Principles of British health visiting

PRINCÍPIOS DO MODELO BRITÂNICO DO VISITADOR EM SAÚDE

LOS PRINCÍPIOS DEL MODELO BRITÁNICO DEL VISITADOR DE SALUD

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ABSTRACT

In an international context, it is sometimes helpful to consider how concepts are understood in different countries, and to explore some different roles. Such knowledge rarely transfers directly from one country or place to another, but to hear about developments from elsewhere can spark ideas and thinking that may be helpful for local developments. This paper gives some brief background about how the health visiting profession developed in Great Britain, and then explains the values and principles that underpin its practice today. Some parallels are drawn with the health situation in modern Brazil.

KEY WORDS

Delivery of health care.
Great Britain.
Needs assessment.

RESUMO

Em um contexto internacional, muitas vezes, é importante considerar como os conceitos são compreendidos nos diferentes países e explorar algumas de suas distintas funções. Esse conhecimento raramente pode ser transferido de um país ou de uma localidade para outra, mas ouvir outras experiências de desenvolvimento, de quaquer parte do mundo, pode despertar idéias e pensamentos que sejam úteis ao desenvolvimento local. Este artigo apresenta um breve histórico sobre como a profissão de visitador em saúde se desenvolveu na Grã-Bretanha, explicando os valores e princípios que, atualmente, servem de base à sua prática, estabelecendo-se alguns paralelos com a atual situação da saúde no Brasil contemporâneo.

DESCRITORES

Assistência à saúde.
Reino Unido.
Determinação de necessidades de cuidados de saúde.

RESUMEN

En el contexto internacional, muchas veces es importante considerar como los conceptos son comprendidos en los diferentes países y explorar algunas de sus diferentes funciones. Ese conocimiento raramente puede ser transferido de un país o de una localidad para otra, no obstante, escuchar las experiencias de desarrollo, de cualquier parte del mundo, posibilitan despertar ideas y pensamientos que pueden ser útiles para el desarrollo local. Este artículo presentó un breve histórico sobre como la profesión de visitador de salud se desenvolvió en Gran Bretaña, explicando los valores y principios que actualmente sirven de bases para su práctica y estableciendo algunos paralelos con la actual situación de salud de Brasil contemporáneo.

DESCRIPTORES

Prestación de atención de salud.
Reino Unido.
Evaluación de necesidades.

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HEALTH VISITING: BACKGROUND

Health visiting is a profession that began in 19th century England, which was a period of rapid industrialization and migration from rural to urban areas[1]. We might speculate about the parallels with today, when we are seeing similar phenomena internationally, with some 80% of the world's population now living in towns and cities. At that time, there were terrible slums in British cities; both homes and the factories where people worked were unsafe, and there was dreadful poverty. In some cities, one in four babies died before reaching their first birthday, mainly as a result of the poverty and adverse living conditions, which fostered epidemics, malnutrition and injuries to adults and children alike

It was a very gender-divided period, with women and men each having their own spheres of influence: men in the world of work, and women in the home. Many public health initiatives and laws were passed, to control the state of buildings, factories and food, alongside municipal developments, such as the installation of water treatment works, sewers and town planning. In Salford, an industrial town in the north of England, a women's public health organisation used this to advantage, believing that the influence of the home and family were paramount. In 1862, they began employing local women to visit homes and families, to offer help and advice about how best to feed the family, care for the sick and improve the chances of their children growing up healthily.

The profession of health visiting as we know it today developed from this small start. Since 1962, 100 years after the start of the profession, health visitors all must hold a nursing qualification, which is still controversial. Health visitors still focus mainly on family health and home visiting, practices that are supported, now, by a large body of research evidence. Early child development has been shown to be a key social determinant of both health and health inequalities[2], and home visiting is a particularly effective strategy for health improvement[3-4]. However, the way in which home visiting is implemented varies widely from one study to another, and in practice, which influences the extent of its effectiveness.

The British health service started in 1948, but until 1974, health visitors were employed by the local (municipal) boroughs. In that year, the public health and primary care services joined the National Health Service, which had formerly been concerned only with hospital care, a move that was similar to the recent unification of the Brazilian health service. Health visitors were worried about this move, and felt the need to explain themselves in this different, more medically focused workplace, so they held an investigation into the principles and process of their work[5].

THE PRINCIPLES OF HEALTH VISITING

The results of the investigation provided a framework to organize the knowledge and skills required for health visiting practice, and a touchstone for continuing development. The profession is frequently under threat, partly because of funding crises within the British national health service (NHS); also because there are different political opinions about whether a health visiting service should continue, as now, to be offered as a universal service to all families with young children. So, last year, an updated version of the principles document was published[6], to clarify the particular contribution made by health visitors to public health and explain why health visitors claim this approach is still needed.

There was agreement across the profession that health visiting is implemented by using four enduring processes, which are known as the *principles of health visiting*. These are:

- The search for health needs
- The stimulation of an awareness of health needs
- The influence on policies affecting health
- The facilitation of health-enhancing activities

There are three things to note about these principles. They are about health promotion, not assistance; they provide an integrated framework, not a list of competences or skills and they are all underpinned by a particular value and view of health. These will be considered in more detail, in turn

HEALTH PROMOTION

The Principles are not concerned with doing things directly to or for someone who is unable to perform essential activities of daily living. Providing help and assistance is a common focus of nursing practice, so this is the first big change for nurses when they enter the additional training needed to become a health visitor. Families being visited in the community are not ill just because they have a new baby, or are living in a very deprived area, and it would undermine them if the health visitor were to offer expertise from a highly professional perspective. Instead, which is much harder than just giving advice and information, the challenge is to enable families to find ways of improving their health for themselves, drawing on their own strengths, knowledge and the expertise developed by living in their own particular circumstances.

To take one example: the relationship between expectant mothers smoking, living in poverty and the birth weight of their babies is very strong in Brazil, as in the UK. Yet, there is also seminal research that explains why young mothers who live in poverty smoke[7]. It is not because they do not know it is bad for them. It is because it helps them to cope

with stress and violent relationships, and the caring responsibilities they face. When money is short, smoking a cigarette stops them feeling hungry. Simply advising them to stop smoking, or even offering a support group or education to help them stop smoking, just makes them feel bad. Then their stress rises and they smoke even more. First, we must deal with their stress, give them some support to cope with their relationships and respect for the way they are coping with difficult circumstances. Then, when we have a strong relationship, we might ask them what they think will help their baby to be healthy; before long they identify smoking as a problem. That is the time to offer them nicotine patches and support groups; they are more likely both to succeed in stopping smoking, and to feel good about themselves.

An integrated framework

The second thing to note about the principles is that they are not separate skills or activities to be learnt. Instead, they provide an integrated and interlinked framework for implementing the knowledge base of health visiting in the interests of public health (Figure 1).

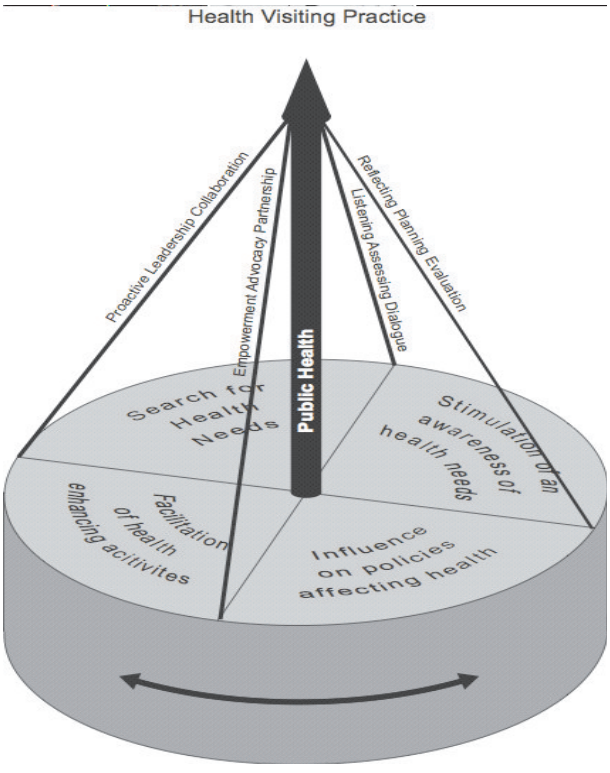

Figure 1 - Principles in practice

One principle or another may predominate as activities and interventions are carried out, but any aspect of health visiting practice is informed by all the principles, with public health as the central pivot and focus. Public health is a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole population through health promotion, disease prevention and other forms of health intervention[8].

The principles of health visiting reflect the need for what has been called the *nutcracker effect* of both top-down, strategic policies for whole populations (like the provision of a national health services, for example), and bottom-up, grass roots activities to engage individuals, families and communities in their own health[9]. Our society is no longer as segregated as when health visiting first began, but there is still a very strong division between those who have power, with the right to speak and be listened to, and those who do not. Practitioners who are in daily contact with the most vulnerable and excluded populations often know best how to describe their real health needs. They need to work in both directions of the nutcracker (bottom up and top down), first by explaining and supporting people to make best use of services and policies designed to help them. Then, because they can also see how, when and why those policies go wrong, they need to explain where the barriers lie, and help policy makers to see what further changes are needed to policy.

The value of health

The third point to note is that the word 'health' features in each of the principles. This focuses attention on both the way this term is understood, and the value afforded to health, rather than (for example) health care, or concerns about illness. Health visitors placed a value on health for its own sake, and a broad understanding of this underpins the principles and practice of health visiting[5].

Even though it has been declared a right for all, enshrined in the Brazilian constitution, *health* is a phenomenon that is fraught with ambiguity, and it defies objective definition and quantification[10]. In accepting that everyone has a fundamental right to the best possible state of health, health visitors take on a responsibility to do something about the present inequalities and inequities in health and health care. Instead of trying to define the value of health in philosophical terms, therefore, they decided to emphasise its practical application through health promotion, identifying seven key, underpinning beliefs that informed their practice (Box 1)[6].

Box 1 - Beliefs about health

1. *Rights and responsibilities*
   - Everyone has a fundamental right to the best possible state of health.
2. *Health in context*
   - Health cannot be separated from the socio-economic and cultural context in which it is experienced.
3. *Choice and blame*
   - Health must be regarded in broad, holistic terms, encompassing individuals and families within their personal situation.
4. *Positive health*
   - Health is a positive concept, encompassing social and personal resources, as well as physical capacities.
5. *Health improvement*
   - A positive sense of health enables people to make full use of their physical, mental and emotional capacities, so they can reach their full potential for achievement.
6. *Empowerment*
   - Achieving health means that people have the power to shape their own lives and those of their families.
7. *Community partnership and participation*
   - Health care services should be readily accessible and acceptable, and involve full community participation.

Box 1 - Beliefs about health

These underpinning beliefs are implemented by a focus on health as a social rather than an individual construct, so understanding the whole family and community perspective is essential. In practice, health visitors appear to treat health as a process (not a state of being to be obtained) and to consider health in its overall socio-cultural context[11]. It is long term work, sometimes taking more than one generation, with beneficial outcomes from home visiting showing up many years later[3].

It is not necessarily the problem that individuals or families face, as such, which determines whether they need support or not; the deciding factor may be the situation in which they are living[12]. Some people face enormous risks without harm, and others come to grief with a lesser level of risk. The extent to which individuals need support and the nature of that support varies according to their own personal resources, and those in the situation they are living in. Personal resources include financial resources, but are by no means only concerned with these. Resources for health include emotional strengths, or physical or practical resources, or the ability to understand and reason about what would help; strong faith or a supportive family or stamina all help. However, families might be destructive as well as helpful; some faith groups are damaging and demanding, and a partner might be abusive and violent instead of supportive. So, to determine whether they are helpful or not, we need to know the extent to which resources are immediately accessible to the individual, and under their personal control. This means that health visitors need to identify their clients' strengths and resources, and how these may change and develop over time, offering more or less support at different periods in the process.

A longitudinal, process approach is unusual among health professionals, who commonly aim to identify a specific diagnosis as soon as possible, since this provides a basis from which a care pathway can be predicted. Communities and family life are less predictable than a medical diagnosis[13], but formal organisations like the health service require predictability as a basis for their planning. If the unpredictability of community and family life is not understood and accepted, health visitors may be regarded by their colleagues as incompetent, because they cannot always specify exactly what will happen.

Taking a longitudinal, process approach helps health visitors to offer support in ways which are the most empowering for individuals and groups at different stages[10,14]. *Empowerment* is viewed as an essential basis for health, but it can only be developed internally by individuals, families or community groups[15]. It cannot be prescribed or dispensed by an outsider, but a facilitator might encourage or assist that development by working in a genuine, respectful partnership[16]. There is a delicate balance between the need to allow, enable and encourage people to own their health in the sense of exercising full autonomy and choices in the way they live their lives[17], and the individualistic approach to health promotion which stresses personal responsibility and blame.

Clients have reported that they did not feel subjugated by health visitors if the interventions were based on acceptance and a professional caring approach[18], although the opposite is true in that individuals can be further disempowered by their interactions with health visitors if practitioners do not accept individuals' views or are shocked by their situation[19].

Relationship skills appear critical in determining the degree to which health visitors are acceptable to clients[20]. These communication skills can be learnt, but need to be at a very high level, especially when engaging clients who are deeply vulnerable and socially excluded. Such people may include young mothers, those whose childhood was deeply insecure, or who use drugs and other illicit substances. They distrust authority in every form, and may reject the health visitor or any offers of support or information as irrelevant.

They may be unreliable in their use of services, perhaps setting out to shock to test the genuineness of respect and concern being offered, or because they have never experienced a strong or positive interpersonal relationship before.

Basic attitudes and personal attributes of empathy, warmth, personal integrity, humility and enthusiasm are all tested by such encounters. They are not frequent, but they show the importance of being open to the great variety of perceptions and expectations about health, family life and norms[14] and of acknowledging that the way people perceive health and well-being affects the way they live their lives. Participation by the whole community begins with partnership working with individuals.

CONTINUING AREAS FOR DEBATE

Even though it is more than 30 years since public health, primary care and hospital services were unified in the British health, there are still many debates about the way that health visitors work, and how their approach fits with that of other colleagues, like nurses and public health medicine[21]. The discussions seem to reflect some of the debates taking place in Brazil as well.

First, there is a continuing issue about whether to improve public health by working with individuals or focusing on whole populations. Most health care costs arise from hospital services, and from delivering care to sick individuals; this is commonly seen as the main purpose of the health service. Yet, to improve public health, we must focus on the whole population, and to think about prevention. For epidemiologists, this often means focusing on population health indicators and planning at a high strategic level. There is a danger that this can lead to a greater emphasis on professionally defined, normative health needs: looking at those needs that professionals think are important, rather than those our clients think are important.

Health visitors are public health practitioners who hold a caseload, that is, one that exists for purposes of prevention and health promotion. They work with individuals, assessing and acknowledging needs in the way their clients see them, rather than through normative indicators. It has been suggested, in Brazil, that infant immunisations, offered to everyone, can provide a starting point and opportunity for engaging clients in an overall assessment and conversation about their particular needs[22]. This would help to contribute to the health of all infants, which is a key public health indicator, so this work with individuals is also working at the collective level.

Health inequalities arise mainly from social class and other social determinants of health. Health care when sick is essential, but the key to reducing health inequalities lies in providing preventive services. However, if we focus only on those people who are living in poverty, we would miss most health needs, which are widely spread across the population. Issues like domestic violence, mental health problems and child sexual abuse all occur across the social gradient. Health visiting services are offered to everyone who has a baby in the UK, but this doesn't mean they all receive the same service. If their health needs are quite small, they might just see the health visitor once, then be asked to come to clinic for immunisations and checks, or to get in touch if they have any worries. But for others, they can have their needs identified and be pointed in the direction of other services, or supported in sorting them out for themselves.

Health visitors are fighting hard to keep this universal service, because delivering a service only to people whose needs have identified according to social class, or where they live, will inevitably lead to stigma. Also, the middle classes pay most of the taxes to fund the services, so they need to believe it is a service worth paying for; if they are dissatisfied, they fight to improve service quality. Professionals may hate the criticism, but it helps to improve the service for everyone.

The public-private question is now broader than when only men were allowed into the world of work, and women had to stay at home. Gender issues are still important, but now the main question is about which services should be funded from the public purse, and which remain the responsibility of the family: private and personal. It is widely acceptable in our culture to talk about going to see the doctor or the nurse for physical symptoms, and there is a clear expectation that tax-payers money should be used to fund this. But there are many grey areas that arise during a home visit: mental health problems, sexual matters, marital and relationship problems, children's misbehaviour and so on. These all contribute to the social environment in which children are growing up, so will greatly affect their future health, but there is no consensus that support for dealing with them is legitimately funded by the health service. Nor is it widely acceptable to speak about them in public; so people may not feel they can ask for help or support around such contested matters, or they may not even realise that these are health needs. They remain very private, and also they are largely women's matters. In most of health care, the problem is that people seem to ask for too much. In these areas, we have the opposite difficulty; people ask too little.

Finally, there is the issue of social or bio-medical models of health. Illness is easier to measure than health and risks are better understood than strengths, yet we know that focusing on strengths is the best way to engage clients in the early prevention that is needed. Also, focusing on early childhood can help in many fields; it helps to reduce crime, improves children's ability to learn, which in turn makes

them more employable as adults, so helps economic productivity and their income once they are adults. Health is improved in long term, by these social outcomes. Longitudinal research from the USA has shown the value of this, over and over[3, 4]. Health service organisations require immediate returns, and may not be interested in outcomes that apply in other public services. So, we need to work across agencies, something that we are beginning to do again. This is a paradox, because by unifying the health service in 1974, we lost unity with social, education and housing service, run by our local (municipal) authorities.

The key to coping with these four aspects is to realise that they are not in opposition; instead they are a continuum of need across the service. Not everyone can do everything; health service provision is like a jigsaw, in which everyone has their part to play. Multi-disciplinary working, or even working with colleagues of the same profession who work in a different speciality, is helped by understanding and respecting the different contribution each has to play. Hopefully, this overview of the practice and values of one group of professionals on the other side of the world will help to stimulate discussions between professionals in Brazil, about the issues of importance to them, in their quest to promote good health.

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