A report is presented on a decade of activity in New Jersey on the basis of its Chronic Illness Act of 1952. This is a clear exposition of a state plan for chronic illness, in which the homemaker service is particularly important.

EXPERIENCE WITH A STATE CHRONIC ILLNESS LAW

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NEW JERSEY adopted its Prevention of Chronic Illness Act in 1952, under the distinguished leadership of Dr. Daniel Bergsma, then state commissioner of health. The act established a Division of Chronic Illness Control, set the broad scope of activities, created an Advisory Council on the Chronic Sick, and set up a system of grant-in-aid for community health facilities, using state, as well as federal funds.

The Declaration of Public Policy contained in the act is a remarkably succinct and able statement of the issues, and I quote:

"26:1A-93. Declaration of Public Policy. "The growing problem of prevention, detection and care of chronic illness, which is of such character as not to be exclusively medical, educational or welfare, has now reached such proportions in this State as to require the participation of the State and of the agencies administering public health, education and welfare within the State and it is hereby declared to be the public policy of this State that the responsibility therefor must be shared by the State and the counties and the several municipalities and health districts and the voluntary agencies and institutions within the State and the public at large."

The passage of this act followed extensive discussions with active medical society leadership and an official study by a commission appointed by the governor. A full scale Governor's Conference which was a landmark in chronic illness control in our state was held soon after the act was passed. The 1961 federal "Community Health Services and Facilities Act" has many close similarities to the 1952 New Jersey law. The New Jersey State Health Department is charged with "the task of providing for the prevention, early detection and control of chronic illness and the rehabilitation of the chronic sick."

Dimensions of Grant-in-Aid

During this decade the Division of Chronic Illness Control has provided grant-in-aid money or equipment in the amount of $1,692,000 of state funds, in addition to $571,500 of grant-in-aid of the usual disease centered categorical federal funds and in addition to the normal leadership and services of the staff of the department. These data omit the recent Federal Chronic Illness or Community Health Facilities moneys. These moneys are expressed in this way deliberately to emphasize that the firm policy has been to build up dynamic, comprehensive, and integrated community health facilities. The staff of the State Health Department and the divi-
sion remain small—but nevertheless a powerful influence, I believe. The grants-in-aid are by policy of the carrot type; that is, they are to be amortized and taken over by the local facility. They are not permanent aid and are not meant to pay for indigent medical care. While the standard contract is designed for a three-year takeover, the record is not quite that good, but generally ranges from 14 to 20 per cent per year. This is partly due to programs, such as services in alcoholism, where the state aid is deliberately sustained.

Generic-Disease-Centered Foci

When the program started, emphasis was placed in areas most lacking at that time, such as general rehabilitation facilities. Opportunism had to play a part also as the state and the local facilities learned to work together. There was, and still is, considerable testing out in both directions. Equipment and monies for staff were provided hospitals to establish comprehensive rehabilitation facilities. Physicians and other staff were trained and much time was spent selling the concepts of rehabilitation. Priority was given to county institutions which have almost completely changed in this decade from almshouses to chronic disease hospitals. Assistance was provided in establishing facilities for cardiac surgery since there were none in New Jersey at that time—now we have too many! In several instances cardiopulmonary centers were created and the foresight of this is paying off now as interest in nontuberculous pulmonary conditions increases and as the functional aspects of cardiac and other diseases grow in importance. A careful study of the rehabilitation results in a large, prominent county hospital was carried out and published, and included the dollar values in reduced hospital stay and in reduction of public assist-

ance.* This study created wide interest and was a fine example of a well conducted demonstration.

There has been continuously a deliberate special emphasis on strengthening generic or more generalized services in the prevention of chronic illness program, at the same time that the traditional disease centered programs have been expanded. For example, the development of trained medical social work staffs in general hospitals has been a point of sustained special effort. As a matter of fact, most of the professionally trained medical social workers in New Jersey hospitals now are in the places where aid was granted to initiate or strengthen the service. Unfortunately, the number is still small and there is still much to be done. On the other hand, where medical social workers have been placed or aided for specialized services, such as alcoholism, arthritis, or rehabilitation, special efforts were made to maximize the integration with the basic generic medical social work unit. Likewise, generalized rehabilitation services have been built in areas where the Vocational Rehabilitation Program under the Department of Labor indicated needs and where they also were helping to strengthen resources. In another area the cardiac classification unit was deliberately built into a hopefully generalized unit. More recently the services directed particularly at rehabilitation of the elderly and institutionalized patient have presented the same opportunities and dilemmas. All such efforts are not successful, of course. Integration is hard and specialization is a seductive siren which has pervasive and insidious power.

Hospital Health Center

The New Jersey program has taken

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seriously the prevention of disability as a basic goal of public health. At this point the preventive, therapeutic, and rehabilitative services all come together and we unite in this goal of the prevention of disability. It is clear, too, that a great deal of the prevention of disability occurs, or should occur, in the general hospitals. With respect to the control of chronic illness and the prevention of disability, the general hospital is in fact the health center—or at least it has that great potentiality and is the place where a major part of the effort can occur if it is to occur at all. For this reason the control of a chronic illness program has dealt directly with hospitals, made contracts with them, furnished supplies and equipment, consultation services, started clinics, financed or provided professional education, and so on. For example, for two years a highly skilled nutritionist with a rich background of institutional dietary services was employed by the State Health Department and assigned to a consultation service operated by the New Jersey Hospital Association. It was widely used and appreciably raised the level of and changed the pattern of food handling and dietary and nutritional services, particularly in the middle-sized hospitals.

I should emphasize that New Jersey's culture is, of course, its own. Our state is small and now the most densely populated. We lack well developed local health services and have 568 municipalities, most of which have sparse local public health organizations. The State Health Department has four well staffed district offices. We have a long tradition of voluntarism and prefer to provide many public health and other health services through voluntary agencies, rather than government, even though tax funds may supply substantial parts of the money. This is one reason why we deal so directly with hospitals and other such agencies.

A good example of this is the homemaker service. This superb service was brought into being through the Division of Chronic Illness Control of the State Health Department by organizing a State Consultant Committee, supplying grant-in-aid funds for local voluntary agencies to organize, and by supporting the training of homemakers through the Extension Service of Rutgers, the State University. This is now a $623,000 business, annually supplying 330,000 hours of service through about 1,400 trained homemakers. Almost all the state is covered. All the agencies are voluntary. Eighty-two per cent of the $623,000 is paid for by the client or his agent. The average administrative cost is only 22 per cent. All the homemakers are part time, which reduces overhead and opens a vast resource of womanpower, so that recruitment has not been a serious problem. The service has been emancipated from the State Health Department and is now directed by its own voluntary State Visiting Homemaker Association. The state has provided only about 17 per cent of the total funds during this period.

An example of a more highly coordinated effort is the New Jersey Consultation Service for Convulsive Disorders.

There had been concern about epilepsy before the passage of the State Prevention of Chronic Illness Act. A "State Plan Regarding Epilepsy" had been formulated in 1950. New Jersey had operated a "State Village for Epileptics" for years with several hundred patients. A Consultation Service for Convulsive Disorders was established after a study financed by the National Institute of Neurological Disease and Blindness. This was a joint project of the major groups concerned and provided itinerant diagnostic and consultation services on schedule at specified local hospitals. The Division of Chronic
Illness Control of the State Health Department, as part of the State Plan, organized a Governor's Conference and then undertook to establish electroencephalographic equipment and suitably trained and supervised technicians in local hospitals through grants-in-aid of equipment and money and by technical assistance and supervision. These instruments have now been established in 17 hospitals and have been completely taken over by the hospitals, although periodic training for technicians continues. The State Village for Epileptics was reorganized beginning in 1952. The results of the entire program have been remarkable.

Before this effort there were 250 annual admissions to the village, with average stays of one to eight years at a cost of $40 per week per patient. Last year there were only six admissions and the average stay was three months! Eighteen hundred patients have been seen in the Consultation Service. This is a well-established program with follow-up, and backs up the extensive normal services in the general hospitals. We are now working to improve the automobile driver control aspects, to modify further the laws and to extend the consultation and diagnostic services to a broad spectrum of neurological diseases.

How can such services be evaluated? On the local public health service side we see several small cervical cytology services. One is conducted by a local health department but is hospital based and has served as a focus of five enlarging hospital-Health Department community programs. Diabetes case finding expands steadily. One local health department did a neat little research project in correlating a chemical it measured in syphilis serology serums with the incidence of arthritis. Public health nursing services have been significantly strengthened, including the provision of physical therapy services and an increasing role in organized home care. VNA's and public health are intimately and extensively involved in improving the care in nursing homes, and it has improved.

Professional education has increased greatly, both in the broad generic fields such as continuity of care and in many specialized areas, but particularly in the principles of rehabilitative and restorative services. These activities have brought together the hospital, public health, welfare, voluntary social welfare and health agencies, and the health professions.

Several lessons have been learned. Perhaps, appropriately in the early phases there was much emphasis on providing equipment. This has become a small activity. Contracts are now more likely to be written for the provision of services, hopefully based on actual costs. One big problem regarding equipment is obsolescence. This problem has been transferred to the hospitals but this is just "passing the buck" to a considerable extent. This is a very real problem as programs operate over even a few years, particularly in this field where technological advance is so rapid.

The new Federal Community Health Services and Facilities Act of 1961 is a bright spot indeed. The availability of the Federal Chronic Illness funds which preceded the act and the Public Health Service staff in this field have and are making their substantial contribution. The fact that this act was passed in 1961, that it was the only important broad health legislation that year, that it went through the Congress with such support, are all evidence of the increasing interest in the control of chronic illness and in the determination to bring out-of-hospital services up to a status comparable at least to the development of hospital services. The deliberately broad invitation for project grants and the wide scope of the act have already brought public health planning into many areas of social welfare where its
influence was not previously felt. The soundness of prevention, of rehabilitation, of restorative services, of the building on abilities rather than disabilities is spreading. We are making progress in the prevention of disability.

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The Image of the Sanitarian

An APHA staff member who appeared in print recently is George J. Kupchik, Dr.Eng.Sc., the Association's director of environmental health. In a Guest Editorial, “Sanitarians Need to Participate in the Professional Societies” which appeared in the October, 1963, issue of “Health Officers News Digest” Dr. Kupchik wrote that according to recent statistics . . . “Most sanitarians (63 per cent) are college graduates and almost all have taken many special courses, yet the annual salary is only $5,960 for the median sanitarian,” who is over 45 years of age and has had about 12 years of professional work experience. . . . There is a need for improvement in the status of environmental personnel by greater recognition of their importance, and compensation more commensurate with their value. The sanitarian is obviously suffering from a failure in public relations. He requires clear-cut identification with a specific kind of work and expanded professional and public visibility.” According to Dr. Kupchik, a survey of the number of sanitarians belonging to professional organizations shows that “the sanitarian is cavalierly indifferent to his needs.”

The survey questionnaire was mailed to nearly 16,000 persons and nearly 70 per cent responded. Only 55 per cent of the sanitarians known to belong to professional societies bothered to return completed questionnaires. Nearly one-fourth of the 11,000 respondents were not affiliated with any national society.

Dr. Kupchik writes, “No sanitarian who is sincerely desirous of improving his own status can feel exempt from the obligation to become a working member of one of them (the three national professional sanitary societies) and share in forming their programs and activities. As these expand and become more effective, additional members will be attracted to them, and as their membership increases they will be able to voice their claims for greater recognition and more adequate compensation more clearly, and with enhanced authority.”

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