The health visiting role has evolved, changed and expanded over the years. How has this affected the professional identity of these practitioners?

Exploring the professional identity of health visitors

In this article...

- A brief history of health visiting
- Issues surrounding its professional identity
- Future challenges for the profession

A long-held practice: undertaking routine reviews of babies

**5 key points**

1. The role of health visitors has been in flux since its conception in the mid-19th century.
2. Health visitors’ role has changed over the years and this has affected the profession’s identity.
3. It has been linked with nursing despite the different origins of the two professions.
4. There is a complex relationship between health visiting and public health.
5. Agenda for Change has also impacted on the profession.

**Historical perspective**

Health visiting originated from the Ladies Sanitary Reform Association, formed in 1862 in Manchester and Salford in response to the high infant mortality rate in the poorer districts (Abbott and Wallace, 1998). “Respectable working women” were recruited to visit the homes of “the poorer classes of the population”, to teach in a range of different areas including hygiene, child welfare, mental health and social support (While, 1987; McCleary, 1933), tasks that still resonate with the health visitor role today.

Although these “health missioners” are the predecessors of health visitors, there is some debate around when the first health visitors were employed (Dingwall, 1977). The title of “health visitor” was first used in Manchester and in 1890 health visitors were paid salaries by the local government (Heggie, 2011; Davies, 1988). From this point onwards other councils across the country began to employ health visitors.

By 1917, these practitioners were expected to visit all mothers as soon after a baby’s birth as possible, to advise on hygiene and infant care. Their duties were also being extended to include visiting pregnant women, and children until they reached school age.

After 1945 a number of significant changes took place. Nursing registration became a requirement for health visitors in 1945. After the NHS was formed in 1948, the widening of the health visiting role caused confusion about whether their main professional relationship should lie with GPs or medical officers of health (Malone, 2000). The Jameson Report (Jameson, 1956) emphasised the importance of maternal mental health, which became a key part of health visitors’ role (Kelsey, 2000; Abbott and Wallace, 1998). This led to further confusion about health visitors’ roles and those of social workers.

To address this confusion, Jameson
(1956) made a clear distinction between these two groups (Kelsey, 2000). Health visitors were described as generalist “case finders” (through their universal access to all families), while social workers were identified as “case workers” (to work with families with identified problems) (Malone, 2000). The lack of clear boundaries between the two roles continued to be problematic, especially in cases of safeguarding children (Malone, 2000).

Health visiting was gradually incorporated into the new NHS structure by “attachment” to general practices. This change also meant health visitors became more involved with individualised medical practice rather than the more community-based public health approach (Symmonds, 1997). In 1974 health visiting was moved from local authority control into the NHS. In 1977, four principles for health visiting practice were published:

- Search for health needs;
- Stimulate an awareness of health needs;
- Influence policies affecting health;

Public health became a national focus from the 1990s, when government policies recognised health visitors’ vital role in improving health and tackling inequalities. The need to strengthen health visitors’ public health role and work in new ways was highlighted in a number of documents (DH, 2001; 1999a; 1999b). Public health thus became a major component of the role once again, while health visitors were also expected to work with individuals, be the lead nurse for safeguarding children and lead on the delivery of the healthy child programme (DH, 2009a).

The health visitor’s role
Hunt (1972a) suggested that “there seems to be a common feeling among health visitors that their role is difficult to interpret to others, and that it is not well understood or agreed upon by those with whom they work”.

Almost three decades later this has not changed. As health visiting does not fit neatly into just one category like some other professions, these practitioners have often been referred to as “jacks of all trades” (Hunt, 1972a; 1972b).

Vague job titles and uncertainty over the associated roles potentially create ambiguity and confusion about professional identity (McCullivray, 2008). The title “health visiting” has been criticised for not being explicit in describing what the title-holder does (Hunt, 1972a), unlike other professional groups where the roles are clearer, such as nurses and teachers. However, Cowley (2002) argued that the title does explain what they do – “health visitors do health visiting”, an umbrella term encompassing a range of different activities. Although social workers, community nurses, public health workers, children’s centre workers and outreach workers may all be involved in providing a range of different activities, it is the combination of tasks that makes health visiting a unique profession (Malone et al, 2003; Cowley, 2002).

Link to nursing
The role has commonly been linked with nursing despite the different origins of the two professions. However, if health visiting as a profession is distinct from nursing then this raises the question of whether it is necessary for health visitors to be qualified nurses before entering the profession. This has been debated by professionals for some time (Brocklehurst, 2004; Malone et al, 2003).

In 2002, this debate was further intensified when health visitor regulation was transferred from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) to the Nursing and Midwifery Council (NMC), a regulatory body whose title did not include the phrase “health visiting”. Health visitors moved from having a unique professional registration to being registered with the NMC under “specialist community public health nurses”. Considering the two services’ differences in organisation and purpose, and that health visitors require an additional qualification, categorising health visiting under the broader “nursing” title could be seen as diminishing the significance of health visiting as a profession. Furthermore, there is no research to show any benefits of treating health visiting as a branch of nursing, while there is increasing evidence that it...
causes harm to health-visiting education, the regulatory process and therefore to practice (Cowley et al, 2000).

Public health
There is a complex relationship between health visiting and public health. In 1999, health visitors were identified as being “pivotal in leading public health practice in communities by developing a wider, family centred public health role, and leading teams of other practitioners” (DH, 1999b). However, there was no clear guidance on what this public health role meant. This led to confusion about which aspects of the role would need to be lost to create capacity for the new (Carr, 2005; McMurray and Cheater, 2003) argued that a public health approach requires “more than just a change in role – it requires an altered ethos”.

According to Craig and Smith (1998), there are two theories about the relationship between health visiting and public health. The first is that “health visitors are public health workers in the entirety of their role” (Standing Nursing and Midwifery Advisory Committee, 1995), and the second is that health visitors serve a public health function when they take a population perspective (Billingham, 1994). It has been argued that health visiting was part of public health from the beginning (Lynch, 1997) and that its primary focus on public health makes it unique among the caring professions (Malone et al, 2003). A contrary argument suggests that the focus of modern health visiting is on the individual, not the wider population and therefore quite distant from public health (Caraher and McNab, 1997). This greatly confuses the professional identity of health visiting.

The ambiguity surrounding health visiting and public health is further amplified by the various titles associated with the role (Craig and Smith, 1998), for example, public health nurse (Malone et al, 2003; DH, 1999b). This has led to a variation in the interpretation of health visitors’ public health role, causing inconsistent and diverse approaches to the delivery of health visiting services (Smith, 2004; Craig and Smith, 1998). An exploratory study on the public health role of health visitors found different perspectives, which resulted in confusion over what this part of their role really meant (Smith, 2004).

The title “public health nurse” can be seen as positive for health visiting as it puts health visitors squarely in the public health arena within primary care (DH, 1999a). However, it has been criticised for fragmenting the core function of health visiting by reducing it to a series of task-oriented, routinised approaches that mirror a medicalised model (Smith, 2004; Craig and Smith, 1998). Besides the confusion surrounding public health, health visitors also face an identity crisis over the social aspects of their role. In 1899 the health visitor was described as the “mother’s friend” (Davies, 1988). At the same time health visitors were responsible for reporting to the authorities on matters of vaccination, disease and home hygiene.

Child protection
Child protection is an area where the health visitor’s role often conflicts with that of social workers. Throughout the 20th century there was a lack of clarity between the two roles due to unclear boundaries and little autonomy for health visitors in comparison with social workers (Brooks and Rafferty, 2010). The implication of health visiting practice is made more complex by the difficulty in identifying a body of professional knowledge unique to health visiting, a problem also found in social work practice (Twinn, 1991). England (1986) argued that “the social worker’s ‘practice knowledge’ is his understanding of his clients and it is this unique understanding which informs and determines his helping”. This can also be applied to health visiting practice in terms of personal attributes, interpersonal and observational skills, and equally to other similar healthcare or public health professionals (Cowley, 1995; Hunt, 1972a).

Other overlapping roles
Other community workers and nurses have also been seen as a threat to the role of health visitors. Practice nurses are increasingly involved in health promotion and preventive work. This has caused anxiety among health visitors that their responsibilities are being eroded by practice nurses and that their autonomy (and therefore professional identity) is being diminished through lack of professional networking by being “attached” to general practices (Williams and Sibbald, 1999). Hunt (1972a) highlighted that 68% of health visitor participants chose to be members of the Health Visitors Association rather than the Royal College of Nursing. This was seen as a way to maintain a sense of identification with health visiting through association with colleagues in a professional organisation (Adams et al, 2006; Hunt, 1972a).

Although health visitors’ role overlaps with a number of other professions, which may pose a threat, it is the combination of health promotion, safeguarding children, education, social work, as well as their accessibility, ability to work with individuals, families and communities that gives health visiting its distinctive identity.

Political impact
Change is continuous in the NHS, and with different political agendas and priorities the role of the health visitor has also altered. A number of perceived threats arising from the changes in the NHS in the 1990s have been documented, such as: Project 2000 training (Craig and Smith, 1998); skill mix and practice nursing (Traynor, 1993); evidence-based purchasing strategies (Roberts, 1996); and the conflict between focusing on the individual and working with a community (Craig and Smith, 1998).

However, these threats can also be seen as opportunities for the health visiting profession. Project 2000 training was presented as “a preparation for nursing practice grounded in the philosophy of health and health promotion” (Twinn and Cowley, 1992), which would better prepare health visitors for their public health role. Skill mix and practice nurses would contribute to the public health agenda, with health visitors providing leadership in this area, as ascribed to them (DH, 2001). Through evidence-based purchasing strategies, health visitors could effectively articulate their core mission and make sound business cases to commissioners for continued investment, thus modernising and raising the profession’s profile.

Working with individuals as well as communities makes health visiting unique in the area of public health, providing opportunities for greater creativity in health promotion and prevention.

During the 1990s, the Labour government showed increased interest in the potential of nursing and promoted this in the NHS, through initiatives such as nurse prescribing, NHS Direct and nurse-led walk-in centres (Brocklehurst, 2004). In 2001, a resource pack for health visitors was published, to help develop their “family centred public health role” (DH, 2001). Since then a number of other documents followed, highlighting the importance of the public health and leadership role for health visitors (for example, DH, 2009a; 2009b), culminating in the recent health
The DH (2010) white paper outlined a number of changes that will impact on health visiting. The abolition of primary care trusts; creation of clinical commissioning groups; staff pay determined locally; a new public health service for vaccination, screening programmes and public health emergencies; ringfenced public health funding; and health improvement responsibilities moving to local authorities are all significant changes for health visiting.

The current national shortage of health visitors, highlighted in the recent Laming (2009) review, has also been recognised by the coalition government, which has committed to recruit 4,200 new health visitors by 2015 (Milton, 2010). The DH’s (2011) implementation plan sets out the vision of the new health visiting service and a call to action for stakeholders involved. Although this provides an opportunity for a revitalised health visiting service, the question remains whether this will impact positively and create more opportunities for the profession, or merely expand and change the role yet again, causing further confusion over professional identity.

**Conclusion**

Since its origin, health visiting has struggled to define its role and has suffered from uncertainty over professional identity. A number of factors have influenced this, such as: its diverse spread across health, education and social care; its link to wider public health functions; its responsibility in child health and protection; and its evolution from 19th-century volunteers into 21st-century professional nurses.

Various political agendas have impacted on health visiting identity, and are the key drivers of change for the profession. The new government proposals herald significant transformations to the NHS in England and especially to the provision of health visiting. It remains to be seen whether these changes impact positively on the profession and give health visitors a stronger identity, both within the NHS and the wider community.

It is clear that professional identity is not static and alters and develops over time in line with changes to professional roles, boundaries and perceptions of the profession. Health visiting is one profession where these changes have been continuous, offering both opportunities and challenges along the way.

**References**


