The Canadian Journal of Critical Nursing Discourse
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Leadership and System Transformation: Advancing the Role of Community Health Nursing

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Cite as: Etowa, J., & Hyman, I. (2022). Leadership and System Transformation: Advancing the Role of Community Health Nursing. *Witness: The Canadian Journal of Critical Nursing Discourse*, *4*(2). pp 5-16 https://doi.org/10.25071/2291-5796.101

Abstract

It is widely recognized that structural and social determinants of health (SDoH) account for a large proportion of health inequities in Canada. According to the Public Health Agency of Canada (PHAC), many health actors are required to provide leadership and direction in tackling health inequities. In this paper we argue that community health nurses (CHNs) are well situated to play a critical role in health system transformation in Canada. CHNs are known for having a holistic and collaborative approach with competencies beneficial for the reduction of health inequities. However, to become more consistently effective advocates of health equity, CHNs require competencies in the principles of equity and social justice, community engagement, communication, coalition building, and system transformation. Having a critical mass of CHNs with appropriate leadership skills in knowledge generation and mobilization, advocacy, and collaboration is fundamental to effectively addressing health inequities in Canada.

Keywords: Community health nursing, Social determinants of health, Leadership, Health system transformation, Health equity

Introduction

One of the greatest challenges of health care systems today is to reduce health inequities across populations and population sub-groups, many of which have escalated due to the COVID-19 pandemic. The health and social impacts of COVID-19 have been much worse for seniors, essential workers, racialized populations, people living with disabilities, and women (Public Health Agency of Canada [PHAC], 2020). Clearly, a shift is needed in health and social systems to be better aligned with current population health needs and to reduce health inequities. Health equity models, which highlight the underlying structural and social determinants of health, must be incorporated into health systems that have largely focussed on treating and controlling disease and modifying individual health risk behaviours (Roncarolo et al., 2017).

Although the terms are often used interchangeably, there is a distinction between structural and social determinants of health inequities (Figure 1). Social determinants of health (SDoH) refer to the *conditions* in which people live and work including, early childhood development, employment and working conditions, income and its equitable

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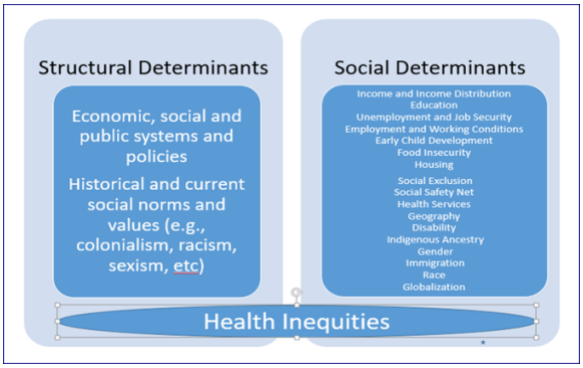
distribution, food security, education, social exclusion, and social safety nets (Raphael et al., 2020). Structural determinants of health are broader and include the economic, social, and public systems and policies and historical and current social norms and values (such as colonialism, racism, sexism, etc.) that directly and indirectly (through SDoH) contribute to inequities (World Health Organization [WHO], 2010). For example, structural racism results in inequitable access to and advantage through material, economic, and socio-political resources, as well as the cultural and ideological patterns that support those inequities. It concerns what has been termed "White supremacy" (Grenier, 2020).

Figure 1. Structural and Social Determinants of Health



Source: Adapted from: World Health Organization (WHO). (2010). A conceptual framework for action on the social determinants of health; and Raphael (Ed.). (2009). Social determinants of health: Canadian perspectives. Canadian Scholars' Press.

There has been insufficient attention to identifying potential partners within the health system to champion and lead this much needed system transformation (McPherson et al., 2016). According to McPherson et al. (2016), addressing health inequities requires collaborative partnerships with communities, health partners, and non-health stakeholders. In this theoretical paper we describe some of the challenges faced by the health system in addressing health inequities and argue that community health nurses (CHNs), who work in diverse urban, rural, and remote settings such as public health units/departments, home health, community health facilities, family practices, and other community-based settings, can play a critical role in this much-needed system transformation in Canada.

Background

Whitehead (1992) describes health inequities as "differences in health that are not only unnecessary and avoidable but also "unfair and unjust" (p. 430). The term *health inequity* is therefore a normative concept which denotes what could or ought to be (Chang, 2002), as opposed to health inequality or health disparity, which are empirical concepts that describe what is and what can be determined by epidemiological data (Reutter & Kushner, 2010). Health inequities are both unjust and avoidable.

The existence of health inequities in Canada is well-documented (Martin et al., 2018; Nixon et al., 2018; PHAC, 2020; Sharma et al., 2018). According to the Public Health Agency of Canada (PHAC, 2018), low life expectancy, infant mortality, unintentional injury mortality, and suicide mortality and mental illness rates are highest among people with low income, low education, and high social and material deprivation. Diet-related health issues or dietary inequities are characteristic of people with low social position (Olstad et al., 2019). Even though Canada is applauded for having universal health coverage (Benatar et al., 2018; Clark & Horton, 2018; Greenwood et al., 2018; Morgan & Boothe, 2016) and for being a global leader in health (Nixon et al., 2018), in nearly one quarter of Canadian households there is someone not taking their medications because of their inability to pay (Martin et al., 2018). The differential impact and burden of COVID-19 on different population groups are also well documented (PHAC, 2020).

Several health equity conceptual frameworks have been developed to help policymakers and planners identify levels of intervention and entry points for action, ranging from policies tackling underlying structural determinants to approaches focused on the health system and reducing inequities in the consequences of ill health suffered by different social groups. For example, the World Health Organization's *Conceptual Framework for Action on the Social Determinants of Health* (WHO, 2010), recently updated by the Pan American Health Organization (PAHO) (Marmot, 2018), clearly identifies political and socioeconomic contexts and socioeconomic positioning, including

racism and social location, as structural determinants of health inequities. Oppression, forced displacement to remote and uninhabitable areas, the residential school system, systemic discrimination, destruction of Indigenous languages and culture, and colonialism contribute to the health inequities experienced by Indigenous people (Roncarolo et al., 2017). Structural racism and social exclusion in health, education, and justice systems are strongly linked to the health inequities experienced by racialized communities (Martin et al., 2018; Nickel et al., 2018).

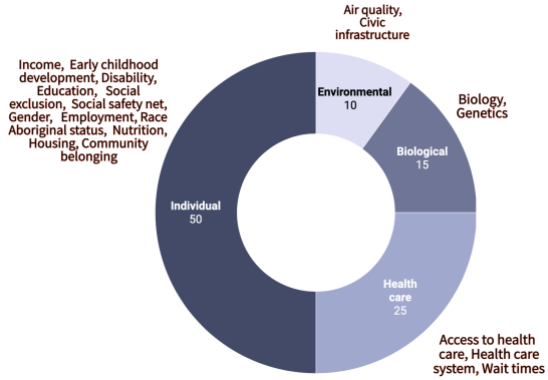
According to Marmot (2011), inequities and inequalities in health are both the result of structural inequalities in society. Since health inequities are avoidable, they can be eliminated. To address inequities, it is necessary to focus on the social conditions that produce them (Falk-Rafael, 2005). If structural and SDoH are created by societies, they can also be dismantled by human efforts (Sharma et al., 2018).

Emergence of SDoH as a Canadian Framework to address Health Inequities

Canada's health system, created in the 1960s, was built on a reactive sickness model characterised by an emphasis on treatment services provided in clinics, hospitals, and other institutions. The prominent health discourse at this time emphasized bio-medical causes and effects and individuals' negative life choices as key contributors to health and disease outcomes (Reutter & Kushner, 2010). *A New Perspective on the Health of Canadians* (Lalonde, 1974), released in the 1970s, was seminal in its recognition that environmental issues, in addition to biology, lifestyle, and the health system, were determinants of health. It argued that we need to look beyond the traditional health care (sick care) system if we wish to improve the health of the public. In the 1980s, the *Ottawa Charter for Health Promotion* (Epp, 1986) identified *prerequisites for health* to include peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. In the 1990s, the Canadian Institute of Advanced Research coined the term *determinants of health*, and population health emerged as a health policy discourse (Evans et al., 1994).

Today it is widely recognized that SDoH account for a large proportion of health outcomes. The SDoH framework, developed by Raphael (2009), has been widely adopted in Canada (CCSDH, 2015; Sharma et al., 2018). According to the Canadian Medical Association (2013)'s Town Hall Report 50% of ill health may be attributed to SDoH and only 25% to health care system factors (Figure 2).

Figure 2. Health Outcomes by SDoH: A Canadian Model



Source: Adapted from the Canadian Medical Association. (2013). *Health care in Canada: What makes us sick.*

To date, there has been limited success in applying Canada's SDoH framework to reduce health inequities because the structural determinants that give rise to the health inequities are rarely addressed. It is widely believed that health inequities persist because the political, economic, and social forces that drive the determinants of health and limit access to resources and power are difficult to address and require the collaboration of many different actors (Lavis, 2002; Raphael, 2008). This is one of the reasons why health system transformation needs to happen.

Best et al. (2012) define health system transformation in terms of "interventions aimed at coordinated, system wide change affecting multiple organizations and care providers, with the goal of significant improvements in the efficiency of health care delivery, the quality of patient care, and population-level patient outcomes" (p. 422).

While there is some agreement on the need for health system reform to address health inequities, system transformation is a complex and challenging process. Some actions to address health inequities are within the purview of health departments and organizations, but most of the interventions that directly influence SDoH flow from the mandates of other government sectors, civil society, and other stakeholders (WHO, 2014). The achievement of health equity clearly requires the engagement and leadership of health, social service and community organizations, business leaders, and policy makers, both within and outside of the health sector (McPherson et al., 2016; PHAC, 2018), especially to address health inequities associated with COVID-19 (PHAC, 2020). Engagement in changing sociopolitical processes have implications for nursing practice at micro (individual client) and macro (system) levels (Etowa, et al., 2020).

Community Health Nursing

Reutter and Kushner (2010) describe nursing as a profession that is well-positioned not only to provide responsive and empowering care to clients experiencing health inequities, but also in working towards changing the underlying social conditions that give rise to them. Community health nurses (CHNs) support and promote the health and well-being of individuals, families, groups, communities, populations, and systems (Community Health Nurses of Canada [CHNC], 2019). They practice outside of hospitals or long-term care, in health centres, homes, schools, and other community-based settings (CHNC, 2019). CHNs are committed to community engagement activities which may take many forms including service-user networks, healthcare boards, or volunteering on advisory groups for project development (De Weger et al., 2018). In 2016, there were almost 65,000 CHNs in Canada (CIHI, 2017), representing 16.4% of the total nursing workforce.

Falk-Rafael (2005) describes community health nursing practice as being,

> …at that intersection where societal attitudes, government policies, and people's lives meet…[and] creates a moral imperative not only to attend to the health needs of the public but also, like Nightingale, to work to change the societal conditions contributing to poor health. (p. 219)

In other words, community health nursing practice is *expected* to engage in and affect social justice. Community health nurses understand the impacts of the SDoH and take strategic actions to advocate for healthy public policy and advance health equity at multiple levels (CHNC, 2020). They are known for having a holistic and collaborative approach with competencies beneficial for the reduction of health inequities (CHNC, 2019; Purtzer & Thomas, 2019) and are passionate about their roles in addressing the SDoH because of their first-hand experience with clients. According to CHNC (2019), community health nurses are experienced health professionals who "understand racism as a social determinant of health and practice cultural humility through self-reflection and lifelong learning to redress health inequity and provide culturally safe care".

The Canadian Public Health Association (CPHA) describes public health nurses (a sub-group of CHNs) as "…leaders of changes to systems in society that support health" (CPHA, 2010, p. 6). Nurses are already leaders in terms of implementing evidence-based knowledge to advance client empowerment, health promotion, and disease prevention (Cummings & McLennan, 2010). CHNs have historically advocated for and collaborated with the families and communities they serve to develop essential services, address the factors that impact on health outcomes (i.e., what are now well-known as the SDoH) (Vukic & Dilworth, 2020). This legacy has positioned CHNs to effectively address contemporary community health needs. As described by Falk-Rafael & Betker (2012), "The advantage that community health nurses have is we're in the homes, we're in the community, and we see what's happening, and we've got that knowledge base to move it up" (p. 320). This perspective creates the committed and passionate qualities necessary to address the unjust inequities in health caused by SDoH and to lead the fight for equity in health policy, with institutions, communities, and especially with government and non-government institutions.

Role of Nurses in Addressing Health Inequities

According to PHAC (2018), many health actors are required to provide leadership and direction in tackling inequities. CHNs can play a leading role in this endeavour by generating knowledge that can benefit system transformation while supporting coordination of efforts across other sectors. As frontline providers in health, nurses hold a unique position to observe how the SDoH affect health outcomes among different sub-populations and communicate their first-hand experiences with key decision makers. Nurse researchers, with their broader views of client experiences and diverse learning from clinical settings, can ascertain whether an intervention framework can address structural and SDoH. In addition, through capitalizing on their advocacy and leadership skills, nurses can play proactive roles in building closer ties with researchers and policymakers and can promote upstream approaches to reduce inequities in care delivery.

Leadership Competency Frameworks

The PHAC has been supporting the development of leadership competencies in public health to supplement core public health competencies. While these public health leadership competencies focus on inequities at the structural level, these competencies (which include population health assessment, surveillance, disease and injury prevention, health promotion and health protection) (PHAC, 2008) are also relevant for the practice of community health nurses (CHNs) who must think globally while acting locally at the frontlines of care.

The Public Health Leadership Competency Statements declared in 2015 (CHNC, 2015) are consistent with the Canadian LEADS in a Caring Environment health leadership capabilities framework (CCHL, 2013). LEADS provides CHNs with a roadmap to take action by helping leaders to accept responsibility for their own performance and continuous professional development, fostering the development of others to achieve quality results, building coalitions, and creating a healthy environment for organizational renewal (CHNC, 2019). It helps public health providers to address the interrelated questions of "Why," "What," and "How," and with mobilizing the evidence to inform policy and program decisions to address health inequities along socio-demographic lines (Kumanyika et al., 2010). According to LEADS, new expectations are placed on CHNs as members and leaders of organizations to promote the creation of environments that are spiritually, socially, emotionally, and physically *safe* for people, cultural humility[1], and a more critical appraisal of data and knowledge. CHNs also need to be equipped with competencies to hold themselves accountable to reducing inequities associated with racism and discrimination. Addressing and measuring key indicators that focus on priority health equity issues such as racism fosters an enabling environment for the commitment, innovation, and sense of purpose necessary to disrupt structural racism at multiple levels. Examples of leadership development competencies that are integral in strengthening CHNs' capacity for system transformation also include CASN's (2014) entry to practice public health nursing (PHN) competencies for undergraduate nursing education. Specifically, competency indicator 4.1 stipulates that a PHN "engages with the community, in particular populations facing inequities, using a capacity building/mobilization approach to address public health issues" (p. 10.) In addition, CASN's Community Health Education Interest Group guidelines (CASN, 2018) included "the ability to advocate for change to address issues of social justice, health equity, and other disparities affecting the health of clients" (Section 6.5).

Current Initiatives in Nursing Leadership Competence Development

Since 2019, CHNC initiated several activities to build nursing leadership competencies. For example, a professional development webinar series was implemented on "CHN leaders in

[1] an approach to health care based on humble acknowledgement of oneself as a learner when it comes to understanding a person's experience

system transformation." In partnership with the Community Health Nursing Leadership Institute and the Canadian Nurses Association (CNA), three leadership webinars were held to advance the integration of the "Leadership Competencies for Public Health Practice in Canada" into CHN practice and education. The CHNC's (2015) leadership competencies report defines leadership in public health as:

> the ability of an individual to influence, motivate, and enable others to contribute toward the effectiveness and success of their community and/or the organization in which they work. It involves inspiring people to craft and achieve a vision and goals. Leaders provide mentoring, coaching and recognition. They encourage empowerment, allowing other leaders to emerge. (p. 2)

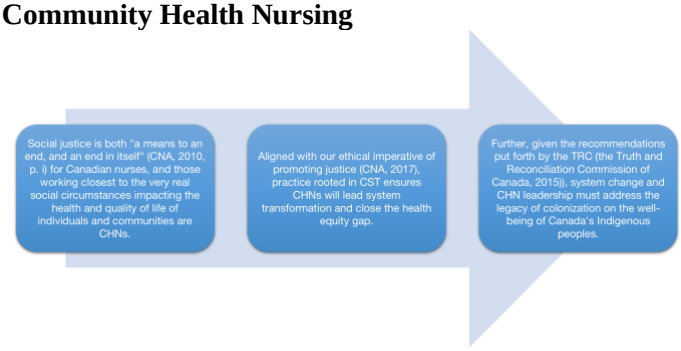
According to CHNC (2015), leadership and culture interact to drive performance. "Leaders influence an organization's culture and in turn its long-term effectiveness. Leaders set the agenda; they are seen as role models and people look to their leaders to see if their actions are consistent with the organization's values" (p. 16). As a result, the CHNC *Standards of Practice* have been revised to include a more prominent role for Health Equity (Standard #6), which states that, "community health nurses recognize the impacts of the determinants of health and incorporate actions into their practice such as advocating for healthy public policy. The focus is to advance health equity at an individual and societal level". However, to become effective advocates for health equity, additional training activities to build leadership competence will be needed.

Moving Forward on Leadership Competence

Nursing leadership capacity development is a priority in Canada, and academic preparation starting in undergraduate education is the basis for producing nurse leaders (Marcellus et al., 2018). Advancing the knowledge, skills, and attitudes of community health nurses in areas such as advocacy for change, drive and motivation to guide change, knowledge mobilization, how to guide change, and system and critical thinking skills, would foster system transformation. It may be argued that public health leadership competencies for system transformation can inform leadership development thus enabling all CHNs to address the SDoH. As Fitzgerald et al. (2017) note, "there are various career pathways that health professionals can follow to achieve leadership competence and ability; these pathways differ according to the career trajectory and nurses' level of experience and training" (p. 88).

The critical social theory (CST) lens is a vital tool for CHN leadership. CST provides the upstream and intersectional analysis necessary for CHNs whose leadership is grounded in social justice. It affords the CHN leaders with the capacity to understand and address the social circumstances and negative power dynamics experienced by disadvantaged communities. CHN leaders can use a critical social justice lens to identify root causes of inequities, engage diverse stakeholders, analyse structural, social, and policy issues, formulate public policy, and create system change including how to secure their place at the policy arenas as equal partners with other stakeholders (Etowa et al., 2018). CHNs should therefore participate in system transformation through developing a critical social justice mindset as part of their moral obligation to close the health equity gap. This would require considerations of the ways not only to provide equal opportunities for all (equality), but also to remove the systemic barriers for everybody to access the available opportunities (equity) as illustrated in Fig 3.

Figure 3. Advancing Health Equity through Community Health Nursing



Source: Adapted Etowa, J. Dosani, A., & van Daalen-Smith, C. (2018, June 26-28). *Critical community health nursing: A Canadian call to action.* [Conference Presentation]. Community Health Nurses of Canada (CHNC) 2018 Annual Conference, Regina, Manitoba.

Consistent with the Leadership Competencies for Public Health Framework (2015), nursing curricula must include a focus on skill development bearing in mind the socio-cultural and historical context of the Canadian health system and the identification of systemic barriers to good health using a critical social justice lens. For example, there is evidence that individuals in food insecure households are at a high risk of having poor health; however, food insecurity occurs in the wider context of poverty (Power, 2005). The consequences of the intersectionality of food insecurity and poverty include difficulty in managing conditions that require adherence to certain dietary specifications. Sharma et al. (2018) use the term *critical consciousness* to mean "reflecting on power, privilege, and the inequities embedded in social relationships, with an active commitment to social justice" (p. 27).

Reutter and Kushner (2010) suggested the need to modify nursing curricula by incorporating a political economy approach to understanding structural and SDoH as a way of preparing nurses to engage in policy analysis and advocacy. For knowledge to have impact, it must be managed and shared in a strategic manner so that it reaches all intended individuals, groups, and categories of the population that are in charge of making the necessary policy changes.

Discussion and Implications / Expected Outcomes

In this paper we argue that system transformation is critical to address the structural and SDoH contributing to health inequities in Canada. To date, however, system transformation efforts have focused more on improving efficiency and quality of health care rather than on addressing structural and SDoH and reducing population health inequities. Knowledge, leadership, and collaboration among different players are among the key facilitators needed for system transformation. Knowledge includes an in-depth understanding of the systemic, structural, and attitudinal barriers that create inequities in health outcomes in the first place as well as how existing health systems, strategies, and processes perpetuate inequities (Baker & Axler, 2015).

The CHNC (2015) leadership competencies for public health practice in Canada report identified leadership as a key category of the core competencies of public health. The report used the Canadian LEADS in a Caring Environment health leadership capabilities framework (CCHL, 2013) to describe the meaning of leadership in public health practice and to map out the various elements of leadership competencies for public health practice in Canada (CHNC, 2015). These competencies are anchored by core public health competencies and values and can be applied in relation to multiple community health nursing issues including "professional development pathways, mentoring programs, and performance appraisals to advance public health practice" (Strudsholm & Vollman, 2021, p. 340). Strudsholm & Vollman further note that "for public health leadership to flourish, leaders must have the ability to adapt to a changing system and to be innovative, creative, and flexible. Such adaptation requires critical thinking skills and evidence-informed decision-making that must go hand-in hand with innovation" (p. 343).

The CHNC (2015) leadership competencies framework clearly delineates the competencies required by CHNs to step into this role of system transformation. CHNs must not only be knowledgeable, they "must [also] have the political savviness necessary to influence the allocation of resources for healthy workplaces and better client care" (Etowa et al., 2020, p. 25). Collaborative and intersectoral efforts of networks located both within and outside the health system help to magnify marginalized voices and leverage diverse set of skills and expertise for more equitable outcomes (Martin et al., 2018). As captured by the title of Charlton's (1998) book, 'Nothing about us, without us' (p. 3), system transformation must also be driven by the knowledge, voices, and experiences of those who are directly impacted by health inequities. Leadership is critical in mobilising, developing, and implementing multi-level and multi-sectoral strategies for systems change (Etowa et al., 2020). It is further recognized that leadership must be distributed across the system in a collaborative manner and include health policymakers,

decision makers, planners, service providers, and consumer groups (Baker & Axler, 2015). The positioning of Chief Nursing Officers in senior administration teams in public health organizations has the potential to lead system transformation through its membership (Peroff-Johnston & Chan, 2012). The recent re-instatement of the position of Chief Nursing Officer of Canada (i.e., Dr Leigh Chapman, August 23, 2022) within Health Canada by the Federal Government is a step in the right direction for system transformation. This is the result of years of advocacy work by nurses and nursing organizations such as the Canadian Nurses Association (CNA).

The main elements of good leadership are: 1) system transformation, (2) achieve results, 3) lead self, 4) engage others, and 5) develop coalitions (CHNC, 2015). Leaders who have the capacity to lead themselves and engage others in coalition building to achieve relevant results make the difference in system transformation. Below are some illustrations of how CHNs are demonstrating attributes of these public health leadership competencies in practice:

- System transformation - CHNs working in the administration domain may use advocacy skills to lobby for healthy public policy and social justice by participating in legislative and policy-making activities that influence the determinants of health and access to services.
- Achieving results - CHNs providing direct care may use their understanding of power structures to advocate for resources that may contribute to client engagement with health promoting services.
- Leading self - CHNs working in research domains may use critical theory and intersectionality frameworks to deconstruct the complex interplay of the social determinants of health among marginalized communities (Dosani et al., 2020).
- Engaging others - CHNs working from the education domain value the educational preparation of nurses at the undergraduate, masters, and doctoral levels. Education plays a key role in preparing nurses for the today's workforce where they are confronted with contemporary challenges including health inequities and structural racism.
- Developing coalition - CHNs working in the policy domain will take action with and for the client at various levels; the organizational, local, provincial, territorial, and federal levels, to address service gaps and inequities in health (CHNC, 2019).

Engagement in research and training is paramount if these outcomes are to be sustainable.

While today's CHNs demonstrate leadership in many ways, including but not limited to their advocacy skills and power that comes with their professional knowledge, the historical marginalization and subordination of nursing as a profession must also be addressed (Dosani et al., 2020). This includes expanding their role in determining how health system and decision making are organized, especially at the macro level where public policies are made level. Although CHNs by the virtue of the body of knowledge they possess, exert power over their clients, particularly at the micro-political level, they are still marginally represented at the macro-political tables where decisions that underpin and reinforce structural determinants of health are made (Etowa et al., 2020). As Dosani et al. (2020) assert, "it is vital for employers to influence working conditions so that CHNs may have various opportunities to either engage in research activities or have sufficient resources at their disposal to make informed practice decisions based on evidence" (p. 607).

Conclusion

CHNs are well positioned to play a leadership role in health system transformation to advance health equity (Betker, 2016; Cusack, 2014; Granger et al., 2018). To this end, CHN leadership development initiatives anchored in social justice and critical social theory principles are imperative. As CHN leaders, CHNs must be forward thinkers and inspire others from the health and non-health sectors to develop collaborations anchored in social justice to target how we conduct research, educate nurses, engage in policy work, and plan and implement culturally safe and responsive programs and services to meet the needs of diverse communities. As CHN leaders, we need to ask ourselves questions such as, what role do we want to play in health

system transformation, including addressing structural racism? Who do we need to influence? Who are our allies? What specific actions can we take? Failing to address the broader SDoH (including structural racism), limits the impact of CHNs' work on racialized communities. The growing health inequities along sociodemographic lines such as race, calls for bold political vision and courage to act to strengthen and transform the health system to eliminate health inequities and advance health equity.

Note: The authors have no conflicts of interest to declare. This manuscript is not based on funded research. No ethical permissions were required for this manuscript.

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