Nursing has always been a health equity and social justice profession, with a long history of improving health in communities and populations by addressing underlying health and social inequities. This study discusses two key nursing movements for health and social justice: the public health nursing movement and the nurse practitioner (NP) movement. A movement is collective organized action pursuing change-oriented goals outside of institutional channels (Snow et al., 2018). Working collectively, nurses in the public health nursing and NP movements developed services outside the established institutions in order to change health care, improve health, and pursue social justice.

In the 1890s, Lillian Wald’s public health nursing movement addressed what we now call the “social determinants of health” while providing care for poor and immigrant families (Jewish Women’s Archive, n.d.; Social Welfare History Project, n.d.; Thurman & Pfitzinger-Lippe, 2017). In the 1960s, Loretta Ford launched the NP movement as an avenue to increase access to care and improve health equity. The public health and NP movements had great success but did not reach their full potential. Both movements were limited by the overarching power of the medical model and lack of sustainable funding, professional autonomy, a viable financial model, and an enhanced educational focus on nursing’s social justice skills are needed for the profession to realize its potential for healing both individuals and populations.

The re-emerging population health movement and increasing nurse activism are building on our history of addressing the root causes of ill health. The population health domain of the new nursing education guidelines reaffirms the role of nursing and the need for nursing skills in addressing health equity and social justice (American Association of Colleges of Nursing, 2020). At the same time, National Nurses United, building on years of nurses collective bargaining and activism, has developed as a voice for nursing for better treatment of the profession, health equity, and social justice for all.
physical health needs but also the social and economic environments that contribute to health-wealth inequity (Fee & Bu, 2010). Wald was influenced by the Progressive reform movement and Florence Nightingale’s home visiting nurse ideas (Buhler-Wilkerson, 1993). In her early career, she was asked to attend a dying mother whose physician would not provide care because she could not pay his fee. Seeing and smelling the squalid environment the family lived in, she questioned how she could be "part of a society that permitted such conditions to exist" (Fee & Bu, 2010).

Affluent social reformers, women’s social clubs, and philanthropists supported the public health nurses, often out of concern for the risks to the broader community posed by poverty and infectious diseases (tuberculosis, typhoid, and cholera) among the poor. They supported visiting nurses as a strategy to reduce those risks (Jewish Women’s Archive, n.d.).

At the time, the prevailing attitude was to blame the poor for their poverty and disease (Fee & Bu, 2010). Wald advocated "The call to the nurse is not only for the bedside care of the sick, but to help in seeking out the deep-lying basic causes of illness and misery..." (House on Henry Street, n.d.). Wald recognized that addressing structural foundations of poverty, including immigration issues and discrimination, was critical to improving health. The public health nursing movement developed and supported new organizations, services, and supports for community development (Social Welfare History Project, n.d.; Thurman & Pfiztizer-Lippe, 2017).

Wald thought the conditions would change if those in power learned of the horrible conditions the poor lived in. To bear witness, to know the community, and to support change, she moved into the neighborhood, with financial support of philanthropist Jacob Schiff (Jewish Women’s Archive, n.d.). This became the Henry Street Settlement House, modeled after other immigrant aid movements in England and Chicago. Wald saw the nurse as link between neighborhood, resources, and politics. The Settlement House became a “hub for social justice” with visiting nurses, a community kindergarten, neighbor sports and meetings, classes, and labor organizing (House on Henry Street, n.d.; Thurman & Pfiztizer-Lippe, 2017).

With a team of like-minded nurses, Wald expanded the home visiting and settlement services. Metropolitan Life Insurance (MetLife) funded the public health nurses as a strategy to save lives and reduce the company’s life insurance payouts. Mortality declined 12% in the target population in 1914 (Buhler-Wilkerson, 1993). The home visiting support from MetLife provided the resources and standing to develop more programs and engage in more activism. The public health nursing movement developed services in the schools and advocated to abolish child labor, protect human rights, oppose immigration quotas and secure women’s suffrage. Wald and her team partnered with and supported what later became the NAACP (Thurman & Pfiztizer-Lippe, 2017). They also supported the women’s peace march in 1914, recognizing that war would take money away from essential social services (House on Henry Street, n.d.; Ruel, 2014). By the time of her retirement in 1933, Wald led 265 nurses caring for 100,000 patients and the community (Fee & Bu, 2010).

In spite of its success, the public health nursing movement was not able to sustain its social justice work (Reverby, 1993). Support for the public health nursing movement and its broad agenda waned as national attention shifted to the war and pandemic influenza (Buhler-Wilkerson, 1985). Nurses were hired to provide sick care services but their prevention work was not supported. Public health nurses employed in health departments worked under the leadership of the organization; they no longer had the autonomy that facilitated the public health nursing movement in its earlier days (Buhler-Wilkerson, 1985). Pulled between curative care and prevention, the role of the public health nurse became increasingly focused on curative care, not on prevention and the underlying causes of illness (Buhler-Wilkerson, 1985; Canales & Dredvahal, 2014).

The vision of public health nursing could not prevail against the rise of medical care, political conservatism, and sexism (Buhler-Wilkerson, 1985; Reverby, 1993). In the early 1900s, physicians had codified their domination over care of the human body through physician licensure. Nursing licensure came after physicians and had to fit around medical hegemony (Safriet, 1994, 2002). The public health nursing model was unable to maintain autonomy in the face of the increasing power of medicine.

The Visiting Nurses Association of New York continues to serve the city 100 years later, but the focus now is mostly on providing home health nursing procedures, which require orders by physicians, for individuals in the home (Visiting Nurse Service of New York, 2020). Public health funding and the role of the public health nurse have diminished significantly (Canales & Dredvahal, 2014; Thurman & Pfiztizer-Lippe, 2017).

3 | THE NP MOVEMENT’S ECLIPSED HEALTH EQUITY AGENDA

The NP movement was built on the public health nursing movement. In 1965, Dr. Loretta Ford, an assistant professor at the University of Colorado and former military nurse, saw the need for pediatric well baby care among low-income families in the local health department. She partnered with Dr. Henry Silver, a well-respected and powerful physician in the medical school, to develop an expanded role for nurses to provide the needed care (Silver, 1985). The NP movement aimed to change the biomedical, physician-dominant, limited access model of health care to one of social and health equity through expanding the nurse role. The NP movement, pushing from outside of established nursing and the institution of medical care, challenged the established scientific paradigm of medical care. Over time the NP role gained wide acceptability but the movement’s impact on health equity has been stymied by NP roles limited to individual 1:1 care, physician resistance to NP professional autonomy, reduced nursing education content on social justice and public health, and a medically dominant payment system.

Several factors facilitated the growth of the NP movement. The 1960s was a period of extensive challenges to the status quo and calls for equal opportunity, social equity, and expanded roles
for women (Bullough, 1976). NPs fit well in the collaborative, social-equity focused community health centers that were developing at the same time (Geiger, 2005). The federal Bureau of Health, Education, and Welfare evaluation of expanded roles for nursing concluded the expansion was essential for providing equal access (Keeling, 2015). The Commonwealth Foundation support to Dr. Ford to develop the educational criteria and curriculum for the NP role added legitimacy in the first decade ( Fleshman et al., 2007). Dr. Ford was unwavering in her vision of expanding the nursing, adhering to core nursing values, and meeting the needs of families. Her strategy was to develop the role and curricula, demonstrate its success, and partner with receptive entities. Moving between the boundaries of academic nursing and the needs in the community, Dr. Ford and Dr. Silver published in professional journals, presenting the NP role, the potential, and the outcomes (Ford & Silver, 1967; Silver, 1985).

The role was fiercely opposed by both established nursing and medicine. While nurses had been providing primary care in Frontier Nursing Service in rural Appalachia and in the Indian Health Service for 40 years, the NP movement expanded nursing to areas less remote. Ford and Silver envisioned NPs working with physicians in a collaborative, collegial relationship, not as physician substitutes (Keeling, 2015). However, leaders in nursing and in medicine saw the NP role as blurring their professional boundaries. Both nursing and medicine seized on the exclusive right of medicine to diagnosis and prescribe and opposed the NP role. Physicians challenged the safety of NPs, opposed physicians who worked with NPs, and even suspended the licenses of some physicians who worked with NPs for “aiding and abetting an unlicensed person to practice medicine” (Fairman, 1999; Henry, 1978).

NPs found the established nursing organizations were not responsive to their needs and formed their own NP advocacy groups, but multiple NP groups divided the movement in focus, tactics, and messaging (Christensen, 2017). It was not until 2013 that the two leading NP groups merged to provide one national voice for NPs of all specialties (American Association of Nurse Practitioners, 2019).

Working outside the established institutions of nursing and medicine, the NP movement earned support external to nursing and medicine. A 1981 federal study recognized the ability of NPs to provide high-quality care (Office of Technology Assessment, 1981). The Institute of Medicine (2010) recommended that regulations allow NPs to practice to the full extent of their education. A Harvard Business Review article recognized NPs as a disruptive innovation in what may be “the most entrenched, change-averse industry in the United States” (Christenson et al., 2000).

Now over 200,000 NPs provide a range in care in a variety of settings in the United States (Bureau of Labor Statistics, 2019). Licensure, educational program accreditation, and national certification provide some consistency and legitimacy but NP regulations vary from state to state, with a wide range of limitations that impede patient access (National Council of State Boards of Nursing, 2021; Rudner, 2016).

The medical establishment continues to oppose NP professional autonomy and NP direct payment from insurance. Yet, it supports having NPs work under the “physician-led care team” (American Medical Association, 2020). NPs cannot practice autonomously, without physician oversight, in about half the states. Reflecting persistent gender bias, states that had passed the Equal Rights Amendment in the 1970s are the states that are more likely to recognize NP full practice authority, not requiring physician involvement (Rudner, 2016).

Since the start of the NP movement, health care payment systems have changed. No longer is care typically provided by small businesses and community hospitals, but instead care is driven by large corporations. Many health care organizations see the benefit of NPs and utilize them, often for billable services that do not address health and social equity. In gaining widespread acceptability, the NP movement has lost some of its unique, non-biomedical strengths and its vision of an alternative style of care. In gaining a foothold in mostly curative care, the NP is often generating revenue in a predominately medical model. This has been further compounded by health care financing with billing based on procedure codes developed and managed by the American Medical Association (American Medical Association, n.d.). This financial structure makes nursing funding an adjunct to curative individual medical care, not prevention and not public health care, limiting public health nursing scope and resources. With the national physician organization defining what services are paid for and the United States’ system of individual health care financing, the potential for public health nursing and NPs to address root causes of health–wealth inequality is eclipsed by the medical giant.

With its success, the NP movement may have a weaker commitment to health equity. As the NP movement has grown and gained wide acceptance, newer NP cohorts may be less politicized and less interested in forging the NP role with its grounding in public health nursing and its commitment to equity. Dr. Ford noted as early as 1985 “a change...in the focus of (NP) programs from a health and wellness orientation to a more medical and disease orientation” (Silver, 1985). As the NP role became more wide spread, schools of nursing shifted the focus of their graduate programs to preparing NPs. Undergraduate programs also reduced actionable content on social activism (Thurman & Pfiztinger-Lippe, 2017). Programs in public health nursing declined dramatically (Canales & Dred Dahl, 2014). NP curricula focused on the “3 Ps”—pathophysiology, physical assessment, and pharmacology—with significantly less content on aggregate health issues, following the American Association of Colleges of Nursing 1996 curricula guidelines (Canales & Dred Dahl, 2014).

4 | DISCUSSION

The ability to implement changes to promote health equity and social justice depended on and still depends on access to power and resources. That ability also depends on alignment with stakeholders’ concerns. Wald, as an educated woman of means, used her access to power to secure resources and to communicate the reality of poverty. The nursing care model she and her team developed aligned
well with the broad concerns of the time, infectious disease, and poverty. The public health nursing movement improved the health and living standards in the community by addressing social determinants of health and prevention as well as sick care. But the ascendancy of the medical model, the decline in infectious disease at the time, the national focus on the 1918 pandemic flu, and WWI limited the scope of the public health nursing movement. Public health nursing became an adjunct to the medical model, with payment focused on procedures and illness care, not on addressing the root causes of poor health (Buhler-Wilkerson, 1985, 1993; Revery, 1993). Public health nursing has diminished significantly, with few schools offering a public health nursing concentration, few public health nursing jobs, and below market pay (Canales & Drevdahl, 2014).

The NP movement grew out of a recognized need, strong leadership, and a consistent strategy to address health equity. The NP movement continued to demonstrate how the expanding nursing role could serve populations in need, addressing not only biomedical health but also the whole person in the context of his or her socioeconomic reality. As the NP movement became more successful, it also became more tied to established medical care delivery systems and its medically focused billing and payment system. As the NP role became more accepted, it became an established profession and less of a movement. The NP movement’s original potential of providing more health equity has been stymied by payment systems held hostage by the medical model.

While health care organization and funding have changed, huge health and social disparities continue today. Addressing health-wealth inequity, the social determinants of health, and the underlying root causes goes beyond the scope and skills of our current individual medical care delivery sector and financing structures. Although health care has recognized social determinants contribute to outcomes, educational content and financial support for nurses addressing root causes and structural issues has been limited (Thurman & Pfitzinger-Lippe, 2017). The nursing profession has continued to encourage nurses to address social injustice, but the pathways to do that have been ambiguous (Thurman & Pfitzinger-Lippe, 2017).

We are entering a new chapter in nursing. As reimbursement moves from payment for units of care based on the biomedical model to risk arrangements which reward outcomes, nurses’ skills in population health and social justice will be more needed than ever, if the profession adapts to this next period of change. Nurses skilled in population health nursing can contribute significantly to outcomes in these new arrangements, if they can fully deploy their nursing skills without being tied to a medical model. Since medical care contributes only 10%–20% of health status, improving health outcomes will require skillfully addressing social determinants (Hood et al., 2016; Magnan, 2017).

This change in funding mechanisms provides an opportunity for nursing to build on its health equity and social justice roots. Responding to the environmental changes and needs, the American Association of Colleges of Nursing is completing a revision of core curriculum guidelines. The updated educational recommendations highlight the need for nurses to develop skills in population health and addressing social determinants of health, health equity, and social justice (American Association of Colleges of Nursing, 2020).

The Future of Nursing 2020-2030 vision for nursing includes “improving the health of individuals, families, and communities by addressing social determinants of health” ... and the “deployment of all levels of nurses across the care continuum, to address the challenges of building a culture of health” (National Academy of Medicine, 2020). This will provide avenues for nursing to improve health of populations in the post-hospital era.

Another sign of nursing’s commitment to its social justice roots is the newest evolution of nurses’ collective activism. National Nurses United (NNU), building on nursing’s long history of collective action through nursing associations, formed in 2009 (Budd et al., 2004; National Nurses United, n.d.). NNU’s vision is to advance the interests not just of nurses but also of patients, by organizing all direct care RNs “into a single organization capable of exercising influence over the healthcare industry, governments, and employers... and to win health-care justice, accessible, quality healthcare for all, as a human right.” (National Nurses United, n.d.). As COVID-19 has laid bare the impact of social inequality and the collective risks, NNU has been a voice for nurses and patients, along with several other nursing organizations.

The original public health nursing and NP movements were based on the power of community and collaboration as well as the potential of nursing as a force for health equity. We are emerging from an era focused on hospital and curative care. Nursing now needs reenergized population health perspectives and skills and a consistent source or mechanism of financing distinct from the medical model that will put the national health focus on prevention, address health-wealth inequities, and move us closer to health for all. Ultimately, it will depend on power, control, and money; the incentives may be aligning well.

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