New Staff for Public Health

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PROFESSIONAL flexibility is the key both to implementing future health programs and to solving the health manpower crisis in the United States. The competent professional in public health today is concerned with the rapidity of change in legislation, funding, and health organization, all factors which affect the practice of public health. He must see opportunity and challenge, rather than threats in this change (*1*).

One favorite, but futile, pastime of public health workers is complaining about the well-known deficiencies in public health services and the continuing shortage of health manpower while insisting that services must be delivered by traditional patterns and staff. Scarcity of personnel is used by some administrators as an excuse for not providing better service. Yet these same diehards resist change in staffing patterns which results in different responsibilities and work assignments, even when such change produces increased efficiency and better organization in the delivery of public health services and extends available manpower.

Resistance to change can have real positive value. In some situations resistance insures continuity and stability and acts as a brake against runaway innovation. When extreme, however, resistance impairs the agency's ability to adapt to new conditions and new needs (*1*). Certainly there is risk in developing new staff and new staffing patterns—but this risk must be taken.

Miles (*2*) observed that John Kenneth Galbraith advances the idea that the modern dilemma in our society is not how to conserve limited resources but rather how to deal with developing and distributing our unrecognized abundance. We maintain that the human resources of most public health agencies are underdeveloped and underemployed because of traditional limitations, compartmentalization, and vested interests.

Professional groups tend to develop economic vested interests similar to those of labor unions. Such groups disdain electricians' unions which attempt to require that only licensed electricians be permitted to change a bulb. Yet, some school physicians have protested the use of trained volunteers for screening vision, public health nurses have been known to resist the use of public health assistants in child health conferences, and veterinarians occasionally have maintained that only they should inspect meat or take a blood specimen from a cow. Hyperprofessionalism results in highly trained professionals discharging duties which can be performed by less trained persons under proper supervision (*1*).

Health workers at all levels place the opportunity to do meaningful work near the top of their needs for job satisfaction. These needs, of course, are stronger in some persons than in others. Nevertheless, supervisors and administrators in every discipline consistently appear to underestimate the ambition and enthusiasm of their subordinates and the desire of lower and middle grade personnel to contribute in a way that is relevant to them.

Recently, Dr. William H. Stewart, Surgeon General of the Public Health Service, pointed

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out the need to develop and use all human resources so that sufficient health services will be available to everyone (*3*). Officials in public health must precisely define needs for services. From these definitions administrators must spell out the exact tasks to be performed and the skills and knowledge required for performance. It then becomes possible to seek and encourage development of the existing and potential talents of personnel and to give promising persons the necessary training in content, attitudes, and skills to accomplish the tasks.

Staff Developed in Allegheny County

Ten new types of staff are working in the Allegheny County Health Department.

1. Health aides, indigenous residents of socially disadvantaged areas, must have at least an eighth grade education and demonstrated community involvement. These aides find persons in need of health services, motivate acceptance of existing services, and facilitate obtaining such services by making appointments, escorting patients, assisting with food buying, and providing reinforcement and support. Some health aides are assigned to Head Start or childhood development centers to assist in the health evaluation program and to carry out followup functions. Thirty-seven positions have been budgeted.

2. Sanitarian aides have the same qualifications as health aides. Sanitarian aides survey for external environmental problems, such as abandoned autos, littered lots and yards, and poor garbage disposal practices; issue orders to correct such conditions; and work with citizens to prevent these and similar nuisances. Sixteen positions have been budgeted.

3. Community supervisors are indigenous residents who are high school graduates with demonstrated community involvement and leadership skills. Directly responsible to the district health officer, they supervise the work of health and sanitarian aides, relate to citizen and community groups, and represent the health department in the community. Eight positions have been budgeted.

4. Public health assistants are primarily auxiliary workers to public health nurses in clinics and child health conferences. High school graduation is required, and hospital or practical nurse training is preferred. Twenty-two positions have been budgeted.

5. Public health inspectors are high school graduates who qualify as entering level workers in environmental health and air pollution control. Forty-five positions have been budgeted.

6. Laboratory assistants are high school graduates who work as auxiliary technicians in the public health laboratory. Seven positions are budgeted.

7. Sanitarian trainees have completed 2 years of college, including courses in the physical and biological sciences. Trainees are expected to continue their college work to qualify as sanitarians after obtaining their bachelor's degree. Their work includes inspections and investigations on a relatively skilled level in a variety of public health programs. Ten positions have been budgeted.

8. Public health representatives are 4-year college graduates who do epidemiologic investigation and followup patients with communicable diseases, particularly tuberculosis and venereal diseases. Twelve positions have been budgeted.

9. Administrative officers are college graduates with 2 years' administrative and supervisory public health experience or equivalent. These administrators assist program directors in environmental health, maternity and infant care, and tuberculosis control. Five positions are budgeted.

10. Public health administrators hold a master's degree in public health and have 5 or more years of public health administrative experience at increasing levels of responsibility. They direct health districts or centralized programs. Six positions have been budgeted.

The Concept of a Career Ladder

The approach toward developing new staff in the Allegheny County Health Department is, however, different from that of some other health, hospital, or welfare agencies. New staff at the aide-technician level and at the top management level are being tried simultaneously. Furthermore, we are developing a career ladder, requiring a combination of formal, accredited education and on-the-job experience.

A human resource pool is visualized as an open-ended pyramid. At the base of the pyra-

mid are a large number of aide-technicians. A bit higher, either by promotion from the first level or by entering the career ladder with superior academic attainment, is a second, smaller group. This second group, who may be graduates from a 2-year community college program, are more skilled than aides and able to carry out some responsibilities formerly assigned to staff trained at a higher level.

A third level on the career ladder can be achieved either by promotion again plus education or at the educational level of the bachelor's degree. At present the number of universities granting a bachelor's degree in public health is limited, but several more are considering such a program. Higher rungs of the career ladder require further training and experience.

The basic principle in developing new types of staff is to use health manpower more effectively by assuring that each task is done by a person with the ability but with minimum training necessary. Health and sanitation aide positions illustrate first-level types of jobs and a way to tap manpower resources previously unused by public health. The public health administrator position, as defined in Allegheny County, illustrates a new type of management in public health.

Since March 1964 the Allegheny County Health Department has employed residents of designated poverty areas to help provide personal and environmental health services in their neighborhoods. This program is supported partly by the Office of Economic Opportunity.

In addition to the expected advantage of adding auxiliary health manpower to the staff, there was a second and more important hypothesis involved in employing neighborhood-based workers. It has been observed that communication with patients from some subgroups is more effective when done by patient peers or near peers than by professionals. The neighborhood worker, by using the vocabulary of the residents to explain public health services, is more able to overcome superstition and isolation and to stimulate community involvement in developing health programs to meet the neighborhood's needs (*4*). Such workers also can tell professionals about otherwise unknown barriers to service.

It is our observation that indigenous and other entering level workers quickly learn the jargon and identify with the attitudes implicit in professional-patient contacts. Although communication between aide and professional may be enhanced, the indigenous worker tends to become less effective with patients if she adopts a professional vocabulary and some of the attitudes. Those concerned with supervision and inservice training must help the indigenous worker to retain peer group communication and to use the newly learned vocabulary only with appropriate audiences. This area is sensitive and needs skilled handling because the indigenous worker is proud of her learning.

In addition to the public health benefits from having these tasks carried out, neighborhood services also have provided employment and hope to a number of persons formerly on relief. Several aides are now enrolled in college; others have been encouraged to take the high school equivalency examination, and all who have done so have passed.

The second new category at the other end of the new staff spectrum are nonmedical public health administrators responsible for directing an important centralized operation or a health district.

In 1957 the Allegheny County Health Department was organized with five decentralized health district offices, each serving more than 300,000 persons. Each district was to be administered by a physician functioning as district health officer.

Because of the shortage of qualified public health physicians, it has proved impossible to staff each district health office with a physician-administrator. Eventually, the department began to question the desirability of using scarce medical talent in positions that entail supervising a major nonmedical component, environmental health, and performing many administrative chores, such as preparing budgets, characteristic of executive positions, as well as a heavy commitment to community work—all functions for which medical training was irrelevant (*5*). Furthermore, releasing physicians from administrative and other nonmedical responsibilities would free them to plan and direct programs which require their particular expertise.

We agree with Dr. Milton I. Roemer, of the

University of California School of Public Health, who points out that to continue to try to use only physicians in public health administration is socially wasteful. Their laboratory, theoretical, and clinical training have equipped physicians to treat individual patients; to have them abandon this function, only to begin to learn about the process of social organization and administration is an extravagance that society cannot afford (*6*). Why is a physician any more capable of directing engineers and sanitarians working in an environmental health program than is an environmental health expert capable of administering a preventive program for personal health?

In August 1966, the Allegheny County Health Department established the position of public health administrator which requires a master's degree in public health and 5 years of increasingly responsible administrative experience in public health. At present four of the five districts and one centralized program are staffed by nonmedical public health administrators. Three of these public health administrators come from a background of environmental health administration, one from nursing administration, and one from public health education.

The administrators receive medical support for problem solving and planning through the physician-directed programs in epidemiology, tuberculosis, venereal disease, maternal and child health, and other medical services. In addition, one full-time physician-consultant tours the districts regularly and is on call for questions and emergencies. Each health officer has on his district staff a full-time, experienced nurse administrator and a full-time, experienced environmental health administrator.

An unanticipated benefit observed during the first year has been that our new health officers seem to interact more effectively with the community—particularly in relation to the citizens' growing concern about health. These health officers seem less threatened by citizens' criticism of the system for delivery of health services and better able to deal with citizen militancy than are most physicians. Certainly the social distance between health officer and citizen is less than that between physician and citizen. The nonmedical health officer is not tied in his own mind or in the minds of others to traditional solutions and systems currently under challenge by citizens acutely aware of the fragmentation and inaccessibility of health services for the city poor.

Education for New Kinds of Manpower

For some years it has been realized that the talents of a physician are not essential to administer a hospital. Consequently, a 2-year curriculum leading to a master's degree has been available to prepare hospital executives, and programs have been proposed for a doctorate in hospital administration and refresher work at the postgraduate level. Similarly, those in public health should realize that nonmedical staff educated and experienced in public health administration can function competently at the executive management level. It is time that curriculums for specialization in public health administration be structured to develop such executives.

Roemer has proposed a revised medical school curriculum to educate physicians in the specialty of administration (*7*). Course content would include epidemiology, community organization, human relations, and management. Clinical studies would receive less than the present emphasis.

These proposals are actually complementary. Although it has been demonstrated that some executive responsibilities in public health can be handled without medical training, there is no question that physicians are essential in a health department. How much more effective they would be, however, with the type of education proposed by Roemer than with the conventional M.D.-M.P.H. degrees! Health manpower shortages will not be solved by considering one or two levels of staff only or by requiring more years of training or by continuing only to increase the number of health professionals.

The assumption that public health executives must first have achieved professional status in a related discipline before their public health training must be challenged. Environmental health and public health education are the only public health disciplines which do not require superimposing a degree in public health onto an existing professional discipline. Yet a bachelor's degree which is directly relevant to public

health practice is not readily obtainable in either environmental health or public health education. Planners of curriculums in colleges and universities, community colleges, and graduate schools need to rethink their roles in preparing health manpower efficiently and at levels responsive to present-day needs.

Allegheny County is particularly fortunate in having a variety of institutions to prepare health manpower. There is, however, little institutional effort visible, with the exception of the community college, to rethink the topsy-like growth characteristic of health manpower education. Now is the time for State and local health departments also to develop a rational plan for health manpower education at all levels. Job qualifications, inservice education, and arrangements for part-time or full-time training by colleges and by public schools all need modification.

At the Federal level a shift of emphasis of traineeship programs and an increase of health manpower training funds is urgently needed. Obtaining financing for the master's degree in public health is not too difficult, but funds adequate for a student to maintain a family while getting a bachelor's degree or even community college level education just are not available. With the ever-younger marriage age, financial support for undergraduates on the traineeship principle of allowances for dependents is mandatory now.

Conclusions

Across the United States, as well as in Pennsylvania, we are witnessing increasing numbers of complex, preventive, diagnostic, therapeutic, and rehabilitative programs of health services. Who is to administer these programs? Who is going to carry out the necessary tasks and to provide the supervision? Who is going to dare to take the risk to rethink the kinds of staff needed and what experience and training they require? Who is going to recognize that we have untapped human resources that can solve our health manpower shortages?

Until now, top-level administrators usually have been physicians whose training does not necessarily equip them to handle problems of social and community organization and whose functioning as generalized public health administrators is a costly use of scarce, specialized medical talent. Lower level responsibilities have been delegated to aides and technicians fixed in dead end careers. As a result, the brighter and more ambitious nonprofessionals leave the health field. Scarcity characterizes the middle-grade and supervisory level personnel categories.

We propose the following means to alleviate shortages of manpower.

1. The development of public health administration as a nonmedical specialty.
2. Further redefinition of new types of staff and new ways to use staff at every level.
3. Simultaneous development of community college, bachelor's level, and master's level training to encourage recruitment of personnel in a career ladder sequence.
4. Federal financial support of education to develop health manpower on a realistic basis.

To proceed will require discipline, courage, and the willingness to take risks. To succeed will mean that manpower resources as yet unused have been tapped and that equal access to comprehensive health care for all persons in the United States may be achievable. The question before us is not "Can we do it?" but "When will we?"

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