# Public Health Nursing in 1Care

***Safurah Jaafar[1],KamaliahMohd Noh[2], MohdRaili Suhaili[3], Andrew Kiyu[4], Flora Ong[5] and Margareth Wong[6]***

*[1]Director, Family Health Development Division, Ministry of Health, Malaysia*
*[2]Deputy Director, Family Health Development Division, Ministry of Health, Malaysia*
*[3]Professor, Faculty of Medicine and Public Health, UNIMAS*
*[4]Consultant Epidemiologist, Sarawak Health Department*
*[5]Principal Assistant Director, Sarawak Health Department*
*[6]State Health Matron, Sarawak Health Department*

**Abstract**
Public health nursingis a specialized nursing combining both nursing and public health principles with the primary focus of improving the health of the whole community rather than just an individual. Its documented history started in the 1800s and has evolved from home visiting to the varied settings that public health nurses find themselves working in as members of public health teams in clinics, schools, workplaces and government health departments.Public health nursing has been a critical component of the country's health care system, uplifting of the health status of Malaysians and playing a dominant role in the fight against communicable diseases, and is set to face the challenges of the 21st century with public health nurses practising to the full capacity of their training in a restructured Malaysian health system – 1Care for 1Malaysia. The health sector reform allows for optimisation of scarce health care resources to deliver expansion of quality services based on needs, appropriateness, equity &allocative efficiency. The proposed model will be better than the current system, preserving the strengths of the current system but able to respond to increasing population health needs and expectations. There will be increased autonomy for healthcare providers with incentives in place for greater performance. Some of the implications of reform include allowing public- private integration, a slimmer Ministry of Health with a stronger governance role, enhancing the gatekeeping role of the primary care providers and the autonomous management of the public healthcare providers. In this restructured health system, the roles of the public health nurses are no less important than in the current one. In fact, with the increasing emphasis placed on prevention and primary care as the hub of community care with nurses as part of the primary care team delivering continuous comprehensive person-centered care,public health nurses in the future will be able to meet the challenge of refocusing on the true mission of public health: to look at the health problems of a community as a whole and work with the community in alleviating those problems by applying the nursing process to improve health, not just as providers of personal care only.

# INTRODUCTION

**Definition**

Public health nursing is a specialized nursing combining both nursing and public health principles with the primary focus of improving the health of the whole community rather than just an individual.

I quote the Public Health Nursing Section of the American Public Health Association, who says thisabout public health nursing:

"Public health nurses integrate community involvement and knowledge about the entire population with personal, clinical understandings of the health and illness experiences of individuals and families within the population. They translate and articulate the health and illness experiences of diverse, often vulnerable individuals and families in the population to health planners and policy makers, and assist members of the community to voice their problems and aspirations. Public health nurses are knowledgeable about multiple strategies for intervention, from those applicable to the entire population, to those for the family, and the individual. Public health nurses translate knowledge from the health and social sciences to individuals and population groups through targeted interventions, programs, and advocacy".

Public health nursing is sometimes called a type of community health nursing and the terms "public health nursing" and "community health nursing" are used interchangeably.

Public health nursing has always responded to the priority health needs of society by serving, individuals, families, groups, or entire communities and populations.

**History**

Public health nursing traces its roots to England where, in 1859, Florence Nightingale assisted in organizing district public health nursing. In Malaysia, this is still practised where each public health nurse is assigned a specific area or district and is responsible for the health of the people living in that geographical area.

Modern public health nursing in the United States was defined by pioneering nurse Lillian Wald in the late 1800s. She established the Henry Street Settlement in New York City, where nurses lived in the neighbourhoods where they worked. In the beginning, public health nursing was primarily concerned with taking care of the sick poor in their homes. Lillian Wald came to the realization that sickness found in the home had its origin in larger societal problems. She set about directing nursing efforts toward employment, sanitation, recreation, and education. It was Lillian Wald who coined the term "public health nurse."

In the early part of the twentieth century, home health nursing evolved from Visiting Nurses Associations to continue the tradition of providing care for the sick in their homes. Public health nursing began to be practiced in both voluntary agencies such as the American Red Cross, and governmental agencies, such as local county and city health departments. Serving the needs of the poor remained a key aspect of public health nursing.

In the mid twentieth century, care shifted from the home to the clinic, where nurses worked in well baby and immunization clinics for the uninsured and were active in controlling communicable diseases such as tuberculosis.

**Training of public health nurses**

In the late 1800's, hospital-based schools of nursing which granted nursing diplomas provided the educational preparation for nurses at this time. In the latter part of the 20$^{th}$ century, nursing education began to move out of hospital-based programs and into community colleges and universities.

Educational preparation for public health nurses varies widely in the United States with some jurisdictions requiring a bachelor's degree in nursing and others accepting a hospital diploma or associate degree from a community college. A bachelor's degree in nursing is considered a minimum requirement for public health nursing practice by many nursing professionals and professional nursing organizations. A bachelor's degree in nursing is thought to provide the background in social science and public health science such as epidemiology and environmental health that a public health nurse needs. Increasingly, public health nurses are enrolling in advanced degree programs in public health, community health nursing, and other public health specialties.

**Public health nursing's contribution to health status**

Public health nursing has been a critical component of the country's health care system and uplifting of the health status of Malaysians and playing a dominant role in the fight against communicable diseases in the twentieth century. Reading a brief history of the World Health Organisation, we realise how much public health nurses have contributed to the global health status. For example, in 1980, the Global Commission for Certification of Smallpox Eradication recommended a halt to routine smallpox vaccination after the last confirmed case of smallpox was detected in Somalia in 1977. This is a tribute to the crucial role played by public health nurses in the immunisationprogramme which continues to this day through WHO's Expanded Programme on Immunization, which aimed to vaccinate children worldwide against diphtheria,

pertussis, tetanus, measles, poliomyelitis, and tuberculosis.

Closer to home, rates of vaccine preventable diseases in Malaysia have dropped in recent years in response to active vaccination programs. Because of the success of our national immunization programme with more than 95% population coverage since the 1990s, in large part due to the untiring efforts of our public health nurses, we have been able to introduce new vaccines into our immunization programme.

For example, the incidence of Hepatitis B has dropped steadily to reach 3.2 per 100,000 (886 reported cases) in 2008 since the introduction of the Hepatitis B vaccine for newborns into the national immunization programme in 1989. The latest introduction into our armamentarium of vaccines is the human papilloma virus vaccine in 2010 which is being given to all 13-year old girls in the country through our school health teams.

Similarly, the rates of other vaccine preventable diseases have declined with rates for diphtheria, neonatal tetanus and pertussis at less than 1 per 100,000 population for the past two decades. Malaysia was certified as a polio-free country along with the Western Pacific Region of the World Health Organization on 29 October 2000 and and the measles elimination programme was implemented in 2002 with the introduction of dual dose MMR vaccine at 12 months and on school entry as compared to the single dose measles vaccine at 18 months previously. Catch up immunisation was also carried out for those less than 16 years. With a measles incidence rate of 1.2 per 100,000 (334 measles cases) in 2008, we are well on our way towards measles elimination.

Maternal and child health indicators are often taken as an indicator of overall health system performance. In Malaysia, it has long been recognized that our public health nurses have contributed greatly to the great strides made in maternal and child health through the public health approach in delivery of our maternal and child health services to every region of our country. Our nurses can not only be found in our static rural clinics, but also travel far & wide in the remote areas delivering services through our mobile clinics, whether through roads, river or by air. This is especially true in Sarawak, where 80% of the population is covered by the static health facilities and the mobile clinics cover an additional 7% of the population.In fact, our innovative method of extending our health care delivery to the remote populations of our country through our mobile clinics, has been developed further with the "KlinikBergerak 1Malaysia" (KB1M), where the vehicle has been expanded from being a mere transporter of staff and equipment into a clinic facility, where a doctor and his team of nurses and assistant medical officer can do consultations, perform minor procedures and diagnostics as well as deliver preventive care, for example, maternal & child health services. The first bus KB1M was launched in November 2010 by the Honourable Prime Minister in Perak and is now serving Hulu Selangor and Kinta. Another four buses are expected to be operationalised in Perak, Johor and Pahang in April 2011. Sarawak is given the honour to pilot the first boat KB1M along the Baramriver and we look forward to improving the coverage of quality health care services to our rural population.

The maternal mortality rate (MMR) in Malaysia has dropped substantially from 141 maternal deaths per 100,000 live births in 1970 to 20 in 1990 and has remained steady since. This is a much lower rate than in some neighbouring countries, such as Indonesia with 420 per 100 000, although higher than Singapore with 14 per 100 1000 and Australia with 4 per 100 000 (WHO World Health Statistics 2008).Infant mortality dropped substantially between 1970 and 2008 from 39.4 to 6.4 deaths per 1000 live births: just above Australia with 5 per 1000 and Singapore with 3.2 per 1000 (WHO World Health Statistics 2008). Maternal mortality in that period dropped from 1.4 to 0.3 deaths per 1000 live births.

Malaysia has made great gains in life expectancy for its people. Life expectancy at birth rose between 1970 and 2008 for men from 61.6 to 71.6 years, and for women from 65.6 to 76.4 years: similar to the average life expectancy of 72 and 76 years for men and women respectively in 2006 in the Western Pacific Region of the World Health Organization (WHO World Health Statistics 2008).

Sometimes we ourselves are unable to appreciate the health gains that we have made – a case of "not seeing the forest for the trees". It takes an outsider to tell us how far we have come and I would like to share excerpts from one of the numerous visitors that the Ministry of Health has received from around the world. Dr. John B Tamaro is the Director of the Health Programme for the Aga Khan Foundation based in Geneva. He visited us last year bringing a delegation from Syria. I quote "First, we were very impressed with the public health system. The existing, very extensive structure provides comprehensive coverage to all Malaysians, and ensures seamless and easy access to all types – outpatient to hospital — and levels of care – primary to tertiary. The fashion in which clients are referred to higher level care, e.g. to hospital-based delivery care, and referred back to the health centre that is the 'home' of the client is commendable and may represent a model of good practice. Also, with a very modest registration fee of 1 RM, finance is not a barrier to accessing care, even for those who are not Malaysian citizens and have to pay a bit more. Also, based on the comments we received and the documents we reviewed, the system provides a

high degree of technical quality and, with the exception of a longer and undesirable 'waiting time,' is judged to be 'very satisfactory' by clients seeking care.

Second, the programmes of the MoH are extensive and based on solid guidelines, well-developed protocols and clear and complete data records. The data system in place is a testimony to the fact that the ministry is very serious about documenting the outcomes and impacts of the programmes in place. Of particular importance to the Joint Delegation, given its interest in care for mothers and children, is the documentation in place to track antenatal, delivery and postpartum care for mothers and essential services to neonates and young infants. The record of the MoH in caring for mothers and their infants in the post-partum period is impressive and may be an example of 'good practice.'

Third, the staff of the MoH is very well trained, highly professional, well informed and working effectively in teams. The staff we met were excited about their work and challenges and very dedicated to ensuring the delivery of healthcare to all Malaysians. One person noted that the MoH took great pride in providing care from the 'womb to the tomb.' While we might question whether the MoH should be responsible for all types of care throughout a Malaysian's life, it is very clear that ministry personnel take seriously their responsibility to ensure good health for all Malaysians.

Fourth, and perhaps most significant from the perspective of the Aga Khan Development Network, Malaysia has achieved marked success in lowering maternal and infant mortality since Independence in 1957 through the development of a Community Health Nurse (CHN) who works in collaboration with the traditional birth attendant (TBA)."

**1Care for 1Malaysia**

We must be vigilant that past gains made in the 20th century against the communicable diseases are not nullified by the looming threat of new public health challengesof the 21st century such as bioterrorism, teen pregnancy, environmental hazards, chronic diseases, HIV/AIDS, and many others. We take cognizance of the lessons learnt in countries such as the US where the practice of public health nursing has been greatly affected by sources of funding. Much of the past focus on clinic work and personal health care for the indigent and uninsured has been driven by the need to limit nursing work to what was reimbursable by a third party, such as Medicaid. Many public health nurses practise in local health departments, which are seen as the providers of last resort for care of the sick poor and the uninsured. County hospital care and out patient services have taken much of the public health funding and attention away from the primary goal of public health, that is, improving the health of the entire community. A major shift in the 1990s to health plans (managed care) and the movement of Medicaid populations, in most states, into managed care programshas made caring for sick low-income people more financially viable for the private sector. Consequently, local health departments and their public health nursing staff have been encouraged to shift their activities back toward the primary mission of public health, which is to work on the causes of health problems and to prevent them.

In Malaysia, the need to serve the people better, achieve greater performance, improve equity, improve quality of care and optimise the use of limited resources in meeting the new public health challenges of the 21st century, has made the government embark on a transformation programme. A part of this transformation is the re-structuring of the Malaysian health system, **1Care for 1Malaysia**, aimed at greater public and private sector integration as well as service expansion based on needs, appropriateness, equity &allocative efficiency.

We currently have a dual system where we have a structured public system complementing private clinics and hospitals that mostly operate independently and in competition to each other. The private sector provides mainly personal health care for the individual, usually when a person is already sick. It is used by those who have the means to pay.The public sector covers not only personal care but also community care – such as dengue vector control measures. We serve everyone in Malaysia.Health care is funded by many different agents. Public financing is mainly through government revenue. Private financing is mainly through out-of-pocket, private commercial insurance and employer funding. Also, there are many different providers for health care both in the public and private sector. They serve different segments of society.

The MOH remains the largest funder and provider of healthcare. We also regulate the health system.

1Care is responsive to the health care needs and expectation of the populationand provides choice of quality health care, ensuring universal coverage for health care needs of the population based on solidarity (in terms of funding where the rich healthy and economically productive will subsidise the poor, ill and dependant) and equity, where people will receive health care services based on their needs irrespective of their ability to pay, geographical access to care etc.

It has the following targets: (a) universal coverage, (b) an integrated health care system of public and private sectors providers, (c) an

affordable and sustainable health care system, (d) equitable, efficient and high quality services, (e) effective safety nets for vulnerable groups, hard core poor, and address catastrophic expenditure, (f) responsive to the needs of the Malaysian population, (g) enhanced client satisfaction, (h) personalised care for individual and family and (i) reduction of brain drain of medical personnel to private sector and other countries.

The proposed model will be better than the current system whose strengths will be preserved.The MOH's main focus would now be the governance and stewardship of the national health system.There will still be some delivery of community health services, namely communicable disease control.The restructuring will change the health care system in three major aspects. Firstly, the separation of purchaser-provider functions from MOH and therefore, the role of MOH in governing and financing the health system is more effective with less issues of conflict of interest. Secondly, the integration of public and private healthcare providers and services, which is part of the 1Care concept. Thirdly, primary health care will be the thrust of health care services with a strong focus on preventive-promotive care and early intervention.The system will be more responsive by increased autonomy to regional and individual health needs and expectations. Payment based on agreed benchmark and clinical practice guideline is an example of paymentfor performance.

The functional relationship in the restructured health systemis between the MOH, the Malaysian Health Delivery System, the National Health Financing Authority, the independent bodies and the professional bodies.

The MOH will be a leaner organization with very highly specialized functions. Highly skilled staff to carry out these new public health functions.The MOH will have three main functions. The primary focus is governance and stewardship which includes policy and strategy formulation; standards setting and regulation, monitoring and evaluation, legislation and enforcement activities. Policies and development will encompass aspects as standard setting, quality and clinical guidelines, cost-effectiveness, HTA, training, ICT and physical infrastructure. For the regulation functions, legislations will be streamlined for all disciplines. Enforcement can be located either within the MOH or an independent body depending on the authority and responsibility.A very important function now in MOH will be the monitoring and evaluation (M&E) to ensure that the autonomous arms of MOH function according to their specified tasks and objectives, and that standards, guidelines and regulations are adhered too. Payment for services in the autonomous arms will be based on their performance and fulfilment of the MOH specifications.

Secondly, the MOH retains some public health services mainly through the centre for disease control, research and other services. These services will be delivered through the existing state & district set-up and through partnership with local authorities and MHDS.There will still be some delivery of community health services, namely communicable disease control.

Thirdly, the delivery of health care will be devolved to the autonomous Malaysian Health Care Delivery System (MHDS) comprising public and private health care providers and this increased autonomy allows it to be more responsive to the population health needs and expectations. The MHDS will coordinate personal and community health care through autonomous state/region-based health services. Primary Health Care Trusts (PHCT) are autonomous agencies accountable to the MHDS and MOH. They will purchase health services from registered providers including independent Primary Health Care Providers (PHCP) which include primary care clinics, dentists and pharmacies.

A provider-payer split will bring about managed competition.The new financing system as a single payer system will help to contain health care cost inflation and allows for integration of public and private health care providers and services. Funding will come from the government and a proposed social health insurance scheme, tempered by minimal copayments at point of seeking care. Funds will be managed by the new National Health Financing Authority that is publicly owned and operates as a not-for-profit institution. The National Health Financing Authority (NHFA) will be established to undertake the task of collection of SHI contributions, pooling of funds and disbursement to PHCTs. NHFA will also work out the formularies for premiums, pay for performance, unit costs/fees and benefits packages in collaboration with MOH, MHDS and PHCTs.

Various functions of MOH will now be under several autonomous bodies such as Drug Regulatory Agency, Health Technology Assessment and professional bodies such as MMC and MDC.

The scope of autonomy of the independent MOH-owned bodies is as not-for-profit organisation, accountable to the MOH and with an independent management board. They manage their own budgets i.e. self accounting, with the ability to hire and fire and with the flexibility to engage and remunerate staff based on capability and performance.

Under the proposed delivery system, primary health care services will be the foundation of the health services with strong focus on

promotive-preventive care and early intervention. Primary health care physicians (PHCP) will function as family doctors and act as gatekeepers to secondary and tertiary care.

Every individual is registered with a PHCP of their choice within their community either in public or private sector. The first point of contact for the patient is their primary healthcare physician (PHCP) where they receive treatment and then return home. Payment for service is by capitation with case-mix adjustments and additional incentives for achieving performance targets and as inducement for working in less desirable areas.

If the patients need referral for specialist care or hospitalisation, arrangement will be made by the PHCP to refer patients to higher levels of care when necessary,either in public or private hospitals. Public hospitals will be coordinated on regional networks and funded through a global budget based on case adjustments using DRG. Private hospitals services will be paid through case-based payments.Upon completion of treatment, the patient will be returned to the PHCP.

Even though patients are registered with their PHCP, they still have a choice to seek treatment from other providers by paying out-of-pocket (OOP) or through private health insurance.Patients will now have access to primary and secondary care either in the public or private sector. The healthcare services are free at the point of service with minimal co-payments, example, for dental and pharmacy. But identified population groups will be exempted from these co-payments.

In the proposed system, current financing arrangements will also be restructured to ensure better financial risk management, equity in financing of healthcare, greater efficiency of government subsidy for health care and accountability of work performance. The proposed financing scheme moves the current Malaysian health care financing picture into a pattern more like upper middle or higher income countries.

Health care will continue to be financed through a combination of mechanisms.But the major components for health financing will now be publicly administered through social health insurance (SHI) and general taxation. SHI contribution is mandatory with contribution from employer, employee and the government. The SHI premiums are calculated as a percentage of income. To ensure greater equity and lower average premiums, SHI premiums are estimated through community risk-rating to cover all family members, and not individually risk-rated as in private health insurance (PHI).

The whole population has to subscribe to SHI. Opting-out from the system is not allowed to ensure a high level of risk pooling and equity in financing.In this way, the healthy will cross-subsidise the ill, the rich cross-subsidise the poor, and the economically productive cross-subsidise the dependant. This model of nationally pooled financing will further enhance social unity and caring as per the 1Malaysia concept.

The Government of Malaysia (GOM) remains committed to funding of health services in the restructured system. Through general taxation, the GOM will fund for specific components,in particular items which are public goods and merit goodssuch as community health measures e.g. communicable disease control, health education, and environmental health issues. The government will contribute to the funding of primary health care services for the whole Malaysian population. At the same time, government will also subsidise SHI contributions for identified vulnerable population groups such as the poor, disabled, and the elderly. As the largest employer in the country, the government will be expected to contribute to the insurance premiums of government pensioners, civil servants and 5 dependants.

The proposed system has several implications on health care delivery and financing including providers and patients. For the providers there will be public-private integration with a stronger governance role in a slimmer Ministry of Health, defined practice standards in the delivery of a benefits package, payment for performance, the creation of registries for providers and patients, a strong gate-keeping role by primary care providers and autonomous management public healthcare providers. For the patients, services are accessed free at point of care with minimal co-pay, mandatory regular contribution (prepaid) under a social health insurance (SHI) and with more funding of health there will be increased coverage.

Through this proposal, Malaysians will receive better services and more choice of both public and private providers. When ill, individuals will not have financial concerns at the point of seeking care.Through prepayments into the SHI schemes, the covered population will be assured of access to healthcare close to their home or workplace.This will lead to better health outcomes, higher work productivity and the ability to pursue individual life choices. All, except government-covered groups, will have to pay to be within the system

The employers' financial burden to provide health care services for their employees will be covered under SHI benefits packages with lower contributions. For example, coverage for both work and non-work related illnesses will be included in the benefits packages beyond coverage under SOCSO. This proposed model exacts lo contribution to cover employee and family as well as reduce administration to process medical benefits. At the same time it avoids unnecessary care whichleads to higher expenditure as can be seen with private health insurance, managed care

organizations and panel doctors.In the long run, there will be healthier workforce and higher productivity. All companies have to contribute and incentives, for example, tax rebate, can be considered.

The restructuring will bridge the remuneration gap between health workers in the public and private sectors thus reducing the brain-drain. Correct incentives will be used to attract staff to work in less desirable areas. Health care providers will maintain acceptable levels of competency through various mechanisms such as credentialing and re-certification, and managed by their own peers through independent professional bodies.

The development of a national health system will strengthen national unity through the social solidarity of cross subsidies. The 1Care concept will emphasize:

1) ethical delivery of care – according to need and not profit-driven motives
2) tackle obvious market failures of the health system for better efficiency
3) address equity issues

1Care also supports greater unity not only at a population level but also through enhancing corporate social responsibility.Financial safety nets will be improved through better risk management. Through SHI, the paying population gains from the large pool of contributors via lower insurance premium and wider benefits. There is assurance no one is denied coverage due to any existing illness or has to pay substantial individually risk-rated premiums owing to ill health.

1Care promotes greater efficiency through various means like higher quality of care, more cost-effective measures, reducing duplications and increasing competition.

This will ultimately contain the rapid growth in health care cost and inflation.

The programme will stimulate the health care market through increase health care spending in line with Malaysia's upper middle income status.

The policy will ensure that the Malaysian health care system remains relevant to Malaysians, and competitive enough to attract highly skilled medical personnel and support health care travel. But at the same time there will not be leakage of SHI funds to the health tourists who will pay for their own care.

The restructured system reduces unnecessary dependence on government fund by decreasing leakage to those who can afford.

Given the scale of the restructuring, it is imperative that change is managed effectively at all levels of stakeholders. While developing the blueprint, many more deliberations with interested parties and stakeholders including the community will be undertaken.

This is to ensure the development of a solid and widely accepted proposal, taking into consideration their concerns. Appropriate training for health care personnel such as training in management of public providers and managers in preparation for greater autonomy has to be conducted. Effective change management will entail initial injection of investments particularly for the restructured public system in order to compete with the private sector on similar footing.

A realistic time frame for phased implementation is required to ensure that the requisite manpower, infrastructure and ICT needs and challenges are addressed. At the same time, there will be better rationalisation of services as the system improves equity and efficiency of service delivery according to population needs. Some facilities may relocate to capitalise on the incentives provided in the restructured system and responding to the bigger market of health care buyers throughout Malaysia. The relevant Acts and Regulations need to be in place to enable change. The current economic & global situation may not be an ideal time for change but is an ideal time for planning & preparing the groundwork.

**Role of the public health nurse in there-structured healthsystem**

This conference seems to be an ideal forum for the public health nurses to deliberate on the future direction of their discipline in the reformed Malaysian health system.

Let me leave you with some food for thought. In October 2010, the Institute of Medicine of the US published a report on "The Future of Nursing: Leading Change, Advancing Health" in order to overcome barriers for nurses to respond effectively to rapidly changing health care settings and an evolving health care system. This report outlined four key messages that structure the recommendations. Firstly, nurses should practice to the full extent of their education and training. Secondly, nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression. Thirdly, nurses should be full partners, with physicians and other health care professionals, in redesigning health care and fourthly, effective workforce planning and policy making require better data collection and an improved information infrastructure.

No matter how the health system evolves, the work of public health nurses will maintain its definition as "primary prevention," which means preventing disease, injury, disability and premature death. Public health nurses will continue to active members of a team with other public health professionals such as environmental health

specialists, health educators, epidemiologists, public health physicians, and nutritionists. As members of this team, they work with local communities to assess and prioritize the major health problems and work on a plan to alleviate or eliminate these problems and the conditions that contribute to their development.

Public health nurses will be able to assist individuals and families to take action to improve their health status through teaching about healthy lifestyle choices in the home, in the workplace, and in community settings. They assist people in applying improved health behavior choices to their everyday lives for example in tobacco use, improper diet, lack of physical exercise, unsafe sexual practices, etc.

Recognisingthat the community and environment in which people live can affect their ability to make healthy lifestyle choices, public health nurses may spend a significant portion of their time on ensuring healthy living conditions in the neighborhoods where they work and on improving the health status of the entire community, not just that of individuals. Examples of community issues on which the public health nurse may work are immunization of all children against communicable diseases,identifying and reducing workplace hazards, and reducing the risk of home injuries through community education.

In honour of the national nurses week 2010 (May 6-12) , CDC Atlanta, which employs more than 160 nurses, gave recognition to thecommitment nurses make every day to protect the public's health in their non-traditional roles as researchers, scientists, educators, managers, analysts, and more. I am sure Malaysia has their own unsung heroes in the public health nursing fraternity who have worked in disasters or with indigenous populations in remote areas. It is just that it is not available over the world-wide web to be easily accessed by interested scholars.

In the future, the work settings of public health nurses will become more varied, whether in schools, workplaces, or in the district as general practice nurses in the district playing a community intervention role or as case managers more inclined to illness-oriented concerns. Home visits and clinic work will continue to take up a significant portion of your time.

With the current mistaken perceptionof public health nurses as providers of personal care only, it is no wonder that some feel that public health nursing has lost its way and needs to refocus on providing continuing, comprehensive, coordinated whole-person/holistic care to individuals, families and their communities.

The challenge for public health nurses in the future is to apply the nursing process (assessment, diagnosis, planning, implementation, and evaluation of interventions) to improve health, not just of individuals, but also with larger segments of the population in partnership with the community.

## CONCLUSION

In strengthening the health care system to meet the challenges posed by demographic & epidemiologic transition, higher expectations of the population and escalating health care cost, the Ministry of Health has proposed **1Care for 1Malaysia** a restructuring of the country's health care system to align it with the country's aspiration to become a high income country.

Primary health care is the thrust of this integrated health care system and this re-emphasis on promotive-preventive careand early intervention, positions the public health nurse to play a key role in the true mission of public health: to look at the health problems of a community as a whole and work with the community in alleviating those problems.

## REFERENCES

1) American Public Health Association Public Health Nursing Section (1996). The Definition and Role of Public Health Nursing. Washington, DC.
2) Buhler-Wilkerson, K. (1993). "Bringing Care to the People: Lillian Wald's Legacy to Public Health Nursing." American Journal of Public Health 83(December):1778–1786.
3) McCarthy M (2002) "A brief history of the WHO" The Lancet, Volume 360, Issue 9340: 1111 – 1112.
4) The face of public health nursing in West Virginia accessed at www.wv.train.org
5) CDC recognises National Nurses Week accessed at www.cdc.gov/Features/NursesWeek.