Public Health Nursing Comes of Age

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Introduction

A decade ago, the World Health Organization's Committee on Community Health Nursing defined the emerging role of public health nursing in primary health care.[1] The report focused attention on untapped nursing potentials and added impetus to the dynamic movement that had begun 10 years earlier with the first Child Health Nurse Practitioner.

By 1974, public health nursing had come a long way since the early 1930s, when it was struggling to assert itself as a full-fledged member of the public health system while coping with differences both within the profession and within the organizational structure of practice. Although the importance of specialized preparation for home visiting had been recognized from the beginning, the majority of nurses in service had little or no academic preparation in public health. And, as Wilkerson points out,[2] the shifting of service from the voluntary visiting nurse structure to the official agency not only relegated decision making for nursing services to health officers, it splintered general nursing into preventive and sick care and fomented rivalry between "visiting" and "public health" nurses which further undermined the possibility of comprehensive health care. It was not unusual to find a nurse assigned to the health department placarding homes for communicable diseases, quarantining children from schools, and advising mothers to have their infants vaccinated, while, at the same time, a visiting nurse took care of the ill patient or the mother and baby, with communication between the two components relying haphazardly on the individual nurses involved.

There were exceptions, of course, in localities where the visiting nurse agency had contracted with the health department to provide the combined services and in rural areas where public health nurses were often employed as "town" or "district" nurses and provided care to both the sick and well in the community.[3,4] Pioneering work by the American Red Cross had demonstrated how effective nurses, properly trained and supervised, could be in providing broad-based county-wide health care to rural communities. (By 1930, there were 636 rural nursing services administered entirely by the Red Cross or in partnership with county health units; from 1919 to 1930, the Red Cross operated 2,972 generalized public health nursing services throughout the country but, by policy, transferred the programs to local agencies as they developed and were able to assume these responsibilities.[5]) Nevertheless, separation of "bedside" care from disease prevention and casefinding services prevailed, and increased with the expansion of city and county health departments.

Economic Crisis and Recovery

The weight of the Great Depression, felt by American families across the country, seriously affected all types of public health services as well. Communities were neither financially nor conceptually prepared to address the enormity of the problem. Decreased funding brought drastic personnel reductions, salary cutbacks, and curtailment of the most basic services. Many public health nurses, facing the effects of poverty, malnutrition, sickness, and deprivation, became social activists.

Federal relief and employment programs under The New Deal finally brought new hope and incentives to public health. Surveys identified the health and medical needs of the nation and work was provided for the unemployed. Over 10,000 nurses were given employment under the Civil Works Administration, assigned primarily to official health agencies.[6] While this facilitated rapid program expansion by recipient agencies and gave the nurses a taste of public health, the nurses' lack of field experience created major problems of training and supervision for the regular staff.

The Sheppard-Towner Act of 1921, aimed at improving maternal and child health care, had stimulated the organization of state health departments. The subsequent Public Health Title VI of the Social Security Act of 1935 went far beyond: through state grants, it strengthened and extended state health organizations; accelerated the growth of local health services; provided funds for the recruitment, training and supervision of public health personnel; and promoted the expansion of services in research, prevention, treatment, and control of pressing health problems.[7]

The public health nursing leaders who had helped draft this legislation were ready to plan its implementation.

- Katherine Tucker, General Director of the National League for Public Health Nursing (NOPHN) worked with the Roosevelt Administration to include bedside nursing care for the indigent in the Emergency Relief grant program:[8]
- Sophie Nelson, Director of Nursing for the John Hancock Insurance Company, was loaned to the US Public Health Service to survey public health nursing needs and advise the Surgeon General of the US Public Health Service on ways public health nurses might contribute to the work of that organization; and
- Pearl McIver, Director of Nursing in the Missouri State Health Department, gave consultation on critical community needs for health care. In 1933, Ms. McIver joined the Public Health Methods and Research Division of the US Public Health Service and, soon after, was transferred to the States Relations Division as the first public health nursing consultant for state health departments.[9] (The 1944 PHS reorganization established an Office, later Division, of Public Health Nursing in the new Bureau of State Services.) Referring to Ms. McIver's appointment in the PHS, McNeil states this was ". . . the beginning of a new era in public health nursing."[10]

Pearl McIver, R.N.

Pearl McIver was pragmatic, courageous in criticizing unnecessary deterrents to program development, and

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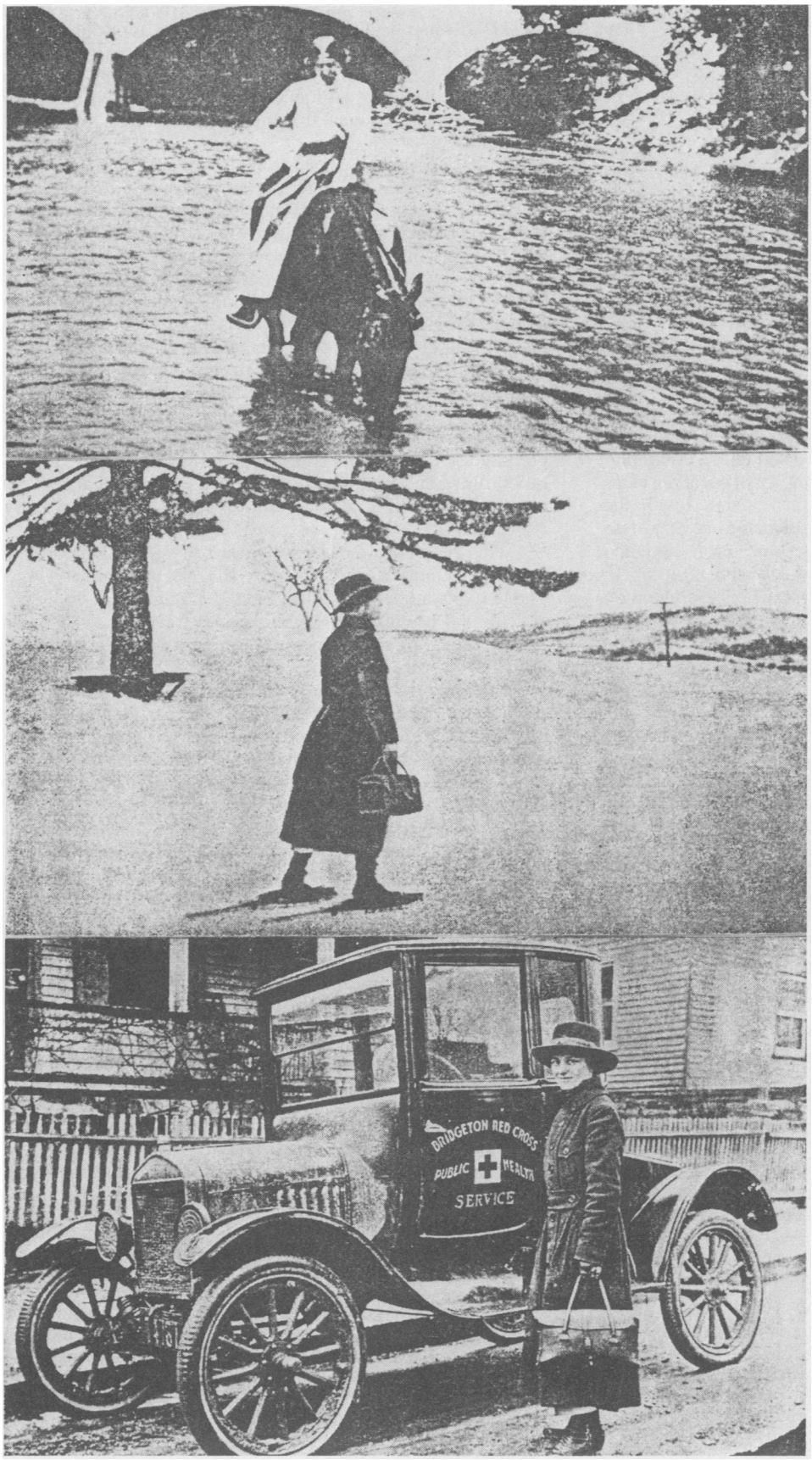

Public Health Nurses Making Their Rounds

. . . on horseback (1915)

. . . on snowshoes (1920)

. . . in a modern convenience (1916)

Photo Source: *The Red Cross Nurse in Action, 1882–1948.* New York: Harper & Brothers Publishers, 1949

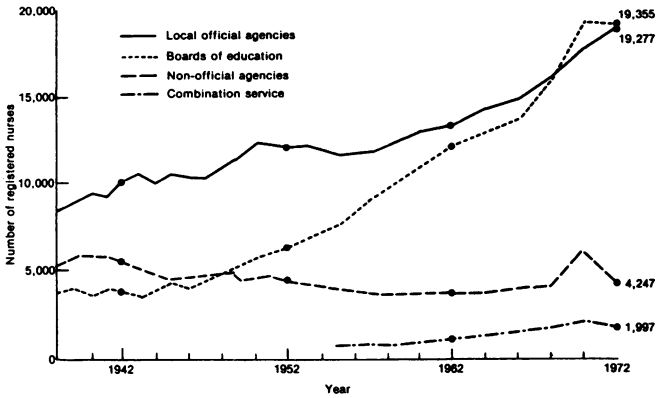

FIGURE 1—Number of Registered Nurses Employed Full Time in Public Health by Local Agencies by Type of Agency, 1938-72
SOURCE: Surveys of Public Health Nursing, 1968-1972, p 13.[27]

unswerving in her faith that nurses could improve the health and well-being of individuals, families, and entire communities. Convinced that the scope and quality of local services depended heavily on wise leadership at the state level, she labored to see a well-prepared nursing director in every state health department. To achieve this, she often assigned nursing consultants to help establish the position or to substitute for an incumbent on study leave. She created an organizational structure which enabled nurses assigned to regional offices and categorical programs of the US Public Health Service to relate professionally to the Service's Central Office of Public Health Nursing, a design which became the prototype for many state agencies.[11] Working closely together, Ms. McIver and Naomi Deutsch, Director of Nursing in the US Children's Bureau, promoted a unified approach to community nursing services and planned with states for the use of grant-in-aid funds for staffing rapidly developing programs and for preparing nurses in public health. The results of these joint efforts ". . . demonstrated what two able, experienced nursing administrators, with a small staff of well selected consultants and the support of professional organizations could accomplish when they are concerned about delivery of services."[10]

By the end of the decade, an upsurge in public health nursing was clearly evident. All of the 48 States, as well as the territories of Alaska and Hawaii, and the District of Columbia had established public health nursing programs. According to the 1938 census, there were 19,379 nurses employed full time by state and local agencies, including 3,887 by Boards of Education; this represented a 24 per cent increase over the previous census of 1931.[12,13] The largest increase (40 per cent) occurred in local health departments, setting the pattern for the next decade (Figure 1). At the same time, there were still 1,077 counties (over one-third of the total) and 26 cities (population 10,000 and over) with no local public health nursing services.[14]

The two national agencies established to promote public health—the National Organization for Public Health Nursing (NOPHN) and the American Public Health Association (APHA)—had formed strong productive ties, as shown in joint statements adopted on minimum qualifications, definition of nursing functions, and standards of practice.[15] Protocols for service records, recording procedures, and cost studies had been prepared and were widely used. The Association of State and Territorial Directors of Public Health Nursing (ASTDPHN)—later changed in 1965 to the Association of State and Territorial Directors of Nursing (ASTDN)—had been organized. This group, working closely with the federal government, professional organizations and the Association of State and Territorial Health Officials (ASTHO), effectively influenced the development of health personnel and services for the nation, states, and local communities.

The training and preparation of public health nurses was of continuing concern. From its inception in 1912, the NOPHN had taken responsibility for promoting educational standards for this specialty. By 1935, 16 approved postgraduate courses in public health nursing were offered by colleges or universities; five years later, this number had grown to 26.[8,11] During the mid-1930s, guidelines for curricula and student field experiences were revised and schools of nursing were urged to include public health in their basic program, to enhance the quality of nursing practice in *all* settings. In 1932, while these efforts were in progress, a survey of public health agencies[8] revealed that only 7 per cent of the nurses employed in public health were adequately prepared. (A nurse was considered to have adequate preparation for public health work if she had completed at least 30 hours of credit in a program approved for public health by NOPHN.)[16]

This problem was given high priority when educational funds became available through the Social Security Act. Those funds alone in 1936 enabled 1,000 nurses to complete educational programs in public health.[9] Even so, this was only a beginning step toward reducing a persistent, knotty problem.

In October 1938, Dr. Thomas Parran, Surgeon General of the US Public Health Service, addressing the Annual Meeting of APHA, reported, "Greater progress has been made in public health during the past two years than in any similar period in our history."[7] He then described the health status of the nation as shown by the recent National Health Survey which had revealed: grossly insufficient preventive services, alarming malnutrition, one-third of the population with little or no medical care, excessive disease and death rates in low-income groups and, while threats of communicable disease were diminishing, the chronic diseases—syphilis, tuberculosis, heart disease, cancer and stroke—had become the chief causes of death. In spite of the recent advances, the ability of public health agencies to cope with these new concerns, given the existing patterns of organization and distribution of services, was questioned.

The rural sanitation movement of the 1920s had promoted the development of local health units, from 109 in 1920 to 505 by 1930. The Depression slowed this growth, however, so that only 41 new units were established during the ensuing five years. Progress had been made through state grants but, by the end of the decade, few states had more than half of their counties covered by local full-time public health services.[7,17]

World War II

Influenced largely by responses to the Depression, the course of public health was soon to make an abrupt change. As the nation became involved in World War II, attention focused sharply on safeguarding the health of military personnel, of families in cantonment areas, and of workers in essential industries. Maternal and infant care, nutrition, sanitation, and control of syphilis and tuberculosis were targeted programs; categorical programming was intensified.

To plan and coordinate activities related to the war effort, the national nursing organizations joined forces to form the Nursing Council on National Defense (NCND). The Subcommittee on Nursing in the Office of Defense (SNOD) was responsible for recruitment and assignment of nurses in military and civilian services for defense. These two groups worked closely together to protect the health of the public at home as well as those sent abroad.

With medical and nursing staffs in hospitals greatly depleted, many patients who would normally have been hospitalized had to be treated at home. Families, already stressed, were expected to care for critically ill members, help with home births, or care for mothers and infants discharged early from the hospital. These family caretakers needed much instruction, support, and assistance with direct nursing care and looked to the public health nurse for this help. Both official and voluntary agencies set aside restricting policies in order to meet these needs. The American Red Cross organized courses in home nursing and training programs for nurse's aides. By the end of 1942, over 500,000 women had completed the American Red Cross home nursing course, and nearly 17,000 nurse's aides had been certified. These numbers continued to escalate so that, by the end of 1946, over 215,000 nurse's aide certificates had been awarded.[5] Volunteers were used in clinics, hospitals, and public health agencies more widely than ever before. As schools of nursing with federal subsidies graduated larger classes, more nurses became available for all types of service.

Public health problems were particularly acute in communities selected for military camps. Local resources were quickly overwhelmed by the influx of servicemen's families and other transient groups. Requests for emergency help poured in to the Office of Civilian Defense (OCD) from military headquarters as well as from state and local health departments. In response, the US Public Health Service recruited and assigned doctors, nurses, and engineers, often in teams, to areas in greatest need. During the war years, nearly 250 public health nurses were assigned to official agencies in 35 states, the District of Columbia, and Puerto Rico.[9]

In 1943, passage of the Emergency Maternity and Infant Care (EMIC) Act enabled the US Children's Bureau to take a vital part in determining both the quality and quantity of services for mothers and babies.[18] These federal funds paid for the cost of medical, hospital, and nursing care for wives and babies of servicemen, but eligibility for reimbursement required local services to meet standards set by the Children's Bureau. Demonstration programs for the control of tuberculosis, venereal disease, and malaria were initiated; protocols for the referral and follow-up of draftees rejected for health reasons were firmly fixed in ongoing programs.[7]

Marion Shehan, R.N.

Public health nurses played a vital role in all of these programs. Nurses coordinated activities, mobilized community resources, and adjusted services to meet emergencies without losing the essence of ongoing programs. The leadership of such notables as Marion Sheahan, Katherine Faville, Elizabeth Fox, Alma Haupt, Mary Beard, Marion Howell, and Pearl McIver gave direction to public health nursing during the war years and guided its development long afterwards.

The most effective strategy designed to increase the supply of nurses for wartime needs was framed by US Representative Frances P. Bolton of Ohio who, having witnessed the effects of nursing shortages in World War I, had funds earmarked for nursing education in federal appropriations for 1941. This support covered courses for basic, postgraduate, and graduate education and, in its two years of operation, enabled schools to increase enrollments by 13,000 students in basic programs and 4,200 in graduate programs; approximately half of the graduate students specialized in public health.[7] This experience stimulated legislation for the US Cadet Nurse Corps program, passed in 1943 and administered by the Division of Nursing Education of the US Public Health Service, under the direction of Lucile Petry Leone. This highly successful program enrolled the quota of 65,000 cadet nurses during its first year and 30,000 the second and final year.[8] When hostilities ceased in the fall of 1945, the program was phased out but, during its short span, nursing education changed dramatically. Traditional curricula had been critically evaluated and shortened, experimental junior college programs were begun, and the number of basic baccalaureate programs had increased markedly, with most including some public health content.

The Immediate Post-War Years

Hopes for a "return to normalcy" after the war did not materialize as veterans returned to their communities, families resettled, and schools and industries tried to cope with myriad complex changes. The health system felt the brunt of these adjustments. Military experiences had heightened public expectations of health care. Local health departments faced sudden increases in emotional problems, accidents, alcoholism, and other disabling conditions not previously considered to be in their domain; many scientific breakthroughs made traditional patterns of practice obsolete. For example, newly available antibiotics were effective in preventing and treating infectious diseases, rheumatic fever, venereal disease, etc. Development of the photofluorogram assisted mass casefinding for tuberculosis. Categorical programming, public participation in health decisions, renewed pressures for health insurance, construction of hospitals and health care facilities, and the extension of full-time local health services to all were dominant issues.

Fears that federal funding of state services would be withdrawn after the war were unfounded; instead, funds were increased and sharply focused to impact on categorical programs: tuberculosis, venereal disease, cancer, and mental health were spearheaded in every region. Registers were established for statistical analyses, casefinding and follow-up purposes; protocols for preventive services and care of patients, families, and high-risk groups were revised and referral systems strengthened. Local health councils were formed, patterned after the National Health Council, to study, coordinate and strengthen the total health care system in their jurisdictions. Funding was again available for training personnel and, in many instances, study programs were set up to prepare specialists in the field. The GI Bill enabled veterans to return to school and to major in almost any field. Many nurses took advantage of this, thereby obtaining a baccalaureate or master's degree, with many specializing in public health. In contrast, categorical funding focused on

TABLE 1—Number and Percentage Increase of Agencies Employing Nurses for Public Health and Full-time Nurses Employed

	Agencies		Nurses	
Year	No	% Increase	No	% Increase
1938	5901	—	19502	—
1957	8010	35.7	28599	46.6
1968	9995	24.8	42541	48.7
1979	13753	37.6	69085	62.4

public health training in the respective disease entities, usually in a three- to six-month study program.

In addition to updating their knowledge of disease, there were many other gains for public health nurses in these new ventures. They were able to work intensively with the community in interdisciplinary teams and to apply epidemiologic concepts to populations at risk in a way that individual and family services did not permit.

In 1942, APHA's Subcommittee on Local Health Units, chaired by Haven Emerson, had found that only two-thirds of the population was covered by full-time local health units, and that the number of personnel was too sparse to provide even the basic services—communicable disease control; hygiene of maternity, infancy and childhood; health education of the general public; vital statistics; laboratory; and environmental sanitation. Double the existing number of public health nurses were needed to reach the recommended minimum requirements of one nurse per 5,000 population, and that ratio should be doubled again if home care of the sick were added. That report, published in 1945,[17] had substantial impact upon the growth of local health departments, thus opening up more job opportunities for public health nurses. Beginning in the post-WWII years and extending into the 1950s, state health departments as well as the federal government became more active in promoting the establishment of local health departments. Several states, notably New York and California, strengthened their own matching grants, using substantial amounts of state tax money to induce local political jurisdictions to establish departments headed by full-time health officers and staffed by nursing directors and supervisors with approved qualifications.

By 1950, 56 per cent of the 3,070 counties in the continental United States were covered by full-time local health services.[19] Five years later, this figure had increased to 72 per cent.[20] Although the growth of agencies providing public health nursing services was marked throughout this period, the increase in public health nursing staff was proportionately greater (Table 1).

Organizational changes of considerable importance to nursing were also occurring. A study sponsored by the National Health Council[8] documented the duplication of effort and uneven performance of many voluntary nursing agencies. One of its recommendations was to reduce the proliferation of community nursing services, and—accepting the concept of the generalized public health nurse serving a designated population as most effective—to encourage mergers among private agencies and better coordination with public agencies. Implementation of these recommendations hastened the development of the "combination service"—a partnership of voluntary and official agencies aimed at delivering comprehensive public health nursing services to the community. This ideal proved difficult to administer, however, because of conflicting organizational policies. Some found the combination untenable and, after a trial period, returned to their original separate structures. On January 1, 1960, 47 combination agencies were reported; by 1968, there were 100, but 11 years later, only 52 were still functioning.[14,21]

Passage of the Hill-Burton Hospital Construction and Survey Act in 1946 provided matching grants for construction of public health as well as hospital facilities. The Act was instrumental in moving health departments, including nursing offices and clinics, out of dilapidated buildings, backrooms, and basements. This did much to boost morale of the nurses and to increase the status of public health nursing in the community.

Far-reaching happenings were also taking place which would influence human health and health care delivery around the world. In 1946, the Constitution of the World Health Organization was drafted and made ready for ratification by the United Nations. US Surgeon General Thomas Parran was highly influential in the organization of WHO and saw to it that Elmora Wickenden, Executive Secretary of the National Nursing Council, was included in the International Health Conference convened in June 1946 to draft the WHO Constitution. From the start, public health nursing was a distinct unit in the WHO Division of Public Health Services, included in all regional offices and in country missions and many team projects as they were developed. WHO has undergone structural and programmatic changes since its founding, but public health nursing has continually played an important role in the organization.

The Prosperous 1950s

The decade of the 1950s began on a note of excitement, prosperity, and expansion for nursing and public health and for the United States in general.

As is usual with rapid change, incongruities were common—for example, rural communities voted simultaneously on bonds for the closure of open sewers and for water fluoridation to prevent dental caries; infant mortality rates in coal mining communities were as much as 127 per cent higher than the national rate; and within states, one found very progressive health departments serving urban populations adjacent to counties with no official health agency.[22,23]

Activities within the NOPHN reflected concerns for the future of voluntary agencies and for bedside care of the sick, in particular, since most tax-supported agencies were again adhering narrowly to preventive services and health supervision. The Metropolitan and the John Hancock Life Insurance companies and the American Red Cross—all important sources of income for voluntary agencies—discontinued their support early in the 1950s. This was a significant loss. The insurance companies had subsidized agencies for the care of policy holders. The American Red Cross, between 1913 and 1947, had established 3,109 public health nursing services in about 1,800 counties. At the end of 1947, when the decision was made to discontinue the program, there were still over 100 in operation; by June 1950, these had either been transferred to local agencies or closed out. Thereafter, the American Red Cross was primarily involved in demonstrations and experiments in nursing service.[5]

Mounting interests in nurse-midwifery, equality and advancement of Black nurses in public health, cost analysis methods and studies, inclusion of nursing services in health

insurance plans, and better coordination of organized nursing as a whole were other major considerations. After more than two years of discussion and mutual planning, this latter activity culminated in 1952 with the formation of a new structure for professional nursing. Three organizations—the NOPHN, the National League for Nursing Education (NLNE), and the Association of Collegiate Schools of Nursing (ACSN)—were dissolved and their functions distributed between the American Nurses' Association (ANA) and the new National League for Nursing (NLN).[8] Henceforth, the professional development of public health nursing would be directed primarily by NLN, supported by and in collaboration with the Public Health Nursing Sections of APHA and ANA.

In 1948, Dr. Esther Lucile Brown's study of nursing education, undertaken for the National Nursing Council, had rocked apprenticeship patterns of nurse training and substantiated the need for professional education, i.e., basic preparation in collegiate programs leading to a baccalaureate degree with advanced graduate preparation for teachers, administrators, supervisors, and researchers.[24] These recommendations solidly supported directions already advanced by NOPHN: the inclusion of public health concepts in the basic baccalaureate curriculum and graduate preparation for public health practice. The Brown report marked an exciting turning point for nursing and it was thought to be for public health nursing as well.

Soon after its formation, the NLN set about implementing the Brown recommendations, declaring that all basic collegiate nursing programs should integrate social and public health concepts throughout the curricula and prepare their students for first level positions in public health. Specialized preparation was to be given at the master's degree level with certificate programs gradually eliminated. All of these objectives were important for the upgrading of public health nursing practice and for bringing the profession in line with peer groups in nursing and in public health. Unfortunately, there was no testing of the plan and the time given for transition was too short for so immense a task.

Short courses, of one- and two-week duration, in public health concepts were devised for faculty all over the country. Public health faculty hastily rearranged schedules and looked for agencies to provide field experiences for the increased numbers of students. This effort was further complicated by the requirement that only baccalaureate graduates with public health preparation could serve as clinical preceptors. Up to this time, experienced public health nursing supervisors and senior staff had coached students, but many did not meet the new requirements. Therefore, young nurses minimally qualified, often with little or no work experience, were employed by the schools as field instructors. In addition, hospital clinics, outpatient departments and similar services largely concerned with individual patient care were used for clinical teaching in public health, thereby reducing and even excluding student contacts with agencies responsible for community health. Unknowingly, this well-conceived, goal-directed program dealt public health nursing a blow from which it has not entirely recovered 30 years later. The contextual fiber of public health, i.e., the group and larger community, was lost to many simply because students and young faculty alike, steeped in the one-on-one tradition of nursing, were not adequately taught basic concepts of public health or provided opportunities to see and use those concepts in practice. For too many, "public health" nursing became synonymous with "out-of-hospital" nursing.

Many public health agencies suffered similar detrimental effects. The spark of having students as an integral function of the agency and the challenges of learning and change that accompany teaching responsibilities were soon lost. Add to that the employment of graduates poorly prepared in public health and it is little wonder that a period of dissatisfaction, criticism, and alternate approaches to public health nursing services was on the horizon.

These events might have had more damaging consequences but for a few counteracting influences. Ruth C. Freeman's textbooks on public health nursing practice and supervision—standard references in most schools—were explicit regarding the basic strategies of public health. As an educator, service director, and consultant, she also helped numerous schools, agencies, and individuals cope with the perplexing problems of the educational change. Another positive influence was the Nurse Training Act of 1956 which provided traineeships to prepare nurses for administrative, supervisory, and teaching positions. These funds enabled many students to enroll in schools of public health, as well as in schools of nursing, where the educational content concentrated on the sciences of public health and the community as an entity. Several State Directors of Nursing, including Marion Sheahan (New York), Anne Burns (Ohio), and Rena Haig (California), among others, counseled schools on agency needs, and helped states and local agencies adopt management strategies to align merit system classifications with NLN's recommendations. Statistically, the gains made during this period were clear. From 1940 to 1960, there was a steady increase in the proportion of nurses employed in public health who were educationally prepared in public health. By 1957, this figure had reached 38 per cent, with over 28 per cent having baccalaureate degrees and 27 per cent having both public health and baccalaureate degree preparation.[25] Nevertheless, the general complaint of service directors was that the newly prepared baccalaureate graduates were unable to function in public health without long intensive inservice training. Moreover, having succeeded in raising job qualifications for professional nurse staff, it was difficult to justify the need for continuing education in processes intrinsic to public health.

During the 1950s, international health services were initiated to accelerate the development of public health and nursing in many countries. A Division of International Health was created in the Office of the Surgeon General, US Public Health Service, with goals similar to those of WHO. Public health nursing was included in the core of the program at headquarters and in team assignments to participating countries. Margaret Arnstein, Mary Forbes, and Virginia Arnold worked diligently with Dr. Henry van Zile Hyde to plan and implement the Division of International Health. Virginia Ohlson, under the Supreme Command of Allied Powers (SCAP) and the Rockefeller Foundation, gave leadership in helping Japan and other Asian countries develop progressive nursing programs.

Margaret Arnstein, R.N.

Field experiences gained earlier through the US Department of State, the Pan American Sanitary Bureau, the United Nations Relief and Rehabilitation Administration (UNRRA), and post-war country restoration strategies under the military had prepared nurses for these new undertakings. To supplement these experiences, intensive multidisciplinary training programs were created to help personnel understand the culture, health problems, work patterns, and related social conditions they would face in carrying out their assignments.

Several events occurred during the decade that gave all public health nurses a feeling of presence and unaccustomed recognition. In 1951, Ruth B. Freeman was appointed to the Executive Board of APHA, the first nurse to attain such an elected position.[10] In 1955, the prestigious Lasker Award was presented to Pearl McIver, Lucile Petry Leone, and Margaret Arnstein, as a group, for their contributions to public health administration. In 1959, Marion Sheahan was named President-Elect of APHA, clear evidence of the high esteem in which she was held.

Revolution in Health Care, the 1960s

The phenomenal post-war growth of the US population passed the 200,000,000 mark in the 1960s, and by 1965 the very young (under the age of 5 years) and the elderly (age 65 and over) each represented approximately 10 per cent of the total population. While a stable economy, buoyant employment, and space explorations contributed to the general public confidence, many observers noted rising racial tensions, urban disorganization, increasing environmental pollution, widespread poverty, and serious inequities in medical care. In 1961, President John F. Kennedy sought legislation to reduce unemployment, protect civil rights, and provide medical care for the aged under social security. It was 1964, however, before the Congress dealt authoritatively with these problems, in response to President Lyndon B. Johnson's War on Poverty and plans for a Great Society. The Economic Opportunity Act provided funds for neighborhood health centers, Head Start, and numerous other community action programs. Categorical funding expanded programs for maternal and child health (maternity and infant care, children and youth projects), mental health and mental retardation, and public health training; it also initiated Regional Medical Programs for heart disease, cancer and stroke.

In 1965, Congress amended the Social Security Act to include health insurance benefits, providing hospital and home nursing care for the elderly (Medicare) and expanded care for the indigent (Medicaid). Although falling short of a national health insurance plan, these programs made a variety of health services available to the population least well covered by health insurance.

As in previous years, state and national nursing organizations had urged passage of the bill, but had pleaded for the inclusion of preventive services and home health care. The bill as passed did not allow for health promotion or preventive care, and reimbursement of home care of the sick was limited to those treatments specifically prescribed by the physician. Organizational consequences of these new programs varied: demands for nursing care spiraled and many small voluntary agencies—unduly stressed by payment restrictions, prolonged delays in reimbursement, and related problems—had to close. The large majority, however, forced to change, ultimately reaped untold benefits such as modernized fiscal management procedures; revised and standardized care procedures; more efficient utilization of personnel, supplemented where possible by practical nurses, homemakers and home health aides; and expanded nursing programs to include physical therapy, occupational therapy, specialized nutrition, social services, and more. Many local and some state health departments rapidly changed their policies to include reimbursable home care of the sick—with considerable concern expressed over the neglect of preventive care. In 1960, only 250 official health agencies offered nursing care of the sick on a continuing basis.[26] By 1968, this number had increased to 1,328 showing that over 50 per cent of all official agencies providing public health nursing services were including sick care in their program.[27] Undoubtedly the most alarming effect of Medicare legislation was the proliferation of proprietary home health agencies and nursing homes throughout the United States. Entrepreneurial groups with no previous interest or experience in health care saw profit-making opportunities and quickly moved into this facet of the health industry.

Early on, APHA and NLN developed a joint accreditation program for community agencies providing home care. Later, in 1970, the National Association of Home Health Agencies was organized to develop standards for personnel and services and, still later, health planning agencies began monitoring community needs for home health care.

Other legislation further compounded the health organization puzzle. While regional medical programs melded service, teaching, and research for cancer, heart disease, and stroke, they splintered state health department programs; model cities and anti-poverty programs supported community health centers, made health care accessible to underserved populations and brought these groups into the planning. New autonomous health planning agencies attempted to take over functions long the provinces of state and local health departments. The 1960s brought a new world of health care delivery, operationalized concepts of health care as a right, but focused that care on diagnostic and therapeutic services. In fact, in 1967, when state nursing directors voiced their concern over preventive care, they were advised to "stop worrying about the health of the community and aim efforts at the target areas of disease and disability."[28]

Combined health and social welfare programming, robust categorical grants, and reorganizations at the federal level prompted parallel changes in the states. Super agencies began to emerge, with the state health department one arm among myriad others. Functions were changing as well; direct state involvement in local public health practice eroded as federal controls increased and multiple support mechanisms became more available to local health departments and independent community projects for the disadvantaged flourished. The authority of state directors for nursing services also underwent change, as nurses in categorical programs became increasingly autonomous and as the director's position broadened to include responsibilities for nursing in hospitals, Office of Economic Opportunity programs, and recruitment and training projects. By 1970, several nursing directors headed divisions of local health services or other multidisciplinary programs. Some of the concerns during this period, as reflected in ASTDN resolutions, included:

- the need for greater representation of nurses on planning councils, policy making, and program development boards;

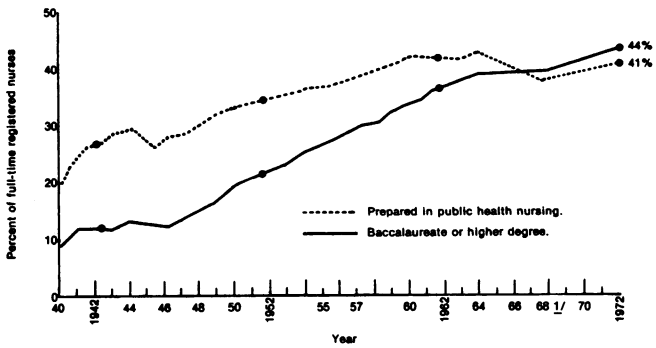

FIGURE 2—Baccalaureate Degree and Public Health Nursing Preparation of Registered Nurses Employed in Public Health, 1940–72
SOURCE: Surveys of Public Health Nursing, 1968–1972, p 16.[27]

- proposals to strengthen existing agencies instead of creating new ones;
- a call for studies of various staffing patterns to improve coverage and cost-effectiveness;
- the need for outreach services for better utilization of health centers;
- development of measures to evaluate the quality of health services;
- revamping of the merit system classifications; and
- making full use of federal traineeships for all disciplines providing health care.[28]

At the local level, assessment of community needs, planning comprehensive health care, coordination of services, and patient-family advocacy were activities within the purview of public health nursing. But community assessment skills were limited and, for the most part, neither the hospitals nor the young, consumer-administered services welcomed outside assistance. Even more important, extensions of hospital services, Medicare programs, and the new community health agencies—all directed primarily toward identifying and treating illness—brought many clinical nurses into the field of public health. Consequently, the 1968 census showed 42,541 nurses employed in community services, a 49 per cent increase over the 1957 total of 28,599 (Figure 1); however, the percentage with public health preparation remained at 38 per cent,[25] despite traineeship funds which became available through the Nurse Training Act of 1964 for specialty preparation including public health (Figure 2). Nurses with baccalaureate preparation had increased by 12 per cent, up from 28.8 per cent in 1957 to 40.7 per cent in 1968 (Table 2).

Two additional factors added to the changes of the 1960s:

- One was the nurse practitioner movement, which began in 1965 at the University of Colorado and was to open a new era for nursing in primary health care. The term "nurse practitioner" (NP) refers to a registered nurse who is prepared at the certificate or master's degree level in the diagnosis and treatment of common illnesses, including such skills as history taking, physical examination, ordering laboratory tests, and having responsibility for medical management and supervision of patients with specified conditions. Although conceived as a public health nurse with extended clinical skills, the nurse practitioner soon became the clinical nurse ready to function in any care setting. Many public health nurses obtained practitioner training and, on returning to their communities, focused on increasing sparse clinical services, i.e., establishing clinics, screening and follow-up programs with physician backup and referral. This was particularly true for rural areas, inner-cities, and populations with a concentration of health-related needs and little medical care.

Initially, there was strong resistance to nurse practitioner programs, from both nursing and medical professions alike, with nurses fearing a diminution of their caring, instructive, and supportive functions and with physicians feeling threatened by the invasion into their traditional functions of history taking, physical examination, and treatment of patients.[29,30] Nor did approval come easily; medical and nurse practice acts were examined, jobs restricted, and competing programs such as those for physician assistants (PA) confused the picture further. But there were sustaining influences for the NP concepts among nurses, doctors, legislators, policy makers, service administrators, and consumers, and acceptance grew as graduates demonstrated that their new skills substantially strengthened and logically extended conventional nursing practice.

- Evaluation of the effectiveness of public health programs was the other commanding feature of the decade. Historically, public health nursing had relied on case studies and quantitative reports of services provided for evaluation purposes. By 1965, federal regulations required states to submit plans for reducing major health problems following a prescribed format, the POME (statement of problems, objectives, methods and evaluation), to give reasonable assurance that funds would be used appropriately. Like others, nursing directors now faced questions of service never before asked, requiring support data which had never been systematically collected.

As early as 1938, Margaret Arnstein had urged the use of selected health states to determine service effects. By 1963, although methods had been developed to document patient benefits related to nursing care, they were time consuming, costly, and their inferences open to question.[31–33] Still more tribulation was in the offing; as small studies were undertaken to examine patient progress, many notions of service effectiveness remained unconfirmed.[31]

The paralyzing effect of these combined forces was partially offset by regional and state work conferences on evaluation processes, and by a few innovative demonstrations of community nursing.[34–37] More research and experimentation were critically needed. Although more funds for nursing research and research training had become available through the Nurse Training Act of 1964, the findings were not yet available.

TABLE 2—Per Cent of Full-time Registered Nurses in Public Health with Baccalaureate or Higher Degree and Per Cent Prepared in Public Health Nursing, 1948, 1957, 1968, 1979

Year	Number Reporting	% Baccalaureate or Higher Degree	% Completed Public Health Nursing Preparation
1948	22,075	16.0	31.1
1957	28,599	28.8	38.4
1968	42,541	40.7	38.5
1979	49,362	46.9	42.3

SOURCE: Refs. 14 and 25.

Research, Redirection, Reaffirmation in the 1970s

The issues of the 1960s continued into the next decade, but signs of changing perspectives were already evident.

Scientific breakthroughs had made contraception safe, economical, and widely acceptable, giving countries a means of addressing problems of population explosion and giving women needed family planning prerogatives. Genetic influences were now better understood, enlarging the etiology of disease production and enabling more precise genetic counseling. Human behavior was being recognized as a causative factor in many diseases and life experiences a determinant in the development of disease and disability as well as in recovery.[38] "Humanism" was in the ascendancy and "the caring process" considered therapy in its own right. A fresh look at categorical programs identified undue competition and duplication of services; block grants and planning across categories were to be emphasized. Prevention of disease regained prominence, eventually becoming one of five major themes of the federal program.[39]

Because the focus of care in the '60s had been on the individual and family, the old question of "what is public health nursing?" was asked more frequently and more stridently than ever before. In response, a multidisciplinary committee of APHA's Council on Health Manpower revised the recommended qualifications for nurses in public health and, attempting to differentiate functions of clinical nursing and public health nursing, introduced the public health nurse specialist, prepared at the master's degree level, to function as an expert in public health.[40]

These tenets and strategies reinforced public health nursing; attitudes of nursing administrators and service plans soon began to reflect new directions. At their September 1969 annual meeting, the ASTDN had given high priority to the need for "studies and demonstrations in new and improved models of community nursing practice based on scientific analyses of health problems." Two years later, at their 1971 meeting, there was a refreshing note of confidence as project directors described service evaluation and research projects being carried out in the states. These included: comparison studies of pediatric nurse practitioner care, demonstrations of primary health care in isolated rural areas, and systematic evaluations of new staffing patterns, of school nursing services, and of prenatal patient care. Program evaluation no longer aroused apprehensions; peer review, record audits, outcome measures, accountability, and quality assurance had become familiar processes.[28]

During the next few years, alternative service patterns became common and a plethora of studies, related primarily to expanded nursing roles, appeared in the public press as well as in medical, public health, and nursing journals. Not all study results were favorable, but many exceeded expectations. The scope of nursing practice, published in 1971 by the US Department of Health, Education, and Welfare,[41] and the 1972 report of the Canadian experience with NPs[42] gave credence to the overall movement and made nursing's role in primary health care explicit. The enlarged concept was spreading to all areas of nursing—maternal and child health, family and adult care, geriatric and care of the chronically ill—and in all care settings. The number of programs preparing nurses for these new functions increased nearly six-fold, from 36 in 1970 to 198 in 1977.[43] Although these programs had graduated over 10,000 NPs, even this number was inadequate to meet all the employer requests.

These developments were seen as a means to extend medical and nursing care and to utilize the competencies of both professions more completely and economically. They also legitimized functions that public health nurses had been doing for years, and added new skills as well.

The WHO Expert Committee on Community Health Nursing, in 1974, envisioned health care for all populations as a realistic goal.[1] The World Health Assembly responded to the Expert Committee's proposals the following year in a resolution which cited "nursing and midwifery as primary providers and teachers of basic health care" and encouraged all member countries to involve nurses and midwives in developing programs. Then, in 1978, the International Conference on Primary Health Care developed a clear definition of the term with guidelines to accelerate progress, and "Health for All by the year 2000" became the motto.[44] In spite of the Conference's comprehensive, community-based definition, most health professionals, including those in the US, interpreted primary health care to mean first contact preventive and curative care of the individual.

The patient-community concept is elusive, complex, and difficult to operationalize, particularly by health practitioners grounded almost exclusively in individual care. In 1979, almost half (49.6 per cent) of nurses employed by state and local health departments had no public health preparation. The 1979 Census showed a total of 56,993 registered nurses employed full- or part-time by 5,802 state and local health agencies; 25.6 per cent functioned primarily in clinical areas. In addition, 21,636 nurses were employed by 7,656 boards of education.[14] A reorientation would be needed if primary health care were to impact on high-risk populations and affect health status at the community level. The 1971 statement of qualifications of nurses for public health[40] depended on schools to encompass community concepts in their curricula and agencies to demonstrate those concepts in practice. Role extensions in diagnostic and therapeutic techniques, however, had tended to reinforce patient-family concepts at the expense of the community in both educational and practice settings. The first attempt to correct misconceptions and put the two main avenues to public health into juxtaposition within a conceptual frame was a national conference on "Redesigning Nursing Education for Public Health" in 1973.[45] The organization of the Association of Graduate Faculty of Community Health/Public Health Nursing followed in 1978; in 1979, a position paper by ASTDN described relevant competencies for public health. A statement defining the role of public health nursing[46] and another describing a conceptual model of community practice[47] were developed in 1980 by the Public Health Nursing Section of APHA and by ANA's Division on Community Nursing Practice, respectively; "Guidelines for Community-based Nursing Services"[48] have been developed by a joint committee of ANA and APHA, appointed in 1983. Numerous papers were presented and articles published during the 1970s and early 1980s elucidating the problem and suggesting solutions aimed at enlarging the principles and practices of community health in the basic curriculum, as well as strengthening the epidemiologic-sociologic focus in graduate study, service environments, and research.[49–52] Controversy reigned over whether or not to approve only graduate programs in schools of nursing, thus underestimating benefits of diverse multidiscipline experiences offered by schools of public health.

International concerns and activities paralleled those in the US. Programs and task forces were sponsored by both WHO and the International Council of Nursing (ICN) to stimulate primary health care in a community context in regions and countries around the globe.[53,54] And guidelines were developed and tested to assist faculty to intensify their teaching content in community health.[55]

Public health nursing and nursing generally were on the move, contributing significantly to the hospice movement, birthing centers, drug abuse programs, day care centers for the elderly, and rehabilitation nursing in long-term care. (In 1975, 10 states took part in a federally funded statewide educational project directed by ASTDN on rehabilitation nursing in long-term care.) In some instances, they developed home health agencies to provide 24-hour support services for families caring for chronically ill and disabled members. Both longitudinal and cross-sectional research was in progress to find ways for improving the distribution of health care as well as advancing the quality of care.[43,56,57] As the 1970s ended, concern over escalating health care costs mounted.

Patterns of Change

As controls were applied to health expenditures, implementation of the aggressive prevention strategies intended in the late 1970s suffered in competition with surging costs of hospitalization, new intensive care therapies, and complicated medical procedures. In addition, goals for improving the quality of care changed to the provision of minimal, safe practice. Slow economic growth and persistent inflation brought curtailment of Medicare/Medicaid coverage, nutrition supplements for school children, food stamps for the marginally poor, and other support programs which had benefited the health and welfare of many. At the same time, the use of outpatient services, health maintenance organizations (HMOs), and private medical care was encouraged. Home health services and nurse practitioner care, having been found cost-effective, were also given priority.[39] Self-help, self-support, and self-improvement were pushed while increased governmental assistance was an outmoded concept.

One of the movements that seemed to catch on in the early 1980s was health education of the public designed to achieve more healthful behavior and life-styles. Advances in health knowledge—instantly reported by television, radio and the press—caught the attention of the public at large and of the business world which saw unlimited mutually beneficial opportunities in the thriving health industry; commercial centers sprang up to: promote exercise and weight control; reduce smoking, alcohol and drug use; increase family-focused activities; and improve social supports and relationships. Consumer groups pressed for laws to confine cigarette smoking to designated areas and to enforce tougher laws against driving under the influence of alcohol. The extent to which public health nurses stimulated or took part in such activities is unknown and, for this reason, a task force was appointed in 1984 by the PHN Section of APHA to "explore the issue and delineate specific health promotion activities of public health nurses in the community."[58] The Section was also concerned with a variety of other issues, such as: the management and productivity of community services, populations at risk for prevalent social and health problems, legislation for community nursing centers, violence in families, theory development in public health nursing, and research.

Early in 1985, two events took place which could direct public health nursing practice through this century and into the next. On January 14, the Secretary of Health and Human Services announced the establishment of a new Center for Nursing Research "to enlarge the body of scientific knowledge that underlies nursing practice, nursing service administration and nursing education."[59] In making this announcement, HHS Secretary Margaret Heckler added that this action was taken to implement the 1983 recommendations of the Institute of Medicine, National Academy of Sciences, for nursing and nursing education for the future and for meeting the needs for nursing research.[59]

The second event also occurred in January during the meeting of WHO's Executive Board, following a discussion of the report of the Expert Committee on the Education and Training of Nurse Teachers and Managers.[60] Summarizing the event, Dr. Halfdan Mahler, Director-General of WHO, stated that it is now evident that nurses are ready to become agents of change in primary health care throughout the world, taking an important role in the Health for All movement.[61] Changes will need to be made, he said, in reorienting nursing curricula to the main social and health needs of society, developing crash training programs for teachers and directors of schools of nursing in primary health and Health for All goals, strengthening bonds between schools of nursing and community health services and preparing administrators and managers to direct those services. Real change, Dr. Mahler indicated, requires reappraisal of health manpower policies for the inclusion of nurses as leaders and managers of primary health care teams and their participation at all levels of planning for national and community health. WHO is actively supporting these directional changes.

Public health nursing in the United States has gone through periods of expansion, recession, and consolidation:

- It has advanced numerically and professionally;
- It has attained recognition as a vital part of the total health care system;
- Its prominence is bound to increase with the continuing shift of health care from hospitals to homes and community settings.
- It is equipped to meet the multi-faceted, diverse needs of US populations with a mix of clinical and public health specialists.
- It has the ability to strengthen concepts of prevention and methods of practice through research.

The public is more health conscious than ever before and ready to support innovative approaches to health care. Health professionals are being challenged to find ways of providing quality, effective, preventive health care for all. The test of public health nursing is to marshal community resources to achieve this goal.

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