Community nursing and health care in the twenty-first century

JANINE SMITH

Janine Smith is a Lecturer in Nursing and Coordinator of Postgraduate Programs at the University of Ballarat, Victoria.

Abstract

This article reports on research into the changing role of generalist community nurses in Victoria during the 1990s. It provides an analysis of the implications of current policy trends and presents an overview of current practice and trends in contemporary health care delivery in the community. It discusses a vision for community nursing inspired by interviews with generalist community nurses throughout Victoria, and offers creative recommendations and strategies that will facilitate planning for the personal and professional changes necessary to take community services into the twenty-first century.

The study in context

This study arose from a perception that shifts in the ideological context of the community health program in Victoria were impacting on the ability of generalist community nurses to fulfil their commitment to a primary health care model of practice. The essential concept of community health nursing has always been one that embodies a philosophy of primary health care in providing initial and continuing nursing care, and advice, advocacy and services to individuals, families and communities for preventive and therapeutic purposes (World Health Organisation 1975; McMurray 1990; Rordan & McLennan 1992; McMurray 1998).

Interviews were conducted with 40 generalist community nurses throughout Victoria to determine what changes had occurred in their practice within the five-year period from 1992 to 1997 and to seek information about their perceptions of the aims, effectiveness and efficiency of the current community health program. Data were also collected about specific health policies and issues which created dilemmas in resource allocation and funding of primary health care programs. The nurses were then invited to comment on their observations of specific problems affecting the health of the community and to offer suggestions for strategies to advance the role and practice of generalist community nurses into the twenty-first century. Although the research was

conducted within Victoria, feedback from other states of Australia since the completion of this study indicates that the findings appear to be reflected in other settings where similar reforms are occurring.

The role and practice of generalist community nurses was examined within the context of current health policies. In particular, the study explored the impact of economic rationalist ideology and managerialist strategies on the ability of generalist community nurses to sustain a viable role in the provision of primary health care into the next millennium.

The study draws on critical social theory, using Habermas's critical theory framework and current social and political theory to research and analyse trends in health policy in relation to the community health program (Habermas 1989; Considine 1994; Calhoun 1996). A critical theory approach facilitates analysis of the culturally and socially embedded practices of nursing within the dominant discourses of health care and economic rationalism, and provides an opportunity for reflective engagement in social change.

The policy context

Current health care policy has become motivated by an economic rationalist ideology that has transformed the health care industry from one of public 'ownership' to an increasingly privatised, market-place enterprise (Kermode, Emmanuel & Brown 1994; Coote 1996; McLoughlin 1996; Baum & Butler 1997). Generalist community nursing ideology, on the other hand, is motivated by a cultural ethic that is most responsive to those members of the community who are unable to function successfully in a privatised market. A special relationship exists between generalist community nurses and communities. This relationship is nurtured by a belief about the quality of life and by community values, as well as by an ethic of care that reflects not only the nurses' working culture but also the culture of the community (Royal College of Nursing Australia 1997; Australian Nursing Council Inc. 1995).

The problem which arises for nurses is how to continue to provide skilled, compassionate, ethical and empowering care for the community while having to cope with more complex caseloads and also to secure a voice in the discourse of health policy decision-making that affects their practice.

Economic rationalist ideology has been a driving force behind a range of managerialist strategies introduced in Victoria since 1992 to rationalise health service delivery, reduce the government's share of health care costs, and to increase the financial accountability of health service providers (Alford & O'Neill 1994; Barraclough & Smith 1994; Lewis & Walker 1997). The combination of a critical level of State debt, rising capital costs and an expanding infrastructure associated with institutionalised illness care were seen by the Coalition government in 1993 to necessitate a response which would address the issue of high-cost health care. It was argued that strategies which were introduced

would ensure that taxpayers receive value for money, and that high-quality services result from a competitive market (Liberal–National Coalition 1992; Tehan 1993). In particular, the concepts of casemix, purchaser–provider splitting, post-acute community care, compulsory competitive tendering, managed care, user-pays and integrated networks were seen to be initiatives which would provide an appropriate base for health services into the twenty-first century (Tehan 1993).

The following discussion provides an overview of the perceptions of the participants about the impact of these strategies on their role and practice. Themes which are identified as critical to the provision of primary health care nursing are illustrated by the 'voices' of the nurses.

Charting the changes in practice

Four interrelated themes emerged from the research. The first theme is concerned with the consistent devaluing of ethical nursing practice by policies which reward efficient economic management. All the participants in this study had experience of economic strategies which both constrain their practice in terms of its primary health care focus, and increase the proportion of administrative work to client contact and program work. Primary among these managerialist and economic reform strategies are compulsory competitive tendering and output-based funding, which, it could be argued, are more applicable to clinically-focused services such as podiatry and physiotherapy. The nurses expressed concerns that current reporting methods do not provide an opportunity for them to describe the complexity of their nursing practice. This shortcoming, in turn, impacts on nurses' ability to develop the type of caring relationships that they believe primary health care requires.

> *There just isn't any way that my stats reflect what I really do, but you don't get funded without supporting stats, so we have to give them what they want.*
>
> *I spend ages agonising over these damned stats because they never seem to have categories for what I do!*

Their concerns arise from deliberations about ethical and value issues which, they say, are exacerbated by economic constraints. For instance, time and financial constraints reduce the nurses' options when assessing the care requirements of many individuals in the community. Nevertheless, the nurses often feel obligated to provide the type of care that their 'nursing ethic' demands, even when that care is an unfunded and unrecorded 'out-of-hours' service. This practice devalues the primary health work of the nurses, and disadvantages them in comparison with the other clinically-based community health services. In the longer term, as the current generation of generalist community nurses leaves, these 'extra' services might disappear – to the detriment of community health servicing community needs.

The second theme is that current restructuring of the community health program relies on the provision of ethical health care by generalist community nurses. The nurses in

this study have a wide range of professional experience and qualifications, together with a caseload which cannot be assigned to other allied health professionals. The nurses, however, are frequently called upon to undertake the roles of other workers and deal with complex problems that require extensive skills and experience. They expressed frustration that much of this contribution is unrecognised and undervalued due to the quantitative focus of current information reporting systems. It is therefore perceived to be counterproductive in terms of raising the status of generalist community nurses.

> *I seem to spend a lot of time picking up other people's messes because I am a generalist. We are dealing with many more socioeconomic-, gambling-, and violence-related problems these days, but the services are stretched trying to provide cover.*

Third, it can be argued that the power and control exerted by dominant interests over the work of generalist community nurses serves to deny the interests of the needy in the community. Daniel (1990), Gardner (1995) and Turkoski (1995), for instance, claim that powerful professional status leads to the legitimate control of knowledge, community resources and the ability to subordinate, limit and exclude other allied occupations. Generalist community nursing is acknowledged to be less powerful than medical, health administration or political interests, when power is defined by an ability to command resources or influence policy decisions. While this power imbalance may not be as overt as that experienced by hospital nurses (Salvage 1985), it is embedded in historical and cultural traditions which are difficult to ignore. Similarly, the nurses in this study expressed concerns that any health policy which is focused on quantitative throughput measurement standards inevitably perpetuates the dominance of medical intervention over preventative, primary health care practice.

This focus on treatment services fails to address a plethora of socioeconomic and health problems that face the community. The findings of this study suggest that many people who need services that are not approved under the government's economic agenda are being disadvantaged by the less powerful position of their nursing advocates.

> *You can call it purchaser–provider split, privatisation, fee-for-service, whatever you like, it all amounts to the same thing. Pass the costs onto the community and save money. But there is a cost – it's a human cost.*

The fourth theme highlights an underlying problem in the way that the primary health role and practice of generalist community nurses is perceived by policy-makers and administrators. It is argued that the professional status of community nursing has not only been disadvantaged by the gendered heritage of nursing culture, but has also been disadvantaged by its marginalisation within the dominant health professions. Persistent, largely media-generated images of nurses being only followers of doctors' orders serve to perpetuate outdated stereotypes, and do not reflect the complexity of current generalist community nursing.

> *I don't think they really know what we do. They would like us to go off and do 'nursing' things so they could count the number of dressings or injections we do.*

Primary health care — a neglected concept

Recent policy changes have seen primary *health* care dominated by primary *medical* care and the participants expressed their concern that community health services need to be re-oriented to a primary care model. This is not to suggest that programs such as hospital-in-the-home are not relevant to modern health care delivery, but they are focused on post-acute patients previously treated in hospital. To transfer their care to community services can be a method of cost-shifting and should not be permitted to reduce resources for community development and support programs aimed at disadvantaged people in the community.

In general, the nurses expressed high levels of frustration associated with a perceived inability to fulfil their roles as primary health care practitioners. In addition, they noted an increasing departmental emphasis on administrative tasks related to shifts in cost-recovery and unit-based funding policies.

> *If we only dealt with one thing like feet or teeth, we could come up with a wonderfully neat plan with measurable outcomes. But we're out there dealing with every problem that society can come up with and there's no way you can get easy measurable outcomes or a tidy image from that.*

Strategies for change

Participants in this study suggest that generalist community nurses need to take a multifaceted approach to improving both their status in the health care industry and the image that they present to the community. Virtually every nurse interviewed recognised that generalist community nursing suffers from an image problem. They realise that much of what they do is unappreciated by politicians, bureaucrats, their colleagues in mainstream health care, and often by the community in which they work. As nurses they have traditionally worked 'behind the screens' (Lawler 1991), maintaining the privacy of their clients and working within teams rather than seeking individual recognition. Paradoxically it seems that the code of confidentiality, which is inherent in an ethic of nursing care, also contributes to the 'invisibility' of community nursing work.

Much can be learned from the publicity campaigns of the pharmacy and physiotherapy disciplines which have produced fact sheets for general distribution. These outline problems commonly encountered in the community; with information about how a specific therapy can assist, and contact details for further information or assistance. It could be argued that generalist community nursing does not lend itself to tidy categorisation, but it should be possible to cite enough broad themes to enable the community to understand when, how, why and where to contact a generalist community nurse. This would also present an opportunity for the nurses to re-evaluate their role, clarify their professional focus and promote their skills to the wider community.

Associated strategies would also include seeking recognition for successful programs through professional publications, conference presentations and press releases. While these are time-consuming, they can be an effective way to network and raise an awareness of the innovative work being done by generalist community nurses. The participants in this study suggested that increased networking, either face-to-face or via the Internet would do much to create a united front and dispel the professional isolation experienced by many nurses.

Nurses also need to lobby the ministers of health, the Royal College of Nursing, key policy advisers, and community health strategists from academic and practice fields, and obtain support for a campaign that will ensure an ongoing place for generalist community nursing. Several nurses pointed out that while the concept of primary health care has received token acceptance from policy-makers over the past 25 years, it has never received adequate financial support. A campaign to develop a comprehensive program to plan, implement and evaluate a pilot study of generalist community nursing practice using, for instance, a primary health care model, would enable the profession to demonstrate that it is possible to achieve positive health outcomes that are cost-effective and replicable. It is essential that such a pilot program be adequately resourced and supported by key professional and political leaders, that it clearly formulates demonstrable goals and achievable outcomes, and that it is integrated with claims by community nurses for recognition of their role.

Conclusion

It appears inevitable that the primary health focus of many community health centres will be further eroded in a continuing climate of economic rationalism, where funding opportunities are dependent on adherence to government directives (Smith 1999). The role of the generalist community nurse is therefore under threat: a premise acknowledged by a number of nurses in this study. As one nurse said, 'When we all go, who is going to tell the next generation about primary health care?'

From a purely pragmatic point of view, the next generation are likely to be chosen for their recent clinical skills – which can attract higher revenue under output-based funding – and may not recognise that their illness-oriented practice has lost its primary health care focus. More important, however, will be the loss of relationships that generalist community nurses have established within communities, relationships which provide a bridge for the community to access the acknowledged 'user-hostile' health service bureaucracy (Patterson 1994).

In order for any proposed study to receive favourable consideration from funding bodies, specified goals and outcomes need to be grounded in a critical analysis of health policy trends and current health issues which will drive future health policy and health care management. Examination of the central issues in contemporary health care suggest that approaches to developing health policy should address the needs of both the community and government.

An optimistic view suggests that the economic rationalist policies of Western countries, most notably those of the United Kingdom and the United States are a 'fashion' which, like all fashions, are transient (Coote 1999). Indeed the 'third way' of policy development proposed by the Blair Government in the United Kingdom calls for a degree of compromise between economic market emphases and communitarian value systems. Community nurses need to be proactive with their input into health policy, and suggest strategies which can demonstrate efficiency and effectiveness while being acceptable and appropriate for the problems which confront modern society.

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