General Assembly Resolution 4  
ANA\C Supporting Public Health Nurses  
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ANA\C  
Supporting Public Health Nurses and their Role in Strengthening the Public Health Infrastructure  
Submitted by Liz Dietz and Anne Becker for the ANA\C Board  
From the American Nurses Association 2003 House of Delegates Action Item

WHEREAS, the largest single professional healthcare workforce in public health agencies is public health nursing; and

WHEREAS, according to the 2000 National Sample Survey of Registered Nurses (Public Health Nursing Section, 2003), the number of registered nurses employed in public/community health settings with the title “public health nurse” has decreased from 39% in 1980 to just 17.6% in 2000; and

WHEREAS, a recent survey (2003) by the National Association of County and City Health Officials (NACCHO) examining the impact of the smallpox vaccination program on local public health services found that limited staffing and resources are forcing local public health agencies to shift workers from other programs, such as communicable disease and immunization programs, to the smallpox vaccination program; and

WHEREAS, the Institute of Medicine’s (IOM) report The Future of the Public’s Health in the 21st Century (2003) raises concerns about the availability of an adequate local public health infrastructure, particularly in terms of staffing and communication systems, to provide critical public health services; and

WHEREAS, the IOM’s report (2003) also found that funding for the public health infrastructure has recently increased to support the infrastructure that relates to bioterrorism and emergency preparedness but may still be insufficient; and

WHEREAS, public health nurses are the primary providers of well child care, including immunizations, and preventive health services for pregnant women, school-aged children, and individuals at risk for or experiencing chronic disease, as well as for linking clients with other health care providers and community resources;

THEREFORE BE IT RESOLVED that the American Nurses Association\California (ANA\C) will advocate for:

1. Acknowledgment of the critical nature of the public health nurse’s role in promoting and protecting the health of individuals, families and communities.
2. State funds to health departments to attract, retain, and continually enhance the role and compensation of public health nurses.

3. Further development and implementation of quality indicators that are sensitive to public health nursing functions.

4. Investment in information systems technology and training to strengthen the public health infrastructure.

**American Nurses Association Report 2003:**

Public health nursing (Quad Council, 2001) is defined as “the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences.” Over the past decade, the responsibilities of public health nurses and the resources, both human and financial, to meet these responsibilities have dramatically changed. According to testimony submitted to the IOM’s Committee on the Work Environment for Nurses and Patient Safety (Greiner & Oppewal, 2003), “the national emphasis on tertiary health care and technology development, combined with the relative invisibility of common public health activities, created an environment in which funding decreased to public health at all levels.” Despite numerous reports and calls for action, the IOM report (IOM, 2003) also states that “the federal government has yet to take the initiative to develop a comprehensive, long-term plan to build and sustain the financing for this infrastructure at the state and local levels so as to assure the availability of the essential health services to all people.”

A 2001 NACCHO survey, that was cited in the IOM report (IOM, 2003), found that the average annual expenditure of the 630 local public health agencies responding was $4.5 million (1999 dollars), but 50% of those agencies had expenditures of $621,000 or less. By contrast, 25% of the agencies serving populations of 500,000 or more had annual expenditures of more than $46 million. On average, local public health agencies reported receiving 44% of their funding from local government, 30% from state governments, 19% from reimbursement for services, 3% from the federal government, and 4% from other sources. The IOM report (IOM, 2003) concludes that “almost no data is available on how much would be needed to adequately build and sustain the necessary public health infrastructure to support the nationwide provision of the essential public health services at the local level.”

The work environment for public health nurses has also been impacted by declining public health funding. Public health departments have had increasing difficulty in recruiting and retaining registered nurses during a time of nursing shortage. As already noted, the number of registered nurses employed in public/community health settings with the title “public health nurse” is only 17.6%. National Sample Survey data (Public Health Nursing Section, 2003) also shows
that the average age of public health nurses is 49 years. With nursing wages starting to rise in the non-governmental sectors, local public health agencies are finding it difficult to compete in the areas of salary, benefits and support systems. Greiner’s IOM testimony speaks eloquently to the concerns related to the work environment, hiring practices and staffing for public health agencies. Greiner (2003) stated that “enumeration of the public health nursing workforce is problematic and data does not exist that adequately captures the scope of the problem nationwide. Hence, nurses who currently work in public health departments often have heavier workloads and responsibilities that intersect levels of patient care at individual, family, group and community levels.”

Following the events of September 11, 2001 and the subsequent release of anthrax, the public health system came under intense scrutiny. Concerns were raised about the overall ability of the public health system to adequately recognize, respond to, and track another disaster, whether manmade or natural, should it occur. Since September 11, 2001, federal and state governments have made a considerable effort to strengthen the public health infrastructure to be able to respond should there be another terrorist attack. It is also hoped that this investment in emergency preparedness will serve a dual purpose and build up the public health infrastructure that handles the more routine, yet no less important, day-to-day services provided by the public health system. According to Greiner (Greiner, 2003), it is this current federal mandate to prepare for bioterrorism and disaster which has further accentuated the need for public health nurses yet, at the same time, has drawn public health nurses away from core function activities. The NACCHO also raises concerns about the current ability of local public health agencies to meet the many demands that confront them. In its research brief (NACCHO, 2003), NACCHO found that of the 718 local public health agencies responding to the survey on the impact of the smallpox vaccination program, 53% reported that bioterrorism preparedness planning has taken away from their other public health programs and activities. One-third (37%) responded that the bioterrorism preparedness planning has helped their public health programs and activities. NACCHO concludes that “limited staffing and resources force local public health agencies to shift workers from other programs, such as communicable disease and immunizations programs, to the smallpox vaccination program. Continued diversion of these resources will increase communities’ vulnerability to ongoing public health threats, such as influenza, West Nile Virus, contaminated drinking water, food-borne illnesses, and chronic diseases.”

Both within the context of emergency preparedness and the overall mission of the public health system, the issue of sufficient infrastructure for disease surveillance, information technology, and communication are of concern. The IOM report (IOM, 2003) calls for an integrated information infrastructure to address these concerns. The current disease surveillance system is hampered by the lack of uniform standards for data elements, collection procedures, storage, and transmission. In addition to this lack of a uniform structure, gaps
exist on data that is collected. For instance, according to the IOM report (IOM, 2003), very little information is collected on chronic diseases and conditions, i.e., asthma and diabetes. The report also points to the need for additional data collection on the health outcomes that are potentially linked to exposure to environmental pollutants and toxins.

With regard to information technology and communication, some effort has been made on the part of federal, state and local governments to address this concern. For example, the Centers for Disease Control and Prevention (CDC) has initiated the Health Alert Network (HAN) which uses the Internet as a means of electronic communication between the health departments and the CDC. It also includes distance-learning activities and provides health departments with the capacity to broadcast and receive health alerts. In its report, the IOM (IOM, 2003) recommends that the Secretary of Health and Human Services facilitate the development of a National Health Information Infrastructure (NHII). The goal of NHII would be to pull together the many separate initiatives and systems into an integrated data system that will give health officials and others optimal access to the information and knowledge they need to make the best possible health decisions for communities.

Nursing has a long, proud history within public health. Every effort must be made to ensure that this system continues and is able to provide the essential services that are core to public health practice (IOM, 2003): "assessment of health status and health needs, policy development, and assurance that necessary services are provided."

REFERENCES:


