

The public health nurse—the linchpin of primary health care

Finland is an example of a country in which primary health care has been put successfully into practice. This could not have been done without the help of public health nurses. At a time when socioeconomic and health status was low, a simple and effective public health nursing service was created to bring primary care to people in their homes and neighbourhoods.

The beginnings of public health nursing

Public health nursing in Finland dates back to the beginning of this century. At that time the country was in many respects at the same socioeconomic and health stage as the developing countries today. It was a poor, agrarian country with a high birth rate. Nutrition and housing were often inadequate, and infant mortality was high. Communicable diseases plagued the population, the greatest menace being tuberculosis. The country's geographic location, low population density, poor communications, and cold climate created additional problems.

For those planning the practical measures needed for health improvement, the options were limited. Secondary and tertiary care were still undeveloped. There were few physicians. Nurses had been trained in Finland since 1889 and midwives since

1816, but despite their high-level education they were not prepared for the tasks called for by the new vision of health promotion.

The solution chosen was a simple and economical model of delivering health care to the local communities. The frontline worker would be a nurse with special training in preventive medicine and in the promotion of the social aspects of health. The training of tuberculosis nurses thus started in 1913, while courses in child health and school nursing began in the early 1920s. As a result of experimentation and evaluation, training was integrated in 1924 in the form of a six-month postgraduate course in public health nursing (1, 2).

A public health nursing service is developed

In developing the service, Finland's pioneers studied the methods of education and practice in use elsewhere, especially in England, Germany and, later, in the USA. After consideration of these models, a family-centred service was seen as the most effective and economical form of public health nursing for Finland.

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In keeping with the Finnish tradition of democracy and decentralized administration, the local communes were given responsibility for organizing the basic services financed by communal taxes and state aid. Recognizing the benefits of a comprehensive service, the communal authorities, in cooperation with voluntary organizations, began to organize the service so that one public health nurse in a small area would deal with the health problems of the whole population and provide all the nursing services needed. The voluntary organizations mobilized and supported community efforts to the same end.

The first regulations prescribing tasks and policies for public health nursing were drafted in 1914 and 1924. The public health nurse was to familiarize herself with local housing conditions, nutrition, life-styles, habits and prejudices. If she became aware of any matters harmful to health, it was her task to try to bring about changes. She was responsible for giving health information to people in their homes and in the community, and for providing advice and support for the care of the sick and the prevention of disease.

The new worker was well received by people and the results of her work started to show, especially in child health and the prevention of communicable diseases. The demand for public health nurses in communes grew faster than the resources to train them. The state took over their education in 1931 and new legislation was envisaged. However, the wars of 1939–44 brought all that to a halt (1, 2).

Mother and child health centres

In 1944, acts were passed obligating the communes to establish a dense network of mother and child health (MCH) centres,

communal midwives and public health nurses, with the help of state grants. There was to be one public health nurse for every 4000 inhabitants. The health team in the community consisted of the community physician, a midwife and a public health nurse. In 1944, 40% of all deliveries took place at home, which is why a specialized health worker—the midwife—was needed for prenatal and maternity care.

The MCH centres were located in small premises called “health houses”. In addition, care was provided in village-level sub-centres. Home visits by the midwife and public health nurse were considered most important. Their services were free and available to all. A unique feature of Finnish MCH is that practically all mothers used the service and do so to this day, even though it has never been compulsory. Health houses also offered facilities for other public health nursing services, so people had easy access to first-level health care.

Once the continuity and financing of services were secured by legislation, it became more feasible to plan and develop resources. Thanks to increased educational efforts, the public health nursing posts required by law were filled by the 1950s, even in remote districts. This was especially

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important in view of the post-war baby boom and the availability of new vaccines (diphtheria-pertussis-tetanus, BCG) (2).

Role of the public health nurse

The public health nurse worked for the local Board of Health. Her closest hierarchical superior was the local medical officer, under whose direct supervision she performed medical functions. However, her work was for the most part complementary to that of the physician. The public health nurse had professional autonomy in matters dealing with nursing care and in planning her own work. Her duties emphasized both preventive work and care when recourse to a doctor was not expedient. As a professional, the nurse knew the scope and limits of her knowledge.

In short, public health nursing was characterized above all by social closeness to individuals and families, continuity of care, and a comprehensive approach to health problems. The public health nurse was a confidant to whom people could turn, with even minor health problems. A great advantage of the Finnish public health nurse was that she could take the initiative in offering her services, even make house calls. When she saw a health problem, she decided on the most suitable way of tackling it.

The service focused on health promotion, health maintenance and primary prevention, but was also extended to include acute and tertiary care. Child care and school health work had always received a great deal of

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attention, but people's expectation of more extensive curative care was obvious in communities where there were shortages of

physicians and home help. The integration of preventive and curative services made it easier to recognize individuals' true health status and to help them attain optimal levels of physical, emotional and social well-being. It also minimized overlapping and gaps in the health and welfare service.

Owing to the flexible organization of the service, local and current needs could be taken into consideration and public health nurses could be used to staff national and regional health projects. That is how, for example, the immunization campaigns were carried out.

The use of the public health nurse as a first-line "health screener" was a good solution, especially at a time of shortage of physicians and finances. But a service of this quality demanded a fine professional education and suitable back-up. The most important support for the public health nurse was the local medical officer, while the local hospital provided support when it came to home nursing. In addition, the public health nurse cooperated with all the health and social welfare agencies available to her clients. As the number of health and social professions increased and the services became fragmented, the role of the public health nurse as integrator and interpreter acquired even greater importance. It ensured the continuity of care and a comprehensive approach to clients and their problems (2).

Education and supervision of the public health nurse

Such extensive duties required a high-level professional education. Post-basic specialization at first lasted six months and was later extended to one year. The programme was evaluated periodically to ensure that it met changing needs and working methods. In addition to health

sciences, the studies included social and behavioural sciences presented pragmatically. Guided practical field-work and acquaintance with the local health and social agencies were a central part of the educational process. The aim was to have public health nurses who were socially trained and motivated to serve the population and able to apply their knowledge in different circumstances and with different people.

At least once every 10 years, public health nurses were required to take a supplementary six-week course to help them maintain their professional skills.

Continuing education and readiness for new challenges were also emphasized managerially. Between 1944 and 1972 there was a public health nursing administrator in the health team at both provincial and national level. The Chief Nursing Officer on the National Board of Health participated in planning, evaluating and coordinating public health nursing and developing its potential. The provincial public health nursing administrators concentrated on helping the local public health nurse in planning her work according to local circumstances and needs. Continuing in-service education reached all public health nurses, which was vital because they worked without direct professional supervision. The hierarchy was small and the organization simple and democratic. This provided the conditions for responsible and inspired health service.

In the development of community health care, experimental work was carried out in teaching and demonstration areas in the 1940s and 1950s with the aid of the Rockefeller Foundation. Those areas also served for the teaching of public health nursing students. One innovation was the use of experts to support the local health

team and the provincial health office in special fields of public health. These successful experiments attracted international interest. In fact, the methods used

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in the demonstration areas were very much like the primary health care concepts and strategies that were to be developed much later (2).

An important milestone in Finnish public health nursing was the WHO European Conference on the subject, held in Helsinki in 1958. The Finnish model was presented as an example of the nurse's role in community health care. The report of the Conference (3) is still of relevance to primary health care.

New challenges

From 1950 on, considerable health resources were invested in creating a network of central hospitals. This was a necessity, but it delayed the development of community health care and preventive work. At the same time, rapid changes were taking place in Finnish society and bringing along new health problems. With the advances in medical science and technology, pressure was building for a reassessment of health services.

It became apparent that the high-level medical care and the increased number of hospital beds were not improving the

general level of health. Morbidity and mortality among working-aged men were very high compared with those of other Nordic countries. Community health services were burdened by the increased

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need for care of the aging population and the increased demands for non-institutional care. There was a shortage of community physicians in many areas of the country. The demand for curative care by public health nurses was rising. Clearly, the nurses had to be responsible for smaller districts if they were to carry out all the activities required of them (1).

Adopting new programmes and expanding the primary health care workforce was, however, bound up with the overall reform of the health services. Many simultaneous social reforms delayed its execution.

1972: a new primary health care system

The reorganization of health services was achieved in 1972. The new Public Health Act brought together the various community health activities in a single organizational entity. It also introduced a method of systematic planning at national and regional, as well as local, level.

The local health services were focused on the health centres, which also provided beds for acutely ill as well as chronic patients. New services were introduced and new

professionals recruited, including physiotherapists, psychologists and social workers. The aim was to provide more efficient preventive services for the whole population and to level the differences in the utilization of health services both regionally and between different population groups. In fact, the reform aimed at extending the concepts and working methods of the MCH centres and the experience gained in preventive work.

Economic conditions in the 1970s were favourable. Resources were available for building health centres, recruiting personnel and providing new technology. Communities could quite independently organize the use of health centre personnel and adjust their activities and tasks to changing circumstances.

Changed role of the public health nurse

The reform led to great changes in the organization of public health nursing. Services were provided mainly in health centres and home visits were reduced. Management and supervision were confined to the local level. The transitional period did not pass without problems. In the planning and execution of the reforms, not enough account was taken of the lengthy experience of public health nurses. Possibilities for experimental work were limited.

With time, professional roles in the enlarged local health team have readjusted. The public health nurse is still a key person in primary health care, along with the doctor. She works directly with her clients and has the right to initiate contacts. She is still easily accessible to people with various health problems. The increased number of nurses, their expanded activities, and their right to consult expert members of the

health team have all combined to make public health nursing more efficient. However, developing the quality and content of public health nursing continues to pose an educational and managerial challenge. At present, public health nursing education has been expanded to four and a half years, including three years of general nursing education, which naturally means more highly qualified staff for primary health care.

The way ahead

The results of preventive health care in Finland, especially the steep decline in infant mortality, have received worldwide attention. Over and above the country's general socioeconomic development, a contributing factor has undoubtedly been the network of public health nurses and midwives, and particularly the MCH centres which are the nucleus of the service. According to Hultin (4), who evaluated the centres, the Finnish model works better than any other known system in lowering maternal, perinatal and infant mortality. Kannisto (5), who studied the infant mortality trends in Finland from 1871 to 1983, states: "The findings support the conclusion that an effective maternal and child health service system, which the public is willing and able to use, can overcome social and economic disparities once a certain threshold in general development has been passed. Beyond this threshold, higher levels of education or wealth do not seem to have much impact."

Since the turn of the century, social and health problems have evolved significantly. Responding to these developments has been

a continuous challenge. The value placed by society on health has increased, and new needs and demands have emerged, but it is questionable whether simple increases in investment yield much of a return in health terms.

With its national strategy for "health for all by the year 2000", Finland is in a sense rediscovering its early roots (6). A partial return to extensive public health nursing and an acknowledgement of the individual's right to his or her own doctor are features of the primary health care system as it is now being replanned. It is clear that social closeness to one's clients, continuity of care, and a comprehensive approach to their health problems—the hallmarks of public health nursing—remain essential to primary care in every country, regardless of its stage of social and health development. □

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