Unit, 1991b). The setting was ripe for the nurturing of ideas that would achieve the ends articulated in the mission statement.

#### *A Theme*

The Northwest region is similar to other northern jurisdictions in that the population generally experiences a poorer health status than the rest of the province. In 1989, Skeena Health Unit engaged in an assessment of the health of the region through an analysis of the available mortality and morbidity information and through a community opinion survey led by the Medical Health Officer and public health nursing managers with the active involvement of public health nursing staff. The results were published in a report called, “Northwest AIMS for Health” (Skeena Health Unit, 1989). This initial attempt to assess the health of the region’s population was fraught with difficulties such as the unavailability of

data, the lack of adequate tools to collect community opinion, and workload issues for the public health nursing staff involved. Nevertheless, a clearer picture of the health status issues in the region emerged. Over the following two years, the public health management team became increasingly frustrated about the limited resources available to public health and the overall lack of local control over these resources. There was a tendency to stretch the limited resources in an attempt to address the myriad of issues facing the prevention of disease and the promotion of health in the region. This often resulted in an ad hoc and less than strategic approach to the region's health issues. Throughout 1990 and 1991, the public health management team met and gradually came to the conclusion that it would be helpful to choose one health status issue as an area of focus rather than fragmenting the effort to a variety of projects or initiatives.

A number of health issues were explored including heart health and tobacco reduction. However, the initial "Northwest AIMS for Health" report revealed that injuries related to motor vehicle accidents and other incidents were a significant cause of death and of potential years of life lost for both women and men in the region (Skeena Health Unit, 1989). The subsequent two annual reports highlighted the incidence of injuries as a particular issue for the region (Skeena Health Unit, 1990, 1991a). For example, the 1991 annual report stated "the excessive loss of young people in Skeena to accidents and violence remains a major preventive challenge which will require a coordinated response from all sectors of our Northwestern society" (Skeena Health Unit, 1991a, pg. 6).

In 1991, the management team selected injury prevention as the health status issue to receive focused attention for two reasons. First, there was preliminary evidence that injuries were a leading cause of mortality and morbidity in the region. Second, there was mounting



evidence that unintentional injuries were amenable to preventive action. In particular, a research study conducted in Sweden, found in an initial literature review, confirmed the direction we had chosen. This study demonstrated that with a long-term concerted effort, child injury deaths had been reduced from rates equitable to the United States to the lowest in the world (Bergman & Rivara, 1991). Although public health work continued on other public health priorities such as communicable disease control, heart health, tobacco reduction, the management team was ready to focus on the development of an injury prevention strategy. Our decision was expedited when the Ministry of Health chose to provide Union Boards of Health with discretionary funding to be used for regional priorities.

### *The Strategy*

Once the management team had selected injury prevention as the health status issue for public health focus, I began to further research the literature related to injury prevention and investigate injury prevention initiatives occurring in other parts of the province. Through this process, I was directed to Cathy Hull from the Ministry of Health, who had recently completed an analysis of how gender differences affected injury rates in males and females (Hull, 1991). Through further discussion with Cathy Hull, I became convinced that injury prevention would be an excellent health status issue to explore in the region. I was also told that the Ministry of Health was considering injury prevention as an issue requiring provincial level strategic planning and action. I returned to the region prepared to work with the management team to plan a child/youth injury prevention project. The team decided that the overall purpose of the project would be to decrease the incidence and severity of unintentional injuries to children between 0-19 years of age (Skeena Health Unit, 1993).

As our knowledge about effective injury prevention approaches developed at the management level, three project phases seemed evident for an injury prevention strategy. These phases included: “increasing knowledge of local injury prevalence and occurrence; raising community awareness and stimulating interest in injury prevention; and assisting communities in developing strategies to reduce injury rates among children and youth.” (Skeena Health Unit, 1993, p. 10).

The first step was to create a project team that consisted of the Medical Health Officer and representatives from public health nursing management. This project team expanded to include interested public health staff as the project evolved. We then developed a budget and secured the discretionary funding for the project with the support of the Skeena Union Board of Health. The next step was to recruit a project leader. We chose to second a project coordinator from the public health nursing department. This public health nurse assumed the project coordinator role in December 1992. She worked closely with the project team to organize the project’s tasks and to discuss potential ideas and approaches. The first year represented a significant learning curve for both the project coordinator and the project team.

The primary purpose of the first phase of the project was to develop an understanding of the issues associated with injury prevention from the international, national, and provincial perspective as well as from our local and regional perspective. To this end, a literature search conducted by the project coordinator uncovered further relevant research that substantiated the positive long-term outcome of injury prevention initiatives and highlighted strategies that had proven effective in reducing the incidence of unintentional injuries. During the course of

this activity, the project coordinator began to make contact with key people across the nation who were involved in injury prevention action.

*Phase one: Data analysis and identification of injury issues and priorities.* The project team then began to paint a picture of the incidence and prevalence of injuries in the northwest by collecting and analyzing the available health status information. Both mortality and hospitalization data for the period 1987 to 1991 were obtained from the Ministry of Health. The project coordinator began to analyze this data in relation to causes of injury death and hospitalization, to age groupings, and to the prevalent developmental characteristics of each age group. This work was done in collaboration with the newly formed Office for Injury Prevention within the Ministry of Health. Part way into this work, the project team realized that additional and specialized assistance was required to collate and analyze the data. We were able to redirect internal funds to obtain the services of a University of Victoria information science student (Skeena Health Unit, 1993). This greatly facilitated the project's work in analyzing the data.

During the first phase of the project, the project coordinator interviewed community groups, nurses, physicians, teachers, RCMP, and fire departments in order to obtain their perspective about the issues surrounding injuries in the northwest. This process served three purposes. It was a way to familiarize and educate key community players about the project and its intent. It set the foundation for future collaborative relationships in relation to injury prevention action. Finally, the insightful perspectives of those contacted put a real face onto the analysis of the statistics.

By the spring of 1993, the project coordinator, with the support of a project assistant, had produced a comprehensive first report, which included a compilation and analysis of the

data. The report also included information obtained from the literature review and opinions and perspectives from key people in the region. A pamphlet summarizing the project goals and data analysis highlights together with a project poster were internally produced and released along with the first report (Skeena Health Unit, 1993).

Throughout the first phase of this project, the public health nurse responsible for the project's coordination actively sought out support and guidance from public health nursing managers, from experts in injury prevention external to the region, and through the practice and research literature. This project represented uncharted territory for the health unit. Through a thoughtful process of discussion and research, the project coordinator clarified and sorted out the work that was required to successfully initiate phase one of this project.

By the time the first report was published, the project coordinator had developed a clear sense of direction for the second phase of the project. Her recommendation in the first report was, "that successful prevention efforts must involve all sectors of the community in targeting specific risk groups" (Skeena Health Unit, 1993, p. 39). As a result, the second phase of the project focused on identifying and bringing together all those with an interest in injury prevention in order to better coordinate initiatives and to develop strategies targeted to injury prevention priorities. An injury surveillance system was implemented during phase two in order to gain a more sophisticated understanding of the injury issues in the region (Skeena Health Unit, 1993).

*Phase two: Community awareness and coalition building.* Throughout the data collection process, it became clear to the project coordinator and the project team that community specific information, essential to engage the community in locally based action, was lacking. During phase one, the coordinator had established contact with the Children's

Hospital Injury Research and Prevention Program (CHIRPP) based in Ottawa, which was working toward developing a national surveillance system for childhood injuries (Senzilet, 1991). In the absence of a national or provincial system, the coordinator was faced with figuring out how to proceed with obtaining community-specific information.

During phase one of the project, the project coordinator had established contact with nurses who worked in the emergency departments and pediatric units in local hospitals. Through further discussion with these nurses, the coordinator made the decision to design a time-limited injury surveillance system in collaboration with hospital staff. The project coordinator had developed a solid understanding of public health theory as it related to health promotion and community development. This knowledge guided her decision to use a collaborative approach. Her foresight in involving hospital staff from the outset in the development of this system contributed to the smooth process of implementation and served to inform the remainder of the initiative.

The project coordinator worked with interested hospital staff to implement the injury surveillance reporting form over the course of the second year of the project. Early on in this process, the project coordinator recognized the need to engage the local public health nurses in supporting the participants from the hospital. The coordinator organized a discussion with the public health nurses to work out their role in supporting the hospital staff. These public health nurses connected regularly with the nurses at the hospital, picked up the completed forms, and provided feedback to the project coordinator. Although the implementation of this system was relatively smooth, two communities became concerned about how the data would be used. One community was anxious that the data could be used to blame people for injuries that occurred. The other community questioned the validity and reliability of the

methodology. The project coordinator sought out people with data collection expertise to assist her in sorting through these issues. She spent many hours in these two communities discussing these issues and reaching agreement regarding the data and its use.

The project coordinator realized the importance of determining what worked well and what did not within the surveillance system. Together with the project team, she was faced with choosing an approach for this evaluation process. She recognized that the need to evaluate this project component had to be balanced with the need to foster community-based action and to respect the collaborative relationships that had been established. The coordinator sought out assistance from an evaluator from the Ministry of Health who recommended a participatory action research approach. As a consequence, a participatory evaluation workshop was held with the participants in the injury surveillance process a few months into implementation of the data collection system. An indirect outcome of this process was an increased level of commitment and participation in the project. Most facilities were able to sustain this data collection system for the entire year with the support and encouragement of local public health nurses (Skeena Health Unit, 1994). At the end of the year, each participating facility was given an award for their commitment and ongoing participation. Although, the project team decided to discontinue the system, the outcomes ultimately contributed to the national injury surveillance system that was developing at the time.

The emphasis in the second phase of the project was to bridge data collection and community action. The project coordinator suggested that the meaningful communication of available injury information to community members could potentially create dialogue, interest, and participation in action planning. To this end, the coordinator discussed the injury

prevention project with the public health nurses in each health unit sub-office. Given the regional priority ascribed to the project, the public health nurses had to sort out how injury prevention activities fit into their overall responsibilities. The nurses were asked to select a public health nurse from each sub-office location to be that community's liaison to the project coordinator and to act as the local facilitator.

Although each community selected a public health nurse for this role, some of these public health nurses were more enthusiastic and involved than others. Those who became actively involved found ways to learn about the region's health status related to injuries and about injury prevention action. The project coordinator and supervisory staff facilitated learning opportunities through conference calls, staff meetings, and inservices. These nurses had to work out their individual contribution to the regional endeavour to reduce injuries. These nurses also had to make decisions about how to fit this work into an already full workload. In some cases this meant dropping other work or giving it a lesser priority. In other cases, this required incorporating injury prevention activities into existing work.

Those public health nurses who chose to become actively involved were invaluable to bridging data collection and community action. They had ideas regarding project development, were well connected to community networks, and thus able to stimulate community development action. The project coordinator worked with this group of public health nurses for the duration of the project. The coordinator used the expertise of this group of public health nurses to develop tools and strategies that assisted in stimulating community action. Some of the strategies that emerged included the development of a community presentation package, direct presentations to community groups by the project coordinator, organization of community events, and media promotion (Skeena Health Unit, 1994).

The coordinator developed the presentation package using the available injury data and injury prevention information. This package was provided to public health nursing staff in each community and over 50 presentations were provided in 1993. Community meetings were organized by public health nursing staff and brought together representatives from a broad cross section of the community interested in injury prevention for the purpose of presenting and discussing the data, determining local injury issues and priorities, and beginning an action planning process. This approach was driven by an underlying belief that public participation was essential to community receptivity and ultimately to improving health, and that data alone would not produce community action. As a result of this process, a group or coalition of people was established in four of the communities across the region (Skeena Health Unit, 1994).

This community action process was aided by other initiatives occurring within the region. For example, public health nurses were involved in a regional Healthy Communities process, led by one of the public health nursing managers (Northwest Connections, 1994, 1996). The nurses identified their need for additional knowledge and skills related to health promotion and community development. As a result, management worked with the public health nurses to organize skill development workshops and inservices focused on group facilitation, partnerships and collaboration, community development, and the determinants of health. The skills developed were transferable to the injury prevention initiative.

*Phase three: Strategy development and community action.* Although community action was well on its way in parts of the region, this phase was formally initiated in the fall of 1994. This phase occurred concurrently with the advent of health reform and the regionalization of the health care system. Transition teams were appointed at both the



community and regional levels to lead the planning of a regionalized health care system. This required public health nurses and public health nursing managers to gain an understanding of the evolving health care reform process and how it would affect public health nursing practice. At the health unit level, the project team had developed a plan for an overall injury prevention strategy for the region. The public health nurses and managers worked to adapt this strategy to fit into the health reform process. The project team developed a proposal outlining the project's goals and objectives, service delivery plan, budget, and evaluation process in the hopes of acquiring permanent resources for the project (Skeena Health Unit, 1995).

Fortuitously, the emphasis in the early days of health reform was on population health and the determinants of health. The Ministry of Health had recently granted "Closer to Home" funding to each of the evolving health regions, with a view to fostering initiatives that would reduce the use of acute hospital services. The transition team put out a call for proposals. The injury prevention proposal was easily adapted to meet the funding criteria and was presented by a public health nursing manager to the regional transition team. The successful work public health nurses had done in the first two phases of the project was used to explain the public health nurses' role in injury prevention to this team. Funding was granted, enabling the project to become permanently established. At this point, the first project coordinator returned to her public health nursing role. Another public health nurse, who had been actively involved in injury prevention action in her community, assumed responsibility for the project's coordination.

There were five aspects to the local and regional planning and implementation process. Much of the groundwork and initial action occurred in the first two phases of the

project. The new project coordinator built on these successes and fostered additional community level action. First, the ongoing development of community coalitions was encouraged. Both project coordinators were confronted with working out a balance between the injury prevention work that was within the purview of public health nurses and the work that required community-based collaborative action. For example, the new project coordinator had been very successful in establishing a broad based community coalition in her community. This coalition had undertaken a wide variety of initiatives ranging from an annual Injury-Free Fair to work with sports teams and coaches to reduce sports related injuries. Although the public health nurse chaired this coalition, participating organizations or groups took the lead role in implementing initiatives of particular relevance to their organization.

When the project proposal for ongoing funding was developed, the project team decided to seek additional funding to stimulate community action. This decision was based on previous success in stimulating community action through the provision of seed funding within Healthy Communities and Healthy Schools processes (Northwest Connections, 1994; Skeena Health Unit, 1992). The project coordinator worked with the public health nurses to develop a process for granting seed funding to injury prevention coalitions and committees for community action projects. This served to further stimulate collaborative planning across the region, including targeted initiatives such as playground safety, bicycle safety, pedestrian safety, and sports safety to broadly oriented initiatives such as Injury-Free Fairs.

Many unique and creative activities arose from these community-based planning processes. For example, one community created a safety mascot that attended all community events to communicate safety messages. In another community, the RCMP gave citations to

children or youth demonstrating good cycling behaviour in the form of an ice-cream coupon (Skeena Health Unit, 1994). Public health nurses were involved in different ways in each community. In some communities the public health nurse provided leadership to the collaborative process, while in others, the nurses were participants in the process. In one community, a group formed without public health nursing involvement to tackle an issue related to playground safety.

One community particularly struggled with proceeding to community action. The public health nurses worked with representatives from a variety of groups and organizations to form a “Safety on Bikes” committee. The public health nurses attempted to coordinate a variety of bike safety initiatives occurring in this community. However, the committee dissolved following their third meeting. The nurses were unable to find ways to overcome the many challenges presented by this committee. The community groups represented were not interested in establishing a mutual vision. Key people were unable to commit to attending meetings and “turf protection” of previously established initiatives became a major barrier to collective action. Events related to bicycle safety in this community continued in an ad hoc fashion but were unable to become part of an overall strategic plan (Skeena Health Unit, 1994).

The nurses involved found this process frustrating and spent time debriefing with the project coordinator, colleagues, and supervisory staff. Although this proved to be a negative experience, these nurses did go on to seek out other opportunities for collaborative partnerships. Some of these endeavours proved to be successful. For example, these same public health nurses implemented a Planned Maternity Discharge Program and a regional

breastfeeding survey in collaboration with a variety of community partners in subsequent years (Skeena Health Unit, 1994).

The second aspect of the project included the design of community education and skill development events to assist targeted groups at risk for injury to make healthy and safe choices. For example, the project coordinator organized one particularly significant event in collaboration with the region's school districts. A speaker from the B.C. Injury Prevention Centre did a regional tour in April 1994 to speak to school students about risk taking and injury prevention. This event received both funding and organizational support from the School Districts across the region and proved to be another successful collaborative endeavour (Skeena Health Unit, 1994).

A third facet of the project involved a reorientation of public health nurses' existing work. Throughout the project, the project coordinators organized monthly conference calls for the public health nursing representatives from each community. This enabled networking and linking around regional, provincial, and national initiatives related to injury prevention. The project coordinator also organized workshops in each community for public health staff to review the injury prevention data, to discuss what injury prevention was, and to familiarize staff with the available injury prevention resources.

Public health nurses actively began incorporating injury prevention strategies into their day-to-day work. The ideas were discussed and developed through the monthly conference calls and were often stimulated by an increased awareness of best practices related to injury prevention. The project coordinator facilitated this knowledge development through seminars and the provision of resources. Each community was provided with a resource box consisting of key journal articles, audio-visual resources, and other literature.

As a result, the public health nurses decided to change their practices during child health conferences to include counselling about age related injury issues. The nurses implemented similar changes to the counselling and education provided through postnatal home visits, child care facility liaison visits, kindergarten health day clinics and so on (Skeena Health Unit, 1994).

These networking strategies spread beyond the region as the project coordinator organized an "Injury Network" which connected the Skeena Health Unit project to other provincial and national initiatives through monthly conference calls with others doing similar work. This was an excellent opportunity for the public health nurses involved in the project to articulate the role of the public health nurse in injury prevention action. Two representatives from the region were also sponsored by the Skeena Union Board of Health to attend the Third International Safe Communities Conference in Norway in 1994. This was a further opportunity to connect the work occurring in the Northwest region to national and international strategies (Skeena Health Unit, 1994).

Advocacy for public policy changes constituted the fourth component of injury prevention action in the region. Some of the public health nurses were able to stimulate community action around public policy early on in the project. For example, several communities actively pursued provincial mandatory bicycle helmet legislation through letter writing campaigns and petitions and one community pursued the designation of bicycle paths by City Council (Skeena Health Unit, 1994). Another example occurred in a community where the public health nurse had a good working relationship with one of the schools. The students in this school developed a project to change the traffic flow pattern for dropping off

and picking up students at their school. They successfully lobbied the school district to make this change.

Finally, the first project coordinator ensured that evaluation strategies were built into the project from the outset. In consultation with the project team, she sought out evaluation expertise early on in the project and thus, attention was paid to collecting both qualitative and quantitative information. Access to health status information was simplified with the development of the provincial Office of Injury Prevention. One of the key activities of this office was the collation and analysis of injury data. Qualitative evaluation processes were undertaken through reviewing the project coordinator's logbooks and weekly summaries (Skeena Health Unit, 1994).

In 1996, a third report was released reviewing the ongoing work related to injury prevention in the region. It was particularly noteworthy that the mortality rate due to unintentional injuries had dropped from 2.2 times the provincial average in 1991 to 1.6 times the provincial average in 1995. Although this reduction cannot be entirely attributed to the initiatives undertaken through this project, it is fair to say that the project made a contribution to the improved health status (Northwest Community Health Services Society, 1997).

#### *Relationship between the Nurse-in-Practice and the Contextual Forces*

Given the backdrop of this injury prevention case example, it is instructive to consider how effective public health nursing practice, replete with order and purpose, emerges from a complex practice environment. This ordered practice, in turn, has been shown to influence the population's health. We can observe pragmatically, through this case example, the taken-for-granted nature of how public health nurses-in-practice configure their practice in light of contextual forces and the push and pull exerted by the practice tensions.

*Influence of changing organizational structures.* The injury prevention project occurred during the beginning stages of health reform in British Columbia. Although there were no major changes to the organizational structure of the health unit for the duration of the project, new ways of doing things emerged in anticipation of a regionalized system. Therefore, it was critical that public health nursing managers, the project coordinator, and the public health nurses identified these new structures and understood their processes in order to ensure that the project could move forward across the region. For example, by the third phase of the project, public health nursing management pursued ongoing funding through the transition team that had been put in place to guide regionalization planning.

Organizational structure contributed contextually to the injury prevention project in four ways. First, the project idea grew out of ongoing work that was already occurring through public health to assess the health status of the region's population. This work was led by the Medical Health Officer in anticipation of the regionalization of health care and actively involved public health nursing staff. Second, the strategies used were endorsed by the Skeena Union Board of Health and public health management and demonstrated their understanding of public health policy and theoretical development. Third, health unit management proceeded to work towards securing and allocating resources in the form of funding, operational support, and community action funds. This served both to get the project underway and to establish the project as an organizational priority, thus enabling the full involvement of public health nursing staff. Finally, the organizational endorsement and sponsorship of this initiative provided credibility to the project coordinator's and public health nurses' efforts to collaborate with other organizations and to engage the community in public awareness activities. These were complex activities that occurred during a time of

immense uncertainty about the future organization of public health services within a regionalized health care system.

*Influence of shifting public health policy developments.* Public health policy developments also influenced the injury prevention project. The project was established during the peak of the socio-environmental approach to health and as population health approaches were beginning to move to the forefront. Health reform had increased interest in and receptivity to health promotion and disease prevention. Concepts such as the determinants of health were discussed in community meetings, workshops, and forums in relation to reforming health care. This environment facilitated the acceptance of the injury prevention initiative by health unit staff, community based partners, and communities in general.

The project drew mainly on three of the approaches to health. The lifestyle oriented approach was evident in strategies such as public awareness media campaigns, community educational sessions and in the injury prevention messages public health nurses incorporated into their work with individuals and families.

The socio-environmental approach was used to guide community-based action as public health nurses formed community coalitions and provided funding for action on community-identified issues. Public health nurses actively examined and reoriented their services to ensure that the needs identified by communities were being met. They also worked collaboratively with community groups to advocate for such public policy changes as bicycle helmet legislation and the designation of bicycle paths. Evaluation methodologies consistent with a socio-environmental approach were used. For example, participatory action research was incorporated into the evaluation of the injury surveillance system. Population



health approaches were used in the compilation and analysis of epidemiological data, in the development of the data surveillance system, and in the release of regular project reports.

Throughout the course of the project, those public health nurses actively engaged in the project pursued knowledge and skills related to injury prevention through the literature, learning from each other, and networking with others around the province. This was accomplished through regular teleconferences, attendance at conferences, educational sessions, and independent learning. Increased understanding of the concepts of health promotion, determinants of health, and population health were required and sought after.

#### *Relationship between the Nurse-in-Practice and the Practice Tensions*

The way in which public health nurses navigate the practice tensions are also demonstrated within this case example. The project implementation process revealed the delicate balance many of the nurses achieved between the individual versus the population as the focus of practice. The public health nurses often worked concurrently with individuals, with community groups or coalitions, and with policy makers on public policy issues. The nurses' success in stimulating the development of community action groups and coalitions was often due to the connections established at the individual level. For example, the relationship a public health nurse had established with the staff at a particular school enabled the students to become involved in public policy action related to traffic safety at their school.

The successful implementation of the project highlights the capacity of public health nurses to work at a number of levels simultaneously. The focus of public health nurses on the individual's health within the context of improving the overall health of the population was critical to successfully moving injury prevention action to the community level. For example,

the public health nurses developed ways to incorporate age related injury information into their one-to-one work with parents. Simultaneously, these same nurses organized community-wide initiatives targeted to playground and bicycle safety.

The nurses in this project also experienced the push and pull of the second practice tension or the individual, autonomous practice of the public health nurse versus the combined public health nursing effort necessary to improve health. The project implementation process demonstrated how a balance was found between the variety of day-to-day roles carried out by individual nurses and the combined action of a group of public health nurses. The balance achieved enabled the development of comprehensive, strategic, and targeted action across the region.

The combined public health nursing effort also enabled the project to be undertaken with a minimum of additional resources. Each public health nurse took on different functions dependent upon her own particular skills and interests. This was worked out within public health nursing teams and in consultation with nursing supervisors and the project coordinator. For example, one nurse in each community within the region took responsibility for leading the community development process. Other nurses participated by incorporating injury prevention activities into child health conferences, new baby visits, and school based initiatives. The nurses set up mechanisms such as monthly conference calls, training sessions and workshops to ensure their individual work remained connected to the project directions. In turn, the project coordinator facilitated connections between public health nursing in the region and provincial, national, and international initiatives targeted to reducing the incidence and severity of unintentional injuries.

Finally, the public health nurses involved in the project worked out partnerships with those external to the public health sector. These nurses experienced tension between their sense of ownership of particular injury prevention roles and responsibilities versus their contribution to a larger societal endeavour to reduce the incidence of injuries in the region. The project coordinator recognized early on in the project that collaborative partnerships would be critical to reducing the incidence of injuries. As a result, the project relied on achieving a balance between action driven by the public health nurses and the nurses' participation in building coalitions and collaborative relationships with others committed to injury prevention action. Comprehensive and strategic action was possible in the communities where nurses were able to work out their roles in collaboration with community partners. Community action did not occur where these relationships did not solidify for reasons such as territoriality, lack of a mutual agreed vision and so on.

Chapters 2, 3, and 4 revealed a practice environment complicated by the interactions and relationships between the contextual forces and public health nursing practice tensions. In this chapter, the ways in which coherent, ordered, and purposeful work can emerge from the complexities of the practice environment have been made visible. The injury prevention example suggests that such work is more likely to produce an effective and responsive program or service that, in turn, has a better chance of influencing health.

This case example has made the nature of public health nursing practice visible. The value of this understanding has been realized in subsequent endeavours. For example, the lessons learned supported public health nurses and managers in another health region to analyze public health nursing work and develop new ways of approaching practice. The process included making the practice environment visible to nurses through facilitated

planning sessions and workshops about such topics as population health and organizational structure. Some of the nurses involved in this process have chosen to embrace what they have come to understand and others have chosen to passively participate in the process. Those that have embraced the complexities in the practice environment have been instrumental in reshaping the depth and breadth of public health nursing work in the region. In the course of doing so, they have found a new sense of confidence, enthusiasm and a sense of being able to shape their future (MacLeod, Ulrich, & Foucher, 2001). We will now turn to the concluding chapter to pursue how public health nurses come to configure their practice given what has been revealed about the practice environment.

## CHAPTER SIX

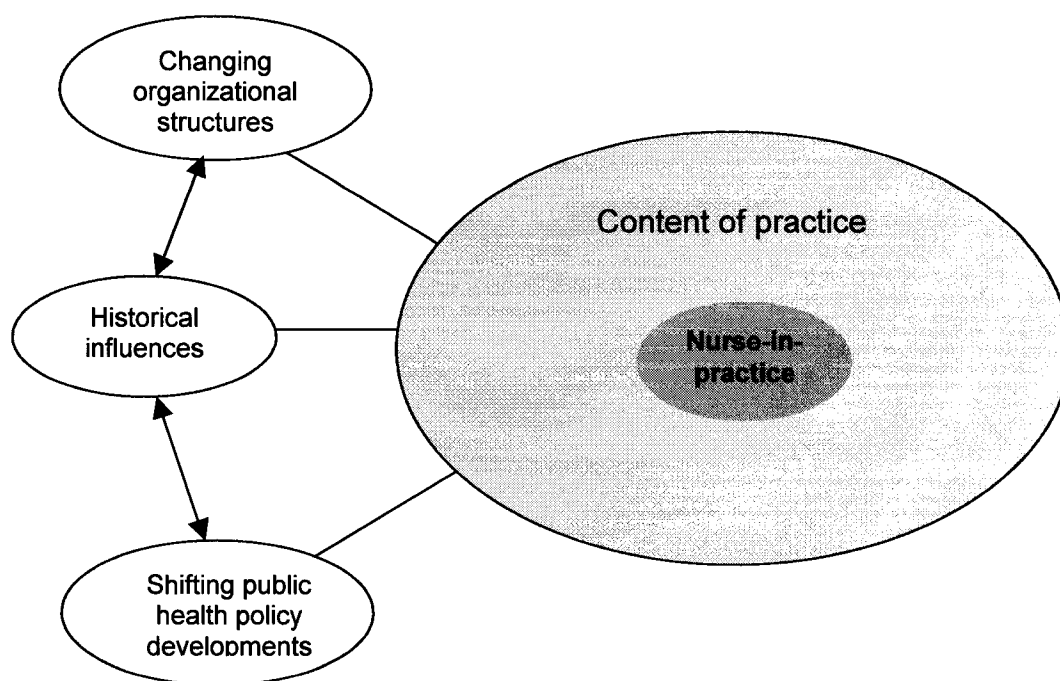
### Discussion and Implications

In the introductory chapter to this study, I highlighted what the literature reveals about the content of public health nursing practice. In Chapters 2, 3, and 4, I proceeded to explore the historical, organizational, and public health policy context of public health nursing practice as it has shaped the public health nursing practice environment. Throughout the course of exploring the context of public health nursing practice, three practice tensions became evident in the practice environment.

In this concluding chapter, I intend to pick up these threads and weave them together to make apparent the fabric of public health nursing practice, drawing out some implications for those involved in and concerned about the practice world of public health nurses. Before turning attention to this analysis, it is necessary to review where this study began and how it has evolved so far.

As I started pursuing this study, I began with the content and context of practice since both are readily evident in the foreground of public health nursing practice. The literature provides us with descriptions and explanations of the content and context of public health nursing practice. However, what was made apparent through the literature did not entirely resonate with my own experience consequently leading to a consideration of what was being taken for granted within my own practice experience. I have come to realize that the descriptions and explanations of public health nursing practice presented in the literature are valid and do indeed contribute to our understanding of public health nursing practice. Thus, the importance of these descriptions and explanations should not be overlooked or

underestimated. However, having said this, the inadequacy I have found in the existing explanations of public health nursing practice would be perpetuated if this study focused exclusively on the content and context of practice evident in the foreground (see Figure 1).



**Figure 1.** The content and context of public health nursing practice as viewed from the foreground of practice.

As this study has unfolded so far, our study lens has been primarily centred on the content and context of practice seeking to explicate the nature of the public health nursing practice environment. The injury prevention example showed the content of practice as carried out within the practice environment to be purposeful and logical in character but when viewed in light of the context of practice, is simultaneously seen to be multi-faceted and complex. The practice environment is revealed to be replete with complicated and messy interconnections between contextual forces and practice tensions. These complexities are largely hidden from view. Further, the way in which the nurse-in-practice sorts out public health nursing practice within this practice environment has been in the background waiting

to be brought to the foreground. As a result, what has become evident about the practice environment is compelling but has remained detached from the world of everyday lived experience.

It is only as our study lens is refocused on the public health nurse-in-practice that the substance of practice can be seen. The nurse exists in the midst of the practice environment with all its complexity. Thus, being a nurse-in-practice reflects a relationship between the nurse and the practice environment that requires a constant working out or configuring by the nurse. Just as found by MacLeod (1996) in the acute care setting, the public health nurse-in-practice forms and is formed by the process of practicing nursing. That is, as the public health nurse's practice is worked out or configured within a complex practice environment, the nature of that practice is shaped through the process of configuring practice.

Since the nature of the practice environment is hidden from view for the most part, even to the nurse in that practice, the configuring of practice often occurs by default in the absence of contextual understanding. A purposeful process is required to make the nature of the practice environment overtly visible. As nurses-in-practice come to understand and embrace the complexities within the practice environment, they are enabled to configure their practice in light of what has been made visible. Configuring practice then becomes an intentional endeavour for the nurse-in-practice who consciously knows and understands the nature of the practice environment. As seen in the injury prevention case study, a coherent set of services, proactively contributing to the goal of improving population health, is more likely when such an intentional process has occurred.

Therefore, I would like to suggest that the ways in which contextual forces converge and interact within the public health nursing practice environment, shaping what becomes the

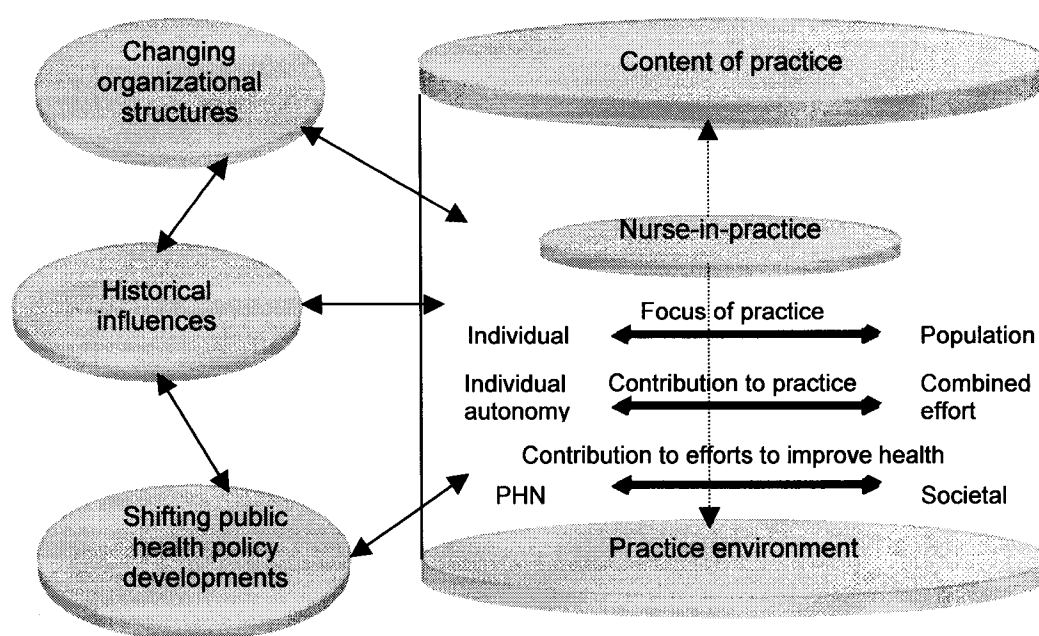
content of public health nursing practice and shifting the tensions inherent within the practice environment, has been largely hidden from the view of both practicing public health nurses and managers with responsibility for public health nursing practice. Further, I would suggest that how public health nurses dwell in practice is constituted by the ways in which they work out the relationship between their practice and the complex and situational nature of the practice environment. The existence of this relationship implies that the public health nurse, as a nurse-in-practice, is actively engaged in configuring his or her practice. Finally, I would suggest that the ongoing work of configuring public health nursing practice can be a deliberate, intentional process or it can happen inadvertently and without intention. This process of configuring practice is largely taken for granted by both nurses-in-practice and those with public health nursing management responsibilities.

An important but puzzling issue that presented itself at the outset of this study bears mentioning at this juncture. Some of the literature suggests that public health nurses' work is undervalued and invisible to those external to public health nursing practice and that this invisibility is related to a lack of role clarity among public health nurses (e.g. Laffrey & Craig, 2000; Leipert, 1996; Rafael, 1999b; Zerwekh, 1992). This is an issue that I hear echoed by public health nurses in the workplace. This is an important issue to resolve if public health nursing is to thrive within integrated health care delivery systems. My purpose in pursuing this study has been to understand the nature of public health nursing practice experience rather than to study how others perceive public health nursing practice. However, if public health nurses were enabled to understand the relationship between public health nursing practice and the practice environment, perhaps they would be better equipped to



articulate, grapple with, and resolve this sense of invisibility. I have chosen to set this issue aside for the remainder of this chapter and will return to it at the conclusion.

We will now turn to an analysis of what was revealed about the practice of public health nursing throughout the course of this study. The analysis will focus on the nurse-in-practice. The following diagram will assist in explicating the discussion that follows (See Figure 2).



**Figure 2.** The nature of public health nursing practice.

There is a risk that this discussion infers a linear process of explanation, beginning with the content of practice, proceeding to the context of practice including the contextual forces and the tensions inherent within the practice environment and ending with the nurse-in-practice. Rather, true to the interpretative approach used in this analysis, an understanding of practice and its meaning for a nurse-in-practice necessitates a circular process, taking us back and forth between the parts and the whole. I have chosen to begin this discussion with a

brief summary of the content of practice, primarily because the content of practice is more readily evident.

### *Content of Practice*

There are two perspectives from which we can view the content of practice. The first perspective emanates from the viewpoint of research and theoretical literature. Herein, public health nursing practice is explained through descriptions and definitions of the content of practice in light of contextual considerations. These explanations are widely used for and by groups such as the organizations public health nurses work for. As previously mentioned in Chapter 1, these explanations of practice have consistently been in the foreground of our understanding of public health nursing practice.

In the introductory chapter, I argued that the literature has successfully captured the content of public health nursing practice in three primary ways. First, public health nursing practice is most commonly described in terms of its roles and functions (e.g. CPHA, 1990, 1996a; Keller et al., 1998). The second approach to describing the content of practice attempts to differentiate public health nursing practice from other kinds of nursing practice. Most frequently, these efforts focus on who constitutes the target population for public health nursing practice (e.g. Laffrey & Craig, 2000). The third and most complex approach entails the development of conceptual models whereby public health nursing strategies, activities, and target populations are integrated into frameworks designed to explain public health nursing practice (e.g. Clarke et al., 1993; Kuss et al., 1997; Laffrey & Craig, 2000).

In sum, these approaches to explaining practice in the literature do accurately define the practice of public health nursing. Having said this, however, the first two approaches, when viewed in isolation, create the impression that public health nursing practice is

acontextual and passive in nature. The third approach, although for the most part unsuccessful in capturing the essence of public health nursing practice, suggests that a more complex, interactive process is at play within that practice.

The second perspective from which the content of practice can be viewed substantiates the notion that there is something more complex and interactive underlying public health nursing practice. This second perspective comes from the viewpoint of the nurse-in-practice, where practice consists of those activities that are carried out in everyday practice. Simply stated, the content of practice from this viewpoint is what is being produced by public health nurses practicing nursing. This suggests an active and dynamic process. The injury prevention example may be helpful in clarifying this stream of thought.

While the injury prevention case example corroborates what the literature says the content of practice should be, it also suggests that public health nurses make sense of their practice as they become actively engaged in the working out of their practice. For example, the literature identifies collaboration as part of public health nursing practice. In and of itself, collaboration is a passive concept. In the injury prevention example, it was only when the project coordinator started to involve others in the data analysis phase that the potential benefits of collaboration began to be understood. Public health nurses used collaborative approaches extensively throughout the data analysis, surveillance system development, coalition building, community action, and evaluation strategy components of the initiative. Thus, it was as public health nurses began collaborating with other organizations and agencies that this aspect of practice gained meaning and value for the nurse-in-practice.

We are, therefore, presented with two perspectives about practice. One view looks over practice, explaining what can be seen and understood within the confines of this

viewpoint. This viewpoint is best exemplified in the descriptions and explanations of the content and context of practice found in the public health nursing practice and research literature. The other looks out at practice in progress, as it is being performed and experienced by the nurse-in-practice. While these two viewpoints seemingly lead to the same understanding of what comprises the content of practice, the distinction proves critical as we move to increase our understanding of how public health nurses work out their practice to produce what is readily seen in the content of practice. The second viewpoint enables us to move past the foreground of practice to the less visible contextual background of public health nursing practice.

### *Context of Practice*

At the beginning of this study, I suggested that public health nursing practice is about a relationship between practice and the situation public health nurses find themselves practicing within. The convergence and interaction within the practice environment of such contextual forces as historical decisions and events, changing organizational structures, and shifting public health policy developments connects the nurse-in-practice to time and place. Although historical events have directly influenced the evolution of commonly accepted public health nursing roles and functions to some degree, history's primary influence on the public health nursing practice environment is more indirect. Historical influences shape and will continue to shape the nature of organizational changes and public health policy developments, thus exerting an indirect force on the practice environment. In contrast, changing organizational structures and shifting public health policy developments are direct forces at play within the practice environment.

Further, the convergence of contextual forces in the practice environment is inextricably linked to the three practice tensions identified at the outset of this study. These practice tensions had their genesis in the past, exist today, and will persist in a predictable form into the future. These practice tensions are pushed and pulled along a continuum through the interaction with the contextual forces within the practice environment. Moving from obscurity into view is a picture of the practice environment. Its complex and situational character is constituted by the interaction and interconnectedness of constantly changing and shifting contextual forces. The emerging picture leads us to examine how the nurse sorts out the relationship between practice and this environment despite the constraining forces at play within the context. This sorting out of practice seems to occur whether or not the nurse is explicitly conscious of the forces interacting within the practice context.

#### *The Nurse-in-Practice: Configuring Practice*

So far in this chapter we have explored the nature of the public health nursing practice environment from the perspective of the nurse-in-practice or the public health nurse practicing within that environment. At the outset, I have suggested that practice appears amazingly coherent given the complexity of the practice environment. I have also suggested that there is a relationship between the nurse-in-practice and the practice environment whereby the public health nurse configures his or her practice within the dynamic and complex nature of the practice environment. Herein can be found the substance of practice.

The configuring of practice occurs as public health nurses confront the contextual forces and practice tensions inherent within the practice environment. The way in which the public health nurse sorts through and figures out these forces and tensions shapes and delineates the nurse's practice. Only the public health nurse can configure his or her own

practice. Thus, the nurse-in-practice is in the driver's seat of how his or her practice turns out over time. There is no right way to configure practice. Nor is the relationship between practice and the practice environment a cause and effect relationship. Rather, the process is non-linear and messy in nature requiring a back and forth relationship with the practice environment.

The public health nurses in the injury prevention example provide a prime illustration of this point. For example, one of the nurses used collaborative approaches to establish an injury prevention surveillance system and participatory action methodologies to evaluate this system. Another nurse was successful in establishing a broad community-based coalition. The process of choosing these courses of action was non-linear in nature and emerged as the nurses interacted with the project team, researched the literature, and explored possible opportunities.

Conversely, the public health nurses who attempted to enter into a collaborative relationship with the community to address bike safety encountered difficulty. In the end this particular collaborative relationship was not sustainable. Confronting this obstacle did not mean that the wrong action had been taken by the nurses. Rather, these nurses had chosen to be actively engaged in sorting out their practice and in the process had opportunity to gain a more explicit understanding of the nature of their work.

Although the configuring of public health nursing practice is inevitable, it seems to occur along a continuum of awareness and understanding about the complexities of the practice environment. At one end of the continuum, it is possible for a public health nurse to configure practice with little explicit understanding of the context of practice. At worst, these nurses will find their practice to be out-of-step and irrelevant to the practice environment,

leading to a lack of engagement with practice. At best, these nurses are able to contribute in meaningful ways to public health nursing practice but by default rather than design.

I would like to suggest that the latter groups of nurses configure practice in one of two ways. They may deliberately choose to disregard what is known about the forces at play in the practice environment in avoidance of the need to sort out their practice in light of this context. They may also be situated within a practice environment that has not been made visible, leaving them frustrated in their attempts to navigate the situations they encounter or to a naïve unawareness about how to purposefully sort out practice.

At the other end of the continuum are the nurses who are engaged in an intentional and informed process of configuring their practice. In order for the configuration of practice to be a rewarding and fulfilling process, nurses-in-practice need to embrace the complexities presented by the interaction of the contextual forces and practice tensions. These nurses become explicitly aware of their practice context, proceed to sort out practice in light of what they come to know and understand and, thus, have a greater guarantee of finding coherence and meaning in their practice. I would argue that these nurses also have a better chance of successfully explaining their practice to those outside of public health nursing. Thus, it behoves public health nurses and organizational leaders to make visible the practice environment for those nurses who are prepared to purposefully engage in the work of configuring their practice.

In summary, public health nurses-in-practice constantly sort out or configure their practice within a complex and messy practice environment that is most often hidden from view. This configuring of public health nursing practice is, for the most part, taken for granted within everyday practice. If the nature of the practice environment is made visible

and explicit and, in turn, embraced by the nurse-in-practice, the configuring of practice becomes an intentional process carried out in light of what is known and understood about the practice environment. As public health nurses intentionally configure their practice, the coherence and order evident and readily observable in the content of practice emerges. The services and programs delivered as a result are more likely to meet the needs of communities and to contribute to improving population health.

The nurses actively engaged in the planning and implementation of the injury prevention initiative demonstrated the kind of results possible when nurses intentionally work out their practice. These public health nurses, who were purposefully and deliberately engaged in working out their practice, were well equipped to explain and rationalize their practice to those external to public health nursing. They were able to establish ongoing collaborative relationships and to secure ongoing funding from an outside source for their work, in part, because of their success in sorting out their practice and demonstrating it to others.

### *Considerations and Implications*

This study has illuminated the nature of public health nursing practice in its complexity. The new understanding that has emerged has implications for practicing nurses, managers and supervisors, policy-makers, nursing educators, and nursing researchers.

*Implications for practicing nurses.* The findings in this study lead to the suggestion that public health nurses who actively navigate the choices and challenges presented in the public health nursing practice environment and find coherence in the working out of practice are important to the practice environment. They are more likely to be involved in the development and delivery of programs and services relevant to improving population health.



As a result, these nurses are well positioned to lead planning, implementation, and evaluation processes with clients at the individual and population level.

In addition, these nurses are more likely to know and understand the context of public health nursing practice. Thus, they are capable of interpreting to others how this context shapes public health nursing practice. As a result, these nurses are able to assume peer leadership roles within the practice environment. They are well equipped to function as mentors for both student nurses and new practicing nurses. They are also well equipped to work collaboratively with other disciplines on projects of mutual interest.

*Implications for managers and supervisors.* Managers and supervisors have a critical role to play in relation to supporting nurses as they configure their practice. In order to foster the purposeful configuration of practice by public health nurses, managers and supervisors with direct responsibility for public health nursing practice have a two-fold responsibility. First, they must work to make the complexities within the practice environment visible to both the nurses seeking to sort out practice and to other managers within the larger organization who have the potential to influence the practice environment. In order to make the practice environment visible, managers and supervisors with direct responsibility for public health nursing require an anticipatory consciousness about what is happening and will happen contextually. They need to analytically determine what the implications are for the practice environment and, in turn, for practicing nurses. They then need to facilitate a purposeful process to make the context of practice visible. This may include formal processes such as workshops, inservices and strategic planning exercises where the contextual forces and practice tensions are discussed and made explicit and relevant to public health nurses-in-practice. It may also include informal dialogues through group meetings and one-to-one

conversations. As these are made visible, the foundation is laid to enable public health nurses to intentionally configure their practice.

Second, it also behoves managers and supervisors with direct responsibility for public health nursing practice to create a coherent practice environment. This involves attending to at least three management activities. The first management activity involves the development of management and supervisory skills that are philosophically consistent with emerging public health policy. For example, health promotion and population health approaches have required an increased emphasis on multidisciplinary teamwork, networking, partnerships, and diffusion of knowledge and skill across disciplines. Managers and supervisors must create structures and processes that facilitate these new ways of working. The second management activity is to create training and professional development opportunities for public health nurses grappling with the complexities of the practice environment. Finally, managers and supervisors must analyze proposed organizational structure changes that have the potential to facilitate or hinder public health nurses as they work out their practice. These changes need to be challenged or fostered by managers and supervisors based on the effect they will have on public health nursing practice.

This study also has implications for managers in senior positions within organizations responsible for public health nursing practice. These managers need to be receptive to increasing their understanding about the nature of the practice environment that public health nurses practice within. They need to seek out opportunities to understand the contextual forces and practice tensions inherent in public health nursing practice environments. They then need to work in partnership with managers and supervisors with direct public health nursing responsibilities to ensure that organizational decisions foster and enable public health

nurses to find coherence within the practice environment. As senior managers gain an understanding of the potential public health nursing contribution to health care and the way in which public health nursing practice happens, there is a better chance that the results of public health nursing practice will be relevant to the organization and its overall direction.

*Implications for policy.* Those involved in establishing regional, provincial, and national policy can also benefit from the findings of this study. Most recently, a national nursing shortage across all practice settings has focused the attention of policy-makers on the recruitment and retention of nurses. A better understanding of the relationship between nurses and their practice environment is critical if policy-makers are to make recommendations that effectively address recruitment and retention issues. Such recommendations need to address the roles and functions of supervisors and managers in supporting the nurse-in-practice and in creating a coherent practice environment.

Changes in the organization of health services are continuing across Canada. Changing organizational structures are an important contextual force influencing the practice environment of public health nurses. Thus, policy development related to new forms of health reform and regionalization must consider the characteristics of an organizational structure that enable nurses to effectively sort out their practice. During these reorganization processes, policy-makers can also influence how approaches designed to improve the population's health are incorporated into reorganized health care systems.

Recently, there has been a resurgence of policy-level interest in the notion of primary health care. Policy-makers have an opportunity to shift primary health care from the margins to the mainstream of the health care system. As primary health care gains prominence, policy-makers will need to analyze the contribution public health nurses could make in a

primary health care environment and how this shift in policy will influence and shape the nature of public health nursing practice.

*Implications for nursing educators.* This study has implications for educators that prepare nurses for practice. Newly graduated nurses need to come to the practice environment prepared with knowledge about and skill in the content of practice. They need to come to the workplace with contextual knowledge about public health nursing theory, nursing history, epidemiology, health promotion, health education, and the health care and social services systems. New nursing graduates also need to know how public health nursing practice can occur in partnership with other disciplines and organizations to improve the health of the population.

Although public health nursing managers and supervisors have the ongoing responsibility to make the practice environment visible to public health nurses-in-practice, nursing educators have a complementary role. Nursing educators are responsible for introducing student nurses to the practice environment through practicum experiences and analyses of these experiences. Educators have opportunity to expose students to the interplay between the contextual forces and practice tensions within the practice environment. This explicit exposure to the complexities of the practice environment begins the process of preparing public health nurses for the work of configuring their practice when they are confronted with the reality of the everyday practice world.

In order for nursing educators to effectively prepare nurses for practice, they need to find ways to learn about new trends and issues affecting the practice environment. They need to go beyond understanding the content of practice and be attuned to the current realities of the practice environment and its inherent complexities.

*Implications for nursing researchers.* Before turning to the implications for nursing researchers, I would like to return to an issue discussed at the beginning of this chapter that has particular relevance for further research. Although this study did not intend to answer the question about why public health nurses often perceive their roles to be undervalued and invisible, some insights have been gained that may be helpful and point to the need for further research. I would like to suggest that there might be two reasons for the existence of these perceptions described in the literature (e.g. Laffrey & Craig, 2000; Leipert, 1996; Rafael, 1999b; Zerwekh, 1992). First, there may indeed be circumstances where there is an irreconcilable disjuncture between the purpose of practice perceived by public health nurses and the purpose demanded from those outside of practice. Thus, it may be insurmountable for public health nurses to sort out their practice in light of what is presented in the contextual environment. For example, the power structures inherent within the overall health care system can make it difficult for public health nurses to make sense of their practice within a traditional, hierarchical, and often patriarchal system.

Second, I would suggest that in many situations, managers with responsibility for public health nursing practice have not rigourously or aggressively pursued the work of making the context of practice visible to public health nurses. This lack of contextual visibility hinders the work public health nurses can do to configure their practice. Further study, including an examination of gender-based and power relations issues would be required to fully clarify the linkage between these perceptions identified in the literature and the findings of this study.

Overall, research is critical to ensuring future gains in understanding the nature of public health nursing practice and in making the context of practice explicit and visible. A

possible area for further research has to do with the interrelationships and interaction between the three practice tensions highlighted in this thesis. The interplay between the contextual forces and the practice tensions has been examined in this final chapter. However, pursuing the possibility that the practice tensions identified in this study influence and shape one another would serve to further clarify the complex relationships inherent within the practice environment.

This study has been presented from the perspective of how I have come to understand public health nursing practice. As such, it has simply touched the surface of what could be made known about public health nursing practice. It would be particularly useful to further investigate how other public health nurses come to understand the practice tensions inherent in the practice environment, how they proceed in explicitly configuring their practice, and how they understand the nature of this work. It would also be useful to pursue the characteristics found within the organizational context that facilitate or hinder public health nurses to move toward intentionally configuring their practice. In other words, do public health nurses become purposefully involved in sorting out their practice more in some organizations than in others or in certain situations more than in others? Finally, it would be instructive to gain an understanding of other possible practice tensions and contextual forces that exist within the public health nursing practice environment. These are topics and questions that require further study and research and would serve to further our understanding about the nature of public health nursing practice.

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