NATIONAL HEALTH FORUM chronic illness

THE National Health Forum is conducted each year by the National Health Council to consider a currently pressing health problem. This year the problem was the mounting "daily disaster" of chronic illness.

Because of the wide concern over the magnitude of chronic illness, 800 health leaders attended the 2-day session of the forum in New York City, March 21 and 22, 1956. They came from the 50 national organizations which are the active, advisory, associate, and sustaining members of the National Health Council, from 35 additional national organizations, and from many State and local groups.

Forum participants heard Leonard W. Mayo, chairman of the Commission on Chronic Illness and director of the Association for the Aid of Crippled Children, in the keynote address, say that chronic diseases account for 88 percent of all disabling conditions in the United States.

Chief speaker at the closing dinner, March 22, was Dr. Lowell T. Coggeshall, recently appointed Assistant Secretary for Health and Medical Affairs, Department of Health, Education, and Welfare.

The address of Mr. Mayo on the problem and the challenge of chronic illness, and Dr. Coggeshall's answers to the challenge plus seven other papers from the forum are presented in brief on the following pages.

"Chronic illness accounts for almost three-fourths of the Nation's daily sickness toll," said President Dwight D. Eisenhower in a telegram read at the opening session by Hugh R. Leavell, M.D., president of the National Health Council. The President's message continued:

"There is urgent need both for more research into such disease and for prompt and widespread application of existing knowledge. For their continuing effort to solve this health problem of vital concern to our Nation, I congratulate the agencies represented in the National Health Council."

In an introductory speech, the chairman of the forum, Theodore G. Klumpp, M.D., who is president of Winthrop Laboratories, described the forum as essentially an effort to discover the type of "gears" needed to meet the new health care demands created by the predominance of chronic illness and how best to "shift" into them. He said the forum's task lay in the realm of human engineering.

"People and institutions are finding it hard to shift gears fast enough to keep pace with the changes that new scientific discoveries are making in the methods by which we may preserve or regain health among people of all ages," he stated.

"We do not wish to discard any of our human and institutional health care machinery, for we have too little of both, but rather to think of retooling and reassembling where changes may do the most good," he said.

Dr. Klumpp cited estimates of the Commission on Chronic Illness, indicating that 28 million persons in the United States—1 in every 6—suffer from some known physical or mental impairment.

More progress has been made in the conquest of disease and the prolongation of life in the last 50 years than had been accomplished in 999 centuries of man's previous existence, Dr. Klumpp said. Life expectancy has moved upward from 49 years in 1900 to almost 70 years in 1955, and, if the population forecast is correct, he continued, 1 in every 7 persons in 1980 will be 65 years of age or older.

"That means a larger burden of the chronic illnesses, though we shall hope that new medical and surgical advances can cut down the toll," he stated.

"Dealing with the long-term illnesses requires a great deal more community cooperation and more individual initiative and understanding than it took to control the communicable diseases," Dr. Klumpp pointed out.

Recommendations for the retooling which Dr. Klumpp urged were numerous throughout the six panel discussions that made up the major part of the forum. One of the panels sought answers to whether a home care program should be hospital oriented or health department oriented, how much responsibility for the chronically ill the general hospital should assume, how the necessary integration of hospital and home care can be realized.

Two other discussion questions were: Can the total of voluntary (direct and prepaid) and public assistance payments be increased to reduce the balance of unmet needs, with all that they entail of individual suffering and human waste? How can we awaken communities to chronic illness needs? Through service and referral centers? Through studies? Through committee action?

Four priorities seemed to emerge from the many needs for action on chronic illness brought out in the panel sessions. These may be stated as:

1. Adopting a "do it yourself" approach to health problems in order that all citizens may seek medical aid in the early detection of chronic diseases and cooperate in whatever changeover is required in each community to meet the new challenges presented by long-term diseases and disabilities.

2. Joining more closely the medical and social sciences since the effective medical care of the patient and his cooperation are to be realized only through good community organization.

3. Providing tools to help professionals and the general public understand more acutely the common denominator aspects of chronic illness so that community health services may develop the flexibility and flow requisite to care of the chronically ill.

4. Taking inventory of the sickness in the Nation and what is needed in the way of additional services and planning.

Samples of the forum's advice may be drawn from the experiences reported to the panel on "Community Action Together." The panel was moderated by Charles H. Brasuell, executive director, Pennsylvania Health Council. Three

Coordination of Communication

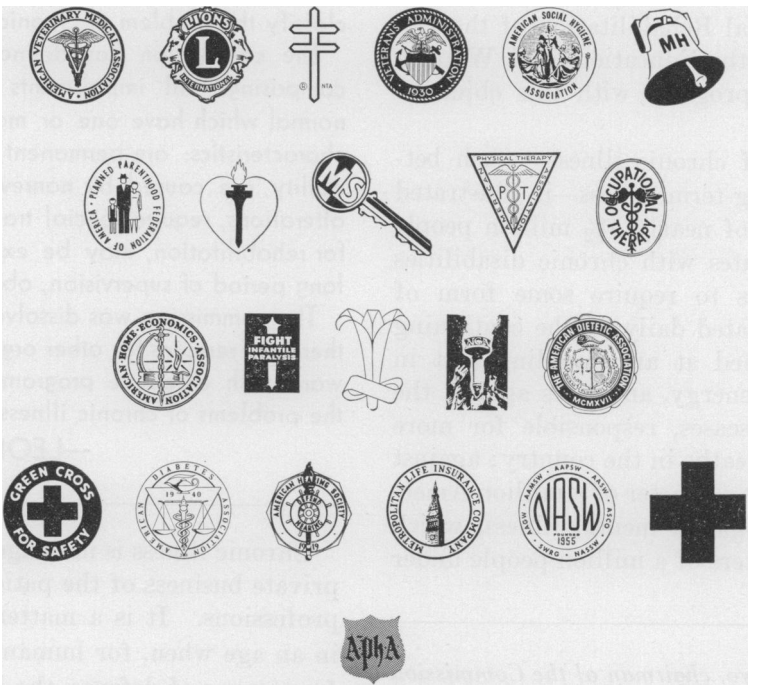
In the hope of encouraging speakers to say what they really mean, rather than repeat ritualistic phrases or shopworn words which have lost their original market value, one panel agreed that a fine would be levied for what James Thurber has satirized as "the gangrenous repetition of threadbarisms." Specified examples included "cooperate," "integrate," and "coordinate," as well as "area" and "level of action." Fines ranged from 5 cents for abuse of "impact" and 10 cents for "field" to 25 cents for "in terms of." The fine for "integration into the basic health structure" was remitted for a speaker who used the phrase at the right point. Panel members so well voiced their thoughts that receipts were zero.

of these experiences are distilled in the following statements:

- A study of community chronic illness can be an instrument to effective action, but if not wisely planned, it can prove to be an obstacle.
- Participation of physicians in any community program for the chronically ill is of key importance.
- People who cannot understand vague references to "the chronically ill" will listen to specifics; for example, "Mrs. Brown is taking Hope Hospital's homemaker service to old Mr. Attarian each day."

Other panel moderators were Arnold B. Kurlander, M.D., chief, Chronic Disease Program, Public Health Service; Cecil G. Sheps, M.D., executive director, Beth Israel Hospital, Boston; George Bugbee, president, Health Information Foundation; G. D. Carlyle Thompson, M.D., executive officer, Montana State Board of Health; and Leona Baumgartner, M.D., New York City health commissioner and incoming president of the National Health Council.

Next year's forum will consider mental health, in its broad implications for all organized health effort. To be held in Cincinnati, March 20–21, it is part of a plan to rotate the annual forums of the council throughout different areas of the United States. Basil O'Connor, president of the National Foundation for Infantile Paralysis, was chosen president-elect of the council.



Symbols of some of the participating organizations of the National Health Council.

Five Million People

PHR brief

Chronic illness is the challenge of this era to hospital, public health, medical, nursing, and all the professional services concerned with sickness and disability. It is a golden opportunity in the golden age of medicine.

The challenge of chronic illness is seen in the lives of all those who are adversely affected physically, socially, and economically, and particularly in the lives of the estimated 2 million adults who, though now idle, could become employable and tax paying if provision were made for their rehabilitation. More than 90 percent of these persons could be brought to complete economic self-sufficiency if adequate facilities for rehabilitation were available to them. The Office of Vocational Rehabilitation of the Department of Health, Education, and Welfare has an extended program with this objective in mind.

The problem of chronic illness—much better defined as long-term illness—is illustrated by the hard core of nearly 5½ million people in the United States with chronic disabilities sufficiently serious to require some form of care. It is illustrated daily by the continuing struggle maintained at an appalling cost in dollars, depleted energy, and lives against the cardiovascular diseases, responsible for more than half of the deaths in the country; against cancer, which kills a quarter of a million Americans annually; against mental illness, which brings three-quarters of a million people under some form of hospital care in the course of every 12 months; against arthritis and rheumatism; against blindness and deafness; against epilepsy, tuberculosis, multiple sclerosis, Parkinson's disease, diabetes, cerebral palsy, and various eye disorders. In short, these diseases and handicaps account for 88 percent of all disabling conditions in the United States.

Commission on Chronic Illness

The Commission on Chronic Illness, composed of nearly 50 interested and knowledgeable citizens and some 30 technical assistants, and served by a highly competent staff, was founded in 1950 by the American Medical Association, the American Hospital Association, the American Public Health Association, and the American Public Welfare Association to help define, identify, clarify, and classify the problem of chronic illness.

The commission has defined chronic illness as comprising "all impairments or deviations from normal which have one or more of the following characteristics: are permanent, leave residual disability, are caused by nonreversible pathological alterations, require special training of the patient for rehabilitation, may be expected to require a long period of supervision, observation or care."

The commission was dissolved in June 1956. It therefore remains for other organizations to go forward with extensive programs designed to meet the problems of chronic illness.

—LEONARD W. MAYO

Chronic illness is no longer the exclusive and private business of the patient and the healing professions. It is a matter of public concern in an age when, for humanitarian reasons and for reasons of defense, the Nation is more conscious than ever before of the need for conserving human resources. In such an age, illness, disability, and preventable death are problems the whole community must comprehend and help solve. The time-honored confidential relationship between the physician and his patient has limited value unless it is supported

By Leonard W. Mayo, chairman of the Commission on Chronic Illness and director of the Association for the Aid of Crippled Children, New York City, who summarizes in brief the principles and recommendations of the commission, to be published soon in a four-volume edition. A midway report on the work of the commission appeared in the March 1954 issue of Public Health Reports, p. 295.

and enhanced by the presence in the community of adequate treatment facilities. Hospitals, clinics, nursing homes of high standard, and like facilities come only as the direct result of citizen interest and community action.

Of the nearly 5.5 million victims of long-term illness, 2.1 million are 65 years old and over, 1.8 million are between 45 and 65, and 1.4 million are under 45. These figures and the record of the rehabilitation of chronically ill persons should put to rest the common misconception that chronic illness is synonymous with old age and generally incurable. The rate of chronic illness in relation to age is, however, significant. It is 1.3 percent for those under 45, 5.8 percent for those between 45 and 64, and 17.1 percent for those 64 years old and older. Disabling illness is 13 times as great for those 65 years of age and beyond as it is for those under 45.

Principles and Recommendations

The Commission on Chronic Illness has evolved a number of basic principles and a series of recommendations as a result of important studies, fact finding surveys, and research. It is both timely and appropriate to list a few of the most germane.

First, as to the individual patient himself—his needs, his rights, his personality are paramount. His needs cannot be met, nor his rights properly recognized, nor his personality fully respected, however, unless he is treated as a whole person. If he is regarded thus, his rehabilitation or restoration will inevitably include the services of many professions and disciplines.

When more than one profession is involved, there arises the need for wise planning, skillful cooperation, and harmonious interplay among the representatives of each profession. This is, in essence, the team, currently a popular concept but not yet fully understood or too effectively practiced.

In this integrated approach to the treatment of chronic illness, perhaps the strongest factor is our knowledge and treatment of the purely physical aspects, and the weakest is that of the social and emotional factors. We have considerable security in dealing with the former, but something less than that in dealing with the latter.

Recognition should therefore be given to the importance of the emotional attitude of patients whose illnesses become long drawn out, permanently crippling, or in other ways a major frustration. These attitudes embrace morale, motivation, and mood. Personnel in institutitions, in the home, and the patient's family must constantly seek to help the patient endure pain, delay, and disappointment; faithfully follow difficult treatment regimens; keep hope alive; maintain a will to live; and develop a philosophy of acceptance as part of a mature faith.

Care of the chronically ill is inseparable from general medical care. While it presents certain special aspects, it cannot be medically isolated without running serious dangers of deterioration of quality of care and medical stagnation.

Care and prevention are inseparable. The basic approach to chronic disease must be preventive, and prevention is inherent in adequate care of long-term patients.

Rehabilitation is an innate element of adequate care, and the process properly begins with diagnosis. Rehabilitation is applicable alike to persons who may become employable and to those whose only realistic hope may be a higher level of self-care. Not only must formal rehabilitation services be supplied as needed, but programs, institutions, and personnel must be aggressively rehabilitation-minded.

With full appreciation of the necessity for adequate institutional facilities, and with the realization that some areas lacking in such accommodations should provide them, the commission feels that henceforth communities generally should place the greater emphasis on planning for care in and around the home.

Hospitals, outpatient departments, health departments, nursing organizations, and others furnishing the specialized services required by the long-term patient should reexamine their policies and practices to assure for him the best modern medical care.

Adequate care of the long-term patient requires arrangements which promote frequent evaluation of the patient's needs and easy flow back and forth among home, hospital, and related institutions.

Coordination and integration of services and facilities are a must in promoting good care for the chronically ill.

No pattern for organizing services is satisfactory for all communities. Programs must of necessity be tailored to fit local situations, taking full account of what is good in existing resources for care at home or in an institution. Planning should be based on facts—both local and regional—as to needs, density of population, financial capacity, and types of illnesses and accidents likely to prevail.

Planning and programs must be directed to the needs of all long-term patients, and not limited to the needs of any special economic, racial, cultural, or other segment of the population.

Personnel shortages in the professions concerned with the chronically ill constitute a major block to improvement of care. The number of personnel must be increased by recruitment, assistance with the costs of education, attractive salaries, and other inducements. This is particularly applicable to personnel associated with physicians in patient care.

The cost of programs to provide care to long-term patients should be measured first as to human values of effectiveness, then as to productivity. The most economical care is that which returns a person as quickly and as fully as possible to the highest attainable state of health and social effectiveness.

The primary function of philanthropy in financing long-term care should continue to be that of strategic investment of venture capital. Philanthropy should play an important role in financing the coordination of community facilities and should lead the way in the provision of more adequate care through research, demonstration, and experimentation.

Public financing of medical care for long-term indigent and medically indigent patients is inadequate in most communities, whether for long-term or short-term general hospital care, mental and tuberculosis hospital care, nursing-home care, rehabilitation services, or care at home.

Increased amounts of public and private funds must be devoted to measures to coordinate the services needed by long-term patients.

Private and public expenditures for research should be expanded.

A vigorous program of public education should be launched to stimulate the achievement of the recommendations for financing outlined herewith.

Investigations of diseases and their origins and studies of the needs and responses for maintaining and improving health should command high priority in the spending of research funds. To increase and extend the application of knowledge gained from research, laboratory and clinical investigations must be correlated with intensive and extensive research designed to measure the dimensions of the chronic disease problem and to reveal the most appropriate and effective methods and procedures for meeting those problems.

Checklist for Any Locality

The effective application of these principles, policies, and philosophy to local communities is basic to meeting the challenge of chronic illness in the United States. An area of 100,000 population, for example, may expect to have 3,500 persons needing long-term care. More than three-fourths of these persons are in their own homes, yet they may need some form of help from a community service at some time.

If a community does not have a committee now studying problems of chronic illnesses as a whole, such a committee should be organized. It could be set up on a town or county basis. It should be composed of both professional health leaders and representatives of other professions as well as business, industry, and labor. It should be developed in cooperation with medical and dental societies, the council of social agencies, the health council, and the health department. Three first steps for such a committee would be to:

- Study the total problem of chronic illness in the area and, with the help of a small staff, bring together facts on the extent and character

of various types of existing resources for care.

• List the kinds of needs represented in a cross section of the people in the town or county who have been ill or handicapped for a period of time—medical, educational, vocational, social needs, and the like—and the kinds of services, facilities, and personnel required to meet such needs somewhere near adequately.

• Determine how a unified program to meet the needs should be financed and administered.

The services and facilities that a typical town or county should expect to develop in about 10 years might be something like the following checklist. It can be adapted to any size community.

A diagnostic, evaluation, and classification center. The center should be located in a hospital if at all possible and should sustain close relations with all hospitals in the area. With the cooperation of the private physicians and hospitals who refer cases to it, the center should provide full diagnostic and evaluation service for the chronically ill and the handicapped.

Counseling and employment service. The service should probably be a part of the diagnostic and evaluation center, though it would be closely related to the board of education and the council of social agencies as well. It would furnish educational, vocational, and employment guidance.

Treatment facilities and services. Every county should have at least the following facilities and services for the benefit of all chronic patients residing in the area.

1. Medical and dental societies interested in the problem of the chronically ill.

2. Adequate public departments of health and hospitals.

3. A program of home care (many chronic patients now in hospitals and nursing homes can be cared for at home with the aid of housekeeper service, public health nurses, and hospital personnel).

4. Licensed nursing homes under public or private auspices or under both and closely related to the hospitals.

5. A private or county hospital or a wing exclusively for chronic patients requiring hospital care for a protracted period.

6. Home industries and educational programs for persons who can carry on a limited amount of work or study at home.

7. Sheltered workshops and special educational classes for adults, children, and young people who cannot meet the demands of regular employment or school.

Along with these services and facilities, there should be sufficient flexibility and fluidity so that a patient may move from one service to another as his condition changes. Thus, a patient might be referred to the diagnosis and evaluation center, be sent to the hospital for the chronically ill, move on to a nursing home if his condition so indicates, go later to his own home, thence to a sheltered workshop, and finally to regular employment if rehabilitation is relatively complete.

It is this dynamic element or movement quite as much as the accession of needed services and facilities that will mark the community and hospital efforts of the next decade as differing from those we have known.

The costs of such a program will not be entirely met by salvaged lives and earning capacities, and by the elimination of duplicating and unnecessary services. Yet, in due course, citizens will find that under a modern dynamic program the number of persons rehabilitated and returned to full or partial employment will go a long way, over a period of time, toward meeting the extra cost.

The words of Thomas Mann suggest the philosophy that should guide us: "Let us think like men of action, let us act like thoughtful men."

Public Programs

The challenge and the problem of chronic disease and disability concern the entire Department of Health, Education, and Welfare—involving to some extent the Social Security Administration, the Office of Education, the

Office of Vocational Rehabilitation, the Food and Drug Administration, Saint Elizabeths Hospital, as well as the Public Health Service.

Because of a lack of basic data it is impossible to define the magnitude of the problem accurately. Excellent specific studies have been made in a few areas since the last nationwide data were compiled in 1936. But these are all too few, and there is no compilation for the country as a whole. If the proposed continuing, national sampling survey of disease and illness is approved, the Public Health Service will derive statistical estimates of the extent of the major diseases, injuries, and impairments. Estimates will be made of the nature and duration of the resulting disability and of the amount and type of medical and related services received.

Scientific research is fundamental in meeting the problem of chronic disease and disability. Thanks largely to science, the modern physician in a few minutes can accomplish more for a pneumonia patient with a penicillin injection than his professional predecessor could by staying up all night awaiting a crisis.

It is significant that—in spite of the new chemotherapeutic agents and antibiotics, improved diagnosis and surgical techniques, extensive use of blood plasma and parenteral fluids, and the steadily increasing emphasis and effectiveness of preventive medicine—our statistical trend of increasing longevity is not fully maintained after we pass the middle age brackets.

Although there has been some improvement in mortality toward the end of middle life, it has been relatively small, and in old age it has been imperceptible. In the United States the decline in mortality for men over 40 has not kept pace with the corresponding decline for men in Canada, Australia, New Zealand, and in most of the countries of northwest Europe.

By Lowell T. Coggeshall, M.D., Special Assistant for Health and Medical Affairs, Department of Health, Education, and Welfare.

Several explanations have been advanced as to why life expectancy among the older age groups has not increased more rapidly. None has been adequately tested. I will dismiss this subject for the moment with this question: Does the youngster who survives a deadly infection, thanks to an antibiotic, have a lessened tolerance to cancer, heart attack, or some other degenerative disease in later life?

We know that people over 65 have almost twice as many disabling illnesses as those between 16 and 64. Moreover, they respond less rapidly to treatment or care, usually requiring twice as much time for satisfactory response.

Knowledge and Practice

Uppermost in the thinking of the Department has been the fact that the burden of chronic disease and disability falls so heavily on older people. However, we deem it unwise to attempt to limit research to what might be commonly regarded as problems of the upper age groups.

The most important discovery for the health of older patients could well come from a study in pediatrics. More fundamentally, a finding in biochemistry, physiology, or genetics may need only minor variations—or none at all—to be applied to conditions prevalent among patients of a given age.

Through basic and clinical research, progress toward effective treatment of some chronic illnesses has been rapid in recent years. Many patients formerly considered incurable can now be cured or their lives prolonged. Although medical research is making encouraging progress, any attitude other than an aggressive one toward further progress would be inconsistent with our beliefs. We must not make the mistaken assumption, though, that providing unlimited funds will solve any research problem. To the contrary, we must acknowledge that research progress will be limited always by at least three factors: facilities, trained manpower, and, above all, ideas.

Fortunately, private philanthropy and public funds have provided strong financial support for research into many major medical disorders. Unfortunately, however, much of the

physical plant now used for medical research was designed or built at the beginning of the century. It is not satisfactory for modern health research.

Even if unlimited sums were suddenly made available for medical research, and satisfactory physical facilities existed in which to conduct expanded research, I doubt that progress could be accelerated in the face of a shortage of adequately trained, properly paid, young people. Too many talented young men and women in the health professions leave teaching assignments, research laboratories, health departments, and hospitals because of financial pressures. Of course, we all recognize that dedication is a prime requisite for a health practitioner. But financial sacrifice need not be an essential requirement for a career in health.

Now, if we have adequate facilities, ample research funds, and sufficient talent, we can make enormous progress by developing a steadily increasing program of basic and clinical research. In my own association with the cancer program over the past few years, primarily as an administrator, my attitude changed gradually from real scepticism to conservative optimism. This change came about largely because scores of the best scientific minds are now attacking the problem with fervor and support. Yet, a few decades ago many talented workers felt that the approaches to basic research in cancer were so unpromising as to hold little hope of solution.

Although full knowledge of the cause of many chronic disease entities appears to be far in the future, substantial progress toward their control is now possible. There must be greater emphasis on efforts to translate present knowledge into improved medical and public health practice. Much more is known about chronic disease and disability than is being applied. We must demonstrate especially that they need not be accepted as inevitable among the older age groups.

Primary preventive techniques, as that term is generally understood in public health, are now feasible for some types of congenital heart disease, for secondary hypertension, syphilitic heart disease, and rheumatic heart disease. Preventive measures may now also be taken against those forms of cancer in which environmental hazards are believed to be contributory or precipitating as well as against certain precursors of cancer.

Among the neurological disorders, it is already possible to institute primary preventive procedures to control cerebral palsy. Much blindness is preventable. Controlled use of oxygen will prevent retrolental fibroplasia among most premature infants who require this aid. Ophthalmia neonatorum and uveitis are preventable through control of the causative agents. Congenital cataract can be prevented among some patients. Avoiding the use of certain mydriatics during examination of the eyes of older people will prevent glaucoma.

The Steps Forward

It is not unreasonable to ask why, since we know the preventive measures needed, we do not proceed at once to take the actions indicated. It may fairly be said that preventive action against chronic disease is under way already—by millions of people in thousands of communities.

Even the casual newspaper reader or television viewer is aware that syphilis and tuberculosis, are, broadly speaking, preventable. The public is learning that maintenance of desirable body weight will contribute to the prevention of diabetes, hypertension, and heart disease. The increasing popularity of long weekends and vacations would indicate, apart from economic factors, that some notion of proper balance between exertion and rest is spreading. On the other hand, the rate of accidents—on the highway, at work, and at home—would indicate either inadequate educational or preventive efforts or, perhaps, both.

The seriousness of neurological and mental disease is now gaining recognition, in terms of statistical prevalence, economic burden, and human misery. Nearly 1 person in 10 can expect to be hospitalized for a mental illness during his lifetime. Mental patients occupy a little less than half of the Nation's hospital

beds. Two patients are admitted to a mental hospital for every patient discharged. Nearly a third of those admitted to the best mental hospitals never return to the community. As much as one-third of the operating budget in some States is devoted to care of the mentally ill.

The National Mental Health Act of 1946 gave Federal support to the development of research, training, and community services. The Joint Commission on Mental Illness and Mental Health, under authority of the Mental Health Study Act of 1955, is making an objective analysis of the prospects in improved methods of care, treatment, and rehabilitation of mentally ill patients.

The expansion of the State-Federal program of vocational rehabilitation through the 1954 amendments to the Vocational Rehabilitation Act is a heartening development in the health field. Vocational rehabilitation is no panacea, nor is it relevant to the needs of many chronically ill patients. But the effect of the previously inadequate level of financial support for the program was to deny its benefits to about three-fourths of the people who could make good use of the service. The downward trend in the proportion of handicapped men and women returned to self-reliance and self-support has now been reversed.

Enactment of the Medical Facilities Survey and Construction Act of 1954 is providing financial assistance to the States for additional chronic disease facilities, outpatient diagnostic and treatment centers, nursing homes, and rehabilitation facilities.

Despite the efforts being made, progress in chronic disease control seems disappointingly slow when compared with the relatively rapid control achieved with certain acute communicable illnesses. Perhaps the halting pace of chronic disease and rehabilitation programs stems from the intrinsic nature of the problems. They are inherently different from the public health problems of the past, which were susceptible by their very nature to efforts by a few in behalf of the entire community.

Previously, the individual assumed little responsibility for public health services—for water purification, pasteurization of milk, enforcement of pure food and drug standards, immunization procedures, and the like. This is not to assert that continued progress can no longer be made through environmental control. Rather, in contrast to the era of environmental controls, we are moving into an era of public health in which individuals themselves must assume more responsibility for protecting their own health.

Community casefinding techniques can locate undiscovered diabetes, and practicing physicians and dietitians can prescribe for and instruct the patient. It is the diabetic patient himself, however, who must use the insulin and watch his diet and exercise. The cardiac patient alone is ultimately responsible for following his physician's instructions concerning digitalis, diuretics, and low-salt diets. The health of these patients is, to a considerable extent, in their own hands. The chronic diseases and disabilities are thus more a problem of the individual than of the community. They cannot be controlled without the understanding, motivation, and cooperation of the individual citizen. This will require new approaches in health education.

Few members of the general public are consciously aware of this fundamental shift in the nature of the hazards to their health. Many, however, do understand the economic consequences of this relatively recent change in health and medical care.

Chronic disease can be catastrophic to family finances. The costs of hospitalization, physicians' services, nursing care, and drugs can be overwhelming. A great need, therefore, is for better insurance protection against the financial risks of long-term illness and other expensive diseases.

To be sure, more than 100 million Americans now have some form of voluntary health insurance protection, but there are important gaps in coverage. Too few retired persons are protected. Only 4½ million people have major medical expense insurance although this form of protection is growing rapidly. Clearly, a great deal remains to be done to strengthen

voluntary health insurance, especially as it relates to long-term illness.

It is relatively easy to foster understanding of the need for individual protection against the costs of medical and hospital care. It is not simple, however, to elicit lasting motivation for the maintenance of good health. It is especially difficult to achieve the effective cooperation that is so clearly called for by the challenge of chronic illness. The physician, the professional nurse, the public health engineer, the medical social worker, the veterinarian, the chemist, the bacteriologist, and the statistician are all needed in this task. More important, the businessman, the legislator, the housewife, the teacher, and the newspaperman—the whole community—must lend a hand to the health worker.

The control of chronic illness and disability thus presents a dual challenge. The arduous quest for cause and cure offers a greater intellectual challenge than any hitherto known to the sciences of public health. And interdicting the causes and introducing the cures into everyday lives brings public health its ultimate challenge and responsibility—that of imbuing every individual with the knowledge and wisdom he needs to make his allotted years healthful, satisfying, and productive.

Preventive Action

PHR brief

In the joint statement, Planning for the Chronically Ill, issued in 1947 by the American Hospital Association, American Medical Association, American Public Health Association, and the American Public Welfare Association, this statement appears:

"The basic approach to chronic disease must be preventive. Otherwise the problems created by chronic diseases will grow larger with time, and the hope of any substantial decline in their incidence and severity will be postponed for many years."

The idea that a vast amount of chronic illness can now be prevented is still new although the Commission on Chronic Illness has done much to present means of prevention and to popularize the concept. Prevention means that—

- Thousands of premature babies in the future will not be blinded by too much oxygen during their struggle for survival.
- Because of insulin hundreds of thousands of diabetic persons are now in relatively good health although only a generation ago their lives would have been snuffed out or maimed.
- A simple, inexpensive test for detection and effective treatment makes it possible for thousands of women each year to be spared from having cancer of the cervix.
- Americans are more alert than ever before to the possible causes of lung cancer, which now accounts for 4 percent of all deaths among men.
- The Salk vaccine may prevent a high proportion of paralytic poliomyelitis.
- Serious rheumatic heart disease is preventable by prophylactic medication, as are many acute diseases which may produce chronic effects.

The Commission on Chronic Illness has listed more than 50 chronic diseases against which preventive action is possible.

Primary and Secondary Prevention

Prevention includes measures which avert the occurrence of disease and measures which halt or retard the progression of disease into disability or death. These two major goals of prevention are classed as primary and secondary prevention.

Primary prevention means keeping a disease from occurring. For example, we prevent silicosis of the lungs and chronic lead poisoning by industrial hygiene.

In the primary prevention of chronic illness, effective nutrition is a major immediate goal. Millions of older people in this country subsist

By Lester Breslow, M.D., chief, bureau of chronic diseases, California State Department of Public Health.

on diets which are inadequate in protein, vitamin C, and other essential nutrients. They suffer impaired health because of lack of education in dietary matters, poor dentition, or low income, which keeps them from purchasing certain important foods.

On the other hand, many people are overweight, with resultant excessive mortality from cardiovascular disease, diabetes, and other chronic diseases, thanks to a generous diet, ease, and lack of physical exertion.

Popularization of optimum diet and optimum weight would carry us a long way toward primary prevention of chronic illness.

Secondary prevention means halting the progression of a disease in its early stages. For example, we find early glaucoma, a condition of hardening of the eyeball, by a simple test, and prevent blindness through treatment.

Major advances in the secondary prevention of chronic illness have been the development of simple, inexpensive tests for early detection of many diseases and the assembling of a battery of tests for screening large groups of apparently well people.

The chest X-ray for tuberculosis and lung cancer, hemoglobin and blood sugar tests, cytology tests for cancer, especially cancer of the cervix, tonometry for glaucoma, height and weight determination, and vision examinations are practical tests for the early detection of chronic disease. Combining the tests into a multiphasic screening battery to test large groups of people appears to be the most feasible means for health departments to accomplish large-scale prevention of chronic disease.

Multiple screening is steadily gaining popular support because it uncovers many cases of previously unrecognized and important diseases. The technique provides an excellent opportunity for health education. It develops and strengthens the patient-physician relationship by referring individuals to their physicians for necessary care. It is inexpensive, as low as 12 tests for $5.

Epidemiological Study

Research is another important aspect of the prevention of chronic illness. Needed perhaps most of all is epidemiological study of chronic disease. For example, why does coronary heart disease cause about 25 percent of all deaths in the United States today—more than in any other country of the world—even when we take into account the age distribution of the population? Patient, epidemiological study will help unravel the answer.

We also need research to improve and expand the array of tests for multiple screening.

State and local health departments, working with the medical profession, voluntary health agencies, and many other community groups, are now gaining the experience necessary to carry through the next great achievements in preventive medicine—the prevention of chronic illness.

National Health Trends

PHR brief

In little more than a decade, medical research has made a major contribution in adding 5 full years to life expectancy at birth. But this gift of added years is a gift of years heavily weighted by chronic illness. With the conquest of the diseases of early life, more people are surviving to the ages when cancer, heart diseases, or other chronic illnesses are most prevalent. That the chronic diseases still unconquered tend to be those associated with aging takes on even greater significance for the future whenever higher proportions of our population will be aged.

Economic security and the maintenance of income have a close relationship to the problems created by chronic illness. Many of the chronically ill cannot work at all. For others, income is reduced, or the period of productive employment is lowered. No threat to eco-

By Charles I. Schottland, Commissioner of Social Security, Department of Health, Education, and Welfare.

nomic security can be greater than that of long-term illness. Nothing eats away retirement income and lifetime savings more effectively than does a long, expensive sickness.

Social Security Program

Let us take a look at the present public income maintenance programs and assess future trends in relation to the problem of chronic illness.

Most people who reach old age today are assured of at least a minimum income through the program of old-age and survivors insurance. During 1956 more than $5½ billion will be paid out in benefits. Beneficiaries now number 8 million persons, including 6½ million aged.

We can confidently predict that more and more of the aged reaching retirement, or forced out of employment because of age or illness, will be assured of some income through old-age and survivors insurance. Others will have basic financial security through our public assistance programs. Planning in the field of chronic illness can, therefore, safely be predicated on the aged and chronically ill having at least minimum income. But assurance of a basic income is only one line of attack. What are we doing about their other problems?

The public assistance rolls include many persons with serious health problems. Of the 2½ million recipients of old-age assistance in the United States, some half million are bedridden or have some impairment which requires substantial care.

Almost 250,000 persons receive public assistance for the permanently and totally disabled. More than 100,000 receive aid to the blind. In addition, some 450,000 persons receive aid to dependent children because of the physical or mental incapacity of a parent.

Thus, nearly 1⅓ million people receive State-Federal assistance because of need attributable primarily to disability, chronic illness, or the severe infirmities of old age. Furthermore, a high proportion of the 2 million recipients of old-age assistance who are able to care for their own daily needs have health and other problems relating to aging.

Although persons are eligible for old-age assistance at 65, the average age of the 2½ million recipients is 75. The typical recipient has been described as a widow aged 75, living alone in her own quarters, able to care for herself. If long-term illness strikes, as is likely at her age, expensive institutional care or special home care arrangements are almost inevitable.

OASI Beneficiaries

The beneficiaries of old-age and survivors insurance (OASI) are representative of the health problems of the aged in their retired years. It seems worth while, therefore, to review some of the findings of our national survey of aged beneficiaries in 1951.

They spent an average of 2¼ days during 1951 in general hospitals. They were incapacitated in other institutions for a little more than 1 day. They spent another 12⅓ days confined to bed at home. The total is approximately 16 days of more or less complete incapacity. It excludes the days when, despite heart conditions, arthritis, or other degenerative ailments, the beneficiaries were up and around.

One in twenty-five reported bed confinement at home or in a hospital or institution for 14 weeks or longer during the year. Incapacity of this duration has a serious impact on the general well-being of the family unit even when no hospitalization expense is involved.

One in every 250 was incapacitated in an institution other than a general hospital for an average of almost three-fourths of the year. More than half spent a full year in such institutions. Most of this care was financed at public expense.

About two-thirds of the total number of days of institutional incapacity was in mental hospitals, tuberculosis sanatoriums, veterans hospitals, or county or city infirmaries—in institutions that depend on public financing even though some patients may be charged on an ability-to-pay basis. Even for the OASI beneficiaries in proprietary nursing homes, an element of public financing was often present in that a public assistance agency was underwriting the bill.

Although less than 1 in 4 had hospitalization insurance, the proportion was significantly higher for those recently retiring than for those

who had come on the OASI rolls in the early years of the program. This indicates growth of voluntary health insurance will help to overcome the problem of financing care of the chronically ill.

The beneficiaries covered by hospital insurance averaged more days in general hospitals than did those without protection against illness costs: 2.8 days in contrast to 2.1. This difference is significant in the light of the lower average number of days of incapacity of all kinds for beneficiaries with insurance: 12.7 days in contrast to 16.6 days. It indicates the effect of prepayment in removing the cost barrier to hospital care.

Outlook for Health

From other sources, we know that an increasing proportion of the population will be able to continue their insurance against hospital and medical costs after retirement. This is hopeful, but there is still a long way to go. While about two-thirds of the population under 65 now have some form of prepaid hospitalization insurance, fewer than 1 in 3 of the aged have this protection.

We see growing concern for the medical care problems of public assistance recipients. The characteristics of recipients are such that we can assume they will in greater degree continue to need long-term care outside their own home. The 1950 census indicates that between 1940 and 1950 the number of persons aged 65 and over who were living in institutions other than general hospitals rose twice as fast as did the total aged population.

The largest relative increase in institutional care took place in homes for the aged and in nursing homes. This factor will add to the cost of medical care as a component of public welfare costs. Efforts of licensing and standard-setting authority, to which the 1950 Social Security Act amendments gave a long-needed impetus, and efforts of nursing-home operators to raise standards can be successful only if better financial support and more adequate personnel are forthcoming.

Our medical research efforts have been tremendously strengthened, and further expansions are proposed. We must also increase our speed and efficiency in applying these findings to the treatment of patients and to our public health preventive programs.

The 1954 amendments to the State-Federal hospital construction program opened up new opportunities for the construction of chronic disease hospitals, nursing homes, diagnostic and treatment centers, and rehabilitation facilities.

I do not need to emphasize the importance of making hospital beds available to the chronically ill in special hospital wings, in nursing homes, and in facilities geared to long-term care and costing the patient much less than care in short-term hospitals. But I do want to point out that it would be unfortunate if methods whereby people pay for long-term care were to lag seriously behind the expansion of suitable facilities.

One hundred one million people in this country now have some form of insurance against hospital costs. Only a fraction, however, have insurance that covers nursing-home care or that is flexible enough to extend the days insured when costs per day are reduced.

A long stride forward was the recognition that there are other and better ways of caring for the chronically ill than in a hospital bed. We are seeing impressive demonstrations of what can be achieved through home care programs designed to provide the most suitable care for the invalid, in many instances at lower cost. Our progress is dramatically demonstrated when older people who have spent long years in mental hospitals are returned to normal existence and happy adjustments in their own communities. Care at home costs much less than care in a specialized hospital, and a bed is released for a younger patient who can be returned to productivity.

It would be folly to think that we can solve mental health problems by a wholesale exodus from mental institutions. But there is evidence that, through improved methods of care and treatment, the average length of hospitalization for mental patients can be materially reduced and a great deal of mental illness can be pre-

vented. The Mental Health Study Act of 1955 has made an important start in this direction.

Using another line of attack on chronic illness, the State-Federal programs of vocational rehabilitation are demonstrating that many individuals handicapped by chronic illness can be restored to productive work.

To take heart disease as an example, the Office of Vocational Rehabilitation has granted funds for research into the rehabilitation problems of persons with heart disease; has provided grants-in-aid and technical advice to State rehabilitation agencies which, in turn, offer counseling, physical restoration, and job placement services; and has encouraged the establishment of local work evaluation units for heart patients.

For the 2,500 heart disease sufferers restored to productive lives through the program in 1955, earnings after rehabilitation were 15 times as great as earnings at the time of applying for rehabilitation services.

Children, too, have a direct stake in the fight against chronic illness. With the assistance of Federal funds, the States have made great strides in extending and improving services for promoting the health of mothers and children. Through prenatal clinics and well-child clinics, and through the provision of health examinations, nursing services, and immunizations, the younger population is equipped with its greatest weapon against chronic illness—a healthy start in life.

The crippled children's program locates children in need of care and provides the means of restoration through diagnosis, medical and surgical treatment, and the alleviation of unfavorable social and psychological influences that increase the degree and duration of disability. Through grants provided for special projects of regional or national significance, the benefits of medical research and new techniques have been made available to children with congenital heart disease who live in rural areas where highly specialized care is lacking.

This view of the future would have had better perspective if we were able to focus against a background of reliable data on the extent of illness and disability.

Illness Absenteeism

PHR brief

Five years ago the Research Council for Economic Security undertook a nationwide survey on prolonged illness-absenteeism among employed persons. The survey includes 6,200 cases of nonoccupational disability only. Analysis of the data and the summary report will be ready for publication later this year. In the meantime, by reviewing the results of a subsample, which represents the illness-absence experience of some 80,000 man-years during which approximately 3,000 absences of more than 4 consecutive weeks each were reported, I can indicate what some of the findings are likely to be.

Meeting the Costs

The average gross medical care cost incurred by the absentees was some $360, but in about one-fourth of the absences medical care cost more than $500. The largest share was spent for hospital services. A little more than one-third was spent for physicians' fees. Almost 60 percent of the fees were for surgical services.

The extensive development of employee benefit plans in recent years is reflected in the subsample. The employing establishments all had some kind of medical care plan. As a result, 88 percent of the absentees received some benefits to help pay these costs. The others, who either were not members of the group plan or were not hospitalized, used medical services not covered by the plans.

Major emphasis in all of the plans is on hospitalization and indemnity payments for surgical procedures. Very few provide benefits for nonsurgical medical services in the hospital. Even fewer provide benefits for medical care costs incurred outside the hospital.

The benefits received covered almost 77 per-

By Gerhard Hirschfeld, director, Research Council for Economic Security.

cent of the hospital charges and about 57 percent of the surgeons' fees but met only 10.5 percent of all the remaining medical care costs. The total benefits received paid for about 54 percent of the gross medical care costs. Some 31 percent of the absentees had other insurance coverage from which they drew some benefits.

The average net medical care cost—after deducting all benefits from insurance sources—was $157. The average net cost for absentees in the higher income groups was somewhat greater, but it was not materially less for those in the lower income groups. This meant that a higher share of their earnings went for the medical costs.

For absentees whose annual earnings totaled less than $3,500, and the largest number were in this group, the average net medical care cost incurred during their absence was $138. The average net medical care cost for the single absence of the average wage earner was 5.5 percent of his annual earnings. For the absentees earning between $3,500 and $5,000, it was 3.7 percent. For those earning more than $5,000, it was 3.3 percent.

To the medical care costs must be added the loss of the wages that might have been earned. Ten weeks was the average duration of absence, and $800 would represent the average gross wage loss.

Again, the extensive development of employee benefit plans is reflected in the fact that 86 percent of the establishments had either sickness compensation or sick leave plans. Many had both. Of course, no insurance plan seeks to provide benefits equaling the full wage loss. These plans, too, like the hospital and surgical programs, are focused on the short-term disabilities. As a result, though they succeed in reducing the wage loss that absentees might have incurred, they succeed only to the extent of paying 43.5 percent of the wages the employees might have earned. The average net wage loss was about $450.

Adding this wage loss to the average net medical care cost, we find that the average prolonged illness-absence among a typical group of employed workers represents a total cost plus wage loss for the single absence of approximately 15 percent of the average annual earnings.

Financial Sacrifice

A primary objective of the survey was to get some idea about the economic impact of prolonged illness. On his return to work, each employee in the sample was asked what financial sacrifice he made to pay the cost of his illness. Here is the picture.

- 43 percent drew on savings set aside for a special purpose, such as a house, car, or household appliance.
- 16 percent borrowed money.
- 15 percent arranged to pay for the medical care on a payment plan.
- Someone in the immediate family of 4 percent of the absentees went to work to help pay the expenses of the illness.
- 2 percent sold property or other belongings.
- 2½ percent applied for assistance outside the family, from a private welfare agency, public agency, company loan fund, or the church, for example.

A number resorted to more than one of these methods of meeting the costs.

Key Role for Industry

We have only begun to provide coverage for long confinements in the hospital, for unusual ancillary charges, and for the services of physicians other than hospital surgeons. There is almost no coverage for institutional care other than in an acute or general hospital. The development of such coverage must, of course, await further progress in construction of adequate facilities. There are great gaps in the coverage of services and other medical costs outside institutions—to cover physicians' care in the office, in clinics, and at home; to pay for other professional services and facilities while the patient is home or for continuous care after his return to work. The latter type of coverage is of particular significance in chronic disabilities.

About half of the absentees were under 45

years of age. Certainly in this age group, a well-organized program of regular examination, early diagnosis, education, and other means, could be effective in preventing short-term illness from developing into prolonged illness.

Industry is in the best position to introduce practical measures for such a program. Prolonged illness-absenteeism may cost a company with 100 employees as much as $10,000 a year.

Chronic Disease Services

As a member of the Subcommittee on Chronic Disease and Rehabilitation of the Committee on Administrative Practice, American Public Health Association, I shared the responsibility of developing a manual on the health department's role in chronic disease and rehabilitation services.

In order to prepare the manual, which is nearly complete, the subcommittee found it necessary to learn about the type and extent of services being performed in health departments. Generally, we have found that State and local departments are not acting as effectively in the field of chronic illness as current professional knowledge permits even though they offer a variety of services for the chronically ill.

State Health Departments

For reference the subcommittee used the Public Health Service publication, Distribution of Health Services in the Structure of State Government, edited by the late Dr. J. W. Mountin. In attempting to bring Dr. Mountin's work up to date the subcommittee concluded that at the State level the widely disparate picture presented in 1950 continues in a similar manner today although more programs have been developed and more States appear to be giving attention to chronic disease services.

Today there is also a wider understanding of the fact that for a long time most State health departments have been providing services related to chronic disease. However, these services are being performed within the context of the more traditional activities.

For example, under the banner of maternal and child welfare, there are three major programs: (*a*) the reduction of maternal mortality, particularly in its program to control toxemia and hemorrhages of pregnancy; (*b*) the reduction of infant mortality with recent emphasis on the prevention of premature birth and the prevention of death from prematurity; and (*c*) the provisions for services to crippled children.

In other traditional areas we find rheumatic fever programs; some aspects of programs for the control of tuberculosis, syphilis, and encephalitis, and for the elimination of pellagra; increasing statistical studies in applying the epidemiological approach to the study of chronic illness; increasing attention to screening and early detection; new emphasis on health education services; and provision of certain laboratory services. In most States we find various degrees of participation in rehabilitation programs.

In summary, the subcommittee study shows a long list of types of services only a few of which, however, are carried out by, or through, more than a small number of State health departments. The broad programs of California, New Jersey, and New York are the exception. There is more service and more consistency of program in States where the State health department received the stimulation of Federal funds, both regular grants and special grants.

Local Health Departments

Information on local health department services is derived from a subcommittee survey conducted in June–October 1955 under a contractual agreement between the American

By G. D. Carlyle Thompson, M.D., executive officer and secretary, Montana State Board of Health.

Public Health Association and the Public Health Service.

We questioned 271 local health departments, generally the larger ones and the ones more likely to be undertaking chronic disease services. Of the 187 replies, 60 percent considered chronic disease activities to be a major responsibility, even though less than 10 percent of the group had established a division or unit devoted specifically to chronic disease.

As one might expect, the departments which consider chronic disease a major responsibility have developed a wider variety of services, and they participate in more of the services provided by other agencies.

Few of the departments had a working knowledge of most of the other chronic disease services available in the community.

More than 60 percent had participated in some kind of community survey relating to chronic disease. About 50 percent have seen the findings put to work by the community.

Only about half of the departments maintain any kind of current morbidity data on chronic disease and disability.

In a large proportion of the reporting departments, public health nurses make use of health workers serving in a wide variety of special fields. These other workers are employed, for the most part, by agencies other than the local health department.

For example, almost 90 percent of the local health departments in the survey make use of social workers, but less than 20 percent employ such personnel directly. Almost 75 percent of the respondents use the services of nutritionists, but less than 25 percent employ a nutritionist on their own staff.

It may come as a surprise that almost 40 percent of the local health departments play a part in providing local chronic disease institutions with nutrition consultation. Obviously, some of these departments use the nutrition consultant of the State health department, either directly or through their public health nurses.

Most local departments provide for physicians or health department patients, directly or indirectly, such laboratory services as cytological studies for cancer cells or blood sugar determinations.

However, between 60 percent and 70 percent do urine analyses for both sugar and albumin and read chest X-ray films for tuberculosis, cancer, and heart disease.

A large proportion of local departments evidence an interest in providing consultative services to local welfare agencies. Other studies by the American Public Health Association, by its Subcommittee on Medical Care, raise some questions about the extent to which such services are actually used, however.

Most of the personal health services directly administered by the local health departments in the chronic disease field are in traditional areas of public health practice, but almost half of the departments offer some kind of screening program for more than one disease entity. And a large majority claim to offer an active referral service for patients needing care not directly provided by the health department.

A small number of the departments have experimented with nutrition classes, group sessions for obese persons, and followup of diabetic patients to make sure that medical supervision is maintained. Many departments offer a regular followup service of this nature for patients with rheumatic fever or for patients recovering from acute poliomyelitis.

Suggestions and Predictions

PHR brief

Chronic illness is a daily disaster. More people are living long enough to suffer from prolonged illness and disability.

The problem is acute and requires community action, but many folks consider it a technical matter, to be solved by experts in medicine, public health, and hospital administration.

By C. Rufus Rorem, Ph.D., C.P.A., executive director, Hospital Council of Philadelphia.

The situation probably will become worse before it gets better. The public requires a shock to awaken a sense of responsibility for action. The following suggestions and predictions are offered.

1. Chronic illness must be considered broadly. It includes disabilities resulting from advancing age, crippling injuries that can be helped by rehabilitation, and general long-term illness. The individual must learn to live with "what he has left."

2. General hospitals should be powerhouses, not storehouses, in the treatment of prolonged illness. A general hospital is not intended for perpetual care. In prolonged illnesses, the hospital serves best for intermittent periods of intensive service.

3. Home care is a desirable alternative, not a "poor relation" of hospital inpatient service. The problem of cost is important, but more important is the idea that a patient may be a hospital patient while receiving supervised care in his home.

4. Outpatient service for long-term illness will increase at hospitals. This is not incidental; it is fundamental. Services provided at a hospital conserve the time of attending physicians, who should be paid for their work to assure continuity in the personal relationship.

5. Long-term illness generally leads to economic dependency. It causes interruption of employment as well as expenses for medical care. Many persons will require public support to supplement insurance benefits and private resources.

6. Much can be accomplished through better use of existing facilities and personnel. Home care by visiting nurse societies may avoid the need for additional hospital beds. Medical services at homes for the aged can serve the health needs of many residents. Rehabilitation through physical medicine, training, and sheltered employment will restore many disabled persons to a condition of self-help or self-support. Recreational and personal services will reduce some of the illnesses attendant upon lonesomeness and boredom.

Meeting the Costs

To an increasing extent, over the years, the medical reasons for people being on public assistance have been in the ascendency. About 43 percent of the 425,000 public assistance recipients in the State of New York in December 1955 were indigent because of a chronic illness or disability. This number included about 100,000 receiving old-age assistance, 40,000 receiving aid to the disabled, 4,000 receiving assistance to the blind, plus about 20 percent of the family heads of the 200,000 aid-to-dependent-children families and of the 80,000 home relief units. Considering all family units as individual cases, we estimate that 73 percent of the 225,000 cases on the public assistance load are there because of long-term illness.

In 1951 the average monthly expenditure for medical care for each public assistance recipient was $3.88 as compared with an average monthly grant for all other purposes of $39.35. In 1954 it was $7.94 compared with an average of $41.62 for all other purposes. The figures for medical care include physicians' services, hospital and infirmary care, drugs, nursing and physical therapy services, and laboratory services. Private nursing-home care is excluded.

The cost of hospital care accounts for a large part of the doubling of medical costs over the past 4 years since most welfare districts pay for hospital services on a per diem basis of actual costs, and, as everybody knows, hospital costs have been rising continuously.

Drug costs have become a serious problem except in the local welfare districts with rigidly controlled programs. Drug costs now comprise from 5 to 25 percent of the total costs of medical care whereas rarely did they exceed

By I. Jay Brightman, M.D., assistant commissioner for welfare medical services, New York State Department of Health, on detail to the New York State Department of Social Welfare.

10 percent in 1951. The increase is largely attributable to the remarkable advances in drug developments over the past decade.

Recognizing that the increased drug costs are largely due to the recent development of "wonder" drugs, drug audits in New York State still have indicated many areas where drug costs could be reduced by amounts varying from 10 to 15 percent. Such reductions lie in the area of greater reliability upon older drugs that are still tried and true, over which new proprietary medications have no established superiority. There is also the area in which more drugs are prescribed than the patient can possibly use without having toxic effects or without giving the drugs away or throwing them out. One gains the impression that the prescribing of drugs, the costs of which are rapidly approximating the costs of physicians' care, is a most inefficient operation.

Physicians' fees have not accounted for any major increase in total costs over the past 4 years although a 20-percent increase was allowed in 1954.

It is doubtful that much reduction in costs can be made in the hospital field except for greater awareness regarding the discharge of chronically ill patients to less costly places which can provide adequate care, mainly, to nursing homes and infirmaries, and to home care programs. We have noticed slight evidence of excessive physicians' calls. We do believe that physician cooperation could reduce drug costs to a small extent.

Many local welfare commissioners believe that welfare costs for the chronically ill are excessive, and they are alarmed at the continuous rise in these costs. Nevertheless, the majority recognize that the problems of welfare care are increasingly related to the problems of chronic illness and aging and that medical costs may be expected to increase both because of the greater number of such persons receiving welfare assistance and because of the continuously increasing costs of care.

Our survey of nursing and convalescent homes in upstate New York, undertaken in cooperation with the Commission on Chronic Illness, indicated that the majority of the homes provided adequate medical and nursing service. Few of the homes, however, provided medical or social rehabilitation, recreational services, or planning for any disposition other than continued stay at the home. Yet, a high percentage of the patients were out of bed except to eat or to rest, were able to walk alone or with the assistance of a cane or a crutch, were mentally clear, and were completely continent. It appeared that there should be immediate steps taken to provide more dynamic social and recreational programs for the long-term and mentally clear patients, and that there should be more intensive social and rehabilitation planning by physicians and social workers concerned with the individual patients. These additional services would naturally increase the costs for care in nursing homes.

The New York State Department of Health and the State Department of Social Welfare have developed a joint demonstration program for the rehabilitation of disabled public assistance recipients at the State rehabilitation hospital at West Haverstraw. The objective is to demonstrate what can be done for these patients and, if the results are favorable, to encourage local welfare departments to provide the full cost of such service.

A Call for Action

The summarizing committee agreed that we would like to consider the National Health Forum from the viewpoint, at least in part, of a member of the "consuming" public—one who must approve or support the types of action that have been discussed in the past 2 days.

By Morton L. Levin, M.D., assistant commissioner for medical services, New York State Department of Health, and chairman of the summarizing committee of the National Health Forum.

We were impressed by the fact that this has been truly a national forum on health. We have received greetings from the President, from 31 State governors, in person from Mayor Robert F. Wagner, and from Mrs. Franklin D. Roosevelt. We have been given the assignment of trying to set up guidelines for the Nation for needed action on chronic illness. In considering what action is needed, we have heard from 17 national, 7 State, and 19 local organizations, from State health commissioners, representatives of hospitals, a school of public health, and various types of voluntary and governmental agencies in local communities.

The Type of Action

What really was the subject of the forum? What have we been talking about? The summarizing committee agreed that these questions needed some clarification.

We have heard chronic illness described as "a daily disaster which is an acute emergency," and as "a major health problem which accounts for more than 70 percent of sickness." At the same time, we have heard chronic illness characterized as something in which hospitals, physicians, and the public generally are not greatly interested and for which it is hard to get money.

There seems to be some inconsistency in these two references to the term chronic illness. It hardly seems possible that there is a widespread lack of interest in the major causes of illness and disability. Perhaps what many people think of as chronic illness is not what we have been talking about, or only part of what we have been talking about. Apparently, to many people chronic illness means only the terminal, hopeless stages of illness, whereas it has been well established that chronic disease, in the sense in which the forum has used the term, need not necessarily bar a person from seeking the highest responsibility in our land.

Both by implication and by definite statement, the panel discussions have revealed that we have been discussing the effects of a large group of diseases which are well known by their individual names, such as cancer, heart disease, arthritis, cerebral palsy, vascular disease. Though many people are familiar with these diseases, apparently they do not know them under the general name of "chronic illness."

Most of the forum discussion was focused on certain types of action, which are needed for many chronic diseases at the same time—action that is not usually planned for a single chronic disease because it is needed for many chronic diseases at some stage of their course. One might call this type of action the common denominator aspect of chronic illness, and apparently this was the subject of the forum.

The summarizing committee was impressed with the repeated evidence that few people understand or are concerned about these common denominator types of activities. One possible conclusion to be reached from the deliberations of the forum is that the first action needed is to explain to the people—and especially to those who, by reason of money, power, and prestige, control community action—exactly what is meant by chronic illness in the terms of reference to the forum. Perhaps the forum has demonstrated that more of this type of explanation is needed before the desirable action is likely to take place.

The forum discussed parts of the common denominator aspects of chronic illness under various headings. Two panels discussed how to provide better care for the chronically ill at home or in institutions. Another panel was devoted to a specific kind of care, that called rehabilitation. Two panels were devoted to action by certain agencies—one by State health departments and one on what various types of city or county agencies were doing in this field.

Some of the Conclusions

The committee agreed that the most significant contribution made by the various panels was in describing examples of successful community action. We have heard many accounts of what may truly be called "success stories"—in developing home care programs; in linking hospital care with nursing homes, old-age homes, rehabilitation facilities, and home care;

and in bringing rehabilitation to people in nursing homes.

The examples we heard indicate that some communities have developed the know-how needed to lessen the disabling consequences of chronic illness, to give sick people the best chance to get back on their feet (that, apparently, is what is meant by "rehabilitation"), or to live their remaining years with as much activity, comfort, and decency as are reasonably possible. But, for some reason, the knowledge gained from these successes is not being used in most places. As to "why not?" the forum did not provide any specific answer.

We do not know why these common denominator types of action, which are obviously desirable, important, and useful, are failing to take place in more areas; we also do not know to what extent they are not taking place. The descriptions of the studies made by the Commission on Chronic Illness in Baltimore, Md., and Hunterdon County, N. J., the rehabilitation study going on in Kansas City, Mo., and in nursing homes in Peoria, Ill., suggest that the gap between demand and supply may be greater than has been suspected. These studies should tell us what are—to use one of the clichés in the field—the unmet needs.

Implicit in this conclusion is the need for an inventory of the extent of illness and disability in the Nation. The findings of the forum support the desirability of conducting a national survey of morbidity as a first step toward determining the most important gaps in providing care for people with all types of illness and especially for people with chronic diseases and disabilities.

A second implication is that a part of the money now being spent by various groups for specific diseases could well be earmarked for support of the common denominator services which are of importance to many chronic diseases. The forum also brought out the suggestion that some of these funds should be expended on an appraisal of how effectively the rest of the money is being utilized for the various special programs.

Largely missing from the various discussions was a description of "the source of motion" for the action described. We were told about what happened but not why. We did not learn how it happened that a particular person or agency took the initiative for action. Exploration of these hidden springs of community action should prove helpful to those interested in promoting action in their own communities.

The discussions, however, did reveal some suggestions concerning the type of person or agency who might take the initiative. A president of a county or city medical society, a health officer, a council of social agencies, a visiting nurse association, a welfare department, and a general hospital were cited as specific examples.

The forum agreed that, when health leaders decide to initiate action, they should, first of all, bring people together to decide what is most needed in their community, and then develop a plan for specific action that people will understand and can start with; in other words, they should not necessarily try to do everything that needs doing at the same time.

As to priorities among programs recommended, there were outstanding examples: for instance, by almost unanimous choice, a home care program. Other activities which have high community acceptance are a referral and counseling service and rehabilitation programs for special groups of disabled persons, such as those in nursing homes.

Finally, the forum brought out the point that, if the need is shown for more effective services for the chronically ill, a good community leader usually can find the necessary money to provide at least part of these services. Apparently, the leader for developing these services should be an "actioneer"—a word coined by the forum—meaning one who combines the ability of an auctioneer in selling programs and the ability of a buccaneer in overcoming obstacles and opposition.