A COMMISSION REPORT

# MODIFICATION OF FEDERAL GRANTS-IN-AID FOR PUBLIC HEALTH SERVICES

ADVISORY COMMISSION ON
INTERGOVERNMENTAL RELATIONS
January, 1961

ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS
Washington 25, D. C.

| | |
|---|---|
| Frank Bane | Chairman |
| James K. Pollock | Vice-Chairman, Ann Arbor, Mich. |
| Robert B. Anderson | Secretary of the Treasury* |
| Hal Bridenbaugh | State Senator, Dakota City, Nebr. |
| John E. Burton | Citizen Member, Ithaca, N. Y. |
| Anthony Celebrezze | Mayor, Cleveland, Ohio |
| Gordon S. Clinton | Mayor, Seattle, Wash. |
| Edward Connor | Councilman, Wayne County, Mich. |
| Leslie Cutler, Mrs. | State Senator, Needham, Mass. |
| Clair Donnenwirth | Supervisor, Plumas County, Portola, Calif. |
| Florence P. Dwyer, Mrs. | Member of the House of Representatives |
| Sam J. Ervin, Jr. | Member of the Senate |
| Arthur S. Flemming | Secretary of Health, Education, and Welfare* |
| L. H. Fountain | Member of the House of Representatives |
| Ernest F. Hollings | Governor of South Carolina |
| Don Hummel | Mayor, Tucson, Ariz. |
| Edwin Michaelian | County Executive, Westchester County, N.Y. |
| Wilbur D. Mills | Member of the House of Representatives*** |
| James P. Mitchell | Secretary of Labor* |
| Karl E. Mundt | Member of the Senate |
| Edmund S. Muskie | Member of the Senate |
| John W. Noble | State Senator, Kenneth, Mo.**** |
| Norris Poulson | Mayor, Los Angeles, Calif. |
| Abraham A. Ribicoff | Governor of Connecticut |
| Robert E. Smylie | Governor of Idaho |
| William G. Stratton | Governor of Illinois** |

William G. Colman, Executive Director

* Membership on the Commission expired January 20, 1961.
** Replaced by John Anderson, Jr., Governor of Kansas, January 19, 1961.
*** Resigned January, 1961.
**** Membership on the Commission expired January 2, 1961.

## PREFACE

Id

The Advisory Commission on Intergovernmental Relations was established by Public Law 380, passed by the first session of the 86th Congress and approved by the President September 24, 1959. Sec. 2 of the act sets forth the following declaration of purpose and specific responsibilities for the Commission.

> "Sec. 2. Because the complexity of modern life intensifies the need in a federal form of government for the fullest cooperation and coordination of activities between the levels of government, and because population growth and scientific developments portend an increasingly complex society in future years, it is essential that an appropriate agency be established to give continuing attention to intergovernmental problems.
>
> "It is intended that the Commission, in the performance of its duties, will--
>
> "(1) bring together representatives of the Federal, State and local governments for the consideration of common problems;
>
> "(2) provide a forum for discussing the administration and coordination of Federal grant and other programs requiring intergovernmental cooperation;
>
> "(3) give critical attention to the conditions and controls involved in the administration of Federal grant programs;
>
> "(4) make available technical assistance to the executive and legislative branches of the Federal Government in the review of proposed legislation to determine its overall effect on the Federal system;
>
> "(5) encourage discussion and study at an early stage of emerging public problems that are likely to require intergovernmental cooperation;
>
> "(6) recommend, within the framework of the Constitution, the most desirable allocation of governmental functions, responsibilities, and revenues among the several levels of government; and
>
> "(7) recommend methods of coordinating and simplifying tax laws and administrative practices to achieve a more orderly and less competitive fiscal relationship between the levels of government and to reduce the burden of compliance for taxpayers."

Pursuant to its statutory responsibilities, the Commission from time to time singles out for study and recommendation particular problems. the amelioration of which in the Commission's view would enhance cooperation among the different levels of government and thereby improve the effectiveness of the federal system of government as established by the Constitution. One problem so identified by the Commission relates to a recommendation which has been made in several previous studies of Federal grants-in-aid--namely, that existing highly specific categorical grants in the field of public health be combined or otherwise modified so as to provide increased latitude in their use by the States and their political subdivisions.

In the following report the Commission has endeavored to set forth what it believes to be the essential facts and policy considerations bearing upon this problem and respectfully submits its conclusions and recommendations thereon to the Executive and Legislative Branches of the National Government and to the States.

This report was adopted at a meeting of the Commission held on January 18, 1961.

Frank Bane
Chairman

TABLE OF CONTENTS

# I. INTRODUCTION

## A. Reason for the Report

Dating from the first "Hoover Commission" every major study group which has concerned itself with intergovernmental relations has identified as one of the problems of Federal-State relations current at the time, the specific categorization of Federal grants-in-aid for public health services and the administrative and budgetary difficulties alleged to be associated therewith. The report of the first "Hoover Commission" on Federal-State Relations in a section entitled "Piecemeal Determination: Public Health" discussed this situation as one which "makes it difficult for the States to balance their own fiscal and administrative activities." 1/ Similar comments were made in the report of the Commission on Intergovernmental Relations in 1955 2/, the report of the Intergovernmental Relations Subcommittee of the House Committee on Government Operations in 1958 3/ and the final report of the Joint Federal-State Action Committee. 4/

The Advisory Commission on Intergovernmental Relations believes that this recurring issue should be brought to prompt resolution, one way or the other, and it is to such end that this report is directed.

## B. Scope of the Report

As indicated by the title, this report is addressed to a specific problem and is relatively narrow in scope. It is concerned only with the question of the method whereby Federal funds are appropriated, apportioned and administered for grants-in-aid to the States for the following health categories: (1) general health; (2) heart disease control; (3) cancer control; (4) venereal disease control; (5) tuberculosis control; (6) mental health; (7) maternal and child health services; and (8) crippled children's services.

---

1/ Report of the Commission on Organization of the Executive Branch of the Government, Senate Document 81, 81st Congress, 1st Session, March 25, 1949, p. 54.

2/ Commission on Intergovernmental Relation, A Report to the President for Transmittal to the Congress, Government Printing Office, June, 1955, pp. 251-2.

3/ House Committee on Government Operations, Thirtieth Report: Federal-State-Local Relations, Federal Grants-in-Aid. (85th Congress, 2nd Session, House Report No. 2533), Government Printing Office, February, 1960, pp. 26; 43; 51-52.

4/ Joint Federal-State Action Committee, Final Report to the President of the United States and to the Chairman of the Governors' Conference, Government Printing Office, February, 1960, pp. 13; 172-185.

The report does not treat, except incidentally, upon the philosophical bases of the present and future roles of the different levels of government in the provision of health and medical services, facilities and manpower. Neither does it deal with the role of Federal grants-in-aid in the equalization of differences among the States in their fiscal capacity and tax effort. These are indeed important questions of intergovernmental relations in the United States and the Commission may be speaking about them in future reports, but they go far beyond the issues of administrative and budgetary methods which are dealt with here. Finally, because of their orientation to facilities in contrast to services, Federal grants for hospital construction, water pollution control, waste treatment works and health and medical research facilities are not covered in this report.

### C. Summary Description of Categorical Programs

Continuing Federal grants for public health activities were inaugurated under the Social Security Act of 1935. Grants for the control of venereal disease were initiated earlier by the Chamberlain-Kahn Act of 1918 but were discontinued after a few years. The Public Health Service Act of 1944, consolidating and expanding previous public health legislation, is now the basic public health statute. Grants are made to assist the States and their political subdivisions to maintain adequate programs for general health and in five specific categories: Cancer control, heart-disease control, mental health, tuberculosis control, and venereal-disease control. Funds are allotted to the States for each category except venereal disease on the basis of formulas which generally take into account population, the extent of the particular health problem, and State per capita income. Funds for venereal disease control are granted on a project basis at the discretion of the Surgeon General and do not require matching. Grants for all other categories must be matched by the expenditure of 1 dollar from State or local sources for every Federal dollar. The programs are administered by the Public Health Service, Department of Health, Education, and Welfare.

Closely related to these categorical grants from the Public Health Service are grants for Crippled Children's Services and for Maternal and Child Health Services which are administered by the Children's Bureau of the Department of Health, Education and Welfare. Allotment of funds takes into account the incidence of the respective problem and the financial need of the State. Part of the grants are unmatched, and part must be matched dollar for dollar.

## II. HISTORY, OBJECTIVES, AND FINANCING OF CATEGORICAL PROGRAMS

### A. Statutory History

The Social Security Act of 1935--This Act authorized various types of Federal grants for public health. Title V of the Act referred to the Children's Bureau, title VI to the Public Health

Service. Under title VI, the Public Health Service was authorized to assist States, counties, health districts, and other political subdivisions in establishing and maintaining adequate public health services, including the training of personnel for State and local health work. For this purpose, $3 million a year was originally authorized and was increased in 1939 to $11 million annually. In 1937, the National Cancer Act established a National Cancer Institute within the Public Health Service to conduct research in cancer and to administer grants-in-aid to universities and other institutions and individuals for cancer research. (The grants are not made directly to States, but the recipient institutions may be State institutions.)

In 1938, the Chamberlain-Kahn Act for venereal disease control was revived and amended, and appropriations of $3 million for 1939 and larger amounts for succeeding years were authorized.

Title V, parts 1 and 2, of the Social Security Act of 1935 authorizes grants to States for (a) "services for locating crippled children and for providing medical, surgical, corrective and other services and care" and (b) "services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress." Grants for the second category--maternal and child health services--were first authorized by the Sheppard-Towner Act of 1921. Opposition to these grants arose and in 1929 Congress allowed them to expire. After re-initiation in 1935, the program has continued uninterruptedly.

The Public Health Service Act of 1944--This Act consolidated and expanded previous public health legislation, and is now the basic public health statute. Aid to States and their subdivisions for establishing and maintaining adequate public health services, including the training of personnel, was specifically extended to cover demonstrations, and the amount that might be appropriated was increased to $30 million. In addition, a separate grant was authorized for tuberculosis control and treatment ($10 million for 1945 and no specified amount thereafter). An authorization for venereal disease grants was also incorporated in the Act, but no sum was specified.

The growth and importance of Federal-State cooperation in the field of public health, especially since 1935, was recognized by the Public Health Service Act, in which a whole section (title III, part B) is entitled "Federal-State cooperation." The Act stated that, in general, and not merely in connection with grants-in-aid, the Surgeon General shall assist States and their political subdivisions in the prevention and suppression of communicable diseases, shall cooperate with and aid State and local authorities in the enforcement of their quarantine and other health regulations, and in carrying out the purposes specified in section S-314 (relating to grant and services to States); and shall advise the several States on matters relating to the preservation and improvement of the public health.

Proposal for Consolidation of Categories

The Department of Health, Education, and Welfare in 1954 initiated a review of its grant-in-aid programs and proposed new legislation with respect to grants for public health services, child health and welfare services, vocational education, and vocational rehabilitation to: a) authorize the use of a uniform grant formula and approach in each of these programs, and b) to combine categorical aids.

The Administration subsequently recommended a single unified Public Health Service health grant structure. Legislation which passed the House of Representatives in April 1954 (H.R. 7397, 83rd. Cong., 2nd. sess.) would have eliminated the categorical programs for venereal disease, tuberculosis, heart disease and cancer control, consolidated these grant funds into a general grant for public health services, and continued grants for mental health for a five-year period. Under the proposal, grants of three types were to be made to the States: support grants, extension and improvement grants, and project grants for experimental purposes. Funds for support purposes were to be allotted among the States on the basis of a formula incorporating population and per capital income factors; the allotments were to be matched on a variable percentage basis (varying inversely with income of the States) within a maximum Federal share of 66 2/3 percent and a minimum of 33 1/3 percent. Extension and improvement grants were to be allotted on the basis of population and matched on a project basis, with a sliding scale depending upon the period elapsing i.e., 75 percent first two years, 50 percent second two years and 25 percent in the fifth and sixth years. The project aid for experimentation was to be distributed administratively. The "packaged" health program did not call for increased Federal expenditures for Public Health Service grants and cutbacks were projected in funds for a number of States.

Opposition to the proposal led to the five year exception of mental health grants from the block grant proposal in the House; the Senate Committee on Labor and Public Welfare did not report out the companion Senate (S.2778) bill.

B. Program Objectives and Financing

Following is a summary description of each of the categorical programs, including the date of establishment, objectives of the program, and the manner in whcih Federal funds are allocated and matched. A more complete description of the programs, their accomplishments and administrative and financial aspects is contained in Appendix A.

General Health Assistance

The general health grant was started in 1936 as title VI of the Social Security Act to provide financial assistance and stimulation to the nationwide development and improvement of State and local public health services for the prevention and control of disease, disability,

and premature death. It was conceived that the mass protection of the population through these services would prolong the productive life of individuals, reduce the costs of medical and hospital care, lower welfare costs resulting from dependency due to loss of personal income, protect against the interstate spread of disease, and generally promote the health and welfare of the people.

Authority for the general health grant was included with relatively little change in the Public Health Service Act of 1944. While the basic purposes of the grant have remained unchanged since its inception, two factors have influenced the major emphasis of programs which it helps to support. The first of these has been the initiation at later dates of grant programs for various categories of disease (e.g., tuberculosis, heart disease, poliomyelitis) that have provided funds for the specialized costs of programs and services for certain disease control programs. The second factor has been the remarkable advancements in scientific knowledge that have made possible the initiation through the general health grant of new programs and services for the control on a community public health basis of diseases and conditions for which there was formerly no prevention or control measures.

General health grant funds are allotted among the States by a formula which takes into consideration the population, financial need, and extent of the health problem in the various States. By administrative determination, 95 percent of the funds is allotted on the basis of population weighted by the reciprocal of per capita income and 5 percent on the basis of extent of the health problem as measured by the reciprocal of population density. Funds must be matched dollar for dollar.

Heart Disease Control

The grant for community programs for heart disease control was authorized by the National Health Act, approved June 10, 1948, by amendment to section 314 of the Public Health Service Act.

The legislation for this grant departed from the previous pattern for other section 314 grants by providing for submission of a plan by a political subdivision of a State or by any public or non-profit organization in the event the State health authority has not submitted a plan prior to August 1 of any fiscal year. To date only one such agency has participated in the program.

Heart disease control grant funds are allotted among the States on a formula which takes into consideration the population and financial need. The extent of the heart disease problem as a factor in the allocation of funds was not included in the heart disease grant legislation. By administrative determination, 24.6 percent of the funds is allotted on the basis of 10 cents per capita for the first 100,000 population. This determination provides a basic $10,000 grant for all

States except the Virgin Islands. The remaining funds (75.4 percent) are allotted on the basis of population weighted by the reciprocal of per capita income.

Federal funds must be matched dollar for dollar.

Venereal Disease Control

The venereal disease control grant was authorized May 24, 1938, by amendments to the 1918 Chamberlain and Kahn Act, to assist States in establishing and maintaining adequate measures for the prevention, treatment, and control of the venereal disease.

The dramatic effect of penicillin in the treatment of syphilis changed the emphasis from inpatient treatment centers to casefinding and outpatient services. Funds for formula grants under section 314 (a) of the Public Health Service Act have not been appropriated after June 30, 1953, and currently, grants are available only for special projects. There is no matching requirement for these funds.

Tuberculosis Control

The tuberculosis control grant was authorized in section 314 (b) of the Public Health Service Act, approved July 1, 1944, to assist States in establishing and maintaining adequate measures for the prevention, treatment, and control of tuberculosis.

The early finding of tuberculosis and the use of drugs and surgery in treatment have materially reduced the tuberculosis death rate. However, the number of new cases each year has not been reduced as dramatically. In order to focus attention on the need for case finding, Congress in the 1955 Appropriation Act (Public Law 472, 83d Cong.) restricted the use of the Federal grant and State and local matching funds for direct expenses of prevention and case finding activities.

Tuberculosis grant funds are allotted among the States by a formula which takes into consideration the population, financial need, and extent of the tuberculosis problem in the various States. By administrative determination, 20 percent of the funds is allotted on the basis of population weighted by the reciprocal of per capita income, and 80 percent on the basis of extent of the tuberculosis problem as measured by tuberculosis morbidity and mortality and evaluation of program needs. Tuberculosis grants must be matched dollar for dollar.

Cancer Control

The high mortality from cancer and the concern of the public over the problem of cancer control created the demand for Federal assistance in developing cancer control programs. The cancer control grant as a separate appropriation was initiated by the 1948 Appropriation Act (Public Law 165, 80th Cong.). However, the 1947 appropriation for

general health was increased $3,250,000 over the previous year, and of that amount $2,500,000 was specifically allotted for cancer control.

The annual appropriation acts which authorize the cancer control grant prescribe no formula or procedure for allotment of funds. By regulation, funds are allotted on a formula which takes into consideration the population, financial need, and extent of the cancer problem. By administrative determination, 60 percent of the funds is allotted on the basis of population weighted by the reciprocal of per capita income, and 40 percent on the basis of the extent of the cancer problem as measured by mortality from cancer (35 percent) and the reciprocal of population density (5 percent). Federal funds for this program must be matched dollar for dollar.

Mental Health Activities

The National Mental Health Act, approved July 3, 1946, authorized the mental health grant by amendment of section 314 of the Public Health Service Act. The appropriation authority of section 314 (c) of the annual appropriation acts, beginning with fiscal year 1948, have included in the appropriation for mental health activities an amount for State grants. The purpose of this grant is to assist the States in establishing, maintaining, and expanding community mental health service in an effort to improve the mental health of people of the United States and to prevent and curtail the need for hospital care of the mentally ill. This legislation for the first time authorized, under section 314 (f) (later redesignated (g) ), the submission of plans by agencies other than the State health authority.

Mental health grant funds are allotted among the States by a formula which takes into consideration the population, financial need, and extent of the mental health problem in the various States. By administrative determination, 30 percent of the funds is allotted on the basis of population weighted by the reciprocal of per capita income and 70 percent on the basis of the extent of the mental health problem. Federal funds must be matched dollar for dollar.

Maternal and Child Health Services

The purpose of this program, established by the Social Security Act of 1935, is to enable each State to extend and improve services for promoting the health of mothers and children, especially in rural areas and areas suffering from severe economic distress. While the program is primarily one of preventive health services, medical care is also a feature in some of the States. The Federal appropriation is equally divided into two funds. Fund A is apportioned partly by an equal grant to each State and partly in

porportion to the number of live births. After reserving an amount for special projects, fund B is apportioned according to the need of each State for financial assistance in carrying out its approved plan. Fund A grants must be matched dollar for dollar. The program is administered by the Children's Bureau in the Department of Health, Education, and Welfare.

Crippled Children's Services

This program, established by the Social Security Act of 1935, is intended to assist the States to extend and improve (especially in rural areas and areas suffering from severe economic distress) services for locating crippled children and for providing medical, surgical, corrective and other services and care, as well as facilities for diagnosis, hospitalization and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling. The definition of a crippling condition is determined by each State; within that definition the State agency indicates the types of conditions it accepts for care. The Federal appropriation is equally divided into two funds! Fund A is apportioned by equal grants to each State, and the remainder prorated according to the number of children under 21 years of age. Twenty-five percent of fund B is reserved for special projects, while the remainder is apportioned according to the financial need of each State for assistance in carrying out its approved plan. Fund A grants must be matched dollar for dollar. The program is administered by the Children's Bureau in the Department of Health, Education, and Welfare.

D. Federal, State and Local Expenditures

Total Federal grants-in-aid for the eight programs and estimated expenditures from State and local sources for the fiscal year 1959 are as follows: 5/

5/ Data supplied by the Department of Health, Education, and Welfare.

TABLE 1

(Thousands of Dollars)

| Category | Federal Grants | State, local and other | Percent Federal |
|---|---|---|---|
| General health | $15,110 | $188,860 | 7.4 |
| Heart disease control | 2,171 | 6,272 | 25.7 |
| Tuberculosis control | 4,073 | 28,705 | 12.4 |
| Mental health | 4,047 | 42,868 | 8.6 |
| Cancer control | 2,229 | 7,190 | 23.7 |
| Venereal disease special projects | 2,283 | 14,579 | 13.5 |
| Maternal and child health | 16,966 | 58,844 | 22.5 |
| Crippled children's services | 15,369 | 41,796 | 26.9 |
| Total | $62,248 | $389,114 | 13.8 |

As shown above, Federal grants accounted for only 14 percent of total expenditures for all programs. In a few States, however, Federal grants in certain categories comprise a significant proportion of total outlays; a breakdown by State for the strictly public health grants (excluding maternal and child health and crippled children's services) is shown in Table 2 below. Breakdowns by States for each of the individual categories are shown in Appendix B. It should be noted that amounts shown here for these eight programs represent only a minor fraction of State and local government expenditure for all health purposes, including hospitals. The 1957 Census of Governments showed State-local expenditure for such purposes as follows; Hospitals--$2,648 million; Health (other than hospitals)--$552 million; Total--$3,200 million. This includes expenditure financed from Federal payments to State and local governments for health and hospital purposes, which were reported by the Census as totaling $111 million in 1957. 6/

6/ Tables 8 and 9, Compendium of Government Finances, Vol. III, No. 5 of the 1957 Census of Governments.

TABLE 2

Total Federal Grants-in-Aid for the Six Programs 1/
and Estimated Expenditures from State and Local Sources, 1959

(Thousands of Dollars)

| State | Federal Grants* | State, local and other* | Percent State and local of total |
|---|---|---|---|
| Alabama | $743 | $ 3,498 | 82.5 |
| Alaska | 127 | 1,342 | 91.3 |
| Arizona | 251 | 1,231 | 83.1 |
| Arkansas | 520 | 1,318 | 71.7 |
| California | 1,786 | 31,052 | 94.6 |
| Colorado | 308 | 1,557 | 83.5 |
| Connecticut | 275 | 4,263 | 94.0 |
| Delaware | 99 | 532 | 84.3 |
| Dist. of Columbia | 198 | 2,872 | 93.6 |
| Florida | 747 | 8,359 | 91.8 |
| Georgia | 912 | 8,098 | 90.0 |
| Idaho | 167 | 699 | 78.2 |
| Illinois | 1,373 | 12,439 | 90.1 |
| Indiana | 622 | 3,422 | 84.6 |
| Iowa | 423 | 1,268 | 75.0 |
| Kansas | 379 | 2,406 | 86.4 |
| Kentucky | 692 | 3,111 | 81.8 |
| Louisiana | 634 | 5,254 | 89.2 |
| Maine | 196 | 941 | 82.8 |
| Maryland | 542 | 7,516 | 93.3 |
| Massachusetts | 658 | 3,550 | 84.4 |
| Michigan | 1,086 | 9,521 | 89.8 |
| Minnesota | 512 | 2,660 | 83.9 |
| Mississippi | 664 | 2,310 | 77.7 |
| Missouri | 708 | 4,948 | 87.5 |
| Montana | 161 | 435 | 73.1 |
| Nebraska | 247 | 1,099 | 81.6 |
| Nevada | 98 | 282 | 74.3 |
| New Hampshire | 114 | 558 | 83.0 |
| New Jersey | 758 | 10,992 | 93.5 |
| New Mexico | 237 | 1,174 | 83.2 |
| New York | 2,292 | 54,959 | 96.0 |
| North Carolina | 1,023 | 7,476 | 88.0 |
| North Dakota | 187 | 649 | 77.6 |
| Ohio | 1,262 | 14,986 | 92.2 |
| Oklahoma | 435 | 1,526 | 77.8 |
| Oregon | 272 | 2,525 | 90.3 |
| Pennsylvania | 1,630 | 16,994 | 91.2 |
| Rhode Island | 135 | 1,734 | 92.8 |
| South Carolina | 640 | 2,301 | 78.2 |
| South Dakota | 169 | 500 | 74.7 |
| Tennessee | 788 | 4,391 | 84.8 |
| Texas | 1,555 | 8,873 | 85.1 |
| Utah | 148 | 1,028 | 87.5 |
| Vermont | 118 | 783 | 86.9 |
| Virginia | 680 | 6,584 | 90.6 |
| Washington | 375 | 6,093 | 94.2 |
| West Virginia | 416 | 1,844 | 81.6 |
| Wisconsin | 507 | 5,274 | 91.2 |
| Wyoming | 113 | 312 | 73.5 |
| Guam | 52 | 335 | 86.6 |
| Hawaii | 127 | 2,500 | 95.2 |
| Puerto Rico | 701 | 7,791 | 91.7 |
| Virgin Islands | 61 | 406 | 86.9 |

* Columns will not necessairly add due to rounding nearest thousand.

1/ Venereal Disease Control, Preventive Tuberculosis, General Health Mental Health, Cancer Control and Heart Disease Control.

Source: Department of Health,Education, and Welfare.

## III. DESIRE OF STATES FOR INCREASED FLEXIBILITY

For the past several years the pros and cons of substituting a general "block" grant, or alternatively, fund transferability among existing public health categorical grants have been discussed extensively. The opposing positions on this question may be summarized briefly as follows. State officials, from the Governor down, naturally favor maximum flexibility in the use of Federal grants at the State level. On the other hand, professional organizations concerned with particular categories (cancer, heart disease, etc.) believe that financial support from the Congress and State legislatures can be more strongly justified in terms of specific, disease-oriented categories. Federal officials occupy a position somewhat in between, but generally tend to the view that maximum stimulation of State and local health activity can be obtained through a focus somewhat more specific than "general health services."

More recently, local, State and Federal health agencies have emphasized the need for a reorientation of public health work to strengthen community health services for the prevention and control of chronic diseases. These agencies have urged coordinated action on chronic disease problems, which would give recognition to the basic services common to many of the chronic diseases and which would better recognize the needs of the individual who often has more than a single disease problem. These discussions lead to a third proposal for modification; namely; a consolidation of the grants for the specific chronic disease categories which essentially require similar community health services. Under this new proposal, only those specific chronic disease categories such as cancer control and heart disease control, which lend themselves to joint case finding techniques, and which require similar community health services would be consolidated. General health grants which seek to aid the States in a wide range of traditional public health services including sanitation, regulatory activities, training of health personnel, vital statistics records, etc., would not be encompassed within the "chronic disease block grant" but would be continued as a basic public health grant. Viewpoints of State and Federal agencies on earlier proposals for block grants and transfers of funds are set forth in some detail below.

In 1950 the National Association of State Budget Officers established a committee to work with a committee appointed by the Director of the United States Bureau of the Budget on "Federal-State Fiscal Realtions." The State representatives at that time urged that the grants-in-aid for the six Public Health Service programs be handled as a block grant in preference to continuing the categorical grant for each program.

Budget officers of the States pointed out that each recipient State knows more about how much money should be spent in the State on these programs than does the Department of Health, Education, and Welfare or the Congress. They stressed that giving this money to the States in a block grant would not in any way affect the accepted practice of the Department in setting minimum standards for each program which the States would have to maintain.

They pointed out that receiving these aids as a block grant would not increase State administrative costs, while on the other hand the Federal agency should find the administration of a block grant program less expensive.

The Committee of the National Association of State Budget Officers went so far as to poll the States to determine if there were any constitutional or statutory objections to block grant. Of the 35 States which replied to the questionnaire, none could find any such objection. 7/

In studies conducted for the "Kestnbaum" Commission in 1953, a considerable number of State officials were reported as strongly favoring some modification of the existing pattern of categorical grants. Surveys were conducted for the Commission in seven States by several management consulting and research organizations as to the administrative and fiscal impacts of Federal grants-in-aid. 8/ In response to the question of what financial or administrative modifications, if any, the State would recommend in existing Federal grant-in-aid programs, modification of the categorical structure of health grants through a block grant or fund transferability was singled out by officials in Kansas, Michigan, Mississippi, South Carolina, Washington, and Wyoming. Of the seven States studied, only Connecticut failed to mention such a recommendation. In another series of State reports the State health officers of Alabama and Massachusetts recommended that public health categorical grants be replaced by a block grant. On a somewhat different note, the

---

7/ Joint Federal-State Action Committee, op. cit., p. 172.

8/ Commission on Intergovernmental Relations, Summaries of Survey Reports on Administrative and Fiscal Impact of Federal Grants-in-Aid, Government Printing Office, June, 1955. The following organizations conducted the surveys: Connecticut-Griffenhagen & Associates; Kansas-J.L. Jacobs & Company; Michigan-Public Administration Service; Mississippi-McKinsey & Company; South Carolina-Governmental Affairs Institute; Washington-McKinsey & Company; and Wyoming-J.L. Jacobs & Company. Modifications of public health grants are discussed on pp. 12-13; 30-32; 43; 58-59; 79; 98-100; 117-119.

Ohio study reported: "...these programs rest upon a number of Federal statutes with an imposing and diverse array of formulas determining the State's obligations and eligibility for participation. Each, in its own right, has been considered meritorious but financially insignificant. Special State planning or administrative coordination for the purpose of handling Federal funds as such has not seemed feasible or important." 9/

The "Kestnbaum" Commission's Study Committee on Public Health conducted a survey of opinions of State and Territorial health officers on the question of block vs. categorical grants for public health. Of the 49 replies, 30 favored a "block" or "general assistance" grant, 7 favored broadening the categories, 8 favored a combination of block and categorical grants and 4 favored a continuation of the existing categorical system. 10/

In its final report in June, 1955, the Commission on Intergovernmental Relations made the following recommendation:

> "...The Commission recommends that health grants be allocated to the States on the basis of a uniform formula, susceptible of flexible administration.
>
> "Such a formula should take into account factors of need for the service, such as incidence of disease and population; matching requirements should be on a sliding scale related to State fiscal capacity. Also, the transference of funds from one program to another should be permitted, within specified limitations, in accordance with health needs as determined by recipient States. The Commission believes that the adoption of such a formula for health grants would simplify administration at both National and State levels and would relate grants more clearly to need and to State fiscal capacity." 11/

---

9/ Governmental Affairs Institute, A Survey Report on Impact of Federal Grants-in-Aid on the Structure and Functions of State and Local Governments, submitted to the Commission on Intergovernmental Relations, Government Printing Office, June, 1955, pp. 34, 201, 304.

10/ Commission on Intergovernmental Relations, A Study Committee Report on Federal Aid to Public Health, Government Printing Office, June, 1955, p.37.

11/ Commission on Intergovernmental Relations, op. cit., pp. 251-2.

In June, 1957, the House Committee on Government Operations issued a report on replies received by its Intergovernmental Relations Subcommittee to a questionnaire dealing with various aspects of National-State-local relations.

The recommendations of State, municipal and county officials regarding the block-categorical question were summarized as follows:

"Seventeen States reported an urgent need for Federal legislation, while only two indicated no such need. The measures receiving most support were:

> "(1) Substitute a single consolidated, or block, grant for the present separate categorical grants; or
>
> "(2) As an alternative to a single public-health grant, permit the transfer of a portion of allotted funds between special purpose categories at a State's discretion.

***

"The principal program modification widely supported by the cities is the placing of greater emphasis on general-purpose health grants and less reliance on special categories.

***

"Several /~counties~/ suggested increasing local administrative flexibility by substituting a general health grant for the special categories and making health grants for periods longer than 1 year." 12/

In hearings before the Intergovernmental Relations Subcommittee of the House Committee on Government Operations, the views of many of the States on the one hand and the U. S. Public Health Service on the other could be characterized by the following excerpts:

> Dr. H. E. Hilleboe, Health Commissioner, State of New York: "...The categorical health grants of the Department of Health, Education, and Welfare should be combined into a consolidated health grant to simplify Federal and State administration, to reduce record keeping and the volume of time-consuming reports, and to increase the effectiveness of State and local health department activities...

---

12/ U.S. House of Representatives, Replies from State and Local Governments to Questionnaire on Intergovernmental Relations. (85th Congress, 1st Session--House Report No. 575), Government Printing Office, June 17, 1957, pp. 10, 17, 20.

"There should be provision for the transfer within the State of some percentage of the funds--at least 20 percent--from one category to another, depending upon changing health needs and patterns; this could be done by the State health officer after consultation with and approval of the Surgeon General of the Public Health Service and the Chief of the Children's Bureau.

"This added flexibility would enable the State health officer to make the best use of combined Federal, State and local funds. As time goes on, new categories may well replace discontinued ones in a consolidated grant, as needs and resources change. It would be simpler to make such changes if the categories were grouped together in a consolidated health grant..."13/

Dr. Leroy E. Burney, Surgeon General, Public Health Service: "...when I was president of the State and Territorial health officers, I believe we presented that viewpoint /a block grant/to the Public Health Service at the time, and I still think it has merit. I think also that there are other aspects to the situation.

"Let me say that I believe the administration of the categorical grants had undoubtedly done more to stimulate activity in a specific area than adding to a general grant...

"...It is difficult to justify it before our own family. You talk about adding more engineers, more nurses, more sanitarians, to provide more services, with the understanding they can do more work in the radiological health, and more work with the aged. But that is not nearly as dramatic or specific as saying that with cancer money you can set up a cytology clinic to examine so many million women for cancer, and similar purposes." 14/

---

13/ U. S. House of Representatives, Hearings before a Subcommittee of the Committee on Government Operations. (85th Congress, 1st Session (Part 1--Boston, Mass., and New York, N. Y.)),Government Printing Office, p. 165.

14/ Hearings, op. cit., (Federal Departments and Agencies), p. 207.

## IV. CONCLUSIONS AND RECOMMENDATIONS

The Commission has considered the following specific questions with respect to existing grants-in-aid from the National Government to the States for public health services:

(1) Have these grants become primarily stimulative or supporting in character?

(2) Does the present arrangement provide adequate flexibility to the States on the one hand and satisfactory general fiscal and program controls to the National Government on the other?

(3) Should the existing grants be combined into a single block grant, or should the specific categorical aids for chronic diseases be consolidated into a chronic disease grant, or should discretion be permitted to States to transfer funds among categories?

(4) If one of these possible modifications is desirable, which existing categorical grants should be included in the amalgamation or transfer arrangement?

(5) Are present apportionment and matching formulas soundly based and working satisfactorily or should they be modified?

### A. Categorical Grants Have Become Permanently Supporting in Character.

The Commission realizes that it is difficult to delineate precisely between a "stimulating" grant on the one hand and a "supporting" grant on the other. In general terms, the Commission conceives a stimulating grant as being one initiated for the purpose of providing an incentive to State and local units of government to undertake a new function of government or to provide a new or expanded type of government service which has been adjudged by the Congress to be in the over-all national interest. One clear-cut example of this device is found in the enactment in 1917 of legislation to provide funds to the States for vocational education which were designed to stimulate State activity in particular occupational fields adjudged to be in short supply because of the demands of a war economy. Throught the continuation of these grants after their stimulating purpose had been achieved, the Congress thereby indicated by implication that it desired to provide partial support on a permanent basis to the conduct of these State and local services. There has been no indication of this intent in the legislative history, however.

The Commission believes it to be evident that although the original purpose of the various categorical grants in the field of public

health were to stimulate increased State and local activity in the particular categorical fields, the Congress has long since by its action in continuing and increasing the sums available, demonstrated an intent that these grants also serve as a permanent contribution by the National Government to the support of the respective State and local activities.15/ The States by their actions in providing funds for these categories, considerably in excess of matching requirements, have shown that they visualize the provision of health services in general, and in each of the categories to be a continuing responsibility of State government.

It is recognized that within each specific category the use of "project" or demonstration grants may serve a stimulating purpose with respect to new approaches and techniques which may be employed to advantage in coping with a particular public health problem. In general terms however, the States no longer need stimulation to establish and carry on the categorical program of the scope envisaged by the grants. Although here and there individual States may not be providing ample funds for all of the categories, it would seem that an adequate time period has been provided (15 years as a minimum) for stimulative purposes.

B. Increased Flexibility Should Be Provided for the States.

As described in the preceding section, it is the considered view of a considerable number of State and local officials that increased flexibility is needed in the utilization of Federal grants for public health services. The Commission does not discount the importance of the existing policies of the Department of Health, Education, and Welfare which are designed to afford, within the limits of the authorizing legislation, a considerable degree of administrative flexibility both to the officials of the Department in administering the grants and to the States which receive them. The fact remains, however, that the amount of funds is presently firmly established in each category for each fiscal year, each categorical sum in turn being dependent upon an individual set of apportionment and matching formulas. The Commission believes that the degree of fiscal and program control exercised by the National Government is certainly adequate to protect the Federal investment; the Commission has not studied in detail the administrative mechanisms employed in these grants and it may very well be that simplifications could be made. In a subsequent report the Commission will address itself to the general question of administrative controls associated with Federal grants-in-aid. Suffice it to say, the existing arrangements seem fully adequate to assure the use of funds in accordance with the intent of the Congress.

---

15/ Although the general direction of these grants has been upward in amount, the period 1952-1957 was marked by some reductions, with increases resuming in 1958. Appendix C shows the amounts for each category for the period 1936-1960.

C. Grants to which Amalgamation or Fund Transferability Should Be Applied.

Two sets of issues are involved in determining the grants to which amalgamation or transferability should be applied. First, there is the question of lines of administrative responsibility. Functional lines of administrative authority are reasonably uniform as between the National Government and the States with respect to the following categorical grants which are administered by the Public Health Service of the Department of Health, Education, and Welfare at the National level and by State health departments at the State level: general health assistance, venereal disease control, tuberculosis control, cancer control and heart disease control. Grants for mental health activities are administered by the Public Health Service at the National level, but in approximately 20 States the grant program is administered by an agency other than the State health department. Grants for maternal and child health services in all States and crippled children services in 33 States are administered by the State health department, but at the National level these grants, although falling within the Department of Health, Education, and Welfare, are administered by the Children's Bureau of that Department.

Second, there are questions of effective program operations and the coordination thereof. In terms of program operations, existing grants for public health work may be divided into three types, namely, (a) those which relate to the general public health agency operations, with traditional emphasis on environmental and sanitation measures for the control of the infectious and communicable diseases; (b) those which relate to the special health problems of mothers and children; and (c) the newer categorical disease programs which focus attention on the personal health services in the community that are required for control and prevention of the chronic diseases. The shift in emphasis of health agency operations from sanitation and enviromental health measures to personal health services, brought about in part by the categorical disease grants, has increased the need for coordination of approaches to individuals in the population for purposes of case finding, dissemination of health education materials, application of disease control and preventive measures.

The Commission believes that initially at least, any new framework for the pulling together of public health categorical grants should exclude grants for mental health, maternal and child health and crippled children services since, as pointed out above, functional lines of responsibility between the National Government and the States do not dovetail with respect to these three activities, the latter two being administered by an agency other than the Public Health Service and the grants for mental health in a number of States by an agency other than the State health department.

D. Authorization of Fund Transferability Among Categories 17/

The Commission has examined the reasons advanced in behalf of retaining the categorical system. It is argued that more adequate financial support of the programs is assured if funds are sought and appropriated in terms of specific disease categories. The categories are well understood by legislators and the public and carry a high degree of "voter appeal." It is also argued that such additional flexibility in funds as any State might find necessary or desirable could more appropriately be achieved through flexibility in use of State or local appropriations. State and local funds in most States and for most Federal health grant programs considerably exceed Federal grant funds and State and local appropriating bodies should be more responsive to local priorities for financing program activities.

---

17/ The Joint Federal-State Action Committee at its meeting May 18-19, 1959, directed the staff to consult with both the National Association of State and Territorial Health Officers and the National Association of State Budget Officers on the feasibility and practicability of block grants for six grant programs administered by the Public Health Service. These programs are Venereal Disease Control, Tuberculosis Control, General Health Assistance, Mental Health Activities, Cancer Control, and Heart Disease Control.

The Co-Chairman of the Joint Federal-State Action Committee appointed the following as a subcommittee to make recommendations regarding the proposal of block grants: Dr. Herman E. Hilleboe, Commissioner of Health, New York; Dr. Malcolm H. Merrill, Director, Department of Public Health, California; Arthur Naftalin, Commissioner of Administration, Minnesota; and D. S. Coltrane, Assistant Commissioner of Administration and Budget Officer, North Carolina.

The consensus of the group was that it should be recommended to the Joint-Federal-State Action Committee that any block grant proposal developed include the six programs named above and the programs for crippled children and maternal and child health. It was also agreed to recommend to the Joint Action Committee that it should direct the staff to prepare a bill for presentation at the second session of the 86th Congress which would provide for the Congressional appropriations for these eight programs on a categorical basis but with the provision that at the recommendation of the Health Officer of the State, with the approval of the Budget Director and the consent of the Governor, not to exceed 33 1/3 percent of any allotment to a State from a categorical appropriation could be transferred from the program for which it was originally allotted to one or more of the other seven programs.

It was agreed that the bill should provide a formula for allotment and matching of these funds which would bring uniformity to the eight programs and it was agreed that the Joint Federal-State Action Committee be urged to approve an apportionment formula which would provide that the funds be allotted to the States on the basis of population weighted by the reciprocal of per capita income, and eliminate reference to the extent of the particular problem in the various States, the latter being difficult to determine and, as programs progress, can materially change. The subcommittee felt that using population and per capita income factors would be fair to all States.

However, it is argued by others that the categorical approach has proved unsatisfactory for the following reasons:

(1) The relative importance of each of the several grant categories varies from State to State and year to year. The categorical formula grant does not provide sufficient flexibility for appropriate support of extreme variations.

(2) As a health problem approaches solution, it may require a sustained level of activity to prevent it from returning to its former proportions. It may be difficult to secure support for continuation of a categorical grant at a level adequate to do this when there is a substantial element of the population that feels the problem has been licked.

(3) Spectacular, and sometimes relatively unimportant, problems have an advantage in competing for tax funds against less conspicuous problems even though they may be the more important.

(4) Categorical grants may be subject to instability. There is a tendency for this type of grant to fluctuate with the public interest of the moment rather than on the basis of an objective analysis of the facts. (For example, for the period 1940 to 1950 categorical grants for heart disease increased by over 50 percent while those for tuberculosis were declining by over 50 percent.)

(5) Categorical grants afford less flexibility in the financing of generalized personnel than would be possible under broader type grants. It is easier to identify the use of funds for staff and equipment that is used exclusively for one category than to keep the records that are necessary to prorate among several categories the cost of activities that serve more than one categorical program. The method of granting funds should not influence organization and staffing.

Finally, the Commission has examined the arguments in favor of a "block grant" approach, whereby the existing categorical grants would be combined into a single grant for public health services. Since the current purpose of all of these grants is to provide partial support on a continuing basis to public health services at the State and local levels, it is argued that this general objective could best be served by an approach which provides maximum flexibility to the States to adjust programs to meet the specific needs of the States while at the same time providing adequate authority to the Secretary of Health, Education,and Welfare to assure effective utilization of Federal funds. In other words, each State could use the funds in accordance with its own system of priorities. Furthermore, under such a block grant there would be a single fund and a broad range of activities for which it could be used as contrasted to categorical grants in which each has a separate fund that must be used within a circumscribed program area. Also, the block grant approach would facilitate the use of generalized personnel and the organization of health services by function rather than by category. Lastly, through the

provision of a separate fund for use on particular problems at the discretion of the Secretary of Health, Education, and Welfare, the opportunity for stimulating State and local activity with respect to new health problems would be preserved.

The Commission does not favor at this time the substitution of a single block grant for the existing eight categorical grants to States for public health services; rather, it is recommended that legislation be enacted which would amend the Public Health Service Act of 1944 by authorizing, at the discretion of the Governor, the transfer of up to one-third of the funds in any one grant category to other programs in the group. It is recommended that this flexibility apply to the following categorical grants: general health assistance, venereal disease control, cancer control, heart disease control, tuberculosis control. 18/

The Commission is mindful of a number of disadvantages to the block grant approach. Following are some of the most frequently cited disadvantages. The Commission does not necessarily agree with all of the stated reasons but recognizes that in toto the variety and force of these arguments make unrealistic the adoption at this time of the block grant approach with respect to public health service categorical grants.

(1) Block grants may require larger Federal outlays than categorical aids. If the Federal aid is restricted to a specific segment of the program area in which there is a national interest, the Federal

---

18/ Secretary Flemming did not concur in this recommendation of the Commission. He expressed the belief that sufficient flexibility is possible within the existing categorical grant system to diminish support for less essential activities and to increase support for and emphasis on an attack on new and emerging problems.

The Secretary noted that the trend toward general health grants can be accelerated and through this means, informal understandings can be reached with the States in the use of part of such general grant funds to attack new and emerging problems of national concern. He also pointed out that another means of bringing attention to bear on new and emerging problems is the use of the project grant approach. This approach provides the means for the Federal Government to assure the marshaling of necessary resources to attack special problems and offers the possibility of assuring application of Federal funds to achieve certain specified objectives.

Lastly, the Secretary expressed the view that the States actually can achieve greater flexibility by simply reallocating their matching support from one category to another. In this connection he called attention to the fact that the States substantially overmatch the Federal Government and therefore they can reduce their emphasis on a particular program simply by reducing the extent to which they overmatch in the category concerned.

aid may be limited to amounts needed to encourage action by States and localities on this particular segment. If the program area is enlarged, as it would be under a block grant, increased Federal support commensurate with the broader program objective would be implied.

(2) Block grants which encompass program areas broader than the sum of the categorical aids also widen the area of application of National standards and controls. Categorical aids limit the "interference" of the National Government with State initiative and leadership to the field of action aided. States are not restricted in their choices in carrying out the broader program objectives.

(3) Block grants enforce a centralization of State administrative organization in the interest of national audit and review of block grant funds; categorical aids permit greater variation among the States in agencies designated to receive the specific types of Federal aid.

(4) Block grants impair the application of sanctions for State failure to act to meet national objectives. The broader the purpose of the grant and the larger the fund into which the grant monies are merged, the more difficult becomes a withholding of Federal funds as the only sanction against the States.

(5) A block grant dilutes the national objectives sought by the Congress since the aids are not specifically directed toward these objectives. A categorical program, in contrast, facilitates the achievement of national goals since these goals are pin-pointed by the purpose of the grant. If stimulation of action is an objective, as contrasted to more fiscal support it cannot be achieved except through a specifically directed grant.

(6) A block grant reduces the number of appropriation items and may make the appropriation appear large in terms of the vaguely defined need; the categories facilitate more precise Congressional review of appropriation requests by clarifying the specific purposes for which funds are sought.

(7) Block grants do not, as suggested by the Canadian experience, lessen the need for categorical aids. A specific national problem, e.g., poliomyelitis, will still require the introduction of a new categorical program to obtain an immediate allocation of State funds for that purpose.

(8) The transition from categorical grants to a block grant will itself require an increase in Federal funds. Increased Federal support would probably be required to assure that no State will lose any funds and that some States gain the added amounts deemed necessary for the carrying out of the broader program. The alternative course is to freeze allotments as of some base period. Such a freeze impairs the application of rational principles in grant allocation and matching

and introduces rigidity in the national program. The rigidity itself will encourage new categorical aids since the social and economic problems for which cooperative national-State action is sought, change.

(9) Block grants do not ensure or even encourage the uniform development of programs on a nation-wide basis.

(10) Unless categorical grants are added to the block grant from time to time or portions of the block grant are earmarked for specific purposes, (experience indicates that we may expect a strong tendency on the part of Congress and pressure from the special interest groups to do this) the grants will not effectively stimulate the appropriation of State and local funds and the development of programs to meet new problems of national concern.

On the other hand the Commission believes that most of the flexibility advantages of a block grant can be obtained while at the same time avoiding some of the above-cited disadvantages, by an amendment to the Public Health Service Act of 1944 which would permit States, at the discretion of the Governor concerned, to transfer from up to one-third of the Federal funds granted in any one category over to one or more of the other four public health categories. It is believed that under such a provision States would have sufficient flexibility in most cases to apply the Federal funds to the categories of the greatest need within the particular State while at the same time providing assurance to the Congress that in terms of the Nation as a whole the categorical areas would receive the relative emphasis placed upon them by the Congress in annual appropriations. 19/

---

19/

The House Committee on Government Operations in Federal-State-Local Relations, op. cit., p. 51, made the following recommendation: "While aware of the administrative difficulties casued by the use of special categories within some programs, the subcommittee, nevertheless, is appreciative of the strong legislative reasons for confining grants to narrow segments of a general activity. As one means for increasing the flexibility of these programs the subcommittee recommends that the Congress provide authority for the transfer of up to 20 percent of Federal apportionments between the special categories of any program, when such transfer is requested by a governor and approved by the responsible Federal agency as being in the public interest. At the present time the subcommittee's recommendation would apply only to the public health and vocational education programs."

## E. Uniform Allotment and Matching Formulae Desirable

It is recommended that legislation be enacted which would establish a uniform allotment and matching formula for Federal grants-in-aid to States presently extended in the following categories: general health assistance, venereal disease control, tuberculosis control, cancer control and heart disease control. In order to establish such uniformity, it is recommended that such formulae provide for the allotment of funds on the basis of State population and financial need as measured by State per capita income, and that matching requirements be placed on a sliding scale relative to State per capita income. 20/

The Commission believes that the present diverse formulae as among the five categorical programs are of doubtful value and cause unnecessary complexities at both the national and State levels. The Commission believes that a combination of population as a general indicator of relative program need among the States, and per capita income, as an indicator of financial need, would be fair to all the States.

While the Commission has not as yet explored the general question of the extent to which grants-in-aid should be used to equalize variations in State fiscal resources, the "Hill-Burton" formula has come into general practice in other public health service grant programs, and the Commission recommends that a formula patterned generally along the lines of the "Hill-Burton" program be applied to disease control grants instead of the diverse requirements presently extant in the categorical grants for public health services.

---

20/ Secretary Flemming did not concur in this recommendation, believing that the variances in the geographical incidence and intensity of the various diseases are such as to make undesirable an attempt to achieve a uniform allotment and matching formula system. He did not agree that the alleged advantages of a uniform system would outweigh the difficulties which may be created from an attempt to create uniformity. He stated that the Department of Health, Education, and Welfare was taking the position that the present system provides a fairly good and widely accepted basis for pinpointing the States that need help the most on particular diseases.

APPENDIX A

# DESCRIPTION OF EXISTING CATEGORICAL PROGRAMS OF FEDERAL GRANTS-IN-AID FOR PUBLIC HEALTH SERVICES, MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES 1/

## A. Nature and Objectives.

### 1. Tuberculosis Control

Title VI of the Social Security Act of 1935 authorized annual grants of $8 million to States for public health work and enabled Public Health Service personnel to stimulate interest in tuberculosis control.

By 1943, only 8 States out of 48 had not established tuberculosis control services. In 1944, with the passage of the Public Health Service Act, a specific appropriation of $10 million was made for the fiscal year 1945, and, for each fiscal year thereafter, a general authorization was granted to provide funds sufficient to carry out tuberculosis control activities.

The objectives of the program are as follows:

First, achievement of a minimum level of standard tuberculosis control services, including case reporting, epidemiology, case finding, out-patient service, such as clinics and public health nursing, and laboratory.

Second, the initiation of more effective control techniques and services such as photofluorography in the past and present, by improved culture work in the laboratory, and in medical case work for clinic and hospital patients.

Third, the continuation and extension of such services mainly through State and local support with minimal grants-in-aid.

The grants-in-aid are used in the States to operate X-ray programs and diagnostic and treatment clinics; to furnish public health nursing services to patients with tuberculosis and their contacts; to provide laboratory services to physicians, hospitals, and clinics; and to conduct the case supervision necessary for a

---

1/ Much of the descriptive material in this section is drawn from the report of the Commission on Intergovernmental Relations, entitled, "Twenty-Five Federal Grant-In-Aid Programs", GPO, June, 1955, Chapter 14.

disease which is both chronic and contagious.

2. Venereal Disease Control

According to Public Health Service records, 28 States had "identified projects" for venereal disease control in 1935; however, only 9 States employed full-time venereal disease control officers. In 1946, all States had programs; and 31 employed full-time control officers.

Beginning in 1936, personnel in State, municipal, and private laboratories performing serological tests were invited to participate in annual tests to check the accuracy of their specimen analyses. Consultants were then loaned to the States, and training and refresher courses offered to participating laboratory workers. By the end of 1946, all State laboratories had attained a reasonably satisfactory level of efficiency in the performance of serodiagnostic tests.

Grant-in-aid funds have aided State and local health departments to develop clinics for the treatment of venereal disease patients throughout the country. The number of such cooperative clinics reporting through State (and Territorial) health departments rose from 656 in 1935 to 3,324 in 1946. Some of these were operated by voluntary agencies which cooperated with official health units and, in turn, received some assistance from them. Except for occasional restrictions regarding persons with adequate economic resources, they provided free service. In 1946, such clinics for the treatment of syphilis were maintained in all States, and for the treatment of gonorrhea in all but one State. Thirty-nine States reported distribution of drugs to public clinics; and the other 9, distribution to private practitioners, hospitals, or other treatment insitutions.

During World War II, special assistance was given State and local health departments for locating the sources of venereal infection in servicemen and for keeping known cases of these diseases under treatment. In 1943, a resurvey of selective service registrants with positive blood tests for syphilis was inaugurated under a plan developed by the Public Health Service and the Selective Service System. Accordingly, State and local health departments, by tracing and treating registrants reported as infected, made additional thousands available for military service. A cooperative arrangement was also made with the armed services whereby persons discharged with positive or doubtful tests were referred to the appropriate rapid treatment center or health department.

Late in 1942, the first rapid treatment center was established. In the beginning, such centers were provided and partially maintained under the authority of the Community Facilities, or Lanham, Act. The demand for them, however, grew out of intensive

research and demonstrations in the rapid treatment of early syphilis which had been carried on for several years by the Public Health Service in conjunction with Bellevue and Johns Hopkins Hospitals and several clinics. Actual development of the rapid treatment centers was a cooperative achievement of the Public Health Service, State and local health departments, other public and voluntary agencies, and physicians in private practice. Beginning with the fiscal year 1946, a protion of grant-in-aid funds available for venereal disease control was allotted to the States specifically for the provision of in-patient treatment. Expenditures for this purpose in 1946 were reported by 30 States, but projects were approved during the year for others, bringing the number with plans for statewide service to 38.

3. Mental Health

Until the end of the fiscal year 1946, all Public Health Service grants-in-aid were handled through the State health departments. The National Mental Health Act permits a departure from this procedure for the first time, by providing that in the case of any State in which a single State agency other than the State health department is charged with the responsibility for administering the mental health program of the State, that agency shall be considered the State mental health authority and shall, instead of the health department, receive and administer the mental health grants. As of May 1959, in 28 States the State health department was the mental health authority; while, in the other 22, the department of welfare, mental hygiene institutions, or other State agencies served in that capacity.

The main objects of the program are to provide training for personnel in mental health, to promote research in that field, and by means of grants and consultative services to support and encourage States to develop treatment.

By the act of July 1946, the amount authorized to be appropriated annually for the grants to States in aid of general health activities was increased by $10 million to a total of $30 million, in order that part of the increase might be earmarked for grants to the States to effect improvements in mental health services at State and local levels. By means of such grants, States were enabled not only to inaugurate and expand mental health services and staffs of the State health department, but, also, by using part of the Federal grant for State-local grants, to encourage communities to establish and maintain out-patient mental health clinics.

4. Heart Disease

The amendment to the Public Health Service Act which became law on June 16, 1948, provided for: (a) Research, demonstrations, and training in diseases of the heart and circulation, and (b) aid to the States in the development of community programs to

reduce mortality from these diseases. Expenditures for heart disease control have only recently become of significant size in the reports of State health departments. Two years before the Federal grant was instituted, only three State health departments reported projects in heart disease control. However, by 1952, 2 years after the beginning of the grant, 51 States and Territories indicated some type of program in this area.

The National Heart Act specifically includes refresher training courses for physicians and permits grants for heart disease control not only to States, but, also--under certain circumstances and upon recommendation of the State health officer --to political subdivisions of States or to any public or non-profit agency, institution, or other responsible organization for the purpose of establishing and maintaining organized programs of heart disease control. Under such circumstances, plans for a heart disease control program will be accepted through the State health authority from the political subdivisions or other agencies which are to receive the grants and which will be responsible for using them properly.

Grants-in-aid for heart disease control are used to support State programs in the following areas:

Clinics.--Early and accurate diagnosis leading to early and accurate treatment.

Physician and Other Professional Education.-- Help the general practitioner who treats most of the cases to keep abreast of great advances in medical knowledge; and assist public health and clinical nurses, and medical technicians in giving the best possible service.

Rehabilitation Services.--After accurate diagnosis,all the health and welfare forces in the community are alerted to assist the patient in reaching his highest efficiency. He is, therefore, much less of a burden to his family or to society.

Casefinding and Followup Activities.--Particularly in the followup of abnormalities of heart shadows noted on mass chest X-ray surveys; also, followup by nurses of known cases to reduce later complications.

Research.--Epidemiological and statistical studies can give much information toward solving the causes of cardiovascular disease. Operational research can improve all services.

Health Education.--An informed public can avoid cardiac disease as in the case of rheumatic fever, and can live longer even when disease cannot be avoided as in the prevention of obesity leading to decreased mortality from heart disease. Patients can derive a fuller benefit from the doctor's treatment

if they understand the low-sodium or reducing diets. The symptoms of disease can be better recognized, thereby leading to early diagnosis.

5. Cancer Control

The authority for the cancer control grant is contained in the Annual Appropriation Act, Public Law 165, 1948. The basic authorization for grants in cancer is found in the Public Health Service Act of 1953. In 1937, the National Cancer Act established the National Cancer Institute within the Public Health Service to conduct research in cancer and to administer grants-in-aid to universities and other institutions and individuals for cancer research. The grants are not made directly to States, but the institutions may be State institutions. The provisions of the Cancer Act of 1937 were incorporated into the Public Health Service Act of 1944, including those relating to research grants and fellowships. The National Cancer Institute is, by statute, part of the National Institutes of Health.

Grants-in-aid for cancer control have supported State and local programs in the following areas:

(a) Educational programs for professional personnel and the general public.

(b) Promotion of improved case-reporting and maintenance of morbidity, mortality, and tumor registers.

(c) Preventive measures to control environmental hazards.

(d) Promotion of casefinding services

(e) Cancer detection, diagnostic, and treatment clinics.

(f) Provision of microscopic tissue examination and cytological test services.

(g) Provision and support to bedside and follow-up nursing service and medical social service.

(h) Hospital care for diagnosis (3-day period).

(i) Special studies and research.

(j) Training of professional personnel.

6. "General Health Assistance"

In contrast to the specialized programs just described, grants for general health services are designed to assist the States and their political subdivisions, including health districts,

to establish and maintain adequate health services, including demonstrations and the training of personnel for State and local health work.

While the basic purposes of the grant have remained unchanged since its inception, two factors have influenced the major emphasis of programs which it helps to support. The first of these has been the initiation at later dates of grant programs for various categories of disease (e.g., tuberculosis, heart disease, poliomyelitis) that have provided funds for the specialized costs of programs and services for certain disease control programs. The second factor has been the remarkable advancements in scientific knowledge that have made possible the initiation through the general health grant of new programs and services for the control on a community public health basis of diseases and conditions for which there was formerly no prevention or control measures.

For the fiscal year ending June 30, 1959 Federal grants in the "general health" category approximated $16.6 million.

7. Crippled Children's Services

The program is administered at the Federal level by the Children's Bureau of the Department of Health, Education, and Welfare. At the State level, the program is administered by the State health department in 33 States and Territories, by the State welfare department in 8 States, by a combined State health and welfare department in 2 States, by a crippled children's commission in 4 States, by the State department of education in 3 States, and by the State medical school in 3 States.

Implicit in the Federal legislation for crippled children's services is a broad concept of medical care which does not stop with surgical treatment, but combines treatment of both the physically handicapped and unfavorable social and psychological influences which together determine the degree and duration of disability.

In providing these services, the State agencies hold crippled children's clinics at varying intervals in different parts of the State. The physicians are specialists, almost always in private practice, who give clinical care in these clinics, in hospitals, and convalescent homes and are paid by the State agency on a part-time salary or fee basis. Hospital care is purchased on the basis of average daily cost per patient. In many programs a pediatrician participates with the orthopedist. Other personnel include the public health nurse, the medical social worker, physical therapist, nutritionist, and speech therapist as needed, and various consultants.

The definition of "crippling" is decided by each State, either by statute or administratively. Within that definition the

State crippled children's agency indicates the types of crippling conditions it accepts for care. Initially these crippling conditions were entirely orthopedic. Since 1939, however, there has been a steady increase in the number of children with other handicaps included in the State services. At present, all State programs include children under 21 years who have a handicap of an orthopedic nature or who require plastic surgery. Over half the States have developed services for children with rheumatic fever. Most of them provide services for children with cerebral palsy, and a few include children who are hard-of-hearing or who have epilepsy. Over half the States include children who have eye conditions which are amenable to surgery. The orthopedic services are statewide (except for the major cities). The other programs usually have limited geographic coverage due to insufficiency of funds and personnel.

The number of children receiving services under these programs has increased steadily. In 1958, under the State crippled children's programs, 325,000 children received care in clinics, in the doctor's office or at home, in hospitals, in convalescent homes and in foster homes.

8. Maternal and Child Health Services

Grants to States for maternal and child health programs and services are administered by the Children's Bureau of the Department of Health, Education, and Welfare. At the State level, maternal and child health programs are administered by State departments of health. The State health departments use the Federal funds for maternal and child health services, together with State and local funds, in accordance with individual local needs to:

(a) Develop, support, extend, and improve services for mothers and children, such as: maternity clinics for prenatal care; well-child clinics for the health supervision of infants and preschool children; health services for school children including health supervision by physicians, dentists, public health nurses, and nutritionists; dental hygiene and prophylaxis dental care; nutrition education; advice to hospitals on maternity and newborn services; licensing and inspection of maternity homes; and provision of incubators and hospital care for premature infants. The programs of the several States vary considerably in relative emphasis among the foregoing.

(b) Provide for postgraduate training for physicians, nurses, and nutritionists through in-service training and institutes, and through payment of stipends and tuition at universities.

While the maternal and child health program is primarily one of preventive health services, medical care is also a feature of the program in some of the States. Sixteen States are purchasing medical and hospital care for premature infants, usually on a demonstration basis; some of the States provide medical and hospital care for mothers with complications of pregnancy; others provide dental treatment in addition to prophylaxis.

The principal developments since 1948 have been in the increase in demonstration programs and other activities in behalf of prematurely born infants, the increase in programs for the post-graduate training of personnel, and much emphasis on the emotional growth of infants and children and the parent-child relationship. Increasing attention is being given to what should be done to reduce the annual toll of about 150,000 fetal and neonatal deaths. Only cancer and cardiovascular disease exceed the number of deaths associated with the birth process.

From State and Federal funds under this program, in 1958, some 257,000 mothers received maternity and clinic services and 554,000 obtained maternity nursing service. About 1.4 million infants and other children received well-child conference services, and 3.0 million received child health nursing service.

## B. Administrative Aspects of Current Programs

### 1. State Plan

The Social Security Act, as amended, requires that each State submit on or before July 1 of every other year a complete State health program or plan, which plans will be approved for each Federal fiscal year or portion thereof. This plan must include the following points of information: (a) Major health and administrative problems; (b) what the State proposes to do; (c) where the State proposes to do it; (d) the method the State proposes to use; and (e) what specific plans the State had made for measuring progress and for evaluating each program and component thereof.

The Public Health Service has required a formal working plan for each State and Territory for many years. In the past, this plan had largely consisted of a statistical compilation of anticipated needs and a statistical analysis of past expenditures as related to future expenditures. In 1953, States were requested to submit narrative plans covering their entire health program. These statements are considerably more comprehensive and informative than the statistical reports previously required. Reports from States will vary in length from 100 pages to 250 pages. Public Health Service officials have indicated that State health authorities desire these narrative reports inasmuch as they also serve as a basic document of value in explaining local programs to State legislatures and executive budget departments.

In order to facilitate compliance by State agencies, joint regulations are generally used by the Children's Bureau and the Public Health Service. For example, a State health department receiving grants for maternal and child health and crippled children's services as well as tuberculosis, venereal disease, etc., develops a single State plan, broken down into chapters, and files multiple copies with the Public Health Service and the Children's Bureau.

2. State Budget

Each State is required to submit a budget showing the total proposed expenditures by source of funds for: (a) The entire operation of the health department; (b) the particular health activities of other State agencies where sufficient funds are used to fulfill matching requirements; (c) each local or special health project to which the State health department allocated any State, Federal, or private agencies funds; and (d) other local projects for which funds are being used by the State to fulfill matching requirements.

As a second major item, each State is requested to show the estimated total cost of selected categorical programs such as venereal disease, cancer, crippled children's services, tuberculosis, etc. The budget outline also requests State health authorities to obtain information from other State agencies on total proposed expenditures by source of funds, following the four-point outline shown above.

Each quarter, the State is required to submit a statement to the budget division of the Public Health Service (and the Children's Bureau in the case of grants from that agency) showing the amount of expenditures made up to that period. This report follows the budget plan format as prescribed in the Public Health Service manual. The final or fourth quarter report than becomes an annual report on expenditures which is, in turn, used as part of the basic data upon which auditors of the Department of Health, Education, and Welfare conduct analyses of fiscal accountability.

3. Reports and Audits

State health authorities and cooperating local and other health agencies are required to make such reports pertinent to the operation of their plans and to purposes for which grants are made available as may be required by the Surgeon General or his designee.

Each quarter, States submit a financial report following the format of the required budget. This is a type of progress report which brings the Public Health Service and Children's Bureau up to date on expenditures made during the previous quarter. The fourth quarterly report in effect constitutes an annual expenditure report.

Local, county, or district health departments also submit an annual report showing the political subdivisions covered; the scope of their program; number and type of personnel employed; and some data as to program operations.

Special programs, such as venereal disease or tuberculosis, submit activity reports on a monthly basis which consist of

statistical data on number and type of cases. The venereal disease report is of aid to the Public Health Service in making allocations for special grants in areas where needs are shown to require special Federal assistance.

Fiscal audits are made by representatives of the Department of Health, Education, and Welfare each fiscal year. These audits involve a detailed analysis of expenditures and require a considerable amount of detail.

Every 2 years, the Public Health Service conducts a program review of federally supported health activities in the States. This review comprises an analysis and evaluation of what has been accomplished in accordance with previously submitted plans, budgets, and other program documents. Program review activities are carried on by Public Health Service personnel in the regional offices. They report in detail upon the health programs of each State; their findings are reviewed with State and other Federal officials.

4. State Personnel

As a condition of public health grants, all States are required to adopt and carry on a merit system of personnel administration with respect to employees of the grant-in-aid State agencies. The Federal Government exercises no authority over the selection, tenure of office, or compensation of any individual employed in conformity with the provisions of such systems. As a part of Federal merit system standards applicable to the health programs, there is a provision that wage scales shall reflect like pay for like work in the area involved. Merit system representatives stationed in the regional offices of the Department of Health, Education, and Welfare are available for advisory services to State health agencies on matters pertaining to personnel administration.

C. Fiscal Characteristics

1. Allotment Criteria

Within the appropriated amount available for allotments to States for public health services, the Surgeon General, with the approval of the Secretary of Health, Education, and Welfare, determines the allotment to each State on the basis of: (a) Population; (b) extent of the health problem generally and within the particular State; and (c) financial need. This is the basis for allotment generally of the Public Health Service grants with the exception of venereal disease control, which is on a project basis at the discretion of the Surgeon General.

Maternal and child health and crippled children's funds are each divided into two equal parts. Fund A is apportioned partly by

an equal grant to each State and partly in proportion to live births and children under 21, respectively, for the two programs. After allowance for special projects, fund B is apportioned according to the need of each State for financial help in carrying out its plan.

The specific weightings of the allotment factor vary among certain of the specific programs. For example:

(a) Mental Health.--30 percent--population weighted by index of financial need (5-year average of State per capita income); 70 percent--extent of problem (extent of emotional and psychiatric disorders considered to be directly proportional to population).

(b) Cancer Control.--60 percent--population weighted by index of financial need; 35 percent--cancer mortality; 5 percent--reciprocal of population density.

(c) Heart Disease Control.--53.5 percent--population weighted by index of financial need; 46.5 percent--population: $0.10 per capita for first 100,000 or fraction thereof in each State.

2. Matching Requirements

Grants for general health, heart disease, tuberculosis control, cancer control, and mental health must be matched on the basis of one dollar from sources within the State for every Federal dollar. Project grants for venereal disease control do not require matching. "Fund A" grants under maternal and child health and crippled children's programs must be matched dollar for dollar.

3. Federal and State Contributions

Comparative Federal, State and Local Expenditure data for each of the categorical programs are shown in Appendix B.

## APPENDIX B

Federal Grants and State and Local Expenditures, for Public Health Categorical Purposes, and for Maternal and Child Health and Crippled Children Services, by States, Fiscal Year 1959

### EXPENDITURES FOR CANCER CONTROL FISCAL YEAR 1959 1/

| State | Federal Grant 2/ | State and Local Funds | Total Funds | Percent Federal |
|---|---|---|---|---|
| TOTALS | $2,229,275 | $7,190,019 | $9,419,294 | 23.7 |
| Alabama | 52,668 | 35,890 | 88,558 | 59.5 |
| Alaska | 6,206 | 18,558 | 24,764 | 25.1 |
| Arizona | 16,303 | 20,416 | 36,719 | 44.4 |
| Arkansas | 34,918 | 18,000 | 52,921 | 66.0 |
| California | 150,647 | 139,205 | 289,852 | 52.0 |
| Colorado | 24,558 | 40,699 | 65,257 | 37.6 |
| Connecticut | 26,418 | 122,714 | 149,132 | 17.7 |
| Delaware | 4,764 | 38,547 | 43,311 | 11.0 |
| Dist. of Columbia | 9,512 | 32,822 | 42,334 | 22.5 |
| Florida | 54,249 | 348,251 | 402,500 | 13.5 |
| Georgia | 56,320 | 427,760 | 484,080 | 11.6 |
| Idaho | 12,810 | 6,836 | 19,646 | 65.2 |
| Illinois | 59,654 | 140,678 | 200,332 | 29.8 |
| Indiana | 52,404 | 223,628 | 276,032 | 19.0 |
| Iowa | 23,601 | 24,613 | 48,214 | 49.0 |
| Kansas | 31,925 | 307,866 | 339,791 | 9.4 |
| Kentucky | 48,837 | 57,989 | 106,826 | 45.7 |
| Louisiana | 46,299 | 126,366 | 172,665 | 26.8 |
| Maine | 17,830 | 19,399 | 37,229 | 47.9 |
| Maryland | 33,771 | 45,818 | 79,589 | 42.4 |
| Massachusetts | 65,251 | 281,855 | 347,106 | 18.8 |
| Michigan | 85,749 | 222,297 | 308,046 | 27.8 |
| Minnesota | 41,107 | 63,305 | 104,412 | 39.4 |
| Mississippi | 44,614 | 82,672 | 127,286 | 35.1 |
| Missouri | 59,563 | 44,715 | 104,278 | 57.1 |
| Montana | 12,598 | 16,445 | 29,043 | 43.4 |
| Nebraska | 24,329 | 38,577 | 62,906 | 38.7 |
| Nevada | 3,862 | 22,397 | 26,259 | 14.7 |
| New Hampshire | 10,375 | 47,113 | 57,488 | 18.0 |
| New Jersey | 67,890 | 171,009 | 238,899 | 28.4 |
| New Mexico | 14,821 | 21,001 | 35,822 | 41.4 |
| New York | 199,897 | 1,865,102 | 2,064,999 | 9.7 |
| North Carolina | 67,013 | 252,163 | 319,176 | 21.0 |
| North Dakota | 14,187 | 24,284 | 38,471 | 36.9 |
| Ohio | 111,662 | 143,569 | 255,231 | 43.7 |
| Oklahoma | 34,707 | 27,734 | 62,441 | 55.6 |
| Oregon | 14,367 | 27,474 | 41,841 | 34.3 |
| Pennsylvania | 119,356 | 456,194 | 575,550 | 20.7 |
| Rhode Island | 11,656 | 48,299 | 59,955 | 19.4 |
| South Carolina | 38,429 | 104,401 | 142,830 | 26.9 |

EXPENDITURES FOR CANCER CONTROL, CONCLUDED

FISCAL YEAR 1959 1/

| State | Federal Grant 2/ | State and Local Funds | Total Funds | Percent Federal |
|---|---|---|---|---|
| South Dakota | 14,034 | 88,854 | 102,888 | 13.6 |
| Tennessee | 53,253 | 43,838 | 97,091 | 54.8 |
| Texas | 116,558 | 58,654 | 175,212 | 66.5 |
| Utah | 13,639 | 94,596 | 108,235 | 12.6 |
| Vermont | 8,681 | 21,808 | 30,489 | 28.5 |
| Virginia | 49,461 | 227,641 | 277,102 | 17.8 |
| Washington | 31,651 | 206,584 | 238,235 | 13.3 |
| West Virginia | 30,908 | 38,641 | 69,549 | 44.4 |
| Wisconsin | 48,036 | 60,321 | 108,357 | 44.3 |
| Wyoming | 7,446 | 13,549 | 20,995 | 35.5 |
| Guam | 1,562 | 3,146 | 4,708 | 33.2 |
| Hawaii | 7,725 | 100,587 | 108,312 | 7.1 |
| Puerto Rico | 40,288 | 71,558 | 111,846 | 36.0 |
| Virgin Islands | 906 | 3,578 | 4,484 | 20.2 |

1/
Excludes State and local funds identified as hospitalization costs.

2/
In addition, Federal funds expended for special projects in cancer control were reported in the amount of $121,072.

Source: Department of Health, Education, and Welfare, Public Health Service.

EXPENDITURES FOR VENEREAL DISEASE CONTROL, FISCAL YEAR 1959

| State | Federal Funds1/ | State and Local Funds | Total Funds | Percent Federal |
|---|---|---|---|---|
| TOTALS | $2,283,108 | $14,578,513 | $16,861,621 | 13.5 |
| Alabama | 49,196 | 34,818 | 84,014 | 58.6 |
| Alaska | - | 59,038 | 59,038 | 0.0 |
| Arizona | 20,952 | 58,011 | 78,963 | 26.5 |
| Arkansas | 91,482 | 94,113 | 185,595 | 49.3 |
| California | 75,607 | 1,577,001 | 1,652,608 | 4.6 |
| Colorado | 23,776 | 54,914 | 78,690 | 30.2 |
| Connecticut | 7,717 | - | 7,717 | 100.0 |
| Delaware | 15,000 | 44,570 | 59,570 | 25.2 |
| Dist. of Columbia | 60,841 | 248,634 | 309,475 | 19.7 |
| Florida | 88,140 | 805,577 | 893,717 | 9.9 |
| Georgia | 182,831 | 736,689 | 919,520 | 19.9 |
| Idaho | 8,269 | 27,206 | 35,475 | 23.3 |
| Illinois | 177,886 | 665,418 | 843,304 | 21.1 |
| Indiana | - | 109,572 | 109,572 | 0.0 |
| Iowa | 6,032 | 32,403 | 38,435 | 15.7 |
| Kansas | 25,814 | 65,570 | 91,384 | 28.2 |
| Kentucky | 47,994 | 163,453 | 211,447 | 22.7 |
| Louisiana | 52,612 | 495,493 | 548,105 | 9.6 |
| Maine | - | 23,047 | 23,047 | 0.0 |
| Maryland | 27,950 | 236,821 | 264,771 | 10.6 |
| Massachusetts | 204 | 278,848 | 279,052 | 0.1 |
| Michigan | 88,173 | 316,792 | 404,965 | 21.8 |
| Minnesota | - | 145,270 | 145,270 | 0.0 |
| Mississippi | 80,313 | 470,263 | 550,576 | 14.6 |
| Missouri | 46,474 | 118,977 | 165,451 | 28.1 |
| Montana | 4,267 | 3,082 | 7,349 | 58.1 |
| Nebraska | 9,218 | 49,422 | 58,640 | 15.7 |
| Nevada | 5,618 | 27,151 | 32,769 | 17.1 |
| New Hampshire | - | 14,750 | 14,750 | 0.0 |
| New Jersey | 60,466 | 500,232 | 560,698 | 10.8 |
| New Mexico | 31,845 | 90,020 | 121,865 | 26.1 |
| New York | 215,701 | 2,945,606 | 3,161,307 | 6.8 |
| North Carolina | 143,132 | 163,564 | 306,696 | 46.7 |
| North Dakota | 11,171 | 18,980 | 30,151 | 37.0 |
| Ohio | 37,286 | 268,303 | 305,589 | 12.2 |
| Oklahoma | 18,814 | 188,837 | 207,651 | 9.1 |
| Oregon | 5,748 | 112,314 | 118,062 | 4.9 |
| Pennsylvania | 90,357 | 791,486 | 881,843 | 10.2 |
| Rhode Island | - | 27,771 | 27,771 | 0.0 |
| South Carolina | 118,908 | 75,033 | 193,941 | 61.3 |
| South Dakota | 6,327 | 23,408 | 29,735 | 21.3 |
| Tennessee | 78,360 | 919,496 | 997,856 | 7.9 |
| Texas | 145,130 | 540,011 | 685,141 | 21.2 |
| Utah | 3,618 | 13,575 | 17,193 | 21.0 |
| Vermont | - | 5,414 | 5,414 | 0.0 |
| Virginia | 45,055 | 269,318 | 314,373 | 14.3 |
| Washington | 1,202 | 108,237 | 109,439 | 1.1 |
| West Virginia | 20,744 | 91,486 | 112,230 | 18.5 |
| Wisconsin | - | 56,973 | 56,973 | 0.0 |
| Wyoming | 5,862 | 3,491 | 9,353 | 62.7 |
| Guam | - | - | None | - |
| Hawaii | - | 37,248 | 37,248 | 0.0 |
| Puerto Rico | 29,753 | 358,665 | 388,418 | 7.7 |
| Virgin Islands | 17,263 | 12,142 | 29,405 | 58.7 |

1/Funds appropriated for special projects.
Source: Department of Health, Education and Welfare, Public Health Service.

EXPENDITURES FOR HEART DISEASE CONTROL, FISCAL YEAR 1959

| State | Federal Grant | State and Local Funds | Total Funds | Percent Federal |
|---|---|---|---|---|
| TOTALS | $2,171,406 | $6,271,832 | $8,443,238 | 25.7 |
| Alabama | 56,619 | 53,015 | 109,634 | 51.6 |
| Alaska | 12,289 | 30,065 | 42,354 | 29.0 |
| Arizona | 3,961 | 5,757 | 9,718 | 40.8 |
| Arkansas | 24,153 | 41,557 | 65,710 | 36.8 |
| California | 119,781 | 241,119 | 360,900 | 33.2 |
| Colorado | 26,606 | 55,287 | 81,893 | 32.5 |
| Connecticut | 25,271 | 22,643 | 47,914 | 52.7 |
| Delaware | 9,434 | 11,901 | 21,335 | 44.2 |
| Dist. of Columbia | 15,779 | 24,813 | 40,592 | 38.9 |
| Florida | 54,601 | 203,942 | 258,543 | 21.1 |
| Georgia | 61,692 | 148,283 | 209,975 | 29.4 |
| Hawaii | 15,806 | 88,239 | 104,045 | 15.2 |
| Idaho | 17,252 | 20,170 | 37,422 | 46.1 |
| Illinois | 86,973 | 246,402 | 333,375 | 26.1 |
| Indiana | 49,476 | 167,565 | 217,041 | 22.8 |
| Iowa | 37,438 | 50,160 | 87,598 | 42.7 |
| Kansas | 32,256 | 24,973 | 57,229 | 56.4 |
| Kentucky | 52,848 | 60,713 | 113,561 | 46.5 |
| Louisiana | 47,211 | 55,225 | 102,436 | 46.1 |
| Maine | 20,713 | 143,689 | 164,402 | 12.6 |
| Maryland | 38,923 | 300,511 | 339,434 | 11.5 |
| Massachusetts | 52,052 | 40,543 | 92,595 | 56.2 |
| Michigan | 72,892 | 229,522 | 302,414 | 24.1 |
| Minnesota | 45,147 | 110,257 | 155,404 | 29.1 |
| Mississippi | 52,285 | 41,965 | 94,250 | 55.5 |
| Missouri | 52,791 | 56,274 | 109,065 | 48.4 |
| Montana | 16,488 | 14,110 | 30,598 | 53.9 |
| Nebraska | 15,631 | 18,247 | 33,878 | 46.1 |
| Nevada | 8,730 | 14,871 | 23,601 | 37.0 |
| New Hampshire | 14,271 | 20,665 | 34,936 | 40.8 |
| New Jersey | 53,427 | 60,095 | 113,522 | 47.1 |
| New Mexico | 20,091 | 20,922 | 41,013 | 49.0 |
| New York | 137,579 | 1,711,152 | 1,848,731 | 7.4 |
| North Carolina | 68,704 | 222,971 | 291,675 | 23.6 |
| North Dakota | 18,454 | 12,204 | 30,658 | 60.2 |
| Ohio | 89,880 | 319,757 | 409,637 | 21.9 |
| Oklahoma | 36,158 | 30,906 | 67,064 | 53.9 |
| Oregon | 14,818 | 45,792 | 60,610 | 24.4 |
| Pennsylvania | 114,212 | 230,429 | 344,641 | 33.1 |
| Rhode Island | 16,992 | 17,092 | 34,084 | 49.9 |
| South Carolina | 47,061 | 120,355 | 167,416 | 28.1 |
| South Dakota | 5,979 | 12,200 | 18,179 | 32.9 |
| Tennessee | 54,967 | 62,989 | 117,956 | 46.6 |
| Texas | 105,753 | 269,413 | 375,166 | 28.2 |
| Utah | 12,582 | 54,674 | 67,256 | 18.7 |
| Vermont | 14,195 | 23,706 | 37,901 | 37.5 |
| Virginia | 33,552 | 328,584 | 362,136 | 9.3 |
| Washington | 33,275 | 64,584 | 97,859 | 34.0 |
| West Virginia | 36,175 | 18,560 | 54,735 | 66.1 |
| Wisconsin | 46,112 | 29,367 | 75,479 | 61.1 |
| Wyoming | 12,550 | 16,085 | 28,635 | 43.8 |
| Guam | 4,149 | 4,693 | 8,842 | 46.9 |
| Puerto Rico | 53,207 | 46,062 | 99,269 | 53.6 |
| Virgin Islands | 2,165 | 6,757 | 8,922 | 24.3 |

Source: Department of Health, Education and Welfare, Public Health Service.

## EXPENDITURES FOR MENTAL HEALTH, FISCAL YEAR 1959

| State | Federal Grant | State and Local Funds | Total Funds | Percent Federal |
|---|---|---|---|---|
| TOTALS | $4,046,717 | $42,868,095 | $46,914,812 | 8.6 |
| Alabama | 82,215 | 151,348 | 233,563 | 35.2 |
| Alaska | 25,831 | 409,944 | 435,775 | 5.9 |
| Arizona | 22,526 | 22,743 | 45,269 | 49.8 |
| Arkansas | 38,119 | 52,340 | 90,459 | 42.1 |
| California | 269,111 | 4,995,247 | 5,264,358 | 5.1 |
| Colorado | 37,039 | 133,127 | 170,166 | 21.8 |
| Connecticut | 45,522 | 973,575 | 1,019,097 | 4.5 |
| Delaware | 25,871 | 83,688 | 109,559 | 23.6 |
| Dist. of Columbia | 25,282 | 331,222 | 356,504 | 7.1 |
| Florida | 93,895 | 883,763 | 977,658 | 9.6 |
| Georgia | 93,757 | 605,933 | 699,690 | 13.4 |
| Idaho | 25,871 | 42,958 | 68,829 | 37.6 |
| Illinois | 200,656 | 1,298,053 | 1,498,709 | 13.4 |
| Indiana | 98,972 | 631,000 | 729,972 | 13.6 |
| Iowa | 59,255 | 338,993 | 398,248 | 14.9 |
| Kansas | 47,866 | 185,581 | 233,447 | 20.5 |
| Kentucky | 76,371 | 115,182 | 191,553 | 39.9 |
| Louisiana | 75,130 | 556,039 | 631,169 | 11.9 |
| Maine | 24,965 | 63,528 | 88,493 | 28.2 |
| Maryland | 70,799 | 267,217 | 338,016 | 20.9 |
| Massachusetts | 94,007 | 1,080,475 | 1,174,482 | 8.0 |
| Michigan | 165,471 | 2,022,027 | 2,187,498 | 7.6 |
| Minnesota | 74,790 | 471,590 | 546,380 | 13.7 |
| Mississippi | 63,626 | 76,321 | 139,947 | 45.5 |
| Missouri | 94,739 | 440,073 | 534,812 | 17.7 |
| Montana | 25,871 | 92,576 | 118,447 | 21.8 |
| Nebraska | 27,268 | 122,015 | 149,283 | 18.3 |
| Nevada | 24,163 | 33,819 | 57,982 | 41.7 |
| New Hampshire | 24,069 | 140,293 | 164,362 | 14.6 |
| New Jersey | 116,523 | 1,607,605 | 1,724,128 | 6.8 |
| New Mexico | 25,871 | 25,535 | 51,406 | 50.3 |
| New York | 330,117 | 14,535,069 | 14,865,186 | 2.2 |
| North Carolina | 114,021 | 477,239 | 591,260 | 19.3 |
| North Dakota | 26,277 | 36,885 | 63,162 | 41.6 |
| Ohio | 195,871 | 2,951,350 | 3,147,221 | 6.2 |
| Oklahoma | 52,209 | 29,605 | 81,814 | 63.8 |
| Oregon | 38,902 | 160,285 | 199,187 | 19.5 |
| Pennsylvania | 240,808 | 2,157,409 | 2,398,217 | 10.0 |
| Rhode Island | 25,166 | 191,734 | 216,900 | 11.6 |
| South Carolina | 62,297 | 199,562 | 261,859 | 23.8 |
| South Dakota | 25,864 | 133,362 | 159,226 | 16.2 |
| Tennessee | 87,341 | 901,543 | 988,884 | 8.8 |
| Texas | 186,561 | 553,858 | 740,419 | 25.2 |
| Utah | 19,135 | 68,730 | 87,865 | 21.8 |
| Vermont | 25,871 | 90,358 | 116,229 | 22.3 |
| Virginia | 88,375 | 958,252 | 1,046,627 | 8.4 |
| Washington | 53,917 | 65,191 | 119,108 | 45.3 |
| West Virginia | 49,096 | 172,427 | 221,523 | 22.2 |
| Wisconsin | 82,129 | 557,507 | 639,636 | 12.8 |
| Wyoming | 24,635 | 60,189 | 84,824 | 29.0 |
| Guam | 25,871 | 13,788 | 39,659 | 65.2 |
| Hawaii | 25,870 | 174,881 | 200,751 | 12.9 |
| Puerto Rico | 65,323 | 104,248 | 169,571 | 38.5 |
| Virgin Islands | 25,610 | 20,813 | 46,423 | 55.2 |

Source: Department of Health, Education and Welfare, Public Health Service.

EXPENDITURES FOR TUBERCULOSIS CONTROL, FISCAL YEAR 1959[1/]

| State | Federal Grant | State and Local Funds | Total Funds | Percent Federal |
|---|---|---|---|---|
| TOTALS | $4,072,617 | $28,705,260 | $32,777,877 | 12.4 |
| Alabama | 91,284 | 212,270 | 303,554 | 30.1 |
| Alaska | 22,754 | 385,287 | 408,041 | 5.6 |
| Arizona | 56,953 | 359,866 | 416,819 | 13.7 |
| Arkansas | 67,388 | 215,465 | 282,853 | 23.8 |
| California | 283,806 | 4,069,925 | 4,353,731 | 6.5 |
| Colorado | 33,646 | 173,201 | 206,847 | 16.3 |
| Connecticut | 39,477 | 412,617 | 452,094 | 8.7 |
| Delaware | 16,000 | 41,926 | 57,926 | 27.6 |
| District of Columbia | 35,914 | 281,663 | 317,577 | 11.3 |
| Florida | 85,189 | 973,911 | 1,059,100 | 8.0 |
| Georgia | 86,929 | 1,556,925 | 1,643,854 | 5.3 |
| Idaho | 14,981 | 36,628 | 51,609 | 29.0 |
| Illinois | 224,914 | 480,384 | 705,298 | 31.9 |
| Indiana | 75,149 | 189,046 | 264,195 | 28.4 |
| Iowa | 35,626 | 120,806 | 156,432 | 22.8 |
| Kansas | 33,056 | 124,423 | 157,479 | 21.0 |
| Kentucky | 107,875 | 256,654 | 364,529 | 29.6 |
| Louisiana | 77,186 | 646,869 | 724,055 | 10.7 |
| Maine | 24,026 | 71,756 | 95,782 | 25.1 |
| Maryland | 136,381 | 334,749 | 471,130 | 28.9 |
| Massachusetts | 104,012 | 252,811 | 356,823 | 29.1 |
| Michigan | 142,403 | 1,265,609 | 1,408,012 | 10.1 |
| Minnesota | 49,066 | 230,002 | 279,068 | 17.6 |
| Mississippi | 62,380 | 396,509 | 458,889 | 13.6 |
| Missouri | 97,613 | 296,940 | 394,553 | 24.7 |
| Montana | 20,280 | 28,093 | 48,373 | 41.9 |
| Nebraska | 21,840 | 62,319 | 84,159 | 26.0 |
| Nevada | 12,246 | 22,762 | 35,008 | 35.0 |
| New Hampshire | 12,024 | 35,626 | 47,650 | 25.2 |
| New Jersey | 111,118 | 731,125 | 842,243 | 13.2 |
| New Mexico | 32,305 | 120,112 | 152,417 | 21.2 |
| New York | 385,828 | 4,334,360 | 4,720,188 | 8.2 |
| North Carolina | 91,445 | 479,717 | 571,162 | 16.0 |
| North Dakota | 16,626 | 85,049 | 101,675 | 16.4 |
| Ohio | 177,231 | 588,391 | 765,622 | 23.1 |
| Oklahoma | 54,302 | 192,771 | 247,073 | 22.0 |
| Oregon | 33,323 | 386,717 | 420,040 | 7.9 |
| Pennsylvania | 227,521 | 2,078,183 | 2,305,704 | 9.9 |
| Rhode Island | 22,259 | 51,804 | 74,063 | 30.1 |
| South Carolina | 61,349 | 344,479 | 405,828 | 15.1 |
| South Dakota | 12,353 | 21,663 | 34,016 | 36.3 |
| Tennessee | 108,356 | 705,202 | 813,558 | 13.3 |
| Texas | 162,432 | 602,308 | 764,740 | 21.2 |
| Utah | 12,939 | 33,771 | 46,710 | 27.7 |
| Vermont | 15,694 | 69,165 | 84,859 | 18.5 |
| Virginia | 103,132 | 2,396,112 | 2,499,244 | 4.1 |
| Washington | 52,676 | 330,889 | 383,565 | 13.7 |
| West Virginia | 54,905 | 257,385 | 312,290 | 17.6 |
| Wisconsin | 58,902 | 303,079 | 361,981 | 16.3 |
| Wyoming | 9,963 | 13,058 | 23,021 | 43.3 |
| Guam | 10,395 | 29,319 | 39,714 | 26.2 |
| Hawaii | 21,399 | 202,562 | 223,961 | 9.6 |
| Puerto Rico | 157,746 | 790,037 | 947,783 | 16.6 |
| Virgin Islands | 8,020 | 22,960 | 30,980 | 25.9 |

1/State and local funds identified for hospitalization are excluded.
Source: Department of Health, Education and Welfare, Public Health Service.

EXPENDITURES FOR GENERAL HEALTH, FISCAL YEAR 1959

| State | Federal Grant | State and Local Funds | Total Funds | Percent Federal |
|---|---|---|---|---|
| TOTALS | $15,109,575 | $188,859,710 | $203,969,285 | 7.4 |
| Alabama | 410,966 | 3,010,958 | 3,421,924 | 12.0 |
| Alaska | 60,317 | 439,293 | 499,610 | 12.1 |
| Arizona | 121,290 | 763,910 | 885,200 | 13.7 |
| Arkansas | 263,780 | 896,729 | 1,160,509 | 22.7 |
| California | 886,708 | 20,029,967 | 20,916,675 | 4.2 |
| Colorado | 162,215 | 1,100,056 | 1,262,271 | 12.9 |
| Connecticut | 130,290 | 2,731,751 | 2,862,041 | 4.6 |
| Delaware | 27,716 | 311,084 | 338,800 | 8.2 |
| Dist. of Columbia | 50,631 | 1,953,276 | 2,003,907 | 2.5 |
| Florida | 370,842 | 5,143,435 | 5,514,277 | 6.7 |
| Georgia | 430,467 | 4,622,063 | 5,052,530 | 8.5 |
| Idaho | 88,224 | 465,211 | 553,435 | 15.9 |
| Illinois | 622,744 | 9,607,693 | 10,230,437 | 6.1 |
| Indiana | 346,041 | 2,100,797 | 2,446,838 | 14.1 |
| Iowa | 260,994 | 701,054 | 962,048 | 27.1 |
| Kansas | 208,353 | 1,697,859 | 1,906,212 | 10.9 |
| Kentucky | 357,962 | 2,457,083 | 2,815,045 | 12.7 |
| Louisiana | 335,460 | 3,373,764 | 3,709,224 | 9.0 |
| Maine | 108,548 | 619,902 | 728,450 | 14.9 |
| Maryland | 233,991 | 6,331,005 | 6,564,996 | 3.6 |
| Massachusetts | 342,851 | 1,615,066 | 1,957,917 | 17.5 |
| Michigan | 531,282 | 5,465,159 | 5,996,441 | 8.9 |
| Minnesota | 301,980 | 1,639,603 | 1,941,583 | 15.6 |
| Mississippi | 360,978 | 1,242,448 | 1,603,426 | 22.5 |
| Missouri | 356,872 | 3,991,519 | 4,348,391 | 8.2 |
| Montana | 81,016 | 280,906 | 361,922 | 22.4 |
| Nebraska | 148,715 | 808,406 | 957,121 | 15.5 |
| Nevada | 42,966 | 161,597 | 204,563 | 21.0 |
| New Hampshire | 53,749 | 299,484 | 353,233 | 15.2 |
| New Jersey | 348,715 | 7,922,237 | 8,270,952 | 4.2 |
| New Mexico | 111,574 | 896,436 | 1,008,010 | 11.1 |
| New York | 1,022,847 | 29,567,555 | 30,590,402 | 3.3 |
| North Carolina | 538,438 | 5,880,818 | 6,419,256 | 8.4 |
| North Dakota | 100,700 | 471,549 | 572,249 | 17.6 |
| Ohio | 650,231 | 10,714,202 | 11,364,433 | 5.7 |
| Oklahoma | 239,014 | 1,056,401 | 1,295,415 | 18.5 |
| Oregon | 165,069 | 1,792,631 | 1,957,700 | 8.4 |
| Pennsylvania | 837,872 | 11,280,436 | 12,118,308 | 6.9 |
| Rhode Island | 58,526 | 1,397,472 | 1,455,998 | 4.0 |
| South Carolina | 311,981 | 1,456,964 | 1,768,945 | 17.6 |
| South Dakota | 104,444 | 220,525 | 324,969 | 32.1 |
| Tennessee | 405,581 | 1,757,521 | 2,163,102 | 18.7 |
| Texas | 839,072 | 6,848,469 | 7,687,541 | 10.9 |
| Utah | 85,502 | 762,856 | 848,358 | 10.1 |
| Vermont | 53,807 | 571,966 | 625,773 | 8.6 |
| Virginia | 360,002 | 2,404,143 | 2,764,145 | 13.0 |
| Washington | 202,759 | 5,317,086 | 5,519,845 | 3.7 |
| West Virginia | 223,875 | 1,265,981 | 1,489,856 | 15.0 |
| Wisconsin | 271,169 | 4,266,963 | 4,538,132 | 6.0 |
| Wyoming | 52,014 | 205,984 | 257,998 | 20.2 |
| Guam | 9,885 | 283,802 | 293,687 | 3.4 |
| Hawaii | 55,939 | 1,897,088 | 1,953,027 | 2.9 |
| Puerto Rico | 355,193 | 6,420,220 | 6,775,413 | 5.2 |
| Virgin Islands | 7,418 | 339,327 | 346,745 | 2.1 |

Source: Department of Health, Education and Welfare, Public Health Service.

REPORTED EXPENDITURES FOR CRIPPLED CHILDREN SERVICES, FISCAL YEAR 1959

| State | Total | Federal | State and Local | Percent Federal |
|---|---|---|---|---|
| United States | $ 57,164,557.37 | $ 15,369,049.52 | $ 41,795,507.85 | 26.9 |
| Alabama | 975,321.46 | 462,479.00 | 512,842.46 | 47.4 |
| Alaska | 366,131.57 | 202,044.65 | 164,086.92 | 55.2 |
| Arizona | - | - | - | - |
| Arkansas | 652,623.87 | 244,452.15 | 408,171.72 | 37.5 |
| California | 7,351,193.71 | 766,863.63 | 6,584,330.08 | 10.4 |
| Colorado | 393,137.02 | 186,542.95 | 206,594.07 | 47.4 |
| Connecticut | 438,875.94 | 231,183,10 | 207,692.84 | 52.7 |
| Delaware | 181,239.13 | 95,750.89 | 85,488.24 | 52.8 |
| District of Columbia | 700,500.00 | 181,903.52 | 518,596.48 | 26.0 |
| Florida | 1,796,795.11 | 289,424.06 | 1,507,371.05 | 16.1 |
| Georgia | 1,658,027.26 | 449,563.00 | 1,208,464.26 | 27.1 |
| Guam | - | - | - | - |
| Hawaii | 278,508.36 | 136,134.89 | 142,373.47 | 48.9 |
| Idaho | 250,200.00 | 120,010.97 | 130,189.03 | 48.0 |
| Illinois | 2,010,786.67 | 477,305.07 | 1,533,481.60 | 23.7 |
| Indiana | 667,386.97 | 266,469.46 | 400,917.51 | 39.9 |
| Iowa | 1,139,816.68 | 313,046.95 | 826,769.73 | 27.5 |
| Kansas | 518,497.27 | 220,361.96 | 298,135.31 | 38.6 |
| Kentucky | 1,149,997.29 | 388,403.56 | 761,593.73 | 33.8 |
| Louisiana | 667,017.00 | 362,490.43 | 304,526.57 | 54.3 |
| Maine | 258,255.61 | 125,486.28 | 132,769.33 | 48.6 |
| Maryland | 879,766.57 | 307,398.29 | 572,368.28 | 34.9 |
| Massachusetts | 2,314,487.26 | 311,091.63 | 2,003,395.63 | 13.4 |
| Michigan | 1,958,351.36 | 505,609.02 | 1,452,742.34 | 25.8 |
| Minnesota | 1,637,605.46 | 446,234.39 | 1,191,371.07 | 27.2 |
| Mississippi | 487,162.89 | 361,741.89 | 125,421.00 | 74.3 |
| Missouri | 1,066,864.55 | 306,864.55 | 760,000.00 | 28.8 |
| Montana | 283,455.84 | 163,420.41 | 120,035.43 | 57.7 |
| Nebraska | 187,229.49 | 102,854.91 | 84,374.58 | 54.9 |
| Nevada | 176,906.19 | 89,993.16 | 86,913.03 | 50.9 |
| New Hampshire | 236,825.00 | 99,620.54 | 137,204.46 | 42.1 |
| New Jersey | 798,641.09 | 244,891.59 | 553,749.50 | 30.7 |
| New Mexico | 308,018.23 | 164,261.78 | 143,756.45 | 53.3 |
| New York | 9,729,539.00 | 566,262.18 | 9,163,276.82 | 5.8 |
| North Carolina | 1,222,123.52 | 623,509.55 | 598,613.97 | 51.0 |
| North Dakota | 257,627.22 | 103,686.00 | 153,941.22 | 40.2 |
| Ohio | 1,756,332.75 | 531,216.00 | 1,225,116.75 | 30.2 |
| Oklahoma | 1,556,954.37 | 316,967.02 | 1,239,987.35 | 20.4 |
| Oregon | 656,674.16 | 169,449.53 | 487,224.63 | 25.8 |
| Pennsylvania | 1,824,125.00 | 665,054.65 | 1,159,070.35 | 36.5 |
| Puerto Rico | 699,798.00 | 387,176.24 | 312,621.76 | 55.3 |
| Rhode Island | 195,123.19 | 98,837.73 | 96,285.46 | 50.7 |
| South Carolina | 721,377.00 | 364,282.00 | 357,095.00 | 50.5 |
| South Dakota | 183,230.00 | 84,865.97 | 98,364.03 | 46.3 |
| Tennessee | 1,188,879.77 | 465,157.33 | 723,722.44 | 39.1 |
| Texas | 1,560,200.00 | 826,055.66 | 734,144.34 | 52.9 |
| Utah | 231,838.65 | 100,029.70 | 131,808.95 | 43.1 |
| Vermont | 176,631.00 | 95,194.99 | 81,436.01 | 53.9 |
| Virgin Islands | 214,172.96 | 86,804.30 | 127,368.66 | 40.5 |
| Virginia | 911,807.61 | 391,817.00 | 519,990.61 | 43.0 |
| Washington | 571,656.73 | 175,965.09 | 395,691.64 | 30.8 |
| West Virginia | 662,853.25 | 288,474.00 | 374,379.25 | 43.5 |
| Wisconsin | 897,500.03 | 322,823.01 | 574,677.02 | 36.0 |
| Wyoming | 156,488.31 | 81,522.89 | 74,965.42 | 52.1 |

Source: Department of Health, Education and Welfare, Social Security Administration, Children's Bureau.

REPORTED EXPENDITURES FOR MATERNAL AND CHILD HEALTH SERVICES, FISCAL YEAR 1959

| State | Total | Federal | State and Local | Percent Federal |
|---|---|---|---|---|
| United States | $75,309,891.21 | $16,965,704.97 | $58,344,186.24 | 22.5 |
| Alabama | 1,056,310.00 | 546,717.51 | 509,592.49 | 51.8 |
| Alaska | 502,000.19 | 157,605.88 | 344,394.31 | 31.4 |
| Arizona | 373,679.20 | 158,140.38 | 215,538.82 | 42.3 |
| Arkansas | 579,327.00 | 292,398.37 | 286,928.63 | 50.5 |
| California | 6,036,364.89 | 801,264.08 | 5,235,100.81 | 13.3 |
| Colorado | 1,140,774.20 | 327,646.91 | 813,127.29 | 28.7 |
| Connecticut | 412,305.49 | 271,308.37 | 140,997.12 | 65.8 |
| Delaware | 224,960.80 | 109,677.03 | 115,283.77 | 48.8 |
| District of Columbia | 1,503,166.00 | 249,820.12 | 1,253,345.88 | 16.6 |
| Florida | 2,747,564.29 | 457,174.61 | 2,290,389.68 | 16.3 |
| Georgia | 2,644.317.00 | 457,973.63 | 2,186,343.37 | 17.3 |
| Guam | - | - | - | - |
| Hawaii | 359,958.25 | 173,714.43 | 186.243.82 | 48.3 |
| Idaho | 264,126.00 | 137,763.00 | 126,362.00 | 52.2 |
| Illinois | 2,356,826.99 | 475,167.36 | 1,881,659.63 | 20.2 |
| Indiana | 1,160,515.00 | 291,996.34 | 868,518.66 | 25.2 |
| Iowa | 378,927.71 | 241,331.71 | 137,596.00 | 63.7 |
| Kansas | 436,115.00 | 207,299.63 | 228,815.37 | 47.5 |
| Kentucky | 2,066,624.78 | 371,980.56 | 1,694,644.22 | 18.0 |
| Louisiana | 1,491,015.00 | 371,848.62 | 1,119,166.38 | 24.9 |
| Maine | 478,838.45 | 155,763.24 | 323,075.21 | 32.5 |
| Maryland | 1,239,667.62 | 425,953.15 | 813,714.47 | 34.4 |
| Massachusetts | 919,842.32 | 430,987.18 | 488,855.14 | 46.9 |
| Michigan | 6,518,134.00 | 561,107.89 | 5,957,026.11 | 8.6 |
| Minnesota | 906,239.00 | 407,359.51 | 498,879.49 | 45.0 |
| Mississippi | 1,146,888.00 | 383,943.64 | 762,944.36 | 33.5 |
| Missouri | 1,021,529.25 | 311,330.48 | 710,198.77 | 30.5 |
| Montana | 277,306.83 | 122,190.98 | 155,115.85 | 44.1 |
| Nebraska | 276,453.31 | 109,063.27 | 167,390.04 | 39.5 |
| Nevada | 273,245.51 | 160,245.65 | 112,999.86 | 58.6 |
| New Hampshire | 168,652.80 | 98,803.17 | 69,849.63 | 58.6 |
| New Jersey | 700,904.48 | 270,844.73 | 430,059.75 | 38.6 |
| New Mexico | 485,834.00 | 218,761.08 | 267,072.92 | 45.0 |
| New York | 7,700,005.00 | 750,566.45 | 6,949,438.55 | 9.7 |
| North Carolina | 1,513,667.44 | 633,471.98 | 880,195.46 | 41.9 |
| North Dakota | 313,436.46 | 112,754.01 | 200,682.45 | 36.0 |
| Ohio | 2,382,314.00 | 591,038.85 | 1,791,275.15 | 42.8 |
| Oklahoma | 955,643.45 | 239,999.16 | 715,644.29 | 25.1 |
| Oregon | 1,228,329.60 | 165,394.87 | 1,062,934.73 | 13.5 |
| Pennsylvania | 7,640,798.00 | 781,612.52 | 6,859,185.48 | 10.2 |
| Puerto Rico | 1,780,132.00 | 372,957.77 | 1,407,174.23 | 21.0 |
| Rhode Island | 254,801.50 | 156,926.26 | 97,875.24 | 61.6 |
| South Carolina | 985,130.00 | 385,976.00 | 599,154.00 | 39.2 |
| South Dakota | 131,332.00 | 72,952.99 | 58,379.01 | 55.5 |
| Tennessee | 1,439,550.85 | 519,734.95 | 919,815.90 | 36.1 |
| Texas | 1,708,935.00 | 675,069.20 | 1,033,865.80 | 39.5 |
| Utah | 533,877.56 | 110,951.46 | 422,926.10 | 20.8 |
| Vermont | 236,490.00 | 107,227.00 | 129,263.00 | 45.3 |
| Virgin Islands | 694,538.67 | 92,609.31 | 601,929.36 | 13.3 |
| Virginia | 3,557,295.46 | 555,732.66 | 3,001,562.80 | 15.6 |
| Washington | 643,450.51 | 298,855.07 | 344,595.44 | 46.4 |
| West Virginia | 441,174.00 | 216,078.25 | 225,095.75 | 49.0 |
| Wisconsin | 843,306.00 | 266,914.92 | 576.391.08 | 31.7 |
| Wyoming | 177,271.35 | 101,698.78 | 75,572.57 | 57.4 |

Source: Department of Health, Education and Welfare, Social Security Administration, Children's Bureau.

APPENDIX C

AMOUNTS OF FEDERAL GRANT-IN-AID TO STATES APPROPRIATED FOR PUBLIC HEALTH SERVICES
FISCAL YEARS 1936-1960
(In thousands of dollars)

| Year | Total | Percent of Increase[1] | General Health | Venereal Disease Formula | Venereal Disease Special Projects | Tuberculosis Control | Mental Health | Cancer Control[2] | Heart Disease |
|---|---|---|---|---|---|---|---|---|---|
| [3] 1960 | $34,775 | 4.08 | $15,000 | - | $2,400 | $4,000 | $4,000 | $2,250 | $3,125 |
| [3] 1959 | 33,413 | 0.60 | 15,000 | - | 2,400 | 4,000 | 4,000 | 2,250 | 2,125 |
| [3] 1958 | 33,213 | 13.69 | 15,000 | - | 1,700 | 4,500 | 4,000 | 2,250 | 2,125 |
| [3][4] 1957 | 29,213 | 30.19 | 12,000 | - | 1,700 | 4,500 | 4,000 | 2,250 | 2,125 |
| [4] 1956 | 22,438 | - 3.55 | [5] 9,725 | - | 1,200 | 4,500 | 3,000 | 2,250 | 1,125 |
| 1955 | 23,263 | 1.86 | 9,725 | - | 700 | 4,500 | 2,325 | 2,250 | 1,125 |
| 1954 | 22,839 | -33.87 | 10,135 | - | [6]2,165 | 4,275 | 2,325 | 2,250 | 1,125 |
| 1953 | 34,537 | - 9.06 | 13,000 | 3,525 | 4,525 | 5,300 | 3,100 | 3,050 | 1,500 |
| 1952 | 37,979 | - 5.97 | 13,500 | 3,525 | 5,924 | 5,800 | 3,100 | 3,100 | 1,500 |
| 1951 | 40,391 | -10.03 | 13,541 | 5,500 | 5,206 | 6,350 | 3,200 | 3,200 | 1,700 |
| 1950 | 44,892 | 13.13 | 14,200 | 7,757 | 5,338 | 6,790 | 3,550 | 3,500 | 2,000 |
| 1949 | 39,681 | 1.65 | 11,215 | 8,800 | 6,046 | 6,790 | 3,550 | 2,500 | - |
| 1948 | 39,038 | 3.27 | 11,217 | 8,545 | 6,986 | 6,790 | 3,000 | 2,500 | - |
| 1947 | 37,803 | 24.98 | 14,250 | 8,764 | 6,109 | 6,880 | - | [7] | - |
| 1946 | 30,248 | 39.88 | 11,000 | 8,757 | 5,291 | 5,200 | - | - | - |
| 1945 | 21,624 | 5.84 | 11,000 | 9,254 | - | 1,370 | - | - | - |
| 1944 | 20,431 | - 2.70 | 11,000 | 9,431 | - | - | - | - | - |
| 1943 | 20,998 | 12.54 | 11,000 | 9,998 | - | - | - | - | - |
| 1942 | 18,658 | 13.20 | 11,000 | 7,658 | - | - | - | - | - |
| 1941 | 16,482 | 19.09 | 11,000 | 5,482 | - | - | - | - | - |
| 1940 | 13,840 | 33.08 | 9,500 | 4,340 | - | - | - | - | - |
| 1939 | 10,400 | 30.00 | 8,000 | 2,400 | - | - | - | - | - |
| 1938 | 8,000 | - | 8,000 | - | | | | | |
| 1937 | 8,000 | 140.00 | 8,000 | - | - | - | - | - | - |
| 1936 | 3,333 | - | 3,333 | - | - | - | - | - | - |

Note: Footnotes-page 2.

FOOTNOTES:

1/ Minus sign (-) denotes decrease.

2/ Does not include amounts for special control projects to public and non-profit institutions.

3/ In addition, under the traineeship program $1 million was appropriated in 1957, $2 million in 1958 and in 1959, and $1,974,000 in 1960. Under the Rhodes Act $450,000 was appropriated in 1959 and $1 million in 1960. Also, for Air Pollution Program $255,000 was made available in 1957, $300,000 in 1958, and $140,500 in 1959 and in 1960.

4/ In 1956 and 1957, $53,600,000 was available under the Poliomyelitis Vaccination Act of 1955 as amended.

5/ Excludes $4,500,000 for poliomyelitis vaccine distribution.

6/ For comparative purposes, excludes $1,335,410 of Grant funds (covering supplies and assignment of personnel furnished in lieu of cash) carried in direct operations in the 1955 Appropriation.

7/ Included under General Health.