The demand for inservice training is growing. How can training best be done? This report and its State case studies are offered to help the health officer answer that question and organize his training effort as effectively as possible.

Why and How State Health Departments Organize for Training

—*Patterns and Trends*—

By HENRY R. O'BRIEN, M.D., M.P.H.

APPRECIATION of the need for training of health workers is growing steadily. Health workers themselves are anxious to learn better how to meet the health needs of their people.

Nurses planning programs for staff meetings, nurses spending evenings and Saturday mornings in extension classes, sanitarians or clerks going to district meetings or taking inservice courses, retired medical officers orienting themselves for new work, people joining professional societies or spending another year at school—all these trends testify to the interest and sense of need for continuous training.

Administrators responsible for the effective working of a department are more and more aware that a good health worker, like a scythe, must be made of good steel. He must be well ground by preliminary education, and must be sharpened from time to time.

Filling a position with a name is far from being enough. The field of public health is so widespread and is growing so rapidly today that untrained or poorly trained workers seldom are effective in an old program and seldom rise to meet the needs of a new one. When measured by effective output, many untrained workers, no matter how willing the spirit or how low the salary, are really expensive to the taxpayer.

Industry knows this. At the Congress of Industrial Physicians in Louisville, Ky., in February 1954, a spokesman for a large company said: "We are accustomed to spending $2,000 on the training of a machine operator, $5,000 on training a supervisor."

A fee of $75 or $125 is a commonplace item

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when a plant is invited to send a staff member to a 3-day institute. If industry finds such an investment worth while, should public service be more timid?

A State health department is generally accepted as responsible for the training provided its staff and for local health workers. Fortunately, an important part of the task is already done when the merit system sets educational and experience requirements and salary ranges. Today's appointees, therefore, may no longer need some kinds of training and may have greater capacity for advanced courses.

At that the need for training is very broad. The last annual survey of nurses (*1*) showed that only 36.8 percent of the public health nurses in State and local organizations have had a vear of formal training in an approved public health program of study. How can this be improved? Sanitary engineers in the Public Health Service have just started a similar study to learn the exact training needs among sanitarians.

How many untrained health officers are appointed?

What is done for those neglected persons, the health department clerk and the institutional worker?

How is the trained health worker kept up to date, the scythe kept sharp?

A sound pattern of training will deal with these and other problems. It will include formal courses, accredited or nonaccredited, as well as orientation, field training, seminars, staff conferences, supervision, refreshers, and so forth, and even correspondence work on occasion.

When a State health department decides to meet its responsibility in training, how should it plan to organize?

To help one State consider that essential question, the Public Health Service regional office in Washington, D. C. (Region III), gathered information from 45 of the 48 States and the District of Columbia. Information so obtained is shared in this paper.

Organization for Training

In every State health department some form of training of State and local health workers is going on. The need is recognized, but some departments are held back by State laws, legislative feeling, or budget cuts. Resourceful commissioners manage to meet the need for training in one way or another.

In many States training is carried on merely in separate divisions, with no evident correlation. Many other States have set up committees, whose members sometimes come from within the health department, sometimes from outside, and sometimes from both. Committees are especially useful in evolving a philosophy of training in the department and in obtaining support for that philosophy.

Effort is focused effectively when direction or coordination of training within a department is made the responsibility, part-time at least, of one person. Some 18 States report having a part-time director, whose activity and degree of responsibility differ from State to State. Eight States now feel that training is important and extensive enough to have a full-time professional worker as coordinator.

Organization of training in the States surveyed falls into various patterns. Various trends are evident. Patterns and trends in turn suggest certain conclusions and recommendations which can be adapted to fit local circumstances.

Training Within the Division

In looking for the simplest form of organization for training in a State health department, we find inservice training going on in separate divisions.

Each office sees a need for training and sets about to meet the need itself, generally without reference to what other divisions are doing. There is sometimes a person in the division spending full time in this work.

The bureau of laboratories in the Maryland State Department of Health, for example, has its own training division.

In numerous States public health nursing has a director of education.

Virginia has a full-time director of sanitarian training.

Some other States have a similar worker loaned by the Communicable Disease Center of the Public Health Service. However, training

activity is confined to a single discipline, and there is little exchange of ideas or experience among divisions. Occasionally one office requests allocation of time or money for training also sought by another office. Then the two requests go to the commissioner of health or the budget authority for decision.

Such is probably the situation in more than half of the State health departments. Usually they are the smaller departments, but not always. When training is confined to divisions, progress is apt to be uneven. Valuable ideas may be lost because they are not shared, and there is nothing in the system to stimulate development of team spirit.

Coordination Through a Committee

The next step in the evolution of organization is the use of a committee.

In Maryland, for example, five carefully chosen State and local health workers set to work recently to plan a State training program from the beginning.

In Kentucky, after training was practically wiped out by budget cuts, a small committee of division heads was appointed to lay new plans.

Florida has a standing committee of three division chiefs, the personnel supervisor, and the director of its inservice training center.

Oregon has two committees. One, made up of staff members from a number of sections, outlined the overall program for the board of health's inservice training. The details of these plans are eventually worked out with the program director and the division head concerned. The second, which is known as the training committee, consists of representatives from the divisions of local health services, of environmental sanitation, of preventive medical services, and of the personnel officer and the director of public health nursing.

Oregon's training committee recommends to the State health officer policies on formal training of State and local health workers and proposes a budget. Some 3 years ago this committee helped to set up a long-term priority program, for (1) public health physicians, (2) public health nurses, (3) public health engineers, (4) sanitarians, (5) health educators and administrative officers, and (6) clerical workers. The committee weighs the training needs of local health departments and of the State and recommends a budget for training available personnel, under these priorities.

Under a Part-Time Director

A committee is excellent for planning or recommending policies, but it is not so effective in administering a program. In operation some one person is needed to give coordination or direction to training in the whole department.

This service is frequently on a part-time basis, as in Delaware, with its three counties. Here all training is directed by the chief of the division of health education.

Wisconsin's training is the responsibility of the assistant State health officer, who also heads general administration in the health department. He is assisted by the personnel officer.

In Indiana, the chief of the personnel and training division reports directly to the commissioner. In the 1955 budget, an effort was made to provide a full-time director of inservice training but without success.

More often such part-time responsibility for training is carried by the director of local health. This is the case in Kansas, which has 14 local health departments and a rather limited State health staff.

In Tennessee, which has much activity in staff education, and in Texas and Washington, training is coordinated under local health services.

In Arkansas and New Mexico, training is directed by the deputy State health officer, who is also in charge of local health. Plans for training are discussed at departmental and division staff conferences.

In North Carolina, which is well organized locally, the chairman of the central training committee is the director of local health or, recently, his deputy. The committee itself is a large one, with 18 to 20 members drawn from State and local departments of health and university people. It has done valuable work in advising on programs, coordinating actual training, and stimulating budget provision.

Michigan's Committees

Michigan has many local units also; its extensive training program is supervised directly

by the chief of local health administration. He is aided by a series of carefully organized committees. There are five different types of committees.

A planning board has since 1950 advised Michigan's commissioner of health in matters of staff education. It has 2 members from the department—the directors of local health administration and of the division of laboratories—and 8 members from the State at large. Two health officers and a nurse are from county departments of health: the other members are from the Wayne University Department of Public Administration, the W. K. Kellogg Foundation, the division of continuing education at Michigan State College, the State bankers' association, and the State training council. The planning board aids in organization of training, drawing of policies, and evaluation of programs.

The coordinating committee is composed entirely of division and section chiefs in the State department of health.

There are 7 technical committees for different professional and clerical workers. In addition, there are 5 project committees—none with permanent membership. The members in general represent State and local departments and the various categories, as well as university and private agency workers. The technical committees maintain liaison between State and local programs, and the project committees are organized to plan and carry out specific training programs. There is also a fellowship selection committee.

When State and local health departments met a serious cut in Federal aid in 1953, the technical committees expressed the needs for adequate funds for the training projects. These were reviewed and supported by the coordinating committee, and the projects were allotted the necessary funds.

Under a Full-Time Director

An increasing number of State health departments have decided that training is important enough to call for a full-time competent professional worker. In a similar situation a full-time director of graduate education is now found in an increasing number of larger hospitals.

In Louisiana

Training in Louisiana is organized around a central State training center, whose primary function is to plan for all State training needs for the health professions. The center has a full-time director, a training staff, and an advisory committee composed of 4 division chiefs, 2 local health officers, and representatives of the 2 medical schools in Louisiana. The director, who is a physician, reports directly to the State health officer. He also has a faculty appointment to the department of public health in the Tulane University School of Medicine.

Louisiana's training center is responsible for:

Determining needs.
Forming overall plans.
Integrating all training programs in the State.
Planning facilities.
Supervising local field training programs.
Planning assignments.
Consultation.
Liaison with educational institutions.
Preparing budgets for training purposes.
Selection of individuals.
Evaluations.
Recommending to local areas the principles and objectives of field training, policies, content of each category, field experience for students, methods, and procedures.

In Upstate New York

Training has probably been most extensively developed in upstate New York, where 337 professional health positions in 1953 were listed in the budget of the State department of health, and 1,396 were listed in county and city departments (*2*). These numbers were exclusive of positions in New York City and in laboratories and hospitals. As elsewhere, training evolved in divisions. This trend started in 1934.

In 1948, the office of professional training was established to integrate and correlate activities of training units in the different divisions. The office itself has only 2 professional workers, a physician, and an engineer. In addition, 3 nurses work full time in a training and education unit in their own bureau, and workers in other divisions give part of their time to training activities.

All these people primarily concerned with

training have scheduled monthly meetings and frequent conferences. Training functions are unified; facilities are used in common; uniform policies and procedures are set up; and funds are distributed equitably through this machinery. The training budget and reports of the commissioner of health, both representing the combined thought of all concerned with training, are submitted through the office of professional training.

The training budget for 1953 was $624,495, some 40 percent of which came from State sources. In addition, some training expenses, especially incidental or part-time expenses, are paid from the regular budget.

As rapidly as needed, separate training programs have been set up for different professions and positions. A careful analysis of needs was made before each program was decided upon. In each field, an advisory committee, chosen both from within the State government and from outside, has been useful in developing policies and procedures.

In New York, as in New Jersey, the training of clerical workers in the health department is handled by the division of personnel.

New York City is not included in this study. Because of its size and the number of personnel employed in public health, it has a separate training program, and a full-time position with responsibility for training has been established in the city health department. A physician fills this position.

In Massachusetts

The Massachusetts program has developed rapidly on a somewhat different tack. In 1950, an outside grant for a period of 5 years made it possible to plan anew and to expand the training work then carried on in the State department of health. A division of training was established in the bureau of administration. The director of the division serves full time as the coordinator and program administrator of all training activities in the department. Educational directors were appointed for each of five special groups (health officers, public health nurses, medical social workers, health educators, and sanitarians). Those in nursing, social work, and sanitation give full time to training; others have responsibilities in other divisions. Educational supervisors are assigned to selected local units. The division naturally receives much help from service workers in other offices, State and local.

Since attention was originally centered on field training the overall advisory group still holds the title of General Advisory Committee on Field Training. The members from the State department of public health are the commissioner and the director of the division of training; the latter is executive secretary. The others on the committee are from educational institutions or local health departments. There are 10 members in addition to the secretary and a consultant. Advisory subcommittees on several aspects of field training were also set up in 1951. A variety of programs have been worked out.

There is a field training center for sanitarians at Amherst College, but various local departments are used in other fields. One feature of the Massachusetts program is close cooperation with various schools of nursing, social work, and medicine, with the University of Massachusetts, and the Harvard School of Public Health.

In Pennsylvania

In Pennsylvania, the division of professional training, with other staff functions, was set up in 1951 as part of the executive office, 1 of 5 groupings in the State department of health. The director is the only full-time professional worker in the division; program activities are carried on through the program directors in the department.

A technical advisory committee on training is made up of some 12 members from outside the department; these are chosen from universities and local health departments, and represent 7 professional interests. A newly created inservice training committee is composed of department staff members, representing major public health professions.

All training is considered as being divided into four parts: graduate, undergraduate, field training, and continued education. Wide use is made of extension courses for public health nurses, and of the Pittsburgh training center for sanitarians.

The budget of the division comes from both State and Federal funds. One great difficulty

is the lack of legislation permitting the State department of health to use State funds in assisting local health department staffs to secure training.

In Georgia

Georgia has a division of training in the bureau of administrative services. This division was organized in 1952 to (*a*) coordinate all training activities existing in the divisions, (*b*) determine need and promote activities, (*c*) attempt to develop public health training potentialities, in any field, of the State systems of higher education, (*d*) develop training centers for all types of personnel, and (*e*) evaluate how activities meet needs.

The staff of the division consists of the physician-director and a secretary. The director feels responsible primarily only for quality, adequacy, and availability of training, and seeks the cooperation of the older divisions. Training itself, he feels, is the task of service divisions.

An advisory committee was formed, made up of division and service directors most concerned with training, with others from certain divisions and from local departments of health. Subcommittees were set up for certain problems. The advisory committee reviewed the content of established training programs and the range of programs offered and prepared papers entitled "Policies for Support of Training" and "Criteria for the Section of Local Health Departments as Field Experience Centers" for the approval of the State director of health.

Field training for sanitarians is concentrated in a new center set up in cooperation with the Public Health Service's Communicable Disease Center and the Fulton County and DeKalb County health departments. Other field training will be scattered through a number of local departments.

In addition to usual features of a good training program, a 12-hour course for division secretaries was arranged in 1953 for the central office.

In California

The training program in California underwent a number of changes during 1954. The former coordinator of training in the division of local health service became the training officer within the division of administration.

A new external advisory committee on training, composed of 13 members appointed by the State board of health, replaced the former internal advisory board on training, which consisted of 7 members including 5 division chiefs and 2 bureau chiefs.

The new committee is made up of people from industry, city government, local health officers, county boards of supervisors, deans of schools, and others. As formerly, the bureau of business management, the personnel officer, and the chiefs of the various divisions, bureaus, and services have certain designated responsibilities, as outlined in a chapter on training policies in the administrative manual of the department.

The training officer is the immediate director of the training aid program. All training matters pass across his desk, and his approval is necessary for each major step. He and others are guided by the training policies referred to above.

The advisory board, with purely advisory functions, is presided over by the director of the State department of public health.

The bureau of business management handles the fiscal details and the direct relationships with the State department of finance; the department of finance must approve all trainee applications in terms of the training budget, which must also have its approval.

The heads of department units are responsible for initially recommending training applicants and for contacts with training institutions. The individual grants and the financial allowances must have the approval of the training officer as to conformity with training policies.

The chief of the division of administration is the responsible head of the financial administration of the training program and is responsible for adherance to administrative policies of the department and relations with the director of the department.

The medical residency training program under the immediate head of the director of the division of local health services operates through the training office.

Training is of all types and in all professional

fields. Inservice training activities also come within the purview of the training office. The great majority of those trained are from or for local health departments.

Funds used come from the various Federal appropriations designated for this purpose. Each fall, requests for training funds for the following fiscal year are submitted to the training officer by the various units of the department. These requests are reviewed within the department, and a budget satisfactory to the director is submitted for approval of the State finance department, and as part of the State budget, for the approval of the legislature and the Governor. The training item in the 1954–55 budget, as signed by the Governor, stands at $144,000.

In Virginia

The Virginia State Department of Health plans to bring a local health director into the division of local health at the central office to be in charge of all training. As previously mentioned, there is already a full-time worker in charge of sanitarian training.

In Ohio

The Ohio State Department of Health has a bureau of direct services which is directly responsible to the director of health. The chief of this bureau, a position now vacant, is in effect the training officer and the research coordinator of the department. The actual training operations are for the most part carried out in the various program divisions, but the budget preparation and control, the overall training philosophy, and the policy and rules governing training originate from this office. The departmental manual has a chapter on training.

There is an effective training committee composed of representatives of the professional disciplines in the department, which acts as a council to establish policy and in other ways to manage the training programs. The divisions of nursing and of sanitary engineering have each on its own staff a training officer, who represents the division on the central training committee. The assistant chief of the laboratory represents that discipline, and one of the medical division chiefs represents physicians. The personnel officer of the department represents the clerical forces, and an administrator from the division of administration serves as the secretary and fiscal officer for the committee. The professional disciplines having fewer workers rotate representation on the committee.

With the help of this committee, the bureau of direct services has prepared two publications entitled, "Definitions of Types of Training," and "Recommended Minimum Standards for Field Training Areas." A general policy outline is presently being developed by the committee and is expected to be completed and promulgated in the next few months. The division of nursing has developed procedures for the use of its staff conferences.

At budget time all divisions submit their training proposals. From these the committee and the training officer establish the training program for the coming year, with regard to balance among professional categories, programs, and types of training.

The budget for the 1954–55 fiscal year was set at $135,000, of which $62,000 was grant-in-aid funds for 11 local departments of health which maintain approved training facilities. It is Ohio's feeling that the training program should be the last item to be deleted among the various programs to which Federal money is assigned.

The present Ohio law does not permit State appropriation of funds for the training of individuals.

Some of the Trends

In all, 8 States have a full-time director of professional training, or plan to have one in the near future. In three States, Georgia, Louisiana, and Massachusetts, recently, the director of training has been given added major responsibilities. The accompanying table summarizes some information about the positions. A study of this table suggests three trends:

The movement toward a full-time director of training seems to be spreading.

States which have made appointments have most frequently chosen a doctor of medicine.

The table of organization usually places the director of training well up in the health department.

Related to the administrative pattern for

Data on States with full-time directors of training

State	Year system started	Degree held by director	Director reports administratively to—
California	1948	Dr.P.H	Director, division of administration.
Georgia	1952	M.D	Bureau of business administration
Louisiana	1946	M.D	State health officer.
Massachusetts	1950	Ph.D	Bureau of administration.
New York	1948	M.D	State health officer.
Ohio	(1)	(2)	State health officer.
Pennsylvania	1951	B.S.E., M.P.H	The executive office.
Virginia	1954?	M.D	Director of local health.

[1] Information incomplete. [2] Position vacant.

training is the question of whether a State sends most or all of its new workers to one training station or disperses them among several. At one time thinking favored a single training center, but the current shifted.

In 1950, after 2 years of study, California changed to the use of dispersed stations, that is, several good local departments able and willing to receive several trainees in one or more fields. In reaching the decision it was felt that (*a*) several centers together could train more workers than one station, (*b*) quality did not suffer, (*c*) local interest was stimulated, and (*d*) cost was less.

Today, Florida and Texas are apparently the only States relying on a single training center. An exception exists with sanitarians, for whom the Communicable Disease Center of the Public Health Service has for some time maintained regional training centers.

When a local department is used for State training purposes, some special aid is usually extended by the State. This may be in the form of a lump sum increase in State aid, or of payment of a fee for each trainee, or of the assignment of extra personnel to the local staff.

Of the States with full-time directors of training, three States—California, Louisiana, and Massachusetts—have been stimulated and aided in development of training by grants from private foundations, either the Kellogg Foundation or the Commonwealth Foundation. Other States, including Michigan, Oklahoma, Tennessee, Texas, and Washington, have also had such aid. The laying of much of the groundwork in training was evidently due to this help from pioneering private agencies.

In California, Indiana, New York, Massachusetts, Michigan, and Ohio, the training office has also some responsibility in recruiting health workers for the department.

While schools of public health are active in formal training of health workers, many schools also contribute in a greater or lesser degree to extramural training or continuation education in the State or region where the school is located. Several schools of public health nursing also offer extension courses.

Some State departments of health are fortunate in receiving distinct aid in training from a nearby university. New Jersey has long been helped by Rutgers University, in both formal and short courses. Kansas, Kentucky, and Oklahoma also depend strongly on the State university. For a decade Florida has offered home study courses to local water works and sewage plant operators. Michigan in 1950 established the policy (*3*) of "limiting the department's sponsorship of training to those fields where the established educational institutions are unable to provide service." This expresses what most States are now doing. In Illinois the department of public health and the university conduct four correspondence courses in sanitation.

Recommendations

Statistical evaluations in so wide a field are difficult, but as a result of this study my personal recommendations are as follows:

Training is a normal function of administration and should include service from the State to localities.

Every State department of health should have a training committee, preferably with members from local departments and from educational institutions whose major concern is with training policies.

Every State department of health should have one person designated as director or coordinator of training. In most States, he will devote part of his time to training and will be selected both for his interest in training and for the related nature of his other duties. In States with a larger number of State or local health workers, he should give his full time to training. Whether on a part-time or full-time basis, this person should work with others who will themselves do the actual training. He should use educational institutions wherever possible. He should preferably be a physician. His position in the department should be high enough to exert influence. He should work and plan with the confidence that the ground swell is setting his way (*4*).

REFERENCES

(*1*) U. S. Public Health Service. Division of Public Health Nursing Services: Annual census of nurses employed for public health work in the United States and Territories on January 1, 1953. Washington, D. C., The Service, 1953, table 3. Mimeographed.

(*2*) Amos, F. B.: The public health training program of New York State. Pub. Health Rep. 68: 295–300, March 1953.

(*3*) Michigan Department of Health: Public health recruitment and training. Fourth annual report. Ann Arbor, The Department, 1954, p. 5.

(*4*) The State health department. An official statement of the American Public Health Association, adopted November 11, 1953. Am. J. Pub. Health 44: 235–252, February 1954.

PHS Staff Announcement

Dr. Clifton K. Himmelsbach was appointed chief, Division of Hospitals, Public Health Service, in March 1955. As chief of the division, he will have charge of all Public Health Service hospitals and outpatient clinics. With the Service since 1931, Dr. Himmelsbach had been assistant chief of the division until his recent appointment. Before then, 1948–53, he was in charge of the Washington, D. C., outpatient clinic, and, earlier, chief of the Medical Operations Branch of the Federal Employee Health Program.

Included under Dr. Himmelsbach's direction is the Lexington, Ky., hospital for the treatment of narcotic addicts. At one point in his career, when he was assigned to the research branch of that hospital, Dr. Himmelsbach directed clinical investigations on the nature and quantification of narcotic addiction and the methods for detection of addiction liability in new drugs.