Federal Health Services Grants

DANIEL I. ZWICK, MA

FEDERAL grants to help develop and support local and State health services exceeded $1.2 billion annually in fiscal year 1972. These funds have increased dramatically in recent years, more than sixfold since fiscal year 1965.

In excess of a billion dollars was available in fiscal year 1972 for health services project grants, and about $250 million was available as formula grants (table 1). These funds assisted a wide variety of community health services (*1*).

The rate of growth of Federal health services grants since 1965 exceeds the increases in both total national expenditures for health and Federal expenditures for health. Private and public expenditures for health about doubled between 1965 and 1971; the public share tripled (*2*). During this same period, Federal health outlays expanded about 400 percent, including increases of more than $2.5 billion in Medicaid and almost $8 billion in Medicare (*3*).

Federal grants-in-aid for health services delivery now exceed comparable Federal aid for biomedical research. The relationship of these two national efforts has changed radically since the middle 1960s when grants for biomedical research were three times greater than similar assistance for health services (*4*).

Project Grants

More than three-fourths of the amount available for Federal health grants is in the form of project grants. These awards are made on the merits of individual applications. The relatively greater rate of increases in this type of assistance, a trend that developed in the early 1960s and that I discussed in an earlier paper (*5*), has accelerated further.

In fiscal year 1972, more than 25 different Federal project grant programs related to the development of health services were in operation (table 2). Only 10 comparable programs existed in 1965. The grant simplification achieved by the amalgamation of seven such programs in the "Partnership for Health" legislation in 1966 (under section 314(e) of the Public Health Service Act) has been more than offset by the initiation of many new efforts.

Similarly, the administrative consolidation achieved by the transfer of maternal and child health (MCH) programs from the Children's Bureau to the Health Services and Mental Health Administration (HSMHA) has been offset by new activities in the Social and Rehabilitation Service (SRS) and the Office of Economic Opportunity (OEO). The SRS and OEO programs accounted for about 17 percent of the total awards in 1972. Small new grant programs have also been initiated in recent years by the Office of Child Development (OCD) and the Office of Education (OE) to advance the health of young children.

The health services project grants seek to achieve numerous purposes. Some have been stimulated by recognition of health care crises that require urgent action; for example, the migrant

Mr. Zwick is special assistant for policy development, Office of the Assistant Secretary of Health and Scientific Affairs, Department of Health, Education, and Welfare. Tearsheet requests to Daniel I. Zwick, Room 5062, 330 Independence Ave., SW., Washington, D.C. 20201.

health and narcotic programs are in this category. Others are initiated to facilitate application of new knowledge developed by advances in science and technology; the vaccination assistance and regional medical programs are examples.

Still others aim to help State and local agencies develop new resources for managing and delivering health services; the health planning grants fall into the former group, and the grants for comprehensive health services, children and youth projects, and community mental health centers are in the latter class.

Table 1. Federal health services grants

Kinds of grants	Fiscal year 1965		Fiscal year 1970		Fiscal year 1972	
	Amount [1]	Percent	Amount [1]	Percent	Amount [2]	Percent
Project	$73.5	40.8	$493.7	72.8	$1,002.9	80.0
Formula	106.8	59.2	184.4	27.2	249.8	20.0
Total	$180.3	100.0	$678.1	100.0	$1,252.7	100.0

[1] Expenditures in millions of dollars.
[2] Funds available in millions of dollars.

Table 2. Health services project grants

Program	Fiscal year 1965		Fiscal year 1970		Fiscal year 1972	
	Amount [1]	Percent	Amount [1]	Percent	Amount [2]	Percent
Areawide health planning	[3] $3.7	5.0	$7.7	1.6	$13.2	1.3
Community health services	45.4	61.8	96.0	19.4	202.7	20.2
Health services development	[4] 13.4	18.3	47.2	9.6	138.9	13.9
Communicable diseases	[5] 29.2	39.7	[6] 34.8	7.0	[7] 39.3	3.9
Migrant health	2.8	3.8	14.0	2.8	18.0	1.8
Lead poisoning	0	.....	0	.....	6.5	.6
Maternal and child health services	10.0	13.6	85.3	17.3	113.3	11.3
Maternity and infant care	4.1	5.6	36.6	7.4	42.7	4.3
Children and youth	0	.....	38.8	7.9	47.4	4.7
Maternal and child health, special	3.5	4.7	5.2	1.1	10.0	1.0
Crippled children, special	2.4	3.3	4.2	.8	11.2	1.1
Intensive infant care	0	.....	.5	.1	.8	.1
Dental health	0	.....	0	.....	1.2	.1
Family planning	0	.....	25.7	5.2	94.8	9.4
Regional medical programs	0	.....	77.7	15.7	130.3	13.0
Mental health	12.0	16.3	68.6	13.9	262.6	26.2
Community mental health centers staffing	0	.....	47.1	9.5	145.1	14.5
Hospital improvement	12.0	16.3	7.5	1.5	6.9	.7
Narcotic addiction	0	.....	2.8	.6	76.4	7.6
Alcoholism	0	.....	11.2	2.3	34.2	3.4
Developmentally disabled (SRS)	0	.....	23.6	4.8	27.8	2.8
Staffing	0	.....	11.0	2.2	10.0	1.0
Hospital improvement	0	.....	8.4	1.7	6.5	.7
Rehabilitation services	0	.....	4.2	.9	7.0	.7
University affiliated facilities	0	.....	0	.....	4.3	.4
Office of Economic Opportunity	2.4	3.3	109.1	22.1	155.4	15.5
Comprehensive health services	2.0	2.7	74.0	15.0	108.0	10.8
Family planning	.4	.6	22.1	4.5	24.0	2.4
Drug addiction	0	.....	4.5	.9	18.0	1.8
Alcoholism control	0	.....	8.5	1.7	5.4	.5
Other	0	.....	0	.....	2.8	.3
School health (OE)	0	.....	0	.....	2.0	.2
Head Start (OCD)	0	.....	0	.....	.8	.1
Total	73.5	100.0	493.7	100.0	1,002.9	100.0

[1] Expenditures in millions of dollars. [2] Funds available in millions of dollars. [3] Includes grants for hospital and medical facility planning and mental retardation planning. [4] Includes grants for cancer demonstration, community health services, and neurological and sensory disease services. [5] Includes grants for tuberculosis control, vaccination assistance, and venereal disease control. [6] Includes health services development grants for rubella, tuberculosis, and venereal disease. [7] Includes health services development grants for venereal disease.

Table 3. Health services formula grants

Program	Fiscal year 1965		Fiscal year 1970		Fiscal year 1972	
	Amount [1]	Percent	Amount [1]	Percent	Amount [2]	Percent
Health planning	0	.....	$8.3	4.5	$7.7	3.1
Public health services	[3] $50.0	46.8	88.9	48.2	90.0	36.1
Crippled children services	28.8	27.0	47.0	25.5	50.7	20.3
Maternal and child health services	28.0	26.2	40.2	21.8	49.2	19.7
Alcoholism control	0	.....	0	.....	30.0	12.0
Developmental disabilities (SRS)	0	.....	0	.....	21.7	8.7
Total	$106.8	100.0	$184.4	100.0	$249.3	100.0

[1] Expenditures in millions of dollars. [2] Funds available in millions of dollars. [3] Includes grants for cancer control, chronically ill and aged, dental health, general health, heart disease control, mental health, radiological health, tuberculosis control, venereal disease, and water pollution control.

A few programs incorporate a number of goals while some have changed their primary emphasis over time.

The largest increases in project grants since 1965 have been directed to developing new resources for the delivery of health services in low income communities. Not only the OEO programs, but many programs administered by HSMHA, are aimed primarily at that objective. Between 1965 and 1972, the OEO comprehensive health services program expanded from $2 million to more than $100 million while related HSMHA efforts grew from $4 million to about $180 million. Grants for family planning services increased to about $120 million. About two-thirds of the total amount available in fiscal year 1972 for health services project grants (table 2) were to help develop new health care resources in poor neighborhoods.

Efforts in low income areas are related to the Medicaid programs developed under title XIX of the Social Security Act. Many project grants were originally seed money for the organization of new services to make more effective use of the substantial sums available under Medicaid for financing health services for the poor. Long-term fiscal support of these services, it was anticipated, would be provided largely through such "purchase" programs as Medicaid and Medicare. However, a variety of administrative and legal problems have been encountered by Federal and State agencies as well as by the local projects themselves in seeking to arrange such payments; thus, only limited progress has been made toward the original goal.

Grants for community mental health services have also increased substantially. The staffing of community mental health services has received high priority, amounting to about $150 million in fiscal year 1972. Efforts to meet the narcotics "epidemic" involved more than $90 million in grants through HSMHA and OEO in the same year.

Local health services were also aided by Federal funds granted as part of broader social programs. For example, the Elementary and Secondary Education Program (administered by the Office of Education), the Head Start program (administered by the Office of Child Development), the Model Cities effort (administered by the Department of Housing and Urban Development), and the Law Enforcement Assistance Program (administered by the Department of Justice) supported certain community health activities. The total cost of health services involved in these efforts is estimated to be more than an additional $100 million.

Formula Grants

Formula grants, which are awarded to State governments on the basis of factors set forth in the authorizing legislation for each program, almost doubled between 1965 and 1970 and increased about a third between 1970 and 1972 (table 3). These gains reversed a downward trend that developed during the first half of the past decade.

Funds were appropriated for six formula grants in 1972. (Grants were authorized but not appropriated for the family planning program.) While a few new programs of this nature have been started in recent years, their total number is still less than in 1965 because of the consolidation in 1966 of 10 programs in the "Partnership for Health" program (under section 314(d) of the Public Health Service Act).

Most of these grants are administered by State health departments. In some States, other

agencies have been assigned responsibilities for managing State programs for crippled children, alcoholism control, mental health, and developmental disabilities.

Nature of Project Grantees

State and local health departments received the largest number of project grants in fiscal year 1970. As shown in table 4, they were awarded more than 40 percent of the grants made in the major project grant programs. (An earlier analysis indicated such agencies received about 60 percent of the project awards in 1965.) Health departments have the major role in the administration of project grants for health services development, migrant health, maternal and infant care, and family planning.

Grants for the development of areawide planning were usually made to nonprofit local agencies. This pattern is similar to the earlier grants for hospital and medical facility planning. Consumers must comprise a majority of the members of the policy-making boards of these agencies.

University medical centers have a major role in administering project grants for services to children and youth and for regional medical programs. A substantial number of the awards for children and youth projects were also made to hospitals. New nonprofit corporations have been established in many places as the focus for the regional medical programs' "cooperative arrangements."

Most of the grants for OEO comprehensive health centers are made to community action agencies or, increasingly, to new neighborhood health corporations. The governing boards of the neighborhood bodies usually include approximately equal numbers of representatives of consumers, health professionals, and other community groups.

When the health services development grants under section 314(e) of the Public Health Service Act were classified by subprograms (table 5), the largest number of grants under

Table 4. Categories of grantees in selected programs, fiscal year 1970

Programs	All projects	State departments of health		Local health departments		Universities and other schools		Professional and voluntary health agencies		Hospitals and other health facilities		Other	
	Number	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Areawide health planning	111	0	.....	4	3.6	2	1.8	0	.....	1	0.9	104	93.6
Health services development	443	167	37.7	91	20.5	61	13.8	14	3.2	73	16.5	37	8.4
Migrant health	140	30	21.4	53	37.9	3	2.1	6	4.3	3	2.1	45	32.1
Maternity and infant care	55	30	54.5	22	40.0	1	1.8	0	.....	2	3.6	0	.....
Children and youth	56	12	21.4	13	23.2	17	30.4	0	.....	14	24.0	0	.....
Family planning	111	30	27.0	47	42.3	8	7.2	16	14.4	7	6.3	3	2.7
Regional medical programs	70	0	.....	0	.....	46	65.7	5	7.1	0	.....	19	27.1
Community mental health centers	243	19	7.8	15	6.2	6	2.5	1	.4	174	71.6	28	11.5
OEO comprehensive health centers	61	0	.....	6	9.8	8	13.1	1	1.6	13	21.3	33	54.1
Total	1,290	288	22.3	251	19.5	152	11.8	43	3.3	287	22.2	269	20.9

SOURCE: Public Health Service grants and awards, fiscal year 1970 funds. DHEW Publication No. (NIH) 72-195, pt. 3 1971.

Table 5. Categories of grantees in health services development programs, fiscal year 1970

Programs	Total	State departments of health		Local health departments		Universities and other schools		Professional and voluntary health agencies		Hospitals and other health facilities		Other	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Comprehensive health	55	1	1.8	11	20.0	11	20.0	3	5.5	10	18.2	19	34.5
Communicable diseases	199	145	72.9	49	24.6	2	1.0	1	.5	2	1.0	0	...
Community health	170	18	10.6	19	11.2	47	27.6	10	5.9	61	35.9	15	8.8
Environmental health	19	3	15.8	12	63.2	1	5.3	0	...	0	...	3	15.9

this authority for comprehensive health services were also awarded to community-based agencies. As in fiscal year 1965, almost all funds for communicable disease activities were received by health departments and most other grants for community health services were made to hospitals and other health facilities.

Geographic Distribution

In fiscal year 1970, all the major Federal health services project grants programs aided one or more projects in a majority of States, as shown in the following table.

Program	*Number of States* [1]
Health services development	53
Community mental health centers	48
Regional medical programs	[2] 42
Family planning	42
Areawide health planning	42
Migrant health	36
Maternity and infant care	35
Children and youth	30
OEO comprehensive health centers	28

[1] Includes District of Columbia, Puerto Rico, and Virgin Islands.

[2] There is nationwide coverage as a result of programs serving more than one State.

Health service development projects (under section 314(e) of the PHS act) were located in every State. Children and youth projects and OEO comprehensive health services programs were the most concentrated.

Previous analyses of Federal project grants in general and health grants in particular have shown that communities in the Northeast and West are particularly successful and those in the Midwest are comparatively less successful in competing for funds. Despite the large increase in health projects, this same pattern was generally maintained.

States in the Northeast (HEW Regions II and III) and the Mountain States (Region VIII) received greater percentages of project grants than formula grants and larger shares than their portion of the population (table 6). States in the Midwest (Region V) and Southwest (Region VI) were granted relatively less.

Some States were especially successful in obtaining project grants. For example, Colorado (with a population about 1 percent of the nation) obtained more than 4 percent of the project grants. This accomplishment is the result in large part, of the large Neighborhood Health Center Program in Denver. Other States that have been comparatively succesful in obtaining funds are New York, Mississippi, Missouri, and Utah. States that have not done well in this regard are New Hampshire, Rhode Island, New Jersey, Virginia, Indiana, Ohio, Wisconsin, Iowa, and Kansas.

The larger States receive a greater percentage of total project grants than formula grants. The income redistribution factor used in allocating grants on a formula basis is more sensitive to statewide conditions than to pockets of poverty in urban areas. Since project grants are granted more for activities in poor urban areas, New York, Pennsylvania, Illinois, and California obtain substantially larger shares of project grants than of formula grants.

The focus of health services project grants on urban problems is revealed by the amounts that were awarded in 1970 to projects in the 10 largest cities of the nation. These areas (which include about 10 percent of the nation's population) received more than 25 percent of the amounts awarded in fiscal year 1970 for health services development, maternal and child health, family planning, staffing community mental health centers, and the OEO comprehensive health services program. Children and youth projects and neighborhood health centers are even more concentrated in urban centers; about one-third of the grant funds in these two programs were awarded to the 10 largest cities.

Discussion

Many goals and interests have contributed to the large-scale expansion in recent years of Federal grant programs and funds affecting the delivery of health services. The most important of these forces has been the desire to develop new resources to deliver health services to ambulatory patients in low income communities. Pressures to expand family planning and mental health services have also been primary factors. Organized consumer and professional groups have participated in planning and developing most of these initiatives throughout the country.

Comprehensive health services to ambulatory persons are being developed through such new local instruments as neighborhood health centers and children and youth projects. These kinds of programs, which received almost no aid in 1965, accounted for approximately 25 percent of total funds in 1972. New resources have been established in more than 150 communities. Grants to assist family health centers and health maintenance organizations will extend this approach.

Special categorical efforts, such as programs to prevent communicable diseases and to control alcoholism and narcotics, have

sometimes been established within comprehensive settings or have been linked to them through staffing or referral arrangements. However, in most cases they have been established separately. While particular services have been substantially strengthened, the organization and delivery of community health services have often been further fragmented.

New neighborhood corporations have been organized in many communities to sponsor health services projects. These agencies have greatly extended public participation in planning and managing community programs. In addition, broader outreach and educational efforts have sought to involve hard-to-reach families and groups.

The organization of communitywide systems to coordinate and integrate separate service programs has received major attention in the past few years. To this end, HSMHA has aided the development of "experimental health services delivery systems" in about 20 communities, and OEO has funded "community health networks" in about a dozen neighborhoods. Similar fusion of effort is being sought through coordinated funding procedures, so that grants authorized under a variety of Federal laws are reviewed and awarded together to implement a common program design.

The "Partnership for Health" legislation, enacted in 1966, was at the time a model of Federal grant consolidation. Seventeen grant authorities were amalgamated into two programs. However, health programs have clearly lost their preeminent position in this regard in recent years.

The obstacles to the development of local service programs by the proliferation of Federal grant programs is receiving much attention and concern. President Nixon, in his State of the Union Message in January 1971, proposed a special revenue sharing plan, along with general revenue sharing, to deal with these difficulties. During 1971, such plans were proposed in six program areas (education, law enforcement, manpower, rural development, transportation, and urban development) involving the consolidation of 129 Federal grant programs (*6*).

Actions to simplify the administration of Federal health grant programs are likely to receive much greater attention in the coming years. The numbers of separate applications and report forms have already been reduced. Procedures for "packaging" various grant programs into consolidated awards and programs are being established.

The long-term financing of grant-aided projects depends upon future policies with respect to national health insurance. As previously noted, expectations that Medicaid would be the major long-term source of support for most of the services provided to poor families through new ambulatory care resources have been frustrated by administrative difficulties as well as by cutbacks in many State programs (*7*). Medicaid has largely financed inpatient and long-term care and has largely abandoned the goal, set in 1965, to develop programs of comprehensive services by 1975. Many poor and nearly poor families have not been eligible for even restricted benefits.

It is estimated that Federal

Table 6. Percent distribution of Public Health Service project and formula grant funds for health services in fiscal year 1970 as compared with percentage distribution of population and personal income, by HEW regions

Region number and inclusive States	Project grants	Formula grants	Estimated population	Personal income
I: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	4.8	5.7	5.8	6.3
II: New Jersey, New York, Puerto Rico, Virgin Islands	16.0	11.3	13.5	15.1
III: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	13.7	11.5	11.4	11.3
IV: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	16.9	19.7	15.4	12.5
V: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	14.7	18.4	21.4	22.8
VI: Arkansas, Louisiana, Texas, New Mexico, Oklahoma	8.5	11.0	9.9	8.4
VII: Iowa, Kansas, Missouri, and Nebraska	5.8	5.5	5.5	5.3
VIII: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming	6.1	4.0	2.7	2.4
IX: Arizona, California, Hawaii, and Nevada	10.9	9.3	11.2	12.7
X: Alaska, Idaho, Oregon, and Washington	2.6	3.6	3.2	3.2
Total	100.0	100.0	100.0	100.0

health services grants in 1972 for the development of services in low income neighborhoods exceeded $800 million. This amount is about 20 percent of the Federal funds available for the support of State Medicaid programs during the same year. In some States, health services grants exceed Medicaid payments. Thus, grant-aided projects have become a major source of support of health services for the poor in some areas.

The "Report of the Task Force on Medicaid and Related Programs" recommended in November 1969 that funds for the development of new resources for the delivery of health services be an integral part of financing programs (*8*). Such an approach would provide a continuing and flexible source of "lead money" for the initiation of new services, especially in low-income areas, and would help insure continuing close links between outlays to finance health care and actions to expand health services and to advance health care practices.

The demonstrations undertaken with project grant funds in recent years have highlighted issues that are likely to affect, in critical ways, the nature of future health delivery and financing activities. Organized programs of ambulatory care have been expanded. Services not commonly included in health insurance policies, such as mental health and dental health benefits, have been stimulated, and their potential contributions and costs are being documented.

Preventive activities have been emphasized. The integral relationship between medical and health-related services, on the one hand, and social and other supporting services, on the other, has been highlighted in efforts to meet the full range of identified individual and family needs.

Experiences in these demonstration projects point up the direction of prospective modifications in the scope of health insurance. They also indicate requirements to improve the relation of health and social service delivery to financing programs.

Until changes are made along these lines, and universal eligibility is established, most of the projects initiated with grant funds will be dependent upon continuing support from such sources if they are to survive. More effective ways to match advances in health services delivery with changes in health care financing need to be implemented.

Conclusion

Federal grants-in-aid for health services have been made for more than 50 years. They have been an important and continuing part of the national scene for more than 30 years, since the enactment of the Social Security Act of 1935. They have helped meet many health care crises and needs and have facilitated a wide variety of constructive changes in the organization and delivery of community services. The last decade has been an especially expansive period.

The nature and thrust of these grant programs are likely to be altered again in the next few years as the result of new legislation concerned with revenue sharing and health insurance. Many of the services and projects undertaken with grant support should be supported from other sources. However, as proved instruments of action, Federal health services grants are likely to continue to contribute in important ways to the achievement of national purposes in health.

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