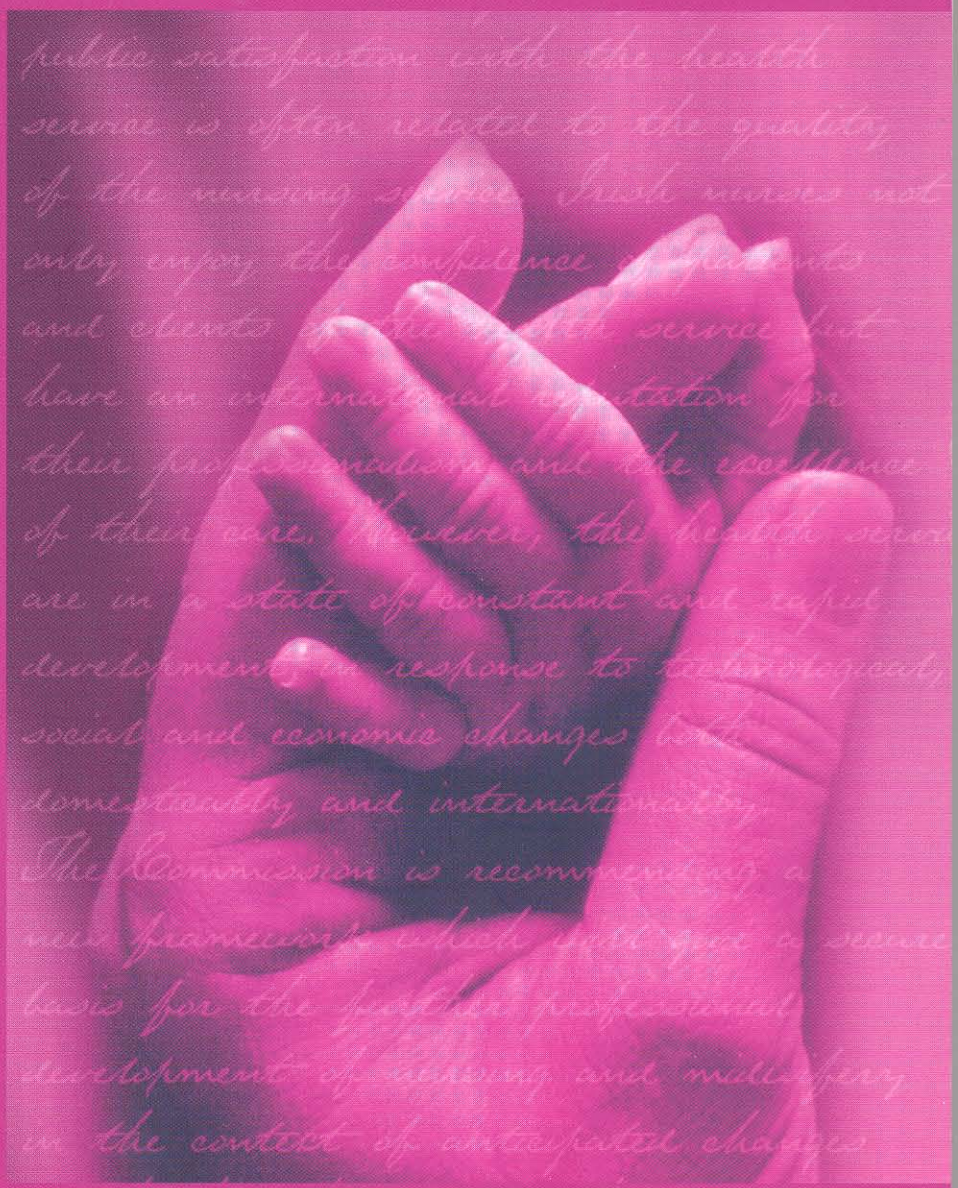
# Community Nursing - An International Perspective

*A report prepared for the Commission on Nursing*



*By Patricia Leahy-Warren*

*Edited by Dr. Geraldine McCarthy-Haslam*

# Community Nursing — An International Perspective

Report Prepared for The Commission on Nursing

July 1998

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# PREFACE

On March 21st 1997, the Minister for Health, Mr. Michael Noonan, T.D., established the Commission on Nursing. The terms of reference were: to examine and report on the role of nurses in the health service including:

- the evolving role of nurses, reflecting their professional development and the overall management of services;
- promotional opportunities and related difficulties;
- structural and work changes appropriate for the effective and efficient discharge of that role;
- the requirements placed on nurses, both in training and the delivery of services;
- segmentation of the grade;
- training and educational requirements; and
- the role and function of An Bord Altranais generally, including, *inter alia*, education and professional development, regulation and protection of the citizen.

As part of the preparatory work a number of reports were commissioned. This report entitled "Community Nursing – An International Perspective" has been prepared by Patricia Leahy-Warren and edited by Dr. Geraldine McCarthy-Haslam.

Mella Carroll

Ms. Justice Mella Carroll
Chair of the
Commission on Nursing

July 1998

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# Introduction

The purpose of this literature review is to provide information about the organisation and functioning of community nursing in a number of countries. Specifically, the terms of references were: "to conduct a review of the literature on community nursing — service models, care delivery, management of, education for, financing etc. with particular reference to literature from the United Kingdom, United States of America, Australia, Canada and Europe, especially Finland."

Chapter one examines the context within which community nursing is practiced. The concept of public health, and how in recent years it has become synonymous with the terms primary health care and health promotion is discussed, as is the valuable contribution of public health nurses/community health nurses. The mixed model of care in the United States of America is discussed in relation to community nursing.

Chapter Two explores community nursing internationally specifically discussing evolution and present models of care delivery. A critical analysis of the community nursing service in Ireland, the United Kingdom, Finland, United States of America, Canada, the Netherlands and Australia is given. Within this chapter a brief historical and socio demographic description of each country is given, followed by an account of how the model of community nursing care is organised and delivered. Research relating to their roles, responsibilities and education is reported and a critical analysis of services provided by the various types of nurses is given.

Chapter Three reviews the literature pertaining to the philosophical basis of community health nursing. The first section is a discussion on the specialist versus generalist debate in community nursing. It concentrates on the issues of expertness and professionalism, the practice nurse, the advanced nurse practitioner and the liaison nurse. The roles and perceptions of these positions are explored using research both from the United Kingdom and the United States of America. Literature relating to education for practice and management issues in community nursing are also addressed. The author provides a brief conclusion which draws together the main elements from the literature.

CHAPTER 1

# THE CONTEXT WITHIN WHICH COMMUNITY NURSING IS PRACTICED

## Introduction

All health systems face similar problems of increasing aging and dependent populations, fewer younger carers, escalating costs, and new forms of medical treatment and technology. Each nation has its own historical roots and beliefs that are transmitted in the philosophies of a health system. The shape of health and socio-economic systems is strongly influenced by socio-philosophies (cultural and religious principles), wealth and economic systems, population density and infrastructure, demography (e.g. birth rates, population growth), social problems, community attitudes and political decisions (Fry, Light, Rodnick, Orton, 1995).

Few people can afford to pay directly for health service costs. In response most western, affluent countries except the U.S.A. have made access to medical services a right of citizenship long ago and therefore use public funding extensively.

Public health is the collective action taken by society to protect and promote the health of the entire population (Beaglehole and Bonita, 1997). In the recent past however, the perception of public health has changed from that of environmental issues and infectious disease and has become linked with the terms primary health care and health promotion. The ethos of public health nursing is founded in the principles of primary health care in which the focus is primarily promotion of health and prevention of disease (World Health Organisation, 1978). Many Westernised countries have adopted primary health care as the philosophy underpinning their health care services. Primary health care is described as first contact, continuous, comprehensive and coordinated care provided to populations undifferentiated by gender, disease or organ system. Primary health care encompasses prevention, health promotion, medical care, rehabilitation and a range of personal social services (Hicks, 1976). Health promotion has been identified as the process of enabling people to increase control over, and to improve their health (WHO, 1986). Health education is seen as an integral part of health promotion in conjunction with the field of prevention. Community nurses internationally endeavour to provide a high quality accessible service to clients, however the organisation of health services in countries like the United States of America are not always conducive to providing an equitable service which contradicts the WHO philosophy (1978), which advocates health for all by the year 2000.

## 1.1 The Concept of Public Health

One of the most used definitions of public health is that from Winslow (1923) cited in Beaglehole and Bonita (1997) and reflects the history of the broad field of public health:

> The science and art of preventing disease, prolonging life and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in the principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and the preventive treatment of disease, and the development of the social machinery which will ensure every individual in the community a standard of living adequate for the maintenance of health (Winslow, 1923, p. 146).

The definition favoured by the author was proposed by the Acheson Report (1988) as: "the art and science of preventing disease promoting health and prolonging life through organized efforts of society" (p. 289). The different definitions of the term public health indicates the different meanings over time. However, both definitions have in common the idea that public health is defined in terms of its aims – to reduce disease and maintain health of the whole population – rather than by a theoretical framework or a specific body of knowledge (Beaglehole and Bonita, 1997). Acheson's definition is appropriate because it encompasses the essential elements of modern public health, i.e. preventing disease, and promoting health in partnership with the populations being served. Public health should remain inclusive and broad in scope, and according to Beaglehole & Bonita (1997) strategies should be developed to achieve its broad aims. The population's perspective on health problems must be central, where prevention of diseases and other health problems must be an essential part of this science.

The context of public health needs to be viewed in the light of changes which have and are currently occurring in the health care systems worldwide. In the nineteen seventies the perception of public health changed from that of environmental issues and infectious diseases and became linked with the terms primary health care and health promotion. This new perspective is based on the fact that health is not only influenced by the medical care system, but especially by biological, environmental, social, economical, cultural and political factors (Ashton and Seymore, 1990). A decisive step in the development of primary health care and health promotion was taken when in 1976, the international conference on primary health care in Alma Ata, USSR, declared "the attainment of all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (World Health Organisation WHO, 1978, p. 6). Thus, since that time health policies in most westernized countries are focused towards primary health care. Primary health care and health promotion were seen as interrelated aspects of the same general efforts; to attain 'health for all by the year 2000' (WHO, 1986). Thus, health services and function in each country are now directed towards meeting national targets based on national health reports. While the majority of commentators welcomed the target-setting process, the reports have been criticised for their failure to grapple with the social origins of ill health, and their lack of attention to health inequalities (Beaglehole & Bonita, 1997). For example, the targets outlined in the Health of the Nation (Department of Health, 1992) do not deal with the broader issues of public health such as poor housing or poverty, instead the targets focus on end results, within a medical framework.

The original public health movement focused on the determinants of health. The early reformers were more concerned with the importance of adequate sanitation than with the

provision of medical services. Whereas today, the focus is on the population and how services can be delivered in 'the most effective' and cost effective, efficient way to meet its ill-health needs (Beaglehole and Bonita, 1997). According to Caraher and McNab (1997), public health is being 'corrupted' to a simple epidemiological approach, in order to decide 'medical' health service needs and provision. The impact of socio-environmental factors on health is being ignored. Pollock and Majeed (1995) in the UK believe a major factor in the weakening of the National Health Service (NHS) public health function is the removal of public health medicine from an operational base. In the UK the introduction of purchasing and provider roles placed public health within the purchaser or commissioner organisation leaving a gap at the provider interface. Since the 1974 reorganisation of the N.H.S., the independent role and voice of the medical officer of health has disappeared, along with the requirement for them to produce an annual, independent health report for their district. Today's regional directors of public health lost the last of their influence in 1996 when their contracts of employment were transferred from the health services to the civil service. They are now directly accountable to the government (Beaglehole and Bonita, 1997).

The organisation of public health in the United States of America shows huge variations among the States reflecting the wide range of governmental (stage, local and federal) agencies providing services. Public health departments have become last resort providers for uninsured patients and for patients rejected by private practitioners. Almost three-quarters of all state and local health departments expenditures are for personal health services. Public health has been increasingly starved of funds and this trend has been exacerbated by the increasing use of federal block grants to states (Beaglehole & Bonita, 1997). Thus, in the USA, public health is unlikely to receive the attention and resources it requires, until the delivery of personal medical services is organised more equitably. According to Igglehart (1996) as long as state public health departments struggle to provide the medical care needs of millions of poor Americans, it is unrealistic to expect these agencies to focus seriously on public health issues.

It is interesting to note that from reviewing the literature on public health in general that nursing per se was not mentioned. Yet, having reviewed the literature on the history of nursing it was very noticeable that the origins of public health nursing lay with sanitary engineering and public health issues, particularly the social aspects of health. Also, the original public health reformers of the 19th century were not primarily influenced by medicine. Chadwick was responsible for the introduction of the first sanitary acts in the UK in 1842 and was a lawyer by training. The medical profession, however, was successful in removing him as the chairman of the Bord of Guardians and it was only with this event that medicine began its domination of public health (Caraher and McNab, 1996). In the United Kingdom and Ireland however, it could also be stated that nursing and nurses played a large part in public health services since the beginning of the 1800's. For example, in Ireland the Sisters of Mercy and the Irish Sisters of Charity educated the population on issues of hygiene and sanitation and began to work with the poor and sick in their homes from 1840 onwards (Baly, 1987, Department of Health, 1975).

With the shift in the pattern of disease from infectious diseases to diseases of lifestyle, the direction of public health services also changed (Ashton and Seymour, 1990). The future was seen to lie in the prevention of such diseases as cardiovascular disease and cancer through health education. It soon became apparent, however that the hope offered by health education was not to be realised. This resulted in the adoption of the concept of health promotion as the process which would achieve reductions in disease mortality

and morbidity (Tannahill, 1985). However, according to Townsend and Davidson (1982) such approaches failed to account fully for the inequalities that exist between various groups not solely influenced by, and only partially explained by, differences in behaviour or lifestyle practice. Such approaches are based on a medical etiology and focus on individuals, as opposed to community determinants of health (Caraher and McNab, 1996). Thus, in time health promotion was seen as the new public health (Ashton and Seymour, 1990). However, the Ottawa Charter (WHO, 1986) stated that health promotion should belong to everyone. The Ottawa Charter focused on community involvement and re-orientation of services to meet the needs of communities and thus broadened the definition of public health. At an everyday practice level, nurses have a wide range of contracts with the public and are thus in a prime position to promote public health. It is argued that public health nursing differs from community health nursing, that it represents population based health education and promotion and does not involve the delivery of personal care services (Salmon, 1993, Stanhope and Lancaster, 1996). However, based on the literature of some European countries of Finland, UK, the Netherlands and Canada, the term community nurses is used to describe all nurses working outside of institutional care. The issue of nurses working in the community will be discussed in detail in Chapter 2.

## 1.2 Primary Health Care and Community Care: Policies and Perspectives

Primary health care as defined by the WHO (1978) in the declaration of Alma Ata is essential healthcare based on practical, scientifically sound and socially acceptable methods. It is accessible to all in the community at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. Countries with more highly developed systems of primary health care according to Starfield (1994) tend to have lower health care costs. Therefore, policies designed to shift the balance from secondary to primary health care, have been a common theme in health service reforms. In the recent past many western countries have reflected this philosophy in their nation health objectives (Department of Health 1986; Public Health Service, 1990, Department of Health, 1997; Canadian Public Health Association, 1986; Epp, 1986), and continue to press for the same in any national health care plans being considered. These reports have identified the need to change health policy from the role of curing and caring involving high technology in the acute hospital setting, to the development of a more positive attitude to health, and a balance between prevention, cure and care. These reports regard primary health care as the central component of the healthcare systems, supported by well-oganised secondary and continuing care sectors in which has been recognized the pivotal services provided by community nurses (Cloutier Laffery and Page, 1989). There are a number of fundamental principles which underpin a primary healthcare system. They must incorporate a comprehensive, integrated, multidisciplinary provision of care for individuals, families and communities. It encompasses prevention, health promotion, medical care rehabilitation and a range of personal social services (Hicks, 1976). According to Poulton and West (1993) the true concept of primary health care encompasses not only medical care but also health promotion and illness – prevention strategies. These are aimed at maintaining and enhancing the health of the population through health education and early identification of health problems.

The term community care and primary care are used interchangeably without differentiation. Currently, primary health care is more concerned with the implementation of community care policies, which are committed to shifting services previously carried out in acute settings to community care settings (Caraher and McNab, 1996). The definition of community involves many aspects, but basically, Clark's (1992) definition is appropriate. Community "is a group of people who share some type of bond, who engage in interaction with each other, and who function collectively regarding common concerns" (p.8). Community health is "the attainment of the greatest possible biological, psychological and social well-being of the community as an entity and its individual members" (Clark, 1992, p.11).

In a very broad sense, the term community care is attractive because it sums up aspirations towards a society in which close-knit, supportive social relations exist to support dependent people, but as Jones, Brown, Bradshaw (1978) cited in Luker and Orr (1996) have pointed out, in practice, community care can mean very different things to different people;

> To the politician it is a useful piece of rhetoric; to the sociologist it is a stick to beat institutional care with; to the civil servant it is a cheap alternative to institutional care which can be passed to the local authorities for action or inaction; to the visionary it is a dream of new society in which people really do care; to the social services departments it is a nightmare of heightened public expectations and inadequate resources to meet them. We are only just beginning to find out what it means to the old, the chronic sick and the handicapped (Jones et al, 1978).

It is helpful to start by attempting to define what is meant by community care.

Unfortunately, as the above quotation from Jones et al (1978) makes plain, there is no single definition of the term. For some people community care is just residential care outside a major institution. For others it includes enabling dependent people to participate as fully as possible in normal life whatever the precise definition. Prior to the late 1970's, the emphasis was on formal care in the community. Since then there has been a far greater emphasis on care by the community, that is, care by family, relatives, neighbours and friends and by voluntary organisations (Curry, 1993). Community health nursing has been described as the practice of simultaneously considering and enabling the health care needs of individuals, families, aggregates (population subgroups) and the total community (McMurray, 1992).

In recent times primary healthcare is becoming more concerned with the implementation of policies to move services previously performed in acute settings to community settings. The effect of this according to Caraher and McNab (1997) is the colonization of primary health care by secondary and tertiary care agendas. Most members of the public and many experts would agreed that it is better to be treated outside the hospital setting; the problem is that it manifests itself as an optional proposition, not an additive (Caraher and McNab, 1997). Hard pressed primary care staff do not usually welcome additions to their workload unless these are accompanied by new resources. If resources are to be released for investment in primary health care, there will have to be a reduced demand for hospital care. This means that the new primary health care services will have to substitute for secondary care by catering effectively for patients who would otherwise have been referred to specialists. According to Coulter (1995) there is as yet little evidence in the UK that developments in primary health care are reducing the demand for secondary care. Primary health care services are not just about services provided by GP's, they are about the contribution of other professionals to care in the

community. It is about teamwork and bringing service planning and service delivery closer to the patient (Thomas, 1997). Teamwork in primary health care is not a new concept and is generally seen as an effective method of providing primary health care because it leads to high levels of communication and provides ample scope for health promotion (Lawrence, 1992). Additionally, it is viewed as a satisfying way of working for professionals (Lambert, 1991). The most commonly quoted definition of a primary health care team, adopted by the Harding Committee (1981) is:

> An independent group of general medical practitioners, secretaries and/or receptionists, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understanding his/her function and those of other members so that all pool skills and knowledge to provide an effective primary health care service (Department of Health and Social Security, DHSS, 1981, p. 4).

However, Symonds (1997) argues that the definition of a team is based on the principle of equality and of inter-dependence. She compares it to the analogy of a football team, where each member of the team has their own specific skills, but the absence of one member destroys the balance and effectiveness of the whole; while there is a captain, this is a role of responsibility, not necessarily one of hierarchy. She goes on to state that a captain is meant to inspire and lead, not to be in a position of 'ownership' of the skills of others. This was never true of the primary health care team; doctors were always in charge and nurses deferential thus mirrorring the hospital 'medical' model of health care (Symonds, 1997). Clay (1987) suggests nurses are trained to accept discipline and to obey without question. This in turn undermines their natural self-assurance and ultimately creates a hierarchy in which no one at any level feels easy about speaking out. Authoritarian and hierarchical structures of training leads to and perpetuates ritualized, stereotyped, unnatural behaviour that subverts and suppresses creativity and reinforces dependency and insecurity (Treacy, 1989). The superior-subordinate physician nurse relationship in the hospital, perfectly matched the male-female role expectation and practice in society in general (McCarthy, 1990). Research is indicated to prove that teamwork is a contentious issue for nurses working in primary health care. While many nurses may not view GP's as natural leaders of the team (Pearson, 1992) nurses appear to be neither viewed nor treated as equal team partners by GP's (Robinson, Beaton, White, 1993).

Primary health care (PHC) is both a philosophy of health care and an approach to providing health care resources. Its basic elements are essential health care, socially acceptable and affordable methods of technology, accessibility, public participation, and intersectoral collaboration. Although the goals and principles of PHC have been well documented, the development of theory specific to the practice of nursing has been lacking. A primary health care system encompasses prevention, health promotion, medical care, rehabilitation and a range of personal social services (Hicks, 1976). The ethos of public health nursing is founded on the principles of primary health care in which the focus is primarily, promotion of health and prevention of diseases. In delivery of services, public health nurses have traditionally practiced under the umbrella of health promotion (McMurray, 1993). Health promotion is described by the Ottawa Charter (WHO, 1986) as a "unifying concept for those who recognize the need for change in the ways and conditions of living ..... a mediating strategy between people and their environments. Synthesising personal choice and social responsibility" (p. 113). In other words it is the

process of enabling people to increase control over and to improve their health. Tannahill (1983) proposes that health promotion embraces three overlapping spheres of health protection, health education and prevention. Thus, the term health promotion encompasses a range of component activities contributing to health. Health, as a concept however, is widely contested (Maben, Macleod-Clark, 1995, Delaney, 1994), although there is agreement in the literature in general and also the nursing literature (Fitzpatrick and Whall, 1989) that being healthy is positive in direction and is broader than the absence of disease.

According to Hanafin (1997b), the key issues which are central to promoting good health include; people themselves having control over their health and the need for an approach which is multi-disciplinary and multi-sectorial in orientation. The role of the public health nurse/community nurse varies from country to country as will be discussed in Chapter 2 of this report, however in many countries it is clear that public health nurses contribute to health promotion activities. These include: needs assessment (Vehvilainen-Julkunen, 1994), provision of education (Dines, 1994), prevention and detection of disorders and health problems (Delaney, 1994, Nelson and Dines, 1995), emotional support (Holden, Sagovsky and Cox, 1989), community development and community based projects (Johnson, Howell and Molloy, 1993; Ruka, Brown, Procope, 1997) and practical help (McCormack, Daly-Mitchell, 1996). Within the framework of health promotion, and ultimately primary health care, public health nurses in Ireland operate at the level of individual, family and community in the provision of their services. The public health nurse has greater autonomy in practice than other nurses and those who recognize themselves as autonomous and respected will in turn model autonomous behaviour and empower clients to participate fully in primary health care (Gibson, 1991). An empowerment approach means valuing knowledge, mutual decision making, respecting diversity and advocating for, and with the community or client, in the creation of structures which facilitate real choice. Health is multi-faceted, meaning different things to different people and individuals can only make healthy choices when real choice is available and they feel empowered and in control of their lives (Hanafin, 1997b). The public health nurse is ideally situated to promoting health within the community. However, a problem often arises from the public's welfare state perspective which encourages passivity and dependency on services available.

## 1.3 Mixed Model of Health Care

The United States (US) is a young nation born out of pioneers and with philosophies of equality of opportunities freedom and democracy. These attributes according to Fry et al (1995), have all been transmitted into their health care system. There is no single system; health care is provided through a multi-mix of private and public schemes. The US health system is the most expensive at over 14% of the GDP and may reach 15% of GDP by the year 2000 (Fry et al, 1995).

As of 1992, there were approximately 603,400 physicians and 2.3 million nurses in the USA providing health care to a population of 257 million. In addition, the population of the US is aging which has further implications for health care provision. It is projected that by the year 2000, 13% of the total population will be over 65 years of age, with the 85 year old and older group growing at a rapid rate (Stanhope and Lancaster, 1996). The infant mortality rate is high at 9.0 per 1,000 births in 1994 (Fry et al, 1995). Health care

financing has evolved throughout the twentieth century from a system financed by third-party contributors, that is, private insurance companies and governments. At present, the combined state and federal governments contributions as third-party contributors are currently higher than those of private "payers". In 1990 third-party contributors contributed 78% toward the total costs of health care for the consumer, leaving only 22% to be covered by out-of-pocket money.

The Medicare program provides hospital insurance, home health services and extended care facilities to persons aged over 65 years and disabled persons under 65 years are eligible after two years post assessment. The medical insurance package of the medicare programme is available to all people who wish to pay a monthly premium. Approx. 96% of the elderly population are insured. The premium cost was $36.60 per month in 1994. The medical insurance package provides for physician services, outpatient hospital care, outpatient physical therapy and speech therapy and home health care not covered in the Medicare Programme. After a deductible (minimum payment), up to 80% of reasonable charges are paid for these services. However, according to Fry et al (1995) medicare covers few home or long term services for the chronically ill. In addition, Medicare often covers only a portion of physicians bills, no drugcosts, no other health professions costs (such as dentists or psychologists) and has significant deductibles before any charges are paid. Because of these gaps in coverage, over 80% of the elderly purchase a supplementary insurance policy for relatively high premiums to help with the potential uncovered expenses.

The Medicaid program provides financial assistance to states and counties to pay for medical services for the aged poor, the blind, the disabled and families with dependent children. The medicaid program is jointly sponsored and financed with matching funds from the federal and state governments. Currently, 32 million people are enrolled in Medicaid. On the whole, while many people may be covered by Medicaid, different states make different decisions about how many services will be covered and about who is eligible. According to Fry et al (1995) strict eligibility rules allow only half or less of those with survival incomes (the poverty line) to be covered. In some states, only one third of those on survival incomes are eligible. Thus, those who are uninsured are likely to be Latinos and African-Americans and when needing medical care, use the relatively small and underfunded public hospital emergency rooms and clinics.

In 1972, 73% of the US population had health insurance provided through their employers. An additional 10% received insurance through public programs leaving 17% uninsured and of this 12% under-insured. This number includes 37 million Americans living in poverty (Fry et al, 1995; Grace, 1990). The typical uninsured person may be a member of a family whose adults do not work or whose employer does not offer health insurance as a benefit. For those people a major illness can result in debt or disability that will keep them or place them at the poverty level. This may ultimately deny them access to health care.

According to Clemenstone, Eigsti and McGuire (1991) although the health care system in the USA provides comprehensive health services, it is largely privately funded and thus its services are neither accessible nor affordable to all people. The USA health care system advocates 'health for all by the year 2000' (WHO, 1978) and recognizes the need to expand health-promotion and disease prevention programs. Measures are being adopted to transform their primarily hospital-based systems to ones that are community based. Ambulatory care and early hospital discharge have been implemented and community-based care and rationalization of services are being explored (Yiu Matuk, Chadwell

Horsburgh, 1992). In the United States, ambulatory centres as well as alternate delivery systems, which include health maintenance organizations (HMO's) and preferred providers organizations (PPO's), are being implemented. These systems are known as 'managed care' organizations. Managed care involves the marriage of several types of service agencies into a unified network : HMO's, physicians' offices, hospitals, home health agencies, nursing homes and support services such as laboratories and public health departments. This network will then provide all services to clients with whom it contracts. Clients could be individuals, business, local and state governments and Medicaid clients in a certain geographical area. The managed care network provides clients choice or providers within the system (Stanhope and Lancaster, 1996). Community nurses and Public Health Nurses in the USA provide primary, secondary and tertiary care in community settings. Their roles and responsibilities will be discussed further in Chapter 2 of this report.

## Summary

Public health has been defined by a number of authors but essentially means preventing disease and promoting health in partnership with the populations being served. The population's perspective on health problems must be central, where prevention of disease and other health problems must be an essential part of this philosophy. The original public health movement was more concerned with the importance of adequate sanitation than with the provision of medical or nursing services. In the USA, public health has become the last "resort providers" for uninsured patients and thus until the delivery of personal medical services is organized more equitably, public health in the US is unlikely to receive the attention and resources required. The direction of public health has changed with the shift in pattern of disease from infectious diseases to diseases of lifestyle. The adoption of the concept primary health care and health promotion thus became the new public health but with little or no emphasis on the community determinants of health. Many countries adopted the philosophy of primary health care which is reiterated in national health care plans. Community nurses work as members of the multidisciplinary primary health care team which endeavours to provide a comprehensive, equitable, accessible service to clients. The team concept has generated much discussion regarding its cohesiveness and effectiveness. The ethos of public health nursing is founded on the principles of primary health care in which the focus is primarily promotion of health and prevention of disease. Public health nurses internationally are pioneers of the original public health movement, and continue to provide primary, secondary and tertiary care in the community. While the role of public health nurses/community health nurses varies from country to country, it is clear they contribute to a number of areas of health promotion.

There is no single health care system in the USA. Health care is provided through a multi-mix of private and public schemes. While this system may provide comprehensive health care, it is largely privately funded and thus its services are neither accessible nor affordable to all people. This contradicts the philosophy of the WHO (1978) which advocates health for all by the year 2000, thus the USA health care system recognizes the need to expand health promotion and disease prevention programs. Community health nurses/public health nurses are ideally placed in the community to provide primary health care services to the community.

CHAPTER 2

# COMMUNITY NURSING INTERNATIONALLY: EVOLUTION AND PRESENT MODELS OF CARE DELIVERY

## Introduction

The term community nursing is used in this report in its broadest sense to include nurses employed in public health, continuing care, home health care and community health centres/schools, clinics throughout the countries being reviewed. Community health nursing as defined by the Royal College of Nursing (RCN, 1992) as:

> professional nursing directed towards communities or population groups as well as individuals living in the community. It includes assessment of the environmental, social and personal factors which influence the health status of the targeted population. It's practice incorporates the identification of groups and individuals within the community who require help in maintaining or achieving optimal health (p. 6).

The aim of a community health nursing service is to promote and preserve the health of communities, groups, families and individuals across their life span, in a continuous rather than episodic process (Canadian Public Health Association, 1990).

Internationally, community nursing has developed as countries seek to improve primary health care, encouraged by the 1978 Alma Ata Declaration. The emphasis on community nursing has increased in many countries starting in the late 1970's and early 1980's. As the largest group of primary health care workers, community nurses have an important part to play in the achievement of 'health for all' (Salvage and Buxton, 1997). In many Western European countries the development or maintenance of community nursing, including home visiting, is described as priority. As the World Health Organisation (WHO) notes, these services are well established in countries such as Denmark, Finland and the Netherlands, but relatively under-developed in France, Ireland and the Mediterranean countries (Salvage and Heijnen, 1997).

The move towards home visiting is being further stimulated by demographic changes resulting in a growing elderly population. In most countries, community nursing is a generic term that includes different functions, such as district nursing and health visiting (roles that are combined under the title public health nurse in Ireland), family planning, school nursing, psychiatric nursing, mental handicap nursing, pediatric nursing, palliative care nursing and health education. In this chapter literature is reviewed on community

nursing in Ireland, United Kingdom, Finland, United States, Canada, Netherlands, and Australia.

## 2.1 Community Nursing in Ireland

### Socio-demographic Background

The population of Ireland in 1996 was 3,626,87 with a population density of 52/km$^2$ (Central Statistics Office, 1996). The infant mortality rate in 1991 was 8 per 1,000 per population which is higher than Finland but considerably lower than the USA or UK. The national health insurance system is government funded and all Irish citizens are entitled to free hospital care in a public hospital bed. Thirty six percent of Irish citizens are covered by health insurance for private or semi private care by paying a certain amount to a health insurance company. The annual percentage of GDP spent on health care in 1994 was 7.3% with 6% public and 2% private (Institute of Public Administration, 1995).

### Historical Perspective to Community Nursing

Public health nursing in Ireland, separate from institutional nursing and midwifery is an amaglam of three separate branches of community nursing services. These are: public domicilary midwifery services, voluntary district nursing service and the public health nursing service. The midwifery service was set up under the Poor Relief (Ireland) Act 1851 at the same time as the dispensary medical system and by 1927, six hundred and fifty seven midwives had been appointed, only 5 of whom had qualifications in general nursing (McCarthy 1997). No major changes occurred until the Health Act, 1953 by which time the majority of midwives were attending less than 20 domiciliary births each year. Subsequently many of the dispensary midwives, who had qualifications in general nursing and were otherwise deemed suitable, attended short courses in public health nursing and were appointed as whole-time public health nurses. Presently, in Ireland, nurses wishing to study for public health nurse education must be registered midwives and general nurses although only 1.2% of nursing time on the district is spent on maternity services (Department of Health, 1975) and home births now account for only 0.4% of total births (Central Statistics Office, 1996). Whilst An Bord Altranais (1994) recommend that midwifery registration was no longer required, it has to date not been removed as a criteria for entry to public health nursing as maternity aftercare continues to be an important part of the public health nurses role (O'Sullivan, 1995).

The district home nursing service was pioneered by a number of voluntary organizations in the late 19th century, the most notable being the Jubilee Nurses and Lady Dudley Nurses. A training school for district nurses was established in St. Stephen's Green in Dublin in 1876 by Lady Plunkett. The Queen's Institute which was founded in 1887 functioned primarily in areas where it was feasible to establish local associations capable of fundraising and employing their own nurse. The Lady Dudley Nursing Scheme was founded in 1903 and always had close liaison with the Queen's Institute. Both these nursing services were initially concerned with the provision of maternity and home nursing care. However, with the development of the domiciliary tuberculosis services in the 1950s, child welfare and school services, both organizations became involved in the provision of these services for which they received subsidies from public sources.

The public health nursing service originated in the child welfare and school health services of the early twentieth century. The Health Act of 1947 provided that a health authority could made arrangements for the provision of a nurse to give advice on health or related matters and assistance to any sick person (Department of Health, 1975). The position of public health nurses was further reviewed in the 1960's, and in 1966 Circular 27/66 (Department of Health, 1966) outlined the areas of public health nursing work, and identified the community groups who would receive the service, (see Appendix 1). In 1967 the Queen's Institute discontinued its training scheme, as did the Lady Dudley Organisation in 1974. Nursing staff from both organizations were taken over by the Health Boards (Department of Health, 1975). The appointment of a Superintendent Public Health Nurse was considered necessary whenever ten or more nurses were employed on district duties (Department of Health, 1975). A senior grade of PHN was established in 1983 following a recommendation of the Working Party on General Nursing (1980). Thus, there are three grades within the present public health nursing service: Public health nurse, Senior and Superintendent public health nurse. Circular 27/66, (Department of Health, 1966) when introduced was a far sighted, all encompassing document and shaped the present structure of public health nursing. However, there has been no revision of this circular to date despite the many socio-demographic and health care changes over the past thirty years. The service has included domiciliary midwifery as required, general domiciliary nursing especially for the elderly, care of clients with mental illness and mental handicap and health care of children from "infancy to the end of the school going period" (Department of Health, 1966, p. 3). In 1975 the Department of Health recommended that nurses being appointed as public health nurses should also be registered in the Midwifery Division of the Register held by An Bord Altranais. They acknowledged that the public health nurse has a great deal to offer and that their full potential in relation to midwifery services were not utilised. The service provision of domiciliary births is currently not being provided even though it is included in the job descriptions of all public health nurses (Department of Health, 1966). Consequently, An Bord Altranais (1994) recommended that midwifery registration should no longer be a prerequisite for entry to public health nursing and suggested its replacement with a maternal and childcare module. However, postnatal care and limited antenatal care still feature in the workload of the public health nurse. One of the primary benefits of midwifery education is its focus on health rather than illness. Educational preparation of public health nurses also centres on a psycho-social model of care with the focus on families and communities rather than just individuals. Provision of health education and assistance of medical practitioners at clinics and dispensaries are also identified as important roles of the public health nurse. However, according to Hensey (1988) the Health Act (1970) which allowed for a choice of doctor for eligible patients, changed the relationship between the public health nurse and the doctor, as areas were no longer deemed necessarily compatible. Difficulties also arise in relation to the provision of other services delivered by the public health nurse. It is widely acknowledged that the workloads of the public health nurse and the organization of the service places unreasonable demands on the services and requires review (Burke, 1986; Department of Health, 1975; O'Sullivan, 1995; Working Party Review on Public Health Nursing, 1997). Today the majority of public health nurses work as generalists in the community as will be described in the next section.

## Organization and Delivery of Services

In Ireland, as in other Westernized countries, the focus of health policy documents since the late 1960's have been to emphasize community rather than institutional services (Department of Health, 1995, 1994, 1990a, 1989a, 1988, 1986a, 1986b, 1966). The Community Care Programme aims to provide and develop services in the community as opposed to within an institutional setting (Curry, 1993). The Community Care Programme has three sub-programmes; community protection, community health and community welfare services (Curry, 1993). Following the declaration of Alma Ata the World Health Organisation (WHO, 1978), identified primary health care as a framework for delivery of services. This perspective was endorsed by the Irish Health Department (Department of Health, 1995, 1994, 1986a).

## The Role of Public Health Nurses

The public health nurse works as part of a multidisciplinary team to deliver community care. Public health nurses number 1,410 which according to McCarthy (1997) are the largest group of professionals, and recognised as one of the longest established professional groups working in the Community Care Programme (National Economic and Social Council, NESC, 1987). The majority of public health nurses work from health centres situated in or near the assigned geographical district. A minority hold specific responsibilities in relation to school nursing, travellers health and community programmes. Districts have average populations of 2,600 (Department of Health, 1993) although this figure varies from district to district (O'Sullivan, 1995). The public health nurses are responsible for the delivery of primary, secondary and tertiary care. They are generalists with a wide range of responsibilities and their client groups include people of all ages living in the community who require a domiciliary clinical nursing service, infants and children including school age children – children at risk, people with physical and mental disabilities, young chronically sick people, those discharged from the psychiatric service and older people. In practice, according to the two workload reports on public health nursing (Dept. Health, 1975; Burke, 1986) the main focus of the service is on children and elderly people. However, with short term hospital stays acute care is now also thought to be a considerable component of the work. Clients may access the service through self referral, family members, hospital or general practitioner referrals.

The role of the public health nurse according to Hanafin (1997a) is threefold, that of manager, clinician and health promoter. Their educational background provides them with a broad base in assessment, planning, implementing and evaluating nursing care in a holistic way with clients. Clients may be individuals, families or the community. Managerial functions include identifying population needs, prioritizing needs and time management, record keeping and report-writing, quality assurance and audit, voluntary and statutory interaction, liaison with other statutory and voluntary agencies and evaluation of the service (Hanafin, 1997a). The public health nurse also recruits home help staff and supervises them when a need has been identified. There are home help supervisors in some areas who work closely with the public health nurse and report to the senior public health nurse. On a community level, public health nurses recognise the necessity for and benefits of community participation and have been actively involved in assisting the community to identify its needs on a formal basis (Quirke, Sinclair, Kevany, 1992).

Similar to other westernized countries, the increase in life expectancy and decreases in the birth rate have led to an increase in the number of older people as a proportion of the total population and this trend is expected to continue (Central Statistics Office,1993b). In the Department of Health (1994) document, it is stated that "the number of persons aged over 65 is expected to grow by 40% in the next twenty five years, while the number of persons over 85 years is expected to grow by 60%" (p. 10). As older age groups are associated with poorer health, the need for home nursing services is likely to increase. Public health nurses also provide care for the terminally ill in the community. They are supported in this in a small way by the hospice nurses who work from, and are administered by, the hospice care institutions.

In 1986, a national survey found that 44% of public health nursing time was spent on home nursing, which included preventive and educational nursing, technical basic and acute nursing, of which elderly care accounted for 50.1% of total nursing time spent (Burke, 1986, see Appendix 2). In 1987, a review of the community care services resulted in the recommendation that registered general nurses and nurses aides should be involved in providing this home nursing service (NESC, 1987). There is an increasing view that much home nursing could be done, and is being achieved in some areas by either registered general nurses or nurses' aids (NESC, 1987; Dept. Health, 1986b; Dept. Health, 1988; Dept. Health, 1980). However, a qualitative study by O'Sullivan (1995) showed that where registered general nurses were employed, they were seen by public health nurses as both a threat and a resource. Keavney (1992) suggests that the clinical skills of the public health nurse are greatly valued by the community and that the commitment of the public health nurse to personal care is of central importance in assuming the "complex technical, managerial and social role of primary health care coordinator" (Keavney, 1992, p.55). According to Hanafin (1997a) the organization of the community nursing services in Ireland ensures that public health nurses will continue to have a clinical nursing function. There is great concern, however that unless there is a substantial increase in resources, the clinical work of the public health nurse may erode her other functions related to the promotion of health and coordinator of the local service (Hanafin, 1997a).

**Midwifery Services**

There are currently two types of domiciliary midwifery services available to women in Ireland. These are independent midwives and the pilot projects being conducted by two health boards. It can be argued that because of location and/or cost, this is not an equitable or accessible service for many. There are currently fourteen independent midwives in Ireland, who are located mainly in Dublin and Cork. They operate a private practice, and charge fees of approximately £300.00 to £800.00 per case. The second type of domicilary service is available only to clients in the catchment area of Sligo General Hospital, in the North Western Health Board. This service was established five years ago by a local general practitioner and a midwife from the labour ward (Dempsey and Mulcahy, 1998). It is now provided by three labour ward midwives only, who work an on-call rota as well as being part of the labour ward staff. The South Eastern Health Board are currently examining the feasibility of providing a domiciliary midwifery service utilising public health nurses. At present a team of two public health nurses who received a specialised midwifery update are providing a limited service in Waterford Community Care Area (Dempsey and

Mulcahy, 1998). There have been calls by the Irish Medical Organisation on the Minister for Health to clarify women's rights on home births (Hegarty, 1994).

**Home Helps**

The home help service in Ireland is supplied by statutory and voluntary bodies and is of critical importance in maintaining elderly people in the community. The majority of recipients of home help are elderly. The home help service varies across health boards in terms of ratio of recipient to elderly population. The national ratio is one recipient of home help to every 33 elderly in the population. Since greater than 80% of home help recipients are elderly, these ratios can be taken to reflect the number of elderly in the population who receive help. Data regarding the organisation of the service are summarised by Finucane, Tiernan, Moane,1994.

Home help services are organised by home help organisers or by public health nurses. Home helps may be employed by the health boards or by voluntary bodies and the majority of them work part-time (Finucane, et al 1994). Home helps, the majority of whom are women, provide a variety of services for elderly people from domestic chores to operating a "sitting service". In a recent study by Finucane et al (1994) it was found that home helps receive training in 46% of community care areas (CCA) while 34% of CCA's had no training for their work. The length of time spent in training varied from one to six weeks. Access to home help service is by referral from clients, family, GP's, hospital personnel or concerned neighbours. There is no waiting list for home help services in 73% of CCA's compared with 15.3% which operate a waiting list. Some CCA's (34%) charge the elderly person a fee for the home help service (Finucane et al, 1994).

The home help service operates on scare resources and therefore priorities are employed in determining the extent of and provision of service. The assessment is conducted by the home help organiser or the public health nurse. A number of factors are always priorities in deciding on provision of home help service. These include 'level of incapacity of elderly person' (62%), 'general state of health of elderly person' (61%) and 'urgency or acuteness of medical need' (54%). If the 'carer of the elderly person is at risk' 46% and forty two percent of CCA's adjust the level of home help they provide accordingly (Finucane et al, 1994).

A number of factors provide criteria for eligibility with regard to the home help service. A factor that is always a condition of eligibility in 35% of CCAs is "must be means tested for this service" (i.e. elderly person only)! Other factors sometimes used as conditions of eligibility, included "must be incapacitated" in 58% of CCAs, "must be living alone" in 50% of CCAs and "must have medical card" in 38% of CCAs (Finucane et al, 1994). It does appear however, that the presence of a carer may have a negative effect in receiving the home help services. The presence or absence of a home help has implications for the overall work of a public health nurse.

**Summary**

In Ireland, the present public health nursing service began in 1956 following the amalgamation of three separate services : midwifery, nurses employed by the local authorities and the voluntary district nursing service. The client groups with whom the public health nurse works were identified in a government circular in 1966, and this has not, to date, been revised. It is widely acknowledged that the workloads of the public

health nurse and the organisation of the service places unreasonable demands on the service and requires review. Public health nurses work as part of a multidisciplinary team and for the majority are attached to a geographical area. This geographical attachment is in contrast to the organisation of community nursing services in other countries. Public health nurses work as generalists and their role is threefold, that of manager, (coordinator of service), clinician and health promoter. The role of the formal health promoter appears to be deminished as work load in other dimensions of the role increase. They work closely with hospice care nurses and community midwives. They report directly to the senior public health nurse who in turn reports to the superintendent public health nurse. Some public health nurses organise the home help service and work with registered general nurses. Other work in specialised areas such as schools, with traveller groups or in community development programmes.

## 2.2 Community Care Delivery in the United Kingdom

### Historical Perspective on Community Nursing

The United Kingdom (UK) comprises England, Wales, Scotland and Northern Ireland. It contrasts demographically with Ireland as it has a population of 57.5 million, which rarely fluctuates, crowded into a relatively small area. According to Fry et al (1995), well developed communications and transport systems ensure that everyone has access to public facilities, including health care. The percentage of elderly (over 65 years) is increasing and is projected to increase from 15.3% in 1987 to 16.3% in 2020, resulting in an increasing dependency rate (Verheij, Kerkstra, 1992). The infant mortality rate was 8.4 per 1,000 births in 1994 (Fry et al, 1995).

Community nursing in England was originally provided by district nurses and health visitors. These two distinct roles emerged in the community and began in the United Kingdom (UK) in the second half of the 19th century following the cholera epidemic in the Manchester area, to offer home care to all sick people, not just the rich. According to Heinrich (1983) the health visiting role was not originally a nursing one but based on environmental health issues such as sanitation and hygiene. During the early 1900's Health Visitors were required to hold a qualification in medicine or nursing or midwifery. Under the 1932 Children and Young Persons Act health visitors were given the additional responsibility of visiting foster parents and children, while a further role was added with the adoption of children Act, which came in 1943. Initially concerned with promoting health and hygiene for the population in general, health visiting began to focus more and more on child health during the first half of the 20th century when infant mortality was very high (Heinrich, 1983). It appears that it was at this time that health visiting became established as a branch of nursing (Baly, 1987). To this day, health visiting is the commonly used term for public health nursing in the UK (Caraher and McNab, 1996). In 1956 a GP was first allocated a health visitor for an infant welfare centre, and over the next 10 – 20 years more health visitors began to work in GP practices (Beine, 1996). Practitioners draw their caseload from a defined geographical area, or the population served by a primary health care team, if they are working from a GP practice. Traditionally, health visitors have defined their own priorities and visiting patterns, rather than relying on medical opinion or direction (Cowley, 1995).

District nursing in the UK originated when in 1859 Mr. William Rathbone decided to retain the nurse who cared for his wife while dying of tuberculosis to help the ailing poor in Liverpool. However in 1861 it became obvious one nurse could not manage alone and with the assistance of Ms. Nightingale, Mr. Rathbone donated money to set up a school of nursing in Liverpool to educate community district nurses (Baly, 1987). By 1887, Queen Victoria gave the Woman's Jubilee a gift of £70,000 to extend district nursing schemes. Thus, the following year the Queen Victoria Jubilee Institute for Nurses came into being. Like so many of the health services, district nursing started as a voluntary service, run by voluntary committees with money being collected from recipients or from charitable efforts or donations. As the years passed, legislation required local authorities to accept more responsibility for the sick in the community and in 1928 the Queen's Institute for District Nursing was formed (Baly, 1987, Heinrich, 1983). In 1948, health visiting as well as district nursing became part of the National Health Service. With the advent of primary health care, the organisation of community nursing care has expanded to include several types of nurses.

**Organization and Delivery of Services**

The British National Health Service was set up in 1948. It is funded largely through public taxation and is one of the 'cheapest' health services as measured by percentage Gross Domestic Profit (GDP) and per capital expenditure. The UK health system costs 6% of GDP per annum compared with 12.4% in the USA in 1992 (Fry et al, 1995). There are divisions in the NHS – hospital (sub specialist), general practice (primary care generalist) and public health (community) services. All are under the control of the Government Department of Health with a Secretary of State at its helm, who is responsible to Parliament. The hospital services are administered by Regional and District Health Authorities (RHA's and DHA's) and the subspecialists are salaried employees of the NHS. General practice is administered by Family Health Services Authorities (FHSA's) and general practitioners (GP's) are independent contractors who are contracted to provide direct access and continuing primary care services to registered patients. They act as 'gatekeepers' to sub specialists in a traditionally controlled referral system. Public community health is a mix of NHS and social, local community services and there is loose collaboration between these three parts of the health system. Each DHA has a community unit, which is divided into several localities, neighbourhoods or sectors. For each locality, neighbourhood or sector there is a manager who is responsible for staff deployment in that area, in which there may be several health centres (Fry et al, 1995).

In 1990, Great Britain enacted the National Health Service and Community Care Act. The current legislation, by accelerating privatization, signals dramatic shifts in the balance of the types of care, funding and the source of professional dominance in long term care provision. The law prioritizes non-institutional forms of long-term care, elevates the personal social services components, and precipitates the transfer of costs outside the NHS. Direct access to private nursing home care is severely restricted, the costs of community care are increasingly passed on to the consumer and both NHS and local government providers of long-term care compete for purchasers under the new structure (Filinson, 1997).

Since April 1st 1993, the extension of the GP fundholding scheme allows GP fundholders, private health care facilities and budget holding health authorities to contract

with NHS provider units for the services of community nurses and other community based therapists. This implies that community nurses may be employed by one of several different organisations (Traynor and Wade, 1994).

Generally in the UK there are several types of nurses working in the community. These include: district nurse, health visitors, community psychiatric nurses, community midwives, schools nurses, GP practice nurses and nurse practitioners. The practice nurse and the nurse practitioner are two relatively new roles in primary health care. While practice nurses are usually employed by the GPs to provide nursing care in a clinic, the nurse practitioner may work in a hospital or the community, is employed by the GP or the health authority, and is authorized to make decisions about patient care and to diagnose, treat and refer patients within the scope of training (Salvage and Heijnen, 1997). District nurses care for people (over 65 years of age) in their own homes and also in old people's homes without registered nursing staff. Children make up only a small part of the patient population, since healthy children are cared for by health visitors and district nurses only care for sick children. For the terminally ill, there is a separate organisation, a McMillan fund, which provides for extra nursing care provided by specialist nurses, in addition to the normal provision of community nurses. In 1989, 73 persons per 1,000 of the population in England were cared for by the district nursing service (Department of Health, 1990). Community nursing work is usually managed and supervised by nursing managers, although growing numbers of nurses are being employed directly by GP's (but remain accountable to the nursing regulatory body). In practice, according to Salvage & Heijnen (1997) community nurses throughout Europe often act on orders from doctors rather than from nurse managers. District nurses take care of the entire sick population in a specific area. There are no government or other regulations stating the maximum amount of care a patient is entitled to receive (Verheij and Kerkstra, 1992).

In the UK in the early 1960's and 1970's several health care changes altered the district nurses' relationship with GP's. The introduction of district nurses' attachment to GP practices has many interpretations. According to Ross (1987) at one extreme it is seen as synonymous with teamwork and at the other little more than an arrangement on paper between professionals who rarely meet and don't communicate. In 1982, 83% of all district nurses were attached to GP's (DHSS, 1982). This means that their patient population is the same as that of one or more specific GP's. The average nurse has to deal with 2 to 3 general practices. The report of the Community Nursing Review (1986) demonstrated that working from a GP practice has the disadvantage that the patients of a GP do not live in a geographically defined area thus causing ineffective use of community nursing services due to long distances being travelled.

Community nursing in the UK is undergoing rapid change due to reforms within the NHS (Lawson and Emerson, 1995). There is growing concern amongst community health care providers resulting from divisions between traditional methods of care delivery and the adaptations required to meet increasing demand for a range of health care services. In district nursing, reductions in acute hospital services and the movement from secondary to primary health care identifies issues of role definition, as well as changing caseloads (Barrett and Hudson, 1997). Twinn (1991) notes that government legislation and changes in nurse education have fueled debate over the role of health visitors. The environment of continuous change has created conflict between disciplines within community nursing. Wood, Farrow and Elliott (1994) and Symonds (1997a) have noted that "practice" and "community nurses" may regard each other as threatening. Another issue at the centre of the primary care debate is the potential role of the 'nurse practitioner' in relation to

both general practitioner – based and community services (Lawson and Emerson, 1995), although the precise definition of this role is unclear.

A recent study conducted by McDonald, Langford and Boldero (1997) examined the future of community nursing, within the wider framework of a rapidly changing NHS. Three questionnaires were sent to twenty four trusts, covering three of the community nursing services : district nursing, health visiting and school nursing. Twenty two trusts responded to the questionnaires. The results indicated that whilst a wide range of management structures and working practices were found between trusts, several common themes and issues of concern emerged. For district nurses these included the shift from secondary to primary care, the changing demands of the patient population served, with increasing numbers of elderly and chronically disabled patients. This led to anxiety over the communication between different providers of care, such as community, acute, and social services and the skill mix and training requirements of nurses. Health visitors and school nurses were concerned about being marginalized in the move towards integrated primary health care teams. Concern was also expressed about measurement of performance on the less quantifiable outcomes of preventative care and hence how specific positions could be justified to purchasers of health care. The researchers did note some limitations to the study. Namely, the trusts were not chosen at random and mostly came from urban and rural trusts of varying sizes but not from the large metropolitan areas where different issues may have emerged as being more important. Taking limitations into consideration, this study has highlighted several common themes for concern which underpin the current structure and future development of community nursing service in the UK.

Health visitors take care of the healthy population. Most of their workload pertains to children and mothers. However, they also work with the 'well-elderly' in the form of screening programmes and follow-up after discharge from hospital or following bereavement. A decreasing percentage of the population above 65 is visited by health visitors (7.4% in 1978, 5.3% in 1987/88) (Department of Health, 1990). In 1987/88, 8.6% of the total population was visited by health visitors. In addition to home visits, 94% of all babies were seen in child health clinics in the year they were born (Department of Health, 1990). Births in the UK usually takes place in hospitals. Home deliveries are rare but early discharge from hospital is common with the support of a community midwife for a minimum of ten days and maximum of 28 days. On Day 11 the health visitor assumes responsibility for the care of mother and baby (Mason, 1996). Health visitors spend all of their time on preventive activities. With the exception of immunization, they rarely perform practical nursing tasks. Like district nurses, health visitors usually work within a GP practice (Baker, Bevan, McDonnell and Wall, 1987). Their patient population is the same as that of a specific GP. Health visitors may also work in defined geographical areas. In this case communication with GP's may be infrequent as Health Visitors may have to deal with up to 20 practices. This raises questions about the quality and quantity of future relations with GP's. As noted earlier, GP's are increasingly becoming the centre of ambulatory care and consequently, practice nurses are increasingly taking over the roles exclusively restricted to HV's previously (Symonds, 1997a). Immunizations are also increasingly being performed by GP's or their nurses.

In 1994, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) provided a new term for health visiting, that of public health nursing. According to the UKCC (1994) health visiting has a legitimate claim to such a title because until 1974 they were employed in the departments of the medical officers of health in

local authorities. These departments were the forerunner of today's departments of public health medicine. Furthermore, the emphasis of the health visitors role is on maintaining and improving the health of communities as a whole as well as specific individuals (Council for the Education and Training of Health Visitors, (1977) which according to Kelsey (1995) reflects the ethos of public health.

According to Symonds (1997b) the move in 1974 to assign Health Visitors to GP practices ended the traditional role of the Health Visitors as an autonomous community-based outreach worker. This move was meant to achieve a team approach to primary health care. However, Symonds (1997b) points out, the definition of a team is based on the principle of equal but different status, and of interdependence. This was never true of the primary health care team : doctors were always in charge and nurses deferential (Symonds, 1997b). As recently as 1991, the Queen's Nursing Institute published the report of a primary care specialty group entitled "Quality Through Teamwork" (Queen's Nursing Institute, 1991), which stated that: the best way to provide comprehensive and high quality primary care was through teamwork. Poulton and West, (1993) argue that these claims are largely unsubstantiated by empirical evidence. Although research has addressed the extent to which multidisciplinary teams exist in primary health care, there have been no studies which have examined intraprofessional team working within the wider team's component occupations (Griffiths, Luker, 1994).

One study in 1994 by Wiles and Robison addressed the issue of the nursing profession's views and experiences of teamwork. The study was based on interviews using a semi-structured questionnaire with practice nurses, district nurses, health visitors and midwives in 20 practices. Six topics emerged as important in relation to the views of nurses, midwives, and health visitors and their experiences of teamwork. These were team identity, leadership, access to general practitioners, philosophies of care, understanding of team members' roles and responsibilities, and disagreement regarding roles and responsibilities. Differences in the various views and experiences of teamwork were identified. Midwives and health visitors emerged as the least integrated members of the primary health care team. Recent changes to the organisation of primary health care services, as well as professional changes, are seen as accounting for the different experiences of the nursing groups (Wiles and Robison, 1994). There have also been no studies which have measured the effects of team approach on patient outcomes (Barnard, 1987).

**Community Psychiatric Nurses**

Community psychiatric nurses (CPN's) in the UK are increasingly working in primary health care settings with clients who have mental health problems (Gournay, Brooking, 1995). The workload of CPN's mostly comprises mentally ill adults who are referred to them by psychiatrists. In England, 47.9% of the clients have had previous psychiatric admission, 42.6% comprise chronically ill persons and 26% with schizophrenia (White, 1990). In 1990, 15.3% of CPN's specialised in caring for a particular client group. Of these 28% specialised in family therapy, behaviour therapy (19.5%), and counseling (12.8%) (White, 1990). Between 1985 and 1990, the GP began to refer clients to CPN's (Verheij and Kerkstra, 1992). A study undertaken by Paykel & Griffith (1983) showed that community psychiatric nurses provided just as good after care to clients as routine follow-up by a psychiatrist. Although they were more expensive in direct costs in the first 6 months of follow-up due to increased contact, in the 18 months of the study as a whole,

CPN care was cheaper. The authors went on to suggest that the relative achievements of CPN follow-up could continue and become more marked as time went on. There was, however, no data to substantiate this assertion.

**School Nurses**

The school health service in the UK was established in 1908 with the Education Act of 1907 which provided for the appointment of medical officers and school nurses (While and Barriball 1993). While and Barriball (1993) conducted a review of the literature pertaining to school nursing. The review revealed that the work of school nurses initially was concerned predominantly with screening and as assistants to the school medical officer. The relatively limited empirical work suggests that schools nurses have the potential to make a major contribution to the health of school children; however, their current role appears to vary enormously nationwide and the issues of competency for the role and integration into the school team is identified as requiring study. While and Barriball (1993) also found that while schools nurses perform their roles in such different way, outsiders and consumers are not presented with a consistent image of the role. This leads to a mismatch between expectations and service provision (Perkins, 1989). The authors of the review called for urgent research for this service if practice and delivery are to be both effective, efficient and cost effective, thus resulting in benefits for the health of school children.

**McMillan Nurses**

In the UK in 1975, the first MacMillan nursing posts were established in South West England with the aim of improving care for people with cancer and their families and thereby enhancing the quality of their lives. From their inception the posts were viewed as complementary to services already available to patients. Since those first appointments, the demands for posts has increased dramatically, so that now there are more than 1,000 Macmillan nurses working throughout the UK. However, MacMillan nurses are responding to change by adapting their role to that of clinical nurse specialist (Webber, 1994).

A postal survey of 148 district nurses was carried out by Hatcliffe and Smith (1996) to explore district nurses' experiences of terminal care and their views of the McMillian nurses (palliative care team). The questionnaire was completed and returned by one hundred and twenty nine district nurses (overall response rate of 87%) from four community trusts. The researchers attributed the high response rate to reflect the district nurses desire to provide high quality care to clients requiring palliative care. The researchers found that size of case load, lack of knowledge and experience in managing difficult symptoms as well as time constraints were all factors which appeared to hinder the district nurses' achievement of quality care. They found high levels of satisfaction with the palliative care team but a need for further education and improved communication. An earlier observational study conducted by Griffiths and Luker (1994) found district nurses referral to clinical nurse specialists (CNS), including McMillan nurses, varied. Most district nurses preferred to consult with the CNS to draw on knowledge to improve the quality of care to her patient rather than allow the CNS to do 'hands on' care. Some district nurses felt that as they had more time and less heavy caseloads they would have preferred to carry out the work of the CNS (palliative care) themselves.

### Registered Mental Handicap Nurses

Registered Mental Handicap Nurses called community mental handicap nurses (CMHN) work with children and adults in both residential and family home settings. According to the Royal College of Nursing, (RCN, 1992) Community Mental Handicap Nurses should have a second community qualification. A key skill is to access the potential of people with learning disabilities and assist them with the help of their families or carers, to reach their full potential. The objective of CMHN's is to help people with severe disabilities to live at home and to achieve a quality of life which increases both their self-esteem and their personal and social fulfillment (RCN, 1992).

### Community Midwifery

Similar to Ireland, midwifery in the UK originated in the community. However, with the advent of hospital births and the decline in home births in the 1940's, most midwives became employees of local authorities. After the Health Service Reorganisation Act 1973, community midwives were no longer employees of local authorities but like hospital midwives became employees of health authorities. The concept of the midwife being part of a team was developed and many community midwives became 'general practitioner attached' which resulted in a loss of autonomy for many community midwives (Leap, Heptinstall, 1997).

Throughout the 1970's and 1980's the home birth rate was reduced to 1% of total births. Thus the focus of community midwifery became postnatal visits with some midwives developing the "Domino" (Domiciliary Midwife In and Out of hospital) scheme which enabled community midwives to provide intrapartum care in hospital with an early transfer home. According to Leap and Heptinstall (1977) there is a move towards a more integrated role, with midwives moving between hospitals and community, providing a service which enables women to have more choice, control and continuity of care in childbirth. Such schemes were developed by the Winterton Report (House of Commons, 1992) and as a response, the government asked Lady Cumberlege to set up a committee to review policy on the NHS maternity care, and to make recommendations. The report of this Expert Maternity Group Changing Childbirth (DOH, 1993) set objectives and action points for both purchasers and providers of maternity care. Community based care and active user involvement in planning and reviewing services are central themes of this report : "services should be based on an understanding of local health, social and cultural needs" (DOH, 1993, p. 83). There have been many community-based midwifery schemes initiated in the UK over the past fifteen to twenty years. The most notable have been the "Know Your Midwife" (KYM) scheme (Flint, 1986). This scheme marked a significant shift in emphasis in antenatal care, from a service characterized by clinical interventions to one that stressed the importance of social care (Oakley, 1992). It has also been suggested by some community midwives that caseload practice is an ideal way to provide woman-centred continuity of midwifery care (Leap, 1994). In 1994 the South East London Midwifery Group Practice became the first group of self-employed midwives to be contracted by the NHS. This group is one of three pilot schemes aimed at providing examples of how caseload practice can be implemented within a community setting (Reid, 1994). Thus the continuing of these schemes will enable women to have more choices about childbirth and hopefully it will also mean that midwives will move more freely between hospitals and community (Leap and Heptinstall, 1997).

### Home Help Services

Home help services in England are not considered to be a part of the health care system at the local level, and yet are a very important complementary support to community nursing. Consequently they operate independently from the NHS. These services are locally organised and funding varies from area to area. In general the agency charges individual patients dependent on their income. Usually a district nurse only has to deal with one home help service agency. Regular contact is not a feature between these services. Similarly, health visitors also consult home help services infrequently, only when clients need referral to this service or when extra help is required. Many hospitals employ liaison district nurses who are responsible for the continuity of care between primary and secondary care and these liaise with the home help services.

### Summary

Community nursing in England originated from the two district roles of health visiting and district nursing. The health visiting role is similar to that of the public health nurse in Ireland. It was initially based on environmental health issues such as sanitation and hygiene but has developed to focus more and more on child health care and on that of the healthy population. District nursing originated in home care of tuberculosis patients especially in the poorer areas. The role has developed to include caring for sick elderly people in their own homes. There are now other nurses working in the community, including; community psychiatric nurses, community midwives, school nurses, McMillan nurses and community mental health nurses. Due to reforms within the NHS, including the extension of the GP fundholding scheme, community nurses may be employed by one of several different organisations. Increasing numbers are working from GP practices unlike Ireland where all public health nurses are geographically based. Working from a GP practice has the disadvantage that the patients of a GP who do not live in a geographically defined area cause ineffective use of community nursing services due to long distances being traveled. The environment of continuous change has created conflict between disciplines and within community nursing. The introduction of nurse practitioners and general practice nurses whose precise role definitions remain unclear is also causing problems. The concept of primary health care teams, providing comprehensive and high quality care remains a contentious issue for community nurses in the UK.

## 2.3 Community Nursing in Finland

### Historical Perspective on Community Nursing

Public health nursing in Finland dates back to the beginning of this century. At that time, similar to other countries, it was a poor, agrarian country with a high birth rate. Nutrition and housing were inadequate, infant mortality was high and communicable diseases such as tuberculosis plagued the population. Nurses had been trained in Finland since 1889 and midwives since 1816 but in 1913 the training of tuberculosis nurses began and soon followed in 1920 with courses on child health and school nursing. Thus, as a result of experimentation and evaluation, training was integrated in 1924 in the form of a six-month postgraduate course in public health nursing (Siivola, Martikainen, 1990). A family-centred service was seen as the most effective model of care for public health

nursing. The public health nurse in a small area would deal with all the nursing services needed. The first regulations prescribing tasks and policies for public health nursing were drafted in 1911 and 1924. The Public Health Nurse was to familiarize herself with local housing conditions, nutrition, life-styles, habits and prejudices. She was responsible for health education in homes and communities and required to provide support for the care of the sick and the prevention of disease (Siivola, Martikainen, 1990).

It was not until the 1940's that a comprehensive public health nursing system covering all municipalities in Finland was created. Up to that time within each area the necessary nursing care, including primary preventive and curative services was usually provided by one public health nurse. In the 1970's Public Health Nurses in Finland began to specialize in activities such as family planning, maternal health, child health, school health, occupational health and home nursing (Lauri, 1989). Today, Public Health Nurses mainly focus on specific preventive care programmes for nationally defined target populations (e.g. all pregnant women and all children aged under 7 years) (Lauri, 1989).

From the very outset public health nurses in Finland had close co-operation with local physicians (GP's.) and midwives. The publicly run multiprofessional health centres were formed in all municipalities under the Primary Health Care Act 1972. In the 1970's and 1980s, the number of physician's employed by the health centres increased more rapidly than the number of public health nurses. In 1990, there were 2,200 inhabitants per physician and 1,100 inhabitants per public health nurse employed by the health centres (Koponen, Oksanen, Pertila and Aro, 1996). In addition to public health nurses, other registered general nurses have been employed by the health centres. These registered general nurses focus on the chronically sick and elderly patients. In 1990 national statistics indicated that there were about 3,700 inhabitants per registered nurse in out-patient care in health centres (Finnish Union of Public Health Nurses, 1995).

Finland is a country of five million inhabitants. Most of the population live in the south of the country and in urban rather than rural areas. Whilst the size of the population has remained fairly stable, the ratio of people over 65 years of age has steadily increased from 7% in 1960 to 13% in 1989 and is projected to be 21.7% by the year 2020 (Verheij and Kerkstra, 1992). The infant mortality rate in 1992 was 4.3 per 1,000 births which according to the WHO (1991) is amongst the lowest in the world. The total health care expenditure in 1991 was 9.1% of the GDP (Finnish Union of Public Health Nurses, 1995).

The organization of primary health care in Finland is organized separately and was established with the Primary Health Care Act, 1972. This act made primary health care a priority by emphasising health promotion and preventative work. This was facilitated by a reallocation of resources to areas of need. The municipal health centre is the focus of primary health care within communities and is publicly run by multi-professionals. However, a 'health centre' does not mean a single building or building complex, but does refers to the single organizational entity supplying the services. The different professions within the health centre are not usually located in the same building (Weale and Wildman, 1995). Primary health care includes services that do not require the competence of a clinical specialist. No referral is needed, and the primary health care services are the normal entry points to the service system as a whole. The health centres normally also incorporates a local hospital for minor illnesses, non specialist care, chronically ill patients, and patients under observation. Health districts have about 25,000 beds. Homes for the elderly are part of the municipal social service system. The health centre activities can be grouped into three categories : preventive services, ambulatory care and hospital services.

Preventive services include maternity and child health services and school health care. Small local authorities tend to have a co-operative provision of health services. In 1992 there were 216 health centre districts. On 31st December, 1994, Finland had 455 municipalities (Finnish Union of Public Health Nurses, 1995).

**Organisation and Delivery of Services**

In primary health care the model of care for community nurses is either individual based, family based or community based. Community nursing is provided by three types of nurses: public health nurses, registered nurses and practical nurses. Education as a registered nurse has ceased to exist since 1987. The term is still used however for all those who graduated after 1987 for those who did specialize in a field other than public health. Becoming a practical nurse takes 1.5 to 2.5 years, dependent on previous education. Public health nursing is considered a specialism and education for practice varies from 3.5 years to 4.5 years, dependent on previous education. A Master's or doctoral degree in health care with public health nursing as a major subject, may be obtained with further university education. (Verheij and Kerkstra, 1992). Public Health Nurses are concerned with both curative and preventive care. RGN's are mainly concerned with curative care and practical nurses are concerned with basic nursing care such as personal hygiene and safe environment. Community nurses usually work from 08.00hrs to 16.00hrs but they may also have regular consultation or care hours in the evenings. Urgent cases are cared for at night and weekends, and many health centres also supply regular community nursing services at night and weekends for patients needing care and support (i.e. chronic, terminally ill). Registered nurses and practical nurses do not care for pregnant women, mothers, newborn and school children. Rather they make home visits to the elderly. The public health nurse also makes some home visits, but considerably less than in the 1940's and 1950's, when home visits were in fact virtually the only way public health nurses were able to gain access to clients. Today a substantial number of client contacts are made at the health centre. One nurse is accountable for care within a specified geographical area; this includes promoting and maintaining the health of the population, preventing illness and providing rehabilitative care and care for the dying (Finnish Union of Public Health Nurses, 1995). In addition to public health nurses, other registered nurses provide care to the chronically sick and elderly patients. In 1990, there were about 3,700 inhabitants per registered nurse in out-patient care in the health centres (Finnish Union of Public Health Nurses, 1995).

Implementation of a population responsibility principle in Finnish health centres began in the late 1980's. Demonstration projects were initiated in the municipalities. Small geographically defined districts (usually 1,500-6,000 persons) were formed and each citizen was assigned to a personal doctor. The team which consisted of a doctor, public health nurse, other community nurses including midwives, receptionist, home help aides and sometimes a social worker, were responsible for preventive and curative services for the people living in the district. Health centres offer both maternal and child health care. Women visit the maternity clinic regularly and usually before the fourth month of pregnancy, because only by doing so will they receive maternity benefit. All births take place within hospitals and there is no indication that this situation is likely to change in the foreseeable future (Weale and Wildman, 1995). Public Health Nurses had traditionally worked in their own districts but these were now adapted to be consistent with the

geographical boundaries of other team members (Koponen, Helio and Aro, 1997). Most nurses in Finland work in terms of a specialized model, delivering only one service, e.g. maternal or child care. The Organization of Community Nursing in the 'population responsibility project' makes a distinction between three models for public health nursing. There were three different task division models and all are in operation in the service. In the first, the comprehensive model, PHN's covered the areas of maternity and child health, school health and open clinic health (ambulatory care) for the citizens in their area. Most of these PHN's also had some nursing responsibilities. In the second, the semi-comprehensive model, the PHN's were engaged in several fields of activity, serving different sub-populations e.g. a combination of school health and home nursing. However, there was no longer continuity of care with families as in the case of the comprehensive model. In the third, the specialized model, the PHN's had responsibility for one or two fields of activity that were closely related to each other with a similar sub population (e.g. maternity health and family planning) (Koponen, 1995).

**Evaluation of the Population Responsibility Principle**

One recent qualitative study conducted by Koponen et al (1997) examined PHN's experiences of primary health care based on the population responsibility principle. The sample consisted of PHN's in ten health centres. A questionnaire was developed based on a qualitative study. The study was conducted in 1990 and repeated in 1992 . The response rate was 84% for 1990 (n =102) and 91% for 1992 (n = 131). In the multivariate analysis of variance type of community (urban/rural), size of the target population, task division model and existence of regular teamwork between social and health care personnel were chosen as the contextual factors to be studied. Age, length of professional experience and having specialist education in midwifery were chosen as personal factors. Dependent variables were: experiences of planning and implementation, perceived influence of population responsibility on nurse – client relationships, comparison with previous experiences, views and experiences on comprehensiveness of care or job satisfaction. The results indicated that the majority of the PHN's experienced only minor changes in their work after the implementation of population responsibility. According to the researchers this may indicate that many PHN's perceived population responsibility primarily as a way to develop medical services, not their own nursing roles. They were most critical about the way changes were planned and implemented, although changes were mainly perceived as positive. When the 1990 and 1992 samples were compared there was a shift from negative and positive responses to more neutral responses and to slightly greater job satisfaction. The researchers suggest these differences are primarily due to changes in the frequency of the different task division models, particularly because the specialized model had become less common. PHN's within the comprehensive model had most positive experiences, more so in urban areas. Several contextual factors were multi-dimensionally related to the PHN's experiences.

The implementation of the population responsibility principle has been evaluated from the point of view of the population, in a study reported by Koponen, Oksanen, Perttila and Aro (1996). The study was conducted to evaluate potential access to personal community nursing services and the desirability of these services from the point of view of different population groups. A random sample of the total population aged 16 to 79 of the ten areas where the population responsibility principle had been implemented, was

selected. The sample was stratified by community and age group. About 20% of the original sample were excluded because they did not have a telephone or were not listed. Thus the results of such a study could not be interpreted for the general population. The final response rate was 71% (n = 2917). A computer-assisted telephone interview with the population was conducted by trained interviewers and the questions asked related to: the use of medical services, self-perceived health status, potential access to and the desirability of personal medical and nursing services. The researchers acknowledged limitations regarding validity and reliability, firstly due to the possibility that respondents may have different images of nursing services, and also that telephone conversations are sensitive to many disturbances during the interview. The results indicated that gender, type of community and employment status had superior explanatory power in having potential access to personal nursing services and in considering these services desirable. However, many of those who considered personal nursing services desirable, indicated that they did not have potential access to such services. It is interesting to note that elderly people over 80 years were not included in the original sample, and also the method used in this study (CATI) may have excluded many potential users of community nursing services : people with diseases or disabilities who could not be interviewed by telephone because of difficulties in communication, and the poor who did not have a telephone. If these groups had been reached, the results might have revealed an even greater imbalance between considering personal nursing services desirable and having potential access to them (Koponen et al, 1996). The researchers suggest that the idea of having personal nurses may be too individualistic and even contradictory to the development of population focused care. This study suggests that there seems to be a need to inform the public about nursing services and to clarify the scope of nursing.

**Summary**

The organisation of health care in Finland is similar to that in the UK, with a system of central regional and local administration. The Ministry of Social Affairs and Health is responsible for planning, resource allocation, research and development. Responsibility for health care is given to local authorities under the supervision of the state who contribute to the funding of services. Primarily health care is a priority in Finland with the health centre as the focus of services. Public health nurses are concerned with both curative and preventive care in a defined geographical area similar to the Irish model of community nursing. However, unlike their Irish colleagues, Finnish public health nurses make considerably less home visits. The majority of client contacts are made at the health centre.

The population responsibility principle project was implemented to support the development of health centres towards population responsibility and to provide multiprofessional primary health care services for people living in the area. This project has been evaluated from both the public health nurses' experience and the clients' experiences. Evaluative studies similar to those conducted in Finland are extremely beneficial to the organisation, effectiveness and improvement of services but unfortunately are not carried out routinely in other countries.

## 2.4 Community Care in the USA

### Historical Perspective on Community Nursing

In the United States of America (USA) home health nursing in the 1990's is a intrinsic part of Public Health Nursing which began in 1892, as an organized Visiting Nurse Service of the New York City Mission's Woman's branch. These women began making home visits in 1888. Lillian Wald described as the First Public Health Nurse by Lavinia Dock, followed the mission's example when she started the Henry Street Settlement House, where community nurses helped individual families. At this time American cities were plagued by overcrowding, recurring epidemics, adequate sanitation and the collection of putreying matter (Heinrich, 1983).

Lillian Wald had been influenced by Nightingale (viewed as the founder of modern nursing) whose prescribed curriculum for student nurses from the 1860's onwards included environmental studies, such as public health and sanitation. Ms Wald was convinced that environmental conditions as well as social conditions were the causes of ill health and poverty, and thus became actively involved in using epidemiological methods to campaign for health promoting social policies. She also helped to establish rural health nursing services through the Red Cross. Simultaneously, nurses were organizing into national groups. In the USA in 1895 the Associated Alumnae of Training Schools for Nurses was established, which in 1911 became the American Nurses Association. In 1912 the National Organization for Public Health Nursing was voted unanimously into existence with Lilian Wald as its first president (Dock, 1922) cited in (Stanhope & Lancaster 1996). The purpose of the Visiting Nurse home visit in Brooklyn was to care for the sick and to teach hygiene. According to Bittel (1988) sterile techniques were not a feature in those visits. The emphasis was on cleanliness. The perspective was that the home was the first point of contact on any one needing health care or health instruction, the sum total of nursing. It was this focus that prompted the first home health care visits in 1888 and remains the focus for home health care nursing today (Kirkis, 1993). The early twentieth century witnessed multiple improvements that both directly and indirectly affected health status. Several significant events influenced the further development of community health efforts in the first half of the twentieth century, including two major wars and an economic depression. The frontier nursing service was influential in the development of community health programs and was characterized by a unique pioneering spirit.

The Social Security Act of 1935 attempted to overcome the national setbacks of the depression, thus it expanded community health nursing. Over the years, community health nursing evolved from a home care service characterized as being delivered by caring women who ministered to both the health and spiritual needs of individuals and families, to a broadly based population focused discipline that considers individuals, families, groups and communities as its scope of practice (Stanhope and Lancaster, 1996). During this period nursing leaders in the USA envisaged a new social role for nurses as health educators in the community. Health education by the visiting nurses became a major factor in the prevention of diseases and infant mortality (Buhler-Wilkerson, 1985). Nursing was conceptualized as holistic, including physical, social and mental aspects as well as promoting healthy lifestyles in the neighbourhoods, homes and schools. Thus in order to educate nurses properly for this independent role in the community, university

programmes were on offer to public health nursing students in the USA by the early 1900's (Boschma, 1994).

**Distinction Between the Terms Public Health Nursing and Community Health Nursing**

In the USA there are a number of organizations for home care and community care which all originated from public health nursing. Public health nursing organizations focused on public health in general in the community. Public health nurses have learned to be 'functional', that is, the form of their practice has from the beginning, followed the functions required by society (Salmon White, 1982). Lillian Wald's founding vision of Public Health Nurses in 1893 was one in which their services reflected the constantly changing needs of the people, rather than a template of what a nurse should do (Buhler-Wilkerson, 1993). In recent years however, according to Salmon (1993) this responsiveness has led public health nurses to assume a more clinical, illness-oriented role rather than the traditional home and community based preventive role. This, Salmon (1993) states has given rise to a case of 'mistaken identity' (p. 1674). For many years now, health departments worldwide have been moving away from public health issues in general, towards providing services for the population as discussed in Chapter One. Public health nurses particularly in the USA have made these services possible. The new assignments however, have diverted public health nurses from their central roles in assessment, surveillance, policy and health promotion and disease and injury prevention activities (Anderson, O'Grady and Anderson, 1985). Thus, as American health departments came to look more like other types of delivery systems, public health nurses came to resemble other nurses providing personal care services in the community (Anderson et al, 1985). However, Lent (1993) does not share the view that public health nurses have a mistaken identity. She claims that the idea that one nurse focuses more on preventive work than another is merely a form of speech, and in many communities has been a source of great difficulty in procuring and retaining the nurse who actually provides bedside nursing and education at the same time.

The American Nurses Association (1980) describe the major objectives of the community health nurse to be the preservation and improvement of the health of the community. Stanhope and Lancaster (1996) states that one way to look at the relationship between public health nursing and community health nursing is to view public health nursing as a specialised field of practice with certain attributes within the broad arena of community health nursing. According to Kuss, Proulx-Girourard, Lovitt, Katz and Kennelly (1997) public health nursing is a subspecialty of nursing, with a specialised function in health promotion and illness prevention through population based interventions as opposed to the individual client.

The term community health nursing was first used when the American Nurses Association (ANA) sought to define all nurses working in scattered community settings. Community health nursing was used as an umbrella term for all nurses working in the community, including those who had preparation in public health nursing (Kuss et al, 1997). According to Rothman (1990), the community is viewed as the setting for community health nursing practice. According to Verheij and Kerkstra (1992), the term community nursing was invented for those types of nursing of which the main concern was to care for individual patients or families. The following terms refer to various types of community nursing, home health care (general care at home), hospice care (for terminal illness), ambulatory care (outpatient care), school care and occupational care (care

organized by employers). Another type of community nursing is provided by nurse practitioners, who have masters degrees in nursing. Most nurse practitioners work independently, often reimbursed by governments and often from an ambulatory care setting. This nurse is allowed to do physical examination, assesses a patient's health history, refers to other care providers and does some limited prescription.

The setting in which public health nurses work has to be primarily in official health agencies, or tax supported agencies with legal mandates. The public health nurses also differ from community health nurses in client focus. Community health nurses may have individuals, families or communities as recipients of service, but the public health nurses' philosophy according to White (1982) is ultimately committed to the larger population. However, public health nurses also actively interact with the community, families and individuals to promote health while maintaining a focus on the greater population. Thus, whereas the community is the context for the community health nurse, the community and population groups are the client or partner of public health nursing practice (Beddome, Clarke, Whyte, 1993).

Public health nurses move in and are trusted in the community like few other professionals. They can be found in schools, homes and churches and on street corners developing relationships, collecting data, assessing needs and providing care (Stanhope and Lancaster, 1996). In addition, with the knowledge that public health nurses have regarding community resource, they, according to Bower (1992), make excellent case managers. The issue of generalists versus specialists in community nursing will be discussed further in Chapter 3 of this report.

**Organization and Delivery of Services**

In the US there are two types of organizations that provide home health care. The Visiting Nurses Association/Agencies and the home health agencies. There are no principal differences between these types of organizations,. However, distinctions can be made; firstly between medicare-certified and non-medicare certified agencies. Secondly between private and public organizations, and thirdly between non-profit and for-profit organizations. The for-profit sector is said to be rapidly developing (Fry, Light, Rodnick and Orton, 1995). As of February 1990 there were 5,701 medicare-certified agencies and 5,500 non-medicare home health agencies in the USA (Stanhope and Lancaster, 1996, Verheij and Kerkstra, 1992).

The Visiting Nurse Service of New York (VNSNY) was the first secular based home nursing service established by Lillian Wald in 1893, who as previously mentioned, was one of the pioneers of home nursing in the USA. The organization's purpose originally was to provide services to the poor, but during the 20th century the services extended not only to provide nursing care but also social work and home health aid (Buhler-Wilkerson, 1993). This organization is a Medicare-certified non-profit private visiting nursing service. The Visiting Nurse Association of Greater Philadelphia (VNAGP) started at the end of the 19th century as an organization for preventive mother and child care, teaching health care to mothers with babies to reduce infant mortality. It developed into a non-profit medicare certified organization delivering all kinds of nursing care including, since 1991, rehabilitation care and home health aid. According to Stanhope and Lancaster (1996) government sponsored home care services are primarily funded through the Federal Medicare program. Additionally, the Medicaid program does allow non-privately insured individuals to purchase home care services in the private market. The most important

sources of income for the VNSNY as well as VNAGP are Medicare and Medicaid. Additional sources of finance for the VNAGP consist of funds raised in the community from private and corporate grants (Verheij and Kerkstra, 1992).

Within the VNSNY organisation a number of programs are available for various types of patients and problems. These include: home health intake (i.e. employs coordinators in 20 hospitals to facilitate discharge planning), hospice program for the terminally ill, adult care programs providing short and long term medical nursing, supportive services and rehabilitation therapy, programs to address the poor health status of infants and children, AIDS service, community mental health services and nutrition oncology and vascular access programs. Nurses in the VNSNY are in most cases specialized in one of the services mentioned above. In 1989 there were 3,500 public health and professional nurses in the VNSNY, in addition, there were 100 licensed practical nurses. According to Moses (1990) cited in Verheij and Kerkstra (1992) in 1988 registered nurses in the USA had varying qualifications, 31% had diploma, 21% associate degree, 37% baccalaureate, 10% masters and 0.1% doctorate. Licensed Practical Nurses (LPN's) have completed a one year program after high school. Nurses aides, orderlies, and attendants usually have on the job training, sometimes with a short formal training program (Roemer, 1986). According to Moses (1900) cited in Verheij and Kerkstra (1992), 6.8% of the total number of Registered Nurses were employed in the community. Thus, the type of nurses employed by the VNSNY include: public health nurses, registered nurses, licensed practical nurses, pediatric nurses, psychiatric nurses and nurses specifically trained to provide infusion therapy. Other personnel also include: physical therapists, nutritional consultants, social workers and volunteers.

The VNSNY employ public health nurses who have completed a four year BSc degree in nursing, at university. Registered nurses hold an associate degree obtained after two years at university plus one year's experience. Pediatric and licensed practical nurses hold a university associate degree in nursing and specialist nurses hold a BSc degree in nursing plus a specialist certificate (Verheij and Kerkstra, 1992). In their client populations, 65% are adult care patients with more than 50% over 65 years, 22% are maternal/child health, 8% pediatrics and the remainder divided equally among AIDS patients, hospice care, long term care and infusion therapy care patients.

**Community Nurse Organization Project**

Recently in the USA, some agencies are participating in the Community Nursing Organization (CNO) Medicare demonstration project funded by the Health Care Financing Administration. Although the care services provided by each CNO site are focused similarly on nursing interventions and case management, of elderly persons, each site has implemented the nursing role in a slightly different way. Thus the author will concentrate on the Visiting Nurse Service (VNS) of New York as one of four sites participating in this project. The CNO is a division of the Medicare-certified home health program of the VNSNY discussed above. Thus their resources, e.g. specialized nurses are available to the CNO. The purpose of the CNO and the role of the nurse in the CNO was modeled after the philosophy and successful practice of its founder, Lillian Wald. Two principle concepts were adopted that exemplify this early approach to community nursing : case management and community-focused nursing provided by home health nurses. According to Bergen (1997) case management is a way of tailoring help to meet individual need through placing responsibility for assessment and service co-ordination with one

individual worker or team. The purpose of the project was to test a nurse-managed model of community health services and to test a capitated reimbursement system with a group of Medicare Community based services. The success of the project will be measured, based on its efficiency and cost effectiveness (Storfjell, Cruise, 1994).

Case management is the core of the CNO nurses' responsibility. The innovative community-focused model uses the nurse as case manager to provide health promotion, screening, and early interventions to clients enrolled in a CNO. These responsibilities include a focus on community. Nurse consultants case managers are assigned a caseload of enrollees in a specific geographic area. Visits may be made to their homes or at the local health centre. The focus is both on health promotion and the provision of nursing interventions as required. A mix of specialized nurses with varied educational and experimental backgrounds are included in the nursing staff. Caseload size varies according to the number of enrollees who are able to access their nurse at the health centre (site) the number who are ill and the number of home bound enrollees (Storfjell, Mitchell, McCormack and Daly, 1997). Nurse consultants actively participate in the recruitment of members and most elderly like the idea of a "named nurse". Computer systems were developed to allow information such as demographic, social, medical and nursing diagnosis, interventions, complexity – of care cost etc. to be monitored over time. This allowed for care plans to be easily compiled and updated accordingly (Daly-Mitchell, 1996). Care plans range from providing preventive services and promoting healthy behaviour to controlling the progress of chronic illness and disability. However, Storfjell et al (1997) state that one of the most important interventions is the development of the caring relationship between the enrollee and the nurse. Thus, it is imperative that community nurses are 'good communicators' and adequately trained in areas such as counseling. Community Nursing Organisation nurses provide necessary home health nursing services (as defined by Medicare) in addition to case management responsibilities. In fact, according to Storfjell et al (1997) fewer home health nursing and home health aide visits have been required per episode by CNO enrollees compared with Medicare health maintenance organization patients who are referred to VSSNY for home health care. Furthermore, the nurse consultant continues as the enrollee's nurse after the enrollee is no longer eligible for Medicare – reimbursed home health services. The service enhances continuity and encourages members to resume their previous level of functioning because they do not "loose" contact with their nurse.

The CNO nursing staff includes diploma, associate, baccalaureate and masters prepared nurses. The advanced practitioner nurses use their assessment skills in treating the "well population" (Daly-Mitchell, 1996). In addition the advanced practice nurses act as consultants to other CNO nurses, including providing staff development programs.

The CNO implemented a flat organizational structure, with the nurse consultants reporting directly to the program director. This has resulted in a reduction of barriers to decision making, easy access to expertise and reduced costs. Regular team meeting are also used for group problem solving and decision making (Storfjell et al, 1997).

Nurse consultants have both a clinical and fiscal responsibility for caseload. They must meet enrollees' health care needs while attempting to manage and reduce costs – both CNO costs and health care costs (Storfjell et al, 1997). According to Storfjell et all (1997), it will take a number of years before the real impact of the CNO on the utilization of home health and other health care services are known. The first years indicate that there is a reduction in the use of home health services by enrollees compared with regular VNS

clients. In addition, the VNS CNO has been able to maintain its financial viability with a capitated reimbursement system.

The VNAGP is a much smaller organization than the VNSNY. Their nursing personnel include advanced practice nurses in medical/surgical specialty, psychiatric specialty and infusion care specialty. Their general nursing staff include maternal/child health nurses and medical/surgical health nurses. The advanced practice nurses are clinical specialists with a masters degree in nursing, or diploma in nursing or a B.Sc. (nursing) combined with a specialty course of 12 months. The general nursing staff hold a diploma or a B.Sc (nursing) degree. Licensed practical nurses are not employed by the VNAGP. More than 90% of their total client population are over 60 years and about 80% receive post-operative and aftercare (Verheij and Kerkstra, 1992).

In the US the specialty of school nurses as a component of community nursing was also introduced by Lillian Wald. In 1897, in response to severe problems with contagious conditions among many of New York City's public school children, the city's department of health hired 150 physicians for one hour per day to inspect children at school (Pollitt, 1994). This program, however, was unsuccessful in addressing the problem, so the chairman of the Board of Education and the city's health commissioner sought the advice of the Henry Street Settlement Nurses. Lillian Wald suggested a school-based nurse who would actually treat children to the extend possible at the schools, make home visits and establish health education programs for children and their families. This was found to be so successful that by 1905 New York City had 50 school nurses which grew into the New York City Bureau of Child Welfare (Pottitt, 1994).

In the century that has elapsed since those early days of community nursing activities, public health nurses and school nurses have been separated into two distinct fields of nursing at the community level. According to Stanhope and Lancaster (1996) public health nurses attend to increasingly complex health needs of field-service-home visit clients, and of clients seen in public health clinics. Meanwhile, issues and policies that challenge school health programs have required that school nurses carry increased responsibility in order to meet even the most basic health needs of children in the school setting (Jossens, Ferjancisk, 1996).

**Summary**

Community health nursing the US, similar to European countries, originated in public health issues, such as environmental conditions as well as social conditions. Lillian Wald described as the first public health nurse, in the USA, became actively involved in using epidemiological methods to campaign for health promoting social policies. However, as in other countries, the health department has been moving away from public health issues towards providing services for the population and thus public health nurses came to resemble other nurses providing personal care services in the community. The American Nurses Association made the clear distinction between community nurses and public health nurses where the public health nurses' focus is the community. Public health nurses operate in and are trusted in the community like few other professionals. The Visiting Nurse service of New York and the Visiting Nurse Association of Greater Philadelphia were started at the end of the nineteenth century. The VNSNY established by Lillian Wald, is funded by Medicare and Medicaid and also receives funds raised in the community from private and corporate grants. They provide a number of programs for various types of patients and employ public health, community health nurses and specialty

nurses. The Community Nurse Organization project, of which the VNSNY participates, provides nursing interventions and case management to elderly persons. The role of the nurse is modeled after the philosophy of Lillian Wald, utilising case management and community focused nursing. Similar to the Irish public heath nurse, nurse consultant case managers are assigned a caseload of enrollees in a specific geographic area. The focus is on both health promotion and the provision of nursing interventions as required. A mix of specialized nursing skills with varied educational and experimental backgrounds are included in the nursing staff, with the advanced nurse practitioners providing consultations and staff development programs.

## 2.5 Community Nursing in Canada

### Historical Perspective on Community Nursing

In Canada, the Victorian Order of Nurses (V.O.N.) was created in 1897 to provide care in the home to the sick and dying and to women during childbearing in cities as well as in rural areas. The organization is the largest non-governmental organization for home care services with branches in nine provinces (Pringle, 1989). The Organization provides preventive as well as direct care services. Until 1975 there were no provincial branches. Each local branch managed financing itself. Governments began to develop insured home care services and contracted with V.O.N. to provide nursing services. The provinces control health in Canada so it was necessary to develop a mechanism to negotiate with governments for fees rather than having each local branch conduct its own negotiations. Therefore, a provincial board was established and provincial Executive Directors hired (Verheij and Kerkstra, 1992).

In Canada, each province is responsible for establishing its own health policies. Community nursing is no exception to this, and consequently there are twelve ways of organising community nursing in Canada. Each Canadian province has its own eligibility criteria and model of service. According to the Canadian Health Act of 1984 all Canadians are insured for all kinds of health care against no direct costs (Palley, 1987).

### Organisation and Delivery of Services

The following description of community nursing will be partly based on services provided by the Victorian Order of Nurses (VON) who are generally considered to be a home care program. Another part of this description will be based on information from the St. John's District Health Unit in Newfoundland, a governmental organization mainly concerned with public health nursing. The review is confined to these to simplify the description to focus on published materials.

The VON is a non-profit, voluntary organization with units at local, provincial and federal level. Four types of nurses work within the VON: clinical nurse specialists, public health nurses, registered nurses and registered nursing assistants. Nurses are almost always assigned to geographic districts in which they provide all necessary nursing care. However, according to Pringle (1989), there are specialized teams in densely populated areas, e.g. palliative care and dementia management teams. The generalist nurses are still responsible for cases without specialist needs (Verheij and Kerkstra, 1992). The St. John's District Health Unit is divided into five Regional Health Units which are mainly directed towards the prevention of disease, the promotion of healthy lifestyles and the protection from

environmental hazards in St. John's and surrounding areas. The organization is staffed by public health nurses, public health inspectors, a health educator, a nutritionist, a social worker and administrative personnel. Nurses work as a team, conferencing on clients but operating individually, each being individually assigned to a patient.

The VON care for patients in their own homes and provide various services mainly to clients over 65 years. Clinical nurse specialists care for any type of patient, dependent on their specialism. Registered nurses usually work as generalists caring for any kind of patient and delivering any kind of nursing care. Health promotion and assessment of groups at risk is the task of public health nurses. Registered nurse assistants provide mainly hygienic care. St. John's District Health Unit Organization provides mainly preventive services and is categorized into nine programs: prenatal, postnatal, early childhood, school health program; adolescent disease control, public health inspection, community nutrition, adult health program and health education. Most clients have a referral visit which includes care delivered and needs evaluated by the nurse. Standard forms are used for assessment and screening. Almost all patients come into contact with the VON services through a home care coordinator, who is almost always a hospital based nurse, and appointed by the local administration to co-ordinate home care. Patients may also be referred by individuals living in the home. However, in Ontario the influence of the home care coordinator is considered to erode the nurses' autonomy (Verheij and Kerkstra 1992). In small communities an individual nurse may have to deal with up to 6 or 8 homehelp services. VON branch staff maintain relationships with home care programs, homecare agencies, family physicians, physio and occupational therapist agencies. Contacts with GP's usually take place by telephone as well as each nurse writing monthly progress reports on every patient to the GP.

St. John's District Health Unit Organization co-operates with physicians, the Department of Social Services, school staff, hospital referral nurses, liaison nurses and other home care agencies. Public health nurses have ongoing consultations with GP's. The education levels of the four types of nurses employed by VON branches are: clinical nurse specialists who have had a four year university education to achieve a BSc (Nursing) and another two years to receive a Master of Science degree in nursing.

Similarly, public health nurses have a four year university education to achieve a B.Sc. Nursing degree. Registered nurses have a 2 to 3 year course in a community college leading to a diploma. Registered nursing assistants have had a 10 months community college course leading to a certificate. In Ontario, nurses working in hospitals attend university for three years to achieve a diploma in nursing. To work in a public health department, nurses who have a diploma in nursing attend university to achieve a BSc in nursing which includes two modules in public health nursing. Thus all public health nurses are educated to a BSc degree level (Brunton, 1998).

The St. John's Organization employs two types of public health nurses; the first have a three year Hospital Diploma plus one year specialty education in Community Health Nursing and the second has a four year university degree program (Verheij & Kerkstra, 1992). According to Pringle (1989) the Bachelors Degree is increasingly replacing the diploma as the common preparation. Some governments question whether this is a desirable trend and if an academic degree is really necessary to undertake the responsibilities involved in home care nursing (Pringle, 1989). Another problematic issue appears to be that nurses in the preventative sector (public health nurses) are moving increasingly to program planning for groups and communities and away from individual work with clients. This requires a different kind of preparation and education focused on

the community as client as opposed to education which is focused on working with individual clients of all age groups (Pringle, 1989). A third educational issue concerns the other registered nurses, not primarily concerned with preventative care working in the community. Here the dilemma is in the form of generalist versus specialist preparation and the organization of services which will be discussed further in Chapter 3 of this report.

**Public Health Nursing in Ontario**

In 1919, the Ontario Provincial Board of Health received funds from the legislature to place 16 nurses in the province, in an effort to decrease childhood mortality and morbidity particularly in small towns, and in rural and northern Ontario (Stuart, 1992). The reason for this was purely economic. The public health nurse cost about half as much as a doctor. Thus, the Toronto board's policy was to have the public health nurse do as much work as feasible, thus making it possible for the public health physician to spend time doing only those things that demand this special skill and training (Stuart, 1992). In the 1990's public health nurses work under the auspices of the office of Public Health, the official local public health agencies in Ontario. This office is funded from government, municipal and provincial grants and are responsible for all aspects of public health including roads, sewage systems, health promotion, healthy growth and development etc. It is headed by a Medical Officer of health with directors reporting from each program. Public health nurses work under the program "Healthy Growth and Development". The director of this program is a registered nurse with a Master Degree in Management. Nurses are funded 75% by municipal government and 25% by provincial government, and the Director of Nursing has control over the public health nursing budget. There are approximately 150 public health nurses for 500,000 population in the Madison area alone a ratio of approximately 1 : 3300. In 1992, Ontario had 2,000 full time public health nurses. Up to September 1997 Public health nurses worked as specialists in areas such as parent and child health (under 5 years), mental health, sexual health, school health (5-12 years), adolescent health or adult/seniors. Since last September however, public health nurses now work as generalists in their defined geographical areas and refer to their colleagues for advice and support in their areas of specialty. They report to a nurse program manager who is appointed for each ten public health nurses. In their areas however, a group of public health nurses choose a team leader from their group who co-ordinates education, in-service training or specific issues within the group and also carries a caseload (Brunton, 1998).

Clients can self refer, but usually referrals are from hospitals, general practitioners or via the liaison public health nurses in the maternity hospitals. Public health nurses work Monday to Friday 8.00am to 4.00pm mainly on a community level, working with the population and deciding relevant issues. The public health nurse on telephone duty will arrange for home visits to families with special needs, e.g. families with new babies who need help with infant care issues, the homeless, those diagnosed with childhood diseases or poisoning or families recently bereaved.

è The public health nurse provides services not only to families but to neighbourhoods as well (at community centres and other sites). The public health nurses can provide services to individuals, families or groups with the following problems or needs; risk for or exposure to certain communicable diseases, including sexually transmitted diseases, Acquired Immune Deficiency Syndrome (AIDS) education, prenatal care to at risk women, women who have difficulty breast feeding or with postnatal depression. They do

not routinely visit all postnatal women, only those referred to them by the liaison pediatric nurses from the hospitals who refer based on strict at risk criteria. They rarely do "hands on" nursing care but if visiting a postnatal woman with breast feeding problems who had a cesarean section then the public health nurse will attend to the wound and her services will be paid by the home care team. This prevents duplication of services (Brunton, 1998). The public health nurses provide an on-call weekend services for emergencies only, e.g. mother and baby after early discharge from hospital.

**Research on Public Health Nurses in Canada**

In the fall of 1992, a survey of public health nurses who work in official public health units in Ontario was undertaken (Chambers, Underwood, Halbert, Woodward, Heale & Isaacs, 1994). The purpose of this was to determine whether the perceptions of the public health nurses of their roles and activities concurred with a 1990 Canadian Public Health Association (CHPA, 1990) report which describes the roles and qualifications of public health nursing in Canada. The survey questionnaire was completed by 1,849 public health nurses in all 42 public health units (response rate of 85%). The public health nurses activities listed in the CPHA document were condensed into eight broadly defined areas of activity for the survey questionnaire: caregiver/service provider; educator/consultant; facilitator/ communicator/collaborator; community developer; social marketeer; policy formulator; researcher/evaluator; and resource manager/planner/coordinator. Respondents indicated on a five-point Leikert-type scales from 1) how frequently they performed each activity; 2) whether this activity would increase or decrease in future and 3) how well prepared they were to perform the activity. Validity and reliability were assured by the researchers. The results showed that about one tenth of the public health nurses reported no activity as a caregiver/service provider. Most public health nurses reported being active in the roles of educator/consultant, social marketeer and facilitator/communicator/collaborator. The community developer policy formulator, researcher/evaluator, and resource manager/planner/coordinator roles were less frequently performed, however, increased activities in such roles were expected in the future. Nurses said they needed further preparation to perform the latter roles. The researchers acknowledged that the results have implications for deployment of public health nurses as Ontario's health system shifts to community health and health promotion.

A more recent qualitative phenomenological study was undertaken by Leipert (1996) in Northern British Columbia in Canada. This study explored and described the value of community health nursing from the perspective of community health nurses. Eleven community health nurses from the health department, all educated to baccalaureate degree level and working in health promotion/prevention settings were interviewed by the researcher. The research question was; from the perspective of experienced community health nurses, what do community health nurses value about community health nursing? The researcher used the qualitative method of phenomenology to enable him to acquire meaning and understanding from the perspective of participants who are living the reality rather than from the researchers' perspective. Understanding and insight were achieved through repeated, in-depth interviews with participants using open-ended unbiased questions.

Each nurse participant (n = 11) was interviewed twice at the health units and three nurses were interviewed three times. The first two phases of interviews were tape-recorded

and then transcribed verbatim. At the end of this lengthy process, five clusters of themes emerged. Validity was determined by returning to the third interview with the three participants with a description of themes. Reliability was achieved through the consistency of the researcher at reaching conclusions which were later validated by two independent researchers. Results demonstrated five central themes as the essence of the value of community health nursing; 1) Collaborative activities/autonomy, 2) The client/context of health practice; 3) knowledge/attitudes; 4) political visibility/consumer awareness; 5) prevention and cost-effective bases/research. The author concurs with the researcher that the findings of this study are particularly important in the light of recent health care reforms focusing on community care. However, in most westernized countries, who recognise primary health care as the way forward, adequate resources to make the shift from institutional care to community care has not been forthcoming. As this study has shown, part of the reason for paying little more than lip service to community health nursing is the invisibility of their practice. Furthermore, research is recognised as necessary to help articulate the value of community health nursing interventions.

A similar qualitative study to Leipert's (1996) was conducted by Reutter and Ford (1996) to explore how public health nurses perceived their work. Qualitative data was gathered through in-dept individual and focus group interviews with 28 female public health nurses in Alberta, Canada. The analysis revealed that public health nurses perceived their work was valuable and worthwhile, enjoyable, demanding and not well understood by others. The issues that the nurses identified were setting priorities, evaluating effectiveness, and marketing their services. Setting priorities related to making work manageable, and also to redirecting efforts to areas where nurses will 'get results', so that they and others can see the value of their work. Evaluation effectiveness was considered an important step in identifying priorities and in marketing services. Nurses, however contend that their work is difficult to evaluate (Fletcher, Jones, McGregor-Cheers, 1991). While the challenges for evaluating the work of public health nursing are considerable (Deal, 1994), nevertheless, budgetary constraints make it imperative that nurses find ways to demonstrate that they make a difference. Support for the effectiveness of public health nurses' interventions may also help to modify others' perceptions of the value of public health nursing (Reutter and Ford, 1996).

Public health nurses are advocates and promoters of health for their populations. They are striving to deliver a service which is based on research evidence rather than routine based practice (Brunton, 1998). In 1989 the Ontario Ministry of Health revised its guidelines to increase the emphasis on population-based services for targeted risk groups in order to accomplish specific health goals. Many public health nurse leaders viewed this momentum towards population-based services with skepticism and uncertainty (Yiu Matuk, Chadwell Horsburth, 1992). For the past five years public health nurses in Ontario have been funded to examine the effectiveness or otherwise of public health nursing interventions. By reviewing and summarizing the findings of research studies and relevant articles they hoped that the most effective and efficient use of public health resources could be promoted. After an extensive search of the literature, 77 articles were considered to be relevant. The studies were most commonly conducted in the United States (46.6%) and the United Kingdom (25%) while 20% were from Canada. The populations' most frequently involved were the parent-child group, followed by pre-school children. The most common category of intervention was counseling and teaching (87.8%) followed by case management (42%) and assessment (22%). The intervention was most likely to be provided by a public health nurse (55%), followed by other registered nurses (16%) and

other professionals (15%). The intervention location always included the home, but also include phone contact (15%), clinic (13.5%), community (12.2%), hospital (4%), health centre (2%), school (1%) and office (1%). In this way, the home visits were sometimes part of multi-pronged interventions. All outcomes were classified into thirteen categories. The most commonly measured outcomes included those in the categories of physical health status and development (65%), mental health status and development (41%) and knowledge or perceptions (33%).

In summarizing the literature the authors (Ciliska et al, 1993) found no negative effects of home visiting. Furthermore, the studies demonstrated a positive impact of home visiting on physical health, mental health and development, social health, health habits, knowledge and service utilization. Some of the articles reported no effect or selective effects, but the effects seemed to be mediated by intensity of the intervention and pre-existing level of health and social status of the client. The authors also found that interventions had more impact on clients of higher risk (e.g. unmarried, low income teen mothers) than on those of moderate or low risk. The authors acknowledged that some of the studies lacked a strong theoretical framework linking the intervention to the expected outcome. However, the implications for practice were that, although outcomes such as altering rates of low birth rate are very difficult to achieve, adequate (in intensity, duration and content) home visiting interventions for pre and post natal women with risk factors, as well as for the frail elderly, are effective and in some cases have been shown to be cost effective, when compared with control groups who are receiving usual care services. The authors took cognizance of the fact that in health service research problems of design and methodology in randomized controlled trials consistently mitigate against finding a true treatment difference. For outcomes that are rare such as low birth weight or reported child abuse, large samples are required for adequate power to detect small differences between groups. Thus, they suggest, when positive effects are found, they probably underestimate, not overestimate the real impact of the intervention. They concluded that public health nurses are at risk of abandoning an effective strategy, i.e. home visits.

According to Brunton (1998), when the authors of this review presented their findings to public health policy makers, managers and clinicians over a period of five years along with other similar reviews the public health nurses were granted an extra $15M to their budget to support their work with "at risk" children. Thus the public health nursing body in Ontario appointed a project coordinator to facilitate the continuation of looking at research to determine the effectiveness of public health nursing interventions. According to Brunton (1998) a review of the public health nursing intervention in the adolescent suicide prevention program is currently underway as is a review of the effectiveness of public health nursing interventions in parent-child health. The findings from these reviews will enable public health nurses to examine the research for evidence pertaining to public health nursing interventions and enable them to make clinical decisions in designing and implementing cost-effective programs and in advocating for these programs in a competitive health care environment.

**Home Care in Ontario**

Ontario has the largest number of citizens in Canada (10 million out of a total of 25 million). Ontario has recently undergone a restructuring of home care services under a new conservative government. Since October 1, 1997, the pre-existing 38 Home Care Programs in Ontario were replaced by 43 Community Access Centres (CAC) which

provide access to in-home services and admission to long term care facilities. In essence, all 38 existing programs kept their geographical boundaries, and Toronto administration itself decentralized to have six agencies instead of one large agency. In the past, the majority of Home Care Programs (HCPs) were administered by either the local Public Health Board, the Victorian Order of Nurses, or by the local hospital (only 2). Two HCPs were administered by independent Boards. Effective from October 1, 1997, all 43 new CACs are administered by independent Boards, and merged with existing local Placement Coordination Services, which provided assessment and access to long term care facilities. Each CAC is accountable to their Board, as well as the local Long Term Care Office (the provincial government's decentralized office). Each community receives the complete funding for community services, which has to include not only CAC services, but supported housing, attendant care programs, meals on wheels, adult day programs, respite services, etc.

The CACs provide in-home nursing, physiotherapy, occupational therapy, speech therapy, nutrition, counseling, social work, and homehelp service, generally on a visitation basis. In some cases, e.g. palliative care situations, the CAC provide nursing care in the home. Under certain circumstances the CAC also provide medical supplies, time limited rental of certain equipment (for 2 months), and drug coverage. The client must require assistance with personal care in order to receive home help service. The CAC are limited to providing a maximum of 3 nursing visits per day, and 40 hours of home help service per month. They have no maximums on therapy services, but the frequency of service is determined by resources, since a waiting list for therapy services exists. Nursing and therapy staff services from outside agencies are also purchased. CACs are now required to go to tender for any services worth more than $55,000 per year.

The Hamilton-Wentworth CAC, have approximately 7,000 clients on their caseload. They have 73 full time employee (FTE) including 16 full-time Case Managers (CM) in 5 local hospitals, for assessment purposes. They have a Pediatric team of 4 CMs, 4 community-based teams (East, West, Centre and Mountain), each with 12 full-time CMs. About 75% of their CMs are registered nurses, with the remainder being social workers, physiotherapists and occupational therapists. The CM role is not a clinical role, but rather one related to assess for services, co-ordination of services, problem solving, crisis intervention, and client discharge planning.

There is no fee for services. With the closure of many provincial hospitals, increasing demands for service and increasing caseloads have been experienced. However, the government has not given any additional funding to compensate for the additional clients. For example, the same budget for services was supplied in both 1997 and 1995; yet 2,000 more clients were served. This has resulted in waiting lists for all services with the exception of nursing. (6 -9 months for a low priority speech/language pathology referral, and 6 weeks for a low priority home help referral (Carmichael, 1998).

**Summary**

In Canada each province is responsible for establishing its own health policies. Community nursing is no exception to this, and consequently there are twelve ways of organising community nursing in Canada. The description given above was based on the services provided by the Victorian Order of Nurses and the St. John's District Health Unit. The VON provide home care nursing and preventive care similar to public health nurses in Ireland and Finland. However, the VON's public health nurses' role is

specifically that of health promotion and assessment of groups at risk. Registered general nurses are mainly concerned with home nursing care. Almost all patients come into contact with the VON services through a home coordinator who is almost always a nurse. St. John's Health Unit Organization provides preventive services and employs public health nurses only. The public health nurses in Ontario up until September 1997 worked as specialists, however, since then, they now work as generalists in a defined geographical areas, and refer to their colleagues for advice and support in areas of specialised care. They work mainly on a community level, working with the population and deciding pertinent issues. They rarely perform "hands on" nursing but if visiting clients that require both home care and public health nursing service they will provide the service and be reimbursed by the home care team. This prevents duplication of services. They also provide an on-call weekend service for emergencies only. A large survey of public health nurses in 1992 found that one tenth of the public health nurses reported no activity as a caregiver/service provider. However, most public health nurses reported being active in the roles of educator and facilitator. These results have implications for the deployment of public health nurses as Ontario's health system shifts to community health and health promotion. A smaller study of public health nurses showed that the public health nursing service is invisible which accounts partly for the reason that little more than lip service is paid to community health nursing. Thus it was recognised that research was necessary to help articulate the value of community health nursing interventions. Public health nurses in Ontario reviewed the literature pertaining to the effectiveness of public health nurses' home visits and found that there are no negative effects to home visiting. Furthermore, some studies showed visits to be affective and cost effective. Since October 1997, the Home Care Programs in Ontario were replaced by Community Access Centres in which the community health nurse provides a pivotal service.

## 2.6 Community Nursing in the Netherlands

### Historical Perspective on Community Nursing

The population of the Netherlands is approximately 14.7 million people. Similar to nearly all countries of the European Union, the Netherlands is being confronted with a steady increase in percentage of elderly in their population. The proportion of people over 80 years of age, in particular, is increasing rapidly (Organization for Economics Co-operation and Development, 1990). This leads to a rise in the demand for professional home care which is enforced by the fact that the role of informal carers, such as family members and friends, is decreasing in most of the countries. Smaller families, a growth in women's employment and an increasing number of elderly single people are the main causes of this development : it is estimated that in the year 2000, 14% of the population will be over 65 years and this percentage will have increased to 19% by the year 2020 (Verheij and Kerkstra, 1992).

In 1875, ten local community nursing organizations were established. The task of these 'Cross Associations', as they were called, was to combat epidemic diseases and to protect the population from the spread of diseases by disinfecting clothes, furniture and houses. They also lent material like beds and blankets to their members (Verheij and Kerkstra, 1992). Several organizational changes have taken place in healthcare in the last few decades. In the early 1980's there was a shift in governmental policy from specialists and

residential care towards home care and primary health care. As a consequence, from 1980 to 1986 the budget of the Cross Associations was allowed to grow by 4% each year. From 1986 onwards the allowable increase was fixed at 2%. From 1980 onwards, a compulsory public insurance scheme based on the General Act of Exceptional Medical Costs provided all residents with access to community nursing care and requiring no prescription from a physician except for medical treatment. The Cross Associations are funded for about 85% of their costs through the public insurance and the remaining 15% is largely paid from patient's membership fees, which vary regionally.

**Organisation and Delivery of Services**

Community nursing services are provided by a number of organizations which operate nationwide but which do not have the same tasks in every region. These include:

- public health services (communicable disease control, environmental health screening of children between 4 and 19 years of age).
- Occupational health services.
- Ambulatory mental health care.
- A small number of for-profit nursing agencies.
- Cross Associations.

In all of these organisations nurses are employed to work in the community as community nurses, general nurses and nurse auxiliaries. Because the regional Cross Associations and the home care organizations are the main providers of home nursing in the Netherlands, and also because there is sparse information available on the number of private organizations for home care, the author will focus mainly on the Cross Associations and integrated home care organization. Within the Cross Associations an organizational distinction is made between a division that provides community nursing care, (preventive as well as curative care delivered by nurses), and a division that provides maternity home care.

**Maternity Home Care**

Maternity home care provided by maternity home care assistants in the Netherlands consists of:

- assisting GP or midwife during delivery
- physical care with the baby
- helping with breast feeding
- providing general health information looking after family members and some housework.

This care is delivered during the first eight days after delivery (Hingstman and Boon, 1988). According to Dr. van der Zee, (1998) (Director of the Netherlands Institute of Primary Health Care) with whom the author spoke, midwives are considered part of the medical faculty and not nurses in the Netherlands. They provide a domicilary, short stay hospital, or long stay hospital service. Approximately one third of all births in the

Netherlands are conducted at home, one third in short stay hospital (i.e. less than 24 hrs.) and one third long stay hospital (i.e. greater than 24 hrs.). For those women and babies with home deliveries, there is a service provided for eight to ten days where a trained maternity carer comes from the hospital to the home to provide help. After this period the responsibility for mother and baby services transfers to the community health nurse in the area.

After home delivery the new mother recovers from the birth at home. This is also the case if the hospital delivery was normal. Almost 80% of new mothers convalesce from childbirth in their own homes (Kerssens, 1994). In 1989, approximately 140,000 new mothers and babies were helped post delivery by almost 5,600 maternity assistants. There are two basic programmes, one in which the assistant spends eight hours per day with the family (full-time) or the second programme consists of $1\frac{1}{2}$ hour visits, starting with two visits a day and ending with one daily visit. The functions performed are the same as those in day care, but household services are not included. A similar programme is carried out in the UK organised by the domicilary midwife and does not include household duties (Flint, 1986).

In the Netherlands the relative frequency of the two programmes is 67% for day care and 19% for home visits. However, the growing demand for maternity home care is not easily met due to governmental spending cuts and shortage of staff. This has resulted in a situation where day care programmes are not available for everyone and the number of programme days are not always up to standard in spite of the Dutch Government's explicit policy that "without sufficiently available postnatal maternity home care of good quality, a system of home delivers is inconceivable" (Teijlingen, and McCaffery, 1987).

A relatively recent study conducted by Kerssens (1994) examined the accessibility and quality of care provided by maternity home care workers from the patient's perspective. A total of 1812 (81%) women who recently gave birth to a child responded to a postal questionnaire addressing the quality of care according to five dimensions: availability, continuity, interpersonal relationships, outcome and assistant's expertise. Almost one third of the new mothers rated the availability as inadequate while the assistant's expertise was rated positively. Postnatal maternity home care was deemed to be personalized, small-scale and recognised childbirth as a life event, attributes expressed by Taylor (1986) in the UK in concluding a study on consumer's maternity preferences. Furthermore, the researcher stated that it is relatively inexpensive and contributes to the satisfaction of recipients (Kerssens, 1994).

**Home Help Services**

In 1990 the umbrella organizations for community nursing (National Cross Association) and for home help services were integrated into the national association for home care. It was hoped that this integration would increase efficiency in home care and avoid unnecessary overlap between community nursing and home help services (Verheij and Kerkstra, 1992). In 1994, about 50% of the home nursing organizations had already merged with organizations for home help services (Hutten and Kerkstra, 1996). At present this integration is also taking place at regional level. Thus home helps are employed by the home help organizations or by the integrated home care organizations. Most of the home care organizations have integrated teams in which community nurses, auxiliary community nurses and qualified home helps work together. In addition, separate teams of unqualified home helps, who only carry out housework duties also exist. In the home

help services, there is a distinction made between the personnel who actually provide home help care. In practice these are: specialized home carers who support households with multiple complex problems; home carers who provide personal care in as far as this cannot be done by members of the household; qualified home helps who do some personal tasks and housekeeping, and unqualified home helps who do housework only.

In addition, there are alpha-helps who are directly employed by the client and only allowed do housework duties for a maximum of twelve hours per week (Hutten, Kerkstra, 1997). In 1993, approximately 45,000 alpha-helps were active in the Netherlands. This is an increase of almost 50% in one year, as the number of alpha-helps in 1992 was estimated at 30,000 (Arts, Kersten and Kerkstra, 1996). In addition to the alpha-helps, there are about 110,000 home helps and home help organizers working in the Netherlands. However, many of these work part-time. A large majority (77%) are unqualified as are alpha-helps. Those qualified have been trained on a part time basis for a period of one to two years. Recently, home help organizations have started in-service training for home helps (Arts et al, 1996). Clients or their families can refer themselves to home help services. However, there are long waiting lists for home help services. In 1992, more than 12,500 clients who were positively assessed for home help services were waiting actual home help. The average waiting time was 45 days (Hutten, Kerkstra, 1997).

According to Arts et al (1996) there is currently no information available on home help services, task differences between the various types of home helps, discrepancies between home help care assessed, and their workload. Thus a national study on home help services is planned to obtain a representative picture of the daily practice and to examine possible overlapping aspects of their jobs. As the main study has not been reported on to date, a pilot study will be reported which was carried out to develop the measurement instruments. Five instruments were developed for this purpose and a pilot study was carried out to establish the reliability and content validity of the main instrument: a registration form to record the activities that home helps perform. Twenty five home helps participated in the pilot study. An observer monitored them during their home visits for a period of one week. Both the observer and the home help recorded the activities that were carried out independently on the registration form. The reliability of the registration form was assessed by inter-rater reliability. The validity of this instrument was estimated by the content validity. The results showed that the registration form in general was a reliable instrument. There was a high level of agreement between home helps and observers in the four main categories : 94% for the household and caring activities, 87% for the psycho-social or supporting activities and 96% for the reporting activities. The content validity of the instrument was found adequate and only a few items needed to be added to the final version (Arts et al, 1996).

**Community Nursing Services**

The Dutch community nursing service is organised at two levels; national and regional. The regional Cross organizations consist of a number of basic units. In these basic units, a chief nursing officer (head nurse), about ten community nurses and two or three auxiliary nurses work in a team. Nurses with varying levels of expertise are employed by the regional cross associations together with a number of dietitians and child health clinic physicians. Specialist knowledge is provided by clinical nurse specialists (CNS), who are usually not concerned with direct patient care and are employed by regional cross associations. The nurse specialists can be consulted by nurses concerning concrete patient

situations. They also have a supporting role in the development of special care programs (Jansen, Kerkstra, Van der Zee, 1996). A basic unit is assigned to a defined geographical area (about 35,000 inhabitants). Within this team each individual nurse, or a sub-team of a few nurses and an auxiliary, is assigned to a specific sub-area (Jonkergouw, Kruyt, Hanrahan, 1990). Cross association can be reached 24 hours a day and care can be delivered in the evenings, nights and weekends. The organisations are 85% funded by public insurance and the remainder from patients' membership fees approximately Df150 per family per annum.

There are four types of community nurses employed: community nurses who have either four years of higher vocational training or $3\frac{1}{2}$ years in-service training with 2 years of intermediate vocational training; nurses working in the community who have had $3\frac{1}{2}$ years in-service training in a hospital to become a registered nurse but do not have additional training in community nursing; an auxiliary community nurse who either has two years in-service training in hospital or nursing home for the elderly and a six month course in community nursing or three years intermediate vocational training in nursing. A community nurse can also become a head nurse after having worked for at least two years in community nursing. A nurse specialist has to study a two year part-time course. It is also possible to follow an eighteen month course and graduate in either professional innovation, management or as a clinical nurse specialist in either child care or chronic health problems, e.g. asthma (Hutten, Kerkstra, 1997). There is also a two year Masters Degree in nursing which prepares nurses to work as clinical nurse consultants, in management or in teaching (Verheij and Kerkstra, 1992). The diverse educational pathways nurses may follow to work in the community and the diversity of their roles makes comparisons difficult.

The ratio of patients per nurse population is approximately 1 : 3,450. Everyone in the Netherlands is entitled to community nursing care which includes: home nursing care, support and care in illness or infirmity due to old age, care when dying and health education activities promoting a healthy lifestyle. All age groups are catered for, especially children under four years old (through well baby clinics) and the elderly (Jonkergouw, Kruyt and Hanrahan, 1990). Nurses work as generalists and care for all patient categories. Mother and child care usually takes place in child health clinics and care for the elderly at home. Until 1993 most community nurses worked as generalists; that is they provided nursing care at home as well as preventive mother and childhealth care in the child health clinic. However, according to Hutten and Kerkstra (1997), the growing complexity and workload of home nursing has affected the viability of working as a generalist. Therefore, since 1993 most home care organizations and regional cross associations made separate divisions for home nursing and child health. As a consequence most community nurses specialize in home nursing or in child health care. Registered general nurses and auxiliary nurses are generally only employed for home nursing.

Most patients initiate the contact themselves, followed by those who are referred by hospitals, nursing homes and occasionally GP's. Consultation with GP's is infrequent and only takes place on an ad-hoc basis. As the home help services and community nursing services are to integrate at the local level, it is hoped that the division of tasks between auxiliaries and home helps will no longer be problematic. A more efficient use of capacities is expected to result from this development. There are some examples of community based liaison nurses, so-called continuity nurses, who are especially assigned to maintaining relations with other care providers and safeguarding continuity of care (Verheij and Kerkstra, 1992).

A quantitative study conducted by Kerkstra and Vorst-Thijssen (1991) aimed to identify factors important in explaining the nature of community nursing care received by patients in their homes. The study was conducted during a two week period where a representative sample of 137 community nurses and 49 community nurses' auxiliaries at 47 different locations in the Netherlands paid a total number of 12,847 home visits to provide care to 3,315 patients. The researchers did not state how the sample were chosen. For each home visit, patient's characteristics, the nature of care delivered by the nurse and the length of the home visit was recorded. The results suggested that three groups of patients could be identified in terms of the nature of nursing care received at home. First, patients who were older, who were also receiving informal care and did not suffer from psychosocial problems, were most likely to receive assistance in their activities of daily living. Second, patients suffering from multiple disorders, whose situation was assessed as unstable, and those who did not suffer from psychosocial problems were most likely to receive technical nursing care. Those patients were visited most often. Finally, male patients suffering from multiple disorders, whose situation was assessed as unstable, especially when new mental or social problems emerged, were most likely to receive psychosocial support and education from the community nurse. These visits appeared to be the most time consuming. The average number of home visits per patient during the two weeks was four with a range of one to fifty eight visits. More than half (58.4%) of the patients received personal hygiene care, health education was given to approximately 40% of patients, 28% of patients were encouraged to do rehabilitation exercises and 40% of patients were given support for psychosocial problems. Finally, informal caregivers received support from the community nurse in 33% of the cases. Thus, this study has shown that patients receiving community nursing care were predominantly elderly (72% were over 70), females (64.7%) and about 46% of these female patients were living alone. In a study carried out in England by Dunnell and Dobbs (1982) similar findings were also reported.

**Summary**

In the Netherlands, all residents have free access to community nursing care. Community nursing services are provided by a number of organizations which operate nationwide but which do not have the same tasks in every region. It is the author's understanding that public health nurses are employed by the public health services, responsible for environmental health and for services to children from four to nineteen years of age.

The description given above focused on the regional Cross Associations and integrated home care organization There are four types of nurses working in the community, clinical nurse specialists, community nurses, general nurses and nurse auxiliaries. Nurses work in basic units, consisting of about 11 nurses and two auxiliaries. A basic unit is assigned to a defined geographical area of approximately 35,000 inhabitants. Cross associations can be reached 24 hours a day and care can be delivered in the evenings, nights and weekends. Nurses work as generalists and care for all patient categories. However, community nurses specialize in child health care and general nurses and auxiliary nurses are generally employed for home nursing. There are a number of types of home helps who are employed to perform a range of duties depending on level of training.

Trained maternity assistants provide a service to new mothers and babies for up to ten days post delivery. Research has found this service to be personalized, inexpensive and contributes to client satisfaction. Recent research in home nursing in the Netherlands has

shown that patients receiving community care were predominantly elderly and female. Similar findings were reported in an earlier UK study.

## 2.7 Community Nursing in Australia

### Socio-demographic Background

The population of Australia in 1992 was 17,581,300 but their population density is only 2.29/km$^2$. Their health expenditure per anum is 8.1% of the GNP which is similar to other countries. Infant mortality rate is 8.2 per 1,000 population (Nursing in the World, 1993) which is comparable with Ireland at 8.0 per 1,000 population. In an era of spiraling health care costs and perceived inequalities in health, both the Commonwealth and state governments are pursuing policies aimed at cost containment and 'value for money' services (Duffield, Baker, Edwards, 1995).

As in other Westernized countries, the population is aging. The accessibility to age-care programs will worsen dramatically as the 'baby boom' generation (those born between 1946 and 1969) ages. It is predicted that the proportion of people aged 65 and over in Australia will reach 14% by the year 2011. The current health and welfare spending for the aged is around 25 to 30 per cent of all government expenditure. That system will become insupportable under the stress imposed by the large proportion of aged people in the population. Furthermore, most patients are being discharged earlier from acute hospitals and with more morbidity than previously (Clare, De Bellis, Jarrett, 1997). Inevitably, the elderly in the community will not be as healthy and will have a considerable impact on home care nursing.

All residents of Australia are entitled to free health care under the National Health Insurance (Medicare). A further 45% of residents have additional private health insurance. As Australia is a federation, the six states and two territories also have health departments. As a general rule the Commonwealth government is responsible for reimbursing individual medical services while state/territory governments are responsible for the provision of public hospital services (Nursing in the World, 1993). Policy Development Division of the Common Wealth Department of Health, Housing, Local Government and Community Services manages nursing workforce and education issues. The Nursing Registration Boards in each State approve and monitor the various nursing courses available. Since 1984, the government transferred all nurse education from hospital based courses to the higher education sector. (Nursing in the World, 1993).

### Organisation and Delivery of Community Services in New South Wales

In New South Wales, there are generalists community nurses who work from community centres and who are responsible for delivery of health services in a geographic area. These nurses endeavour to provide health education and health promotion to their clients which include; mother and babies, pre school children and post hospital patients. They follow the principles of primary health care and work 35 – 40 hours per week with rostered week-end work (Newman, 1997). Most of the registered nurses who work in the community have a Bachelor of Nursing and others hold a Masters degree in community nursing or a related field. Usually those who hold a Masters degree are referred to as community nurses and those without are referred to as general nurses. The Bachelor of Nursing programs are three years, have content in the curricula which supports the work of a first level graduate and are generic. All nurses are encouraged to do a Masters degree, however

community nurses find it difficult to get study leave. Some students can be admitted to the graduate diploma of community nursing if they can demonstrate a previous academic qualification other than a BSc (Newman, 1997). Within a community centre, there is a nurse unit manager, who is answerable to the manager of the community centre. This position can be held by either a medical or a nursing professional, who also holds a Masters degree in health management or an MBA (Masters Business Administration). Financing the community health centres is a responsibility of the State government. Most often the state is divided up into Area Health Services. Each community centre becomes part of an area Health Service and competes for funding with the tertiary level of health care or hospitals, particularly teaching hospitals attached to a University. However, to date, the tertiary level of health care procures the majority of the funding at the expense of the community health services (Newman, 1997).

**Summary**

The New South Wales State is divided up into Area Health Services. Community care services are an integral part of these Area Health Services where they compete for funding with the tertiary level of health care or hospitals. Community Care appears to be divided into various programs of care which are managed by teams from the community health centres. Community nurses work on these various programs providing primary health care services to defined populations. The author acknowledges the paucity of published literature available on the roles, responsibilities and functions of the different community health nurses.

It is the author's understanding that each Area Health Service is responsible for primary, secondary and tertiary care. Community Health Services and Programmes (CHS&P's) compete with the hospitals for funding. Within each CHS&P, are a number of programs with separate teams providing community care services from different community health centres. These programs include; aboriginal health, child protection, women's health, health promotion and home nursing care, including aged care and palliative care.