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Countdown

The world has been talking about community health for years. It's time to act—and for governments to listen

By Dean Sioban Nelson, RN, PhD

Florence Nightingale once described hospitals as only an 'intermediate stage of civilization', believing health was something that arose from a healthy environment. While the world's most famous nurse is best known for her work at the Crimean War and the establishment of the training school for nurses at St. Thomas's Hospital, London, her greatest passion was for public health. As a statistician and pioneer health science researcher, Nightingale's monumental report that followed the war not only showed that more soldiers died of disease than as a result of enemy action, but that in peacetime a soldier's mortality rate was high compared to that of civilians due to the poor sanitation of military barracks. This report led to major reforms in military housing as well as hospital design.

Less well known was Nightingale's longstanding interest in India and her campaign to have the colonial government make the provision of clean water its major priority. Cholera originated in the Ganges Delta of India and is spread by contaminated water and food, and poor environmental management. Over the course of the 19th century, cholera killed millions of people in successive waves of epidemics across Europe, North America, Africa, Asia and, of course, India. According to the World Health Organization, cholera is once again on the rise and has re-emerged as 'a global threat to public health and one of the key indicators of social development' Nightingale's plan for clean water for India lost out to commercial interests and the development of the Indian railroad. If she had succeeded, perhaps cholera would be a disease of the past and at least one of the WHO's millennium goals would have been achieved.

In 19th century North America, crowded cities, poverty and infectious disease created enormous public health challenges which were taken up by remarkable women, such as nurse Lillian Wald, of the famed Henry Street Settlement in New York, which was founded in 1893 to work among the immigrant poor of the Lower East Side of Manhattan. Long before the concept of social determinants of health was coined, these nurses were driven by political idealism and commitment to justice to address the appalling health of immigrants, providing direct care to families, education on hygiene and nutrition, and eventually expanding to a whole range of other services.

Thus, by the time the catastrophic influenza of 1918-19 cut its swathe across the globe, in the UK and North America, there had been something of a 50-year tradition of what was to become known as public health nursing and community care. In the days before it was possible to manage common medical conditions, or to treat infections, it was recognized that what the system needed was an army of highly trained nurses to ensure the health of mothers and babies, to educate families, to work within schools to ensure healthy fit citizens for the future and to prevent the spread of infectious disease. This was the new public health nursing and in 1920 the nursing school at the University of Toronto, under the name Department of Public Health Nursing, was established to serve that end.

The sense of vulnerability to infectious disease that had been a simple fact of the human condition since the rise of agriculture actually began to wane in affluent countries during the 20th century, as immunizations became widespread and the management of acute conditions became increasingly effective. But of course that was merely an illusion. Tuberculosis, once the blight of the world and so effectively remedied with the development of streptomycin in 1943 and prevented through immunization programs, is back today and rising around the world, with multiple resistant strains causing near hysteria among quarantine agencies and the media. New diseases have emerged, such as AIDS, while other known diseases, such as influenza, have continued to mutate and cause widespread concern (H5N1 and H1N1). The category of influenza-like illness (ILI) is now the new risk. Interestingly this current issue that is occupying so much policy and media time illustrates well how far the circle has come. We are approaching H1N1 the way we approached many illnesses in the 19th century, when there was uncertain aetiology and/or few effective interventions. Then and now the best approach is supportive measures based on principles of infectious disease management. In other words: wash your hands, stay home if ill, keep well hydrated.

It is hard not to be struck by the 'back to the future' element to contemporary discussions about public and community health. The return of the sceptre of infectious disease is only one such ghost of the past that we now realize our health-care systems ignored at our collective peril. Twentieth century hubris about the progress of medical science solving society's health problems has also led to the almost absurd situation that today, with our relative wealth, high levels of education and access to virtually limitless information, we are sick and getting sicker from 'life-style' diseases. Fast food and processed food of low nutritional value, inactivity and smoking are taking a disastrous toll on our collective health, and, most concerning, that of our children. Tragically, around the world, these health problems come hand in hand with economic growth and social development, burdening so many countries with diseases of both poverty and wealth.

It is sobering to think that the problems of western diseases that we now face were predicted decades ago – and solutions proposed. In 1978, the WHO proposed in the Alma Ata meeting that health for all could only be achieved through the establishment of a vigorous primary health-care network to serve and work with communities, identifying their needs and working with inter-professional teams to collaboratively create custom-made, effective strategies to prevent disease and promote health. Later, in 1986, the Ottawa Charter of Health Promotion pointed towards inter-sectoral collaboration, healthy public policy and community development, among other strategies, to produce health for all. Canadian

nurse academics have been teaching and researching about such ideas since their inception and those in practice have been working to achieve the ideal of health for all.

More recently, innovative approaches to primary health care and public health services are being acknowledged by governments in Canada and elsewhere as the way forward (even if those words are at times not being supported by resources).But despite its great virtues, the contemporary primary health-care team model is still about individuals getting themselves to a clinic to see a physician or a nurse practitioner, at least in the first instance. Homecare services are stretched with high volumes of vulnerable clients with complex care needs. Program specific public health services continue to stretch thinner and thinner across our communities serving target audiences. How many ordinary citizens do public health nurses reach today? How do any of these services even begin to address the social determinants of health, the root cause of so much ill health?

pressures on the acute system. Around the world—and Canada is certainly no exception—first and foremost the solution relies upon redirecting resources from individual clinicians (be they physicians, nurse practitioners or other fee-for-service providers) and placing our dollars in programs and salaries. One would think that in a publicly funded health-care system this would not be such a tough call, but it is. However challenging the politics of health care is on this matter, the fact remains primary health-care in its broadest sense is not simply a case of having more individual providers, or even teams of them. It is about meeting people where they are, and working with communities and schools and grassroots organizations to promote health where it is produced: in people's everyday lives, outside of a decreed clinical consult time. Only by fully grasping this issue, and its implications for the way our systems are organized, can we ever hope to dissipate the tsunami of acute-on-chronic disease that is heading our way as baby boomers age.

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There is no question we need to continue to work to cure disease and to more effectively manage those who are suffering from the consequences of disease or injury in the acute-care sector, long-term care or in the home. Nurses, along with colleagues across the health sciences, play a vital role in this ongoing story. But as the health-care professionals who spend the most time with patients and families and who work in communities and in people's homes, the real asset that nurses bring to the health-care system (and society) is the opportunity to prevent illness, to support individuals, groups and communities to engage in healthier practices, to advocate on their behalf when needed, and to establish partnerships with the population to share knowledge and encouragement to improve health and people's quality of life. And despite a great many efforts on behalf of dedicated health professionals and service providers, in our hearts we all know that it is farfetched to think that effective education and support for behaviour change can take place while an individual is stressed, unwell and disconnected from her/his family or community during an acute episode, or during the pressured encounter of a clinic appointment or home visit.

If we all agree on the vision then, in the end, change is about commitment and resources. Transferring health-care dollars to the areas where they are needed to improve health, prevent the development of chronic disease, to guard against infectious disease and create communities with fewer accidents and injuries is easy to declare but hard to operationalize. We are caught in a trap of responding to urgent current needs, instead of creating a system that leads to decreasing the

Community health-care costs are minor compared to those of the acute care sector. Nonetheless the acute sector has the gravitational pull of Jupiter on our health-care solar system dollar, and whenever the squeeze is on it is the non-urgent sector that, to our peril, keeps getting cut. Cuts to prevention services tend not to end up on the front page of the *Globe and Mail* for creating a disaster overnight. But disasters are certainly created in the long term. Our current 'obesity epidemic' was decades in the making.

Canada has much to be proud of: Alma Ata and the Ottawa Charter led the world in defining the true goals for health, and in recognizing that the critical 'system' in question is not the health-care system but society as a whole. There is no debate that poverty, inequitable access to education, unemployment and lack of services (such as health services) create the conditions for disease. Florence Nightingale would certainly have agreed with that observation. Today, as our leaders debate the 'sustainability' of our health-care system, Canadians need to be reminded of what community health nurses have long known: the promotion of health is the only way to build a sustainable future.

One wit described the current health-care funding model as buying more mops to fix an overflowing sink. Well, we are up to our waists in water these days, with an acute care sector stretched to capacity and flood waters gathering upstream. We are beyond mops now.

We know the answer is to keep people well. This century we just have to mean it when we say it.