The Nonmedical Health Officer in New Jersey

New Jersey is the first State to adopt a policy of licensing nonmedical, full-time local officers of health on the basis of specified qualifications and training. For nearly a hundred years, New Jersey has been developing its full-time local health organization on this basis. One of our pioneer sanitarians, Charles-Edward Amory Winslow, had his first job as a New Jersey local health officer after receiving his baccalaureate degree at Massachusetts Institute of Technology.

It is not to be expected that every local health officer—medical or nonmedical—will turn out to be another Winslow. However, the potential of meeting local needs in a rapidly changing society by employing well-trained nonmedical personnel need not be disregarded. As the two articles following this introduction indicate, New Jersey has learned much in exploiting that potential and has much to teach other States feeling the pinch of the personnel shortage.

State Experience

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The art of public health, because it is based on a constantly developing body of scientific knowledge in a society with a rapidly shifting cultural, economic, and political structure, is always changing to meet new needs. Evaluation of existing methods and organization and exploration of new ideas are our day-to-day responsibilities. In this context, the role of the nonmedical health officer in New Jersey merits study.

Background

The statute creating a local board of health in each municipality in New Jersey dates back to 1887. These boards were permitted to employ health officers and other public health personnel. Fifty years ago, most of the larger cities had full-time health officers, and all but one or two were nonmedical. The major responsibilities of these health officers were to enforce the sanitary laws concerning water, milk, and foodhandling, to abate nuisances, and to perform the routine isolation and disinfection measures to control communicable disease. Their health education activities were devoted, for the most part, to immunization campaigns, tuberculosis control, and securing ordinances requiring pasteurization of milk.

The health officers of 30 to 50 years ago came to their positions from three disparate backgrounds. There were the physicians who, except for a handful, served part-time. There were the college-trained nonmedical health officers, some of whom had studied under Sedgwick at the Massachusetts Institute of Technology. This small but well-trained group brought to New Jersey the seeds of professional public health administration. They were re-

sponsible in large part for the introduction of sound local health practices and served to set a high standard of performance. They were the preceptors who set the pattern for the generation of nonmedical health officers who provide leadership today.

The largest number of health officers, however, were those without formal education, who had served apprenticeships as sanitary inspectors and communicable disease investigators in local health departments. The New Jersey Health and Sanitary Association, organized in 1874, the New Jersey Health Officers Association, organized in 1911, and the annual conference of State and local health officials, sponsored since 1911 by the State department of health, represented the major educational opportunities for the practicing health officer. Both the Health and Sanitary Association and the Health Officers Association were active in sponsoring and supporting new health legislation. Leadership was also provided by a group of nonmedical epidemiologists and administrators in the bureau of local health adminstration of the State health department.

The capacity of the nonmedical health officers to use modern knowledge effectively in organizing health services is attested by the scope of services, the level of performance, and the continuing exploration of new avenues of public health progress by a number of local health departments in New Jersey. The East Orange Health Department, discussed in the following paper, is a prime example.

Licensing

Our statutes provide for the licensing of health officers, as well as other public health personnel, by the State department of health. Our State sanitary code requires that the board of health of each municipality of more than 10,000 population employ a licensed health officer to be its executive officer and its general agent in the enforcement of health laws and ordinances. Other laws relate to salary, tenure, removal procedures, and other employment conditions of health officers.

To be admitted to the health officers' examination, an applicant must meet the basic requirements of education and experience set by the public health council of the State health department. Each application is reviewed by the licensing board to determine eligibility, and approved applicants take a multiple-choice examination prepared and scored by the professional examination service of the American Public Health Association. This examination covers each of the major facets of a modern public health program and thus insures that the newly licensed health officer has a working knowledge of all essential programs. Licenses are valid indefinitely without reexamination. Although the licensing procedure was instituted in 1903, only since 1950 has a college degree been a requirement for admission to the examination.

Despite the provision of the State sanitary code, of the 567 municipalities in the State only 197 have licensed health officers, and of these only 97 have full-time health officers. The need for full-time licensed health officers is especially urgent in surburban communities that have rapidly developed in formerly rural areas. The major reorganization of local government that is required in such areas to meet the needs of a vastly increased population is usually delayed for many years.

Training

Training of local health officers has been considered a State health department responsibility since 1925, when, in cooperation with the department, Rutgers University instituted special extension courses for health officers and sanitarians. These courses have been expanded and are given regularly. Since the college degree was established as a requirement for licensure of health officers, the extension courses have been directed primarily toward preparation of sanitarians. Rutgers University provides an undergraduate program leading to a degree in the sanitary sciences.

For some years, it has been clear that the pattern of local health services must change radically if we are to meet the major public health challenges of today. Control of the long-term illnesses associated with aging must become the major focus of health department activity. Beginning in 1956, the State department of health, with the cooperation of the Health Officers Association, instituted an inservice training program for full-time health officers. A

series of 2-day resident workshops was organized. Workshops were held on diabetes, cancer, heart disease, tuberculosis, public health nursing, mental health, administration in public health, and community relations. The content of these sessions was developed by members of the education committee of the Health Officers Association and representatives of the State department of health. Each workshop was attended by 30 to 40 health officers and 15 to 20 staff members of the State health department. These sessions provided specific knowledge to the practicing health officer, acquainted specialized personnel in the State health department with the problems and opportunities for services on the local level, and, most important, developed types and methods of activities currently practical for adoption by local health departments.

Status

The effectiveness of a health officer in influencing community action is directly related to the general status of health officers. Full-time health officers have been strongly represented on each committee appointed by the State commissioner of health to write new codes for adoption by local boards of health. The committee that developed the legally enacted Recognized Public Health Activities and Minimum Standards of Performance for Local Health Departments at the request of the State commissioner of health was made up entirely of local health officers. The committee that is now working on the revision of our basic State laws on public health has as its core a group of our most active health officers. Health officers are included on such committees because their knowledge, competence, and understanding of the community, its needs, and reactions, have been demonstrated time and again to be a major factor in insuring the soundness of committee recommendations.

The rising status of the health officer in New Jersey can be credited largely to a group of 10 to 15 of their number. Their dedication to public health, their devotion and application to their work, and their broad concepts of public health have impressed citizens and both State and local public officials, as well as professional public health workers from State and national agencies.

Objective evidence substantiates this rise in status. The average annual salary of nonmedical health officers in New Jersey has risen from $4,000–$6,000 in 1952 to $8,000–$11,000 in 1962. As a result of the major role nonmedical health officers played in the organization in 1959 of the New Jersey Public Health Association, the first and third presidents of the association were nonmedical health officers. Within the past several years, a number of nonmedical health officers have been elected to fellowship in the health officers section of the American Public Health Association.

Organization of Services

Local health services in New Jersey present problems similar to those in other northeastern States in which local government rests primarily in the municipality and the entire State is divided into townships and other municipalities. County government is generally limited in legal responsibilities, and its scope of services usually includes little in public health. A large majority of our 567 municipalities have a population and tax base that make modern public health services organized on the basis of individual municipalities impractical. In spite of legislation permitting the formation of regional, district, and county health departments, there are only three small regional health commissions. No health departments have been organized in accordance with the District Health Act. Within the past 2 years, three county governments have employed licensed health officers together with appropriate staffs and have offered health department services to municipalities by contract. Fourteen of the 16 municipalities in Cape May County and 12 of the 14 municipalities in Cumberland County have contracted with their county governments for public health services.

Tools for Action

In accordance with the basic health laws, the public health council has promulgated the Recognized Public Health Activities and Minimum Standards of Performance for Local Health Departments, which became effective in April

1961. These standards serve as tools for two major types of action. They enable the health officer to go to his budget-making body with a plan for a full program of public health activities supported by legally enacted standards. They enable the State department of health to present to the citizens and officials of municipalities providing inadequate health services a measure of their needs, a clear picture of their responsibilities, and a well-documented case for the establishment of necessary services, either through the organization of a municipal health department or by joining together with other communities to form a regional, district, or county health department.

In accordance with a recommendation made by the bureau of government research of Rutgers University following a study of public health needs in New Jersey, a bill has been prepared which would provide State aid to local health departments that meet specific criteria. One criterion is the employment of a full-time licensed health officer.

The State department of health has specific legal powers to insure establishment and maintenance of effective local health services by the municipal boards of health. However, major reliance is placed on the use of consultants in the various public health disciplines to inform local officials and citizens of needs and of effective methods to meet these needs. The division of local health services has four district offices, each with a staff under the direction of a district State health officer and including consultants in public health engineering, sanitation, epidemiology, community organization, public health nursing, medical social work, and nutrition. Assistance from the district staffs is readily available to the local health officer as well as to other officials, voluntary health agencies, and citizens generally. In those communities served by full-time health officers, all local activities are channeled through these health officers.

Major Challenges

Many problems concerning local health officers in New Jersey await solution. I shall briefly recount a few, in an order which does not bear on their relative importance.

A number of well-qualified, energetic, and, in a sense, pioneering health officers will have to be found to head local health departments in the large areas of New Jersey that now have grossly inadequate services. The need will be intensified under the impetus of the minimum standards and the proposed State aid program.

Like local health officers throughout the United States, ours must establish relationships with hospitals, visiting nurse associations, and other health, social, and welfare agencies so that effective programs for the control of chronic illness can be organized and maintained.

As an immediate and I hope transient result of the adoption of the minimum standards, a few of the health officers have accepted retainers from municipalities with inadequate health services. Their names and licenses provide compliance with the letter of the law without their assumption of actual responsibility for effective public health services in these communities. Only a few health officers are involved, and with continuing community education I believe these practices will be minimized.

A significant number of communities still employ part-time health officers. We are convinced that persons who derive the major part of their earnings from other activities and who are not available for their health department responsibilities during regular working hours cannot provide the necessary leadership in public health. Therefore, our department discourages such arrangements. In discussing workshops, committee work, and other activities, I have referred to the full-time health officer. Part-time health officers do not participate in these activities. Again, a program of community education is slowly overcoming this problem.

Raising the status of the local health officer remains a major challenge. This problem faces medical as well as nonmedical health officers. Disease prevention and community action in health have never received the public attention and prestige given to caring for the sick and disabled. A fire engine rushing to a fire is more exciting than a campaign to clean up flammable rubbish. Local health officers individually and as a group must play a more active role in influencing the reorganization of the

local health department to meet today's needs. We cannot sit by and wait for specialists to force new programs upon us or, worse yet, see public health fragmented by the establishment of independent specialized agencies. The Community Health Services and Facilities Act gives the local health officer a unique opportunity to participate in pioneering in public health.

Recruitment and training of the nonmedical health officer have not yet been given sufficient thought and study. In the normal evolution of a profession a formal method of training is developed and becomes part of the pattern of the profession. The nonmedical hospital administrator became a well-established discipline when universities added graduate degree programs in this specialty. In view of the tendency of some schools of public health to limit their graduate training in public health to physicians and to give precedence to the preparation of research personnel, we must direct attention to the need for trained health administrators, both medical and nonmedical.

We have developed in New Jersey a group of trained people who have a clear-cut professional discipline. They have demonstrated their effectiveness as public health administrators and have gained public acceptance. They are moving toward an improved community status which, as in other professions, is accompanied by increased formal requirements of education and experience. They are serving an important function in the organization and operations of local government.

Local Experience

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East Orange, N.J., a community of 80,000 people in the populous district directly west of Newark and Manhattan, has been served by a series of distinguished nonmedical health officers. My predecessor, Frank J. Osborne, dean of New Jersey health officers, was educated at the Massachusetts Institute of Technology in the era of Sedgwick and Winslow and served East Orange with distinction from 1924 to 1961. During his tenure, the East Orange Health Department won national recognition.

East Orange has changed since the middle twenties from a tranquil, wealthy, suburban town to a thriving residential and commercial city. The present population density of 20,000 per square mile is one of the heaviest. The age distribution pattern has also changed from the normal pattern to one dominated by young families and senior citizens, accompanied by a shift from one- or two-family homes to apartment houses. At present there are 12,500 school children and 15,000 persons over the age of 62 years in East Orange. These drastic changes in East Orange have been met by responsive changes in the programs of the health department.

The city has a mayor-council form of government and the health department is governed by a five-member board of health appointed by the mayor. Members are appointed to 3-year terms in staggered years so that no more than two vacancies occur in any year. The staff of the East Orange Health Department consists of the health officer, assistant health officer, health educator, four sanitarians, nine public health nurses, laboratory director, bacteriologist, and seven stenographic and clerical workers. In addition, we employ a part-time chief of medical services, two part-time dentists, and enough part-time physicians to staff 16 weekly clinic assignments.

Basic Programs

The department's regular activities are broad in scope and follow the traditional recognized responsibilities of a local health department.

The nursing department provides services to the city's six parochial schools and to eight weekly child health conferences; cooperates with the board of education in their tuberculin testing, poliomyelitis immunization, and health education projects; and helps supervise 75 foster homes for children.

The laboratory's major service is performing diagnostic and other tests for the physicians and dentists of the community. These include serologic examinations, blood typing, stool and sputum examinations, and throat and mouth cultures. In addition, the laboratory supports