Health Planners and Local Public Finance—the Case for Revenue Sharing

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UNDER THE NATIONAL HEALTH PLANNING and Resources Development Act (Public Law 93-641), health planners at the State and local levels are responsible for implementing health plans aimed at improving access, controlling costs, and educating the public concerning health, among other goals. If local health planners are even to attempt to achieve such ambitious goals, they will have to influence the expenditures of funds by local government. The resources directly controlled by health systems agencies (HSAs) are small in comparison with the amount of local public funds devoted to health. For example, Bureau of Census data for 1975 show that cities and counties spent more than $6.4 billion on hospitals and $2.6 billion on health programs in comparison with the $152 million invested by the Federal Government in the national health planning program in 1979 (*1*).

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In this paper we review the extent to which one potentially significant source of funds, general revenue-sharing dollars, has been used to support health services. In addition, we explore the roles that certain HSAs have adopted with regard to general revenue sharing and local public finance issues. There is evidence which indicates that health planning officials knowledgeable about revenue sharing and other public funding can exert a significant impact on the manner in which these funds are spent.

The State and Local Fiscal Assistance Act (Public Law 92-512), commonly known as general revenue sharing (GRS), went into effect on January 1, 1972. A major purpose of the Revenue Sharing Act was to give people at the local level both the resources and flexibility to solve their problems. In 1976, the act was amended and extended (Public Law 94-488) for another 3¾ years. The formulas used for allocating the funds to the States are based on the factors of population, tax effort, and income or on the factors of population, per capita income, State income tax collections, and tax effort, depending on which formula yields the greater amount of money. Within each State, one-third of the money is allocated to the State government and the rest goes to local government based on the local

jurisdictions' population, tax effort, and relative income. (Tax effort is a relative measure of how much of a government's fiscal capacity it is actually using—how far it is reaching.)

The 1976 amendments to the GRS Act placed no restrictions on the funds to the localities so that the money can be used for any project or for operating costs. The original act required local governments to use the funds in one or more of eight priority areas: public safety, environmental protection, public transportation, health, recreation, libraries, social services for the aged or poor, and financial administration. The 1976 amendments eliminated the matching prohibition of the original act. GRS funds can be used now as matching funds for other Federal monies. The amendments also required that public hearings be held on both the proposed use of GRS funds as well as the city budget. Because these GRS funds (approximately $6.9 billion yearly) are distributed to more than 39,000 State, county, and city governments, health planners should be particularly aware of them. Moreover, there are virtually no limitations concerning how they should be spent, and there is substantial evidence that amounts spent for health vary greatly from locality to locality.

Previous Studies of GRS

Our purpose in this literature review is to identify how GRS funds have been used to support health activities and also to identify factors that have influenced levels of support for health.

Previous research on revenue sharing has addressed general issues of public funding. Few of these studies, to be summarized subsequently, have focused on specific substantive areas, such as health, in examining the impact of GRS. Three major categories of studies have assessed the overall expenditures for health from GRS.

Combinations of approaches. These were employed by the Brookings Institution researchers directed by Richard Nathan (*2,3*). In their latest report (*3*), the Brookings group used both survey and statistical approaches in developing the data base. Twenty-three field associates from various professional backgrounds who were not officially connected to the sample jurisdiction generated data on the use of GRS funds in 65 jurisdictions. These observers assessed the use and impact of GRS funds by reviewing documents and interviewing key decision makers and then combining this information with general knowledge of the community.

Interviews. A major study, conducted by the Survey Research Center, University of Michigan, was based on approximately 2,000 interviews with State and local officials (*4*). This survey covered all 50 State governments, 149 counties, and 668 municipalities. For each sample jurisdiction, two to four officials (the chief executive officer, the chief financial officer, the heads of appropriation committees, and the chief administrative officers) were interviewed.

Mail questionnaires. Each year Cole and Caputo conducted mail questionnaire surveys of the chief executive officers of cities with populations of more than 50,000 (*5,6*). They asked how funds were spent as well as a variety of impact and attitudinal questions.

Methodological Issues

Each of these three approaches to studying GRS suffers from problems of validity. The largest difficulty in studying the impact of GRS (and similar grants programs) is fungibility—that is, interchangeability of money. GRS funds may be assigned to a particular budgetary area according to the use reports submitted to the Federal Government. But the funds that otherwise would have been assigned to that use are freed for other purposes, and the real impact of GRS funds may be in a budget area not mentioned in the use report. These tracking problems make it difficult to identify where GRS monies are being used, especially since more and more governments tend to lump GRS funds within their general budgets. Another problem is that the categories specified in the use reports required by the Federal Government are extremely general. For example, the term "health" does not identify the type of health expenditures for which general revenue-sharing funds are spent. Is money spent to support service programs or for capital expenditures? Despite the many methodological problems, all the studies just described that used different methodologies have tended to agree fairly closely concerning the extent to which GRS has affected health funding at the local level.

Findings

In all three studies (*3,4,6*) it was shown that the majority of GRS funds were allocated to public safety (police and fire departments), transportation and roads, public works, and education; health is not a major recipient in percentage terms. Health receives only about 6 percent of the GRS funds at the State level and less than 2 percent at the city level, or a total allocation of about $400 million a year to health. Although this percentage is small, the $400 million spent on health from GRS is a significant sum, as we will discuss subsequently.

A great diversity among the municipalities with regard to how GRS funds were allocated was docu-

mented by these studies. Juster (*4*) reported that the largest cities tend to use the funds to maintain existing programs, towns with less than 100,000 population tend to use the money for capital outlays, and cities with populations between 100,000 and 299,000 use the funds for tax reduction or stabilization (all figures are based on data for fiscal years 1974 and 1975). However, there has been a recent trend for the cities and counties of all sizes to use the money for tax abatement and for operating outlays rather than for capital outlays. This phenomenon is due to (*a*) a realization by the governments that the funds are not transient; that is, the governments have assurance that GRS will be funded up to 1980, (*b*) the fact that inflation and costs have limited the cities to maintenance of their vital services, and (*c*) a perceived need to reduce the heavy burden of local property taxes.

Thus, all the researchers agreed that recipient governments placed little emphasis on social service or health programs, including those programs benefiting the disadvantaged low income and minority groups. Only 7 of the 65 sample jurisdictions in the Brookings study used GRS funds to give direct services to the disadvantaged. Few studies have focused specifically on the health and social services sector, but Estes (*7*) investigated the GRS role in programs for the aged. She found that of the $9.5 billion expended as of June 1974 from GRS, only 4 percent had been allocated to services for the poor or aged and that State governments made the largest of such commitments.

Wallace and co-workers (*8*) used 1973 and 1974 data to examine the use of GRS funds by States and cities of more than 100,000 population for maternal and child health care (MHC), crippled children (CC), and related services. They surveyed State MCH and CC service directors and city and county health officers in 153 cities. Approximately 86 percent of the States reported that GRS funds were not allocated to MCH or CC programs; only one respondent State reported using GRS funds for those services. Additionally, few States requested that GRS funds be allocated to MCH or CC services, and several States had no mechanism for applying for the funds. About 40 percent of the respondents did not even know that the State received GRS funds.

The situation was similar in cities. In a few, substantial sums were expended on MCH services such as well-child clinics, family planning, maternity care, pediatric services, and lead poisoning programs. But in most, service directors were not even aware that the city received GRS funds. The researchers concluded that MCH and CC directors should take advantage of GRS and request funding for their programs.

Terrell (*9*) examined the effect of GRS on social programs in California, including the programs for model cities, community action, county health, county mental health, county welfare, and community mental health centers. He concluded that the availability of GRS had engaged the interest and involvement of local human service agencies' staff and that GRS has expanded human service concerns and commitments among elected officials. According to Terrell, a few agencies had initiated proposals for use of GRS funds and even developed alliances with certain groups to increase their success in obtaining funds. He found that 64 percent of those agencies that actively sought funds had received them. In general, county governments were more successful in securing funds than were private agencies and entities such as federally funded community mental health centers, which are essentially independent of local government. Terrell concluded that it is the responsibility of the social agencies to take the active role in seeking GRS funds.

Political characteristics of localities, in combination with other elements, affect the percentage of funds devoted to health. According to one study (*10*), communities with nonreformed governments spend more on health under the following conditions: they are suburbs, have populations of 50,000-100,000, the median income is high, the percentage of the population that is black is low, and the community is located in the West. (A "nonreformed" city holds partisan elections and is run by a mayor-council system rather than a professional city manager).

Another study relevant to GRS and health resources was conducted by the Advisory Commission on Intergovernmental Relations (ACIR) concerning the Partnership for Health (314 b) block grant program (*11*). The block grant program, initiated in 1966, was developed to consolidate nine categorical formula grants into one comprehensive health services grant. This program's objectives were to lessen the administrative burden, increase the flexibility of States with respect to Federal assistance, and increase intergovernmental responsibilities. Thus the purposes of the 314 (b) program were virtually identical to those of GRS.

According to the ACIR study, once the grant reached the State, it ceased to be an identifiable program but rather became another source of funds. Comprehensive health planning (CHP) agencies generally were not influential in making decisions concerning the distribution of funds under this block grant. In only six States did CHP agencies play a major role in the allocation decisions. The ACIR researchers concluded that (*a*) the block grant does not bring decision-making power closer to those most affected by the program, (*b*) there was

Table 1. General revenue-sharing (GRS) funds and expenditures for health, fiscal year 1979

Governmental unit	Total GRS entitlement allocation	Total general budget	Health budget	Health as percent of total budget
Maryland State	State retirement fund ..... $45 million	Not obtained	$567.4 million	...
Baltimore City	Financial department ..... $50,000 Fire department ..... $22,818,152 Health ..... $100,000 Library ..... $500,000 Recreation $4,304,530	$1.037 billion	$34.93 million	3.37
Montgomery County, Md.	Police department ..... $8 million	$467.9 million	$13.6 million	2.9
Rockville, Md.	Total ..... $367,000 Senior citizens ..... $80,000 Police ..... $127,000 Special services ..... $20,000 Code enforcement ..... $30,000 Housing code ..... $20,000 Storm water control ..... $70,000 Cultural arts $20,000	$11.7 million	No health budget	...
Gaithersburg, Md.	Road building $106,000	Not obtained	No health budget, health is county function	...
Prince Georges County, Md.	Board of education ..... $13.3 million	$474.6 million	$12 million	2.5
Laurel, Md.	Police, recreation, senior citizens .. $120,000	Not obtained	No health budget	...
Fairfax County, Va.	Bypass ..... $386,250 New road ..... $386,250 Parking lot ..... $225,000 Debt service ..... $6.23 million	$461.4 million	$13.8 million	3.0
Vienna, Va.	Administrative ..... $23,900 Financial department ..... $27,535 Public safety ..... $25,170 Public works ..... $118,000 Parks and recreation $19,485	Not obtained	No health budget	...
Alexandria, Va.	Public safety ..... $293,635 Environmental protection ..... $573,191 Transportation ..... $3,735 Health ..... $510,000 Recreation ..... $603,000 Financial department ..... $52,912 General government $125,277	$82 million	$1.2 million	2.0
Dallas, Tex.	Debt service ..... $9 million Police ..... $6.6 million Administrative $200,000	Not obtained	Not obtained	...

little programmatic flexibility, and (*c*) the money generated very little innovation (*11*).

However, there is a major difference in the amount of funds in the 314 (b) program and revenue sharing. The 314 (b) program never received substantial support from the Federal Government. In 1968, there were only $90 million or about 3.2 percent of all States' budgets in it. In contrast, although health constitutes only about 6 or 7 percent of all GRS expenditures, they amount to more than $400 million in health expenditures per year. Thus, GRS funds are the fourth largest source after the Department of Health, Education, and Welfare; Department of Defense; and the Veterans Administration of Federal contributions to health. For example, an increase of about 1 percent in the relative proportion of funds devoted to health would mean an overall increase of about $70 million spent in percentage terms. In short, it appears that GRS is an important source of funds that health planning officials at the State and Federal levels need to be aware of.

Overall, the literature concerning revenue sharing does give a rough assessment of the percentage of GRS funds expended on health. It also suggests certain factors that may influence the levels of GRS funds for health activities. However, previous studies do not identify what types of health expenditures are supported by GRS funds, nor is it clear what role health planners or other health officials play in the allocation of GRS funds. Finally, in none of these studies has there been an assessment of the impact that the 1976 amendments

to the act have had on the use of GRS funds for the health area.

Exploratory Study

Because of the potential significance of this issue, the Office of Planning, Evaluation, and Legislation of the Health Resources Administration sponsored an exploratory study to determine if GRS data were available from city and county health budgets, the role of citizens in the hearing process, and expenditures of GRS money for health. Financial or budget directors at State, county, and city levels within certain localities in the Washington, D.C., area (and the city of Dallas, Tex.) were telephoned to find out how GRS funds were allocated in their area. Table 1 summarizes the results from the discussions with financial officials and data from city and county budgets.

Table 1 shows that, within the sample units, about 3 percent of the budgets were devoted to health (this percentage includes mental health and hospital support), a smaller proportion than the 7 percent of city budgets devoted to health as reported by the Bureau of the Census. Only two localities allocated GRS funds to health projects (table 1). The city of Baltimore used $60,000 for a mobile dental health program for nursing home occupants and $40,000 for a school dental health education project. Alexandria allocated $510,000 for health projects in fiscal year 1979. Alexandria used $2,934,608 of its GRS funds from January 1972 to June 1978 for health projects, or about 24 percent of the city's GRS entitlement. Table 1 also indicates that the health share of the overall budget for these governments is in the 2–3 percent range. Table 2 indicates that in only 1 of the 11 jurisdictions was there substantial citizen participation in decisions concerning the allocation of GRS funds. Table 3 shows the distribution of the general revenue sharing allocations in the various communities by program function. The main recipients were the police and fire departments, education, retirement funds, and debt services. Thus, health received only $610,000 of the approximately $120 million of revenue sharing funds, or only 0.5 percent.

Some budget directors stated that GRS money was used in a single program, primarily to make it easy to administer. For example, a county council decided to use the funds for a single purpose only to avoid the complex process of dividing the GRS funds among several categories of expenditures. The $100,000 allocated to health in Baltimore was initiated by the city council. Council members requested the health department to submit a proposal for utilization of the money. The adult health services proposal was accepted by the health department and submitted to the council. The city of Alexandria sent letters to neighborhood associations and private social service agencies requesting them to submit a proposal or some ideas on how to allocate the GRS funds. During the hearings, which were well attended, the ideas were discussed and the GRS budget was developed. However, some of the groups did not have sufficient time to respond. A major issue raised by this exploratory study is whether concerted action by the local health systems agency (HSA) and others concerned with health resources development would have led to an increased allocation for health purposes.

Table 2. Citizen participation in general revenue-sharing (GRS) allocations, fiscal year 1979

Governmental unit	*Citizen participation in GRS hearing*	*Additional comments*
Maryland State	No hearing	Legislative decision to put GRS funds in the retirement fund
Baltimore City, Md.	No one at hearing	City council requested proposal from health department
Montgomery County, Md.	No one at hearing	Administrative decision to put the money into the police department
Rockville, Md.	4 people at hearing	.....
Gaithersburg, Md.	Little participation	Saving GRS money for each year to build a road
Prince Georges County, Md.	No one at hearing	Put into education to increase their entitlement, they have 2 county hospitals
Laurel, Md.	No one at hearing	.....
Fairfax County, Va.	1 or 2 people at hearing	.....
Vienna, Va.	Little input	.....
Alexandria, Va.	Full house	City council asks community groups for proposals
Dallas, Tex.	No one at hearing	In the past they had an elaborate allocation but have decided to support only a few areas

Response of the HSAs to Revenue Sharing

Discussions with executive directors of four HSAs and one State health planning and development agency (SHPDA) in the Washington, D.C., area were held to determine if they were familiar with the GRS program, had used any GRS funds, and had participated in the GRS hearings. In addition to the director of the Maryland SHPDA, the directors of the northern Virginia, central Maryland, southern Maryland, and Montgomery County HSAs were contacted. All were familiar with the GRS program, and all but one knew that GRS funds could be used for matching purposes. None of the directors had requested GRS funds. Some of the reasons for not requesting GRS funds follow:

1. The budget was comprised almost entirely of direct Federal funds. The HSAs clearly look to the Federal Government for their major sources of income. GRS funds were not considered Federal funds, since the State and local officials acted as the allocators. Moreover, HSAs in this sample had not received significant support from local sources. The Montgomery County HSA was the only agency which received more than 10 percent of its budget from the county and was the only Maryland HSA to receive local support. The Virginia HSA received no State support and less than 10 percent of its budget from local governments.
2. Requesting GRS funds was not feasible, since GRS money is put into the general budget. This response was an expression of the fungibility issue. Since GRS money was in the general budget, the directors were not able to request it specifically.
3. Local money was not needed. Several directors felt that their Federal and State grants were sufficient for their needs. They did not want to receive local money. One director felt that all funding should come directly from the Federal Government. The Montgomery County HSA director was the only one who had participated in any GRS or budgetary hearings. He mentioned that the GRS funds in the county went into the general budget; therefore, at the hearings he had advocated health projects and their funding from the general budget and not specifically from GRS funds. Many of the directors were surprised that approximately $400 million was being put into the health sector from GRS funds. They had not believed that they would be able to influence how that money was distributed.

HSAs and Local Public Funding

During the discussions with the HSA and SHPDA directors, local public financing was discussed. (Before examining their views, it must be pointed out that the SHPDA and one HSA were in State or county departments, two HSAs were nonprofit corporations, and the third was a regional planning body.) The directors generally believed that they had no direct role in local budgetary processes. As mentioned previously, only one person, as a planning director, had ever participated in a budgetary hearing in his area. All felt that they could influence budgetary decisions regarding health projects indirectly by advocating the priorities developed in their health systems plans. Several directors expressed the view that if they did their planning job well the rest of the pieces would "fall into place." They were not sure, in some cases, that they wanted to deal with local budgetary processes. The feeling of dissatisfaction in having to work with local officials was expressed by several directors. One director commented, "Issues are

Table 3. Percentage of general revenue-sharing entitlement allocated to various program areas

Program area	State of Maryland	Montgomery, Prince Georges, and Fairfax Counties	Dallas and Baltimore [1]	Other cities [1]
Health	....	....	0.23	18
Social service	....	....	....	3.5
Education	....	47	....	....
Library	....	....	1.15	....
Recreation	....	....	9.88	22.6
Public environment and public works	....	....	....	28.5
Transportation	....	4	....	3.9
Police and fire departments	....	28	67.51	15.5
Financial department, administrative	....	....	0.57	8
Debt service	....	21	20.65	....
Retirement fund	100	....	....	....
Total funds	$45,000,000	$28,527,500	$43,573,682	$2,848,916

[1] Figures do not add to 100 percent due to rounding.

too parochial at the local level and it is too difficult working with local officials, especially if they have contributed to the agency's budget."

Only one planner believed that it was both beneficial and important to secure support from local officials in the health planning efforts. He emphasized that agreement between the county executives and officials on health priorities increased the HSA's authority in implementing its programs. According to this planner, most HSA directors believed that their agencies should act as interest groups or advocates for health in their areas. They thought that by bringing the issues into the public eye the public in turn would influence public health decisions.

Most of the directors also agreed that it will take time to develop a good rapport with the local government. Although some were leery of local officials and their support, most directors wanted a role in the funding decisions and agreed that their planning success depended on close coordination with the local governments. They acknowledged that to increase their influence they would have to demonstrate the benefits of planning and the agencies' ability to function effectively. In discussing possible means of enhancing their relationships with local governments, some directors pointed out the importance of educating local officials about the purpose of health planning and ways in which planning can help to solve community health problems.

The "review and approval" process (Public Law 93-641 gives the HSAs the function of reviewing and approving or disapproving all local federally funded health projects) was considered a means for the HSA to exert some control over these local projects. The idea of expanding the review and approval concept to State and local funding of health projects was viewed as a possible means of controlling local development.

Another issue is the development of a profile of the flow of community health funds. This profile consists of developing an analysis of "sources-of-funds" for health projects at a local level and an "expenditure" analysis for the same projects. With such analyses, HSAs would have a better sense of where money is coming from and where it is going and could increase their control of health development at the local level. All the HSA directors acknowledged that they were planning analyses in the near future.

The Bureau of Health Planning of the Health Resources Administration has published a handbook (*12*) to help HSAs conduct a community health funds flow analysis. In addition, the Bureau staff is compiling a marketing manual to help HSAs secure non-Federal money (*13*). But no effort is underway to define or strengthen the role of HSAs in local public financing.

Conclusions and Implications

HSAs have a role in promoting health issues and influencing local financing of curative and preventive health programs, and they have a responsibility to coordinate health services through funding mechanisms. But the dimensions of the role and how it should be developed must be investigated. The relationship of local public financing to the development and promotion of health resources needs consideration. By examining and probing these issues, the role of the HSAs can be further shaped and perhaps improved.

It is apparent from the interviews with local HSA directors that they have not influenced the allocations of GRS money nor have they influenced local health decisions significantly. If HSAs are to be effective, they will have to develop linkages with the local officials and increase their influence over funding decisions. Local financing of health projects seems to have been ignored in the past by health planners, but the evidence shows that to develop an effective health delivery system and to improve the quality of health at the community level there must be coordination between health planners and local elected officials. The GRS program is only a small part of the money handled by local government officials but, by analyzing how these funds are used and the HSAs' relationship to these funds, more general conclusions can perhaps be reached as to how HSAs can strengthen their role in local public financing.

Our general conclusion from the discussions with HSA executive directors was that they have had no role in local budgeting. In many cases, there was not even close coordination between the health planners and the local government officials concerning substantive issues. All the directors wanted a role in the health funding and budgeting decisions and agreed that their planning success depended on coordination with the local governments. They felt that, through developing effective health systems plans and demonstrating their ability to plan, they could increase their influence in the local governmental arena.

We believe that HSAs should promote health issues and influence local financing of curative and preventive health programs. They should have a responsibility to coordinate health services through funding mechanisms. However, the HSA staffs have not addressed local public financing and its connection with health planning.

If health planning is to be effective, health planners need to understand local public financing and be able to function in that area. It is hoped that through the examination of these issues a variety of strategies can be developed which will help health planners to plan effectively for the health needs of their community.

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SYNOPSIS

ROCHELEAU, BRUCE (Northern Illinois University), and WARREN, STEVEN: *Health planners and local public finance—the case for revenue sharing. Public Health Reports, Vol. 95, July–August 1980, pp. 313–320.*

Little attention has been paid by health planners or researchers to questions of local public finance. However, a review of the literature concerning general revenue sharing (GRS) funds indicated that about $400 million per year from this source is spent on health services and resources. GRS funds, about $6.4 billion per year, are distributed to more than 39,000 State, county, and city governments. The 1976 amendments to the General Revenue Sharing Act eliminated restrictions on the use of the funds, and they can be employed as matching funds for other Federal monies.

An exploratory study of the use of GRS funds for health purposes was conducted in several localities, with particular attention to the health systems agencies. Its results confirmed that there are wide variations among localities in the use of revenue-sharing funds to support health services. Also, not only did the health systems agencies' officials have little impact on the allocation of revenue sharing funds, but only in one locale had an HSA official taken a direct role in the budgetary process. Health planners, who were interviewed during the study, described what they considered their agencies' proper role in local budgetary matters.