P U B L I C H E A R I N G

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

Prevention of Chronic Illness

Held:
April 9, 1979
Freeholders Meeting Room
Bergen County Administration Building
Hackensack, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Anthony Scardino, Jr., Chairman
Senator Anthony E. Russo
Senator William J. Hamilton

ALSO:

Eleanor Seel
Michael Bruinooge
Office of Legislative Services

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I N D E X

SENATE, No. 3045

STATE OF NEW JERSEY

INTRODUCED JANUARY 18, 1979

By Senators SCARDINO, HAGEDORN, FELDMAN, HERBERT and SKEVIN

Referred to Committee on Institutions, Health and Welfare

A SUPPLEMENT to the "Local Health Services Act," approved March 3, 1976 (P. L. 1975, c. 329, C. 26:3A2-1 et seq.).

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Any county health department may provide county-wide public health services pertaining to chronic illness and communicable diseases pursuant to the Standards of Performance. Such services may be provided solely by the county health department or by the county health department acting jointly with any other local health agency pursuant to contract.

The governing body of said county may appropriate such emergency funds as necessary to the county health department for the provision of said chronic illness and communicable diseases services by the county health department until such time as current contracts are renewed.

The county health officer of said county shall, starting with the next fiscal year following the effective date of this act and annually therafter, submit a detailed report to the governing body of the county and to the Division of Local Government Services in the Department of Community Affairs which shall include, but not be limited to, a description of the chronic illness and communicable diseases services provided solely by the county health department and such services as may be provided by said department with any other local health agency pursuant to contract, an accounting of the number of said services delivered, documentation of the costs incurred and the allocation of costs of providing such services among contracted and county-wide agencies.

2. Any municipality within said county which is presently providing chronic illness and communicable diseases services may elect to continue to do so or may elect to have the county assume responsibility for the provision of such services and shall notify the governing body of its intent within 3 months of the effective date

of this act. If said municipality elects to continue to provide such services, it shall, starting with the next fiscal year following the effective date of this act and annually thereafter, submit a detail report to the county health officer on the provision of such services, which shall include, but not be limited to, a description of the chronic illness and communicable diseases services provided, an accounting of the number of said services delivered, and documentation of the costs incurred in the provision of such services. Upon receipt of said report, the county health officer shall submit, as part of its annual budget submission pursuant to section 19 (C. 26:3A2–19) of the act which this act supplements, a request for funds to reimburse the municipality for said documented costs.

3. This act shall take effect immediately.

STATEMENT

The "Local Health Services Act" requires all municipalities to meet certain "Standards of Performance" and requires the State Department of Health to monitor compliance with the Standards. An increasing amount of public attention has been recently given to the areas of chronic illness and communicable diseases. It is felt that certain diseases, such as cancer, tuberculosis, rabies, or venereal disease may be environmentally-related or region-specific. Meeting the more stringent chronic illness and communicable diseases standards may place a strain on the resources of a small municipality, because of the sophisticated and costly screening techniques, immunization programs and reporting requirements mandated by the State. Furthermore, it is recognized that certain public health issues are essentially regional in nature, such as the control of certain communicable diseases in a given geographical area.

For these reasons, this bill would allow the county to provide such services to municipalities which anticipate difficulties in meeting such standards in the particular areas of chronic and communicable diseases services. Furthermore, municipalities now providing such services and wishing to continue to do so would be recognized and reimbursed by the county under this bill.

An evaluation of the appropriate level of government for the provision of all health services is now being undertaken by the County and Municipal Government Study Commission. Pending their recommendations, this bill would provide local units of governments with needed assistance in the delivery of mandated chronic illness and communicable diseases services.

FISCAL NOTE TO

SENATE, No. 3045

STATE OF NEW JERSEY

DATED: OCTOBER 11, 1979

Senate Bill No. 3045 permits any county health department to provide countywide public health services pertaining to chronic illness and communicable diseases.

The Department of Health states that since this legislation is permissive on the part of the county health departments, it would be extremely difficult to arrive at a realistic fiscal note for this bill. The standards of performance list several care activities within communicable disease, and chronic illness which could be provided countywide.

If one or more of the four currently organized county health departments were to provide these services countywide, it would increase the county budget substantially. A reduction in municipal health expenditures would follow unless the municipality decided to provide the services and thus go it alone.

The department further states that the bill has no monetary impact on the State.

In compliance with written request received, there is hereby submitted a fiscal estimate for the above bill, pursuant to P. L. 1962, c. 27.

SENATOR ANTHONY SCARDINO, JR. (Chairman) : I want to welcome all of you here this morning to a public hearing on the prevention of chronic illness and on behalf of the Senate Institutions, Health and Welfare Committee, I want to thank those of you who are going to be with us today, especially those of you who are going to participate in what I think we all agree is a very vital subject to our society in this day and age. On my right, I want to introduce to you my good colleague from Union County who made the trip here today to join me and that is my good friend, Senator Anthony Russo. I expect Senator Hagedorn from Bergen County to be with us shortly and I really don't know who else from the Committee is going to be with us today.

I do have several points that I do want to go over with you before we entertain comments from the witnesses who are with us today and I guess it will be more or less an overview of why the Senate Institutions, Health and Welfare Committee has decided to entertain a public hearing of this nature.

The definition of "chronic illness" is "a disease of long duration, often of gradual onset", as opposed to acute disease which is characterized by rapid onset and a generally short duration. Neither term describes the severity of an illness. The common cold and smallpox are both acute afflictions and atheletes' foot and leprosy are both chronic. The source for this information is the Penguin Medical Encyclopedia.

The Senate Institutions, Health and Welfare Committee scheduled the public hearing in order to determine whether chronic illness may be prevented in New Jersey by means of a comprehensive State plan and a concerted effort of responsible parties, whether federal, State, county or municipality, public or private, proprietary or non-profit.

The following six topics are of special concern to the Committee and we hope to address them in whole or in part by those of you who are going to testify today. They are, one, the scope of chronic illness in the State and the feasibility of preventing it. Questions that we will be asking in this particular category are as follows: What are the most severe or debilitating chronic illnesses in New Jersey? Now, in the few weeks that we have spent in putting together this meeting, it really is questionable at this point as to just what describes or defines chronic illness. We do have an understanding of the major chronic illness, as defined by our present day society. But, are there others and should we begin to define precisely what they are? Can chronic illness be prevented and if so, how? If resources are limited, which illnesses should attention be given to first?

The second category is that which deals with the preliminary State Health Plan, which most of us know is now in draft form. I have not had the opportunity yet to go through that plan myself nor do I believe have any of the members of our Committee, but we would like, today, to see if we can get a glimpse of what the Health Department has in mind, from the Committee's standpoint and for the public interest as well. How does this plan address the issue of the prevention of chronic illness?

The third category is the Prevention of Chronic Illness Act, Public Laws 1952, Chapter 102, and the questions under this category are, has this Act accomplished its purpose of encouraging a shared responsibility among the State, counties, municipalities, and volunteer agencies for the prevention, detection and care of chronic illness? Have all the provisions of the Act been fully implemented? Does the Act need to be amended? Should it be repealed or replaced? Again, we don't have the answers yet, but we're hoping that collectively we can come up with some answers to these questions.

The fourth category is federal initiatives and monetary assistance and the questions under this category are as follows. What has the Congress done to promote the prevention of chronic illness? What federal funding exists for the use of states in preventing chronic illness? Has New Jersey obtained all the federal funds available to it? How should federal funds be disbursed to public health agencies in the State?

The fifth category, is the Department of Health's standards or performance in the area of chronic illness. Are the standards appropriate and in the best interest of the citizens of New Jersey? Are municipalities capable of meeting them? Do they need to be changed?

The sixth category--and of course, we're not limited to these and if there are others that we may have missed, we would welcome your telling us about them--the sixth category and the final one on this list deals with Senate bill 3045, which I sponsored, and the questions that we're asking in terms of Senate bill 3045, is this bill, which provides for county assistance to municipalities in meeting standards for chronic and communicable disease services, useful and worthwhile legislation? Does it need to be amended? Is the bill itself necessary? Now, I, as the sponsor of the bill raise this question and I raise it not just because it is my bill, but it should be raised in the case of any piece of legislation sponsored by any legislator and the purpose of public hearings of this type is to try to determine whether or not the concept, the idea behind the bill is worthwhile and whether or not it will, in fact, impact positively in terms of what our objectives may be and I welcome, as my committee does, the comments, pro or con, regarding Senate bill 3045.

To sort of, also, give a bit of background in terms of what we're talking about, regarding chronic illness, I would like to offer to you some background data that was supplied to the Committee, which I think is pertinent and ought to be made a part of the record. Since 1900, life expectancy at birth in the United States has increased by about 25 years. This increase is attributable, mainly, to a decline in infant and child mortality. In place of deaths and desirability from communicable diseases, the nation has witnessed a major increase in heart disease, cerebral-vascular disease lung cancer, cirrhosis of the liver, accidents, homicides, suicides and has even been linked to human behavior, individual as well as collective. On the other side of the coin, expenditures for health care in the United States have been increasing at an alarming rate since 1950. They are now approaching 10% of the Gross National Product, as opposed to 4.6% of the GNP in 1950. The alarming rate of increase in health care costs is probably most evident in the cost of hospital care, which has risen more than 1000% since 1950. Between 1967 and 1976, annual health care expenditures per person rose 169% from $208 to $552. Evidence is accumulating to show that despite the great increase in expenditures for disease care, there has been, during that time, no significant change in the U.S. mortality or morbidity rates. So, the United States still ranks sixth in the world in mortality and morbidity. Some would claim that even present spending levels for disease care have reached a point of diminishing returns. On the other hand, there is a growing body of evidence that shows that well planned and implemented health promotion and disease prevention programs can have a dramatic impact in lowering mortality and morbidity rates, as witnessed in programs demonstrated elsewhere. New Jersey's three leading causes of death are diseases of the heart, malignant neo-plasms, and cerebral-vascular disease. Together, they accounted for 73.1% of all resident deaths in 1976. While the State's mortality rates for diseases of the heart and cerebral-vascular disease have declined, there have been increases in mortality rates for malignant neo-plasms and suicides.

We would like to discuss highlights, some of the points that are addressed in that particular commentary and we hope to do that during the course of this day.

Lastly, for the record, I want to refer, once again, to Senate bill 3045, which permits counties to engage in county-wide health services. As I indicated earlier, this Committee is not suggesting that this the answer or the cure-all. It may, if anything, simply be an interim step towards consolidation, towards establishing a coherent program eliminating fragments where they may exist, eliminating duplication that exists, but, I think, more importantly, plugging up the holes, if you will, that exist in the system right now and providing for a linkage that may not, in fact, be visible at this point in time. If the bill does that, if it moves in that direction in providing that kind of coordination between all groups, agencies, State or otherwise, responsible for chronic illness, in this case, we will hopefully determine this.

It has also been indicated to me and suggested by some people who will probably be here during today's testimony, but I want to bring it out beforehand, that this bill, in effect, attacks home rule and anyone who knows Senator Scardino and I'm sure that Senator Russo shares the same philosophy that basically and fundamentally I believe in leaving things at the local level for whatever the local level can most adequately and best provide for itself, but there are cases,and we're suggesting that chronic illness may be one of them, where a broader perspective ought to be taken, not just in terms of providing greater services for the local level, but also providing services beyond that level, where they may not exist, and helping one another, not only in identifying, detecting the causes of chronic illness, but fundamentally arriving at the best preventative program on a coordinated basis that we can come up with and in Senate bill 3045 there are incentives there, which I hope will be addressed today, which will allow the municipality greater latitude and interest, perhaps, in participating and I might also add that the bill itself is permissive, that municipalities, should the bill become law, that municipalities do not have to or it is not mandatory that they participate.

So, with that, I will now ask my colleague, Senator Russo, if he has any comments or questions that he may have at this point in time.

SENATOR RUSSO: No, not at this time, Mr. Chairman. You covered everything very well.

SENATOR SCARDINO: Our first witness is going to be representing Freeholder John Curran, who can not be with us this morning and he is our Bergen County Administrator, Mr. Steve Cuccio.

S T E V E C U C C I O: Thank you, Senator. I would like to welcome you here this morning. As a victim of chronic disease myself, I know how important it can be. A victim of heart disease and diabetes,I am in a position, because of my earning power, to be able to take care of myself adequately. But, there are many people in the State who cannot and I hope this Committee will see fit that it will foster some kind of care, to help prevent and educate people in the area of chronic disease. But, I am here to give a statement prepared by John Curran and let me present the statement. "The Board of Chosen Freeholders is honored that our County has been selected as the site for the hearing today held by the State Senate Institutions, Health and Welfare Committee on the topic of the prevention of chronic illness throughout the State." As a Freeholder, John Curran is responsible for County health services. He extends his special welcome to this prestigious committee and its Chairman, Anthony Scardino, Jr. At the cost of seeming immodest, on behalf of the Freeholders, I want to remind you that our

own Department of Health and Environmental Protection has long been concerned with the prevention of chronic diseases, so long neglected, in favor of treatment of those diseases. It is particularly appropriate today that we are meeting in a part of the nation that has been characterized as "Cancer Alley" because of the high incidence of various types of cancer in Bergen County, including lung cancer, gastro-intestinal, bladder and breast cancer. It is tragic that as our knowledge has increased, we are aware that death and disability rates should be and could be drastically reduced at the preventative levels, but it is lagging. Today, there is no doubt that preventative education and action can also reduce illness and death from heart and cerebral-vascular diseases. Heart risk factors, which testimony today will deal with, are commonly known, but most of us only pay lip service to the very down to earth ways in which these factors can be minimized or utterly abolished. We will be reminded, too, how something as prosaic as what we eat and drink causes or prevents chronic illness. As we consider the whole of factual knowledge and experience, which this Committee will review today, we must ask ourselves repeatedly, why not or not why we have ignored the lessons we should have learned, but rather what can we do from this day forward to extend longevity of thousands of men and women in New Jersey to preclude the wracking pain and wasting of human lives and to save the hard earned money of our people and to bring healthier and happier lifetimes to those at all economic levels and of all races and creeds. We can anticipate that testimony today will describe ways in which federal, State, county and municipal agencies, both governmental and non-governmental, can work together effectively in a crusade for preventative education and ways of living that can reach out toward the not impossible dream of abolishing chronic illness. We will learn what is needed in time, money, legislative action and the dedication of people for people. We will not seek any cure-all vaccine or magic pills to combat chronic diseases. Instead, we will search out the workable ways of reaching all the people in the State of New Jersey.

SENATOR SCARDINO: Thank you very much Steve. Any questions Senator Russo?

SENATOR RUSSO: No.

SENATOR SCARDINO: Thank you. Dr. Donald B. Louria, College of Dentistry and Medicine, New Jersey?

D O C T O R D O N A L D B. L O U R I A: Well, I'm not so sure how much my remarks will speak to the needs that you just outlined. What I thought I would do is just make a couple of points and then, offer two suggestions for your consideration.

As you've indicated, it is clear that we have plenty of chronic disease and as we all know, heart disease is number one and cancer, number two. I don't think it matters whether we are designated "Cancer Alley". In point of fact, the latest available statistics on a national level suggest that we are not number one in age adjusted cancer rates, but whether we're one or two or three, the evidence is abundantly clear that we have more cancer than we would like.

As you indicated, treatment is expensive. We're soon going to get national expenditures of over $200 billion and the estimates, as you know, for the year 1990 or so run as much as $1 trillion. So, we're spending an enormous amount of money for care of people who get sick. Obviously, prevention makes a great deal more sense.

I think the critical point is that we now have enough information to prevent somewhere between 60 and 70% of heart attacks and in the range of 50% of cancer, if, by prevention, you mean total prevention so it doesn't occur,on the one hand, or intervention so early that it is treated successfully before it has spread. So, we can do

a great deal right now to have a preventive program that works. It must be removed from the doctor's office and gotten to the public. It has to be simple, inexpensive, acceptable and broadly applicable. Now, in my department at the med-school, we have our own program that we think meets these criteria. It covers 15 points and I won't go over them today. I think it would take much too much time, but it is readily available to you if you would like it. The points I would like to make relate to how we're going to implement prevention programs and I think there are two levels at which we have to do it. One is in the schools and the other is in the communities. It surely is clear that if we want prevention to work a decade from now or two decades from now, with regard to both acute and chronic disease, we have somehow got to inculcate school children effectively and that, of course, means health education. Now, as you know, we have mandated health education in our schools, but it seems to me extraordinary that as of 1979, there is no evaluation to tell us whether or not any of these educational efforts are in any way beneficial. Now, when I first got to New Jersey a decade ago, we were asked by the Chancellor of Higher Education to initiate programs relating to drug abuse education, because at that time, New Jersey, as the rest of the nation, had a burdgeoning problem. Well, we did this and as part of it, one of the people in my department looked carefully, then and subsequently, at the effect of so called education on drug abuse patterns in the United States, and it turns out that although we were"educating", and although we, as other states, had mandated education in drug abuse, the fact of the matter was that there was no evidence that it was beneficial and indeed, some of it was counterproductive, that is, it was inciting curiousity and potentially increasing drug use. Or, just look at the problem with smoking. At the same time that we were urging our school children to abandon smoking, the evidence was in this State, according to studies carried out by Dr. Lavinar in my department, was that although there was a modest diminution in the amount of tobacco smoking among boys in my schools, the fact was that it was growing precipitously among girls and these figures have been replicated on a national level. So, obviously what we were doing was not very effective for a substantial segment of the population in the high schools. As a matter of fact, high school cigarette use did not decrease one bit because whatever reduction there was in the boys was more than counter-balanced by an increase among the girls.

So, we would propose the following, and by that, I mean my department would: that in the State of New Jersey, there be thorough evaluation of what we're doing in the field of health education. Now, Dr. Lavinar has just completed a study that he hasn't yet published in which we were permitted to send a two wave questionnaire to the schools in the State of New Jersey, and got a reasonable enough response to make the questionnaire results valid, we believe, and the questionnaire asked what was being done in regard to health education, who was teaching it, at what grades, what the curriculum was, etc., and what we found is that health education in this State is extraordinarily uneven. In some areas, there is a lot of what appears to be adequate health education. In others, it is done in fragmented and rudimentary fashion, at best, and is being taught by people such as coaches and atheletic directors and not people who have any training in health education. Now, I don't mean to imply that that doesn't mean that they don't function effectively, but they are not trained health educators and there is even more reason to evaluate it. So, what we would propose, as a follow-up to this study, that monies be allocated and we figure that it would cost a minimum of $25,000 a year to do a partial study and in the range of $75,000 a year to do an effective study, and that isn't very much money. What we would propose is that on some sort of regular,randomized basis or if we had enough money, to do every school

in the State, that students be evaluated by questionnaire, by anonymous questionnaire, at certain periods in the school, say, the 7th, 9th, 11th grades, 8th, 10th, 12th grades, to determine whether efforts at health education have resulted in changes in attitudes, behavior, knowledge in regards to such critical areas say such as alcohol use, smoking, attitudes towards nutrition, heart disease, etc. Only if this is done, can health education be made effective in the State. It is extraordinary that we are spending as much money and effort as we are in health education and we have no idea whether it is doing any good at all. By this technique, you could determine, suppose the students are being taught in grade 6 or 8 or 10, by looking at them in grades 7,9 and 11, you could make a judgement as to whether what was being taught was effective and if the answer was that it was not, it wasn't providing knowledge or changing attitudes or behavior, you could then modify the programs and then retest them to see whether or not those programs are doing the job,because, surely it makes no sense at all for you in the Legislature to mandate health education,for health education to be implemented, and then, have no knowledge about whether that education is any good or in effective or actually counterproductive. So, that is suggestion number one.

Number two relates to the utilization of health education programs in the community. Now, this county happens to be very active in that area and that, of course, is highly commendable. It, of course, makes sense to develop a state-wide program for prevention. But, as with school health education, it does not make any sense unless we make some preliminary tests to make a judgement as to whether what we are doing will be accepted by the public. One of the problems with health education, as I see it, is that we in the public health fraternity, we do all sorts of things as far as programs for health education. There is a health hazard appraisal program, which is really very good. But, that is all professional oriented and doctor oriented and does not really get to the needs of the public and the evidence so far is that our prevention efforts are not being adopted, at least in large part. Now, if we're going to have a state-wide plan, if we're going to attempt to create prevention within communities, then there has to be some test of what we're doing, and what I would suggest is that money be specifically allocated, it is not very much money, to attempt, in a small community in New Jersey with a proper comparison community, to inundate that community with a specific health education program. Of course, we would utilize ours, which we think is all that needs to be done and is all that can be done in health education and is very simple and inexpensive, and there, at the end of a one year period, to once again, by questionnaire before and after, test whether attitudes are changing, knowledge is changing, and more important among the adults, health behavior is changing as far as getting the tests that are needed to effect prevention. It seems to me that if we did those two things, that is attempt to make an evaluation of health education in the schools and make it more effective, and attempt to develop a state-wide prevention plan and test it now, since we have the information, then I think we could make prevention in this State potentially very effective. It seems to me, as I said, it wouldn't cost very much money and this is a critical period, critical in that we have an enormous amount of chronic disease and we have the capacity, right now, to modify those diseases. Thank you.

SENATOR RUSSO: Dr., I like what you say. I have just one question. When should the questionnaire be sent out, approximately a year after the--

DOCTOR LOURIA: You mean to the communties? This could be done at the same time you are developing a State plan. You would pick the two communties, do a questionnaire survey immediately to see what the current status is, take one of those communities, and we think it would be very easy using newspapers, local community leaders, seminars, etc., and inundate that community with our fifteen points, and make the tests easy for people, easy and inexpensive, tests such as a cholesterol level, or blood pressure test,

and then, at the end of one year, look and see what you've done. If you're doing well, then, apply that, as is, to the rest of the State. If you're failing in certain areas, then, modify your program, retest and also apply it. So, in other words, I don't think it incurs the valid criticism that all you would be doing is restudying. What it is, in essence, is applied prevention and I think it can be applied right now, only I would like to make sure, as we do it, we test so that we know what we're doing and we don't waste money and effort.

SENATOR RUSSO: Dr., you earlier stated that in your opinion the drug use education program in New Jersey and smoking education both have been ineffective, no benefit at all.

DOCTOR LOURIA: Well, no.

SENATOR RUSSO: Of very little benefit. I think smoking education has been of no benefit. We've had a decrease as far as the boys are concerned and an increase as far as the girls are concerned.

DOCTOR LOURIA: Right.

SENATOR RUSSO: Is there any specific reason, in your judgement, why that has happened, in both areas, drugs and tobacco?

DOCTOR LOURIA: If you don't mind my biases because nobody can give you an absolute answer as to why health education is ineffective. In the first place, a lot of it has been done by a lot of people who don't know what they're doing in education, at least in these areas, and we know that's true because when we were first asked to prepare teachers for educating about drug abuse, we held the first seminar at the New Jersey Medical School for teachers. It was held after school during the summer and we asked to be able to select the teachers. We weren't given that privilege. Instead the teachers were sent to us and we gathered, at that time--remember it is a decade ago--while the State provided the money and we gathered the best people in the United States to teach it. We were able to bring them here, we knew them and so we were able to pick people who, A, were articulate, B, were knowledgeable, and C, represented a variety of views on drug abuse, so the teachers would be exposed to controversy in proper fashion. Well, I personally monitored every session. I used to sit in the back of the room and watched the people we were sent. I would say 50% of the people we were sent were there because they were told to be there and had no real interest in drug abuse. So, we pre-tested them and we had one specific question that was--and I won't go into it because we don't need to--but it was a controversial area on which every expert agreed. It was in relation to the addiction capacity of one of the drugs that was being used popularly and the answer to the simple question was that it wasn't an addicting drug. Now, I happen to very much opposed to that drug's legalization. A lot of other people there were very much in favor of its legalization. Everybody said to the teachers, "Whatever else you say about this drug, it is not addictive." Well, we tested the teachers before and 25% of them before thought it was an addicting drug. We tested them after a period of several weeks, daily, with us, on a full-time basis and 25%, afterward, thought it was still an addicting drug. The teachers hadn't learned a thing. So, if we had been able to select them, we would have picked teachers who were really interested and related to the kids and I think we would have done a better job. So, one problem is that a lot of times the people we select to teach aren't necessarily interested or knowledgeable or authoritative in these areas.

Second, I think we have made enormous assumptions in the medical profession. I've watched some of my colleagues go into a group of students and say, "I am a doctor, I'm authoritative and medically, I'm God, and I tell you, don't smoke," and walk out. You talk to the doctor and say, "What have you been doing," and he says, "I've been educating in regard to smoking." He hasn't been educating. He's gone in and ordered

the students to stop smoking because he thinks that smoking isn't a good idea and that's not education. Now, maybe it works, but the odds are that it doesn't work and it's never been tested. So, I think the biggest defect, the reason our programs don't work in large part is because we don't bother to look at what we're doing and a lot of times we don't have the right people doing it. I think there are other reasons. In drug abuse, we never bothered to pay attention to the peer group. We never attempted to get peer group anti-drugs and that's happening but it is happening by natural evolution, not by what we did as educators. I don't want anybody to castigate the people who are trying to teach. It's not that I say that we're ineffective in health education. It's that we have no idea what we're doing. In some places it may be very effective and in some places it maybe dismally ineffective and the Legislature's mandated that we do something and the Legislature and everybody in the State wants it to be effective. How in the world can we introduce a program and not ever look at what we're doing?

SENATOR RUSSO: Very good. Thank you very much.

SENATOR SCARDINO: Dr. Louria, you don't want to castigate the people in the system who are responsible or should be responsible,on the one hand, and yet, on the other hand, you would have preferred it if your group could have gone in and picked the people that you felt would be most able, capable, by whatever measure of competency that you devise, to carry out the program that you suggest is ideal from your own investigations and experiences. If that's the case in the area of health, it seems to me it would apply in any area of responsibility that a professional has within the educational plan. If you were to follow that analogy, and I'm beginning to wonder what you say on the one hand, if you're not castigating and on the other hand, you're saying that you would rather select the people and make sure that they have the competency to carry it out. We should do the same thing for English, history and all of the other important subjects and reasons for a child to be in school. How can we, then, develop a program, regardless of what we come out with because we don't know what the ideal program is, you have one and I'm sure other people have others or maybe a combination of programs, how do we know what that is or how can we effectively carry it out unless we put our faith and trust in the people who are in the education system now, getting paid to do the job we put them there to do?

DOCTOR LOURIA: That's a fair point. Remember, I was refering to a situation ten years ago, when we were looking, particularly, for people in a controversial area who would communicate with kids and were interested in them. Now, a lot has changed since then. We now have in many of the school systems bona fide health educators. Of course, I didn't mean that we ought to be able to select health educators now. But, by the same token, I think it is important that we look carefully and see that everybody has bona fide health educators or those who are not can truly educate. For example, to me, it doesn't make any sense at all to have health education, in essence, part of athletics. Health is an important specialty. It's of enormous importance and I think the two ought to be separated. They are different disciplines. Now,if a coach happens to be very interested in health education, he may be a marvelous health educator, but if that coach is interested in coaching and has engrafted on his responsibilities health education and gives it short shrift, then that is not likely to be productive or effective. So, I'm glad you brought that up because I don't want to be misinterpreted and that was a single situation a decade ago. But, I feel very strongly that health educators, as you pointed out, as with any specialty, have to be interested in health education. They either have to be trained in it or at least their activities ought to be assessed, whether or not they're trained in it, to see whether it is effective. Now, I think we can do the job in health education and I think we can do it now. But, we cannot do it

if we call something health education and don't look at what we're doing and if we're not doing the job, modify it. I can show you schools in this State that are not compelled to have health education programs, who do not or groups that give absolute lip service to it. They don't have any health educators. Now, one of the points that one of the schools made to me was, why should we waste our time with health education when there's no evidence it does any good, and that's a valid criticism if we don't test it and they point to things such as smoking, for example. So, I think we can work with what we have so long as we make sure we have the expertise.

As for your other point, it is also a valid one. Now, how are you going to select the program? Well, of course, we happen to have a proprietary interest emotionally, not financially, but emotionally in our own program. I think if you look at public health information, that you could devise a program that makes sense. Now, sure, it doesn't have to be our program, but I can virtually guarantee that, for example, the program that Mike Guarino uses in Bergen County, that his program and ours will differ only in nuances and it really is easy, not difficult, to establish a sensible program that includes what you really need to do as a base line and then, different communities might differ in certain additional aspects, but I don't really think---

SENATOR SCARDINO: Dr. Louria, can I try to get more specific with you, if I can? Presently, as you indicated, the law mandates that health education be taught in the schools in our State. Are there some standards that these districts will follow, State standards that have been submitted to them? I would assume that there are.

DOCTOR LOURIA: Sure, the curricula, but that's not a standard. That's a curriculum.

SENATOR SCARDINO: So, the standards themselves, primarily, or what is going to be taught and what emphasis is going to be placed is primarily left up to the local district itself, is that correct?

DOCTOR LOURIA: Correct.

SENATOR SCARDINO: Now, in contrast to that, what is it you feel ought to be done? Do you feel that this State ought to come through with a comprehensive program of some kind, spelled out to the local district, precisely what the State expects to be taught at the local level? Is this what you're saying?

DOCTOR LOURIA: No. What I think ought to be done is just what I indicated, that we ought to test what's being taught in every school. Let them do their own teaching within the guidelines, of course, evaluate what they're doing. So, if it turns out that one school is doing a marvelous job and it is changing attitudes--

SENATOR SCARDINO: Alright, but what is the determining factor here? What determines marvelous from not marvelous? How do you measure that?

DOCTOR LOURIA: You have a standardized questionnaire. You have certain goals and you have a standardized questionnaire that can be applied across the State that measures attitudes, behavior and knowledge, and if a school is meeting them well, doing well, you can measure it. If they are not doing well, you measure that too.

SENATOR SCARDINO: Can you give us an idea of the type of question you would be asking and what the typical response or what the response should be?

DOCTOR LOURIA: Sure, you could ask them about knowledge in regard to the consequences of cigarette smoking, heart, lung, other areas. You could ask them about their attitudes toward cigarette smoking. You could do it before and after. You can find out, by the time they're in high school, how much they're smoking. The same would be true with alcohol. You could find out if they're using seat belts. It doesn't apply to your chronic disease, but you could find out what their attitudes are towards seat belts and what percentage of them actually use seat belts. Some of these, you can actually validate with observations. We found, in the drug abuse questionnaire, we were

delighted by the evidence that the students were answering the questions very honestly, once they knew that they were truly anonymous.

SENATOR RUSSO: Dr., the Essex County Grand Jury recently revealed the fact that there is a great deal of prevalence of drugs, usage among the young people in Essex County. In your opinion, would this be attributable to, A, a lack of monitoring, B, lack of knowledgeable teachers who are conveying their thoughts to the children, or C, perhaps a failure to initiate the programs at an earlier level in school, or D, some other reason?

DOCTOR LOURIA: I can't answer that. For a period of, I guess, five years, we did yearly studies in some of the schools. I would have to look at it more closely and not having read that, just in the newspapers, I'm just not knowledgeable enough, except that I'm absolutely convinced that a large amount of our "education", in regard to drug abuse, is wasted.

SENATOR RUSSO: Why? It's not being monitored?

DOCTOR LOURIA: Yes, it's not being monitored, and we know this to be a fact, and in some cases, the people who are teaching it had it thrust upon them and are really not, themselves, educated and are giving out misinformation. That's the quickest way to turn kids off.

SENATOR RUSSO: Then, I would assume that the fault, at this point, lies with the State Board of Education, for lack of a follow-up program of some sort.

DOCTOR LOURIA: Well, I would put it a little differently. I think that somehow health education has gotten lost, except once the curriculum was established. The law mandated it, the curriculum was established. All that was done very well. I personally think that if State education is not willing to assess what is being done and modify it, then that indeed would open them to criticism. I don't think there has been enough of a call to them to expend monies or to acquire monies to monitor. But, I think that's just what we're doing today and I think if they don't in the future, that it would be hard to explain not doing it.

SENATOR RUSSO: Is the attitude, as far as the State is concerned, for the most part, that it's something that we should put in place, health education, but it's not of extreme importance, so let's concentrate in other areas and not in health? Has that been the general attitude?

DOCTOR LOURIA: Well, I haven't been at hearings and I hesitate to be dogmatic on that, but I don't think there's any question that health education has not, in the past years, received as much focus and attention that it should have. For example, take the fact that it hasn't been separated from athletics. I think that indicates that it has been given a secondary place. Now, as part of that, and again, I don't want to be in the destructive role of castigating, I think part of that is that they have not been convinced that health education really makes a difference or is necessary at that age, except in some very superficial areas. I think the evidence suggests, now that we know how much we can prevent and now that we think we have programs that we'd love to discuss with the State, I think now is precisely the right time to make a major move in health education in the schools.

SENATOR RUSSO: It would seem to me that heal th education should be more important and paramount in the minds of the educators than history, algebra and all the other courses because it could be the difference between life and death and it could make the difference, whereas the failure to learn algebra properly or American history would not prevent a person from leading a normal, healthy, prosperous life.

DOCTOR LOURIA: Well, I absolutely agree with you, Senator Russo, but again, because I don't want to throw stones when I'm in a glass house in my own department,

we spent our time on a lot of individual projects, drug abuse, lead poisoning, etc., but it's only in the last year that we have formally committed the department to health education. So, as the major preventive medicine department in the State, we can hardly castigate others for not having gotten there quicker. I think we're there. We believe in it and we think the evidence bears us out. I think part of the problem was that until two years ago, nobody was sure that we had a cohesive health education program that we could apply. Now, we have it. We can apply it and I think now is the time, rather than look backwards and say, "It should have been done before." I think we should have been there before and they should have too, but rather than do that, I think we can say, we have a program, we know what we can prevent, let's move together, reassess our programs and then, continuously do better.

SENATOR SCARDINO: Doctor Louria, have you had any involvement, direct or indirect, with the preliminary State health plan that is now in draft form, you or the college, have you had any input into it?

DOCTOR LOURIA: Well, I'm sure the college has, but I can't detail it.

SENATOR SCARDINO: You have no familiarity with that?

DOCTOR LOURIA: I have not been directly involved.

SENATOR SCARDINO: It would seem to me, theoretically, that some of what you are suggesting here today should very well be highlighted, if not incorporated, in that plan somewhere. It would be interesting to see just whether it does or not.

DOCTOR LOURIA: I couldn't agree more.

SENATOR SCARDINO: Would you be good enough to tell us what your definitions are, today, of chronic illness, just what they are? Could you identify what you see prevalent in our society today?

DOCTOR LOURIA: Well, I think you defined chronic illness perfectly normally. It's really any mental or physical abnormality that persists for a substantial period of time and that's a very vague definition, but what you gave is as good as any I've heard.

SENATOR SCARDINO: What about the specific diseases themselves, such as heart disease, stroke, etc.

DOCTOR LOURIA: Heart disease, cancer and stroke are, of course, the big three and those are clearly, in large part, preventable.

SENATOR SCARDINO: Now, getting back to the schools for a moment, are you suggesting that emphasis, specificity, if you will, ought to be placed in those areas we define as most chronic, naming the three that mention now, in addition to alcohol, drug abuse, smoking and any others? I guess I highlighted the big ones. Are there any that I left out?

DOCTOR LOURIA: Sure, some of it is acute. For example, accidents are the major cause of death up to age 35 in this country. That's true in this State. That would be a major part of an education program. Nutrition is important. Weight control is related to that, the proper role of exercise and I think what we would like to do is, in essence, convince them that in large part, they have control of their bodies and that this control sometimes needs discipline, but that this control can prevent an enormous amount of disease.

SENATOR SCARDINO: Let me be frank with you. I understand what you're suggesting in terms of the problems with the schools, but I'm not sure, at this point, absent continued discussion, deliberation and documentation on the subject, I'm not so sure that we can measure, adequately, the outcome of a health program in school systems. For example, how can you tell how many youngsters you've kept from abusing drugs or from becoming hard users of alcohol or learning to take care of themselves, physically

and mentally, so that they don't get into other problems? It is an immeasurable quantity and I find that difficult to understand at this point. But, what I can understand, and I'm anxious to see what the response from the educators is going to be, is the point that you make concerning the people who are teaching health courses and the present mode that we use in the State of New Jersey in terms of the setting that we use now. You talked about it being a part of the athletic plan and not a separate and distinct function in and of itself. It is my understanding, Doctor Louria, that teachers are professionals and are certified, to some extent, to teach the course that they are responsible for. So, on the one hand, I keep coming back to the same point. On the one hand, you talk about selecting the person to teach, but if they have the credentials and the certification to do it, shouldn't that be enough? I mean, aren't we now, perhaps, indicting our colleges that produce these teachers and saying that maybe they're not adequately providing courses and resources necessary to arm these people with the knowledge to teach youngsters what they should be taught in health courses?

DOCTOR LOURIA: Well, your point is a good one, but in the first place, a lot of the people who are teaching in the State of New Jersey are really not qualified in health education. Secondly, health education--

SENATOR SCARDINO: They're not qualified?

DOCTOR LOURIA: Right.

SENATOR SCARDINO: But, if they're being graduated from the teaching colleges--

DOCTOR LOURIA: But, they're not health educators. They're qualified as teachers.

SENATOR SCARDINO: But, they have been given courses in college specifically to qualify them to teach and to perhaps to teach in the area of health education.

DOCTOR LOURIA: No. Some of them come from other disciplines, such as coaches, for example, and they really have not had specific training.

SENATOR RUSSO: Is there such a thing as a major in health education?

DOCTOR LOURIA: Oh, sure. Actually, what you would like in your school are people who had a Masters in health education. See, if you're teaching history, you could measure that by an exam. What you're looking for are two things as a teacher: one, to teach kids how to think; and the other, to inculcate a certain amount of knowledge. Well, with health education, it's a little bit different. Not only do you want to inculcate knowledge, but you want to change attitudes and beliefs and then, look at behavior patterns. Now, we don't do that for history or English. It's a different kind of specialty. So, even if somebody is a health educator--I'm allegedly a health educator. What I do in education ought to be tested too. All I'm saying is that it is not only your training, but also communication, etc., and that we can make things better if we test it. Suppose something isn't working. Then, you might want to change the kind of information that you're giving to students. Now, you're a perfectly qualified health educator, but what you're doing isn't working. Now, it's a new enough field and what we have to do is different enough from conventional education. So, I think we have to constantly evaluate.

SENATOR SCARDINO: Then, the responsibility lies with the State Board of Education, the Commissioner of Education in terms of responding, very specifically, to the questions and concerns that you are raising before us today.

DOCTOR LOURIA: Well, I think that's part of it.

SENATOR SCARDINO: Initially, I think that's where it's at. Even before you consider legislation and regulatory changes, you have to give the Commissioner and Department of Education an opportunity to respond to the points that you made.

DOCTOR LOURIA: Absolutely. I talked to Commissioner Burke a couple of days ago and he's very much interested in this area. Obviously, interest of the legislators will give further thrust to it, but they're very much interested.

SENATOR SCARDINO: There obviously ought to be a cooperative effort between the Commissioner of Health and the Commissioner of Education and we will make note of that and obviously, I think, follow up, in terms of querying both the Commissioner of Health and the Commissioner of Education as to just what their feelings are in regard to your point.

DOCTOR LOURIA: May I make just one other little point? I appreciate your concern about how you measure this and you are absolutely right, and I don't want to be glib about it. It's not easy because part of your education, as you point out, where you're really measuring, is whether they will carry it into their adult life. So, your measurement--you have to do long-term follow-up in the community. But, there are certain things you can measure and you can measure them as soon as you've initiated your programs. Smoking is one. Alcohol is another. Driving patterns is another one. Attitudes toward nutrition is one. Now, they're easy questions that you can validate and measure. But, your point is also a very good one, that, for some of this, heart disease, stroke, cancer, your final measurement is in incidents of disease in your communities and obviously, that is followed by death certificates, morbidity analyses, etc. So, I think we can do it, but I don't want to imply that we can tell in Grade 9 whether we've done enough to prevent somebody from having a heart attack at age 40. Of course, we cannot do that.

SENATOR SCARDINO: Thank you very much, Dr. Louria, for your presence here. We appreciate your testimony.

We have with us a Bergen County Freeholder who is going to testify next and she is Joan Steinacker, Freeholder. Good morning Joan. Thank you for being with us today.

J O A N S T E I N A C K E R: Thank you. I am delighted to be here today.

SENATOR SCARDINO: We appreciate your opening your doors so graciously to us today.

MS. STEINACKER: Well, it's your county, Tony, you know that.

Specifically, senators, I did come here to testify against S3045. However, after hearing Dr. Louria's testimony, I just wanted to say, ditto, to all of his testimony because I do run into that problem all over this County as to how health is being taught in the schools. I know, by the time that you took with him, that you are paying attention to what he is saying and the two words I wanted to add that he did not add that we screen constantly, accountability and evaluation of programs. I will now get on to my own testimony. I just had to add to that. I was intrigued by his comments.

I am here today as the municipality's liason and I appear here today to testify against S3045 because this bill appears, to me, to be vague, contradictory, in its requirements and to be lacking in vital information regarding funding of health programs.

While I can agree that there is a need for programs for prevention and control of chronic illness and communicable disease, I do not feel that this bill answers that need.

S3045 would allow counties to provide health services pertaining to chronic illness and communicable disease or to act jointly with the municipal governments to provide those services. It mandates a reporting system that would include a listing of provided services and documentation of cost.

I find, however, a serious lack of detail on how services would be funded. This lack of detail raises many questions in my mind.

The bill mandates a report from the municipality to the county health department on the services they have provided, the costs they have incurred. The county health office, in turn, is mandated to make a report to the county governing body, which is where I sit. The bill does not specify, however, if the county is mandated to cover the cost of the program or if those costs would be picked up by the State.

Does this mean the county would be required to assume all costs for new health services provided under this bill? The bill does not say.

Does this mean that costs would be included in the current budget caps or exempt from them? The bill does not say.

Does this mean that the county will once again be required by the State to add new programs without any change in our budget caps? The bill does not say.

It appears to me that this bill would be just one more instance of the State providing or mandating programs without any though to how those programs would be funded.

Bergen County has repeatedly asked the legislature to attach a fiscal note to all bills that would mandate costs upon the counties so that we might knpw what impact any given bill would have upon our budget. We have repeatedly asked for some type of system to relieve counties from the effects of State mandated programs upon our budgets, so that we do not have to continue cutting local programs in order to provide for the mandated programs.

Yes, we want our residents to have access to good health services, including services to prevent and control chronic illnesses and communicable diseases and programs to provide some assessment of the impact of environmental factors upon public health, and in this county, that's very important. But, I do not believe S3045 is the answer either to solving local health problems or providing services to the municipalities.

Now, that's my written statement, but I do have to add some more to that. In Bergen County, our health department does provide educational programs. So does our narcotics task force and the drug abuse program. So does some of the local municipalities, and I cannot agree with Dr. Louria more in saying, somebody had better be taking a look at who's doing what. There has to be some cohesion and there should be a pilot program, but in the meantime, with this kind of a bill, you're going to make us cut in other areas when you say the county will reimburse the municipality. From where? It is fine to say it in the nice words from the testimony, but I have to ask you straight out, from where? I'm our municipality's liason and they're having a lot of problems and when you say that they cannot afford to provide some of these services, you're really waving a red herring around because if we're mandated and if it's exempt from caps, regardless, we still have to raise their taxes to provide it. So, gentlemen, I beg you, take another look at this bill and for heaven's sake, will you stop mandating without giving us a cost.

SENATOR SCARDINO: Joan, thank you for your testimony and the number of questions that you've raised concerning Senate bill 3045. First, let me respond to the question about the caps. You're right about the point mandating something that may well be within the caps and would restrict you even further than you're restricted now in many cases. We are, that is my staff has been instructed sometime ago to work some provision into the bill which would exempt any increased funding in this area from the cap program. That, I think, answers that question.

The other question dealing with the fiscal impact, that is presently being

worked on by our Office of Fiscal Affairs and if they're not doing it, we will certainly put them on notice to do it and remind them that they should do it, to determine just what the costs are. I don't know if you were here when I made my opening comments, but I indicated specifically, at the time, that we are not tied into this legislation to a point where this is what we consider to be the answer or the cure-all. Even though I'm the sponsor of the bill, as I do with any of my bills, and as my colleagues do with theirs, we recognize that while we may have something that sounds good conceptually, in all practicality, when the people who have to live with whatever the bill will mandate or whatever the bill may provide for, they may show us that there is really no need for the bill or the bill itself might have to be amended. That's why I'm particularly pleased with your questions and your comments because they're extremely valid. As I understand the thrust of the bill, in terms of the involvement of the municipalities and the counties, let me point this out to you. A, it is permissive, as far as the county's involvement in the program. It says, "may", they "may" get involved in such a program. They may go beyond the environmental responsibilities that have been put before them. It doesn't say that they "shall" get involved in this program. The same way with the municipalities. They do not have to participate under the provisions of the bill. If you feel otherwise and you can articulate that, we'll be careful and make sure that is corrected in language, to make it clear that it is permissive.

Now, when you talk about reimbursing the municipalities for their involvement, I think this is very tricky and I'm not clear, Joan, exactly how it will work now. We're going to need more discussion, but as I see it at this point, it's really a matter of identifying what municipalities are doing, what they're not doing, what the counties are doing that municipalities can very well relieve themselves of and take advantage of, that's readily available to them and they're not, and I guess this is in the form of reimbursement because they could really take a responsibility that they're taking on themselves and turn it over to a county or their county which is already doing pretty much the same thing. So, this is not a program that would necessarily cost more by doing it. It's just a transfer of responsibilities, but it's also a transfer by mutual consent, not by mandate. The bill would further--we're asking questions, for example, as to whether or not time isn't right for the classification of health services into a number of categories. There are those that can be provided by a municipality, and very adequately, so it should be provided by a municipality. There are those that should be provided by a regional entity and there are also some that could be performed at either level, but working cooperatively. Now, in sum and substance--I know it's a long statement--but the bottom line to this,and interestingly enough, is, as I understand it, is that the very example and basis for the kind of bill that I'm talking about is right here in our own county. Bergen County is doing and has been trying to do pretty much what this bill is calling for and I suppose what we're saying here is that what we have as a start, as a workable plan here in Bergen County may be useful to those counties that want to pick it up, if they desire to do so, not that they must do so. That's what I see as the thrust of this particular bill.

MS. STEINACKER: Senator, I have gone through the bill very thoroughly and I would like to bring your attention to the bottom paragraph on page one. "Any municipality within said county which is presently providing chronic illness and communicable disease services may elect to continue to do so or may elect to have the county assume responsibility." I have no problem with that. That's permissive. However, page two, "If said municipal ity elects to continue to provide such services, it shall, starting with the next fiscal year following the effective date of this Act and annually

thereafter, submit a detailed report to the county health officer." Now, Senator, with all due respect, anytime you start puching more paperwork, more reports, you do cost the county health department money, you do cost municipalities money and in effect, you are infringing upon home rule. When you say you are mandating, when it says "shall", you are mandating and that's some of the language I would like taken out of there. I do not think that this county exists by telling our 70 municipalities what they must do and I don't think the State Legislature should be insisting that we be "Big Brother" to the 70 municipalities. We are here to help, not to mandate and I would not like to be in that position.

SENATOR SCARDINO: Joan, I couldn't agree with you more. I too believe, as you do, that the local level is where it's at, that's the base and we should do everything we can ti maintain that sovereignty and the willingness and the ability for the local level to do all and as much for itself as it can. But, you and I both recognize, having been involved at both levels and now, at a higher level, that are occasional needs to get involved to get involved in a broader scope, where municipalities have to share with other municipalities and we get back down to the regional base. I'm sure you wouldn't be a freeholder if you didn't believe in county government, at least I never heard you say that you didn't believe in county government and that, in effect, is regional. But, the point that I want to make is that, if, on the one hand, we're going to be talking about coherency, if we're going to be talking about eliminating fragmentation, if we're going to be talking about identification, if we're going to be talking about classification of what responsibilities health departments, regardless of what level, are to do and how they are to address themselves, the only way we're going to do that is by communication and by knowledge, by constant awareness on the part of all parties as to what each one is doing. Now, if the county does involve itself in a program dealing with chronic illness and that county is obviously comprised of municipalities, it seems to me that it makes sense for those at the municipal and county levels to communicate and that's the way I see that particular report. Now, if it appears that the detailed aspect of it, getting down to very, very specifics, as this wording seems to imply, we'll take another look at that. But, I do agree with the point that there has to be some form of communication. If a county opts into a chronic illness program, there has to be some dialogue between the municipality and the county, an awareness of what each one is doing; for the benefit of the public, for the benefit of the people.

MS. STEINACKER: I couldn't agree with you more, but I would specifically request that you look into that language more carefully.

SENATOR SCARDINO: Yes, we will. I would also add, Joan, that this is not a hearing on a bill, where the Committee is going to vote the bill out. The bill has not been formally put before the Committee for deliberation, when we will, then, take a position one way or the other and release it or not release it for a floor vote. Announcements will be forthcoming, if and when we get to that point. So, there is a great deal of discussions yet to be had on Senate bill 3045. Thank you.

MS. STEINACKER: Thank you for the opportunity.

SENATOR SCARDINO: I want to welcome Senator Bill Hamilton, who came all the way up from Middlesex County to join us today and I do appreciate that Bill.

SENATOR HAMILTON: Mr. Chairman, I'm sorry I was delayed.

SENATOR SCARDINO: Mark Guarino, representing the New Jersey Health Officers Association?

M A R K G U A R I N O: Good afternoon, Senators. I'm here representing the New Jersey Health Officers Association for John Carlano, who couldn't make it today. I will try to handle the pertinent points that we discussed at our Chronic Disease Committee meeting of that Association.

There are a number of points of interest to this Committee. The first one, in terms of scope of the problem, I think it was well iterated by the preceding witnesses here that chronic disease is a major problem in New Jersey, not only in New Jersey, but throughout the whole country. Heart disease, cancer, diabetes are ubiquitous, they are with us as the major health problem now in the country. You mentioned in your opening statement how communicable diseases and infectious illness have been pretty much put under control to a great extent, but the area of chronic disease is with us and with us at all age groups. The whole idea of public health is that we have to deal with prevention. That is the main thrust and prevention comes with health education, as Dr. Louria has chosen to be the main focus of his presentation. I think what I would like to deal with, go over, is number two of the draft that was put together by the State Health Department. I had a chance to read over a preliminary draft and I have a few problems with it.

SENATOR SCARDINO: Can you be specific about what you're discussing?

MR. GUARINO: Well, we're talking about the chronic disease guidelines, drafted and put together by the State Health Department.

SENATOR SCARDINO: What I want to do,Mark, is caution you to the fact that none of the Committee members have read that plan. They have not seen it. So, you can try to be specific as you can, so that we can follow you as close as we can. Your comments, obviously, will be duly noted in the record and when we do go through the plan itself we will then relate the points that you raise with the document itself.

MR. GUARINO: Just to continue, the three items I feel are most important pertaining to chronic disease programming are, thorough and efficient planning, coordination and evaluation, and this is to be set in a standardized procedure which would be implemented state-wide, in order for us to really set some objective evaluation criteria, to see what we're doing in the area of chronic disease down the line. What's happening now with the State proposed guidelines are a set of model types of generalized components that could be included in a hyper-tension program, a cancer program, a diabetes program. These are the general components that should be included in each one of the particular implementation activities. However, the problem I see with it is that this particular guideline could be put on the desk of the health officer at the State and we would have as many different interpretations on how we might implement the particular plan. This leads us to the same kind of a situation that we had in the past. Everybody is left to creating their own wheel. We do not have a standardized evaluation schedule to go by. We would not really know what we're trying to--we would not be able to see clearly what we have been accomplishing by this type of programming. What I see as a way of dealing with this is to establish some sort of corps, manpower training, literature research and evaluation component, where we would have a standard operating procedure type of guideline developed, taken, maybe, from a number of programs ongoing in the State and added to by the experts in the field. I, myself, in Morris County have developed a program we labeled as The Morris County Chronic Disease Program. We were fortunate to get funding out of CETA and we solicited good people and they were trained well and we put together a program that we feel very proud of and in our limited evaluation, for the short time it's been operating, it has been quite successful and accepted by the community and this type of program deals with intake questionnaire, establishing risk, risk determinents among the population that we screen. It selects those at high risk and only those at high risk are referred to the medical screening component, which we set up with the local hospital. There is a one to one counseling component, which deals with fact sheets and data and follow-up after these people leave us to see how they're doing and it falls very much in line with what I see coming out of the State trend and the national trends in literature. We were also fortunate enough

through this short-term funding, to have people on staff just to research the literature and to keep us updated because things are coming out every day, especially in the health education field, dealing with risk, as far as diet, sanitary life style, occupational health. They are needed ingredients, needed information in order for us to deliver a quality program, in terms of prevention, lifestyle intervention.

We see this as a program that has a lot of valuable components and we're not saying that it's the only program in Morris County or it's the only one that's going to work. We're dealing in small urban areas, Morristown, Dover and some of the small surburban areas. I don't know how applicable this approach would be to Newark or Camden or Jersey City, but I'm sure that these implementation models, like something like Mike is doing here in Bergen County and some of the other health officers and health officials across the State could put their heads together and develop a standard operating procedure, which could be evaluated and could be looked at and could be worked into the State guidelines that the State is now coming down with.

The problem, again, with this kind of thing is funding and just addressing the law in terms of regionalizing a county oriented chronic disease activity, I'm very much in favor of it, just for the fact that we can not set these limited, geographical boundaries to deal with the problem that has such a wide-ranging scope. It is totally cost ineffective to apply some health education program from one community in some multi-media approach. We have to give a lot of time to attitudinal changes through health education activity on a large population area, so that we can actually see the number of people who have been exposed to the same kind of information and awareness rate. It's something that I think is a good direction in enlarging the scope of operation, especially in the chronic disease area.

The specific item of funding, one of the problems that I've had, especially dealing with my chronic disease program in Morris County, is the fact that most of the federal and State funds are specific oriented. We have demonstration projects dealing with hyper-tension. We have monies coming down from the federal government for certain cancer programs. I see that most of this money, now, is being spent to study, to do more studies. I don't see any of that money coming down for implementation. I see it being--the guidelines for receiving this money are specialized. How many times do we do a hyper-tension demonstration project? The information is in. We know about overuse of salt. We know of stress. We know of sanitary lifestyle. We know of many warning signs and risk factors that are involved with hyper-tension. It's time now to put that into effect and in a comprehensive way. The fact of life is that in most of these chronic disease areas there are many common denominators in terms of--for example, what is a risk factor for cancer might be a risk factor for hyper-tension and diabetes. Our contention is that we should deal comprehensively. The funds that do come down should not be just for a hyper-tension program or a cancer program. We should be programming where when we get somebody on a one to one basis, we're going to give them the whole bit, we're going to be dealing with the whole chronic disease area. Our pitch in education is going to be dealing with lifestyle and behavior modification and we're going to follow-up in that same line. We have to remember that we can offer all the programs we want, we can have health fairs, we can have educational lectures, we can have screening of all the chronic illnesses, but the biggest problem is getting the people to participate, the awareness. It's showing what the value of these programs are to the community and the only way we're going to do this is that we have to set up a model of outreach, of health education, where we're going to start attitudinal changes so that we do something on a community base and then, we can get them into our programs, into our local health departments or our county units, who are offering this one to one service and they can

plug into the health system, not the illness system, the wellness system, and we're talking about prevention, so that we can actually look at these things over a period of time and then we have objective, by standardizing our procedure, objective criteria for evaluation. One of the criticisms that I had from the State when I presented my program was, "Where are your statistics, how do we know what you're doing is effective?" This was kind of shocking to me because it is like putting the cart before the horse. We cannot evaluate attitudinal changes in a year. We cannot do it even in two years. This is something that is a process, that has to be done on a broad scope, in a comprehensive way. It has to have the thrust and impact that our commercial market has in many times telling us the negative things to do. Then, we have to look at it all the time and be able to, by standardization, take a look at evaluation and then, maybe in five or ten years, we can see the impact and really talk in terms of lowering medical costs and hospital stays and death and illness from these diseases.

That's about all I have to say and I would welcome any questions that you might have.

SENATOR RUSSO: How long has your Morris County program been in effect?

MR. GUARINO: Senator, it is actually a year and six months now and we were funded,the first year, as a cancer early detection and prevention program. The second year, in order to continue our funding, we modified our objective and we expanded that to hyper-tension and diabetes. We had, originally, a six person staff and the second year--rather it was seven people the first year and a six member staff the second year.

SENATOR RUSSO: And you're in three major areas?

MR. GUARINO: Yes, three major areas.

SENATOR RUSSO: What kind of population are you serving?

MR. GUARINO: Well, our population that was stated in the grant was to serve the high risk population based on the risk information that is available relating to these particular diseases. You know, in certain areas, hyper-tension, there would be a certain emphasis on the black population. In certain areas of cancer, people over forty, there are certain dietary habits or whatever and it was very specific as to who we would want to get to. Unfortunately, it wasn't the easiest thing in the world to accomplish and this is one of the problems, showing the value of this kind of implementation plan, so the people would come in, especially the people at risk.

SENATOR RUSSO: How much does it cost to implement and administer the entire program?

MR. GUARINO: Well, the first year of funding was about $82,000 and the second year was about $72,000. This is a case where a program of this nature, we were very fortunate that we did it under a PEP program and we developed a sophisticated program under an employment program. However, this program, if you ever tried to evaluate it cost effectively for the population we serve, there is no way, shape or form that this program is cost effective.

SENATOR RUSSO: How much of it was federally funded?

MR. GUARINO: Well, through CETA, it's a federal works program, so it was totally federally funded.

SENATOR RUSSO: As far as your staff is concerned?

MR. GUARINO: Staff and administrative costs, that, I think, was 10% of the salaries and wages and what we did, we also contracted with some other municipalities to go out and do that kind of work, the screening for Pequannock and Dover up in Morris County. We also ran a benefit to supplement some of the needs and services.

SENATOR RUSSO: Are there any similar programs in effect anywhere in the State today.

MR. GUARINO: Not exactly, but in Bergen County Mike has an education oriented program that has many similarities. I think we were fortunate, because of this grant, to actually have the manpower and staff to develop a comprehensive picture where we're talking about the paper screening, we set up medical referral component with Morristown Memorial Hospital. We had the manpower to do the intense follow-up. This same program can serve a much, much larger population and I'm not saying that this is the program that's the answer. I'm saying that this kind of a program could be a training component where standards of operation can be set. you have manpower to go out to your county or local units, to train the manpower that are going to be doing this program, doing this type of activity, the chronic disease mandated activity. There can be a computerized setup set up where we would, by our intake questionnaire, we wouldn't be talking about mortality, we wouldn't be talking about morbidity, we would be talking about risk information. We would be talking about human risk in terms of how it relates to chronic illness. This is a broad spectrum of matrix information that could be an incredibly valuable planning tool for the future to modify this program to be most effective. If we have pockets of risk, we see where we are finding these people who are dealing in habits that relate to chronic illness or are going to lead to chronic illness, we can emphasize our health education activities in those areas. We can possibly modify our program in finding out what's working and what's not working in terms of these risks. We would have an incredibly sophisticated data bank because now we're using a standardized procedure. We would have a core group of evaluators and trainers to look at this and to desseminate this information among the agencies that are implementing the program. I see this as being very important in any kind of project proposal.

SENATOR RUSSO: The operation of your program, specifically--let's take the area of sugar diabetes, what do you offer, what are some of the highpoints involved in your questionnaire and so forth.

MR. GUARINO: Alright. I'm sorry I didn't bring copies of it. I didn't realize that I was going to get specifically into this program. Let's take diabetes or hyper-tension. We would have a questionnaire that would discover areas of risk in terms of their behavior, their individual behavior. We would find out about warning signs that are established in the literature in terms of diabetes, in terms of hyper-tension. We would look at the medical histories, relationships, if there was diabetes in the family. We would look at their age and sex and relate it to what the literature has to say about this in terms of what risk, weight, it would have on that particular answer and we take all this information together and, utilizing our trained cousellors and questioners, we make a determination that this person is a high risk for a certain problem. Now, if the person is in that high risk area, it may be very necessary that that person be refered to the prime physician, to a clinic for actual hands-on testing, for early detection. If you have a person who has a bleeding colon, this is a definite indication that we might need testing for colon-rectal cancer. They might have overlooked this. Then, we would have a component in the program where we would follow this person over a period of time. We would look at their family, we would be asking questions, there would be a phone call made.

SENATOR SCARDINO: This is all done at the county level?

MR. GUARINO: No, this is done at the municipal level.

SENATOR SCARDINO: And every municipality does this?

MR. GUARINO: No, no. This is done only through this program.

SENATOR SCARDINO: How many municipalities are involved in your county?

MR. GUARINO: This program was started out with two municipalities.

SENATOR SCARDINO: Out of how many?

MR. GUARINO: In Morris County, 39.

SENATOR SCARDINO: And only two municipalities are involved in what you're describing to us.

MR. GUARINO: No, this was the first year. The second year, the program emphasis changed. It turned into a training program because I knew that I wasn't reaching enough people and what I wanted to do before this program became defunded, I wanted to, at least, be able to expose the other officials, health officials in the county to a concept or a programatic scheme that might be workable in terms of their meeting chronic disease.

SENATOR SCARDINO: You were able to start this program because of a federal grant.

MR. GUARINO: Right.

SENATOR SCARDINO: And the use of CETA employees.

MR. GUARINO: Yes.

SENATOR SCARDINO: Okay, that's understood. What happens, though, when the CETA grant is exhausted? You now have the option at the county level or at the municipal level. The choice is there for the program to continue, is that correct?

MR. GUARINO: I'm trying like hell, Senator.

SENATOR SCARDINO: I understand that. I know the obstacles of developing and getting the government body to come up with the dollars necessary to continue the program. But, what I'm trying to establish here is the fact that there are no restrictions, there is nothing in your way to prohibit you from continuing your objective in establishing this kind of coherent approach to chronic illness identification and prevention and so forth that you described to us. I mean, there's nothing at the State level that blocks you from doing that. Is there anything that you see in the preliminary State Health Plan that prohibits you from doing that?

MR. GUARINO: I see lack of formal coordination.

SENATOR SCARDINO: But, that lack, that deficiency is something that you can clear up, locally, if you want to do it and you do want to do it. There's nothing coming down from the State that prohibits you from doing it.

MR. GUARINO: No.

SENATOR SCARDINO: And that's really what we want to hear. We want to know whether or not there are any obstacles from the State standpoint. We are, obviously, representing the State's interest and concern here, as State legislators. So, if you say to us that you don't have the obstacles there, then, the nex question is, what can the State do or what should the State do that it is not doing to help foster the program that you think is absolutely essential?

MR. GUARINO: Alright, I can answer that. I agree with you that there are no formal obstacles set up by the State to coordinate such an effort. However, there is the reality of home rule that does exist, especially in Morris County where we do not have a county health department. The municipalities, mostly, are of an affluent nature and they want to maintain their own little setup. They don't have the interest in regionalization to a great extent. This is a reality that I'm dealing with and the answer to the question is that that is something that is a political decision. I encourage it as much as possible from my status as a health officer. We have to regionalize certain projects, we have to put them together. But, without a formal region to design this kind of approach, we have to do what we can with the established system. My suggestion is that we have either a quasi-public or State monitoring agency or component that goes along with chronic disease that does the things that I explained before, that does standardize.

SENATOR SCARDINO: Are you familiar with Senate bill 3045?

MR. GUARINO: I read it briefly, Senator.

SENATOR SCARDINO: Well, you ought to take a look at that and perhaps, in a way, perhaps more direct than indirect, this will impact on the problem area that you are describing to us. Because, as Freeholder Steinacker pointed out in her testimony, on the one hand we allow municipalities to participate, making it a permissive law and not a mandated law, and on the other hand, you require each year that they report to the county,by statistical data, analysis or whatever is required, as to what the municipality is doing in addressing the chronic illness component and, of course, these reports will come subsequent to the State identifying and categorizing chronic illnesses and the responsibility at the respective levels. You talk about this one community in Morris County, for example, that may not want to opt in and that's how it should be. If they feel they have the resources and the capability to do it for themselves, then they should do it and nobody should stand in their way. On the other hand, since we all agree that the problem of chronic illness supercedes any jurisdiction, it is clear that cooperatively and I think responsibly, we have to work together and this kind of reporting procedure is the dialogue and the communication that is necessary between the municipality and the county and the State, so that each one knows what the other one is doing. The municipality knows what you are offering at the county level and what's there for them if they want to participate, and on the other hand, the municipality is telling you, "Well, we don't want to participate because we're doing it this way ourselves and here's how we are addressing ourselves to the problem." Because, no one at any one of those levels is going to sit here and tell me that chronic illness isn't a problem. I don't think there's anyone that is going to say that we don't have a problem and that we shouldn't be reacting to it or addressing ourselves to some form of remediation here.

MR. GUARINO: Senator, the reporting system I see as being after the fact. My thrust of interest is setting up procedures where we can report and evaluate those reports with a degree of accuracy and objectivity. I don't see that happening through guidelines that include just components of what should be applied in a chronic disease program. There is counselling information. There are ways of taking blood pressure.

SENATOR SCARDINO: Let me just interrupt you Mark, because I don't want to get too far afield here. I want to try to stick as closely to the area itself and I think what we're trying to deal with here is, first of all, the seriousness of chronic illness in the State of New Jersey, what do we describe as chronic illness, and what are the municipalities, county and State agencies doing in response to that, where are the obstacles in the system--and you've identified some that you have experienced particularly, and that's fine. Now, is there anything other than that. For example, there's one question that I have. In your experience, do you feel that there are federal dollars out there that we have not been getting because of one reason or another, or are we exhausting everything that is at our disposal right now, from every level, county, State and local, to participate in the availability of funding that's there?

MR. GUARINO: I feel that right now there is sometimes competition among agencies that have objectives that are the same in terms of the State receiving federal grants to do programs that are related to chronic illness and the cancer and the hypertension areas and I feel that I don't have a handle on all the funds that are out there that might be available to us, but I do think that a lot of this money could be put more into implementation because we do have a lot of information right now and I think it is time to use it, rather than just keep studying it.

One other point, and this is the last point, is health education. Reiterating what Dr. Louria said, another obstacle that I've found is that one of the main problems with health education in the schools is that there is no real formal liason with the local school districts and the health departments. There is a constant idea where the local health department is an outside agency coming in and infringing on State education plans and this kind of thing. It's something that I feel should be looked at from the State level because this one of the most important areas. There are many programs that are outside the school program that are proving successful in other areas that are just lower in priorities.

SENATOR SCARDINO: We will make it a point to ask the Commissioner, in her presentation this afternoon, that question. Senator Hamilton?

SENATOR HAMILTON: Mr. Guarino, I hope you'll convey my regards to John Carlano. He's from my district and he's certainly an outstanding leader of your organization and a real fine person to be speaking for the health officers of New Jersey. I don't know, since you are, in a sense, pinch hitting for him today, whether you had an opportunity to see the announcement of the public hearing and the several questions that were delineated in there.

MR. GUARINO: Just briefly.

SENATOR HAMILTON: I don't want to put you on the spot and only to the extent that you can respond, I would like to specifically take a couple of those questions and get your feeling, not just from the Morris County perspective, but from New Jersey as a whole. I believe, in your testimony, you refered to some feelings about the most severe, debilitating chronic illnesses in New Jersey. Could we get a statement for the State as a whole, from your experience?

MR. GUARINO: Which are they?

SENATOR HAMILTON: Yes.

MR. GUARINO: Heart disease and cancer.

SENATOR HAMILTON: Now, the next question, as posed here, is, can chronic illnesses be prevented, and I suppose if you had the full answer to that, you wouldn't be spending your time with us here this morning, but what would your comment be in that area?

MR. GUARINO: Senator, with the evidence and the research that has been displayed to us over the years, the past few years, and we've had a great deal of research in this area, I feel definite that by lifestyle intervention, health education, preventive health activity, we can greatly reduce the problem of chronic illness in this country.

SENATOR HAMILTON: With respect to those two diseases, I assume that you would point primarily to the heart diseases as being preventable by intervention, education, lifestyle modification and not cancer since we're still groping with the cause of cancer, is that right?

MR. GUARINO: Well, Senator, we're finding out more and more each day that there are related life habits that are causal in certain types of cancer and we know that there are preventable and curable cancers, if we detect it at an early stage and we're finding out now, more and more, that by certain possible dietary changes and sexual habits and genetic awareness that we possibly could detect early or possibly prevent some of these more curable cancers, which, if not found out, could be fatal. The information is coming in. I want to reiterate that this is why it is necessary to be constantly updating.

SENATOR HAMILTON: Alright, you've indicated heart disease, which encompasses at least three or four different items, and cancer. Given that, I don't think we have to say, do we have to prioritize any more, because with those two, we really encompass the whole lot of the mortality rate that we have and I don't think that prioritizing is essential. But, to what extent would you say there are detection programs and intervention programs with respect to cancer and with respect to the heart diseases, throughout the State? Could you give us a general picture, not on a county by county basis, but how widespread is it?

MR. GUARINO: Senator, there are programs ongoing. The levels and the quality and the scope varies from area to area, from municipality to municipality. I think these types of programs are something that is relatively new in terms of the sophistification that's needed to apply the most effective, preventive health education and manpower training that's needed to develop a quality comprehensive program.

SENATOR HAMILTON: I will try not to get in trouble with your Association by asking you to name more effective or less effective levels of government or municipalities or counties with respect to those programs, but is it possible to generalize whether a municipal program or a county level program is more effective?

MR. GUARINO: Senator, I think if you want to speak specifically to Bergen County with Mike, who I have known for a while and I had a good chance to take a look at his program and I can say that that's a program that's in the right direction and if you let it continue to grow, it's going to be the kind of a program that's going to meet a lot of the needs. I can't speak to other county programs because I don't know them that well. Municipal programs? It depends on the type of population, the funding of the local health departments, the initiative of the staff and health officers and the boards of health, what they see as the needs and the way they approach it. I know many municipal governments, including Morristown, where I was working. They have a very conservative attitude. You know, if you're sick, you go to the hospital. The whole idea of chronic illness and prevention and health education programs were very lowly prioritized. It's not something that they feel is that important and really shifted their budgetary priorities. So, the assistance needed from local municipalities and the State is the awareness that this is a major problem that should be addressed with a good deal of attention.

SENATOR HAMILTON: Are you suggesting that the State, in some way, has to be the educators of other levels of government about the importance of these programs?

MR. GUARINO: I think it would be very helpful.

SENATOR HAMILTON: Other than the availability of funds or by the mandating of standards or programs, how would suggest that the State engage in that? I have found, and I've really come to believe over the last three or four years and I don't come with any home rule bias, but I find myself voting, more and more, on the last three or four years, like a real home rule advocate would because I don't find that the State can deliver that many services or do that many things well. I find that our role ought to be more particular in areas like health, standard setting and not in the delivery of services and if you're suggesting that, in some way, we ought to deliver informational services, I really don't know how we can do that well and I fear that we would spend money and not accomplish what you want to have accomplished.

MR. GUARINO: Senator, I'm speaking to something that is more centralized, planning, possibly some administration. But, decentralize implementation. I feel that they have the budget and the capability and the desire to deliver a good program, where others, smaller in nature and smaller in size. For some municipalities, this would be impossible. What I'm saying, from a State level, as I stated before, we need some

sort of focal corps to allow, specifically in the chronic disease area, to keep a standardized training procedure in operation and a reporting evaluation procedure where we could actually find out what we're doing in terms of chronic disease on a State level. Right now, it is fragmented.

SENATOR HAMILTON: Let me ask this and I'm jumping to Item #3 on the announcement, which raises the question, "Has the Prevention of Chronic Illness Act accomplished its purpose of encouraging a shared responsibility among the State, county, municipal and voluntary agencies for the prevention, detection and care of chronic illness?" Have all the provisions of the Act been fully implemented or does the Act need to be amended or possibly repealed or replaced? Can you address that, at least in general terms?

MR. GUARINO: Well, generally, I don't see that coordination existing right now. I don't see it to any great extent. I see the whole idea of Public Law 329, minimum standards, coming down as an attempt to more define the scope of operations of the local health department and agencies that are involved with providing health services. I see that there was a hue and cry from the local health officers on some "how to" answers and it was because of that hue and cry that we're coming together with guidelines. I see that the law provides for this kind of liason and encourages this kind of cooperation. I don't see it happening to the extent it should and could within the State.

SENATOR HAMILTON: I'm sure that there is blame all over, but where do you assess the principal blame with respect to that lack of coordination?

MR. GUARINO: That's a very hard question to pinpoint.

SENATOR HAMILTON: Is it at the local level? Is it the State being not responsive to what local people, who are knowledgeable, say or is it structural?

MR. GUARINO: I have seen some of the things changing in the last ten years, in terms of what the role of the State Health Department has been, what the local health departments are being asked now to provide to the community. I haven't seen this in the past. These are recent developments. Laws are now being written and guidelines are now being set by the State Health Department that are regional and county oriented. They are not locally oriented. It is very, very difficult for a locality, a municipality to implement public law 329, minimum standards, to its fullest extent, without a huge budget. This law would be possibly best implemented in a larger area, not that a locality couldn't do it to a certain extent, to a limited degree.

SENATOR HAMILTON: If we do it in a larger area, we're getting away from the home rule pride that I think many people genuinely feel. If we do it in some other fashion, we're told that we're mandating costs. If the Commissioner does it, getting away from chronic disease for a moment, in terms of other programs, like emergency medical service, we find that a whole lot of volunteer and private providers of very valuable services are very resistant, and while in my municipality of New Brunswick there was widespread support for emergency medical regulations, on a statewide basis, the Health Care Administration Board pulled them back. So, we're the cutting edge in terms of the inter-play of power and responsibility among the various levels of government.

MR. GUARINO: I very much agree with you. What I'm stating is that's how the guidelines are coming down now to locals. I'm not saying that the locals are not providing adequate and necessary services to the community. I feel that there are services, in terms of environmental health, food establishment inspection, complaint response, the kinds of things where the direct people contact and the rapport and the communication level is very important to get the job done and that is best being done at the local level.

SENATOR HAMILTON: I certainly wouldn't quarrel with that, but let's get back for a moment, perhaps I'm the one that got you off the track, talking about the intervention and education programs that you do with respect to heart diseases and the detection programs that you do with respect to cancer. What's the appropriate level for those services to be implemented, by and large, throughout the State?

MR. GUARINO: I think this is a question that we have to look at within our local jurisdiction in terms of local health officers or county units and do a health needs assessment and evaluation of the community and then apply the proper amount and degree of programming that is necessary to meet those demands and needs. We don't have all that information right now.

SENATOR HAMILTON: I can't disagree with that, but I would say that it kind of comes back to what you said earlier in your testimony and I fully agree with it, that we spend an awful lot of time studying things and not enough time implementing it. Yet, on this particular one, we have to look at it more and study it. That's the dilemma we find ourselves in. Now, you are an expert and I think most of the people who will testify here today are health experts. Senator Scardino, while he has a tremendous interest in this area, Senator Russo and myself are generalists. We are not specialists, we're not experts. We're not even experts in the three areas that this Committee is charged with in corrections, health and human services. We have to address tax problems. We have to address environmental problems and we have to address labor problems and what have you, and we really come out here to get an input from those of you who are very knowledgeable in recognizing that there is a divergence of viewpoints and in some instances, you may need more local control and on some other issues, it would be appropriate for some regional cooperation. But, in trying to put something together, we really have to get some hard answers out of these kinds of structural things because, until we get them out of the way, the funding can't really be what it should be. I was just trying to put forward our dilemma in terms of where you are.

SENATOR SCARDINO: We do have to move on and I think that you've made some very good points, Mark, but I also feel, relative to the very questions that you've raised, Bill, that a lot of the answers that we're getting back really are opinions. We're getting some specifics, but not really as much as we want and I think that that goes back to the point that Senator Hamilton made where, on the one hand, we're talking about implementing what we've already learned and on the other hand, we're saying, we need more study, and there's just an imbalance there that we're going to have to straighten out somehow. It seems to me, Bill, because of the line of questioning that you had here, when the Commissioner comes on board or anyone else that would like to enlighten us, maybe they ought to tell us a little bit of the history of local health facilities in the first place, what it is that they were supposed to be doing and have been doing and are doing today and whether or not they are up to date and contemporary enough to handle the myriad of problems that we know exist out there and know that we've identified them, and specifically, the chronic illness area. What role should they now play in today's society? What role should the county now play? What role should the State play? I suppose the bottom line to this whole thing is for us to determine precisely what those roles are going to be. Bill, do you have any additional questions?

SENATOR HAMILTON: No. As you usually do, Mr. Chairman, you put together what I was trying to get to in just the right fashion. Thank you.

SENATOR SCARDINO: Mark, thank you very much. I hope you're going to stay with us today because the Commissioner is going to come on and answer a lot of the questions that you raised. Alice Wittsten, President, New Jersey Nutrition Council?

A L I C E W I T T S T E N: Good afternoon Senators.

SENATOR SCARDINO: Good afternoon. How are you?

MS. WITTSTEN: Well, I hope. I see I am listed as President of the New Jersey Nutrition Council and I am that, but only part of the time. What I am much more of the time is Public Health Nutritionist in Bergen County and I guess, all of the time, a consumer. Some of the things that I have to say, I think, are redundant. They've been said already.

SENATOR SCARDINO: Well, if you could just highlight it, that would be most appreciated.

MS. WITTSTEN: Okay. My comments are very limited. I was very concerned with that first aspect, the scope and prevention of chronic disease and I think a great deal has already been said about the scope of chronic disease. So, if you will, I'll skip that part.

I'm more interested in the prevention of chronic disease, particularly as it would involve the activities of a nutritionist. Can chronic disease be prevented? Certain people all too often, those with a vested interest in maintaining the status quo, argue that we lack hard evidence, the smoking gun which would indisputably link lifestyle with chronic disease. This is an attempt to create confusion with half-truths. Man is a complex organism, coping with an environment that is equally complex. Chronic disease appears to be multi-causal in origin. It is my opinion that we shall never accumulate hard evidence of cause and effect, at least not until we confine men to cages, monitor their total environment and then, only if we can come up with some way to speed up their life cycle. I think the time has come for us to take action to make do with what we have and that's good epidemiological evidence supported by animal studies. I refer you to the incredible amount of data gathered by the United States Senate Select Committee on Nutrition and Human needs during their hearings on diets and the killer diseases. These hearings culminated in a report titled, "The Dietary Goals for the United States." This report recommended that we alter our excessive consumption of calories, sugar, fat, salt and alcohol in order to prevent or, at the very least, delay the onset of chronic disease.

Now, I wanted to make some comments on the dietary goals because I am concerned about the type of media coverage they have gotten. This media coverage has been very sensational and it would have us believe that the dietary goals are highly controversial. I don't think this is so. I feel we are being led up the garden path by those who stand to lose if these goals are implemented. I am a professional nutritionist. I exchange views with other professional nutritionists and I have not found any great controversy about these goals among my peers and I wanted to point out that most nutritionists, along with our professional associations, and these would include the American Dietetic Association, the American Public Health Association, and the Society for Nutrition Education, support the dietary goals and principles. The quibbling that has occured among professional nutritionists has concerned mainly the numbers mentioned in the goals, not the concept. I think that it is crucial that we persuade people to alter their lifestyles, especially their eating habits, if they wish to prevent the onset of chronic disease. As has already been said, this will require an exhaustive public health effort and one, I feel, should not be left solely in the hands of the medical profession. Dr. Theodore Coupa, who is Dean of the Cornell University Medical College, stated in testimony before a Senate sub-committee that allied health professions should be accorded a major role in general public education efforts, reflecting their unique capacity to visit, assist and counsel throughout the community. I would like to reinforce Dr. Coupa's recommendations. Much of the behavioral change we are seeking is related to eating.

It has been documented time and again that nutrition is sadly neglected in medical school curicula. Even if this situation was to be corrected, it would still take too long to get knowledgeable, practicing physicians into our communities. I feel very strongly that education for dietary change must be assigned to the health professionals who are trained and eager to affect it, namely, the registered dieticians. I think that would sort of cover it. Thank you.

SENATOR SCARDINO: Thank you. Any questions of Ms. Wittsten?

SENATOR HAMILTON: Just one. Ms. Wittsten, I certainly can subscribe to everything you say. Is there implicit in what you're saying, as well, a suggestion that this kind of health education that a professional dietician can provide ought to be a part of our health program in the early grades at school. In other words, by the time you get to the 12th grade, that's about the last time most people are going to have formal education in their life. Really, it is the organized school years, when people are there and you have a captive audience and only the people that are interested hear these things later on and I wonder if that is part of your suggestion.

MS. WITTSTEN: It is. I think that a person trained in nutrition should, in some way, be involved in the education of people and also in the offering of services. I guess, because I am a nutritionist, I feel this so strongly. You will find, if you look at the State programs, and I'm thinking of Titles 18, 19 and 20, these programs mandate certain health services. Some of them are actually nutrition related. The programs do not say who should perform these services. So, we find again and again, as has been said earlier, health education in schools, particularly the nutrition aspects of it, is being taught by people with no nutrition background. You find nurses are the ones that go out and offer diet counselling in the home, under home health care. It is really an absurd situation. These people are not prepared to do it. Registered dieticians are and yet, they are not specified in planning legislation and the rest of it.

SENATOR HAMILTON: Senator Scardino was telling me that that was explored in some detail before I got here. Thank you very much.

SENATOR SCARDINO: Thank you.

MS. WITTSTEN: Thank you.

SENATOR SCARDINO: We will now break for lunch and resume promptly at 2:00 PM.

(at which time a luncheon recess was taken)

SENATOR SCARDINO: I would now reconvene this hearing on chronic illness. I am Senator Anthony Scardino of Bergen County. On my right is Senator Anthony Russo of Union County and on my left is Senator Bill Hamilton of Middlesex County and we're here today representing the Senate Institutions, Health and Welfare Committee and we're now going to resume the hearing chronic illness, which is the subject today and I want to know if Patricia Williams is with us right now. We have testimony from Miss Williams, but I don't whether she intends to present it personally or not.

MEMBER OF AUDIENCE: She does, Senator, but probably within the hour.

SENATOR SCARDINO: Okay, thank you. Is Robert Callahan with us? Mr. Callahan, would you be good enough to come up here and testify at this time.

Welcome, Mr. Callahan. I appreciate your presence today. If you could take us through your testimony, I would appreciate it very much.

R O B E R T C A L L A H A N: Thank you very much. My name is Robert Callahan, Chairperson of the Bergen-Passaic Health Systems Agency and vocationally, Director of Health for the City of Paterson and the Boroughs of North Haledon, Haledon, Prospect Park, Hawthorne and West Paterson. I am here today in my capacity as the chairperson

for the Health Systems Agency in Area I and will discuss briefly the findings of the Agency's Task Force on Prevention, as they relate to chronic diseases in Bergen and Passaic Counties.

This Task Force was composed of 27 members representing consumers and providers, drawn from the health service area, who met regularly over a one year period under the chairmanship of Robert Milligan, Director of Health for the City of Passaic and Dr. Marvin Rubin of Hasbrouck Heights, a podiatrist.

The Task Force reviewed the incidence and prevalence of a variety of chronic and other diseases for which it was felt that preventive efforts could make a significant inroad in reducing disability and death. A fundamental finding of this Task Force was that the local health department should be the locus of many of the preventive services that are provided, especially in the detection of chronic disease. A primary factor in the Task Force decision to call for assigning increased responsibility and funds to the public health department is that the public health programs are specifically designed to increase availability and accessability of services to the medically needy.

In addition, the Task Force also recognized the need for a regional health resource center which would provide support to local and county health departments in terms of special resource material, in the development of prototype programs and specific health programs which might be beyond the capacity of some individual health departments, and to provide area-wide coordination for preventive health services. The Task Force also recommended that several programs should be provided on a regional basis, since their services would normally require a higher level of expertise than that found in many local health departments. These programs include sexually transmitted diseases, family planning, genetic counselling, smoking withdrawal, diabetes counseling, and some cancer support and coronary disease programs.

In terms of area need regarding chronic diseases, the Prevention Task Force identified that there are approximately 162,000 people in Bergen and Passaic Counties who have hyper-tension, based on figures supplied by the 46 programs in these two counties, which conduct high blood pressure programs. Only 38,000 visits were made to these screening programs in 1977, and since this figure undoubtedly includes repeat visits, it is clear that the population in the area is grossly underserved. Hypertension is an important contributor to fatal myocardial infarcts and cerebral vascular accidents, and the cost of these illnesses is staggering on the national level (at an approximate cost of $5 billion a year). The cost of treatment for hyper-tension, which varies from approximately $70.00 to $600.00 per year per patient is minor when compared to the national costs and will have an enormous positive effect on the individual whose life might be saved and also in preventing the tremendous loss of wages which occurs because of the effects of this illness, and the cost of acute medical treatment which is made necessary when hyper-tension is not detected in its early stages.

In terms of cancer, which was the second leading cause of death for both sexes and all ages in 1975, the Task Force has several recommendations specific to several types of cancer in New Jersey.

The first is cancer of the cervix. The Pap test, which is in widespread use in the Bergen-Passaic area, is an extremely effective mechanism for detecting cervical cancer. However, its impact is limited by the fact that the women among the low-income population do not have access to a private physician and, thus, run substantially higher risks of developing invasive cancer of the cervix than do other groups. The cost of a Pap smear is low; however, when one organizes an outreach program to attempt to deal with the high risk, medically underserved population, that cost may rise as high as $25.00 per person in public settings. Based on data collected for the Bergen-Passaic area, we

can expect approximately 120 new cases of invasive cancer of the cervix every year, as well as another 290 cases of carcinoma in situ. This, along with other cancers of the reproductive system, can be expected to produce 430 cases of new cancers in women annually, here in the two county area.

Cancer of the colon - cancer of the colon and rectum is the second leading cause of cancer deaths in both males and females of all ages. Based on age adjusted rates, the Heath Systems Agency anticipates 325 cancers of the colon in Bergen and Passaic Counties to occur annually, based on 1970 data. A major problem with cancer of the colon is that most patients who are found to have this cancer are found to be beyond cure when it is diagnosed. The most effective way to reduce deaths is clearly through the diagnosis of cancer in a localized stage when cure rates are much higher. Unfortunately, except for those cancers which result in the passage of blood in the stool, present screening techniques for cancer of the colon are both expensive and uncomfortable. The recommended screening time of every three years for individuals over the age of 40 is a minimum level of screening activity which should be adhered to.

Cancer of the lung - cancer of the lung is essentially a disease related to individuals with a history of long term smoking and in some cases, environmental factors. It is estimated that 540 individuals in the Bergen-Passaic area will contract lung cancer annually, and while the sputum cytology test seems to hold promise in detecting lung cancer, it must be repeated frequently, since cancer of the lung can develop from a local to regionalized stage within a six month period. Treatment of lung cancer includes surgery, chemotherapy, and radiation therapy. This treatment is both expensive and difficult in advanced cases. It should be noted that the five year survival rate for patients with cancer of the lung is one of the lowest for the various cancers.

Cancer of the breast - breast cancer is the leading type of cancer among women, both in terms of incidence and death and is also the leading cause of death in women between the ages of 40 and 44. Nationally, five out of one hundred will develop breast cancer during their lifetime. Based on the annual incidence rate for New Jersey, it is estimated that 563 new breast cancer cases will develop in the Bergen-Passaic area on an annual basis. Early detection of breast cancer has been encouraged from a variety of sources, which have received widespread publicity in recent years. The cost of the screening ranges from $5.00, when a physical examination is done by a professional,to the cost of a mammogram of approximately $45.00. A particularly effective mode of screening is that of self-breast examination, which can be done frequently and at no cost. Therefore, we strongly support health education methods which teach this self-examination technique.

An inventory of cancer death programs in the Bergen-Passaic area indicates that there are 31 agencies providing cancer detection programs. The Task Force in reviewing its data recommended a a variety of activities which should be carried on at both a regional and local level. These exclude expansion of the colon cancer detection program and smoking withdrawal classes on a regional basis and the incorporation of cervical cancer detection programs into annual visits to adult health consultation programs or general health care clinics. The Task Force also felt that separate cervical cancer programs should be discouraged, since the number of willing participants would be small.

The Task Force recommended that local lung cancer detection programs should be discouraged except for pilot programs to test the effectiveness of new detection programs.

In summary, while the agency has not taken a stand on many of the six topics noted as a special concern by the Committee, we believe that local health departments and regional health coordination bodies are the strongest elements in combating chronic disease. Many of the questions asked by the Senate Health and Welfare Committee deserve further study at both the State and regional level, and since resources are limited, it may be necessary to make decisions as to what chronic illnesses should receive priority attention and how local, county and State resources can be coordinated to insure that the preventive detection and care of chronic illnesses are carried out at the most effective level.

Historically, New Jersey's concern with home rule has been mirrored in the development of local health departments providing across the board services to the residents of their communities. Recent legislation has required that a minimum form of affiliation of municipalities for health services take place and in some cases, the regionalization of this function. This approach has been presumed to have had substantive positive effects on the ability of those organizations to deliver improved health services. The proof of this effort awaits the implementation of adequate programs of evaluation, as well as a need for adequate resources to implement all of the programs which local and regional health departments are mandated to provide. It is clear that more funding would be beneficial to both the local and regional health departments and that clearer targeting of this funding to the prevention and detection of chronic illness would insure that this need would receive more attention than it has in the past. We, therefore, applaud the effort of the legislators to make more funds available for a renewed emphasis on chronic disease, but specifically caution that this emphasis should not be one which forces the agencies to divert resources from current programs to meet this need. Thank you.

SENATOR SCARDINO: Thank you very much, Mr. Callahan. Senator Russo?

SENATOR RUSSO: I have no questions.

SENATOR SCARDINO: Senator Hamilton?

SENATOR HAMILTON: I just have one or two questions, Mr. Callahan. On page 5 of your statement, Mr. Callahan, you say there 31 agencies providing cancer detection programs. How many of those are local health departments and how many are private agencies?

MR. CALLAHAN: I do not know that, sir. I do not know how many are private and how many are local.

SENATOR HAMILTON: Can you estimate the coverage that you're getting with those 31 agencies in the Bergen-Passaic area? How many people are actually being screened as a result of that effort?

MR. CALLAHAN: I would be comfortable answering, perhaps, more comfortable answering for Passaic County rather than both. I think Mr. Guarino, Mike Guarino from the Bergen County Health Department might be able to answer the question in more detail for Bergen County. The City of Paterson and the five municipalities that I refered to are six of the sixteen municipalities in Passaic County, which represents approximately 225,000 people, about one half of the Passaic County population. These screening programs are available to that population most definately. To my knowledge, they are also available to residents of Wayne, Clifton, and to Passaic, and to some extent, West Milford and Bloomingdale. I don't think I can answer definately beyond those.

SENATOR HAMILTON: So, what you're saying is that the programs are available to something in excess of 50% of the population.

MR. CALLHAN: Yes sir.

SENATOR HAMILTON: But, you probably screen what kind of a percentage of the population?

MR. CALLAHAN: We are screening probably somewhere 5 and 10% at a maximum. I would say it would probably be closer to 5%.

SENATOR HAMILTON: I assume you would subscribe to all the thoughts that all the other witnesses have voiced, the need for educational programs.

MR. CALLAHAN: Definately.

SENATOR HAMILTON: Perhaps you answered your own question that you voice at the bottom of page five, when you say it may be necessary to make decisions as to what chronic illnesses should receive priority attention. What is your specific answer to that?

MR. CALLAHAN: I would say heart disease, cancer and cerebral-vascular accidents, probably in that order. I think they lend themselves to preventive efforts and they can be done with reasonably cost effective procedures. That, of course, does not involve all cancers, but a substantial number.

SENATOR HAMILTON: If it would be possible, without imposing on your offices and the other things that you have to do, if you could give us any further data about those 31 agencies and how many are public and how many are private and any other statistical kind of data, that would very helpful.

MR. CALLAHAN: We would be more than happy to do that, Senator.

SENATOR HAMILTON: I'm very impressed with your grasp of this problem, Mr. Callahan, thank you.

SENATOR SCARDINO: Mr. Callahan, I have a couple of questions. In your statement, the last paragraph on the first page, you talk about the Task Force recognizing the need for regional health resource centers, which would provide support for local and county health departments in terms of special resource material, the development of prototype programs and specific health programs, which might be beyond the capacity of some individual health departments and to provide area-wide coordination for preventive health services. Now, were you with us this morning?

MR. CALLAHAN: Yes, I was.

SENATOR SCARDINO: If you will notice, there was a question of infringing on the local level and taking away from that level the home rule concept, so to speak, and doing things for themselves. How would you propose doing something like you're suggesting here without impacting on a municipality that may want to just be isolated from all this?

MR. CALLAHAN: This is not a mandatory health resource center. This is a health resource center established by the Bergen-Passaic Health Systems Agency, making use of its extensive library of health resources, the health planners and research people who are available to that agency. It is not a "you must come in and talk to us about this" kind of approach at all. It is just that if you are interested--this would be the approach--if you are interested, this information is available to you and is available to you at no cost.

SENATOR SCARDINO: I guess I'm just reacting to the last sentence, which says, "To provide area-wide coordination for preventive health services", and I'm looking at it in its most ideal sense and saying, in order to do this, one hand must know what the other hand is doing. If one of the members is missing, you're incapacitated to some extent. In your judgement, working on both the county and local level, can you tell us how prevalent this attitude is at the local level, not to participate because some would lead us to believe this morning that many municipalities don't want to become involved and I don't know if I share that feeling.

MR. CALLAHAN: I think that the concept of home rule is very strongly reflected, particularly throughout Passaic County. I don't think there's any question about that. It has historically been strong and it continues to be strong.

SENATOR SCARDINO: Right. It's as strong and as clear in Bergen as it is in most municipalities in the State of New Jersey.

MR. CALLAHAN: Right and one of the reasons that I think this is true in Passaic County, particularly, is that there is no county health department. Consequently, the development has been, until very recently, largely one of the larger municipalities having the necessary funds and resources, proceeding forward, sometimes at a faster pace, than other municipalities, other municipalities without adequate resources being unable to keep up. I think that we do have a cooperative effort which involves the various agencies, either on a contract basis or individually, and municipalities are now well represented. Each of the 16 municipalities in Passaic County has available to them a health officer, with the necessary expertise to do the job. I can only comment on the five municipalities with which we contract. Our contracts do not provide for so many hours of my time or a nurse's time. It provides that we will provide for the five municipalities all of the services which are currently available for the residents of the City of Paterson, which is a somewhat different approach. In other words, it makes available a health center which costs some $2.5 million and it is rather sophisticated and the expertise which goes with it to those communities.

SENATOR SCARDINO: Just as to my question, specifically, do you feel that most, if not all, municipalities would cooperate with the program of detecting, identifying, classifying, if you will, categorizing, chronic illness and then working on an approach on the regional level or through the regional level, if that's necessary, to address itself to the needs of prevention, etc., etc.?

MR. CALLAHAN: I would say, Senator, only if you can demonstrate that this regional level is the way to go and that it holds some benefit for that municipality.

SENATOR SCARDINO: But, the Task Force that you cite here in your report recommends that.

MR. CALLHAN: That's right. That is precisely true.

SENATOR SCARDINO: And, I would take it that you agree with the Task Force recommendation.

MR. CALLHAN: I agree with the Task Force's recommendation, by and large. There are some, I think, provisos which must be made. I think that the recommendations fit Bergen County more successfully than they fit Passaic County, because in Bergen County you have the Bergen County Health Department, a strong health department, and in Passaic County--in other words, you have a history in Bergen County, where the county has been active. In Passaic County, you do not have this. The localities, historically, have been providing for themselves. That is a different situation.

SENATOR SCARDINO: I guess what we're trying to establish here is,if it is agreed that there are, as the Task Force pointed out, services which would normally require a higher level of expertise, this is what the report says and I assume that you have professionals who are sitting on the Task Force, require a higher level of expertise than that found in many local health departments. Now, if that's the case, and you identified the need to do something more in a concerted effort than we're doing now in addressing ourselves to the chronic illness problem, how do we get the community involved, over and above what we're doing now?

MR. CALLHAN: It must be on a voluntary basis and we have to provide the community with information relative to what we have. The communities in Passaic County and I'm sure many in Bergen County are not at all aware of the preventive health

plan from which this is taken. The Task Force, although the reports were certainly widely distributed, I'm sure, have not gone across the governing bodies of many of the 16 municipalities. They haven't seen it yet and I think that's where we're missing the boat.

SENATOR SCARDINO: Forgive me for interrupting, but I want to try to stay with the specific question and that is, unless the leadership really comes from those of you who know what the problems are, who understand it more readily, who work with it day in and day out and then, subsequently, can identify what the remedial actions ought to be and then, recommend those actions to the appropriate party, we're not going to get very far with this because we may end up in the same dilemma that we were in, in cases where many of you on the front lines and in a respectable, professional capacity will start to complain and scream and holler because the Department of Health of the Department of Human Services suddenly is going to come out with a plan that they're going to say is the cure-all for the entire State of New Jersey. I'm suggesting that right now, by virtue of what you told us here today, that you ought to really take the initiative from the bottom up rather than waiting for it to come from the top down and tell us how to go about doing it. Senator Hamilton?

SENATOR HAMILTON: Do I understand, Mr. Callahan, that there is a regional health resource center or that there should be?

MR. CALLHAN: There currently is being established a regional health resource center. The necessary information is available, but it is not yet functional.

SENATOR HAMILTON: With respect to the funding of that resource center that is being established, can you tell us, is it sufficiently far along that you can tell us where the funding is coming from in terms of local dollars, State dollars, federal dollars, county dollars?

MR. CALLHAN: Currently, it would be established under federal dollars, 93:6-41, establishing the HSA and providing for the funding.

SENATOR HAMILTON: And, is that under a program that you will have ongoing entitlement or is that under a program that you will have to look from year to year?

MR. CALLAHAN: It is year to year, depending upon the recertification of the Health Systems Agency. The funding level is established also from year to year.

SENATOR HAMILTON: I don't want to take on the whole federal grant system, but therein lies the core of a whole lot of our problems. We ask the people of Bergen and Passaic Counties to get into some important and innovative areas and give them federal grant money to do it with no promise that there will be any ongoing money and then, you get two or three years down the road and you find out that there isn't any more federal money. You justifiably look to other levels of government, which in the meantime has been meeting other priorities, and it really gets back to the point that Mr. Carlano made that we don't have enough inplementation. You have enough to get started and about the time that you have something that is going to be very smoothly operated, you're going to be out of money and you're going to be knocking on somebody else's door for it and they're going to be hearing taxpayers' screams. Let me ask one other thing about that. You have indicated that this must be voluntary and I understand that from the point of view of political sensitivity and yet, on the other hand, I have to question, in light of the fact that you folks are doing what you are on a voluntary basis and presumably, many other people are doing nothing or very little. If the need isn't for those that won't do something on a voluntary basis and maybe that need shouldn't be spelled out or required by State government and I'm sure that it shouldn't be spelled out by federal government, but if you folks are doing something, you don't need too much prodding. You may look for resources. It is the people who aren't doing anything about detection, about screening or whatever who maybe need the spur and it's ironic that you say

that it ought to be voluntary because the people who would do it voluntarily don't need State government to do anything, except give a dollar where they can.

SENATOR SCARDINO: Did you want to respond to that?

MR. CALLAHAN: I just wanted to quickly respond. Obviously, it cannot be all done voluntarily. I think that is the optimo way to approach it. The reason that the 16 municipalities in Passaic County currently have the representation that they have comes directly from Chapter 329. There's no question of that. I'm sure that would not be the case if Chapter 329 had not mandated meeting certain services.

SENATOR HAMILTON: Well, I think that's where Senator Scardino makes the point and I would subscribe fully to what he said, that rather than wait until either the Legislature or the Executive Branch lays something on you and you say, "hey, you're intruding on our powers," if those of you who are the front line, to borrow the Senator's phrase, would say to us, "Listen, design a system, design a structure that takes this much away from us in terms of local control, but gives us this much in terms of what we can expect to have by way of resources", and let you tell us how to design the system, rather than have it superimposed. It would be very, very helpful.

SENATOR SCARDINO: Would you just take us through the steps here that you feel local health departments, county and State would involve itself in? Are the categories screening, detection, prevention? Did I leave anything out or do you have anything to add to that?

MR. CALLAHAN: Health education, I think, is primary.

SENATOR SCARDINO: Well, in what order would you put them?

MR. CALLAHAN: I think we have to have health education in order to make the public aware.

SENATOR SCARDINO: So, we're talking about education, then screening, then detection, and then prevention.

MR. CALLAHAN: And follow-up plus evaluation of the programs. Are they cost effective? Are we getting to what we want to get?

SENATOR SCARDINO: Well, that would be included in the follow-up and evaluation.

MR. CALLAHAN: Right.

SENATOR HAMILTON: Mr. Chairman, I think the follow-up is a medical follow-up and that's a separate thing from the system follow-up or the oversight or whatever.

MR. CALLAHAN: Follow-up would be a medical follow-up and follow-up would also be evaluation.

SENATOR SCARDINO: Medical and evaluation of the program itself?

MR. CALLAHAN: Yes sir.

SENATOR SCARDINO: Would you say, and I'm asking this not knowing the answer, because I've only just seen some capsulization of the Task Force report because of the fact that you're with us today, would you say that this report leans more on the screening and detection than it does on the prevention component?

MR. CALLAHAN: No, I think it is fairly well split and to give you some feeling of this, the prevention Task Force was not just something which was included in the plan. It is also included in the annual implementation plan, which means it must happen this coming year. We're looking for it to happen. We're not looking for just some beautifully drawn fiction on paper or a five year plan way down the road. We're looking for it to happen.

SENATOR SCARDINO: I want to ask you one final question, if I may. It is a point that you brought up that wasn't brought up or at least emphasized this morning and that was the target population. Would it be or could it be defined in terms of wealth, position in society, whatever, regarding the people who would, A, take advantage

of whatever preventative programs are being offered, and then, coupled with that is a related question as to who really are in the greatest need for these programs in terms of social status, in terms of wealth. You talked about the low income population and the indigents. Would you say that they are the ones that would really be those that we ought to set our sights on primarily?

MR. CALLAHAN: I think the minorities and the working poor, who are the ones who are medically poor or medically indigent, most definately, that's where we have to aim the public programs.

SENATOR SCARDINO: Do you think those who are in a higher income bracket, for example, are more sophisticated and knowledgeable in terms of quality of good health care prevention?

MR. CALLAHAN: No, I don't think that is the case. However, what I do think is the major problem and I'm really trying to approach this. If you go in and you make the people who have some money, some resources available for a given threat of health, you can reasonably expect that they will assume some of the burden for their own health care. They will visit a physician. If you go back and ask them whether or not they did, you would expect to see some results that are measurable. On the other hand, you can screen, let us say, 500 of perhaps the lower economic group from the City of Paterson and if you went back three months later and you had not provided the wherewithall for follow-up, the medical follow-up, it wouldn't be done. Nobody would have gone to see a private physician. What I'm really saying is, if we went in and we did a hyper-tension screening program and then we identified those people who were high risk and we felt, for instance, should have a blood chemistry profile in order to more closely determine whether or not they were at risk. We can't send them to a physician and expect that that would be done. We can't make it their own burden. We have to pick up the burden. The essence is that most of the money has to go to where it's needed.

SENATOR SCARDINO: I just want to bounce a statement off of you and see what your reaction is. It is reasonable to conclude that the time is right for classification of health services into a number of categories: Those that can be provided by a municipality; those that should be provided by a regional entity; and some that could be performed at either level. To some extent, this classification has already taken place. Municipalities are contracting with the counties to perform some services, while retaining the basic responibility for others. Counties are agents to some mjnicipalities for all or part of the services or maybe agents for all the municipalities within their boundaries for all services. One gets the impression that decisions on which services are to be performed locally and which should be area-wide is "cafeteria style", picking and choosing on a basis of individual preference rather than in terms of a logical approach to the nature of a particular health problem. I would simply like your reaction to that, if you would be good enough to give it to me.

MR. CALLAHAN: I believe that the statement is largely accurate. I am sure that's been the case, that if a choice were available, it might be made for many reasons other than actual need. It may have meant additional monies or coverage of some service that was mandated, as opposed to an actual need procedure, that is the establishment of need and then providing the services to meet that need. I don't know that in all cases a county agency is the logical way to go. I would have serious reservations about Passaic County in that particular gamut. I have no reservations about Bergen County.

SENATOR SCARDINO: Thank you very much, Mr. Callahan.

SENATOR HAMILTON: Before you leave, Mr. Callahan, what kind of cooperation do you generally get from the larger employers with respect to any of these screening programs? Do you take them out to the plant site? Are you able to do any of this on a mobile basis or is it feasible to do any of this on a mobile basis?

MR. CALLAHAN: We currently do nothing on a mobile basis. We have found that most of the larger manufacturers and corporations are interested if it applies directly to them, in a measurable manner. For instance, if we provide cytology screening of urine, certainly the aniline dye plants in the area would jump on board. This saves them something. They see a definite benefit. The unions operative in their plants find that very beneficial. They'll jump on the bandwagon. On the other hand, if we come in with a general hyper-tension screening program, we have not particularly seen manufacturing outfits ready to fall over backwards and say, "Here's my arm, put the cuff on."

SENATOR HAMILTON: Well, what I'm interested in, and to stimulate some thinking about what you're talking about, is that we not try to redesign a whole new wheel, a whole new system for things. If we could, in some way, do some of the detection and some of the screening on a mobile basis, perhaps using some grant money, and get the assistance of employers, we would be reaching certain target populations and in the same way, we have existing senior citizens programs, nutrition programs and we have a whole welfare system that perhaps could be tied in as a requirement of participation for certain types of screening, if that is seen to be appropriate for those categories of persons and that may be too complicated to coordinate, but if we're missing a whole lot of people, if you're reaching 5% in the area that you say and you appear to have a good operation, it may be that we need to, in some way, try to tie in the existing community support infrastructure that we have.

MR. CALLAHAN: I agree with that. We have been attempting to do just that through volunteer groups and other groups which are formulated within the boundaries.

SENATOR HAMILTON: Well, is there a way for the Legislature to require someone who gets State funds to run a senior citizen program, for instance, have someone come in and talk about the available health services that are provided through the county or through the local agency once a year or to the extent the State money is received for nutritional programs. We should have that kind of a requirement.

MR. CALLAHAN: I think it is an excellent idea. We, in fact, currently do that. Our public health nurses make these calls and provide this information of the nutrition sites to the senior citizens. We go to where they are because they can't come to us.

SENATOR HAMILTON: And that's generally received well by the people?

MR. CALLAHAN: Most definately.

SENATOR HAMILTON: Thank you.

SENATOR SCARDINO: Thank you very much, Mr. Callahan. Patricia Williams?

P A T R I C I A W I L L I A M S: Good afternoon. I am Patricia Williams, health educator, a member of the professional staff of the Bergen County Health Department. I wish to present my views as a Public Health Educator and as a consumer.

We are a disease oriented, pill popping society. We don't hesitate to run to the doctor with a pain or take any of the numerous over-the-counter drugs to treat ourselves. Yet, most of us fail to think about what we can do to lessen the chances of obtaining a chronic disease.

Some individuals live their life like a game of Russian Roulette. Victims of chronic disease tend to be largely disinterested until their unconcern has brought them actual pain, often coupled with fear. This is because the nature of chronic disease is not to produce symptoms until it has progressed past the early stages.

Not enough is being done in most school systems in educating children to make the informed decisions regarding behavior patterns most will keep the rest of their lives. Physicians, in part due to extremely busy schedules, usually do not educate

patients in prevention. They may tell the patient, after the first heart attack, that now he has to give up smoking, but during the ten or twenty years that he was a patient, the doctor usually said little or nothing about the habit.

Man creates his own environment. Our environment is a lifestyle made up of choices of what we eat and drink, of whether or not we exercise, of the amount of stress in our lives, and of whether or not we smoke. As Americans, we tend to overeat, eat wrong foods, smoke, drink, worship the sun and ride rather than walk.

60 to 70 % of chronic illnesses, such as cardiovascular disease, which includes heart attack and stroke, respiratory disease and cancer are caused by man himself. Only 20% are occupationally caused. What man creates, he can undo.

The problem with getting people to change behavior is that most enjoy all their bad habits and really cannot relate to future orientation, fail to admit that their behavior, unless altered or stopped, will lead to the road of chronic illness.

As a nation, our priorities have been freedom and growth--admirable under certain contexts. Part of the current problem lies within the fact that we subsidize the tobacco industry to the tune of $76 million. We do this knowing that this subsidy will lead to direct and indirect health care costs, which are included in the economic impact of smoking.

The tobacco industry has an extremely powerful lobby to continue with their deleterious products. When they advertise, "Step into Marlboro Country", they neglect to say, "and welcome heart attack, stroke, emphysema, cancer, high blood pressure and other diseases."

The direct cost of smoking is estimated at $7.5 billion, which is approximately 7.9% of all direct health care costs in the nation. The total cost of smoking includes direct care cost, fire damage, and lost earnings. American smokers have actually paid $15.7 billion annually for the privilege of incurring diseases that cost us $25.9 billion annually.

Having this knowledge, the federal government has allocated $1.6 million for disease prevention. It is a sad commentary on the American way, when we would rather spend more money to create disease than to prevent it.

Traditionally, health education has dealt mainly with chronic disease. Professional health workers have always been able to predict a problem when it is visible and financial resources are usually planned for implementation to this end. Most professionals have lacked the imagination to envision potentials in preventing chronic illness. It is only within the last couple of years that the federal government has directed the way toward health information and health promotion.

Such critical areas as heart risk factor, nutrition, cancer risk factors and alcohol abuse may seem unexciting and be ignored at preventive and even incipient levels. Yet, both preventive education risk factor modification can preserve the well-being and the lives of thousands.

Regretably, ignoring these major elements breeds ignorance of not only health information, but also of the resources, usually within our communities, which offer education, early detection, counselling, often available at little or no cost. The result is a general lifestyle that renders people prone to minor and major diseases, which, to a dramatic degree, could be avoided.

A program that is in development at the Bergen County Health Department is designed, in the words of a United Nations committee, "to help individuals to become competent in and carry on those activities they must undertake for themselves, as individuals or in small groups, in order to realize fully the state of health defined in the Constitution of the World Health Organization (complete physical, mental and social

well-being, not merely the absence of disease or infirmity)." Toward that end, our strategy is to implement a plan to help families increase their health knowledge, become aware of and utilize community health resources, modify their behavior to develop health positive lifestyles, and improve the quality of life within the population.

To alert and inform the public in representative communities, a concerted, in-depth education program is planned to focus upon the following areas: heart risk factors; nutrition risk factors; cancer risk factors; and alcohol abuse.

Pre- and post-questionnaires, interviews, as well as medical profiles based on physicians' examinations will be used, along with personal goal committment cards for individuals to carry as continual reminders. Various media will be utilized to concentrate efforts in selected communities: weekly "shopper" newspapers delivered to each home; posters and flyers; printed materials distributed to program participants; exhibits and displays in public and quasi-public institutions; films; slides--especially where relevant on-site components can be introduced; T.V. programs on public service stations; cable T.V. programs; speakers at group meetings; etc.

Program staff will work with community organizations to maximize contacts with target audiences and, conincidentally, to benefit from local approval of the program, which is implicit in organizational cooperation. This would include groups as diverse as PTA's, fraternal, service and veteran groups, business and professional societies, social agencies and so forth.

In the Heart Risk Factor Program pre-questionnaires administered by staff will show whether client has or lacks knowledge, attitude and behavior to avoid or reduce risk factors. Physicians' physical assessments will indicate levels of blood pressure, blood cholesterol. A follow-up questionnaire, conducted by program staff, three months after the physical examination by a doctor will reveal whether clients' knowledge, attitude and behaviors now contributes to low or no risk levels in blood pressure, blood cholesterol and readiness to have tests every two years, and smoking cessation or reduction to a maximum of ten cigarettes daily or participate in smoking withdrawal program.

Nutrition Factors linked to heart and cancer will be apparent in results of pre-questionnaire by staff, timed to follow immediately the Heart Risk Factor post-questionnaire. Special attention will be given to present consumption of highly processed foods, sugar, fats, salt, utilizing the department's "Eat Defensively: Protect Your Health" series of nutrition pamphlets and assessing possible overweight problems and inadequate exercise. Three months later, a follow-up questionnaire will reveal possible gains in nutritional knowledge, attitude and behavior modification, or need for reinforcement.

Cancer Risk Factor pre-questionnaire, related directly to lung, colon-rectal, breast and uterine cancers will reveal whether a client has or lacks knowledge, attitude and behavior to avoid or reduce risk factors, such as cessation or reduction of smoking.

Physicians' physical assessments, involving hem-occult and PAP tests and breast examination will indicate risk factors. Cancer Risk Factor pre-questionnaire, as well as physicians' physical assessments, will be timed to follow immediately the Eat Defensively post-questionnaire. After an interval of three months, the post-questionnaire regarding Cancer Risk Factors will determine whether the clients have achieved basic knowledge of attitudes toward such periodic testing as: hem-occult yearly after age 40; PAP smear every two years after age 25; breast self-examination every three months after age 30, and yearly by an expert. The follow-up questionnaire will also reveal whether clients who were smoking have now stopped smoking or reduced cigarette smoking to a maximum of ten daily on their own or entered a smoking withdrawal program. It will also show a change in dietary habits.

Alcohol Abuse will be addressed in staff pre-questionnaire approaches to knowledge, attitude and behavior regarding consumption or abuse of alcohol. As with other areas of the overall program, after an interval of three months, there will be a staff post-questionnaire to evaluate knowledge, attitude and behavioral changes in relation to alcohol consumption, including any clients that may have entered supportive therapy.

Manpower Training: As the various facets of program inplementation expand, community volunteers will be sought, including such individuals as nurses, retired persons and others. They will be trained to perpetuate progress of the program. The slide presentations will be duplicated to accomodate community needs. Printed materials produced by the County Health Department will be supplied as the demand continues. Department staff will also be available for consultation with local leaders.

Evaluation: A major aspect of evaluating the effectiveness of the program would derive from measurement of behavior change and modification of lifestyles within the selected groups. The bulk of the comparative data would come from questionnaires, interviews and physicians' examinations.

Physical assessmentw by clients physicians will develop profiles to enable staff to assess status of individuals' risk factors and reveal whether any kind of modifications are needed or indicated. Staff pre- and post-questionnaires and interviews will show whether the client has or lacks the knowledge, attitude,behaviors to avoid or reduce risk factors.

In summation, I believe the value of life is infinite, but the value of pain and suffering is also significant. Society does not place any monetary value on pain and suffering, unless work days are lost.

Our own decisions concerning preventive health care are molded by media support for programs of various health organizations. The economic value of mass screening has been questioned, especially in Britain, on the grounds that widespread use of tests has not been conclusively shown to be associated with reduced mortality.

The cost-effectiveness decision involved in the direct expenditure of public funds for chronic illness must be re-examined. Our advanced technology in the health industry leads to a wide range of services that can be purchased, but we cannot afford all the choices. The only choice we can afford and must make is for preventive health. Community programs must be reinforced through the media.

Beginning with health information and health promotion, people will understand how to stay well and develop healthful habits. In this way, everyone should want to make good health his responsibility.

SENATOR RUSSO: Very good. How will it be financed?

MS. WILLIAMS: It is already underway. We did start it and it is financed through the various fundings that come straight into the Department and I can't answer that specifically because I really don't have anything to do with that.

SENATOR RUSSO: Do you have any idea of the anticipated cost of implementation, at least for the first year?

MS. WILLIAMS: No, I'm sorry, I couldn't answer that. Mr. Guarino could answer that better than I could.

SENATOR RUSSO: The program relies heavily on many areas, including education, and earlier testimony today went into education at the school level and detailed the importance of education and professional teachers and so as to treat it as a major subject. What are your thoughts in relation to education at the school level in preventive medicine?

MS. WILLIAMS: I would like to see more health education and I would like to see it from kindergarten on through 12th grade. Unfortunately, too many of the issues are not taught or they are taught at a very minimum amount. We don't do drug education unless it is really mandated and that's a minimum of ten hours in the high school. Some schools do more and others wait until they have to do it and it's too bad that we have to mandate our health and our healthful habits, but it should begin in kindergarten on up. It should be all the way through, just as English, math and reading, because if you don't have your health, you can't utilize the other components.

SENATOR RUSSO: Then, it is your opinion that it should receive the same attention as any major subject?

MS. WILLIAMS: It most certainly is.

SENATOR RUSSO: Your statistics are interesting in regard to the war on tobacco. Right now, it looks like a losing cause. What can we do in the State of New Jersey, with respect to tobacco usage to help prevent the occurence of lung cancer? Do you have any thoughts on that?

MS. WILLIAMS: The first thing I would do is stop the subsidy, but that's a bit of fantasy, I'm sure. The realistic part is that we can educate people only so much. The idea behind health education is that you must use all types of media. You mentioned before about maybe some people and their socio-economic levels, they have more knowledge. Maybe they do, but some still have not internalized this knowledge and that makes the difference. Whether you smoke or you don't smoke, you have to internalize the knowledge of what happens and the first thing you can do is educate the children. There's been an increase of young females from 11 to 19 by 20% that have started smoking. The male population has decreased by 40%. So, we're not doing enough with our young people.

SENATOR RUSSO: You would favor, then, the educational factor more than anything else in the war against tobacco?

MS. WILLIAMS: Yes, and coping skills and decision making.

SENATOR SCARDINO: Senator Hamilton?

SENATOR HAMILTON: I couldn't agree more with your observations about media, but in a free society where you try to inform people about about what's good for them and then hope to God they do what's good for them, you have some real problems. It isn't the unavailability of programs, as demonstrated by your testimony here today. It's getting the message across to the people about the things that are good for them and I don't know how you legislate that, whether you're talking about the mayor or the freeholder or the Legislature. You're right, the advertising agencies, the media people can be a great help. I think you ought to use and I think everyone in your business ought to use cable television. They have a requirement for community access. They have a requirement for public service programming and if the quality of the presentation can be put together with an appropriate use of audio-visual, I think you can make a start. But, let me ask you this. We have, as one of the items on Senator Scardino's notice about this public hearing, we have in New Jersey a Prevention of Chronic Illness Act and we have a Division of Chronic Illness Control. Are they effective? Do they say what they ought to say? Should they be scrapped and should we start with a different approach? Do you have any thoughts on that?

MS. WILLIAMS: I don't think we should just completely scrap it. You have to build from within and embroider onto it. You have people that have disease. You have people who are at risk level. They are close to or have the very beginning stages. You can reach those people. You can prevent them from going into disease at a more in-depth inter-disease. I don't think we should just eliminate. We don't have that

much to eliminate, but I think what is there should be turned around.

SENATOR HAMILTON: I understand what you would do at the local level and I applaude it and I approve it, so far as I understand it.

MS. WILLIAMS: May I give you one example?

SENATOR HAMILTON: Surely.

MS. WILLIAMS: If you think back to when John Kennedy was President of the United States, he emphasized physical fitness and at that point, everybody started jogging, whether they were physically fit to jog or not. But, they started jogging. Schools started mandating Physical Education. A person could not graduate unless he had X number of years of phys. ed., something that had never been before. If you have your figures high in politics emphasize the things that every American should do, people pay attention. When John F. Kennedy said everybody should exercise, in every aspect of life, you saw people exercising.

SENATOR HAMILTON: Well, you've got Former Governor Apodaca, who is President Carter's Physical Fitness Adviser. You probably have the most atheletic and physically fit governor in New Jersey's history and I don't say that by way of a political endorsement, but I think Governor Byrne, in his private life as well as his public life, is clearly somebody that sets that kind of a standard and I suspect that among the 50 governors, he is probably in the top two or three and I suspect he may be the top one, but that doesn't mean there is a lot of us who are over weight and smoke and drink.

MS. WILLIAMS: It's one thing to do it in your personal life and it's another thing to promote it in your political life.

SENATOR HAMILTON: On the other hand, if I make a point of the fact that I jog in the morning, and last October I did start jogging, people are going to say that I'm using that to enhance my political career and that I'm not really interested in health at all. So, you're damned if you do and you're damned if you don't.

MS. WILLIAMS: Except, if you believe in what you're doing, it doesn't matter.

SENATOR HAMILTON: I agree with you as to the delivery of that message in that way. I don't think that is the total answer. I think the schools are vitally important. I think the media is vitally important and I think people in public life are probably a part of that, but certainly I found the information you had about your program and your statistics very, very interesting and I would like to thank you.

SENATOR RUSSO: Is your group also involved with the A.A. unit in Bergen County?

MS. WILLIAMS: We have started with the Heart Risk Factor program. As I said, every three months we will go back to an organization. So, we have not been up to the alcohol program. We do refer people to A.A. That's an ongoing process at all times. But, the thing is, when we get into the community, what we're trying to do is saturate the community.

SENATOR SCARDINO: Thank you very much.

MS. WILLIAMS: Thank you.

SENATOR SCARDINO: Pat Wood, President-elect of the New Jersey Public Health Association?

P A T W O O D: My name is Pat Wood. I am a licensed health officer and President-Elect of the New Jersey Public Health Association. This is my first opportunity to testify at a Committee hearing and I am grateful for the opportunity.

In passing, I would just like to comment that I am employed as Director of Services at the Paterson Home Health Agency, and I wanted to make one comment on the nutritionist's statement earlier this morning in which she mentioned that the public health nurses were in fact doing nutrition counseling in the home of patients. We do this with the orders of a physician. This is not something that the nurse takes upon herself - even though many of us in our education have in fact worked in nutrition clinics, and I personally spent two years majoring in nutrition before I received my Bachelor's Degree in Public Health Nursing, so that we do have an educational background in nutrition which is not as extensive as a nutritionist,but it is sufficient so that we can carry out a physician's order.

The New Jersey Public Health Association had its beginnings in 1875, even before its parent group, the American Public Health Association. Its membership includes individuals from all health disciplines in this State. I will name but a few: doctors and dentists in private practice, professors from our State College of Medicine and Dentistry, psychologists, health educators, health planners, members of local boards of health, consultant staff members of the State Department of Health, public health nurses, registered sanitarians and environmentalists, students and private citizens. Last but not least, I represent our members who are state, county and municipal health officers. I will limit my remarks today to Senate Bill Number 3045, Section Two, lines 13, 14, and 16. I quote, "The county health officer shall submit a request for funds to reimburse the municipality."

On January 23rd of this year the President of the United States in his State of the Union message to Congress said, and I quote, "We must act now to protect all Americans from health care costs that are rising one million dollars an hour, twenty-four hours a day doubling every five years." How then can you justify a bill which begins a new funneling of health monies through a county health department in counties where no county health department exists. How can you justify a bill that would discourage successful regional cooperation of existing local health departments? How can you justify a bill that would diffuse into the under-developed municipalities, the presently successful effort of a county health department? To create by legislation another level of government where none presently exists would be inflationary. We must keep the taxpayers in mind and use one as our existing health leader. You heard some of them this morning. Leaders surface in unexpected places. To assume that the county health officer is the leader in any area is not borne out by the facts. To assume that the umunicipalities should march to the county drummer does not give proper recognition to the high standard of health services now being paid for by the local taxpayer in some of our state communities. We must work to use more efficiently our present health manpower and resources as available monies continue to shrink. We must act now to save our taxpayers from rising health care costs. Thank you.

SENATOR SCARDINO: Thank you very much, Pat. I appreciate your comments, especially the points that you raised in Senate Bill 3045. You have been here since this morning, I presume, when I made my comments relative to that - the fact that we want people to do precisely what you did today, so that we can see the basic objections and weaknesses, if there are weaknesses, and I am sure there are, in the legislation itself, where they exist and what subsequently we ought to do about it.

So, I do appreciate the points you have raised today. Of course, you understand this is not a Committee meeting on this bill. We will be having subsequent meetings specifically on this legislation later on.

Senator Hamilton.

SENATOR HAMILTON: I have no questions, Mr. Chairman.

SENATOR SCARDINO: Thank you very much. Dr. Finley, we have given you a few minutes to relax. I know you have had a very heavy schedule today. Are you prepared to appear before the Committee at this time?

We will now have the Commissioner of Health, Dr. Joanne E. Finley.

D R. J O A N N E E. F I N L E Y: Senator Scardino and Senator Hamilton, I am prepared to do a number of different things in relation to your charge and then I received a separate letter suggesting some additional things I should go into, and I think rather than read,I hope,intelligent, but very hastily prepared testimony, I would like to tell you the kinds of things I am prepared to do and maybe let us answer questions.

As I see it, the overall charge is to discuss certainly what our leading health problems are, which are chronic diseases, talk about the prevention of same, and I can go into what our leading problems are, what are preventable, how you define preventable in either its level of prevention,or is the knowledge there to prevent. I think if the knowledge isn't there, one would assume then you support research if it is a leading problem. I can even define my own view of the leading problem in the chronic disease field.

Also, I think from seeing some of the questions that you asked and hearing a little bit of the previous people who testified, you are interested,as a legislative committee in, let us say, knowing whether statutes are necessary, and if so, what about the ones that exist or what about newly proposed ones. I am prepared to discuss that.

I think you also will have questions, which,between the three of us, I hope we can answer, about how money,both federal and state, does or doesn't funnel, to go back to the first question. I mean, what should we be doing, and what really is preventable, what do we know something about? So, within that --- Oh, also, I gather - and I am very glad that you are - you are interested in what I would call the local arrangements for delivery of chronic disease preventive services, or just,let's say, preventive services, what should be our structure in the State of New Jersey, while applying this knowledge to the people.

So, which place do you want to start?

SENATOR SCARDINO: All of the areas that you touched on are areas that concern the Committee. We touched, to some extent this morning, on some of this, awaiting your presence today to get it all straightened out. But, you touched on all of the critical issues that have been highlighted. So, you start wherever you feel you would like to. We are interested in all of the points that you have raised.

DR. FINLEY: Well, let me go in the order that I suggested them in. One of the problems that besets the nation is that we have - and I am glad to see that it is happening - a tendency to try to prevent,and we may run out and do it in a shotgun sort of way - let's prevent something - and we may not know the cause, or if we know the cause, we may not know enough about preventing it. But, in those cases, either you need to do epidemiology first, which would help us

learn and understand the cause, or you may need - and I think this belongs more to the Federal Government - some basic research.

SENATOR SCARDINO: May I interrupt you at this point, Commissioner? Perhaps if we start with the basics and maybe get a clear definition from you and the Department as to what you define as chronic illness, and then move into the area of addressing the issue itself,and who should be most involved, that would be a good way to start.

What are, in your judgement, the areas of chronic illness that we ought to be involved in, regardless of the level at this point? Because later on we are going to have to define it as to who should be responsible, where and how?

DR. FINLEY: Well, chronic illness is an illness or a disability that won't go away, no matter what you do. It will not go away. It is there in the person. Now, there are several levels of prevention. Some categories of chronic illness are primarily preventable. I mean, we have enough knowledge to keep them from happening in the first place. I will come back to examples of those. I think some of the examples of what we know will surprise you.

SENATOR SCARDINO: They were defined specifically this morning. Most people agreed that they were heart disease, cancer, and stroke, among others, but those are the primary ones.

DR. FINLEY: Those are the numerically leading causes of death from chronic disease. They are not necessarily the ones about which we know the most to prevent.

SENATOR SCARDINO: Okay, thank you.

DR. FINLEY: Well, let me give some facts and figures, which you have probably already heard. In New Jersey, and in the nation, our rank orders of causes of death do not differ. In other words, what is one, two, three in the nation is also one, two, three in New Jersey. Of this rank order, I will read off the ones that are quantitatively the leading causes of death, numerically, diseases of the heart, and that are also chronic diseases, and although the trend here is downward cancer is number two, and stroke is number three, and diabetes is number six, and cirrhosis of the liver is number seven, and arteriosclerosis is number eight.

I think of more importance in terms of what do we do in New Jersey is, in what instance does our death rate exceed the national death rate. And,you figure this in terms of deaths per hundred thousand persons. In heart disease, cancer and stroke, we do exceed that national rate, and in cancer most specifically, and I will give you an example there.

The cancer deaths in 1977 - which I said in the car coming up - sounds like an awful long time ago for statistics, but those are the latest in which we can compare to the nation, in New Jersey our rate was 377.? per hundred thousand, compared to 331.6 for the U. S. as a whole. In other words, that is more than 40 people per hundred thousand more that die in New Jersey from cancer. So, that puts a statistical dimension onthe problem, and that is one way, I think you can look at the problem. Quickly - because it is my favorite area - I would like to put a monetary dimension on it. I mentioned in my hearings before the Joint Appropriations that in the State budget recommended by the Governor for the Health Department, a total of $4,917,000 was asked for all preventive services, chronic and communicable disease. And, the hospital budgets asked of us for the same fiscal year totaled $2.5 billion. Actually, the giving, and this is just within New Jersey, of hospital budgets granted were somewhat less than

that, but you can see the vast difference in terms of what we spend for prevention and what we spend for hospitalization and obviously, you understand,I keep bringing this up because I do indeed believe that we would have to spend less on this hospitalization if we could spend more on prevention.

So, from that monetary and statistical dimension, then I would like to jump to the definition of preventable and apply that to the numerical, because I honestly am going to try to say that I don't think it is the job of public health to work on scatter gun applying of knowledge, or,trying to do something when we don't have the knowledge. Instead, we should be getting the knowledge and getting ready to apply it.

I think that you establish priorities in part by knowing what affects the greatest number of productive people. We also must think in terms of causes, and we also must think in terms of existing and imminent scientific and operational knowledge. And, that is the definition, incidentally, that the Center for Disease Control gives to a preventable health problem - a death or an illness that could be prevented because we have knowledge to apply to preventing it.

Now, some examples which are in themselves chronic diseases or which lead to chronic diseases about which we have this kind of knowledge are, tuberculosis, polio, measles - and I said I would say some things that would surprise you - but polio and measles you think of as acute diseases, but we can prevent them, and the reason we prevent them is because they lead to chronic diseases. Some others are: chronic obstructive lung disease, lung cancer, hypertension and stroke, genetic disorders and substance abuse. That list of what we have the existing knowledge to do something about is a little different than the numerical list. Let me take this existing knowledge framework and apply it to some of our numerical leading problems. If you could prevent chronic obstructive lung disease - and I think probably we would be able to say the two leading causes of that - and that is where lungs are all gunked up, they just don't work anymore. They may be fibrotic in which they are all scarred, or they may have other kinds of conditions which really occur from external factors, not from infectious agents. I think that smoking and inhalents in occupations are probably the two leading causes. It is obvious for coal miners, but is it as obvious to you for foundry workers, and people breathing certain vapors in some industries. Smoking and occupational exposures are the two leading causes of chronic obstructive lung disease, and it certainly will give you some knowledge of what we know about how to prevent it. And, in preventing the chronic obstructive lung disease, we would definitely decrease death from both heart disease and lung cancer.

It sounds circular, but why? One form of heart disease, which is called right-sided heart failure, and is not the usual kind of heart failure you would think about is the leading cause of death from heart disease. It means that the lungs are so damaged or scarred up that the return of the blood supply through the pulmonary artery from the lungs can't occur, so that it backs up in the right-side of the heart because it can't get into the lungs and it can't be returned back to the left side of the heart. It is the opposite kind of heart failure, but it is the leading cause of heart failure and it is related to a lung condition. So, one piece of heart disease could be prevented by dealing with chronic obstructive lung disease. Lung cancer also does seem to run an even higher incidence in people who have chronic obstructive lung disease. And,

Dr. Copeland who was with the mine workers for many years will tell you of the extraordinarily high death rate from lung cancer in miners who in turn have silicosis-pneumonoconiosis, caused by the breathing of coal dust.

Now, the prevention of polio and measles, while it would not reduce any of our leading causes of death, certainly can prevent life-long chronic crippling conditions or brain damage. That is why you get a measles vaccination, because you prevent, in one out of two thousand cases, measles encephalitis, which permanently brain damages the person who gets that.

So, some of the things that we think of as infectious disease control actually are meant to control and prevent - primary prevention - of chronic diseases.

On the other hand, for diabetes, the only true example of primary prevention - preventing it from happening at all - that I can think of lies in genetic counseling, and unfortunately the decision of two parents both of whom have family histories of diabetes, the decision not to have their own children but to adopt. Diabetes is not preventable externally. It is by and large an inherited condition and very likely to occur if both parents have families who have had diabetes. Secondary prevention - and I am sure you went through all this this morning - we can't prevent it in the first place, but we can certainly prevent from leading to something worse, keep the person productive.

Hypertension control is an example of secondary prevention, and that in turn can definitely lead to the reduction of stroke, and one other heart disease, congestive heart failure, or congestive heart disease which leads to heart failure. But, now I have given two examples of pathways that lead to the prevention of death or disability from heart disease, but by no means does this encompass all of the heart diseases. One is related to the lungs, as I said, and another is related to high blood pressure, which is hypertension. If we wanted to go into heart disease, we would have to break it down into different causes of heart disease, and death from heart disease, and we would really have to deal with many aspects. We would have to have a comprehensive approach. And, I hope out of these hearings we can get back to comprehensive approaches, because I really do feel that funding, our own in the State and federal funding, has tended to have us dealing with a piece of a problem. Although I certainly don't turn the money away for hypertension screening, I would never pretend that that controlled the whole spectrum of a leading cause of death which is all the forms of heart disease.

I am not going to talk about tertiary prevention, which is the third level, because that says that you have not prevented in the first place, and you have not prevented from worsening, and you basically tried to keep the person habilitated, and I do think that belongs more to the medical care sector than the public health sector, although, as long as we are not getting on with the job of preventing in the first place, and we are not to the degree that we could in this State or the country, we cannot drop attention to the curative and the rehabilitation afterward, but on the other hand, I do worry about piling up a nation of people who live longer, but live a poor quality of life because we couldn't prevent. I believe in their longer life, but I don't think we have gotten on with preserving the quality of life, which preventing at least the worst parts of chronic diseases would do.

My next question to deal with is, do we need statutes. No, I don't think so, at least not as conceived in 1952, which was one of your questions,

although I think that the 1952 law was extremely well-intentioned and certainly flexible. It really said the Department should have a Division and the Division should deal with the problem comprehensively, and I am asking to get back to that with maybe a few little "unnecessities" trimmed off. But, on the other hand, I can assure you this doesn't mean I mind a legislature legislating the organization of a Department, but I simply don't think it is necessary. I can assure you that the preamble to the existence of every health department in the country is you are supposed to do whatever is necessary to deal with the leading problem to keep the people well and deal with the leading problems. And, since chronic diseases are our leading problems, as a matter of course, one would do it. I am not saying that means to take the statute off the books. I will also in response to direct questions deal with 3045, because I just don't see where that fits in at all. I am not at all sure how that is intended to deal with the broader problem as you have expressed it.

Now, we may need other kinds of statutes, however, not those specific statutes that you have asked about, and that gets me to the issue of what kind of local delivery service should we have for all preventive activities. I think perhaps I don't need to remind you, but I will, that my definition of a State Health Department - and this is particularly so in New Jersey - is that it is very much like a mini-Federal HEW. We are very seldom the deliverers of service. We may be the gatherers of Federal and State money; we may be the standard setters, and the program designers, and the technical assistants, but except in the substance of this field, where the State law specifically gave the responsibility for delivering the treatment and rehabilitation services directly or through others - and much of it we do directly - we have no mandate, nor do I think it is necessary to have a mandate to go out like Ann Klein does and run a State Hospital or run a program.

On the other hand, I feel very strongly about our directing and indicating what is the highest quality, most cost effective program. So, obviously the next level is, how do you get this knowledge, where it exists, which is our responsibility to give out, how do you get it to the people. And, that is where the need for a local system to effectively, cost effectively, deliver preventive services is needed in New Jersey.

I do feel that we still need to change state statutes in that regard. I believe that 3045 was a sort of a side door attempt. We have had a series of extremely well-intentioned, and, I thought, workable, but now I think also side door attempts, since I have come to New Jersey. We have gone in just four years from what then was a small, and it is still now even smaller, but a State Aid to Local Health Departments Fund, which just says the fund shall exist and the Health Commissioner may give it out, and we were left with kind of our own notion of how to give it out, and we had some notion of standards, and we didn't give it to people who didn't meet certain standards. We went from that to Chapter 329 which was an improvement, a mandate on the Department to set standards, certainly, do you have chronic disease control programs, you must have them as one of those standards. We have gone from that to the Public Health Priority Funding Act, which is a new way of saying that money - which isn't enough - can only be spent for certain activities which really are, we think, a step closer. So, if you do these things in this way, you are likely to reduce the problems, because after all, the whole goal of spending the money or organizing is to do something about the problems, and not just to please us that the status quo goes on, although the status quo is very

well-intentioned. I think that this is all progress, but I still do not think that we have an evenly uniform, high quality local network of preventive services delivered in the State of New Jersey. I think the reason is because our T & E of health law, which was Chapter 329, still gives you four different ways to go. I know it is risky to say this. I know the health officers are tired of hearing me say it. I know that in New Jersey,like every place else, one does not overcome a very likeable desire of people in fairly small communities to do things their own way, and I am not still talking about doing something radical, but I have been here almost five years, and only these steps have occurred. Five years is a fairly long time.

So, we can still have a community of as few as 25,000 form a health department providing they have a full time health officer, so we still have 300 some odd health departments - we have 119 in a State with only 21 counties, and only a handful of big cities.

SENATOR SCARDINO: How many, Doctor?

DR. FINLEY: We have 119 separate health departments. Now, that is fewer than before Chapter 329. But, it is a lot. They may be little, and they may not have very much in the way of money, and they may not have very much in the way of support, but if they meet the standards of a full time health officer and 25,000 in population, they can call themselves a health department. Or, you can have two or three or four municipalities get together and form regional health departments. We have had some of that happen, and that is a step, and they still have to have a full time person. I know in New Jersey that is quite a step when three or four communities will join hands and call themselves a region.

SENATOR HAMILTON: How many of them are there?

DR. FINLEY: Six.

SENATOR SCARDINO: Can you tell us which ones they are?

DR. FINLEY: I can't tell you that right at this point.

SENATOR SCARDINO: Are the counties considered?

DR. FINLEY: I am coming to that. I will give you the details there. The next step up is two different ways, and this is all under 329, so I say four ways. But, the next step up is two different ways of forming what would be called the county health department, and I can give you the details there. This is what I call inching toward workable, viable units.

You can either have a county board of health and then reach out and cover as many municipalities as will join you, or you can go the other way around. You can have a county health officer and try to get municipalities to contract with that set up.

Now, let's take the first. Altogether, one way or the other, fourteen of our twenty-one counties have what we call a county health department. But, let's look at that. There are five that have a county board of health. I am not sure the board of health is the answer. I think that we are talking about how to encourage both financially and by statute the governments that will cover the widest amount of people, the widest tax base, and also will be able to zero in on the parts of the county or larger areas where the problems are. Chronic disease problems are not all over the county, and one of my answers to, should every municipality have to live up to the same minimum standards is, no, although now they have to. If you don't have a heart disease problem, I am not sure why you should have a heart disease program.

But, certainly in a county or wider region you are going to have the problem somewhere. I would rather have the money spent on that somewhere where the problem is. But, you can't do that until you can coelsce people better.

All right, the five counties with the county board of health are Monmouth - but only 20% of the municipalities in Monmouth County participate - Atlantic County with 99%, and I presume Atlantic City which sorely needs help in the public health area at this point, casinos do cause a few public health problems---

SENATOR SCARDINO: You said 99%.

DR. FINLEY: 99% of the municipalities are coverd by the county health department but the one municipality that has left itself out is the city. Cumberland County - bless them, we better bring them up and find out how they did it - has a county board of health that covers 100% of the municipalities in the county. Ocean has 80% of the municipalities covered by the county health department. I think we almost had fewer than that, and after a big struggle they kept it at 80%. And, in Warren County it is 100%.

Now, we have nine counties that have county health officers with whom a varying number of municipalities contract.

SENATOR HAMILTON: Commissioner, before you go on with that, these counties that have 99% and 100%, did any of them have that structured before chapter 329?

R O N U L I N S K Y: Well, there was a county health department in those counties, but prior to Chapter 329, there was not a board of health in that county.

DR. FINLEY: But they had the structure as far as county-wide coverage.

MR. ULINSKY: Right, the county-wide coverage was there, but it was done by contract, rather than a board. With the advent of Chapter 329, the freeholders chose to create a county board of health.

SENATOR HAMILTON: We have changed the county structure within a county with the advent of Chapter 329 in those counties, but we have not changed the fact that they were all together cooperating as they were before Chapter 329.

MR. ULINSKY: That is correct.

DR. FINLEY: I think that is very good. And, as a matter of fact, when I mentioned for example Ocean County, or Warren County where the structure was there for 100%, in my personal opinion 329 - without intending to - almost started things going backwards. In both instances there were a couple of municipalities that said, "Well, if we just get a full time health officer, we can now break away from the county and go on our own." I think we saved, we and the county health officers together, these situations. But it took a great deal of energy. So, well-intentioned law, in some instances, has encouraged people to go backwards, in my opinion, and that bothers me very much.

The counties by contract--- You have a county health officer and you have municipalities, I guess, more or less voluntarily, contracting, but there is a nucleus there that I certainly think we could do something with and I really am asking for statutory encouragement to go a little faster - as I said, five years is enough, and I don't think they are going to have the best delivery of chronic disease prevention services until you deal with the structural problem.

In your own county, Senator Scardino, Bergen County has a very good county health officer, but 12% of your municipalities contract which means the rest of them do their own thing.

Burlington County,again God bless it, is a county health department with 100% of the municipalities contracting.

SENATOR HAMILTON: What was its status before 329?

DR. FINLEY: Exactly the same. Sussex County, 90% of the municipalities; Middlesex, 60%, and I don't think any of this has changed, has it? Chapter 329 has not made it better or worse.

MR. ULINSKY: No.

DR. FINLEY: Camden County, which I can use as an example of what a county health department can do for a city, because there is an awful lot that the Camden County Health Department is doing for the city of Camden, and I am quite impressed, including building a new health center, initiating family health care, all with public budget, building in chronic disease control into a conprehensive care program which I really think in many instances is a much better way to do it than decide that this week we are going to do hearts and next week we are going to do toes.

But, Camden County Health Department, which I said does a great deal for the City of Camden, has 99% of the municipalities. Dr. Ziskin on my staff is embarrassed to admit that her municipality of Cherry Hill is the only one that won't play.

Cape May County, 100% of the municipalities contract; Salem County, 100%; Hunterdon County 100%, and Gloucester County 100%.

SENATOR HAMILTON: What is the total?

DR. FINLEY: Fourteen,all tolled,of the twenty-one counties have, one way or the other, a county health department. But, we still are not to 100% of the municipalities covered by the structure.

SENATOR HAMILTON: You have fourteen with a county health department and five with a county board of health and nine with the health officer.

DR. FINLEY: Right.

SENATOR SCARDINO: You said there were fourteen with a county health officer?

DR. FINLEY: There are fourteen with a county health department, and five of those come about by having developed a county board of health. In other words, essentially that county health officer only has one boss, and that is somebody that the freeholders set up. Conversely, Walt Tomlin who is the county Health Officer in Burlington County where, yes, 100% of the municipalities contract, recently has said to me,"You know, I have forty-six bosses; I have the freeholders who are one boss, and forty-five municipalities, their elected officials, because they contract, are my boss too." I thought, "You are a very brave man, because that is a lot of bosses to have."

SENATOR SCARDINO: Okay, just for clarification, you said there were fourteen counties under the County Health Department structure.

DR. FINLEY: Either by setting up a county board of health, or by the municipalities contracting.

SENATOR SCARDINO: That is the total.

DR. FINLEY: Yes.

SENATOR SCARDINO: All right, because I understood,from what Senator Hamilton said, that you were talking about fourteen under the county health department and five.

DR. FINLEY: No, fourteen altogether.

SENATOR SCARDINO: Okay, that is what I needed to be clarified.

DR. FINLEY: And then I think within that, only seven of those counties, whichever way it comes about, cover 100% of the municipalities within the county.

SENATOR HAMILTON: But your percentage is much higher in the county health officer structure than it is in the county board of health structure.

DR. FINLEY: Yes, right. I think that is enough to set the stage for some questions.

SENATOR SCARDINO: The question I would like to start off with, Commissioner, is there any preference, in your judgement, as to one or the other in terms of the county health department and the county board of health, or is it conceivable that we can live with the structure as it is now with modifications.

DR. FINLEY: I have found Senator Hamilton, from conversations, more conversant with local funding than I am, and I think a lot of the answer, so that I am not imposing my will--- Obviously, I believe there should be large units. I think that will also lead to proper funding, and it will lead to better programming. Funds and program do mean something together here. But, as to what the most acceptable way to garner in the finances that you need to really give substantial base to a broader structure, I am not sure, and you may know. I would think the county board of health--- Does it have the same rights to raise money from the municipality as through the contract system? You are going to have to choose the way that will get the most resources.

SENATOR SCARDINO: You are saying that even if we were to deal with the percentage factors here, that it doesn't matter if someone who lives under the county board of health is at 100% and someone who is living under the county health department concept is not necessarily the same. The rules of the game could be different and are different, okay? This is what I understand to be. And, if that is true, then it goes back to my original question, under the rules of the game and in terms of the chronic illness subject area that we are dealing with here, which one is most applicable?

DR. FINLEY: It is likely that it doesn't matter, so long as the municipalities can't opt out.

SENATOR SCARDINO: Can they opt out?

DR. FINLEY: The first two of the four ways seem to me, under Chapter 329 - which again I understand the New Jersey style of home rule pride which you hate to mess around with - are obviously the least funded --- We are doing an evaluation now. Dr. Ziskin is here to tell you about it. Also, probably, and I am not sure, in terms of measuring the outcomes of their programs if they have had such and such a chronic disease problem, have their programs really reduced that problem. That is the way we think we should evaluate.

I would guess, honestly, simply because size and money unfortunately have something to do with each other, that those first two ways, the 25,000 and you can have your own health officer, or two or three municipalities can go together, I am guessing, but I think they will turn out to be the least likely to be producing results, simply because of smallness, and therefore lack of funds. I can't be

positive until we do the evaluation. In the world where small is better is a new phrase, I know I am talking the other way, but I am thinking of resources. I am thinking of the resources of people, money, and everything.

SENATOR SCARDINO: Well, let's deal with the reality of the situation. You have seven out of the nine counties that opt for the county health department provision, and 90% or better of their municipalities participated in the program. The exceptions to that are Middlesex and Bergen Counties, both representatives are sitting here---

DR. FINLEY: Ocean and Monmouth.

SENATOR SCARDINO: I am talking strictly about under the county health department concept. Seven of the nine are 90% or better. Okay, now doesn't this say something in terms of the fact that you now have local municipalities, since we are emphasizing the fact that we don't want to step on anyone's toes, and we don't want to infringe on the home rule concept, doesn't that indicate in the seven of the nine that they have already opted in and will cooperate in a consortium effort in terms of addressing ourselves to chronic illness, because that is the subject we are dealing with.

DR. FINLEY: Except that 329 isn't what did it. We already explained to you that it was the way it was before 329, and because of options A and B, under Chapter 329, we have had in Mercer, Warren, Ocean, and Bergen County recently efforts to go the other way to set up their own small municipal. They say, "Well, 329 says, as long as we do this, this,and this we are okay." And, it has actually turned out to be an encouragement in some places to pull out of the existing county structure rather than move further toward that.

SENATOR HAMILTON: Let me ask you this: You used the phrase before, smaller is better. I am not prepared in this to say that smaller is better or larger is better. Could you take a moment, you mentioned evaluations. I am still finding my way with some of these statutes, but I take it that evaluations were provided for in Chapter 329; is that correct, and are not yet required under the law?

DR. FINLEY: No, we set the minimal standards,which is now a printed manual, to which health departments must live up, or the law says that if they do not meet the minimal standards- they, meaning any municipality- by a certain time, the State can come in and directly provide or arrange for the services and bill the municipality.

SENATOR HAMILTON: Right. But we haven't yet begun to evaluate the adherence to the minimal standards in a definitive fashion to determine that anyone is going to have money lost; is that right?

DR. FINLEY: We have not begun to evaulate in a way that satisfies me. Maybe I am stubborn, but I want to know. I want evaluation to be in terms of outcome or impact on the people whose health is supposed to be improved.

SENATOR HAMILTON: You have not taken money away from anyone yet.

DR. FINLEY: No. But we do evaluate in a sense by having a long, long questionnaire which people fill out their structure, if they have a full time health officer, and a license, and how many nurses, and what I would call being service oriented. So, it isn't that we are doing no evaluation.

SENATOR HAMILTON: I understand that. But, that is all pretty objective and it is not subjective or qualitative, and you said that you guessed with regard to the first option, the local health department, and I appreciate the fact, because

I think that was candid, that they probably would not do as good a job. Is it fair to start moving us? Maybe it is fair for you, because you are a professional. Is it fair to start moving us - and I don't suggest that you are - to legislation that is going to move local government in a particular direction until we get some data that says, "Hey, you should use that mode; you should be in some other structure." Because there are very sensitive political types of judgement, and unless it is very clear that 93% of the municipalities under a certain number can't do an effective job, at least judged by some objective criteria, and shouldn't be moved in that way.

DR. FINLEY: I agree with what you are suggesting, and that would be one of the reasons why Pat Wood who has preceded me - and she probably has different reasons than I do - opposes 3045. But, I think 3045, as I say, is a side door approach. But it doesn't deal with the structural problem, I agree. This is why I am so determined. I even brought two pages of what kinds of problems we feel we can measure the outcome of the different configurations on.

SENATOR HAMILTON: I didn't want to preempt Senator Scardino, but I wanted you to enlighten me as to that point. I yield back to you, Mr. Chairman.

DR. FINLEY: If we are wrong, and one health officer and one nurse, and one sanitarian for 25,000 people will have to be a problem,that is there. If the place has no problems, I can't measure it. But, every place has some problem. If I am wrong and that configuration of three or four good trained, dedicated people have made a demonstrable impact on their problem, and a larger unit hasn't, then I am wrong.

SENATOR HAMILTON: My point is, I didn't find this structure of the four ways to go, which ended up as being three ways, one of which has two varities - that is not demonstrably ineffective at this point. It is different. It lends itself to administrative problems from your point of view and anamolies, I suppose, from the other point of view, but I don't think it is demonstrably bad based on what I have heard so far.

DR. FINLEY: Well, if you are going to think in terms of that, you should go through the order and find out what are the leading problems that are chronic diseases - cancer and it is a much higher rate in parts of the State, but not all of the State, but if we are not reducing it, is it increasing in rate, and we have agreed that the State Health Department should not go out there and give all of the direct services implied. And, of course, we do not know what to do in all areas of cancer, but in some we do.

Then, something is missing. I mean, we haven't got a structure getting those known services to the people. Because, there is a problem that is getting worse. It is not getting better. And, well, our rate of death from - and I like to talk in terms of premature death; I am not here to say that people should live forever, but the forty-five to fifty year old male who dies from a heart attack is a premature death. That is a productive person, and that is a death that you should prevent. While we are dropping in our rate in New Jersey, like in the nation, we are not dropping as rapidly as in the nation. So, again, something is missing in terms of the way of getting these services to the people.

I don't want to say anything is bad, but apparently we could be more effective.

SENATOR HAMILTON: Well, you have such a high level of personal choice about things that we heard about all day in terms of diet, use or abuse of alcohol,

nutrition, and given the patterned nation that we have, you are never going to get to kind of an average level of performance. You might have a whole tribe of Irishmen - and I can say that because I am Irish - that are going to continue to drink no matter what you tell them about it being bad for their health. So, I don't think we can fault ourselves just because we have people dying of heart disease or cirrhosis, or cancer. I mean, there are so many variables at this point. I think we have to make progress, yes, you are right, but I am leary of too early or too easy a conclusion. Was it Will Rogers who said that for every complex problem there is always a solution that is easy, quick and wrong? I think we can do that with the kinds of numbers that are here.

DR. FINLEY: I think that the other side of the coin--- I said, I agree with your pragmatism, and as a scientist, I want to be able to prove my point, before I ask for what, for New Jersey, would be a drastic change since we have made inches or feet, rather than miles of change.

On the other hand, I guess, if it is possible without too much tumult, I would like the same from the other side. There shouldn't be any change backwards either. Let us hold the status quo until we have the facts, and the backward part is coming from the unintentioned encouragement in Chapter 329 for very small communities, really. Of all of the states I have ever worked in, that is the smallest unit of population I have ever seen permitted to have its own health department. In Connecticut, which we always say is rather like New Jersey, you had to have 110,000 in population in order to have a local health department, and you got absolutely zero state aid.

SENATOR HAMILTON: Well, where were we pre-Chapter 329?

DR. FINLEY: It didn't matter. There wasn't anything.

SENATOR HAMILTON: Okay, so you can't say that is all bad, and may be bad from one viewpoint---

DR. FINLEY: Can we ask the other side to hold the fort too, until we evaluate?

SENATOR HAMILTON: How many municipalities are there with no health officers?

DR. FINLEY: There are only four. now, and there were more before 329.

SENATOR HAMILTON: Do you know how many more?

MR. ULINSKY: I would like to say substantially but in excess of 25.

SENATOR HAMILTON: Okay, so that in modes one, two, three and four you have 583 municipalities and before that you may have had 552.

DR. FINLEY: Dr. Copeland reminds me to remind you that in addition to all this array I have given you, there are at least 57 municipal health departments.

DR. COPELAND: That is the fourth category, like Newark.

DR. FINLEY: And some cities maybe should have their own.

SENATOR HAMILTON: How does that differ from category one?

DR. FINLEY: That would include the 57. The 57 would include the small and large.

SENATOR SCARDINO: So, what Senator Hamilton is saying in effect is it is three categories and not four.

DR. COPELAND: There are four.

SENATOR SCARDINO: Can you go through the four? We know and understand the county health departments and the county board of health and we understand the 25,000 in population. What are the other?

MR. ULINSKY: The regional and the contract.

SENATOR HAMILTON: The contract is county?

MR. ULINSKY: No, the contract is if one municipality chooses to contract for services with another municipality without forming a region such as--- Paterson has a contractual arrangement with several other surrounding town.

SENATOR HAMILTON: You mean a municipal contract.

MR. ULINSKY: Yes.

DR. FINLEY: One other thing I would like to add, you did have some questions about funding and I have as many details as I can get, what is federal and what is state and so forth, but one of the problems that we are really struggling with and that I am bothered about is that this state particularly in the past has tended to give the predominant federal funds, whether for alcohol or for drugs abuse or cancer control or hypertension, whatever chronic diseases problem or even for some of the communicable disease problems, we have tended to give them to the private sector. Basically, as a public health person I am opposed to that. I mean, public health is public health and it means that up front the taxpayers are saying this is a problem we want to do something about. I am also interested in assisting public hospitals. I think the taxpayer should get help with what they are saying directly they want to attack.

Again, it comes back from the Federal government and the guidelines and you have to have a certain capability to be a recipient of these federal funds that we pass througha in very liberal amounts. I think you have heard that way over 60% of my budget is federal money and very little of it is kept by us. It has to go to contractors, sub-contractors, if you want, whom we again monitor, set the standards for, give technical assistance to, and frequently again because of this kind of crazy-quilt of local health delivery systems in New Jersey, we are simply not able. They don't have enough---

SENATOR SCARDINO: Commissioner, let me go back to the question I asked several minutes ago. If you admit that this is a crazy-quilt pattern that we are dealing with in the State, which out of the four, if any, is the way to go, and if none of those is the answer, then what do you suggest? What do you recommend? Or, do you have something presently in the works. Are you developing an approach that may not be ready for announcement at this time? We want to know whether or not the Department of Health is in fact addressing itself to that problem.

DR. FINLEY: Well, I agree with Senator Hamilton that it is too early to change the legislation until I can prove my point. I have in the back of my head two - I think that you could leave - options in the law, and one I would call regional which might cross county lines. We have certainly experienced this with regional sewer commissions and regional other things, because I do think that we have some counties that work together in other ways, and may have a small enough population so that even just a county as a base would not make sense, but then I would define regional differently than it is defined presently.

That definition of regional might leave it possible for a large city to have its own health department. Some large cities may have such severe problems that they need their own. On the other hand, I would like to make the counties help the cities, and I would have some new definition of regional and then county, a county board of health, total county structure option.

SENATOR SCARDINO: At this point, I must almost apologize to you for being a layman, because maybe there are just some things that I just can't seem

to comprehend in this whole crazy-quilt pattern that you talk about. But, if we are dealing with chronic illness as the issue here, and we will define it even further to say that we are talking about the prevention of chronic illness, that implies that perhaps we have been paying a lot of attention, and maybe not enough attention, to the protection component, but not enough to the prevention component. And, the question then is, after we have defined what we understand to be a general concensus as to what chronic illness is, and I think all the people you have heard here today which is a good cross-representation, I think, all agree on the basic areas of concentration, the definition in essence of chronic illness. But, what we cannot seem to fput a firm grip on is the delivery of services, who is to deliver the services, and what services are we talking about, and where does the responsibility lie in that delivery?

Let me just follow this a bit further, and here again you might have to correct a layman. And that is, if we have - out of the fourteen counties that are in a plan where they have tried to encourage municipal involvement by some contractual arrangement - and of the fourteen we have ten of those fourteen, and fourteen represents two-thirds of the counties in the State of New Jersey, and ten out of those fourteen oare 90% or better in terms of participation. Am I then to conclude that those ten primarily are already in a system fixed, ready to go in terms of cooperating in the delivery of preventative information, if not anything else at this point, regarding chronic illness.

DR. FINLEY: They are more ready. I could not say whether they are totally ready, until I went back to the standards services statistics. I would have to tell you more about what kind of programming they do, what they are prepared to do, what kind of staff they have, and so forth, but I certainly feel they are more ready conversely, and when I am in Bergen County I can talk about South Jersey. But, conversely, I don't klike Cherry Hill to be able to stay out of a beautiful set up that is concentrating money and resources on the part of that county, Camden County, where the problems in chronic diseases are. I don't think that is fair. I mean, that is a county that, except for that one municipality is doing a really good job. They are ready to prevent and deal with and even treat for some people all kinds of chronic diseases. They have one hold out that won't play and I don't think that is right.

SENATOR HAMILTON: Well, is that town doing a good job, even though it may not be showing the proper social conscience, as we both might agree? Are they doing a good job - while at the same time the county is doing a good job.

DR. FINLEY: May I ask her to comment? She is my Director of Research and Evaluation who is going to do this evaluation. She lives in Cherry Hill.

SENATOR HAMILTON: I don't want to get her in trouble at home.

D R. Z I S K I N: First of all, I would like to say, Senator Hamilton, you are absolutely right. This evaluation is not going to be done overnight. We are trying to do it very carefully, and it is going to take time. So, it won't be easey. And I appreciate your conception and perception of that fact.

Secondly, comparing Cherry Hill which has a population of 60,000 or 70,000 to the rest of the county which I think is close to 500,000 - Camden City has a population of about 90,000 --- That is trying to put the numbers in perspective. In Cherry Hill, I am going to try to estimate now the per capita income--- I think if you live in Cherry Hill and you bring home $20,000 to $25,000 a year---

SENATOR HAMILTON: I broadly understand the demographics in Cherry Hill having talked about the tax formula in years past that I hope will never be on us again.

DR. ZISKIN: All right, are they doing things that you want to know as comparatively then, is that health department doing things for its population compared to the county?

SENATOR SCARDINO: In the area of chronic illness.

DR. ZISKIN: All right, what I know they are doing is saying that people --- If you want to, you can go to a private practice kind of set up and be screened at the county's expense, I believe. I personally find that this is unnecessary and I dislike the fact that the Cherry Hill Health Department is doing this. Whereas, I feel my own dollar should go to support the county health department which is providing a service to those who really can't afford and who do not get this kind of preventive service within the context of their private physician.

SENATOR HAMILTON: But all that seems to suggest to me at this point in time - which is a very tentative point in time to me - is that perhaps there ought to be a different level of funding or a different option in the formula of funding if you got somebody who doesn't have to provide a broad based delivery system because they don't have a population that is medically needy, for instance, but the fact that it might be a preference suggests only that that is a personal opinion that you are certainly entitled to, but as a policy maker, and again I recognize the fact that you are not urging it on us today, that is a far cry from saying, "Well, because they opted out and they do it this way, that is not as good as doing it the other way, and therefore, they shouldn't be in the system."

DR. ZISKIN: That is only a piece of it. Another piece might be, though, they may not be looking adequately at where the problems lie. Because they may not need to spend their public monies on chronic disease, and not say they have an alcoholism need or a need for an alcoholism clinic, or a teenage drug problem, that their public monies should go toward that. I haven't assessed that yet at this point.

SENATOR HAMILTON: I can see all decision making ultimately being vested in Trenton if we follow that to its logical conclusion, and because we might be slow to respond, or we might be slow to put our money where our mouth is in terms of standards or criteria or performance, I am concerned about that. I think the Commissioner is trying to get back into this dialogue.

DR. FINLEY: I think Dr. Ziskin said most of it, but one thing I just have to disabuse people of is the idea that public health, because it is tax funded, means it is just for indigent people.

SENATOR HAMILTON: I understand that.

DR. FINLEY: Public health is a method. Yes, in Camden County you should be concentrating energies on Camden City because the leading problems that public health methods can deal with are there. But, in chronic diseases, the common ordinary episodic visit to the physician's office, rich or poor, is not going to in an organized way deal with the hazardous substances you are breathing at work that are causing your problem in the first place. They may catch the problem by the time you have it, but it is not going to do anything.

I mean, medical care and public health organizations are two completely different methods of taking care of people.

SENATOR HAMILTON: Well, the Doctor gave other examples.

DR. FINLEY: Cherry Hill has as much need for those methods as Camden City.

SENATOR HAMILTON: Possible need for an optical screening program.

DR. FINLEY: Yes, that is a good example.

SENATOR HAMILTON: I understand that, and I am not getting hung up on the population, and the socio-economics of it at all. But, only in terms of governmental structure, you can sweeten things and get more done sometimes than you can by hitting the horse on the nose. And, how well we saw that again in the tax thing.

Getting into this health area is so brand new in the education area that Senator Scardino claims far more expertise than I do. We have certain weighted dollars when we get into certain types of learning disabilities, when you get into certain kinds of population. Maybe when you develop a sophisticated enough funding system and there is enough money to do it with, you will go to that kind of a thing as judged by a statistical incidence sort of a base, but I think we are probably two or three jumps away from that at this point in time.

DR. FINLEY: Except for the fact that the federal money is ahead of us in New Jersey. It is not as good as it should be, and until we contain hospital costs, there won't be any left over. But, this problem of not gbeing able to pass through federal money to the public structures because the public structures are not there to meet the standards of the federal government, that deprives both Cherry Hill and Camden County but more Cherry Hill than Camden County.

SENATOR HAMILTON: You heard me say before - and I said before you arrived - the chase after the federal dollar may be our ruination, and I hate to sound like a crimudgeon, but as we sit here today the Congress of the United States is talking about taking away the State share of revenue sharing this year not next year, and I say to you that is going to undercut the Federal system and the sooner we get to be self-sufficient and get a long-term commitment for the kinds of federal aid we are going to get, the better off we are going to be.

To do everything to satisfy a federal - it is more than a whim - dictate that may change next year or the year after is very, very harmful in terms of efficiency long-term. We have done that before, and we don't have to do that again.

SENATOR SCARDINO: Now that we are in this area of federal initiatives and monetary assistance, I happen to agree with Senator Hamilton. A number of us were in Washington last week with the Task Force on Economic Affairs with the Eastern Regional Conference, and the Council on State Governments, and to our surprise we learned that Congress has in fact uput into place a recommendation, I think at this point, it is not anything else, to relieve the states of their state/federal revenue sharing. And they have recommended to Congress that they approve this. nNeedless to say, if this happens, it is going to impact quite severely I think to the tune of $83 million to New Jersey.

And, the point, the real point is the fact that this is just another step in impacting upon the people of the United States that Congress is taking a reversal position in terms of federal funding. They have done it in this case. They have done it in this case, and they are threatening to do it in other respects, too. So, Senator Hamilton's point, I suppose, is a message to all of us. Whether we agree with it or not is not the point any longer. It is just a fact of

life that we have to be prepared to respond somehow responsibly within our own jurisdiction and with what resources we can muster to at least continue the programs at a basic minimal level.

But, in dealing with federal funding, the other question I have is whether or not federal funding exists for the use of states in preventing chronic illness and has New Jersey obtained all of the federal funds available to it. Assuming there are programs, and assuming these programs do not get cut, is New Jersey, is the State Department of Health availing itself of every possible means at its disposal to get its federal funds? And, if they are unable to obtain those federal fund, what are the reasons?

DR. FINLEY: Well, first I would like to say that you cannot equate federal assistance for preventive health programs to counter-cyclical aid and revenue sharing, programs as basic as maternal and child health programs which are really meant to prevent the chronically deformed and poorly born babies, and do. These programs and funding like that goes back to the 1910's and 1920's, before there was an HEW.

Certain categorical funds just for hypertension, just for this or that, do tend to get folded into more block grants, but which I approve of, because then that lets the State spend it where the problem is and on the leading problem. Although some of it was Congressional action, not pPresidential, you will notice the fine print in opposing rescition and/or raising the Carter budget did occur mostly within HEW. So, there has been a pretty steady level of federal funding for certain basic programs that cross state lines. If you keep your population healthy, you keep your economy healthy. That has been long understood in certainly preventing problems, especially communicable diseases. That helps the economy, so you do not have the same problem of here it is today and gone gtomorrow with the federal funds.

Yes, I think a little bragging, but especially since I came and some good new staff has been added that is skillful, at grants are concerned, we are getting our due.

SENATOR HAMILTON: What about a grant that you keep for a year or two years or three years and then it evaporates---

DR. FINLEY: I just explained that. You were out. The MCH funds go back to 1910. This is a state/federal partnership that has been consistent for many, many years.

SENATOR HAMILTON: I understood that. I tried to get caught up before I came back. But, let's say you are getting money today to do some alcoholism treatment or some drug treatment money. I don't see the same sort of long-term commitment as you have in some of those other areas, and some of these things are of an epidemic proportion in some areas. And, I don't see that you get the long-term federal commitment on those types of things that you get by grant, unless you get it by entitlement money, which I gather the maternal care money is. And that is fine.

DR. FINLEY: It is. These are formula grants under the public health services act which goes back many, many years and does keep getting new pieces added to it.

SENATOR HAMILTON: As entitlement money?

DR. FINLEY: Yes, which is what a formula grant means to me.

SENATOR HAMILTON: You are saying that New Jersey is getting its just due.

DR. FINLEY: Yes, but I do have to accentuate, I am getting in the State Health Department, but I am giving the majority of it to the private sector to spend on the indicated programs rather than a public health department and I would rather give it to a public health department, but I have to have the other problem of structure and so on and so forth.

SENATOR SCARDINO: How much money are you talking about, without holding you to specific numbers? How much money are you saying is going now to the private health sector that could go into the public health sector if we would make some changes?

D R. C O P E L A N D: Senator, there are 185 grants that go to agencies in the state through our health department primarily passing through with some required standards federal dollars. Of those, only 45 go to local health departments. They are basically for tuberculosis control or hypertension control or a few programs on cancer.

SENATOR SCARDINO: Are these 185 grants primarily dealing with chronic illness and the subject we are discussing today?

DR. COPELAND: A lot of them do.

SENATOR SCARDINO: Would you say most of them do?

DR. COPELAND: Drug abuse is a very large part of this. If you call that---

DR. FINLEY: That is a chronic illness.

SENATOR SCARDINO: Well, I am trying to stay with the basic issue and the subject today. In other words, is it possible that the forty-five that now go to the local health agencies are primarily those that deal with a chronic illness component?

DR. COPELAND: The forty-five are tuberculosis, hypertension, cancer, and they are primarily in that area.

SENATOR SCARDINO: Okay, but what about the remaining 140? Are many of those also in the chronic illness category?

DR. COPELAND: Yes, they are, sir.

SENATOR SCARDINO: Okay, how much is the total allocation? How much is the total federal grant in the 185 programs?

DR. FINLEY: Roughly $50 million.

SENATOR SCARDINO: And how much of that goest to local health boards?

DR. COPELAND: I would say it is less than $2 million.

DR. FINLEY: That's right.

DR. COPELAND: That may be an exaggeration, Senator.

SENATOR SCARDINO: When you define local you are including the county?

DR. COPELAND: All four categories.

SENATOR SCARDINO: You are saying if some changes were to come about, that you could redirect the funding now that goes to the private sector and to the public sector. Before I ask the obvious question, let me ask one that maybe isn't as obvious. What would happen if you de-emphasized the private sector, could that have an impact? In other words, are there things that are being provided for out there in the private sector, that if you read the record, these things, because of changes might have a deleterious effect.

DR. FINLEY: Well, you would have some screaming and yelling like you always do. I do not necessarily think it will have a deleterious effect. First of all, frequently these are single agency or categorical programs. They just deal with hypertension, or they just deal with blindness, or they just deal with that.

SENATOR SCARDINO: For some reason these private sectors whether they are profit, non-profit or otherwise are certainly taking advantage of something that is there for them and they are coming to the county health department, and the county health department looks over their program and says, "Here are the bucks; go out there and do your thing." And, they do that.

Why is it that the private sector has the capability to do something, and the public sector does not by virtue of the four categories that you talked about.

DR. FINLEY: I am sorry, why does the "Mom and Pop" grocery store charge higher prices, and the supermarket can do a better job? Or, let me talk about what a health department can do. In Philadelphia, the mental health programs, the mental retardation programs, the intermediate care homes for retarded children, all chronic diseases control or laboratory, all communicable diseases control, all maternal health and child programs that in the State of New Jersey are given almost entirely to the private sector, they are all run by a public health department for every walk of life. We have 15 beautiful health centers, that any family could come and get total medical care in.

SENATOR SCARDINO: Don't you control that? Don't you have the authority to say where this money goes?

DR. FINLEY: You have to meet standards. You have to meet certain standards for staffing. If you are going to get MCH grant you have to be big enough and have enough capability to have a full time trained OB-GYN person on your staff. No small health department is possibly going to do that, they are going to contract for somebody to come in three hours a week.

SENATOR SCARDINO: What about a county health department or a regional health department?

DR. FINLEY: I used Camden County as an example. A beautiful thing is happening because it is a county health department. They are building with federal EDA funds a public health center, and it is going to be a family health care center. They are going to have comprehensive family health care at Cooper Hospital's family practice program that has a federal urban health initiative grant and has to have a place to train people in family practice. They are going to use the public health center to train people, and that is all being done because---

SENATOR SCARDINO: Is this going to be a new program, or are you taking away from the private sector and giving it to the public sector in this case?

DR. FINLEY: In this case I am talking about dollars that even go beyond HEW that can be funneled in. No, it is not taking anything away, I don't think, because it is mostly new, but the structure was there so that you can get money even from other agencies. The money to build the building is from HUD.

SENATOR HAMILTON: You are talking about the program money, because the EDA money is something else again.

Is there bias in the federal law that results in that, or is it the structure of the delivery system in New Jersey that results in the disproportionate money going to the private sector as opposed to the public?

DR. FINLEY: I think that is an excellent question. I think the structure of the delivery system in New Jersey, but that would also go back to the fact that in a state in which you basically have many affluent suburban counties and cities with concentrations of problems that have carved away, you probably have had a long traditional leaning away in health delivery from the public sector doing the kinds of things that I am describing. That is the sociological attitude. So, I think it is both an attitude in this state and it is also that the attitude has supported the weak structure.

SENATOR HAMILTON: May I go further with that, Mr. Chairman? In my hometown of New Brunswick we have the Middlesex General Hospital which is running a family health center. I don't pretend to know the origins of that, but I know it became an endangered species and is now got a lease on life, kind of a shorthand way to do it. Is that considered to be private, or is that considered to be public? And, why is that on the endangered species list if it is the kind of thing that ought to be done and it appears to measure up very much like what you are talking about at Cooper.

DR. FINLEY: It always was private in that the Robert Wood Johnson Foundation funded it. The reason it was given an additional lease on life was because eventually the medical school affiliation with Middlesex General Hospital will be able to support it as a family practice teaching sort of thing. I frankly don't know whether New Brunswick has an urban health initiative grant or not, which is an underserved area which gets national health corp manpower funds and so forth.

One of the questions I asked when I was trying to help the group in Middlesex County save that, but without attenuating the private philanthropy, because that is bound to run out as you feel some title grants are to run out, and I think soon it runs out and probably should, why don't you go to your health department and because I just read you that because there is a county health department it only covers around 60% of the municipalities and I don't think New Brunswick is plugged into it. So, we didn't have a structure to go to like Camden.

SENATOR HAMILTON: Yes, it is.

DR. FINLEY: Okay, but it wasn't strong enough.

SENATOR HAMILTON: Well, because you have other hospitals that because of certificate of need have been able to come on line, but are in some kind of a constituent organization, and there is some politics there, again, in the best sense of where your commitment is, if it is to an inner city or is it to the suburb, or is it to a rural area. That is highly complex.

SENATOR SCARDINO: Thank you, Commissioner, for your patience. I would like to get into some specific areas, or specific questions that we asked in our announcement of today's meeting.

I would like to talk about the prevention of chronic illness act, Public Law 1952, Chapter 102, and some of the questions that the Committee had in relationship to that, and the question is as follows: Has this act accomplished its purpose of encouraging the shared responsibility among the state, counties, municipalities, and volunteer agencies for prevention, detection and care of chronic illness?

DR. FINLEY: I think only in part. I think I should answer why I say that, because it certainly has accomplished its purpose of the shared responsibility between the older and more traditional structure of the state and voluntary agencies,

and/or private hospitals and so forth. In fact, Bill Hamilton, I just thought the answer in Middlesex, the hospital got the set up first rather than the health department having the set up that the hospital needed.

But, I think in relationship to municipalities and counties, we have abundantly answered that it has not accomplished its purpose, not for lack of will but for lack of a structure with which you could connect.

SENATOR SCARDINO: Is this because the act itself is just unworkable or not working or is it because maybe the provisions of the act have not been fully implemented? Do you still have latitude somewhere within the act itself to do things to remedy the problem that you have now cited for us?

DR. FINLEY: The latitude is not supplied by this act because other statutes that we have discussed are out of phase with this act.

SENATOR SCARDINO: So, all of the provisions of the act have been fully implemented, or even if they haven't been, they really don't impact on what we are talking about right now, I would suppose.

Should the act be amended to conform to what you feel would be a better situation?

DR. FINLEY: I don't think this is the place to do it. I think it is other acts that we have talked about that do deal with the public health structure, so that it can be brought into phase with the very good intentions.

SENATOR SCARDINO: Is it possible that it ought to be replaced or repealed and have a new statute come into being where necessary?

DR. FINLEY: When you are ready to amend the local health services act, I would say that you could incorporate certain aspects of your intentions in the chronic diseases act, and then by reference repeal this. Because you could also order - if properly structured - local health departments to work together with other agencies as they frequently do, but again it puts the public health types in - just as I am in a certain relationship to the private sector - that same relationship.

SENATOR SCARDINO: Let's move on to the department of health's standards of performance in the area of chronic illness. Are the standards appropriate, and in the best interest of the citizens of the State of New Jersey? And, are municipalities capable of meeting them, and do they need to be changed?

DR. FINLEY: If you are referring to the standards, I think there are two different meanings for standards. If you are referring to the regulations adopted under 329, which were the minimum standards, the regulations adopted under 329, which were the minimum standards, which take cancer services, diabetes services, and heart and circulatory diseases services and make them core or mandatory activities of local health departments, yes, I think in terms of numbers and some degree of knowledge to apply, that those are the most important services to make mandatory. I am not sure that everything is under elective, which says that the department may or may not get involved in these things, such as alcoholism, for example, which is to me a big chronic disease problem and perhaps eventually should be brought into mandates.

SENATOR SCARDINO: In meeting these standards, Commissioner, are there any incentives in the State in terms of state and federal aid?

DR. FINLEY: Public health priority funding, but that is based on only a sum of a little bit over $2 million of local and state health aid.

SENATOR SCARDINO: Is that what you talked about before, that comparison you made between private grants and public?

DR. FINLEY: No, that was federal money.

SENATOR SCARDINO: This is state.

DR. FINLEY: This is the state aid to local health departments.

SENATOR SCARDINO: Which is a little over $2 million.

DR. FINLEY: Yes, it is targeted by the new formula in public health priority funding, but you can figure for places with big problems in the chronic diseases area that this is probably a little less than 25¢ per capita.

SENATOR SCARDINO: Where would the federal funding impact here? Again, back to the response that you gave us, concerning the possible redirection of funding from the private to the public sector, would it apply in this case, or could it apply?

DR. FINLEY: It could be additive. You could give a local health department its piece of state aid, which it can only spend on priority activities, and you can also target or add a federal grant in the same area to that. But, the state aid is very, very small as you can see. I think it is one of the smallest in the country.

SENATOR SCARDINO: I am specifically talking about the federal dollars we talked about earlier. You said you have $50 million worth of federal grants, and then $2 million of that goes to the public health sector. Under the department of health standards of performance, is it possible that in complying with that that you might be able to redirect some of those federal funds?

DR. FINLEY: No, because all this says is that they have to have a program to offer cancer services. They have to have a program to do this and that. It doesn't--- That is why I said there are two different definitions of standards. It does not do what I am asking Dr. Ziskin to do, which is measure the effectiveness of the program. They can check a box and say, "Yes, I have a program,"and they can then spend the money on that program, but it doesn't define the program in terms of applying it.

SENATOR SCARDINO: But, if the State defined the program and if the State established a minimum standard, if you will, for a specific program, and the local level opted into compliance with that state program, could they then possibly put themselves in the position where the federal monies might be earmarked?

DR. FINLEY: I think the answer is yes, and we have some examples where in the cancer field we have gotten federal money, or in the hypertension field we have federal money and because it is again a minimal number of grants that we put up, whether a certain local health department has decided it wants to apply. In other words, we set up our own guidelines in accordance with the federal guidelines and we ask for responses to these RFP's and of twenty respondents, two are health departments. And, the health departments got two of the grants in those fields. That can happen. I think you get into a problem. I think the next question should be, how many of them will opt. The problem is that they are so underfunded which really,at least in the mind of the administration, relates back to the structural question. It is a vicious circle.

Well, what good are they doing, and I have heard this from very high sources, because they are too small, or they serve too few people or they are underfunded, therefore, why fund them more? It is a vicious circle that they are caught in, and we have to stop it. So, a lot of them, even knowing that if they met

those standards--- Yes, I would be more than willing. I am out hunting for health departments to give some of these funds to, and I am very happy when I can find them. And, Dr. Copeland has had a whole project in which he has asked his whole part of the health department,which is really the services part, to give them a list of all of their grants and to whom they are going now and when they expire, and he is working on what can be taken from here and put to a health department. But a lot of them might find it difficult to get the financial support from their own municipalities to meet the standards the federal government would require.

SENATOR SCARDINO: Senator Hamilton.

SENATOR HAMILTON: Mr. Chairman, Commissioner, I do remember when you mentioned that number of $2 million, because we put that back a couple of times in the budget. But, that is the number, and that suggests to me that that is another endangered speciies in 1975 and I think in 1977, if my memory holds correct. That $2 million in state aid to local health departments as we define them here today is what portion of the total state, local and county health dollars that are spent.

DR. FINLEY: Oh, heavens, you mean all the state aid?

SENATOR HAMILTON: No, the $2 million in state aid is what proportion of the total budget spent by these agencies whether they are county or local or---

MR. ULINSKY: The amount of public health priority funding going to local health departments as we have said is a little in excess of $2 million. That is not a very substantial portion of the total expenditures by local health agencies in New Jersey. We feel that it is important because for the small expenditure of public health priority funding, we are directing a large proportion of the local health department budget in the areas that we feel are priority areas. in the chronic diseases.

SENATOR HAMILTON: I understand your position, and I am not being critical. Is it like 10% of the total that they are spending in these areas?

DR. FINLEY: It would depend entirely on what municipality you are talking about. I have a table that I can send you that Ron worked out that frankly I sent to the Treasury before it ever went before appropriations in order to substantiate how important increasing state aid was. It really depends. He just did the arithmetic in his head and he thinks it is about 4% overall. In some communities it is much higher than that. But, there is no community in the state that isn't putting in a lot more, from whatever its collection of sources are, than the state aid amounts to.

SENATOR HAMILTON: It sort of strikes me that we get 90-10 federal money for some highway construction and they have to get 90% federal money in order to do it, and that kind of thing, and here with that little bit of money you can do something with it.

I would like to get those statistics if I could. A little earlier in your testimony, though, Commissioner, you used the phrase "properly structured local health department," I think in terms of talking about delivery. And, I am wondering whether in light of all of the discussion we have had, especially with you, but in my own mind earlier today, how you define that?

DR. FINLEY: I hate to be pinned to figures---

SENATOR HAMILTON: No, no, I don't mean to ask for what you may come up with later. I want to know what is there now that you find improperly structured that can be pointed to specifically that is inherent in the use of that phrase "Properly structured."

DR. FINLEY: Well, again, in order to be comprehensive I think that you are going to have to be large enough and financed well enough so that you have the ability to do the kinds of things that the state does. The state can hand over these responsibilities to you. You are going to have to be able to do epidemiologic investigation, at least together with the state, and define your leading problems. And, then you have to take into consideration the spectrums of life and say, perhaps, we should be concentrating on children because they are going to grow up and be, we hope, even healthier than this generation. I think you need a division of maternal and child health, not just one nurse, but a division, which means a full time medical director of same. Certainly you need to be strong in the environmental areas because at least in most places we have them detached, environmental health at the local level, from health which is detached at the state level.

You need to be able to do chronic disease control which means doctors and nurses and community outreach people and health educators and so on and so forth filled in. You have to pretty much follow the divisional lines that the state health department follows and be able to have an adequate full-time competent staff to actually do those services, and places with public hospitals, you might as well have the department of health and hospitals, as far as I am concerned.

SENATOR HAMILTON: Assume that is given and that is good, and from where I am sitting now I am willing to say that those things are good and necessary and proper. Do we have to approach it in terms of you must have per 10,000 population one public health nurse, one-quarter of one pediatrician X, Y, Z, or couldn't we do it in terms of providing - I hate to use the phrase, but it was used by you and by others - a thorough and efficient program for screening detection of heart disease, hypertension, et cetera, et cetera. In other words, we have to do it in a quantitative measurement or can't we do it in terms of a mandate of the kind of services athat have to be provided if you are a county with excessive population or you have any incidents of cancer, breast cancer or cervix cancer, or what have you?

DR. FINLEY: I would much rather do it the latter way, and leave some of the conceptualization to the different localities depending upon their problem. And, they can have us offering technical assistance. I, frankly, hate this business of saying if you have one of this and one of that, and half of that, that adds up to a good program, because it may not.

SENATOR HAMILTON: You see, perceptually, I think, and maybe I am wrong. Maybe I don't know where all the home rule attention comes from. I think, describing it in the terms of a kind of program with some local leeway probably will get you less opposition than rigid, quantatative kinds of numbers, and I think if this dialogue was being exchanged at the League of Municipalities convention of the counties or the New Jersey Association of Counties meeting it might be better than just here with the health officers--- They have trouble getting money too.

SENATOR SCARDINO: If I understand the sense of the dialogue going back and forth, it seems to be a matter of recommendations, conjecture, theories and so forth and so on. I know what we are all looking for here is simply something more specific. I think that specificity has to come from the Department of Health obviously and hopefully done in concert with the appropriate representation of all groups in the development of an approach. I don't know what else to look for at this point except to implore the department to develop something that we can look at.

I guess you talked about your difficulty in giving us more specifics in that respect now because you are saying that you are in the throes of developing the data and information necessary to ultimately come in with a planned approach or solution from the department's standpoint.

DR. FINLEY: Okay, Senator Hamilton mentioned the T & E law, and as I understand it, it says that there shall be public education provided that would insure a thorough and efficient education, and then it left a big debate. It left the applicability measures - how you know that budget in that district with that size staff is producing a well educated child. Now, that is some of the ups and downs the Commissioner of Education has had. Dealing with that, how do I tell if it produces a thorough and efficient education, but I would rather still go that way than the quantatative way of saying, one of this and one of that in terms of staff will produce it. Because your problems are different. I would rather have a law that says, you will have a structure and tax base sufficient to solve your leading problems as defined by the epidemiologic investigation or whatever, and to reduce the rate of disease and disability, mortality and morbidity where there is knowledge to apply to reducing those trends. And, then make us measure, have they done it.

SENATOR SCARDINO: Wait a minute, there is one measurement that you have to consider when you are dealing with the educational component and that is, very often weven with the new T & E law, where its application in my judgement has failed is that it has not created and is not moving in the direction generating a balance where districts will be equal in terms of the number of odollars they put behind the child in education. You still have districts in the State of New Jersey that are better, quote, unquote, than other districts. That, I think, is fundamental and remains part of the old concept that still remains now and that is the local level's willingness to do more for itself - in this case, education. I think I see the same thing possible here in terms of health, and that is, you first of all must provide the incentive for the local level to define for itself what it feels it needs to redress, or change or establish programs for remediation.

But, the point that I am not clear on is precisely what is the state's role in helping provide the incentives necessary for the local level to do this, what expertise will the state provide in establishing the standards, or in identifying the areas? It could be a multitude of areas that have been identified by the State, but the local level can choose among those which are most prevalent at that level. And, I find this component missing in all of this discussion.

DR. FINLEY: Well, number one, traditionally your state health departments are both the collectors of the basic statistics that even the givers of the basic statistics of the federal government by which you can profile the community - not that we couldn't refine our statistics, but I think this is one thing that Dr. Ziskin will do, because I don't think that measuring just death rates is sufficient. We do send out regular reports to all local health departments, and I think we should do more about analyzing those or drawing out. And, not just in the county, but I would like to do it for cancer, this block in this kind of family that works in this kind of occupation. You need to get really refined data, and then pass it back to people. Here is the profile and here are your leading problems.

The next is what we use the difficult word, "standards," and I would rather call it manual how-to, you know, how to do something about this worked out

together with the local people, because their helpfulness is their trade. They have degrees in public health, and by 1980 they all have to have degrees in public health. But, we would like to work it out together.

They talk about, what do we know about how to solve this problem, and then I say, you should then have a place that can concentrate its resources on solving that problem. But, on the other hand, social conscience or whatever you want to call it is not going to hurt a place with a few problems to concentrate on the part of a larger area that has a problem. Health problems, both economically and in terms of cost, if the person becomes dependent or it is communicable and many of them start with something communicable, but become chronic, affect everybody.

SENATOR HAMILTON: Commissioner, I understand that. I think I am as urban oriented as you are, but I also have to recognize in a real political world sometimes you can't make a Bergen County do all the things that an Essex County feels it has to do. And, I think some local initiative, or some leeway--- We are picking up all the educational buzz words today, but they may be appropriate, although I have to say, in the educational scheme we spend over $1 billion state dollars and we have an average level of support of 40% and we are talking here, from what you have told us, that we are supporting local health people maybe on a 2% and 4%. This certainly gives us a whole lot less reason for the state to be arbitrary in terms of the standards that it sets. And, unless we are prepared to create a greater level of support, we have less right to write things on stone.

SENATOR SCARDINO: Commissioner, may I just get into this area dealing with the preliminary state health plan now in draft form. How does the plan address the issue of prevention of chronic illness and does it in your judgement do it adequately?

DR. FINLEY: Yes, despite the federal requirements that the state health plan concentrate on getting those quantitative - reducing excess hospital supplies and so forth. In New Jersey, the State Health Coordinating Council and the HFA have a lengthy preventive chapter. I think it is pretty good. I know we had a hand in helping with it. I think it is interesting when you talk about how they have translated that rather vast plan into priorities for action in the first year, and the HFA is not part of the state health department at all. We just work well together. They have translated the first two activities that they are determined to see implemented in New Jersey in the preventive area, one in dual service that will prevent a great deal of both cost and illness and that is getting the Commissioner of Environmental Protection who has the authority to mandate fluoridation of the public water supply to do his job - and you can recognize how difficult this may be in certain areas, but they have all the details on what those would reduce in terms of digestive disorders in older people because they can't chew to the cost for dental care.

The other is structural. They have made their second priority activity in the preventive area for the coming year and regionalization of the delivery of preventive health services including local health departments.

SENATOR SCARDINO: Commissioner, I have no further questions at this point. Is there anything else that you or members of your staff would like to add at this time? (No response)

Senator Hamilton, do you have any additional questions?

SENATOR HAMILTON: Just to say this, I would like to get into some

further discussion about an answer about the federal requirements, because I think that is the dialogue that I want to keep going with you, as well as with other persons, because it disturbs me whenever I hear it, and I certainly thank you for your help in trying to make me understand the subject matter before us today, and I suspect everyone who has been present.

SENATOR SCARDINO: There was one question that was raised this morning, and I almost forgot to ask it. That is, competition in federal funds, in terms of trying to obtain federal funds, competition, and I got the vision here that the competition may be between the State Department of Health and local health. Is that possible? Is there competition of sorts out there?

DR. FINLEY: I don't know who raised it, but I think it would be more likely that it is a problem I have talked about between giving the funds to the private sector or the public health sector.

SENATOR SCARDINO: That may have been the way it was intended.

DR. FINLEY: Secondly, since we have mentioned the HFA's as the State Health Coordinating Council's State Health Plan, the implementation, but for everyone's sake I have to remind you that we use this as another stimulant to help improve, upgrade, and make able to receive all these funds--- But, the HFA's now fully designated in this state are now in charge of reviewing and commenting and approving directly through the Secretary of the HEW most of the federal grants for chronic diseases control, for example, that we have been talking about, so that they are in effect going to have even more say over who gets them than I am.

Now, as far as the HFA's and the State Health Coordinating Council I feel that the State Health Department is very well connected in that process. It is a good partnership. There is a growing connection of some local health officers. But, we have all delegated the same family or the future chance of federal funding for health departments will vastly improve and will vastly improve their chances to get federal funding, I hope, if they are left out of the planning process.

SENATOR SCARDINO: Commissioner, I know that we didn't have time to spend on Senate Bill 3045, but I would appreciate it if you would, directly or through your staff, submit to me your reservations, concerns with the bill, so that we could have an opportunity to react to it. Because I would appreciate that very much. You did mention it earlier in your comments.

DR. FINLEY: I will talk to you another time. I can't even figure out what it was designed to accomplish.

SENATOR SCARDINO: Okay, fine. Maybe we can answer questions you may have and submit to you the purposes for which it was entered in the first place. That may be a better base to respond.

I want to thank you and members of your staff for being with us today. I recognize what a heavy schedule you have had today.

Mike Guarino, Director of Bergen County Department of Health and Environmental Protection.

M I C H A E L G U A R I N O: I am Michael A. Guarino, Director of the Bergen County Department of Health and Environmental Protection.

I have a prepared statement that I think I am going to scrap for now.

SENATOR HAMILTON: Why don't you submit it, and we can put it in the record. I am sure it will be of some help to us.

MR. GUARINO: Okay, fine. (Statement begins on page 1X in the Appendix.)

I think I would like to talk about two basic concepts as far as the control of chronic illness in New Jersey. The one concept we should be talking about and we should be interested in is the need for developing a state plan to control chronic disease in New Jersey. I think there is a definite need for county health departments and I think there is a very definite need for local health departments. I don't think the existing structure relates to that at all. I think we could have an impact on controlling disease in New Jersey with a state plan.

The plan should look at strategies and not just centralizing the problem. I think we all know the problem of chronic illness in this state. The other concept is the state of the art and the way it relates to health prevention, what do we know today and what can be done, and how that should dovetail into a strategy in our health plan.

First of all, we are all talking about chronic illness, but what do we really know about it? I am going to have to stand up for this. What is the progression of the chronic disease? First, an individual is born. Let's say he is born healthy and he remains healthy for a certain percentage of his life, and it varies for every individual. From health, he develops risk factors for a disease. From the risk factor state he develops a disease. From the disease, to disability, and from the disability he dies, and that is the progression. Today's so-called health care system addresses disease and disability. What we have to do is start putting money up front. Not necessarily new money, but it can be just coordinating our resources. We may have enough resources within an area. I think if we coordinate we will see an impact. Barring, the risk factor modification would be early disease detection, getting him before he has visible signs or signals.

Excuse me, gentlemen, for getting up and down. In the United States today, we are not controlling chronic disease because we spend our thought and time and money on sickness. We talk about a health care system, but in fact we have failed to create a health care system. We have a sick care system. When an individual suffers pain he knows how to enter the system via the private physician or hospital emergency room. People can relate only to pain, and pain therefore becomes the sole motivation for entry into the system. One of the challenges in New Jersey is to put together a health care system. The point of entry into a health care system has to be provided where people are brought together, through a school, industry and community based program with the major emphasis on primary and secondary prvention.

Primary prevention - educating people to anticipate good health instead of sickness

Secondary prevention - educating people to improve their lifestyles through intervention and early disease detection

The state of the art as it relates to the prevention of chronic disease is becoming more and more sophisticated. This sophistication, developed through research embodies the concept that our modern lifestyles are the cause of many current health problems. Therefore, it is imperative that any health plan include strategies that carry this message to the general public.

There are a few public health practitioners in the country today who feel that the public can be better informed regarding current lifestyles and that they could be motivated to change. But in order to achieve this there must be a concerted effort amongst legislators, health agencies, medical providers and the consumer.

What we are attempting to envision here at the local, county and state levels has support in both philosophy and potential funding at the federal level in Public Law 94-317 which can augment our efforts to initiate health and information programs and disease prevention and control programs.

The time is now fully ripe. We should wait no longer to unite these forces to create and implement an effective health plan to prevent and control chronic disease throughout the state.

Now, several speakers addressed the fact that heart disease is going down in this country. It is. Heart disease is going down. There are 20,000 less strokes in the United States every year because we are controlling three major risk factors. One, the blood cholesteral levels in this country are going down in all age groups. Number two, more people with high blood pressure are controlling the disease by taking their medication, because of medical intervention. We see more adults who have stopped smoking, and those are the three main reasons why cardiovascular disease is going down. Now, there is no plan locally or federal that is doing anything. In other words, the public health movement in this area is negligible. I think if we develop a plan, we could have a greater decrease in cardiovascular disease.

What do I mean when I say, there is no plan, and yet the disease is going down? Blood cholesterol levels are going down in this country because it is an industry problem. You have the vegetable growers industry fighting the dairy industry. All you have to do is watch your T. V. There are more people eating low fat dairy products and less oleo because two industries are fighting. Oleo and oleo products have been part of the market, and the dairy industry came out with low fat products and then turned the consumer around, so that people are eating less high fat products and therefore the blood cholesterol level is going down.

Number two, high blood pressure. High blood pressure, there was a national effort by the federal government to start putting money into education and strictly education. So, what did they do? They brought the message to providers of health services as well as consumers, and what did we see? We saw a tremendous impact on hypertension, as far as controlling it. There are more people that know about high blood pressure, and have it under control, and therefore, another major risk factor under control that definitely has an impact on reducing heart disease in this country.

Of course, again, the smoking. We have less people smoking today, especially people in my age category - and I am not going to tell you what that is - but anyway, it was a good year, the year of the crash - but the data is there. More and more people have stopped smoking. We are seeing more young people coming into the smoking arena. I think we have to develop strategies for that, and it can be done. This disease process, as I showed you, is dynamic. Disease is dynamic. Once you get something, you know the process this takes. The public health ssystem is not dynamic. The disease overcomes, and that is what happens with chronic disease. We saw the same thing happen to communicable disease, and

then the public health people started to enter into the picture and we started to control a lot of our communicable diseases.- many diseases that Dr. Finley brought out in her statement.

As far as cancer, the three leading causes as far as cancer deaths in this country are lungs, colon-rectum, and breast. There is enough information to reinforce the concept that cigarette smoking is probably the leading cause of lung cancer. And, we definitely have to develop strategy in the schools. Colon-rectal cancer is climbing up. Epidemiologically, it is in the literature, it is definitely a disease of nutrition. I have another card, and I would like to go over it.

This card demonstrates that in Japan 100% equals four death rates in Japan. The Japanese have a very low colon-rectal cancer death rate, and a very high stomach cancer death rate. For some reason or other, the Japanese, when they come into our country, they get inculcated immediately. After the first generation you see it going up, colon cancer, and we see stomach cancer going down. The second generation proves to be about the same. In the third generation, they are equivalent to the U. S. white rate, and the stomach cancer is down. That is equivalent to the U. S. white rate. What is the white rate? Colon-rectal cancer is 500% more cases here than they do in Japan, and the death rate for stomach cancer is 80% less. There is a definite relationship between our dietary habits and colon-rectal cancer.

Again, I feel there should be strategy for cancer control in the schools, as far as behavioral modification in eating. I have read several studies which think that our consumption of fat, sugar and salt are part of the reason for us having so much chronic disease. Again, you have had statements on this already today. I think a state health plan zeroing in on the school population, zeroing in on industry and the community, will help. I am not worried about the structure, because I think we have the capability and we need a plan and I think we should get it implemented on the grass roots level. That is why I thought I would give testimony here today. Thank you. (Applause)

SENATOR SCARDINO: Thank you, Mike. We do appreciate your testimony and the charts that you used for examples. When you talk about a state plan, are you suggesting that there is no state plan at the moment?

MR. GUARINO: If there is, I have not seen it. I am talking about state-owned plans for chronic disease. There are health plans which are state plans for T. B. control, for venereal disease, for maternal and child health, but I am looking for something dealing with chronic disease which can be given to the people in this state. I think the schools, industry, and the community at large---

SENATOR SCARDINO: What would the plan do, or what would the plan say? Can you give us an example by perhaps giving us a specific illness, and suggesting what the department could devise, and how it could then funnel this down to the local level?

MR. GUARINO: Okay, fine, let's talk about smoking. I think we should develop smoking withdrawal classes within the primary grades. And, Dr. Lauria gave testimony as well that we should evaluate this. We should find out what programs are the best and what programs are effective. In other words, how many children are not smoking after a given period of time. In Bergen

County we are seeing 15,000 fourth and fifth graders a year, and we don't evaluate them until they are in high school. We do see a significant difference in the number of non-smokers once they are in high school, because they were exposed to the program in the fourth and fifth grade. Now, the objective that we could accomplish is by reducing the number of smokers, we have to reduce chronic diseases that relate to smoking.

SENATOR SCARDINO: I think that Mike has a chronic problem.

MR. GUARINO: Yes, I agree.

SENATOR SCARDINO: The Commissioner didn't have the benefit of having Dr. Lauria's testimony, and Dr. Lauria's testimony indicated that the schools ought to be more involved, even though there are mandated health programs today. His contention is that they are not doing enough. This is not merely his own personal contention but this is based on studies that are being made through professional groups including the College of Medicine and Dentistry which he represents, and he even went as far as to say that the people who are put into positions of teaching health related subjects are really having two problems, one is, they have not been trained to do it in a number of cases, and the other problem is that many of them do not want to do it, but are forced into it because someone higher up says you are going to be given this responsibility, therefore, carry it out. And, he said that this really takes away from the impact, the positive impact, that should be had on the part of the student. The other problem that he very much highlighted was the question of follow-up as Mike pointed out, in terms of whether or not the programs themselves - whether it be smoking or any other subject - what are we doing in terms of an evaluation of impact. How are we coming across. Are youngsters statistically smoking less? Will they be smoking less in 1982 than they are in 1979 when we put this program into effect? Are we impacting on it somehow? His contention is that we have not really been going back and looking at what we have been doing.

I raised the point, Mike, that I would ask the Commissioner to respond to that question. Unfortunately she didn't have a chance while she was sitting here, but this certainly talks about a two-pronged approach. It is just not the Commissioner of Health here that has to get involved. We are talking about the Commissioner of Education also in working in concert in developing whatever approach is necessary.

MR. GUARINO: I think we all want to bring in the Commissioner of Education.

SENATOR SCARDINO: Commissioner Finley would like to respond to that.

DR. FINLEY: The other thing you could do, when you get ready to change the sections is to put school health into public health, which is pretty much done around the country. In most places it is not separated. And, certainly, there are cordial relationships between the Department of Education and the Department of Health, but the Department of Education has a board which has to pass on to local school boards, as you well know. We don't have that problem and neither does the health officer. I would like to see the health officer in New Jersey able to mandate - or whatever you want to call it - or able to be involved in school health. It is mostly done in places where health ddepartments ran the school health program.

SENATOR SCARDINO: Thank you, Commissioner. Senator Hamilton.

SENATOR HAMILTON: Well, I just wanted to say that what I hear from Mike and what I heard from virtually all of the front line people - the people in the trenches - the health officers, the nutritionists and whatnot, suggest to me that much of the problem we are talking about today is one that can at least be helped by attitudinal changes, and it is in line with what the Commissioner has said about education. I think that is a part of it. I am wondering the extent to which the Department of Education, or perhaps the Department of Higher Education, has put together materials - canned materials that even someone like me could present - for use on cable television, for use on public television, or as a whole package of instructional materials in the primary and secondary grades about diet and exercise, which are a part of the problem.

I wonder if Commissioner Finley knows the answer to that? Are there materials that can be used? Or, is everyone who teaches health left to devise their own curriculum?

MR. GUARINO: I can answer that question, Senator. It is not just partaking of knowledge---

SENATOR HAMILTON: I understand it is not just. I understand that.

MR. GUARINO: I think we have to develop better marking techniques. I mean, I think some of our programs now in the schools which are related to health are very bland, to put it mildly. You may go there and talk about the traditional four as it relates to nutrition, and yet they are going out every night, or two or three times a week, let's say, and eating at fast food chains. We have to turn that around.

SENATOR HAMILTON: You have to make them like Sesame Street.

MR. GUARINO: Yes, maybe a little bit better. We have to get some good marketing techniques. There is a direct relationship to our consumption--- You talk about the prevention of chronic disease, and there is more and more coming out in literature that says we consume too much salt in this country. How many people realize that just one slice of bologna contains 250 milligrams of salt, and you only need 500 a day. And, when you have a bologna sandwich, how many people just use two slices?

SENATOR HAMILTON: You are leading me right into a point that I was going to make. There is not enough said about the fact that we just consume too much in a day. And, having just read in the papers, and I think appropriately, that we are calling for a meatless day on Wednesday - not because of any religious considerations, but because of the high cost of food - and recognizing that as an economic reason, shouldn't we say to the Commissioner, why doesn't she come out with a public statement that says, "Hey, besides being a good antidote, for the high cost of living, this is really going to be very good for you from a health point of fview,"if in fact, that is the case.

And, Commissioner, you were not here before, but Pat Williamson testified and said the leadership exhibited when John F. Kennedy was President in terms of exercise being good for you, and lifestyle was a very positive thing. If in fact, it is sound, that as long as you don't eat nothing but macaroni on Wednesday, this can be good for you from a health point of view. Maybe it could be a caveat that says you are not depriving yourself, but it is an opportunity actually to come up with a better diet, but make sure that you go towards, A, B, and C in terms of health. That may not be your goal, but if you don't --- The Governor

is not going to do it. He is not going to know what to say, even if in fact he wanted to say it. It just suggests itself in light of everything we have heard here today.

MR. GUARINO: The United States is so far behind, you know, that it is frightening. You see the Canadians putting more money in preventive health, changing health behavior.

SENATOR HAMILTON: You know one reason they do it? Because they pay more dollars of governmental money to take care of people, and they have a bigger state.

MR. GUARINO: And then we see England coming up with a health strategy, Finland, Norway, and the latest country is France, where they are really doing something with television and getting society - not just children - to try and change their habits. And, here we are in the United States still groping with the problem.

SENATOR SCARDINO: Thank you, Mike. The hour is late, but we do have some other people who want to testify. Is there anyone here who would like to testify from our list?

If there is anyone who would like to forego giving of oral testimony, and you have something written out, we will submit it so it will be entered into the record, and the Committee will then be able to review it.

Basil Potenza.

B A S I L P O T E N Z A: I sat here all day but I have not heard one word said about preventive medicine. I have been practicing it personally for eight years. This is one form, nitroglycerin. This is only one form.

The elderly have not been mentioned here at all today. We have programs - and I believe, Senator, when you were the Mayor we had the PAP test - medical examinations, but no follow-up. That is a form of preventive medicine, and these people, the people I am talking about, we do carry insurance. In this State when you are age 65 - or throughout all the states - you must go on blue Cross Supplementary Coverage. It is not enough.

Now, I am speaking from personal experience, and also through experiences of people I associate with every day. I belong to the AARP. In fact, I am the Legislative Chairman for the Rutherford area. They cannot follow-up many times. The supplementary coverage many times does not help fully. I happen to have the experience of running up a bill of almost $9,000 in the past two years. You can imagine what I have to pay. I have been fortunate for eight years to take care of my own responsibilities and so have many others, but it has gotten to the point where many of them cannot follow-up on preventive medicine because they just don't have the means. And, they call the county offices and say, "What do I do now? They didn't give me anything to go and get my glasses. I can't afford to pay $25 for an examination, let alone pay $75 for glasses."

What I am here for is, I would like to know what we can do for that group of people. The doctor here this morning talked about helping the kids in school. We have thousands here in this state that are going through this every day. Why not take them and see what you can do there? There is a lot of work that can be done there, follow-up on preventive medicine. What is being done? I personally can't see anything. We don't want a group that is paying for insurance which isn't enough. You can just about stay above water there,

and nothing is being done. They have the means to just go so far, and they stop because they can't follow-up. What can we do for that group? There are thousands of them. They are trying to pay their way.

I am asking, is there anything you can put on your bill as an amendment?

SENATOR SCARDINO: The purpose of the public hearing is to hear comments of the public, so you can tell us how you feel we could best address ourselves to the situation. As you know, we talked today on the subject of chronic illness, and I think we made one thing very clear, and that was, we are doing part of it in terms of screening and detection, which you know you have been involved in yourself at the local level with senior scitizens or anyone for that matter. If there was not a program for senior citizens, it could have been for the general population. where the county health department or the local level provided some kind of program for screening for detection.

What we are trying to emphasize here is what you have mentioned, and that is, prevention. We feel that we are falling short in this respect. We recognize that. We know that there are certain things that have to be done, and what we are trying to do through the public hearing today is to get people who are knowledgeable to tell us what the best approach to take is, and how we can do the kinds of things you are talking about.

Senator Hamilton handed me a note while you were talking - becuase one of the questions you asked was, what are we doing for the elderly, in terms of prevention in trying to help them. I should have known the answer without having been reminded of it, because I have been so much a part of it, and he points out to me the pharmaceutical assistance to the aged acts, which certainly was a tremendous step in the right direction. Now elderly people are getting prescriptions for their own health and welfare which they didn't get before, simply because they couldn't afford to get it. This is certainly a good example of preventive medicine, if you will. But, I do appreciate, Basil, your comments today and they are on the record, and we will certainly take them under advisement.

MR. POTENZA: Well, the only thing is, I believe the thing was on prevention. What I am trying to say is, the group I am speaking for, they are just at a standstill. What can they do? Is there an amendment they can add on to your bill that is something which will help them?

SENATOR SCARDINO: We will consider that, Basil.

MR. POTENZA: That is all I am asking.

SENATOR SCARDINO: That is a good point, and we will take it into consideration.

Again, my thanks to our staff, the stenographers, and everyone who stayed with us today. I appreciate your cooperation and support. Thank you.

HEARING CONCLUDED

PREVENTION OF CHRONIC ILLNESS IN NEW JERSEY

PUBLIC HEARING--APRIL 9, 1979

Statement by Michael A. Guarino, M.P.H., Director,
Bergen County Department of Health and
Environmental Protection

Item 2: Preliminary State Health Plan
Item 4: Federal Initiative and Monetary Assistance

There are several types of procedures that can be used by a health agency in developing a plan. One method is to depict the health problems within its area and then to articulate over numerous pages the need to further study these health problems. To circumvent all of the time required to do this, I would submit that we initially recognize the need for a state health plan with a strategy for implementation of a program for the control of chronic disease that will cover primary and secondary prevention and that will include both the public health and medical resources within the State.

Since 1900, life expectancy at birth in the United States has increased by about 25 years. This increase is attributable mainly to a decline in infant and child mortality.

In place of deaths and disability from communicable diseases, the nation has witnessed a major increase in heart disease, stroke and cancer. These have been linked to human behavior, individual as well as collective.

On the other side of the coin, expenditures for health care in the United States have been increasing at an alarming rate since 1950, now approaching 10% of the gross national product as opposed to 4.6% of the GNP in 1950. The alarming rate of increase in health care costs is probably most evident in cost of hospital care which has risen more than 1000% since 1950. Between 1967 and 1976 annual health care expenditures per person rose 169% from $208 to $552.

Evidence is accumulating to show that despite the great increase in expenditures for disease care, there has been during that time no significant decline in the U.S.disease and death rates. And so, the United States still ranks 6th in the world rates for mortality and chronic disease. Some would even claim that present spending levels for disease care have reached the point of diminishing returns.

On the other hand, there is a growing body of evidence showing that well planned and implemented health promotion and disease prevention programs can have a dramatic impact in lowering disease and death rates as witnessed in demonstration projects. In order to develop this public health philosophy it is imperative that we have a State health plan that will generate health programs for the school, industry and community.

In the United States today we are not controlling chronic disease because we spend our thought and time and money on sickness. We talk about a health care system, but in fact we have failed to create a health care system. We have a sick care system. When an individual suffers pain he knows how to enter the system via the private physician or hospital emergency room. People can relate only to pain, and pain therefore becomes the sole motivation for entry into the system. One of the challenges in New Jersey is to put together a health care system. The point of entry into a health care system HAS TO BE provided where people are brought together, through a school, industry and community based program with the major emphasis on PRIMARY and SECONDARY PREVENTION.

STRATEGIES FOR HEALTH PROMOTION/HEART and CANCER CONTROL PROGRAMS

1. Primary Prevention -- educating people to anticipate good health instead of sickness
2. Secondary Prevention - educating people to improve their lifestyles through intervention and early disease detection

The state of the art as it relates to the prevention of chronic disease is becoming more and more sophisticated. This sophistication, developed through research, embodies the concept that our modern lifestyles are the cause of many current health problems. Therefore, it is imperative that any health plan include strategies that carry this message to the general public.

There are a few public health practitioners in the country today who feel that the public can be better informed regarding current lifestyles and that they could be motivated to change. But in order to achieve this there must be a concerted effort amongst legislators, health agencies, medical providers and the consumer.

What we are attempting to envision here at the local, county and state levels has support in both philosophy and potential funding at the federal level in Public Law 94-317 which can augment our efforts to initiate health and information programs and disease prevention and control programs.

The time is now fully ripe. We should wait no longer to unite these forces to create and implement an effective health plan to prevent and control chronic disease throughout the state.

LIFESTYLE/ENVIRONMENTAL FACTORS That Interact and Cause Cancer

INDIVIDUAL	ELEMENTS	CHEMICALS
FAMILY HISTORY	AIR	FOODS
OCCUPATIONS	WATER	DRUGS
SMOKING	SUN	COSMETICS
DRINKING ALCOHOLIC BEVERAGES		HOUSEHOLD CHEMICALS - FERTILIZERS - PESTICIDES - CLEANING AGENTS - GLUES
DIETARY HABITS		
VEHICHLES OF TRANSPORTATION		

SYNERGIST – An agent that stimulates the action of another creating a total effect greater than each agent operating by itself.

SMOKING has a synergistic effect on most all factors that cause cancer.

BERGEN COUNTY
DEPARTMENT OF HEALTH
AND ENVIRONMENTAL PROTECTION
355 Main Street, Hackensack, N.J. 07601
646-2500

STRATEGIES FOR CANCER CONTROL

HEALTH EDUCATION / BEHAVIOR MODIFICATION

CANCER	PREVENTION	RISK FACTOR MODIFICATION	EARLY DETECTION
LUNG #1 Cancer killer	Antismoking education in primary grades	Smoking withdrawal classes/education	
COLON-RECTUM #2 Cancer killer	EAT DEFENSIVELY - PROTECT YOUR HEALTH Eat a varied diet of basic foods in moderation for your health. Dietary education: Reduce dietary fats and increase dietary fiber.		Hemoccult test
BREAST #3 Cancer killer			Breast self-examination
CERVICAL #9 Cancer killer			PAP smear test

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A HEALTH CARE SYSTEM FOR BERGEN COUNTY

SCHOOL PROGRAMS

Health Assessments & Counseling
Recreational Sports
Classroom Programs
- Nutrition
- Anti-Smoking
- Alcohol
- Communicable Disease

INDUSTRIAL PROGRAMS

Health Consultation/Education
- Heart Risk Factor
- Cancer Risk Factor
- Alcoholism

COMMUNITY PROGRAMS

Health Consultation Program
- Early Detection
- Health Counseling
- Health Education
- Referral
  - Private Physicians
  - Hospital Clinics
  - Community Resources for Behavior Modification

Adult Education Program

Heart & Cancer Risk Factors
- Quit Smoking
- Weight Control
- Exercise
- Stress Reduction

Nutrition
Alcoholism
Communicable Disease

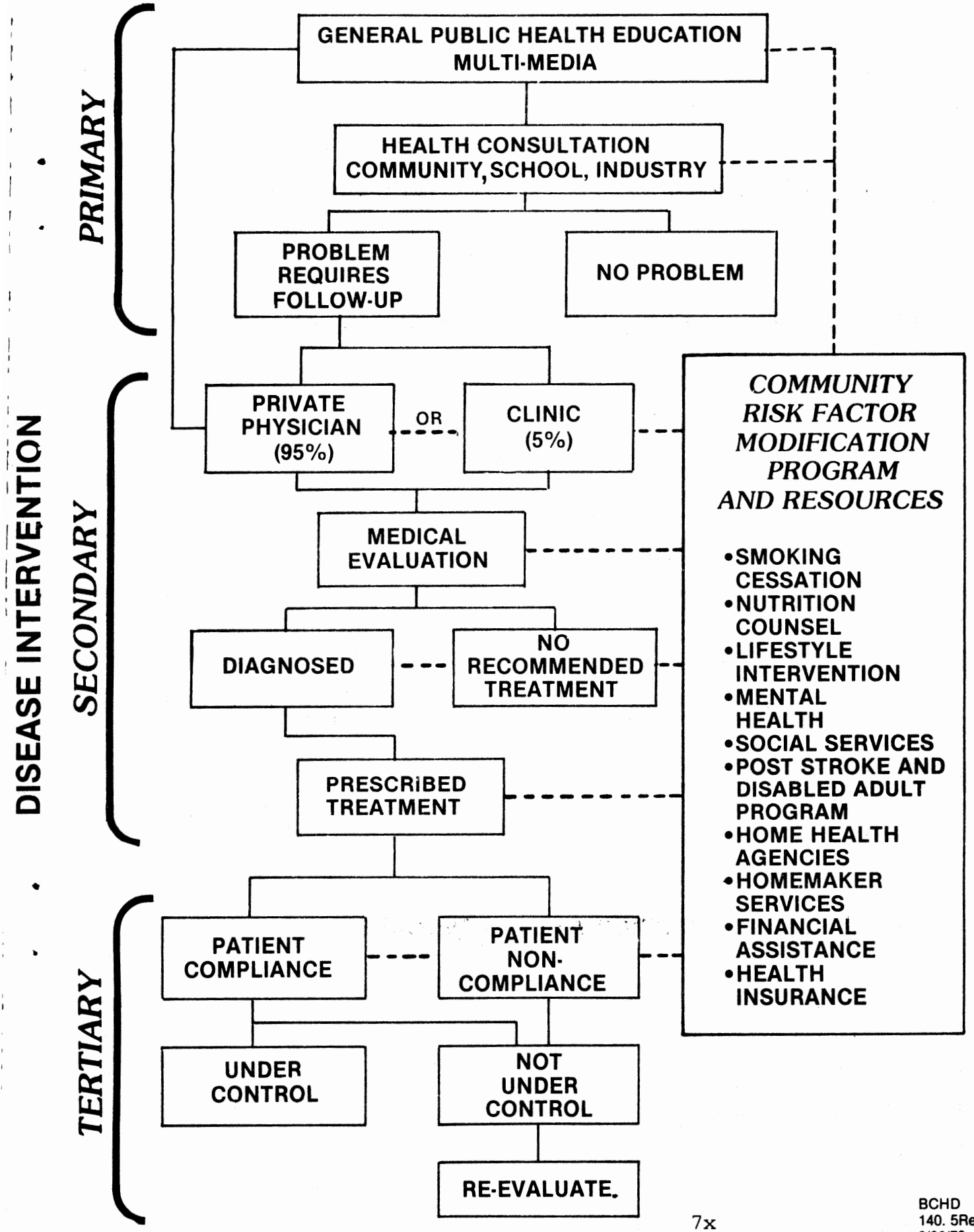
Multi-Media Health Education
- Community Groups
- TV and Cable TV
- Radio
- Pamphlets
- Magazines

PARTICIPATING AGENCIES

- Health Departments
- Professional Organizations
- Voluntary Agencies

BERGEN COUNTY
DEPARTMENT OF HEALTH
AND ENVIRONMENTAL PROTECTION
646-2600

BERGEN COUNTY HEALTH PROMOTION PROGRAM



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BOARD OF HEALTH

CLIFTON, NEW JERSEY
CITY HALL ANNEX

STUART B. PALFREYMAN, M.S.E.H., R.S.
HEALTH OFFICER

M.F. KALETKOWSKI, M.D.
PUBLIC HEALTH PHYSICIAN
PHONE 473-2600

April 9, 1979

State of New Jersey
Senate Institutions, Health
and Welfare Committee
Room 318-A State House
Trenton, New Jersey 08625

RE: SENATE INSTITUTIONS HEALTH AND WELFARE COMMITTEE
COMMENTS RELEVANT TO THE PREVENTION OF CHRONIC ILLNESS IN NEW JERSEY

Dear Sir:

Due to circumstances beyond our control, we are unable to testify at the Public Hearing on the Prevention of Chronic Illness in New Jersey at the Bergen County Administration Building in Hackensack on April 9, 1979.

Please accept our written testimony in our behalf. Enclosed also find eight copies for the committee and staff members.

Thank you for your cooperation.

Very truly yours,

Stuart B. Palfreyman

Stuart B. Palfreyman
Member of Passaic County
Health Officers Association

SBP:cml

Enclosures

BOARD OF HEALTH

CLIFTON, NEW JERSEY

CITY HALL ANNEX

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RE: SENATE INSTITUTIONS HEALTH AND WELFARE COMMITTEE
COMMENTS RELEVANT TO THE PREVENTION OF CHRONIC ILLNESS IN NEW JERSEY

Dear Sir:

I am speaking as a representive of the Passaic County Health Officers Association. We applaud the efforts of the committee in it's attempt to bolster the activities of many diverse groups, state wide, in the identification, prevention and control of Chronic Disease.

As we are sure you will agree, the bulk of the medical establishment as it now exists, is oriented towards "curative" medicine. Public Health, on the other hand, has it's roots founded in the Preventive Aspects of disease both from the Environmental and personal levels of concern. Perhaps the bottom line, the inevitable fact, you are grappling which was succinctly stated more than 200 years ago by the elderly statesman and sage Benjamin Franklin when he said, "A penny's worth of prevention is worth a pound of cure". That advice is still with us and quite accurate today.

Our current medical situation in this State indeed the country is reminiscent of a gentlemen I met in Jacksonville, Florida. He was in charge of initiating a county wide Emergency Medical Service in an atomosphere where the local morticians were providing the ambulance service. Fist fights were breaking out at accident scenes over who would get the dead bodies and who would get "stuck" with transporting the injured survivors to the hospital.

His relevant comment on the state of affairs, and in his distinct Florida accent, he said, "When your up to your buttocks in alligators ---- who worries about draining the swamp".

Quite literally, the medical industry has been battling the alligators for over a century and when equated to the financial outlay; a miniscule amount of financing has gone to "draining the swamp".

Your question of are the needs in Chronic Disease Prevention being met -- the answer is quite simply -- no! But it is of extreme relevance to this investigation to understand the reasons why.

COMMENTS RELEVANT TO THE PREVENTION OF CHRONIC ILLNESS IN NEW JERSEY

Adequate statuatory mechanisms are in existance to "drain the swamp" and thereby create a reduction in the alligator threat. Specifically, I am referring to Chapter 329 Public Law 1975, and the recognized Public Health Activities and Minimum Standards of Performance for local Boards of Health in New Jersey. Our problem, indeed your problem, is not necessarily a statuatory modification but rather a two prong program aimed at the heart of the situation. We need enforcement of existing statutes and the priority on the money to run the programs.

A man dying from cancer does not really care too much if New Jersey gets a professional sports team, or if he can bet on the race horses or if he has the money to gamble away at Atlantic City. He does care that the chemical industry he worked for had no interests in controlling carcinogen he was working with. He does care how his family is going to get along with out him and he wonders why no facilities were available to find his disease at an earlier and perhaps curable stage.

Public Health Prevention programs are at the bottom of the barrel when it comes to state priorities. Public Health Priority funding is at best a pittance. In real numbers, approximately 50¢ per person is appropriated for 28 Public Health programs mandated by the State. Why even pap smears -- one small part of just one program, costs $3.00 each, and that is cheap.

Simply put, chronic diseases can be substantially impacted and reduced <u>if</u> the State would enforce it's existing laws on the subject and back up the enforcement by placing Chronic Disease Prevention in a much higher priority financially.

Public Health Departments Voluntary agencies and other organizations are a mechanism in place and viable. They are capable of solving your problem -- all they need is your help.

We would like to make specific mention of one problem we foresee which is germane to our prior discussion. We do not see S-3045 as it is presently written in solving the problem -- only complicating it.

In our estimation the bill can be paraphrased in the following manner. County Health Departments are to be held responsible for the "coordinated" delivery of Chronic and Communicable diseases either by themselves or in conjunction with municipal and or other agencies as long as the latter case is governed by contract.

Futhermore, the county shall raise by municipal tax sources the money for the programs and may reimburse the municipalities for their efforts.

We are cognizant of the fact that in some more rural counties of New Jersey the only Public Health Department is the County Health Department and in that case we feel the bill is fine, there are however, a number of counties where there is mixed coverage i.e. A County Health Department and a few municipal Health Departments and also some counties where there is no County Health Department and <u>all</u> towns are covered by municipal Health Departments i.e. Passaic County.

COMMENTS RELEVANT TO THE PREVENTION OF CHRONIC ILLNESS IN NEW JERSEY

We see no logic or reason to create a County Health Department where one presently does not exist. All that would accomplish is to add another level to the bureaucracy and further dilute the available financial resources which are already the root of the problem.

The State Health Department has control over every municipality and can mandate Chronic Disease programs yet for some reason it has chosen not to enforce it's existing law.

We see no benefit in the passage of S:3045; it can only be a costly waste. Public Law 329 mandates that the programs be run and offers 4 options in how that may be accomplished. Minimum Standards mandates how the program will be run and Public Health Priority funding act dangles a small carrot as an incentive to get going.

Simply enforce the laws in existance and provide more money and S:3045 will not be needed.

We thank you for the opportunity to testify before this committee even if the notice of this hearing came two working days ago. If we didn't know better, we might be tempted to suspect that someone was trying to ramrod through. Or that someone had already made up their minds and didn't want to be confused with the facts.

Very truly yours,

Stuart B. Palfreyman

Stuart B. Palfreyman
Member of Passaic County
Health Officers Association

SBP:cml

Brunoogl

GRETA KIERNAN
ASSEMBLYWOMAN, DISTRICT 39 (BERGEN)
62 SPRING STREET
HARRINGTON PARK, N. J. 07640

LEGISLATIVE OFFICE
428 OLD HOOK ROAD
EMERSON, N. J. 07630

RES. 201-768-9115
LEGIS. OFF. 201-967-1100

GENERAL ASSEMBLY
OF NEW JERSEY
TRENTON

To: The Senate Institutions, Health and Welfare Committee

From: Anita Siegenthaler, aide to Assemblywoman Greta Kiernan
Member and Vice-Chairman, Bergen/Passaic Health Systems Agency
Member, Community Development Funds, Northern Valley
Former Councilwoman, Harrington Park

Date: April 9, 1979

Re: Public Hearing on the Prevention of Chronic Illness, Hackensack

As we all know, the most effective way to avoid the economic and social costs of chronic illness is to prevent the illness occurring in the first place.

The more we discover about the causes of any illness and its method of progression, the better the advice on avoidance or treatment will be. And the advice will be as variable as the illnesses.

But, regardless of the particular chronic disease -- regardless of its particular debilitation -- we do know that certain chronic illnesses, like diabetes, tend to "run in families"....and we do know that lifestyle -- e.g. diet, exercise -- can encourage or discourage the onset and the effects of chronic disease.

We know that some screening tests for chronic illnesses should be targeted to particular high-risk people....and that when certain diseases "run in families", the family members are likely to be high-risk. Who are the high-risk people for which chronic illness....and how should they be identified? And who should keep the records on high-risk individuals and their families?

April 9, 1979
Senate I, H, & W Comm.
Siegenthaler

Physicians who see a patient regularly and know family background do identify some high-risk people. But not everyone sees a physician regularly. And our society is mobile, so not everyone sees the same physician throughout his lifetime. And even if an individual did have a lifetime family doctor, how would the doctor know about great Uncle Fred who bathed his left foot in oil of wintergreen solution and had either gout, athelete's foot, or diabetes----depending on who you talked to in the family... The physician can't be expected to be the complete and permament repository for family health history and folklore.

And no one of us would want a nationwide, computerized health data bank with the health records of all families since 1890 forward available....for a variety of reasons familiar to us all.

So, who should know what "runs in families." Who should keep family health history....who should be alert to the possibility of a particular chronic disease occurring....the common sense answer is the family members themselves.

Family health history should be as familiar and well kept as any family tree that traces ancestory. Family health history is more important than any family tree because it truly charts the futures of all the family members. It determines how that family tree will grow.

April 9, 1979
Senate I, H, & W Comm.
Siegenthaler

Since it really seems sensible, to me, to have an educated person be his own first line of defense against chronic illness, I would hope that whatever recommendations this committee makes will include recognition of education as a primary means of prevention.

Health education programs in the elementary schools should include detailed information of the various types of chronic illness, the health habits that might discourage the illness, and the necessity of recording family health history.

Public health education programs for adults should include all of the above, and additionally stress that ancestoral illnesses are not for hushed, no-name discussions after the kids have left the table....but that these illnesses are tools for prevention of the recurrence of that illness or its unnecessarily devasting effects ....tools to be used by and for the children to maintain the best health possible....tools they can use to prevent themselves from becoming permanent patients.