WE CAN FASHION THE FUTURE, BUT WHAT FASHION WILL WE CHOOSE?

Helen Glass

A response to "Fashioning the Future"* by Verna Splane

This response is to the article "Fashioning the Future" by Verna Splane in the Fall 1984 issue of **Nursing Papers.*** I have been asked to comment briefly on the article, and nursing's involvement in events sequential to the Canada Health Act (CHA). In the article Splane has brilliantly portrayed the development of the health care system in a social, political, and economic framework, identifying nursing's role in shaping the health care system up to the CHA. She has established that nursing did not have a key role. For the most part nurses provided "input" into events as they happened from 1934 to 1984. She indicates that the role of the nursing profession in this period has yet to be described, but it did progress from a representational reactive role to a proactive one, seeking to ensure influence on policy decisions on national health and advancing from a limited nursing viewpoint to a health system perspective (Splane, 1984).

The CHA activity, led by the Canadian Nurses Association (CNA) and entered into enthusiastically by provincial associations and their members, established nursing's potential for proaction. To what extent has that potential been exploited in the period following the CHA? How has nursing acted to inhibit further erosion of the health care system? How has it responded to the issues in the wake of the CHA, especially in regard to the recommendation of the Honourable Madame Bégin, the then Minister of Health and Welfare, Canada, "To use the nurse as the point of first contact and the doctor as the final point of referral" (1982, p.3-4).

Nursing has always strongly supported the Health Charter for Canadians -- universality, accessibility, comprehensiveness, public administration, and portability principles. In an effort to foster Bégin's alternative direction, CNA has continued to press the federal government through dialogue with Jake Epp, the current Minister of Health and Welfare, Canada. His responses to an interview with Allen (1985) indicate that while supporting the use of nurses as first contacts this is within a team concept, and that

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while the "legislative signal" in the CHA has been sent, the federal government "does not deliver the health care system and cannot act independently" (p.39). It will be up to nurses to convince the provinces that the position that has been taken is valid. He further reiterated the federal government's interest in models of community health. The CNA recently commissioned and has released for study a background paper on "The Future of Health Care in Canada and Nursing's Role Within It" (Glass, 1984). A Think Tank is scheduled for September, 1985, when models of delivery of nursing services will be discussed along with the numerous issues, constraints, and approaches to be taken in achieving the ideal of a strong preventive and health promotive community health care system.

There is evidence also, that the federal Department of Health and Welfare is putting out feelers about remunerating physicians for preventive and health promotive services. This would serve to entrench the medical remunerative system that exists even further, and does not acknowledge the role of nurses in prevention and promotion of health. Responses from physicians are not clear, but some maintain that they are already doing health promotion and prevention (CBC, Winnipeg, 1985). Nursing has not, to my knowledge, responded to that feeler. Clearly, there is a need for action. But what has been happening in the provinces, where action has to be initiated?

Using two provinces as examples, because of the short nature of this response, it is clear that nurses in the provinces are thinking proactively. Pat Kirby, newly elected President of the Registered Nurses Association of Ontario (RNAO), in her presidential address, noted the need to review the Established Programs Financing Act, "Because the Act provides the dollars, our involvement is even more vital than it was for the Canada Health Act" (Kirby, 1985, p.4). She listed a number of suggestions that nurses "want" the government of Ontario to do, among them, "We want the new Premier to make a serious commitment to universality and accessibility of health care in Ontario" (Pipher, 1985, p.9). Referring to the activities in which Ontario nurses are involved, she pointed out that the need for "continuing" political activity was unanimously reaffirmed at the convention (p.4). Evidence of their intent is operationalized in five political Bulletins and in other Memos. One result of this was involvement in depth in the recent provincial election (D. Dick personal communication, August 18, 1985). Some of the other activities are occurring through the new Social Policy committee which has recently been established. Broad aspects of health, such as the plight of elderly citizens, child poverty, wife assault, and increasing collaboration with others are being looked at as means of addressing specific health and social issues. The concentration on identifying community nursing needs is a healthy direction, in keeping with the community health care system, to which both the federal government and nursing are committed. The strategies and actions the RNAO uses to make changes bear watching.

The Saskatchewan Registered Nurses Association, (SRNA) almost immediately after the CHA, documented and presented to the government the functions and activities of nurses, and at its 68th Annual Meeting in Regina, passed resolutions which included: "working towards obtaining increased funding to nursing homes to provide day care, night care and safe enclosed wandering areas, approaching the government to provide funding to ambulance owners to encourage the hiring of registered nurses as ambulance crews" (News, 1985, p.14). In discussing this with Jane Knox, Executive Director of SRNA, she described a meeting that they had initiated with a variety of professional groups interested in the "health care practitioner" clauses in the CHA. It was a productive meeting and will be followed up. Further, SRNA has adopted a position paper on Primary Health Care and Nursing Services (J.Knox, personal communication, August 18, 1985). This too, supports the stance on community health services as the mode of delivery of the future. A proactive direction is evident in the declared intentions and actions of these two provinces and there is no doubt such actions are occurring in other provinces as well. Time and space do not permit their being documented here. However, the strategies nurses choose to obtain results they want will speak to how effective such intentions will be.

There are still areas where proaction is almost unknown. Splane tells us in her article that it is not only the two senior levels of government that must be approached, but other professional groups and users of health care as well, if the use of the skills and abilities of nurses is to be understood. Steps taken by CNA to come to grips with the interprofessional clinical concerns have been initiated with the Canadian Medical Association (CMA). Less headway has been made in resolving what Splane calls the "opposing views of health care" between the two professional groups. A strong reminder of that difference is the current legal suit that physicians have pending with the government in regard to extra billings by doctors. Nurses' opinions on this issue need to be heard.

Overtures have been made by the Canadian Public Health Association (CPHA), for CNA to assist in a study designed to look at what is being done in hospitals in regard to health promotion and prevention of illness and disability. Unfortunately the CNA is not able to respond since primary health care principles have not yet been entrenched as essential aspects of hospital care (D. Lafortune personal communications, August 18, 1985).

What part have Canadian Nurses played in supporting the "Health for All by the Year 2000" concept which is being adopted in both developing and developed countries? CNA has moved decisively to expand the basic tenets of primary health care (PHC), and its position statements clearly reflect this. In addition, CNA has actively engaged in workshops assisting other countries in their understanding and implementation of PHC. However, little attempt has been made to work in depth with nurses in Canada as yet.

As a member of the Canadian Delegation to the World Health Assembly in 1983, and again in 1985, I was able to see the growing emphasis on nursings' increasing role in "Health for All". Clearly nurses are leading the way and recognition of that is now given by the Director General of the World Health Organization (WHO). Mahler has stated, "...it is now time that nurses were brought in much more than hitherto 'fairly and squarely' as leaders and managers of the Primary Health Care/Health for All Team, together with others" (WHO, 1985a, p.1). It was decided that a radical change was necessary -- not only in nursing know how, but in nurses' relationship with other health personnel and the community in need of health care. How Canadian nurses will individually and collectively respond to that challenge remains to be seen.

Primary health care is articulately oriented to self-care, self-determination, self-reliance, and consumer involvement. Many of these concepts are incorporated into educational programs and nursing services. Splane, in her article, urges nursing educators to take up the challenge which faces us here in Canada. Advocacy of clients, by nurses in their care alone, may not be the answer. Participation with users and consumer involvement with the health care system is more the direction for the future of health care (Glass, 1985, p.69). Such a conceptual shift will require that all nurses, and especially nurse educators, know and understand primary health care. In service, new modes of delivery await development.

The nursing literature in Canada is replete with demonstrations of new ways to deliver nursing care. Many examples of the application of PHC exist internationally. In Portugal, for example, nurses have opened a clinic in which thirty-six public health nurses provide multi-services to the public, and they make referrals to physicians ald obstetricians as needed (WHO, 1985b). This is truly an example of enabling nurses to have first contact with clients, at the same time demonstrating what nurses can do, where the people are, and where the services are needed. Such demonstrations will help bring nursing services to the attention and benefit of the public. In that way response to nursing's new initiatives can be fostered.

On balance, in this short response, there are positive and negatives in our responses to the CHA. There is a clear desire on the part of nurses to be positive. Can we move in alternative directions positively unless committed to really making change in the system and from a **united** stance? To answer begs the question even as nurses nationally are not speaking with one voice on major issues. For our potential power to be felt, it is essential to maintain a united membership, thus supporting CN''s power to influence issues of national and international importance. Without this unification, we will no longer be able to lay claim to representing the nurses across Canada in our arguments for or against particular health related issues. We are given pause for thought in the light of Splane's challenging article. We can fashion the future, but what fashion will we choose?

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