Healthy People Healthy Places

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Healthy People, Healthy Places

Introduction

Vice Chancellor, Pro Vice-Chancellors, distinguished guests, colleagues, students, ladies and gentlemen, thank you for coming along this evening to share a few thoughts together. This evening, I would like to paint a mosaic of health and health care where nurses play a feature role in the maintenance of healthy people and healthy places. I hope my comments are at least a bit thought provoking in relation to your own vision of what nurses know, and think, and do, and how their activities support individual and family health and the health of our community.

Healthy People

Health is a product of the interactions between many factors, including such things as biology, heredity, personal history, lifestyle, situational factors such as family circumstances, health resources and the way we choose to utilise those resources. The conditions which precipitate favourable or unfavourable outcomes from the myriad combinations of these factors, are found within our environment. Most of us recognise that individual choices play a large part in adopting behaviours with varying levels of risk, such as food consumption, lifestyle and activity patterns, smoking, use of alcohol or other toxic substances, sexual practices, participation in sporting behaviours and exposure to a variety of stressors (McKie et al, 1993). However, the propensity to risky behaviours is socially and culturally embedded in the contexts of our lives.

Good health is therefore a product of the constant and multi-layered interchange between people and all of their environments: physical, psychological, social, cultural, and spiritual. The environment is therefore as important to health and well-being as the characteristics bestowed upon us by nature. This conclusion is shared by member states of the World Health Organisation (WHO) and represents the culmination of widespread and prolonged global deliberations on how to improve the health of populations.
In 1978, the challenge of public health; that is, securing the highest level of health for the greatest number of people, formed the agenda for a meeting of public health delegates from 134 countries throughout the world, held in Alma Ata, in the former U.S.S.R. For years, various health ministries had been grappling with the failure of public health systems to achieve significant health improvements among their populations, and this meeting was convened in an attempt to examine the possibilities for global solutions to the problem. The delegates articulated their vision in the Declaration of Alma Ata, wherein a primary health care approach was adopted as a way of empowering people themselves, rather than health professionals, to have control over decisions that affected health in their families and communities (WHO UNICEF, 1978).

The Declaration of Alma Ata and the Health for All (HFA) movement which flowed from it, guided us to embrace the primary health care principles of access, equity, self-determinism, cultural sensitivity and intersectoral collaboration as a way to foster better health for all people. The HFA movement was based on the overarching notion of social justice, which encompassed primary health care principles as a code of practice. The primary health care philosophy guides us, as health professionals, to refocus health promotion strategies from individuals to populations; to reframe our expectations in terms of the linkages between people and the conditions of their lives; to redirect our caring activities to a model of partnership with empowered communities; and to reaffirm the centrality of equal opportunity and social justice to the attainment of health for all (Holzemer, 1992).

A few years after the Declaration was signed, the strategic principles of primary health care were circumscribed within the Ottawa Charter for Health Promotion. The Ottawa Charter introduced a community development approach, to be achieved by building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services toward a more comprehensive, holistic definition of health (WHO, Health and Welfare Canada, CPHA, 1986).

The community development approach can be contrasted to the dichotomy of consumer-provider, where one party (in this case, health professionals) provides, and the other (the public) consumes. In the consumer-provider model, there is a distinct power differential, in that the provider holds the key to such resources as information, services or consumables, and the consumer must abide by the rules set down by the provider to gain the information, goods, or services. The community development model replaces this power structure with partnerships, where all parties collaborate and negotiate with one another for information or other resources, or services. The major role of the health professional is therefore as advocate for what can be described as indigenous, or native, decision making and leadership; one that sees experts on tap rather than on top (Courtney, 1995; McMichael, 1993).

In 1997, the community development approach was endorsed and extended by member nations participating in the 4th International Conference on Health Promotion, which culminated in the Jakarta Declaration on Health Promotion into the 21st Century (WHO, 1997). The Jakarta Declaration further
entrenched health promotion toward the social, economic, and environmental conditions which either constrain or facilitate health, by focusing on social responsibility for health, and the notion that health is a social investment (WHO, 1997). Its central tenets are as follows:

**Jakarta Declaration on Health Promotion into the 21st Century**

1. Promote social responsibility for health
2. Increase investments for health development
3. Consolidate and expand partnerships for health
4. Increase community capacity and empower the individual
5. Secure an infrastructure for health promotion

(WHO 1997)

The Jakarta Declaration embodies the priorities of the World Health Organisation, which, at its Fifty-First Assembly in May of this year, underlined the importance of community participation, healthy settings and health promoting environments (WHO, 1998). The WHO view is based on the assumption that health is an indication of the extent to which people are, on the one hand, able to develop aspirations and satisfy needs, and on the other hand, to change or cope with their environments (Kickbusch, 1997). In this way, it exemplifies ecologic, rather than economic, rationalism.

Three fundamental questions inform this type of approach. The first is what creates health? If we believe that good health is a product of coherent interactions between people and their environments, we must work toward strengthening people’s sense of coherence in the setting of everyday life. This suggests that we should focus our efforts on supporting their schools, hospitals, workplaces, towns and villages (Kickbusch, 1997).

The second element of this model is the public health dilemma: which health related investments create the largest health gain? The key resource questions revolve around the relationship between health investments and outcomes. Health policies direct the deployment of resources to lead to optimal health outcomes for the population. Because health is created from a pattern of factors related to living and working as well as things such as social support, genetic make up and individual behaviour, community health gains are made possible from public investments in areas other than health: in places where people live, love, learn, work, play, shop, receive care, and worship (Kickbusch, 1997). Some researchers contend that the two greatest investments in health lie in improving child health and working conditions, particularly in relation to the social gradients that exist in the provision of child care and housing, poverty, unemployment, working conditions and diet (Whitehead & Dahlgren, 1995). By directing our research agenda to such important issues, we may be able to model strategies for better health across the entire population.
The practical premise is the third aspect of the health promoting environments approach, and this involves the somewhat symbiotic relationship between community development and organisational development. Practically, health is achieved in communities where healthy organisations promote community development across all the settings of our lives (Harris & Wills, 1997). Taken together, all three represent what is now called the settings approach to promoting health.

Healthy Places

The settings approach emphasises the natural linkages between health and place. It is based on an assumption that people are social creatures who come to know themselves through their connection with the wider community to which they belong (Shotter, 1985). Places "not only constitute the spatio-temporal settings where human life and activity are conducted"; they are also imbued with a mosaic of meanings held by those who inhabit them (Hudson-Rodd, 1998, p. 55). People's meanings and symbolism of place; that is, their literal and metaphorical geographies, their sense and feeling of place, their previous experiences, are central to health (Gesler, Thorburn Bird & Ojjeski, 1997; Hudson-Rodd, 1997, 1998). Place represents "the nodes of the life biography, which is, itself a unique web of situated life episodes" (Paasi, cited in Thompson Fullilove, p. 1517). As a repository of meanings, our residential place helps us maintain the balance between physical, psychological and spiritual health. At a social level, the dislocation of place through war, homelessness, decolonisation, epidemics, natural disasters, or even institutionalisation runs counter to both personal and community health (Thompson Fullilove, 1996).

In each place we inhabit, unique mixtures of local and wider circles of social relations accumulate. At the community level, this cumulative set of relations is often referred to as social capital (Cox, 1993; Hudson-Rodd, 1997). Through interactions, we become valued participants in the community, and this can have a health enhancing effect on our lives. A person's sense of place is also an expression of communal culture, and as such, helps set the agenda for activities related to health and illness, and the way services are used to sustain each (Hudson-Rodd, 1994). Interaction with others in the context of a common place, also provides us with the empowering potential of a collective voice to lobby for the structures and processes necessary to sustain community health.

Individuals are linked to their place through three key psychological processes; attachment, familiarity and identity (Thompson Fullilove, 1996). Attachment to others in the context of a familiar place is fundamental to the development of self, particularly in cultivating human intimacy and other types of relationships (Cutchin, 1997; Goffman, 1995). The theory of attachment suggests that we each have a personal environment that serves as an "outer ring" of life-sustaining systems complementary to the "inner ring" of systems that maintain physiological homeostasis" (Bowlby, 1973, p. 150). This attachment is important to our sense of identity, safety, and satisfaction with life (Thompson Fullilove, 1996). Attachment to home is the core of
successively wider attachments, including neighbourhood, region and country. People who are dispossessed of their homes and community therefore lose an important aspect of their self (Thompson Fullilove, 1996).

The loss of place also represents a loss of important aspects of culture, which is embedded in the context of people's lives. This loss is perhaps most acutely experienced by migrant people, and in Australia, by rural people who have had to seek economic refuge in cities. It is also relevant to those who have dispersed from rural towns to outstations and smaller communities (Wakerman & Field, 1998). It is profoundly experienced by indigenous people, given their deep and spiritual sense of belonging to the land, which is central to their cultural identity and helps maintain traditional bonds between successive generations (Hudson-Rodd, 1997). Our indigenous people have a deep sense of place in that their practices and beliefs are "intimately bound up with features of the landscape which were made in the creative 'Dreaming' by mythical ancestors" (Brady, 1995, p. 1494). To Aboriginal people, Mother Earth provides a means of articulating this spiritual connection, which is open to all of Aboriginal blood who feel for the land in an indigenous way (Swain, in Brady, 1995). In many countries, indigenous knowledge of geography and of nature is considered fundamental to life, as an opportunity for co-operative planning and the formation and maintenance of economic relations with other indigenous groups. Such knowledge has ensured the survival of many peoples living in fragile habitats, from the nomadic pastoralists of West Africa to the Inuit of the frigid Arctic regions (Hudson-Rodd, 1997).

Sustaining Healthy People, Healthy Places

The reciprocity between healthy people and healthy places should inspire us to direct our efforts at sustaining both, in an atmosphere of conviviality, ecological conservation, prosperity and equal opportunity (Hancock, 1994). As one of our environmental colleagues explains, a geographic community is sustainable when it has at its disposal, an amount of land that supplies all the resources it consumes and absorbs all the waste it produces (Lowe, 1994). In matters relating to health, to be sustainable means that the community has a type of health-illness carrying capacity; that is, all the health resources it needs and the capacity to respond to all the illness it produces. Included is the will and ability to accommodate change at both the environmental and service level (Kickbusch, 1997). For example, where there is a constant influx of new populations into the community, a healthy system of assisting the newcomers through the numerous transitions of their lives would include providing assistance with language, education and workplace services, and culturally appropriate health care.

The following quote encapsulates the meaning of sustainable health.

"Becoming sustainable individually and collectively requires all of us to commit our lives to building communities of fully empowered, compassionate, nonviolent, honest, loving human beings who live joyfully and beautifully within the limits of their physical environment" (Leland, 1995, p. 2).
Within the health professions, we are embracing the discourse of ecology, to explore alternatives that would shift the focus from the preferred options of the health care professional, to the communities we serve. As nurses, we are seeking out multiple community partnerships that will help us understand and respect local dynamics and needs, within a framework that values conservation and diversity, social justice and tolerance. This renewed commitment to our communities is occurring within a period of dynamic changes to our social, political and professional landscape.

The Changing Landscape of Nursing and Health

1. Financial Constraints and the Commodification of Health Care

One of the major contemporary changes to the environment within which nursing conducts its core business of caring has been the gradual commodification of health and health care. This has become a burden to us and to all members of the health professions for several reasons. One of these is the centrality of advocacy to our work, and the possibility that some of our actions may subordinate patient, family or community advocacy to an ethic of fiscal utility (Mohr & Mahon, 1996). It has been suggested that, the corporatisation of health care carries with it, the threat of overwhelming our therapeutic functions. In the U.S., for example, health care has entered the brand name era where health services are "product lines"; administrators seek to "corner markets" and faceless investors look for profitable manipulation of the interactions between providers and consumers (Mohr & Mahon, 1996). Here in Australia, as well as in the U.K. and Canada, we haven't gone quite that far, but in the context of developing our own health care reform agenda we have accepted a form of managerialism; for example, in the development of integrated services and strategies designed to achieve cost efficiencies in the purchase and provision of services.

Although there is nothing wrong with using marketplace principles to achieve cost containment, the corporate embrace has led to a number of changes for the nursing profession; not all of them desirable or consonant with the way in which many of us were professionally socialised. Managerial control over the workplace has, in some cases, threatened nursing values and integrity and, to some extent, led to a few compromises in the quality of our work life. Some nurses have adapted to the situation by seeking alternative roles, primarily in non-hospital settings, while others have themselves, gravitated to management and attempted to work within the new constraints.

2. Technology and the Proliferation of Scientific Knowledge

Another marker on our horizon has emerged from the combined effects of rapidly developing technologies and the proliferation of knowledge and knowledge systems. Besides changing clinical practice, technology has had a profound effect on nursing scholarship. Nursing research and scholarship have predominantly focused on developing therapeutic effectiveness and the ways to cultivate this, such as optimal educational processes and effective
management. The high tech environment of today carries with it, a plethora of new and more complex issues, and demands a care giver who is prepared for discretionary advocacy within a rapidly evolving ethical milieu. This requires encyclopaedic knowledge or access to it, in tandem with highly refined articulation skills. So, in the classroom, and in practice settings everywhere, we caution our young that failing to embrace and to understand the impact of communications and other technologies, will compromise their ability to guide wisely.

The rapid expansion of technology has also left us bombarded with information, to the extent that we must now be selective in defining our scientific knowledge base. The evidence-based nursing (EBN) movement, like the evidence-based medicine movement, provides us with a filtering network for systematic review and dissemination of nursing knowledge. Sharing such knowledge has made a significant contribution to building substantial and relevant evidence for practice. This information has informed midwifery and child health practice, helped us to understand patient and family adaptation to various conditions and settings, and assisted us in clinical decision-making based on comparative clinical strategies and outcomes. By researching our practice base in collaboration with the international community, we have enhanced our internal cohesiveness and external credibility, and ensured that all aspects of nursing work are valued and consistent with the globalised health care community.

3. Globalisation and Nursing

Globalisation is a feature of modern society that touches our lives almost daily. As part of the global community, our health-illness carrying capacity is reliant upon others. No single country or single community can produce all the goods and services it needs to sustain its people; therefore not one place can afford to be insular in any policies affecting its people. We need one another. We must trade and barter with one another, and to do this, we must understand the nature of one another’s resources, how they are allocated, and how they will be replenished.

Our economies, like our knowledge networks and our social mores, are also intertwined with, and transparent to the global community, and this places all aspects of our social life, including health care practices, under constant scrutiny. For a country that was once isolated by geography, this has been a good thing. Our neighbours help us adapt to a common evolving social consciousness related to the way we deal with indigenous people and those of other cultures, those with sub-optimal health care, and those whose choices are predetermined by a range of environmental factors.

In nursing, closer links with the international community have served to validate the things we do well and allowed us to learn from the innovations of others. We enjoy considerable advantage from the aggregation and exchange of information. The way we deal with changing demographics in our own communities is underlined by international and global analyses used to model possibilities for the future, thereby informing common planning
strategies. Through these activities, we have learned to adopt shared approaches to meeting people's needs within the contexts of increasing urbanisation, shifting family structures, the changing nature of work and work opportunities, family and community care giving strategies and population ageing.

Throughout the past few years, I have learned an inordinate amount about my profession from interacting with nurses from other countries, including Japan, Indonesia, Hong Kong, Malaysia and Canada; some of the countries I have visited. These nurses grapple with similar issues as we do in Australia, and like us, they try to 'think global' but 'act local'. Each of these visits has left me with some fresh insights into the importance of rational planning for care giving, particularly at a time of increasing complexity in health services.

4. Complexity of the Health Care Environment

The 1980's ushered in the era of economic rationalism, and none of us have been the same since. As a result of the changes, the nature and setting of health care have undergone dramatic and irreversible change. Where once, people were cared for in hospital for extended periods of time, they are now discharged to home, community and extended care facilities for the majority of their rehabilitation. For nurses, this has meant increased emphasis on the places of people's lives where health can be generated and sustained and where, in cases of illness, they can be restored to optimal functioning. The shift in emphasis from acute care to community, has meant that, to some extent, both hospital and community-based nurses have had to reshape their roles in terms of increasing patient acuity in non-hospital settings. This has also had an important impact on our nursing education and research agendas.

One research study, for example, conducted recently at Gold Coast Hospital, was devised to see how well nurses, medical officers, GP's, and patients coped with the complexity of what is now being called the "hospital-in-the-home" model of care. The results showed that all coped very well, with almost all of the 124 patients receiving parenteral (I.V.) therapy in their homes, expressing a preference for out-of-hospital care. The views of both patients and caregivers were remarkably similar, and widely endorsed by the economic analysis which revealed a potential annual cost savings to the hospital of $444,000 just for this group of patients. Perhaps more importantly, this type of choice encouraged greater family participation in health care planning (Foster & McMurray, 1998). The major outcome is that it will now inform the development of local I.V. therapy centres, when financial support can be secured. Another issue highlighted in this study concerns the importance of the family to the health and well being of its members.
Families and Nursing

Nursing in any setting can no longer afford to dismiss the importance of the family for its influence on the social and cultural construction of health and the way health needs are identified and secured. Family nursing research has gained momentum over the past decade; primarily in examining care-giving and family members' health-related behaviours. For example, my colleagues and I conducted a study of family needs, preferences and patterns of utilisation of health services in one Australian community. The study revealed some differences in utilisation patterns for separated and intact families; greater gender balance in assuming the role of family caregiver; some similarities in attitudes towards exercise and fitness among very young and older families; and a greater than expected level of awareness and motivation among the elderly for the preservation of our environment (McMurray, et.al., 1998a). These findings are of interest to us in hypothesising about the match between expectations of both carers and patients, with respect to service provision. They are also of interest in helping us overcome some of our stereotypical notions; for example, in acknowledging the need to define older people's health needs in terms of their engagement with the social contexts of their lives, and in refocusing our perceptions on their health competence rather than incompetence.

This latter conclusion reinforces the need for our nursing research agenda to examine closely, not only the caregiver's perspective, but family characteristics, family history, and family dynamics, and the way these intersect with the environment within which people become healthy. Another of my own research interests has focused on some of these issues, in looking at the way family configurations, and people's perceptions of our institutionalised socio-legal practices, influence family health and well being following separation and divorce. In a set of studies examining the factors influencing non-residential parents' relationships with their children, it became evident that up to one-fifth of all fathers and many more mothers than most people are aware of, live in circumstances where they are unable to enact their parenting roles (McMurray, 1992; McMurray & Blackmore, 1993). In some cases, family violence was present as both cause and consequence, creating a spiral of hopelessness and victimisation for all family members. The reason we, as nurses, need to continue this type of research is that we are often the first line of assistance for such families. In the spirit of evidence-based practice, we need this type of information to ensure that prevention and care-giving strategies are based on information that is relevant, contextualised, and of sufficient depth to allow individual, family and societal healing to occur (McMurray, 1997).

This aspect of nursing work would come as a surprise to many people, who encounter media images of nurses from TV shows such as ER. Nurses do, indeed, give emergency care swiftly, dramatically, heroically, sometimes, by leaping onto patients, and sometimes by leaping onto the planes of the Royal Flying Doctors. But, these days, for many nurses, a major part of our role is enable healthy people to live harmoniously in healthy places.
Harmonising Healthy People, Healthy Places

As members of the most numerically dominant health profession, nurses have the opportunity to facilitate health and well being in a multitude of settings; primarily because of their accessibility. However, political processes determine the flow of strategic activities in the health care system and so, the full potential of this role has yet to be realised. At the present time, nurses are working toward an expanded role to better serve the population of rural and remote Australia, including indigenous people. This initiative is focused on legitimising their existing role in rural and remote settings, that would allow nurses to undertake a number of specified clinical procedures and prescribe medications from a pre-determined formulary (McMurray et al, 1998b). The very thought of this has sent a few shudders through parts of the system; however, we are exploring the cost benefit of this idea in the context of primary health care principles of access, equity, self-determinism and intersectoral collaboration.

We are also encouraging social and political activism among our young, as we participate more fully in public lobbies for healthy policies and healthy organisations that would sustain healthy places for healthy people. This includes initiatives that recognise the importance of programs for healthy women, healthy men, healthy children and healthy older persons. In child health, we are urging policy makers to restructure family health services to restore and expand the role of child health nurses to focus on family support and guidance. For children of all ages, we are exploring the Healthy Schools Initiatives that have been implemented in other countries as a community one-stop-shop to provide resources and support for all family members (Adelman & Taylor, 1997). For adolescents, we have successfully achieved an expansion of the Queensland school health nurses’ role, where nurses are managing programs such as alcohol and drug prevention strategies.

For adults, we would like to see a focus on the workplace as an eco-system, where the worker is seen as its biological core and the key to community socio-economic capacity (McEvoy, 1997). For the elderly, we are urging financial concessions for wellness as well as illness care, and a greater emphasis on the socioeconomic conditions of the lives of older people and their caregivers. For Aboriginal people, we are attempting to draw attention to the fact that some of our health policies may have to reflect some cost inefficiencies to ensure cultural sensitivity, territorial security, and preservation of the spiritual environment within which health can be created. And, in our immediate neighbourhood, we are seeking a renewed commitment to the physical environment by supporting the collaboration between our colleagues at Griffith University, and the Gold Coast City Council Healthy Communities Project, to ensure that we’re all working toward sustaining this healthy place (Chapman & Davey, 1997).

As nurses, we recognise that health is a communal artefact. We cannot aspire to help people toward their true health potential without participation in the communities of their lives. Knowing that healthy places provide the template for the creation of health, we will continue to advocate for healthy
schools which set the stage for a balanced life of industriousness, play and social interchange. In healthy occupational settings, we are helping adults develop the skills to maintain a healthy work life free of injury or occupational illness. At play on healthy golf courses, beaches or ski slopes, healthy patterns of interactions with others are developed in safe environments conducive to physical and psychological well being with our encouragement. In hospitals, nurses are working toward both illness prevention and treatment, and they are trying to ensure that the refuse produced in treating illness, does not perpetuate the decline of our natural environment. In other institutionalised settings, nurses are acknowledging that healthy churches, and healthy places of learning must be imbued with a spirit of participation that values sharing rather than condescension, equity rather than imposition.

In the Universities, we are attempting to link this philosophy with a research agenda that advances the knowledge base of our profession in increments, within the goals of evidence-based practice and, in the parlance of contemporary WHO initiatives, where the best investments in health lie. We are unified in the understanding that, to create and sustain healthy people and healthy places requires resourcefulness, information exchange, receptivity to new ideas and strategies, a tolerance for difference, a willingness to change, and a common goals of social justice and community development. To be part of this is a privilege of my profession. I would like to thank you for allowing me to share it with you this evening.
References


