Block Grants and the Resurgence of Federalism

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ONE INTENSELY DEBATED FEATURE of the economic package that the Administration sent to Congress in early March 1981 was the proposal to consolidate a variety of categorical grants into a very few block grants. Two of the block grants were to transfer to State custody some 25 health services and preventive health programs.

The proposal did not survive its trip up Capitol Hill intact. Indeed, the portion that dealt with health programs was modified substantially. But out of that process of debate and compromise has emerged a new view of the Federal role in health, a way of looking at relationships, resources, and realities that differs markedly from the view that has prevailed for the past 20 years. This view promises to have a profound effect on the course of health care in this country for many years to come.

Old habits of delivering and paying for health care are difficult to change, of course. They became engrained in our thinking and entrenched in our budgets. Even so, the Executive Branch and the Congress exhibited a remarkable ability, this past spring, to agree on old habits that needed to be changed. In a time of rather severe economic austerity, we collaborated on a lean health budget, one that takes the harsh realities of the economy into account. While making allowances for the persistence of familiar behavior, we took strong steps in the direction of a new federalism. We embarked on a journey, in other words, the purpose of which is not simply to conserve resources in a time of scarcity or to restructure Federal programs, but to revitalize this nation's health care system.

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The Expansion of Federal Influence

Still, there can be no downplaying the immediate and long-range importance of cutting Federal spending and power. Both before his election and after, President Reagan promised to reduce inflation in this country by reining in one of its prime stimulants, an ever-growing Federal budget. At the same time, the President said that he would do whatever he could to spread the power and authority that had accrued to the Federal Government among the States, their communities, and the private sector. In the field of public health, cooperation and shared responsibility were to be the rules.

To begin to appreciate the magnitude of the job that the President took on, one need only realize that by 1979, when the spending spree that had begun roughly 20 years earlier reached its peak, the Federal Government was funding 492 categorical grant-in-aid programs in the areas of education, social services, the criminal justice system, the environment, housing, labor, public works and, of course, health, which accounted for 69 programs. There is nothing to be gained by debating the merit of those programs. It should be sufficient to know that most were proposed and enacted by reasonable men and women who wanted their Government to respond to perceived human needs. But after nearly 20 years, those hundreds of programs were exacting enormous costs, in both economic and social terms.

That was, and is, the view, in any event, of a great many students of government and other knowledgeable observers, the President and his advisers included. It was also a concern, it turns out, of most members of Congress. The plethora of programs brings to mind a

remark of Edmund Burke, the British philosopher and statesman. "The people never give up their liberties," Burke said, "but under some delusion." The deluge of categorical programs brought with it a delusion of expanded and improved health and social services. We assumed there was a positive ratio of costs to benefits, and in many cases there undoubtedly was; but overall, the accumulation of programs spawned an administrative machinery that became, for all intents and purposes, a program in itself. Unfortunately, this program was expensive to maintain and unwieldy to operate; it was often unfair and unresponsive. And by the very fact that it existed, it signified that State and local government and virtually every element of the private sector had given up a sizable share of their liberties.

The Block Grant Remedy

It was this state of imbalance that the Administration hoped to address in its block grant proposal of March 10. Calling the block grant a bridge—a bridge, one might say, between Burke's state of delusion and a more balanced condition of liberty—the President proposed two block grants in health—one that would consolidate 11 health services grants and another that would encompass 15 preventive health programs.

This was no bookkeeping exercise, it should be understood. By means of these block grants, the Administration intended to transfer to State control very real funds and authorities. Within certain general guidelines, block grant recipients, which is to say State health authorities, would make their own decisions on which programs to emphasize and on ways of making them more efficient. Although held strictly accountable to the public and to the Federal Government for the implementation of their plans under the block grant mechanism, States would be better able to make their publicly funded health programs more immediately responsive to the needs of their citizens. The block grant proposal, in short, reflected the Administration's faith in the willingness and ability of States to recognize and meet their own most pressing needs.

The 97th Congress saw the advantages of the block grant mechanism in essentially this same light, but its bill consolidated 21 programs, rather than 26, into four block grants, and it authorized a number of other categorical aid programs. Brief descriptions of the four block grants follow.

Alcohol, drug abuse and mental health. This largest of the block grants consolidates Federal funding previously provided on a categorical basis for alcohol, drug abuse, and mental health services. Funds will be distributed among States in proportion to the allocations for the existing categorical programs. For this block grant and the others, as well, reduced funding levels should be offset, in large part, by the increased flexibility that States will have under the block grant mechanism and by fact that Federal overhead, or administrative, costs will be dramatically reduced.

In this connection, a State may choose to take over administration of the block grant as early as October 1, 1981, or it may delay this step for up to a year—a transitional period—when the Department of Health and Human Services (DHHS) will continue to administer the programs in the block. But States must take over administration of the block by October 1, 1982, and they must use the funds to supplement, not supplant, the support that they or any other non-Federal sources already spend in this area.

In the same vein, no more than 10 percent of block grant funds may be spent on administrative costs. But up to 7 percent of a State's allocation may be transferred by that State to other block grants, as needs dictate.

Maternal and child health services. The block grant for maternal and child health services consolidates seven existing categorical programs into one entity; its purpose is to permit States to develop programs that will assure mothers and children of access to quality maternal and child health services, reduce infant mortality and the incidence of preventable disease and handicapping conditions among children, provide rehabilitation services for blind and disabled children, and provide for locating and delivering services to children who are crippled. In this block the programs are Maternal and Child Health Services (Title V)/Crippled Children's Services, SSI Disabled Children's Services, Hemophilia, Sudden Infant Death Syndrome, Prevention of Lead-Based Paint Poisoning, Genetic Diseases, and Adolescent Health Services.

As with the alcohol, drug abuse, and mental health services block grant, States may assume administration of the maternal and child health services block grant on October 1, 1981, or at any time in the next year. They must have done so by October 1, 1982, to receive FY 1983 funding.

With these funds, States will have wide latitude to establish their own priorities in the provision of services for mothers and children. In the first year, fiscal 1982, 15 percent of the funds appropriated will be retained by the Department and spent on research, demonstration, and training projects of national or regional significance. They will also be used to fund hemophilia centers and genetic disease counseling and screening centers. In succeeding years, 10 to 15 percent of the funds appropriated will be allotted in this way.

There can be no transfer of funds appropriated for this block grant to other block grants, and there is a matching provision: States must match every four Federal dollars received with three State dollars.

Primary care. The Community Health Centers (CHC) Program, presently administered by the Bureau of Community Health Services, Health Services Administration, is the only activity covered by the primary care block grant. It is a large and far-reaching activity: In FY 1981, the Federal appropriation of $324 million funded 845 CHCs, which served about 5 million persons.

Under the block grant mechanism, the CHC Program will continue to support the delivery of family-oriented health services in medically underserved areas, both rural and urban. Fiscal year 1982 will be a transition year, however. During it, administration of the CHC Program will remain with DHHS, and States, at

their discretion, may apply for funding for fiscal years 1983 and '84. Since many States may need assistance in shouldering the Program's administrative responsibilities, a total of $2.5 million in Federal planning grants will be available in FY 1982.

A State that applies for and receives an allotment of funds in FY 1983 must make grants to all eligible community health centers that were funded in FY 1982. A State that first applies for funding for FY 1984, however, is under no such stricture. The Department will continue to administer the CHC Program in any State that does not apply for funding. Should a State, once approved, decide to relinquish its authority to operate its CHC Program, the Department would again assume responsibility for it.

The distribution of funds to States for FY 1983 will be based proportionately on the amount of funds received by CHCs in each State in FY 1982. To be eligible for an allotment, a State must match Federal funds with its own funds or with its own in-kind services and supplies, or both. The State match in FY 1983 is 20 percent; in FY '84 it is 33⅓ percent. No Federal funds may be used to pay State administrative costs, nor may funds from the primary care block grant be transferred to other block grants.

Preventive health. This block grant, which consolidates eight existing categorical programs, will support State efforts to provide preventive health services for individuals and families, especially for those of limited means, to improve the quality of life and to reduce preventable illness, accidents, violence, and death. The programs are emergency medical services, health incentive grants, hypertension control, rodent control, community and school-based fluoridation, health education-risk reduction, home health services, and rape prevention and services.

With the exception of the rape prevention and services program, for which $3 million is authorized each year, to be allocated according to State population, funds will be distributed to each State in proportion to the FY 1981 funding of the eight categorical programs. States may take over administration of the block as early as October 1, 1981; they must do so by October 1, 1982. Until a State acts, DHHS will administer the programs.

The preventive health block grant has no matching requirement, but block funds must supplement, rather than supplant, State and local spending for prevention. Up to 10 percent of the block funds received by a State may be used to pay State administrative costs, and another 7 percent may be transferred to other health block grants.

New Budgets, New Directions

In his budget presentation to the Congress on March 10, the President asked for $7.4 billion to operate the Public Health Service in FY 1982. The differences between this request and the funding levels that the Congress authorized in the Omnibus Reconciliation Act of 1981 were not large. They were reasonable.

We are now constructing our budget for 1983, and we are beginning to think about the shape of the budgets for 1984 and '85. Although long-range budgeting of this sort necessarily involves a certain amount of guesswork, there can be no mistaking the areas of concern and opportunity that we believe the Public Health Service must emphasize in the years ahead.

We are firmly committed, first, to the prevention of illness and to the promotion of increasingly higher levels of health in America. It is our consensus and that of the public health community, generally, that prevention should be this nation's top public health priority. Accordingly, we will be turning much of our attention, in the coming year, to the 5 major goals and 15 prevention objectives presented, respectively, in "Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention" and in the more recently issued "Promoting Health/Preventing Disease. Objectives for the Nation."

Next, we intend to support strongly the development of new knowledge in the biomedical and behavioral sciences. Although we in the Public Health Service tend to think of research as the domain of our own National Institutes of Health, we also know that the ultimate development of new knowledge is realized most often by the thousands of creative, talented men and women who labor in the laboratories of universities, foundations, private concerns, and State and overseas governments, as well. We must continue to assist these men and women in their work, the products of which form the foundation upon which virtually all of our public health programs are based.

Finally, we will maintain and improve the delivery of health services to those populations, chief among them Native Americans and Alaskan Natives, for whom we, traditionally and by law, have been responsible.

Summary

In an address, this past summer, to the National Convention of State Legislatures, President Reagan captured the essence of the block grant proposal in a sentence. "Our task," the President said, "is to restore the constitutional symmetry between the Central Government and the States and to re-establish the freedom and variety of federalism."

Consolidating the current profusion of complex and often overlapping Federal health grants into four State-administered packages will greatly reduce administrative costs and allow us to make wise use of scarce health dollars in a time of economic trial. At the same time, these changes will give States the managerial and policy flexibility that they need, but have lacked, to respond to their own most pressing needs. Of perhaps most importance in the long run, this system of grants will return a just portion of responsibility for the preservation and improvement of our health care system to the States, their communities, and the people.

It is precisely this kind of equilibrium, this symmetry, that the President had in mind and that, for too many years, the Federal-State-Private partnership in health has been without. The restoration of this equilibrium, it should be noted by all, is underway.