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## Community Health Nursing Rhetoric: Our Daily Bread or Pie-in-the-Sky?

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By: Em Pijl Zieber\*

For decades now, the future of health care has been predicted to be increasingly community based, upstream, and focused on the broader determinants of health instead of a strictly ‘sick care’ system. The rhetoric of primary health care has become a mantra in all levels of health governance, from the World Health Organization to nursing regulatory bodies and undergraduate nursing curricula in the West. And yet, governments seem reluctant to pursue this model of health governance and delivery. In this paper I question whether this rhetoric is the substance of community health nurses’ work and to what degree it is largely unattainable in a climate of fiscal restraint and government preoccupation with downstream and acute care services. I question whether this rhetoric may place both an unfair burden on community health nurses, who lack the power and resources to enact the rhetoric in daily practice, and an unrealistic expectation on new

nurses, who expect to participate in this work within a system that is currently not amenable to it. Further, the author questions whether baccalaureate nursing education today prepares graduates who can work in existing, traditional community health roles, or whether today's graduate is being prepared for a health care system that has yet to materialize. In this paper, the term 'community health nurse' is used to describe nurses who work in roles such as public health, visiting nursing, and home health.

### **Community Health Nursing: Rhetoric versus Reality**

The World Health Organization, the International Council of Nurses, and professional nurse regulatory bodies in Canada suggest that in the years to come there will be an increased focus on addressing the determinants of health and on health promotion, and greater collaboration across sectors and health disciplines to enable health for all, although not as a replacement for illness care and supportive care which will remain a priority (Canadian Nurses Association, 2008; Her Majesty's Government and Department of Health, 2006; Institute of Medicine, 2011; International Council of Nurses, 2003a; National Expert Commission 2012; Royal College of Nursing, 2012b; Villeneuve, 2006b; World Health Organization, 2008). The International Council of Nurses, in their framework of competencies for the generalist nurse, state that "in virtually every country of the world, major health reforms are underway," most significantly a "steady shift from primarily a 'sick' service... towards a focus on health, and a primary health care led service. This shift is to materialize without neglect of the acute service" (International Council of Nurses, 2003a, p. 11). The document goes on to provide reasons for these "widespread reforms" (International Council of Nurses, 2003a, p. 11). Reasons include finite financial resources, the need to act on the determinants of health as root causes of illness, and humanitarian reasons.

These ideals have been a long time in the making; however, we have yet to see the community health rhetoric become reality in Canada. Governments and traditional health care systems are generally preoccupied with the funding of acute and curative care at the individual level, at the expense of broader population health promotion measures that act on the root causes of illness. With governments' ongoing commitment to acute care—and lack of a similar resource commitment to upstream and population health measures and the determinants of health—and fiscal austerity requiring measurable and cost-saving outcomes, community and public health areas continue to see funding shortfalls and fiscal clawbacks (Royal College of Nursing, 2012a; Underwood et al., 2009). In fact, it is in times of fiscal austerity that we tend to see a decrease in population health funding, revealing a distinct lack of commitment conceptually and pragmatically.

Despite the decades of rhetoric, the prognosticated shift in health services has not yet materialized. In the United Kingdom, for example, the Royal College of Nursing (2012a) reports that, all things considered, the percentage of nurses working in the community has seen little change, or even a decline, over the past decade, which "belies both the consistent policy drivers demanding an increase in community capacity and an 'acute to community' shift" (p. 13). Similarly in Canada, despite predictions that by the year 2020, 60% of nurses would be working in the community (Villeneuve, 2006a), the percentage of nurses actually working there has remained fairly constant at around 16%, for a decade or more (Underwood et al., 2009). Without government endorsed infrastructure and taxpayer funded measures, the lofty ideals of "a focus on health, and a primary health care led service" (International Council of Nurses, 2003a, p. 11) remain beyond the reach of community health nurses. And yet, the rhetoric remains at the forefront of our minds, our regulatory documents, the extant literature, and nursing curricula.

### **Can Community Health Nurses Carry out Ideal Competencies?**

Competencies for professional nursing practice underscore nursing's commitment to a community focus. While the International Council of Nurses (2003a, 2003b) has put forth a set of competencies



generalist nursing practice, each country is responsible to take into account their own contextual factors that impact nursing, health care, and health policies, as they delineate their own competencies for professional nursing practice—generalist, specialist, and entry-to-practice. Some countries, such as Canada and the United States, are developing community health nursing competency statements that identify the knowledge, skills and abilities required for practice in areas such as public health and home health, the largest areas of community health nursing practice in these countries (Canadian Association of Schools of Nursing, 2014; Community Health Nurses of Canada, 2009, 2010; Quad Council of Public Health Nursing Organizations, 2011). These specific competency sets are useful in defining nursing practice within the community. Unfortunately, ideal practice, as delineated by holistic and population focused competency statements, is not always possible within existing Canadian health care structures and role descriptions of nurses working in the community. Except in rare instances, for example, population level work represents but a small portion of community health nurses' work, and even then, these activities are often carried out 'off the sides of their desks' when their traditional roles allow (Royal College of Nursing, 2012a). These population level activities are well articulated by the relevant competency frameworks, leading to the question of whether the full mandate of community health nurses is to be accomplished without dedicated time and resources, and without legitimizing power from the employing organization to give traction to the community health rhetoric.

Competencies for community health are both bold and powerful. Their language harnesses the very essence of primary health care, social justice, equity and health for all. But are these competencies even attainable by nurses who are contracted to provide care at the individual level, or are they mere 'pie-in-the-sky', a lofty ideal to which we longingly ascribe? Does nurses' failure to fully operationalize their ideals lead to burnout and moral distress?

A further complication in the community health rhetoric is that with the rise of licensed practical nurses in Canada as a cost saving measure, the role of the professional nurse is necessarily called into question. Kikuchi (2009) predicts that soon "LPNs will seek, successfully, to be designated as RNs" (p. 30). This creeping credentialism, she predicts, will result in a return to diploma-prepared RNs, effectively turning back the clock on the nursing profession in Canada. One of the thrusts of baccalaureate preparation was a focus on community health, and while community health roles were once reserved for baccalaureate-prepared nurses, there are increasing numbers of LPNs working in these roles. What impact might such a shift in staffing have on the upholding and pursuit of the ideals of primary health care? Do practical nursing education programs seek to prepare nurses that can practice in accordance with the principles of primary health care and act at the population level? Are practical nurses positioned professionally to carry the torch of the rhetoric of community health and health for all?

### **Are Schools of Nursing Preparing Graduates for Community Health Practice?**

Despite the growing lists of competencies for areas of community health practice such as public health and home health, there is little agreement about whether or not students are being prepared for community health nursing practice roles through their undergraduate experiences, or in some cases, whether they even should be. There is also little agreement about which community health-related competencies are more important than others. A new graduate, for example, may be comfortable searching research databases for current studies on a population health topic, but may be unable to safely and competently manage the workload of a professional nurse in a community setting. Both of these items represent distinct competency points, and yet clearly, the latter would have more egregious consequences in the workplace. The former may be beneficial at the policy level; however, policy work is generally not considered to be the proverbial 'daily bread' for most public health, visiting, or home care nurses.



Nursing students in community health clinical experiences are sometimes preceptored in traditional community health areas. The use of preceptored experiences is diminishing in many programs due to a reduction in funding for public and community health practice areas, which results in fewer placements and fewer preceptors available to students (Betony, 2012; Dean, 2010; Hjalxmhult et al., 2012; Keller et al., 2011; Valaitis, 2008). As such, most students instead experience non-traditional community health placements that often have a population-health focus and that lack opportunities to develop areas of nursing knowledge and skills that comprise the daily work—the daily bread, as it were—of community health nurses. While non-traditional community health clinical placements allow nursing students to work at the population level, incorporate the principles of primary health care, enact social justice and equity, increase access to services, and address the determinants of health (Boutain, 2008; Ladhani et al., 2012; Reimer Kirkham et al., 2005; Wade and Hayes, 2010), they do not expose students to nurses' work in actual health care settings. These nursing students graduate from a program that was focused on community *health* nursing at the population level with a skillset suitable to the advancement of primary health care principles and the ideals of community health nursing. However, they then enter a system of community-based nursing that is focused on individuals and curative care (Cohen and Gregory, 2009). Thus, it becomes increasingly unclear to what degree Canadian schools of nursing should be preparing students for: actual nursing practice in the present health care system; and/or, the future ideal health care system based on principles of primary health care. Unfortunately, the role of the registered nurse is largely dependent upon government support and resources, and uncertainty grows concerning how best to educate new nurses for a range of professional roles. While most nurses would agree that it is not possible for a student to learn how to be a community health nurse without ever observing or participating in the work of a community health nurse, the outstanding question remains: to what degree should students be prepared for these roles?

### Taking the Lead

Many factors contribute to the community health nursing rhetoric and also its reality: government, the World Health Organization, and national and international nursing and health regulatory bodies, not to mention the community agencies 'on the ground' who employ registered nurses. But who, really, is in the driver's seat of the registered nursing profession, and who will steer the ship into the harbor where the community health rhetoric becomes a reality—if such a thing is even possible? Is the nursing profession unified in its vision of primary health care, or is it merely a mirage on the professional horizon that remains perpetually elusive? Perhaps baccalaureate-prepared nurses will lead the way in actualizing the primary health care rhetoric, and positions for this important shift will be created within the Canadian health care system. In the meantime, however, the role of the baccalaureate-prepared nurse in community practice areas may continue to fall short of the rhetoric to which it adheres on paper. In a time when rhetoric is king, community health managers as well as curriculum planners must consider the meaning behind the rhetoric—whether by community care what is really meant is non-hospital tertiary care as a cost-saving measure, or whether governments will finally overcome their preoccupation with acute, downstream care in favor of population health promotion that acts on the determinants of health. Critics of primary health care decry the rhetoric entirely, arguing that the evidence upon which it is based is highly suspect (Cunningham & Sammut, 2012), leading one to wonder whether community health nurses have been early adopters to a model that lacks the necessary political investment for implementation in the long run.

Perhaps community health rhetoric is so far ahead of policy ambitions that it is simply unachievable in the daily work of nurses. Or perhaps there are collective steps that the registered nursing profession can take to advance the primary health care agenda for the health of Canadians. Perhaps, in discussions between health authorities, professional nursing bodies, and schools of nursing, new collaborations and innovations forged that foster both the present and future roles of the registered nurse so that primary health



more readily actualized in Canada. It is unlikely that a governmental fiscal commitment analogous to what is given the acute care sector will provide nurses with the resources to actualize the rhetoric of community health. In the meantime, nursing leaders must continually engage in the conversation about what it means to be a registered nurse in a turbulent time characterized by both fiscal austerity and promises of health care reform. The registered nursing profession must be prepared for both current and future realities, so that Canadians have the health care they deserve.

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