In New Jersey, allocation of State funds to local projects is proving successful in assisting control of chronic illness.

State Grants for Local Projects in Chronic Illness Control

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

THIS statement of public policy is taken from the Prevention of Chronic Illness Act of New Jersey. It represents another evolutionary step in the development of a chronic illness control program in this State—a program which began in 1949 when the Governor appointed a Temporary Committee on the Chronic Sick. The Prevention of Chronic Illness Act, passed in 1952, also called for the establishment of a division of chronic illness control in the State health department, the appointment of an Advisory Council on the Chronic Sick, and the selection of a Committee of Technical Advisors.

In December of 1952, the Governor called the first of a series of governor's conferences on chronic illness. This conference served to focus the attention of both professional and nonprofessional health leaders on the importance of the chronic illness problem and the need for concerted effort to solve it. Following this conference the decision was made to allocate State chronic illness funds to local sponsors.

State aid for locally sponsored projects was not a new concept in New Jersey. The basic laws of that State emphasize "home rule." The State health department has for several years contracted with local health departments for the provision of certain local health services. This policy, with only one important change, was simply extended to cover services for the chronically ill. The chronic illness grants-in-aid, however, are not limited to local health departments as are other grants-in-aid. Local boards of chosen freeholders, local nonprofit hospitals, and local voluntary agencies also can sponsor chronic disease grant-in-aid projects.

Contract Specifications

Contracts covering the State-local grants-in-aid are between the State health department and the local sponsor. They call for the provision of specific services in return for a grant-

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in-aid, which may be in the form of money, personnel, or equipment.

When a grant-in-aid provides for the employment of personnel, the local sponsor recruits, hires, and supervises the personnel. This arrangement has proved to be more satisfactory than the assignment of State health department personnel to local projects because it gives the local agency a greater sense of responsibility for the project and because other employees accept the new employees as a part of their organization, subject to the same personnel policies. To insure the employment of qualified personnel, the State health department includes in the contract basic minimum qualifications for positions covered in each contract, based on State civil service standards. These qualifications must be met by employees recruited by local sponsors.

At periodic intervals the State health department checks the local program to make sure that the services contracted for are being provided.

Each contract provides for a specific termination date for State aid, after which the project must be maintained solely by the local sponsor. Gradual amortization is usually achieved. The contract may be terminated by either party 60 days after written notification has been given. It provides for quarterly payments to reimburse the local sponsor for actual expenditures, and it calls for the submission of quarterly reports to the State health department.

The contract also requires that the sponsor maintain proper records, make expenditures in accordance with budgets approved by the State health department, and accept general supervision and consultation by the State health department.

Federal grant-in-aid funds allocated to the State health department for the control of heart disease, cancer, and tuberculosis are not included in the State-local chronic illness grants-in-aid. They are allotted to local sponsors in much the same manner as State funds but under separate contracts. A single local sponsor may enter into one or more contracts with the State health department for the State-derived funds and also one or more contracts for federally derived funds.

Scope of Program

The following table shows the planned expenditures for chronic illness grant-in-aid funds during the fiscal year 1955–56. In conformance with the Prevention of Chronic Illness Act, the expenditures are broken down into five general categories:

Category	*Amount*	*Percent*
Early detection	$102,685	56
Prevention [1]	2,500	1
Public health nursing and homemaker services	13,300	7
Rehabilitation	47,160	25
Research [2]	20,049	11
Total	185,694	100

[1] Primary prevention only.

[2] $3,400 was allocated directly for research. In addition, 10 percent of the funds originally allocated for early detection and 10 percent of the funds originally allocated for rehabilitation were transferred to the research category.

To illustrate the diversity of activities and the broad geographic coverage that can be achieved by the use of State-local grants-in-aid, a few of the projects that have been or are being undertaken are mentioned.

Nine local hospitals have been assisted in developing multiple screening services for hospital personnel and all persons admitted to the hospital. Four hospitals are utilizing State aid to develop rehabilitation services. Two hospitals are engaged in evaluating screening tests related to diabetes control. Four community hospitals have made pilot studies of rheumatic fever prophylaxis.

The need for including bedside nursing among the services routinely offered by public health nurses has been recognized, and a study has been authorized to develop this type of program conversion. Seven community homemaker services are now functioning in New Jersey. One of these, organized on a county basis, is being assisted with a grant-in-aid to demonstrate the importance of a trained medical social worker in this field.

Two large projects are providing rehabilitation services in county institutions and hospital centers. For these projects, the grants-in-aid are in the form of trained personnel and labor-saving equipment.

A significantly large sum of money has been allotted to a medical center to provide screening services to patients of private physicians upon request. Five outpatient alcoholism clinics have been started in local hospitals.

Other local projects being developed through the grants-in-aid program include multiphasic screening of State employees, cervical cancer screening in demonstration hospitals, and screening for hearing defects and the rehabilitation of the hard of hearing in two hospitals.

This is not a complete list of the many local chronic disease projects in which the New Jersey State Health Department is participating. However, it does serve to indicate how quickly and effectively a large number of institutions, agencies, and people can become involved in developing local services for the chronically ill through the expenditure of a relatively small amount of money.

The chronic illness activities of the State health department are not limited to the allocation of grants-in-aid. The division of chronic illness control is responsible also for coordinating all health services which are designed to assist the chronically ill, for public and professional education, and for planning a long-range coordinated control program.

Achievement of Objectives

The operation of a grant-in-aid program in no way negates the need for basic research work, the objective of which is to determine the causes of the degenerative and malignant diseases. Nor does it prevent the normal entrance of many nonsubsidized individuals, agencies, and institutions into the field of chronic illness control. The program does favor the more rapid achievement of several important public health objectives:

1. It almost automatically enlists the interest and support of many professional people in local chronic illness control activities.

2. It multiplies the resources and personnel engaged in chronic illness control.

3. It offers new opportunities for learning how to provide local services that are better designed to find, treat, and rehabilitate the chronically ill.

4. It builds on spontaneous local interest where it exists. This tends to insure the efficient and economical administration of projects and favors their continuance when State aid is withdrawn.

5. It permits the State health department to exert leadership in the evolution of the chronic illness control program by selecting from among the many local applicants those that can contribute most effectively to the planned statewide program.

The rapid expansion of interest in New Jersey in chronic illness control is evidenced by the increasing popularity of the several governor's conferences which have been held since the original conference in 1952. Subsequent conferences have been held on diabetes, cardiovascular diseases, alcoholism, and new horizons in chronic illness control, including rehabilitation. All of these conferences have attracted large audiences and have resulted in excellent publicity. As a result, where originally there was a dearth of local applicants for the grant-in-aid funds, there now is a plethora.

The State-local chronic illness grant-in-aid mechanism in New Jersey is succeeding in increasing the number and quality of services offered locally to persons with chronic illness. Its important features are its simplicity of operation and its persuasiveness in obtaining the participation of local people in the solution of their own problems. Other State health departments might find that their chronic illness program can be accelerated by the adoption of the grant-in-aid mechanism.

Chronic disease grants-in-aid have proved to be, in part at least, an answer to a statement the Governor of New Jersey made in 1952: "Unless something is done by the way of effective prevention, there must inevitably be greater outlays for institutional care, and we must bear all the additional social costs—the costs in human suffering and in damaged family relationships."