Program Notes

Public Health Nursing in New Jersey

Roscoe P. Kandle, M.D.

PUBLIC HEALTH nursing remains a basic ingredient of official public health services. It continues to be the backbone of personal health services. Like all public health practice, the needs, goals, and techniques have changed a great deal. In contrast to former concentration on infant hygiene and communicable disease control, public health nursing must now be concerned with comprehensive services to handicapped children and adults, and with health promotion in competition with the most skilled advertising techniques and the prejudices of older people.

I bring up this issue because, frankly, I am concerned about the quality, coverage, and comprehensiveness of the public health nursing provided by the official public health agencies.

I hope we can reach agreement on several essentials.

1. Public health nursing is a major public relations factor for any health department, either by its absence or presence, good or bad. A neutral or wholly inconspicuous effect would be per se a damning indictment.

2. Official public health nursing services in New Jersey are usually specialized and must thereby be defended. I do not want to imply that specialized services are necessarily bad. They are often highly effective for a particular job or point of view. They may, however, be ineffective from a broader vantage point. Often specialized services are inefficient and get only a part of the job done, and therefore they are expensive. We must, in good conscience, have accurate data and know where we, as the responsible administrators and board members, are on this issue.

3. Public health nursing care today must be as comprehensive as possible. It must include home nursing care of the sick and have available auxiliary services such as nutrition and physical therapy. While no one nurse may provide all these services, the system should provide them.

4. Increasingly, public health nursing demands mobilization of community resources, skilled referral, followup, and all the exasperating difficulties of working through and with other people in contrast to comforting direct patient care or health promotion. It's tough, but it's a fact. It necessarily involves skills which require formal inservice training and experience. These take even more energy, concentration, and "stick-to-it-iveness" than walking up apartment and tenement steps.

5. Increasingly, too, public health nursing is closely related to hospital and other community health and social welfare services. This means intimate knowledge and close, enduring friendly personal relationships with the hospitals and agencies. It takes a stable, well-respected organization to build and maintain such bridges.

6. Public health nursing is expensive and scarce. We have an urgent responsibility to gauge its costs accurately, to know definitely that the public is getting its money's worth, and that the scarce commodity is being used as effectively and efficiently as possible. In this respect, public health nursing is more advanced

---

Dr. Kandle is State commissioner of health of New Jersey. *This article is based on a paper presented at the 49th Annual Conference of State and Local Health Officials of New Jersey, Trenton, March 25, 1960.*

592948—61——5

than most other areas since we have available the tested and effective standardized method of calculating nursing costs prepared by the National League for Nursing.

Let us examine public health nursing in New Jersey. There are 1,646 public health nurses employed as follows:

- 339 by 46 visiting nurse associations with a range in size from 1 to 38 nurses per agency. About 22 percent are employed by visiting nurse associations.
- 686 by school boards, or 42 percent.
- 538 by 206 local boards of health, or 32 percent. Local boards of health also employ 65 part-time public health nurses, a total of 603.
- 41 by State agencies.

Most home nursing care of the sick is provided by the visiting nurse associations. This is a matter of tradition and not one of principle. Indeed, some of the earliest and most sustained combination agencies providing all types of service are in New Jersey. A blend of tax dollars, as well as fees, community chests, and other voluntary contributions now supports the VNA's. In New Jersey tax sources supply from 0.6 to 60 percent of VNA budgets, with a median contribution of 28 percent. The last national average I have seen was 15 percent. In a number of instances local boards of health, or at least municipalities, support both their own direct public health nursing services and VNA.

Of the 603 (538 full-time and 65 part-time) public health nurses employed in the official agencies, Newark and Jersey City have 201, or 30 percent. Paterson, Elizabeth, Camden, Trenton, Atlantic City, and Ocean County account for 52, or 8.5 percent. The remaining 198 local boards of health employ 286 full-time public health nurses and an unknown number of part-time nurses. To finish the statistics, according to the data available, 68 official agencies employ 1 nurse only; 24, 2 nurses only; 10, 3 nurses; and 9, 4 nurses.

Quality of Nursing Service

My real concern is with the quality, effectiveness, and efficiency of the local health department's direct public health nursing services. I freely admit that I do not have detailed data. I am not speaking about any particular municipality. I have deliberately not tried to gather specific data about specific programs because I wanted to be as detached as possible. From the services I have known in the past, from reading your annual reports and the reports from the State Districts, from the information, reliable and otherwise, given me on my travels around the State—from all of these sources, I have impressions that I want to share with you and suggest some possible improvements.

I hear tales of delivery of birth certificates. This was a gimmick we all sponsored once as a way to get into homes. We know now that the people's needs have changed and there are better ways to accomplish the goal. I hear about local health department nurses pinch-hitting for doctors on emergency calls. I hear about one-horse programs in schools. I hear about wasteful, old-fashioned, and inappropriate activities in communicable disease control. I hear, too, about lots of fine, good, exciting, personal, and beyond-the-call-of-duty dedicated service. I am sure that most of the services are good, often superior.

My basic point is that the services of a local health department must be the best or we must make some changes. In good conscience as health administrators, we cannot afford to have anything less, nor can we afford to have the official services weak or subject to just criticism.

Frankly, I am also concerned about the number of one- and two-nurse agencies. I do not mean that big agencies are always better or efficient, or that little agencies can't be efficient and effective. The batting averages, however, certainly favor larger agencies, particularly when one thinks in terms of comprehensive and total family services. I am concerned about coverage throughout the week. My greatest concerns, however, are whether the people of New Jersey have the right kind of public health nursing service when and where they need it, and is it as sensible and effective as we can make it? Overspecialization and multiple agencies add to this problem.

We must recognize too that field visits by public health nurses cost real money, some $3 to $5 per visit. We have to be sure that each visit is justified and that the public gets $5 worth of benefit. The same goes for per hour or per day, or any other unit of cost.

Improving Services

There are things which can be done. Let me cite a couple of crude examples.

The most effective use of the telephone and other contacts with community resources will repay careful, explicit attention. The old issue of "getting the nurses out in the field" is too simple for today's needs. It's quality that counts, not quantity in numbers of visits, or some other criteria, although this aspect can obviously be overdone.

Another step to take is constant examination and revision of medical standing orders and policies to keep them up to date.

Part-time nurses, nurse aides, practical nurses, and volunteers are all important, but it takes real organization, supervision, training, and solid administration to make them work right. For example, New York City a few years ago undertook major efforts to increase and improve public health nursing services. In brief, these steps consisted of:

1. Increasing salaries.

2. Using more part-time and ancillary personnel, so that the staff of the health department is now distributed approximately as follows:

Staff administrators, consultants, supervisors	97
Adequately trained public health nurses	449
Staff nurses (registered nurses only)	102
Part-time public health nurses (20,000 sessions)	110
Part-time staff nurses (10,000 sessions)	69
Public health assistants (high school graduates trained by health department)	435
Vacant positions	92

3. Increasing training opportunities for staff.

4. Redistricting the city and using a cadre system of public health nurses, staff nurses, and public health assistants.

5. Purchasing services by contract from VNA's.

6. Continuing and strengthening the combined health department and VNA agency.

With the minimum standards of performance in effect April 1, 1961, according to State law, we have to look at total care. Let's therefore consider our services first and then the total services people are getting.

I urge courageous and open minds about the value of combination services. In New Jersey we make extensive use of VNA's, and they are often very good. They aren't all good, nor am I saying categorically that they are better than the official agencies. I am a firm believer in combination agencies; from our experience I think they are especially good for New Jersey. We must somehow, through joint efforts, build larger, better, stronger, and fewer public health nursing agencies which can literally give comprehensive services 7 days a week.

Whatever the system, we can, in public health nursing, pay for the services to be provided, almost on a fee-for-service basis. There should be no more deficit budgeting or flat fees for support of agencies. This part of public health administration can be regularized, and we need to get this job done.

Not many agencies, I imagine, will wish to get into the collection of fees, yet this is a basic aspect of today's public health nursing. People do not want and should not get free services for many types of public health nursing if they can afford to pay, and long experience demonstrates that they can and will pay. There is no basic reason why official agencies cannot charge and collect fees, but we have set a tough precedent in this regard. Only a few do, and the combination agency is the best way out of this dilemma.

I want to make one point crystal clear. I am not against local health departments supplying public health nursing service. I am not favoring VNA's over official agencies. But both official and voluntary have some housecleaning and changing to do. It is my guess that the people in the Nation, like those in New Jersey, do not yet have adequate, high-quality, effective, and efficient public health nursing services.