The Partnership for Health Act: Lessons from a Pioneering Block Grant

THE INTERGOVERNMENTAL GRANT SYSTEM: AN ASSESSMENT AND PROPOSED POLICIES

ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS
Washington, D.C. 20575
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Preface

Pursuant to its statutory responsibilities authorized in Section 2 of Public Law 380, passed during the first session of the 86th Congress and approved by President Eisenhower on September 24, 1959, the Commission singles out particular problems impeding the effectiveness of the federal system for study and recommendation.

The current intergovernmental grant system was identified as such a problem by the Commission in the spring of 1974. The staff was directed to probe four features of this system: categoricals, the range of reform efforts that stop short of consolidation, block grants, and the changing state servicing and aid roles. This report is the second in the series that resulted from this basic Commission decision. It deals with Partnership in Health, the first block grant to be enacted in modern times; is one of four studies done under the block grant phase of the overall report; and was approved at a meeting of the Commission on March 11, 1976.

Robert E. Merriam
Chairman

Acknowledgments

This volume was prepared by the governmental structure and functions section of the Commission. Major responsibility for *Chapters I-V* was undertaken by Robert L. Baitty, on assignment with the ACIR staff from the Office of the Assistant Secretary for Planning and Evaluation, Department of Health, Education, and Welfare, during the period of May 1974 through June 1975. Carl W. Stenberg, senior analyst, played an important role in getting the research underway and Albert Richter, senior analyst, was invaluable in the completion of this volume. The Research Group, Inc., of Atlanta, Georgia, researched and prepared the six case studies found in *Appendix C.* Research on this volume was assisted by dissertations supplied by Leonard Robbins, Janet Shickles, and Lawrence Susskind, for which we are grateful. The secretarial-clerical services provided by Margaret Moore, Deborah Engstrom, Ann Goldsmith, Patricia Alston, and Linda Silberg were, of course, indispensable.

A special note of thanks is due to those exposed to drafts of the study for review and comment, including John Marshall of the Health Services Administration, DHEW; Frank Beck of the Bureau of Community Health Services, DHEW; Gladys Kruger, Health Services, DHEW; Robert Nash of the Association of State and Territorial Health Officials; William Kopit, Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, DHEW; Peter Fox, Office of the Deputy Assistant Secretary for Planning and Evaluation/Health, DHEW; Edward D. Kelly, director of the Bureau of Community Health Services, DHEW; Nobel J. Swearingen, director of the Washington Office of the Association of State and Territorial Health Officials; Alan Jensen, U.S. House of Representatives Ways and Means Committee, Public Assistance Subcommittee; Joseph E. Cannon, M.D., director of the Rhode Island State Department of Health; Theodore Ervin, director of the Michigan Department of Public Health; Michael Gemmell, National Association of Counties; and Melvin Bergheim, National League of Cities. In addition to supplying us with their dissertations, Leonard Robbins, Janet Shickles, and Lawrence Susskind also gave us substantial assistance in critiquing the study.

We also thank all 50 state public health directors for their cooperation in filling out the questionnaire upon which much of the information in this volume is based.

The Commission gratefully acknowledges financial assistance received from the Department of Health, Education and Welfare for support of this study.

The completion of this volume would not have been possible without the cooperation and assistance of the persons and agencies identified above. Full responsibility for content and accuracy rests, of course, with the Commission and its staff.

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Chapter I

Introduction

Late in 1966, the Congress passed, and President Johnson signed, what later came to be called the *Partnership for Health Act.* This act is probably best known for the system of state and areawide comprehensive health planning agencies it "established," but the same legislation also combined seven categorical project grant programs into a single, broad, project grant, and consolidated nine categorical formula grant programs into a block grant for comprehensive public health services.

Creation of this block grant was the first major consolidation of Federal grants. It completed a cycle in Federal health grant legislation which began with the passage of the *Social Security Act* in 1935, an act which initiated, among other things, a small program of Federal formula grants for the support of general health services. In subsequent years, the Federal grant structure for health became increasingly categorical until the 1966 legislation went back to the early concept of a broad, flexible grant to states for health services.

In the years since 1966, the block grant funding mechanism has increased in importance within the Federal grant universe. Block grants were enacted in the areas of law enforcement in 1968, manpower in 1973, and both community development and social services in 1974. While these developments indicate that interest in the block grant concept is now quite high, the concept nonetheless remains a controversial one. Critics of block grants question their usefulness as instruments of national policy, their ability to focus in on high priority problem areas, and the potential for adequate accountability they afford. On the other hand, block grant proponents applaud the flexibility of these grants but

question their ability to gain sufficient political support to ensure their survival and growth. Accordingly, the future role of the block grant as one of the three major components of the Federal grant structure – along with general revenue sharing and categorical grants – is far from settled.

The basic purpose of this volume is to examine the pioneering Federal block grant, the comprehensive public health services formula grant authorized by section 314(d) of the *Public Health Services Act*, to determine what lessons it may offer for the current debate about block grants. It is, however, a relatively small program with appropriation levels never exceeding $90 million and this basic fiscal fact should be underscored at the outset, since it heavily conditions the history of the program. Moreover, it is not well known, despite the eight years of operation behind it. Together with the law enforcement block grant, this program comprises the totality of Federal experience, of any appreciable duration, with the block grant mechanism. Thus, the heuristic importance of the health services block grant is greater than would be suggested by its size or the amount of attention it has heretofore received.

The study begins with a detailed review of the legislative history of the 314(d) block grant. This review encompasses the development of a categorical-oriented system of Federal health grants between 1935 and 1966, and traces the emergence of two fundamental criticisms of the categorical approach to health grants. The Executive Branch and Congressional actions leading to the *Comprehensive Health Planning and Public Health Services Amendments of 1966* then are analyzed. Later amendments to the original statute are discussed next, particularly the *Partnership for Health Amendments of 1967* and further modifications in 1970. Subsequently, the two-year legislative battle between the Administration and Congress regarding, among other health services issues, the proposed termination of the health block grant, is recounted with special emphasis on the vetoed Congressional attempt at transformation of the program into special health revenue sharing in 1974, and the 1975 amendments enacted over a Presidential veto. This legislative history concludes with an analysis of the objectives and expectations of the consolidation. This covers the Congressional intent, as it appeared in 1966 and as it has evolved since then, as well as brief mention of the Department of Health, Education and Welfare's interpretation of the legislative intent for this program.

The major features of Federal administration of the block grant are considered in *Chapter III.* The organizational location and staffing of this program are described and the basic shifts which have occurred in HEW and Administration policy toward the block grant are probed. The Federal administrative style evidenced in the 314(d) program also is reviewed. In this review, both central and regional office responsibilities are addressed, and this picture of the Federal role in the 314(d) program is compared with state health agency perceptions of the Federal administrative style.

Attention then turns to state administration of the block grant. After an overview of state administration, state decision making for expenditure of block grant funds is examined. Following and closely related to state-level expenditure decisions is the exploration of the patterns of local government and private sector involvement in the administration of the block grant component of the "partnership for health." The reality of state flexibility under the block grant is then taken up, followed by an analysis of state expenditure of block grant funds. The fourth chapter closes with consideration of state health agency attitudes toward this block grant, and the block grant concept applied to health, after eight years' experience with the 314(d) program.

The study concludes with a summary of major findings, analysis of the most important intergovernmental issues posed by these findings, and the Commission's recommendations regarding these issues. Finally, significant field research is set forth in *Appendix C* where the general findings and comparative analysis of six state case studies, along with the individual studies, are presented.

Legislative History

EARLY BACKGROUND

Prior to 1935, the Federal role in the provision of public health services was largely limited to direct services to special groups, chiefly veterans and members of the merchant marine. With the passage of the *Social Security Act* in 1935, that role was expanded to include the provision of financial assistance to state governments in support of their public health responsibilities. This assistance, authorized by Title VI of the act, was provided through grants to state health departments, made on a formula basis keyed to population. The grants were for the provision of general health services, and hence were usable for a very broad range of health related activities. Although the amounts involved were modest, never reaching a level of more than $17 million per year, this initial Federal step into the permanent support of health activities through the grant mechanism represented Federal underwriting of a fraction of all state health department activities.[1]

In the 30 years following passage of the *Social Security Act*, the Federal role in financing public health services expanded, and the period was marked by enactment of numerous new grant programs for specialized purposes. As particular health problems came to national attention, the Federal government responded with grants directed at each emerging problem. This pattern was evidenced only in part in a proliferation of grants made on a formula basis to states for relatively circumscribed purposes. In addition, a previously little used type of grant in the health area, the project grant for particular public health services, gained steadily in

Table 1

Federal Formula Grant Programs for Support of Health Services, 1966[1]

Name of Program	FY 1966 Appropriations (in thousands)	First year of operations
General Health	$10,000	1936
Maternal and Child Health Services[2]	40,000	1936
Crippled Children's Service[2]	40,000	1936
Tuberculosis Control	3,000	1945
Cancer Control	3,500	1948
Mental Health	6,750	1948
Heart Disease Control	9,500	1950
Chronic Disease and Health of the Aged	12,300	1962
Radiological Health	2,500	1963
Dental Health – State Control Programs	1,000	1965
Home Health Services	9,000	1966
Total	$137,550	

[1] Some health-related programs are not included in this list, as they are usually considered social service or rehabilitative programs rather than health programs. Examples include a number of programs whose objective is vocational rehabilitation.

[2] Maternal and Child Health and Crippled Children's Services are the only programs on the list not then administered by the Public Health Service; these were the responsibility of the Children's Bureau.

Source: Department of Labor, and Health, Education and Welfare Appropriations Act, 1966, Statutes at Large 70, 589 (1966). Some individual program appropriations not available in the *Appropriation Act* are taken from U.S., Congress, Senate, Committee on Labor and Public Welfare, *Comprehensive Health Planning and Health Services, Hearings before a subcommittee of the Senate Committee on Labor and Public Welfare on S. 3008.* 89th Cong., 2nd sess., 1966, p. 47.

importance (so much so that it now accounts for well over half of all Federal health service grant outlays, exclusive of Medicaid and Medicare). This device was characterized by extensive discretion on the part of Federal officials regarding the awarding of the grants, usually with applications undergoing competitive review and selective approval. Taken together, these new types of health grants dwarfed the original general health grant, with the result that by 1966 the system of Federal financial assistance for health services was predominantly one of numerous grants for relatively narrow purposes or categories of health services. The general health grant, which in 1936 constituted 100 percent of Public Health Service (PHS) grant funds for health services, comprised only about 6 percent of such funds by 1966.[2] In fact, the funding level of the general health grant actually declined from a high of $17 million in 1961 to $10 million in 1966, while new categorical programs were created and older ones enlarged. On the formula grant side alone, one PHS program in 1936 had become nine programs in 1966, as shown in *Table 1*.

This proliferation of small, narrowly defined, Federal grant programs in the field of health was in response to a number of forces shaping the Federal role in financing health services. Innovations in methods of combating particular health problems, often pioneered in state or local health departments, led to demands for the Federal government to promote nationwide adoption of the improved methods. The creation of a limited purpose Federal grant program to assist states and localities in implementing programs in these new areas, or to improve or expand their present efforts, was often felt to be the most direct way to demonstrate Federal leadership in controlling health problems. This was the

pattern followed in Federal support for tuberculosis control and other specific categories of disease.[3] New programs were preferred over expansion of the general health grant on several grounds. Proponents argued that categorical disease control programs resulted in the most highly targeted impact of limited Federal financial aid. It was feared that adding funds to the general health grant would not achieve a greater impact in a particular program area, given the many competing demands on state and local health departments. Programs directed at specific health problems also demonstrated the responsiveness of the Federal government to these problems, and to the constituencies which developed around them. Proponents of particular programs also favored categorical grants, because success with Congress made it unnecessary to cope with the ambiguities of state legislative processes. Lastly, an increasing and permanent Federal participation in the financing of health services naturally led to a desire on the part of Congress and the administering officials to more actively shape state and local decisions regarding aided activities.[4]

Early Criticisms of the Categorical Approach to Federal Health Grants

Despite the above rationale for the categorical approach to Federal health grants, by the late 1940s concern was being expressed over some aspects of categorical grants thought to be undesirable. Perhaps the earliest important criticism of the categorical structure of Federal health grants was that contained in the report and studies of the first Hoover Commission. Formally titled the Commission on Organization of the Executive Branch of the Government, this commission's work from 1947 to 1949 covered an extremely broad range of subjects relating to the operation of the Federal government and its relations with other levels of government. While the commission's focus in the health function was on direct Federal operations, its sweep also encompassed grants-in-aid for health services.

With respect to health grants, the commission's committee on Federal Medical Services concluded that these grants generally had been quite successful in stimulating greater financial participation by state and local governments in public health, in increasing the quality and quantity of public health personnel nationwide, and in extending public health services to a much greater proportion of the population. Categorical grants in particular were given credit for having "fostered new programs and enlisted support from interested groups."[5] On the negative side, however, the committee determined that the categorical approach hampered the ability of local health officers to develop "balanced health programs adapted to meet varying local needs," and asserted that this problem would worsen as expenditures for public health increased.[6] Having previously determined that public health was intrinsically a function best handled at the state or local level, the full commission advocated the maximum possible simplification and decentralization of Federal health grants, and urged conversion to a general health grant system, complemented by Federal assistance for the further development of local health units staffed by full-time personnel. Federal administration of such general health grants would be guided by the principle of minimum supervision of the states consistent with sound management. While the committee did not probe the eligibility and allocation question, it was more specific regarding the scope of these general grants. Excluded would be only those categorical grants then administered by the Children's Bureau (maternal and child health and crippled children's services), and even here only for an interim three-year period during which health-related agencies would be adjusting to the proposed creation of a single cabinet-level department unifying Federal health, education, and social security functions.[7] No Congressional action was taken on the Hoover Commission's recommendations for reform of Federal public health grants, although administration bills which would have created a single health block grant were submitted in the 80th and 81st Congresses.[8]

A few years later, another critical assessment of the structure of Federal health grants emerged, this time by the U.S. Commission on Intergovernmental Relations. This commission, like the Hoover Commission, was a temporary body established by statute with a broad charge to examine the role of the national government in relation to state and local governments. The report of the commission (popularly known as the Kestnbaum Commission) was submitted to the President in 1955, after two years' work. It contained both a general assessment of the American federal system and analyses of intergovernmental responsibilities in selected functions, including public health.

Like the earlier Hoover Commission, it generally endorsed the current system of Federal health grants,[9] based on the interstate spillover effects inherent in public health, and what it determined had been admirable performance of Federal health grants in stimulating state and local assumption of greater responsibility for public health (as reflected in increased expenditures), and in improving the quality of state and local administration. Categorical grants were specifically praised for limiting Federal influence to a few selected areas of a

function, thus preserving the primacy of state and local governments in the entire function.[10]

At the same time, the commission expressed concern with certain features of such grants. Believing that the proper purpose of categorical health grants was to "encourage the adoption of improved measures for controlling diseases and the demonstration of new public health methods,"[11] the commission argued that the need served by categorical grants naturally disappeared after a number of years and to continue them indefinitely was an unnecessary expenditure of Federal funds. Moreover, the restrictive nature of these grants was deemed an obstacle to the frequent changes of method and emphasis required in a rapidly developing discipline such as public health. The flexibility needed by state and local health departments to adapt to new approaches in disease control, the commission feared, was compromised by permanent categorical grants in the health services sphere. In addition, the existence of numerous, small, specialized grants was cited as presenting excessive administrative reporting and accounting problems for grant recipients.

To alleviate these problems, the commission recommended that all Federal health grants be "allocated to the states on the basis of a uniform formula, susceptible of flexible administration,"[12] rather than a blanket elimination of, or reduction in, the categorical grants. To further mitigate the undesirable consequences of categoricals, the commission favored a gradual phasing out of programs as their objectives were fulfilled and the transfer of funds from one program to another, within limitations set by law, in light of varying health needs as determined by each state. The latter recommendation was prompted in part by the commission's conclusion that, more than many other fields, public health was particularly susceptible to the allocation of public revenues based on "emotion, and the vigor of pressure groups of proprietary interests."[13] It was the opinion of the commission that resource allocation decisions at all levels would be improved by a greater reliance on measures of health needs. Lastly, to combat administrative fragmentation of health-related programs at the national level, the commission's health study committee proposed consolidation of the Public Health Service with the Children's Bureau so that state and local agencies would be required to deal with only one Federal organization concerning health grants.

Several surveys taken by the commission revealed that these criticisms and recommendations for improvement were shared, to varying degrees, by many officials and organizations concerned with public health. Responses by 26 health-related associations showed a preference for increasing the role of broad or general health grants relative to that of categorical grants, and for increasing the flexibility of administration under all health grants. Separate surveys of schools of public health and of state public health officers found even stronger support for health block grants.[14] Of the former, 42 percent of the respondents preferred a shift to block grant funding and another 29 percent favored a system combining block grants with some categoricals. Open-ended responses indicated a perceived need to lessen national specification of state and local administrative patterns and to move in the direction of a block grant for public health. The state health officers were aligned solidly behind the block grant, with 61 percent favoring this approach and 17 percent preferring both a block grant and categoricals. Another 14 percent desired a broadening of categorical grants short of forming a block grant, and only 8 percent recommended maintaining the present system.[15] It is worth noting that these negative reactions to the proliferation of categorical health grants were expressed at a time when the total number of such grants was only eight.

While the work of the Commission on Intergovernmental Relations was in progress, the new Department of Health, Education and Welfare (HEW) began an internal review of its grant-in-aid programs, including those for health. This review produced recommendations for the use of uniform allocation formulae and administrative approaches in many HEW grant programs, and for the consolidation of a number of categorical grants. The Eisenhower Administration subsequently proposed legislation to consolidate all Public Health Service grants into two: a formula grant for basic support and for service improvement, and a project grant for experimentation. The House of Representatives passed legislation in 1954 which would have substantially accepted the Administration's recommendations, eliminating all PHS grants for health services with the exception of mental health grants, and transferring these funds to a consolidated grant for general public health services.[16] The inclusion of mental health within the consolidation was strongly opposed and dropped from the final version of the bill (H.R. 7397, 83rd Cong., 2nd sess.). A companion Senate bill (S. 2778) was not reported by the Senate Committee on Labor and Public Welfare, and action on consolidation stalled at this point.

Next to address the functioning of the Federal grant structure, including public health, were the House Intergovernmental Relations Subcommittee and the Joint Federal-State Action Committee. As part of a two-year examination of Federal-state-local relations, the Intergovernmental Relations Subcommittee pro-

duced an assessment of Federal grants-in-aid. This 1958 report was critical of the problems caused by categorical grants, but viewed them as necessary in many cases.[17] The report suggested that the worst consequences of categorization could be handled by permitting recipients to transfer a portion of each grant program's funds to other categories. Consolidation was not proposed, even though subcommittee surveys of state, municipal, and county officials revealed a preference for general health grants on the part of these officials. Soon afterward, the final report of the Joint Federal-State Action Committee was released, and it contained similar conclusions and recommendations. The committee was a temporary body formed by the National Governors Conference, at the suggestion of President Eisenhower, to identify means of strengthening the American federal system by sorting out the roles of the different levels of government, and by strengthening the states within this system. The same undesirable effects of categorical grants mentioned in earlier studies were cited. The committee was particularly interested in the possibility of consolidating all Federal health services grants to states (with the exception of the two programs managed by the Children's Bureau) into a single, flexible block grant for public health; yet, its final report reflected the advice of a special advisory committee on public health that "past Congressional opposition made a block grant proposal unrealistic at this time."[18] Instead, the committee endorsed the proposal that a transfer of up to one-third of the funds from one health grant program to any other be authorized, this time including the Children's Bureau programs.

Previous ACIR Report

The debate continued, and in 1961, the newly established Advisory Commission on Intergovernmental Relations took up the subject of Federal health grants. Noting the history of complaints against categorical health grants and the financial and administrative problems they create for recipients, the commission's report urged that this "recurring issue should be brought to prompt resolution, one way or the other." The positions of the major interests on the question of consolidation were characterized 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.'[19]

Proposals for partial consolidation of certain programs also were noted.

In evaluating these arguments, the commission concluded that although the initial purpose of the categorical grants had been stimulative, the Congress clearly had demonstrated its intention to continue them as part of an on-going Federal effort to support public health activities. The commission determined that increased flexibility for grant recipients was definitely needed in the public health field, and could be achieved in a variety of ways. It believed, however, that any consolidation or fund transfer arrangement should omit mental health, maternal, and child health, and crippled children's services; the first because in many states mental health and other public health activities were handled by different agencies, and the last two because Federal administrative responsibility lay with the Children's Bureau rather than the Public Health Service.[20]

The commission weighed the pros and cons of retaining the categorical structure and urged its modification so as to increase recipient flexibility, but not the consolidation of health programs within a block grant. While recognizing the limitations of categoricals, the commission did not overlook the arguments advanced in opposition to a switch to block grant funding (some of which were to prove prophetic in light of the later history of the Partnership for Health block grant). On balance, it decided against urging formation of a health block grant, since "... the variety and force of these arguments make unrealistic the adoption at this time of the block grant approach... ."[21] Instead, it recommended ammendment of the *Public Health Service Act* to permit the transfer of up to one-third of the funds from any of the following programs to any other within the group: general health, cancer control, venereal disease control, heart disease control, and tuberculosis control. It also recommended that uniform allotment and matching formulae for these programs be established in the legislation. With enactment of these proposals, the commission believed that most of the flexibility of the block grant approach could be achieved, while avoiding

some of the financial and political problems associated with that funding mechanism.

Programmatic Criticisms Emerge

Despite the reform efforts of these various panels, many participants in shaping the health system, including members of the Congress, seemed to adhere to the view that as long as categorical grants improved the quality and accessibility of particular health services, any detrimental systemic effects were of secondary importance. In other words, the program purposes were the prime concern, and any attendant disorganization, fragmentation, or deviation from ideal governmental arrangements, so long as they did not imperil the achievement of these purposes, were seen as a reasonable price to pay for progress in health care. Only when broad concern emerged over the effectiveness of these grants, as means of generating significant advances in the provision of health care, did the drive to modify the health grant structure gain momentum.

The work of the National Commission on Community Health Services in the early 1960s was the first in a series of sweeping criticisms of the provision of health care in the nation's communities. This four-year study was sponsored by the American Public Health Association and the National Health Council, and delved into more aspects of health care than its title indicates. The planning, organization, delivery, and financing of health services at all levels; the development of health resources including education and training; the construction of facilities; and the costs of health care were all probed. Such severe problems were found that the commission's report spoke of a corrective effort that would encompass the lifetime of its readers. The health system was scored for being "... splintered into a crazy quilt of disconnected and rambling services, with excessive specialization in all aspects of health care."[22] As a corrective, the national commission advocated comprehensiveness in the planning, organization, and delivery of health care.

Against this backdrop of an inadequate health care system, the national commission turned its attention to the financing of health care. Here it called for a "partnership for health" involving all levels of government, but concluded that the primary public authority for provision of health services should rest with the states.[23] Regarding Federal financial assistance, the report apparently accepted some of the earlier arguments in favor of a health block grant, and recommended that:

> The Federal government should assist in financing community health services through the states by awarding grants in as flexible a manner as possible, consistent with the maintenance of standards of quality. Categorical project grants should be employed only to assist in solving specific serious health problems currently needing special emphasis; categorical formula grants should be reviewed periodically as to accomplishments and phased into the basic grant when the categorical approach is no longer justified; and, the basic (general) formula health grant should be increased both absolutely and as a proportion of total grants.[24]

The national commission's Task Force on Financing Community Health Services and Facilities went into greater detail. It recommended an immediate $90 million increase in the funding level of the general health formula grant with some of the funding coming from reductions in existing categorical programs. In addition, a regular annual increment of about $20 million over a five-year period was urged for the general health grant, following a few years of adjustment to the proposed higher funding level.[25] While it did not contemplate the complete elimination of categorical health grants, the task force was clearly calling for creation of a sizable block grant for public health services. In view of the "... widely known reluctance of Congress to increase the size of the general health grant ...,"[26] the task force also considered a number of compromise proposals directed at instilling greater flexibility in the Federal health grant structure, short of consolidation, including the fund transfer provision advanced by the ACIR and others. It concluded that these indirect measures were desirable, though not a substitute for more basic structural reforms, and added its voice to those of earlier block grant proponents.

The task force clarified the recommendation language calling for Federal financial assistance "through the states," and noted the belief of many large cities that the states were not sympathetic to their unique problems. Hence, it urged that "... an appreciable portion of the general health grant received by a state be passed on to local health departments."[27] Although its reports were not published until 1966-67, the commission's work received widespread attention and helped to shape the conclusions of other studies of American health care undertaken in the mid 1960s.

The work of this commission was repeatedly mentioned during the 1965 Congressional deliberations on extending the legislative authority for a number of

public health formula grant programs. Final action, as embodied in Public Law 89-105, was an agreement to extend these programs for a year, pending thorough reviews by the Department of Health, Education and Welfare and by the Association of State and Territorial Health Officers in conjunction with the Public Health Service, and in anticipation of the forthcoming recommendations of the National Commission on Community Health Services.[28] The President had urged such an interim measure in his health message to the Congress:

> . . . I have directed the Secretary of Health, Education and Welfare to study these programs thoroughly and to recommend to me necessary legislation to increase their usefulness. . . . So that a thorough review may be made, I recommend that the Congress extend the authorizations through June 30, 1967.[29]

The climate in 1965-66 was right for serious consideration of changes in the structure of Federal health grants. Concern over the quality of virtually all aspects of the American health care system was widespread, and demands for action were increasing in frequency and intensity. The shift in official assessments of the status of health care was reflected in the report of the National Conference on Medical Costs and the report of the National Advisory Commission on Health Manpower. While publication of both of these reports postdate the 1966 Congressional action on health grants, their themes were influential and shared by many involved in the 1966 debate. Both reports decried the fragmentation and categorical nature of health services, and called for changes in the mode of delivery, administration and planning, and financing.[30]

Perhaps the most immediate stimulus to legislative modifications in the Federal health grant structure was the 1965 White House Conference on Health. Its scope was broad, in keeping with President Johnson's charge, and its proceedings indicated considerable (though not unanimous) dissatisfaction with, among other things, the categorical nature of health services planning, finance, and delivery. At the same time, the need to form a truly integrated system of health care from the unconnected components at each governmental level and in the private sector was reiterated frequently. Though no formal recommendations emerged from this conference, a popular view among participants was that "comprehensiveness" should be made a goal for future approaches to health services.[31] This November conference, along with the other two reviews mentioned above, seemed to solidify the Administration's policy toward the health grant system. They were followed shortly afterward by a Presidential health message which signaled the beginning of final action on revision of Federal health grants.

THE COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES AMENDMENTS OF 1966

President Johnson's health and education message to the Congress early in 1966 began with a recounting of the unprecedented volume of legislation produced by the 88th and 89th Congresses. The message referred to "20 landmark measures" in health and a doubling of appropriations for Federal health programs. But the message proceeded to discuss a number of important actions needed to realize the promise of this auspicious beginning toward achieving "good health for every citizen to the limits of our country's capacity to provide it."

The message set forth the entire health legislative program of the Administration for that year, including proposals to reorganize the Public Health Service, increase funding for health facilities construction, establish a new research and demonstration program dealing with the organization and delivery of health services, provide for increased training of certain kinds of health personnel, enact higher funding levels for medical research, and respond to several specialized health problems (mental retardation, child nutrition, alcoholism, and family planning). The most important portion of the message, however, dealt with proposals for comprehensive health planning and services. Speaking of the need to coordinate all available health resources, the President recommended " . . . a program of grants to enable states and communities to plan the better use of manpower, facilities, and financial resources for comprehensive health services."[32] The proliferation of categorical, formula grants for specific diseases, which " . . . leads to an unnecessarily rigid and compartmentalized approach to health problems" and encourages "inefficiency and confusion and failure to meet the total health needs of our citizens,"[33] was criticized and a new formula grant was recommended for comprehensive public health services – a block grant for health services – beginning in FY 1968. In addition, a program of project grants was proposed for special health problems not found in all parts of the country, in order to permit a targeting of resources in areas of greatest need.

Thus, the President recommended a multifaceted effort to redirect the use of health resources, keyed to comprehensive planning and greater flexibility in Federal

health grants to permit more concerted action on the basis of such planning. The design was that this arrangement would result in the provision of more complete health services, better use of all health resources at each level of government, and, therefore, a curb on rising health care costs and greater coordination of the health activities of governmental and private agencies. A partnership between all levels of government and the private sector, working toward a systematic approach to health care, was envisioned.

On the day following the President's message, the Administration's bill to enact such a "partnership for health" was introduced by Senator Lister Hill, the chairman of the Health Subcommittee of the Senate Committee on Labor and Public Welfare. Officially titled the *Comprehensive Health Planning and Public Health Services Amendments of 1966*, Senate bill 3008 had as its declared purposes the development of comprehensive health planning at all levels of government, the strengthening of state health agencies, and the support of state and local health services in a broader and more flexible manner. The overarching goal for Federal financial aid was support for " . . . marshalling of all health resources . . . to assure comprehensive health services of high quality for every person."[34]

Senate bill 3008 called for five new subsections to section 314 of the *Public Health Service Act*. A new section 314(a) would establish a program of Federal grants " . . . to assist the states in comprehensive and continuing planning for their current and future health needs. . . ." Grants would be made to a "single state agency" designated in each state as solely responsible for administering or supervising comprehensive health planning functions. States would be required to submit and have approved state plans for comprehensive health planning; they then would be "entitled to allotments" on the basis of a formula keyed to population and per capita income, with the restriction that no state would receive less than 1 percent of the total. Actual awards would then be made based on expenses incurred by the states with the specific "Federal share" determined by the Surgeon General, up to a maximum of 75 percent for fiscal year 1970 and thereafter. This program was authorized from FY 1967 to FY 1972, but no specific funding levels were included in the bill.

Proposed section 314(b) authorized a program of project grants for comprehensive health planning on a "regional, metropolitan, or other local area" basis. These grants could be made, with the approval of the state comprehensive health planning agency, to "any other public or non-profit agency or organization" and could cover up to 75 percent of the cost of such planning. Here too, the authorization period was FY 1967 to FY 1972, and no specific funding levels were mentioned.

Section 314(c) would authorize project grants over the same period for training, studies, or demonstrations of more effective comprehensive health planning. Eligible recipients were to any " . . . public or non-profit private agency, institution, or other organizations. . . ." Grants could cover all or part of the cost of such activities; again, no specific authorization level was cited.

New Section 314(d) authorized the appropriation of "such sums as may be necessary" for fiscal years 1968 through 1972 for grants to state "health or mental health authorities," in order to " . . . assist the states in establishing and maintaining adequate public health services, including the training of personnel. . . . " This section would create a health services block grant by consolidating all nine of the Public Health Service categorical formula grants into one comprehensive health services grant.[35] Each state would be "entitled to allotments" according to a formula based on "population and financial need." Actual grant awards would be made according to the expenses incurred by a state under its state plan for public health services, with the "Federal share" varying among the states from one-third to two-thirds according to a formula which considered the differences in state per capita income levels. As in the case of grants under section 314(a), the state plan would have to be approved by the Surgeon General. Moreover, it would have to certify that the Federal funds would be used " . . . to make a significant contribution toward providing and strengthening public health services in the various political subdivisions . . . " and such funds would " . . . be made available to other public and non-profit private agencies, institutions, and organizations, in accordance with criteria which the Surgeon General determines are designed to secure maximum participation of local, regional, or metropolitan agencies and groups. . . . " These Federal funds also were to be used " . . . to supplement and, to the extent practical, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds." In addition, two restrictions were placed on the allocation of funds within the states: at least 15 percent of the funds were to be earmarked for the state mental health authority to provide mental health services; and at least 70 percent of both the public health and mental health funds were to " . . . be available only for the provision . . . of services in the communities of the state."

Lastly, proposed section 314(e) authorized for FY 1968 through FY 1972 the appropriation of "such sums

as may be necessary" for grants to "any public or non-profit private agency, institution, or organization" for such purposes as: meeting health needs of "limited geographic scope or of specialized regional or national significance;" stimulating and temporarily supporting new health service programs; or conducting studies, demonstrations or training for new or improved methods of health service provision. This section also was a consolidation of existing grants, combining seven categorical project grants into one. Awards were to be made on a project basis, and were "to cover part of the cost" of the activities listed above. In effect, this section and the previous one would merge 16 previously separate categoricals into two broad grants.

Other sections of the bill covered general matters, including a requirement that the Surgeon General consult with the affected state agencies before issuing or later amending regulations under sections (a) and (d) above, and secure their agreement where practical. Finally, in keeping with the theme of partnership, a new subsection (f) authorized the Secretary of HEW to arrange for the temporary assignment of departmental personnel to state or local health agencies, or vice versa.

Senate Hearings

The Health Subcommittee of the Senate Committee on Labor and Public Welfare held two days of hearings on S. 3008, on March 16 and 17. In his introductory remarks, Chairman Hill observed that there had been growing sentiment among health officers and other health leaders that Federal funds could be used more effectively if they were made less restrictive and accompanied by comprehensive health planning. As the hearings progressed, it became clear that two facets of the bill were getting prime attention. One was the proposed comprehensive health planning system, while the other was the consolidation of existing formula grant programs into a health services block grant. Since the latter is the major concern of this chapter, it will be treated here in some detail: the planning provisions of the measure will be discussed only insofar as they relate directly to the block grant.

The testimony of then HEW Under Secretary Wilbur Cohen stressed the complementarity of the different components of the bill, asserting that it would improve the capacity of the states to provide health services. This, he felt, would be accomplished in two ways: the ability to plan comprehensively for health services would be developed; and Federal funds would be provided in a manner which would permit flexible resource allocations based on locally determined priorities. The under secretary spoke of an expanded "partnership for health" which "... will allow us to pursue national goals through state and local planning and decision making."[36] This kind of partnership was necessary, he added, because recent legislation had greatly increased the responsibility of state and local agencies for providing health services. Their assumption of this responsibility required increased capacity for leadership and coordination, and the comprehensive planning provisions would provide support in this area. It also required redirecting the grant programs toward the total health needs of people and the block grant approach would assist in this effort by thus giving "... states and localities greater flexibility in using Federal assistance to meet their most important problems."[37]

The statement of Deputy Surgeon General Gerhig echoed these remarks, adding that:

> S. 3008 embodies . . . a fundamental revision of the Federal health grant structure. Federal grant funds would be made available to states and through them to local communities, on a non-categorical basis . . . states and communities would be able to use these funds to provide services . . . focused on individuals and families . . . rather than on separate disease conditions. . . . Among the kinds of public health programs which would be covered by grants under S. 3008 would be expansion of activities now being undertaken with the formula grants for disease categories. Additionally, other types of public health programs . . . would also be eligible.[38]

Dr. Gerhig elaborated on several features of the new block grant program. He defended the department's request for authorizations which, on top of an initial large increase from the current level of $55.5 million for the categorical formula grants, would rise from $170.5 million in FY 1968 (though the Administration bill contained no specific authorization level) to $300 million in FY 1972. He maintained that the exercise of state and community leadership, and the promise for improved health care offered by the legislation, warranted higher authorizations. With respect to the "earmarking" of at least 15 percent of the block grant funds for mental health, its necessity was argued on grounds that in most states mental health and public health were the responsibility of separate agencies. Regarding the proposed requirement that at least 70 percent of the block grant funds be used for "services in communities,"

he explained that this stricture could be satisfied by services provided either by local agencies or by the state directly, depending on the pattern of state-local relations for health services in each state. Lastly, he stressed that one of the key provisions of the measure was that the services financed with block grant funds must " . . . be in accord with the planning decisions which have been made by the state health planning agency and its planning council."[39] The basic intent of this provision was described as ensuring that services are directly linked with comprehensive state planning.[40]

As for the other witnesses, the extent of disagreement with this basic restructuring of Federal health grants was surprisingly limited. While there were extensive comments on a number of the bill's provisions, only two of the specialized health interests appearing registered opposition to the measure. The National Association for Retarded Children suggested an additional "earmark" (10%) for services for the retarded, citing the failure of Federal "encouragement," short of earmarking, to generate the needed attention to this group. Without this protection, the association feared that consolidation would be of little value to its clientele. Moreover, its spokesman argued that the case for a mental retardation earmark was no less urgent than that for the mental health earmark already in the bill. The American Dental Association raised a similar objection to decategorization, requesting a 5 percent earmark for dental health.[41]

In contrast to this limited opposition, the Association of State and Territorial Health Officers, the American Public Health Association, and the National Association of State Mental Health Program Directors expressed strong support for the block grant portion of the bill, and these were joined to varying degrees by other special health interests. However, these same groups did express some concern with the details of the comprehensive health planning provisions of S. 3008, particularly regarding the composition of state and areawide comprehensive health planning boards. They also lamented the absence of specific authorization levels and urged the inclusion of adequate funding authority in the final version of the bill. One important interest, the American Medical Association, took no position during the Senate hearings, although by the time House hearings were held the AMA had decided to oppose the bill.[42]

Judging from the hearing record, the area of greatest Congressional interest relative to the block grant was the character of the formula to be employed in allocating block grant funds to the states. Considerable concern was voiced regarding the formula proposed by HEW (an explicit formula was not contained in the legislation, although the factors to be used in it were). Questions of its adequacy in treating densely settled urban states versus rural ones, and wealthy versus poor states, were raised. Regarding the block grant approach generally, several Senators spoke against the fragmentation involved in categorical grants, while one Senator, a practicing doctor, defended categorical funding. Overall, the block grant was not a subject of intense debate in the Senate hearings; the same was largely true of other sections of the bill. Consolidation appeared to be an idea whose time had arrived, since it already was widely embraced by representatives of most health-related interests.

The bill was reported on September 29, largely unchanged from the Administration version. Specific authorization figures were added, at the levels recommended by the Department of Health, Education and Welfare: $170.5 million for FY 1968, rising to $300 million for FY 1972. Appeals for further categorization of funds within the new block grant were rejected, although the 15 percent earmark for mental health was retained. In the committee report the block grant provision, section 314(d), was hailed as a "fundamental revision of the health grant structure,"[43] moving away from the prior piecemeal approach that focused on categories of disease. Lastly, new sections were added to S. 3008 which amended the *Mental Retardation Facilities and Community Mental Health Centers Act of 1963* to permit grants for initiating services at mental retardation facilities, and to support training of physical education and recreational personnel for retarded children. With these amendments, S. 3008 passed the Senate on a voice vote on October 3, and was sent to the House.

House Hearings

While the Senate held two days of hearings on S. 3008, hearings in the House were conducted late in the session, in one morning, and then only after Administration pressure for action. The chairman of the House Committee on Interstate and Foreign Commerce, Rep. Harley Staggers, opened the proceedings with the announcement that there was not sufficient time to consider properly S. 3008. Instead, he introduced a more limited bill, supported by the chairman of the Special Subcommittee on Investigations of the Department of Health, Education and Welfare, Rep. Paul Rogers.

This measure, H.R. 18231, would have authorized expenditures only until FY 1969 and at a much lower level than the Senate-passed measure. The Senate requirement that, beginning in FY 1971, the services supported with block grant funds must be included in

the state's comprehensive health plan was not included, given the bill's limited authorization period, nor was the provision that at least 70 percent of the funds be available for provision of services in communities. A "hold harmless" clause was added to ensure that each state would receive at least as much money under the block grant as it had under the categorical formula grants.[44] Moreover, the Kennedy amendment to the Senate bill, authorizing the Secretary of HEW to develop national health goals and guidelines to assist in the comprehensive health planning process, was omitted.[45] Thus, one possible link between national priorities and the state-determined needs that could guide the use of block grant funds was absent in the House bill.

In testimony on the measure, Surgeon General Stewart expressed the department's strong preference for the larger funding levels and longer authorization period of the Senate bill. However, Dr. Stewart also conveyed the department's willingness to accept a more limited bill, in view of the short time remaining before adjournment and in the interest of getting the comprehensive health planning process underway. This compromise was advanced with the clear understanding that HEW considered the funding levels of H.R. 18231 inadequate for successful implementation of the legislation, and would return the following year to seek a considerably expanded funding level. In response to questioning by the chairman, Dr. Stewart further indicated that the department could accept a shorter authorization period, covering fiscal years 1967 and 1968. But again, the department's desire to seek the broad goal in 1967 was underscored.[46]

Subsequent questioning of the Surgeon General established the intent of the Committee regarding the block grant, and revealed its basic, but not unqualified, support for greater state flexibility in the use of Federal health funds. Representatives Rogers and Watson expressly stated their concern that the department might administer the block grant in such a way as to restrict state discretion. This, they declared, would be completely contrary to the purpose of the legislation. When pressed on this point, Dr. Stewart asserted that there was really no issue here, since the states and the Surgeon General were " . . . all trying to do the same thing."[47]

This statement of confidence regarding the congruence of program interests between the Federal government and the states highlights a critical assumption underlying the block grant funding mechanism. From the Federal perspective, the success of a block grant frequently is determined by the degree to which state and Federal concerns are, in fact, identical. Indeed, while Representative MacKay also stressed the need to provide greater flexibility to the states through this bill, other members of the committee seemed willing to place limits on that flexibility. Representatives Friedel and Carter, for example, urged HEW to take a more aggressive role in encouraging the states to include family planning services as a priority item in their use of block grant funds, although they did not suggest an earmarking for this purpose.[48]

In their testimony or hearing statements, the major groups supporting the "partnership for health" approach – the Association of State and Territorial Health Officers, the American Public Health Association, and the National Association of State Mental Health Program Directors – all strongly urged higher authorization levels for the block grant. They argued that the language of Federal government partnership would be without substance at the modest funding levels proposed in the House bill, and called for enactment of the Senate-passed bill instead. At a minimum, they requested the omission of a specific authorization for FY 1969, contending that the issue could be taken up more fully early in 1967.[49]

Final Action

The House Committee on Interstate and Foreign Commerce reported H.R. 18231 on October 13. The only major change from the bill as introduced was elimination of specific authorizations for FY 1969. The House accepted the committee bill by voice vote on October 17, and returned the bill to the Senate. Congressman Staggers described it as a "stopgap measure" and indicated the matter would be taken up in greater detail early in the next Congress. Despite substantial differences in the two versions of the bill, the Senate agreed to the House amendments by voice vote on the following day. *Figure 1* compares the block grant features of the different versions of this legislation, including that of the bill as enacted. The measure was signed on November 3, with the President asserting that P.L. 89-749 would broaden the base of state and community health programs and enable their full utilization of the benefits of modern medicine.[50]

In summary, passage of P.L. 89-749 effected a basic reform of Federal health grants covering both formula and project grant programs and a new comprehensive health planning system. The block grant provision of that act eliminated all nine existing formula grant programs for health services which were the responsibility of the Public Health Service. These were replaced with a single block grant for comprehensive health services, whose scope was potentially broader than the

Figure 1

Comparison of Block Grant Provisions of Bills Considered by The 89th Congress, 1966, and of Public Law 89-749

Feature	Administration Bill H.R. 13197	Senate-Passed Bill S. 3008	House-Passed Bill H.R. 18231, and Public Law 89-749
Period of Authorization	FY 1968-1972.	FY 1968-1970.	FY 1968.
Authorization Levels	Such sums as may be necessary.	FY 1968 – $170,500,000 FY 1969 – $230,700,000 FY 1970 – $230,700,000	$62,500,000.
Purpose	Assist the states in establishing and maintaining adequate public health services.	Assist the states in establishing and maintaining adequate public health services.	Assist the states in establishing and maintaining adequate public health services.
State Plan Required?	Yes.	Yes.	Yes.
Link With Comprehensive Health Planning	Services must be in accord with any state comprehensive health plans. Starting in FY 1971, services must be included in state comprehensive health plans.	Services must be in accord with any state comprehensive health plans. Starting in FY 1971, services must be included in state comprehensive health plans.	Services must be in accord with any state comprehensive health plans.
State-Local Division of Responsibility	Funds must be made available to other public or non-profit private bodies so as to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of services.	Funds must be made available to other public or non-profit private bodies so as to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of services.	Funds must be made available to other public or non-profit private bodies so as to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of services.
Intra-state Allocation of Funds	At least 15 percent to state mental health authority for mental health services. At least 70 percent of both mental health and public health portions must be available for provision of services in communities.	At least 15 percent to state mental health authority for mental health services. At least 70 percent of both mental health and public health portions must be available for provision of services in communities.	At least 15 percent to state mental health authority for mental health services.
State Allotment Formula Basis	Population and financial need.	Population and financial need.	Population and financial need.
Federal Share	Between 1/3 and 2/3, based on state per capita income.	Between 1/3 and 2/3, based on state per capita income.	Between 1/3 and 2/3, based on state per capita income.
"Hold Harmless" Provision	None.	None.	No state's allotment can be less in any year than the total amount alloted to it in FY 1967 (under the prior formula grants) under this section.

Source: Texts of the following bills introduced in the 89th Congress, 2d sess., 1966: H.R. 13197; H.R. 18231; S. 3008. Also P.L. 89-749, U.S. Code, vol. 42, sec. 246 (1970).

sum of the categorical programs it replaced. At the same time, the act contained a special earmark for mental health services, stipulating that at least 15 percent of the block grant funds must go to the state mental health authority; thus, in effect, continuing a categorical program within the block grant structure. Basic administrative responsibility was assigned to state health and mental health departments. A single state plan was mandated, requiring approval by HEW. While involvement of local agencies in providing services under the block grant was clearly intended, the act contained no requirement for a "pass-through" of funds to local or regional units. An important legislative compromise was the funding level for the block grant, with the final authorization providing only a modest increase over the total funding levels of the prior categorical programs. Finally, and perhaps most importantly, the act was not clear about the resolution of potentially conflicting state and Federal priorities. On one hand, the purpose of the block grant was simply to support state health department activities; on the other hand, there were ambiguous allusions to the role national priorities would play in the block grant, through the state plan process. Moreover, there was no requirement that the use of block grant funds be explicitly covered in the comprehensive health planning called for by the act; the only stipulation was that services supported by the block grant had to be "in accordance" with any comprehensive health plans developed by the states.

The Partnership for Health Amendments of 1967

In keeping with its chairman's promise, the House Committee on Interstate and Foreign Commerce conducted a thorough examination of the *Partnership for Health Act* in 1967. Occurring less than a year after its enactment and before any meaningful implementation had begun, these hearings nevertheless produced some substantive amendment to the original legislation. The primary focus of the hearings was clearly on other matters, but three modifications of the block grant portion of the *Partnership for Health Act* were made by H.R. 6418, the *Partnership for Health Amendments of 1967.*[51]

The first dealt with the period and levels of authorization for the block grant. The Administration argued that the $62.5 million authorized for FY 1968 fell far short of what was required to realize the block grant's potential for improving the capability of state health departments, and for increasing the states' flexibility in allocating Federal health grant funds. Hence, HEW Under Secretary Cohen emphasized that the FY 1968 funds under section 314(d) would be used primarily to continue activities already approved, and that the requested $70 million funding level would permit only modest expansion of these activities.[52] The implication was that enactment of a block grant through consolidation of existing grants would achieve very limited recipient flexibility in the absence of significant increases in funding levels. The national associations of state and local public health officials, and of state mental health officials, advanced similar arguments and requested a nearly five-fold increase in funding over the current categorical levels, by FY 1971. In response, several committee members mentioned the Vietnam War as an important limiting factor on funding levels, and others expressed some uncertainty whether the states would be able to expand their share of health services funding as rapidly as would be called for by these requested levels.[53] The committee ultimately decided to authorize somewhat higher funding levels for each of the next four fiscal years, including a supplemental authorization for FY 1968. The proposed new figures were $70 million, $90 million, $100 million, and $110 million for fiscal years 1968 through 1971, respectively.[54]

A second area of concern was the division of responsibility between the states and local governments in providing comprehensive public health services. The Administration again proposed that at least 70 percent of both the public health and mental health funds allocated to the states under section 314(d) be used only for providing services in communities. In so doing, HEW officials indicated that the higher funding levels would make such a provision workable and insure that few, if any, states would end up with lower levels of Federal support for state level health department activities. Reacting to earlier departmental clarifications of the local services requirement, especially the explanation that direct state expenditures for local services would satisfy this provision, the National Association of Counties (NACo) urged the committee to ensure that local governmental policies and plans would guide the provision of such services.[55] On this point, the committee accepted the Administration's argument and incorporated the so-called "70 percent provision" in the bill as reported, to apply beginning in FY 1968, but without the NACo suggested primacy for local priorities.

The final change was a provision permitting the Secretary of HEW to use up to 1 percent of the funds appropriated under section 314(d) (and three other sections) for evaluations of the effectiveness of these programs. The Secretary was strongly encouraged to use this authority, and to report to the Congress regarding the findings of such evaluations.[56] With these amend-

ments, H.R. 6418 passed the full House in September by an overwhelming margin. The major departure from the Administration bill was the inclusion of specific authorization levels for years after 1968, in contrast to the "such sums as may be necessary" language favored by HEW.

No new issues were raised regarding the health block grant during the 1967 Senate hearings, which also were largely preoccupied with other portions of the bill.[57] There was further clarification of the intent of the "70 percent provision," however. In the view of the Senate Health Subcommittee, this feature was designed to ensure that Federal funds were used to support actual health services rather than administrative costs.[58] The only change from the House version involved the elimination of FY 1971 from the authorization language. The Senate passed the bill as amended in November, the conference accepted virtually all of the Senate amendments, and H.R. 6418 became Public Law 90-174 on December 5.[59]

1970 AMENDMENTS TO THE PARTNERSHIP FOR HEALTH ACT

The block grant authority was amended again in 1970. The basic features of the program remained unchanged, but one important shift in the Congressional approach to the block grant occurred. For the first time, Federal priorities were specified within the block grant, though not by an actual earmarking of funds. The sections dealing with the content of the state plan for comprehensive health services were modified by inclusion of requirements that services aimed at drug and alcohol abuse be provided under the plan, "commensurate with the extent of the problem."[60] At the same time, a small program of project grants for tuberculosis control was phased into the block grant. This action, combined with modest funding increases for the block grant, on balance left some states with less Federal health grant funds under these programs than in prior years. In addition, the authority for the block grant was extended for three years, with authorized funding levels of $130 million in FY 1971, $145 million in FY 1972, and $165 million in FY 1973. The House Interstate and Foreign Commerce Committee report on the amendments asserted that it was essential to expand the program if the initial investment were to pay off. Finally, P.L. 91-515 stipulated that the block grant's state plan must contain assurances of its compatibility with the total health program of the state.

An Administration proposal to combine the comprehensive health services program with the regional medical program (a then $100 million program of regional centers for developing innovative approaches to the treatment of heart disease, stroke, cancer, and kidney disease) and with health services research and demonstration activity was rejected. The committee felt more time was needed for these programs to develop before merger should be considered.[61]

Yet, even with the expanded authorizations, it was clear that the comprehensive health services block grant was not maintaining its position as the primary source of Federal support for state and local public health activities. Such a role for the program had been cited in the house report on the 1967 amendments.[62] But, appropriations to match these authorization levels were not forthcoming; the highest appropriation for the health block grant prior to 1975 had been $90 million. In addition, Congress had enacted a number of new categorical health programs since the initial 1966 consolidation, several of which logically could have been folded into the block grant. One such example was the passage in 1970 of new programs for the prevention of alcohol and drug abuse, despite their inclusion as priority items within the block grant in the same year. As a result, the stature of the block grant within the Federal health grant system began to decline, rather than rise as anticipated by its proponents and "promised" by HEW and the Administration in 1966-67.

SUBSEQUENT AMENDMENTS AND EXTENSIONS

The *Partnership for Health Act* for the most part did not receive major attention from Congress again until 1974. But during the interim, the legislation was extended and modified slightly. In 1972, Public Law 92-255 strengthened the 1970 language calling for attention within the block grant to the drug abuse problem, by requiring state plans to provide for licensing of treatment facilities and for expansion of state mental health and other programs in the field of drug abuse. No related funding increases, however, accompanied this expanded directive. In 1973, the legislation was extended without detailed review. The only change in the block grant section was the $90 million authorization for FY 1976.[63] This was a sharp drop from the 1973 figure of $165,000,000, reflecting the legislative committees' recognition that the Appropriations Committees were not going to provide the higher funding levels authorized for the block grant in recent years. With this action, the original intent of the Congress and the Johnson Administration to develop the block grant into

the principal source of Federal funding for community health services was completely reversed.

1974 ACTION

The block grant authority was closely examined and substantially revised in 1974. The House acted first, in an environment conditioned by the Administration's proposals to combine or eliminate most Federal health services grant programs. With respect to the 314(d) block grant, the Administration proposed continuance of the program at the current level and elimination of the 15 percent earmark for mental health services.[64] In response, the House reported a bill that incorporated few of the Administration's suggestions, although maintenance of the block grant was one of them. Even so, the House bill would have more than doubled the program's authorization and retained the mental health earmark.[65] In addition, the form and content of the state plans required for receipt of block grant funds were specified in some detail. HEW's post-1971 policy of not requiring submission of these plans for approval was explicitly rejected, and language was added designed to require approval of 314(d) plans by the state comprehensive health planning agency.[66]

The major issue for the block grant was accountability, with the House Committee on Interstate and Foreign Commerce expressing considerable concern over the lack of adequate information on, and evaluation of, program expenditures by the states. Several factors were mentioned as contributing to this problem, including variation in the sophistication of state reporting systems – especially for funds sub-allocated to local health units. The committee called for greatly increased effort in data collection and evaluation to surmount these problems, and to allow determination of whether certain kinds of services – especially mental health and alcohol and drug abuse control – should be supported through a comprehensive funding arrangement or through separate, specialized programs.[67]

At the same time, the block grant was retitled as "Health Revenue Sharing," to emphasize the flexibility attendant to its use. Yet, the request for more detailed program information was said to apply to all services for which the block grant could potentially be used, not just the Federal and state matching funds. This expansion was defended on grounds that " . . . it would be inappropriate to require that . . . " revenue sharing funds " . . . be earmarked by the states in such a manner that their specific use could be reported upon."[68] Thus, the basic tension in this block grant program remained. Balancing particular national interests and the mechanisms of control needed to assure such interests, against the flexible support of basic state and local health activities and its quite different administrative implications was still to be achieved. Despite this ambiguity, the increase in authorizations to $200 million for FY 1975 (and $220 million the following year) was evidence that the House still believed the comprehensive health services block grant was an important component of the total Federal grant structure for health.

The Senate also extended the block grant program, though only for one year and with significant changes from the House-passed version. The limited extension was chosen because the Senate Health Subcommittee was considering alternatives to the current block grant mechanism, in particular a proposal by the Association of State and Territorial Health Officers and the National Association of Counties for Federal payment of a fixed percentage of total state and local expenditures for a defined set of health services. For this reason, the Senate rejected increased authorizations for the block grant and favored continuation at the current $90 million level. In addition, a new program for treatment and prevention of hypertension (at a level of $70 million) was authorized under section 314(d), and the block grant, state plans were required to provide for expansion of drug abuse control programs. Other titles of the Senate bill continued some existing programs and created three new ones: a small, largely research-oriented program for rape prevention and control; another small program for treatment of hemophilia; and a program of demonstration grants for home health services.[69]

The Senate committee echoed the House demands for better program data and evaluation, and approved modification in the procedural and reporting requirements designed to make the block grant program " . . . more responsive to committee concerns for health problems of broad national scope."[70] This statement in the committee report was followed by the declaration that, "It is not the committee's intent . . . to further limit state discretion in the administration of funds . . . ." As was true for the House, the Senate had not resolved the basic dilemma of block grant administration. And unlike the House, the Senate gave clear notice that it was no longer certain the block grant mechanism was the proper one for achieving this kind of Federal financial assistance in health.

The House-Senate conferees filed a report on December 5 which extended the block grant for two years and retitled it "Health Revenue Sharing." The conference bill differed from current law in five major respects:

1. A new category – hypertension – was

added within the block grant, with a minimum 22 percent earmark for this purpose. This was in place of the separate authority passed by the Senate, and was the first category to be added within the block grant since the original 15 percent minimum for mental health services.

2. Nominally to compensate for this addition, the authorization level was increased to $160 million for FY 1975 and 1976.

3. Despite the revenue sharing title, the new law contained several procedural requirements which would result in more stringent Federal review than was current practice, in particular the reaffirmation that states must submit state plans to HEW for approval.

4. Congressional displeasure with the inability to determine what use had been made of these funds was evident in several sections of the bill, especially those requiring states to determine their "most serious" health problems (but not requiring any particular action based on this determination), specifying a number of categorical problems which must be addressed within the block grant, and requiring more detailed reporting on services provided and funds expended.

5. Requirements for the states to match the Federal funds at a specified rate were dropped in recognition that the states and localities already were spending far in excess of the required matching contribution on these programs.

The final version of H.R. 14214 was passed and sent to the President on December 10. President Ford pocket vetoed the bill, noting in a memorandum of disapproval that the reasons for the veto were primarily budgetary.[71] Programs authorized under this bill were extended under a continuing resolution until late February of 1975. By that time, it was explained, a new Congress would be able to consider the future of the health services block grant. Meanwhile, the Administration decided to phase out the block grant, by recission of spending authority for the last two quarters of FY 1975 and termination of the program when the current authorization expired. In so doing, the Administration argued that the services supported by the block grant could be supported under existing categorical programs; hence, the block grant was unnecessary.

Thus, at the close of 1974 the future of the block grant mechanism in Federal health assistance was extremely uncertain. A trend toward recategorization of the block grant itself was reflected in the earmarking of funds for particular categories of service and in requirements for the block grant, state plan to provide for services in particular problem areas. Finally, even the continued existence of the block grant was threatened by a change in Administration policy engendered by national economic and budgetary problems.

THE SPECIAL HEALTH REVENUE SHARING ACT OF 1975

Rather than an immediate attempt to reenact the bill vetoed by President Ford, the new 94th Congress preferred to send an identical bill through committee review again in both chambers. The House acted first, holding hearings on H.R. 2954, the *Health Revenue Sharing and Health Services Act of 1975*, in mid February. In addition to modifying the 314(d) block grant, this bill also would continue several expiring categorical health service programs. Since an identical bill had gone through the committee process the previous year, and had encountered little controversy, the only witness was HEW Secretary Weinberger, who presented the Administration's arguments in opposition to the legislation. The Secretary reiterated the Administration's objection to the authorization levels of H.R. 2954, and summarized the Administration's policy objectives to categorical grants:

> ... the detailed manner in which the bill specifically prescribes program activities would limit our management flexibility to administer the ongoing program effectively. Consequently, we believe it is necessary to have a general authority for supporting the development and operation of programs of community health services. Within a broad flexible authority, we believe we could continue to administer certain specific programs contained in H.R. 2954. We do not, however, support the detailed legislative and programmatic provisions of the bill, and this is, of course, fully consistent with the basic administration policy that the state and local

governments know their priorities better than we do.[72]

Because of budgetary constraints, this philosophical preference for "broad flexible authority" for grant programs apparently did not apply to the prime (and together with the consolidated 314(e) project grant, the only) example of such authority in the health field, the 314(d) block grant. As the Secretary noted:

> The bill's authorizations . . . are inconsistent with the President's revised 1975 budget which would terminate the program effective April 1, 1975. Additionally, in 1976 over $633 million will be available through other Federal health programs to help support many of the same kinds of activities now covered under the comprehensive health grants to states program.[73]

Since these "other Federal health programs" are categorical programs, HEW seemed to be arguing that while categorical grants are inherently undesirable, the broadest and most flexible existing health grant should be terminated because categorical programs are available to support many of the same types of activities. It may be surmised that the root of this logical inconsistency was the Administration's determination that, in the face of severe budgetary problems, the most politically vulnerable programs should be the target of cost reduction efforts, regardless of their compatibility with its grant philosophy.

Secretary Weinberger also objected to the use of the revenue sharing label for the block grant authorization, noting that the procedural requirements and programmatic restrictions of H.R. 2954 – especially the mental health and hypertension earmarks – were inconsistent with the revenue sharing concept. He went on to state the department's preference for continuation of the 314(e) project grant program (which H.R. 2954 would terminate), and its desire to transform this program into a flexible source of support for states and localities, presumably much like the current block grant but including direct grants to local governments.[74] In response, one minority member of the committee indicated reservations about the degree to which the committee's program goals would be adhered to under such an approach, as well as its dissatisfaction with the department's record of restricting grantee administrative and programmatic flexibility.

No new issues regarding the block grant were raised in testimony or in statements submitted for the record. Several of the statements, however, stressed the harm which would result from the Administration's proposed termination of the 314(d) program, and a letter from the National Association of Counties urged removal of the 22 percent hypertension earmark from the block grant, since this seemed a "retrenchment to the categorical approach." Moreover, the AMA reversed its earlier opposition to the block grant, noting that the 314(d) program remedied many problems associated with predecessor categorical grants by helping to overcome service fragmentation and by supporting state-determined priorities.[75] The evolution of the AMA position illustrates how broad the acceptance of the block grant had become within the health field.

In view of the absence of support from other quarters for the proposed termination of the 314(d) program, and in response to a large-scale lobbying effort on the part of state and local chief executives and health officials in opposition to termination, on May 7, the committee reported a revised health services bill which continued the block grant. Title I of H.R. 4925 extended the 314(d) authority through FY 1977, with slightly increased authorization levels ($100 million in FY 1976 and $110 million in FY 1977). The bill basically was identical to the one vetoed in 1974, with four important exceptions.

- First, the hypertension earmark was removed from the block grant, although a separate $15 million hypertension program was inaugurated by amendment of section 314(d) of the *Public Health Service Act*; the report was not clear, however, regarding how this new program would relate to the block grant with respect to Federal and state administration.[76]

- Second, the complicated, tripartite, planning requirements of the 1974 bill were eliminated and the stipulation was added that comprehensive public health services would be provided " . . . in accordance with the state plan prepared in accordance with section 1524(c) or the state plan approved under section 314(a), whichever is applicable. . . ."[77] At the same time, the requirement of the 1974 bill that states annually submit, and have approved by the Secretary, applications covering several statutory requirements and other information defined by the

Secretary was retained. These actions brought the block grant planning provisions into conformance with P.L. 93-641, the *Health Planning and Resource Development Act of 1974*, which became law in January 1975. No attempt to link this block grant and areawide health planning was made in H.R. 4925, since P.L. 93-641 already required submission of state plans and particular project applications under them to areawide health systems agencies for review.

- Third, to compensate for the potential loss of program information brought about by these simplified planning requirements, the House bill also required the states to submit (at least annually) expenditure reports on the comprehensive public health services provided in each state. This reporting must be through a uniform national reporting system (presumably much like the Association of State and Territorial Health Officials health program reporting system, discussed later in this report), and must use reporting categories prescribed by the Secretary of HEW. This requirement reflects the committee's continuing frustration with achieving accountability to the Congress under the block grant, and its endorsement of the ASTHO reporting system as a possible solution. It is not quite clear, however, in either the text of the bill or the committee report, whether these reporting requirements would apply to all state and local public health expenditures, or only to the Federal 314(d) funds and state and local funds associated with them; *i.e.*, used for "comprehensive public health services."

- A final modification affected only the mental health component of the block grant. Congressional encouragement of community-based alternatives to institutional care in the 1974 legislation prompted concern by mental health hospital employees. To alleviate this concern, the committee added a provision in H.R. 4925 requiring states to protect the rights of such employees in any hospital closings or other potential staff displacements brought about by the Congressional emphasis on de-institutionalization. With these modifications, H.R. 4925 passed the House by voice vote on June 5.

Meanwhile, the Senate Committee on Labor and Public Welfare had considered, without new hearings, the health services legislation vetoed by the President after the previous Congress had adjourned. This bill and another vetoed measure dealing with nurse training were combined in S. 66, which was unanimously approved by the committee on January 28.[78] As approved, the block grant provisions of S. 66 were identical to those of the final 1974 bill. The Senate passed the measure on April 10, by a 77 to 14 vote.

The House-Senate Conference Committee resolved the differences between the two versions by accepting all the major provisions of the House bill, including the lower authorization levels.[79] This authorization action was a departure from the usual practice of splitting the difference in funding levels to arrive at a compromise figure, but was taken to lessen the likelihood of a veto. With respect to the block grant, only one minor change from the House bill was made: a provision of the Senate bill, requiring the Secretary of HEW to consult with the Secretary of Labor regarding the protection of mental health institution employees' rights, was retained by the conferees. The conference report on S. 66 was accepted by voice votes and without debate in the Senate on July 14, and by the House two days later.

The Congressional effort to avoid another veto by reducing authorization levels from those of the 1974 bill proved unsuccessful. President Ford vetoed the bill on July 26. The reasons given were that the cost of the included programs still exceeded those in the Administration's budget, that the creation of four new categorical programs was counter to the Administration's philosophy regarding the Federal grant structure, and that several programs would be continued which the Administration wished to terminate.[80] The block grant was not among the programs specifically cited in the veto message as meriting termination.

The veto was immediately overridden, however, by wide bipartisan margins (384-43 in the House and 67-15 in the Senate), and S. 66 became Public Law 94-92 on July 29, 1975. The President's budgetary argument clearly had little appeal to Congress. Significant reductions in authorization levels under the 1974 bill already had been achieved in the attempt at compromise, and the fact that these budget arguments were directed at authorizations — which nearly always exceed budget

requests – rather than appropriations made the Administration's cost concerns more difficult to defend.[81] This combination of factors resulted in the first successful attempt to override a Presidential veto by the 94th Congress, which initially had been characterized by some prognosticators as "veto proof."

Thus, despite the two-year extension, some administrative simplification, and the abandonment of attempts to specify national programmatic priorities for the public health portion of the 314(d) program achieved by Public Law 94-63, the future of the block grant mechanism in Federal health assistance remains highly uncertain. What had begun in FY 1968 as the major source of Federal formula grant funds for health services, had by 1975 become a relatively small part of the Federal health grant structure. The block grant has not grown as anticipated by its advocates, either in dollar terms or by the folding of other categorical programs into the block grant. Instead many new categorical programs have been created, including several formula grant programs in areas which logically could have been covered by expansion of the 314(d) grant.[82] And it is far from clear how well the somewhat simplified block grant will fare in future budgetary competition with categorical grants.

Against this legislative history, the operation of the 314(d) grant must be examined to determine the reasons behind Congressional and Executive Branch attitudes toward the block grant, and to attempt to sort out which of the problems encountered by this program are endemic to the block grant, funding mechanism rather than specific to the history and environment of this program. This will begin with the concluding section of this chapter, which probes the objectives of the 314(d) grant consolidation.

CONGRESSIONAL INTENT: INITIAL AND EVOLVING

An assessment, on any level, of whether the 314(d) block grant has "worked," must consider what the Congressional intent was in enacting the consolidation. Ascribing a single or congruent set of purposes to a multimembered deliberative body is always a hazardous task, but the committee reports on the 314(d) block grant point fairly unambiguously to several predominating concerns. One was quite simple and straightforward – the consolidation of separate grants was a way to lessen, for recipients, the administrative burden associated with Federal grants. The other motives were more complex.

Among the most important was the issue of program direction. One reading of the record suggests that the block grant mechanism was intended to provide greater flexibility to state health agencies in the use of Federal grant funds. Accordingly, the purpose of the block grant section of the *Partnership for Health Act* was stated as assisting the states in "establishing and maintaining adequate public health services."[83] This impressively broad statement of goals, supported by relatively unrestrictive procedural and administrative requirements, implies that state flexibility in administration was the primary goal of the consolidation. Moreover, this interpretation seems to be confirmed in both the Senate and House committee reports from the inception of the program to the present, as was noted in the previous section recounting the block grant's legislative history.

Others have read the record differently and have found the statements of intent relating to the entire *Partnership for Health Act*, rather than the block grant portion alone, more persuasive. From this perspective, they argue that innovation, experimentation, and attempts to reform the health care planning and delivery system – not simply the objective of maintaining the adequate service – were the ultimate goals behind the move to increased state flexibility.[84] The version of Congressional intent one adheres to will naturally condition one's conclusions about the performance of the block grant mechanism; hence, a choice must be made before proceeding.

On balance, the record seems to provide support for a composite interpretation of Congressional intent. Different sections of the *Partnership for Health Act*, after all, give different emphasis to different reform objectives. The block grant, in this context, was designed to provide basic, continuing financial assistance to state health agencies; by so doing, it was anticipated that improved capacity would be developed in these agencies for handling their expanding responsibilities. With this forming the foundation, reform and innovation would be pursued primarily through the comprehensive health planning and demonstration-project grant authorities; block grant expenditures would only have to be compatible with the comprehensive health plans. While not unassailable, this interpretation will be employed throughout this report, since it appears to be the more convincing alternative.

As alluded to above, another basic facet of Congressional intent regarding the 314(d) program was that of assuring complementarity of the block grant and comprehensive health planning activities. Congress clearly viewed the individual pieces of new section 314 (of the *Public Health Services Act*) as forming a consistent

whole. If state discretion in the use of block grant funds were to be productive, close ties to state and local assessments of health needs and determinations of health service priorities – expressed through the comprehensive health planning (CHP) process – were essential. While Congress stopped short of requiring CHP agency approval of the expenditure of 314(d) funds, the statutory language requiring the pattern of services supported by the block grant to be in accordance with any existing comprehensive health plans evidences the intent of Congress that the link between these activities should be substantial and mutually supportive. The history of the program shows recurring Congressional attempts to strengthen this linkage even further, particularly as its weakness became more widely perceived. This aspect of the Congressional intent regarding the block grant is widely recognized and unchallenged.

An additional concern of the Congress was that the block grants funds be used primarily to provide services rather than for administrative costs associated with either state or local health agencies. This desire, rather than any specific conception of the proper state-local division of responsibility for the operation of the block grant, was the impetus behind the requirement that at least 70 percent of the block grant funds in each state be used for "provision of services in communities." Some writers have interpreted this requirement to constitute a mandated "pass-through" of block grant funds to local health agencies. But both Congressional committee reports and HEW policy statements have explicitly and consistently interpreted this provision as simply setting a limit on the percentage of block grant funds which can be expended for purely administrative purposes.[85]

Another clear Congressional purpose was that other public and non-profit private organizations should actively participate with the states in the provision of services financed by the block grant. P.L. 89-749 required – as have all subsequent amendments of the act – that 314(d) state plans assure that funds will be "made available" by the state to such other organizations, so as to "secure maximum participation of local, regional, and metropolitan agencies and groups" in the provision of services. This was to extend the partnership concept, both between levels of government and between the public and private sectors, to the basic health services block grant. Since no guidance was given by Congress regarding how extensively these funds should be made available to other organizations, and in view of the unambiguous rejection of a "pass-through" requirement, it is difficult to guage accurately what the Congress expected and felt was an appropriate division in this area. The permissive HEW interpretation of this provision has never been challenged by the Congress, however, and that may provide some indication of the actual intent of this language.

In all of the above areas, Congressional intent appears to have remained relatively constant. But in another critical area, the situation is entirely different. The degree to which block grant funds were to be spent in pursuit of national priorities for health services has been the single most important source of ambiguity and controversy throughout the program's history. In the initial legislation, Congress avoided attempts to prescribe particular programmatic priorities for the use of block grant funds. The only such stricture was that at least 15 percent of the funds were to be reserved for state mental health authorities for financing mental health services, and this was done because, in most states, mental health and public health responsibilities were assigned to different agencies. Thus, the states were left with very wide latitude concerning the content of the block grant state plans and service delivery activities. Beginning with the 1970 amendments, and accelerating with each subsequent revision of the authorizing legislation, however, Congress began to mandate attention to specified problems of national importance. This trend toward recategorization of the block grant evolved from initial directions that state plans must cover provision of alcohol and drug abuse services "commensurate with the extent of the problem," to the incorporation in the vetoed 1974 health services legislation of a new 22 percent earmark for hypertension services. It is in this issue of program content that the fundamental tension of the block grant mechanism – between supporting basic state and local activities in a given function, on one hand, and pursuing specific national priorities, on the other – is most clearly highlighted.[86] The history of this program suggests that an inherent instability of the block grant on this point, given the inability on all sides – Congress, HEW, and the states – to resolve the program's basic purpose has dominated the evolution of the 314(d) block grant.

HEW INTERPRETATION OF THE LEGISLATIVE INTENT

The details of HEW's administration of the 314(d) block grant will be covered later in this report. At this point, it is sufficient to observe that the department's overall policy regarding the administration of the block grant was to ensure largely unrestricted state flexibility in the use of Federal funds, and to remain neutral, for the most part, with respect to state program content. There were modifications in this approach over time, but

in contrast to the Congressional pattern, HEW policy evolved from modest attempts to control state program activities at the outset to virtually no such attempts in more recent years. Since HEW officials were certainly aware of the development of Congressional thinking regarding accountability and responsiveness to national health service priorities, this contrasting evolution in administrative practice poses intriguing questions about the relative strength of different forces affecting block grant administration at the Federal level.

Against this background of the objectives of the consolidation, attention now will shift to the manner in which the block grant has been administered by Federal and state officials.

FOOTNOTES

[1] Small grants for venereal disease control and for maternal and child health services were made to states by the Federal government for a brief period after World War I. The *Social Security Act* also authorized, under Title V, grants for maternal and child health and for crippled children's services. These more restricted forms of Federal financial aid for health were initially administered by the Children's Bureau, and were often considered social service or child welfare programs rather than health programs.

[2] Estimated obligations in the FY 1967 *Appendix to the U.S. Budget* show the general health grant at $10 million for FY 1966, compared to a total of about $58 million for all health services formula grants administered by PHS, and about $105 million for all health services project grant programs of the PHS. Thus, the general health grant comprised only $10 of the $163 million for all PHS health services grants, or about 6 percent.

[3] The development of tuberculosis control practices in the U.S. is described in brief in Robert R. Henderson, Michael D. Koontz, and John K. Olverson, "Effects of Discontinuing Categorical Project Grants for Tuberculosis Control – A Pilot Study," January 1975, by GEOMET under Center for Disease Control (CDC) Contract Number 21-74-539.

[4] Overviews of the development of public health in the U.S. are given in several basic works on the subject of health care administration. See for example: John J. Hanlon, *Principles of Public Health Administration*, 4th ed. (St. Louis: the C.V. Mosby Company, 1964); or David G. Smith, "Emerging Patterns of Federalism: the Case of Public Health," in Mary F. Arnold, L. Vaughn Blankenship, and John M. Hess, ed., *Administering Health Systems* (Chicago: Aldine-Atherton, 1971).

[5] Commission on Organization of the Executive Branch of the Government, Committee on Federal Medical Services, *Task Force Report on Federal Medical Services* (Appendix O of the full commission report), January 15, 1949, pp. 64-65.

[6] *Ibid.*, p. 65. See also three reports to the Congress by the full Commission on Organization of the Executive Branch of the Government: *Overseas Administration(,) Federal-State Relations (and) Federal Research*, March 1949; *Reorganization of Federal Medical Activities*, March 1949; and *Concluding Report*, May 1949.

[7] This initial proposal was later dropped by the full commission; instead it recommended creation of a unified health agency consolidating many Federal health activities, but omitting those of the Children's Bureau among others. In a supplemental Committee report, it was asserted that this reversal did not negate the prior recommendations, including those regarding grants-in-aid for health. Commission on Organization of the Executive Branch, Committee on Federal Medical Services, *Task Force Report*, (Appendix O), Supplement, March 1949.

[8] Selma J. Mushkin and John F. Cotton, *Sharing Federal Funds For State and Local Needs*, Praeger Special Studies in U.S. Economic and Social Development (New York: Praeger Publishers, 1969), p. 113.

[9] It should be noted that at the time of the Kestnbaum Commission, as well as that of the Hoover Commission, Federal grants to states for health services consisted of one general health grant and grants for seven categories of health problems: tuberculosis control, cancer control, heart disease control, venereal disease control, mental health, maternal and child health, and crippled children's services. The formula grant for venereal disease control received no appropriations after FY 1953, although the project grant program for venereal disease continued to be funded.

[10] U.S. Commission on Intergovernmental Relations, *A Report to the President for Transmittal to Congress*, June 1955, pp. 121-142 and 248-252. Also see the commission's special report on public health: Study Committee on Federal Aid to Public Health, of the U.S. Commission on Intergovernmental Relations, *Study Committee Report on Federal Aid to Public Health*, June 1955, especially pp. 1-6 and 31-38.

[11] U.S. Commission on Intergovernmental Relations, *Report*, pp. 251-52.

[12] *Ibid.*, p. 252.

[13] Study Committee on Federal Aid to Public Health, Report, p. 3.

[14] At the time of this survey, the term "block grant" was used to denote any broad based, functional grant, whether formula or project.

[15] *Op. cit.*, Study Committee, *Report*, pp. 31-38.

[16] Maternal and Child Health and Crippled Children's Services grants, administered by the Children's Bureau, were not part of this consolidation. Information regarding 1954 legislative action is taken from Advisory Commission on Intergovernmental Relations, *Modification of Federal Grants-In-Aid for Public Health Services* (Washington, D.C.: U.S. Government Printing Office, January 1961), p. 4.

[17] U.S., Congress, House, Committee on Government Operations, *Thirtieth Report: Federal-State-Local Relations, Federal Grants-In-Aid*, 85th Cong., 2nd sess., August 8, 1958, pp. 26-27; 43; 47-49; 51-52.

[18] Joint Federal-State Action Committee, *Final Report to the President of the United States and to the Chairman of the Governor's Conference*, (Washington, D.C.: U.S. Government Printing Office, February 1960), p. 13. See also pages 4 and 172-85.

[19]ACIR, *Modification of Federal Grants-In-Aid for Public Health Services*, p. 11.
[20]*Ibid.*, pp. 16-24.
[21]*Ibid.*, p. 21.
[22]National Commission on Community Health Services, "Health Is A Community Affair," a prepublication edition of the Report of the National Commission on Community Health Services (Cambridge, Mass., Harvard University Press, 1966) p. 205 (mimeographed).
[23]*Ibid.*, pp. 203-204.
[24]*Ibid.*, pp. 29, 209.
[25]National Commission on Community Health Services, Task Force on Financing Community Health Services and Facilities, *Financing Community Health Services and Facilities* (Washington, D.C.: Public Affairs Press, 1967), pp. 19, 74-75.
[26]*Ibid.*, pp. 77-78.
[27]*Ibid.*, p. 76.
[28]See for example, U.S. Congress, Senate, Committee on Labor and Public Welfare, *Community Health Services Extension Amendments of 1965*, S. Report 117 to accompany S. 510, 89th Cong., 1st sess., 1965, p. 4. The House report on the companion bill, H.R. 2986, and hearings in both chambers clearly indicate that Congress was awaiting the results of these studies before altering the programs.
[29]U.S., President, "Advancing the Nation's Health," Special Message to Congress, January 7, 1965, *Public Papers of the Presidents, 1965*, Vol. I (Washington D.C.: U.S. Government Printing Office, 1966) p. 20.
[30]U.S., Department of Health, Education and Welfare, *Report of the National Conference on Medical Costs, June 27-28, 1967*, (Washington, D.C.: U.S. Government Printing Office, 1968) pp. x-xii, 157-202; and National Advisory Commission on Health Manpower, *Report*, 1967, pp. 188-95.
[31]U.S., Department of Health, Education and Welfare, *Proceedings of the White House Conference on Health, November 3-4, 1965.* See, for example, pages 4, 6, 24, 33, 317, 380-384, 387-89, 393, and 400.
[32]U.S., Congress, House, *Health and Education Message From the President of the United States*, March 1, 1966. H. Doc. 395, 89th Cong., 2nd sess., 1966, p. 3.
[33]*Ibid.*, pp. 3-4.
[34]U.S., Congress, Senate, "Comprehensive Health Planning and Public Health Services Amendments of 1966," S. 3008, 89th Cong., 2nd sess., 1966, p. 2.
[35]These were programs for: general health; tuberculosis control; cancer control; heart disease control; chronic diseases and health of the aged; radiological health; dental health; home health services; and mental health. See *Table 1* of this chapter for additional information on these programs.
[36]U.S., Congress, Senate, Committee on Labor and Public Welfare, *Public Health Planning and Grants, Hearings before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare on S. 3008*, 89th Cong., 2nd sess., 1966, p. 40.
[37]*Ibid.*, p. 41.
[38]*Ibid.*, pp. 55-56.
[39]*Ibid.*, pp. 56-57.
[40]Some have suggested that HEW's support for the new block grant was heavily conditioned by its assumption that the program would serve as a vehicle for gaining state support for the comprehensive health planning agencies.
[41]*Ibid.*, pp. 88-97; 108-113.
[42]*Ibid.*, pp. 80-88; 105-108; 113-125; 152. Also see a subsequent communication from the National Tuberculosis Association on pages 146-147 of these hearings, supporting the block grant but opposing decategorization of health project grants, and statements for the record by other interest groups on pages 147-153. ACIR had also revised its earlier position regarding a block grant for public health, and supported S. 3008.
[43]U.S., Congress, Senate, Committee on Labor and Public Welfare, *Comprehensive Health Planning and Public Health Services Amendments of 1966, S. Rept. 1965 to Accompany S. 3008*, 89th Cong., 2nd sess., 1966, p. 10-11; 13.
[44]See the texts of H.R. 18231 and S. 3008 contained in *Comprehensive Health Planning and Public Health Services Amendments of 1966, Hearings before the House Committee on Interstate and Foreign Commerce on H.R. 13197, H.R. 18231, H.R. 18232, S. 3008.* 89th Cong., 2nd sess., 1966, pp. 2-30.
[45]*Congressional Quarterly Weekly Report* "Health Services," October 7, 1966, p. 2406.
[46]House Committee on Interstate and Foreign Commerce, *Comprehensive Health Planning and Public Health Services Amendments of 1966, Hearings*, pp. 30-54.
[47]*Ibid.*, p. 49.
[48]*Ibid.*, p. 49.
[49]*Ibid.*, pp. 56; 93-94; 113.
[50]"State Health Services," *CQ Almanac, 1966*, (Washington, D.C.: Congressional Quarterly Service, 1966), pp. 322-25.
[51]The bulk of the hearings dealt with a controversial proposal for Federal licensing of medical laboratories doing business across state lines, rather than the matters commonly identified with the *Partnership for Health Act.*
[52]U.S., Congress, House, Committee on Interstate and Foreign Commerce, *Partnership for Health Amendments of 1967, Hearings before the House Committee on Interstate and Foreign Commerce on H.R. 6418*, 90th Cong., 1st sess., 1967, p. 17.
[53]*Ibid.*, pp. 73; 96-105.
[54]U.S., Congress, House, Committee on Interstate and Foreign Commerce, *Partnership for Health Amendments of 1967, Report with minority views to accompany H.R. 6418*, 90th Cong., 1st sess., 1967, p. 2.
[55]House Committee on Interstate and Foreign Commerce, *Partnership for Health Amendments of 1967, Hearings*, pp. 32-33; 170.
[56]House Committee on Interstate and Foreign Commerce, *Partnership for Health Amendments of 1967, Report*, p. 15.
[57]U.S., Congress, Senate, Committee on Labor and Public Welfare, *Partnership for Health Amendments of 1967, Report together with individual views to accompany H.R. 6418*, 90th Cong., 1st sess., 1967, pp. 5-6, 36. For hearings see U.S., Congress, Senate, Committee on Labor and Public Welfare, *Partnership for Health Amendments of 1967, Hearings before the Subcommittee on Health of the Committee on Labor and Public Welfare on S. 1131 and H.R. 8418*, 90th Cong., 1st sess., 1967.
[58]*Ibid.*, pp. 35-36.
[59]*CQ Almanac, 1967*, "Partnership for Health Bill Includes Rat Control Funds" (Washington, D.C.: Congressional Quarterly Services, 1967), p. 445.

[60]"Grants and Services to States," *U.S. Code*, Vol. 42, sec. 246 (1973).

[61]*CQ Almanac*, 1970, "Medical Programs Extension" (Washington, D.C.: Congressional Quarterly Services, 1970), p. 598.

[62]House Interstate and Foreign Commerce Committee, *Partnership for Health Amendments of 1967, Report*, p. 14.

[63]Public Law 93-45, Title I, sec. 106, June 18, 1973, 87 Stat. 92.

[64]This was in keeping with other proposals for program consolidations, and the Administration's position generally opposing categorical grant aid.

[65]H.R. 14214, as contained in U.S., Congress, House, Committee on Interstate and Foreign Commerce, *Health Revenue Sharing and Health Services Act of 1974, Report together with minority and additional views*, 93rd Cong., 2nd sess., 1974 (House Report No. 93-1161), pp. 114-118.

[66]*Ibid.*, p. 69.

[67]*Ibid.*, p. 68.

[68]*Ibid.*, pp. 66, 68.

[69]This last program was directed at health services provided in nursing homes, through Medicare; in contrast, the original home health program was concerned with care provided in the patient's own home.

[70]U.S., Congress, Senate, Committee on Labor and Public Welfare, *Health Services Act of 1974, Report to accompany S. 3280*, 93rd Cong., 2nd sess., 1974, p. 58.

[71]U.S., President, Memorandum of Disapproval, *Disapproval of the Health Revenue Sharing and Health Services Act of 1974*, December 23, 1974.

[72]U.S., Congress, House, Committee on Interstate and Foreign Commerce, *Health Services Programs, Hearing before the Subcommittee on Health and the Environment on H.R. 2954 and H.R. 2955*, 94th Cong., 1st sess., February 19, 1975, pp. 143-4.

[73]*Ibid.*, p. 145.

[74]*Ibid.*, pp. 185-6.

[75]*Ibid.*, p. 217; the National Association of Counties letter is on pp. 277-8 of the hearing record.

[76]U.S., Congress, House, Committee on Interstate and Foreign Commerce, *Health Revenue Sharing and Health Services Act of 1975: Report, together with separate, additional and minority views, to accompany H.R. 4925*, 94th Cong., 1st sess., May 7, 1975, pp. 17-22.

[77]*Ibid.*, pp. 1-2. Section 1524 refers to P.L. 93-641, the new health planning legislation enacted in 1974.

[78]The Report on this bill was not filed until March 6, 1975. See U.S., Congress, Senate, Committee on Labor and Public Welfare, *Nurse Training and Health Revenue Sharing and Health Services Act of 1975, Report to accompany S. 66*, 94th Cong., 1st sess., March 1975 (Senate Report No. 94-29), pp. 3-12; 45-49; and 145-148.

[79]U.S. Congress, House, Committee of Conference, *Health Services and Nurse Training, Conference Report to accompany S. 66*, 94th Cong., 1st sess., July 11, 1975 (House Report No. 94-3485), pp. 1-4; 71-75.

[80]U.S. Congress, Senate, *Message From the President of the United States, Vetoing S. 66*, 94th Cong., 1st sess., July 26, 1975, (Senate Document No. 94-82), pp. 111-4.

[81]*Congressional Quarterly Weekly Report*, "Congress Overrides Health Services Veto " (August 2, 1975), p. 1668.

[82]This point is stressed in Robins, 1974, pp. 161-174.

[83]*U.S. Code*, Vol. 42, sec. 246, 1970 edition.

[84]See Lawrence E. Susskind, *Decision-Making and Resource Allocation in State Government: A New Perspective on Revenue Sharing and Block Grants*, Ph.D. Dissertation, M.I.T., February, 1973 (publication forthcoming). This study provides a critical assessment of the 314(d) and Law Enforcement Assistance Administration block grants in Massachusetts.

[85]This view is shared by Robins, 1974, p. 124. At the same time, some states subsequently set up pass-through project grant programs – in part as a response to their reading of this provision.

[86]See Leonard Robbins, "The Impact of Decategorizing Federal Programs: Before and After 314(d)," Doctorial Dissertation, University of Minnesota, 1974, esp. pp. 161-179.

Federal Administration

In all Federal grants, the link between the legislative design of the program and its state and/or local implementation is provided by Federal agency administration. The character of this link is of paramount importance to the ultimate performance of any grant program; in the case of block grants, the Federal administrative role in program execution is particularly delicate and crucial. This chapter traces HEW administration of the 314(d) block grant and attempts to identify the forces which shaped the department's style of administration. The environment, organizational location, and staffing of the program are considered first, followed by analysis of the content and tone of Federal administration in the block grant.

The intent here is not to judge the adequacy of HEW program management but to extract lessons from this program – the first major grant consolidation – which can illuminate some fundamental features of block grant administration. These lessons are of basic significance when considering the proper scope and application of the block grant funding mechanism. They, after all, along with the counterpart lessons derived from examining state block grant administration, are the primary foci of this section of the report. Throughout, then, the emphasis will be on the fundamental block grant issue – the balance struck between recipient flexibility and responsiveness to national priorities.

FEDERAL ORGANIZATION AND STAFFING

Administrative theory contends that the organizational placement of a given responsibility, and the

backgrounds and interests of the persons charged with the responsibility, will have an important bearing on the manner in which the responsibility is carried out. Accordingly, a description of the locus and environment, within HEW, of responsibility for administering the 314(d) block grant precedes discussion of the exercise of that responsibility.

Currently, the public health portion (85%) of the 314(d) program is administered in the HEW central office by the Bureau of Community Health Services, an organization whose other duties include the operation of formula and project grant programs directed at particular health problems or client groups, such as maternal and child health, family planning, and migrant health. Of this bureau's total FY 1975 budget authority – $726 million – the 314(d) program constituted approximately 12 percent. The entire Bureau of Community Health Services is one component of the Health Services Administration, in which responsibility for most public health services programs is lodged. The Health Services Administration, in turn, joins with five other agencies concerned with mental health and drug and alcohol abuse (Alcohol, Drug Abuse and Mental Health Administration), health planning and resources development (Health Resources Administration), health and medical research (National Institutes of Health), direct Federal provision of preventive health services (Center for Disease Control), and regulatory activities (Food and Drug Administration), to constitute the purview of HEW's assistant secretary for health. This larger organizational entity encompasses most of HEW's major health grant programs. Yet, the department's two largest health programs – Medicare and Medicaid – are administered by still other agencies within HEW.[1] Thus, administrative responsibility for the 314(d) program is placed many layers down from the top of the HEW hierarchy, as is the case for most other grant programs.

The mental health portion of the 314(d) block grant is administered by the National Institute of Mental Health, within HEW's Alcohol, Drug Abuse, and Mental Health Administration. This split responsibility was not so pronounced in the initial years of the *Partnership for Health Act*, when a predecessor agency (the Health Services and Mental Health Administration) encompassed all five major portions of the act. Even then, however, mental health program specialists handled the mental health part of the block grant. Within HEW, the mental health portion of the block grant is administered much like any other categorical formula grant program. For this reason, this chapter deals almost exclusively with the public health services component of the block grant.

Central office responsibilities for the 314(d) program are largely limited to preparation of program regulations and issuance of program policy and guidance material. Within the Bureau of Community Health Services, one person is assigned part-time to the program for these purposes. Day-to-day program administration is decentralized to health staff in the ten HEW regional offices. Manpower allocated to the 314(d) program varies slightly from region to region, but common practice is for two persons in each regional office to spend a portion of their time on the block grant, one for programmatic concerns and one for financial management matters. Typically, these persons will have several other responsibilities of at least comparable importance to the 314(d) block grant. Regional office staffing guidance material suggests that each region assign one-half man-year to this program annually; even this level, it should be noted, would represent an increase in staff allocated to the program in many regions. As will be discussed later, some regions experienced a period of several years during which no one was assigned programmatic responsibility for the 314(d) block grant.

This study has not developed detailed information on the backgrounds of HEW staff assigned to the 314(d) program. Some general observations in this regard can be made, nonetheless. At the time of the consolidation in 1966, staff for implementing the new programs, including the block grant, were drawn mainly from the prior categorical programs folded into 314(d) or from other categorical health programs, supplemented naturally by new employees.[2] This was true in both the central and regional HEW offices. Through time, normal staff turnover increased the proportion of new employees assigned to 314(d); but it is still true that most 314(d) staff had experience in the administration of categorical health grant programs exclusively, and now divide their time between the block grant and other categorical health programs.[3] In nearly all cases, then, they work in an environment in which the categorical grant, with its different administrative implications, predominates. In short, the administration of a block grant is foreign to the traditional and dominant way of doing business for most of the 314(d) program administrators.

BASIC POLICY SHIFTS

The policy environment within which the 314(d) block grant has been administered is also important to note. In the first few years of the program's history, the departmental posture was to request significant funding increases for the block grant. These requests were accepted by the Bureau of the Budget, and incorporated

into the Administration's budgets.[4] Administration support for the program declined during the 1969-73 period, however, both within HEW and in the Office of Management and Budget (OMB), as reflected in its acquiescence in the relatively stable funding levels established by Congress. Advocacy for the program reached its nadir during 1974 and 1975, when the Administration proposed termination of the 314(d) block grant. It is significant that the 314(d) program had not been identified as a candidate for termination by OMB, but by the department itself, in response to OMB requests for suggestions regarding where funding reductions could be achieved. Within HEW, the nomination of the 314(d) program came from the Health Services Administration, and was accepted with no controversy by higher policy levels in HEW, and by OMB.

The Administration's legislative proposal for termination of the 314(d) block grant was accompanied by proposed recision of its budget authority for the last half of FY 1975.[5] Strenuous and sustained objections from state and local health officials succeeded in convincing the Administration to discontinue that approach; nevertheless, it continued to argue against extension of the 314(d) legislative authority. In brief, then, the program enjoyed initial vigorous support from top policy levels in HEW and from OMB, followed by years of passive support at best. Having described the environment within which the 314(d) block grant is administered at the Federal level, the content of administrative policy for this program may be examined.

FEDERAL EXECUTIVE POLICY TOWARD BLOCK GRANT ADMINISTRATION

This section deals with the style of Federal block grant administration exhibited in the 314(d) program. It will be argued that two distinct such styles were employed, one for the initial period of Federal adjustment to the new administrative problems posed by a block grant, and a second representing the pattern of administration adopted by HEW for the post-1970 period. In this section, an administrative style will be considered to be partly manifested in six key administrative activities: direct influence over state program content, as expressed in review and approval of 314(d) state plans; resolution of any disputes between state and Federal officials arising from this review or other Federal administrative activities; provision of technical assistance to state health agencies; program monitoring and enforcement of requirements for state program reporting; substantive program evaluation; and financial auditing of state and local programs. A style of administration also is reflected in the way statutory requirements are translated into program policy through regulations and guidelines. In many of these areas, it will be essential to distinguish between formal statements of policy and the informal policy implied in actual practice.

It should be noted at the outset that Federal 314(d) program administration is largely decentralized. Responsibility for the administrative activities mentioned above is lodged in HEW regional offices. Development of broad program policy, through the issuance of regulations and guidelines, is a central office responsibility, as is program evaluation. Resolution of state-Federal disputes involves both central and regional staff. Central office responsibilities are discussed first.

Central Office Policy Development

In the development of program regulations and guidelines, three major interpretive tasks confronted Federal administrators during the course of the program. One such task concerned the extent of local agency involvement in the basically state-run program. The initial legislation mandated that 314(d) funds be used to "make a significant contribution toward providing and strengthening public health services" in localities, and that they be made available to other agencies to secure "maximum participation" of local agencies and groups. Program regulations and guidelines followed the Congressional example and failed to clearly define what would constitute a significant contribution toward strengthening local health services or achievement of maximum local participation. The only guidance regarding the strengthening of local health services was that this would be measured by the extent to which all areas of the state would be served, and by expansion or reorganization of existing services and development of new services.[6] This call for reprogramming and some innovation was counterbalanced, however, by statements that decategorization "in no way implies that the activities previously supported by such grants should be discontinued or de-emphasized."[7] Yet, the following paragraph relays the expectation that new and different methods of service provision would be funded where innovation was needed. A state health official might have experienced some difficulty in determining what the Federal policy was with respect to innovation in, and the strengthening of, local health services under 314(d); though the level of funding, the strength of ongoing program advocates, and the cautionary reminder that such programs need not be discontinued tended to eliminate most doubt.

Statutory language regarding maximum local partici-

pation was given less amplification in the 314(d) guidelines, which merely echoed the requirement that funds be "made available" to local agencies and organizations. No target figure for such suballocations was suggested, nor were the methods by which such funds should be made available specified, except to say that, in decisions on suballocation, the state must consider whether the proposed services would be of high priority, high quality, and addressed to localities with the greatest need for such services.[8] When the 1967 amendments required that at least 70 percent of 314(d) funds be used for provision of services in communities, this requirement was interpreted as placing a limit on state administrative expenses rather than mandating allocations to local agencies for service provision; the guidelines were clear in stating that direct state expenditures for services, for training, and for disease prevention were acceptable for meeting the 70 percent restriction.[9] This broad interpretation was congruent with the legislative intent, as expressed in committee reports and described earlier in this report.[10]

A second important interpretive task concerned the integrity of the components of the *Partnership for Health Act*, in particular the relationship between the block grant and the state and areawide comprehensive health planning programs. The law required that block grant services be "in accordance" with any existing state comprehensive health plans. Program regulations and guidelines stipulated that this requirement was pertinent only if the state comprehensive plans specifically included recommendations for services under the 314(d) plan.[11] This interpretation did nothing to encourage close linkage between these portions of the *Partnership for Health Act*, as was envisioned by many of its Administration and Congressional supporters. On the other hand, the regulations and guidelines provided a mild stimulus for furthering the spirit of the law by requiring state agencies to "consider" any comments made by local comprehensive health planning (CHP) bodies in deciding among requests from local agencies for 314(d) funds.[12] Still, neither the states nor local applicants for 314(d) funds were actually required to make such applications available to areawide CHP agencies for review, nor was a specific time period for this or other reviews mentioned in the guidelines. The state agency was completely free to decide against the recommendation of the areawide CHP body, and was not required to notify that body of either its dispositions on local applications or the overall pattern of service provision supported by 314(d) funds in the CHP geographic area. On balance, the pattern of Federal program administration did little to spur a close linkage between the comprehensive planning and service delivery components of the *Partnership for Health Act*.

The final interpretive task discussed here entails clarification of the fundamental purpose of the consolidation – whether the block grant was intended to support basic state and local health services, or to further particular national programmatic priorities in health. Federal program officials received little guidance on this point from Congressional action, but could have attempted to communicate their interpretations of program purpose with a view to ameliorating this ambiguity. Alternatively, they could have recognized this inherent dilemma and indicated criteria which would be applied in particular instances to decide whether Federal control over, and accountability for, program content were of greater importance than recipient flexibility, thereby providing some guidance regarding where the limits, if any, to state and local flexibility under the block grant might lie.[13] Either course would have been difficult, given the statutory ambivalence on this matter. Federal program guidelines do not indicate a consistent approach to this issue. On one hand, the guidelines assert that the intent of the law is to provide states with flexibility in order to permit targeting of Federal funds on problems of greatest need and priority. They also stressed that recipient planning and evaluation should guide the use of these funds, and that new and innovative approaches to health services were expected under the block grant. On the other hand, the same document emphasized the continuing importance of existing services supported by the prior categorical health grants, and went beyond the statutory language in suggesting some types of service "encouraged" by the act, and in directing that state plans show that services "include special attention to the health needs of high-risk population groups in terms of age, economic status, geographic location, or other relevant factors."[14]

One last point on the matter of Federal interpretation of the block grant's legislative requirements involves the frequency with which such interpretations were revised and reissued. The legislative history shows a clear trend to recategorization over the years. While program regulations were issued and reissued at least four times, largely in response to substantive statutory amendments, interpretive guidelines have not been published since the initial 1968 program year. In addition, the 1970 legislation requirements for attention to alcohol and drug abuse problems within the block grant were not incorporated in revisions to the regulations until very late in 1972, an unusually long lapse in a fundamental administrative responsibility. Thus, formalized Federal

efforts to communicate to the states the evolving direction of the program were minimal, and were a source of complaints by both state and Federal regional office personnel. This record certainly reflects the low priority ascribed to the block grant within HEW in later years. Whether this low priority reflects Public Health Service frustration with an unfamiliar and ambivalent form of financial assistance – one which clearly suffered from decreasing Congressional support in comparison with categorical grants – is more difficult to determine, though some observers make this case persuasively.[15]

Day-to-Day Administrative Activities

Relatively distinct phases in Federal administration of the 314(d) block grant are more easily discerned in discrete day-to-day administrative activities than the broad process of interpreting program purpose and requirements. Toward that end, six major components of Federal administration were listed in the introduction to this section. Although sources of information regarding these components of Federal administrative practice in the 314(d) program are fragmentary and not plentiful, their findings are consistent and permit description of the Federal role with some confidence.

The first such activity considered here is evaluation. At least three different levels of evaluation are possible: assessment of the effectiveness of Federal and state or local program implementation; evaluation of the scope, content, accessibility, and efficiency of service provision under the program; and determination of the impact of those services in terms of ultimate program goals – in this case, the health of people served. In the 314(d) block grant, all three forms of evaluation are primarily central office responsibilities. Though one might expect that the switch from categorical to block grant administration would be marked by increased Federal emphasis on evaluation (plus auditing and technical assistance) as a means of influencing state and local programs and maintaining Federal accountability, very little evaluation of any kind has been conducted for the health services block grant; in fact, in the first seven years of program operation, only one evaluation had been performed.

This 1970 effort was a management-oriented evaluation directed at state program administration, performed under contract with an Atlanta-based consulting firm.[16] It focused on linkages between 314(d) resource allocation decisions and state and local comprehensive planning supported by sections 314(a) and (b) of the *Public Health Service Act*, and on how, procedurally, state agencies were responding to the mandate to provide special attention to the health needs of "high-risk populations," especially residents of "Model Cities" areas. The study was spurred by central office interest in increasing the use of PHS programs in support of Model Cities programs. It only tangentially addressed the nature of services supported by the block grant, and did not attempt to assess the impact of those services. The study does not appear to have been used to shape program policy.

In 1975, as uncertainty and controversy over the continued existence of the program peaked, a second evaluation was initiated by the Health Services Administration. This short-term study was to provide HEW with a capsule view of program operation in four states and four HEW regional offices, and is in progress.[17] No other management evaluations have been conducted by Federal central or regional offices, either directly or by contract. No HEW evaluations of 314(d) service delivery or of service impact have been conducted by any means.[18]

Although not strictly an evaluation, a major attempt to obtain information on state expenditure of 314(d) funds should be briefly mentioned here. Most HEW program legislation, including 314(d) permits expenditure of up to 1 percent of each program's funds for evaluation studies.[19] A portion of these funds has been used over the last four years to support the development of the Health Program Reporting System (HPRS). This project, receiving approximately $400,000 per year, is operated by the Association of State and Territorial Health Officials (ASTHO).[20] This effort was initiated by ASTHO because of its dissatisfaction with HEW's failure to develop a uniform program reporting system which could provide adequate responses to Congressional inquiries regarding the 314(d) and other programs. After an initial three years of exploration, the project was extensively evaluated and extensively revised. The first complete set of data from the revamped system was assembled in 1975. This is the only source of state-by-state fiscal data which not only reports on the 314(d) program, but also compared this funding source with other financial support for state health department and related programs.

In its early years, many state health officials complained about the extent of detail in the system and its lack of utility at the state level. There now is a growing consensus among state health officials as to its present and potential usefulness. An initial but limited probe indicates that problems remain in reconciling the system's data with that of individual state accounting systems.[21] The goal, however, is to have states report data consistent with what would be reported to their legislature or assembly. Since the HPRS has only begun

to yield results, it has not yet been used widely in formulation of Federal program policy. The data, however, were effectively used by ASTHO in communications to the Congress which supported the override of the President's veto of S. 66.

These three efforts are the totality of Federal Executive Branch evaluation efforts directed at the health services block grant, though the General Accounting Office is now conducting its first study of the program. Each is quite limited in scope and none has yet been used to affect program administration. While no objective data was obtained on evaluation practice under the prior categorical programs, regional staffs describe it as having been more extensive than the practice under 314(d).[22] It may be that evaluation of 314(d) is considered a state responsibility, as one source has suggested.[23] Yet, Federal officials have not insisted upon state-conducted evaluations of this program.

Closely related to evaluation is the performance of program audits. A quasi-independent agency within the department, the HEW Audit Agency, conducts program audits. These can be initiated by the audit agency itself, or by program officials; a recent innovation allows regional staff to suggest audits. The scope of these audits frequently extends beyond financial propriety to state and local program management and service delivery. Federal 314(d) administration has never been the subject of an audit agency review. Even though the program is in its ninth year of operation, very few state programs have been audited.[24] This is so despite the fact that the results of some audits do not suggest that the program was so well managed as to require little additional review. Regional office staff assigned to the 314(d) program are aware of the infrequency of audits and are critical of this practice. Some observers believe audits should be utilized more extensively under block grants than categorical,[25] but the perception of many Federal officials involved in this program is that the reverse has occurred.[26]

When considering regional office responsibilities, the Federal role in the preparation and review of 314(d) state plans must be assessed. In the pre-consolidation period, regional staff viewed the nine small formula grants as basically state entitlements, but nevertheless worked with the states in preparing the state plan for each program, and later reviewed these plans with the intention of exerting some Federal control over the content of state programs.[27] This pattern was continued in the initial years of block grant administration, with a handful of state plans challenged by regional officials prior to 1971. These officials sought to withhold block grant funds from the offending states until deficiencies in the plans were rectified. Each of these attempts was vetoed by the central office, which informed the regions that the states were entitled to these funds, and that payment could not be withheld. Up to this point, there had been no central direction to the regions on plan review; accordingly, regional review and reaction to state problems were not uniform.[28] Regional response to this policy was to give only perfunctory attention to program content during plan review, but several regions continued to work with their states in developing management-by-objective (MBO) systems to guide preparation and execution of the state plans.

Before these systems were fully operational, a central policy change deeply affected their implementation. The requirements for detailed state plans in all Public Health Service formula grant programs were reviewed as part of the Nixon Administration's Federal Assistance Review project. These reviews concluded that the 314(d) state plans were a burden on the states and were not utilized by Federal officials.[29] A recommendation that these detailed plans be replaced by a simple "pre-print" state plan document, containing only state assurances that a detailed plan had been prepared which met all applicable Federal requirements, was accepted by program administrators. The institution, by regulation,[30] of the Simplified State Plan Review System in 1972 caused the regions to discontinue their work with the states on MBO systems. Combined with the constant 314(d) appropriations after 1970 (while new categorical programs were legislated and expanded with the encouragement of HEW), the new system was the signal for regional staff to cultivate a profound disinterest in the program. Henceforth, attention paid to the block grant was sporadic, with several regions experiencing a period of years in which no one was assigned programmatic responsibility for 314(d). Regional staffs report only infrequent contact with the states regarding the plans; site visits to verify the "pre-print" certifications are often interspaced by years; and virtually no visits were conducted between 1972 and 1974.[31] It appears that 314(d) state plan preparation and review have become largely paper exercises.

The next activity reviewed is the provision of technical assistance to states or localities. There are two distinct ways such assistance is provided in the 314(d) program: the first is the familiar practice of consultation, advice and technical guidance by Federal regional staff; the second entails the long-term assignment of Federal personnel to a state or local health department with his salary paid from the state's allotment of 314(d) funds. The latter method was widespread in the prior categorical programs and seems not to have been

affected by the consolidation. The former practice, however, has changed under the block grant. As in the case of state plan review, the provision of this form of technical assistance initially continued the categorical pattern. With the decline of Federal attempts to substantively review state 314(d) programs after 1970, the provision of technical assistance was sharply reduced.[32] Whether this reduction was the result of diminishing Federal interest in the program or of a declining state demand in light of perfunctory Federal program review, is problematic.

Other activities exhibiting distinct phases are program monitoring and enforcement of reporting requirements. Monitoring *via* site visits to state or local health departments declined after 1970 and is now minimal,[33] as described in the above discussion of state plans. States are required to submit budgets and expenditure reports for 314(d), but the lack of common formats for these items undermines their usefulness. States are often very late in submitting these reports, and some have never been submitted. In such cases, regional staffs usually write to the states requesting the information, but seldom follow up to insure that the information is provided. Since the earlier unsuccessful attempts to force recalcitrant states to submit these materials, the regions have generally avoided confrontations over reporting requirements. Little attempt is made to verify the content of reports when submitted, though a recent review in three states found these were often inaccurate.[34] In short, all aspects of program monitoring appear to be treated more lightly under the block grant than under the prior categorical programs folded into 314(d), or under current, categorical, health, formula grant programs.[35]

The last activity under consideration is the resolution of disputes between the state and Federal program officials. Such disputes have been rare since the unsuccessful attempts to disapprove state plans, but a few have occurred. One example may illustrate current conflict resolution processes. In October 1974, one regional office believed a state was not complying with the 314(d) maintenance-of-effort requirement. The state was notified of this and was requested to explain whether expenditure of non-Federal funds under the 314(d) plan was actually lower than that of the preceding year. Four months later, no answer had been received from the state. No further action was taken by the region, and it would seem none is contemplated.[36] Apparently still gun-shy from the 1970 embarrassments, and believing they should not attempt to interfere with the state programs, the regions earnestly avoid conflicts with the states. When a problem arises that cannot be ignored, as above, the region will notify the state and request corrective action. If it is not forthcoming, the region will desist, since they believe the central office has informally instructed them to do so.

STATE PERCEPTIONS OF FEDERAL BLOCK GRANT ADMINISTRATION

The preceding description of Federal block grant administration draws from both objective evidence and the perceptions of Federal 314(d) officials about their work, as reported by previous studies. It is important to determine whether this picture of Federal administrative style is the same one seen by the states, in order to provide a balanced view of 314(d) administration. *Table 2* presents state perceptions of which elements of Federal administration have changed since the consolidation, and the direction of change. These responses indicate that the states perceive a very definite change in all components of Federal administration, a change which, at a national level, is uniformly in the direction of a less substantial Federal role.[37]

With respect to preparation of 314(d) state plans, six states report a greater Federal role now than before consolidation; 35 states report the reverse; and eight perceive no change. In what is perhaps the most sensitive area and the one in which the greatest post-consolidation adjustment had to occur, Federal review of state plans, six states report a stronger Federal role, 26 a diminished role, and 15 no change. In three other functions, the perception is overwhelmingly unidirectional. In monitoring, only one state perceives a stronger Federal role now, while 33 believe it has diminished, and 15 report no change. Only two states perceive a stronger role now in technical assistance, which is seen as decreasing by 32 states, and unchanged by 15. Three states find financial reporting requirements and enforcement more substantial now, while 28 report a lesser Federal role, and 18 no change. Evaluation shows the most dramatic change, with not a single state reporting a greater Federal role under the block grant; 32 perceiving a decline, and 16 no change. Auditing produces somewhat different responses; two states note a stronger role and 20 a lesser role, but fully 26 observe no change. This may be partially explained by the independence and organizational separateness of the HEW Audit Agency; whatever the reason, on this function state and Federal perspectives do not agree as closely as in other aspects of block grant administration.

As shown later in *Table 7, Reasons for Manner of State Administration*, only three states mentioned Federal suggestions as a factor in their handling of the

Table 2

State Perception of Changes in Federal Administrative Roles as a Result of Consolidation of Formula Grant Programs into the 314(d) Block Grant

Elements of Federal Administration[1]

States, by Federal Region	State Plan Preparation	Technical Assistance	State Plan Review	Program Monitoring	Evaluation	Financial Reporting	Auditing
REGION I							
Connecticut	+	–	+	0	0	0	0
Maine	–	0	0	–	–	0	0
Massachusetts	–	–	–	–	–	–	–
New Hampshire	+	–	+	–	–	0	0
Rhode Island	–	–	–	–	–	+	+
Vermont	0	0	0	0	0	0	0
REGION II							
New Jersey	–	0	–	–	–	0	0
New York	–	–	0	–	0	–	–
REGION III							
Delaware	–	–	–	–	–	–	–
Maryland	0	0	0	0	0	0	0
Pennsylvania	+	+	+	–	–	–	–
Virginia	0	0	0	0	0	0	0
West Virginia	–	–	–	–	–	–	–
REGION IV							
Alabama	–	–	0	+	0	+	–
Florida	–	–	–	–	–	–	0
Georgia	0	–	0	–	–	0	0
Kentucky	–	0	–	–	–	–	0
Mississippi	–	0	0	0	0	–	–
North Carolina	+	–	+	–	–	–	–
South Carolina	–	–	–	–	–	–	–
Tennessee	–	–	–	–	–	–	–
REGION V							
Illinois	–	–	2	0	2	0	2
Indiana	+	0	+	–	–	–	0
Michigan	–	–	–	–	–	–	0
Minnesota	–	–	–	–	–	–	0
Ohio	–	–	–	–	–	–	–
Wisconsin	–	–	–	–	–	–	–

Table 2 (Continued)

State Perception of Changes in Federal Administrative Roles as a Result of Consolidation of Formula Grant Programs into the 314(d) Block Grant

Elements of Federal Administration[1]

States, by Federal Region	State Plan Preparation	Technical Assistance	State Plan Review	Program Monitoring	Evaluation	Financial Reporting	Auditing
REGION VI							
Arkansas	0	0	0	0	0	0	0
Louisiana	–	–	–	–	–	–	0
New Mexico	–	–	2	–	–	–	–
Oklahoma	–	–	–	–	–	–	–
Texas	+	0	0	0	0	–	0
REGION VII							
Iowa	–	–	–	–	–	–	–
Kansas	–	0	0	0	0	–	0
Missouri	–	–	–	0	–	–	–
Nebraska	0	0	0	0	0	0	0
REGION VIII							
Colorado	–	–	–	–	–	–	–
Montana	–	–	+	–	–	–	–
North Dakota	–	–	–	–	–	+	+
South Dakota	3	3	3	3	3	3	3
Utah	–	–	0	0	0	0	0
Wyoming	–	–	–	–	–	0	0
REGION IX							
Arizona	0	0	0	0	0	0	0
California	–	0	0	–	–	0	0
Hawaii	–	–	–	–	–	–	–
Nevada	–	–	–	–	–	–	0
REGION X							
Alaska	–	+	–	–	0	0	0
Idaho	–	–	–	–	–	–	–
Oregon	0	0	–	0	0	0	0
Washington	–	–	–	0	0	0	0

KEY: + = greater Federal role
– = lesser Federal role
0 = no change in Federal role

[1] An "Other" category was included in the questionnaire, but no state so responded.
[2] Ambiguous response; not used in tabulations.
[3] Respondent did not know whether the Federal role had changed since 1967.

Source: ACIR compilation of state health department (or equivalent) responses to ACIR survey questionnaire of April 1975.

Table 3

State Reporting of Disputes with Federal Officials Regarding the 314(d) Block Grant

States, by Federal Region	Has a Dispute Ever Occurred?			Subject of Dispute	Was Resolution Fair?		
	Yes	No	Don't Know		Yes	No	Not Applicable
REGION I							
Connecticut		X					X
Maine		X					X
Massachusetts	X			Reporting requirements		X	
New Hampshire		X					X
Rhode Island		X					X
Vermont			X				X
REGION II							
New Jersey			X				X
New York	X			Fund allocation in transition period	X		
REGION III							
Delaware		X					X
Maryland		X					X
Pennsylvania		X					X
Virginia		X					X
West Virginia		X					X
REGION IV							
Alabama		X					X
Florida			X				X
Georgia		X					X
Kentucky		X					X
Mississippi		X					X
North Carolina			X				X
South Carolina		X					X
Tennessee		X					X
REGION V							
Illinois	X			Interpretation of 70 percent rule	X		
Indiana		X					X
Michigan	X			Local merit system requirement	X		
Minnesota		X					X

Table 3 (Continued)

State Reporting of Disputes with Federal Officials Regarding the 314(d) Block Grant

States, by Federal Region	Has a Dispute Ever Occurred?			Subject of Dispute	Was Resolution Fair?		
	Yes	No	Don't Know		Yes	No	Not Applicable
Ohio		X					X
Wisconsin		X					X
REGION VI							
Arkansas		X					X
Louisiana		X					X
New Mexico		X					X
Oklahoma		X					X
Texas	X			Federal pressure for innovation	X		
REGION VII							
Iowa		X					X
Kansas		X					X
Missouri		X					X
Nebraska		X					X
REGION VIII							
Colorado		X					X
Montana		X					X
North Dakota		X					X
South Dakota		X					X
Utah		X					X
Wyoming	X			Transfer of funds	Pending		
REGION IX							
Arizona		X					X
California			X				X
Hawaii		X					X
Nevada		X					X
REGION X							
Alaska		X					X
Idaho		X					X
Oregon		X					X
Washington	X			Planning and reporting procedures	X		

Source: ACIR compilation of state health department (or equivalent) responses to ACIR survey questionnaire of April 1975.

314(d) block grant; still, the maintenance of an audit trail was cited by 26 and ease of Federally required planning and reporting by 26, so some Federal requirements were factors in these decisions. Moreover, as *Table 9* will show, eight states said Federal officials were major actors in 314(d) allocation decisions, 17 said they were minor actors, and 19 reported no important role for Federal staff in this decision. These figures seem to suggest a stronger Federal role than those in *Table 2*, but they cover absolute answers pertaining to 314(d) only, while the latter show comparisons between the block grant and prior categorical programs. Hence, they are not necessarily contradictory. States view the Federal role as declining but still significant in many cases; and they are apparently more inclined to view the Federal role in this light than are Federal officials themselves. Lastly, *Table 3* indicates that only seven states reported ever having a dispute with Federal officials regarding 314(d). One such case is pending, but all except one of the earlier disputes were resolved to the satisfaction of the states.

In summary, Federal administration of the 314(d) block grant has been marked by a transitional period (roughly fiscal years 1968 to 1970) of uncertain adaptation to an unfamiliar grant mechanism, capped by unsuccessful attempts to retain a degree of Federal control over state programs. This was followed by slow adoption of the *laissez faire* attitude toward state administration and program content which characterizes the current Federal administrative style for 314(d). Manpower assignments to the program are very low, as is the current level of interest in the program on the part of most regional staff assigned to it. This declining administrative activity is generally matched by, and interrelated with, a lack of enthusiasm for the program, both by higher levels in the Executive Branch and by Congress at budget time. From their perspective, most states report a significant decline in Federal involvement in the program since the consolidation. One observer has suggested that certain functions – especially evaluation and auditing – ought to receive more emphasis under a block grant, while others should remain stable or decline in importance.[38] Yet, this clearly has not happened. The lack of a normative model for block grant administration has undoubtedly made the transition more difficult for Federal program officials,[39] though how much difference such a model would have made in the way this program evolved is hard to assess. In this context, it is interesting to note the absence of pronounced regional variation in the state perceptions highlighted in *Table 2*. Apparently, after initial unevenness stemming from insufficient formal communication of program policy, the regions coalesced around the informal policy of not "interfering" with the states and their 314(d) "entitlements."

Having examined the Federal response to block grant legislation, the report next considers the patterns of state block grant administration.

FOOTNOTES

[1]The Medicare program is administered by the Social Security Administration; the Medicaid program by the Social and Rehabilitation Service.

[2]This information was obtained in ACIR staff interviews with HEW officials currently responsible for 314(d).

[3]These assertions are based in part on preliminary findings of Janet Shickles, "Examination of the Use of Section 314(d) Funds by State and Local Agencies," draft report of HEW Contract No. SA-5994-75, July 1975.

[4]This and succeeding statements concerning the budgetary history of the 314(d) program are based on *U.S. Budget Appendices* for FY 1968 through 1976, and on interviews with budget personnel responsible for the program in HEW and OMB.

[5]U.S. Office of Management and Budget, *Appendix to the Budget of the U.S. Government, Fiscal Year 1976* (Washington, D.C.: U.S. Government Printing Office, 1975), pp. 380-381.

[6]U.S. Department of Health, Education and Welfare, Public Health Service, *Grants to States for Public Health Services, Section 314(d) of the Public Health Service Act, Regulations*, July 1, 1968, p. 3; and U.S. Department of Health, Education and Welfare, Public Health Service, *Grants to States for Public Health Services, Section 314(d) of the Public Health Service Act, Policy Statement*, July 1, 1968, p. 5.

[7]U.S. Department of Health, Education and Welfare, Public Health Service, *Grants to States . . . Policy Statement*, July 1, 1968, p. 2.

[8]*Ibid.*

[9]*Ibid.*, pp. 12-13.

[10]See the discussion of the objectives of the consolidation in *Chapter II*.

[11]U.S. Department of Health, Education and Welfare, Public Health Service, *Grants to States . . . Regulations*, 1968, p. 4; *Policy Statement*, 1968, p. 7.

[12]*Regulations*, 1968, p. 4; *Policy Statement*, 1968, pp. 5-6. Note that states were not required to approve any such requests.

[13]One observer, who forcefully argues the central importance of this choice, rejects the assumption of a continuing congruence of Federal and state interests in a grant program and believes this lack of congruence applies to the *Partnership for Health*

Act. See George Douglas Greenberg, "Decentralization Efforts at HEW," testimony prepared for U.S. Congress, House Committee on Government Operations, *New Federalism, Hearing before the Subcommittee on Intergovernmental Relations*, 93rd, Cong., 1st sess., January 1974.

[14]U.S. Department of Health, Education and Welfare, Public Health Service, *Grants to States . . . Policy Statement*, 1968, pp. 2, 7.

[15]See, for example, Greenberg, "Decentralization Efforts at HEW," pp. 326-7, 330; and Richard M. King, *An Analysis of the Development and Administration of Section 314(d) of the Public Health Service Act, As Amended*, M.S. Thesis, M.I.T., June 1973, pp. 25-28. This view is also supported in Shickles, 1975.

[16]Diversified Information Systems Corporation, *"Study of the Flexibility and Utilization of Formula Grants to States for Public Health Services Under Section 314(d) of the Public Health Service Act, Including Relationships With Comprehensive Health Planning Agencies,"* Public Health Service Contract No. HSM-110-70-404, 1971 (Mimeographed; available as NTIS report PB 213 249).

[17]A preliminary report of this study has been cited earlier; see Shickles, 1975.

[18]King, 1973, p. 35. This finding is supported by ongoing contract studies by the Health Services Administration and ACIR, and by a forthcoming GAO report; although two Federal regions (San Francisco and Denver) were not visited by these studies, there is no evidence to suggest evaluations were conducted in either region.

[19]Most of these funds have been used by higher levels in the HEW structure for studies not directly focused on the 314(d) program.

[20]This project is also mentioned in the discussion of 1975 legislative action, and is discussed at greater length in the section dealing with state block grant expenditures.

[21]The Health Services Administration probe in four states found that only two could completely reconcile the HPRS data with state accounting system data at this stage of the project. See Shickles, 1975, pp. V i-19.

[22]Preliminary version of the Health Services Administration 314(d) evaluation report, 1975; Shickles, 1975; and preliminary case study reports by the Research Group, Inc., under ACIR contract for field work in health block grant administration in six states and regional offices, 1975.

[23]Draft GAO report, *How States Plan For and Use Federal Grant Funds to Provide Public Health Services, Maternal and Child Health Services and Crippled Children's Services*, 1975, p. 62. This study examined the program in Indiana, Kentucky, and West Virginia.

[24]HEW Audit Agency staff report that their audit workplans have not proposed a study of the 314(d) program since 1970. While their filing procedures do not facilitate retrieval of audit reports on small programs such as 314(d), the staff further indicated that few audits have been performed on this program, and that the use of audits was more widespread under the prior categorical formula grants.

[25]Susskind, 1973, p. 412.

[26]Shickles, 1975, p. III-5; and comments of HEW Audit Agency staff.

[27]King, 1973, p. 19. Also see *Appendix C* for a description of how this pre-merger pattern of administration applied in six states.

[28]*Ibid.*, pp. 24-25; and Susskind, 1973, p. 354.

[29]Internal HEW memorandum, "Simplification of HEW Grant Programs" to the Associate Administrator of the Health Services and Mental Health Administration, from the Formula Grant Task Force, January 23, 1970.

[30]Federal Register, Subpart B – "Grants to States for Comprehensive Public Health Services," 37 FR 24667, November 18, 1972. The current version of the "pre-print" document itself is form PHS-5153-1, dated October 1973.

[31]Shickles, 1975, pp. III 7-16; and see the six case studies presented in *Appendix C*.

[32]King, 1973, pp. 19-25; Shickles, 1975; also refer to the case study reports presented in *Appendix C* for further confirmation of this generalization.

[33]Draft GAO report, 1975, p. 59; Shickles, 1975, pp. III 7-18.

[34]Draft GAO report, 1975, pp. 59-60.

[35]*Ibid.*

[36]Shickles, 1975, p. III-15.

[37]More modest change was reported by Robins, 1974, p. 124, based on a 1972 survey questionnaire; this contrast tends to support the generalization that the style of Federal administration changed after 1972.

[38]Susskind, 1973, p. 412.

[39]This point is stressed in King, 1973, pp. 50-51.

State Administration and Attitudes

This chapter describes the different ways states administer the public health portion of the 314(d) grant. The mental health funds within the block grant are generally not treated, since they are allotted separately to state mental health authorities, and are administered apart from the public health portion of the block grant in most states. An overview of the states' approach to the block grant is presented first. Next is a treatment of the state decision-making process as applied to the use of 314(d) funds. Discussion of the reality of block grant flexibility follows treatment of the role of local governments and the private sector in this program. After an analysis of state expenditures under the program, the chapter concludes with consideration of state attitudes toward this block grant.

OVERVIEW OF STATE ADMINISTRATION

At the beginning of each fiscal year, HEW's Health Services Administration notifies each state health and mental health authority of the amount of 314(d) funds available to it. The public health and mental health funds are separated for each state by HEW, with 15 percent automatically allotted to the mental health authority unless that would result in a lower allotment for mental health than occurred in fiscal year 1967, or unless state officials recommend a higher percentage for mental health.[1] In no case is the mental health allotment adjusted to less than 15 percent. This option has seldom been exercised, as *Table 4* shows. Consequently, the

Table 4

Percentage of 314(d) Funds Allocated to Mental Health, FY 1968-1975, in States Which Allocated More Than the Minimum 15 percent[1]

State	1968	1969	1970	1971	1972	1973	1974	1975
	Fiscal Year							
Arizona	23.8	17.9	17.3	–	–	–	–	–
Hawaii	20.4	17.8	16.1	16.6	–	–	–	–
Trust Territories	–	–	21.9	17.4	–	–	–	–
Utah	–	27.0	22.6	26.0	26.4	26.4	26.2	26.0
Vermont	–	18.8	–	–	–	–	–	–

[1] Percentages not shown are 15.0, the statutory minimum.

Source: 314(d) program staff, Bureau of Community Health Services, Health Services Administration, HEW.

Table 5

Organizational Placement of State Public Health Authorities

States	Health Agency Part of Consolidated Human Resources Agency or similar "Super Agency?"		Policy Guidance from State Health Board or Commission?		States	Health Agency Part of Consolidated Human Resources Agency or similar "Super Agency?"		Policy Guidance from State Health Board or Commission?	
	Yes	No	Yes	No		Yes	No	Yes	No
U.S. Totals	21	29	40	10					
Alabama		X	X		Montana		X	X	
Alaska		X	X		Nebraska		X	X	
Arizona		X		X	Nevada	X		X	
Arkansas		X	X		New Hampshire	X		X	
California	X			X	New Jersey		X	X	
Colorado					New Mexico	X		X	
Connecticut		X	X		New York		X	X	
Delaware	X		X		North Carolina	X		X	
Florida	X			X	North Dakota		X	X	
Georgia	X		X		Ohio		X	X	
Hawaii		X	X		Oklahoma		X	X	
Idaho	X		X		Oregon	X		X	
Illinois		X		X	Pennsylvania		X	X	
Indiana		X	X		Rhode Island		X		X
Iowa		X	X		South Carolina		X	X	
Kansas		X	X		South Dakota		X	X	
Kentucky	X			X	Tennessee		X	X	
Louisiana	X		X		Texas		X	X	
Maine	X			X	Utah	X		X	
Maryland		X		X	Vermont	X		X	
Massachusetts	X		X		Virginia		X	X	
Michigan		X		X	Washington	X		X	
Minnesota		X	X		West Virginia		X	X	
Mississippi		X	X		Wisconsin	X		X	
Missouri	X		X		Wyoming	X		X	

Source: ACIR compilation of state health department (or equivalent) response to ACIR survey questionnaire of April 1975.

Table 6

Manner of State Administration of the 314(d) Block Grant

States, by Federal Region	Federal and State Matching Funds Administered as a Discrete Program	Federal and State Matching Funds Identifiable, but Merged Operationally with Other Revenues	Federal and State Matching Funds Not Identifiable, but Merged Operationally with Other Revenues	Other
U.S. Totals	2	35	11	2
REGION I				
Connecticut		X		
Maine		X		
Massachusetts		X		
New Hampshire		X		
Rhode Island		X		
Vermont		X		
REGION II				
New Jersey		X		
New York		X		
REGION III				
Delaware		X		
Maryland			X	
Pennsylvania		X		
Virginia			X	
West Virginia		X		
REGION IV				
Alabama		X		
Florida		X		
Georgia	X			
Kentucky			X	
Mississippi		X		
North Carolina		X		
South Carolina		X		
Tennessee		X		
REGION V				
Illinois		X		
Indiana		X		
Michigan		X		
Minnesota		X		

Table 6 (Continued)

Manner of State Administration of the 314(d) Block Grant

States, by Federal Region	Federal and State Matching Funds Administered as a Discrete Program	Federal and State Matching Funds Identifiable, but Merged Operationally with Other Revenues	Federal and State Matching Funds Not Identifiable, but Merged Operationally with Other Revenues	Other
REGION VII				
Iowa		X		
Kansas		X		
Missouri		X		
Nebraska		X		
REGION VIII				
Colorado		X		
Montana		X		
North Dakota		X		
South Dakota		X		
Utah		X		
Wyoming			X	
REGION IX				
Arizona		X		
California			X	
Hawaii		X		
Nevada			X	
REGION X				
Alaska			X	
Idaho		X		
Oregon		X		
Washington				X[1]

[1] Federal funds identifiable, but state matching funds completely merged with other resources.

Source: ACIR compilation of state health department (or equivalent) responses to ACIR survey questionnaire of April 1975.

dominant practice is for 85 percent of the 314(d) funds to be awarded to state public health authorities.

Location of the public health authority within the state organizational structure varies, as *Table 5* indicates. In 20 states, the public health agency is part of a consolidated human resources department or a similar "super-agency." Of these, 16 receive policy guidance from a state health board or commission, and six have no such policy oversight. Of the 30 states in which the health department is an independent agency, 25 are provided policy guidance from state health boards or the like, and only five are not. Thus, the incidence of policy boards is greater in the independent agencies than within umbrella agencies. It is frequently claimed by the advocates of state human resources departments that such organizational structures facilitate policy and administrative coordination between their programmatic components, such as between public health and mental health, or between health generally and other human services agencies. From this perspective, it would be anticipated that the six states with such departments, but without special health policy boards (Alaska, California, Florida, Kentucky, Maine, and Wyoming), would find interprogram coordination an easier task. This study

did not develop data on coordination between health and other program areas, although it may be noted that the allocation of additional funds to mental health occurred somewhat less frequently in the human resource department-no policy board states than in the three other categories.[2] As will be shown later, organizational structure did not seem to affect state public health officials' reactions to the 15 percent mental health earmark.

The most striking fact about the way the public health portion of the 314(d) block grant is administered by these agencies is that the block grant ceases to be a "program" when it reaches the state, and becomes simply a source of funds.[3] *Table 6* presents state health department descriptions of how 314(d) funds are administered. Only two states (Georgia and Ohio) report that the block grant (and state matching funds) is administered as a discrete state program. In all other states, these funds are merged with other revenues in support of state or local health programs. Despite this operational merger of revenues, most states (35) report that the Federal 314(d) and state matching funds are identifiable within the programs they support. Two states indicate that Federal block grant funds remain identifiable but that state matching funds do not. Eleven states report that both Federal and state matching funds are completely intermingled with other revenues, and can be "identified" only by making pro rata estimates of the amounts involved in each program or activity. There are no sharp regional differences in the approaches taken by the states, except that four of the five states in Federal Region VI, Dallas, adhere to the latter two approaches.

As would be expected from this finding, a second fundamental fact is that "314(d) staffs" in the states are generally reported as either non-existent or very small (one to three persons).[4] In the latter case, they are commonly financial management staff who handle, among other assignments, the receipt of Federal 314(d) funds and their allocation to state program accounts. The two seeming exceptions, those states reporting that 314(d) funds are administered as a discrete program, indicated that the question of manpower assigned to block grant administration was not applicable.[5] An observer who went into a state in search of the "314(d) program," then, would have a difficult time finding it, at least if he were expecting the sort of program identification found in the central office of large Federal grant programs.

States decided to administer these funds in the manner described above for a wide variety of reasons, as *Table 7* attests. Some of these reasons would apply as strongly to Federal categorical grants or state funds as to 314(d); several are specific to this program as it has developed since 1968; and one relates directly to the block grant mechanism itself. The reason most frequently mentioned is one peculiar to block grants: 35 states cited the broad scope of the program as one of the primary reasons for their decision on the manner of administration. Maintenance of an audit trail and ease of meeting Federal reporting and planning requirements each were mentioned by 26 states. Ease of financial management was cited by 24 states. These three answers show that administrative convenience was of great importance in this decision. Only 11 states failed to cite at least one of these factors, suggesting that the block grant enabled most states to employ relatively non-burdensome modes of grant administration.

Twenty-one states reported that the number and restrictiveness of other Federal health grants was a factor in their decision, thus indicating that Federal grants are interrelated in their impact on recipient administration, as well as on expenditure patterns. Apparently, the size of the block grant had a relatively minor influence, since only 12 states offered this as an important factor. This is admittedly an ambiguous response, since it is not known whether it was the absolute or relative size of the grant that was deemed significant, and whether states considered the size of the grant to be large or small. Yet, this grant constitutes a fairly constant percentage of health department revenues,[6] so the variation in state responses suggests it is the absolute size of the grant that matters. In addition, most of these 12 responses were from states whose 314(d) award was relatively small.

The degree of certainty attached to the 314(d) funds was not a frequent response. Nearly as many states consider the funds uncertain as certain. As mentioned earlier, only three states reported that Federal suggestions were important in their decision. The fact that two of these were within one Federal region may reflect the lack of uniformity in early Federal block grant administration described in the preceding section. Several other reasons for their handling of the block grant were given by a few states. These will not be discussed except for the following observations. Only one of the Federal restrictions on the use of block grant funds was mentioned as influencing the manner of state administration; this was the requirement that at least 70 percent of the funds be expended for services in communities, cited by four states. Six states mentioned retention of the administrative system used for categorical grants, or the need to continue support for expiring categorical programs.

The above outlines a picture of state administration

Table 7

Reasons for Manner of State Administration of 314(d) Block Grant

States, by Federal Region	Ease of Financial Management	Maintenance of Clear Audit Trial	Ease of Federally-Required Reporting or State Plan Preparation	Suggestion of Federal Program Officials	Size 314(d) Grant Award	Certainty of 314(d) Grant	Uncertainty of 314(d) Grant	Broad Scope of 314(d) Grant	Number and Restrictive-ness of Other Federal Health Grants	Other	Unknown
U.S. Totals	24	26	26	3	12	7	5	35	21	15	1
REGION I											
Connecticut	X				X			X		X[2]	
Maine						X		X	X		
Massachusetts										X[3]	
New Hampshire		X	X	X							
Rhode Island	X		X					X		X[4]	
Vermont											X
REGION II											
New Jersey		X	X					X	X		
New York			X			X		X	X		
REGION III											
Delaware		X				X		X			
Maryland	X	X			X			X	X		
Pennsylvania										X[5]	
Virginia	X							X	X	X[6]	
West Virginia					X		X	X	X		
REGION IV											
Alabama			X		X		X		X	X[1]	
Florida	X	X	X					X	X		
Georgia	X	X	X					X			
Kentucky	X		X		X			X			
Mississippi	X	X	X					X			
North Carolina	X	X	X					X	X		
South Carolina		X	X								
Tennessee	X	X	X								
REGION V											
Illinois	X	X	X		X	X		X			
Indiana		X	X	X							

States, by Federal Region	Ease of Financial Management	Maintenance of Clear Audit Trial	Ease of Federally-Required Reporting or State Plan Preparation	Suggestion of Federal Program Officials	Size 314(d) Grant Award	Certainty of 314(d) Grant	Uncertainty of 314(d) Grant	Broad Scope of 314(d) Grant	Number and Restrictive-ness of Other Federal Health Grants	Other	Unknown
Michigan	X	X	X		X		X	X		X[3]	
Minnesota								X	X	X[4]	
Ohio		X	X	X				X			
Wisconsin					X			X	X		
REGION VI											
Arkansas	X		X					X			
Louisiana	X				X			X	X	X[1]	
New Mexico			X			X		X	X		
Oklahoma	X	X	X					X			
Texas		X	X						X	X[3]	
REGION VII											
Iowa								X		X[3]	
Kansas	X	X				X		X	X		
Missouri		X								X[1]	
Nebraska	X	X						X			
REGION VIII											
Colorado							X				
Montana								X			
North Dakota		X				X		X			
South Dakota		X						X	X		
Utah	X	X	X					X	X	X[1]	
Wyoming								X	X		
REGION IX											
Arizona	X	X					X	X			
California	X	X	X					X	X	X[6]	
Hawaii								X	X	X[2,7]	
Nevada	X		X		X						
REGION X											
Alaska					X						
Idaho	X		X		X			X			
Oregon	X	X	X								
Washington	X	X	X					X	X		

[1] Comply with "70 percent rule."
[2] Replace expiring categorical program.
[3] Retain system used in prior categorical grants.
[4] Meet health service needs, or fill gaps in service.
[5] Comply with state accounting policy.
[6] Permit state-local development of priorities.
[7] Comply with state appropriations requirements.

Source: ACIR compilation of state health department (or equivalent) responses to ACIR survey questionnaire of April 1975.

of 314(d) block grant funds, in which they are considered chiefly as another revenue source, yet as a source with some special characteristics. This view also is supported by the extent to which states claim that these funds play a unique role in their total health programs, distinct from that of categorical grants. Thirty-seven states so reported, while 12 stated that the block grant funds did not serve a different purpose than categorical grants do.[7] The most frequently cited examples of this unique role are: that use of these funds is governed by state and local priorities, not Federal priorities (16 states); that these funds support broad service provision, especially local health services (13 states, of which one stated that these funds are the sole support of local health services, and five that they support the essentials of local services); and that their flexibility permits program changes as new problems emerge and others decline (seven states). Four states cited variations of across-the-board program costs or supportive services, such as laboratories, as being more easily funded under the block grant; two mentioned program experimentation; five indicated that block grant funds are used to fill particular gaps in the services supported by categorical grants; one state cited the availability of scarce technical assistance in particular health disciplines; and one referred to discretionary funds at the disposal of the state health officer. This description of the role of the block grant in state health programs matches the intent of section 314(d), in its emphases on flexibility, on expenditures based on recipient priorities, and on support of non-categorical service provision.

STATE DECISION MAKING FOR BLOCK GRANT FUNDS

As the preceding section implies, the concept of a formalized planning process is inapplicable to the way most states handle 314(d) block grant funds. While states may have a planning system for health department activities in their entirety, the 314(d) grant relates to this process only as one of many revenue sources covered, and not as the subject of a primary or even a subsidiary planning process. Yet, the decisions made regarding allocation of 314(d) funds, whether within a formal planning system or not, are the proper focus of inquiry to determine how state health departments approach the use of these resources, and the opportunities which exist for affecting these decisions by other public and private interests in the state.

One fundamental question affecting the ability of all parts of state government and other interested parties to become aware of, and to influence, health department use of the block grant is whether this grant is subject to the budget process in each state. A common apprehension about the effects of Federal grants on the vitality of general purpose governments is the frequency with which grants either bypass such governments entirely or operate outside the regular budgetary process of recipient jurisdictions. However, responses of state health officials to a recent ACIR survey, compiled in *Table 8*, indicate that such concern is generally not warranted for this block grant. Fully 43 states responded that the 314(d) grant is included in the regular state budget process (with only executive or legislative action applying in five of these), and only six states replied to the contrary.

Another basic issue is whether the pattern of block grant review within the state budget process is different from that for categorical health grants. The same table shows that comparable treatment is generally afforded both types of grants, with 39 states indicating that all other Federal health grants also go through at least part of the regular budget process. In 34 of these, both executive and legislative branch action are involved in the review process. Each state which responded that the block grant did not go through this process indicated that this was true of all categorical health grants as well. In three states, the block grant is included in the budget process, but some categorical health grants are not. These omissions, it should be noted, include new categorical grants in states with biennial budgets, where such grants are acted on by the executive branch only until the next legislative review. In one state, the block grant is apparently the only Federal health grant to go through the budget process. Overall then, the block grant is somewhat more often included in the state budget process than are the categoricals.

A critical component of the block grant rationale, which figured prominently in the 314(d) program's legislative history, is that broad purpose grants permit determination by states and localities of program priorities, which then can be more reflective of varying patterns of need than is the case with categorical grants. It is, therefore, important to note whether such priority setting for block grant expenditures is explicitly pursued by the states, and how interests outside the state health department participate in determination of the use of block grant funds. With respect to the first concern, *Table 11* later in this chapter shows that 42 states attempt to priority rank health problems and allocate funds on that basis in preparing the required 314(d) state plan. Only seven states make no such attempt. One possible explanation of the latter practice is that the

Table 8

Application of the State Budget Process to 314(d) and Other Federal Grants

States	314(d) Grant Goes Through Regular State Budget Process				All Other Federal Health Grants Go Through Regular State Budget Process				
	Yes	Executive Branch Action Only	Legislative Action Only	No	Yes	Executive Branch Action Only	Legislative Action Only	No	Some Do, Others Do Not
U.S. Totals	38	4	1	6	34	4	1	7	3
Alabama				X				X	
Alaska	X				X				
Arizona	X				X				
Arkansas	X				X				
California	X				X				
Colorado	X				X				
Connecticut	X				X				
Delaware	X				X				
Florida	X				X				
Georgia	X								X
Hawaii	X								X
Idaho	X				X				
Illinois	X				X				
Indiana	X				X				
Iowa				X				X	
Kansas	X				X				
Kentucky		X				X			
Louisiana	X				X				
Maine				X				X	
Maryland	X				X				
Massachusetts				X				X	
Michigan	X				X				
Minnesota				X				X	
Mississippi[1]									
Missouri	X				X				
Montana	X				X				
Nebraska	X				X				
Nevada	X				X				
New Hampshire		X				X			
New Jersey		X				X			
New Mexico	X				X				
New York		X				X			
North Carolina	X				X				
North Dakota	X				X				
Ohio	X				X				

Table 8 (Continued)

Application of the State Budget Process to 314(d) and Other Federal Grants

States	314(d) Grant Goes Through Regular State Budget Process				All Other Federal Health Grants Go Through Regular State Budget Process				
	Yes	Executive Branch Action Only	Legislative Action Only	No	Yes	Executive Branch Action Only	Legislative Action Only	No	Some Do, Others Do Not
Oklahoma	X							X	
Oregon	X				X				
Pennsylvania	X				X				
Rhode Island	X				X				
South Carolina				X				X	
South Dakota	X				X				
Tennessee	X				X				
Texas			X				X		
Utah	X				X				
Vermont	X				X				
Virginia	X				X				
Washington	X				X				
West Virginia	X				X				
Wisconsin	X				X				
Wyoming	X								X

[1] State did not respond to this item.

Source: ACIR compilation of state health department (or equivalent) responses to ACIR survey questionnaire of April 1975.

314(d) program has never included large amounts of money unencumbered by ongoing state health services. Under these circumstances, some states may feel use of health priorities as a guide to 314(d) fund allocations is unfeasible.

With respect to external participation in decision making, state health department evaluations of the practical importance of selected interests in allocation decisions for 314(d) funds are given in *Table 9*. Most often mentioned as major participants in these decisions are the governor, the central budget office, appropriations committees of the state legislature, and local general governments. Fourteen states listed the central budget office as a major participant; eight cited it as a minor participant; and 21 indicated no important role for this office. Appropriations committees were considered major actors by 13 states, as minor participants by 14, and not important by 18 states. The governor's role was listed as major by 11 states, minor in 11, and unimportant in 24 states. These findings seem to indicate that, while the 314(d) grant does go through at least part of the regular budget process in 42 states, in some states this budget review is largely perfunctory. Fully 11 of these states list no important role in 314(d) allocation decisions for the three budget process participants in *Table 9*. Surprisingly, health committees of the state legislature generally appear to be uninvolved in the 314(d) grant.[8]

Local general purpose governments tended either to be major participants (12 states) or to have no important role (28 states). Only seven states indicated these governments exert a minor influence over 314(d) allocation decisions. Comparison with *Table 10* suggests that these units are important participants only where states suballocate a portion of the 314(d) grant to local organizations; their influence over state level expenditures, including those supporting direct state provision of services in communities, is apparently minimal.

Table 9 also indicates that comprehensive health planning (CHP) agencies are generally not major partic-

ipants in decisions on the use of 314(d) funds. State CHP agencies were mentioned as major participants by six states, as minor by 23, and as unimportant by 18. A similar pattern of relatively insignificant involvement by these agencies has been noted in previous studies.[9]

Areawide CHP bodies were listed as major actors by five states, as minor participants by 12, and as unimportant by 28 states. This trend also has been underscored in earlier studies.[10] For example, a 1971 study which included a sample of 17 areawide CHP agencies found that none of these agencies was familiar with the content of the 314(d) state plans.[11] While some improvement in the relationship of block grant expenditures to comprehensive health planning – one of the key concepts of the *Partnership for Health Act* – may have occurred in recent years, it appears that a strong linkage between these activities is still the exception rather than the rule. It should be noted, however, that new health planning legislation (P.L. 93-641, the *Health Planning and Resources Development Act of 1974*) mandates a much stronger role for comprehensive health planning bodies (now health systems agencies) in the operation of Federal health grants. Following this approach, the *Special Health Revenue Sharing Act of 1975* will transfer planning responsibilities for the 314(d) grant to state CHP agencies, or the agencies established under P.L. 93-641. These legislative actions are evidence that, thus far, the relationship between the block grant and comprehensive health planning has been a definite disappointment to proponents of the *Partnership for Health Act*.

The broader system of review and comment, by state and local "clearinghouses," on applications for certain Federal grants, established under *OMB Circular A-95*, shows a similar pattern. Only five states mentioned these clearinghouses as important participants in 314(d) allocation decisions, while 12 rated them as minor participants and 28 as having no real role. The remaining interests listed in *Table 9* also are viewed as not generally influential in block grant allocation decisions. In decreasing order of involvement, these are Federal program officials, citizen's groups, private non-profit health related organizations, and private health care providers.

The scenario which emerges from this cast of possible actors is one of very limited involvement by persons outside state health departments in state block grant allocation decisions. In fact, six states reported that no one outside the health department had an important role in these decisions, and another five states cited only one or two of the actors in *Table 9* as having any appreciable involvement. In many states, block grant funds are apparently allocated unilaterally, or nearly so, by the state health department. The importance of participation in these allocation decisions, however, is closely related to the opportunity for external involvement in other aspects of block grant administration. Such opportunities are the focus of the following section.

Local Government and Private Sector Roles in Block Grant Administration

The *Partnership for Health Act* clearly intended that local and regional public agencies and the private sector would be intimately involved in administration of the 314(d) block grant. The preceding section examined state block grant allocation decisions and concluded that, while in some states these actors are important participants, their involvement generally is not extensive. Another avenue for involving such organizations in the block grant, encouraged but not required by the act, is for a state to suballocate part or all of its 314(d) grant to local organizations. As *Table 10* shows, most states have made such suballocations to local or regional agencies. Ten states do not award block grant funds to local agencies, and presumably meet the 70 percent requirement in the act by directly providing community health services. This grouping includes all the very small states in which decentralized service provision makes little sense, as well as several larger, predominantly rural states. Thirty-seven states allocate part of their 314(d) grant to other agencies,[12] and three states indicate that their entire block grant award is suballocated to local or regional units. It should be noted that in two of these three states,[13] local health departments are staffed by state employees; hence, under these circumstances the state health department is not really relinquishing control over the funds.

The 40 states which make subawards to local or regional units differ widely in their methods. In 18 states, the awards are made on the basis of applications for particular projects or as contracts. Twelve states make awards by a formula, and nine states utilize a mixture of formula and project methods.[14] Although ten states impose no restrictions on the use or administration of these funds by recipients, 29 states attempt to place some controls on suballocations.[15]

These 29 states include 15 which rely on the project mechanism for suballocations, eight which use formula grants, and six employing a combination of both methods. Of the 15 using project awards, one state restricts recipient use of these funds to state-designated priorities and requires a particular mode of recipient administration; eight restrict use to state priority areas;

Table 9

Practical Importance of Selected Actors in State Decisions Regarding Allocation of the 314(d) Grant Award

States	Governor	Central Budget Office	State Legislature Appropriations Committees	State Legislature Health Committees	State[2] CHP Agency	Areawide[2] CHP Agencies	A-95[3] Clearing-house	Local General Governments	Private Health Care Providers	Private Non-Profit Health Related Organizations	Citizens' Groups	Federal Program Officials
Alabama	0	0	–	–	–	–	0	0	0	0	–	–
Alaska	+	+	+	0	–	0	–	0	0	0	–	–
Arizona	0	0	0	0	–	–	0	–	0	0	0	0
Arkansas	–	+	–	–	–	–	–	0	0	0	0	–
California					–	–		+		–		
Colorado	0	–	–	0	–	0	0	0	0	0	0	0
Connecticut	–	+	+	–	–	0	0	0	0	0	0	0
Delaware	+	+	+	+	+	0	0	0	0	0	+	0
Florida	0	0	0	0	0	0	0	0	0	0	0	0
Georgia												
Hawaii	+	+	+	+	+	0	0	0	0	–	–	+
Idaho	–	–	–	–	–	–						
Illinois	+	+	+	0	+	+	+	0	0	0	0	+
Indiana	–	0	0	0	–	0	0	–	0	–	–	–
Iowa	0	0	–	–	–	–	–	+	–	–	–	0
Kansas	–	–	–	–	–	–	–	+	–	–	–	–
Kentucky	0	0	0	0	0	0	0	0	0	0	0	0
Louisiana	0	0	0	–	0	0	0	0	0	0	0	–
Maine	–	–	0	0	–	0	0	0	–	+	0	0
Maryland	†	+	+	–	–	–	–	†	–	–	–	–
Massachusetts	0	0	0	0	0	0	0	0	0	0	0	–
Michigan	+	+	+	0	0	0	0	0	0	0	0	–
Minnesota	+	0	+	0	–	+	0	+	0	0	0	0
Mississippi	0	0	0	0	0	0	0	0	0	0	0	–
Missouri	0	0	–	0	–	+	0	+	–	–	–	–
Montana	0	0	0	0	–	0	0	0	0	0	0	0
Nebraska	–	–	–	–	–	–	–	–	0	–	–	–
Nevada	0	+	+	0	0		0	0	0	0		
New Hampshire	0	0	–	0	–	0	0	0	0	0	0	+
New Jersey	–	–	0	0	+	+	+	0	–	–	0	+

Table 9 (Continued)

Practical Importance of Selected Actors in State Decisions Regarding Allocation of the 314(d) Grant Award

	Governor	Central Budget Office	State Legislature Appropriations Committees	State Legislature Health Committees	State[2] CHP Agency	Areawide[2] CHP Agencies	A-95[3] Clearing-house	Local General Governments	Private Health Care Providers	Private Non-Profit Health Related Organizations	Federal Citizens' Groups	Federal Program Officials
New Mexico	0	0	0	–	0	0	0	+	0	0	0	0
New York	+	+	+	0	–	0	0	0	0	0	0	+
North Carolina	+	+	–	0	–	–	–	+	–	–	–	–
North Dakota	0	0	0	0	–	–	–	0	0	0	0	0
Ohio	0	0	0	0	+	+	+	+	0	–	+	+
Oklahoma	0	0	0	0	0	0	0	0	0	0	0	0
Oregon	+	+	+									
Pennsylvania	0	+	–	–	0	0	0	+	0	0	0	+
Rhode Island	0	–	0	0	–	N.A.	–	–	+	+	–	–
South Carolina	0	0	0	0	0	0	0	0	0	0	0	0
South Dakota	0	–	–	0	0	0	0	0	0	0	0	0
Tennessee	–	–	–	0	0	0	–	0	0	0	0	+
Texas	0	–	–	0	0	0	0	–	0	0	0	–
Utah	+			+				+				
Vermont	–	0	+	0	0	0	0	0	0	0	0	–
Virginia	0	+	0	0	+	0	0	+	0	0	0	0
Washington	0	0	0	0	0	0	0	–	0	0	0	–
West Virginia	–	+	+	–	–	0	+	–	0	0	–	–
Wisconsin	0	0	0	0	0	0	0	0	0	0	0	–
Wyoming	–	0	+	–	0	0	–	0	0	0	0	0

[1] Key: + = major role
– = minor role
0 = no important role
Blank space indicates no response on this item

[2] CHP refers to Comprehensive Health Planning bodies established in the *Partnership for Health Act.*

[3] A-95 refers to an Office of Management and Budget Circular requiring State and local clearinghouse review of applications for certain types of Federal grants.

Source: ACIR compilation of state health department (or equivalent) responses to ACIR survey questionnaire of April 1975.

Table 10

State Allocation of 314(d) Block Grant Funds to Local or Regional Agencies

States	Allocations to Local or Regional Units?			Primary Basis of Suballocation			Restrictions on Recipient Use or Administration			
	Yes, Entire Award Sub-allocated	Yes, Part of Award Sub-allocated	No Sub-allocations	Project Basis	Formula Basis	Part on Formula Part on Project Basis	None	Use Restricted to State-Desig-nated Priorities	Particular Mode of Ad-ministration Required	Other
U.S. Totals	3	37	10	18	12	9	10	13	7	13
Alabama	X					X	X			
Alaska		X		X				X		
Arizona		X		X						X[1]
Arkansas[4]		X								
California		X				X				X[2]
Colorado			X							
Connecticut		X		X					X	X[1]
Delaware			X							
Florida		X			X		X			
Georgia		X			X					X[2]
Hawaii			X							
Idaho		X				X	X			
Illinois		X		X				X		
Indiana		X		X						X[1]
Iowa		X				X		X	X	
Kansas		X		X				X	X	
Kentucky		X			X					X[2]
Louisiana		X				X				X[2]
Maine		X		X				X		
Maryland		X				X				X[2]
Massachusetts			X[3]							
Michigan		X			X				X	
Minnesota		X		X					X	
Mississippi		X				X	X			
Missouri		X		X				X		
Montana		X			X					X[2]

Table 10 (Continued)

State Allocation of 314(d) Block Grant Funds to Local or Regional Agencies

States	Allocations to Local or Regional Units?			Primary Basis of Suballocation			Restrictions on Recipient Use or Administration			
	Yes, Entire Award Sub-allocated	Yes, Part of Award Sub-allocated	No Sub-allocations	Project Basis	Formula Basis	Part on Formula Part on Project Basis	None	Use Restricted to State-Designated Priorities	Particular Mode of Administration Required	Other
Nebraska		X		X					X	
Nevada		X		X			X			
New Hampshire			X							
New Jersey		X		X				X		
New Mexico	X				X			X		
New York		X				X		X	X	
North Carolina		X		X				X		
North Dakota		X			X		X			
Ohio		X		X				X		
Oklahoma		X			X		X			
Oregon		X		X			X			
Pennsylvania		X			X			X		
Rhode Island			X							
South Carolina			X							
South Dakota		X		X				X		
Tennessee		X			X		X			
Texas		X		X						X[2]
Utah		X			X					X[2]
Vermont			X							
Virginia	X				X					X[1]
Washington		X				X				
West Virginia			X							X[2]
Wisconsin		X		X			X			
Wyoming			X							

[1] Use must comply with contract.
[2] Use must comply with approved plan and/or budget.
[3] Funds are in part used to support regional offices of the state health department.
[4] State did not respond on method of allocation.

Source: ACIR compilation of state health department (or equivalent) responses to ACIR survey questionnaire of April 1975.

Table 11

Extent to Which Preparation of 314(d) State Plans Attempts to Priority Rank Health Problems and Allocate Funds on That Basis

States	Priority Ranking in State Plan?		Similar Priority Ranking Required of Substate Fund Recipients?		
	Yes	No	Neither	Yes	No
U.S. Totals	42	7	15	15	19
Alabama	X				X
Alaska[4]					X
Arizona	X			X	
Arkansas	X		X[3]		
California		X		X	
Colorado	X		X[2]		
Connecticut		X	X		
Delaware	X		X[2]		
Florida	X				X
Georgia	X			X	
Hawaii	X		X[2]		
Idaho		X			X
Illinois	X			X	
Indiana	X				X
Iowa	X			X	
Kansas	X			X	
Kentucky		X		X	
Louisiana[5]	X				
Maine	X		X[3]		
Maryland	X		X[3]		
Massachusetts	X		X[3]		
Michigan		X			X
Minnesota	X				X
Mississippi	X			X	
Missouri	X				X
Montana	X				X
Nebraska	X		X[3]		
Nevada	X				X
New Hampshire	X		X[2]		
New Jersey	X			X	
New Mexico		X			X
New York	X			X	
North Carolina	X			X	
North Dakota	X				X
Ohio	X				X
Oklahoma	X				X
Oregon	X			X	

Table 11 (Continued)

Extent to Which Preparation of 314(d) State Plans Attempts to Priority Rank Health Problems and Allocate Funds on That Basis

State	Priority Ranking in State Plan?		Similar Priority Ranking Required of Substate Fund Recipients?		
	Yes	No	Neither	Yes	No
Pennsylvania	X			X	
Rhode Island	X		X[2]		
South Carolina		X[1]	X[2]		
South Dakota	X				X
Tennessee	X				X
Texas	X				X
Utah	X			X	
Vermont	X		X[2]		
Virginia	X			X	
Washington	X				X
West Virginia	X		X[2]		
Wisconsin	X				X
Wyoming	X		X[2]		

[1] State response indicates no 314(d) state plan exists.
[2] Not applicable because no 314(d) funds are suballocated to regional or local health agencies.
[3] Response difficult to analyze; perhaps best treated as "NO".
[4] State did not respond regarding priority setting in the state plan.
[5] No response regarding priority setting by recipients.

Source: ACIR compilation of state health department (or equivalent) responses to survey questionnaire of April 1975.

three require a particular mode of administration; and three states require only conformance to approved contracts, plans, or budgets (some states in the three former groupings also utilize such requirements, as *Table 10* shows). Two of the eight states employing formula based allocations restrict use to state priorities; one mandates a particular mode of administration; and the remaining five states only require conformance with approved contracts, plans, or budgets.

Of the six states utilizing both funding approaches, two stipulate the mode of administration and restrict use to state priorities; the remaining four require only conformance with state-approved contracts, plans, or budgets. In summary, nearly 80 percent of the states using the project mechanism restrict recipient discretion as to use or mode of administration, while 50 percent of the states relying on formula based allocations so restrict recipients, and 33 percent of the states using both mechanisms similarly limit recipient discretion.

The importance of this variation in state financial aid systems is that the same Federal funding mechanism can have many different implications for local recipient discretion. A Federal block grant may appear to some ultimate fund recipients as more restrictive than some categorical Federal grants, depending on the interaction between the Federal and specific state administrative systems. Other permutations of this relationship are also possible. Given the variety of state aid systems, it is not possible to predict with certainty whether that part of a Federal grant which passes through the states to localities will exhibit more or less flexibility at the local level than was intended by its national designers. At least this is so, unless an explicit attempt is made to minimize the effects of this variety through special provisions in

Table 12

State Health Officials' Perceptions of Changes in State-Local Relations Attributable to the Consolidation of Federal Formula Grants under the *Partnership for Health Act*

States	Relations Improved	Relations Deteriorated	No Change Attributable to the Con-solidation	Don't Know
U.S. Totals	17	2	29	2
Alabama		X		
Alaska			X	
Arizona	X			
Arkansas			X	
California	X			
Colorado			X	
Connecticut			X	
Delaware			X	
Florida			X	
Georgia	X			
Hawaii			X	
Idaho			X	
Illinois	X			
Indiana	X			
Iowa	X			
Kansas	X			
Kentucky	X			
Louisiana			X	
Maine			X	
Maryland			X	
Massachusetts			X	
Michigan	X			
Minnesota	X			
Mississippi			X	
Missouri		X		
Montana	X			
Nebraska	X			
Nevada			X	
New Hampshire	X			
New Jersey			X	
New Mexico	X			
New York			X	
North Carolina			X	
North Dakota			X	
Ohio			X	

Table 12 (Continued)

State Health Officials' Perceptions of Changes in State-Local Relations Attributable to the Consolidation of Federal Formula Grants under the *Partnership for Health Act*

States	Relations Improved	Relations Deteriorated	No Change Attributable to the Consolidation	Don't Know
Oklahoma			X	
Oregon	X			
Pennsylvania			X	
Rhode Island	X			
South Carolina			X	
South Dakota				X
Tennessee			X	
Texas				X
Utah	X			
Vermont			X	
Virginia			X	
Washington			X	
West Virginia			X	
Wisconsin			X	
Wyoming			X	

Source: ACIR compilation of state health department (or equivalent) responses to survey questionnaire of April 1975.

Federal grant requirements. This kind of specificity, however, may not be appropriate in grants intended to increase state level flexibility as well, such as the 314(d) block grant. In such instances, then, one is faced with an administrative dilemma.

Closely related to the kinds of restrictions on local flexibility discussed above is the extent to which states require fund recipients to priority rank health problems as a condition of such allocations. As was noted earlier, *Table 11* illustrates that 42 states, in preparing 314(d) state plans, attempt to priority rank health problems and allocate funds on that basis.[16] For the 40 states which allocated block grant funds to local agencies, a comparison with *Table 10* is possible. It shows 14 states which establish priorities in preparation of their state plans, also require fund recipients to determine health priorities, while 20 of these states do not. Of the six states which award 314(d) funds to localities and do not set health priorities, two require recipients to priority rank health problems and four do not. There is, therefore, considerable variation in the extent to which priorities for block grant funds are set by the state (28 states), by local recipients (two states), jointly by states and local recipients (13 states), or perhaps not at all (seven states).

In light of such extensive interstate variation, it is very difficult to determine the net impact of the block grant on state-local relations. One subjective assessment, from the perspective of state health officials, is contained in *Table 12*. Significantly, most state health officials (29) do not perceive any real change, due to block grant funding, on relations between their agencies and local governments, after eight years of the program's operation. Of at least equal interest, however, is the overwhelmingly favorable assessment of the block grant's impact by 17 of the 19 officials who do perceive

Table 13

State Health Officials' Assessment of the Role of the Private Sector in the Operation of the 314(d) Block Grant

States	Private Health Providers			Role of Private Non-Profit Health Related Organization			Private Sector Role in the Block Grant, as Compared to Prior Categorical Health Grants			
	Major	Minor	None	Major	Minor	None	Greater Role	Lesser Role	No Change	Don't Know
U.S. Totals	2	11	36	2	18	30	6	10	29	5
Alabama		X			X			X		
Alaska			X			X				X
Arizona			X			X			X	
Arkansas			X			X			X	
California			X		X		X			
Colorado			X			X		X		
Connecticut			X			X		X		
Delaware			X			X			X	
Florida			X			X			X	
Georgia		X			X					X
Hawaii			X			X		X		
Idaho			X			X			X	
Illinois			X			X			X	
Indiana		X			X				X	
Iowa		X			X				X	
Kansas		X			X			X		
Kentucky			X			X			X	
Louisiana			X			X		X		
Maine	X			X			X			
Maryland		X			X				X	
Massachusetts										
Michigan			X			X			X	
Minnesota			X			X		X		
Mississippi			X			X			X	
Missouri		X			X				X	
Montana			X			X		X		
Nebraska			X		X				X	
Nevada		Unknown			X		X			
New Hampshire			X			X			X	
New Jersey		X			X					X
New Mexico			X			X			X	
New York			X			X		X		
North Carolina		X			X		X			
North Dakota			X			X		X		

Table 13 (Continued)

State Health Officials' Assessment of the Role of the Private Sector in the Operation of the 314(d) Block Grant

States	Private Health Providers			Role of Private Non-Profit Health Related Organization			Private Sector Role in the Block Grant as Compared to Prior Categorical Health Grants			
	Major	Minor	None	Major	Minor	None	Greater Role	Lesser Role	No Change	Don't Know
Ohio			X		X				X	
Oklahoma			X			X			X	
Oregon			X			X			X	
Pennsylvania			X			X			X	
Rhode Island	X			X			X			
South Carolina			X			X			X	
South Dakota			X			X				X
Tennessee			X			X				X
Texas			X			X			X	
Utah			X		X				X	
Vermont			X		X				X	
Virginia		X			X				X	
Washington			X		X				X	
West Virginia			X			X			X	
Wisconsin			X			X			X	
Wyoming		X			X		X			

Source: ACIR compilation of state health department (or equivalent) responses to survey questionnaire of April 1975.

some effects as a result of the consolidation. Yet, the state health departments were a major force behind the initial consolidation and may be viewed as a biased group. At the same time, results of ACIR-supported case studies of block grant administration indicate that local governments also frequently share this favorable assessment.[17] While the available evidence regarding the impact of the block grant on state-local relations is far from definitive, there is at least little to suggest that significant harm has resulted.

An additional area of concern to block grant proponents was that the private sector should be more effectively integrated with public health activity. *Table 13* records state health officials' assessments of the private sector role in the 314(d) block grant. Private health providers generally are not regarded as important in the operation of the program. Only two states listed them as having major roles and 11 described them as having minor roles, while 36 states asserted that these institutions have no role in the program. Private non-profit health-related organizations are described as only slightly more important actors; two states rank their role as major, 18 as minor, and 30 as nil. When the involvement of these interests under the block grant is contrasted with their role in the prior categorical programs, a majority of states (29) reported no observable change. Of the 16 states indicating a change had occurred, six states reported an increased private sector role under the block grant, but ten cited a diminished role. This mixed record suggests that if the 314(d) experience in this respect is generalized to other block grants, the block grant mechanism is not necessarily an

Table 14

314(d) Program Requirements Judged by State Health Officials To Actually Constrain Recipient Flexibility Under the Program

States	None	70 Percent for Services in Community	15 Percent Mental Health Earmark	State Matching Requirement	Local Matching Requirement	Maintenance of Effort	Local Merit System Requirement	Other
U.S. Totals	23	14	16	6	5	6	10	2
Alabama		X				X	X	
Alaska		X					X	
Arizona	X							
Arkansas	X							
California		X					X	
Colorado			X					X[1]
Connecticut	X							
Delaware	X							
Florida				X				
Georgia			X					
Hawaii			X					X[1]
Idaho		X	X	X	X	X		
Illinois		X					X	
Indiana	X							
Iowa	X							
Kansas		X	X	X	X	X		
Kentucky	X							
Louisiana	X							
Maine[2]								
Maryland				X	X	X		
Massachusetts			X					
Michigan			X					
Minnesota		X	X				X	
Mississippi	X							
Missouri		X					X	
Montana		X	X		X		X	
Nebraska		X	X			X	X	
Nevada							X	
New Hampshire	X							
New Jersey	X							
New Mexico	X							

Table 14 (Continued)

314(d) Program Requirements Judged by State Health Officials to Actually Constrain Recipient Flexibility Under the Program

States	None	70 Percent for Services in Community	15 Percent Mental Health Earmark	State Matching Requirement	Local Matching Requirement	Maintenance of Effort	Local Merit System Requirement	Other
New York		X	X	X				
North Carolina		X	X					
North Dakota	X							
Ohio	X							
Oklahoma			X					
Oregon			X					
Pennsylvania	X							
Rhode Island			X					
South Carolina	X							
South Dakota	X							
Tennessee	X							
Texas		X	X					
Utah	X							
Vermont[2]								
Virginia	X							
Washington	X							
West Virginia	X							
Wisconsin		X		X	X	X	X	
Wyoming	X							

[1] These states remarked that the 314(d) allocation formula penalizes small states.

[2] States did not respond to this item.

Source: ACIR compilation of state health department (or equivalent) responses to survey questionnaire of April 1975.

appropriate device for engendering stronger public-private linkages in the operation of Federal grant programs.

In summary, there is considerable variety in the patterns of state decision making for the use of 314(d) block grant funds. In most states, the block grant goes through the regular state budget process; but in some, this appears to be a pro forma review. Hence, block grant decisions in these instances are made by the state health departments with very limited involvement by other state or local interests. The close linkage between the block grant and comprehensive health planning intended by the *Partnership for Health Act* generally has not occurred. On the other hand, some states are characterized by an open decision-making process with respect to the block grant and this permits a significant role for CHP agencies.

Regardless of the varying character of these basic allocation decisions, this section shows that participation in the operation of the block grant is enhanced by the widespread practice of suballocating part of the 314(d) award to local organizations. The mechanisms used for

Table 15

State Responses Concerning Whether the Constraining Influence of 314(d) Program Requirements Would Change If the Level of 314(d) Funding Were Higher, or If 314(d) Comprised a Larger Fraction of Their Total Federal Health Grants

State	Would Constraining Influence Change If 314(d) Grant Were Much Larger?			Would Constraining Influence of Requirements Change If 314(d) Grant Comprised a Much Greater Fraction of Federal Health Grant Funds?		
	Yes	No	Don't Know	Yes	No	Don't Know
U.S. Totals	7	39	3	6	37	5
Alabama		X			X	
Alaska	X				X	
Arizona			X	X		
Arkansas		X			X	
California		X			X	
Colorado		X			X	
Connecticut			X			X
Delaware		X			X	
Florida		X			X	
Georgia		X			X	
Hawaii	X			X		
Idaho		X				X
Illinois		X			X	
Indiana		X			X	
Iowa		X			X	
Kansas		X			X	
Kentucky		X			X	
Louisiana	X			X		
Maine		X			X	
Maryland		X			X	
Massachusetts		X		X		
Michigan	X			X		
Minnesota		X			X	
Mississippi		X			X	
Missouri		X			X	
Montana		X			X	
Nebraska		X			X	
Nevada		X			X	
New Hampshire		X				X
New Jersey		X			X	
New Mexico	X				X	
New York		X			X	

Table 15 (Continued)

State Responses Concerning Whether the Constraining Influence of 314(d) Program Requirements Would Change If the Level of 314(d) Funding Were Higher, or If 314(d) Comprised a Larger Fraction of Their Total Federal Health Grants

State	Would Constraining Influence Change If 314(d) Grant Were Much Larger?			Would Constraining Influence of Requirements Change If 314(d) Grant Comprised a Much Greater Fraction of Federal Health Grant Funds?		
	Yes	No	Don't Know	Yes	No	Don't Know
North Carolina	X					X
North Dakota		X			X	
Ohio		X			X	
Oklahoma		X			X	
Oregon		X			X	
Pennsylvania		X			X	
Rhode Island		X			X	
South Carolina		X			X	
South Dakota		X			X	
Tennessee	X			X		
Texas			X		X	
Utah		X			X	
Vermont[1]						
Virginia		X			X	
Washington		X				X
West Virginia		X			X	
Wisconsin		X			X	
Wyoming		X				

[1] State did not respond to this item.

Source: ACIR compilation of state health department (or equivalent) responses to survey questionnaire of April 1975.

these allocations, and the degree of policy control over these funds retained by the states, vary widely as the Federal grant interacts with state administrative systems.[18] Yet, in many states, the net effect of these practices is to provide an important role, often including considerable initiative in priority setting, for local governments. In contrast, it appears that integration of public and private health activities has not occurred under the block grant. Hence, the legislative intent that the private sector play an important role in the block grant has not been realized.

The next section considers the extent to which state flexibility in the use of Federal grants has, in fact, been increased and used under the block grant.

STATE FLEXIBILITY UNDER THE BLOCK GRANT

At the very heart of the block grant rationale is the desire to provide recipients, in this case state health agencies, with greater flexibility in the use of their Federal grants. If a block grant fails to accomplish this objective, it would be difficult to form a favorable assessment of its impact. A block grant could fall short

Table 16

Impact of Mental Health Earmark Within 314(d) Block Grant, as Judged by State Public Health Agencies

States	Impact of Earmark on Total State Use of 314(d) Grant			Attitude Toward Removal of Earmark			Attitude Toward Removal Given Much Higher 314(d) Funding Level		
	Beneficial	Detrimental	No Effect	Favor	Oppose	Neither or No Opinion	Favor	Oppose	Neither or No Opinion
U.S. Totals	5	7	37	23	8	18	22	8	20
Alabama			X			X			X
Alaska[2]			X					X	
Arizona	X				X			X	
Arkansas	X				X			X	
California	X				X			X	
Colorado			X			X			X
Connecticut			X			X	X		
Delaware			X		X				X
Florida			X			X			X
Georgia		X		X			X		
Hawaii		X		X			X		
Idaho	X			X			X		
Illinois			X			X			X
Indiana			X			X			X
Iowa			X			X			X
Kansas		X		X			X		
Kentucky			X			X			X
Louisiana			X			X			X
Maine			X	X					X
Maryland			X		X			X	
Massachusetts			X	X					X
Michigan[1]				X			X		
Minnesota		X		X			X		
Mississippi			X	X			X		
Missouri			X	X			X		
Montana			X	X			X		

Table 16 (Continued)

Impact of Mental Health Earmark Within 314(d) Block Grant, as Judged by State Public Health Agencies

States	Impact of Earmark on Total State Use of 314(d) Grant			Attitude Toward Removal of Earmark			Attitude Toward Removal Given Much Higher 314(d) Funding Level		
	Beneficial	Detrimental	No Effect	Favor	Oppose	Neither or No Opinion	Favor	Oppose	Neither or No Opinion
Nebraska		X		X			X		
Nevada			X			X			X
New Hampshire			X	X			X		
New Jersey			X			X			X
New Mexico			X		X			X	
New York			X	X			X		
North Carolina			X			X			X
North Dakota	X					X	X		
Ohio			X	X			X		
Oklahoma			X	X			X		
Oregon			X	X			X		
Pennsylvania			X		X			X	
Rhode Island		X		X			X		
South Carolina			X	X			X		
South Dakota			X			X			X
Tennessee			X			X			X
Texas			X			X			X
Utah		X		X			X		
Vermont			X			X	X		
Virginia			X			X			X
Washington			X		X			X	
West Virginia			X	X					X
Wisconsin			X	X			X		
Wyoming			X	X					X

[1] State response indicated no knowledge of effect of earmark.

[2] No response was given regarding the removal of the 15 percent earmark.

Source: ACIR compilation of state health department (or equivalent) responses to survey questionnaire of April 1975.

in this regard if the structure of restrictions embodied in the program so constrains the recipient as to nullify the effects of the program's breadth of scope and formula allocation basis. While this possibility need not be faced in considering an idealized block grant, the compromises from ideal types always present in actual programs require that this possibility be explored.

The 314(d) block grant contains a number of restrictions on the use or administration of Federal funds. Most notable among these are the 70 percent (of expenditures for services in communities) requirement, the 15 percent earmark for mental health, state and local matching requirements, a maintenance of effort requirement, and merit system requirements for local fund recipients.[19] *Table 14* presents the state health officials' evaluations of the extent to which each of these restrictions actually constrains their discretion under the block grant; that is, whether a modification of the requirement would result in changes in the states' public health program, as opposed to the generation of counterbalancing shifts in the use of 314(d) funds and other revenues. A near majority (23) of states responding to this item indicated that not one of these requirements actually constrains their discretion under the program. Apparently, the opportunities for rebudgeting revenues, or otherwise minimizing the impact of the requirements, are so extensive that any conceivable alteration in them could be neutralized in most states without any effect on public health services. On the other hand, 25 states indicated that at least one of the Federal restrictions did limit their discretion. Most frequently cited was the mental health earmark, mentioned by 16 of the state public health agencies. The requirement that at least 70 percent of the block grant funds be used to support services in communities was a close second, listed by 14 states. Ten states cited local merit system requirements; six mentioned the maintenance of effort provision; and the same number listed state matching requirements. Five states mentioned the local matching requirement, and two states nominated the 314(d) allocation formula as a constraint. The summary impression is that these restrictions generally are not having any major effect on recipient discretion, as reflected in state program operations.[20]

In order to determine the extent to which these responses reflect the small size of the 314(d) grant or the fungibility of Federal grants, the state public health officials also were asked whether their answers would change if the 314(d) grant were much larger or constituted a much larger fraction of all Federal health grant funds in their states. This second set of responses, representing hypothetical extrapolations from the present impact of these six restrictions, is presented in *Table 15*. Only seven states responded that the effect of these restrictions would change if the block grant were larger. Of these, two mentioned that the state matching requirement would be more difficult to meet; one state said the 70 percent requirement would require more attention; and one said the 70 percent requirement would be more enforceable but less important, since central administration could be covered by 30 percent of a much larger grant. Three states indicated that, whatever the effect on enforceability of the requirements, their importance would be reduced due to expansion of the flexible block grant funding mechanism. Six states indicated that the impact of the requirements would alter if the block grant were a larger fraction of all Federal health grants. One state felt the 70 percent rule would become more difficult to meet, another indicated that both the state matching and the 70 percent rule would be more enforceable, and a third state provided no illustration of what changes would result. Three states answered that regardless of the effect on enforceability of these requirements, the overall effect would be to lessen constraints on state discretion. In short, few states perceive the size of the block grant, either absolutely or relative to all other Federal health grants; as the reason for the inability to monitor these restrictions. If the states' responses are accurate predictions of the effects of expanding the block grant, it would appear that the ineffectiveness of these restrictions stems not only from fungibility but also from qualities inherent in these provisions.

Since the presence of a categorical mental health grant within the block grant was the restriction most frequently cited as actually limiting the state's discretion on the use of 314(d) funds, it is appropriate to examine public health officials' perception of the impact of the 15 percent earmark, as presented in *Table 16*. Considering the bias in the sample, it is surprising that most public health officials (37 states) view the mental health earmark as having no impact on state ability to make optimum use of the block grant, and that the balance between favorable and unfavorable assessments by those officials perceiving some impact is so close. Nevertheless, in 23 states public health officials favor removal of the mental health earmark, while only eight oppose its removal and 18 are neutral. These aggregate figures remain nearly unchanged with respect to an expanded 314(d) grant, as shown in *Table 16*, although a handful of states switched responses within these totals. Comparison with *Table 14* reveals that the 16 states indicating that the mental health earmark actually limits state options were much more likely to identify impact

Table 17

State Public Health Officials' Perception of Their State's Discretion under the 314(d) Block Grant

State Discretion Regarding Use of Funds

State	Discretion Greater Than in Prior Categoricals			Was Any Increase in Discretion Used in Terms of New Activities or Changes in the Relative Levels of Existing Activities?			
	Yes	No	Don't Know	Yes	No	Don't Know	Not Applicable
U.S. Totals	44	3	3	30	12	5	3
Alabama		X					X
Alaska		X					X
Arizona	X			X			
Arkansas	X			X			
California	X			X			
Colorado	X			X			
Connecticut	X				X		
Delaware	X			X			
Florida	X			X			
Georgia			X			X	
Hawaii	X				X		
Idaho	X				X		
Illinois	X			X			
Indiana	X			X			
Iowa	X			X			
Kansas	X			X			
Kentucky	X			X			
Louisiana	X				X		
Maine	X			X			
Maryland	X			X			
Massachusetts	X				X		
Michigan	X			X			
Minnesota	X			X			
Mississippi	X				X		
Missouri	X				X		
Montana	X			X			
Nebraska	X			X			
Nevada	X			X			
New Hampshire	X			X			
New Jersey	X			X			

Table 17 (Continued)

State Public Health Officials' Perception of Their State's Discretion under the 314(d) Block Grant

State Discretion Regarding Use of Funds

State	Discretion Greater Than in Prior Categoricals			Was Any Increase in Discretion Used in Terms of New Activities or Changes in the Relative Levels of Existing Activities?			
	Yes	No	Don't Know	Yes	No	Don't Know	Not Applicable
New Jersey	X			X			
New Mexico	X			X			
New York	X			X			
North Carolina	X			X			
North Dakota	X			X			
Ohio	X					X	
Oklahoma	X					X	
Oregon	X				X		
Pennsylvania	X				X		
Rhode Island	X			X			
South Carolina	X				X		
South Dakota			X			X	
Tennessee	X			X			
Texas	X			X			
Utah	X			X			
Vermont			X			X	
Virginia	X			X			
Washington	X				X		
West Virginia	X				X		
Wisconsin		X					X
Wyoming	X			X			

Source: ACIR compilation of state health department (or equivalent) responses to survey questionnaire of April 1975.

– and an overwhelmingly negative one – of the earmark on state use of the entire 314(d) grant. Only one of these states reported that the earmark was beneficial. In contrast, six of the seven states reporting a detrimental impact for the earmark were in this grouping. Similarly, 12 of these 16 states favor removal of the earmark, and would continue to do so if the 314(d) funding level were much higher. On balance, the surprisingly conciliatory attitude of public health officials toward the mental health earmark probably reflects their acceptance of the political importance of this compromise in obtaining and sustaining the block grant.

The information presented thus far in this section suggests that state discretion under the 314(d) block grant is quite substantial. The perceptions of state public health officials, presented in *Table 17*, regarding the extent to which the block grant resulted in greater state discretion than existed under the prior categorical

Table 18

Funding Levels For the 314(d) Block Grant, FY 1968-1976 (in thousands)

Fiscal Year	Obligations	Appropriations	Authorizations
1968	57,270	60,200	70,000
1969	65,642	66,032	90,000
1970	85,783	90,000	100,000
1971	76,481	90,000	130,000
1972	94,303	90,000	145,000
1973	89,092	90,000	165,000
1974	89,410	90,000	90,000
1975 (est.)	90,000	90,000	90,000
1976 (est.)	90,000	90,000	90,000

Source: Appendix, U.S. Budget, Fiscal Years 1970-1976; all outlay figures and estimated obligations for fiscal years 1975 and 1976 taken from Health Services Administration Congressional budget justification material for the last three fiscal years.

formula grant programs, support this contention.[21] Fully 44 states believe that their discretion is greater under the block grant, while only three states report no improvement and an additional three states do not know how the former categoricals compare with the block grant in this respect. In addition, 30 of these 44 states assert that this increased flexibility had been used, and is reflected in new activities or changes in the levels of support for existing activities. Among the more frequently offered examples were additional support for local health department activities (although the predecessor programs did not prohibit this use of Federal funds), increased funding of cross-categorical health services (such as public health nurses and broad diagnostic services), greater assistance to basic supporting services like central state laboratories, and increased emphasis on particular health problems such as tuberculosis and chronic disease. One state indicated that the consolidation enabled it to claim its entire Federal formula grant allocation for the first time, since the earlier categorical heart disease grant was ill-suited to the state's priorities. On the other hand, 12 of the states reporting greater discretion under the block grant indicated that they had not used this discretion in the eight years of block grant operation. This presumably is due, at least in part, to the lack of major funding increases under the block grant, a situation which requires that some existing state health programs be cut back to accommodate large increases in other areas or development of new health services. Most states, faced with employee tenure protected under merit systems and the political interests which develop around established services, have apparently chosen to make limited use of this option.

In summary, there is little doubt that the consolidation of formula grants achieved under the *Partnership for Health Act* has resulted in a measure of increased state flexibility in the use of Federal grant funds.[22] Despite variation in state utilization of this discretion, it is clear that this aspect of the legislative intent, emphasized in HEW's administration of the block grant, has been realized, although the extent of such realization has been constrained by the small amounts of "new money" available under the program. A review of the pattern of expenditure of 314(d) block grant funds now is in order.

STATE EXPENDITURE OF BLOCK GRANT FUNDS

Thus far, this chapter has concentrated on administrative features of the 314(d) block grant. Attention now turns to expenditure of these funds. Since many states claim they have used the program's flexibility to

Table 19

Reported Expenditures of State Health Agencies, by Source of Funds, FY 1974 (in thousands)

State	Total	Federal	State	Local	Fees and Reimbursements	Other
U.S. Totals	2,131,978	443,954	1,463,527	81,061	115,048	28,380
Alabama*	19,796	8,604	11,193	–	–	–
Alaska*	7,424	1,913	5,302	40	–	168
Arizona	34,259	5,580	27,904	–	776	–
Arkansas*	12,216	5,566	6,605	–	42	3
California*	528,577	55,379	429,065	–	38,491	5,642
Colorado*	15,504	8,491	6,966	43	5	–
Connecticut	54,851	5,767	49,045	–	–	38
Delaware	10,252	1,477	8,776	–	–	–
Florida	73,447	18,855	32,969	14,849	3,847	2,927
Georgia	28,092	9,027	18,806	–	259	–
Hawaii	58,868	5,228	32,376	–	21,053	210
Idaho	2,989	1,226	1,686	16	61	–
Illinois	31,829	12,093	19,736	–	–	–
Indiana	12,695	6,168	6,526	–	–	–
Iowa	7,069	3,749	2,457	863	–	–
Kansas*	7,480	3,683	3,317	–	477	2
Kentucky	63,532	16,378	43,353	–	3,800	–
Louisiana*	22,075	7,617	8,302	4,976	–	1,180
Maine	6,041	3,314	2,727	–	–	–
Maryland	109,148	15,059	152,907	21,751	–	431
Massachusetts	67,655	6,899	60,756	–	–	–
Michigan*	64,601	26,723	35,572	137	1,564	605
Minnesota*	9,044	5,111	3,556	–	134	244
Mississippi*	20,635	9,545	7,104	3,066	920	–
Missouri*	28,494	4,279	13,606	10,607	–	3
Montana	6,168	3,678	2,152	–	126	212

alter their previous expenditure patterns, comparison of the pre- and post-block grant patterns will be the focus of this discussion. At the same time, it must be stressed that the available data on 314(d) expenditures do not provide the basis for confident conclusions in this regard, and there are both inherent practical problems and serious conceptual difficulties involved in attempting to understand the impact of this (or any other Federal health grant) program separate from the bulk of state health expenditures.

As was noted in the 314(d) legislative history, this program did not fulfill its advocates' hopes that it would assume a predominant position in the Federal health grant structure. Instead, as *Table 18* shows, appropriations for the block grant rose only gradually from the FY 1966 level ($57,550,000) for the categorical formula grant programs folded into 314(d), and have remained at $90,000,000 since 1970. When the effects of inflation over this period are considered, it is clear that the level of services supported by the program has actually decreased substantially since 1970. At the same time, state and local expenditures for public health services have been rising. To provide some perspective on the context within which the 314(d) grant operates, *Table*

Table 19 (Continued)

Reported Expenditures of State Health Agencies, by Source of Funds, FY 1974 (in thousands)

State	Total	Federal	State	Local	Fees and Reimbursements	Other
Nebraska	5,451	3,377	2,073	–	–	–
Nevada*	4,002	1,463	2,361	100	71	7
New Hampshire	5,002	3,102	1,885	15	–	–
New Jersey*	42,352	22,039	20,273	–	–	40
New Mexico*	5,462	2,342	2,631	474	–	15
New York*	182,205	17,153	145,972	–	10,000	9,079
North Carolina	27,534	9,305	17,309	–	–	920
North Dakota*	9,256	3,333	3,701	–	2,193	29
Ohio	30,543	17,540	10,111	–	–	2,893
Oklahoma	14,603	5,124	4,499	3,184	1,795	–
Oregon*	8,755	3,991	2,500	–	1,365	899
Pennsylvania	65,215	13,127	50,920	59	881	227
Rhode Island	10,875	2,848	8,027	–	–	–
South Carolina*	32,999	11,286	17,965	–	3,749	–
South Dakota*	3,667	2,109	1,066	228	–	263
Tennessee	50,264	10,618	28,962	2,965	5,619	2,100
Texas	70,964	21,773	36,405	–	12,786	–
Utah*	7,054	3,142	3,719	–	–	193
Vermont*	4,307	1,538	2,768	–	–	–
Virginia	58,395	9,700	32,393	14,179	2,122	–
Washington*	17,129	10,010	6,715	111	292	–
West Virginia*	12,354	4,689	4,417	3,247	–	–
Wisconsin	12,269	5,010	7,258	–	–	–
Wyoming*	3,635	2,915	519	151	–	50

*Figures for these states include part of the state's Medicaid program.

Source: Association of State and Territorial Health Officials, Health Program Reporting System, ***Initial Report on Programs and Expenditures of State and Territorial Health Agencies, FY 1974,*** (Washington, D.C.: ASTHO, May 1975), pp. 44-45.

19 lists total reported expenditures by state public health authorities, disaggregated by major revenue sources. Even though these figures are incomplete, especially with respect to local revenues and expenditures, it is clear that the public health portion of the 314(d) grant comprises only a small fraction of state health agency support. This point is elaborated in *Table 20,* which shows the composition of Federal grant funds expended by state public health authorities. Although overall the 314(d) grant comprises only a little over 3 percent of total reported health department expenditures, it represents almost 16 percent of total Federal health grants received by these agencies, with individual state figures ranging from 7.3 percent in Kentucky to 38.5 percent in Missouri. To the extent that total Federal grants are critical to the states' health programs, the 314(d) block grant still is an important but clearly decreasingly revenue source for these programs.

While it is a simple mechanical exercise to track these block grant funds to state level recipients, from that point on it is very difficult to ascertain the uses for which these funds are expended. The categorical reporting systems attached to the nine grant programs folded into 314(d) were replaced after the consolidation with

Table 20

Reported Expenditures of State Health Agencies From Federal Grants, by Source, FY 1974[1]

State	Federal ($000)	314(d) ($000)	314(d) Percent of Total	Total Formula Grants ($000)	Formula Grants as Percent of Total	Total Project Grants ($000)	Project Grants as Percent of Total
U.S. Totals	$ 443,954	$ 70,577[2]	15.9%	$ 226,712	51.1%	$ 191,062	43.0%
Alabama	8,604	1,384	16.1	3,240	37.7	5,132	59.7
Alaska	1,913	335	17.5	741	38.7	1,048	54.8
Arizona	5,580	774	13.8	2,654	47.6	2,926	52.4
Arkansas	5,566	850	15.3	2,474	44.4	2,157	38.8
California	55,379	5,739	10.4	42,107	76.0	9,404	17.0
Colorado	8,491	926	10.9	3,063	36.1	5,096	60.0
Connecticut	5,767	1,061	18.4	2,446	42.4	3,321	57.6
Delaware	1,477	407	27.6	914	61.9	563	38.1
Florida	18,855	2,368	12.6	4,056	21.5	13,467	71.4
Georgia	9,027	1,510	16.7	4,519	50.1	4,508	49.9
Hawaii	5,228	452	8.6	1,062	20.3	3,208	61.3
Idaho	1,226	154	12.6	439	35.8	673	54.9
Illinois	12,093	3,193	26.4	5,471	45.2	6,623	54.8
Indiana	6,168	1,581	25.6	3,890	63.1	2,278	36.9
Iowa	3,749	1,072	28.6	1,935	37.5	1,814	48.4
Kansas	3,683	896	24.3	1,996	54.2	1,638	44.5
Kentucky	16,378	1,191	7.3	10,614	64.8	5,106	31.2
Louisiana	7,617	1,331	17.5	4,201	55.2	1,491	19.6
Maine	3,314	530	16.0	2,292	69.2	1,022	30.8
Maryland	15,059	1,324	8.8	4,194	27.9	10,865	72.2
Massachusetts	6,899	1,826	26.8	4,234	61.4	2,436	35.3
Michigan	26,723	2,766	10.4	11,205	41.9	9,552	35.8
Minnesota	5,111	1,360	26.6	3,000	58.7	1,432	28.0
Mississippi	9,545	1,053	11.0	4,058	42.5	4,771	50.0
Missouri	4,279	1,646	38.5	2,986	69.8	1,274	29.8
Montana	3,678	481	13.1	1,907	51.8	1,772	48.2
Nebraska	3,377	662	19.6	1,293	38.3	2,085	61.8
Nevada	1,463	388	26.5	836	57.1	518	35.4
New Hampshire	3,102	484	15.6	1,432	46.2	1,671	53.9
New Jersey	22,039	2,177	9.9	7,934	36.0	13,788	62.6
New Mexico	2,342	597	25.5	1,512	64.6	802	34.3
New York	17,153	5,146	30.0	9,828	57.3	5,148	30.0
North Carolina	9,305	1,982	21.3	5,980	64.3	3,325	35.7
North Dakota	3,333	432	13.0	1,525	45.8	919	27.6
Ohio	17,540	3,144	17.9	11,495	65.6	6,045	34.5
Oklahoma	5,124	1,065	20.8	2,044	39.9	3,080	60.1
Oregon	3,991	887	22.2	1,662	41.6	2,225	55.8
Pennsylvania	13,127	3,522	26.8	9,803	74.7	3,324	25.3
Rhode Island	2,848	531	18.6	1,588	55.8	1,260	44.3
South Carolina	11,286	1,113	9.9	3,800	33.7	7,177	63.6
South Dakota	2,109	443	21.0	1,334	63.3	650	30.8
Tennessee	10,618	1,504	14.2	5,270	49.6	5,082	47.9
Texas	21,773	3,357	15.4	10,953	50.3	10,820	49.7
Utah	3,142	528	16.8	1,492	47.5	1,319	42.2
Vermont	1,538	431	28.0	890	57.9	282	18.3

Table 20 (Continued)

Reported Expenditures of State Health Agencies From Federal Grants, by Source, FY 1974 [1]

State	Federal ($000)	314(d) ($000)	314(d) Percent of Total	Total Formula Grants ($000)	Formula Grants as Percent of Total	Total Project Grants ($000)	Project Grants as Percent of Total
Virginia	$ 9,700	$ 1,610	16.6%	$ 5,865	60.5%	$ 3,835	39.5%
Washington	10,010	1,239	12.4	2,425	24.2	7,246	72.4
West Virginia	4,689	812	17.3	2,504	53.4	2,037	43.5
Wisconsin	5,010	1,583	31.6	2,925	58.4	769	15.4
Wyoming	2,915	324	11.1	1,237	42.4	462	15.9

[1] Components may not add to total Federal funds, due to the existence of an "other" category, in addition to project and formula grants, in the ASTHO data.

[2] This figure represents the $90,000,000 appropriation minus a 1 percent reservation for evaluation, the mental health portion of the program (slightly over 15 percent), and the salaries of 63 Federal health professionals assigned to states and paid from those states' 314(d) allotment.

Source: Association of State and Territorial Health Officials, Health Program Reporting System, *Initial Report on Programs and Expenditures of State and Territorial Health Agencies, FY 1974* (Washington, D.C.: ASTHO, May 1975), pp. 44-45; 58-59.

successively less detailed reporting requirements. Some observers view this as the beginning of the block grant's weakness in reporting.[23] Others contend that, given the manner in which these funds were administered in some states, it is doubtful that requirements for detailed reporting would produce reliable data. Whatever the reason, the lack of detailed expenditure data for the 314(d) grant has been a major problem area since the program's inception. There has been no way for Congress and affected interest groups to determine which programmatic categories have benefitted and which have fared poorly as a result of the consolidation, nor for Federal administering officials to develop a clear understanding of what the block grant has accomplished.

Prior to 1975, the only financial analysis of the 314(d) program occurred in conjunction with Congressional hearings on the *Communicable Disease Control Act of 1972*. During these hearings, HEW prepared an analysis of the budgets submitted with previous 314(d) state plans. The results of this analysis are presented in *Table 21*, but should be interpreted with caution. As HEW noted in submitting this data, it represents only the state's budget estimates in the 314(d) plans, not actual expenditures. Further, the data is incomplete; that is, all state and local expenditures for public health are not covered, and how much of the total was covered in each state's 314(d) budget is unknown. Moreover, the breakdowns by programmatic categories may be forced and artificial, hence not accurate. Finally, since the 314(d) and matching funds are a small fraction of total state expenditures for public health, they may be arbitrarily allotted to a few categories for the sake of accounting simplicity; the reported use of 314(d) funds then may not reflect the actual impact of these funds on state health programs.

In view of these limitations, it would be unwise to place much confidence in the picture of general stability (with respect to the relative shares of the nine categories) which *Table 21* presents. The largest variations, in absolute terms, are found in mental health and general health, but the major fluctuation in the latter appears to be due primarily to a sharp decrease in reporting of local health expenditures in 1970; and the large increase in mental health percentages is undoubtedly due to inclusions of state, local, or other Federal funds rather than a redistribution within the 314(d) block grant. This table, however, does suggest that heart disease control and home health services programs fared poorly under the block grant. The decline in budgeted expenditures for home health services seems to indicate that this pro-

Table 21

Comparison of Budgeted Allocations of 314(d) Funds, FY 1968-1971, with Prior Categorical Formula Grant Programs, FY 1965-1966

Program Category		Appropriated Federal Formula Grant Funds for Fiscal Years:		Estimated Expenditures of Federal 314(d) Funds, Plus Required Matching Funds, Plus Some Local or Private Funds, From 314(d) State Plan Budgets for Fiscal Years:			
		1965	1966	1968	1969	1970	1971
General Health	$	10,000,000	10,000,000	120,044,720	141,519,791	113,814,330	170,732,386
	%	22.2	17.4	38.6	39.6	26.2	33.6
Chronic Disease, Chronic	$	11,750,000	12,330,000	18,839,992	15,352,782	10,131,995	7,733,343
Illness and Aging	%	26.1	21.4	6.1	4.3	2.3	1.5
Tuberculosis Control	$	3,000,000	3,000,000	11,654,434	17,830,513	25,867,225	23,463,742
	%	6.7	5.2	3.8	5.0	6.0	4.6
Heart Disease Control	$	7,000,000	9,500,000	4,353,801	4,245,521	2,980,498	2,810,172
	%	15.6	16.5	1.4	1.2	0.7	0.6
Cancer Control	$	3,500,000	3,500,000	4,472,806	3,977,600	3,523,699	3,715,158
	%	7.8	6.1	1.4	1.1	0.8	0.7
Radiological Health	$	2,500,000	2,500,000	3,932,743	2,777,858	2,542,047	2,090,330
	%	5.6	4.4	1.3	0.8	0.6	0.4
Dental Health	$	520,000	1,000,000	3,071,293	3,897,793	3,336,478	2,322,741
	%	1.2	1.7	1.0	1.1	0.8	0.5
Home Health Services[1]	$	–	9,000,000	2,620,090	1,895,775	1,041,031	1,427,405
	%	–	5.6	0.8	0.5	0.2	0.3
Mental Health	$	6,750,000	6,750,000	87,337,066[2]	93,912,586[3]	132,800,750[4]	218,527,771[5]
	%	15.0	11.7	28.1	26.3	30.5	42.9
Other, or Unallocable	$	–	–	54,304,505	71,897,257	138,704,977	75,977,957
to Program Components	%	–	–	17.5	20.1	32.0	14.9
Total	$	45,020,000	57,550,000	310,631,450[6]	357,407,476[7]	434,743,030[8]	508,801,005[9]
	%	100.2	100.0	100.0	100.0	100.1	100.0

[1] FY 1966 was the first year of operation for the Home Health Services Program.
[2] Of this, $9,089,835 were from 314(d).
[3] Of this, $9,004,264 were from 314(d).
[4] Of this, $13,506,820 were from 314(d).
[5] Of this, $13,531,790 were from 314(d).
[6] Of the non-mental health funds herein, $55,553,350 were from 314(d).
[7] Of the non-mental health funds, $54,001,694 were from 314(d).
[8] Of the non-mental health funds, $75,397,460 were from 314(d).
[9] Of the non-mental health funds, $75,504,143 were from 314(d).

Source: Figures for FY 1968-1971 are taken from U.S. Congress, House, Committee on Interstate and Foreign Commerce, *Communicable Disease Control Amendments 1972, Hearing before the Subcommittee on Public Health and Environment,* 92nd, Cong., 2nd sess., 1972, p. 48. For the source of FY 1965-1966 figures, see *Table 1.*

gram's single year of operation as a categorical grant was insufficient to develop a strong following which could sustain it in the absence of a Federal earmark of funds. In the case of the heart disease control program, the explanation may lie in the low opinion of this program held by many public health professionals, as judged by the frequency with which such persons cite the heart disease program as an example of the irrationality of the small, pre-1966, categorical formula grants.[24] Regardless of the tentative conclusions drawn above, it appears that, because of the unreliability of this data, neither Congress nor HEW atempted to use these proposed expenditure figures for national policy considerations relative to the consequences of grant consolidation.

In an attempt to alleviate the continuing lack of expenditure data for the 314(d) program and to provide both financial and programmatic data on health department activities, in 1970 the ASTHO persuaded HEW to fund the research and development of the Health Program Reporting system, discussed earlier. The long range objective is the development and implementation of a standardized health program reporting system which would encompass state and local public health programs and all funding sources – Federal, state, and local. In view of the magnitude of the task, the project carried out several pilot data collection operations, which were extensively evaluated in 1973-74 by an expert committee made up of representatives of the ASTHO and a panel of knowledgeable outside consultants. This led to the definition of output, the collection, and now to the reporting of the first data on a reasonably standardized basis. Results of this effort, with respect to aggregate expenditure data for the 314(d) program, are given in *Table 22.*

These figures indicate that by far the largest share of 314(d) public health funds (30.0%) is expended for general health services. A breakdown of this category (see *Appendix Table A*) shows that the major items include operation of state laboratories and general public health-oriented programs of local health departments. These items account for approximately 80 percent of the general health category. Other widespread uses of 314(d) funds are: communicable disease control; "other programs, services, and administration;" unallocable local health department activities; chronic diseases; and general environmental health.

In light of the differences in data bases and reporting categories, it is not possible to directly compare *Table 22* with *Table 21* for all nine programs folded into 314(d). For example, the heart disease and cancer programs of *Table 21* are components of *Table 22's* chronic disease category (along with renal disease, general chronic disease, and other chronic disease activities) and there is no way to isolate the 314(d) funds in each component. Also, the tuberculosis control category of *Table 21* is one of five components of the communicable disease category in *Table 22*, again with no way to allocate 314(d) funds among these components. Those categories for which comparison is possible do not generally exhibit striking differences between the two sets of figures, although two exceptions require elaboration. It was previously noted that the high figures for mental health in *Table 21* result from inclusion of other state, local, or Federal funds in addition to the mental health portion of the 314(d) grant, rather than a massive internal redistribution of block grant funds in favor of mental health. This observation is confirmed in *Table 22*, which indicates that only 0.1 percent of the public health portion of the block grant has been spent on mental health. Therefore, the total percentage of 314(d) funds spent on mental health is about 15.1 percent, or substantially the *minimum* percentage dictated by the 15 percent mental health earmark. The other area of difference concerns the higher percentage of block grant funds allocated to radiation control in FY 1974. The absolute difference is not great in any event, and any actual resurgence of these activities probably is due to the expanded use of nuclear energy in recent years, and continuing concern over exposure to X-ray devices.

Examined from the perspective of the contribution made by 314(d) funds to particular state health programs, *Table 22* tells a somewhat different story. On a national aggregate level, the block grant constitutes only 3.2 percent of reported state health department expenditures, but this figure conceals some important variations in particular activities. For example, 314(d) funds comprise 22.8 percent of all reported expenditures for radiation control, 14.5 percent of chronic disease outlays, 12.4 percent of communicable disease totals, and 10.6 percent of general environmental health funding. Block grant funds are also disproportionately important sources of support for general health and preventive services, general consumer protection, and administrative costs. The importance of 314(d) funds to these essential and well established health activities, and to the states' entire public health programs, was recently highlighted by the strong and sustained protest by state and local health officials regarding the Administration's proposal to terminate the block grant.

The above national figures are compilations of individual state reports, which have been tabulated by the Health Program Reporting System Project.[25] These state reports are too voluminous for inclusion here, although four summary tables are included in the *Appendix.* As

Table 22

Reported Expenditures of 314(d) Funds (Public Health Portion only), FY 1974, and Comparison with Reported Total State Health Department Expenditures

Program Categories	Reported Expenditures Total Public Health Programs	314(d) (Public Health Portion) ($000)	314(d) as Percent of Total Reported Expenditures	Percent of Total 314(d) Expenditures
Total	$ 2,317,541	$ 73,072	3.2%	100.0%
Personal Health	1,734,598	41,719	2.6	57.1
General Health and Preventative Services	250,489	21,918	8.8	30.0
Maternal and Child Health	310,094	1,006	0.3	1.4
Communicable Disease	89,191	11,045	12.4	15.1
Dental Health	19,186	675	3.5	0.9
Chronic Disease	36,927	5,343	14.5	7.3
Mental Health	317,584	79	—	0.1
State-Operated Institutions	711,126	1,654	0.2	2.3
Environmental Health	167,957	11,695	7.0	16.0
General Environmental Health	41,384	4,393	10.6	6.0
Air Quality	10,718	14	0.1	—
Water and Water Quality	20,331	884	4.3	1.2
Solid Waste	7,091	236	3.3	0.3
General Consumer Protection	27,296	2,163	7.9	3.0
Radiation Control	5,847	1,332	22.8	1.8
Occupational Health	6,517	209	3.2	0.3
General Sanitation	33,512	1,704	5.1	2.3
Laboratory Services	15,263	760	5.0	1.0
Health Resources	128,908	2,806	2.2	3.8
General Health Resources	11,285	129	1.1	0.2
Health Planning and Resources Development	29,743	635	2.1	0.9
Health Facilities and Services Regulation	55,754	1,299	2.3	1.8
Health Manpower Regulation	4,694	81	1.7	0.1
Vital and Health Statistics	27,431	662	2.4	0.9
Other Programs and Administration	143,516	9,868	6.9	13.5
Funds to Local Health Departments Not Allocable to Program Categories	142,562	6,984	4.9	9.6

Source: Taken from Association of State and Territorial Health Officials, Health Program Reporting System, *Initial Report on Programs, and Expenditures of State and Territorial Health Agencies, Fiscal Year 1974,* (Washington, D.C.: ASTHO/HPRS, May 1975), p. 24.

the HPRS project has cautioned, at this time, the data are useful only at a national level, as the best available gross indicator to state health program operations. State-by-state comparisons will be feasible only as the HPRS project is able to pursue its continuing objectives to standardize definitions, capture or estimate total local expenditures, and account more rigorously for differences in responsibilities assigned to state health agencies and differences in fund flow, such as purchase-of-service arrangements. A current, Health Services Administration funded study of the 314(d) program has highlighted these problems at the current stage of development of the data system. The author of this study argues that the basic concept of categorical reporting by source of fund is inappropriate for a block grant and forces artificial and, therefore, meaningless or misleading accounting and reporting. The finding of this study corresponds closely to a position long held by the ASTHO, which has urged that the Federal government should evaluate 314(d) only as one funding source for a much larger public health program, rather than trying to track the detail of the small Federal dollar contribution through the much larger system.[26]

The fundamental reason for this skepticism about the value of reports on 314(d) expenditures is the fungibility of revenue sources available to state and local governments. The existence of many separate Federal grants, in addition to state, local, and private sources of program support, makes it impossible as a practical matter to determine which revenues support which activities, or to assess the impact of a given revenue source on total state or local health programs. Requiring identification of expenditures by source of funds presents a state health agency with two alternatives: separate accounts and billing systems can be established for each revenue source; or funds can be commingled, with some procedure established for identifying — usually on a prorated basis — the revenues used to support each activity. In the first instance, a cumbersome and expensive mode of grant administration will be the result, with an inherently strong temptation to arbitrarily "allocate" funds so as to minimize accounting complexity. In the latter case, accounting costs will be kept low, but the accuracy of reporting will suffer correspondingly. Most importantly, under either approach an examination of one revenue source will not reveal the true role of these funds in relation to the total health program of the state. And it is precisely the impact on total state and local health department activities which is the appropriate question for a health block grant reporting system. All these problems are experienced in their extreme form in a program such as 314(d), which, though broad in scope and small in absolute size, represents a small fraction of all Federal health grants. Hence, the opportunity for fungibility to confuse the issue is enormous.

For these reasons, there exists no adequate information on 314(d) block grant expenditures after eight years of program operation, though, the Health Program Reporting System is beginning to produce some useful data. The extent to which the Congress is aware of and concerned about the deficiencies in the Health Program Reporting System data is unclear, but in the absence of alternative information sources the House Committee on Interstate and Foreign Commerce has strongly endorsed the continuation of this uniform reporting system project.[27]

In summary, the available data on state block grant expenditures is inadequate as the basis for assessment of the impact of the consolidation, either on total state and local health department activities or on the prior, legislatively protected categories. The little evidence which does exist suggests that a few of the disease categories may have experienced declining support under the block grant, while other activities, not fundable under the categorical formula grant programs, have received some 314(d) allocations. The magnitude of these changes is not great, however, and the general impression is that most of the established categorical disease control activities have continued to receive grant support after the consolidation.[28] These tentative findings are consonant with the prevalent qualitative assessment that absence of major funding level increases under the block grant has greatly limited the states' flexibility to alter the mix of health services provided with 314(d) support.

STATE ATTITUDES TOWARD THE 314(d) BLOCK GRANT

To this point, this section has reviewed the manner in which the states administer the 314(d) block grant, and the uses to which block grant funds have been put. The question remains, however, as to how, on balance, the states themselves evaluate this grant program. While many state health officials indicated displeasure with certain aspects of the program, and especially the failure of its funding level to grow as "promised" in 1966, all but four states reported general satisfaction with the block grant.[29] This is an exceptionally favorable rating (92%), even considering the sample bias and the current battle over continuation of the program. Of the four dissidents, Alabama voiced frustration with the program's failure to keep pace with rising costs and its

undependability for planning. Texas echoed this concern over funding levels and also cited the failure to fold the 314(e) project grant program into the block grant, while West Virginia and Wisconsin found the participation of Federal program officials inadequate in the areas of planning and goal setting, program evaluation, and technical assistance.

When asked for their single, most important recommendation for improving the program (other than higher funding levels), six states suggested removing the 15 percent earmark for mental health, the 70 percent requirement for local health services, or both (one state, three states, and two states, respectively). Two states called for removal of all existing restrictions on the 314(d) grant, and six states cited the need for earlier appropriation action by Congress to permit program planning. Five states mentioned some variation of the need for greater Federal-level political support for the program, including resisting the temptation to recategorize the block grant. Four states recommended closer working relationships between Federal and state (and local, in one case) health officials, especially in the areas of technical assistance, planning, and evaluation. Three states proposed revisions in Federal reporting requirements, to focus on the total state health program instead of isolating the 314(d) component (two states), or not to require impossible reporting of local agency expenditures. Individual state suggestions included: allowing states to carryover unexpended funds to succeeding fiscal years; removal of the requirement for local merit systems; eliminating A-95 coverage of the block grant in view of the new health planning legislation; and scrapping the maintenance of effort and matching requirements to permit use of block grant funds for innovations for which state or local funds are not available.[30] Seventeen states did not recommend any specific improvement, with several of these expressing complete satisfaction with the program as currently operated. It is worth noting that each of these suggestions is consistent with the block grant concept; in fact, most of them are in the direction of bringing the 314(d) grant closer to the ideal construct of a block grant.

State health officials' perceptions of the major advantages and disadvantages of the block grant, in comparison with categorical Federal health grants, are also enlightening. On the positive side, one response stands out overwhelmingly: the flexibility to use funds where the needs are the greatest or priorities highest, and to respond to changes in health needs over time, is the most prized feature of the block grant, and was mentioned by all but one of the states responding to this item. Some of the specific responses underscore the intensity of this state viewpoint:

- The country varies in the priority of needs unmet in the public health field, and the block grant potentially provides the flexibility to meet these various priorities – *Delaware*.

- Placement of dollars based on state and local, rather than Federal, needs and priorities – *New Jersey*.

- Funds can be used comprehensively, with the state agency establishing its own priorities with regard to whom, how, and where the funds can be best utilized in helping satisfy the public health needs of the state's citizens – *Texas*.

- Social, economic, geographic, health factors, and state budget limitations vary from state to state. Block grants permit the governor and the health agency head to budget block grants to the most pressing health problems of the state – *New Jersey*.

- It is flexible so we can respond to needs that are precluded using categorical grants – *Vermont*.

- Ability to meet peculiar public health needs as they arise – *Ohio*.

- Allows flexibility in use of funds within a given ceiling and eliminates categorical program matching – *Hawaii*.

- We are able to focus our attention on actual problems rather than expend resources on low priority areas – *Kentucky*.

- Local priorities can be funded rather than national priorities that might not affect our state – *Utah*.

- 314(d) program grants provide the mechanism for meeting the most pressing health needs on a statewide and individual locality basis – *Virginia*.

- In practice, allows states to set their own priorities for program funding commensurate with local and state needs – *New York*.

- Capability of shifting program emphasis (this is usually done evolutionarily rather than dramatically) – *Tennessee*.

These arguments are summarized in the following response from Washington:

> The key advantage is flexibility. The funds are flexible among programs (*e.g.*, equally applicable to personal health or environmental health activities), flexible among applications (*e.g.*, used for a direct service or to develop a better management and control system), flexible to meet individualized agency needs (*i.e.*, agencies in different areas with different health needs can use these funds to support their particular priorities), and flexible over time (*i.e.*, funds used on this year's priorities may be switched to support a different set of program priorities next year). Thus, the funds are available to manage problems and meet changing needs and priorities.

Other advantages mentioned by the states include: simplified administration or lower administrative costs (nine states); provision of a dependable financial support for basic state health programs (three states); greater state and local responsibility and accountability for the funds (two states); comparative ease of meeting matching requirements (four states); stimulation of local health services, or better utilization of local health department staff (three states); ability of the state to use all of its allotted Federal grant funds (one state); and reduction in Federal supervision or pressure for particular usage of grant funds (three states). Overall, these comments correspond closely to the theoretical distinctions between block grants and categorical programs, with flexibility clearly regarded as the dominant block grant attraction and administrative convenience a distant second.

With respect to disadvantages in comparison with categorical grants, the one most frequently cited is lower or uncertain funding levels, mentioned in some form by 30 states. Most states offering this response also indicated that the reason for the relatively poor budget performance of the block grant is the inherent difficulty of obtaining sufficient political support for noncategorical activities. The following highlight state awareness of this fundamental block grant dilemma:

- Block grants by their nature do not generate constituent support in the community or in the legislature. Also, they are more susceptible to budget cutting because of the relative difficulty of assessing damage – *New York*.

- Level of funding will be less as Congress is more responsive to categorical grants – *Louisiana*.

- The process of demonstrating specific program accomplishments is made more difficult by allowing merging of funds versus specific objectives – *Wisconsin*.

- There is a lack of understanding of the 314(d) provision and it is hard to obtain increases from Congress since there are no concrete, identifiable, health problems for which support can be specifically solicited – *Colorado*.

- Funding level has not kept pace with inflation, dwindling state resources, Federal promises, and public health needs – *Rhode Island*.

Next in frequency among the responses was the disclaimer, made by 16 states, that any disadvantages to block grants exist. No answer other than the preceding two was given by more than one state. One such individual state response was that block grants actually create greater administrative difficulty, since fundable activities and reporting bases are less clearly defined. Other statements included the following:[31]

- In a few instances, important programs not well understood by the public or state officials can be lost under 314(d) as opposed to categorical grants.

- Occasionally major segments go into replacement of state funds and into programs which may not always be new, different, or helpful and in which the dividends are not always optimal.

Table 23

Attitudes of State Public Health Officials Regarding Expansion of the 314(d) Block Grant

States	Preference for Expansion			If Preference is for 314(d), is Expansion by Consolidation of Categorical Grants Favored (Keeping Total Grant Levels Constant)?			If Expansion by Consolidation is Favored, Should any Categorical Grants be Excluded From Such a Consolidation?		
	314(d) Block Grant	Categorical Grants	No Preference	Not Applicable	Yes	No	Not Applicable	No	Yes
U.S. Totals	46	1	3	4	36	10	13	28	6
Alabama	X				X			X	
Alaska			X	X			X		
Arizona	X				X			X	
Arkansas	X				X			X	
California	X				X			X	
Colorado	X				X			X	
Connecticut	X				X			X	
Delaware	X					X	X		
Florida	X				X			X	
Georgia	X					X	X		
Hawaii	X				X			X	
Idaho	X				X			X	
Illinois	X				X			X	
Indiana	X				X			X	
Iowa	X				X			X	
Kansas	X				X			X	
Kentucky	X					X	X		
Louisiana	X				X				X[1]
Maine	X				X				X[2]
Maryland	X				X			X	
Massachusetts	X				X			X	
Michigan	X					X	X		
Minnesota	X				X			X	
Mississippi	X				X			X	
Missouri	X				X			X	
Montana	X					X	X		
Nebraska	X				X			X	
Nevada	X				X			X	
New Hampshire	X					X	X		
New Jersey	X				X				X[3]
New Mexico	X				X				X[4]
New York			X	X					X[5]
North Carolina	X				X			X	
North Dakota	X				X			X	
Ohio			X	X			X		
Oklahoma	X				X			X	
Oregon	X					X	X		
Pennsylvania		X		X			X		
Rhode Island	X				X			X	
South Carolina	X					X	X		

Table 23 (Continued)

Attitudes of State Public Health Officials Regarding Expansion of the 314(d) Block Grant

States	Preference for Expansion			If Preference is for 314(d), is Expansion by Consolidation of Categorical Grants Favored (Keeping Total Grant Levels Constant)?			If Expansion by Consolidation is Favored, Should any Categorical Grants be Excluded From Such a Consolidation?		
	314(d) Block Grant	Categorical Grants	No Preference	Not Applicable	Yes	No	Not Applicable	No	Yes
South Dakota	X				X			X	
Tennessee	X				X			X	
Texas*	X				X				
Utah	X				X				X[6]
Vermont*	X				X				
Virginia	X				X			X	
Washington	X					X	X		
West Virginia	X				X			X	
Wisconsin	X					X	X		
Wyoming*	X				X				

*Texas, Vermont, and Wyoming did not respond to the third item.

[1] Examples: non-traditional or new types of programs; and health education grants.

[2] Examples: immunization grants; venereal disease.

[3] Examples: maternal and child health; crippled children.

[4] Example: none given.

[5] Example: crippled children.

[6] Examples: venereal disease; immunization grants.

Source: ACIR compilation of state health department (or equivalent) responses to survey questionnaire of April 1975.

- This same flexibility can permit continuing support of an existing program pattern without evaluation or response to changing needs.

All these replies indicate that state health officials are well aware of the basic tension in the block grant mechanism. On the one hand, these officials value the flexibility and ease of administration the block grant affords, and on the other hand they deplore the lack of political support and low funding levels which accompany these desirable features.[32] One way to resolve how the pros and cons of block and categorical grants balance out, from the perspective of state health officials, is to determine whether they would prefer expansion of the 314(d) block grant or of categorical Federal health grants. This would be followed by determining whether those who favor expansion of 314(d) would do so if the mechanism were merger of categorical grants within 314(d) — with total grant levels kept constant, and lastly by inquiring, if this second answer is also yes, whether there are any types of categorical grants which they feel should not be consolidated within 314(d)?

These questions, in fact, were posed in the ACIR survey questionnaire and the responses are presented in *Table 23*. There is no mistaking the states' preference for the block grant mechanism, despite their concern over the failure of the block grant to generate Federal Executive Branch and Congressional support, since 46 states would rather see the 314(d) program expand than categorical grants. Only one state took the contrary position, commenting that Federal funds should be used to meet national priorities. Three states expressed no preference for either mechanism, suggesting that they consider the level of Federal grant support more important than the means by which these funds are

distributed.[33] As the following comment illustrates, this group tended to consider this a Hobson's choice:

> You are asking do I still beat my wife. As the answer above indicates, the block grant does have some administrative considerations that are attractive to states; *e.g.*, use of money as the state sees priority and for state problems. However, the block grant fails to build a constituency while a categorical grant does.

Interestingly, of the 46 states which prefer expansion of the block grant, ten would not favor an increase in the 314(d) program accomplished by a corresponding decrease in categorical health grants, in effect consolidating these grants within the block grant. Enthusiasm for further grant consolidations may be tempered by the current political climate surrounding Federal grant programs. Some state and Federal program administrators now view proposals for consolidation with suspicion, considering them part of a strategy for achieving Federal budget reductions. This attitude was not present during the 314(d) consolidation, which, after all, occurred in a period of rapid expansion in Federal grant programs. But now this concern is a major factor in Congressional, interest group, and state reactions to grant consolidation proposals. Notwithstanding this suspicion, over 70 percent of state public health agencies favored an increase in the 314(d) program even by merging existing categorical grants into it, and this is an impressive endorsement of the block grant approach.

Finally, when these 35 states were asked whether there were some Federal health grants which should not be folded into the 314(d) grant, 28 of the 33 states responding indicated that no such exceptions were necessary. Thus, over half of the state public health agencies could be characterized as "hardliners" toward the block grant, in that they favor merging all Federal health grants within 314(d), despite the budgetary hazards associated with this approach. As *Table 23* shows, the five states suggesting exceptions (plus New York, which, although declining to state a preference on the first two questions, nevertheless indicated that exceptions would be required) mentioned six programs or classes of programs. Those for crippled children were cited by two states, as were venereal disease control programs and immunization grants. Maternal and child health grants, health education grants, and "nontraditional or new types of programs" were each mentioned once, while one state reported that exceptions would be necessary but did not provide an example. The reason given for the recommended exceptions was that these programs required special Federal support, either because they were new and not yet established, or because they were considered important but politically vulnerable.

In summary, state public health agencies generally are strong advocates of the block grant concept for public health. To them, the block grant's attractiveness lies in its flexibility – across public health problems, priorities, and approaches to solutions, and over time – and in its relatively simple and inexpensive administration. They also perceive an inherent weakness in the block grant with respect to generating political – and therefore budgetary – support by the Federal government, and are quite concerned on this point. In fact, many state officials feel betrayed by the failure of the block grant funding levels to increase dramatically, as was clearly anticipated in the 1966 legislation. Further, many report that the relatively stable funding levels of this grant have tended to undermine the flexibility theoretically attendant to the block grant mechanism. This suggests that the effects of a grant consolidation can be very different from those of a completely new block grant. Despite these misgivings, the majority of state public health agencies clearly regard the block grant more favorably than categorical Federal health grants, even to the point of favoring the consolidation of all existing categorical grants into the 314(d) program.

The message which comes through strongly is that state public health officials consider the record of the 314(d) grant spotty in many respects, but desire to retain the block grant approach as part of the Federal health grant structure, preferably an increasingly important part. Toward this end, the Association of State and Territorial Health Officials, in conjunction with other public interest groups, is pushing aggressively for a modified and greatly expanded version of the 314(d) program. In short, they would like to see the block grant experiment in health redirected somewhat, but definitely continued.

FOOTNOTES

[1] Recommendation must be made jointly by the state health and mental health authorities, or by the governor. *Federal Register*, "Grants to States for Comprehensive Public Health Services," Subpart B, 37 FR 24667, November 18, 1972, section 51.106.

[2] See *Table 4*.

[3] Also see case studies in *Appendix C*.

[4] Based on state responses to the ACIR survey questionnaire.

Responses are not presented in table form because the working of the instrument apparently misled a number of states into listing (including service providing staff) the total personnel whose salaries are supported in whole or part by these funds, and not merely those involved in administration of the block grant.

[5] Whether this indicates there is no overhead involved in the program, or casts doubt on their statement that the funds are administered as a discrete program, was not determined.

[6] See the last part of this chapter, dealing with 314(d) expenditures, for details.

[7] ACIR compilation of state health department (or equivalent) responses to ACIR survey questionnaire of April 1975.

[8] See the Oregon case study in *Appendix C* for an exception.

[9] Diversified Information Systems, Inc., pp. 44-47; Robins, 1974, pp. 131-155. The latter study was the first nationwide study of the 314(d) program, using data obtained from a 50-state survey. This study also found that state CHP influence in the 314(d) program was greater for agencies located within the health department than those located in the governor's office.

[10] Robins, 1974, pp. 131-149; and the Susskind case study of the 314(d) program in Massachusetts, pp. 348, 352.

[11] Diversified Information Systems, Inc., p. 50.

[12] Figures on the exact proportion of 314(d) funds thus allocated are not readily available, since Federally required budget submissions in this program are retained in the HEW regional offices. Further, the Health Program Reporting System of the Association of State and Territorial Health Officials does not collect data in a manner which separates direct and indirect service provision.

[13] New Mexico and Virginia.

[14] One state did not indicate the method of allocation.

[15] Totals add to 39 because one state did not indicate method of allocation.

[16] See *Table 11*; also see the six case studies in *Appendix C* for analysis on what these plans really entail.

[17] See the 314(d) case studies in *Appendix C*.

[18] See the six state case studies in *Appendix C*.

[19] See the legislative history in *Chapter II* for detailed information on these restrictions. There is also a requirement for state merit systems, but this was not explicitly included in the survey, nor mentioned by any state under the "other" category.

[20] A similar finding in 1972 was reported by Robins, 1974, pp. 120-124.

[21] Also see Robins, 1974, pp. 119-130.

[22] It should be recalled that increased state flexibility in a Federal grant program does not necessarily imply increased local flexibility as well.

[23] King, 1973, p. 40.

[24] This observation is based on state health agency responses to the ACIR survey questionnaire, and on interviews with HEW personnel and staff of national associations of public health officials.

[25] Association of State and Territorial Health Officials, Health Program Reporting System, "Fiscal Year 1974 Expenditures (Total and 314(d)) and 1975 Estimates by Program Titles as Reported by Individual State and Territorial Health Agencies," 1975 (mimeographed).

[26] Shikles, 1975, p. V-19.

[27] U.S., Congress, House, Committee on Interstate and Foreign Commerce, *Health Revenue Sharing and Health Services Act of 1974, Report Together with Minority and Additional Views to Accompany H.R. 14214*, 93rd Cong., 2nd Sess. (House Report No. 93-1161, June 27, 1974), pp. 7-8.

[28] A similar conclusion was reached in the GAO report on the 314(d) grant (and two other Federal grants) in three states. See U.S. General Accounting Office, *How States Plan For and Use Funds to Provide Health Services*, Washington, D.C.: GAO, December 1975, p. 33; also see the Massachusetts, Oregon, Tennessee, Texas, and Virginia case studies in *Appendix C*.

[29] Based on state health department (or equivalent) responses to an ACIR survey questionnaire of April 1975; also see Robins, 1974, pp. 189-193.

[30] The *Special Health Revenue Sharing Act of 1975* removed the requirement for state matching of 314(d) funds.

[31] From state health department (or equivalent) responses to an ACIR survey questionnaire of April 1975.

[32] These ambivalent feelings also were identified in 1972 by Robins, 1974, pp. 190-193.

[33] Conceivably, more state health officials might have adopted this position had the question been phrased in terms of specific higher level categorical funding versus a lower 314(d) allocation.

Major Findings and Issues

FINDINGS

The preceding sections of this report have traced the origin and evolution of the 314(d) block grant component of the *Partnership for Health Act*, and have examined the way this block grant is administered by Federal and state officials. In the course of this examination, conclusions have been reached in such areas as: the impetus for the initial consolidation; the themes present in subsequent modifications of the block grant's legislative base; the objectives of the consolidation; changing styles of Federal administration of the block grant; patterns of state block grant administration; the roles of local government and the private sector in the program; the reality of state flexibility under the block grant; an overview of block grant expenditures; and the attitudes of state public health officials toward this program. Specific findings in each of these areas are briefly summarized below.

Impetus for the Initial Consolidation

Permanent Federal grant support for health services began in 1935 with a general health formula grant program. Over the next 30 years, this broad grant – actually a small block grant – was joined by many specialized programs directed at particular client groups or diseases. By 1966, this had produced a Federal health grant structure dominated by categorical programs.

As early as the late 1940s, however, this categorical structure came under criticism for inhibiting the development of balanced and flexible state and local health

programs, and for imposing an excessive administrative burden on grant recipients. The first Hoover Commission, the Kestnbaum Commission, the House Intergovernmental Relations Subcommittee, the Joint Federal-State Action Committee, and a 1961 ACIR report on Federal health services grants all expressed concern with these negative aspects of categorical grants. Each acknowledged that categoricals often had been effective in promoting new health programs, stimulating increased state and local expenditures for public health services, and enlisting political support for such programs. At the same time, they generally concluded that the predominantly categorical health grant structure had inhibited the development of a desirable system of Federal-state-local responsibilities in this functional area. The major recommendation of the five studies was a call for greater recipient flexibility in the administration and expenditure of Federal grants, although the specific means to this end varied from modification of the categorical system to its replacement by a block grant for public health services.

These systemic criticisms of categorical grants were not sufficient to produce revision of the Federal health grant structure, as long as it appeared that the programmatic purposes of categorical grants were being achieved. It was only after these concerns were joined by mounting dissatisfaction with the quality of health care that legislative action occurred. In the early and mid-1960s, four major study commissions profoundly influenced official assessments of categorical health grants. Beginning with the National Commission on Community Health Services and continuing with the 1965 White House Conference on Health, the National Conference on Medical Costs, and the National Advisory Commission on Health Manpower, the nation's fragmented and excessively specialized health care system was scored, and categorical grants were cited as contributing to this condition. As a step toward achieving comprehensiveness in health care, a much stronger role for the block grant, within the Federal health grant system, was advocated.

These two streams of thought converged in the mid 1960s resulting in the *Comprehensive Health Planning and Public Health Services Amendments of 1966*. This act, commonly known as the *Partnership for Health Act*, accomplished a fundamental revision of the Federal health grant system. All nine categorical health service formula grants were consolidated into one block grant;[1] a similar merger converted seven project grant programs into one; and grant support for state and areawide comprehensive health planning was authorized. These components were intended to constitute an integrated approach, involving all levels of government and the private sector, to the planning, financing, and delivery of public health services.

The block grant, created by Section 314(d) of the act, was adopted with little controversy in 1966, although previous consolidation attempts had generated intense opposition from specialized health interests. Potentially the strongest opposition, that of the mental health constituencies, was avoided by retaining a minimum 15 percent earmark for mental health services within the block grant. Other key features of the original 314(d) block grant are noted below.

- Grants were to be awarded to states on a formula basis, contingent on HEW approval of a state plan for comprehensive public health services submitted by each state's health and mental health agency.

- The initial (FY 1968) authorization, $62.5 million, was only a slight increase from the combined levels of the consolidated categorical grants, but it was clearly intended that the block grant would grow rapidly to a level four to five times that size.

- The requirements for state-local matching were variable, ranging between one-third and two-thirds of a state's total expenditures under its 314(d) allotment, depending on its per capita income level.

- The basic purpose of the block grant was simply to assist the states in "establishing and maintaining adequate public health services." Despite this broad statement of goals, the record clearly shows that the basic block grant dilemma – striking an appropriate balance between providing relatively unrestricted financial support for state and local health programs, and promoting national health care priorities – was not resolved.

- The link between the block grant and state and local comprehensive health planning (CHP) was left somewhat vague, the only stipulation being that block grant services must be "in accord with" any state CHP plans. No connection with local CHP activities was specified.

- Lastly, P.L. 89-749 required that block grant funds be "made available," by the state agencies to other public and private non-profit organizations, to secure their "maximum participation" in the provision of block grant services. Here, too, the manner in which funds were to be made available, and any measures or targets for maximum participation of other agencies, were left unspecified.

Themes Underlying Subsequent Amendments

The modifications of the block grant authority since 1966 evidence two main themes, both of which are manifestations of the basic tension in the block grant between furthering national priorities and supporting virtually any state and local health programs. The stronger theme has been the tendency of Congress to recategorize the health grant system by mandating attention within the block grant to particular health problems, and by creating numerous new categorical programs outside the block grant. With the exception of the vetoed 1974 amendments, which would have created a 22 percent earmark for hypertension control, these actions stopped short of setting aside a minimum portion of block grant funds for specific categories. Instead, state health agencies were required by the 1970 amendments to address alcohol and drug abuse in the preparation of 314(d) state plans, and to provide such services pursuant to the plan commensurate with their importance in each state. In 1972, these provisions were strengthened by requiring 314(d) state plans to provide for licensing of drug treatment facilities, and for expansion of programs in the field of drug abuse. The *Special Health Revenue Sharing Act of 1975*, however, reversed this trend by eliminating special encouragement of these categories, and by omitting the 1974 bill's inclusion of an earmark for hypertension. It remains to be seen whether Congress henceforth will be able to resist the temptation to reinstate categories within the block grant. Beyond partial categorization of the block grant, Congressional preference for this approach is demonstrated by absence of major funding increases for the block grant and by the creation of nearly 20 new categorical programs since 1966 which would logically have been made a part of the block grant. The 1975 legislation indicated no change in this pattern.

The second theme has been the search for an appropriate link between the block grant and the comprehensive health planning (CHP) called for by the *Partnership for Health Act*. In 1970, this linkage was addressed by requiring 314(d) state plans to contain assurances of their compatibility with the total health program of the state. This was carried further in the 1974 bill, which would have mandated approval of 314(d) plans by the state CHP agency. The 1975 legislation modified this language to account for the *Health Planning and Resources Development Act of 1974*, stipulating that services supported by the block grant must be in accord with either the CHP state plan or the state plan prepared under the new health planning act.

These developments illustrate the Congressional desire to tie the block grant to broader state decision making and priority-setting processes, and simultaneously to impose national priorities on the program. Both tendencies highlight the need for accountability of the block grant to someone, but represent attempts to fix the locus of this accountability at different levels.

Objectives of the Consolidation

Six different, and in some cases conflicting, elements of legislative intent have been highlighted in this report. These are crucial to any assessment of the block grant's record.

- One objective was simple and quite clear, though not of overriding importance. Consolidation of separate grants was viewed as a way to lessen the administrative burden – in terms of time and cost – which (it was felt) categoricals imposed on recipients.

- Perhaps the most important goal was providing state health agencies with greater flexibility in the use of Federal assistance, which then would be spent in accord with the peculiar health needs and priorities of each state. This flexibility also was sought because it was believed that the states would be better able, with this greater discretion, to provide services directed at the total health needs of their populations, rather than services directed at particular disease categories.

- In potential conflict with this emphasis on flexibility was another purpose, not present in 1966, but which emerged in 1970 and increased in intensity in succeeding years. This was that block grant

funds were to be expended to further national health services priorities. This objective generated the trend toward partial recategorization of the block grant discussed earlier and the refusal to fold into the grant new categoricals that were functionally related to it.

- A fourth objective was assuring the complementarity of the block grant and comprehensive health planning activities, as discussed above.

- Congress also clearly intended that block grant funds would be used primarily to provide services, instead of covering administrative costs. To ensure this, the legislation stipulated that at least 70 percent of the 314(d) grant must be used to support "services in communities," thereby limiting expenditures for administrative purposes.

- Lastly, broad participation of other public and private non-profit agencies was clearly desired in the state health agencies' provision of comprehensive public health services. This was essential to achieving the intergovernmental and intersector "partnership" envisioned in the original act.

Changing Styles of Federal Block Grant Administration

Administration of the 314(d) block grant by HEW falls into two, more or less, distinct periods. The first, dating from the program's inception to approximately 1970, was a period of adjustment to the new administrative problems posed by a block grant. During this period, program administrators in the HEW regional offices, accustomed to managing categorical grants and lacking a model of block grant administration, made sporadic attempts to exercise a degree of control over the content of 314(d) funded programs. These efforts received no support from the HEW central office, and gradually became less frequent.

The implementation of a 1970 decision not to require submission of detailed state plans for 314(d), and to replace these plans with preprinted assurances that a plan exists which satisfies all applicable Federal requirements, marked the beginning of the second period. The style of administration which has characterized this period, up to the present, is one of very little attention to the block grant, and a corresponding lack of interest in it. This pattern, of course, is the opposite of that sought by Congress, which has exhibited a growing tendency to increase controls over the block grant.

In general, the current picture is one of less Federal involvement in all aspects of administration under the block grant than was the case in the categorical grants consolidated into 314(d). To a great extent, the pattern reflects the strong emphasis placed by HEW on the objectives of administrative simplification and recipient flexibility, relative to the other four objectives mentioned above. Central office policy basically was to treat this program as money to which the states were "entitled" regardless of the use to which it was put.[2] The following specific findings concerning different aspects of Federal administration of the 314(d) program underscore this generalization.

- Manpower allocated to this program is minimal. In the central office, one person is assigned to this program on a part-time basis. Recent guidance on regional office staffing recommended that only a one-half man-year per region be assigned to 314(d), and even this level would result in an increase in many regions. Several, in fact, have experienced a period of years in which no one was assigned programmatic responsibility for the 314(d) grant.

- Central office policy has followed the legislative intent where that was clear, but generally has not clarified legislative ambiguities in the areas of local and private sector involvement, the importance of innovation and reform under the block grant, and the relationship of comprehensive health planning to the block grant. Above all, little has been done administratively to help resolve the conflict between supporting state programs and furthering national priorities, where these differ.

- Evaluation by Federal officials has been less extensive under the block grant than the prior categorical grants. Only one Federally supported study was conducted in the first seven years of program opera-

tion, and this was of limited scope. A second study was undertaken in 1975, when controversy over the program was at its peak. The state health agencies concur in this assessment, since in our 50-state survey, 32 reported a decline in Federal evaluation activities under the block grant, while 16 observed no change and no state indicated an increased Federal role.[3]

- Auditing also is regarded by both Federal and many state officials as less extensive now. Very few states have been audited in recent years; only two states suggested an increased Federal role in auditing, while 20 indicated less activity now, and 26 observed no change.

- Federal involvement in both the preparation and review of state plans appears to have declined since 1966. With respect to plan preparation, 35 states reported a diminished Federal role, and only six suggested the reverse; in plan review, 26 states cited a decrease and six, an increase. These changes, it should be noted, occurred largely during the second phase of HEW's administrative evolution.

- Technical assistance, monitoring, and enforcement of reporting requirements also are regarded by Federal officials as having declined under the block grant, and the states overwhelmingly confirm this view.

- Disputes between state and Federal officials, concerning the 314(d) program, have been very rare since 1970. Only seven states report ever having had such a dispute, and in all but one of these cases, the outcome was deemed satisfactory by the state involved.

Thus, while some observers suggest that certain functions, especially evaluation and auditing, ought to receive greater Federal attention under a block grant, this has not happened under this program. Instead, the Federal role appears to have decreased in all functions since the consolidation.

Basic Patterns of State Block Grant Administration

Perhaps the most important finding here is that, once the block grant reaches the states, it ceases to be an identifiable program in the normal usage of the word and becomes instead simply another source of funds. These funds are merged with other revenues in support of numerous state or local health programs, with the 314(d) funds sometimes, but not always, traceable in state accounting systems to particular activities. It is not surprising, therefore, that the states report "314(d) staffs" as either nonexistent or very small – usually financial management staff who allocate 314(d) funds to state program accounts. The broad scope of the 314(d) grant and its administrative convenience are major factors in decisions regarding the way states administer these funds. Still, block grant funds are viewed by most states as having a separate role in their total health programs from that of categorical grants.

Decisions regarding allocation of 314(d) funds are made with limited involvement of persons outside the state health agencies. While most states report that the block grant goes through the regular state budget process, their responses regarding the practical importance of major budget actors (governor, central-budget office, and appropriations committees) in 314(d) allocation decisions call into question the impact of this review in some states. Other interests, including comprehensive health planning agencies, are seldom important participants in block grant allocation decisions in any states. The following specific findings support these general conclusions.

- Only two states report that the 314(d) funds are administered as a discrete state program. In contrast, 35 states indicate that block grant funds are merged with other revenues but can be traced to particular state health programs, while 11 states report that these funds are merged with other revenues and are not identifiable within particular activities.[4]

- The reasons given for the manner of administration varied considerably. The broad scope of the block grant was cited as a factor by 35 states; maintenance of an audit trail and ease of meeting Federal planning and reporting requirements were each noted by 26 states; and ease of financial management, the number and

restrictiveness of other Federal grants, and the size of the block grant were mentioned by 24, 21, and 12 states, respectively. The suggestions of Federal officials were a factor for only three states.

- Thirty-seven states indicated that the block grant plays a unique role in their total health programs, while 12 stated that these funds have the same function as categorical grants. The essence of this unique role is the block grant's availability for expenditure based on state and local priorities, and for support of broad, cross-categorical servicing efforts. In 43 states, the block grant reportedly is covered in the regular state budget process, while six states indicated a different treatment and one did not respond to this question. This is somewhat different from the response on categorical health grants, which 39 states indicated are covered by the state budget process.

- The major participants in 314(d) allocation decisions, cited by the states, include the central budget office, appropriations committees in the state legislature, local general purpose governments, and the governor, listed by 14, 13, 12, and 11 states respectively. In 11, the governor, the central budget office, and the appropriation committees – are all reported as having no important role in 314(d) allocation decisions; this finding suggests that the budget review applied to the block grant is largely perfunctory in some states.

- Comprehensive health planning agencies are generally not major participants in 314(d) expenditure decisions. State CHP agencies were listed as major actors by only six states, as minor participants by 23, and as unimportant by 18. Areawide CHP agencies were even less involved and were cited as major participants in only five states.

- Federal officials, the private sector, and citizens' groups, along with A-95 clearinghouses, are generally viewed as unimportant in this block grant's allocation decisions.

Local Government and Private Sector Involvement in State Block Grant Administration

Despite the relatively minor role of these interests in state expenditure decisions, most states involve local or regional agencies in the operation of the 314(d) program by making suballocations of block grant funds to these units. The devices employed for these suballocations include formula-based awards, project grants, and combinations of both approaches, and the states vary in the degree to which they impose restrictions on recipients' use or administration of these funds. Due to this wide variation, from the perspective of a local governmental or private agency, the block grant will have very different implications for local-level involvement and flexibility in different states.

Private health care providers and private non-profit health-related organizations generally are not involved in these programs. For the most part, consolidation apparently caused little change on this score. But, those states that discerned an impact of the block grant mechanism on private sector roles, more often than not, saw it as decreasing private sector involvement. An expanded partnership between the public and private sectors clearly did not occur under the block grant.

Over all, most state health officials perceive little impact on state-local relations in the public health sphere attributable to the switch to block grant funding, but those who do, overwhelmingly view it as a positive one. The following facts elaborate on these conclusions.

- Ten states make no block grant suballocations to local or regional agencies, while 37 allocate part of their 314(d) award to such agencies, and three report the entire award is suballocated. Of the 40 states which made suballocations, 18 reported that they do so on a project basis, 12 by a formula, and nine by a mixture of both methods. Ten states indicated that no restrictions are placed on recipient use or administration of these funds, while 29 employed such restrictions. Those states relying on the project grant for suballocations most often impose restrictions (80%), followed by those using formula

allocations (50%), and those utilizing both methods (33%).

- Priorities for expenditure of block grant funds are set by the state most frequently (28 states), by local recipients in two states, and by joint state-local actions in 13 states. In seven states, priorities are not set at one level, but it is not clear from the responses whether they are set at the other level.

- Private health care providers are described as having a major role in the 314(d) program in only two states, minor participation in 11, and none in 36 states. Private non-profit health related organizations are assigned a major place in the program in two states, a minor role in 18, and no part in 30 states. In comparison with the position of these organizations under the prior categorical programs, 29 states report no change under the block grant, six claim an increased role, and ten cite a diminished status for these bodies.

- Overall, 29 states report no impact on state-local relations due to the block grant, while 17 states cite a beneficial impact, and only two states indicate a negative effect.

Reality of State Flexibility Under the Block Grant

The issue of greater recipient discretion is at the heart of the block grant rationale, and is one area in which the legislative intent clearly has been realized. The states overwhelmingly report that the block grant affords them greater flexibility than did the categorical grant programs, although many note that this has been severely limited by the absence of significant funding increases for the block grant. Furthermore, most states indicate that this increased flexibility has been utilized, as reflected in new activities or changes in the levels of support for existing activities. With respect to the few restrictions in the 314(d) block grant, nearly half of the states assert that none of these provisions actually constrains, nor could restrain, their public health activities. The restrictions most often cited as limiting state discretion include the mental health earmark, the 70 percent minimum for services in communities, and local merit system requirements. Yet, none of these was cited by more than one-third of the states. Apparently, the difficulty of enforcing these restrictions does not relate only to the small size of this program, or the potential for fungibility presented by other Federal health grants, since few states indicated the impact of these restrictions would change if the 314(d) grant were larger or represented a larger percentage of Federal health grant funds. These difficulties, then, may arise from problems inherent in the nature of these restrictions, or from the opportunities for fungibility presented by large non-Federal health expenditures. These contentions are based on the findings outlined below.

- State discretion under the block grant, relative to that under the old categorical grants, is viewed as greater by 44 states, and not greater by three, with three states unable to make this comparison. Of these 44 states, 30 report that they have used this increased flexibility in such areas as supporting local health departments, funding of cross-categorical health services, and basic supportive services such as central state laboratories. Twelve states indicate they have not used the increased flexibility, presumably because, in the absence of significant funding increases for the block grant, new activities would have been undertaken at the expense of existing programs.

- Twenty-three states maintain that none of the six major restrictions in the 314(d) program limits their discretion under the block grant, while 25 cited one or more of these provisions as an actual constraint. Most frequently mentioned were the mental health earmark (16 states), the 70 percent rule (14 states), and local merit system requirements (ten states), followed by the maintenance of effort and state matching requirements (six states each). Five states cited the local matching requirement. Only seven states responded that the impact of these restrictions would change if the 314(d) program were larger — generally in the direction of greater constraint, and only six states anticipated a different impact if the block grant represented a larger percentage of all Federal health grant funds.

Overview of State Block Grant Expenditures

The lack of adequate data on expenditure of 314(d) funds has been a perennial weakness in the block grant. While progress is being made in this regard by the Association of State and Territorial Health Officials' Health Program Reporting System, the necessary data do not exist for confidently comparing block grant expenditure patterns with those of the prior categorical grants. For a variety of reasons, especially the unverified nature of the data and the inconsistent and incomplete reporting of local expenditures, the accuracy of the available figures is questionable. In addition, it is not clear what meaning should be attached to even "accurate" expenditure data for this (or any other single) program, due to the problem of fungibility of revenue sources.

With these caveats in mind, several tentative conclusions can be offered. The first is that, while the 314(d) grant is small on a national basis in comparison with total state health department expenditures, its importance varies considerably among the states. Moreover, its role in the support of certain health activities is disproportionately large, particularly in radiation control, chronic disease, and communicable disease control programs. Perhaps of greatest interest is the picture of general stability across categories over time which the available data suggest. Only two of the prior categories, heart disease control and home health services, appear to have fared poorly since the consolidation, while the general health category, alone, significantly increased its share of block grant funds. No other major shifts are evident, however. The following data illustrate these points in greater detail.

- As reported by the ASTHO reporting system, the block grant comprises only about 3.2 percent of state health department expenditures nationwide (FY 1974), but individual state figures range from 0.8 percent in Hawaii to 15.2 percent in Iowa, with 12 states in which the share of expenditures derived from 314(d) is 10 percent or more. Similarly, the block grant represents nearly 16 percent of total Federal grant funds received by the state health departments, while individual state figures range from 7.3 percent in Kentucky to 38.5 percent in Missouri.

- While the 314(d) block grant accounts for only 3.2 percent of total state health department activities, it is not evenly distributed among particular health activities. The block grant represents a disproportionate share of reported state health department expenditures in general health (8.8%); communicable disease (12.4%); chronic disease (14.5%); general environmental health (10.6%); general consumer protection (7.9%); radiation control (22.8%); general sanitation (5.1%); and laboratory services (5.1%). In some other areas, it represents a very small part of total expenditures.

- Block grant funds have been allocated mainly to the following areas: general health (30.0%); communicable disease (15.1%); chronic disease (7.3%); funds to local agencies not identified by categories (9.6%); and "other programs and administration" (13.5%). Of the prior legislative categories, the dental health share of 314(d) funds is now down to 0.9 percent, compared to a preconsolidation figure of 1.7 percent; general health's 30.0 percent compares with 17.4 percent in 1966; and the 15.1 percent share for chronic disease contrasts with 21.4 percent in 1966.

State Public Health Officials' Attitudes Toward the Block Grant

Probably the most clear cut and least surprising finding is that state public health officials like the block grant. By an overwhelming margin, they report general satisfaction with the operation of the 314(d) program. They consider its chief advantage to be its flexibility across program categories, regarding types of activities, in light of local conditions, and over time. A distant second among the advantages cited was simplified or less costly administration. The main disadvantage of the block grant, relative to categorical grants, is perceived to be the lower political support – and, therefore, funding levels – it obtains. Despite this drawback, on balance, nearly all state public health officials declared a preference for expansion of the block grant rather than of categorical grants. Most held to this preference even if it were to be achieved by consolidating categorical grants within 314(d), and a majority would like to see all existing public health categoricals folded into the block grant. This strong support for the block grant is reflected in the following specific findings.

- The block grant is viewed as generally satisfactory by fully 46 states, with only four states responding in the negative. Its chief attraction is flexibility, cited by 48 states, while administrative simplification was mentioned by nine states. The major disadvantage associated with the block grant is low or uncertain funding levels, cited by 30 states, while 16 states deny that any disadvantages exist in comparison with categorical grants.

- In keeping with the above, 46 states prefer expansion of the block grant to that of categorical grants; three states indicate no preference between the two; and one state declared a preference for categorical expansion. Of these 46, all but ten of the 45 states responding would continue to favor expansion of the block grant, even if achieved by melding existing categoricals into the 314(d) grant. Lastly, of these 35 states, 28 are determined block grant advocates, favoring consolidation of all existing categorical grants within the block grant, while five states suggest exceptions which should be retained as categorical programs, and two states did not respond to this item.

INTERGOVERNMENTAL ISSUES

The history of the 314(d) block grant raises many issues which may be salient to broader consideration of the role of block grants in the intergovernmental aid system in this country. This determination, of course, must be made by comparing the results of this case study with those of other block grants. Whether these issues prove to be generally applicable to block grants or not, they must be addressed in considering the future course of the 314(d) program.

To sharpen possible generic block grant questions and to highlight certain continuing dilemmas specific to the 314(d) grant, four basic questions should be addressed.

- First, is the basic purpose of the Federal block grant essentially the furtherance of state and local health services priorities, or rapidly changing national program priorities, or both?
- Second, can an appropriate Federal administrative role be defined for a block grant?
- Third, is recipient flexibility necessarily achieved under a block grant; if not, under what conditions is this flexibility achieved?
- Fourth, what are the political effects of a block grant; who fares well and who fares poorly under this form of Federal aid?

These broad issues, of course, are highly interrelated. But, to clarify the analysis, they are discussed separately insofar as is possible, and in the context of the 314(d) block grant.

To What Extent Should the Block Grant Be Responsive to State, Rather Than Federal, Priorities?

It has been observed repeatedly in this chapter that the fundamental dilemma of the 314(d) block grant is the ambiguity surrounding its basic purpose – whether the block grant is intended chiefly to support practically any state and local health activities the recipient prefers, or to further particular national priorities in public health. Stated in terms of fiscal accountability, are block grant funds meant to be responsive to state and local, or to national priorities? Neither Congress nor HEW came to grips with this question during the measure's legislative development. Instead, HEW asserted that national and state interests were complementary; hence, the question was academic. While the committees expressed some skepticism that this would always be the case, they provided only ambiguous guidance as to how disagreements between Federal officials and the states should be resolved.

This presumed congruence of state and Federal interests is not supported by the history of the 314(d) program. The early years of the program were marked by a number of disputes over state program content. In the absence of prior resolution of this issue, these disputes caused great administrative confusion. The states involved maintained that they were entitled to the funds, regardless of how they intended to use them, while HEW's regional offices argued that Federal accountability for the program could not be preserved without authority on their part to exercise a degree of control over state programs. These conflicts were resolved by acceding to the states' viewpoint, but at a cost of a very considerable decline in HEW's interest and Congressional confidence in this program. With Congress, the lack of congruence between state and Federal

interests under the block grant led to repeated moves to partially recategorize the block grant, by requiring that the states address certain problems of national concern with these funds, and to the establishment of new public health categoricals.

This evidence that state and Federal public health priorities do not coincide perfectly means that it is necessary to face the issue of the extent to which the block grant should be responsive to state, rather than Federal, interest. A corollary issue is the question of whether a state-dominated block grant can develop sufficient political support at the national level to survive the severe competition with categorical grants for limited resources.[5] The failure of the 314(d) block grant to achieve the higher funding levels envisioned at its inception, and the recategorization of the Federal health services grant structure since 1966, suggest what the answer to this question may be if insufficient recognition is given to the need for national level accountability under the block grant. After all, it is easier to mobilize political support around assaults on particular health problems than for general or comprehensive health services. Furthermore, if the block grant is not responsive to the need of Congress and HEW to demonstrate action on well publicized health problems, or does not document what has been achieved by the states with block grant funds, it will be at a considerable disadvantage in the Federal budget process. This holds true regardless of the merit of the activities supported with block grant funds. Such has been the experience of the 314(d) grant. Based on its record, it may be surmised that, despite this year's reaffirmation of Congressional support of the program, the continued survival of this block grant in its present form is problematic, unless a better accommodation is reached between Federal concerns and state or local priorities. At the same time, moving too far in the direction of responsiveness to Federal influence would undermine the recipient flexibility and administrative simplification which distinguish block from categorical grants; and the latter, after all, were crucial factors in creating the block grant in the first place.

How Should The Federal Administrative Role Be Defined In A Block Grant?

Intertwined with the previous issue is that of defining a Federal administrative role appropriate for the block grant. The awkward period of adjustment by Federal program officials to this new funding mechanism, after the 1966 consolidation, was no doubt due in part, as some observers have argued, to the lack of a normative model of block grant administration. Without such a model, HEW administrators turned initially to the style of operation they were accustomed to under categoricals, and later adopted a management style that bordered on abdication. Neither of these extremes seems satisfactory, for reasons discussed above. Yet, no appropriate middle ground has been articulated.

In searching for this higher middle ground, three major aspects of Federal block grant administration must be considered. The first involves the Federal administrative functions treated earlier in this study: provision of technical assistance; review and approval of state plans; program evaluation; monitoring of state programs; auditing; and resolving disputes which arise over program implementation. All of these activities, of course, could apply to either a block or a categorical grant. The issue is deciding which of these functions should be emphasized, and which de-emphasized, in block grant administration. Some observers have suggested that the administrative style best suited to this block grant is one which focuses on the evaluation and audit functions, whereas, in fact, these functions appear to have received the least attention by 314(d) officials. Other commentators have stressed different functions, particularly plan review and monitoring, while still others argue that technical assistance should take on increased importance under a block grant, both as a natural complement to a change in the locus of decision making for grant funds, and as an avenue for encouraging response to problems of national prominence. Selecting from, and achieving a balance among, these functions is the essence of block grant administration. Neither task can be safely avoided, since they both have substantial implications for the survival of a block grant. After all, the ability of Federal officials to devise an administrative role in which they feel comfortable is an important determinant of their attitudes toward a program, which in turn strongly affects the treatment afforded the program in the budget process.

A second key aspect of Federal block grant administration is selecting an appropriate focus for these functions, especially monitoring and reporting requirements, evaluation, auditing, and technical assistance. Should Federal attention be directed to the block grant funds only, to all Federal funds, or to state and local public health expenditures in their entirety? Traditionally, Federal officials have concentrated exclusively on the block grant (or particular categorical program) funds, but some observers maintain that this focus is too narrow to obtain a meaningful picture of what the block grant is accomplishing. Instead, they suggest the entire state and local public health program as the proper

subject of these administrative functions. Underlying this argument are the problems of fungibility of revenue sources, and the apparent tendency of many state health agencies to allocate block grant funds to program accounts in such a way as to minimize accounting complexity. On the other hand, expanding the focus in this manner would subject all state and local health activities to Federal review, even those financed entirely by state and local revenues. Such a course, particularly in the case of reporting requirements, might substantially increase the cost and burden of state and local grant administration, not to mention the likelihood of political and legal resistance. And such results would weaken one of the major arguments advanced in favor of the block grant.

The last aspect of Federal block grant administration considered here is whether the particular program requirements are enforceable. This issue arises, of course, from the problem of fungibility. Nearly half of the state health agencies report that not a single one of the restrictions embodied in the 314(d) statute has any impact on their total health program, while most of the remaining cite only one or two of these requirements as having such an impact. This situation appears to result from the existence of plentiful opportunities for rebudgeting revenue sources in particular program areas, so as to counterbalance the effects of Federal program requirements. In short, the presence of categoricals and of major recipient outlays from own sources must be considered when constraints are contemplated. The imposition of restrictions which cannot be enforced can have few beneficial effects on the integrity of Federal and state grant administration. At best these requirements serve to communicate Federal policy preferences, while at worst they force Federal and state officials to engage in a devious and debilitating form of intergovernmental grant administration. Moreover, they may unconsciously establish a dual standard of recipient administration which is more restrictive for less sophisticated or more circumspect states. For these reasons, definition of an appropriate mode of Federal block grant administration must consider the enforceability of current or proposed program requirements. While the preceding statement also applies to the administration of some categorical grants, the broader scope of block grants may render them somewhat more susceptible to this problem.

To What Extent is Recipient Flexibility Actually Realized Under a Block Grant?

Probably the most important objective of the 314(d) consolidation was to provide recipients with the flexibility to expend grant funds on the basis of their own health service priorities. This examination of the 314(d) block grant suggests that several factors (in addition to program restrictions discussed above) may jointly determine the extent to which recipient flexibility is actually realized under a block grant, and the manner in which it is exercised. One such factor is the size of the block grant. Even though it removes all categorical restrictions on expenditures (with the exception of the 15 percent mental health earmark), the magnitude of the 314(d) block grant clearly places limits on the flexibility it provides. This program, after all, operates in an area dominated by categoricals, and it is small in relation to total state and local health expenditures. Hence, its discretion may be less fully utilized than that of an identical block grant which comprises a greater share of its program area.

Another potentially significant factor is the origin of the block grant. Those block grants, such as 314(d) which are formed by consolidating existing grants may have very different implications for recipient flexibility than block grants in largely new program areas (such as the LEAA program). The former will have inherited established programs and their vested constituencies, while the latter at least initially have no corresponding claimants for continuing support. The political difficulty of eliminating established programs may be a strong counterforce to a state block grant administrator's desire to initiate new programs or to alter the funding levels of existing programs. Similarly, the presence of "new money" – that is, increases in real funding levels – in the initial year of consolidation, and in later years of both consolidated and "new" block grants, may be a prerequisite to large-scale exercise of a block grant's flexibility. In both types of block grants, the dynamics of program support tend to lock administrators into a continuation of the previous year's activities, and "new money" often provides the real margin for flexible resource allocation.

Finally, as was noted in the body of this report, even where state level flexibility is achieved under a Federal block grant, there is no guarantee that local-level flexibility will be similarly enhanced. Widely varying patterns of state aid systems interact with the 314(d) block grant to produce widely varying effects on local recipient flexibility. It is possible to specifically prohibit states from recategorizing or otherwise restricting the portions of the 314(d) grant they suballocate to local agencies, but doing so would diminish state administrative flexibility. Thus, in a block grant which is awarded directly only to state-level recipients, state and local flexibility may constitute conflicting program objectives.

Alternatively, Federal block grant awards could be made directly to both state and local recipients, although such a practice would considerably increase the complexity of the 314(d) block grant and, in many cases, tend to ignore the states' prime role in this functional area.

What Are The Political Consequences of Block Grant Funding?

In the view of many observers, the most critical block grant question is who fares well and who fares poorly under a block grant? Put more specifically, in comparison with categorical funding, which programs, types of activities, population subgroups, and geographic areas tend to benefit and which tend to suffer, under the block grant mechanism? This question is even more pressing in the case of block grants formed through consolidation, such as the 314(d) program, where established programs are no longer protected by legislative categories and are compelled to compete at the state and local levels for continued funding. Despite the overriding importance of this issue, the paucity of detailed expenditure data for the 314(d) block grant precludes authoritatively answering this fundamental question. The available evidence suggests that large-scale redistribution of resources has not occurred under the 314(d) grant, although heart disease control and home health programs have lost ground to general health activities (the probable reasons for this general stability were discussed in the earlier section on recipient flexibility). Yet, this issue is of considerable interest to Congress and the special health constituencies, and is the primary concern of block grant opponents. Clearly, if block grant allocation decisions appear to have been made on capricious or purely political basis, or to be systematically detrimental to certain groups or activities in favor at the national level, the future role of the block grant will be problematic.

FOOTNOTES

[1] Several health programs not then administered by the U.S. Public Health Service were excluded from this merger.

[2] To a certain, but lesser, extent this view applied to the previous health formula grants as well.

[3] Two states were unable to compare previous and current Federal evaluation practices.

[4] Numbers may not always total 50, due to non-responses to some items.

[5] See Robbins, 1974, pp. 156-161.

Recommendations

This volume of the Commission's study of the *Intergovernmental Grant System: An Assessment and Proposed Policies,* has focused on the Partnership for Health program, the first block grant to be enacted in recent times. The Commission believes that lessons regarding block grants in general and public health programs in particular can be learned from this case study.

In assessing the decade of experience with this program, the Commission concluded that some form of broad, block grant was still the best intergovernmental approach in the public health services area. Hence, it rejected proposals that would leave the categoricals supreme in this field and that would maintain the 314(d) program essentially in its present, distinct position. Moreover, while recognizing the merit of authorizing the transfer of a specified percentage of the funds from one health grant to another,[1] the Commission believes the time is ripe for a bolder, more innovative approach to the problem of achieving greater recipient flexibility while recognizing national concerns in public health services.[2]

Yet, in devising such an approach, the Commission is convinced that it should be confined essentially to the program terrain covered by the score of existing categoricals, the 314(d) program, and any future enactments relating to public health services. In our opinion, the practical, programmatic, administrative, and fiscal hurdles facing any basic reform proposal in this area are high enough without adding the even higher hurdle of personal health care.[3]

In short, the Commission finds that the existing public health services block grant has failed to live up to the commendable flexible servicing, expanded funding, and broad systemic goals of its framers, essentially because of the subsequent failure of Congress and the Administration to abstain from categorical enactments, thereby failing to achieve an effective balancing within the program of national priorities and state-local program discretion. Hence, . . .

The Commission recomends that Congress enact legislation authorizing Federal cost sharing for a range of statutorily specified public health services up to an overall per capita ceiling within each state modified in accordance with appropriate need factors with the added provision that any changes in national health protection priorities, as determined by Congress, would be reflected in a temporary variation in cost sharing modified to recognize regional and state differences, for the service(s) in question.

The Commission also recommends, that with enactment of this cost sharing program, Congress repeal section 314(d) of the *Public Health Services Act* and, over a reasonable period of time, fold into this new program other public health programs.

The Commission further recommends that Congress include in this cost sharing legislation provisions requiring:

- **each participating state – in conjunction with the units of local government involved, where appropriate – to develop a comprehensive annual plan applicable to its (their) program and priorities for rendering public health services;**
- **such plans to be published and generally made available to the public for review and comment, before submission;**
- **the appropriate unit in the Department of Health, Education and Welfare to give substantive review in light of statutorily determined public health program goals and priorities, to approve such plans, to monitor the process by which they were developed as well as their implementation, and periodically to evaluate the effectiveness of this cost sharing arrangement.[4]**

This omnibus recommendation with its three major components is designed to achieve five broad and interrelated objectives.

First, it is geared to recognizing national, top priority, public health concerns while simultaneously expanding state and local discretion in this broad servicing area and each within the context of a single omnibus program and process.

Second, through the proposed cost sharing arrangement capped by an overall per capita ceiling for each state, it seeks to expand state and local participation in this program area, while avoiding the danger of an "open-ended" Federal assistance program.

Third, it realistically views consolidation of all existing public health categoricals as a gradual phasing-in process, but seeks to achieve some of the benefits of the block grant approach more immediately.

Fourth, through its state planning process, it seeks to involve affected local governments, chiefly counties, as well as the public in developing a balanced ordering of public health services within each state.

Fifth, it attempts to clarify the administrative role of HEW under this evolving block grant program by specifying four basic activities that are necessarry to maintain a proper protection of the Federal interest, while excluding activities that would unnecessarily compromise state-local discretion.

This reform proposal parallels that of the Association of State and Territorial Health Officials (ASTHO) and the National Association of County Health Officers.[5] Under it, the existing 314(d) block grant would be replaced with a Federal reimbursement of fixed percentages of state and local expenditures for a statutorily defined set of health services. Moreover, the numerous related categorical grants directed at public health services would be gradually repealed and folded into the new program. The basic factor prompting this phasing-in strategy, of course, is its greater political feasibility.

How then would this modified block grant approach work? Fiscally, the level of Federal funding in any one year would vary under a ceiling depending on each state's pattern of expenditures for health services which are eligible for cost sharing. The ceiling, a per capita dollar figure adjusted according to appropriate need factors, would serve as the means of making this into a "closed-end" program. Under one version of this plan, the Federal government on an interim basis would assume 75 percent of the cost of eligible expenditures added after the year of enactment until such time as the state's per capita maximum level was reached. The per capita ceiling would average $4.00 nationwide under that version. A pass-through of Federal funds to local governmental units would occur in those health services areas where such units are the basic providers and a maintenance of effort provision would bar states and localities from substituting Federal cost sharing funds for their own outlays in the affected program areas.

The only departure from this basic funding arrangement would be where Congress designated certain services as high priority national concerns. Such action would escalate the interim Federal match and, in some

cases, the per capita ceiling to a higher level for the service or services so designated, but following a statutorily determined period the match or per capita ceiling would decline to that which applies to the foundation cluster of eligible services. This feature, of course, recognizes the Congress' continuing concern with topical public health services and provides an effective means within the new program for expressing this concern without resorting to a series of categorical enactments.

The most distinctive programmatic features in this cost sharing proposal relate to the eligibility and merger questions. What state-local programs then would be eligible for cost sharing? Congress would indicate the range of eligible programs in the enabling statute, within and among states, the cluster of services covered by this arrangement could vary from year to year. The particular mix would depend largely on the outcome of each state's program planning process, analyzed below. Yet, the range of services included in any state plan inevitably would be conditioned by the list of services that Congress specified as being eligible for cost sharing in the authorizing legislation. This list might well include the more than 20 categorical programs that now comprise the public health assistance package, as well as other program areas for which states and localities have assumed prime responsibility. In any event, the degree of recipient program flexibility here would hinge heavily on Congressional specification of a wide variety of existing and potential public health efforts in the enabling enactment.

On the question of consolidating existing public health categoricals with the cost sharing program, a gradualist approach is recommended. The politics of public health, after all, has created more than a score of categoricals, with separate vocational interests, varying matching, and divergent eligibility provisions. Yet, gradualism is not a synonym for stasis.

The repeal of the 314(d) program would constitute the first hurdle here, since this would eliminate the mental health earmark within the program. Yet, in practical administrative terms, this involves potentially direct conflict only between two units within state governments. If the ostensibly separate vocational concerns of public and mental health cannot be reconciled — hopefully with gubernatorial and state legislative support — then the prospects of additional program mergers are bleak indeed. Secondly, in developing the draft legislation, Congress might well focus on a procedure that assures an early folding-in of the five formula based categoricals[6] that presently are largely the responsibility of state public and mental health agencies. As with the mental health earmark, the strategy here is to single out those programs that now are administered by state health units, the rationale being that a minimum disruption of administrative patterns and practices would result from such mergers and that current gubernatorial and state legislative sentiment would be supportive of such an effort. Finally, Congress is well aware of the major difficulties facing those attempting to merge the 16 project grants in the health services field.[7] Yet, six of these are directed primarily to state and local general government health agencies and this narrowing of recipient eligibility to the public sector may suggest a second generation of consolidation candidates. It is with the remaining nine, primarily benefiting private non-profit agencies, the greatest difficulty will be encountered. Hence, these probably should be slated for a still later folding into the new grant program. A mechanism that Congress might consider in developing a schedule for consolidation is to require that, by the end of each succeeding three-year period following enactment of the cost sharing legislation, all health service formula grants be automatically merged with the program unless Congress reviews and specifically exempts one or more of them from consolidation. With the public sector project grants, the period of time might be extended to four or five years, while for the private non-profit oriented, project grants, the period might be five or six years. Regardless of method, however, Congress should build into the authorizing legislation a set procedure for coping with the question of consolidations.

The process by which the state plans would be developed somewhat modifies present practice. Essentially, all public providers of health services within a state initially would participate in a state-sponsored effort that would identify continuing and new health protection needs, establish priorities, and culminate in a broad state program plan. This, in turn, would have to be compatible with the overall comprehensive state plan prepared by the statewide health coordinating council pursuant to sections 1513(3) and 1524(c)6 of the *Health Planning and Resources Development Act of 1974* (P.L. 93-641). Elected officials of the various jurisdictions involved, especially the governor and probably the health committees of the state legislature, also should participate at the appropriate stage of this planning process. Moreover, the resulting plans should be published and generally made available to the public for assessment and reactions prior to their submission to the Department of Health, Education and Welfare. States could adopt varying methods to implement this citizen review requirement. Not to be overlooked in all this is

the basic goal of converting the process into one wherein generalists and the public alike have a clear opportunity to interact with the health professionals to develop a broader concept of the public health interest. If this effort were to succeed, the pressures on Congress for special service designations would diminish appreciably.

But what of the non-profits? A basic factor in facilitating the ultimate merger of the project grants would be the extent to which states succeed in involving these servicing units in the health protection planning process. This will be no easy task given the strength and separatism of the private sector providers. Yet, the cause and the cost of public health services within the states will not be given proper recognition, if the present highly fragmented pattern of delivery is ignored.

Finally, to help clarify the potentially controversial role of the Department of Health, Education and Welfare (HEW) in this program, the proposed legislation would provide statutory guidelines for the department's role in substantively reviewing the state plans, in monitoring their development and implementation, and in evaluating their effectiveness. As with any block grant, these efforts are vital to the success of the program. Moreover, if a delicate balance is not struck here between effective substantive involvement, on the one hand, and non-intrusiveness, on the other, the merits of this approach are lost.

To sum up, the Commission believes that this cost sharing approach, in effect, would resolve the basic dilemma of achieving a broad block grant approach in this program area by defining the Federal purpose simply as sharing in the cost of state and local public health services, while permitting changing national priorities to be addressed through a gradual change in the list of eligible services and through temporary variations in Federal matching rates for the services involved. The Commission feels that the problem of funding uncertainty would be reduced considerably by the nature of the matching. Local government flexibility and popular participation, as well as a prime state role, all would be enhanced under the proposed arrangement. The Commission stresses that while a major incentive to increased funding of health services by recipient governments is a basic feature of the program, adequate Federal fiscal controls are also present. Its consolidationist features, the Commission emphasizes, are realistic and ultimately promise to make recipient program flexibility more of a reality than it is today. Finally, the Commission supports this cost sharing arrangement because it would return to state and local governments the basic authority and responsibility for setting their area's health service priorities, for meeting their special needs, and for determining the total level of their public health program outlays; but, it also provides an appropriate method for recognizing service areas of high national priority; for providing positive but not meddling HEW leadership; and for properly informing Congress on the program's effectiveness.

FOOTNOTES

[1] This was the position taken by the Commission in its 1961 report on *Modification of Federal Grants-in-Aid for Public Health Services* (A-2).

[2] For the purposes of this chapter and recommendation, public health services excludes health manpower and planning programs.

[3] In addition, the Commission in its 1969 report on *State Aid to Local Governments* (A-34), recommended national government assumption of full financial responsibility for public assistance, including the Medicaid and general assistance programs.

[4] Secretary Hills dissented from this recommendation, chiefly on grounds that it should include a non-matching provision. Mr. Cannon abstained from the final vote, citing his brief participation in the debate as the reason.

[5] For more details on the ASTHO proposal, see Association of State and Territorial Health Officials, "A National System for Health Protection" (Washington, D.C.: ASTHO, September 1975) mimeographed.

[6] These include Maternal and Child Health Services Formula Grants (42 U.S.C. 703), Crippled Childrens Services Grants (42 U.S.C. 704), Alcohol Abuse Prevention Formula Grants (42 U.S C. 4571), Drug Abuse Prevention Formula Grants (21 U.S.C. 1176), and Developmental Disabilities Basic Support Formula Grants (42 U.S.C. 6062). They would not include Medicaid (Title XIX of the Social Security Act). All of the above is based on the U.S. Code, 1970 Edition, Supplement 4, 1974 .

[7] These include Disease Control Project Grants (42U.S.C. 247b), Venereal Disease Control Project Grants (42 U.S.C. 247c), Migrant Health Project Grants (42 U.S.C. 247d), Community Health Centers Projects Grants (42 U.S.C. 254c), Family Planning Project Grants (42 U.S.C. 300), Sudden Infant Death Syndrome Information and Counseling Project Grants (42 U.S.C. 300c-11), Hemophilia Diagnostic and Treatment Centers Project Grants (42 U.S.C. 300c-21) Blood Separation Centers Project Grants (42 U.S.C. 300c-22), Emergency Medical Services Project Grants (42 U.S.C. 300d-1-300d-3), Home Health Demonstrations Projects Grants (42 U.S.C. 1395x), Community Mental Health Centers Planning and Initial Operations Project Grants (42 U.S C. 2689a, 2689b), Implementation of Uniform State Act for Alcoholism and Intoxication Treatment Project Grants (42 U.S.C. 4574), Prevention and Treatment of Alcohal Abuse and Alcoholism Project Grants (42 U.S.C. 4577), Childhood Lead-Based Paint Poisoning Control Project Grants (42 U.S.C. 4801), Developmental Disabilities Project Grants (42 U.S.C. 6081), and Drug Abuse Special Project Grants (21 U.S.C. 1177).

Expenditure Tables

Table A-1

Components of the General Health Care and Preventive Services Category of Table 22 – Total and 314(d) Public Health Portion

Program Component	Expenditures (in thousands) Total	314(d) Public Health Funds
Total	**$250,489**	**$20,471**
Laboratories	54,945	7,015
Public Health Nursing	49,027	3,000
General Public Health Programs	34,728	5,238
Handicapped Adult Health	19,172	–
Programs of Care Not Primarily in Institutions	13,613	–
Home Care	12,791	554
Unallocated Grants to Local Health Departments	11,953	–
Emergency Medical Services (Planning)	8,789	256
Migrant Health	7,923	80
Local Health Department Programs Only	6,235	2,076
Nutrition	5,172	173
Neighborhood Health Centers	4,591	277
Supporting Professional and Administrative Services	2,900	518
Other Health Professional Support	2,652	43
Medical Examiners	2,488	–
Health Education	2,482	208
Medicaid – Not Single State Agency	2,116	–
Accident Prevention	1,868	17
Miscellaneous Special Groups (Minorities, Poor, Etc.)	1,390	950
Manpower Development	1,343	–
Employee Health, Occupational Health	1,129	19
Adult Health	902	–
Epidemiology (Except Communicable Disease Epidemiology)	583	47
Rehabilitation	562	–
Low Income – above Medicaid	487	–
Research	435	–
Emergency Services	182	–
Other	29	–
Amount Not Allocable to Programs	–	1,447

Source: **Taken from Association of State and Territorial Health Officials, Health Program Reporting System, *Initial Report on Programs and Expenditures of State and Territorial Health Agencies, Fiscal Year 1974* (Washington, D.C.: ASTHO, 1975), p.25.**

Table A-2

314(d) Public Health Portion Expenditures as Percent of Net Total State Health Agency (SHA) Net Non-Federal Expenditures as Percent of SHA Expenditures Fiscal Year 1974

(in thousands)

State	Net Total SHA Expenditures	314(d) Public Health Expenditures	Percent of SHA Expenditures	Net Non-Federal Expenditures	Percent of SHA Expenditures
(1)	(2)	(3)	(4)	(5)	(6)
Alabama	19,796	1,384	7.0 %	11,193	56.5 %
Alaska	7,424	335	4.5	5,510	74.2
Arizona	34,259	774	2.3	28,680	83.7
Arkansas	12,216	850	7.0	6,650	54.4
California	528,577	5,739	1.1	473,198	89.5
Colorado	15,504	926	6.0	7,014	45.2
Connecticut	54,851	1,061	1.9	49,083	89.5
Delaware	10,252	407	4.0	8,776	85.6
District of Columbia	63,947	437	0.7	58,935	92.2
Florida	73,447	2,368	3.2	54,592	74.3
Georgia	28,092	1,510	5.4	19,065	67.9
Hawaii	58,868	452	0.8	53,639	91.1
Idaho	2,989	154	5.2	1,763	59.0
Illinois	31,829	3,193	10.0	19,736	62.0
Indiana	12,695	1,581	12.5	6,526	51.4
Iowa	7,069	1,072	15.2	3,320	47.0
Kansas	7,480	896	12.0	3,796	50.4
Kentucky	63,532	1,191	1.9	47,153	74.2
Louisiana	22,075	1,331	6.0	14,458	65.5
Maine	6,041	530	8.8	2,727	45.1
Maryland	190,148	1,324	0.7	175,089	92.1
Massachusetts	67,655	1,826	2.7	60,756	89.8
Michigan	64,601	2,766	4.3	37,878	58.6
Minnesota	9,044	1,360	15.0	3,934	43.5
Mississippi	20,635	1,053	5.1	11,090	53.7

Missouri	28,494	1,646	5.8	24,216	85.0
Montana	6,168	481	7.8	2,490	40.4
Nebraska	5,451	662	12.1	2,073	38.0
Nevada	4,002	388	9.7	2,539	63.4
New Hampshire	5,002	484	9.7	1,900	38.0
New Jersey	42,352	2,177	5.1	20,313	48.0
New Mexico	5,462	597	11.0	3,120	57.1
New York	182,205	5,146	2.8	165,051	90.6
North Carolina	27,534	1,982	7.2	18,229	66.2
North Dakota	9,256	432	4.7	5,923	64.0
Ohio	30,543	3,114	10.2	13,004	42.6
Oklahoma	14,603	1,065	7.3	9,478	65.0
Oregon	8,755	887	10.1	4,764	54.4
Pennsylvania	65,215	3,522	5.4	52,087	79.9
Rhode Island	10,875	531	4.9	8,027	73.8
South Carolina	32,999	1,113	3.4	21,714	65.8
South Dakota	3,667	443	12.1	1,557	42.5
Tennessee	50,264	1,504	3.0	39,646	78.9
Texas	70,964	3,357	4.7	49,191	69.3
Utah	7,054	528	7.5	3,912	55.5
Vermont	4,307	431	10.0	2,768	64.3
Virginia	58,395	1,610	2.8	48,694	83.4
Washington	17,129	1,239	7.2	7,118	41.6
Wisconsin	12,269	1,583	13.0	7,258	59.2
West Virginia	12,354	812	6.6	7,664	62.0
Wyoming	3,635	324	8.9	720	19.8
Subtotal	2,131,978	79,577	3.3	1,688,024	79.2
Territories					
Guam	2,679	206	7.7	1,946	72.6
Puerto Rico	154,312	1,697	1.1	106,204	68.8
Trust Territory	9,717	374	3.8	7,860	80.9
Virgin Island	18,856	218	1.2	16,386	86.9
Grand Total	2,317,541	73,072	3.2	1,820,420	78.5

Source: Taken from Association of State and Territorial Health Officials, Health Program Reporting System, *Initial Report on Programs and Expenditures of State and Territorial Health Agencies, Fiscal Year 1974* (Washington, D.C.: ASTHO, 1975), pp. 88-89.

Table A-3

314(d) Funds, Excluding 314(d) Mental Health Funds, Expended by State Health Agencies, by Program Area
Fiscal Year 1974
(in thousands)

State (1)	Total 314(D) Public Health Funds Expended (2)	Personal Health (3)	Environmental Health (4)	Health Resources (5)	Other Programs, Services, and Administration (6)	Funds to Local Health Departments not Allocable to Programs (7)
Alabama	1,384	869	–	–	65	450
Alaska	335	136	116	–	30	52
Arizona	774	212	29	–	533	–
Arkansas	850	558	118	#	174	–
California	5,739	3,479	1,228	–	971	–
Colorado	926	521	405	–	–	–
Connecticut	1,061	552	82	67	361	–
Delaware	407	357	39	–	11	–
District of Columbia	437	422	–	–	15	–
Florida	2,368	774	–	34	879	681
Georgia	1,510	191	–	–	–	1,319
Hawaii	452	332	25	76	18	–
Idaho	154	154	–	–	–	–
Illinois	3,193	1,476	823	261	633	–
Indiana	1,581	115	255	7	75	1,129
Iowa	1,072	818	56	80	119	–
Kansas	896	745	54	–	96	–
Kentucky	1,191	104	113	–	–	973
Louisiana	1,331	509	742	25	55	–
Maine	530	298	53	27	152	–
Maryland	1,324	838	486	–	–	–
Massachusetts	1,826	408	114	524	779	–
Michigan	2,766	1,101	429	100	480	655
Minnesota	1,360	391	266	60	644	–
Mississippi	1,053	164	590	–	299	–
Missouri	1,646	1,198	428	–	20	–
Montana	481	177	102	48	49	105

Nebraska	662	246	137	21	91	167
Nevada	388	203	55	–	35	94
New Hampshire	484	245	146	46	47	–
New Jersey	2,177	1,496	241	74	367	–
New Mexico	597	597	–	–	–	–
New York	5,146	3,253	1,447	274	171	–
North Carolina	1,982	1,488	160	24	311	–
North Dakota	432	239	128	–	65	–
Ohio	3,114	2,127	450	17	519	–
Oklahoma	1,065	659	–	–	–	405
Oregon	887	597	–	–	290	–
Pennsylvania	3,522	3,392	–	30	100	–
Rhode Island	531	302	90	138	–	–
South Carolina	1,113	461	545	–	108	–
South Dakota	443	308	83	26	26	–
Tennessee	1,504	1,247	–	–	258	–
Texas	3,357	3,090	79	120	68	–
Utah	528	96	26	–	216	190
Vermont	431	336	24	55	16	–
Virginia	1,610	1,191	417	2	–	–
Washington	1,239	60	–	–	417	762
West Virginia	812	499	113	9	192	–
Wisconsin	1,583	514	543	417	108	–
Wyoming	324	269	41	8	7	–
Subtotal	70,577	39,815	11,339	2.572	9,868	6,984
Territories						
Guam	206	206	–	–	–	–
Puerto Rico	1,697	1,341	356	–	–	–
Trust Territory	374	139	–	235	–	–
Virgin Islands	218	218	–	–	–	–
Grand Total	73,072	41,719	11,695	2,806	9,868	6,984

#—over $0 but less than $500.

Source: Taken from Association of State and Territorial Health Officials, Health Program Reporting System, *Initial Report on Programs and Expenditures of State and Territorial Health Agencies, Fiscal Year 1974* (Washington, D.C.: ASTHO, 1975), pp. 82-83.

Table A-4

314(d) Funds, Excluding 314(d) Mental Health Funds, Expended by State Health Agencies for Personal Health Programs, by Program Category Fiscal Year 1974

(in thousands)

State	Total	General and Supporting	Maternal and Child Health	Communi-cable Disease	Dental	Chronic Disease	Mental Health	Programs in State-Operated Institu-tions	Other	Funds Not Allo-cable to Programs
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Alabama	869	800	–	44	–	26	–	–	–	–
Alaska	136	61	–	33	–	–	42	–	–	–
Arizona	212	88	–	51	73	–	–	–	–	–
Arkansas	558	342	–	148	9	59	–	–	–	–
California	3,479	3,479	–	–	–	–	–	–	–	–
Colorado	521	112	–	269	–	92	26	–	–	22
Connecticut	552	376	31	7	–	118	–	–	19	–
Delaware	357	48	–	19	13	23	–	–	–	255
District of Columbia	422	326	–	38	–	58	–	–	–	–
Florida	774	–	–	692	–	82	–	–	–	–
Georgia	191	–	–	191	–	–	–	–	–	–
Hawaii	332	162	–	156	15	–	–	–	–	–
Idaho	154	140	–	–	–	14	–	–	–	–
Illinois	1,476	224	96	611	75	127	–	343	–	–
Indiana	115	100	–	15	–	–	–	–	–	–
Iowa	818	734	–	84	–	–	–	–	–	–
Kansas	745	402	19	267	–	–	–	–	–	57
Kentucky	104	–	–	22	–	83	–	–	–	–
Louisiana	509	50	109	348	#	#	–	–	–	–
Maine	298	236	–	47	–	14	–	–	–	–
Maryland	838	–	–	838	–	–	–	–	–	–
Massachusetts	408	300	–	108	–	–	–	–	–	–
Michigan	1,101	707	–	159	–	235	–	–	–	–
Minnesota	391	324	–	33	–	23	11	–	–	–
Mississippi	164	–	–	–	–	52	–	112	–	–

Missouri	1,198	547	–	116	7	21	–	–	–	507
Montana	177	52	10	75	–	39	–	–	–	–
Nebraska	246	121	–	15	–	–	–	–	–	110
Nevada	203	186	7	–	9	–	–	–	–	–
New Hampshire	245	121	–	40	37	47	–	–	–	–
New Jersey	1,496	427	–	771	11	97	–	–	190	–
New Mexico	597	9	–	148	73	–	–	–	–	367
New York	3,253	1,862	#	1,164	–	114	–	–	113	–
North Carolina	1,488	12	–	461	2	443	–	–	–	570
North Dakota	239	118	–	51	15	54	–	–	–	–
Ohio	2,127	1,027	12	642	86	361	–	–	–	–
Oklahoma	659	252	42	189	–	176	–	–	–	–
Oregon	597	218	176	203	–	–	–	–	–	–
Pennsylvania	3,392	15	–	1,322	–	1,222	–	834	–	–
Rhode Island	302	77	–	151	23	51	–	–	–	–
South Carolina	461	22	–	10	–	210	–	219	–	–
South Dakota	308	222	21	54	11	–	–	–	–	–
Tennessee	1,247	456	353	326	–	112	–	–	–	–
Texas	3,090	2,735	–	4	–	344	–	7	–	–
Utah	96	–	–	96	–	–	–	–	–	–
Vermont	336	142	–	121	35	39	–	–	–	–
Virginia	1,191	949	31	91	118	2	–	–	#	–
Washington	60	60	–	–	–	–	–	–	–	–
West Virginia	499	240	–	99	41	120	–	–	–	–
Wisconsin	514	78	98	112	8	219	–	–	–	–
Wyoming	269	189	–	62	17	1	–	–	–	–
Subtotal	39,815	19,149	1,006	10,504	675	4,677	79	1,515	323	1,888
Territories										
Guam	206	142	–	–	–	–	–	–	–	64
Puerto Rico	1,341	134	–	541	–	666	–	–	–	–
Trust Territory	139	–	–	–	–	–	–	139	–	–
Virgin Islands	218	–	–	–	–	–	–	–	–	218
Grand Total	41,719	19,425	1,006	11,045	675	5,343	79	1,654	323	2,170

#—over $0 but less than $500.

Source: Taken from Association of State and Territorial Health Officials, Health Program Reporting System, *Initial Report on Programs and Expenditures of State and Territorial Health Agencies, Fiscal Year 1974* (Washington, D.C.: ASTHO, 1975), pp. 86-87.

Table A-5

314(D) Funds, Excluding 314(D) Mental Health Funds, Expended by State Health Agencies for Environmental Health Programs, by Program Category
Fiscal Year 1974
(In thousands)

State (1)	Total (2)	General Environmental Health (3)	Potable Water (4)	Water Quality (5)	General Consumer Protection (6)	Radiation Control (7)	Occupational Health (8)	General Sanitation (9)	Laboratory Services (10)	Other (11)	Funds Not Allocable to Programs (12)
Alabama	–	–	–	–	–	–	–	–	–	–	–
Alaska	116	114	–	–	–	–	–	–	3	–	–
Arizona	29	–	–	–	–	–	–	9	–	20	–
Arkansas	118	107	–	–	–	11	–	–	–	–	–
California	1,288	–	250	–	400	150	–	–	289	200	–
Colorado	405	–	6	–	217	90	–	–	81	–	10
Connecticut	82	–	25	–	21	–	–	35	–	–	–
Delaware	39	–	4	–	10	–	–	25	–	–	–
District of Columbia	–	–	–	–	–	–	–	–	–	–	–
Florida	–	–	–	–	–	–	–	–	–	–	–
Georgia	–	–	–	–	–	–	–	–	–	–	–
Hawaii	25	25	–	–	–	–	–	–	–	–	–
Idaho	–	–	–	–	–	–	–	–	–	–	–
Illinois	823	21	26	–	331	166	–	271	–	9	–
Indiana	255	40	15	–	92	47	31	3	27	–	–
Iowa	56	56	–	–	–	–	–	–	–	–	–
Kansas	54	54	–	–	–	–	–	–	–	–	–
Kentucky	113	–	–	–	–	53	–	–	61	–	–
Louisiana	742	706	–	8	–	–	–	–	20	8	–
Maine	53	53	–	–	–	–	–	–	–	–	–
Maryland	486	448	–	–	–	38	–	–	–	–	–
Massachusetts	114	49	–	–	65	–	–	–	–	–	–
Michigan	429	–	144	–	–	175	–	110	–	–	–
Minnesota	266	79	–	–	–	57	–	4	126	–	–
Mississippi	590	413	60	–	118	–	–	–	–	–	–
Missouri	428	7	–	–	10	53	–	#	–	–	357
Montana	102	–	–	–	–	12	–	58	31	–	–

Nebraska	137	66	–	–	–	29	–	–	–	–	41
Nevada	55	55	–	–	–	–	–	–	–	–	–
New Hampshire	146	86	–	–	–	–	52	–	–	8	–
New Jersey	241	240	–	–	1	–	–	–	–	–	–
New Mexico	–	–	–	–	–	–	–	–	–	–	–
New York	1,447	412	193	–	540	301	–	#	#	–	–
North Carolina	160	41	–	–	–	–	39	–	–	–	79
North Dakota	128	–	47	–	6	16	#	57	–	2	–
Ohio	450	81	–	–	–	–	36	73	–	260	–
Oklahoma	–	–	–	–	–	–	–	–	–	–	–
Oregon	–	–	–	–	–	–	–	–	–	–	–
Pennsylvania	–	–	–	–	–	–	–	–	–	–	–
Rhode Island	90	–	–	–	53	37	–	–	–	–	–
South Carolina	545	–	1	9	142	#	11	288	88	6	–
South Dakota	83	–	–	–	–	4	–	48	32	–	–
Tennessee	–	–	–	–	–	–	–	–	–	–	–
Texas	79	–	37	12	–	–	–	30	–	–	–
Utah	26	–	–	–	–	–	–	26	–	–	–
Vermont	24	–	10	–	12	–	–	3	–	–	–
Virginia	417	64	–	–	70	–	–	254	–	27	–
Washington	–	–	–	–	–	–	–	–	–	–	–
West Virginia	113	–	25	13	8	25	5	34	3	–	–
Wisconsin	543	–	–	–	69	66	34	374	–	–	–
Wyoming	41	41	–	–	–	–	–	–	–	–	–
Sub Total	11,339	3,257	843	41	2,163	1,332	209	1,704	760	542	488
Territories											
Guam	–	–	–	–	–	–	–	–	–	–	–
Puerto Rico	356	356	–	–	–	–	–	–	–	–	–
Trust Territory	–	–	–	–	–	–	–	–	–	–	–
Virgin Islands	–	–	–	–	–	–	–	–	–	–	–
Grand Total	11,695	3,613	843	41	2,163	1,332	209	1,704	760	542	488

#—over $0 but less than $500.

Source: Taken from Association of State and Territorial Health Officials, Health Program Reporting System, *Initial Report on Programs and Expenditures of State and Territorial Health Agencies, Fiscal Year 1974* (Washington, D.C.: ASTHO, 1975), pp. 86-87.

ACIR Questionnaire

ADMINISTRATION OF THE FEDERAL COMPREHENSIVE PUBLIC HEALTH SERVICES BLOCK GRANT

(Public Health Services Portion Only)

1. Which of the following best describes the manner in which Federal 314(d) funds are administered in your state? *(Please check only one)*

   ___Entire Federal grant and required state matching funds are administered as a discrete program.
   ___Federal and state matching funds are identifiable, but merged operationally with other revenues in support of one or more programs.
   ___Federal and state matching funds are completely intermingled with other revenues in support of one or more programs; 314(d) funds are identifiable only by making pro rata estimates of the amounts involved in each activity.
   ___Other, as described below.

   ____
   ____
   ____

2. Primarily for what reason(s) was the decision made in your state to administer the 314(d) funds as indicated above? *(Check as many as are applicable)*

   ___Ease of financial management.
   ___Maintenance of a clear audit trail.
   ___Ease of Federally required reporting and/or state plan preparation.
   ___Suggestion of Federal program officials.
   ___Size of 314(d) grant to your state.
   ___Certainty (or lack of same) of 314(d) grant (underline the appropriate words).
   ___Broad scope of 314(d) grant.
   ___Number and restrictiveness of other Federal health grants.
   ___Other(s), as noted below.

   ____
   ____
   ____

3. In your state does the 314(d) block grant play a role in your total health program unique from the role(s) played by categorical Federal health grant programs?

   ___Yes___No

   If yes, what is this unique role?

   ____
   ____
   ____
   ____

4. Are part or all of your state's 314(d) grant funds suballocated to local or regional organizational units?

___Yes, all ___Yes, part ___No

If yes, is this suballocation basically on a project-by-project basis or on a formula basis?

___Project basis ___ Formula basis ___Part formula, part project

If yes, are restrictions placed by the state on the use or administration of these funds by recipients?

___ No ___Yes, as noted below:

(check as many as are applicable)

___Use restricted to state-designated priority purposes.

___Particular mode of administration required.

___Other; as specified below.

If yes, do allocations to all areas of the state and all types of recipient (*e.g.*, general local governments, consortia of local governments, independent public agencies, private profit or non-profit institutions, etc.) follow the same procedures, or is there an attempt to treat different recipients differentially on the basis of need, size, competence, etc.?

___ All areas and recipients treated alike.

___ Differentiation on the following basis(es): *(check as many as are applicable).*

___Population size of jurisdiction.

___ Financial need.

___ Severity of health problems.

___ Administrative competence.

___Preference given to units of general local government.

___Other, as noted below.

---

5. Please indicate the practical importance of the following in your state's decision regarding how 314(d) funds are allocated, to both particular purposes at the state level, and to particular recipients and purposes at the local/regional level (if such suballocations are made to local/regional units).

	Major Participant	Minor Participant	No Important Role
Governor.	___	___	___
Central budget office	___	___	___
State legislature – Appropriations Committee(s)	___	___	___
State legislature – Health Committee(s)	___	___	___
State Comprehensive Health Planning (CHP) Agency	___	___	___
Areawide CHP Agencies	___	___	___
A-95 Clearinghouses	___	___	___
Local General Governments.	___	___	___
Private Health Service Providers	___	___	___
Private Non-Profit Health-Related Organizations	___	___	___
Citizens' Groups	___	___	___
Federal Program Officials	___	___	___

6. In your state, do the 314(d) funds go through the regular state budget process, including both executive and legislative action?
___Yes ___Executive branch action only ___Legislature only ___No
Do all categorical Federal health grants go through the regular state budget process?
___Yes ___ Executive branch action only ___ Legislature only ___No
___ Some do, others do not
If the answer to either part above is not *yes*, please briefly indicate why.

7. In the preparation of your state plan for 314(d), is there an attempt to priority-rank health problems and allocate funds on that basis?
___ Yes ___ No
If funds are allocated to local/regional units, is such priority-setting required of recipients?
___N.A.___ Yes ___No

8. In your opinion has the mental health earmark within the 314(d) block grant aided or hindered your state in making the best use of the entire 314(d) grant award?
___ Aided ___ Hindered ___Made no difference
Would you favor or oppose eliminating this earmark?
___ Favor ___ Oppose ___ Neither/no opinion
If the funding level for the 314(d) program were greatly increased, would you favor or oppose eliminating this earmark?
___Favor ___Oppose ___Neither/no opinion

9. In your opinion, if the funding level of the 314(d) grant were greatly increased, would the purposes for which these funds are expended in your state probably change?
___Yes ___ No ___ Don't know
If yes, probably in what direction?

10. In your opinion, if the funding level for the 314(d) grant were greatly increased, would this grant probably continue to go through the current decision process regarding fund allocation in your state?
___Yes ___No ___Don't know
If no, what sort of change would probably occur?

11. Which, if any, of the Federal restrictions on the use and administration of 314(d) funds actually constrains your state's discretion regarding these funds? That is, which ones would, if altered or removed, result in changes in the services provided under the entire state public health program, as opposed to causing shifts in the use of 314(d) funds which would be compensated for by shifts in the use of other revenues – leaving the overall state health program unchanged? *(Check as many as are applicable)*
___"70 percent for services in communities" requirement.
___15 percent mental health earmark.
___Financial participation by the state.
___Financial participation requirement for local/regional recipients of funds.
___Maintenance of effort requirement.
___Merit system requirement for local/regional recipients of funds.
___Other(s), as noted below.

___ None

Would your answer probably be the same if the amount of 314(d) funds coming into your state were much larger than at present?
___Yes ___No ___Don't know
If no, how would your answer probably change?

Would your answer probably be the same if the 314(d) grant constituted a much larger fraction of all Federal health grants received by your state?
___Yes ___No ___Don't know
If no, how would your answer probably change?

12. Has a difference of opinion ever arisen between your state and the Federal 314(d) officials regarding any requirements or restrictions of this Federal grant program?
___Yes ___No ___Don't know
If yes, please give one typical example.

If Yes, in your opinion, was the resolution of this difference fairly arrived at?
___Yes ___No

13. In your opinion is the discretion afforded your state under the 314(d) block grant significantly greater than the discretion existing under the previous categorical Federal health grants folded into 314(d) in FY 1968?
___Yes ___No ___Don't know

14. Has the scope or level of public health activities undertaken in your state changed significantly since FY 1968, in a way which would have been very difficult or impossible before the consolidation of Federal categorical health grants, or which was encouraged by that Federal consolidation?
___Yes ___No ___Don't know
If yes, please give one typical example of such changes.

15. In which, if any, of the following areas, is the Federal administrative role in the 314(d) block grant significantly different from the Federal role in the prior categorical grant programs folded into 314(d)?

Area of Change	Direction of Change	
	Greater Federal Role	Lesser Federal Role
___Preparation of the state plan.	___	___
___Provision of technical assistance.	___	___
___Review of the state plan.	___	___
___Program monitoring.	___	___
___Program evaluation.	___	___
___Financial reporting.	___	___
___Auditing.	___	___
___Other, as noted below.	___	___

____

____

16. Overall, has the relationship between the state health department and local/regional governmental units changed since FY 1968, as a result of the consolidation of Federal health grants into the 314(d) block grant?
    ____Yes, improved ____Yes, deteriorated ____No change attributable to Federal grant consolidation
    ____Don't know

17. Which best describes the role of the private sector in the operation of the 314(d) block grant in your state?
    Private health providers:
    ____Major role ____Minor role ____No important role
    Private non-profit health-related organizations:
    ____Major role ____Minor role ____No important role
    In general, would you say the role of the private sector in the operation of the 314(d) grant is greater or less than was the role of the private sector in the prior categorical health grants folded into 314(d)?
    ____Greater ____Less ____No difference ____Don't know

18. Are you generally satisfied with the operation of the 314(d) block grant?
    ____Yes ____No
    What would be your single most important recommendation for improving the operation of this program (other than higher funding levels)?
    ____
    ____
    ____
    ____

19. What, in your opinion, are the major advantages and disadvantages of the Federal 314(d) block grant as compared with categorical Federal health grants?
    Advantages:
    ____
    ____
    ____
    ____
    ____

    Disadvantages:
    ____
    ____
    ____
    ____
    ____

20. Would you prefer expansion of the 314(d) block grant or expansion of categorical Federal health grants?
    ____314(d) ____Categorical grants ____No preference

    If your preference was to expand 314(d), would you favor expansion by reducing categorical Federal grants and increasing 314(d) funding levels in equal amounts, in effect merging categorical grants within the 314(d) block grant?
    ____N.A.____Yes ____No
    If yes, are there any types of categorical grants you feel should not be reduced in favor of 314(d)?
    ____Yes ____No
    If yes, what types of grants and why?
    ____

Thank you for your cooperation in completing this questionnaire.

It would assist us in tabulating the results if you could also answer a few general questions relating to the position of your agency within your state's organizational structure.

a. Is your state health department an independent agency, or is it part of a consolidated human resources department or some other "super agency?"
   ___ Independent agency   ___ Part of larger agency
b. Does your health department have a state health board or commission which provides policy guidance to the department?
   ___ Yes ___ No
c. Approximately how many full-time-equivalent professional staff are assigned to the administration of the 314(d) block grant in your state? ___
d. How many years have you been in this state health department? ___
e. Name of respondent: ___
   Position: ___
   Agency: ___
f. Do you wish your answers to the attitudinal portions of this questionnaire to be confidential?
   ___ Yes ___ No

Case Studies

From analysis of the experience with the 314(d) block grant in the states of Massachusetts, Missouri, Oregon, Tennessee, Texas, and Virginia, described in detail in the attached six case studies, certain findings emerge with respect to achievement of the objectives of the legislation, compliance with the legislative requirements, and the intergovernmental effects of the program. These findings are summarized here under the following headings:

- Priority Setting: State and Local;
- Planning;
- Monitoring, Quality Control, and Evaluation;
- Local and Other Non-State Involvement in the Allocation of Funds, Setting of Priorities, and Delivery of Services;
- Federal Regional Involvement; and
- Other General Findings.

Based on these findings from the six state case studies, some conclusions are drawn concerning the validity of certain expectations, or "conventional wisdom," about the block grant process.

PRIORITY SETTING: STATE AND LOCAL

Decategorization under 314(d) offered states (and localities, to the extent the states shared the funds with them) an opportunity for setting their own priorities in allocating public health and mental health funds. In the following summary of the six states' approach to

priority setting, therefore, the procedures and arrangements that the six states employed to allocate 314(d) funds are first identified. Then, the way the states used these procedures, in terms of making changes in the allocation of funds, is summarized.

The Mechanics of Allocation

The setting of priorities for expenditure of 314(d) block grant funds involves the mechanism for allocating funds according to program needs, at the state level, the formula for allocation to localities, and the system for distributing the funds once they reach the local level. The priority-setting system is usually different for the public health and mental health portions.

State priority setting for the expenditure of public health funds is generally an administrative action of the administering agency, where discernible or stated priorities are set at all. In all states, the 314(d) funds are identifiable but are merged with other public health revenues for operational purposes. In Oregon, priorities are principally set by budgetary allocations made by the state legislature. The state 314(a) agency has issued broad policy guidance for the expenditure of their funds, but this direction is largely ignored. In Massachusetts, the Executive Office of Human Services in the governor's office sets policy for disbursement of 314(d) funds. In Texas, public health fund priorities are set by the Department of Health Resources and mental health fund priorities by the Division of Community Service in the Department of Mental Health and Mental Retardation.

In Massachusetts, 314(d) block grant funds for public health are not transferred to local health departments in cities and towns. In the other states, allocation of 314(d) public health funds to local governments varies, but is not usually based on state priorities or policies. In Tennessee, allocations are made on the basis of population and relative wealth of counties. In Oregon, county compliance with state administrative guidelines for programs and budgets is a condition of eligibility for part of the public health fund allocation, while in Missouri, allocations are based on a formula which primarily considers assessed property valuation in each locality. In Virginia, state priorities are not set for either public health or mental health funds. Funds are allocated to local units for use at their discretion. Virginia's system of allocation to local public health programs is based on the community's ability to contribute to the program. Program need and conformance to statewide policies are not elements of consideration in the allocation.

Once local agencies receive funds for public health in Tennessee, Oregon, and Missouri, the local directors set their own priorities for expenditures. Budgets, including 314(d) funds, are usually perfunctorily approved by county governments.

In state priority setting and substate allocations, mental health portions of 314(d) block grants are generally handled in a manner similar to that of public health funds, although criteria for allocations may be even less related to discernible priorities. For example, in Tennessee and Oregon, mental health moneys are equally divided among local mental health centers with no apparent consideration of differences in needs or priorities.

In Missouri, applications are received by the state from local mental health offices. With no written criteria for judgments, the Department of Mental Health funds certain selected projects. In Texas, mental health funds are allocated as "seed money" for establishment of community centers. Centers are chosen on the basis of the state staff's knowledge of each locality and citizen input.

In Massachusetts, the mental health funding priorities set by the Commission of Mental Health are reviewed by the coordinating, policy-making Executive Office of Human Services, and a local project development and review system is used to determine local funding priorities.

Local mental health priorities are set in Tennessee and Oregon by local mental health department administrators. In Massachusetts and Missouri, expenditures must be in conformance with applications approved by the states' agencies for mental health.

Mental health expenditures at the local level in Virginia must reinforce the state's concern for expansion of services offered by local mental health clinics. However, great discretion in supporting this policy is given to local agencies.

The Impact on Fund Allocations

What actually happened in the six states under 314(d) in terms of changes from the previous categorization of public health and mental health funds?

For two states, Massachusetts and Oregon, the public health programs have remained largely those available under the categorical programs. They also have not changed much during the seven-year block grant period. Some difference in proportionate levels of expenditures among the categories is noticeable in Oregon, but nothing of great significance.

The reasons given for this rigidity in the light of

potential flexibility are somewhat different in the two states. In Oregon, because the decategorization did not increase the availability of funds, the state saw no need nor opportunity for new programming. This was also a consideration in Massachusetts. In addition, however, Massachusetts health officials were constrained by the fact that staff positions funded under the categorical programs were civil service and could not be easily eliminated. So the money continued to flow to the same positions to carry out the same programs although with some changes in service patterns.

State staff said there had been no great change in services in Missouri either. A review of the budgets, however, indicated that district offices had been opened and state laboratory services increased substantially over the eight-year 314(d) block grant period. Ironically, these examples of flexibility were away from direct services delivered at the local level to administration and indirect health services.

In Texas, Tennessee, and Virginia, the funds, after decategorization, were passed through, in large part, to city, city-county, county, and regional health departments. How much change was experienced when the decision making was moved to this level is hard to determine, because the commingling of state and 314(d) funds makes it almost impossible to identify how 314(d) funds are spent. The cases do present overall expenditure patterns and the same type of services as during the categorical period seem to prevail. Interviews in those states with both state and local personnel indicated that services available at the local level had not changed substantially with the advent of, and during, the block grant period.

PLANNING

The Partnership for Health legislation provided for three sets of health plans under section 314. These were the 314(a) state plans, the 314(b) regional plans, and the annual 314(d) program or projects plans. The 314(d) plan was to be reviewed by the 314(a) and 314(b) agencies in light of their plans, though the 314(d) plan did not have to conform to the state and regional plans. Also, the 314(d) annual program plan was to be prepared with consideration of the goals, objectives, and priorities of the state and regional health plans. As a matter of fact, in the six states studied, none of this plan review and interaction took place until recently and then only in part, except for Massachusetts.

In the first place, none of the states had a 314(a) state health plan before 1974. Only Texas and Massachusetts have completed one since then. In Virginia, the Comprehensive Health Planning Council (314(a) agency) does review the 314(d) expenditure proposals, but not against a state 314(a) plan. An official in Oregon stated: "We don't bother with reviewing 314(d) expenditures against any state health plan goals and priorities. They are so broadly stated that any health expenditure would fit."

As would be expected, with no state 314(a) plan or agency review prior to 1974, there was no process or system for 314(b) regional review. In some instances, in some states, regional health planning has taken place, but 314(d) expenditures are not reviewed or commented upon.

Apart from the absence of state 314(a) and (b) planning processes, a major deterrent to 314(d) plan review is the fact that there is no 314(d) state plan. It is a title for a non-existent document and process.

In 1972, with the institution of the simplified 314(d) format, all six of the states studied prepared only the annual estimated expenditure statement required in the format. As has been indicated in the cases themselves, this expenditure statement was only an estimate, as 314(d) funds were commingled with state health funds. The requirement that the 314(d) state plan be reviewed and revised annually is met only through the preparation of an annual expenditure statement. None of the states studied has a 314(d) planning process.

Only since 1974 and only in the state of Massachusetts did the case studies find an attempt at 314(a) and 314(b) agency review and involvement in the 314(d) process. The effect of that review has been noteworthy, as an indication of what might have happened if the planning and review process had been implemented.

In Massachusetts, the 314(a) agency prepared a lengthy report in 1974 entitled "314(d) Options." The report recommended that the 314(d) priorities and expenditures be set down separately from the overall health budgets and that accounting be reviewed in the light of the newly completed 314(a) state health plan. Further, the "Options" paper recommended that the 85-15 percent public health-mental health 314(d) fund allocation be adjusted to provide 20 percent of the funds for mental health, based upon the objectives and priorities of the 314(a) state health plan. That recommendation prevailed and is reflected in the FY 1976 budget. Massachusetts is the only state of the six studied where the public health-mental health ratio has been changed.

To sum up, without 314(a) and 314(b) plans and no 314(d) plans after 1972, there never was a planning system or review process in the six states except for Massachusetts in 1974. In light of the recent Massachu-

setts experience, one might speculate on what effect a planning and review process might have had in the six states if it had been in effect from 1968 to 1974.

MONITORING, QUALITY CONTROL, AND EVALUATION

The 314(d) program requires evaluation, quality control, and monitoring. A distinction should be made at the outset among the three terms.

- Monitoring of funds is how accountability for expenditures is obtained. Monitoring tells if expenditures which were projected in the budget were made and, if so, whether they were for the desired units of service. In other words, how much service was delivered for how much money and to whom?

- Quality control is the measuring of the efficiency of the service. It answers the question, "How well was the service delivered?"

- Evaluation, often confused with the other two activities, is a qualitative assessment of the effectiveness of the service. It is usually problem or goals oriented. Evaluation tells the assessor what difference the delivery of the service made in the recipients' well-being.

In regard to monitoring, only in one of the six states studied, Missouri, can both public health and mental health 314(d) funds be traced through the budget, the appropriation, the allocation to both state and locally administered projects, and the expenditure of those funds. That situation is almost true in Oregon. There, the 314(d) funds are identifiable in the budget documents and appropriations, but not for a complete audit trail. Specific allocations of 314(d) funds to programs and, then, to specific projects are shown. The Joint Ways and Means Committee of that state is able to identify 314(d) funds and plays a role in their expenditure. As an example, the committee has moved mental health 314(d) funds from special projects to the state mental health grant-in-aid program. Parenthetically, this was the only case of direct legislative involvement in the expenditure of specific 314(d) funds found in the six states.

In the other four states (Tennessee, Virginia, Massachusetts, and Texas), the 314(d) funds are commingled with state funds for mental health and public health allocations. Hence, as the cases show, it is difficult to dètermine how many 314(d) dollars are spent on any specific program or project. Estimated percentages and approximations were given by state officials of what proportion of a given expenditure was 314(d) financed.

At the local level, even these types of estimates were not possible. In those locally administered program states, the counties and cities could not differentiate either in the state allocation or their expenditures between state funds and 314(d) funds.

Because of the comingling problem, states' monitoring efforts must generally be confined to tracing the expenditure of the commingled funds, rather than to the specific expenditure of 314(d) funds. Within that context, all six states monitor and conduct quality control of programs delivered either by direct state administration of funds or state supervision of local administration. Measurable objectives against which to compare program performance have been developed in Oregon for state and local programs; and in Missouri and Tennessee for local health services only, although only in broad terms in Tennessee. In Virginia, a management by objectives approach was begun in 1975. The Massachusetts Department of Public Health has not developed a set of specific, measurable objectives for services provided with 314(d) moneys.

Quality control suffers from the same disability as monitoring where funds are commingled. However, the problem is more serious. Though all states require an accounting by their departments, local units, and grantees, they do not all require measures of effectiveness.

Evaluative efforts are minimal in the six states studied. In Massachusetts, the Department of Public Health, in late 1975, filed with the Secretary of State an annual report of program progress reports evaluating achievements in expenditures of both Federal and state funds. Evaluation of each mental health project funded with 314(d) moneys will be undertaken in 1975 for the first time since the program started. The Texas Department of Human Resources has begun to address evaluation of public health programs through a program budget process.

Missouri state staff indicated that informal staff evaluations were made of the effectiveness of local programs funded with 314(d) moneys. However, there was hardly any documentation that this was done or that evaluation was utilized in any decision making. Little qualitative evaluation of the effectiveness of programs is undertaken in Oregon, although a great deal of emphasis is placed on quantitative assessments of

programs (monitoring and quality control). The opportunity for evaluation is present in that problem statements are included in the "problems, objectives, methods, and evaluation" (POME) statements which must be developed for each program or project funded with state-administered moneys (including 314(d) moneys).

In Tennessee, the nine regional offices of the Department of Public Health are charged with evaluating programs funded with 314(d) money. Mental health programs are purportedly evaluated on an annual basis by a Tennessee Department of Mental Health evaluation team. Neither public health nor mental health programs funded by 314(d) have been evaluated in Virginia.

In summary, there is little information on what 314(d) funds are spent for, how effectively they are spent, and the impact of the expenditure on the intended ultimate beneficiary. This shortcoming is due at least in part to special characteristics of the block grant, *i.e.*, fungibility and simplification of administrative requirements.

LOCAL GOVERNMENT AND OTHER NON-STATE INVOLVEMENT IN THE ALLOCATION OF FUNDS, SETTING OF PRIORITIES, AND DELIVERY OF SERVICES

One of the stated purposes of the 314(d) program is to strengthen public health services in both the state government and in political subdivisions of the state. The law allowed 314(d) funds to be made available to non-profit private organizations. The law also said that 70 percent of the funds were to "be available only for the provisions of services in the communities of the state."

The debate over the meaning of the 70 percent provision can be found in the cases and is delineated in *Chapter II*. Hence, it will not be repeated here. Suffice it to say that the act does imply a local and private non-profit involvement in the programming and expenditure of 314(d) funds.

The experience of the six states' studies in passing through funds for programming and utilization by units of local governments, private agencies, and other non-state entities varied greatly.

In *public health funds*, there were wide differences in the six states:

- Some did allocate funds to community and local units; some did not. Only Oregon allocated public health funds to private agencies.

- Some of the states had not allocated funds to local units prior to the block grant and began doing so in 1968. Some had not and continued not to do so. Some had and continued to do so.

- A significant factor was whether the health system in the state was a state-administered system; a county or locally administered system; or a dual state-local administered system.

With reference to the individual states:

Only in Massachusetts were none of the 314(d) public health funds passed through to local health agencies. In that state, there is a state and local service system. The local system does not receive financial support from the state, but state public health services support and complement local health services.

Oregon is second in lack of financial support of local agencies, distributing about 10 percent to 12 percent annually for specific projects of local (county) health departments and private non-profit agencies. These funds are granted through an application system and on a project basis. The remainder of the 314(d) public health funds in Oregon are spent by the state, except that when such funds are not totally spent, the remainder is allocated to local health departments on a population basis.

Missouri has a mixed system of state and locally administered services. The policy is to pass through about 33 percent of the 314(d) funds to the local units through an application procedure. In 1975, approximately 13 percent of the funds were passed through.

Tennessee and Virginia have state-supervised, locally administered public health systems. They both pass funds through to the county and city health departments on a formula basis. The formulae were established for state funds prior to the decategorization of Federal health funds in 1968. Local departments and governments in these two states determine how the formula-granted funds which include state and 314(d) resources will be spent. Prior to decategorization, the local units spent the funds on the specific categorical programs.

Texas also has a state-supervised and locally administered public health system. There are 69 city-county or city departments and ten regional (multicounty) agencies. The 314(d) funds are allocated by the state to these units for salaries for personnel. Although they must meet certain state-imposed requirements, there is no service or programmatic review.

This varied pattern in the public health expenditures

of 314(d) funds suggests that state-administered systems, such as Massachusetts, may be reluctant to share the funds. Also, where there are dual state and local systems, such as Oregon, and Missouri, the states spend all or most of the funds. However, in the state-supervised, locally administered systems of Tennessee, Virginia, and Texas, the decategorization of the public health programs resulted in the funds being allocated to local units on a basis (formulae or salary support) that allowed the local units to make the service and program decisions.

In these three states, the state did not recategorize the funds before they were allocated to the local political subdivision. Neither could the project applications in Oregon and Missouri be considered recategorization, for project eligibility is much broader than under the previous categorical programs.

In summary, were the local systems given more latitude and were they more involved in decision making and expenditure because of the 314(d) public health block grant program? In Tennessee and Virginia, yes. In Texas, to a lesser extent, because funds were directed to local salary support. In Missouri and Oregon, only marginally so through the local project programs. And in Massachusetts, no.

The picture in *mental health* is very different. Only one state, Virginia, uses its 314(d) mental health funds solely for state-administered services. This expenditure is through a state network of mental health centers.

Massachusetts, Texas, and Tennessee pass almost all of their 314(d) mental health funds through to private non-profit agencies that run community mental health centers to provide local services such as outreach centers and counseling services. Grants are made on a project basis and by contract in Massachusetts and Texas. Tennessee distributes the funds on a formula basis.

Missouri allocates 70 percent of its 314(d) mental health funds for specific projects. The funding is for one year only at a full 100 percent rate. Oregon has an annual grant program to 34 county-operated mental health centers, utilizing the 314(d) funds.

Thus, the mental health 314(d) funds are used predominately by local public and private agencies and service providers in five of the six states studied. In those states, contracts, project grants, formula, and the "seed money" approach for innovative programming (Missouri) are all used to improve local services and involve local institutions. This is in general contrast to the picture for 314(d) public health funds.

One reason for the difference may be that mental health policy nationwide during the period of the 314(d) block grant program has been towards the elimination of state institutions and the deinstitutionalization of the client. All of the states studied are moving toward community-based mental health centers and services. The 314(d) funds, though only a small fraction of any of the states' expenditures for mental health, have been an important resource during this period of change.

FEDERAL REGIONAL INVOLVEMENT

Prior to the block grant, in all of the six states studied, there had been significant Federal involvement in the categorical programs. This included not only the review of the categorical plans for each program, but significant consultation and advice on program content and quality.

Though the categorical plan review was considered by state officials to be too specific and intrusive in state administrative matters, the assistance in program content was professionally sought and accepted. Regional HEW offices had program specialists in each of the categorical areas who were available and utilized by each of the six states.

The advent of the block grant eliminated the categorical plan review by regional HEW personnel. With the institution of the simplified plan in 1972, and its utilization by all six states, virtually all plan review by Federal officials ceased.

With the elimination of the plan review, the programmatic consultation was either lost or severely cut back. Regional HEW office staff assigned to 314(d) matters often became less than one full-time person for four or five states. States no longer sought Federal technical assistance in program content and regional HEW offices offered little, if any.

This side effect of the elimination of the categorical programs and their individual plans and grants was avoidable if the regional offices had differentiated between their functions of plan approval and program consultation. However, they did not differentiate, and with the demise of one, the other also faded away.

OTHER GENERAL FINDINGS

- One of the purposes of block grants is to provide administrative simplification. With the doing away of the categorical plans and other requirements, administrative procedures necessarily were simplified in the six states studied.

- None of the six states studied could be said to have a systemwide approach to specific health problems. The introduction of the block grant was not identified

as an inhibitor to such an approach, but, on the other hand, neither did it generate such an approach.

- In every state, the block grant for either public or mental health is such a small percentage of the total funds expended by the state that there is no problem in meeting the matching requirement.

- Assuring that 314(d) moneys do not replace state or local funds is extremely difficult; yet, because of the relatively minor magnitude of 314(d) funds in comparison with total state funds for public and mental health purposes, this issue is of little fiscal consequence in any case. Also, the fact that the 314(d) money continued to equal or exceed the total of the previous categoricals, and total state and local public and mental health expenditures expanded greatly, suggests that there was an expansion of state and local money, rather than a replacement by Federal money.

SOME CONCLUSIONS ABOUT 314(d) AS A BLOCK GRANT

Four main areas where block grants are expected to have a different effect than categorical grants are: responsiveness, accountability, flexibility, and innovation. To elaborate, it is generally thought that:

- Block grants will bring decision-making power closer to those most affected by programs and allocation decisions (*Responsiveness*).

- Block grants will be administered as carefully and expenditures monitored as well as categorical grants were by the state governments (*Accountability*).

- States will use funds for services of a higher priority need (*Flexibility*).

- Block grants will encourage innovation by allowing states to pursue new approaches that are uniquely suited to their needs (*Innovation*).

The six state case studies provide the basis for conclusions as to the validity of this "conventional wisdom" as it applies to 314(d).

Increased Responsiveness

The decategorization of public health funds through the institution of the 314(d) block grant program resulted in a broader participation in the decisions as to what services would be provided and at what levels in half the six states studied. In Tennessee, under 314(d), the public health funds were distributed by the state on a formula basis to the county governments for them to use without respect to program category. The same situation applies in Virginia where city health departments are also included and in Texas where there are some multicounty departments.

The participation by persons and agencies other than the state agencies is much less in Missouri and Oregon. Missouri continues to spend at the state level almost 87 percent of the 314(d) funds on the basis of administrative decisions in the Division of Health. There is no discernible non-state participation in how these funds are allocated. The same holds true in Oregon, with the state figure being about 88 percent.

In Massachusetts, prior to the decategorization, middle-level and program management staff recommended content and funding level for the categoricals. That has remained the same for public health.

With respect to Tennessee, Virginia, and Texas, the increased responsiveness to local needs came about because there was already in existence a system whereby funds were to be allocated to localities for them to spend according to their determination. Removing the categorical limitations meant that the local units would have the channeled 314(d) funds upon which to impose their local discretion.

In Missouri, Oregon and Massachusetts, on the other hand, decategorization had little or no effect in changing or broadening the participants in the decision-making process regarding public health funds expenditures because the state-local relationship provided for state-local monopoly or dominance of expenditure decisions.

The picture is somewhat different with *mental health* funds. Massachusetts, in 1971, switched from funding staff positions at the state level in previous categorical programs to financing local projects. Missouri spends about 70 percent of its mental health 314(d) funds through the financing of local projects. Oregon, Virginia, Tennessee, and Texas spend most of their 314(d) mental health dollars in state mental health grants-in-aid to, and contracts with, local mental health centers and service

providers. Though the dollar amounts are small, the mental health funds are widely dispersed to local governments and non-profit private case providers.

Does, then, decategorization bring decision-making power closer to those most affected? For the six states studied, the response must be, "Not necessarily and not always." Though this dispersal of decision making may be desirable, decategorization of public health programs through 314(d) didn't make it happen in all places. Factors such as state organization, and previously established state-local relationships may be much more important than decategorization in bringing about such systemic change.

Accountability

As indicated in the summary of findings, the commingling of 314(d) funds with other state funds in at least four of the six states makes it impossible to trace the expenditure of 314(d) funds. The Federal taxpayers' dollar in 314(d) funds generally gets the same attention as the state taxpayers' dollar in health funds. Sometimes that attention is inadequate. Expenditures are not reported by program; dollars are not related to results; and resources are not directed toward specific objectives.

If the statement at the outset of this section were reworded to say, "Block grants will be administered as carefully and expenditures monitored as well as are state funds," then the result would be attainable.

Flexibility

From the summary of findings, the conclusion must be drawn that there was little programmatic flexibility attempted though its potential was there. The categorical services were in place and staffed. They were expected by the public and programmed by the professionals. No effective planning or priority systems were operating in the six states to identify new service needs or recommend alternative programs.

At the same time, the 314(d) grant provided no new funds in 1968 and only modest increases, considering inflation, in 1970. Thus, there was license and opportunity for flexibility, but no new financial wherewithal.

Speculation leaves the question: "Would it have been different if there had been additional funds?" "Would the effective integration of the Partnership for Health planning components with the 314(d) program offered new program approaches?"

Innovation

The question of innovation is almost moot – after the discussion of program flexibility. If little different was done, then even less new could have been attempted.

The commingling of funds for local grants in states such as Tennessee and Virginia removes almost any possibility of determining if 314(d) funds encouraged innovation. There is simply no way to decide whether 314(d) funds played any role in new programming. Likewise, grants related to staff positions at the local level rather than to program components as is practiced in Texas does not lend itself to state funding to accomplish innovation. In Oregon, Massachusetts, and Missouri, where most of the 314(d) public health funds are spent by the state, the cases discovered little flexibility and less or no innovation.

Mental health 314(d) expenditures varied and did provide for potential innovation. Since Missouri and Massachusetts allocated these funds on a project basis by an application procedure, some innovation was experienced. But only in the Missouri 314(d) mental health program did the cases discover a specific state policy for innovation. There, almost all of the 314(d) mental health funds are expended in one-year, $10,000 seed money grants for new projects not eligible for other funding.

Decategorization could be a powerful tool for innovation, even with small expenditures. In order to assure innovative efforts, the state or its localities would have to be prohibited from using the funds exactly as they did prior to decategorization.

Massachusetts

The Commonwealth of Massachusetts has initiated two distinct approaches to the allocation and utilization of block grant funds for the delivery of state-administered public health and mental health services. This case study provides a description of these two approaches and discusses recent changes in administration of the 314(d) block grant in Massachusetts since 1974.

Administration of the annual allocation of 314(d) funds within the Commonwealth of Massachusetts involves four state agencies. These are:

- Executive Office of Human Services;
- Office of Comprehensive Health Planning – 314(a) agency;
- Department of Public Health; and
- Department of Mental Health.

The Departments of Public Health and Mental Health administer the provision of services under policy direction by the Executive Office of Human Services. In Massachusetts, the 314(a) agency serves as the planning and policy development arm of the Executive Office of Human Services for health services and programs.

Table 1 presents the organizational relationship of the key agencies involved in the 314(d) fund's administration at Federal, state, regional, and local levels. The table is followed by an overview of organizational involvement in the 314(d) block grant process at the state and local level.

The state Department of Public Health has annually expended 85 percent of the 314(d) funds over the eight-year history of utilization of 314(d) block grant funds. The Department of Mental Health has annually expended the remaining 15 percent of state 314(d) funds.

In Massachusetts, the Bureau of Administration in the Department of Public Health prepared the initial 314(d) state plan to allocate block grant funds for the 1968 fiscal year. Since that time, the staff has annually reviewed the plan but has not recommended any major changes. The commissioner's office is responsible for authorizing expenditures of the current $1.8 million annual Federal allocation to public health in Massachusetts through the 314(d) grant.

The Federal allocation to public health is annually incorporated into the departmental budget estimate of anticipated public health revenues. These total funds, including the 314(d) block grant, are then approved by the state legislature in the departmental budget and expended accordingly during the following fiscal year. The budgets and plans of the commissioners of public health and mental health in Massachusetts are subject to the review of the secretary of the Executive Office of Human Services.

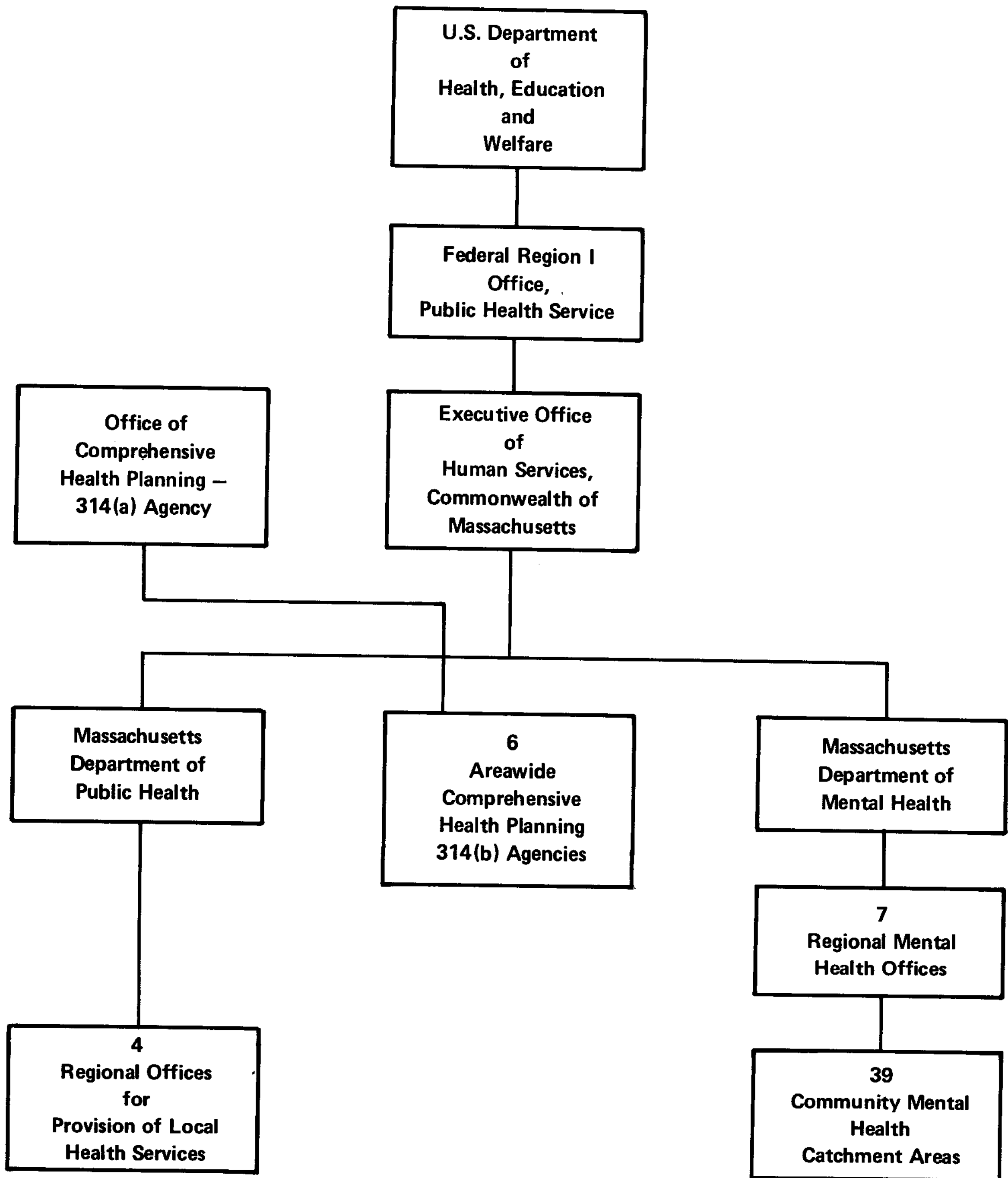
Block grant funds are used to provide a wide range of services. The allocation is utilized in the department's central administration, education, training and transportation services (35%); health care standards activities (16%); and the state laboratory institute (9%). These three uses account for 60 percent of the 314(d) fund allocation to public health in Massachusetts.

The Commonwealth of Massachusetts has a state-administered system for the delivery of public health and mental health services. Although cities and towns throughout the state also provide public health services, they are not financially assisted by the state in their local public health programs. There is no direct "pass through" of 314(d) funds for public health to local governments. However, mental health 314(d) funds are allocated to local recipient agencies that are private non-profit corporations established to provide mental health services at the substate level.

State service delivery is channeled through four regional public health offices. These offices serve four

Table 1

Agencies Related to the 314(d) Block Grant Mechanism in Massachusetts



multicounty areas of the state that do not coincide with other substate planning and service delivery regions used by state departments and agencies.

The Bureau of Planning of the Department of Mental Health prepared the first 314(d) state plan for mental health services for FY 1968. Since 1971 that staff has utilized a local project development and review system for the 314(d) fund allocation process.

Planning coordination between the Departments of Public Health and Mental Health is now achieved through the 314(a) agency – the Office of Comprehensive Health Planning. The 314(a) agency serves as the planning and policy development staff of the Executive Office of Human Services.

Planning for health matters in Massachusetts is conducted below the state level through substate regional organizations under the direction of the 314(a) Office of Comprehensive Health Planning. The state is divided into seven substate planning regions. Six of these 314(b) areawide comprehensive health planning agencies are staffed. Regional planning is coordinated through the state 314(a) agency. The seven substate comprehensive health planning regions and the seven service delivery regions of the Department of Mental Health have the same boundaries.

In the following sections of this case study, further information is provided on the application of the state's planning, administration, and evaluation methods to influence the use of 314(d) block grant funds. A detailed account is given of the allocation and use of 314(d) funds by the Commonwealth of Massachusetts, including changing patterns of usage since the initial receipt of the funds in the state's 1968 fiscal year. This case study also includes a description of the impacts or changes in the delivery of public health and mental health services attributed to the use of the 314(d) block grant in the state.

BLOCK GRANT ALLOCATION AND USE

The Federal allocation formula provided Massachusetts with $1,385,800 or 2.3 percent of the $60 million block grant appropriated by Congress for FY 1968. At that time, the Massachusetts fiscal year and the Federal fiscal year were the same, July 1 to June 30.

Federal to State Allocation

This section describes the Commonwealth of Massachusetts 314(d) program in terms of Federal to state allocation; state allocation of 314(d) funds; and utilization of the block grant.

For Massachusetts, the Federal to state allocation of 314(d) funds may be best understood by examining two points in time. They are the Massachusetts fiscal years of:

- 1968, when the first 314(d) allocation was received and dispersed by the state; and
- 1974, when state administrative reforms were accomplished to assure planning and budgetary coordination between the Departments of Public Health and Mental Health. FY 1974 is the last period for which the 314(d) expenditure records are complete.

Under the initial (FY 1968) Federal allocation formula, Massachusetts received a block grant sum of $1.39 million. Of this total, $1,177,900 (85%) was allocated to the Department of Public Health and $207,900 (15%) to the Department of Mental Health. In the year prior to the availability of block grant funds, the Commonwealth of Massachusetts received approximately $1.1 million in Federal support from the nine categorical grant programs for health and mental health.

The 314(d) block grants provided a 7 percent increase in Federal funding for Massachusetts health and mental health programs in FY 1968. The annual allocation to Massachusetts for FY 1970 was $718,500 greater than the FY 1968 allocation. Thereafter, the total allocation to public health and mental health stabilized at around $2.1-2.2 million. *Table 2* presents the annual allocation to Massachusetts over the eight years of the block grant's existence. Federal appropriations under the 314(d) block grant have been frozen at the 1970 level, although Congress originally authorized a continual expansion of the block grant through 1973 from $62.5 to $165 million for the nation.

State Allocation of 314(d) Funds

At the onset of the 314(d) block grant program in Massachusetts during 1967, both the Departments of Public Health and Mental Health reviewed the previous array of services provided by categorical Federal funds. In both cases, the middle level planning and program management staffs of the two departments recommended to their respective commissions that the use of funds not be altered to provide services different from those being provided with Federal financial assistance under the previous categorical grants.

In addition, the previous services were analyzed as being essential public health and mental health functions proper to the state which should not be altered. The positions created with categorical funds were under the protection of the state's civil service system so that comparable positions at equal salaries would have to be offered any state health or mental health employee displaced by the creation of block grant funding and the lapse of the previous categorical funding.

The commissioners of public health and mental health, faced with these initial constraints to change or innovate (internal staff resistance and state civil service requirements), both elected to continue the allocation of the new 314(d) block grant to previously established categorical uses. This allocation pattern for public health uses of the 314(d) fund has been annually reviewed by a series of public health commissioners over the past eight years but not substantially changed.

In 1967, during the planning for the initial 1968 fiscal year, there was no management viewpoint within state government outside of the Department of Health. Thus, no local input was utilized to monitor or influence this initial block grant allocation decision. The state's 314(a) agency – the Office of Comprehensive Health Planning – was then a subordinate unit within the Department of Public Health and did not serve as a planning coordination agency concerning 314(d) funding.

In 1974, this same agency became the planning coordination and policy development arm of the newly formed Executive Office of Human Services. The executive office was created to coordinate the planning and budgetary aspects of five state departments involved in the provision of human services for Massachusetts, including the Departments of Public Health and Mental Health. This grouping of five related departments under an executive office did not produce a new "super-department," since many of the original internal administrative responsibilities were retained by the five individual commissioners who head the separate departments. These administrative responsibilities include the hiring, promotion, and firing of staff; the provision of mandated services; the administration of all departmental activities within budgetary constraints; and the sustained relationships with advisory boards.

The Executive Office of Human Services does have the final decision on budgetary requests from the related departments. Beginning in 1974, for the 1975 fiscal year, the executive office began a review of the 314(d) allocation and utilization patterns existing over the previous six years in both public health and mental health. After an analysis of the block grant's use, completed by the 314(a) Office of Comprehensive Health Planning, a reallocation of a proportion of the total resources available under the 314(d) block grant was recommended by the 314(a) agency for imple-

Table 2

The 314(d) Block Grant Allocation to Massachusetts, Fiscal Years 1968-1975*

	Public Health	Mental Health	Total Allocation
FY 1968	$ 1,177,900	$ 207,900	$ 1,385,800
FY 1969	1,314,400	232,000	1,546,400
FY 1970	1,788,700	315,600	2,104,300
FY 1971	1,769,200	312,200	2,081,400
FY 1972	1,818,800	321,000	2,139,800
FY 1973	1,827,300	322,500	2,149,800
FY 1974	1,832,900	323,500	2,156,400
FY 1975	1,837,900	324,300	2,162,200

*Information provided by Department of Health and Mental Health.

mentation by the secretary of the Executive Office of Human Services for the 1976 and 1977 fiscal years.

Allocation of the $323,500 in FY 1974 314(d) mental health funds is achieved through an entirely different approach than the public health 314(d) fund retention for state-level service provision. In FY 1971, the Massachusetts Department of Mental Health departed from its practice of allocating 314(d) funds to departmental staff positions and allocated at least part of its 15 percent on a local project basis as an independent portion of the total 314(d) block grant. In FY 1974, virtually all (98.3%) available 314(d) funds were so allocated.

The service goal for such allocations is to create a network of community-based mental health services as alternatives to institutional care. Departmental objectives (as stated in the mental health 314(d) state plan for fiscal year 1975) are:

Decision Making

1) decentralization of decision making,
2) development of greater responsiveness to the needs and desires of people through increased citizen participation in the various mental health regions and catchment areas within these regions,
3) development of more sophisticated evaluation and monitoring mechanisms for the purposes of program assessment and better allocation of scarce resources,

Mental Health Services

4) greater emphasis on prevention and early treatment,
5) constructive dialogue between clients and providers of service – nurtured where it exists and initiated where it does not,
6) provision of assistance to enable mental health staff to function in roles much different from the traditional roles of prior years,

Service Coordination

7) reinforcement of community programs through a variety of cooperative efforts with other public and private agencies in the human services system, and
8) analyses of the cost effectiveness of various community-based programs as compared with institution-based programs.

A total of 65 percent of all available mental health 314(d) funds is annually assured in seven equal parts to the mental health regions. The remaining 35 percent is annually reserved for a statewide competitive pool to fund projects of statewide mental health significance. If any regional funds are not committed to specific projects within a separate region by January 1 of each year, such funds revert to the statewide competitive pool.

The allocation process for the 314(d) funds begins with local project applications for funding consideration and ends with funding approval of the selected projects.

Each local applicant agency (usually a non-profit private corporation) completes a form covering the project's budget, scope of activities, and suggested evaluation method. The application is reviewed by both the mental health area board and the mental health regional advisory council. Composition of the area boards and regional advisory councils is at local discretion except that all such bodies must have at least six citizen representatives. The regional body must also request representation from the health planning council of the region's 314(b) agency.

After these two reviews to obtain local and regional comments, the application receives a final approval or denial by the Federal Funds Committee-314(d) in the State Department of Mental Health for inclusion in the 314(d) state plan (and funding thereafter). This Federal Funds Committee-314(d) has the following members:

- commissioner of mental health;
- deputy commissioner of mental health;
- four assistant commissioners;
- one regional mental health administrator;
- seven citizens (citizen members are recommended by the Mental Health and Retardation Advisory Council of the state department).

A further consideration related to the allocation and utilization of 314(d) block grant funds is that the Department of Mental Health requested in 1974 and obtained the right to receive an increased portion of Massachusetts' allocation of 314(d) funds to become available in FY 1976 and FY 1977.* In FY 1976, the

*The Federally defined ratio between public health and mental health has been 85-15 in the states, territories, and the District of Columbia since the inception of the 314(d) block grant.

Table 3

Public Health and Mental Health Services Provided in Massachusetts, Fiscal Year 1974*

	314(d) Funds	Total Federal and State Funds	314(d) as a Percent of Total
REGIONAL-PROVIDED			
Mental Health Services			
Local Projects	$ 323,500	$ 191,562,400	0.2%
Health Services			
Regional Offices	136,200	1,084,000	13.0%
Hospitals	—	36,121,200	.03%
Health Protection			
Surveillance and Disease Control			
Tuberculosis Control	$ 107,900	$4,196,600	3.0%
Communicable Diseases	—	2,168,100	.0%
State Laboratory Institute	164,300	3,512,800	5.0%
Environmental Health	49,000	2,864,900	2.0%
Food and Drugs	65,300	1,816,400	4.0%
STATE-PROVIDED			
Health Regulation			
Health Care Standards	$ 303,500	$ 2,655,500	11.0%
Health Planning and Statistics	153,200	766,500	20.0%
Certificate of Need	67,300	213,200	32.0%
Health Services			
Alcoholism	—	4,381,900	.0%
PUBLIC HEALTH COMMISSIONER'S OFFICE-CENTRAL ADMINISTRATION			
Administration	$ 521,300	$ 1,121,600	46.0%
Health Education	132,500	345,200	38.0%
Car Pool	55,000	146,600	38.0%
Training	63,000	146,700	43.0%
TOTAL REPORTED:	**$ 2,142,000**	**$ 253,103,600**	**0.8%**

*Based on information in expenditure reports for FY 1974, submitted to Public Health Services, Region 1, U.S. Department of Health, Education and Welfare.

department will receive approximately 20 percent of the state's 314(d) allocation in a phased increase designed to allocate 25 percent of the block grant fund, in FY 1977, for the provision of mental health services.

This increased portion for the Department of Mental Health is a product of several years of lobbying by officials in the department. Public health officials have consistently opposed any cutback in allocations to the Department of Public Health due to the fact that it has been operating at a deficit in recent years. 314(d) funds have been used to support civil service positions in the Department of Public Health, and these moneys have been unable to keep pace with step-pay increases to state employees. Thus, any cutback in 314(d) allocations would result in a further deficit for the department.

In 1974, the state Office of Comprehensive Health Planning, the 314(a) agency, along with the Executive Office of Human Services acted as an arbiter between the Departments of Health and Mental Health in relation to DMH's request for increased allocations. The 314(a) agency prepared an option paper analyzing the issue. Several categories of issues were examined – program, financial management, and financial analysis or impact – to determine the repercussions of an increase of allocation to the Department of Mental Health.

On the basis of this option paper, the secretary of human services determined that the FY 1976 314(d) allocation to the Department of Mental Health should be increased to 20 percent of the available Federal funds. The primary rationale for the decision was DMH's utilization of the block grant funds for expanded project services at the community level and the increased ability of the state to account for 314(d) funds.

Utilization of 314(d) Funds

Block grant funds are received separately by the Departments of Public Health and Mental Health and are utilized in two different ways. These approaches may be termed:

1) state provision of services; and
2) state funding of local projects.

The Massachusetts Department of Public Health follows the first allocation approach while the Department of Mental Health follows the second. Each approach is discussed below in terms of FY 1968 and FY 1975.

In the initial year of 314(d) block grant funding, (1968), the Massachusetts Department of Public Health did not change the pattern of utilization of funds from the prior Federal categorical programs that were provided to the state during FY 1967. Changes in service patterns since that time, provided in part by 314(d) funding, have meant a changing utilization of the same professional public health staff. These staff positions, supported previously by categorical grant funds, were not discontinued with the advent of the 314(d) grant.

All of the original categorical programs are partially funded in FY 1975 by 314(d) moneys and are now referred to as state-provided services. Although the block grant legislation removed the categorical restriction on the use of funds, the Department of Public Health asserts that "... it in no way implies that the activities previously supported by such grants should be discontinued or de-emphasized."*

A total of 158 state public health positions are funded by the 314(d) block grant in FY 1975. Of the total $1.8 million annual public health allocation, 73 percent of the funds are spent on state public health officer salaries.

From the state's perspective, $1,826,000 in FY 1975 314(d) funds supplement a total public health budget totaling $67,655,000. These 314(d) funds accounted for 2.7 percent of the total amount expended for public health in Massachusetts. The $324,000 in 314(d) funds for mental health supplement a mental health budget of $191 million and constitutes 0.2 percent of that total.**

Table 3 presents the pattern of public health and mental health services being supported in Massachusetts with 314(d) funds during FY 1975. These services are described below in terms of their objectives; by amount of support with 314(d) funds; percentage of 314(d) funds allocated for public health services; and by relationship to the original categorical programs.

1. **Public Health Commissioner's Office-Administration.** The central administration of all departmental programs is in part funded with 314(d) funds. Administrative activities include training for public health staff, health education for the general public, car pool expenses of public health officials traveling statewide in the delivery of state services, and general administration.
   Level of Support: $639,300
   Percent of 314(d) Allocation: 34.8%

*Letter from the state commissioner of public health to the regional health administrator, U.S. Public Health Service, Federal Region I, dated January 24, 1975.

**Information provided by the Department of Health and Mental Health.

Relationship to Original Categoricals: Staff from three former categorical programs are used in this activity area — general health, heart disease control, and home health care.

2. **Health Regulation-Health Care Standards.** This program sets performance criteria involving more than 2,000 health facilities in the state, including hospitals, nursing homes, and clinics. It also includes continuous inspection of all diagnostic and therapeutic x-ray units in hospitals and private offices.
Level of Support: $303,500
Percent of 314(d) Allocation: 16.5%
Relationship to Original Categoricals: Staff from six of the former categorical programs are used in this activity area — cancer control, chronically ill and aged, heart disease control, home health, radiological health, and general health.

3. **Health Protection-State Laboratory Institute.** This laboratory provides statewide services including the production and distribution of serums and vaccines; performance of a variety of clinical tests on specimens; diagnosis of rare and exotic diseases; back-up services for laboratory quality control; and primary research.
Level of Support: $164,300
Percent of 314(d) Allocation: 9.0%
Relationship to Original Categoricals: Staff from three of the former categorical programs are used in this activity area — general health, chronically ill and aged, and heart disease control.

4. **Health Regulations-Planning and Statistics.** This program provides a centralized information system. The information system includes departmental activities such as blood bank monitoring; computerized mailings under the *Controlled Substances Act*; annual hospital statistics and inventories of medical facilities.
Level of Support: $153,200
Percent of 314(d) Allocation: 8.3%
Relationship to Original Categoricals: Staff from four of the former categorical programs are used in this activity area — cancer control, chronically ill and aged, heart disease control, and general health.

5. **Health Services-Regional Offices.** Local health services are provided by four regional public health offices in the state. These offices coordinate general field activities between the state and local health services; day care licensure; home health agency certification; and enforcement of the *State Sanitary Code.*
Level of Support: $136,200
Percent of 314(d) Allocation: 7.4%
Relationship to Original Categoricals: Staff from three former categorical programs are used in this activity area — chronically ill and aged, heart disease control, and general health.

6. **Central Administration-Health Education.** Health educators are assigned to two regional offices to provide educational programs to local boards of health, regional planning agencies, community groups, and school personnel. This program also involves production of health education materials, visual aids, and exhibits and coordination of the department's involvement with the various news media.
Level of Support: $132,500
Percent of 314(d) Allocation: 7.2%
Relationship to Original Categoricals: Staff from three former categorical programs are used in this activity area — general health, cancer control, and chronically ill and aged.

7. **Health Protection-Tuberculosis Control.** This program no longer provides services. The new program functions are to set standards and to maintain community surveillance with technical support to the private medical sector.
Level of Support: $107,900
Percent of 314(d) Allocation: 5.9%
Relationship to Original Categoricals: Continuation of original Federal program in tuberculosis control with the same state staff.

8. **Mental Health Services-Local Projects.**

More than 40 current projects provide for a wide range of local mental health service innovations to be implemented on a one-year basis.
Level of Support: $318,000
Percent of 314(d) Allocation: 98.3%
Relationship to Original Categoricals: Continuation of original Federal program in mental health.

To meet the department's stated goal and related objectives, five project categories have been defined in which local mental health projects are solicited.* These categories accompanied by the approximate percentage of available 314(d) funds allocated to each category, are:

- **Service Programs.** Innovation and demonstration programs are especially sought. Proposals which have multiagency elements will be encouraged, as well as those presenting opportunities for greater effectiveness and efficiency. Within this project category, high priority will be given to services directed towards children, minority groups, and other high risk populations. Each project is expected to have an evaluation component to measure progress.
  Percentage of 314(d) Allocation: 60%
- **Training and Staff Development.** During this transition period of reducing institution-based services, there is a critical need for training and retraining of staff as role changes occur. The capacity of former institutional employees to perform in community-based settings will determine the success or failure of many programs.
  Percentage of 314(d) Allocation: 15%
- **Evaluation and Research.** Little has been done to assess the efficiency or impact of community-based mental health services. It is important to know which kinds of programs work in the community setting, specifically, for which clients, and why this is so. Comparative cost analyses are necessary elements in such efforts.
  Percentage of 314(d) Allocation: 10%
- **Administrative and Operational Innovations.** In this period of rapid change, new administrative and operational systems for more effective delivery of services must be explored.
  Percentage of 314(d) Allocation: 10%
- **Education and Information Dissemination.** The development policy and implementation procedures fall under this project category. Of equal importance is the support of the dissemination of information about successful pilot studies.
  Percentage of 314(d) Allocation: 5%

*Information contained in Massachusetts Department of Mental Health 314(d) plan for FY 1975.

PLANNING, ADMINISTRATION, AND EVALUATION

This section describes the experience of Massachusetts in terms of ten basic Federal requirements pertaining to the 314(d) block grant.

Planning Requirements

In Massachusetts, the basic planning requirements have been met only in part.

Provide services in accord with the adopted 314(a) Comprehensive Health Plan of the state. The Office of Comprehensive Health Planning, the state's 314(a) agency, is currently preparing an update of the comprehensive state plan. This revision began in 1974 with the development of a long-range, comprehensive health plan format and recommended planning process reviewed by the substate 314(b) health planning agencies. There is, however, no particular relationship between 314(d) allocations and the 314(a) plan.

In addition, the 314(a) agency in the "314(d) options paper" conducted a special study of the 314(d) funding mechanism in terms of annual allocations and current use in public health and mental health services for Massachusetts. The 314(a) recommendations related to future 314(d) allocations and utilization patterns will be incorporated in the forthcoming 314(a) state health plan* and reviewed by the substate 314(b) agencies within the plan framework.

The 314(b) agencies also have direct representation on the regional advisory councils for mental health in

*Under the *National Health Planning and Resources Development Act of 1974* (P.L.93-641) this document will be termed simply the state health plan.

annually selecting projects for inclusion in the mental health 314(d) state plan.

Prior to 1974, neither the six regional 314(b) agencies nor the state 314(a) agency reviewed the 314(d) allocations to public health or mental health against their own long-range health plans (many of which, in turn, had not been put into final form or adopted by their respective policy bodies).

Specify the extent to which services to be provided are directed at public health areas of high priority, are of high quality, and will reach people in local communities in greatest need of such services. Public health services financially assisted with the 314(d) block grant are essentially those of high state and Federal priority in 1967. Without additional Federal funding for new priority areas, the Department of Public Health elected to continue those services defined by the Federal categorical grants in public health (with the exception of dental services). These services have been provided through the support of the salaries of state civil service personnel who have responsibility for state-administered programs. Thus, no assurances exist that high-priority services are reaching people in local communities with the greatest need for such services.

In contrast, the Department of Mental Health established an allocation system that encouraged local project generation and competition for the available 314(d) funds. This latter system has been gradually expanded since 1971 in proportion of 314(d) funds allocated on the local project basis. In 1971, only 16 percent of the funds were so allocated; by the 1975 fiscal year, 98 percent were allocated to local projects.

The project approach utilized by the Department of Mental Health has a weakness in that needed projects may not find willing and capable sponsors at the local level and so not be competitive for the available 314(d) mental health funds. Nevertheless, the mental health funding strategy does tend to reflect Congressional intent of channeling funds to local services.

Consider the comments of state 314(a) and regional 314(b) comprehensive health planning agencies in preparing the resource allocation to services in the 314(d) state plan(s). Prior to 1974, comments of the state 314(a) and regional 314(b) agencies were not solicited or considered in the annual review of the public health and mental health 314(d) state plans, largely reflecting a highly centralized system of administration. For FY 1976, however, the 314(a) and 314(b) comments have appeared to result in the reallocation of the 85-15 percent ratio to 80-20, increasing mental health services with former public health 314(d) funds.

Allocate funds so that public health services are significantly strengthened in various political subdivisions of the state (including the funding of other public or non-profit private agencies to assure maximum participation of local, regional, and metropolitan agencies). The Department of Public Health has not transferred any of the 314(d) block grant funds to local health departments in Massachusetts cities and towns. Nor has the department transferred any other of its financial resources directly to the local health departments. Officials in the Department of Public Health hold that the state-provided public health services do "significantly strengthen the various political subdivisions of the state" and meet the Federal requirement that 70 percent of the block grant be made available for local services by providing state public health services that would be fragmented, duplicated, and expensive to provide locally. They feel that local units of general purpose government would have to provide them if the state did not. Such services are the approach that the Department of Public Health takes to attempt to assure that 70 percent of the 314(d) allocation in public health benefits local units of government.

Local mental health services supported by 314(d) funds since 1974 have far exceeded the 70 percent requirement. Mental health services are provided by private non-profit agencies rather than cities and towns in Massachusetts.

Define health services to be provided in terms of specific objectives. Like most state health departments, the Massachusetts Department of Public Health has not developed a set of measurable objectives specific to services provided with 314(d) financial assistance. The Department of Mental Health requires that 314(d) funded projects contribute to achieving departmental objectives. These objectives, however, are not quantified and progress against them is not readily measurable in terms of funded 314(d) local projects in mental health.

Provide for the review and modification of the 314(d) state plan(s) as appropriate on an annual basis by the state health agency and state mental health agency. 314(d) state plans for both public health and mental health have been annually reviewed since 1974 by the 314(a) agency on behalf of the secretary of human services. The 314(a) agency recommends changes appropriate to both departments for review and implementation by the secretary.

Administrative Requirements

There are three basic administrative requirements.

Provide for the state administration or state supervision of local administration of the funds by the state health agency and state mental health agency. The Department of Public Health has provided for state administration of the 314(d) funds over the past eight years. The Department of Mental Health has moved into the position of supervising the local administration of the 314(d) funds in mental health. Local service provider agencies in mental health are private non-profit entities, not units of local general purpose government.

Assure that the block grant funds will not be used to supplant other non-Federal funds. The Department of Public Health utilizes 314(d) funds to support the salaries of state civil service employees. The Department of Mental Health seeks to fund only portions of local projects that have other funding commitments. In addition, the Department of Mental Health limits the duration of its project grants from 314(d) funds to one year. Both of these policies assist in assuring that 314(d) mental health funds will not replace other local financial resources.

Require recipient agencies utilizing 314(d) funds to participate in the costs of the supported services. There are no direct recipient agencies in public health beyond the Department of Public Health. The Department of Mental Health, in its 314(d) project funding approach, does not require local matching contributions but strongly encourages the provision of local funds in projects to be selected. As the total 314(d) annual allocation is limited in mental health, projects seeking 100 percent state 314(d) support are discouraged.

Evaluation Requirement

Provide methods of evaluating the performance of activities carried out with 314(d) funds. The Department of Public Health, in late 1975, filed with the secretary of state an annual report of program progress evaluating achievements in expenditure of both Federal and state funds. The Department of Mental Health has required that each project proposed for 314(d) funding contain its own evaluation component. Reporting of achievements from these evaluation components is anticipated to begin during FY 1976 but has not yet proven itself as an effective evaluation method when applied to departmental goals and objectives for the 314(d) program.

CHANGES ATTRIBUTED TO THE BLOCK GRANT PROCESS

Within the Commonwealth of Massachusetts, there has not been a consistent response to Federal adoption of the 314(d) block grant mechanism. The approach used by the Department of Public Health has attempted to minimize staffing and financial changes in the state as a result of the transition from Federal categorical public health grants to the 314(d) block grant mechanism. Although state-provided services financed in part with 314(d) funding have changed, existing staffing patterns and service delivery methods before 314(d) have not changed.

A major change has occurred between the Department of Public Health and the Federal regional office of the Public Health Service of the U.S. Department of Health, Education and Welfare, administering the 314(d) block grant in Region I. Prior to the advent of the block grant, in FY 1968, individual Federal program specialists in the previous categorical public health areas provided both formal technical assistance and informal advice to Massachusetts public health officials as to the availability, procurement, and limits of utilization of the various Federal funds for public health. Today, Federal regional officials leave the details of financial and program management to the state.

For example, the regional office of grants administration is not concerned with the details of how state 314(d) money is spent in Massachusetts in support of the particular programs funded with Federal 314(d) dollars on a matching basis. The primary Federal interest is in assuring that the total state contribution to 314(d) programs equals the amount required through the population formula, rather than to impose any Federal priorities within the block grant framework.

Federal officials in the Public Health Service of Region I are in a difficult position to assess the administration, allocation, or utilization of the 314(d) funds for public health in Massachusetts. This is a change in Federal-state relations from the previous categorical grant period when detailed plan submissions were annually required by the Federal regional officials. The detailed planning requirement in turn stimulated a close relationship between Federal and state staffs responsible for the planning, administration, and evaluation of fund usage in a multiplicity of public health areas. Now, Region I Federal officials concede that because there are no restrictions on the programmatic use of 314(d) funds, there is little opportunity for Federal-state interchange of ideas and Federal influence over program and planning decisions and priorities. In addition, it is

difficult for Federal officials to assess funds in accord with Congressional intent.

In contrast, Federal regional officials may now be able to monitor and evaluate the use and effectiveness of 314(d) funds allocated to mental health. The Department of Mental Health has adopted an approach that facilitates innovation and positive change in several ways. These include:

- emphasis upon new local projects with demonstration and transfer values;
- limited project funding so that they must become locally viable in one year's time; and
- granting of 314(d) mental health funds are limited "seed money" to projects scattered throughout the seven mental health regions to encourage change in all parts of the state.

Block grant fund availability and utilization in Massachusetts has not resulted in additional state appropriations for public or mental health services. Grant moneys, particularly in public health, have been designated for internal administrative and staffing purposes rather than to create new programs for which additional state funds might have been necessary.

Additional funds have not been stimulated on the local level for public health services. Local service providers have almost no knowledge of the allocation process or usage of 314(d) funds. Concomitantly, local governmental officials would have little incentive as a result of the 314(d) block grant to provide more funds for local health service delivery.

According to state officials, local funds for mental health have not been stimulated to any great degree by the block grant program. They perceive that there has been an increase in that local funds have been used to match 314(d) money which partially supports local projects. On the other hand, regional authorities contacted view these projects as very often funded totally by the 314(d) block grant, and thus, the stimulation of local money is not maximized.

The matching requirement of the block grant mechanism has not created fiscal or management problems at the state level. This is attributable to the small percentage of the overall budgets of the Departments of Public and Mental Health which 314(d) funds comprise (2.7 and 0.2 percent, respectively). Inasmuch as 314(d) moneys are matched at the state level, matching causes no difficulty at the local local – the Department of Public Health does not pass through 314(d) funds to local units of government and the Department of Mental Health encourages, but does not specifically require, local recipients to contribute any discernible share for 314(d)-supported projects.

State public health and mental health officials view the 314(d) block grant mechanism in two entirely different ways. The 314(d) block grant has caused no basic change in the manner of delivery of public health services in the Commonwealth of Massachusetts. The changing demand for public health services since 1966 has been accommodated through assignment of new responsibilities to the former categorically specialized staff while retaining their former job classifications.

On the other hand, the 314(d) block grant mechanism has enabled the Department of Mental Health to establish a local project-by-project allocation system within the broad goals, objectives, and project categories established at the state level. To a certain degree the Department of Mental Health has re-established a "category and project grant" approach to allocating the 314(d) fund, this time at the state rather than the Federal level. It is the project-by-project allocation of the block grant, with its goal to create alternatives to institutionalized care, which has resulted in innovations in health service delivery in Massachusetts attributable to 314(d) funds.

Regional and local public health officials perceive differences between Federal categoricals and the block grants. However, these perceptions are limited by the fact that regional and local experience with the 314(d) funds has been limited to the mental health area. Regional public health officials have some staff members salaried through 314(d) funds with no other direct exposure to the 314(d) block grants.

Regional mental health personnel view the 314(d) funds as flexible and useful in funding innovative programs. These perceptions come as a result of direct experience with the block grants which are used on a project-by-project basis as the department's program strategy. However, the nominal amount of block grant funds allocated to mental health resulted in some preference for comprehensive mental health services grants (which are usually used for staffing purposes) rather than the block grant mechanism.

Only in the allocation of funds to mental health projects has any measure of new flexibility become possible for local users of the 314(d) block grant in Massachusetts. In the area of public health, neither local access to the 314(d) funds, nor the relatively stable state staffing patterns have made significant changes at the local level in terms of local discretion or flexible funding assistance for locally determined public health services.

Federal, state, regional, and local reactions to the

previous categorical grants and 314(d) block grant usage in Massachusetts have resulted in a consensus on several items:

- **Lower level of involvement of Federal officials** in the state planning, administration, and evaluation of the 314(d) block grant in contrast to the Federal role under prior categorical grants. This is not always viewed as a desirable change by health and mental health officials within the state who now experience uncertainty as to the Federal priorities (if any) in public health and mental health. Federal regional officials agree as to the lack of Federal guidance on the 314(d) process but feel that the states should proceed without Federal intervention.

- **Lack of direct involvement of either the governor or the state legislature** in the block grant mechanism under section 314(d). The state legislature has never shown interest in the 314(d) state plans nor indicated knowledge of them. Any major change to the allocation of funds to, or within, the State of Massachusetts has been reviewed by the governor over the mandatory 45-day period but the governor has not instituted changes to the suggested allocation. Even the current reallocation of 314(d) funds from public health to mental health has received no attention from the governor or state legislature.

One area of concern lacking common agreement among state, regional and local public health officials, state mental health officials, or state and regional comprehensive health planners is:

- **Sufficiency of the amount of public health services received on the local level.** State public health officials feel that their utilization of 314(d) funds adequately provides health services on the local level. However, regional and local health officials have almost no knoweldge of block grant utilization at the local level or of its positive impacts.

SUMMARY AND CONCLUSIONS

The utilization pattern for 314(d) funds in the Commonwealth of Massachusetts has taken a different direction for public health services than for mental health services. In the case of public health services, under its strategy of direct state administration of activities under the 314(d) plan, the state does not "pass through" 314(d) funds directly to the public health departments of cities and towns. Rather, the state public health services have continued to support and complement local public health services without the transfer of Federal or state public health funds to localities.

With the advent of the block grant, staff personnel supported by prior categorical grant funds have been continued under new categories. These staff are responsible for state-administered services. Changes in service patterns, provided in part by 314(d) funding, have meant a changing utilization of the same professional public health staff.

In the case of mental health services, the state has moved in the direction of allocating virtually all of the 314(d) funds to local, private, non-profit service providers on an annual project basis. For local mental health services supplemented with 314(d) funds, the emphasis has been new programs and short term 314(d) financial support. This practice represents a gradual departure from the Department of Mental Health's allocation of 314(d) funds to departmental staff during FY 1968 through 1971.

Between the years 1968 and 1974, the various Federal, state, regional, and local agencies involved in the planning, administration, and evaluation of the 314(d) block grant in Massachusetts did not operate in a coordinated or systematic manner. Rather, service provider agencies responded autonomously to immediate problems associated with the block grant and the comprehensive health planning agencies were not involved. State plans for public health and mental health offered minimal guidance.

In 1974, the two commissioners of public health and mental health were brought together under the secretary of human services. The secretary utilizes the Office of Comprehensive Health Planning — the 314(a) agency — as a planning and policy development arm of his office.

The state 314(a) agency has analyzed the problem of resource allocation through the 314(d) block grant mechanism and prepared alternative recommendations on the proportion of 314(d) funds to be divided between public health and mental health for consideration by the secretary.

The analysis by the 314(a) agency in 1975 and its

implementation has initiated a new set of working relationships involving the 314(a) funding mechanism. Planners and service providers are now in direct communication in the decision-making process involving the 314(d) annual allocation.

Coordination efforts between the secretary of human services, the state 314(a) agency and the Departments of Public Health and Mental Health still do not extensively involve the governor, legislative officials, or Federal regional officials.

Major reorganizational and procedural changes in 1974 should lead to improvements in coordination of 314(a) and 314(b) planning activities with 314(d) block grant allocations. The services provided are still not well defined in terms of objectives nor are they presently evaluated.

The Massachusetts experience under the 314(d) block grant is largely reflective of a state policy in public health in which the state has maintained responsibility for public health programs rather than providing direct financial assistance to localities for public health purposes.

Missouri

The State of Missouri has initiated two distinct approaches to the allocation and utilization of block grant funds for the delivery of state-administered public health and mental health services. This case study provides a description of these two approaches and their response to Federal regulations related to the planning, use, administration, and evaluation of 314(d) block grant funds.

Administration of the annual allocation of 314(d) funds within the State of Missouri involves three state agencies. These are:

- Office of Comprehensive Health Planning, Division of Special Services, Department of Social Services;
- Division of Health, Department of Social Services; and
- Department of Mental Health.

Public health services in Missouri are provided by the Division of Health of the Department of Social Services. Mental health services are delivered by the Department of Mental Health. *Tables 1 and 2* present the organization structures of the two agencies involved in the delivery of public health and mental health services in the State of Missouri.

The Division of Health is located in the Department of Social Services. The director of the division is appointed by the Board of Health but is operationally responsible to the director of the department. The Board of Health serves as an advisory body to the director of the Division of Health and is not responsible for establishing division policy. Budget and administrative activities of the division are the responsibility of the division's deputy director under the supervision of the division's director.

Priority and policy determinations on the use of the public health portion of the 314(d) block grant are the responsibility of the division's deputy director. Approximately two-thirds of the annual 314(d) allocation is being used for state administration and state-administered local services such as laboratory services and health service delivery through the state's seven district health offices. The state's allocation and use of this portion of the public health 314(d) block grant has been guided by previous year's commitments.

Approximately one-third of the public health portion of the annual block grant is allocated to public health agencies at the city and county level. Local agencies seeking state funding assistance submit an application to the division where it is reviewed by program staff. Funding recommendations are submitted by the program staff to the division's deputy director who is responsible for the administrative allocation of the 314(d) funds. The allocation of the 314(d) funds mixed with state and other Federal funds is made on the basis of a variable formula relating to assessed property evaluation. In addition, the state's allocation to a local health agency is limited to a percentage of the local agency's cost of personal services.

Discussion with the deputy director of the Division of Health revealed that neither the Office of Comprehensive Health Planning (the 314(a) agency) nor any of the state's 314(b) areawide health planning agencies specifically review the division's allocation of 314(d) funds. However, the deputy director indicated that he has met periodically with a subcommittee of the governor's Advisory Council for Comprehensive Health Planning to review the entire division's plans and budgets.*

The director of the Department of Mental Health is appointed by the Mental Health Commission with the

*Source: Interview with deputy director, Missouri Division of Health.

Table 1

**State of Missouri,
Division of Health,
Department of Social Services***

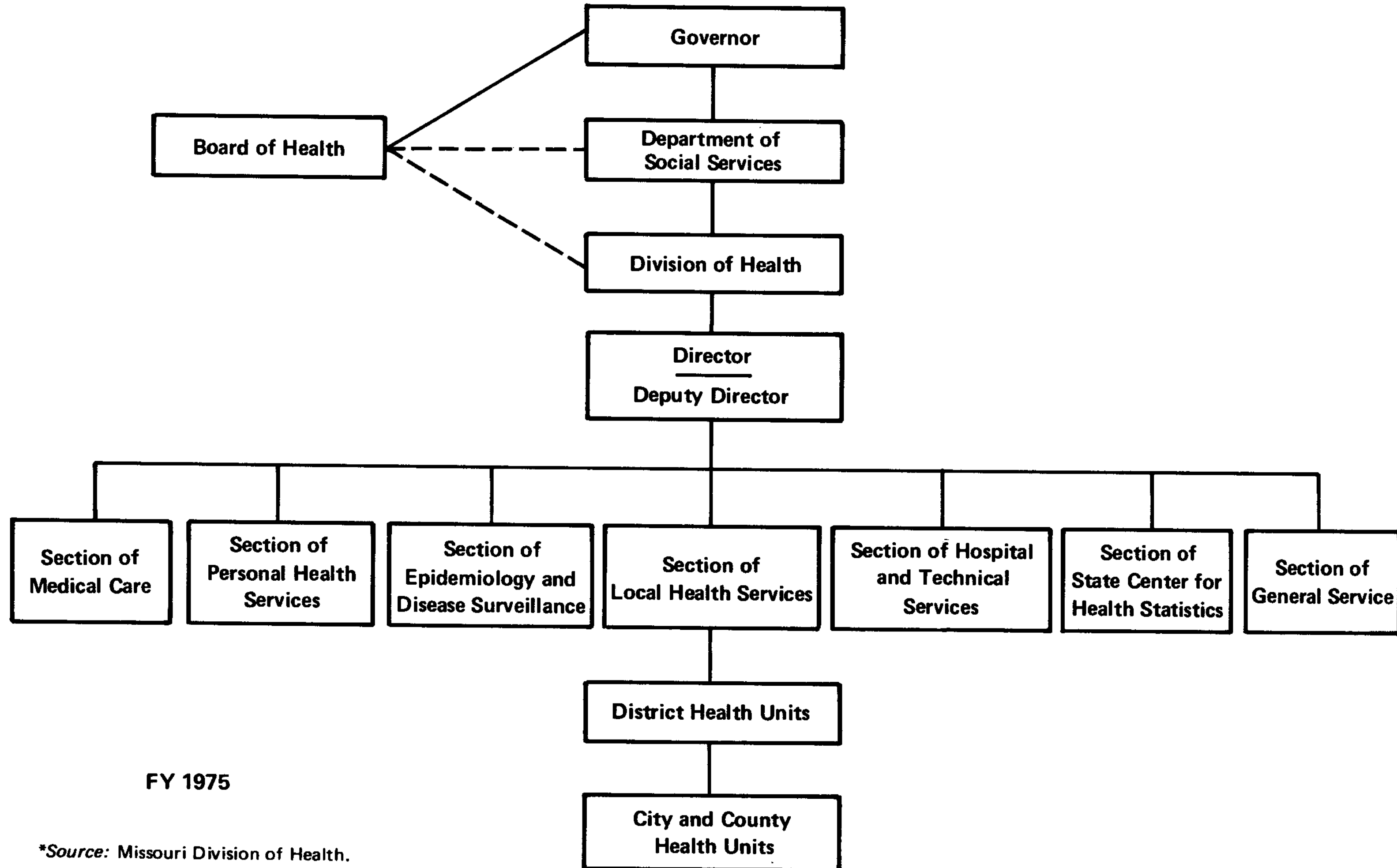
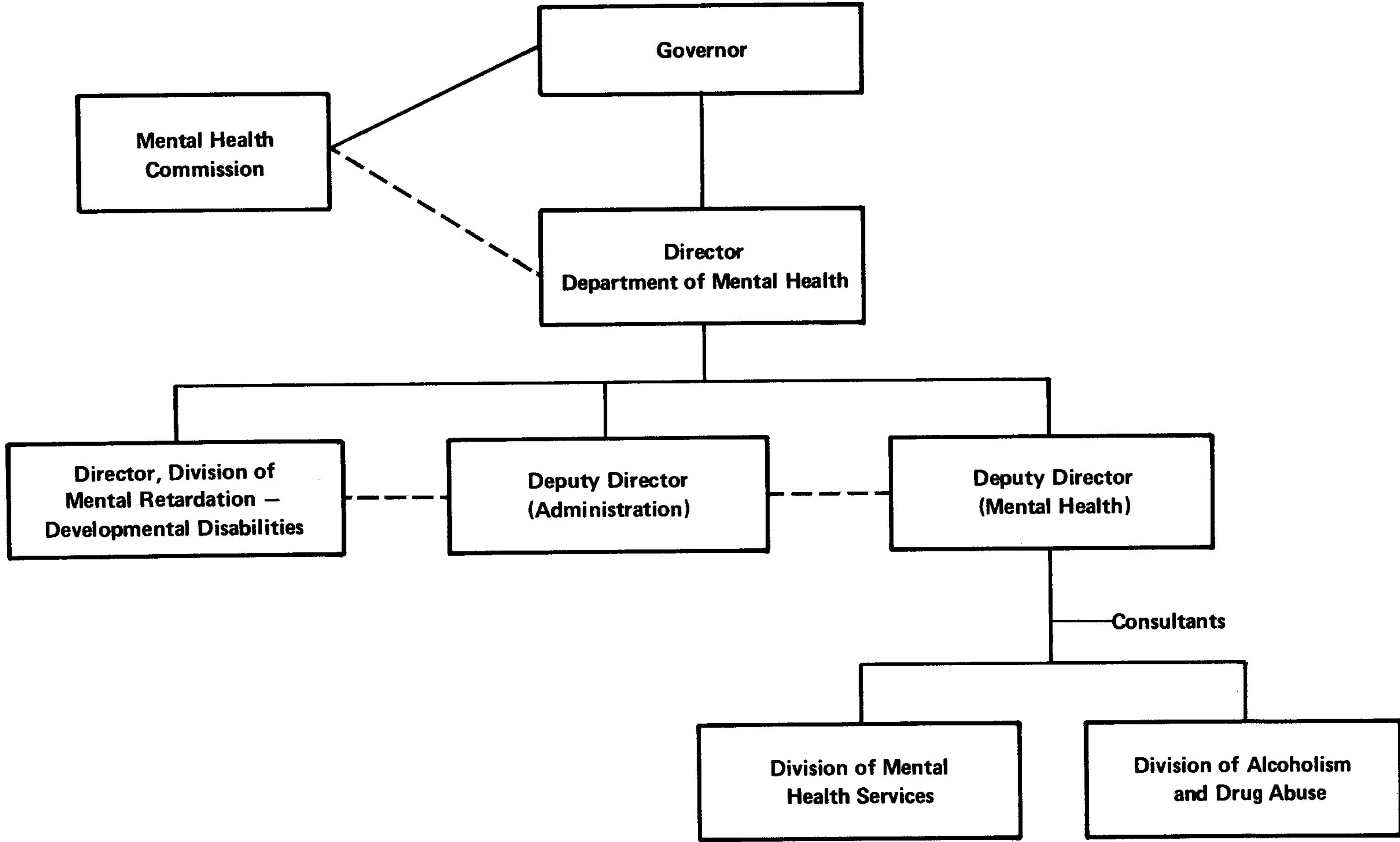


Table 2

**State of Missouri,
Department of Mental Health***



**Source:* Missouri Department of Mental Health.

advice and consent of the state senate, The Mental Health Commission serves as an advisory body to the director of the department and is not responsible for establishing departmental policy. Budget and administrative activities of the department are the responsibility of the deputy director for administration under the supervision of the department's director.

Priority setting and policy determinations concerning the use of the mental health portion of the state's 314(d) block grant take place in several steps. The deputy director for administration, upon learning the state's annual allocation, determines the amount available for two expenditure categories:

1) administration, including professional and clerical salaries and training and public education materials; and
2) local mental health projects.

Approximately 30 percent of the funds are allocated to the administration category and 70 percent to the local mental health projects category.

Funds allocated to the local mental health projects category are suballocated on the basis of the review, recommendation, and approval of application requests from local mental health agencies by the state's Mental Health Authority Review Council.

Upon completion of the review and approval of local mental health project applications and the allocation of the 314(d) funds to the selected projects, the deputy director for administration compiles the approved project descriptions and a description of the state's use of the administrative portion of the block grant into a mental health state plan document.

Discussion with mental health staff indicated that the state's Office of Comprehensive Health Planning and the affected 314(b) areawide health planning agencies review and comment on project applications from local mental health agencies.

In Missouri, both the public health and mental health portions of the annual 314(d) block grant can be traced to very specific expenditure areas and determinations can be made as to the amount of 314(d) money being used to support a particular activity in relation to the amount of state funds or other Federal funds being used.

Neither the Division of Budget of the Office of Administration nor the Missouri General Assembly have ever taken action to affect the programming of 314(d) funds, although each of these entities is included in the review and budgeting process that sanctions the administrative allocation of the 314(d) block grant.

BLOCK GRANT ALLOCATION AND USE

This section describes the State of Missouri's allocation and use of 314(d) block grant funds. It includes the amount of block grant funds that the state has received under the Federal allocation formula in certain key years, a description of how the allocation decisions are made, and how the state has spent the funds compared to their expenditure of categorical grant funds.

Federal to State Allocation

During the last year (FY 1967) of the categorical grants that were folded into the 314(d) block grant, the State of Missouri received $1,041,068. During the first year (FY 1968) of the 314(d) block grant, the state received $1,116,800, an increase of $75,732. Missouri's allocation of $1,116,800 was 1.86 percent of the national appropriation of $60 million. When the tuberculosis control program was included in the 314(d) block grant in FY 1970, the state's allocation increased to $1,670,500. The block grant has remained at approximately that level through FY 1975 when the state received $1,628,500. *Tables 3 and 4* on the following pages provide detail on the categorical grants received in FY 1967 and the annual amount of block grant funds recieved by the State of Missouri for public health and mental health since the start of the 314(d) block grant program.

State Allocation of the 314(d) Block Grant

In Missouri, 85 percent of the 314(d) annual block grant is allocated to the Division of Health of the Department of Social Services and 15 percent is allocated to the Department of Mental Health. The actual allocation takes place before the funds are received by the State of Missouri.

However, under provisions of P.L. 89-749, neither the governor nor the Missouri General Assembly has requested that the Federally specified 85-15 allocation be changed in any manner.

In Missouri, the allocation of the public health portion of the 314(d) block grant is the responsibility of staff within the Division of Health. This allocation takes place without policy guidance from the 314(d) state comprehensive health planning agency, the general assembly, the Board of Health, the Division of Budget, Office of Administration, or the governor. The deputy director of the Division of Health has primary responsi-

Table 3

Public Health and Mental Health Categorical Grants, Fiscal Year 1967*

PUBLIC HEALTH		$909,868
General Health	$213,500	
Heart Disease	144,800	
Dental Health	17,200	
Cancer Control	66,200	
Tuberculosis Control	67,400	
Chronic Illness	297,800	
Radiological Health	51,800	
Home Health Services	51,168	
MENTAL HEALTH		131,200
TOTAL		$1,041,068

**Source:* Deputy director, Missouri Division of Health.

Table 4

The 314(d) Block Grant Allocation to Missouri, Fiscal Years 1968 through 1975*

	Public Health	Mental Health	Total Allocation
FY 1968	$1,116,800	$179,500	$1,296,300
FY 1969	1,222,400	215,700	1,438,100
FY 1970	1,652,700	291,520	1,944,220
FY 1971	1,647,700	290,800	1,938,500
FY 1972	1,659,000	292,800	1,951,800
FY 1973	1,657,600	292,661	1,950,261
FY 1974	1,646,100	292,500	1,938,600
FY 1975	1,628,500	287,400	1,915,900

**Source:* Public health allocations provided by the deputy director of the Missouri Division of Health. Mental Health allocations provided by the deputy director for administration of the Missouri Department of Mental Health.

bility for allocation and administration of the state's public health 314(d) block grant.

Budget information transmitted by the Division of Health to the Division of Budget, Office of Administration, and, subsequently, to the general assembly and the governor groups all Federal grants together as a single revenue item. In reviewing the health division's budget, legislators and budget staff are not able to determine what activities are funded with 314(d) funds. Detailed records are kept within the division that enable tracing the allocation and expenditure of the 314(d) funds to a level of detail that satisfies the most rigorous of audit procedures.

The allocation of the mental health share of the 314(d) block grant is carried out by staff of the Department of Mental Health with the advice of the Mental Health Authority Review Council. The review council is composed of state mental health program officials, staff from the 314(a) state comprehensive health planning agency, university specialists, and representatives of the state mental health association and local mental health agencies.

A major Federal requirement affecting the state's allocation of the public health and mental health portions of the 314(d) block grant is that 70 percent of each portion must be used to provide direct community services. In Missouri, the Division of Health is technically meeting this requirement. For example, in FY 1975, approximately 72 percent of the public health 314(d) block grant was allocated to expenditure categories classified as direct community services.

The requirement that at least 70 percent of the state 314(d) allocation be spent for services in local communities has been interpreted in several ways. The Missouri Division of Health has interpreted the requirement literally to mean the provision of services at the local level by either state or local agencies or personnel. This has resulted in approximately 80 percent of the local pass-through portion of the block grant being expended by the division for services by state employees at, or for the benefit of, local communities.

In FY 1975, only 12.9 percent or $209,181 of the total public health share of the 314(d) block grant was allocated to services performed by local agencies.

For the mental health portion, 100 percent of the pass-through portion was expended by local agencies using local employees.

Public Health Utilization of 314(d) Funds

The following sections provide detailed descriptions of the utilization of the public health and mental health portions of the 314(d) block grant.

The Division of Health in the Department of Social Services is responsible for the administration of the public health portion of the 314(d) block grant to Missouri.

Analysis of the state's use of the public health portion of the 314(d) funds is presented for FY 1968, FY 1970, and FY 1975. FY 1968 represents the initial year of the block grant; FY 1970 is the year in which the tuberculosis control categorical grant appropriation was included in the block grant; and FY 1975 is the most recent documentation of the state's use of the funds. Information is also presented on the state's use of the categorical grants during FY 1967 in order to present utilization comparisons between the categorical grants and the block grant.

Initiation of the 314(d) block grant in FY 1968 did not result in significant changes in the Division of Health's utilization of Federal funds. The block grant funds were used to fund the same services that the categorical funds had been supporting in FY 1967.*

Table 5 shows the FY 1967 utilization of the eight public health categorical grants that were folded into the 314(d) block grant. (Seven of the eight grant programs formed the 314(d) grant for FY 1968 and the tuberculosis control grant became a part of the 314(d) block grant in FY 1970.) The state received a total of $909,868 in the eight categorical grant programs. The largest single use of the grants was the operation of the state's five district health offices equaling 34.1 percent of the total funds received. Program expenditures related directly to the appropriate categorical grant received 25.9 percent of the funds received. Program funds were used primarily for program specialists' salaries.

Table 6 shows the Missouri utilization pattern of 314(d) public health block grant funds in relation to the FY 1967 utilization of categorical grant funds. Analysis of the FY 1968, 1970, and 1975 314(d) allocations shows that the state's use of 314(d) funds is generally similar to the state's use of the categorical grants in FY 1967. The most significant change brought about by the 314(d) block grant is the substantial increase in the amount of funds allocated to support the state's Bureau of Laboratory Services. In FY 1967, laboratory services received $31,000 or 3.4 percent of the total categorical funds. In FY 1975, laboratory services received $529,007 or 32.5 percent of the state's public health 314(d) grant. The state's district health offices, which have increased from five to seven in number since FY

*Source: Interview with deputy director, Missouri Division of Health.

Table 5

Utilization of Public Health Categorical Grants, State of Missouri, Fiscal Year 1967*

State Usage	Categorical Grants: General Health	Heart Disease	Dental Health	Cancer	Tuberculosis	Chronic Illness	Radiological Health	Home Health	Totals: Amount	Percent
Local Health Service	$ 12,865	$ 3,756	–	$ 5,038	–	$ 3,402	–	–	$ 25,070	2.8
District Health Units	95,774	25,373	–	23,815	–	165,099	–	–	310,061	34.1
Local Health Departments	73,461	60,076	–	4,059	$12,000	10,570	$10,000	–	170,166	18.7
Orientation and Training	–	3,600	–	1,500	1,500	500	–	–	7,100	0.8
Program	–	46,986	$17,200	31,788	48,005	20,757	41,800	$29,118	235,654	25.9
Laboratory Services	31,400	–	–	–	–	–	–	–	31,400	3.4
Local Health Nursing Services	–	5,000	–	–	5,895	–	–	–	10,895	1.2
Nursing Home Program	–	–	–	–	–	97,472	–	–	97,472	10.7
Section of Medical Care	–	–	–	–	–	–	–	22,050	22,050	2.4
Totals	$213,500	$144,80	$17,200	$66,200	$67,400	$297,800	$51,800	$51,168	$909,868	100.0%

**Source:* Deputy director, Missouri Division of Health.

Table 6

**Utilization Pattern of Public Health Funds,
State of Missouri,
Fiscal Year 1967 – Fiscal Year 1975***

State Allocation	Combined Categorical Grants		314(d) Block Grant					
	Fiscal Year 1967		Fiscal Year 1968		Fiscal Year 1970		Fiscal Year 1975	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Local Health Service	$ 25,070	2.8%	–	–	–	–	$ 37,954	2.3%
District Health Units	310,061	34.1	$462,272	41.4%	$317,424	19.3%	473,988	29.1
Local Health Departments	170,166	18.7	88,672	7.9	438,140	26.5	209,181	12.8
Orientation and Training	7,100	0.8	4,000	0.4	18,000	1.1	31,000	1.9
Programs	235,654	25.9	212,929	19.1	297,176	18.0	144,497	8.9
Laboratory Services	31,400	3.4	119,900	10.8	434,769	26.3	529,007	32.5
Local Health Nursing Services	10,895	1.2	–	–	28,400	1.7	11,466	0.7
Nursing Home Program	97,472	10.7	68,326	6.1	–	–	–	–
Section of Medical Care	22,050	2.4	28,410	2.5	40,429	2.4	46,789	2.9
Central Office Administration	–	–	23,736	2.1	48,449	2.9	–	–
Community Environmental Health Services	–	–	108,555	9.7	29.913	1.8	144,618	8.9
Total	$909,868	100.0%	$1,116,800	100.0%	$1,652,700	100.0%	$1,628,500	100.0%

**Source:* Deputy director, Missouri Division of Health.

1967, consistently received a substantial amount of the categorical as well as the 314(d) block grant.

Presented below is a detailed description of the use of the FY 1975 314(d) public health allocation.*

1. **Local Health Services** – $37,954

   a. Administration of Section of Local Health Service – Salaries – $18,902

   b. Bureau of Community Sanitation – Salaries – $19,052

2. **District Health Units** – $473,988

   a. District 1 – Salaries $66,501; Travel 12,240; Total $78,741

   b. District 2 – Salaries $33,966; Travel 17,136; Total $51,102

   c. District 3 – Salaries $60,792; Travel 13,464; Total $74,256

   d. District 4 – Salaries $67,840; Travel 14,280; Fire & Utilities 2,500; Communications 6,000; Lab. Supplies 12,000; Total $102,620

   e. District 5 – Salaries $96,803; Travel 14,280; Communications 10,000; Lab. Supplies 12,000; Total $133,083

   f. District 6 – Salaries $13,686; Travel 6,120; Total $19,806

   g. District 7 – Salaries $8,260; Travel 6,120; Total $14,380

3. **Local Health Departments** – $209,181

   a. Local Support Nurse Travel – $10,236

   b. 13 Local Public Health Agencies – $198,945

4. **Orientation and Training** – $31,000

   a. Training Workshops and Travel – $31,000

5. **Programs** – $144,497

   a. Bureau of Veterinary Public Health – Salaries – $20,651

   b. Bureau of Chronic Disease Surveillance – Salaries – $15,294

   c. Bureau of Epidemiology and Disease Surveillance – Salaries – $33,872

   d. Visiting Nurses Association – Salaries – $11,000

   e. Drugs and Biologics – Salaries – $10,000

   f. Bureau of Radiological Health – Salaries $47,460; Travel 6,120; Contractual Services 100; Total $53,680

6. **Laboratory Services** – $529,007

   a. Bureau of Laboratory Services – Salaries $454,787; Travel 6,120; Lab. Supplies 65,000; Contractual Services 3,100; Total $529,007

7. **Local Health Nursing Services** – $11,466

   a. Bureau of Public Health Nursing – Salaries $ 9,426; Travel 2,040; Total $ 11,466

8. **Section of Medical Care** – $46,789

   a. Administration – Salaries – $46,789

*Source: Interview with deputy director, Missouri Division of Health.

Table 7

Allocation of Mental Health Funds, State of Missouri, Fiscal Year 1967–Fiscal Year 1975*

State Allocation	Categorical Grant FY 1967		314(d) Block Grant Funds FY 1968		FY 1969		FY 1970		FY 1971		FY 1972		FY 1973		FY 1974		FY 1975	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Administration	$34,100	26.0%	$25,650	14.3%	$50,019	23.2%	$66,544	22.8%	$45,710	15.7%	$50,872	17.5%	$62,225	21.0%	$60,243	21.0%	$82,159	29.0%
Local Projects	97,100	74.0	153,850	85.7	165,681	76.8	224,976	77.2	245,090	84.3	241,928	82.6	230,436	79.0	232,257	79.0	205,241	71.0
Total	$131,200	100%	$179,500	100%	$215,700	100%	$291,520	100%	$290,800	100%	$292,800	100%	$292,661	100%	$292,500	100%	$288,400	100%

**Source:* Deputy director for administration, Missouri Department of Mental Health.

9. **Community Environmental Health Services – $144,618**

   a. Four functions in the Department of Natural Resources: Administration, Bureau of Water Supply, Solid Waste Management, Community Health Engineering.

The block grant has not affected a significant change in the pattern of health services supported with Federal funds. This lack of change, except for the increased support of laboratory services, supports the findings that the flexible nature of block grant funds is not being exploited in Missouri and the funds are not being used to fund innovative approaches to the delivery of public health services.

Mental Health Utilization of 314(d) Funds

Missouri is utilizing the mental health portion of the 314(d) block grant for the same purposes that the mental health categorical grants supported from FY 1964 to FY 1967.*

Table 7 shows the simplified pattern of utilization of the categorical grant and the 314(d) block grant from FY 1967 through FY 1975.

Each year, the Department of Mental Health has used more than 70 percent of the block grant funds to support local mental health projects. A major factor in the department's strategy to use the funds to support locally operated mental health projects has been the state's lack of an aid program to local agencies to support mental health services. Thus, the department has used the block grant as "seed" money to foster the development of community mental health programs and innovative service delivery projects at the local level.

Local project grants were funded at 100 percent for one year and are limited to $10,000 per project.*

For FY 1975, the department utilized $82,159 for administration and $205,241 for local projects.*

Projects range from community education and in-service training and development projects to planning for a proposed community mental health center program to special projects related to children, drug abuse, and chronic alcoholism.

The individual projects were not analyzed for FY 1975. However, brief project descriptions set forth in the mental health, 314(d), state plan indicated that the

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*Source: Interview with deputy director, Missouri Mental Health Department.

funds were being utilized by both consumers and service providers at the local level. However, by far the largest proportion of these local project funds were being used by traditional mental health services providers.

PLANNING, ADMINISTRATION, AND EVALUATION

This section describes Missouri's use and administration of 314(d) funds in relation to ten Federal requirements pertaining to the block grant. The ten requirements are drawn from the law and subsequent amendments and Federal regulations.

Planning Requirements

Planning requirements of section 314(d) call for certain assurances to be contained in the state's plan for expenditures of block grants for both mental and public health services delivery. Priorities of selected services and service objectives are to be set for the expenditure of 314(d) funds. The planning document (or incorporated assurances contained in state legislation and administrative regulations and procedures) is to be reviewed at least annually by state public and mental health authorities. Amendments or modifications are to be submitted to the governor for a 45-day review and then submitted to the Surgeon General of the U.S. Department of Health, Education and Welfare for approval.

In Missouri, the planning requirements are not being met in full. Involvement of the 314(a) and 314(b) agencies is not found in the public health area but is evident in the mental health area. While priorities have been set for the Division of Health and the Mental Health Department, 314(d) allocations and expenditures are not made to address or satisfy the priorities. This is evident particularly in the Division of Health.

The Missouri block grant planning process is presented below in a narrative form. The basic planning requirements are:

Provide services in accord with the adopted 314(a) Comprehensive Health Plan of the state. The Office of Special Services of the Department of Social Services is the designated 314(a) agency in Missouri. The agency has not completed a detailed, comprehensive health plan for the state. With HEW approval, the agency has developed broadly stated component plans from which the 314(b) areawide agencies are to develop detailed regional plans related to health service needs. As such, there is no specific plan by which 314(d) public health and mental health allocations and expenditures can be evaluated.

Discussions with Division of Health staff indicated that state allocations of the public health portion of the 314(d) block grant are not determined on the basis of the 314(a) plan components. The staff indicated that the division was aware of the plan components developed by the 314(a) agency and felt that the division's 314(d) allocations were in accord with the plan components.

Staff of the 314(a) agency serve on the Mental Health Authority Review Council that reviews, evaluates, and makes funding recommendations on local mental health projects funded with the mental health portion of the 314(d) block grant.*

Specify the extent to which services to be provided are to be directed at public health areas of high priority, are of high quality and will reach people in local communities in greatest need of such services. The state's use of the public health and mental health portions of the 314(d) block grant did not change radically over the state's use of the categorical grants that existed prior to FY 1968.

Allocation of the public health portion of the 314(d) block grant is carried out by the deputy director of the division. Key factors in the allocation decisions have been a continuation of the prior year's allocations and recommendations of program specialists and district health staff on the allocation of the 314(d) funds to meet the public health needs of local city and county health departments.

Priorities for the use of the mental health portion of the 314(d) block grant are established by program and administrative staff of the Department of Mental Health. For several years, the department's 314(d) state plan has included several standards for the review of local mental health project applications by the Mental Health Authority Review Council. The standards reflect a combined statement of funding priorities and administrative guides. As stated in the FY 1975, 314(d), Mental Health State Plan, the standards include:

1) training projects involving local project staff as well as broad based community education programs;
2) projects proposed by agencies with limited budgets that will result in the improvement or increase in service delivery;
3) projects designed to meet a special need,

*Source: Director of the Division of Special Services, Missouri Department of Social Services.

i.e., agencies planning a community mental health center program;

4) innovative projects that provide a new method of addressing old problems (nine of the 25 projects funded in FY 1975 are considered as innovative);
5) projects serving high-risk elements of the population;
6) projects dealing with special problems in the areas of drug abuse and alcoholism; and
7) children's programs.

Consider the comments of state 314(a) and regional 314(b) comprehensive health planning agencies in preparing the resource allocation to services in the 314(d) state plan(s). The Division of Health, which administers the public health portion of the 314(d) block grant, has developed a simplified state plan since FY 1972 and has submitted the appropriate plan descriptions and budgets to HEW each year.

Division staff indicated that the public health 314(d) allocations are not reviewed or commented upon by either the 314(a) agency or any of the 314(b) areawide health planning agencies. However, the division's deputy director indicated that the overall plans, programs, and budgets of the Division of Health are reviewed periodically with the 314(a) agency.

For mental health, staff from the 314(a) agency serve on the Mental Health Authority Review Council which evaluates local mental health agencies' request for 314(d) assistance. In FY 1975, $205,241 or 71 percent of the total 314(d) mental health allocation of $287,400 was allocated to local projects.

Allocate funds so that public health services are significantly strengthened in various political subdivisions of the state (including the funding of other public or private non-profit agencies to assure maximum participation of local, regional, and metropolitan agencies).

A considerable share of the public health portion of the state's 314(d) allocation described as expended for direct community services is utilized to strengthen local services provided by state agencies through state employees. During FY 1975, state services to local communities provided through the state's district offices and the state laboratory received $1,002,995 or 61.6 percent of the state's total 314(d) public health allocation of $1,628,500. On the other hand, local public health departments received $209,181 or 12.8 percent of the state public health allocation.

Discussions with the deputy director of the Division of Health indicated that the division was interested in encouraging the development of regional health service delivery organizations. These regional organizations would parallel the boundaries of the 20 substate planning districts of the state and would operate locally in lieu of single city or county health departments. The deputy director indicated that if the multicounty or regional organizations were to become a reality, then the existing state-operated district health offices would probably cease to exist and supervision of the regional organizations would be handled by a state central office.

Since FY 1968, the Department of Mental Health has utilized at least 70 percent of the mental health portion of the annual 314(d) block grant to develop and sustain the delivery of mental health services at the local level. Prior to FY 1968, the mental health categorical grant was used to support local mental health services. A major factor in this policy has been the lack of a state grant-in-aid program to local agencies for the operation of community mental health programs. In 1969, the Missouri General Assembly authorized counties to levy up to three mills of property tax to support local mental health services. No counties have implemented the legislation. However, some cities and counties have allocated general revenue sharing funds to support the delivery of local mental health services.*

Define health services to be provided in terms of specific objectives. For public health, only those health services that are to be provided by local agencies have been defined in terms of specific objectives. Such services are defined in the project applications submitted to the Division of Health. Services being provided by the Division of Health's staff are not defined in terms of objectives. As such, this requirement is not being met by the state.

In many cases, the amount of public health funds allocated to a local agency is so small, *e.g.* $1,200, that the local project application is in letter form. As such, the request indicates what personnel the funds will be supporting but does not include service objectives.

For local public health projects involving more than a minimal amount of funds, project applications submitted to the Division of Health contain both qualitative and quantitative statements of project objectives and projected performance. Discussions with division staff did not indicate that these statements were ever used to monitor or evaluate project performance or had an impact in future allocation decisions.

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*Source: "FY 75 Missouri 314(d) State Plan for Mental Health."

The mental health 314(d) state plan for FY 1975 provides an adequate description of broad service objectives to be achieved with the expenditure of 314(d) funds. Local project descriptions provide quantitative service objectives by which some form of statistical evaluation can be performed; whereas, objectives for administrative support services to be provided by Department of Mental Health staff are qualitative statements of service delivery goals.

Provide for the review and modification of the 314(d) state plan(s) as appropriate on an annual basis by the state health agency and state mental health agency. Since the Federal government adopted regulations allowing a 314(d) plan to contain assurances which are incorporated by reference from other state legislation and regulations, Missouri has utilized a simplified state plan format for submission to HEW.

The Department of Mental Health annually updates and reviews a 314(d) state plan. The FY 1975 plan is a document that briefly describes the department, procedures and standards used to evaluate and fund local projects, justification of the state's use of the administrative share of the funds, and a compilation of local project descriptions approved and funded by the agency.

Administrative Requirements

Administrative requirements concerning the 314(d) block grant funds are not extensive. They generally seek to assure that the state possesses the capacity to administer the 314(d) funds and that financial efforts are made for the provision of health services by non-Federal funding sources. Missouri appears to be in accordance with them. The requirements are:

Provide for the state administration of state supervision of local administration of the funds by the state health agency and state mental health agency. The Missouri Division of Health exerts strong supervision over the local administration of block grant funds. Contractual documents between the state and local health units provide several key controls including:

> that tne local health unit shall accept responsibility for the discharge of state public health programs as assigned to the local unit in keeping with the adequacy of their personnel and in conformity with the procedural manual of the Division of Health;
>
> that all persons in positions under this proposal, shall be employed in accordance with the State Merit System Law, the rules and regulations of the State Personnel Advisory Board, and the Federal Standards for a Merit System of Personnel Administration;
>
> that all employees under this proposal are to be given technical consultation and advisory services by the Division of Health; and
>
> that this agreement is subject to local, state, or Federal audit procedures.*

The Department of Mental Health's control over local use of block grant funds has been implemented in several ways. First, it has limited projects to $10,000 and one year of funding, and second, it requires the local agency to submit an audit report within 30 days of the project's completion or espiration.

Assure that the block grants will not be used to supplant other non-Federal funds. The relatively small amount of the block grant in comparison to the total health and mental health appropriations of Missouri state and local governments makes it impossible to determine if 314(d) funds are being used to supplant state or local funds.

Discussions with the deputy director of the Division of Health indicated that the 314(d) block grant for public health was not supplanting state or local funds. To the contrary, the deputy director indicated that the relatively static amount of the block grant over the last five years has caused a lessening of the impact of the funds due to inflation and in fact state funds were being used to supplant 314(d) block grant funds.

Another facet of the lessening impact of the block grant, due to its static funding level, is the increase in the number of local public health agencies – from 68 in FY 1965 to 98 in FY 1975 – which has brought about significant increases in the expenditure of local funds for public health services.

A major utilization strategy of the mental health portion of the 314(d) block grant has been as "seed" money to foster the development of community mental health programs at the local level. The funds have not been used to supplant either state or local funds since no

*Text provided by deputy director, Division of Health.

state aid program exists to fund local programs and only few local governments have appropriated local tax dollars to mental health services. Only recently, several local governments have allocated portions of their general revenue sharing funds for mental health services.

A major consideration of the Mental Health Authority Review Council in their evaluation of proposed local projects is the ability of the project to obtain local support for future activities.*

Require recipient agencies utilizing 314(d) funds to participate in the costs of the supported services. The use of 314(d) funds to support public health projects at the local level is governed by contracts between the state and the local health unit. These contracts require the local unit to participate in the costs of the supported services. In FY 1974, contracts with local units were far in excess of $10 million with state and Federal funds (partially 314(d) funds) equalling about 20 percent of the total amounts.

State-administered services supported in part with 314(d) block grants are satisfactorily matched with state-appropriated funds. The deputy director of the Division of Health administers the block grant and is able to demonstrate in each expenditure category the amount of 314(d) funds in relation to the amount of state, other Federal, or local funds.

Most of the mental health portion of the 314(d) block grant is used to support local projects. As stated previously, project grants are limited to $10,000, a requirement that almost assures satisfactory matching funds to meet the requirement. Until the beginning of FY 1976, the Department of Mental Health did not require that local grant recipients share in the costs of the services supported. In June 1975, a Federal review of the state's 314(d) plan (that was initiated at the request of the state) resulted in the state beginning to require that local projects assume a share of the costs.**

Evaluation Requirement

The evaluation requirement of section 314(d) is provided to enable the state to assess the effectiveness of block grant supported activities in achieving state objectives.

The requirement for evaluation is:

Provide methods of evaluating the performance of activities carried out with 314(d) funds. Project applications submitted for 314(d) funding to the Division of Health and the Department of Mental Health are required to state objectives and the method(s) of evaluation to be employed.

Interviews with state staff indicated that very few projects are evaluated to determine the effectiveness of the 314(d) expenditures. These reviews are informal and are based upon the direct working relationship of state program staff with local agencies.

Services and activities supported with 314(d) funds that are provided by state employees of the Division of Health and the Department of Mental Health are not being formally evaluated.

*Source: "FY 1975 Missouri 314(d) State Plan for Mental Health."

**Source: Letters between state and Region VII HEW-Public Health Service staff dated June 19 and June 27, 1975.

CHANGES ATTRIBUTED TO THE BLOCK GRANT PROCESS

The block grant mechanism has led to very few discernible changes in Missouri's delivery of public health and mental health services. Both allocation and utilization patterns for Federal allocations are basically the same under the block grant as they were when categorical grants were in effect.

State-provided services which are financed in part with 314(d) funds have experienced little change, and methods of providing, measuring, and evaluating services have varied little in response to the initiation of the block grants.

Within the Division of Health, most of the health problems treated by programs funded with categorical moneys have continued to be addressed under operational programs. The most significant change that has taken place in the shift from categorical funding to block grant funding has taken place in the public health area. The Division of Health is using the block grant funds for the same services that were funded by the categorical grants. However, the block grant has enabled the division to increase substantially the amount of Federal funds being used to support the Bureau of Laboratory Services. For example, in FY 1967, under the categorical grant, laboratory services received $31,400 or 3.4 percent of the total categorical grants. In FY 1975, laboratory services received $529,007 or 32.5 percent of the public health portion of the state's total 314(d) allocation.*

Other changes attributed to the block grant include reduced involvement by Federal health program special-

*Source: Dollar amounts provided by deputy director, Missouri Division of Health.

ists, and replacement of the annual detailed applications by a skeletal plan document.

State public health and mental health officials expressed opinions that the block grant did not affect the role of the governor, the general assembly, local agencies, or interested citizens in the allocation of health resources. The officials indicated that the state's budgetary process is the same now as it was when the funds that are now in the block grant were categorical grants. In the state's budget process, the block grant funds are grouped with categorical funds and appear in budget documents as "Federal funds." The decision on how to spend the 314(d) dollars is made by administrative officials within the state's health and mental health agencies. In the Division of Health, programming the 314(d) funds is the responsibility of the deputy director. Within the Department of Mental Health, this function is vested in the Mental Health Authority Review Council.

The block grant has had limited impact on the stimulation of additional state or local expenditures. Interviews with state officials indicated that the stabilized amounts of 314(d) block grant funds received annually since FY 1970 have been seriously affected by inflation and that the funds were not "buying" as much services in FY 1975 as they were in FY 1970. As such, major portions of services supported in FY 1970 wholly by 314(d) funds are being supported with a majority of state funds. State officials characterized this as state funds supplanting Federal funds.

State officials attribute increased state health expenditures to other factors including the use of program improvement funds for innovative programs; the increased number of local health agencies; increases in other Federal grants; and inflation. *Table 8* shows the increases in public health expenditures in Missouri between FY 1970 and FY 1975. As indicated, total public health expenditures increased 59.8 percent from $27.8 million to $44.5 million with the most significant increase at the state level of $12.4 million, an increase of 103.9 percent. During the same period, local public health expenditures increased only 14.5 percent or $1.4 million while Federal grants to the state increased by 45.6 percent or $2.9 million. The $12.4 million increase in Missouri public health expenditures during the period was not attributed primarily to the 314(d) block grant. The primary factor affecting higher state expenditures was inflationary costs.

The primary use of the public health portion of the 314(d) block grant has been to supplement state expenditures in existing state programs. Not having used the 314(d) funds for the development of innovative programs at the state or local level considerably reduces the capability of the funds to stimulate expenditures of new funds. State health officials indicated that 314(d)

Table 8

Public Health Expenditures, State of Missouri, Fiscal Year 1970 and Fiscal Year 1975*

Funding Source	FY 1970	FY 1975	Percent Increase
State	$ 11,906,895	$ 24,275,881	+103.9%
Local	9,647,135	11,050,264	+14.5%
Private	3,000	8,000	+166.6%
Federal	6,276,267	9,136,588	+45.6%
Total	$ 27,833,297	$44,470,733	+59.8%

**Source:* Deputy director, Missouri Division of Health.

funds have not been used for innovative purposes simply because the "buying power" of the 314(d) grant has been reduced considerably by inflation and the state, also suffering with inflation, has had to emphasize the delivery of basic health services in lieu of innovations.*

In mental health, the portion used to fund local projects has had some effect on increasing local expenditures. This is due to the lack of a state aid program to local agencies for mental health services. Use of the funds by the state as "seed" money to foster the development of locally operated community mental health programs has resulted in increased expenditures by local governments.

Even though the state has granted the funds to local agencies without a matching requirement, thus giving the appearance of not encouraging increased local expenditures, the state has limited the funding of local projects to one year and evaluates its funding decision on the basis of the project being able to obtain other support for the second year of operation. Several projects funded initially with 314(d) funds have been funded for the second year by local governments using part of their general revenue sharing funds.

Beginning in FY 1976, the Department of Mental Health plans to require a match by local projects supported with 314(d) funds. Department officials did not believe that this action would stimulate additional expenditures at the local level. The action was being taken to meet the Federal requirements for a matching share. It was precipitated by a Federal review of the FY 1975 mental health 314(d) state plan that was requested by the department.

The block grant has had little effect in Missouri on the use of public health or mental health Federal categorical grants.

Public health officials indicated that the static level of 314(d) funding has resulted in "the funds not buying as much services" in FY 1975 in relation to FY 1970, due to inflation of costs. In turn, other Federal funds, which increased by $2.9 million dollars between FY 1970 and FY 1975, have been used to pay for services previously supported with 314(d) funds.

In mental health, 314(d) funds have not altered or replaced Federal categorical funds.

The flexible nature of the 314(d) block grant has received only limited demonstration in Missouri. As stated previously, there was little change in the purposes for which the state expended the categorical grants prior to FY 1968 and the block grant since FY 1968. The most significant example is the funding of the Division of Health's Bureau of Laboratory Services. In FY 1967, that bureau received approximately $31,000 from the categorical grants. The flexibility of the block grant enables the division to allocate over $500,000 in FY 1975 to the bureau. It is not likely that this level of expenditure could have been obtained under the rigorously monitored categorical grants.

State public health and mental health officials in Missouri, when asked to cite the major differences between block grants and categorical grants, mention "increased flexibility" as the major difference. For the most part, this flexibility is defined not as much from the perspective of how, or for what, the money is programmed and budgeted but from the perspective of monitoring, evaluation, and accounting controls. In Missouri, the 314(d) block grant funds are being used for the same purposes and many of the same programs as the categorical grants were used.

However, state officials are very aware that they are not being monitored, evaluated, or, in most cases, audited on their use of the 314(d) block grant. It is the lack of Federal controls that results in state officials describing the 314(d) funds as "flexible" and easy to administer.

SUMMARY AND CONCLUSIONS

It is accepted that one of the objectives of the *Partnership for Health Act* was the development of a planning system at the state and regional levels that would, with the assistance of health service consumers and providers, increase the effective utilization of resources to meet health needs.

In Missouri, neither the "flexible" 314(d) block grant nor the creation of a state 314(a) agency and areawide 314(b) agencies has fostered a systemwide approach to the planning, coordination, administration, delivery, and evaluation of public health and mental health services in Missouri.

Related to public health services, there is little coordination between the activities and planning efforts of the state's Office of Comprehensive Health Planning (the 314(a) agency) and the Division of Health's allocation of its portion of the 314(d) block grant. Local projects funded through the state's public health portion of the 314(d) block grant funds are not reviewed by the 314(b) areawide comprehensive health planning agencies in the state.

Since 1964, the state's mental health agency has used the mental health categorical grant and its share of the state's 314(d) block grant to foster the development of community mental health programs and services. The

*Source: Deputy director, Missouri Division of Health.

314(a) agency has actively participated in the review and evaluation of proposed projects. This participation has assured coordination between the state's comprehensive health planning effort and the Department of Mental Health.

Comparison of the state's expenditure pattern in FY 1967, under the public health and mental health categorical programs, with the FY 1968, 1970, and 1975 expenditure patterns under the block grant program indicates that implementation of the 314(d) block grant program had only a minor effect on the use and allocation of Federal health funds. Most of the programs and types of activities that were funded in FY 1967 are still being funded in FY 1975.

Administrative allocation and legislative approval of the utilization of the funds is the same under the block grant program as it was under the categorical grants. Budget documents submitted to the legislature group all funds, categorical and block grants, as one revenue source described as "Federal funds." When legislators take action to appropriate funds, they have no idea that the funds they are appropriating are 314(d) funds.

To date, Missouri has met in part the requirements established for the 314(d) block grant mechanism. The requirement that 70 percent of the allocation be expended in local communities is being satisfied fully by the Department of Mental Health. The Division of Health regards the 70 percent pass-through requirement as including the provision of services in the community by state employees and officers of the division as well as expenditures in local communities by local staff in order to increase the service delivery capacity at the local level.

Accounting and documentation procedures in both agencies are such that 314(d) state allocations and expenditures can be traced to the activity and item level.

Previous plan submissions by the state to HEW had contained the statement that local mental health projects were funded 100 percent without a matching requirement. The Federal official who reviewed the plan and suggested that the state begin using the match in order to meet Federal 314(d) administrative regulations apologized to the state for his department's oversight of the state's previous plan submissions' statements concerning 100 percent funding. The Federal official cited the "casual" review of state plans since the implementation of the "simplified" document requirement as the reason why the state had not been informed earlier of the matching requirement.

This is an example of the diminution of the Federal role in monitoring state programs and expenditures which existed under prior Federal categorical grants. Federal officials are not now in a position to either impose any Federal priorities nor to assess to any great degree individual state capacity to administer a block grant program.

"Flexibility" is often cited as one of the positive characteristics of the 314(d) block grant. As stated before, analysis of the state's utilization of the block grant funds in comparison to the prior categorical grants indicates that the state is expending the funds under the block grant for the same types of programs that were funded by the categoricals. This led to the conclusion that the "flexibility" perception of state officials results from the lack of Federal monitoring, auditing, and evaluation under the block grant rather than the flexible programming allowed by the block grant.

Neither the public health agency nor the mental health agency is evaluating the effectiveness of their use or local agencies' use of 314(d) funds although each agency reviews performance and audits each project.

Only the mental health agency actively involves the state comprehensive health planning, 314(a) agency and the areawide comprehensive, 314(b) health planning agencies in the programming and budgeting of 314(d) funds.

Non-Federal funds are not being supplanted by the public health and mental health agencies in Missouri.

In conclusion, Missouri, of the six states studied in this series of cases, possessed the most detailed accounting and descriptive material on the state's expenditure of 314(d) funds.

Oregon

Allocation and utilization of 314(d) funds in Oregon involve two separate approaches by state public health and mental health authorities. This study is an examination of the two approaches and their implementation in FY 1968 when block grant funds were first received; in FY 1970 when the tuberculosis categorical grant was added to the block grant; and in FY 1974 and 1975, which reflect current state actions for the respective provisions of public and mental health services.

Allocation and administration of 314(d) funds in the State of Oregon involve the following entities:

- Budget Division, Executive Department;
- Ways and Means Committee, state legislature;
- Health Division, Department of Human Resources; and
- Mental Health Division, Department of Human Resources.

The Health Division and Mental Health Division are units within the Department of Human Resources. They operate independently of one another. Similarities of operation are that division officials charged with budget responsibilities work with the Budget Division of the Executive Department and the legislature's Ways and Means Committee.

The Health Division is guided by the Health Commission which is by statute the policymaker and long-range planning agency for provision of public health services in Oregon. The commission serves in the following roles: advisor to the legislature on health related matters; as the state Hill-Burton agency; and as the reviewer of certificates of need for health services facilities. The commission is comprised of 13 members who, by law, are appointed by the governor and approved by the state senate. A majority of the commissioners must be consumers.

In addition, the commission is the advisory body for the 314(a) agency which is located within the Health Division.

Most priority setting and other policy determinations concerning both the expenditure of 314(d) and other Federal and state funds for public health services are made through the budget process by staff within the Health Division in coordination with the chiefs of its six offices. Neither the Health Commission nor the 314(a) agency play a strong role in these activities.

The legislature through the Joint Ways and Means Committee also plays an active role in allocating block grant expenditures. The committee reviews the state's health and mental health budgets and confers extensively with the division's administrators and office chiefs to coordinate assessments of health and mental health priorities and to allocate funds. *Tables 1, 2, and 3* present the organizational relationship of key agencies involved in the administration of block grant funds for the provision of public and mental health services in Oregon.

Health Division regional offices are located in Roseburg, Bend, and Pendleton. These offices are staffed with engineers and sanitarians and are responsible for performing certification and inspection of facilities throughout the state.

County health departments are under the indirect administrative control of the Health Division in that they are required to comply with division guidelines for budget and program plan preparation in order to qualify for receipt of certain Federal categorical grants administered at the state level. The state is divided into 14 districts for planning, but these planning agencies do not deliver public health services.

The Oregon Mental Health Division of the Department of Human Resources is organized with a central administrative and program staff located in Salem and program staff in three other locations in the state. The

agency's administrative offices provide central supervision and administer programs including:

- mental or emotional distrubances (MED),
- mental retardation-developmental disabilities (MRDD), and
- alcohol and drug problems (AD).

Regional offices in Salem, Wilsonville (near Portland), and Pendleton also have program components for MED, MRDD, and AD.

Allocation and use of the 314(d) mental health block grant are centered within the MED program office in Salem which administers the state's Mental Health Grant-in-Aid Program that funds mental health programs at the local level. Thirty-four community mental health programs (CMHPs) are in operation throughout the state's 36 counties. In 32 instances, the CMHPs are operated by single county, public health agencies, and in two cases multicounty, private, non-profit corporations serve as the MCHP. In FY 1975, approximately 71 percent of the state's 314(d) mental health funds were included in the state's Mental Health Grant-in-Aid Program to local communities.

Federal allocations for public health are included in the Health Division's bi-annual budget. The budget is comprised of 314(d) funds, other Federal categorical moneys, and state expenditures for public health. The budget is prepared by the administrator of the division with aid from the Office of Administrative Services.

The administrator then confers with the Budget Division of the Executive Department and a total budget request for 24 months is presented to the Joint Ways and Means Committee of the state legislature (the legislature convenes every other year).

Block grants are used in a variety of ways to provide public health services in Oregon. The Health Division allocates the funds to its Office of Community Health Affairs, the Office of Preventive Medical Services, and the Office of Administrative Services which provide public health services through their operational programs on both state and community levels.

State services are provided on the local level in two ways. First, the offices of the Health Division conduct and administer operational programs consisting of administrative or direct services provided for county health departments. Second, a sum – generally 10-12 percent of the 314(d) funds – is allocated to specific projects coordinated by the public and/or private non-profit agencies, usually the metropolitan county health departments.

These are the usual ways that public health services are provided in Oregon and the block grant mechanism has not significantly altered the Health Division's approach to utilization and administration of state and Federal funds.

In addition, if block grant funds are not totally expended, they are allocated to local health departments pursuant to a formula based solely upon population. These allocations will be discussed in greater detail in a later portion of this study.

The state's policy on the use of 314(d) block grant funds for mental health services had not changed since FY 1968, the first year the state received and programmed the block grant. In fact, current state policy on the use of the mental health funds pre-dates the initiation of the block grant. Since FY 1963, the state has used significant portions of either the mental health categorical grant funds or the mental health portion of the 314(d) block grant funds to develop and support an expanded community mental health effort at the local level.

Over the years, the Oregon legislature has played an active role in the development of the state's mental health program.

While 314(d) block grant funds have been used to support state and local mental health purposes and projects, the role of the 314(d) funds has not been a significant factor in the development of the state's mental health program. Mental Health Division officials indicated that 314(d) funds are identifiable, as are other Federal funds, in the division's budget requests.

Legislative actions occur with direct knowledge and cognizance that particular state activities and programs are being funded from a particular source, or mix, of funds. However, the budget does not specify the suballocations that are made by division staff, particularly those suballocations that are made to local mental health clinics through the state's Mental Health Grant-in-Aid Program. However, once the Mental Health Division's budget is approved, the division maintains a monthly record of expenditures, remaining allocations, and the amounts allocated to the local mental health clinics.

Thus, the identification and monitoring of how 314(d) funds are being used is possible during the budgeting process as well as during their administration.

BLOCK GRANT ALLOCATION AND USE

In Oregon, 85 percent of the annual 314(d) block grant is used for public health purposes and 15 percent for mental health purposes. Approximately 90 percent

Table 1

**Organizational Structure,
Department of Human Resources,
State of Oregon***

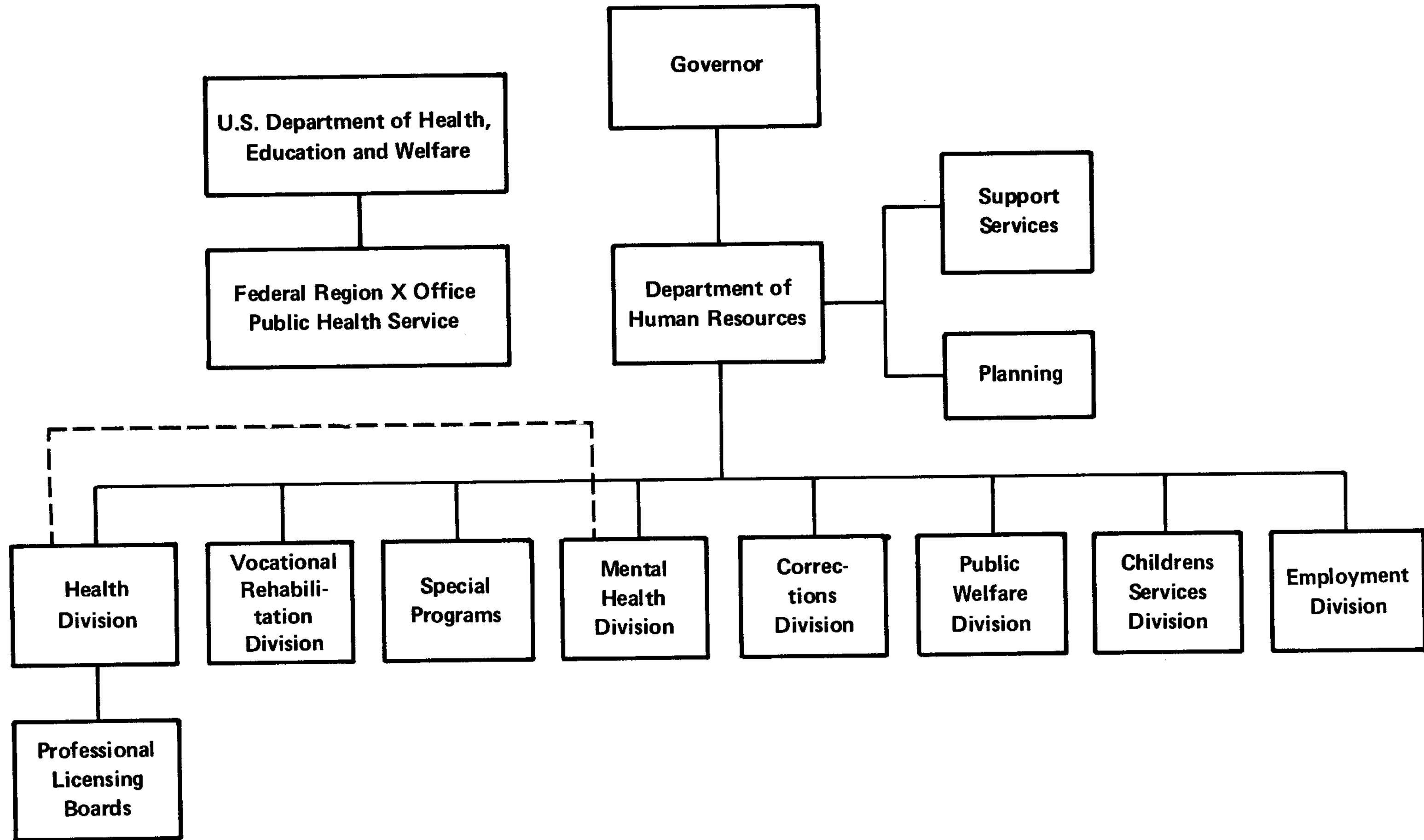

*Table provided by Oregon State Health Division.

Table 2

Organizational Structure of the Oregon State Health Division*

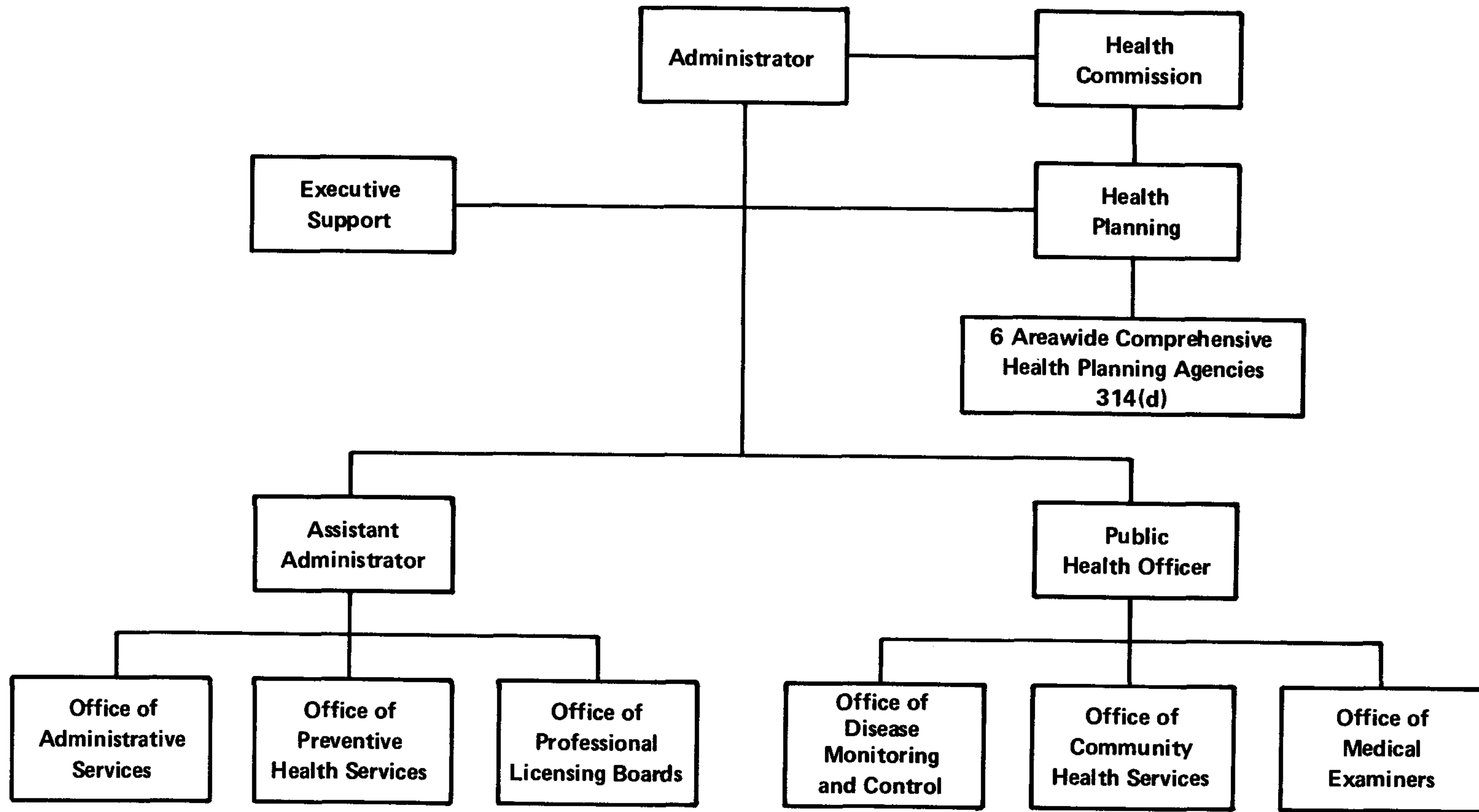

*Table provided by Oregon State Health Division.

Table 3

Organizational Structure of the Oregon State Mental Health Division*

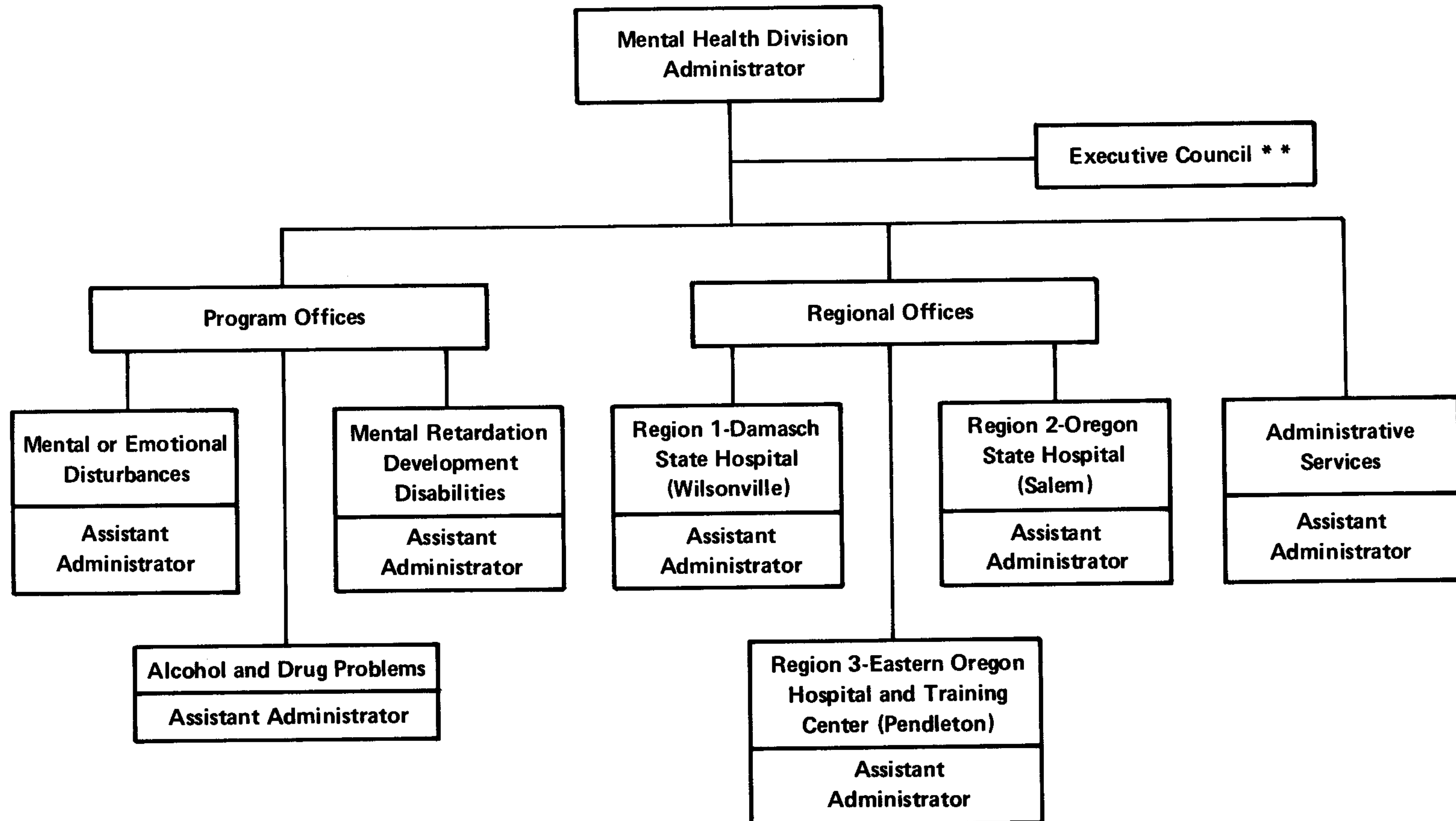

*Table provided by Oregon State's Mental Health Division.

**The Executive Council is composed of the division's seven (7) assistant administrators. The council meets weekly and advises the division's administrator on policy matters.

of the public health portion of the block grant is used in support of Health Division operational programs which provide services to county health departments. The Mental Health Division, on the other hand, allocates at least 70 percent of its 15 percent share of the block grant to the state's Mental Health Grant-in-Aid Program which funds the operation of mental health clinics at the local level.

Meeting the state's share of the formula for either public health or mental health has not presented a problem for the State of Oregon. Like other states, the 314(d) block grant represents a very small amount of the funds (less than 3%) expended by the State of Oregon and its local governments for the provision of health services.

This section discusses Oregon's administration of 314(d) funds in two phases: (1) Federal to state allocation, and (2) state and local relationships for allocating and utilizing 314(d) block grant funds.

Federal to State Allocation

In FY 1968, Oregon received $537,600 for public health and $94,900 for mental health services. The total funding for the first year of the 314(d) block grant was $632,500.*

In the year before 314(d), Oregon was the recipient of $584,200 under the nine Federal categorical health grants.*

With the receipt of block grant funds, Oregon experienced an increase of $48,300 or 8.2 percent in Federal funding for public and mental health programs in FY 1968. Between FY 1968 and FY 1970 the annual allocation to Oregon increased by $381,400. This increase resulted from the inclusion of the tuberculosis categorical grant in the 314(d) national allocation. Since then, block grant allocations have remained at approximately $1 million. *Table 4* presents the total annual 314(d) allocations to Oregon since the block grant program started.

While the total 314(d) block grant has maintained an annual level of about $1 million, it has not affected the increasing amounts appropriated by the state for public health and mental health services.

The Office of Health Planning, the 314(a) agency in Oregon, has played virtually no role in the allocation of the 314(d) block grant. The 314(a) agency as part of its health planning requirements under P.L. 89-749 has developed broadly stated policy and priority guidelines related to the planning and delivery of public health services in the state. Actual priorities and decisions for the expenditure of 314(d) funds have been made within the Health and Mental Health Divisions without adherence to the 314(a) agency's guidelines. Administrators within the divisions stated that the 314(a) policy and priority guidelines were so broadly defined that almost any 314(d) expenditure item could satisfy

*Information provided by the Office of Administrative Services, Oregon State Health Division.

Table 4

The 314(d) Block Grant Allocation to Oregon for Fiscal Years 1968 through 1975*

	Public Health	Mental Health	Total
FY 1968	$537,600.00	$ 94,900.00	$ 632,500.00
FY 1969	667,700.00	117,800.00	785,500.00
FY 1970	861,800.00	152,100.00	1,013,900.00
FY 1971	857,600.00	151,400.00	1,009,000.00
FY 1972	872,400.00	153,900.00	1,026,300.00
FY 1973	892,000.00	157,400.00	1,049,400.00
FY 1974	891,700.00	157,400.00	1,049,100.00
FY 1975	897,700.00	158,400.00	1,056,100.00

*Table provided by Office of Administrative Services, Oregon State Health Division.

any one of a number of the 314(a) agency's priority categories.

While the state's health and mental health agencies are divisions of the Oregon Department of Human Resources, Oregon's budget process is carried out directly between the divisions and the Joint Ways and Means Committee of the legislature. No other staff within the department has a direct role in the budgeting and allocation of funds administered by the Health and Mental Health Divisions, including the annual 314(d) block grant.

The legislature, through its Joint Ways and Means Committee, has final authority for the allocation of 314(d) block grant funds. The committee finalizes its decision after conferring with personnel from the Health and Mental Health Divisions and passes its recommendations along to the legislature. The administrator of the Health Division is the principal spokesman of that authority, but in the course of budget hearings, office chiefs also present requests based upon priorities established for each operational program. It is these priorities, developed by each division, which the legislature deals with in allocating 314(d) funds.

Of the six case studies, Oregon's legislative body is the only governing body that receives, as a standard procedure, detailed proposed allocations and suballocations for the expenditure of 314(d) funds. Because it receives the proposal in a detailed format and, therefore, has the opportunity to affect specific programs and activities, it is considered that the Joint Ways and Means Committee plays an active role in the allocation and use of 314(d) block grant funds.

In the other five states, the legislatures do not receive the level of detail on allocations that the Oregon legislature receives. As such, those legislative bodies have been characterized as playing a passive role in the allocation of 314(d) funds.

State Provision of Public Health Services

The Health and Mental Health Divisions of the Oregon Department of Human Resources have separate responsibilities for the administration and utilization of block grant funds. The two divisions are operationally independent, and accordingly they will be discussed separately. Analysis is presented for public health services in terms of FY 1966 and FY 1967 under the categorical grant systems, of FY 1968 when the block grant funds became available, and FY 1974, the latest year of fully documented expenditures. Also included is a brief discussion of the increased allocation to the state that occurred in FY 1970 when the tuberculosis categorical grant program was included in the 314(d) block grant. For mental health services, analysis is presented in terms of FY 1967, FY 1968, FY 1972, and FY 1975.

The Health Division has generally allocated 314(d) funds in two ways. The bulk of the moneys have been directed to three offices within the division – Administrative Services, Community Health Services, and Preventive Medical Services. These offices carry out public health activities on the state and community levels, both through operational programs and internal administrative services. A second mode of allocation is undertaken through the Office of Community Health Services. Generally 10-12 percent of the block grant is passed to county health departments and/or private non-profit agencies to serve as financial support for specific projects. Generally, six projects per year are funded in whole or in part by 314(d) funds.

A third method of allocation has infrequently been used by the Health Division. If any of the 314(d) block grants are unexpended at the end of a fiscal year, they are allocated to local health departments on a formula basis. The funds are used by local units as a supplement to their own budgets.

The formula is based strictly on the population within the jurisdiction of each health department. The formula was devised by the chief of the Office of Administrative Services and selected local health officials communicating on an informal basis. Additionally, eligibility of receipt of such allocations is predicated upon compliance with certain requirements set by the Conference of Local Health Officers and administered by the Health Division. The conference is a confederation of representatives from county health departments which seeks to establish community health needs and communicate them to state public health officials.

These requirements, which set minimum staffing, personnel, and budgeting (with a management by objective process), are more fully discussed in the planning, administrative, and evaluative section of this study.

The block grant moneys have been allocated to local health departments on a formula basis. There is no documentation of these allocations, but estimates (by the Office of Administrative Services) are that they occur approximately every third year. Sums disbursed using the formula have been minimal, with $25,000 being the maximum amount ever so allocated.

The staff responsibility for allocating the mental health portion of the 314(d) block grant lies with the assistant administrator of the Mental and Emotional Disturbances Program Office (MED) of the Division of Mental Health (DMH) and the assistant administrator of

administrative services of the division. This staff allocation which takes place as a part of the division's budget preparation is subject to review by the administrator of the division prior to submission to the Budget Division of the Executive Department and, consequently, to the Joint Ways and Means Committee of the Oregon Legislature for review, change, and/or approval. Throughout the divisional staff, executive, and legislative allocation process, the 314(d) funds are identifiable. Division staff stated that their principal concern once the proposed allocation left the division was to make sure that 70 percent of the 314(d) funds remained in expenditure categories or allocations related to the provision of direct services at the local level.

In FY 1963, Oregon initiated the state Mental Health Grant-in-Aid Program to foster development and support of the provision of a broad range of mental health services at the local level. From FY 1963 to FY 1967, a majority amount of the funds that the state received under the mental health categorical grant and the mental health portion of the 314(d) block grant was allocated legislatively to the state Mental Health Grant-in-Aid Program. Since FY 1968, over 70 percent of the 314(d) mental health allocation has been expended at the local level by locally operated public and private, non-profit agencies. Prior to FY 1963, a majority amount of the mental health categorical grant was allocated to the mental health agency for suballocation to child guidance clinics at the local level.

Mental Health Division staff indicated that the Joint Ways and Means Committee of the Oregon legislature plays a strong role in the 314(d) allocation process. For example, in the division's FY 1974 budget, the legislature, in order to meet increasing costs for the operation of local mental health clinics due to inflation, shifted funds from special demonstraton projects to the state's Mental Health Grant-in-Aid Program.

The suballocation of 314(d) mental health funds to local agencies for the provision of services or the conduct of special demonstration projects is the responsibility of the staff of the Mental and Emotional Disturbances Program Office and fiscal staff of the Administrative Services Section of the Mental Health Division.

Public Health Utilization of 314(d) Funds

The availability of 314(d) funds in FY 1968 did not result in significant changes in the Health Division's utilization of Federal funds. Operational programs and the staff implementing them were continued as the transition was made from categorical to block grants. The programming of the 314(d) block grant has remained basically the same to date.

Even though an additional $194,100 was added to Oregon's public health portion of the 314(d) block grant in FY 1970 as a result of the tuberculosis categorical grant being added to the national allocation, the state's expenditure pattern was not affected. The state utlized the additional funds to support tuberculosis projects.

Tables 5, 6, and 7 present the allocation of prior categorical grants in 1966 and 1967 and utilization of the block grant in 1968 and 1974, respectively.

Activities which were funded by prior categorical grants were continued under the block grant within the operational programs of the Health Division carried out by three of the offices of that agency – Community Health Services, Administrative Services, and Preventive Medical Services. Documentation of 314(d) expenditures has not been maintained in such a manner that direct relationships between programs funded by categorical grants and those funded by block grants can be ascertained. However, discussions with Health Division personnel and analysis of 314(d) expenditures for the years 1968 through 1974 indicate the disposition of funds supported by following prior categorical grants:

- **Chronic illness and the aged, cancer control, and heart disease control** have been addressed within the chronic disease element of Preventive Medical Services.
- **Dental services** are now provided primarily on a project-by-project basis, funded primarily by the state's allocations to local health agencies.
- **Radiological health services** were never heavily utilized and are not actually identifiable in current usage patterns of 314(d) funds.
- **Mental health services** have been absorbed by the 15 percent allocation of 314(d) funds to authorities in that field.
- **Tuberculosis control** is readily identifiable as an element in the Preventive Medical Services program.
- **Home health services** were not extensively utilized but are now identifiable in occasional project grants or in the public health nursing portion of community health services.
- **General health services** have been provided by the Office of Community Health Services in almost all of its programs and

Table 5

Federal Categorical Grants
Oregon – Fiscal Year 1966 and Fiscal Year 1967*

	FY 1966	FY 1967
Cancer Control		
Allocation	38,018.90	35,300.00
Expenditures	17,967.89	21,602.39
Reversion	20,051.01	13,697.61
Chronic Illness and Aging		
Allocation	125,915.65	118,500.00
Expenditures	119,372.41	116,327.82
Reversion	6,543.24	2,172.18
Dental Services		
Allocation	13,348.00	12,500.00
Expenditures	13,173.58	12,480.33
Reversion	174.42	19.67
General Health Services		
Allocation	106,818.97	105,600.00
Expenditures	103,403.63	105,595.66
Reversion	3,415.34	4.34
Heart Disease Control		
Allocation	136,830.14	121,400.00
Expenditures	96,021.33	108,010.04
Reversion	40,808.81	13,389.96
Home Health Services		
Allocation	85,200.00	75,000.00
Expenditures	55,630.16	64,787.98
Reversion	29,569.84	10,212.02
Radiological Health Services		
Allocation	26,768.95	24,500.00
Expenditures	26,769.00	24,495.89
Reversion	(.05)	4.11
Tuberculosis Control		
Allocation	28,110.56	26,400.00
Expenditures	27,940.00	26,395.68
Reversion	170.43	4.32

*Table provided by the Office of Administrative Services, Oregon State Health Division.

by Preventive Medical Services, particularly in its laboratory activities.

Although the Health Division does not specifically document staff salaries in terms of personnel funded by the 314(d) block grant, it is estimated that 40 persons are budgeted from 314(d) funds in the division. Furthermore, six projects were partially funded by the block grant in FY 1974 in local health departments employing several additional full-time personnel and part-time services of dentists and other professional and supporting personnel. All are paid with block grant funds.*

*Letter from the deputy administrator of the Oregon State Health Division to Senator Mark O. Hatfield, dated March 18, 1975.

Table 6

Expenditure of 314(d) Federal Funds for Provision of Public Health Services in Oregon for Fiscal Year 1968*

Category			Amount
Administration			
Business Management		$ 15,787.70	
Personnel		21,436.09	
Planning and Special Services		14,408.87	
	Total		$ 51,632.66
Local Health Services Division			
Office of the Director		$ 42,496.52	
Training		13,666.75	
Formula Grants to Counties		8,000.00	
Project Grants to Counties (General)		36,744.35	
Public Health Nursing		16,500.36	
	Total		$ 117,407.98
Preventive Medical Services Division			
Office of the Director		$ 9,410.88	
Chronic Diseases		124,713.12	
Project Grants to Counties (Chronic Disease)		25,200.00	
Dental Health		5,800.39	
Project Grants to Counties (Dental Health)		2,618.20	
Occupational Health		40,220.10	
Farm Labor Health		11,938.07	
Public Health Laboratory		78,723.31	
Radiological Health		36,961.62	
Tuberculosis		31,264.20	
	Total		$ 366,849.89

*Table provided by the Office of Administrative Services, Oregon State Health Division.

Table 7

Summary of the Use of 314(d) Funds in Fiscal Year 1974 by the Oregon State Health Division*

Programs	Level of Service State	Community	Total
A. Office of Community Health Services			
1. Director's Office	$ 53,305	$ 25,633	$ 78,938
2. Local Health Officer's Conference		281	281
3. Grants to Local Areas		87,113	87,113
4. Emergency Health Services		41,108	41,108
5. Health Education General	8,299		8,299
6. Health Education–Film Library		7,220	7,220
7. Health Education–Reference Library	6,782		6,782
8. Training	13,361	15,819	29,180
9. Public Health Nursing	41,350		41,350
B. Office of Administrative Services			
1. Director's Office	23,122		23,122
2. Fiscal Services	7,586		7,586
3. General Services	26,290		26,290
4. Health Planning	41,351		41,351
C. Office of Preventive Medical Services			
1. M.C.H.–Grants to Local Areas		46,000	46,000
2. M.C.H.–Hearing and Vision Conservation	8,203	86,419	94,622
3. M.C.H.–School Health	7,089		7,089
4. Laboratory–Administrative	29,328	25,738	55,066
5. Laboratory–General Bacteriology		16,123	16,123
6. Laboratory–Serology		9,861	9,861
7. Laboratory–Streptococcus		31,917	31,917
8. Laboratory–Virology		2,014	2,014
9. Laboratory–Water Bacteriology		22,780	22,780
10. Tuberculosis		118,869	118,869
11. Chronic Disease		72,607	72,607
12. Venereal Disease Control		11,319	11,319

*Table contained in "Report on Programs Supported With Section 314(d) Grant, Fiscal Year 1974," Oregon State Health Division.

For purposes of discussion, the FY 1974 operational program of the Health Division can be divided into three broad categories corresponding to the three offices – Administrative Services, Preventive Medical Services, and Community Health Services – with responsibility for their administration. There is one exception in that 314(d) funds allocated to the director's Office of Community Health Services, which provides administrative services, are discussed with the programs of the Office of Administrative Services. The programs are discussed below both in terms of public health problems addressed; amounts of 314(d) funds used in support of services provided; and percentage of 314(d) funds allocated to provide public health services.

Administrative Services

1. **Director's Office and Fiscal Services.** This program provides administrative and support services to assist program managers in the division. A researcher and lead secretary in the office are paid with 314(d) funds. Support services include the preparation of plans and reports for division programs with the goal of

optimizing available resources in order to effectively achieve program objectives.

Allocations to specific programs are made on the basis of budgeting through a mangement-by-objective procedure. Each program officer is required to submit to the Office of Administrative Services a request which describes five items:

1. **The problem** is defined in quantitative terms which the program is designed to alleviate.
2. **The objective of the program must be presented showing consistency with the health** need (as described in #1 above). The objective must be significantly attainable, both in light of scope and expected available resources, and measurable.
3. **A method** must be described indicating quantifiable activities to be carried out to alleviate the problem.
4. **An evaluation** by measures or comparisons to indicate achievement of stated objectives must be presented.
5. **Accomplishment** of results actually achieved during the preceding year must be described as well as those anticipated for the next year.

Allocations to specific operational programs are then made based on this procedure of defining problems, objectives, methods, and evaluations.

Level of Support: $30,708
Percent of Total 314(d) Allocation: 3.1%

2. **General Services.** Block grant funds are utilized to support General Services which provide mail services for the Health Division. This category also includes pick up and delivery for all laboratory specimens to the post office. Four of the five persons who provide mail services are supported from 314(d) funds.

Level of Support: $26,290
Percent of Total 314(d) Allocation: 2.9%

3. **Director, Community Health Services.** 314(d) funds are also allocated to the director of the Office of Community Health Services for the salaries of a program executive, his assistant, and a clerk. The responsibilities of the office are to help local health departments develop new health programs and assist in developing grant proposals and requests for aid from state and other Federal funding sources.

In addition, the Office of Community Health Services reviews the overall program plans of local health departments and has authority over grant approvals to local health departments for programs using other Federal funds such as the Federal food supplement for Women, Infants, and Children (WIC).

Besides the program plan, a prerequisite to receipt of such grants, local health departments are required to submit a POME for projected programs. The Office of Community Health Affairs lends technical assistance in developing POMES and has ultimate responsibility for approving them.

Level of Support: $78,938
Percent of Total 314(d) Allocation: 8.8%

4. **Health Planning.** The program executive of the 314(a) agency is paid with 314(d) funds under the category of Health Planning.

Level of Support: $41,351
Percent of Total 314(d) Allocation: 4.6%

These activities comprise almost 20 percent of the 314(d) funds allocated to the provision of public health services in FY 1974. They are essentially a continuation of programs utilized before the Partnership for Health Act was enacted. Many of the staff providing these services were funded under the prior categorical, General Health Services.

Preventive Medical Services

1. **Child Health Services.** Maternal and Child Health Services are provided utilizing

both 314(d) funds and MCH categorical moneys. Grants of 314(d) funds are provided to local areas to support multiphase screening programs throughout the state. These programs are administered jointly by Health Division officials and local health departments.
Level of Support: $147,711
Percentage of 314(d) Allocation: 16.5%

2. **Laboratory Services.** The Health Division's laboratory services are in large part funded through the 314(d) block grant. Fourteen of 50 persons employed in the laboratory are funded from 314(d). The laboratory is a primary provider for venereal and communicable disease control in that tests for the analysis of samples for local health departments are provided in the following areas: contamination of drinking water; streptococcal throat infections; rubella, serology, and general bacteriology.
Level of Support: $137,761
Percentage of 314(d) Allocation: 15.4%

3. **Tuberculosis Control.** 314(d) funds are used to conduct screenings and clinics in local areas throughout the state. The physician in charge of tuberculosis control, a program executive, and a secretary are all paid with block grant funds. The program supports the purchase of tuberculosis treatment drugs, their disbursement throughout the state, and doctors retained for a fee to provide services in remote areas.
Level of Support: $118,869
Percentage of 314(d) Allocation: 13.3%

4. **Chronic Disease Control.** Screenings are conducted throughout Oregon in areas of diabetes, hypertension, cervical cancer, and glaucoma. In addition, consultation is provided to local health departments by a public health nurse consultant, occupational therapy consultant, and a health education expert in chronic disease programs. These staff members are all funded by 314(d).
Level of Support: $72,607
Percentage of 314(d) Allocation: 8.1%

Community Health Services

1. **Public Health Nursing.** Two of the six public health nursing consultants and one secretary are paid by 314(d) funds. Supervision and consultation is provided to local health departments in basic areas of public health. In addition, 300 home health aides in Oregon receive their training through the state nursing staff.
Level of Support: $41,350
Percentage of 314(d) Allocation: 4.2%

2. **Training in Public Health Education, Emergency Medical Services, and Health Education.** Training programs are provided to local health departments as are health education literature and films. Specific courses include pediatric practitioner training and family planning training which permit public health nurses to work with indirect medical supervision. Additionally, programs are established to train emergency medical technicians throughout Oregon.
Level of Support: $92,589
Percentage of 314(d) Allocation: 10.3%

3. **Local Grants – Special Projects.** The Oregon State Health Division annually provides for the allocation of 314(d) funds to local areas usually for partial funding support of special projects. Projects are generally funded for a three to four-year duration with increasing increments of local financial support. Multiyear projects are preferred in that they allow for establishment of ongoing programs and ensure local participation in the costs of the program.

   Prospective recipients are required to file applications using the POME procedure. A screening committee comprised of Health Division staff and local health officials reviews grant requests and approves them utilizing the submitted POME. The administrator of the Health Division has final responsibility for project approval or disapproval, but he generally accepts the recommendations of the screening committee.

In FY 1974, six projects were funded as indicated in *Table 8*.

All projects were continuations from the previous fiscal year. With the exception of allocations for dental care, the activities supported by the block grant were undertaken in the two most populous counties of the state, Multnomah, and Lane, respectively.

Total Level of Support: $87,113

Percentage of 314(d) Allocation: 9.8%

The block grant mechanism has not effected a significant change in patterns of health services delivery. Funds available under the prior categoricals have been utilized in much the same manner as 314(d) moneys. Some categoricals – notably heart disease and cancer control which are now in the Health Division's chronic disease program – have been folded into existing operational programs. General Health Services money has continued to be used for administrative and training purposes. These actions reflect the view that the block grant is better used as "seed money" to supplement

Table 8

Summary of Projects Funded in Fiscal Year 1974 with the 314(d) Block Grant

Program and Local Agency	Total Cost	314(d) Funds	Project Description
Dental Care			
Washington County	33,986.43	10,600.00	Provision of services through the operation of dental clinics for indigent children.
Polk County	24,866.16	9,998.47	
Water Quality			
Lane County	35,205.44	10,100.00	Reduction of water borne infections; development of standardized reporting and surveillance on existing and proposed water systems in Lane County.
Accident Prevention			
Lane County	8,001.80	4,898.00	Reduction of fatalities and injuries through development of programs to effect defensive driving; first aid program; and education for prevention of accidents and fire in the home.
Health Planning Research			
Multnomah County	67,898.85	14,231.32	Provision of definitive information for resource allocation and utilization of services in order to determine priority health needs and facilitate development of necessary health department programs.
Intensification of Tuberculosis Control			
Multnomah County	167,940.15	37,385.33	Provision of services to eliminate tuberculosis in Multnomah County.

Table 9

Comparison of 314(d) Expenditures, by Category, for Provision of Public Health Services in Oregon for Fiscal Year 1968 and Fiscal Year 1974*

Category	Percentage of 314(d) Expenditures**	
	Fiscal Year 1968	Fiscal Year 1974
Administrative Services	17.6%	20.0%
State-Provided Services	68.9	65.0
Project Grants		
Dental	.5	–
General	6.9	9.8
Formula***	1.5	–
Chronic Diseases	4.7	–
MCH	–	5.2
Total	100.0%	100.0%

*Provided by Office of Administrative Services, Oregon State Health Division.
**Figures are rounded.
***Formula grants reflect allocations to county health departments of 314(d) funds unexpended at the end of the fiscal year.

other available funds, and it has not been considered a new source of money useful in providing extensive new programs.

The stability of the Health Division's expenditure pattern throughout the years of the block grant program is reflected in *Table 9*. Utilization of 314(d) funds in the operational programs of the division involving administrative and state-provided services has remained constant (approximately 85% of the 314(d) expenditures) while a lesser amount (15%) has been allocated to specific projects on the community level. The pattern of project expenditures has shifted slightly reflecting an increase in general projects accompanied by a diminishing categorization of projects.

Mental Health Utilization

Oregon's pattern of utilizing the mental health portion of the 314(d) block grant in FY 1975 is very similar to the utilization pattern that existed in FY 1968, the first year that the state received the block grant. Changes between FY 1967, the last year of the mental health categorical grant, and FY 1975 have occurred in two expenditure categories: (1) the state's grant-in-aid program to local mental health agencies and (2) special demonstration projects conducted by local agencies. *Table 10* provides an overview of the state's expenditure pattern from FY 1967 through FY 1975. The data in *Table 10* indicate the following:

1. The state has consistently spent more than 70 percent of the mental health 314(d) funds at the local level. Local level expenditures equal the amounts expended for grant-in-aid plus special demonstrations. In FY 1968, FY 1972, and FY 1975, local expenditures for projects were $63,825 (67.3%), $117,700 (76.5%), and $115,874 (73.2%) respectively. These amounts do not include 314(d) expenditures by the state for training and workshops for local mental health staff. Inclusion of these figures would increase the percentage of 314(d) expended at the local level to approximately 75 percent of the annual 314(d) mental health allocation.

2. As the number of local community mental health programs (CMHPs) has in-

creased, the state has shifted funds from special demonstration projects to the state Mental Health Grant-in-Aid Program which supports the operation of 34 CMHPs by county governments on a 50-50 matching basis.

As indicated, the Mental Health Division's 15 percent share of the state's 314(d) block grant in FY 1975 was $158,400. This share represents .0039 percent of the total mental health appropriation by state and local authorities of $40,223,341. In FY 1972, the 15 percent mental health share of the 314(d) block grant was $153,900 representing .0049 percent of the total state and local mental health appropriation of $31,155,635.*

*Information provided by the assistant administrator, Programs for Mental or Emotional Disturbances, Oregon Division of Mental Health.

This indicates that the stabilized 314(d) mental health allocation each year represents a smaller share of the state's total mental health budget. Because the 314(d) mental health allocation represents only a small proportion of the state's total mental health expenditures, satisfying the matching requirements of the 314(d) block grant has never been a problem for the state nor the community mental health programs operated at the county level.

Since FY 1963, the state's strategy for the utilization of Federal mental health grant funds, categorical and block grants, has been to develop locally operated mental health programs and clinics for the provision of a broad range of mental and health services as an alternative to institutional care. In 1970, when the state received an increase of $34,000 in the mental health portion of the 314(d) block grant as a result of the tuberculosis categorical grant being folded into the national 314(d) allocation, the entire amount was

Table 10

Mental Health Expenditure Pattern Transcending Categorical Grant and 314(d) Block Grant Period, State of Oregon, Fiscal Year 1967 – Fiscal Year 1975*

Mental Health Expenditure Category	Categorical Grant		314(d) Block Grant					
	Fiscal Year 1967		*Fiscal Year 1968*		*Fiscal Year 1972*		*Fiscal Year 1975*	
	Amount	**Percent**	**Amount**	**Percent**	**Amount**	**Percent**	**Amount**	**Percent**
State Mental Health Grant-in-Aid (Local)	$21,612	33.3%	$31,000	32.7%	$83,550	54.3%	$112,774	71.2%
Special Demonstration Projects (Local)	13,082	20.1	32,825	34.6	34,150	22.2	3,100	2.0
Training and Workshops (State and Local)**			12,530	13.2	7,854	5.1	12,387	7.8
	19,561	30.1						
Program and Administrative Staff (State) **			16,338	17.2	28,346	18.4	30,139	19.0
Reversion—Unused	10,745	16.5	2,207	2.3	—	—	—	—
Total	$65,000	100%	$94,900	100%	$153,900	100%	$158,400	100%

*FY 1967 and FY 1968 financial data provided by HEW/HSA, Division of Grants Management, Rockville, Md. FY 1972 and FY 1975 data from Oregon Mental Health Division.

**Categorical grants for FY 1967 concerning Training and Workshops, as well as Program and Administrative Staff are combined.

allocated by the state to support the development of local mental health programs and clinics.

As described earlier, the Oregon Legislature reviews, changes, and/or approves the staff-proposed allocation of the mental health portion of the 314(d) block grant as set forth in the Mental Health Division's budget. Since FY 1963, legislative allocations of the mental health categorical grant and the 314(d) block grant funds have been to four major categories of expenditures within the Mental Health Division. These categories presented in *Table 10* are set forth below with a brief description of how and by whom the funds are used within each category; the FY 1975 allocation to the category; a description of the suballocation process within each category; and percentage of total 314(d) mental health funds.*

1. **Central Office Administrative and Professional Staff.** Funds are used for salary and fringe benefits of clerical staff in the office of the administrator of the Mental Health Division and for the salary and fringe benefits of a mental health specialist II in the central office staff of the MED program. The mental health specialist II has responsibility for working with regional MED staff, local general hospitals, and CMHPs in the development of day treatment alternatives to institutionalization of patients at the state mental hospitals.
   FY 1975 Allocation: $30,139 or 19.0% of total FY 1975 314(d) funds.
   Suballocations Within Category: None

2. **State and Local Staff Training, Conferences, Workshops; Related Travel Expenses; and Division Library Supplies.** 314(d) funds are used to support the personal development of mental health employees at the state and local level.
   FY 1975 Allocation: $12,387, or 7.8% of total FY 1975 314(d) funds.
   Suballocations Within Category: State and local mental health employees request financial assistance to pay for travel and expenses to training and workshop conferences in their area of interest. Requests are approved by the staff of the MED program office and the fiscal staff of the Administrative Services Office of the division.

3. **Special Demonstration Projects.** Funds are used to support special, innovative projects. Examples include: a statewide mental health needs study; first day treatment research project; patient aftercare needs study; and project impact survey.

   FY 1975 Allocation: $3,100 or 2.0 percent of total FY 1975 314(d) funds. Prior to FY 1973, approximately $25,000 per year was allocated to this category. However, the House Ways and Means Committee of the Oregon Legislature shifted funds from this category for FY 1974 and FY 1975 to the state's Mental Health Grant-in-Aid Program in order to meet the inflationary costs of operating mental health clinics at the local level. Division staff anticipate that the FY 1976 allocation will return to the level of prior years.
   Suballocations Within Category: While this program was active, suballocations or decisions to support specific demonstration projects were made by staff of the MED program office with assistance from an advisory body composed of state MHD division research specialists, university mental health research specialists, and representatives from local mental health programs. Grant awards were 100 percent, one year in duration, and limited to $10,000 per project. Eligible applicants included all public and private non-profit organizations within the state that were carrying out mental health research or delivering mental health services. Applicants submitted project assistance requests using the same application format in use at that time by the National Institute of Mental Health (NIMH) for review and evaluation of research proposals.

4. **State Mental Health Grant-in-Aid Program.** Funds are used to supplement the state's program of providing financial assistance to 34 community mental health programs (CMHPs) that provide services at the local level. CMHPs are operated and staffed by local county general purpose government employees. An example of mental health services

provided by the CMHPs at the local level include the following major components of a CMHP's* grant-in-aid request:

(1) Drug Treatment, including Methadone Maintenance
(2) Child Guidance
(3) Audlt and Child Crisis
(4) Parent Education
(5) Day Treatment Program
(6) In-Patient Services
(7) Alcohol Abuse

FY 1975 Allocation: $112,774 or 71.2% of total FY 1975 314(d) funds. The 314(d) allocation supplemented a state appropriation to this category of approximately $3 million.

Suballocations Within Category: 314(d) mental health funds are identifiable and traceable to the point where they are combined with the state's appropriation. It is not possible to trace the funds to a specific program at the local level.

Suballocations or decisions affecting the amount of funds to be granted on a 50-50 matching basis to CMHPs are determined by regional and central office MED staff of the Mental Health Division. CMHPs submit application/budget requests using a "management by objectives" format to the regional MED program office staff for review. MED regional and central staff compile the requests and make decisions on funding amounts in conjunction with fiscal staff of the Mental Health Division. Suballocations to CMHPs are not made on the basis of a formula but are based upon the general criteria of past CMHP performance, local staff capabilities, and demonstrated service needs.

PLANNING, ADMINISTRATION, AND EVALUATION

This section describes Oregon's use and administration of 314(d) funds in relation to key Federal requirements pertaining to the block grant. The requirements are drawn from the law and subsequent amendments and Federal regulations.

In Oregon, basic planning requirements have been met in part. Internal priority setting for 314(d) expenditures has been particularly visible, but requirements concerning the involvement of 314(a) and 314(b) agencies are not being fully complied with.

Planning Requirements

Following below are key planning requirements of the 314(d) block grant and brief statements of Oregon's response to those requirements.

Provide services in accord with the adopted 314(a) Comprehensive Health Plan of the state. A comprehensive health plan has been developed by the 314(a) agency but such plans have not been prepared by each of the six federally funded 314(b) regional health planning agencies.* The absence of the latter plans handicaps evaluation of the state's allocation and use of 314(d) block grant funds.

Specify the extent to which services to be provided are to be directed at public health areas of high priority, are of high quality, and will reach people in local communities in greatest need of such services. Oregon has not responded directly to this requirement. Neither the Health nor Mental Health Divisions produce a document that specifies or justifies that the allocation of 314(d) funds is to high quality services that will reach people in the greatest need of such services.

Planning, priority setting, and programming of the public health and mental health portions of the 314(d) block grant are carried out by staff of the Health and Mental Health Divisions followed by the formal review and approval of the Joint Ways and Means Committee of the Oregon Legislature.

While no formal document exists in either division, both divisions have adopted "management-by-objectives" administrative procedures that satisfy the intent of the requirement.

Public health services financed by 314(d) funds are in part the same as those assisted by Federal allocations under the old categorical programs. The Health Division chose to continue most of these services within the operational programs of its Offices of Community

*Program examples abstracted from the work programs of two CMHPs: Marion and Benton Counties, Oregon.

*Information provided by the Oregon 314(a) agency.

Health Services, Preventive Medical Services, and Administrative Services.

Allocations to specific programs are made on the basis of budgeting through a management-by-objective procedure. Each program officer is required to submit to the Office of Administrative Services a POME request which describes five items:*

- the problem,
- the objective,
- a method,
- and evaluation, and
- accomplishment.

Allocations to specific operational programs are then made based on this POME procedure. Those programs which fail to accomplish projected objectives are given lessened emphasis and 314(d) funds are allocated to other activities which have succeeded in achieving stated goals.

Mental health activities supported by 314(d) block grant funds are in four categories:

- central office administration and program staff;
- staff development – conferences and workshops;
- special demonstration projects; and
- community mental health grant-in-aid.

Individual community mental health program (CMHP) descriptions for receipt of state grant-in-aid funds for mental health services at the local level, over 71 percent of the state's FY 1975 314(d) mental health block grant, contained a generalized priority ranking of component services and set forth predominantly qualitative and quantitative performance objectives for the service elements described.

Mental Health Division officials stated that program staff from the division's regional offices provide technical assistance to the 32 CMHPs in determining local mental health needs, resources to meet the needs, and service element objectives for each annual program.

For the special demonstration projects that were funded by 314(d) block grant funds for mental health prior to FY 1973, applicants were required to use the same application format that was being used at that time by the National Institute of Mental Health (NIMH) for review and evaluation of national research projects. Each application was structured in a manner that met the provisions of this requirement. Prior to funding approval, the project applications were reviewed by mental health research specialists from within the division, universities, and local CMHPs. Final decisions on project awards, however, were made by staff of the MED program office of the division.* Evaluations of the projects were carried out by division staff.

Consider the comments of state 314(a) and regional 314(b) comprehensive health planning agencies in preparing the resource allocation to services in the 314(d) state plan(s). Since FY 1972, the Health and Mental Health Divisions have not developed a 314(d) state plan. Both divisions utilize a "simplified" state plan. The Health Division's "Report on Programs Supported with Section 314(d) Grant" is considered by the division as a simplified state plan when in fact it is a document that reports how funds have been expended. The Mental Health Division's simplified state plan consists of the expenditure report that the division submits to the Health Resources Administration of HEW.

No specific comments are made by the 314(a) agency in regard to the block grant expenditures of either division. However, the chief of the agency regularly participates in periodic staff conferences of the Health Division and thus has an opportunity to discuss and influence the formulation of the 314(d) plans and the supporting budget.

Comments from regional planning agencies are not continuous or extensive. There are no formal comments made in regard to the bulk of 314(d) allocations to the Health Division or the Mental Health Division. In regard to public health grants for specific projects to the local level, the 314(b) agencies (where they exist) make comments to the screening committee which approves or disapproves specific project allocations.

Comprehensive mental health programs at the local level maintain continuing contact with the regional 314(b) agencies but do not provide those agencies with program applications as a part of the A-95 review process.**

Discussion with 314(a) agency staff and selected 314(b) regional health planning staff indicated that their health planning activities to date were in basic agreement with the state legislative policy to provide a broad range of mental health services through clinics operated by the CMHPs at the local level.

*Source: *Report of Formula Grant: Total 314(d) Expenditures, Fiscal Year 1973*, Oregon State Health Division.

*Information provided by assistant director, Programs for Mental or Emotional Disturbances.

**Information provided through interviews with directors of two single county, comprehensive mental health programs.

Allocate funds so that public health services are significantly strengthened in various political subdivisions of the state (including the funding of other public or private non-profit agencies to assure maximum participation of local, regional, and metropolitan agencies). Approximately 10-12 percent of Oregon's public health 314(d) allocations are passed directly through to local levels of service delivery on a project-by-project basis. These moneys are allocated to both county health departments and public or private non-profit agencies.

Each applicant for project funding is required to describe the project using the POME procedure. Requests are then considered by a screening committee composed of both Health Division staff and local health officers from the area in which the project applicant is from.

There is some disagreement in Oregon over whether the Federal requirement that 70 percent of the public health portion of the block grant be expended for local public health services is being met since major allocations (88-90%) are made to operational and administrative programs of the Health Division.

In 1973, the Conference of Local Health Officials passed a resolution calling for increased 314(d) expenditures on a project basis. The administrator of the Health Division agreed with this view and presented a budget with a majority of block grant funds to be expended. However, the legislature has continued to budget funds as they have been in the past.

Since FY 1963, mental health categorical grant funds and, subsequently, the mental health portion of the 314(d) block grant have been utilized to develop and support the delivery of mental health services at the local level through local public and non-profit agencies. In FY 1975, over 71 percent of the mental health portion of the 314(d) block grant was allocated to the state's Mental Health Grant-in-Aid Program which provides 50-50 matching grant funds to mental health clinical programs operated at the local level by county public health departments or non-profit corporations in those counties not having a health department.

Define health services to be provided in terms of specific objectives. As noted, the Health Division allocates funds utilizing the management-by-objectives contained within the POME process. Expenditure records are kept for each program. These records contain a quantification of objectives and a percentage of the division's achievement of each.

Mental health services provided by CMHPs at the local level develop annual program applications-budgets for state grant-in-aid funds. These program assistance requests contain service elements with specific objectives and past performance statements. These statements are written in a style that is more qualitative than quantitative; however, some objectives are described in measurable, quantitative terms. Mental Health Division officials indicated that the division had been utilizing this "management-by-objectives" approach since FY 1969.

Provide for the review and modification of the 314(d) state plan(s) as appropriate on an annual basis by the state health agency and state mental health agency. Since the Federal regulations allowing a 314(d) plan to contain assurances which are incorporated by reference from other state legislation and regulations were adopted, there has been no definable 314(d) plan in Oregon.

Annual submissions to HEW have been documents that describe how the state expended the previous year's 314(d) allocation.

Administrative Requirements

Administrative requirements concerning the 314(d) block grant funds are not extensive. They generally seek to assure that the state possesses the capacity to administer the 314(d) funds and that financial efforts are made for the provision of health services by non-Federal funding sources. These requirements are only partially applicable to the Oregon experience in that public and mental health authorities do not have direct financial or administrative control over local health authorities. Where the requirements are applicable, however, Oregon appears to be in accordance with them. The requirements are presented below followed by brief statements of Oregon's response.

Provide for the state administration or state supervision of local administration of the funds by the state health agency and state mental health agency. To the extent possible, the Health Division has provided supervision of local administration of block grant funds. However, administration of county health programs is limited somewhat in that local health departments are not under the direct control of state authority.

The division has required that 314(d) allocations to the local level on a project basis be governed by the POME requisites. This has not resulted in state supervision of the mechanics of these programs, but it has provided a degree of guidance to local health departments and other recipient agencies.

Similarly, in those cases where the division has disbursed the remnants of unused block grant funds to

county health departments, certain requirements have been imposed upon recipients in order to qualify for receipt of the 314(d) funds. Among these requisites are that the county have a budgeted, full-time, health department staff (numbers and types of personnel vary with the size of the county); that personnel be adequately trained; and that personnel, budget, expenditures, services, and other special reports required for carrying out the overall state public health programs be provided to the Health Division.

Locally operated CMHPs derive approximately 50 percent of their funds from a state-supported Mental Health Grant-in-Aid Program. This grant-in-aid program receives an annual state appropriation of approximately $3 million which includes approximately $113,000 in 314(d) mental health block grant funds.*

Program and fiscal staff of the Mental Health Division review and approve the annual program request as well as the monthly vouchers submitted by the CMHP to the state. In addition, fiscal staff of the Executive Department also review and approve the monthly vouchers.

Discussions with CMHP staff in selected agencies revealed that the state had not conducted an on-site audit of CMHP expenditures.

Assure that the block grants will not be used to supplant other non-Federal funds. The Health Division does not supplant non-Federal funds in its budgeting of 314(d) block grants either for its own programs and administrative services or in allocations to the local level on a project-by-project basis. The Office of Administrative Services coordinates the budget requests for 314(d) funds within the divisions. It ensures that state funds are not displaced by the block grant. That office also has the responsibility to ensure that the level of state spending for operational programs and administrative services supported by 314(d) is at least as extensive as in the previous year.

This maintenance of financial effort is also required of recipient agencies receiving project grants. Those projects which are approved for multiyear duration are required to be supported increasingly each year by local sources of funds. The general pattern involved in 314(d) allocations has required a phasing out of Federal funds on an incremental basis. Recipients are required to commit themselves to provide support of the total cost as follows: 25 percent the first year; 50 percent the next year; 75 percent the following year; and finally total support. Although this Health Division policy is flexible, local applicants who have been either unwilling or unable to provide local funding for projects have often been passed by or given a low priority by the screening committee.

*Source: Fiscal staff of Oregon Mental Health Division.

The Mental Health Division's expenditure of 314(d) funds does not supplant other non-Federal funds. The state's grant-in-aid program began in FY 1963 and since that time at least 50 percent of funds received under the pre FY 1968 mental health categorical grant and 70 percent of the 314(d) funds since FY 1968 have been used to support the delivery of mental health services at the local level by locally paid employees. The grant-in-aid program was designed to be a 50 percent state – 50 percent local matching grant program. In recent years, the state's appropriation to the program has stabilized at about $3 million per year while, according to Mental Health Division staff, local funds in support of the program have increased to approximately $3.5 million.

State mental health funds have not been replaced by 314(d) funds. The closest the state has come to supplanting state funds was FY 1973 when approximately $30,000 was shifted from the funding of special demonstration projects to increasing the amount of 314(d) funds being used in the state's Mental Health Grant-in-Aid Program. However, at the same time, the legislature increased the state's appropriation to the grant-in-aid program characterizing the shift of 314(d) funds as supplemental to an expanding state effort.*

Require recipient agencies utilizing 314(d) funds to participate in the costs of the supported services. As is the case in assuring non-supplanting of non-Federal funds, the Office of Administrative Services sees that 314(d)-supported activities in the division's operational programs and administrative services are also supported by state funds. In regard to allocations for specific projects, the Health Division's policy, enforced by the screening committee, of requiring increasing increments of financial support by local applicants ensures that recipient agencies participate in the costs of supported services.

Community Mental Health Programs (CMHP), the recipient of 314(d) funds for the provision of mental health services at the local level, are required to match 50 percent of the funds received from the state grant-in-aid program.

Evaluation Requirement

The evaluation requirement of section 314(d) is

*Source: Assistant administrator, Programs for Mental or Emotional Disturbances, Oregon Mental Health Division.

provided to enable the state to assess the effectiveness of block grant-supported activities in achieving stated objectives. In Oregon, the Health Division has met the requirement in part.

Provide methods of evaluating the performance of activities carried out with 314(d) funds. The Health Division, in adopting a budget based on the management-by-objective or POME process, has provided methods of evaluation. Each 314(d)-supported activity is reviewed yearly in terms of measurable achievement of objectives.

Evaluations and, presumably, allocations of funds are made on the basis of quantifiable accomplishments. Such items as POMEs reviewed by the Office of Community Health Services or numbers of screenings conducted to identify cases of hypertension and glaucoma are documented. However, this method of evaluation may have limited value in assessing the efficiency of block grant-supported activities in that little evaluation is undertaken in qualitative terms.

Evaluation of mental health services supported by 314(d) funds is a part of the annual application-budget review process carried out by the program and fiscal staff of the Mental Health Division of the CMHP's request for assistance from the state's Mental Health Grant-in-Aid Program. As stated earlier, the application-budget is developed utilizing a management-by-objectives format that requires the CMHP to indicate service needs, cite prior performance against previously stated objectives, and to set objectives for the forthcoming year.*

CHANGES ATTRIBUTED TO THE BLOCK GRANT PROCESS

The block grant mechanism has led to very few discernible changes in Oregon's delivery of public health and mental health services. Both allocation and utilization patterns for Federal allocations are basically the same under the block grant as they were when categorical grants were in effect.

State-provided services which are financed in part with 314(d) funds have experienced little change, and methods of providing, measuring, and evaluating services have varied little in response to the initiation of the block grants.

Within the Health Division, most of the health problems treated by programs funded with categorical moneys have continued to be addressed under operational programs. Allocation of funds to areas of health needs has continued to be the responsibility of the office of Administrative Services. The POME evaluation procedure of budgeting has become somewhat more refined during the time that the block grant has been in effect. However, state public officials indicate that this management-by-objectives approach did not result as a response to managing 314(d) funds but resulted from general management improvements in the division.

Similarly, the Mental Health Division's allocation and utilization of Federal moneys has not been significantly altered by the block grant mechanism. This is true even though current Federal allocations exceed the FY 1967 mental health categorical grant by almost $100,000. Staffing patterns have remained stable as have other uses to which 314(d) funds have been applied. The division, for instance, has retained the large category of grant-in-aid to local authorities, expanding it proportionately to increases in Federal funds.

Both the Mental Health Division and Health Division consider block grants important, but small in amount. There is an attitude that the 314(d) funds should be used as a supplement rather than to create new programs.*

Thus, the funds have been utlized only in small part to fund local projects and generally (at least in public health) these allocations only supplement other non-Federal local sources of funding. Similarly, the block grants have been used within the two divisions' budgets for staffing and operational programs as supplements to state public and mental health revenue sources. In only a few isolated instances have the funds been used to innovate change in the delivery of services. Innovations within the state have resulted primarily from increased state expenditures particularly in the mental health service delivery at the local level.

Health Division personnel, as well as local public health officials, feel there are significant differences between the block grants and categorical moneys, both those replaced and current ones. State officials view the 314(d) funds as much more flexible and applicable to community needs. However, their utilization of the block grant funds to provide the same services that were provided with categorical grants indicates that their perception of the flexibility of the block grant is based upon reduced administrative requirements and limited Federal oversight. The block grant moneys have been used to supplement categorical grants when needed, but at other times have been removed from one categorical program and added to another as needed.

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*Source: On-site review of Comprehensive Mental Health Program application-budget.

*Source: State public health officer, Oregon Division of Health.

Local officials also perceive 314(d) funds as more flexible and oriented toward community needs. However, most county public health administrators feel that too much of the public health portion of the 314(d) funds are utilized to support state-provided local services as opposed to being used directly by local health agencies for locally determined health service needs.

Although there is some disagreement concerning efficacy of provision of services to the local level, there is a general consensus that the block grant has facilitated communication between state and local public health officials. Since the advent of the program, there has been an expanded review process of local requests of 314(d) funds to be used on a project-by-project basis. In particular, the screening committee which reviews grant requests has provided a forum for local health officials and Health Division staff to discuss allocations of funds to the community level.

This communication is of a limited nature and does not imply a causal link between the block grant and a systematic approach to the planning and delivery of public health services.

The POME procedures required of applicants make Health Division officials aware of local interpretations of priorities and health needs. But this process involves only the 10-12 percent of the block grant funds which are made available on a project-by-project basis.

Both approval of, and requests for, 314(d) funding of local projects have primarily involved larger, more sophisticated health departments such as Multnomah and Lane counties, which serve more heavily populated and urbanized areas. It does not appear that availability of block grant funds is widely recognized. Thus, increased communication between state and local officials does not represent a cross section of communities.

One change in Oregon's utilization of Federal funds is that larger percentages of moneys available for public health services have been expended. Under some of the prior categorical grants, large amounts, though allocated, were not expended. In particular, significant sums of chronic illness, heart and cancer control often reverted back to the Federal government. These categories are examples of health needs which were given a lower priority and thus, did not mesh well with ongoing operational programs of the Health Division.

With the advent of the block grant, however, funds have been shifted to programs where they are used. Moreover, any rare unexpended amounts of the block grant have been allocated to local health departments on a formula basis.

One other major change attributable to the block grant is the lessened administrative and supervisory role played by the officials at the Region X Public Health Service Office of the U.S. Department of Health, Education and Welfare. Under the categorical programs, there was extensive contact between HEW and the Oregon State Health Division. Federal generalists were in constant contact with state officials to discuss health priorities and assist the state in establishing program plans. In addition, each categorical grant was supervised by a Federal expert or consultant who worked with state officials providing technical assistance in planning, monitoring, evaluating, and reviewing activities within a narrow sphere of interest.

Under the block grant, however, there is little contact between Federal officials charged with 314(d) responsibilities and Mental Health Division or Health Division staffs. There is cooperation, however, between Federal program officials and the divisions in those specific areas where the divisions feel there is Federal expertise to help the state.

There is, therefore, little continuing contact between Federal regional officials and the Health and Mental Health Divisions in regard to the block grant mechanism. Because of current certification procedures, Federal officials now find it difficult to assess Oregon's 314(d) program in a manner which was possible under the old Federal categorical grants. The latter involved the Federal office in programmatic details, but now there is no such depth of review. Federal officials now only receive reports of how money is spent and not the plans which designate expenditures. This limited involvement of Federal officials does not allow them to differentiate among the states in terms of interest or capacity to undertake block grant programs or to effectively evaluate a state's success or failure in maximizing the use of the block grant.*

Federal, state, regional, and local assessments of previous categorical grants and 314(d) block grant allocation and utilization in Oregon coincide in the following areas:

- **Lack of a systematic approach to address public health issues in Oregon due to the block grant mechanism.** There is a consensus that local health authorities have become more involved in assessing health needs which have to some degree been communicated to state officials. However, there has been no systematic ap-

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*Source: Assistant regional health administrator for state coordination, Region X, Public Health Service of HEW.

proach to planning and administration linking local and state officials with citizens or private health services providers.

- **Lower level of involvement of Federal officials in the public health program** of Oregon under the block grant mechanism as compared to prior categorical grants. Federal officials feel a lessening of the administrative burden on states from the old certification of 314(d) plan procedures is healthy but that current checklist reviews leave too much latitude to the state. Oregon officials appreciate the increased discretion allowed by the block grant but miss the extensive and specialized consultation which existed under the prior categoricals.

- **Increased involvement of the state legislature in the public health program** of Oregon under the block grant mechanism. The legislature has long been active in the allocation of resources for the planning and delivery of health services. It is felt that the block grant has given the legislature increased flexibility in establishing priorities in public health, thus strengthening its role somewhat. This strengthened role has been particularly visible in two instances: (1) when the legislature rejected the administrator of the Health Division's proposed increased allocation of 314(d) funds for specific projects on the community level; and (2) when the legislature reallocated the block grant from demonstration projects to the Mental Health Division's grant-in-aid program.

Items of disagreement between Federal, state, regional, and local health officials include:

- **Sufficiency of local services provided by activities supported with 314(d) funds.** Local health officials feel that the block grant is being utilized to underwrite the costs of the Health Division's operation and that more money should be passed directly to local authorities for projects. State officials, while sensitive to the need for further 314(d) disbursements for projects, feel that effective local services are provided through their operational programs and administrative services.

- **Lack of planning to assure maximum benefits to local areas.** Local officials do not feel that the expenditures of 314(d) funds adequately address local health needs as assessed by considering statewide local priorities.* State officials, however, maintain that the management-by-objectives budgeting process succeeds in establishing local problems to be addressed by operational programs of the Health Division, but local officials feel that this process merely results in the aggregation of local priorities and does not respond to specific and individualized community needs.

- **Stimulation of additional state or local funds.** State health officials perceive, though they are unable to document, that the block grant has stimulated additional expenditures for health services on both the state and local level. In particular, they feel that incremental expenditures required of applicants for 314(d) project grants in public health have necessitated that increased financial support be provided on the community level. In addition, it is felt that these projects have stimulated local health authorities to increasingly assess health needs and pursue funds to address them. Local health officials, however, feel that the block grant, because of its relatively low level of funding and accompanying lack of significant effect on a community level, has had little effect upon amounts expended for public health services.

SUMMARY AND CONCLUSIONS

Thie section is directed to providing a summary of Oregon's experience with the 314(d) block grant mechanism.

The 314(d) block grant has not effected a system-

*Source: Interviews with county public health officers in Multnomah, Benton, and Marion counties.

wide approach to the planning, adminstration, and evaluation of health services in Oregon. Though limited changes have taken place, particularly concerning local awareness of the need to address health needs, the coordination of health agencies on the Federal, state, regional, and local levels envisioned by the *Partnership for Health Act* has not become a reality.

Although priorities for health-related expenditures have been set by the Health Division, they are not a product of interaction between state and regional planning agencies or local health authorities.

Allocation procedures for the block grant funds have remained much as they were under prior categorical grants. There has been little linkage between levels of government in determination of priorities of health needs. The Health Division determines the priorities on an internal basis with little input from comprehensive planners or citizens.

The legislature has retained, and even strengthened somewhat, its influence over allocation of funds for the provision of health services. However, the Joint Ways and Means Committee still approves the health budget in much the same manner as it did under the prior categoricals. Hearings are held in which the Health Division, having negotiated with the Executive Department's Budget Division, remains the predominant party conversant with priorities for allocation of 314(d) funds.

The 314(a) agency has set some broad policies and priorities for spending moneys. However, 314(d) expenditures are not related to a comprehensive statewide health plan. Comments from 314(a) and 314(b) agencies have seldom been obtained regarding block grant expenditures. Comments have generally been limited to those by 314(b) agencies in regard to the 10-12 percent that is utilized on a project-by-project basis.

The relationship between state and local health authorities has not been strengthened by the block grant experience. There has been increased activity in the identification of health needs on the local level with an increased, but limited, communication of these findings to state authorities. This additional input is, however, limited to the 10-12 percent of 314(d) funds utilized to support local projects. Achievement of a systematic approach to providing health services is hampered since local authorities in both mental and public health are, for the most part, operationally independent of each other on the state level.

Since the development of the state's Mental Health Grant-in-Aid Program in 1962, the delivery of mental health services has gradually developed into a coordinated, local-state mental health system. This system has resulted in state administration and operation of institutional facilities and comprehensive mental health centers and the local agencies administering and operating local mental health clinics to meet locally identified needs. The systemics are that mental health services are not dominated by statewide needs or priorities but meet locally determined needs and priorities.

The mental health portion of the 314(d) block grant did not stimulate the development of a state-local effort. However, the use of 314(d) funds to supplement state and local expenditures for the provision of local mental health services through the state Mental Health Grant-in-Aid Program has facilitated the continued development of the mental health service delivery system.

There is disagreement in Oregon between state and local health officials in regard to whether the block grant has resulted in additional expenditures for health services. State officials, while they admit a difficulty in substantiating this, feel that 314(d) has been an incentive to increased local and state expenditures. Additional state and local expenditures may reflect a general trend away from an emphasis on traditional health services to more expensive programs accenting such needs as ambulatory care. State officials also perceive that allocations to local authorities for project grants have stimulated local interest in addressing health programs. It is felt that the Health Division's policy of requiring incremental increases in local participation has also stimulated additional expenditures.

Local health officials, on the other hand, feel that Federal allocations have had limited effect. They feel that the small amount of the 314(d) allocation which goes directly to the local level is relatively unnoticed and thus not an incentive to additional expenditures.

The mental health portion of the 314(d) block grant has not stimulated directly the use of additional state or local funds. Such stimulation for mental health services is primarily the result of state action in 1962 that created the 50 percent state-50 percent local Mental Health Grant-in-Aid Program. In FY 1975, the state's appropriation to this program was approximately $3 million with an estimated $3.5 million being contributed by local governments.

However, because of the fact that 314(d) funds are allocated to supplement a state matching grant program, it can be stated that the 314(d) funds increase the amount of money available for local services and that the local agencies must produce an equal match to obtain the state matching grant funds. As such, additional local money is stimulated for the provision of local mental health services.

The block grant has had little effect in Oregon on the

use of public health or mental health Federal categorical grants. The old categorical moneys were for the most part in 1968 placed in existing categories using 314(d) funds, and most of those areas of public health needs continued to be addressed. State and local officials feel that 314(d) money has had virtually no effect on the usage of current categorical grants although in some isolated instances the two have been combined on a specific project basis.

Allocations of 314(d) block grants have provided increased flexibility in the provision of health services in two regards: (1) The block grant has allowed state officials to shift Federal moneys from one category to another where it can more effectively address health needs; this could not be done under prior categorical grants; and (2) section 314(d) funds have been used to support local projects which address specific health problems in a given area. These needs are developed on the local level and presented to the screening committee which recommends projects to be funded after evaluating the POMEs which accompany grant applications.

The perception of differences between categorical and block grants by state and local officials is associated with the increased flexibility of the block grants. Oregon's public health officer perceives that the block grant supplemented by special categorical programs can more effectively address an isolated health problem than can block grants. This perception is based on the premise that categoricals usually devote a higher sum of funds to a particular health need and their success or failure can be more easily addressed than activities funded with the block grant. Block grants, on the other hand, are viewed as limited in effectiveness by their low level of funding. They are thus considered as "seed" money which is utilized to supplement other funds rather than as an independent basis of support for a particular activity.

State mental health officials' perception of the flexibility of the block grant is associated to a limited extent with the usage of funds but more directly associated with those "flexible" aspects that have resulted in less paper work, less involvement of Federal officials, and reduced accountability to the funding source.* Part of this is due to the fact that the state's usage of the funds that were in the mental health categorical grant that became part of the 314(d) block grant did not change when the block grant was initiated and has only changed in a few minor instances since that time to the present. The changes that have taken place, *i.e.*, shifting allocations from special demonstrations to the state grant-in-aid program, are attributable to the flexibility of the block grant. Such changes would have been difficult under the categorical grant system requiring such items as amended applications, Federal review, and changed budget submissions.

To date, Oregon has in part met the Federal requirements established for the 314(d) block grant allocation. It has, to the extent possible, provided state supervision of local administration of 314(d)-supported activities by imposing certain administrative requirements upon county health departments which apply for projects, utilizing either 314(d) or other Federal moneys.

Through the use of a management-by-objective budget process, public and mental health authorities have planned and allocated 314(d) funds to meet certain objectives in areas of health need determined to be of high priority. They have, thereafter, evaluated programs in terms of objectives accomplished. In addition, allocation procedures of both the Health and Mental Health Divisions ensure the non-Federal funds are not supplanted by 314(d) funds and that recipient agencies participate in the cost of 314(d)-supported activities.

Oregon has not, however, been in compliance with planning requirements calling for 314(d) expenditures to be made in accord with the comprehensive health plan of a 314(a) agency; neither are comments upon block grant expenditures consistently obtained from the 314(a) or (b) agencies throughout the state.

Allocation and utilization of 314(d) funds in Oregon have been treated separately by public and mental health authorities. In the area of public health services, the Health Division allocates the vast majority of the block grant to its own operational programs which provide direct and administrative services to county health departments. The block grant has never been considered a new source of revenue, but has rather been treated as a supplement to state moneys budgeted to provide public health services.

The Mental Health Division's use of Federal funds also has changed little with the advent of the block grant. Unlike the case in public health services, however, the 314(d) funds have been allocated to local mental health authorities to support community mental health programs with more of an emphasis on locally determined service needs.

The allocation and utilization pattern for the block grant funds in Oregon has demonstrated a successful effort by both public and mental health authorities to disburse 314(d) funds in order to achieve established objectives. The budget processes of both the Health Division and the Mental Health Division involve an allocation of block grant funds based upon evaluation of the success of 314(d)-supported activities accomplishing stated objectives.

*Source: Staff interviews, Oregon Mental Health Division.

Tennessee

The administration and allocation of 314(d) funds within the State of Tennessee involves both the Department of Public Health and the Department of Mental Health. These state agencies have responsibility for 85 percent and 15 percent of the funds respectively. *Table 1* shows other Federal, state, regional, and local agencies that are participants in the process.

The commissioners of the Department of Public Health and Mental Health administer two free-standing state agencies which are not part of a unified department of health or human resources. There is no mandate to coordinate the planning or administration of public health and mental health services in Tennessee.

This lack of human service coordination may be illustrated by the Department of Public Health seeking to implement a regional administrative structure parallel with other planning and service districts in the state, while the Department of Mental Health maintains 30 service areas which do not conform to the public health and multifunctional regions of Tennessee. The Bureau of Administrative Services in the Department of Public Health initially prepared, annually reviews, and recommends changes, if any, in the public health 314(d) state plan to the commissioner of public health. The commissioner's office is responsible for administration of the $1.5 million annual allocation to public health in Tennessee through the 314(d) state plan. Neither the state central budget office nor the Tennessee legislature play a role in specifically allocating 314(d) funds.

The 314(a) agency in Tennessee is the State Office of Comprehensive Health Planning. It is located within the Department of Public Health and its chief officer is appointed by the commissioner of the department. The major functions of the office are to coordinate the state's areawide comprehensive health planning agencies and serve as an advisor to the commissioner on matters of regional planning. There was no adopted statewide comprehensive health plan in the spring of 1975.

There are eight areawide comprehensive health planning agencies in Tennessee. Half are supported by section 314(b) of the *Partnership for Health Act*, and the remaining four are funded by state sources and the Appalachian Regional Commission. The primary function of these areawide planning agencies has been to review certificates of need for public health facilities, and they have played little role in the planning for allocation and utilization of 314(d) funds.

A major portion (71%) of the total 314(d) funds in public health are utilized by local county health departments. The 95 Tennessee counties have been aggregated, for administrative purposes and the delivery of special health services, into nine public health regions. Virtually all of the 314(d) allocation for mental health services is utilized equally in general support of each of 25 community mental health centers in Tennessee.

The Program and Development Office in the Department of Mental Health initially prepared, annually reviews, and recommends changes, if any, in the mental health 314(d) state plan to the commissioner of mental health. This is an entirely separate state document from the public health 314(d) state plan.

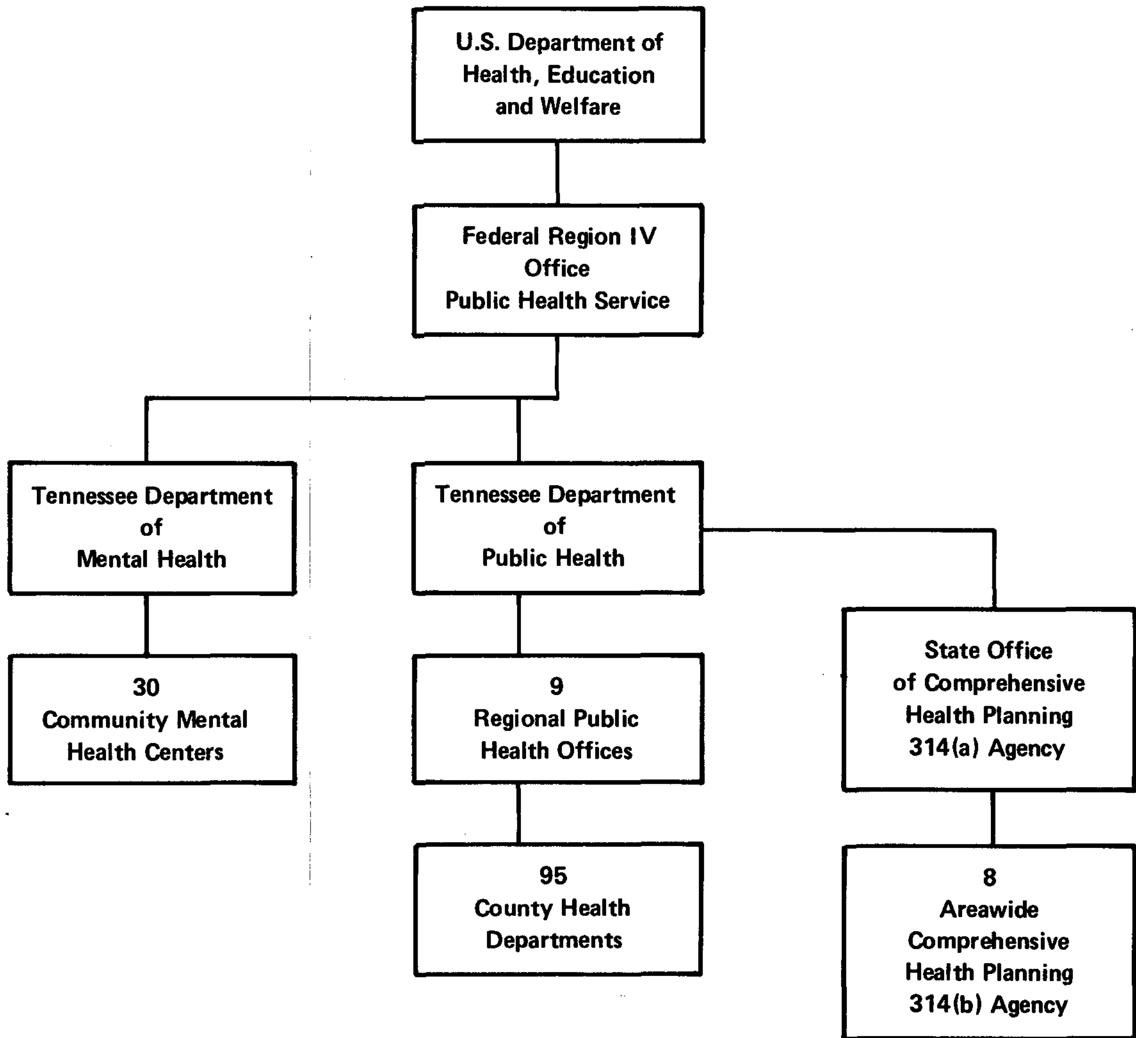
The Tennessee public health system is a state-supervised, county-administered system.

BLOCK GRANT ALLOCATION AND USE

This section describes the allocation and use of 314(d) funds in the State of Tennessee.

Table 1

Agencies Related to the 314(d) Block Grant Mechanism in Tennessee



Federal to State Allocation

For the State of Tennessee, the Federal to state allocation of 314(d) funds can be shown for three points in time. They are the following Tennessee fiscal years:

- 1968 when the first 314(d) allocation was received and disbursed by the state;
- 1970 when the amount of the Federal allocation was increased by a revision of the Federal formula; and
- 1975 and the current allocation of the 314(d) funds.

Under the initial Federal allocation formula, Tennessee

received a block grant sum of $1.48 million in FY 1968. Of this total, $1,260,000 was allocated to the State Department of Public Health and $223,000 to the State Department of Mental Health.*

In the year prior to the availability of block grant funds, Tennessee was receiving approximately $1.42 million in Federal support from the nine categorical grant programs. With passage and funding of P.L. 89-749, the combined services support of $1.48 million resulted in a net increase for Tennessee of approximately $60,000. All nine categorical grants were utilized by the state in 1966.* The 314(d) block grants provided a 4 percent increase in Federal funding for Tennessee health and mental health programs in the 1968 fiscal year.

In 1970, when the appropriation was increased by including the funds for the prior categorical, Tennessee, in tuberculosis control, received only $340,000 in the adjustment. However, this loss was offset by an increase of the 314(d) block grant to Tennessee from $1.48 to $1.82 million annually received thereafter. A net decrease in Federal health service funds of $270,000 was incurred due to this formula adjustment.

The total Federal block allocation to Tennessee stabilized in 1970 and has remained constant through FY 1975.

State to Localities Allocations

In Tennessee, 314(d) block grant funds are (along with Federal maternal and child health funds, mixed with state-appropriated health services funds) channeled to the 95 counties in the state. Of the total $12.8 million state and Federal health service funds allocated in FY 1975, 12 percent are 314(d) funds in origin. State budget procedures treat block grant funds as state funds. With the advent of the block grant, the Federal funds were treated in the same manner as the state funds.*

From this composite of state and Federal funds, each county receives a basic allocation of $20,000 to support a "minimal core of full-time health services." The core generally consists of a public health nurse, an environmental health officer, and a clerk. This was true also during the categorical period.

Remaining state and Federal dollars are allocated to the 95 counties through a state-developed formula. The state formula was initiated in 1961 pursuant to legislation directing the commissioner of public health to develop a means of allocating state moneys to counties for the provision of health services. It has been used as a method to allocate the 314(d) funds to localities since 1968. A combination of population and relative wealth of the county (as determined by per capita property value) determines the state internal allocation. The formula is reviewed each year by the commissioner of public health and approved by the commissioner of finance and administration and the comptroller of the treasury.

The formula is intended to balance total population and the relative wealth of individual counties. High-population/low-income counties are most favored while low-population/high-income counties are least favored.

The state formula allocates funds only up to a maximum amount or ceiling that is adjusted annually but remains in the range of $150,000 per county. In addition, county health departments are required to contribute funding at a level at least equal to that of the previous year.*

With the advent of the block grant program, the commissioner and his deputies decided to allocate 314(d) funds pursuant to the state formula. It was felt that the formula was the most efficient means to direct 70 percent of the funds to the provision of community services. Local public health departments assisted in the development of the original state allocation formula in 1961 that is now utilized for both state and Federal public health funds.

A local health budget committee of the state Department of Public Health had considerable influence over the formula-setting process. It is composed of selected regional health officials and staff from the Public Health Department's Division of Local Health. This committee meets with and advises the state director of local health, who in turn makes recommendations to the commissioner of public health as to what changes should be made in the formula each year to refine the allocation in light of current inequities or newly identified considerations.

Regional health officers are responsible for working with county health officials in administering state health programs at the local level and offering technical assistance to prepare local public health budgets. According to regional officials interviewed, regional officers follow the predetermined policies issued by the Department of Public Health in preparing local budget requests. In regard to 314(d) funds, regional officials annually advise the counties of fund availability under the state formula. There is no particular influence exercised formally by regional officers in determining the specific uses of the funds with county public health programs.

Regional officials do not actually monitor the expen-

*Information based on data provided by the Bureau of Administrative Services, Tennessee Department of Public Health.

diture of state or 314(d) funds by county health departments. Neither are the health departments required to submit programs or evaluations of local health expenditures. Funds received pursuant to the state formula are considered a legislative entitlement.

The allocation of the $273,000 in 314(d) annual mental health funds is achieved simply by allocating $10,920 to each of 25 community mental health centers in Tennessee. The total number of centers operating each year is divided into the mental health portion of the block grant and each center receives an equal share.

The original method used by Tennessee for distributing 314(d) funds for mental health was to provide each center a portion; however, with the advent of Federal community mental health center staffing grants and with the requirement for evaluation of the effect of 314(d) funds, a decision was made to place all the 314(d) money in the budgets of three or four centers which (1) did not have staffing grants, and (2) did not provide inpatient services. This practice was changed by a decision of the former commissioner, and equal distribution among all the centers made in 1973-74 and 1974-75. *Table 2* summarizes the annual allocation process of the 314(d) block grant fund as it exists in Tennessee in the 1975 fiscal year.

County health departments receive approximately 71 percent of the 314(d) funds available for public health services through the state allocation formula. Once the block grant moneys have been received, they are allocated to specific activities at the discretion of these local health units.

The official primarily responsible for making allocation decisions is generally the director of the county health department, who is actually an employee of the Department of Public Health. It is the director who determines local public health priorities, often after communicating with regional officials. Decisions as to the allocation of 314(d) funds which are contained in the state formula are not specifically undertaken.

The director of the health department is ultimately responsible to the county governing body which approves the local health budget. There is no indication, however, that county commissioners are ever aware of the presence of the block grant funds contained in the county's allocation under the state formula.

Utilization of 314(d) Funds

The use of the initial Federal block grant funds allocated to Tennessee in the 1968 fiscal year represented a changed pattern from the usage of funds under the previous categorical health and mental health funds. The state public health officials in Tennessee anticipated that the Federal requirement for 70 percent of all 314(d) funds to be used in the provision of local health services would require a major departure from the existing pattern of state-administered categorical health programs. They decided to pass at least 70 percent of the available 314(d) funds, pursuant to the state formula, to the county health departments. The remaining amount of the funds were allocated to two state programs – training of personnel and heart disease control.

The previous categoricals had each required separate plans and administrative activities. The new block grant was allocated through a single 314(d) state plan to the local level and two state uses. Only one of the state uses was a categorical service (heart disease) under the prior 1967 funding. The other eight categoricals were continued with increased state-appropriated funds which became available.

In 1970, when additional Federal funds were made available to Tennessee through an adjustment of the Federal formula, the same three major uses were maintained and expanded. Since 1970, some 314(d) funds have been gradually shifted away from the state-administered training of personnel and heart disease control service areas to include other state-administered services. These now include:

- purchase of drugs,
- diabetes detection,
- multiphasic screening, and
- regional services.

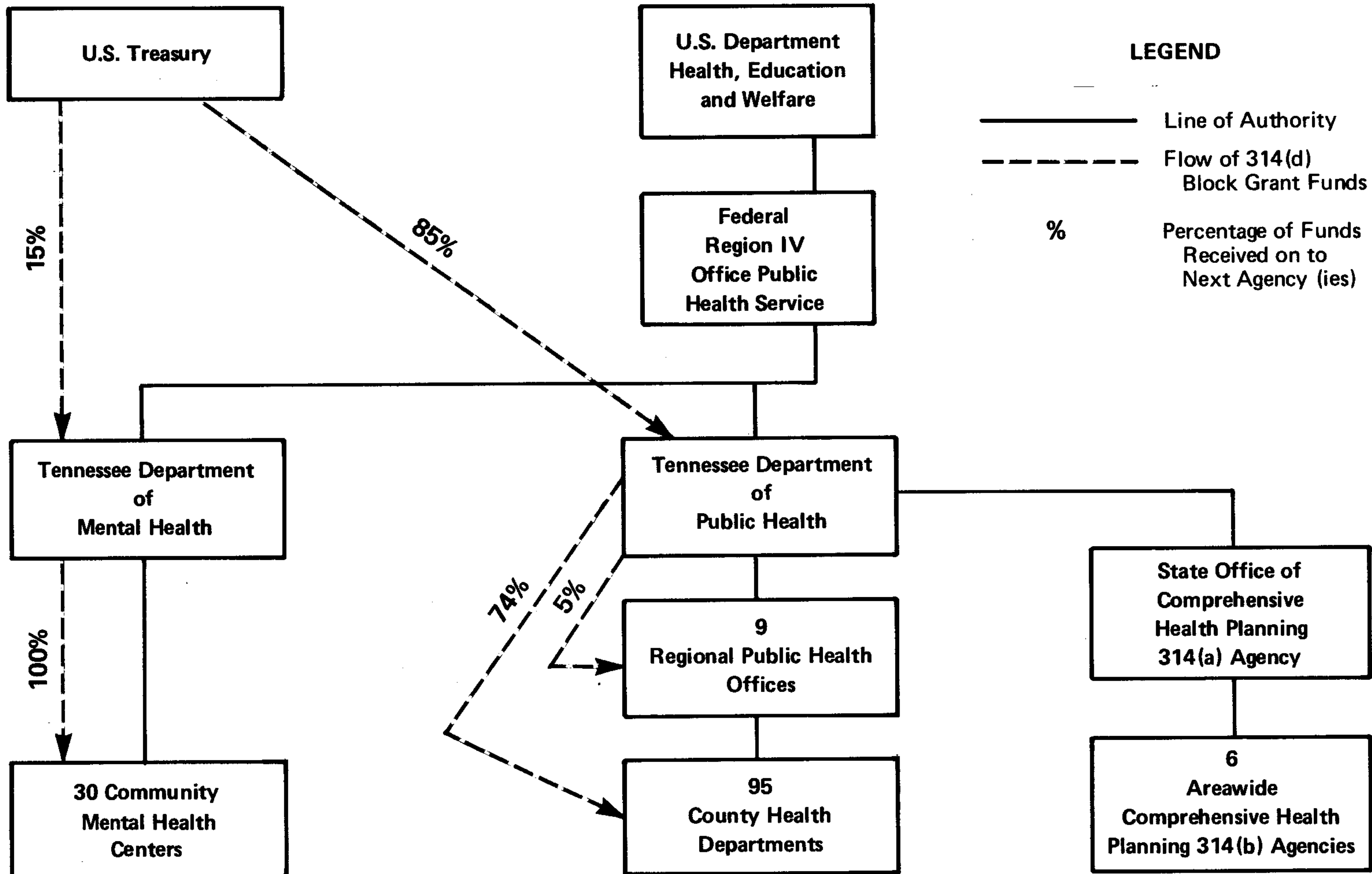
The prior categorical programs and these new programs funded in whole or in part by 314(d) funds reflect a changed approach in health service delivery. Although no specific innovations can be attributed to the block grant mechanism, there has been a change in that at the local level actual service delivery, as opposed to preventative, measures are now being emphasized.

Table 3 presents the pattern of public health and mental health services being supported in Tennessee with 314(d) funds during the 1975 fiscal year by amounts per service area. These services are described below in terms of their objectives, level of support by 314(d) funds, and relationship to prior categorical programs, where such relationship exists.

These programs were designated by the Department of Public Health to be supported by block grant funds on the basis of broad objectives established by the commissioner and his staff. Specific program objectives are established by staff of the department with specific program administration responsibility.

Table 2

Allocation Pattern Among Agencies Involved with the 314(d) Block Grant in Tennessee*



*Bureau of Administrative Services, Tennessee Department of Public Health, Tennessee Department of Mental Health.

Table 3

The Array of Public Health and Mental Health Services Provided in Tennessee That are Supported with 314(d) Funds in Fiscal Year 1975*

		314(d) Funds by Service	Total State and Federal Funds by Service	Percent 314(d) Total
Federally Administrated	Local Health Services	$1,100,000	$11,500,000	9.5%
	Regional Services/ Administration	78,000	86,000	90.7%
	Community Mental Health Service – Adult Outpatient	273,000	2,779,000	9.8%
State-Administrated	Public Health Personnel Training	125,000	125,000	100%
	Heart Clinics	70,000	70,000	100%
	Fiscal and Administration	50,000	933,000	5.3%
	Multiphasic Screening	32,000	81,000	39.5%
	Purchase of Drugs	20,000	20,000	100%
	Diabetes Program	12,000	12,000	100%

*Bureau of Administrative Services, Tennessee Department of Public Health, Tennessee Department of Mental Health

Complete 314(d) Funding Support

1. **Heart Diagnosis Program.** Providing diagnostic services annually to 10,000 patients who are medically indigent and suspected of having heart disease. This program is directly related to the prior heart disease categorical under which local health departments subcontracted with the state department to provide diagnostic services.

2. **Purchase of Drugs.** Providing drugs to medically indigent rheumatic fever patients and maintaining a rheumatic fever registry. In 1975, there were 13,000 medically indigent patients receiving these drugs; the rheumatic fever registry reported 28,000 for the same year.

3. **Diabetes Detection.** Screening for diabetes and referral to physicians for subsequent diagnosis and treatment. An estimated 40,000 unknown diabetics reside in Tennessee with approximately 15,000 persons being screened annually for diabetes detection.

4. **Training of Public Health Personnel/ Accredited.** Training in changing methods and techniques within the public health field. Approximately 35 state public health employees are annually involved in learning necessary new skills. The program is related to the prior categorical, home health services, which trained public health nurses who provided home health services outside of local health departments.

Partial 314(d) Funding Support

5. **Regional Services/Administration.** Organizing and maintaining nine regional public health offices to coordinate local services with regional specialized services and to administer state-supported local programs. The program is related to the

categorical general health services which provided administrative services to the personnel in local health departments.

Level of Support: 90.7%

6. **Multiphasic Screening.** Detecting early cancer, heart, kidney, and other catastrophic illnesses in the high-risk, low-income population. Approximately 3,600 persons are screened annually. A portion of this activity is a carryover from the categorical cancer control which provided diagnostic screenings at the local level.

   Level of Support: 39.5%

7. **Community Mental Health Services: Adult Outpatient.** Providing a full range of community-based mental health services to adults between the age of 18 and 60 through 25 community mental health centers. This activity is essentially a continuation of the prior mental health services categorical and it receives 100 percent of the Department of Mental Health's 314(d) allocation.

   Level of Support: 9.8 %

8. **Local Health Services.** The local health services program utilizes 71 percent of Tennessee's 314(d) allocation of funds for public health services. Funds are disbursed to local health departments pursuant to the previously discussed state formula.

   314(d) funds are used to provide direct health care services through nine regional offices and 95 county health departments. Services provided vary according to each health department's internally established needs.

   Services supported by 314(d) funds include:

   - immunizations,
   - crippled children services,
   - home health care,
   - communicable disease control,
   - environmental health,
   - diagnostic screenings,
   - family planning, and
   - dental care.

   It is at the local level, pursuant to communication between county health department and regional officials that decisions are made regarding utilization of core staff (the $20,000 base funding from the block grant) and allocations of state formula funds to specific activities. No conscious allocation or identification of 314(d) funds, which are included in the formula, is made by local health officials.

   Level of Support: 9.5%

The utilization of Federal funds in Tennessee has changed. Though the allocation formula has remained the same, the state has given the counties broad program discretion in the expenditure of the funds and the counties have financed new services because of this flexibility.

PLANNING, ADMINISTRATION, AND EVALUATION

This section presents the experience of Tennessee in terms of ten basic Federal requirements pertaining to the 314(d) block grant.

Planning Requirements

In the state of Tennessee, the basic planning requirements have been met only in part.

Provide services in accord with the adopted 314(a) Comprehensive Health Plan of the state. The 314(a) Office of Comprehensive Health Planning has not completed state plan recommendations to assist in the allocation decision for the 314(d) funds. There is no adopted state comprehensive health plan. Therefore, the 314(a) agency does not take the lead in determining statewide public health or mental health needs for possible 314(d) funding.

Specify the extent to which services to be provided are directed at public health areas of high priority, are of high quality, and will reach people in local communities in greatest need of such services. For the bulk of the 314(d) funds in public health, state priorities are not formally set. Rather the funds are passed by the

Department of Public Health to county health departments to support local services. The funds are expended according to local discretion, but no formal priority setting is required of local health units. Priorities are informally established by county health department directors in cooperation with regional officials who convey broad objectives established by the Department of Public Health. The remainder of 314(d) funds, approximately 25 percent, are allocated to eight operational programs administered on a statewide basis. These programs are selected on the basis of informal priorities established by the commissioner of public health and his staff.

This dual approach has been used to meet the requirement that the 314(d) funds will reach people in local communities according to their needs while simultaneously allocating some of the total funds to state high-priority areas. The dual approach was deliberately selected by the commissioner of public health in the 1968 fiscal year at the beginning of block grant funding.

For the expenditure of 314(d) funds in mental health beyond the designation of 314(d) funds for adult outpatient services of community mental health centers, priorities have not been formally set for mental health services by the Department of Mental Health. Twenty-five of the 30 mental health centers receive an equal share of the 314(d) appropriation, which the centers may use at their own discretion so long as the funds are restricted to the adult outpatient services category. The department now plans to allocate all funds available through 314(d) to geriatric services. In this event, centers with either no geriatric staffing or those with a planned geriatric program ready for expansion will receive additional funding under the new state priority in mental health.

Consider the comments of state 314(a) and regional 314(b) comprehensive health planning agencies in preparing the resource allocation to services in the 314(d) state plans. The Tennessee Department of Public Health has not systematically considered the comments of the 314(a) Office of Comprehensive Health Planning in annually reviewing the 314(d) resource allocation plan for services to be provided with 314(d) block grants. As a division within the Department of Public Health, the office does review and comment upon the overall public health budget before it is submitted to the legislature. No specific review of the allocation of 314(d) funds is undertaken, however.

The 314(b) areawide comprehensive health planning agencies, which are coordinated by the Office of Comprehensive Health Planning, also do not consistently review 314(d) expenditures although there is occasional comment through the A-95 review process. These omissions have been in part offset by the fact that the commissioner of public health serves as the chairman of the 314(a) policy board and is, therefore, aware of the long-range planning concerns of the 314(a) agency and board as they may relate to service funding proposals. There is no formal coordination method with the Department of Mental Health and its independently developed and reviewed mental health 314(d) allocation plan.

Allocate funds so that public health services are significantly strengthened in various political subdivisions of the state (including the funding of other public or non-profit private agencies to assure maximum participation of local, regional, and metropolitan agencies. The 314(d) funds in Tennessee have been channeled into the county health departments and the regional public health offices. Other public agencies and non-profit private agencies (with the exception of the non-profit community mental health centers) have not been fund recipients under the 314(d) allocation.

Define health services to be provided in terms of specific objectives. The 314(d) state plan documents for both public health and mental health the services to be provided so as to meet specific objectives. The state department of health is currently seeking to administer the 314(d) and other programs through use of these objectives at the regional level. Beyond the requirement that 70 percent of 314(d)-supported services must reach the local level, the department has not altered its broad objectives for service delivery. This is attributable to the fact that the block grant is neither considered to be a new source nor significant level of funding. The state Department of Mental Health is not currently using the service objectives to supervise the local administration services in the community mental health centers.

Provide for the review and modification of the 314(d) state plan(s) as appropriate on an annual basis by the state health agency and state mental health agency. Major allocation changes since the initial 1968 plan occurred in 1970 when the Federal allocation formula increased the state's funding levels. Both state plans were revised at that time and reviewed by the governor and Federal officials. Since 1970, the revisions to both plans have occurred internally in the two departments, resulting in minor modifications.

Administrative Requirements.

In Tennessee the three basic administrative requirements have been met.

Provide for the state administration or state supervision of local administration of the funds by the state health agency and state mental health agency. The Department of Public Health provides for the state management of some of the health services funded under section 314(d) and for state supervision of local administration of the bulk of the 314(d) funds passed through to regional and local health departments. The Department of Mental Health provides for the state supervision of local administration of the local community mental health centers in the expenditure of mental health 314(d) funds.

Assure that block grant funds will not be used to replace other non-Federal funds. The Department of Public Health has assured that the block grant funds will not supplant other non-Federal funds. A maintenance of financial support is established at a constant level by the counties to obtain the blended state and Federal funds for public health. This blend includes the 314(d) fund allocation to individual counties. In the mental health program, there is no assurance that Federal funds will not displace local funds.

Require recipient agencies utilizing 314(d) funds to participate in the costs of the supported services. Under the Department of Public Health's requirement of maintaining a constant level of local support, the recipient counties and their public health departments are automatically required to participate financially in the provision of the 314(d)-supported services, although a specific percentage of matching funds is not required. In the mental health program, there are no local matching requirements for the 314(d) funding share. However, the 314(d) funds are only a minor portion of the total budget of each community mental health center.

Evaluation Requirement

In Tennessee, neither the Department of Public Health nor the Department of Mental Health have fully met the evaluation requirement.

Provide methods of evaluating the performance of activities carried out with 314(d) funds. The evaluation requirement has been met in part by the Department of Public Health through current efforts to establish and utilize nine regional public health offices to evaluate services against objectives at the regional level. By 1975, this effort was partially operating in four of the nine regions where the objectives of the 314(d)-funded services among all public health services have been determined.

Mental health services attributable to 314(d) funds have not specifically been evaluated although the objectives for the mental health services have been developed at the state level within the mental health 314(d) state plan. However, all programs of each mental health center are evaluated at least annually by a Tennessee Department of Mental Health evaluation team.

CHANGES ATTRIBUTED TO THE BLOCK GRANT PROCESS

From the Tennessee case study, a comparison may be made of the 314(d) block grant utilization with categorical health grants. The comparison that follows highlights the eight-year experience in Tennessee.

Tennessee was utilizing the full array of nine categorical grants when those grants were merged into the block grant by P.L. 89-749. The total level of funding to Tennessee from those categoricals to the first block grant increased by only 4 percent.

There is a contrast and change in the Federal regional role as perceived in Region IV *vis-a-vis* Tennessee. Categorical grants required detailed plan submissions to the Federal regional officials stimulating a close technical relationship between Federal and state staffs responsible for the planning, administration, and evaluation of fund usage. With the 314(d) block grant, the detailed health and public health services presented in nine separate grant applications to Federal officials were merged into the two 314(d) state plan documents (one for public health and one for mental health). These documents provided much less program detail. From this point, tracking the former categorical funds became difficult for Federal regional officials.

Beginning in 1970, Federal regional officials annually approached the state officials of Tennessee with a checklist derived from the Federal regulations which was applied to the current 314(d) state plan. From that point, the changed Federal-state relationship can be characterized as that of the Federal regional office providing technical assistance to Tennessee at the state's request, rather than performing monitoring and plan and program evaluation functions required under the previous categorical grants in public health and mental health. The Federal office does, however, conduct a

regional review of a programmatic nature which can result in the modification plans, or utilization, or expenditures of 314(d) funds by Tennessee and other states. However, the nature of this and the checklist review does not permit Federal officials to assess the various states' interest in and capacity to undertake block grant assisted programs or evaluate their success.

Federal officials in the Atlanta Region IV office now find it difficult to either monitor or evaluate the specific effects of the block grant mechanism. They feel the need to have more specific detail on the use of 314(d) funds in the states – including Tennessee – not for purposes of controlling the use of the funds, but to defend and improve 314(d) block grant utilization within the region.

State public health and mental health officials do not see the 314(d) block grant in Tennessee as a new funding concept except in terms of simplified grant application requirements. As an example, in correspondence, it is sometimes referred to as the "314(d) categorical funding program."

The mix of services provided with block grant funds has substantially changed since the advent of the block grant in Tennessee, especially during the state's 1968 fiscal year when block grant funding began. State officials see the change as due to the Federal requirement that a minimum of 70 percent of the block grant funds support the delivery of local services within communities. However, the block grant is not reported to have altered the use of other Federal categorical programs. State officials in Tennessee perceive a vast simplification in block grant planning and administration compared with the demands of the prior categorical planning and administration.

Major planning efforts accompanied the preparation of Tennessee's initial 314(d) plan and its revision in 1970, which accommodated receipt of an additional $338,000 in Federal funds. Thereafter the 314(d) plan has not been significantly altered by either public or mental health officials.

The establishment of statewide priorities for both public health and mental health services has been accomplished by passing at least 70 percent of the 314(d) block grant to the local health units to be used at their discretion. In mental health, 25 community centers are the recipients of 314(d) funds, and, in public health, the funds are disbursed to 95 county health departments. Other public health priorities are reflected in the allocation of approximately 29 percent of the block grant to state-administered programs.

The state Department of Mental Health began to address the establishment of state priorities for use of 314(d) funds in 1973. It has been unable to trace direct effects of block grant funding, due largely to the small amount of 314(d) funding available to the community mental health centers.

State public health officials of Tennessee feel that the emphasis on public health services has changed significantly since the initial receipt of 314(d) funds in FY 1968. Changes are not ascribed entirely to the 314(d) block grant mechanism. However, the changes which are attributable to the shift from categorical to block grants are in areas of administration and decentralized service delivery; baseline funding of the 95-county network of local health departments; and the capacity to support a program of health care services both at state and local levels. These emphases have been encouraged, not mandated, by state officials to guide regional and local 314(d) fund utilization. Consequently, state influence in health service program composition has diminished since the advent of the block grant.

At the regional and local public health levels, important differences are perceived between Federal categoricals and the block grants. Block grants are strongly preferred, primarily because they are more flexible than prior categorical grants, both programmatically and administratively.

By 1975, eight years after the initiation of the 314(d) block grant to Tennessee, the state has moved away from funding more than half of the original Federal categorical services in public health. The state has taken advantage of the block grant flexibility to partially redefine the services to be provided with block grant support.

Most importantly, the bulk of 314(d) funds are reallocated under a state formula to county departments of public health for use at their own discretion. For this major proportion of the funds (71 percent), state priorities are not imposed on the local level. Local public health officials agree that the state and Federal funds they receive from the state formula (including the 314(d) funds) are unrestricted and are successfully applied to locally determined needs.

Categorical grants in public health are considered very restrictive in use and administrative aspects. One local respondent indicated that as much as 80 percent of Federal 314(d) money goes toward service delivery while nearly half of the categorical money was sometimes spent in administration. Categoricals caused replication of effort in that special staff were usually retained to deliver each component of the categorical services. The more flexible 314(d) funds allow public health generalists to be retained who can provide services in a wide range of public activities.

Effectiveness of categoricals is also limited in that

some public health programs may not be accepted in the community, either due to the feelings of an administrator, local officials or a group of potential service recipients. On the other han\', flexible 314(d) funds can be shifted to meet local priorities. The 314(d) block grant was also cited by local health officials as a valuable tool in filling in public health gaps which existing categorical grants did not reach.

Most local respondents favored folding all public health categoricals into the 314(d) block grant. Special programs such as speech and hearing programs for the handicapped were considered appropriate for retention of a separate identity, because skilled staff are needed to provide these services.

The chief benefit of the block grant's flexibility in meeting localized needs is seen in the improvement of medical services provided in rural areas. This has occurred in Tennessee through the extensive upgrading of home health services in many rural counties since 1968, as one example. Improvement of home health services has enabled private physicians to spend more time on direct medical needs rather than providing home services that convalescent care nurses now provide under the doctor's direction.

As a result, according to local health officials interviewed, there are fewer of the chronically ill in hospital beds. They are now treated at home equally well. Hospitals are cited as being less crowded, and doctors are spending less time traveling to see those patients once they leave the hospital. This is important in rural areas where formerly as much as half of a physician's day was spent in travel to see remotely located patients. The former Federal categorical grant in home health care would have achieved the same effect had adequate funding levels been available locally.

The 314(d) block grant mechanism is not considered to have stimulated either renewed interest by state legislators or the general public in increasing local and state support for public health and mental health programs of Tennessee. The 314(d) plan documents from their inception were not widely reviewed or generally discussed. No new state funds have been allocated for use specifically under the 314(d) state plan although these funds have been used in new areas of public health service while state funds have been used to continue former categorical programs.

At the local level, where the 314(d) dollar is not separately identified as a part of the state and Federal funds, officials report that new local funding support from the counties has occurred occasionally. State Department of Public Health policy requires each county to continue its public health funding support at a constant level. As new or expanded local public health problems arise, counties have sometimes expanded specific programs which are also Federal and state supported. In the eight-county region examined in this research, only two counties had increased local funding support to respond to increasing local need beyond the funding availabilities of the state allocation to the counties.

The matching requirements of the block grant program have not created fiscal or management problems for the Department of Public Health. This is due to the fact that 314(d) funds comprise but 12 percent of Tennessee's overall public health budget. At the local level where 314(d) funds are not separately identifiable, matching also presents no fiscal difficulties since counties are required to contribute at least an equal amount as the previous year for their public health budget.

Federal, state, regional, and local comparisons between the previous categorical grants and 314(d) block grant usage in Tennessee have resulted in a consensus on several areas.

- **Lack of direct involvement of either the governor or the state legislature in the block grant mechanism under section 314(d).** The state legislature has never shown interest in the 314(d) state plans. Neither have they appropriated 314(d) funds with conscious knowledge of their existence. The legislature has generally exhibited an approval of the overall goals of the public health program in Tennessee, and it has not involved itself with the appropriation of funds to specific programs, which it considers to be a function of the executive.

  Any major change in the allocation of funds to, or within, the State of Tennessee has been reviewed by the governor over a mandatory 45-day period but the governor has not instituted changes to the suggested allocation. Additional state support to the Department of Public Health is attributed to independent efforts of the department, not the block grant mechanism.

- **Absence of national priorities** under the 314(d) block grant mechanism in contrast to the clear priorities (by Federal funding levels) of the previous categoricals. This

change is viewed at state, regional, and local levels as the major benefit of the 314(d) block grant. The state Departments of Public Health and Mental Health have not taken steps to set and implement state priorities in lieu of the fading Federal priorities.

- **Low level of involvement of Federal officials** in the state planning, administration, and evaluation of the 314(d) block grant in contrast to the Federal role with prior categoricals. This is considered as a desirable change by health and mental health officials within the state. Federal regional officials agree as to the desirability but feel the need to document the 314(d) program in Tennessee so as to be able to more effectively provide assistance when requested to do so.

- **Low Federal funding of the 314(d) mechanism that severely limits its utility** in Tennessee in terms of allowing for systematic planning, administration, and evaluation. Officials generally agree that the low level of funding since the program's beginning has prevented the development of a systematic approach to its planning, administration, and evaluation. On the local level, those county health officials who are cognizant of 314(d) funds believe them to be a helpful supplement to their programs. However, they feel the sums received under the block grant are not sufficient in amount to warrant a separate budgeting and evaluation procedure.

One area of concern lacking common agreement among state, regional, and local public health officials, state mental health officials, or state and regional comprehensive health planners is:

- **Allocation of a high proportion of 314(d) funds to counties of high identified need.** The state allocation formula is relatively insensitive to specific health or mental health patterns in individual counties, so that local, regional, and state public health officials are continuously making fine adjustments to the state allocation to achieve a greater degree of equity.

SUMMARY AND CONCLUSIONS

The utilization of 314(d) funds in Tennessee has in part met Congressional intent. However, the planning and evaluation of block grant-supported activities had not effected the systematic approach to the delivery of public and mental health services envisioned by the *Partnership for Health Act.*

Public and mental health officials have allocated the bulk of the block grant to local health departments and community mental health centers. This has resulted in more than 70 percent of 314(d) funds providing services at the community level. Since the funds are used at the discretion of local health officials, increased flexibility in the administration of Federal funds has resulted. This flexibility has been both administrative and programmatic.

Although there has been a change of emphasis from a preventive orientation to actual service delivery, the 314(d) block grant has not resulted in innovation. Neither has it served to stimulate additional local or state expenditures for the provision of public health services.

State budget procedures have treated the block grant as state funds. As a result, when county health departments receive their allocation pursuant to the state formula, 314(d) funds are not an identifiable component of local public health activities. Beyond the use of the formula, there is no assurance that block grant funds are used in communities of greatest need.

The block grant is treated as state funds because of its relatively low proportion of the total state and Federal public health budget and because it is not considered a new source of funding.

As a result, the block grant mechanism has not effected a systemwide approach to the delivery of public and mental health services in Tennessee.

The various Federal, state, regional, and local agencies involved in the planning, administration, and evaluation of the 314(d) block grant have not operated in a coordinated manner. Rather, each agency has responded autonomously to immediate problems associated with the block grant. In addition, neither government, the private sector, nor public interest groups have played a role in planning for the administration and utilization of 314(d) funds.

The state Departments of Health and Mental Health have planned for the allocation of the funds without long-range guidance from the state's comprehensive

health planning agencies – 314(a) or 314(b). The two state service delivery Departments of Public Health and Mental Health have then provided services in multi-county regions of the state which are separately defined by each department. Neither service delivery nor health objectives have been coordinated.

The Federal regional office of the U.S. Department of Health, Education and Welfare has been hampered in evaluating the services provided by the decreasing Federal requirement for program details.

Key state policy officials, such as the governor and the state legislature, have not become involved in evaluating the services provided or in altering the allocation of 314(d) funds. The block grant mechanism has had no effect on the power position of elected chief executive or legislative officials. Nor has it had any effect on the political climate at the community level.

Tennessee has met the planning requirements for the 314(d) block grant only in part. State plans and planning recommendations required by section 314(a) and 314(d) are not linked. The 314(d) allocations over the past eight years have not included funds to other public or private non-profit agencies – except for the community mental health centers of the state. The 314(d) state plans (prepared in 1970) for both public health and mental health have set broad service objectives but have undergone little modification since their initial preparation.

Tennessee has met the administrative requirements to provide for the state administration and state supervision of local utilization of the 314(d) funds; assure local contributions towards the cost of 314(d)-supported services; and assuring that the 314(d) do not replace other non-Federal funds.

Tennessee is also working to develop a regional management system in its Department of Public Health which will include an evaluation of 314(d)-supported services in terms of the objectives of the individual services provided. Decentralization of service delivery through the creation of nine public health regions has been partially created. While the flexibility of 314(d) funds has complemented this decentralization, the block grant mechanism is not considered to be a cause of such regionalization.

In conclusion, a shortcoming of the Tennessee approach is that actual changes and improvements to the state and its local jurisdictions are not documented, nor is there a history of systematic evaluation of 314(d)-supported services. The advantages of the Tennessee administration and utilization of the block grant are that the bulk of 314(d) funds are allocated expeditiously and utilized at the community level pursuant to the discretion of local health officials with a minimum of Federal or state intervention.

Texas

Allocation and utilization of 314(d) funds in Texas involve two separate approaches and attitudes of state public health and mental health authorities. This study is an examination of these two approaches and their implementation both in FY 1968, when block grant funds were first received, and in FY 1975, when current state actions for the provision of public and mental health services were reflected. In addition, the effect of the transition from categorical to block grants in FY 1967 and FY 1968 is analyzed.

Allocation and administration of 314(d) funds in Texas involve the following:

- Executive Department (Budget Liaison);
- State Legislature (Legislative Budget Board);
- Department of Health Resources; and
- Department of Mental Health and Mental Retardation.

The Departments of Health Resources and Mental Health and Mental Retardation are autonomous units charged with the responsibility of delivering public health and mental health services, respectively. Budget officials in both departments work closely with officials from both the executive and legislative departments in preparing bi-annual public and mental health budgets (the legislature in Texas convenes every two years).

The Texas Department of Health Resources (DHR) was organized in FY 1975. Formerly it was known as the Department of Health. The department is operating under the control of the Board of Health Resources. The board, which has the authority to operate the DHR, is composed of 18 individuals appointed by the governor. Its executive director is the deputy director of DHR (the director will serve this function when that position, currently vacant, is filled).

The Department of Health Resources is the implementation arm of the board. Though it operates under the aegis of that group, the DHR is at present a policymaker and implementation agent. It is the staff of the department which sets priorities for, and directs the flow of, 314(d) funds for public health in Texas.

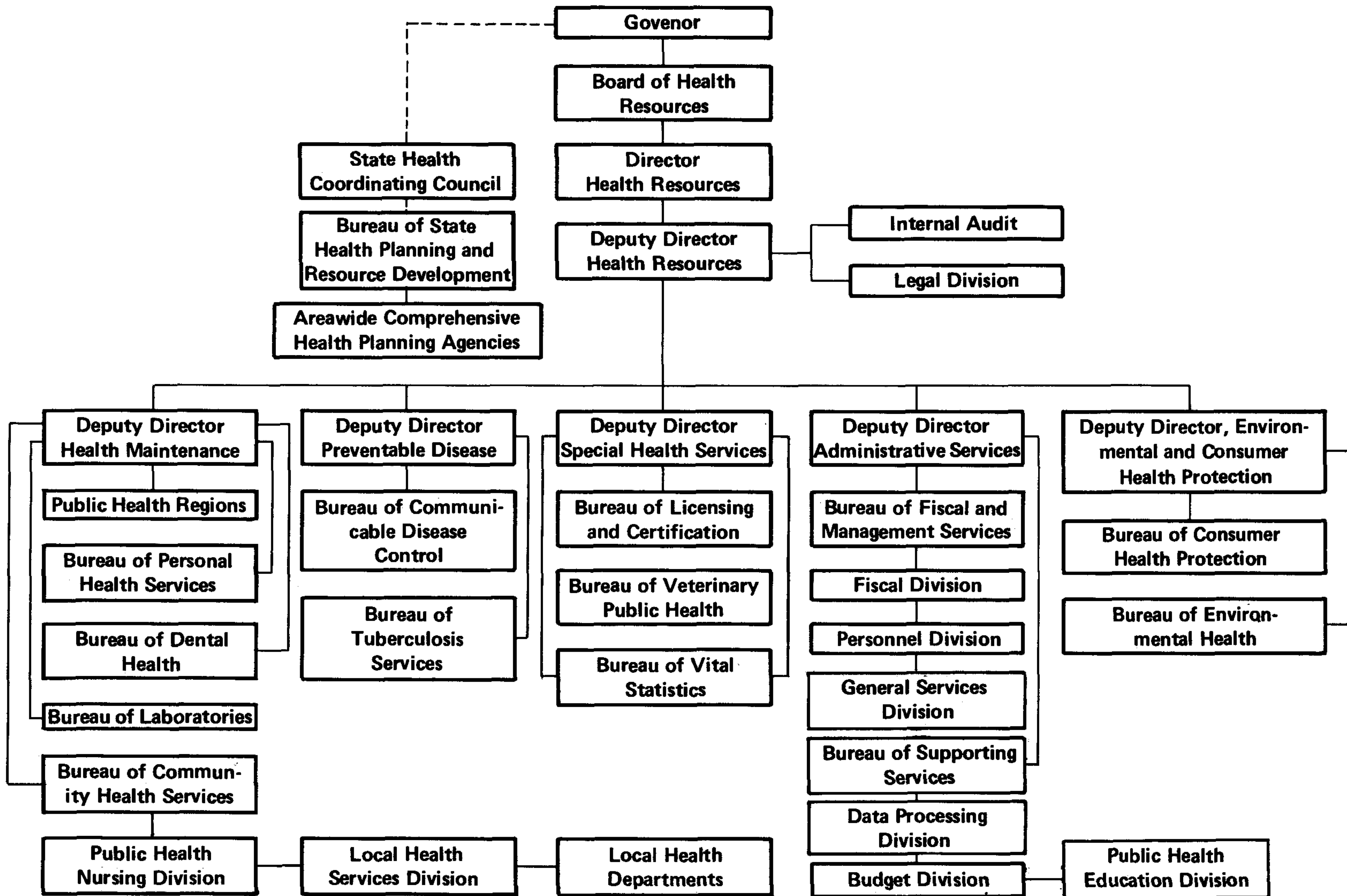
The Bureau of State Health Planning and Resource Development is the planning body for the department, and it establishes broad policies and comprehensive public health goals for DHR. The bureau, which serves as an advisor to the DHR, receives input on public health goals and objectives from the state Health Coordinating Council. The council is authorized by statute to perform this function. It is composed of both consumers (at least 60% as mandated by statute) and health service providers. Its members are also appointed by the governor. The council was established in response to the *National Health Planning and Resources Development Act of 1974.*

The Bureau of State Health Planning and Resource Development contains the staff of the former 314(a) agency, the governor's Office of Comprehensive Health Planning. This office, when it was operating, never established a comprehensive plan for health services in Texas, nor exercised real policy-making power over public health decisions in general, or 314(d) funds in particular. It no longer formally exists. The office has been merged into the bureau, which performs the comprehensive health planning functions of a 314(a) agency.

There are 24 314(b), areawide comprehensive health planning agencies in Texas. Five of these, located in the larger metropolitan communities, are supported jointly by Federal and local funds. The other 19 have staffs of one person supported by moneys allocated pursuant to section 314(a) of the *Partnership for Health Act.* These planning agencies were established for the purpose of

Table 1

Organizational Chart of the Texas Department of Health Resources and Related Agencies*



*The information in this table was provided by the Texas Department of Health Resources.

evaluating the public health needs of areas in which such determinations had previously not been undertaken.

Table 1 sets out the organizational structure for the planning and delivery of public health services in Texas.

Priorities for 314(d) block grant usage have been established by the Department of Health Resources. Decisions concerning the disposition of these moneys and other state and Federal funds are made through the budget process by the staff of the department. Neither the 314(a) agency nor the old state Board of Health played a significant role in decisions concerning 314(d) funds.

The Texas state legislature has traditionally had a strong role in formulation of the state's public health budget. This input does not, however, specifically concern 314(d) funds which have been used in conjunction with state revenues to support the delivery of public health services. The Legislative Budget Board is able to identify the 314(d) funds when it confers with DHR budget officials in preparing the public health budget for presentation to the full legislature, but the block grant has never been considered by the legislature to be a separate source of funding for these activities.

Public health services in Texas are delivered in two primary manners. There are 69 local health departments serving 76 counties and five cities, covering approximately 80 percent of the state population. In addition, the state's 254 counties are divided into ten public health regions which provide health services to 178 counties which do not have local health departments.

The 69 local health departments operate independently of the Department of Health Resources. However, the departments are recipients of both 314(d) benefits and state moneys, and as a prerequisite of such receipts, they must meet certain state-imposed requirements, related to staffing, budget, and program plans.

Public health regions in Texas are oriented toward serving the basic health needs of those areas of the state without formal organization for local health service delivery. Region 7, activated on May 1, 1970, with total support from 314(d) funds, was the first to become activated. To date, six public health regions are operational, and by September 1976, decentralization of the Department of Health Resources, with the addition of four regions, was scheduled to be completed.

Expenditures of 314(d) funds by DHR have constituted a basic continuation of both allocation and utilization patterns followed during the years of prior Federal categorical grants. The block grant has been directed to support ongoing operational programs of the department which provide both statewide services and, in part, fund staff of local health departments.

As is the case in public health, ultimate responsibility for planning and delivery of mental health services delivery is vested by statute in the Texas Board of Mental Health and Mental Retardation. The board is composed of nine individuals appointed by the governor. Policy making and implementation is carried out by the Department of Mental Health and Mental Retardation (DMHMR). That body is responsible for the administration of 28 state-operated mental health institutions which include eight hospitals; 11 schools for the mentally retarded; three human development centers; and other institutions such as local mental health and retardation centers.

Table 2 depicts the organizational structure for the planning and provision of mental health services within the state.

Priority setting and allocation of block grant expenditures is primarily the responsibility of the Division of Community Services which reviews projected 314(d) allocations with DMHMR's Budget and Finance Division and representatives of the Legislative Budget Board. The Division of Community Services provides legally mandated support for 27 organized community MHMR centers and other departmental local facilities.

Mental health services in Texas are provided in two ways. First, 27 community centers deliver services in those areas where the centers are formally organized. The centers become functional as local government officials and members of the community join together for the establishment of a local board of trustees to operate a community center. When this legislatively mandated procedure is completed, the center becomes eligible for state grant-in-aids and other state-administered Federal moneys to support their operation.

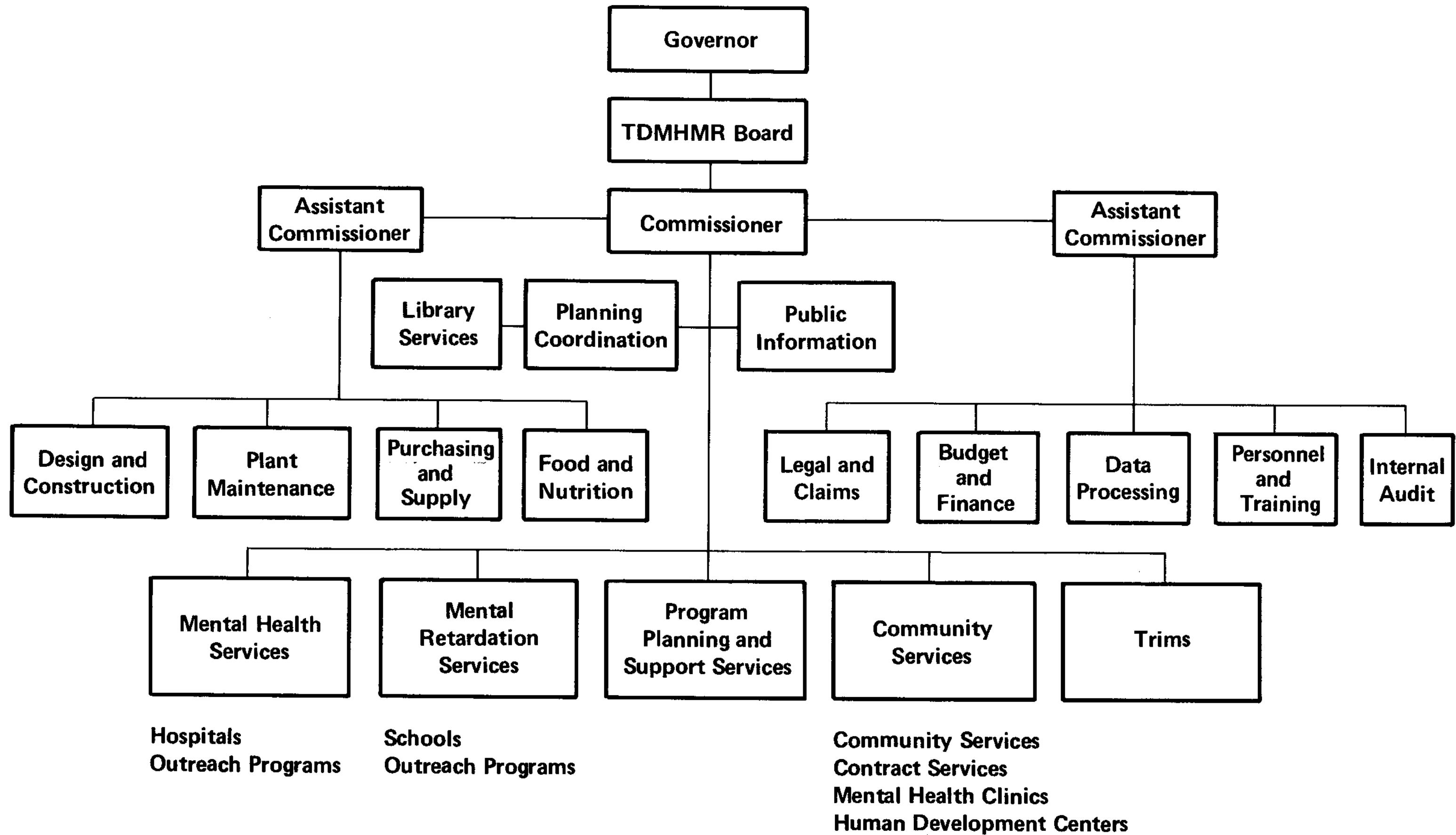
Although community centers are not programmatically administered by the Department of Mental Health and Mental Retardation, they must, nevertheless, comply with the DMHMR's rules and regulations governing the operation of centers. These and certain audit requirements are a prerequisite for receipt of state grant-in-aid moneys.

The second way in which mental health services are delivered is through state-administered MHMR facilities and local institutions. The bulk (64.4% in FY 1975) of 314(d) expenditures have gone to support local facilities with the goal that such facilities will eventually become a part of the state grant-in-aid network for delivery of mental health services.

For mental health, Texas is divided into ten service regions which are coterminous with the Department of Health Resources' regions. Unlike public health, however, there are no regional offices with staff to coordi-

Table 2

Organizational Structure of the Texas Department of Mental Health and Mental Retardation*



*The information in this table was provided by the Texas Department of Mental Health and Mental Retardation.

nate and deliver mental health services. Instead, a mental health region is considered operational when there is present a community center in the area which has contracted with DMHMR to receive grant-in-aid moneys.

The following section describes in detail the state's allocation process and profiles its use of the public health and mental health 314(d) block grants since FY 1968. In addition, the section describes the changes that have taken place as the funds changed from categorical grants to block grants.

BLOCK GRANT ALLOCATION AND USE

This section discusses the Texas administration of 314(d) funds in two broad phases: (1) Federal to state allocation and (2) state and local relationships for suballocation and utilization of block grant funds.

Federal to State Allocation

In FY 1968 Texas received $3,012,800 in 314(d) funds, $2,560,900 for public health and $451,900 for mental health.*

Immediately prior to the block grant program, in FY 1967, Texas was the recipient of $2,746,960 under the nine Federal categorical health grants.

With the receipt of block grant funds, Texas benefited from an increase of $265,840 or 9.7 percent in Federal funding for public and mental health programs in FY 1968. Between the Texas' FY 1968 and FY 1971, the annual allocation to Texas increased by approximately $1,382,770. This increase resulted both from a readjustment of the Federal formula and the inclusion of the tuberculosis categorical grant in the 314(d) national allocation. Since then, block grant allocations to Texas have remained at approximately $4.4 million. *Table 3* depicts the total annual 314(d) allocations to Texas since the beginning of the block grant program.

314(d) block grant funds are considered by both public health and mental health authorities in Texas to be an integral portion of their activities. The Department of Health Resources considers the funds, which totally support 315 salaried positions, valuable for their flexible and comprehensive nature. The moneys have been used to support both the department's regionalization program and as an aid to local health departments throughout the state. The Department of Mental Health and Mental Retardation has used the funds to support administration of local services both through intradepartmental activities and direct financial aid to communities.

The 314(a) agency in Texas, the governor's Office of Comprehensive Health Planning, consistently played an

*Information obtained from Bureau of Supporting Services, Texas Department of Human Resources.

Table 3

The 314(d) Block Grant Allocation to Texas for Fiscal Years 1968 – 1975*

	Public Health	Mental Health	Total
FY 1968	$2,560,900	$451,900	$3,012,800
FY 1969	2,375,000	470,300	2,845,300
FY 1970	2,665,100	664,600	3,329,700
FY 1971	3,731,300	664,200	4,395,500
FY 1972	3,719,800	656,400	4,376,200
FY 1973	3,723,400	657,100	4,380,500
FY 1974	3,763,600	664,100	4,427,700
FY 1975	3,789,700	668,800	4,458,500

*Based on information provided by Bureau of Supporting Services, Texas Department of Human Resources and Division of Community Services, Texas Department of Mental Health and Mental Retardation.

insignificant role in the allocation of block grant funds. The thrust of its activities was to provide technical assistance to the 24 314(b) agencies in providing basic health planning throughout the state. As a result, both the DHR and DMHMR have had major policy-making authority in deciding how to allocate 314(d) funds.

The legislature in Texas has characteristically played an active role in the preparation of the health budget for the state. However, in both public and mental health, this participation has not reflected a conscious knowledge of 314(d) funds.

In preparing its public health budget, the Department of Health Resources receives input from both the governor's office and the Legislative Budget Board. The board, which consists of key members of the legislature, confers extensively with staff of DHR's Bureau of Supporting Services in preparation of the public health budget. Interviews with department staff indicate, however, that the board, which reports an appropriations bill to the full legislature, does not particularly consider the block grant to be a separate source of Federal funding, although 314(d) funds are separately identified in the DHR budget.

In mental health, the legislature has an even slighter involvement with 314(d) funds, which are directed to the DMHMR's Division of Community Services to be suballocated. The block grant becomes a part of the mental health budget after community services officials coordinate their budget request with the Division of Budget and Finance. The entire budget then is reviewed by the commissioner and passed on to the Board of Mental Health and Mental Retardation, which in turn presents its request to the Legislative Budget Board. Significantly, the budget which is presented to that group does not contain 314(d) funds – they are listed separately from other state and Federal moneys to be allocated for the provison of mental health services.

Therefore, although the legislature can separately identify block grant funds for both public and mental health early in the budget process, it has never been involved with allocations of 314(d) funds in particular. All decisions for allocation of block grant funds are instead made within the Departments of Health Resources and Mental Health and Mental Retardation.

State Provision of Public Health Services

In Texas, there is no agency with overall authority for allocating moneys to the various human resources programs carried out by the state. Thus, the Departments of Health Resources and Mental Health and Mental Retardation are autonomous units with separate responsibilities (exercised for their respective boards) for the administration and utilization of 314(d) funds.

Although the two departments administer the block grant pursuant to priorities which have been internally and informally established, the pattern of allocation and utilization of 314(d) funds is different for the DHR and DMHMR. They will be discussed separately. Analysis is presented for public health in terms of FY 1967 under the Federal categorical grant system, FY 1968 when block grants became available, and FY 1975, the most recent year for expenditure of 314(d) funds. For mental health, analysis is presented in terms of FY 1966, 1967, 1968, and 1975.

The Department of Health Resources allocates 314(d) funds in the same manner today as it did in FY 1967. The block grant is allocated to the operational programs of the DHR which are administered by the department's deputy directors of five divisions – health maintenance; preventable diseases; special health services; administrative services; and environmental and consumer health protection. It was the decision of the director and his deputy directors to basically continue prior Federal categorical programs utilizing 314(d) moneys. The decision was based on the belief that these programs were efficiently serving public health needs on the local level.

There is no formal priority setting for expenditures of 314(d) funds. The block grant is allocated just as other Federal and state moneys are – through the budget process. The public health budget is designed pursuant to broad priorities established by the director of the department and its five deputy directors. The input provided by the deputies is based upon their discussions with the bureau chiefs in their respective divisions.

Of the five deputy directors, the key actor in the 314(d) allocation process is the representative of health maintenance. This division is ultimately responsible for the administration of the programs which are the major recipient of 314(d) funds – the public health regions; programs in cancer and heart disease and laboratories; and the 69 local health departments throughout the state. As a liaison to local health departments and regional administrators and program officers, he is cognizant of community health needs. Thus, 314(d) funds are allocated pursuant to priorities which are established on the basis of input informally generated through the hierarchy of the public health structure in Texas.

The Department of Mental Health and Mental Retardation allocates block grant moneys to the Division of Community Services which is charged with the responsibility for suballocating the 314(d) funds. The amounts so disbursed are the bulk of the 314(d) mental health

allocation in FY 1975, 79.5 percent. The major exception is that salaries of the four division assistant deputy directors of the divison are totally funded by the block grant.

In recent years, the Division of Community Services has allocated 314(d) funds to three programs – a data analysis system which serves local mental health facilities and the 27 established community health centers; contractual services, which either initiate or support activities such as counseling services and outreach programs in communities without established community health centers; and the expansion of programs in such centers.

Priorities for allocating 314(d) funds are formulated informally by the staff, assistant deputy directors, and deputy director of the Division of Community Services. It has been the policy of the Department of Mental Health and Mental Retardation to strengthen and make mental health services more accessible throughout the state. The basic strategy has been to use the block grant as "seed money" to initiate or support services in communities which have not yet become organized as a part of Texas' grant-in-aid community centers.

Decisions regarding which communities are in greatest need of these "bridging services" are based upon the staff's knowledge of each locality and citizen input. Three of the four assistant deputy directors of the division spend approximately two-thirds of their time travelling the state, determining areas of high priority, and providing technical assistance to communities in developing programs and budgets for mental health services. Since these activities predate the block grant mechanism and are oriented toward the development of independent MHMR centers throughout the state, the staff of the Division of Community Services are particularly attuned to local mental health needs.

In addition, staff personnel utilize citizen input in deciding what areas should receive 314(d) moneys. This input is usually initiated by representatives of local citizen boards who approach division personnel with requests for financial aid in creating or expanding mental health services.

Citizen boards are organized at the community level, usually at the initiation of local elected officials – county judges or state legislators. There is, however, no indication that local citizen boards are particularly cognizant that they are requesting a portion of the division's 314(d) block grant allocation.

Public Health Utilization of 314(d) Funds

The advent of the block grant program in FY 1968 brought no change in the utilization pattern of expenditures of Federal funds for the provision of public health services by the Department of Health Resources. The programs supported by prior categorical grants were continued in their entirety. These programs have been retained to the present time.

One departure from the DHR's utilization pattern of 314(d) funds occurred in FY 1971. When Texas received an increase of $1.38 million due to the readjustment of the Federal allocation formula, it budgeted $240,000 (22 percent of the increase) for total funding of the core staff of its first public health region. The 314(d) funds now support approximately one-half of the salaries of the Region 7 staff.

Table 4 presents the expenditures of both the prior categorical and block grant funds for the years 1967, 1968, and 1975. Analysis of that data indicates that 314(d) funds provide public health services through statewide operational programs of the department and through the support of salaries of staff of both regional and local health departments throughout the state.

The activities which are major recipients of 314(d) funds in FY 1975 are described below. They represent both statewide operational programs, which provide services to the local level (cancer and heart, laboratories, and home health) and programs which support the staff of local health officials (Region 7 and local health departments) and are the recipient of 85.4 percent of Texas' 314(d) allocation. These are discussed in terms of public health problems addressed; amounts of 314(d) funds used in support of services provided; and percentage of 314 funds allocated to provide public health services.

- **Bureau of Laboratories.** The DHR laboratory performs analysis of specimens in the fields of bacteriology, serology, parasitology, entomology, and virology. Services are provided to regional laboratories and private physicians. This program also includes workshops and training programs for laboratories throughout Texas.
  Level of Support: $609,173
  Percentage of 314(d) Allocation: 16.6%

- **Home Health Services.** This activity seeks to encourage local agencies and institutions to establish or expand home health agencies by providing consultation on the local level on formation and operation of such services.

Table 4

Public Health Expenditure Pattern Transcending Categorical Grant and 314(d) Block Period State of Texas*

	FY 1967									FY 1968	FY 1975
	General Health	Chronic	Heart	Cancer	Tuber-culosis	Radiological Health	Dental	Home Health Services	Total		
Public Health Regions											241,294
Nutrition Services											21,036
Cancer and Heart			233,576	99,060					332,636	268,264	341,515
Chronic Disease		77,001							77,001	73,712	41,964
Dental Health							15,390		15,390	4,504	
Laboratory	78,659		5,436		29,760	5,436			119,291	439,527	609,173
Local Health Services	15,497	6,375							21,872		8,052
Public Health Nursing	3,035								3,035		
Local Health Departments	302,008	388,633	92,040	35,640	100,350	25,032	26,482	168,257	1,138,442	1,264,396	1,784,731
Communicable Disease	5,415								5,415	22,528	4,992
Tuberculosis Control										2,400	10,000
Nursing and Convalescent Homes		71,996							71,996		
Home Health Services								109,474	109,474	137,555	148,876
Records and Statistics		5,100	28,212	12,840					46,152		
General Services	25,072	51,204	34,944	12,852		9,944	2,500	3,800	140,316		
Public Health Education	29,026		5,436						34,462		
Sanitary Engineering	87,971								87,971	105,684	
Occupational Health						74,526			74,526	90,937	
Wastewater Tech. & Surv.											13,538
Employee Benefits	30,517	50,491	20,656	14,708	12,290	7,562	2,728	4,669	143,621	151,393	434,203
Total	577,200	650,800	420,300	175,100	142,400	122,500	47,100	286,200	2,421,600	2,560,900	3,659,374

*Table prepared by Bureau of Supporting Services, Texas Department of Human Resources.

Level of Support: $148,876
Percentage of 314(d) Allocation: 4.1%

- **Cancer and Heart.** DHR staff operate screening clinics for the detection of cancer and heart disease. There are 50 of these clinics throughout the state. The activity also entails the operation of educational programs to publicize the dangers of cigarette smoking.
Level of Support: $341,515
Percentage of 314(d) Allocation: 9.3%

- **Public Health Region 7 – Core Staff.** 314(d) funds provide approximately 50 percent of the core staff of this regional office. Region 7 serves 36 counties in eastern Texas, 24 of which do not have organized health departments. It was originally activated with impetus of 314(d) moneys.

Region 7 was the first of Texas' public health regions to be activated. DHR's predecessor, the Department of Health, had made plans for several years to decentralize health service delivery throughout Texas. The state legislature authorized public health regions in 1969 through a rider to the appropriation bill, but did not provide funds to complement the regional concept. When additional 314(d) funds became available to Texas for FY 1971, health department officials were able to convince the legislature to authorize $240,000 of the $1.38 million increase for the creation of Public Health Region 7 in May 1970.

Regional office responsibilities include the provision of public health services through the administration of Department of Health Resources operational programs and Federal categorical programs.

The core staff supported by 314(d) funds are a public health physician; public health nurse; a public health dentist; administrators; clerks and secretaries; sanitarians; a public health veterinarian; and public health inspectors and engineers.
Level of Support: $241,294
Percentage of 314(d) Allocation: 6.6%

- **Local Health Departments.** 314(d) funds provide the salaries of approximately 300 staff personnel located throughout the state's 69 local health departments. The staff who are actually on the DHR payroll serve a broad range of locally determined health needs. In isolated instances, physicians have been salaried. Other positions include public health nurses (50%), clerks (20%) and sanitarians (30%). 314(d)-supported staff are utilized in general support of the overall public health programs of local health departments, whose activities include:

  - Tuberculosis Control,
  - Adult Health Services,
  - Immunizations,
  - Family Planning,
  - Dental Health Services,
  - Public Health Education,
  - Veneral Disease Control,

Table 5

Comparison of 314(d) Expenditures by Category for Provision of Public Health Services in Texas*

Category	Percentage of 314(d) Expenditures*	
	FY 68	*FY 75*
Cancer and Heart	10.5%	9.3%
Laboratory	17.2	16.6
Home Health	5.4	4.1
Local Health Departments	49.4	48.8
Public Health Regions	–	6.6
Employee Benefits	5.9	11.9
Sanitary Engineering	4.1	–
Occupational Health	3.4	–
Other	4.1	2.7
Total	100.0%	100.0%

*Based on information from Bureau of Supporting Services, Texas Department of Human Resources.

Table 6

Mental Health Expenditure Pattern
Transcending Categorical and Block Grant Period
State of Texas
Fiscal Year 1966 – Fiscal Year 1975*

Mental Health Expenditure Category	Categorical Grant		314(d) Block Grant			
	FY 66		*FY 68*		*FY 75*	
	Amount	Percent	Amount	Percent	Amount	Percent
Salaries and Administration Community Services Division	$268,640	87.2%			$136,857	20.5%
Projects and Workshops	$ 39,380	12.8%				
Program Analysis and Statistical Research			$198,983	44.0%	$ 58,603	8.8%
Development of Services in Areas Without Organized Mental Health Centers			$191,355	42.3%	$430,962	64.4%
Aid to Mental Health Centers			$ 53,949	12.0%	$ 26,383	3.9%
Manpower			$ 7,612	1.7%		
Other					$ 15,993	2.4%
Total	$308,020	100%	$451,900	100%	$668,800	100%

*Based on information provided by the Division of Community Services, Texas Department of Mental Health and Mental Retardation.

- Child Health Services,
- Crippled Children Services,
- Chronic Disease Services,
- Water and Sewage Systems, and
- Food, Milk, and Meat Sanitation

Level of Support: $1,784,731
Percentage of 314(d) Allocation: 48.8%

The above expenditures represent a utilization pattern of Federal funds for public health services that has existed under both prior categorical and current 314(d) block grants. This is reflected by *Table 5*. The Department of Health Resources has maintained this pattern under the more flexible block grant program because it feels it is the most effective means of addressing the public health needs of the state in light of the fact that DHR otherwise has no legal authority directly to disburse funds to local health departments to be used at their discretion. In addition, the support of personnel in local health departments enables state officials to remain attuned to local needs and exercise a degree of administrative control over local health departments which are not otherwise programatically controlled by the DHR.

Mental Health Utilization of 314(d) Funds

The Department of Mental Health and Mental Retardation, unlike the Department of Health Resources, did not maintain a stable utilization pattern for expenditures of Federal funds as the transition was made from categorical to block grant.

Under the mental health categorical program, the bulk of Federal funds was used to support the staff of the Community Services Division. in FY 1966, 87 percent of the moneys provided salaries for four psychiatric social workers and one public information consultant. Thirteen percent was utilized, in part, to support projects and workshops in local mental health facilities. Projects varied from being short range – essentially seminars and workshops carried out on the local level which examined both mental health problems and the

intricacies of administering a mental health facility – to long range – supporting part of the salaries of psychologists and psychiatric social workers.* The 1967 utilization pattern of the mental health categorical grant was essentially the same, both in scope of services and amounts expended.

Table 6 presents the expenditures of Federal mental health funds in FY 1966, 1968, and 1975.

In response to the block grant requirement that 70 percent of all 314(d)-funded activities provide mental health services on the community level, emphasis for the expenditure of Federal funds has been shifted to support the direct delivery of mental services to the community level. Since FY 1968, such activities have comprised a majority of the allocated 314(d) funds, and they reached a level of approximately 68 percent in FY 1975. This percentage does not reflect data processing services provided to local facilities and community centers by program analysis and statistical research, which documents patient flow and types of mental health services delivered. This program was initiated in 1970 by the DMHMR and has continued to date. The emphasis on local service delivery is also reflected by the fact that salaries of the Community Services Division staff are no longer a major portion of the state's 314(d) mental health allocations.

As the network of grant-in-aid community health centers (operated pursuant to legislative mandate by local boards of trustees) has become more established and secure in its operation, 314(d) funds have been shifted from the support of local facilities not contained within the state grant-in-aid system. In FY 1975, 64.4 percent of the block grant allocation was utilized for this purpose.

Discussions with DMHMR staff indicate that block grant funds have been an invaluable tool in the establishment of the state's grant-in-aid network of community mental health centers. The funds are considered to be directly responsible for the establishment of the 27 community centers in that they provided both financial and moral support to local communities to organize systems of mental health services delivery.

The DMHMR utilization of block grant funds for FY 1975 is presented below. 314(d)-supported activities are presented under the broad categories of community level services and administrative services. Description is provided in terms of problems addressed; expenditure of 314(d) funds; and percentage of 314(d) funds allocated to provide mental health services.

*Information provided by Division of Community Services, Texas Department of Mental Health and Mental Retardation.

Community Level Services

1. **Development of Services in Areas Without Organized Health Centers.** Community mental health and mental retardation services receive 314(d) funds which are considered "bridging services." These services begin through local initiative in areas of population too small to support a full community MHMR center; they are locally supported and staffed by the areas' resources to the extent possible. To supplement local and available state resources, contracts are established with DMHMR for the receipt of 314(d) funds.

   Contractual services result in a wide array of activities such as out patient clinics, general counselling, and outreach programs which refer patients to participating hospitals. In addition, staff personnel such as psychiatrists, clinical psychologists and psychiatric social workers are often supported by 314(d) funds.

   Level of Support: $430,962
   Percentage of 314(d) Allocation: 64.4%

2. **Aid to Community Mental Health and Mental Retardation Centers.** The program supports less established grant-in-aid community centers which are in need of supplemental funding. In FY 1975, all suballocations in this category were directed to the Grayson County MHMR Center. As is the usual case, 314(d) funds provide salaries to staff personnel and support in part fees paid to private physicians who render services to the center.

   Level of Support: $26,383
   Percentage of 314(d) Allocation: 3.9%

Administrative Services

1. **Program Analysis and Statistical Research.** 314(d) funds support data processing and analysis activities carried out by this program. Documentation is maintained in order to ascertain the progress DMHMR is making in expanding mental health services throughout the state.

Both grant-in-aid community centers and local facilities receive the data processing services of the program, which documents patient flow in mental health facilities throughout the state; type of treatment provided; and amount of time expended per patient and service provided.
Level of Support: $58,603
Percentage of 314(d) Allocation: 8.8%

2. **Community Services Administration.** 314(d) funds provide the salaries and benefits to the four assistant deputy directors of the Community Services Division. The division is responsible for the administration of the state grant-in-aid program and enforcement of the rules, regulations, and standards for community NHMR centers and administration of state-contracted community level services. Its duties also include the evaluation of community mental health services in Texas.
Level of Support: $136,857
Percentage of 314(d) Allocation: 20.5%

PLANNING, ADMINISTRATION, AND EVALUATION

This section describes the use and administration of 314(d) funds by Texas in relation to ten Federal requirements pertaining to the block grant.

Planning Requirements

In Texas, basic planning requirements have been met in part. Internal setting of priorities and objectives for 314(d) expenditures has been undertaken, but requirements concerning the involvement of 314(a) and 314(b) agencies have not been complied with.

Provide services in accord with the adopted 314(a) Comprehensive Health Plan of the state. The governor's Office of Comprehensive Health Planning was, until recently, the 314(a) agency in Texas. It has now been disbanded, and its functions are performed by the Bureau of State Planning and Health Resource Development contained within the Department of Health Resources.

For most of the period in which the block grant has been in effect, there was no 314(a) health plan. In 1974, a plan was completed. However, it is not comprehensive in effect. No statewide documentation or analysis of health needs was undertaken. Rather, the plan is a compilation of individual area health needs as documented by the 24 314(b) agencies throughout Texas.

Following receipt of data collection by 314(b) agencies, the governor's Office of Comprehensive Health Planning formulated a list of specific issues to be addressed in programmatic terms. However, no specific means of implementation were recommended.

Discussions with the former acting director of the 314(a) agency revealed that the agency viewed its role as one of providing guidance to the 314(b) agencies throughout the state in order to provide basic health planning services to areas which previously had none. Particular emphasis was given in those areas to collection of data and a study of methods to address health needs.

This emphasis on providing basic local health planning services explains the lack of a statewide analysis in the current 314(a) plan. There is, as a result, no comprehensive 314(a) plan by which 314(d) expenditures for either public or mental health services can be evaluated.

Specify the extent to which services to be provided are to be directed at public health areas of high priority, are of high quality, and will reach people in local communities in greatest need of such services. The public health services supported with 314(d) funds are essentially the same as those funded by the prior Federal categorical grants. The Department of Health Resources decided to continue these categorical programs because its director and five deputy directors felt they were valid activities which address the public health needs of Texas.

There has never been a formal statewide priority setting process carried out by the DHR. Priorities have always been established by the director's office utilizing input from various program officers. This informal process has been coordinated both with staff officials serving as liaison to local health departments and with those personnel who coordinate priorities with regional administrators and regional program officers.

For FY 1975, the department, pursuant to legislative mandate, has established a program budget process. Allocation of 314(d) moneys along with other Federal and state moneys, is now made after both an examination of specific program objectives and an analysis of the alternative methods which could be employed to achieve those objectives.

314(d) funds provide public health services both through the operational programs of the department on a statewide basis and through funding of salaries of staff

in the regional offices (predominantly Region 7) and the 69 local health departments throughout the state. All such allocations are now made pursuant to the program budget process.

In the allocation of 314(d) funds to support salaries of local health departmental staff, the department seeks to provide services in areas of greatest need. For FY 1975, 48.8 percent of the block grant is so utilized. The designation of specific categories of personnel and of particular levels of support to local health departments was made originally by the department on an informal basis. It was essentially an evaluation of the needs of each department. Over the years of the block grant, salaried positions have tended to be continued each budget period.

The Department of Mental Health and Mental Retardation has consistently allocated the major portion of the block grant for the purpose of providing mental health services to communities which do not have operational mental health centers (for FY 1975, such expenditures constitute 70.65% of DMHMR's 314(d) allocation) or to such centers in the earlier years of their operation which were in need of supplemental funding.

There is no particular criteria or priority setting process by which the department decides what communities are of greatest need. Rather, staff of the Division of Community Services utilize citizen input and their knowledge of the state's mental health needs to determine the localities with which to contract in order to support community-based mental health services utilizing 314(d) funds.

Consider the comments of state 314(a) and regional 314(b) Comprehensive Health Planning agencies in preparing the resource allocation to services in the 314(d) state Plan(s). For Texas there is no separate 314(d) plan for public health services. This has been the case ever since the Department of Health, Education, and Welfare approved the simplified state plan process by which 314(d) plans could be incorporated by reference to state documents and administrative procedures.

Therefore, the governor's Office of Comprehensive Health Planning did not review a 314(d) plan. In fact, only in one instance did the office review the total public health budget for Texas. However, the 314(a) agency did, in the past, review copies of the Department of Health Resources' (and its predecessor, the Department of Health) 314(d) budget requests.

The review and comment process had been made difficult by the fact that there was no formal contact between the 314(a) agency and the department. Rather, the agency reported directly to the governor's office, which characteristically minimized the role of a 314(a) agency and showed no interest in comprehensive planning for health service delivery. However, now that the responsibility for statewide comprehensive health planning has been assigned to the Bureau of State Planning and Health Resource Development (an advisor to the director of health resources), more communication between health services planners and providers may result.

For mental health services, the Department of Mental Health and Mental Retardation prepared a 314(d) plan in 1968. This task was performed by the Division of Community Services. The 314(d) plan for mental health, a flexible, goal-oriented document, has remained essentially unchanged since the adoption of the simplified state plan process in FY 1970.

There was almost no review of this plan by the 314(a) agency, which maintained minimal contact with the DMHMR. Informal communication was accomplished, however, through the fact that the former commissioner of the department was originally a director of the governor's Office of Comprehensive Health Planning.

Similarly, there has been no formal comment and review process undertaken by the state's 314(b) agencies in regard to 314(d) expenditures. Their activities have been largely confined to the collection of data and documentation of local health needs in particularized areas of Texas.

Allocate funds so that public health services are significantly strengthened in various political subdivisions of the state (including the funding of other public or private non-profit agencies to assure maximum participation of local, regional, and metropolitan agencies). For public health there is no direct pass through of 314(d) funds to political subdivisions. A significant portion (48.8% in FY 1975) of the block grant is used, however, to totally support the salaries of local health departmental staff. Recipients are local units of government. There are no private non-profit agencies receiving this service.

For mental health, 314(d) funds are used to strengthen services in localities without community mental health centers. Contracts are made with both local units of government and private non-profit agencies for the provision of counselling services and outreach clinics.

Define health services to be provided in terms of specific objectives. The Department of Health Resources budgets funds, both Federal and state, utilizing a management-by-objective process. Each program is analyzed in terms of the public health problem it

addresses; the objective to be accomplished; and methods of service delivery by which goals and objectives can be met. These objectives are determined by the deputy director of the department and various program officials. Allocations of funds are then made pursuant to this program budget process.

The Department of Mental Health and Mental Retardation does not utilize specific objectives in its allocation of 314(d) funds. Rather, the Division of Community Services has, in recent years, allocated the block grant with the broad objective of providing mental health services to areas which have no organized community centers in order to eventually expand the department's grant-in-aid network.

Provide for the review and modification of the 314(d) state plan(s) as appropriate on an annual basis by the state health agency and state mental health agency. Since the simplified state plan process came into effect, there has been no separate 314(d) plan for public health in Texas. Block grant expenditures are reviewed each year as a part of the DHR's regular budget process. In addition, alterations in the level of 314(d) funding sought by program officers must be accompanied by a formal budget revision request presented to the Bureau of Supporting Services. Following such a request, 314(d) expenditures are reviewed and modified in terms of a management-by-objectives analysis.

The Department of Mental Health and Mental Retardation still has a 314(d) plan. However, it has not annually reviewed and modified the plan since the initiation of the simplified state plan. Nevertheless, the Division of Community Services prepares an annual progress report in which it analyzes activities supported by 314(d) funds.

Administrative Requirements

In the State of Texas, the three basic administrative requirements have been met. The administrative requirements are:

Provide for the state administration or state supervision of local administration of the funds by the state health agency and state mental health agency. Although the 69 local health departments in Texas are not technically a part of a state-administered public health services program, they are required to meet certain regulations imposed upon them by the Department of Health Resources in order to qualify for receipt of state and Federal moneys, including staff positions funded by the 314(d) block grant. These requirements include:

- submission of a budget request on a standard DHR form which includes documentation of local expenditures for public health and an evaluation of the percentage of time each staff member spends on activities;
- monthly reports of the activities carried out by the health department; and
- assurances that all personnel meet minimum state merit system qualifications.

These requirements result in a significant degree of administrative control imposed by the DHR. In fact, one reason the department allocates 314(d) funds to support local health departmental staffs is to ensure this degree of control over the operation of local health departments, which are otherwise not constrained by any programmatic guidelines of the DHR.

Similarly, the Department of Mental Health and Mental Retardation imposes certain requirements upon the local governments and private non-profit agencies with which it contracts to provide mental health services supported by 314(d) funds. Among these prerequisites are that the recipient:

- file quarterly budget reports and programs narratives;
- maintain documentation of all patients treated; and
- operate a facility in accordance with the standards of case contained in the departmental *Rules, Regulations, and Standards* for community MHMR centers, where applicable.

Assure that the block grants will not be used to supplant other non-Federal funds. The Department of Health Resources does not supplant non-Federal funds in its allocation of 314(d) block grants, either in operation of its own programs or designation of 314(d)-supported salaries of local health departments. In fact, block grants comprise but 3.4 percent of a total public health budget of $108 million. The majority of that amount is comprised of state revenues.

The Bureau of Supporting Services coordinates the budget requests for 314(d) funds within the department and ensures that state funds are not displaced by the block grant. This is accomplished by requiring each program officer in the department to submit an annual expenditure report with an assessment of the time spent on 314(d)-supported activities. On the basis of this information, bureau personnel are able to discuss the

Texas matching share of 314(d) funds and maintain state spending at a level at least equal to that of the previous year.

For mental health, the Budget and Finance Division of the DMHMR is responsible for ensuring that state maintenance of expenditures meets the necessary level. Recipients of 314(d)-provided services are required to match the Federal funds to the extent of their financial capability, but the 314(d) funds are actually matched on the departmental level prior to their allocation.

Require recipient agencies utilizing 314(d) funds to participate in the costs of the supported services. Both the Departments of Health Resources and Mental Health and Mental Retardation require recipients of 314(d)-supported activities to contribute funds to the best of their ability. In the case of public health, a 50-50 match is sought but not mandated. Both departments ensure that the block grant is matched by state revenues to the extent that local funds are unable to provide the necessary amount.

Evaluation Requirement

In Texas, this requirement has been met in qualitative, and in part, quantitative terms.

The requirement for evaluation is:

Provide methods of evaluating the performance of activities carried out with 314(d) funds. The Department of Health Resources in adopting a program budget process has begun to address this requirement more fully than has been done in the past. Although costs per capita for service delivery are projected, objectives of public health programs are still presented in relatively qualitative terms. As such, evaluation of 314(d)-supported activities can not be anticipated in terms of quantitative achievement of objectives.

The Department of Mental Health and Mental Retardation has utilized the block grant with the broad objective of providing mental health services in communities without established treatment centers. Its program analysis and statistical research activities do, however, break service delivery down into unit costs. In addition, documentation of patient in-and-out flow, types of treatment, and time expended for treatment is maintained. In this manner, DMHMR is able to evaluate relative increase and decreases in the provision of mental health services to the residents of Texas.

CHANGES ATTRIBUTED TO THE BLOCK GRANT PROCESS

The block grant mechanism led to no discernible change in the procedures for allocating Federal funds to provide for public health or mental health services in Texas. Neither has it effected an alteration of expenditures of Federal moneys by the Department of Health Resources. The Department of Mental Health and Mental Retardation, however, has significantly changed its utilization pattern in the transition from a categorical to a block grant.

Both the DHR and DMHMR have retained their basic methods of allocating Federal funds. The 314(d) block grant passes through the normal budget process just as prior categorical funds did. Allocations are still based upon a prioritization of expenditures which is an internal process. Priorities are decided upon informally by key staff officials charged with responsibility for allocating 314(d) funds. In the case of public health, the DHR has adopted a program budget which allocates both Federal and state moneys pursuant to stated objectives. However, this process, which just began in FY 1975, is a result of legislative mandate and not the presence of block grant funds and their accompanying Federal regulations.

The Department of Health Resources has utilized 314(d) funds, with one exception, to continue operational programs which were in part supported by prior categorical grants. These programs provide public health services on the local level on a statewide basis – inuring to the benefit of local health departments and regional offices; they also provide the salaries of some 300 employees working in local health departments.* The exception to this pattern is that Public Health Region 7 initially received full suppport from the block grant in 1971, and, to date, one half of the core staff is salaried by 314(d) funds. The block grant has also had no effect on the level of DHR's usage of present Federal categorical funds which it seeks to secure whenever they are available.

The Department of Mental Health and Mental Retardation significantly altered its usage of Federal funds with the advent of the block grant. In order to provide 70 percent of its 314(d)-funded activities on a community level, the department changed its emphasis from funding a central staff in the Community Services Division to providing direct mental health services to local areas of population throughout Texas.

Both DHR and DMHMR consider the block grant an important portion of their work program. The DHR views 314(d) funds as a needed supplement to revenues designed to provide services to both local health departments and regional offices. Its staff considers the funds

*Information from Bureau of Supporting Services, TDHR.

to be the initiating source behind its major innovation of recent years — the decentralization of public health regions. DHR officials feel, however, that the low level of funding provided under the block grant has constrained the initiation of further innovative programs. DMHMR officials believe the block grant instrumental in expanding its network of grant-in-aid community services to its present level.

For mental health, the block grant mechanism has led to an increased involvement between local units of government and state authorities, with local officials having increased participation in the mental health program of Texas. 314(d) funds, used as "seed money," have supported contractual "bridging services" which provide basic mental health programs where none previously existed. The funds have, therefore, provided initiative to local communities eventually becoming a part of the state network of MHMR community centers.

In public health, however, there has been almost no awareness on the local level of 314(d) funds. In fact, until the possibility arose this fiscal year that block grant moneys would be rescinded, local health officials viewed 314(d) as a label under which certain staff personnel were provided by the state. Now, local officials are more aware of the block grant program, but they know very little about its purpose, scope, or administration by the Department of Health Resources.

Department of Health Resources officials perceive that block grant funds have indirectly led to an increased involvement of the state legislature in the Texas public health program. Although the legislature is not specifically aware of 314(d) funds, it was the block grant which initiated operation of the state's public health regions. Following the activation of Region 7, the legislature has appropriated state funds to activate the other operational regions in the state.

Both DHR and DMHMR officials feel that the block grant is more flexible than the prior categorical grants. In particular, DHR officials cite the fact that they are able to shift 314(d) funds from one operational program to another, a practice which could not be undertaken with the prior categorical funds.

Public health and mental health authorities in Texas feel that the block grant program has stimulated the expenditure, on state and local levels, of additional funds for the provision of health services.

Department of Health Resources staff point to the activation of five public health regions subsequent to the organization of Region 7, supported originally in its entirety by 314(d) funds, as evidence of additional expenditures on the state level. The block grant is considered to be the impetus to the legislative appropriations for these regional units. There is no documentation that the block grant has stimulated increased local financial participation. However, state officials perceive that an atmosphere has been created in which local officials are more cognizant of public health needs, and thus, more likely to appropriate additional funds to address these needs.

The Department of Mental Health and Mental Retardation attributes a degree of the state grant-in-aid system's expansion to the block grant. It is felt that the expenditure of 314(d) funds on the local level has provided a good deal of initiative to local authorities to expand or initiate mental health services.

The relationship between Federal regional officials of the U.S. Department of Health, Education and Welfare and the DHR and DMHMR has been significantly affected by the advent of the block grant.

Under prior categorical grants, there was a more extensive interaction between DHR and Federal officials, who had significant input into the programmatic aspects of activities supported by Federal moneys This interaction consisted of HEW officials assisting in preparation of, and commentary upon, the operational programs of DHR. Since the adoption of the simplified state plan process, however, Federal participation in the Texas public health program has been minimal, consisting of the on-site review which is a part of that process.

In mental health, the block grant initially resulted in increased contact between HEW officials and the Department of Mental Health and Mental Retardation. As was the case for public health, Federal officials had extensive input into the preparation and review of programs supported by 314(d) funds. Prior to that time, the Federal administrative role had been minimal since the DMHMR had utilized almost all of the Federal categorical grant for mental health to support the salaries of staff on the Division of Community Services. Under the simplified state plan, however, DMHMR has utilized an essentially unchanged 314(d) plan and has not sought input from Federal regional officials. Consequently, HEW contact with the Department of Mental Health and Mental Retardation has once again become minimal.

SUMMARY AND CONCLUSIONS

Responsibility for the allocation and utilization of the 314(d) block grant in Texas rests in public health with the Department of Health Resources and in mental health with the Department of Mental Health and Mental Retardation. Both departments set priorities internally for allocation of the block grant. Neither has

significantly changed its policies for allocation of funds as the transition was made from categorical to block grants.

Similarly, the Department of Health Resources has maintained a stable expenditure pattern for the 314(d) funds in utilizing the block grant to supplement operational programs and to support the salaries of staff in local health departments across the state. The Department of Mental Health and Mental Retardation, however, significantly changed its direction of 314(d) expenditures. The block grant has been shifted from support of central office personnel at DMHMR to the provision of direct mental health services on the local level for the purpose of expanding a statewide network of community centers.

Allocation and utilization of 314(d) funds has not resulted in a coordinated approach to public health services delivery in Texas. In mental health, however, the block grant has reflected, to a limited degree, a systemwide approach in addressing the mental health needs of the state.

This effect is visible in the linkage between DMHMR officials and local governments in administration of the department's 314(d)-supported contractual services to areas without organized community centers. The program has resulted in increased local participation in the state's mental health activities and a communication between state (Division of Community Services) officials, local government, and community-level citizen boards.

In public health, Department of Health Resources officials cite the block grant as increasing the involvement of the state legislature in the public health program for Texas. This has occurred through 314(d) funding of Public Health Region 7, which is credited with giving impetus to the legislature's subsequent appropriation of state revenues to activate five more public health regions.

These changes are, however, limited in scope and are not the comprehensive systemwide approach that Congress envisioned in the passage of the *Partnership for Health Act.* There has been no overall planning for health services delivery in Texas. Nor has there been citizen participation in the 314(d) program beyond the DMHMR's coordination of local input in its efforts to expand mental health services delivery. And, while the Texas legislature may well have taken an active interest in the establishment of public health regions, it is not conscious of 314(d) funds in its approval of either the state's public or mental health budgets.

In addition, the state's 314(a) agency, prior to its being disbanded, played no role in the allocation of block grant funds, nor did it undertake comprehensive planning activities: its thrust largely being to coordinate and guide the state's areawide planning agencies in their endeavors to assess local health needs in the communities they served.

Both public health and mental health authorities have attempted to utilize 314(d) funds on the community level. In the case of public health, the Department of Health Resources addresses the 70 percent requirement through its statewide operational programs and allocation of almost 50 percent of its 314(d) funds to salaries of local health department staff. There is no assurance, however, that public health services are significantly strengthened in political subdivisions throughout the state or directed to areas in greatest need of such services.

On the other hand, the Department of Mental Health and Mental Retardation provides mental health services on the state level (program analysis and statistical research) and on the local level (initiation or expansion of services in areas without community centers). These services represent in excess of 70 percent of the department's 314(d) allocation for FY 1975.

Other planning requirements have been met by both the DHR and DMHMR. One significant exception is that neither public nor mental health 314(d) expenditures have been made in accord with the comprehensive health plan of a 314(a) agency; nor have comments on specific expenditures been obtained from 314(a) or 314(b) comprehensive health planning agencies.

Evaluation and administration requirements for 314(d) funds have essentially been met in Texas, although evaluation of services, particularly in public health, is not undertaken in quantitative terms.

In sum, the block grant mechanism has not resulted in a significant departure by public or mental health officials in their allocation of Federal funds for health services delivery. Utilization patterns have remained stable for public health expenditures while 314(d) funds have increasingly been passed to local units of government and private non-profit agencies. However, 314(d) funds have been credited with providing initiative to the decentralization of health services through the creation of public health regions and the provision of mental health services to communities which previously had none.

Virginia

The commissioners of the Departments of Health and Mental Health and Mental Retardation administer two free standing state agencies which have not been consolidated into a unified department of health or human resources. Interagency coordination is achieved through the Office of the Secretary of Human Affairs. This gubernatorially appointed, cabinet-level position acts as coordinative unit for the two departments and nine other state health and human affairs commissions and agencies. The office is not an umbrella agency; rather, the secretary serves the governor in an advisory capacity, addressing general problems and setting broad budgeting priorities in the field of human affairs.

The Bureau of Comprehensive Health Planning, the state 314(a) agency, is a division of the Virginia Department of Health. The bureau serves as an advisor to the commissioner of the department and it establishes broad goals and objectives for the delivery of health services in Virginia. However, it has no policy implementation authority and, although the Bureau reviews both the Departments of Health and Mental Health and Mental Retardation's budgets, it is not instrumental in setting priorities to guide utilization of 314(d) block grant funds.

Table 1 depicts the relationships between the various Federal and major state agencies involved in the disbursal and utilization of 314(d) block grant funds in Virginia.

Administration of the annual allocation of 314(d) funds within the Commonwealth of Virginia involves both the Department of Health and the Department of Mental Health and Mental Retardation. These state agencies receive and administer 85 percent and 15 percent of the Virginia 314(d) block grant respectively.

The Department of Health initially prepares, annually reviews, and recommends changes, if any, in the 314(d) expenditures for public health. The commissioner's office is responsible for administration of the $1.64 million current annual 314(d) allocation to public health in Virginia.

Under existing policy set forth by the commissioner of health and approved by the state legislature in appropriating moneys for the public health budget, the current public health portion of the block grant ($1.64 million) is incorporated in the Division of Local Health Services' part of the Department of Health's budget. 314(d) funds are identified in the budget, but the legislature has never taken any specific action in regard to block grant moneys.

State and local funds, in 1975, constituted approximately $37 million, or 96 percent of the division's budget. Block grant funds provided the remaining 4 percent. The maintenance of local level effort for Virginia is $16 million so that non-Federal public health expenditures are far in excess of the matching requirements of P.L. 89-749.

All 314(d) public health funds are allocated to local health departments in Virginia. State law provides that each city and each county may create and fund a local health department and that governing bodies of local health districts may enter into a contractual agreement with the Virginia Department of Health for the operation of local departments. Further, these local health departments are authorized to administer services jointly.

Consequently, the 136 Virginia local general purpose governments have created 38 multijurisdictional health districts for delivery of public health services. Budgeting of local funds and submission of requests for state support is carried out by each of the supporting local governments. They, in turn, make funds available to health districts or to their health department as appropriate. Health departments may provide services or may join for the provision of services in a larger geographic area as a health district.

There are eight areawide comprehensive health plan-

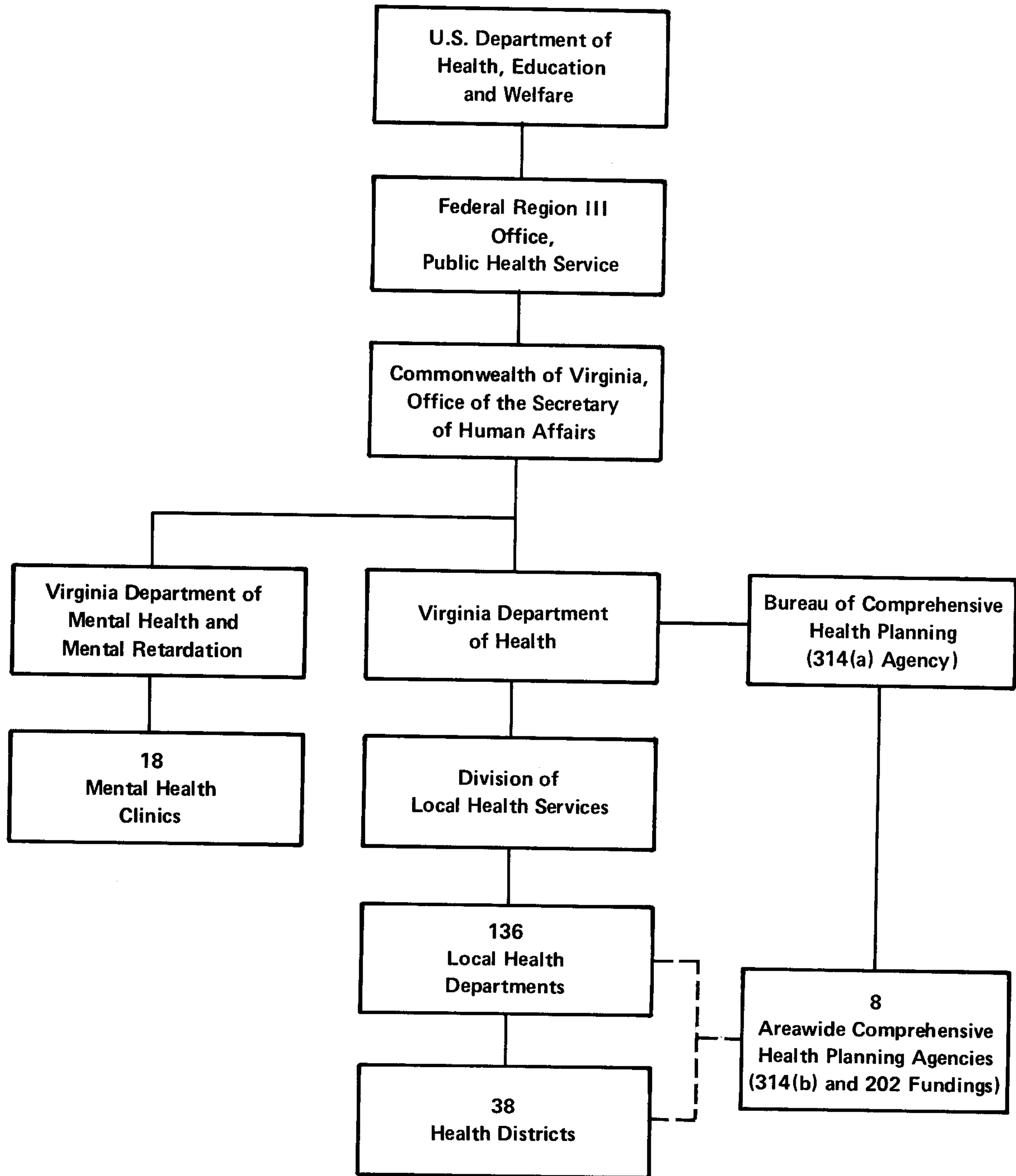


Table 1
Agencies Related to the 314(d)
Block Grant Mechanism in Virginia
U.S. Department of
Health, Education
and Welfare
Federal Region III
Office,
Public Health Service
Commonwealth of Virginia,
Office of the Secretary
of Human Affairs
Virginia Department of
Mental Health and
Mental Retardation
Virginia Department
of Health
Bureau of Comprehensive
Health Planning
(314(a) Agency)
18
Mental Health
Clinics
Division of
Local Health Services
136
Local Health
Departments
8
Areawide Comprehensive
Health Planning Agencies
(314(b) and 202 Fundings)
38
Health Districts

ning agencies in Virginia funded jointly by Federal and local moneys. Two are public agencies while six are private non-profit corporations. These eight agencies which cover more than 71 percent of the state's population are not linked formally to the state (a) agency, the Bureau of Comprehensive Health Planning.

The eight 314(b) agencies are linked informally to the Bureau of Comprehensive Health Planning in that they file quarterly activity reports with the 314(a) agency for that agency to review. In addition, these 314(b) agencies receive consultation from the bureau on such matters as plan development, data maintenance, and project review. There is, however, no communication particularly in regard to the planning for utilization of 314(d) funds.

Other areas of the state rely upon a similar network of areawide health planning agencies which operate without Federal funds as part of regional substate district planning agencies, which provide varying degrees of health planning and project review support.

The Office of Community Mental Health Services in the Department of Mental Health and Mental Retardation initially prepares, annually reviews, and recommends changes, if any, in the expenditure of 314(d) funds for mental health services to the commissioner of mental health and mental retardation. Recommendations for change are then presented to the state Comprehensive Health Planning Council for review.

The council serves as an advisor to the Bureau of Comprehensive Health Planning, the 314(a) agency. It is composed of 51 percent consumers and health service providers who are appointed by the governor. In addition to setting broad policies for the Bureau of Comprehensive Health Planning, the council annually reviews the projected 314(d) expenditures of both the Departments of Health and Mental Health and Mental Retardation.

Block grant funds allocated to the Department of Mental Health and Mental Retardation are commingled with the budgeted funds for the Office of Community Mental Health Services. Eighteen mental health clinics provide services to communities throughout the state, using 314(d) fund support.

Virginia is shifting mental health clinic responsibilities from state to local control. State clinics have decreased from 38 to 18 during the past three years. The 314(d) block grant funds for mental health ($290,000 annually) available to the department are used in support of these clinics. Goals, objectives, and priorities for suballocations of 314(d) block grant funds are established by the department and its Office of Community Health Services.

The Virginia case study includes sections providing information on the application of the state's planning, administration, and evaluation methods to influence the use of 314(d) block grant funds. A detailed account is given of the allocation and use of 314(d) funds by the state, including changing patterns of usage since the initial receipt of the funds in the state's 1968 fiscal year. The Virginia case study also includes an analysis of the impacts or changes in the delivery of public health and mental health services attributed to the use of the 314(d) block grant.

BLOCK GRANT ALLOCATION AND USE

This section describes the State of Virginia's experience in terms of the Federal to state allocation; state to localities allocation of the block grant; and utilization of 314(d) funds.

Federal to State Allocation

For the Commonwealth of Virginia, the Federal to state allocation of 314(d) funds may be illustrated at three points in time. They are the following fiscal years:

- 1968, when the first 314(d) allocation was received and disbursed by the state;
- 1970, when the amount of the Federal allocation was increased by a revision of the Federal formula; and
- 1975, and the current allocation of the 314(d) funds.

Under the initial Federal allocation formula, Virginia received a block grant sum of $1,307,700. Of this total, $1,111,500 was allocated to the Department of Health and $196,200 to the Department of Mental Health and Mental Retardation. At the time of the transition from categorical health service grants to the 314(d) block grant, Virginia was utilizing seven of the nine categorical grants replaced by 314(d) funds. Those not used were home health services and chronic illness and the aged. Interviews with staff at the Department of Health reveal that there was virtually no change in the level of Federal funds as a result of the transition from categorical to block grants.

At the end of 1966, Federal categorical grants to the state for mental health were $143,253. With the shift from categorical funding, the Department of Mental Health and Mental Retardation began receiving mental health services block grant support at $196,200 for 1968, an increase of 37 percent. Fund distribution did

not change. The state network of mental health clinics was the recipient of the block grant support.

In the 1970 fiscal year, the Federal allocation formula was adjusted to eliminate the rural weighting factor and a part of the tuberculosis control categorical grant was added to the 314(d) block grant to provide additional Federal funding.

Virginia had been receiving tuberculosis categorical funds approximating $254,000 annually prior to 1970. When the categorical funds for tuberculosis control terminated in 1970, Virginia's 314(d) block grant increased to $2,010,700.

Although application of the Federal to state allocation formula resulted in small adjustments in the Virginia allotment between 1970 and 1975, the size of the annual grant declined slowly to $1,933,300 for FY 1975. The following table summarizes the three benchmark years and funding levels as provided by the Public Health Service, Region III and central office, Rockville, Maryland.

The Virginia block grant recipient agencies review their overall departmental budgets with the Bureau of Comprehensive Health Planning and the Virginia Comprehensive Health Planning Council. The Office of the Secretary of Human Affairs and the governor's office also review the annual budget requests, and the state legislature approves the entire budget for both public and mental health. 314(d) funds are identified in the budget, but the legislature has never taken an action specifically based on the presence of 314(d) funds.

State to Localities Allocation – Public Health

In Virginia, 314(d) block grant funds for public health are mixed with state-appropriated health services funds to be channeled to the 136 local health departments in the state. State budget procedures treat block grant funds as state funds insofar as intradepartmental priority setting is concerned. The 314(d) funds are actually allocated to the Department of Health's Division of Local Services which, in turn, has responsibility to allocate them to local health units.

To adequately explain the allocation of block grant funds by the Virginia Department of Health, an explanation of the nature of the state-local structure for public health services must be presented. Virginia's cooperative plan for the provision of public health services represents a partnership between state and local governments seeking to provide comprehensive health services to the people in the commonwealth.

In 1954, the general assembly of Virginia passed enabling legislation for a system of local health departments. It provided two things: first, for any county or city, or any combination thereof, to create a district health department; and, second, for the governing body of the district health department thus formed to enter into a contractual agreement with the state health department for the operation of the district health department.

The local health director, recruited and employed by the Department of Health with the concurrence of the local governing body, is the key individual in the operation of the partnership. He is responsible for the administration and direction of all health services and program activities within broad program standards and policies established by the state department of health.

The contractual negotiations in creating and operating the partnership are centered around the annual development of a budget for the local health district or department. The budget is initiated locally by the local health director in consultation with the local governing body. It is then presented by the local health director to the department of health for fund matching.

Financial support of the local health department is

Table 2
Virginia
314(d) Block Grant Fund Allocations

	1968	1970	1975
Public Health	1,111,500	1,700,100	1,643,300
Mental Health	196,200	310,600	290,000
Total	1,307,700	2,010,700	1,933,300

shared by the state and the locality under a formula based on the locality's ability to pay. Using the estimated true tax value of the locality at a certain date, the county with the lowest tax value supports 18 percent of the operation of the local health department; the counties or cities with the highest value provide 45 percent. The state, therefore, contributes no less than 55 percent and no more than 82 percent to the operation of local health departments.

Prior to July 1, 1954, financing for local health departments varied considerably due to numerous factors such as size of area, density of population, number of personnel furnished, and local financial resources. In years past, when there were fewer local health departments, the amount of state and Federal funds available for distribution tended to result in a state practice of requiring only a very small portion of the total operating budget from local sources. A reluctance on the part of many local areas to assume financial liability for local health services whenever it was possible to have these obligations met from state or Federal sources resulted in a relatively low percentage of the costs being borne by the localities.

The many inequities that were apparent in the total amounts contributed locally toward the overall cost of operation of local health departments demonstrated the need for the development of a state formula to provide a more equitable and rational approach to the financial participation of the individual localities in the support of health departments. It was this rationale which served as an impetus to create legislation enabling a partnership arrangement between state health authorities and local units of government.

An attempt to develop an equitable formula was the subject of considerable effort by various committees representing state and local departments of health during the two-year period prior to July 1, 1954. A formula evolved based upon the estimated true value of the locally taxable property in relation to the overall operating costs of the local health service. This formula was placed into operation July 1, 1954.

The formula is particularly adaptable to the needs in Virginia and the centralized health department system, with the localities arranged in districts and each paying into the state Department of Health a calculated proportion of the cost of operation of local health services. The base calculation is determined from an estimate of the overall operating cost for the local department. These costs include the personnel considered as permanent members of the local health department staff and those other factors concerned in the cost of operating a health department in a given locality.

The formula embodies the principle of giving some advantage to those localities less able to pay and fixes the greatest financial burden on the wealthiest areas. In setting a standard of not less than 20 percent nor more than 45 percent of health department costs to be borne by local governments, consideration was given to the pattern of local appropriations in the past. A minimum local support level of 20 percent of department annual costs was established. Forty-five percent was fixed as the maximum appropriation expected from the wealthiest county. An effort was made to secure appropriations locally according to the formula, effective July 1, 1954. Considerable readjustment of local budgets was necessary for a number of localities. The Department of Health permitted localities to appropriate the full amount required locally over a period of one, two, or even three years as circumstances warranted.

Since the fiscal year beginning July 1, 1957, each jurisdiction has been charged the exact percentage of the estimated cost of the budget for their local health department as determined by formula. This method of procedure is now a definite and fixed operational policy of the department.

Each locality pays on the basis of the estimated true value of its locally taxable property as determined by the state Department of Taxation. This formula requires local participation of a maximum of 45 percent and a minimum of 20 percent of the total local health department budget. The locality with the lowest estimated true value is assigned 20 percent.

During 1964, a joint study committee composed of officials of the League of Virginia Counties and the Virginia Municipal League was formed to review the workings of the formula percentage arrangement of determining local appropriations for financing local health department operations. This committee recommended: (1) revision of the formula percentages for all localities as often as possible in order to keep it current with the latest available estimated taxable values; (2) the percentage of the locality with the lowest estimated taxable value be reduced from 20 percent to 18 percent; and (3) an estimated value of $391,951,000 be used as the maximum estimated tax value for a locality in the formula while localities with estimated values above this figure be expected to contribute the maximum percentage (45%). These recommendations were subsequently adopted by the Department of Health.

Application of the formula is as follows:

1. Each local health department or district director formulates a proposed budget for the upcoming fiscal year. Budget propos-

als are submitted to the Department of Health.

2. Department of Health staff aggregate the local health department budgets. Estimated 314(d) funds available to the state are added to the proportion of the local departmental requests to be provided by local funds – according to the formula. Funds needed to balance the local health department assistance part of the Department of Health budget are requested from the general assembly.

3. Upon adoption of a state budget, the combined state funds and 314(d) funds are distributed to the 136 local health departments according to the match formula. There is no indication given to the local governments that block grant funds are included in this partnership support from the Department of Health.

The local share is earmarked to the Department of Health by the supporting local government(s) where it, along with block grant funds allocated to the state, is considered as revenue to be appropriated by the state legislature.

Through the enabling legislation which allowed the development of this partnership plan, every local government unit in the state has now contracted with the Department of Health for the operation of a local health department, and thus receives 314(d) funds.

State to Localities Allocation – Mental Health

In Virginia, all 314(d) block grant funds allocated for mental health services annually by the U.S. Department of Health, Education and Welfare are directed to support of mental health clinics. The Department of Mental Health and Mental Retardation is responsible for maintaining the clinic program element of the state's mental health services delivery system.

The department is carrying out its policy which calls for the transfer of state-owned and operated clinics to a network of community-operated clinics. At the present time, 18 facilities remain under state ownership. These clinics are the recipients of the full amount of block grant funds. They are primarily found in rural areas or less populated communities.

Operation of the state-owned clinics is not supported exclusively by state and Federal funds. From the period when Virginia received categorical grant funds for mental health services, local support of clinics and services has been a part of departmental policy. In 1966, local funding accounted for more than a third of the community mental health services budget. By 1975, though, the total community mental health services budget had risen from $1,356,220 to $11,021,829 during the nine years, local support was 15 percent of the total.*

Allocation of 314(d) block grant funds to the state clinics is the responsibility of the Office of Community Services. Allocations are made to the clinics in proportion to their level of support.

The Office of Community Services seeks to require 50 percent local matching for the funding of state clinics. However, this policy is not rigid; and in some poverty stricken areas, state and accompanying 314(d) moneys support the entirety of mental health services. There are no specific criteria used to determine what the local capacity for support should be. This is determined in negotiations between local authorities and office staff who base their decision both on financial considerations and the feasibility of implementing programs projected for the clinic.

Three allocations are included in the block grant allocation for categories without local support: clinics at the Medical College of Virginia and the University of Virginia, and a 1 percent deposit to the state merit system for administrative purposes.

Determination of funding priorities has been set by the Office of Community Services to strengthen the statewide clinic network of pre-care and after-care mental health services. That emphasis has persisted through the period of categorical grant support to the present mix of block grant-state-local mix of funding for mental health facilities and services in Virginia. It has also been the policy of the department and office to utilize 314(d) funds either for the expansion of existing programs or support of new projects.

In 1971, amended state legislation for delivering of mental health services in Virginia provided for formation of areawide, "Chapter 10," mental health boards to develop plans and priorities for community health. The boards are created by local units of government, and their members are appointed by local elected officials.

"Chapter 10" boards negotiate directly with the Department of Mental Health and Mental Retardation for allocations of state funds. Prerequisites to receipt of such moneys are an adopted program and budget

*Information provided by the Division of Administration, Virginia Department of Mental Health and Mental Retardation.

approved both by the local governing body and DMHMR.

Block grant funds made available to clinics between 1971 and 1975 have been visualized as a means of stimulating and strengthening those new institutions. As they have reached a state of institutional and financial independence, state clinics have been transferred to local control.

State funds, without block grant support, are channeled to 14 clinics now under local control which were transferred from state ownership during the past five years.

State officials conclude that allocation and use of 314(d) mental health funds channeled to clinics have facilitated the objectives of strengthening services and increasing responsiveness to local needs by allowing effective development of the community-centered policy mechanisms – the "Chapter 10" boards.

Public and Mental Health Utilization

Utilization patterns for 314(d) block grant funds have been relatively stable in Virginia. With one exception, in public health, the moneys have been used in the same manner throughout the 314(d) program. Similarly, uses of 314(d) funds for mental health services have not varied significantly.

In fact, the transition from categorical to block grant funding had no effect on the Department of Mental Health and Mental Retardation's expenditure of Federal moneys. Community mental health centers have continued to date to be the recipient of 314(d) funds.

These clinics are able to use block grant funds at their own discretion. The Department of Mental Health and Mental Retardation only requires that expenditures be compatible with its broad objectives. There has yet to be a case, however, in which a clinic's program failed to meet these broad objectives.

It is not possible to categorize mental health services provided by 314(d) funds, which are commingled with state moneys when allocated to the clinics. Discussions with staff of the Department of Mental Health and Mental Retardation reveal that community clinics provide such a wide range of services, each particularized to the needs of an area, that they could not assess what services generally are funded in part by the 314(d) block grant.

In the provision of public health services, too, the

Table 3

Public Health Expenditures of 314(d) Funds in the Commonwealth of Virginia, Fiscal Year 1968*

	314(d)	State and Local	Total
Administration	$ 22,000	$ 276,495	$ 298,495
Tuberculosis Control	76,900	649,850	726,750
Nursing Homes	15,000	-0-	15,000
Cancer Control	74,600	123,875	198,475
Dental Health	22,000	301,100	323,100
Radiological Health	29,265	29,265	58,530
Health Education	12,000	62,360	74,360
Laboratories	15,000	532,610	547,610
Heart Disease	70,110	-0-	70,110
Medical Rejectee	25,000	-0-	25,000
Local Health Districts	749,625	12,987,195	13,736,820
Total	$1,111,500	$14,962,750	$16,074,250

*Table contained in Virginia Department of Health's FY 1968 314(d) plan.

transition from categorical to block grant funding had little immediate effect upon expenditure patterns. In FY 1968, the first year of the block grant, the Department of Health received virtually the same amount of Federal funding as it had the previous year. Expenditures were made pursuant to a 1968 314(d) plan which utilized funds in the same manner and amount as had been done in FY 1967.* *Table 3* presents these expenditures by category and is based upon information provided by the Bureau of Vital Records and Health Statistics of the Virginia Department of Health. It is followed by a brief discussion of the role of the 314(d) dollars in each category of health service.

- **Administration.** 314(d) funds were utilized to aid the Department of Health in providing overall administrative supervision to assure localities of public health programs consistent with recognized criteria.

- **Tuberculosis Control.** Clinicians and nurses based in the central office maintained a statewide network of regional chest clinics for diagnosis, treatment, and follow-up care of patients with tuberculosis.

- **Nursing Homes.** The primary responsibility of the staff based in the central office was to render actual services in upgrading nursing homes throughout the state and to maintain quality services for licensure and accreditation.

- **Cancer Control.** 314(d) funds in this program were utilized for three-day hospitalization for diagnosis of cancer; for collecting information at selected local hospitals for incorporation into a central cancer registry; and for a Pap smear cancer detection program available to indigent patients throughout the state.

- **Dental Health.** A locally rendered service program, which provided dental care to approximately 61,000 children, was supported in part by the block grant.

- **Radiological Health.** Federal funds supported radiological health specialists who survey X-ray equipment in the offices of all practicing dentists in the state and in the various local health agencies, doctors' offices, and hospitals.

- **Laboratories.** Funds support the performance of tests on specimens sent in by the localities and local practicing physicians, with reports going back to the localities.

- **Heart Disease.** Block grants supported a program of eight clinics, located in medical centers throughout the state, for the diagnosis and treatment of adult heart disease.

- **Medical Rejectee.** A special project was conducted to support personnel in two local induction centers to provide counseling and referral of medical rejectees.

- **Local Health Districts.** 314(d) funds were disbursed according to the departments' state-local partnership funding formula to be used for the general support of the programs of local health departments.

The 314(d) plan for 1968-69 suggested that 97 percent of the allocated funds would be used for direct health services, with 67.5 percent of the total going to local health districts. Administration and health education were the only activities regarded as those which did not directly provide improved health services to the people of the state.

Following fiscal year 1968, the department's expenditure pattern of 314(d) funds changed significantly and has remained stable. Throughout the remaining years of the block grant mechanism from fiscal year 1969 to date, 314(d) funds have been allocated to the Division of Local Health Services which channels the moneys in their entirety to local health departments to be used at the discretion of the recipient. Local health departments are, however, as partners with the Department of Health, required to meet basic program and administrative requirements of the department.

Each local health department is staffed with a local health director and supportive staff of public health nurses, sanitarians, clerks, dentists, and home health aides. Personnel are responsible for providing the public health services which include:

*Information supplied by the Virginia Department of Health. No specific documentation available.

- immunizations;
- family planning;
- maternal and child health services;
- venereal disease control;
- tuberculosis control;
- crippled children services;
- sanitary sewage disposal;
- food and water inspection; and
- restaurant sanitation.

As was the case in describing the provision of mental health services, it is not possible to accurately assess what particular public health services are provided by the 314(d) funds. *Table 4*, prepared by the Department of Health staff, reflects a breakdown of 314(d) expenditures for FY 1973. These were obtained by listing every program contained within the local health services budget and prorating the percentage contribution of 314(d) funding on the basis of rates of the block grant to the overall budget. This analysis has limited utility especially in light of the fact that local health department officials are not cognizant of block grant funds as an element in their budget. It is, however, the only documentation that the Department of Health has maintained for expenditure of 314(d) funds.

PLANNING, ADMINISTRATION, AND EVALUATION

This section presents the experience of Virginia in terms of ten basic Federal requirements pertaining to the 314(d) block grant.

Planning Requirements

In the Commonwealth of Virginia, the basic planning requirements have been met only in part.

The basic planning requirements are:

Provide services in accord with the adopted 314(a) Comprehensive Health Plan of the state. The Virginia 314(a) agency, the Bureau of Comprehensive Health Planning, has not adopted and published a state comprehensive health plan. There is an unofficial plan which was drawn up in 1968 but was never published.

The bureau does have a set of goals and objectives independent of those of the Department of Health. The 314(a) agency's goals are much broader than those of the department and are in no way specifically related to expenditures for 314(d) funds. Thus, the agency does not take the lead in determining statewide public health or mental health needs for possible 314(d) funding.

Specify the extent to which services to be provided are directed at public health areas of high priority, are of high quality and will reach people in local communities of greatest need of such services. For Virginia 314(d) funds used in public health, state priorities are not set. Instead, the funds are passed through the Division of Local Health Services of the Department of Health to the local health departments to supplement local services.

This approach, along with allocations pursuant to the department's formula, has been used to meet the requirement that the 314(d) funds will reach people in local communities according to their needs. Such a strategy was deliberately selected by the department at the beginning of block grant funding.

Priorities have not been set for mental health services by the Department of Mental Health and Mental Retardation. Community Mental Health Centers receive block grant funds annually to use at their own discretion. This distribution accounts for 100 percent of the mental health 314(d) funds which are utilized by Virginia.

The Department of Mental Health and Mental Retardation plans to allocate any new funds available through the 314(d) mechanism to establish a mental health service evaluation process. This shift in funding will not take place until the remaining state-owned and operated mental health centers are transferred to community control.

Consider the comments of state 314(a) and regional 314(b) comprehensive health planning agencies in preparing the resource allocation to services in the 314(d) state plans. The Virginia Department of Health has systematically considered the comments of the 314(a) Office of Comprehensive Health Planning and its advisory body, the Virginia Comprehensive Health Planning Council, in annually reviewing the department's budget which includes services to be provided with the 314(d) block grant. However, 314(d) plans and, since 1970, the simplified state plan, have not been submitted to the 314(a) agencies for review.

Areawide comprehensive planning agencies work with directors of local health departments, who serve on the boards of 314(b) agencies, in annually reviewing the department's overall, public health program. However, as is the case with the 314(a) agency, no specific review and comment of 314(d) expenditures is undertaken.

The Department of Mental Health and Mental Retardation annually submits any recommendations for changes in 314(d) expenditures to the 314(a) agency and its advisory council for review.

Table 4

Estimated 314(d) Funds by Program and 314(d) Funds as a Percent of Total Dollars Spent per Program by the Virginia State Health Department in Fiscal Year 1973*

	Total Dollars Spent	314(d) Funds Spent	314(d) as Percent of Total Dollars
Total	$40,337,446	$1,634,195	4.1 %
Migrant Labor Project	162,855	369	0.2
Medical Social Work	233,236	12,059	5.2
Home Health Services	424,892	11,953	2.8
Mental After-Care and Illness	1,293,654	66,884	5.2
Public Health Nursing - NPR	5,565,679	287,687	5.2
Maternal Health	2,056,885	63,778	3.1
Child Health	5,626,319	233,137	4.1
PKU and Other Inborn Errors of Metabolism	185,239	4,439	2.4
Child Development (Mental Retardation)	718,585	16,111	2.2
Family Planning (General)	1,623,864	83,818	5.2
Orthopedics (CC)**	2,410,516	66,076	2.7
Facial Deformity (CC)	337,723	4,665	1.4
Pediatric Urology (CC)	329,735	8,324	2.5
Pediatric Surgery (CC)	245,808	6,397	2.6
Eye Surgery (CC)	313,034	9,375	3.0
Congenital Cardiac (CC)	716,813	17,872	2.5
Child Neurology (CC)	901,569	35,584	3.9
Burn Surgery (CC)	57,725	582	1.0
Plastic Surgery (CC)	254,670	5,641	2.2
Defective Hearing (CC)	544,989	17,039	3.1
Pediatric Neurosurgery (CC)	224,527	4,347	1.9
Cystic Fibrosis (CC)	172,052	6,259	3.6
Rheumatic Fever (CC)	297,781	9,993	3.4
Hemophelia (CC)	43,919	1,357	3.1
Rheumatoid Arthritis (CC)	40,427	678	1.7
General Communicable Disease Control	877,727	25,792	2.9
Venereal Disease Control	993,976	26,116	2.6
Immunization Activities	476,808	10,016	2.1
Diabetes Screening	107,820	1,813	1.7
Tuberculosis Control	3,703,054	150,623	4.1
Dental Health Patient Care	404,696	20,283	5.0
Food (Restaurants) (EH)***	1,244,705	63,144	5.1
Pest Control (EH)	269,652	13,942	5.2
Solid Waste (EH)	556,854	28,790	5.2
Swimming Facilities (EH)	63,025	3,259	5.2
Housing (EH)	1,289,971	66,694	5.2
Sewage, Private (EH)	2,446,102	126,464	5.2
Rabies (EH)	408,619	15,908	3.9
Weeds (EH)	185,086	9,569	5.2
Water (EH)	614,692	31,781	5.2
Air Pollution (EH)	63,823	3,300	5.2
Milk (EH)	233,552	10,060	4.3
Environmental Service - NPR	957,343	49,496	5.2
Radiological Health	88,221	371	0.4
Vital Records and Registration	569,314	2,350	0.4

* Table provided by Virginia Department of Health.
** Crippled Children.
*** Environmental Health.

Allocate funds so that public health services are strengthened in various political subdivisions of the state (including the funding of other public or non-profit private agencies to assure maximum participation of local, regional, and metropolitan agencies). The 314(d) funds in Virginia have been channeled into the local health departments and multigovernmental health districts. Other public agencies and non-profit private agencies (with the exception of the non-profit community mental health centers) have not been direct fund recipients under the 314(d) allocation.

Define health services to be provided in terms of specific objectives. The 314(d) state plan documents for both public health and mental health have defined health services to be provided so as to meet departmental objectives. In each case, the goals for use of block grant funds are straightforward. For public health, block grant funds are earmarked for exclusive use by local health departments to meet their service needs and priorities. For mental health, all block grant funds are used to assist the support of mental health clinics to meet their defined needs.

The Department of Health has initiated an effort to revise internal management and priority setting. A management by objectives approach was begun in 1975. When operational, this approach could conceivably result in a different set of objectives for utilization of resources for community health services.

However, to date, neither the Department of Health or the Department of Mental Health and Mental Retardation have allocated 314(d) funds on the basis of specifically defined quantifiable objectives.

Provide for the review and modification of the 314(d) state plan(s) as appropriate on an annual basis by the state health agency and state mental health agency. No formal plan document is prepared each year for 314(d) funding since it is no longer required by the U.S. Department of Health, Education and Welfare. The simplified state plan is prepared by each department and consists only of assurances that statutory requirements for use of block grant funds are being met and that such evidence is available in Virginia.

Annual review of the public health and mental health 314(d) utilization of block grant funds is conducted by the state Departments of Health and Mental Health and Mental Retardation. Federal officials from the Region III office of the Public Health Service Department of Health, Education and Welfare do not review simplified state plans except for compliance with procedural requirements.

Administrative Requirements

In the State of Virginia, the three basic administrative requirements have been met. The administrative requirements are:

Provide for the state administration or state supervision of local administration of the funds by the state health agency and state mental health agency. The Department of Health provides for the state management of the health services funded under section 314(d). This management is exercised through the fact that local health departments operate under general administrative control of the Department of Health as a feature of the Virginia public health services system of partnership between state and local authorities.

The Department of Mental Health and Mental Retardation provides state supervision of mental health 314(d) funds allocated to its community mental health centers.

Assure that the block grant funds will not be used to replace other non-Federal funds. The Department of Health has assured that the block grant funds will not supplant other non-Federal funds. A maintenance of financial support is established through application of the state-local partnership funding formula which requires local participation in the provision of public health services. In 1967, $16 million was provided by the state and local governments. By 1975, non-Federal support of public health had increased to $38 million. Local health departments obtain the blended state and Federal funds for public health. This blend includes the 314(d) fund allocation to individual local health departments.

In the mental health program, there is no assurance that Federal funds will not displace local funds, though the pattern of local funding of mental health clinics shows an increase of almost $1 million annually between 1966 and 1975, having grown from $559,148 to $1,552,304 per year during that period.

Require recipient agencies utilizing 314(d) funds to participate in the costs of the supported services. Under the Virginia Department of Public Health's requirement of maintaining local support, the recipient local governments and their public health departments are automatically required to participate financially in the provision of the 314(d)-supported services, although a specific percentage of matching funds is not required for 314(d) funds. The state formula for local support of health departments does result in an estimated average

of 40 percent of local agency budgets dependent upon local funds.

In the mental health program, there are also local matching requirements for the 314(d) funding share. Even the state-owned and operated clinics are sustained by required local funding of 50 percent of operating costs.

Evaluation Requirement

In the Commonwealth of Virginia, neither the Department of Public Health nor the Department of Mental Health and Mental Retardation have fully met this requirement.

The requirement is:

Provide methods of evaluating the performance of activities carried out with 314(d) funds. Evaluation has been difficult to achieve by the Department of Health since block grant funds are not related to specific services in the budgets of local health departments. Therefore, any assessment of their use and impact is based on a pro rata assignment of funding to the full array of local departmental activities. This pro rata assignment has been developed for FY 1973 and has been previously discussed. No qualitative evaluation of 314(d) fund performance can be drawn from such an analysis.

Mental health services, however, have not been evaluated in any formal manner beyond tabulation of services rendered and patient and facility loans. An evaluation approach has been designated by the Division of Community Mental Health Services. That evaluation approach, spanning the entire mental health services system, will be activated as the 18 state-owned and operated mental health clinics are transferred to community control. Once that transfer is complete, it is anticipated that block grant funds will be used for evaluation purposes.

CHANGES ATTRIBUTED TO THE BLOCK GRANT PROCESS

The mix of services provided with block grant funds has not substantially changed since the availability of the block grant in Virginia. State officials see this lack of change as a result of the pre-block grant commitment by Virginia to its state-local health partnership approach which commingles state, Federal, and local funds to meet locally determined needs. Shifts in Federal funds result more in the redistribution of state and local funds than in programmatic changes.

State officials in Virginia perceive a vast simplification in block grant planning and administration compared with the demands of the prior categorical planning and administration. Nevertheless, even the present administrative efforts are seen to be excessive for the amount of funds available to mental health services.

However, state officials do perceive block grant funds as much more flexible than the prior categorical grants. They cite the fact that all 314(d) funds are suballocated under a state formula to local departments of public health for use at their own discretion. State priorities are not imposed at the local level. Local public health officials agree that the state and Federal funds they receive from the state formula (including the 314(d) funds) are unrestricted and are successfully applied to locally determined needs, although local officials do not perceive that the funds they receive contain 314(d) funds. The funds are perceived as state funds.

At the regional and local public health levels, there is not a high level of awareness of differences between Federal categoricals and the block grants insofar as they affect local health service delivery. This is attributable to the fact that block grant recipients are unable to identify the 314(d) funds in their budget.

State officials believe block grant funds have allowed a more effective response to the greatest medical needs in the community. The 314(d) funds can be used for programs which are tailored to the community. Regional health planning staff observe that block grant funds tend to lead toward a more uniform profile of health services provided by local health departments. In fact, with Virginia's system of commingling state, Federal, and local funds, there is no way to measure 314(d) fund impact.

State health officials in Virginia feel, but are unable to substantiate, that the availability of block grant funds has stimulated increases in local and state support of health services. Since the block grant funds are used in the annual process to establish the level of local and state general fund support, their availability has been cited as a stimulus for both local and state legislative support each year for health services appropriations. Block grant funds are credited with stimulating some proportion of the increase in local and state community health services appropriations of $16 million in 1968 to more than $38 million in 1975.

Mental health services support has risen from $1.9 million in 1968 to $10.7 million in 1975. But the small amount of annual block grant funds for mental health is not considered to have stimulated increased non-Federal support, according to state officials.

There is a contrast and change in the Federal regional role as perceived in Region III of the U.S. Department of

Health, Education and Welfare *vis-a-vis* Virginia. Categorical grants required detailed plan submissions to the Federal regional officials, resulting in a working relationship between Federal and state staffs responsible for the planning, administration, and evaluation of fund usage. With the advent of 314(d) block grants, plans for health and mental health services presented in nine separate grant applications to Federal officials were merged into the two 314(d) state plan documents (one for public health and one for mental health). These new documents provided much less program detail. From this point, 1968, tracking the former categorical funds became difficult for outside observers, such as Federal regional officials.

Beginning in 1970, Federal regional officials initiated the simplified state plan, a checklist derived from the Federal regulations applied to the current 314(d) state plan, as a means of providing basic assurances of compliance with procedural matters to permit block grant funding. From that point, the changed Federal-state relationship can be characterized as that of the Federal regional office providing technical assistance to Virginia at the state's request, rather than performing monitoring and plan and program evaluation functions required under the previous categorical grants in public health and mental health.

Federal officials in the Philadelphia, Region III office are not now in a position to either monitor or evaluate the effects of block grant utilization. More specific detail on the use of 314(d) funds in the states – including Virginia – is required, not for purposes of controlling the use of the funds, but to be able to evaluate 314(d) block grant utilization within the region.

Federal, state, regional, and local reactions to the changes between previous categorical grants and 314(d) block grant usage in Virginia have resulted in the following observations:

- **Lack of direct involvement of the state legislature in the block grant mechanism under section 314(d).** The state legislature has never shown interest in the 314(d) state plans. This is not surprising in view of the small proportion of total health and mental health funds required to meet state obligations.

- **Decreased involvement of Federal officials in the state administration and evaluation of the 314(d) block grants in contrast to the Federal role with prior categoricals.** This is considered as a desirable change by health and mental health officials within the state. Federal regional officials agree as to the desirability, but feel the need to document the 314(d) program in Virginia so as to be able to more effectively provide assistance when requested to do so.

  There is a consensus that the Department of Mental Health and Mental Retardation is more receptive to technical assistance from Federal regional and central office staff than is the Department of Health.

- **Funding of the 314(d) program has not been large in amounts.** However, the block grant is considered a valuable supplement to state and local funding of the public and mental health budgets in Virginia. In the Department of Health, threatened loss of 314(d) funds resulted in estimates of employee reductions in local health departments of 400 to 500. Such an effect would have a significant impact upon maintaining public health services in the state.

- **Virginia's approach to block grant utilization does not permit systematic evaluation of 314(d) fund impact.** By channeling all block grant funds to local health departments and to mental health actions as part of the combined Federal-state-local operations budget, the ability to identify the impact of block grant support in specific program terms is not available.

SUMMARY AND CONCLUSIONS

Strategies for allocation of block grant funds for public health and mental health in Virginia are based upon the basic principle which guides major state human services programs: health care is a joint responsibility of state and local governments. Virginia law has provided for local health departments and community mental health and mental retardation services programs. State budget procedures provide for commingling of Federal and state funds and allocation of Federal funds has not changed with the advent of the block grant mechanism.

Both the Department of Health and the Department of Mental Health and Mental Retardation require local

support as a prerequisite to state and Federal funding. The Department of Health maintains a formula which accounts for ability to pay while Mental Health and Mental Retardation seeks to require 50 percent local funding. Discretion is used in a situation where application of this policy would incur a hardship.

Block grant public health funds usage followed the categorical pattern for approximately one year. Since 1969-70, block grant funds allocated to the Department of Health have been provided to the local health departments for use at their discretion. When this change was accomplished, support for previous categorical programs was provided by allocating additional state funds to them.

Mental health block grants have been used to support the jointly funded system of mental health clinics and to aid in the execution of a state policy for increasing the community responsibility for such clinics.

The unique partnership between the state and local general purpose units of government has facilitated a decentralized, systemwide approach to solving public health and mental health problems. The availability of block grant funds has strengthened the flexibility of local health districts and local health departments with regard to the provision of services needed in each respective geographic area.

Nevertheless, Virginia's experience with the block grant does not reflect the systematic approach envisioned by the *Partnership for Health Act.* Allocation and utilization decisions concerning 314(d) funds are made virtually independently by the Departments of Health and Mental Health and Mental Retardation. There has been no participation by the governor or state legislature in the process. Neither have the private sector nor public been involved in the planning or administration of block grant funds, a procedure in which 314(a) agencies have not played a significant role.

Other planning requirements for the 314(d) block grant mechanism have been met only in part. State plans and planning recommendations required by section 314(a) have not been completed as a guide for resource allocation. The 314(d) allocations over the past eight years have not included funds to other public or private non-profit agencies — except for the community mental health centers of the state. The 314(d) state plans (prepared once and amended in 1970) for both public health and mental health have proposed distribution of funds to strengthen public health and mental health services in the various political subdivisions of the state. This objective has been met.

Virginia has met the administrative requirements to provide for state administration and state supervision of local utilization of the 314(d) funds; assure local contributions towards the cost of 314(d)-supported services; and assure that the 314(d) block grants do not replace other non-Federal funds.

Required evaluation of 314(d)-supported activities has not been performed in full. However, the Department of Mental Health and Mental Retardation is scheduled to activate a comprehensive mental health services evaluation effort with 314(d) funds as the shift in state to community-owned mental health clinics is completed.

In conclusion, utilization of 314(d) block grants during the eight-year history in Virginia has substantially met Congressional intent to increase flexibility and state discretion in Federal financial assistance to needed public health and mental health services.

The Virginia approach to the allocation and utilization of the available block grant funds has been to move from the previous categorical restrictions and to pass all block grant funds through to local service providers in both public health and mental health.

A shortcoming of the Virginia strategy is that changes and improvements in health services and mental health services directly attributable to block grant fund availability are not documented nor is there a history of systematic evaluation.

Furthermore, it is not possible to accurately determine utilization of 314(d) funds for both public and mental health services due to the commingling of Federal and state money in the respective budgets of the Departments of Health and Mental Health and Mental Retardation.

The advantages to the 314(d) block grant approach in Virginia is that the bulk of the 314(d) funds are allocated in a manner mutually acceptable to state and local officials and utilized locally with a minimum of Federal or state intervention.

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