PUBLIC HEALTH NURSING IN BRITISH COLUMBIA FROM 1960 TO 2005: TRANSFORMATIONS IN POLICY AND GOVERNANCE STRUCTURE—A HISTORICAL REVIEW

By

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Abstract

A great portion of the history of public health nursing in British Columbia is intricately linked to major public policy developments and changes in governance structure through the years. This link is not often well understood in discussions about the role of Public Health Nurses and their shifting scope of work. Understanding this link will help us identify the ways in which Public Health Nurses have come to preserve health, control disease, and treat illnesses in the province. The focus of this Scholarly Practice Advancement Research project is to examine the historical development of public health nursing in British Columbia during the period from 1960 to 2005 through the lens of public policy and governance structure. Using historical research, including oral nursing history, the project examined what key policy documents, reports, and major developments have influenced nursing practice in public health from 1960 to 2005 in British Columbia, with a particular focus on the City of Vancouver as a case example. This project further complements a series of oral history interviews with Public Health Nurses recently completed within the UBC Consortium for Nursing History Inquiry and deposited into the UBC Archives collection, and it provides historical context to the stories of the nurses who have been interviewed. By capturing the history of policy development in public health nursing, this project shows how Public Health Nurses' work has shifted in response to the sociopolitical environment and the restructuring of the health care system in British Columbia.

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Chapter One: Introduction—Scope of Research

A great portion of the history of public health nursing in British Columbia (B.C.) is intricately linked to major public policy developments and changes in governance structure through the years. This link is not often well understood in discussions about the role of Public Health Nurses (PHNs) and their shifting scope of work. In B.C., "the history of public health nursing is closely tied to the development of the province...and [to] the evolution of local health [care] services" (Green, 1984). Understanding this history will help us identify the ways in which PHNs have come to shape both the care for the sick and the promotion of health in the province (Canadian Nurses Association [CNA], 2007). There is a need for a critical examination of the key policy documents, reports, and major developments that have shaped this particular branch of nursing in Canada. The purpose of this Scholarly Practice Advancement Research (SPAR) project is to review the historical development of public health nursing in B.C. during the period from 1960 to 2005 through the lens of public policy and governance structure.

Background

Public health is a scientific discipline that is defined as "the organized efforts of society to keep people healthy and prevent injury, illness, and premature death. It is a combination of programs, services, and policies that protect and promote the health of all Canadians" (Canadian Public Health Association [CPHA], 2010, p. 7). Public health is a shared responsibility of federal, provincial, and municipal governments. Provincially, public health activities are governed by a public health act or equivalent (Dhari, 2013). "British Columbia's public health program was established in the early 20th century in Canada, with a focus on immunization and communicable diseases, including sexually

transmitted diseases" (Dhari, 2013, p. 28). Today, public health plays a wide variety of valuable roles in B.C. including:

- ensuring people have access to safe drinking water and food;
- developing and delivering province-wide vaccination programs;
- reporting on the health of British Columbians;
- preventing and managing outbreaks of disease;
- providing at-home visits by public health nurses to young, vulnerable first-time mothers;
- encouraging people to use healthy behaviours and create supportive environments, in order to prevent chronic diseases and injuries (Province of British Columbia [PBC], 2017, para. 1).

The Ministry of Health, at present-day, supports and funds these roles to ensure British Columbians meet their health care needs (PBC, 2017). Further, the Ministry regulates the activities of all regional health care authorities—including all public health services and programs in B.C.—through healthy public policy initiatives (PBC, 2017; Hancock, 1985).

A major function of public health is the development of public policies meant to address local and national health problems that are no longer assumed an isolated concern (World Health Organization [WHO], 2016; Raphael, Rioux & Bryant, 2010). "At minimum, public policy is decisions made by governments" (Raphael et al., 2010, p. 239). These decisions are shaped by political, economic and social factors, and they influence the quality of the social determinants of health (Raphael et al., 2010; Pender, Murdaugh, & Parsons, 2011). "One important indicator of the general shape of public

policy is the extent to which nations distribute resources among the population" (Raphael et al., 2010, p. 240). Government expenditures run parallel to public policy and influence the successful development and implementation of policy (Pender et al., 2011). It is well recognized that the health of British Columbians results from a wide range of public policy initiatives. (Hancock, 1985; Raphael et al., 2010). Health promotion, disease prevention, population health and health protection are all cornerstones of these initiatives and have gone on to guide the practice of PHNs today.

PHNs promote and protect the health and wellbeing of British Columbians, including individuals, families, communities, and larger populations (PBC, 2017; Boschma, Roberts, Dhari, Mahabir, Walter & Haney, 2015). "They are leaders of changes to systems in society that support health, and they play key roles in disease, disability, and injury prevention, as well as in health promotion" (CPHA, 2010, p. 6). As a profession, public health nursing has built upon the basic foundations of registered nursing practice through advance certifications, and it has evolved over the decades to become recognized as a specialized field of nursing and an important growing body in public health care. Public health nursing is regulated by provincial governing bodies, like the College of Registered Nurses of B.C., and has its own professional organization, the Community Health Nurses of Canada (CHNC), which has created standards and developed competencies for PHNs and home health nurses alike (Dhari, 2013; CNA, 2016). In B.C., public health nursing had its roots in the pioneer days (Green, 1984). Since then, public health nursing has played many roles in providing health promotion, disease prevention, intervention and support services to women, children, youth, and families living across the province (Ministry of Health [MH], 2000; Boschma et al.,

2015).

Several works have examined and contributed to the momentous history of public health nursing in B.C., including: Robert Defries' (1940) *The development of public health in Canada: A review of the history and organization of public health in the provinces of Canada*; Monica Green's (1983) *Through the years with public health nursing*; Nora Whyte's (1988) *Provincial public health nursing in British Columbia from 1939-1959: A social history*; Susan Riddell's (1991) *Curing society's ills: Public health nurses and public health nursing in rural British Columbia 1919 -1946*; Carol Harrison's (2011) *A passion for prevention: Public health nursing in skeena health unit 1937-1997*; and Ranjit Dhari's (2013) *An exploration of factors influencing public health nurses' capacity to engage in health promotion*. These accounts of nursing history focus on the early twentieth century, and emphasize the general changing nature of public health nursing in B.C. I build upon these foundations and plan to focus on the developments of public health nursing during the latter half of the twentieth century. In my analysis, I will emphasize the impact of larger national and international, as well as provincial, events and policies, and the changes in provincial governance structure and regulations of public health, and make links between these policy changes and the transformation of the local work of PHNs in B.C. over the last forty to fifty years.

Research Question

To understand the historical development of public health and the nurses work in B.C. from 1960 to 2005, the following research question guided the search for, interpretation of, and review of data: What are the key policy documents, reports, and

major developments influencing nursing practice in public health from 1960 to 2005 in British Columbia?

Objectives

The objectives of this SPAR project are set forth as follows: a) to familiarize myself and readers with the major Canadian historical developments in public health care, with a particular emphasis on provincial health policy in B.C.; b) to examine the impact of public policy and changes in governance structure on public health nursing in B.C.; c) to explore and present social, political, and economic factors influencing the development of public health nursing in B.C.; and d) to contribute to the preservation of B.C.'s nursing history. This project further complements a series of oral history interviews with PHNs recently completed within the UBC Consortium for Nursing History Inquiry and deposited into the UBC Archives collection, and it provides historical context to the stories of the nurses who have been interviewed.

Significance

This SPAR project serves as a historical background paper to a public health nursing oral history project, titled *"Nobody ever asked me about my career": Public health nurses' oral histories preserved*, organized by Geertje Boschma, Erica Roberts, Ranjit Dhari, Gilda Mahabir, Susan Walter, and Catherine Haney (2015). Boschma et al. (2015) interviewed eight recently retired PHNs, from the Vancouver, B.C. area, whose careers spanned from the late 1960s to the early 2000s. In an effort to preserve the nurses' contributions to the changing public health work, the interviews also provided insight to greater social changes in the practice and politics of public health (Boschma et al., 2015). My project specifically helps to place these eight oral history interviews into

context, and further allows for critical interpretation of the changes that occurred throughout the nurses' careers. Moreover, a historical review of public health nursing in B.C. has the potential to reveal new insights on the past. Accounts of public health nursing from the latter half of the 20th century, particularly in B.C., are limited and have not yet been fully documented, making this project significant within the broader field of nursing history.

Methodology

Given the scope of the chosen project, this study utilized the methodology of historical research. This SPAR project, therefore, provides a descriptive analysis and review of important developments in public health nursing, and it is guided by the topics and themes touched upon within the eight oral history interviews conducted with PHNs, in the Vancouver area, by Boschma et al. (2015). Existing literature, including standing publications on public health in Canada, key policies, reports, and accessible documents were reviewed with a prime emphasis on public health in B.C.

The initial phase of data collection involved the identification of resources and determination of their location. Many sources were traced online through e-documents; others were found through UBC stacks and ASRS storage in the UBC Woodward, Koerner and Irving K. Barber libraries. Non-circulating library sources were photocopied following copyright restrictions. These sources included annual reports of the B.C. Department of Health and of Public Health Services of B.C. From there, data collection and analysis occurred simultaneously. Although both primary and secondary sources were used in this review, importance was given to secondary sources. Primary sources were utilized occasionally and when available in published documents to support the

reliability and comprehensiveness of the review; whereas secondary sources were utilized to gain context for the historical events and to further provide traces on additional primary sources (Polit & Beck, 2012; Lewenson & Hermann, 2008).

To delimit the topic, I deliberately selected the time period from 1960 to 2005, as the 1960s marked a post-Second World War era that came with societal change, which greatly impacted the people of this province, and more importantly had a significant influence on PHNs and their practice (Whyte, 1988; Green, 1984). The period from 1960 to 2005 also reflected the career span of the eight oral histories of the PHNs interviewed within the UBC Consortium for Nursing History Inquiry project (Boschma et al., 2015).

From the eight oral history interviews, I was able to identify the main developments in the careers of the nurses, in their own words, and was then able to describe how these career developments coincided with larger provincial and Canadian public health policy. Interpreting the aforementioned historical data from different sources and perspectives helped to offer a diversity of ways in which to explain and understand the development of public health nursing in B.C. from 1960 to 2005.

Theoretical Framework

“Historians use a variety of tools and frameworks to help recapture and make sense out of the past” (Buck, as cited in Lewenson & Hermann, 2008, p. 45). Utilizing a theoretical framework of nursing history, including oral nursing history (Boschma et al., as cited in Lewenson & Hermann, 2008), provided focus and direction to my project, and additionally offered insight into the preceding historical events in question. Historical research is more than simply a listing of significant events, dates, and facts: Historical research is about looking beyond these facts of the past by searching for relationships

among the events and influencing forces (Lewenson & Hermann, 2008; Whyte, 1988). I drew guidance from these existing nursing history methods to conduct a basic review of the historical developments that have formed the context of specific changes in public health nursing practice in B.C.

Social and policy historical frameworks, in particular, were utilized to conceptualize data in nursing history (McPherson, 2003; Lewenson & Hermann, 2008). Social history has provided a framework for reinterpreting the past from the bottom-up, including movements, developments, major events, and the experiences of ordinary people through the conceptual lens of gender, class, and race (D'Antonio, 2005; Lewenson & Hermann, 2008). It also allowed for the examination of broad historical events from the perspective of people who have lived the history in an attempt to explain the values and beliefs associated with the event (Lewenson & Hermann, 2008). While the focus of this project was on existing policy documents and not on the interpretation of primary archival sources or oral history data, the social history framework nevertheless informed my focus on exploring relationships between policy and the main events related in the oral history interviews, with certain emphasis on the social determinants of health. Policy history, on the other hand, provided a framework for examining the past to inform present and future policy development, helping to understand larger historical phenomena, and uncovering the involvement and influence of key stakeholders in policy development (Lewenson & Hermann, 2008). These approaches were built upon to inform how and why developments in public health came about when they did and the ways in which the work of PHNs was shaped in B.C. from 1960 to 2005.

Organization of the Project

In the next chapters, I will provide a chronological and thematic overview of major changes in policy and governance structure of public health in the province of B.C., with particular emphasis on developments in the City of Vancouver as a case example. I will discuss these changes in light of larger public health policy development, both nationally and provincially. In each chapter, I will point out significant implications of these main policy and governance changes for the work and careers of PHNs. To highlight these points, I will draw from the summaries of the above-mentioned Oral History Project interviews with PHNs who worked in Vancouver and the Lower Mainland. The abstracts from the PHNs' stories will serve to illustrate the main changes in policy as reflected in nurses' work. I will divide the review into three major time periods. The organization of the remaining sections of this project is as follows: Chapter Two: Public Health Policy from 1960 to 1980—Health Departments; Chapter Three: Public Health Policy from 1980 to 1995—Regional Health Boards; Chapter Four: Public Health Policy from 1995 to 2005—Regional Health Authorities. The conclusions, which include a summary of the main shifts in public policy, and a discussion of the dissemination of knowledge and limitations of the project, are presented in the fifth and final chapter.

Chapter Two: Public Health Policy from 1960-1980—Health Departments

In chapter two, I address changes to public health and public health nursing in the post-Second World War era up until the late 1970s. Discussion will centre on the emergence of public health policy focused on the commitment to primary health care, and on the new concepts of health promotion and the social determinants of health. This era marked a shift away from the traditional focus on disease prevention to a more social model of care, which included understanding individual risk factors that could increase the likelihood of developing a disease. During this time, the dominant provincial governance structure of public health can be characterized as the period of health departments or health units. The Vancouver Health Department will be discussed as a case example of this governance structure. I end this chapter by exploring the influence of public health policy on the careers and work of PHNs in B.C. I comment on the way policy from 1960 to 1980 translated into particular directions and use examples from the PHNs interviewed in the Oral History Project to show how these directions subsequently shaped public health nursing during this period.

National Policy

Canadian Medical Care. As the Canadian health care system continued to evolve in the 1960s, rising costs for medical services led citizens, "progressive health professionals" like PHNs, and selected politicians to argue that health care was a social need and not just another "purchasable commodity" (Canadian Museum of History, 2010, para. 1). After Medical Care was introduced in 1966 as Canada's national health insurance program, Canadians were assured that all residents would be entitled to health care coverage and would have reasonable access to medically necessary services,

including hospital and medical services. (Health Canada, 2016; Raphael et al., 2010). Leading the guiding principles for the 1967 *Medical Care Act*, Medical Care became a joint responsibility of the federal and provincial governments (Raphael et al., 2010). The Act primarily dealt with federal transfers of money to provincial governments who upheld the principles of the Act (Wilson, 1995; Raphael et al., 2010). "In fact, the arrangement was roughly a 50/50 sharing of costs" between the federal and provincial governments (Wilson, 1995, p. 10). Provincial governments, moreover, took charge of the delivery and provision of health care services to the general public (Raphael et al., 2010). This program of pre-paid services substantially removed the financial barriers to hospital and medical care for Canadians (Lalonde, 1974). With Medical Care in place throughout B.C., it became less time-consuming for PHNs to see that needed medical care and treatment was arranged for individuals (Green, 1984). " No longer was it necessary to spend a great deal of time finding organizations to sponsor the corrections of defects such as cleft palates, dislocated hips, and visions problems etc" (Green, 1984, p. 129).

A New Perspective on the Health of Canadians. "The Lalonde Report, named after the then [M]inister of [H]ealth in Canada and published in 1974, was the first government publication that drew awareness to the distinction between health and health care" (Raphael et al., 2010, p. 18). Also known as *A New Perspective on the Health of Canadians,* the report largely called for a new redirection in health care, and introduced health promotion as a key strategy (Lalonde, 1974; Crichton, 2000; MH, 2000). It highlighted the limited role of health care in improving health, stimulated interest and discussion on future health care programs for Canadians, and proposed a comprehensive

framework for understanding the determinants of health (Lalonde, 1974; CPHA, n.d., para. 5). Lalonde (1974), "...looked at health as something that individuals had some control over, and promoted nutrition, exercise, non-smoking, and other healthy behaviors" (Harrison, 2011, p. 34). The report stated that the organized health care system at that time could do more than merely serve as a "catchment net" for the ill, noting that lifestyle, physical and social environments, and genetic risks were more likely to impact the health outcomes of Canadians than medical or hospital care alone (Lalonde, 1974, p. 5; Criston, 2000). Additionally, the report emphasized the need for improvements in the environment, reductions in self-inflicted health risks, and greater knowledge of human biology as a necessity to improve quality of life in more Canadians (Lalonde, 1974). "Although hailed as ground-breaking, [*A New Perspective on the Health of Canadians* 1974] really only echoed what Public Health Nurses [had] been saying for decades" (Harrison, 2011, p. 34). The 1974 report led to the health promotion movement and shifted health care from a biomedical model to a social model of care (Crichton, 2000; Dhari, 2013). PHNs, like those in British Columbia, saw this as a shift from an illness treatment and disease focus to an emphasis on collaborative partnerships and a time of empowerment (Dhari, 2013). "[PHNs] engaged in the health promotion movement through strengthening community action and community development, which led to the creation of many health promotion initiatives..." (Dhari, 2013, p. 5). Subsequently, activities that focused on lifestyle and changing behavior emerged in B.C., including exercise, diet, and anti-smoking campaigns (MH, 2000).

The Alma-Ata Declaration. In 1978, the *Alma-Ata Declaration* was adopted from the World Health Organization's International Conference on primary health care in Alma-Ata Russia, and emerged as a significant milestone in the field of public health (WHO & United Nations Children's Fund [UNICEF], 1978). The document affirmed that the health status of the people of the world was unacceptable and stressed for a new approach to health and health care, which would permit individuals to live socially and economically productive lives (WHO & UNICEF, 1978). As the first international declaration recognizing the importance of primary health care (WHO & UNICEF, 1978; Stewart, 1995), the document identified the need to formally adopt primary health care as a strategy to meet the goal of 'Health for All' by the year 2000 (WHO & UNICEF, 1978). The Declaration called for "... urgent and effective national and international action to develop and implement primary health care throughout the world..." (WHO & UNICEF, 1978, p. 6). Primary health care was defined as a model for

> ...[E]ssential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individual and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO & UNICEF, 1978, p. 3)

The model stressed creating conditions that would help improve the health of all Canadians, by putting individuals and families across the continuum of care at the center of health services, through overall social and economical community developments (WHO & UNICEF, 1978; Stanhope, 2008; CNA, 2016). Member countries of the World Health Organization, including Canada, accepted this approach of primary health care,

and they agreed to work towards principles of 'Health for All' in accord with the Declaration (WHO & UNICEF, 1978; Stewart, 1995). The document also reaffirmed that governments had a responsibility for the health of their people, and it further pressed governments to exercise political will to formulate national policies and strategies to sustain primary health care as a part of their national health insurance programs (WHO & UNICEF, 1978). It further called on all international and national organizations and health care workers, including PHNs, to support this new commitment to primary health care by protecting and promoting the health of all people (WHO & UNICEF, 1978). The *Alma-Ata Declaration* of 1978 served as a basis for major lobbying efforts by PHNs in B.C., and nationally "...provided the impetus for the Canadian nursing profession to articulate and disseminate its vision of a future health care system" (Stewart, 1995, p. 40).

Provincial Policy

Health Security for British Columbians. In B.C., the NDP government commissioned Richard Foulkes to review the health care needs of provincial residents (Crichton, Hsu & Tsang, 1990). Foulkes was a physician and had been a hospital administrator for some time (Crichton, Hsu & Tsang, 1990). The 1973 *Foulkes Report*, officially titled *Health Security for British Columbians,* was a thorough study that assessed B.C.'s $600 million health care industry and presented recommendations for a completely integrated health delivery system focused on preventive medicine (Ford, 1974; Thompson, 1974). As the first provincial study in more than two decades, the report suggested merging physical, mental, and public health divisions by a complete reorganization of the B.C. Ministry of Health (Ford, 1974; Thompson, 1974). Foulkes projected that several shortages in the health care system at the time were due to the lack

of system itself, consequently urging the need for restructuring (Ford, 1974). These shortages included fragmentation of health services, misdistribution of medical workers, escalating health care costs, and the exclusion of consumer decision-making (Ford, 1974). The report suggested moving towards a health care model with a focus on family, community, behavioural sciences, and comprehensive continuing care (Ford, 1974). This was in contrast to the medical model that stressed life sciences and a crisis orientation to care (Ford, 1974). The *Foulkes Report* concluded that more preventative health services and reallocation of governance over the management of health care resources like funding were needed (Green, 1984; Ford, 1974: Thompson, 1974). "Other recommendations dealt with drinking water, noise pollution, fluoridation, marine disposal of garbage and sewage, oil spills, domestic sewage, and the quality of bathing beach water" (Thompson, 1974, p. 353). Although Foulkes received great criticism and scepticism for his assessment from other physicians and the Health Advisory Council (Thompson, 1974), the 1973 provincial report resonated principles of health promotion and the social model of care, which went on to be recognized more widely in the aforesaid federal *Lalonde Report* and national *Alma-Ata Declaration*. These principles also became leading directives in the development of public health policy at the departmental level of governance in B.C.

Vancouver Health Department

Until 1980, PHNs in Vancouver worked under the jurisdiction of the municipal government in what was known then as the Vancouver Health Department (Dhari, 2013; Crichton, 2000; Vancouver Health Department [VHD], 1983). In 1886, under Mayor Malcolm Alexander MacLean, the Vancouver Health Department was established to

"...monitor, maintain and improve the health of the Vancouver community" (VHD, 1983; VHD, 1983, p. 1). Led by a Medical Health Officer, the Department worked hard in the provision and coordination of community care, by adopting a growing public heath mandate, monitoring patterns of morbidity and mortality, and adjusting to the changing political, economical and organizational climate within the province (VHD, 1983). Health status accounting was a primary responsibility of the Vancouver Health Department, in addition to the enforcement of federal government regulations, particularly relating to food purity and environmental control (VHD, 1980; City of Vancouver Archives, 2016). The first major health hazards the Department faced during the early twentieth century included: contaminated milk and water, typhoid fever, and waste disposal (VHD, 1983). As community concerns broadened, public health departments in B.C., like the Vancouver Health Department, developed new priorities and community goals, resulting in a shift in health care services (VHD, 1983).

Over the years the Health Department was charged with providing a wide range of health care services including: medical, clinical and preventive services, communicable disease control, continuing care, as well as mental health and occupational health services, and public health nursing (CNA, 2016). These services functioned and were delivered in accord with the Departments central goals:

1. to reduce preventable disease and disability;
2. to increase the public's knowledge, awareness and use of measures that maintain and improve health;

3. to ensure that quality community health services are available and accessible to those who need them;
4. to reduce health hazards in the physical environment;
5. to ensure that public policies reflect a greater concern for the public's health (VHD, 1983, p. 2).

Further, these services complimented the work of local hospitals, health agencies, long term care facilities, and private health service providers (VHD, 1983).

"Although [PHNs were] employed as Provincial Civil Servants, they [were] assigned to local health units to function as members of the health services" (Department of Health Services and Hospital Insurance, 1968, p. 60). PHNs were situated in a number of local health service areas managed by the Vancouver Health Department, which amalgamated over time into four health units. (VHD, 1983; VHD, 1990) These health units were segregated by geographical boundaries within the community for easy public access (Dhari, 2013; VHD, 1983; VHD, 1990). Each health unit, respectively, had its own character and was associated with unique demographics, social conditions, and health care needs within its service delivery environment (VHD, 1983; VHD, 1990). The South Unit, for example, primarily served "...middle-class, younger adult population, over 40% of which [had] English as a second language" (VHD, 1983, p. 49); The West Unit, on the other hand, primarily served the upper income, better educated, English-speaking population, with a higher portion of elderly residents (VHD, 1983). PHNs also provided services through a number of outreach sites including clinics, schools, day cares, and childcare centres held in local churches and community centres (VDH, 1983). "Each [PHN was] responsible for [public health nursing] service in her district within the

framework of the policy of the local health unit and the Health Branch" (Department of Health Services & Hospital Insurance [DHSHI], 1968, p. 60). This allowed for similar public health nursing services to be available to all residents across the province, from urban and city areas to more rural parts of B.C. (DHSHI, 1968; Green, 1984).

Funding. The Vancouver Health Department held key external relationships with the City of Vancouver, the University of British Columba, the Vancouver School Board, Voluntary Health Agencies, and the B.C. Ministry of Health for funding, programing and coordination (VHD, 1983). In comparison, "the Vancouver Health Department's expenditures [were] only a small fraction of overall Provincial and Municipal expenditures..." (VHD, 1983, p. 3). By program, the Health Department spent on average 42 % on prevention, 20% on home care, 16% on long-term care, and 7% on environmental health (VHD, 1983). Sources of revenue included the following: federal and provincial governments, other municipalities, the Vancouver School Board, Medicare, University of British Columbia, and Vancouver Community College, along with immunization and prenatal class registration fees (VHD, 1978).

> In 1977, in response to rapidly increasing health care expenditures and a recession, the federal government passed the *Federal Provincial Fiscal Arrangements and Established Programs Act*. This Act replaced [federal-provincial] cost sharing with block transfers and grant payments to provinces, thus leading the way for decreased federal payments (Wilson, 1995, p. 10).

In B.C., the Vancouver Health Department's expenditures continued to steadily increase. In 1978 alone, the department spent $11,924,135 over a twelve-month period, breaking even with their source of revenue (VHD, 1978). Expenses included salaries, special

services and programs, professional education, rent, supplies and general costs of operation (VHD, 1978). Come 1982, this number had nearly doubled to $22,415,000 (VHD, 1983).

Implications for Public Health Nursing

The sixties and seventies were a period of growth and change both in the province of B.C. and in the service of public health. “Nurses [then] worked in a generalist public health nursing role, providing services to families ranging from prenatal to children aged 24 years” (Dhari, 2013, p. 3). They did everything from birth to death and acted in a full range of duties to get whatever needed to be done (PHN B. Allen, oral history interview, April 2, 2015; PHN B. Selwood, oral history interview, April 2, 2015). “As generalized [PHNs], their work [was] not limited to any particular age-group or segment of society and their services [were] available to all” (DHSHI, 1968, p. 60). Through the 1960s, great emphasis was directed towards secondary prevention (Green, 1984). Public health nursing services focused on immunization, screening, referral, and follow-up to newborns, young children, youth, and their families in childcare facilities, local clinics, schools, and homes (Green, 1984; VHD, 1993). During this time, public health nursing in interior B.C. was reportedly quite different from public health nursing in Vancouver (PHN B. Copeland, oral history interview, May 5, 2015). In poor and impractical working conditions, PHNs would travel away from home to remote communities in B.C. to run immunization, screening, and assessment clinics (PHN B. Copeland, oral history interview, May 5, 2015; PHN B. Selwood, oral history interview, April 2, 2015). Besides providing basic public health services, PHNs in rural B.C. were expected to do a variety of procedures (such as x-rays), help solve community problems, and adapt their services

to better meet the lifestyle and needs of the non-indigenous people they served (PHN B. Selwood, oral history interview, April 2, 2015; PHN S. MacLeod, oral history interview, May 5, 2015).

Over the years, "public [h]ealth [n]ursing continued to expand its outlook [on health] to include new areas of concern due to the changing health needs of the population..." (Green, 1984, p. 144). In the early 1970s, it became clear that existing broad-range health measures like immunizations, safe water, and food were not the only solutions to good health (Green, 1984). As emphasized in the *Lalonde Report*, *Alma-Ata Declaration,* and *Foulkes Report*, it was found during this time that more effort was needed to maintain and improve the well-being of individuals in the province (Green, 1984). As a result of this new direction, PHNs began to redirect their focus to encouraging individuals to improve their health and quality of life through preventive measures like nutrition and physical activity (Green, 1984). PHNs also began to stress the importance of drug and alcohol control in addition to safety education with counseling, group teaching, and learning sessions (Green, 1984). In contract with the Vancouver School Board, PHNs provided a wide range of supports and education programs to assist students to develop healthy attitudes and behaviors through screening and health promotion practices (VHD, 1993). PHNs were considered part of the school staff and had their own working office (PHN J. Warnyca, oral history interview, May 15, 2015). They partnered with teachers to teach family-life education and provided any necessary first aid at the school (PHN J. Warnyca, oral history interview, May 15, 2015). PHNs also became responsible for prenatal care for families living around the schools, which included parenthood education classes to expectant parents; together with, support,

teaching and referral services to new mothers (PHN J. Warnyca, oral history interview, May 15, 2015; VHD, 1993). By the end of this period, public health policy increased focus and funding on health promotion in addition to disease prevention in B.C., which helped allow PHNs to expand more preventative programs and services in both city and rural areas of the province alike.

Chapter Three: Public Health Policy from 1980-1995—Regional Health Boards

In chapter three, I address changes to public health and public health nursing from the period of 1980 to 1995. Discussion will build upon the ideals of primary health care, together with health promotion and the social determinants of health, and centre on the introduction of a population health focus. This era marked a shift in public health policy and in the work of PHNs from a focus on health promotion concerning individual risk factors, better known as the self-care movement, and towards the new population health discourse. The definition of health grossly evolved during this period from terms of disease and illness to a way of living. During this time period, the dominant provincial governance structure of public health restructured into one of regional health boards as a result of national changes and health care reform. The Vancouver Regional Health Board will be discussed as a case example of this governance structure. I end this chapter by exploring the influence of public health policy on the careers and work of PHNs in B.C. I comment on the way policy from 1980 to 1995 translated into particular directions and use examples from the PHNs interviewed in the Oral History Project to show how these directions subsequently shaped public health nursing during this period.

National Policy

The Canada Health Act. Following the 1957 *Hospital Insurance Act* and the 1967 *Medical Care Act*, extra billing became an issue, whereby people were having to pay a portion of their health care bill (Wilson, 1995). Efforts by PHNs, politicians and the general public generated awareness about the erosion of publicly funded *Medical Care*, which lead to the *1984 Canada Health Act* (Stewart, 1995; Wilson, 1995). The Act itself was a union of the previous 1957 and 1967 Acts, except with a few major amendments

(Wilson, 1995). The purpose of the Act was to establish criteria and conditions related to extended and insured health care services that provinces had to fulfill in order to receive federal money contribution (Health Canada, 2010; Wilson, 1995). The Act not only strengthened Canada's commitment to universal health care by prohibiting extra billing, but it also added the principle of accessibility, which meant that all Canadian's had the access to insured medical services on a prepaid basis, without direct charges at the point of service (Raphael et al., 2010; Wilson, 1995; Health Canada, 2010). Moreover, the Act added a penalty clause, which gave the federal government power to collect financial penalties on a dollar-per-dollar basis against provinces that failed to comply with the five principles of the Act—universality, comprehensiveness, portability, accessibility, and public administration (Wilson, 1995). Resulting the passing of the 1984 *Canada Health Act*, the nursing profession turned focus to community and public health nursing services in new and advanced roles (Stewart, 1995). "This new legislation allowed nurses and health professionals other than physicians to be fully used in a reformed health care system inspired by primary health care" (Stewart, 1995, p. 40).

Achieving Health for All: A Framework for Health Promotion. By the mid-eighties, greater emphasis was placed on health promotion and the social determinants of health following Health Minister Jake Epp's 1986 federal report *Achieving Health for All: A Framework for Health Promotion* (CPHA, n.d.). This report proposed a national framework for health promotion as an approach to help Canadians prevent worsening health problems, create healthy communities, and meet new emerging health challenges (Health Canada, 2004; Stanhope, 2008). Epps's framework identified three major health challenges that needed specific attention: a) reducing inequalities between the rich and

poor; b) increasing prevention efforts; and c) helping people to enhance their capacity to cope with their health circumstances including mental and physical disabilities, and chronic conditions (Health Canada, 2004; Stanhope, 2008; CPHA, 2010). Self-care, mutual aid, and healthy environments were stated as the three mechanisms believed to be intrinsic to health promotion and key to meeting the identified health challenges (Health Canada, 2004; Stanhope, 2008). Self-care referred to the personal decisions or choices made and practices adopted by individuals to preserve his or her health (Health Canada, 2004; Stanhope, 2008). Mutual aid, otherwise known as social support, referred to individuals helping others to deal with their health concerns (Health Canada, 2004; Stanhope, 2008), while healthy environments referred to the creation of surroundings favorable to health, like smoke-free spaces (Health Canada, 2004; Stanhope, 2008). The 1986 *Epp Report* went on to purpose several strategies to enable Canadians to achieve ‘Health for All’, and reflected stronger emphasis on the determinants of health. These strategies included fostering public participation through helping people take control over the factors that influence their health; strengthening community health services through coordinating health promotion programs; and developing healthy public policy across the nation (Health Canada, 2004; Stanhope, 2008). Epp stressed the importance of public participation in implementing health promotion programs within communities and believed that decisions about health should not wholly belong to governing bodies (Health Canada, 2004).

The Ottawa Charter of Health Promotion. Later that year, the World Health Organization, together with Health and Welfare Canada, and the Canadian Public Health Association, hosted the first international conference on health promotion in Ottawa, at which the 1986 *Ottawa Charter for Health Promotion* was adopted "...to achieve Health for All by the year 2000 and beyond" (CPHA, n.d.; WHO, Health and Welfare Canada, & CPHA, 1986, p.1). "This conference was primarily a response to growing expectations for a new public health movement around the world" (WHO et al., 1986, p.1), and it built upon the developments made through the 1978 *Alma-Ata Declaration* on primary health care. The *Ottawa Charter* defined and outlined the concept and workings of health promotion, as well as provided a framework for moving health promotion into practice (Stanhope, 2008; Dhari, 2013). Health promotion was conceptualized as "...the process of enabling people to increase control over, and to improve their health" (WHO et al., 1986, p.1). This meant reaching a state of complete physical, mental, and social well-being—a process which shared responsibility with individuals, groups, communities, health professionals and governments alike (WHO et al., 1986; CPHA, 2010). Moreover, the *Ottawa Charter* redefined health as "...a resource for everyday life, not the objective of living" (WHO et al., 1986, p.1), and it identified fundamentals for health including peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity (WHO et al., 1986; Stanhope, 2008; CPHA, n.d.). In order to make these fundamentals favorable, the *Ottawa Charter* listed five major strategies for promoting health: a) building healthy public policy, by directing policy makers to make better decisions and accept their responsibilities for health; b) creating supportive environments, through the conservation of natural resources and systematic assessments

of changing environments; c) strengthening community action, by empowering communities; d) developing personal skills, through teaching and learning to help make choices favorable to health; and e) reorienting health services, by paying attention to health research, creating mandate that supports the needs for a healthier life, as well as changing professional training and education (WHO et al., 1986, p. 2-3). The *Ottawa Charter for Health Promotion* besides the *1986 Epp Report* demonstrated progressive thinking towards matters of population health and gained political will for health care reform (Stewart, 1995). Provinces across Canada, like B.C., created advisory boards and commissions to determine appropriate models of health care for their respective communities (Stewart, 1995). These task forces shaped recommendations for primary health care, which included this new perspective on population-based health promotion, and "...reflected the messages of the nursing profession's submissions to these committees and commissions" (Stanhope, 2008; Stewart, 1995, p. 41). In causal sequence, the *Ottawa Charter* created a change in the roles assumed by healthcare professionals, including PHNs (Stanhope, 2008). "Health professionals moved from the expert role 'in control' to the roles of advocate, facilitator, supporter, and mediator" (Stanhope, 2008, p. 72).

Health for All Canadians: A Call for Health-Care Reform. From 1985 to 1993, the Canadian Nurses Association (CNA) showed striking leadership in the move toward making primary health care an effective reality in Canada through publicly addressing issues related to health care, supporting the development of public health policies, and enabling political action for change (Stewart, 1995; CNA, 1988). One specific example of this was the 1988 CNA publication, *Health for All Canadians: A Call*

for Health-Care Reform, in which the association refined their commitment to primary health care and advocated for the universal implementation of primary health care in Canada (Stewart, 1995; CNA, 1988). The document urged federal, provincial, and territorial governments to actively pursue the goal of 'Health for All Canadians' by putting primary health care first on the agenda for major health policy creation or changes (CNA, 1988). The CNA argued that although some progress toward 'Health for All' had been made in Canada, "[m]any sectors of the Canadian health-care system continue[d] to be preoccupied with cure and treatment rather than disease prevention and health promotion" (CNA, 1988, p. 15). The 1988 document called for the restructuring of the health care system in Canada and recommended several lobbying strategies for reform "...to better and more appropriately meet the health care needs of Canadians" (Stewart 1995; CNA, 1988, p. 3). These strategies were guided by the five basic principles of primary health care—accessibility, prevention and promotion, public participation, intersectoral cooperation, and appropriate technology—and aligned with the plans identified in the *Epp Report*. *Health for All Canadians: A Call for Health-Care Reform* openly supported the Epp document, calling the framework for health promotion a "national mandate" and a "beginning frame of reference" (CNA, 1988, p. 21-30). In other respects, the 1988 CNA publication clarified the role of nurses in primary health care, provided a body of evidence to support the success of nursing advances towards primary health care, and equally proved to be a national professional voice for PHNs across Canada (CNA, 1988; Stewart, 1995).

Strategies for Population Health. In 1989, the Canadian Institute of Advanced Research (CIAR) introduced population health as a new approach to understanding the complex relationship among the social determinants of health and understanding their influence on the health of groups within populations (Stanhope, 2008; Public Health Agency of Canada [PHAC], 2013; Dhari, 2013). CIRA proposed "...that individual determinants of health do not act in isolation" (PHAC, 2013, History section, para. 3), and that the more we knew about these interactions, the better we would be able to understand why some groups of Canadians are healthier than others despite having timely access to health care, and how factors and conditions outside of the healthcare system can have a strong effect on the health of a population (PHAC, 2013; MH, 2000; Minister of Supply Services of Canada [MSSC], 1994). Much like health promotion, the goal for population health was to "...maintain and improve the health of the entire population and to reduce inequalities in health between population groups" (MH, 2001). After great debate, federal, provincial, and territorial governments formally adopted population health as a new integrated approach to health following the issue of the 1994 national discussion paper *Strategies for Population Health: Investing in the Health of Canadians* (Stanhope, 2008; PHAC, 2013; MSSC, 1994; Dhari, 2013). The report provided an overview on what was known about the key determinants of health, including "...income and social status, social support networks, education, employment and working conditions, safe and clean physical environments, biology and genetic make-up, personal health practices and coping skills, childhood development, and health services" (MSSC, 1994, p. 12), and it discussed at length the growing body of evidence on how these determinants influenced population health (MSSC, 1994). Based on the key determinants

of health, the report recommended three strategies to move ahead with a population health approach: a) to strengthen public understanding and support for the determinants of health; b) to build understanding and support for the determinants of health among policy and key decision-makers in all government divisions, including other non-government stakeholders; and c) to develop collaborative initiatives for priority areas (MSSC, 1994). Unlike traditional health care strategies, which exclusively focused on clinical risk factors of individuals related to disease or illness, the population health strategies aimed to address the wide range of conditional factors that determine health of an entire population (MSSC, 1994). National and interprovincial benefits of this approach included "...increased prosperity, because a healthy population is a major contributor to a vibrant economy; reduced expenditures on health and social problems; and overall social stability and well-being for Canadians" (MSSC, 1994, p. 1). This 1994 discussion paper "...signaled the official endorsement of population health approach in Canada" (Health Canada, 2001, p. 3), and as a result, it marked a shift in the delivery of public health services and in the work of PHNs in B.C. (Dhari, 2013).

Provincial Policy

Closer to Home. B.C. was one of the last provinces in Canada to assemble a provincial health advisory board following the 1986 *Epp Report* and the *Ottawa Charter for Health Promotion* (Crichton, 2000). The Seaton Commission—which was appointed by the Ministry of Health and chaired by Judge Peter Seaton, alongside a former dean of medicine, a hospital CEO, a health economist, and a lawyer—inquired into the status of the health care system in B.C. and made recommendations for its reform in the 1991 report titled *Closer to Home* (Crichton, 2000; Weaver, 2006). The Commission reviewed

the organizational structure and process of the current health care system, including acute and long-term care services, and examined health care costs (Crichton, 2000). The Commission also assessed public health policies to consider alternative health care delivery models and foster health (Crichton, 2000). Findings reported a severe lack of direction and dissociation in the B.C.'s health care structure and made a number of recommendations on all aspects of the system (Office of the Auditor General, 1998). "One of the key recommendations from the Seaton Commission report was to shift management of health care services in the province from a centralized bureaucracy to regional and local levels..." (Crichton, 2000, p. 11). By adopting a regional health care system, autonomous of the government and the Ministry of Health, the Commission believed there could be more community participation and better allocation of health care resources, including access and delivery of services across B.C. (Crichton, 2000; Weaver, 2006). Other recommendations of the 1991 report pressured the provincial government to reconsider "...the regulation of health professions, the shift from acute to community care, the social determinants of health, and quality assurance and utilization management" (Crichton, 2000, p. 15). With national pressure to implement a regional health care system, *Closer to Home* shaped the regionalization of primary health care in B.C. and directed a decade of significant public health policy change within the province (Crichton, 2000; Weaver, 2006).

New directions for Health in BC. Acting on the Seaton Commission's findings and recommendations, the Ministry of Health announced that government would adopt the Commission's policy in its 1993 publication *New Directions for Health in BC: Action for a Healthy Society* (Weaver, 2006; Crichton, 2000). The publication outlined the

Ministry's strategic framework for reforming the provincial health care system in B.C. to better "...promote and provide for the physical, mental and social well-being of all British Columbians" (Weaver, 2006; Crichton, 2000, p. 16). The *New Directions* policy sought to achieve five objectives: a) clarification on provincial health goals by a shared vision towards health promotion and prevention; b) increased public interest and participation in health care decision-making by ensuring public representation in all professional governing bodies; c) growth in local management of health care services by restructuring the Ministry of Health; d) respect for health care providers through the creation of safe working environments; and e) better institutional management by increasing emphasis on organizational accountability (Weaver, 2006; Crichton, 2000; Office of the Auditor General [OAG],1998). In Vancouver, "the focus was on creating community awareness, forming a community planning group, developing a community health plan, and applying for designation as a community health council or regional health board" (Crichton, 2000, p. 17). Based on these objectives, the province aggressively began transferring much of the power for planning, management and delivery of public health care services away from the Ministry of Health and toward local regional health boards, in which the context of public health nursing also shifted (Weaver, 2006; Dhari, 2013).

Vancouver Regional Health Board

With the regionalization and decentralization of health care services in the early 1990s, PHNs no longer worked under the jurisdiction of the municipal government. All western provinces, including B.C., shifted the responsibility of public health services from health departments to regional health boards (Ministry of Health & Ministry Responsible for Seniors [MH & MRS], 1996b; OAG, 1998). "Existing health unit regions

were used as a starting point for defining [Regional Health Board] boundaries based on geography, population, travel and referral patterns as well as the existing mix of services and the capacity for regional self-sufficiency" (MH & MRS, 1993, p. 24). In general, regional health boards, in conjunction with community health councils, were responsible for planning, coordinating, and allocating equitable funds for health care services within their regional boundaries, and for representing populations of their regions (MH & MRS, 1993; MH & MRS, 1996a). The Boards were also accountable for contributing to greater provincial health goals, which were based on the determinants of health and were intrinsic to health promotion and population health (MH & MRS, 1993; OAG, 1998). In B.C., the regionalization process called for the formation of 20 regional boards, one of which was the Vancouver Regional Health Board (MH & MRS, 1996b).

After a considerable amount of transition time, the Vancouver Regional Health Board started work in January1995 (Crichton, 2000). The Ministry of Health directly selected one-third of the members of the Board, while the remaining were appointed by the City of Vancouver (Crichton, 2000). The Vancouver Regional Health Board was specifically responsible for the delivery of health care services to the City of Vancouver, which excluded adjoining towns or cities (Director of City Plans & Director of Community Services [DCP & DCP], 1996). The Board's earliest priorities were to define an organizational purpose and direction through the identification of its primary objectives, and to develop a comprehensive regional health plan—which included reviewing the health status of the population, identifying population concerns, and creating focused community driven health care services (DCP & DCS, 1996). Public involvement was key for the implementation and operation of this new governance

structure (DCP & DCS, 1996). The Board's work supported the conditions of the World Health Organization as well as the 1984 *Canada Health Act* (Crichton, 2000), and furthermore it adopted principles outlined in the aforementioned national and provincial policies, including the 1986 *Epp Report* and *Ottawa Charter for Health Promotion*, and the 1994 discussion paper *Strategies for Population Health*.

Funding. The provincial government, represented by the Ministry of Health, assumed 100% of public funding responsibility for regional health care services (MH & MRS, 1993; General Manager of Community Resources [GMCR], 1995). Regionalization assessment teams were set-up to assess regional differences and demand for health care resources (MH & MRS, 1993; GMCR, 1995). Population health outcome information and regional service cost and utilization information were key to allocating fair and equitable funding to regions, as well as integrating health care services at the local level in the most cost-effective manner (MH & MRS, 1996a; MH & MRS, 1993). "The transfer of authority for health service delivery to the regions provide[d] an opportunity to establish mechanisms to ensure public spending [was] used appropriately to support and improve health" (MH & MRS, 1996a). It was estimated that full provincial funding and the transfer of the Vancouver Health Department to the Vancouver Regional Health Board was worth roughly a net $2 million annually to the City of Vancouver (GMCR, 1995). This did not include revenue from the sale of Health Department assists or the transfer of the B.C. Nurses Union contract from the municipal sector to the provincial health sector (GMCR, 1995).

Implications on Public Health Nursing

The eighties and early nineties were another period of significant growth and rapid change in the province of B.C. and in the service of public health. Through the 1980s, educational workshops facilitated PHNs to adopt the health promotion framework in all aspects of their work (Dhari, 2013; Stewart, 1995). PHNs became increasingly involved in community development work, including research, and they took on leadership roles to support community capacity building and to develop various health promotion initiatives and programs—which adopted the social determinants of health, supported achieving ‘Health for All’, and furthermore guided health policy making across the province (Harrison, 2011; Dhari, 2013; PHN P. Mauch, oral history interview, March, 20, 2015; PHN C. Whalley, oral history interview, March 20, 2015). “It was at this time that [PHNs] began to organize and facilitate groups, such as the parent–infant group, a program for postpartum families, and a parenting program for parents of adolescent children” (Dhari, 2013, p. 6). Most PHNs became community consultants or key stakeholders on program committees, in which they reviewed policy and procedures with other nurses, advocated for community resources in their areas, and participated in city planning (Harrison, 2011; PHN P. Mauch, oral history interview, March, 20, 2015). “This was a challenging change for many [PHNs] who were used to more traditional ideas of public health nursing such as home visits to new [moms]...” (PHN C. Whalley, oral history interview, March 20, 2015), and working in schools with children (Harrison, 2011).

By the early 1990s, following regionalization and aligning with emerging policy on population health, there was a shift in the way public health nursing was delivered. As

a result, many PHNs were displaced and experienced practice change (Gogag, 1996). PHNs were reorganized into aged-focused care, in which their scope of practice changed from a generalist to a population focus (Dhari, 2013; PHN B. Allen, oral history interview, April 2, 2015; PHN P. Mauch, oral history interview, March, 20, 2015). PHNs "...no longer had a district focus, caring for all ages and needs. Instead, [they] used a focused approach in which each nurse focused on a particular age group within a wider geographic area" (PHN S. Weatherill, oral history interview, May 5, 2015). PHNs who once followed families—from pregnancy through to birth, to childhood clinics, to school-age and youth programs, for example—now solely cared for infants and toddlers or the pre-school population (Harrison, 2011; PHN B. Allen, oral history interview, April 2, 2015; PHN J. Warnyca, oral history interview, May 15, 2015). At large, "...the role of public health nursing shifted from engaging the community, building collaborative relationships, and addressing disparities, to delivering standardized programs designed to respond to the prevalence and incidence of health issues in the population" (Dhari, 2013, p. 17). Many PHNs saw this change as unsatisfying and as a loss, since they no longer were able to develop close lasting relationships with community members (Harrison, 2011; PHN S. MacLeod, oral history interview, May 5, 2015; PHN S. Weatherill, oral history interview, May 5, 2015). By the end of this period, public health policy increasingly focused on population health services in B.C., which affected the mandated scope of practice of PHNs in the province and limited their ability to participate in health promotion work.

Chapter Four: Public Health Policy from 1995-2005—Regional Health Authorities

In chapter four, I address recent structural changes to public health and public health nursing from the period of 1995 to 2005. Discussion will focus on the reorganization of public health care and the integration of acute and community health care services. Much of the policy development in this era centered on health care renewal and sustainability into the 21st century, which included transferring and integrating services and funding to create a regionally focused health care system that aimed to address local needs and delivered quality health care 'closer to home' in all communities across Canada. During this time period, the dominant provincial governance structure of public health reformed to join regional health authorities. The Vancouver Coastal Regional Health Authority will be discussed as a case example for this governance structure. I end this chapter by exploring the influence of public health policy on the careers and work of PHNs in B.C. I comment on the way policy from 1995 to 2005 translated into particular directions and use examples from the PHNs interviewed in the Oral History Project to show how these directions subsequently shaped public health nursing during this period.

National Policy

Building on Values: The Future of Health Care in Canada. In early 2001, the federal government assembled the Commission on the Future of Health Care in Canada, headed by Commissioner Roy J. Romanow, to review *Canadian Medical Care*, involve Canadians in future planning of the health care system, and make policy and procedure recommendations (Romanow, 2002; Health Canada, 2009). After 18 months of extensive efforts, the Commission released its conclusions and recommendations in the 2002 report

titled *Building on Values: The Future of Health Care in Canada* (Romanow, 2002; Health Canada, 2009). The Commission conducted its work by analyzing existing reports on Canadian health care, consulting with policy experts and key stakeholders, contracting research, and conducting site visits to refine priorities and to gain new perspectives (Romanow, 2002; Health Canada, 2009). The Commission also worked collaboratively with universities, business and advocacy groups, and broadcasters to raise awareness of the challenges facing the Canadian health care system and furthermore to engage Canadians "...in an informed decision about the future of health care in Canada. Tens of thousands of Canadians... participated in the process, which included public hearings, workshops, policy dialogues and other consultations" (Romanow, 2002; Health Canada, 2009, para. 3). By the end of its review, the Commission brought forward 47 detailed recommendations that called for extensive changes and outlined actions needed for reform and health care renewal to improve the system's overall quality and long-term sustainability into the future (Romanow, 2002; Health Canada, 2009). These recommendations ranged from modernizing the foundations of *Canadian Medical Care* to reconsidering Canada's role in improving health on the global platform (Romanow, 2002). Recommendations, in brief, drew attention to health care funding and budgets, quality and safety, government partnerships, access to health care and home care services, new roles for health care professionals, and aboriginal health, as well as drug coverage, technology and equipment (Romanow, 2002). Romanow (2002) ensured these recommendations were evidence-based and reflected the core values, like equity, Canadians looked for in their health care system (Health Canada, 2009).

Building on Values: The Future of Health Care in Canada was recognized as a voice for ordinary Canadian citizens, health care workers, and health experts alike. It was one of the first reports from the early 2000s that urged for health care renewal and encouraged new primary health care investments. The Commission thought by making primary health care a central focus of the Canadian health care system, provinces and territories could:

- take immediate action to prevent illness and injury, and improve the health of all Canadians;
- reduce costly and inefficient repetition of tests and overlaps in care provided by different sectors and different providers;
- replace unnecessary use of hospital, emergency, and costly medical treatments with comprehensive primary health care available to Canadians 24 hours a day, 7 days a week;
- break down the barriers between health care providers, facilities, and different sectors of the health care system and concentrate on the common goal of improving health and health care for Canadians (Romanow, 2002, p. 116).

Moreover, the 2002 document stressed the growing need for investments in home care services (Romanow, 2002; Stanhope, 2008). By investing in home care, the Commission believed Canadians, especially seniors and those living with long-term disabilities or chronic illnesses, would be able to stay within their homes and communities "...with the assurance that someone will be there to monitor their health" (Romanow, 2002, p. 171). This not only would save health care dollars but also improve care and the quality of life for those Canadians who alternatively would be left hospitalized (Cohen et al., 2009;

Romanow, 2002). On the whole, the 2002 report aimed to direct the focus of new public health policy away from hospitals and medical treatments, and towards prevention and promotion efforts at the local and regional level (Romanow, 2002).

Accord on Health Care Renewal. In 2003, the First Ministers—consisting of federal, provincial, and territorial governing leaders—put forward an action plan for health care reform in the document *Accord on Health Care Renewal* (Health Canada, 2003; Health Canada, 2012). Under the Accord, the First Ministers agreed to work collectively with each other, with health care providers, and with Canadians at-large to renew and sustain publicly funded health care (Health Canada, 2003; Health Canada, 2006). "The Accord committed governments to work toward targeted reforms in areas such as accelerated primary health care renewal; supporting information technology...; coverage for certain home care services and drugs...; and better accountability from governments" (Health Canada, 2012, Background section, para. 9). The main objectives of the Accord were to ensure that Canadians received access to an appropriate health care provider all hours of the day and all days of the week; received timely access to diagnostic testing and procedures; received access to needed drugs and treatments, regardless of financial restraints; and received access to quality care and services on the basis of need, no matter where they lived (Health Canada, 2003, p.1-2). These objectives reflected the concerns expressed by Canadians and the recommendations put forward by national and provincial reviews (Health Canada, 2003; Health Canada, 2006). Its focus on accelerated primary health care renewal, for example, reflected and built upon the recommendations put forward by the 2002 *Romanow Report*. In general, the 2003 document proposed structural changes to the Canadian health care system and called for a

better balance between acute and community health care delivery systems. In response to the Accord, the federal government created a five-year, $36.8 billion Health Reform Fund that increased cash transfer payments to provinces and territories in support of primary health care renewal (Health Canada, 2003; Health Canada, 2006; Health Canada, 2012).

Provincial Policy

Health Authorities Act. In 1996, the B.C. government passed the *Health Authorities Act*, as a legal framework for regionalization and restructuring of health care services in the province (MH & MRS, 1993; Ministry of Justice and Legislative [MJL], 1996; Dhari, 2003). The Act defined new provincial roles and responsibilities of regional health boards, community health councils, and the Ministry of Health. (MH & MRS, 1993; MJL, 1996; OAG, 1998). The Act also set out provincial standards for the amalgamation of two or more regional health boards and designated corporations, like local regional health authorities (MJL, 1996).

> As laid out in the *Health Authorities Act*, the [Ministry] of Health [was] responsible for establishing provincial standards for the provision of health services, specifying the types and levels of service that must be provided in a region or community, and ensuring that, once grants [were] allocated, boards and councils [complied] with applicable regulations (OAG, 1998, p.37).

Regional health boards, under the Act, were responsible for implementing a regional health plan; developing, monitoring, and evaluating regional policies and standards; allocating federal funds to community health councils; and delivering regional health services in collaboration with other publicly funded health care institutions or agencies

(MH & MRS, 1993; MJL, 1996). Members of a regional health board were appointed by the Ministry of Health to ensure fair representation of the region (MH & MRS, 1993). The 1996 Act, "...provid[ed] a balance between public accountability and ensur[ed] groups traditionally under-represented in [the] health care system [were] included" (MH & MRS, 1993, p.23). Regionalization of provincial health care services was found to be an important step in better managing provincial health care resources (OAG, 1998; Weaver, 2006). Additionally, regionalization was sought to expand on the traditional perception of health by moving focus and funding away from expensive institutions, like hospitals and long-term care facilities, to other areas of the health care system, such as public health, home, and community care services (MH, 1997; MH, 2000; Weaver, 2006; Cohen et al., 2009).

Better Teamwork, Better Care. In a continuing effort to improve the health care system in B.C., the provincial government implemented the 1997 *Better Teamwork, Better Care* approach to regionalization (MH, 2000; Weaver, 2006). This new action plan replaced the 1993 *New Directions for Health in BC* framework for strategic health care reform and set out specific changes for the amalgamation of health care services and systems in B.C. (Weaver, 2006). *Better Teamwork* transferred the governance of regional health boards and community health councils, including regional health care services, from the Ministry of Health to regional health authorities (MH, 2000). This policy change meant regional health authorities were now accountable to the Ministry of Health, instead of local communities as originally intended in *New Directions* (Weaver, 2006). The key objective of *Better Teamwork* was to simplify and coordinate the management of health care services in B.C. by creating a single health care governance structure (MH, 1997;

MH, 2000; Weaver, 2006). In doing so, it was thought to improve health care service management and delivery, reduce bureaucracy, prevent redundancy in resource allocation, and above all, save the province health care dollars (MH, 1997; MH, 2000; Weaver, 2006). Together, the 1996 *Health Authorities Act* and the 1997 *Better Teamwork, Better Care* approach called for the reduction and amalgamation of approximately 700 independently working health care delivery systems in the province (Vakil, 1997, as cited in Weaver, 2003). These systems included regional health boards, community health councils, hospitals, community and public health care services, home health services, mental health agencies, and long-term care facilities (MH & MRS, 1993; MJL, 1996). Regional health boards, for example, were reduced from 20 to 11, and community health councils were reduced from 82 to 34 (Weaver, 2006). As such, "the joining of the acute and community sector led to structural changes of public health services" (Dhari, 2003, p. 4).

Vancouver Coastal Regional Health Authority

Because of health care renewal and restructuring, regional health boards merged with the acute sector to join local regional health authorities. In 2001, for instance, the Vancouver Regional Health Board amalgamated into the Vancouver Coastal Regional Health Authority (Dhari, 2013). This transition proved to be challenging for most regional health authorities, largely due to the lack of leadership and clarity in B.C.'s health care system at the time (Weaver, 2006). Many health authorities struggled to understand their new role and responsibilities, and were confused about what exactly was expected of them (OAG, 1998; Weaver, 2006). In particular, health authorities were uncertain about their imposing boundaries, and about whether they needed approval from

the Ministry of Health before making critical health care decisions (OAG, 1998). "Among other things, the lack of clarity meant the [regional health authorities] were unsure of how to meet the goals of regionalization as communicated by the province" (PBC, 1998, as cited in Weaver, 2006, p. 57), which made it difficult for regional health authorities to be accountable (Weaver, 2006).

Today, the Vancouver Coastal Regional Health Authority is one of five regional health authorities in B.C., and employs approximately 13,080 full-time and part-time staff, including PHNs (PBC, 2017b; Vancouver Coastal Health [VCH], 2014a; MH, 2000). As one of B.C.'s largest health care providers, Vancouver Costal Health delivers a number of primary care, hospital care, public health, mental health, addictions, and residential and home care services to more than one million B.C. residents (VCH, 2014a; VCH, 2014b)."The geographic area covered by [Vancouver Coastal Health] includes 12 municipalities and four regional districts in the Coastal Mountain communities, Vancouver, North Vancouver, West Vancouver, Richmond and 14 Aboriginal communities" (VCH, 2015, p. 5). Overall, the Vancouver Coastal Regional Health Authority strives to support the health and well-being of its population by delivering accessible patient-centered practices and services (VCH, 2015).

Funding. Annually, the Vancouver Coastal Regional Health Authority receives $3.4 billion in funding to provide health care services within the Vancouver Coastal region (VCH, 2014a). The majority of the funding is received from the Ministry of Health (VCH, 2015). Other sources of revenue include the Medical Services Plan and non-provincial government sources like the Vancouver General Hospital and University of British Columbia Hospital Foundation (VCH, 2015). By service, Vancouver Coastal

Health spends roughly $2,115 millions on acute care, $242 millions on community care, and $98 millions on population health and wellness (VCH, 2015).

Implications on Public Health Nursing

The period of 1995 to 2005 was a time best referred to as the ‘big shakeup’ in public health care in B.C. (PHN B. Allen, oral history interview, April 2, 2015). Following significant employer and health care organization changes, a “hospital acute care approach” was included and implemented in public health practice (PHN B. Allen, oral history interview, April 2, 2015). “Changes in health care delivery...resulted in shorter hospital stays and more services being delivered at home rather than in hospital” (Romanow, 2002, p. 180). Home care services, for example, grew to include a wide range of treatments, including post-acute care follow-ups, dialysis, wound care, and home intravenous therapy (Romanow, 2002). Although this new model generally cost less than keeping individuals in hospital, it provided a narrow, top-down approach to public health care and affected the work of PHNs (Romanow, 2002; PHN C. Whalley, oral history interview, March 20, 2015). The “hospital acute care approach” limited the ability of PHNs to be proactive in preventive care and made it difficult for them to participate in community development and health promotion practices that had initially been conceptualized in the *Lalonde Report* (PHN C. Whalley, oral history interview, March 20, 2015; Dhari, 2013). Likewise, joining of the acute and community sector resulted in substantial public health nursing funding, time, and human resources restraints (Dhari, 2013). This arguably eroded the ability of PHNs to devote time to community needs and preventive care work that PHNs had traditionally understood as the central role of public health nursing (Dhari, 2013). For example, with the integration of more acute-care like

services in public health practice, PHNs found themselves spending more time on immunizations and providing acute clinical care to post-partum mothers and newborns (Dhari, 2013). This new focus provided less time for PHNs to engage in health promotion planning and implementation, which took a lot of time on its own (Dhari, 2013). "Orientation for public health nurses [also] became shorter and new public heath nurses no longer got in-the-field mentorship" (PHN B. Allen, oral history interview, April 2, 2015). In conjunction with experiencing changes in their working conditions, PHNs felt unsupported, had fewer opportunities for continuing education, voiced discontent in their work, and experienced burnout (PHN B. Allen, oral history interview, April 2, 2015). Moreover, PHNs believed that the new management and bureaucracy, including policy makers, did not understand the original goals of regionalization and what public health nursing entailed or offered (PHN B. Copeland, oral history interview, May 5, 2015; Weaver, 2006; Dhari, 2013). Furthermore, PHNs feared they would not be well represented in the health care decision-making processes under this latest organizational structure of health care (Bruce, 1997). Overall, PHNs experienced the increased focus on acute care in public health practice as a loss. Policy makers also picked up this loss as they continued to create policies, operating standards, and practice guidelines that marginalized the social determinants of health to integrate more acute-orientated services into communities (Raphael et al., 2010). By the end of this period, public health policy increasingly focused on health care sustainability by consolidating health care services in B.C. and transferring more acute care-like services 'closer to home' in communities. This transformation expanded home care services; however, it also consequently restricted the traditionally valued preventive care work of PHNs.

Chapter Five: Conclusion—Summary, Dissemination & Limitations

This Scholarly Practice Advancement Research project set out to review the historical development of public health nursing in B.C. during the period from 1960 to 2005 through the lens of public policy and governance structure. Using oral history interviews of PHNs from the Vancouver, B.C. area, as well as both primary and secondary sources, the project examined what key policy documents, reports, and major developments have influenced nursing practice in public health from 1960 to 2005 in B.C. The key objectives of this project were as followed a) to familiarize myself and readers with the major Canadian historical developments in public health care, with a particular emphasis on provincial health policy in B.C.; b) to examine the impact of public policy and changes in governance structure on public health nursing in B.C.; c) to explore and present social, political, and economic factors influencing the development of public health nursing in B.C.; and d) to contribute to the preservation of B.C.'s nursing history. These objectives have been achieved by dividing this project into three distinct time periods: Public Health Policy from 1960 to 1980—Health Departments; Public Health Policy from 1980 to 1995—Regional Health Boards; and, Public Health Policy from 1995 to 2005—Regional Health Authorities. In each period, major changes in national and provincial public policy and governance structure of public health were reviewed, with a particular focus on the City of Vancouver as a case example. The effect of these policy and governance changes on the work and careers of PHNs at the time was then assessed.

Public health policy from 1960 to 1980—including *Canadian Medical Care*, the *Lalonde Report*, *Alma-Ata Declaration*, and the provincial *Foulkes Report*—affirmed

commitment to primary health care by protecting and promoting 'Health for All' (WHO & UNICEF, 1978). These public policies ensured responsible access to medically necessary services and called for a new direction in health and health care. The concepts of health promotion and the social determinants of health were introduced to improve health outcomes of Canadians. Additionally, these polices gave rise to the health promotion or self-care movement, which incorporated identifying and understanding individual risk factors that could increase the likelihood of developing a disease or illness, strengthening community action and development, and investing in new healthy living programs and initiatives. Much of the policy development in this period shifted the focus of public health away from the traditional biomedical model of care to a more social model of care. At the time, the dominant provincial governance structure of public health was characterized as the period of health departments or health units. PHNs then worked as generalists, providing a full range of supports to families from prenatal and birth, to young adult and death (Dhari, 2013). As a result of public policy, PHNs increased their outlook on health to focus on more health promotion and preventative services.

Public health policy from 1980 to 1995—including the *Canada Health Act*, *Epp Report*, *Ottawa Charter for Health Promotion*, *Strategies for Population Health* and *Closer to Home*—further strengthened the commitment to primary health care by building on the ideals of health promotion and the social determinants of health. National frameworks for moving health promotion into practice were introduced to help Canadians prevent worsening health problems, create healthy communities, and meet new emerging health challenges (Health Canada, 2004; Stanhope, 2008). Furthermore, much like health

promotion, the concept of population health was introduced as a new approach to understanding the complex relationship among the social determinants of health and their influence on the health of groups within populations (Stanhope, 2008; PHAC, 2013; Dhari, 2013). Public policies from 1980 to 1995 grossly evolved the definition of health from terms of disease and illness to quality of life and a way of living. Overall, these policies demonstrated progressive thinking and called for the restructuring of the health care system to better meet the health care needs of Canadians. At the time, the dominant provincial governance structure of public health restructured into one of regional health boards succeeding national changes and health care reform. PHNs then were leaders in health promotion, prevention, and community development work. Following public policy, the scope of public health nursing changed from generalist into population age-focused teams. As a result, the role of PHNs shifted away from engaging communities through health promotion to delivering standardized programs designed to target the health needs of particular populations (Dhari, 2013).

Public health policy from 1995 to 2005—including the *Romanow Report*, *Accord on Health Care Renewal*, *Health Authorities Act* and *Better Teamwork, Better Care*—encouraged new primary health care investments to improve the health care system's overall quality and long-term sustainability into the future. These policies focused on regionalization and the integration of acute and community health care services. Furthermore, these policies encouraged more home care service investments to better support Canadians, especially seniors and those living with long-term disabilities or chronic illnesses, in their homes and communities. Much of the policy development in this period strived to improve health care service management and delivery, reduce

bureaucracy, prevent redundancy in resource allocation, and primarily save the country health care dollars (MH, 1997; MH, 2000; Weaver, 2006). At the time, the dominant provincial governance structure of public health reformed to join regional health authorities. Due to this public policy, public health nursing faced substantial restructuring. As a result, PHNs experienced a "...shift in their work from using health promotion strategies to design programs in response to community needs to...delivering clinical services predetermined by external forces..." (Dhari, 2013, p.80).

Conclusion

From the analysis of my historical review, it is apparent that evolving public policy and changes in governance structure directly influence nursing practice in public health. Over the course of forty to fifty years, public policy has done well in creating a reformed health care system that has been committed to primary health care and achieving 'Health for All'. Still, as this historical review of public health nursing in B.C. from the latter half of the 20th century has also shown, further policy work is required to restore autonomy, health promotion, and prevention practice in public health nursing. It is evident from previous conclusions that health promotion and prevention initiatives are valued public health nursing roles, and that they are key to building healthier populations (Dhari, 2013). Despite the need to incorporate more acute care focused services into home and community services, traditional preventative and health promotion aspects of public health work should not be overlooked. Since the future public policy and governance structure cannot be foreseen, it is important to encourage health policy makers and planners to emphasize and sustain health promotion and prevention initiatives in future health care decision-making to help create meaningful and lasting improvements

in public health and the work of PHNs. Furthermore, the analysis of the more recent experiences of PHNs seem to convey a strong message encouraging health care leaders and elected politicians to heighten lobbying efforts for health promotion and prevention services, and to pressure for more decentralized management of health care services to assist communities and PHNs in assuming their rightful role in public health decision-making.

Dissemination

This historical background paper serves to illustrate how change has come about in public health nursing from the latter half of the 20th century in B.C. By capturing the history of policy development in public health nursing, this project shows how Public Health Nurses' work has shifted in response to the sociopolitical environment and the restructuring of the health care system. I believe that the knowledge gained from this project will provide context for experienced PHNs and new graduate nurses alike to understand the rationale behind the practice of public health nursing, as well as, help to provide support for a clearer direction for future public health nursing planning. This knowledge will encourage critical reflection on the value of the nurses' work in public health and provide professional identity among nurses (CNA, 2007). Furthermore, the review and analysis conducted within this project has contributed to the growing research base of B.C. nursing history.

Limitations

This project uses the City of Vancouver as one case example for the evolution of public health nursing and governance structure in public health policy. Hence, findings from this review may not be representative of other regions of B.C. or other provinces, and instead call for further historical study of other regions and geographic areas. Additional historical research may provide further insight into the rich and varied social, economic, and political developments of public health and public health nursing in Canada.

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