# PUBLIC HEALTH NURSES IN NEW ZEALAND: THE IMPACT OF INVISIBILITY

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## Abstract

Public health nurses have provided care to individuals, families and communities in New Zealand since the early 1920s. This research study examined the role of the public health nurse. Utilising community needs analysis method, 17 key informants and two focus groups were asked questions to determine perceptions of the public health nurse. Findings indicated that participants lacked knowledge regarding the role of the public health nurse. Additional findings intimated that participants had difficulty in accessing public health nurse services and that 'knowing the system' was beneficial to receiving needed care. One of the major conclusions of this study was that many facets of care managed by public health nurses were invisible to the communities in which they work. Conclusions suggest that public health nurses need to enhance their service by improving accessibility to services and promoting their service in a more visible manner.

**Key Words:** Public health nurses, 'knowing the system', invisibility

## Introduction

The origins of public health nursing and the public health nurse (PHN) in New Zealand extend back as far as the 1920s. In 1924 all nurses were seen as having some type of public health role, but by 1929 there was a growing recognition that public health nursing was a specialty all of its own (Wood, 1999). PHNs were seen as having a role in maternal and infant health, school nursing, Tuberculosis and Venereal Disease Clinics, industrial nursing, and rural and native health nursing (Wood, 1999). Despite continuing to focus on these areas of health delivery, in more recent times PHNs have, increasingly specialised in particular positions. This 'new-look' PHN concentrates on only one area of public health nursing, for example, adolescent health, early childhood health, school health, sexual health or communicable disease. This study focuses specifically on the realm of the public health nurse working with school-aged children (5 to 10 years) within an urban area of New Zealand's North Island.

The area of speciality PHN practice that was under examination in this research was that of school-based primary health care for school-aged children, youth and their families/whanau. In this context the PHN role

includes the provision of assessment, case co-ordination and referral services, facilitation of health promotion programmes including Health Promoting Schools and provision of child protection assessment, monitoring and referral. Public health nurses also provide immunisation programmes and immunisation information as accredited non-medical vaccinators (Edmonds, 1999). PHNs work as part of a multi-disciplinary team including Maori and Pacific Island Community Health Workers, Social Workers, Medical Officers, Dieticians, and Health Promoting Schools Facilitators. The PHN visits schools usually once per week and is also available for home visits as required.

Prior to undertaking additional research into the impact of extending the PHNs' scope of practice within the New Zealand setting, it was felt to be important that the community's perspective of the PHNs current mode of health care delivery was examined. Through undertaking such research it will be possible to assess the community's perceptions of how effective the PHN service is at meeting the health needs of the community. In order to gain additional information about the community's awareness of the PHN service, this research was undertaken to assess the perceived role of the PHN in the context outlined in the previous paragraph. Community needs analysis was the method used to collect and analyse the data. The findings of this research are presented and interventions are suggested to assist in raising public awareness of the PHN role within the community.

## Method

The method used to undertake this study was community needs analysis. This can be defined as the process of assessing and defining needs, opportunities and resources involved in initiating community health projects (Haglund, Weisbrod, & Bracht, 1990). Lillie-Blanton and Hoffman (1995, p. 226) claim that the techniques used for community needs analysis '...when applied with a sensitivity to a community's past experiences and present concerns...' are a valid tool for exploring the needs of a community. Community needs analysis results in a dynamic community profile that integrates qualitative data on a community's expressed needs and wants with quantitative data such as demographic and health indicators. A community needs analysis goes beyond a community profile or assessment by drawing conclusions and making recommendations based on the analysis of the data collected (Billings & Cowley, 1995; Glick, Hale, Kulbok, & Shettig, 1996; Haglund, Weisbrod, & Bracht, 1990; McClennan Reece, 1998; Murray & Graham, 1995; Reviere, Berkowitz, Carter, & Ferguson, 1996; Ruta, Duffy, Farquharson, Young, Gilmour, & McElduff, 1997).

### The Study

For the purposes of this study one primary school was selected based on its enrolment numbers and decile ranking. That school and its surrounding physical and social environment constituted the community. Ethics approval to undertake the study was gained from

the Health Funding Authority Northern Region Ethics Committee (Committee X) and the Massey University Human Ethics Committee. The Principal and Board of Trustees of the school concerned also gave the researcher consent to focus on the school. All participants involved in this research study signed a consent form.

Data were collected from three sources - known demographic data, key informant interviews and focus group interviews. Demographic data included population statistics, health statistics, morbidity and mortality rates, a school profile, a community profile, and economic factors.

Participants in the research were accessed in two ways. The first set of data was obtained from individual interviews with 17 key informants. The key informants worked or lived in the community in which the study was undertaken. Examples of the types of key informant who participated included the school principal, two local medical practitioners, ethnic group representatives, and a number of other health and social service providers including a social worker and several nurses. The second set of data was obtained from two focus groups held at the school in question. Of the two focus groups, the first group consisted solely of parents. The second group was made up of parents and school staff.

The participants involved in this study were asked questions regarding their understanding of the role of the PHN. Participants were also asked questions regarding their perceptions of the health needs of the community. Analysis was conducted in a manner consistent with community needs analysis, drawing together the qualitative and quantitative data from the interviews and the available demographic data. The approach to the data was primarily explorative and descriptive in nature.

## Results

Key informants and the two focus groups were asked what services they could identify that the PHN provided, whether they had ever used the services of the PHN, and if they could think of any 'other' services the PHN could provide. The results are as follows.

### Current Services Provided by the PHN

Most participants recognised the educative role of the PHN and their involvement with children, and most were also able to give examples of why children were seen, for example, to treat scabies. Most were aware also of the PHNs home visiting capabilities. Examples are:

> *"...asthma education, advocacy between the child, teacher, parent...her door's always open..."*
>
> Maori Community Health Worker

> *"...as a parent if you have an issue you can arrange to see her on that day and if a teacher has an issue about a certain child then they can refer to her..."*
>
> Parent

A few were less clear. Two were unable to articulate what a PHN did and indicated that they were generally unaware of his/her role, and one participant was somewhat hesitant in her response:

> *"I think she...follows up on medication...I...haven't met her..."*
>
> Dental Therapist

Although most participants were able to articulate the visible aspects of PHN work i.e. child health, education and child protection, they were less able to articulate the more hidden aspects of the PHNs work e.g. advocacy, referral, networking and health promotion.

**Additional or 'other' Services that could be provided by the PHN**

In determining if there were other services a PHN could provide to the children and families of the community, participants had numerous suggestions. Examples included targeting of individual children; working in the home with the family; focusing on health education and health promotion; obtaining the right for the public health nurse to prescribe medications; having a nurse in the school on a fulltime basis; having a clinic service in the school; and family counselling:

> *"if you had something in the school...and with prescribing rights for ear infections and school sores and dressings, that would be an amazing situation."*
>
> Practice Nurse #2

**Use of PHN Services**

When asked if they had ever used the services of the PHN in the school, most participants recalled some form of contact with her:

> *"Frequently it's for the Health Camp issues...occasionally it's been for follow ups for suspected neglect or suspected abuse...we try to be proactive but the PHNs are more appropriate in that situation"*
>
> Practice Nurse#1

> *"I think most people have talked to her...I asked her about my son's health at one stage..."*
>
> School Psychologist

> *"We've had phone conversations with her [for the 5 year check]...our public health nurse is very friendly, she did tell me if I needed any help she's only a phone call away...touch wood I haven't needed her."*
>
> Indian Community Representative

Some participants referred to difficulty associated with dealing with the PHN, such as getting hold of the right one:

> *"...if I'm wanting to find something out I end up having to go through ten phone calls to get to the person required - always!"*
>
> Practice Nurse #2

or having an advantage through 'knowing the system'

> *"[We use the PHN] more so now...because with having been*

*in the PHN system I know the shortcuts and I know the ways around."*

Practice Nurse #1

Many of the participants had used a PHN as a health professional for making a referral to a secondary health service or for health related advice. Another point of connection with the PHN was through the PHN contacting a parent regarding a health issue relating to child, as a part of the health check made on all five-year-old children as they enter primary school in New Zealand.

## Discussion

### Study Limitations

The results from this research study, a small 'snap shot' into community perceptions of the role of the PHN, must be viewed with caution. Some of the participants had only limited experience with one or two public health nurses. Based on the fact that participants were asked to reflect on their personal experiences with the PHN, the pros and/or cons of dealing with one or two specific nurses could influence their answers. Therefore the results from this research are not intended to be indicative of the entire public health nursing service in New Zealand. However, there are lessons to be learned from gauging community perception on the role of PHNs.

### Knowledge of services provided

Participant knowledge regarding the services provided by the public health nurse appeared to be high and participants were all able to give an example of services provided by the PHN. However, when probed in order to discover what 'other' services such nurses may be able to provide, over half of the suggestions given by participants were for services already provided by the PHN. For example, targeting of individual children, working in the home with the family, focusing on health education and health promotion have been aspects of practice undertaken by the PHNs in the area in which the study was conducted and also by PHNs throughout New Zealand for many years.

These findings indicated that the knowledge in this particular community regarding the diverse services provided by the PHN was limited. Despite public health nurses (and their service) knowing that much of the additional work as suggested by the participants is already being done, many of these activities seem to be invisible to the participants in this study.

The notion of the invisible nature of the work of the nurse is not new. Street (1992) discusses the visibility and invisibility of the nurse with regard to the experience of nurses working in the acute care setting. Although not immediately applicable to the nurse in the community, many of the concepts are similar. Despite the fact that much of the nurses' work within the acute care environment is undertaken within public scrutiny, much of that work is functionally invisible to many people (Street, 1992). Street argues: "this invisibility can adversely affect the access to knowledge and the capacity to engage in decision-making processes based

around power relations" (Street, 1992, p.149).

Colliere (1986) refers to how care (as opposed to cure) is not considered by society as valuable or even necessary. She argues that the work of nurses is "invisible work done by invisible women" (Colliere, 1986, p. 103), and that it is only those tasks that can be measured and quantified which are recognised as valuable. Colliere states: "Consequently care remains invisible, priceless in health institutions as well as at home, and those who provide it remain socially unconsidered, and unknown" (Colliere, 1986, p. 105). In a more recent New Zealand study that examined two communities' perceptions of the role of nurses working in the community, the public health nurse was considered the least visible and the least well described in terms of roles (Condor, 1999).

Within the New Zealand community context, the invisibility of public health nurses is made worse by a continuing disempowerment of the PHN. This has occurred as a result of ongoing funding cutbacks, job and service restructuring and redundancies that, despite a relatively small increase in some funding recently, have been continuing since the mid-1980s. Hinder (2000) refers to the continual economic downsizing of the public health nurse workforce suggesting that this acts to facilitate the invisibility of PHNs by placing restrictions on their scope of practice because of service delivery boundaries. "The community receives a child and youth health service that is committed, professional and accountable - but restricted" (Hinder, 2000, p.2). These restrictions inhibit ability to be adaptable and responsive to the needs of the community, thus the nurses are forced to continue working invisibly (Krothe, 2000).

Hinder's (2000) research uncovered some thoughts by PHNs themselves on the invisibility of their role:

> Raising our profile can create problems...we are dealing with social problems, sure health comes into it but we are dealing with social issues. We need to raise our profile not politically but within our communities so there is ownership of the problems. The problem is the community doesn't know what we do.
>
> (Hinder, 2000, p.60)

Participants in Hinder's study often had difficulty in articulating their practice as PHNs and expressed the concern that if they couldn't talk clearly about their own practice then how could they ever expect communities and funders to understand the work they did (Hinder, 2000).

**Accessing the public health nurse**

Accessing the public health nurse was considered a problem for some participants and the concept of 'knowing the system' was construed as advantageous. Ossege (1993) discusses how for participants in her study of 22 African Americans not 'knowing the system' was regarded as a barrier to seeking health care. From this evidence the opposite could be implied that 'knowing the system' increases access to the health care

service desired. 'Knowing the system', combined with the effort it took one participant to reach the public health nurse required, implies that the system within which public health nurses currently work is considered difficult to negotiate by those without prior knowledge. Stanhope and Lancaster (2000) also concur with the importance of communities being knowledgeable about available services as a factor in facilitating ease of service access.

**Implications for public health nurses**

Participants in this study suggested that the nurses increase their profile through increased advertising. However there is a difficulty associated with this seemingly simple solution. Despite recent small increases in funding for PHNs working in schools with low socio-economic status, the number of PHNs in the New Zealand workforce has been steadily decreasing since the mid-1980s. At the same time, however, their workload has increased. Burnout associated with these factors is not unusual. If the advertising is successful and the demand for services increases, there is concern that the numbers of clients and referrals will rise beyond levels at which safe care can be made available. The problem is compounded by the fact that unless PHNs do take steps to increase their visibility to the public and to funders, funding levels will continue to decrease and the service will remain invisible, and a downward spiral is likely.

A participant in Hinder's (2000) research discusses the need for PHNs to raise their profile through writing and publishing articles:

> "Writing is all well and good, but nurses write articles for other nurses...we need to raise our profile within our communities. If we are doing something in the community, how many PHNs contact the press? We need to let people know of the neat things that we do."
>
> (Hinder, 2000, p.59)

Participants in the present study also attributed difficulty in accessing the PHN to the complex system within which she/he works. Even if a person is well versed in the role of the public health nurse and has reason to access those services, it is clear that this is not as simple as picking up the phone. Firstly, not all those wishing to contact the PHN may have access to a telephone. Secondly, the continuing specialisation and fragmentation of PHN services has moved the PHN role from being a generalist to that of a specialist, with resulting increase in the possible options from which a person trying to access a PHN has to choose.

The issue of poor communication systems needs to be addressed. Providing PHNs with answer services, cell phones and pagers will only partially address this problem. As Hinder's participant implies, in order to bring about the desired changes PHNs must work to increase their visibility within the community where they work. There are numerous possible solutions to the invisibility of PHNs and their work, for instance having set hours where a PHN is available at a school or pre-school,

and also offering a readily available information pack that lists the different PHN services to local organisations and health providers (which would also assist those making referrals to the PHN). Displaying posters, and having flyers in a variety of languages appropriate to the community, may provide an additional source of information for residents.

Individual PHNs need to establish feedback mechanisms so that the community has access to forums by which the most appropriate ways to work within that particular community are articulated. Not only would such feedback help to improve the PHNs profile within the community, but it will also significantly improve the quality of service delivered to the community (Krothe, 2000). At the health care organisational level, managers can work to ensure all those employed by that service are aware of the role and services provided by the PHN, and as well, lobby funders for the resources necessary to ensure that PHNs can continue to provide a high quality service

## Conclusion

Public health nurses have provided primary health care to children, families and communities in New Zealand for nearly 80 years. This study examined a particular community's perception of the role of the PHN. Findings indicate that, for these participants, knowledge of the role of PHNs within their community was limited. For many much of the work of the PHN was invisible. Participants acknowledged that there were problems associated with accessing the PHN, and that 'knowing the system' was advantageous. These results have implications for public health nurses. As a workforce PHNs need to take note of them and implement steps to increase their visibility to both the communities in which they work, and those who fund their services.

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