Commentary: Going to the People—Public Health Nursing Today and Tomorrow

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Public Health Nursing Today

Public health nurses practice in the neighborhoods and homes of the most vulnerable people in America. They go to the people, know them well, and have their trust. In this paper I describe the status of public health nursing as an invisible profession, show that the effectiveness of public health nursing has been clearly documented, clarify the contribution of public health nursing to population-based services, and propose neighborhood-oriented nursing as the practice structure for the future.

Public health nurses continue to be the largest group of health professionals upholding the public health infrastructure in local communities. For instance, in 1991 all county health departments in Oregon taken together employed the equivalent of 12 full-time physicians, 85 sanitarians, 15 nutritionists, 17 health educators, and 460 nurses. Yet, despite their numbers, public health nurses remain peculiarly invisible. In the Institute of Medicine report, the very existence of public health nursing is barely acknowledged. Many nurses have personally felt the effects of the decline in funding for public health. For instance, the approximately 1000 public health nurses serving the 8 million people of New York City in the 1970s has today been reduced to 225. Public health nursing has been diverted from its ideal of primary prevention to provide damage control for individuals and families already suffering from medical, psychological, and social problems. In Washington State, a survey of all 32 local health department nursing directors revealed that two thirds of public health nursing activity is focused on high-risk perinatal care. Public health nurses are growing exhausted and discouraged in their efforts to care for patients in worst-case conditions (J. V. Z., unpublished survey).

Most countries with infant mortality rates lower than that of the United States consider home visits to be a key dimension of their maternal child health programs. Public health nurses know how to develop partnerships with pregnant women and mothers that are effective in reducing infant mortality and morbidity. In a randomized trial, prenatal and postpartum home visits by nurses in Elmira, NY, resulted in improved diets, a reduction in smoking, improved birthweights in infants of smokers and young adolescents, a decrease in child abuse, a reduction in emergency visits, higher levels of employment, fewer days on public assistance, and postponed pregnancies. The effects were most striking for impoverished adolescent mothers. In another randomized study, home visits for very-low-birthweight babies of high-risk mothers resulted in a significant reduction in hospital and medical costs as well as diminished incidences of failure to thrive, foster home placements, and child abuse reports.

Although public health nursing demonstrably benefits the public, the practice competencies involved are subtle and difficult to explain. A central tenet of practice, according to a qualitative analysis of the narratives of expert public health nurses, is to encourage family self-care. This can be done only with a foundation of strong trusting relationships and deliberate development of family strengths. The less experience people have with trusting relationships and the less sense of personal power and control they have, the more time public health nurses must spend developing trust and strength. This emphasis on empowerment contrasts with the myth that nursing services foster dependency.

Instead, family self-help is fostered in many ways: community connections are built; intractable problems and crises are resolved; and parents are counseled to work through emotional issues, educated to encourage child development, and often persuaded to change risky behavior. When children need to be protected against abuse and neglect, public health

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nurses use the threat of law and authority. To match proposals for change with family readiness for change, nurses time interventions by watching for nonverbal and verbal clues.10 The public health nurse assesses the well-being of families in daily life. Clues to environmental, interactional, behavioral, and physiological function that are not evident during a medical office visit can be detected by a nurse during a home visit.12 Morbidity can be diagnosed in the clinic; the environmental and psychosocial origins of morbidity are found where people live and work.

Responding to Urgent and Emergent Public Health Needs

Public health nurses are well placed by position and education to benefit populations at high risk for illness: an aging population whose numbers are about to be swollen by baby boomers; children and adults with chronic illness and disability; impoverished women and children; racially and ethnically diverse people exposed to prejudice and disadvantage; persons who live in shelters and on the streets; migrant workers and refugees; people confronting violence in their homes and neighborhoods; those struggling with alcohol and substance abuse; and all people threatened by the return of rampant acute and chronic communicable disease.

During the very period that the numbers at risk have expanded, much of the public health nursing infrastructure has been dismantled. The control of tuberculosis is an example. Mallison wryly comments that the campaign to “get government off our backs” has liberated not only the taxpayers but also Mycobacterium tuberculosis.13 Direct observation of therapy and follow-up of nonadherent populations were eliminated; the rise of multidrug-resistant organisms followed.14,15 As in the past, public health nurses are well suited for community-based intervention against tuberculosis. Skilled in developing trusting relationships with marginalized populations, nurses are practiced in screening, case management, and health education. They can directly observe adherence to treatment, develop strategies to improve adherence, and manage associated conditions.

The Crossroads: Survival or Extinction

In the United States, public health and clinical practices have been separated. The longstanding mission of public health services is health promotion for populations. By contrast, most health departments only reluctantly provide direct clinical services for the underserved in their communities. Indeed, the American Public Health Association’s 1993 statement on “Public Health in a Reformed Health Care System” proposes to privatize most personal clinical services provided by local health departments; community- and population-based services would be retained and strengthened.16 In 1980 the Public Health Nursing Section of the American Public Health Association distinguished public health nursing by its emphasis on the care of whole communities or populations rather than direct care of individuals and families.17 The mission of effective population-focused services must continually be informed by public health nurses who know the daily lives of the people and the forces that threaten their health. Nurses who go to the people provide qualitative data that bring quantitative data to life and foster program planning for the entire community.

The practice knowledge of public health nurses is indispensable to population-based services. Nevertheless, large numbers of public health nurses who now provide direct services could become dinosaurs in a leaner, meaner public health system that no longer provides direct clinical services. If public health does finally divorce itself from direct patient care, alternative structures will be needed to preserve these public health nursing services that are essential to the public’s health. The work cannot simply be taken over by others.

Contemporary medical care treats episodes of illness outside the context of home and community. Nursing focuses on people’s response to illness in the context of everyday life.18 A prescription for sulfonamides for a urinary tract infection has no bearing on the sexual abuse that may underlie the infection. Oxygen administered for advanced chronic obstructive pulmonary disease becomes dangerous when the home is at risk of fire because of a defective stove.

Likewise, existing home health agencies cannot take over the work of public health nursing because the care they offer is determined by what will be reimbursed for an acute illness episode. Reimbursement does not include assessment and management of community and family needs for nursing care over time.

Public Health Nursing Tomorrow

How might public health nursing survive and thrive? Practice organized around the neighborhood could replace the current structure, which is organized around funding categories. Nursing services organized within defined geographic boundaries (a neighborhood, a district, a block) are economical and ensure access and continuity of health supervision.19,20 The Pew Health Professions Commission notes the failure of contemporary health services to manage a person’s safe passage through the system so that medical tests and interventions have a clear purpose, psychosocial factors contributing to illness are discovered, illness prevention is remembered, and death is dignified.21

The Pew solution is to bring health professionals “closer to the patients and families” and to gain an understanding of the underlying causes of human behavior under stress. This, as I have argued above, is the appropriate domain of public health nursing. Neighborhood-oriented nursing would provide broad-based case management and case coordination within neighborhoods or rural regions. It would be closely akin to community-oriented primary care, which Geiger describes as the merger of clinical care with public health sciences, health education, and community development.22 Care of the individual is determined by knowledge of the community’s needs and care of the community is determined by knowledge of the people as individuals.

Imagine the neighborhood nurse as a health care generalist responsible for a neighborhood or region. A fundamental skill would be the careful development of trusting relationships; nurses know the people and the community resources and are the ultimate case managers.23 They work closely with pregnant women and mothers in the neighborhood to develop self-care plans, immunize and screen children, and provide health education. They detect emergent problems early and, before they become crises, refer the patients to physicians, nurse practitioners, or social service agencies. They provide health promotion services and care to whole families, including follow-up for those living with chronic illness and disability and support for those facing the challenges of aging and dying. This role ensures continuity of care for all citizens.

The neighborhood nurse might work out of a neighborhood health clinic governed by a citizen–professional partner-
ship. Some local health departments might choose to function in this way. The clinic would be a natural meeting spot for mutual help groups and cooperative networking among neighbors. It could be a site for neighborhood health campaigns that might range from reducing teen smoking to improving day-care access to reducing toxic discharges from nearby industry. The neighborhood nurse would work in partnership with social agencies and health professionals as well as community health assistants, whose work might vary from cleaning, cooking, and personal care to advocacy and family education. The status, wages, and educational benefits of these assistants would rise as they assumed increasing responsibilities.

By providing personal services and promoting family self-care, public health nurses offer a humane approach to preventing the problems that result in extraordinary social and economic costs for emergency care, intensive care, lifelong special education, and penitentiaries for people who could have been helped by early intervention. □

References