Federal Health Services Grants, 1980

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FEDERAL HEALTH SERVICES grants are again in a period of transition. These programs have experienced many changes since they were established on a continuing basis almost 50 years ago by the Social Security Act of 1935. The proposal of President Reagan in February 1981 that most of these activities be consolidated into "block grants" began a new phase of development. The initial action of the Congress on the President's proposal, that was completed in July 1981, indicated a willingness to approve some, but not all, of the proposed changes in direction and emphasis.

Federal grants for the development and support of State and local health services have served many purposes. A primary aim of many was to stimulate and assist desired changes in the organization and delivery of needed health care, especially to low-income families and others with serious health problems. These funds have also helped to meet medical emergencies, extended the structure of public health services, and enhanced capacities of local health agencies to consider and prepare for the future.

A pattern and tradition of cooperative federalism has characterized these grant activities over the years. Originally, the partnership was largely between the Public Health Service and State health departments. In the 1950s and 1960s, many other private and public agencies at State and local levels became important partners as well (*1*). The changes proposed by President Reagan will substantially alter relationships among the participants, enhancing the roles and responsibilities of State agencies.

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In view of the adjustments that may occur in the next few years, it is timely to review the nature and status of these activities at the beginning of the new decade. This analysis provides a baseline for measuring prospective changes. It also updates earlier reports of Federal health services grant programs that I had prepared for the years 1963, 1965, 1970, and 1975 and published earlier in *Public Health Reports* (*1–3*).

The 1980 Status

In fiscal year 1980, Federal health services grants exceeded $2 billion. This amount is almost three times the funds expended for these purposes in 1970 and more than a third greater than the outlays in 1975. Altogether, there were 8 formula grant programs and 36 project grant programs in 1980; in 1975, these figures were 7 and 24 respectively.

The growth in grant dollars and the increase in percentages over the decade follow:

Type of grant	*Amount in millions*		
	1970	*1975*	*1980*
Formula	$184.4	$ 458.5	$ 669.4
Project	507.7	1,008.0	1,344.5
Total	$692.1	$1,466.5	$2,013.9

	Percent increase	
	1970–80	*1975–80*
Formula	263	46
Project	165	33
Total	191	37

Much of the increase in dollar amounts, however, was offset by inflation. The Implicit Price Deflator for the Gross National Product, the measure of inflation

for the general economy of the country, increased 39 percent between 1970 and 1975 and 94 percent between 1970 and 1980 (*4*). When the expenditures for health services grants are adjusted for inflation and compared to the base year of 1970, the real increase between 1970 and 1980 was about 50 percent. There was no real increase in total outlays for these grant programs between 1975 and 1980, because the rise in expenditures was exceeded slightly by the rise in inflation. The following index indicates the rates of real increases in expenditures beginning in 1970.

Type of grant	*Fiscal year*		
	1970	*1975*	*1980*
Formula	100	170	187
Project	100	143	137
Average	100	152	150

Table 1. Health services formula grants, fiscal years 1975 and 1980 (expenditures in millions of dollars)

Program	*1975*		*1980*	
	Amount	*Percent*	*Amount*	*Percent*
Health planning:				
State programs	$ 12.2	2.7	$ 32.0	4.8
Local programs	...	...	124.7	18.6
Health incentive grants (public health services)	90.0	19.6	68.0	10.2
Crippled children's services	64.9	14.2	86.1	12.9
Maternal and child health services	176.2	38.4	214.0	32.0
Alcoholism control	52.0	11.3	54.8	8.2
Drug abuse prevention	28.2	6.2	38.0	5.7
Developmental disabilities	35.0	7.6	51.8	7.7
Total	$458.5	100.0	$669.4	100.0

Formula Grants

Federal health services grants that are allocated among the States on a formula basis increased about $200 million between 1975 and 1980. Most of this increase was due to the health planning program authorized by Public Law 93–641 that was approved in 1975; the largest portion were awards to approximately 200 newly established local health systems agencies throughout the country (table 1). The gains for all but one of the six other programs in this group were less than the increase in inflation.

Other formula grant programs of the Federal Government, such as general revenue sharing and aid to elementary and secondary education, also provide funds for certain local health services. For example, in a study of general revenue sharing funds, it was estimated that about $400 million a year of these grants, about 6 percent of the total, were being used for the support of health activities (*5*).

Project Grants

Federal health services grants that are awarded on a discretionary basis to projects proposed by individual applicants, usually local agencies, increased about $340 million between 1975 and 1980 (table 2). These grants had expanded substantially between 1965 and 1975, more than tenfold in total dollars and sevenfold in real dollars (*3*). This trend ended between 1975 and 1980. Although there was a 50 percent increase in the number of project grant programs, the total amount expended for these types of programs declined slightly in real dollars during these 5 years.

Three project grant programs account for about half the total amount: community health centers,

community mental health centers, and community services related to drug abuse. The community health center program had the largest dollar increase during the period, about $125 million. Another relatively large dollar increase, more than $60 million, was for family planning services.

Prevention and health promotion programs had a relatively large percentage increase between 1975 and 1980. In addition, many of the community health services programs and the mental health and substance abuse activities include prevention aspects. This trend was highlighted by the report, "Healthy People," issued by the Surgeon General in 1979 (*6*). New grants for preventive health services were established by Public Law 95–626, the Health Services and Centers Amendments of 1978.

A number of other new project grant programs were also begun between 1975 and 1980. They include funds

Table 2. Health services project grants, 1975 and 1980 (expenditures in millions of dollars)

Program	1975		1980	
	Amount	Percent	Amount	Percent
Health planning: local programs	$ 16.7	1.7	$	....
Community health services	409.1	40.6	753.3	56.0
Adolescent pregnancy services	....	....	6.5	.5
Appalachian health demonstrations	23.3	2.3	21.8	1.6
Black lung clinics	....	....	4.5	.3
Cancer control	4.7	.5	23.5	1.7
Community health centers	196.6	19.5	320.0	23.8
Crippled children's services	3.5	.3	16.0	1.2
Emergency medical services	32.2	3.2	35.1	2.6
Family planning	94.5	9.4	155.9	11.6
Genetic diseases	....	....	11.6	.9
Health maintenance organizations	22.7	2.2	32.2	2.4
Hemophilia centers	....	....	3.0	.2
Home health services	....	....	5.0	.4
Hypertension services	.8	.1	19.9	1.5
Indian self-determination projects	....	....	16.6	1.2
Maternal and child health services	5.1	.5	29.4	2.2
Migrant health	23.8	2.4	39.7	3.0
Primary care demonstrations	....	....	9.8	.7
Sudden infant death syndrome	1.9	.2	2.8	.2
Prevention	56.3	5.6	115.5	8.6
Childhood immunizations	....	....	24.5	1.8
Communicable disease projects	34.2	3.4	....	....
Fluoridation projects	....	....	5.0	.4
Health education—risk reduction	....	....	6.0	.4
Health program for refugees	....	....	4.8	.4
Lead-paint poisoning projects	9.0	.9	11.3	.8
Smoking and alcoholism prevention	....	....	10.0	.8
Urban rat control projects	13.1	1.3	14.0	1.0
Venereal disease control	....	....	40.0	3.0
Regional Medical Programs	83.0	8.2	....	....
Mental health and substance abuse	403.2	40.0	451.3	33.6
Alcoholism demonstrations	....	....	4.6	.3
Alcoholism treatment and rehabilitation	79.9	7.9	60.8	4.5
Community mental health centers	197.6	19.6	217.3	16.2
Community support for the chronically mentally ill	....	....	7.2	.5
Drug abuse community services	117.9	11.7	145.7	10.8
Drug abuse demonstrations	....	....	2.5	.2
Drug abuse prevention	....	....	12.8	1.0
Mental hospital improvement	7.8	.8	.4	.1
Other	39.7	3.9	24.3	1.8
Child abuse and neglect	.4	....	13.5	1.0
Developmental disabilities	23.2	2.3	10.8	.8
Head Start	15.2	1.5	....	....
School health services	.9	.1	....	....
Total	$1,008.0	100.0	$1,344.5	100.0

for adolescent pregnancy activities, genetic disease testing and counseling services, hemophilia programs, home health services, and primary care demonstration programs (all authorized by Public Law 95–626). In addition, assistance to Indian tribes for self-determination health projects was authorized by the Indian Self-Determination Act of 1975, grants for black lung clinics were established by the Federal Mine Safety and Health Act of 1977, and funds for meeting public health needs associated with refugees were approved in the Refugee Act of 1980.

Congressional interest in additional categories for special effort appears to continue to be strong. For example, formula grants for disabled children's services have recently been initiated through the Supplemental Security Income Program, and the Mental Health Systems Act of 1980 authorized a number of new grant programs in that field.

Discussion

Federal health services grant activities and funds continued to grow from 1975 to 1980. However, the rapid expansion of the previous decade ended. The total increase in expenditures did not quite equal the increase in inflation; a few programs increased substantially, and a number of others were initiated.

Project grant programs continued, in line with practices since 1965 (*1*), to be the dominant grant instrument. They accounted for about two-thirds of the total. The percentage increase for formula grant funds, however, was larger than the increase for project grant funds over the 1975–80 interval, 46 percent compared with 33 percent.

The proposal of President Reagan in February 1981 to consolidate 26 categorical health grant programs into two large block grants to the States would change these relationships substantially (*7*). One such grant would include 11 existing grant programs for preventive health services and the other would include 15 other health services programs. The proposed budget for the two larger block grants was about $500 million less than the 1980 expenditures for these programs, a proposed reduction of about 25 percent. The new grants would be distributed among the States on a formula grant basis, taking into account the previous distribution of funds for the consolidated programs (*8*).

Congressional action on this proposal in July 1981, included a number of substantial modifications of the President's proposal (*9*). Four new block grants were established, rather than 2, including 18 former categorical programs. Limits on a State's discretion to use grant funds were included. Authorized funds were reduced about 20 percent. The four new block grants are for (*a*) maternal and child health, (*b*) health prevention and services, (*c*) alcohol, drug abuse, and mental health, and (*d*) primary care.

On two previous occasions, health services grant funds have been merged into consolidated grants. In 1966, 19 health services grants were grouped as part of the "Partnership for Health" program (*10, 11*). In 1975, project grants for maternity and infant health projects and children and youth projects were consolidated into existing formula grants for maternal and child health services (*12*).

In 1976, President Ford proposed to consolidate 15 categorical health grants and the Medicaid program into a new grant program amounting to $10 billion. The Congress did not act on that proposal. The relevant congressional committees did not respond favorably to the recommended revisions.

The Congress has approved block grants, however, in recent years in other fields. These have included programs in manpower development, community development, law enforcement, and social services (*13*). Thus, this approach has its own precedents and traditions.

In 1980, the Office of Management and Budget under President Carter issued a report on the development of Federal grant programs in the 1980s, noting that "a major source of complexity in Federal assistance management is the continuing expansion in the number of narrow categorical assistance programs" (*14*). The report, called for by the Federal Grant and Cooperative Agreement Act of 1977, presented a series of proposed reforms aimed at facilitating coordinated implementation of various Federal assistance programs. It also urged, without success, passage by Congress of a regularized process by which the President could propose consolidation of existing grant programs and proceed with them unless Congress objects.

Numerous other efforts have been made to attempt to alleviate or overcome the problems of fragmentation of programs and administrative complexity that are reported to arise from the large number of specialized categorical grant programs (*13*). These efforts have included a variety of "services integration" approaches at national, State, and local levels. Some of the activities have been focused on duplication and overlapping functions. Others have concentrated on the costs of administrative complexities. Still others have been concerned about gaps in needed services that can develop in responding to the varied needs of families with multiple problems (*15*).

A report of the Advisory Commission in Intergovernmental Relations in 1981 concluded that the

network of intergovernmental relations and grants-in-aid had become "dangerously overloaded." The Commission observed that, in the last two decades, too many problems and programs had been addressed through new grant activities. The members strongly urged adjustments in and simplification of these approaches (*16*).

In an evaluation of the impact of Public Health Service grant programs on State health goals and activities, it was found that these relationships are complex and varied. In general, Federal programs and policies were not the predominant influence. The conditions and priorities of the individual States tended to determine most outcomes (*17*).

Meanwhile, advances in knowledge and technologies—and evolving societal values—continue to identify opportunities for addressing health problems that often result in new categorical interests and grants. The intensity and persistence of these factors have been repeatedly demonstrated over the more than four decades of the history of the Federal health services grants. The new programs initiated in recent years, such as the health center, primary care, adolescent pregnancy, and genetic disease programs, attest to the continuing validity and strength of these pressures and interests.

The development of innovative approaches and activities has been a principal purpose of Federal health services grants. Often, the grants have provided seed money to encourage and facilitate changes in the delivery and organization of services. In recent years, much of this effort has been focused on the development of ambulatory care and other noninstitutional services. Analyses of block grant programs indicate that they are not usually supporters of innovation (*10*).

The relationship of health services grant programs to the established third-party mechanisms for financing most health care in the United States is likely to be of continuing importance (*3*). In some cases, such payers—Blue Cross and Blue Shield, commercial insurance companies, Medicare, and Medicaid—have modified previous policies to incorporate innovative services. Often, though, it has been difficult to terminate grant support because of the absence of alternative funding. Under the best of circumstances, making revisions in established benefit packages is a slow process. Engendering effective support for new activities and desirable changes that improve the delivery of appropriate health services is not likely to be easy, although experience has indicated the critical importance of such capacities.

The decade of the 1980s will probably bring a new character and balance to Federal health services grants. The nature of the partnership is likely to change as some partners assume different roles and responsibilities. However, as federalism remains a fundamental aspect of the American governmental system, Federal health services grants are likely to continue to contribute both to the development of intergovernmental relationships and to the advancement of needed and improved health services.

References

1. Zwick, D. I.: Project grants for health services: statistical analysis. Public Health Rep 82: 131–138, February 1967.
2. Zwick, D. I.: Federal health services grants. Health Services Rep 88: 77–83, January 1973.
3. Zwick, D. I., and Behney, C. J.: Federal health services grants, 1965–75. Public Health Rep 91: 493–495, November–December 1976.
4. Survey of current business. Bureau of Economic Analysis, U.S. Department of Commerce, Washington, D.C. 1981 issues.
5. Rocheleau, B., and Warren, S.: Health planners and local public finance—the case for revenue sharing. Public Health Rep 95: 313–319, July–August 1980.
6. Healthy people, the Surgeon General's report on health promotion and disease prevention, 1979. DHEW Publication No. (PHS) 79–55071. U.S. Department of Health, Education, and Welfare, Washington, D.C., 1979.
7. A program for economic recovery, February 18, 1981. The White House, Washington, D.C.
8. Testimony of Secretary Richard Schweiker before the Senate Committee on Labor and Human Resources. Apr. 1, 1981. Office of the Secretary, Department of Health and Human Services, Washington, D.C.
9. Conference report on the Omnibus Budget Reconciliation Act of 1981. U.S. House of Representatives Report No. 97–208, July 29, 1981.
10. Advisory Committee on Intergovernmental Relations: The Partnership for Health Act: lessons from a pioneering block grant. No. A–56, Washington, D.C., January 1977.
11. Government Accounting Office: How States plan for and use Federal formula grant funds to provide health services. Washington, D.C., December 1975.
12. Coburn, A.: Implementation and child health policy. Thesis. Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Mass., 1981.
13. Advisory Commission on Intergovernmental Relations: The intergovernmental grant system as seen by local, State and Federal officials. No. A–54. Washington, D.C., March 1977.
14. Executive Office of the President, Office of Management and Budget: Managing Federal assistance in the 1980's. Washington, D.C., March 1980.
15. Roemer, R., Kramer, C., and Frink, J.: Planning urban health systems. From jungle to system. Springer Publishing Co., New York, 1975.
16. Advisory Commission on Intergovernmental Relations: The Federal role in the Federal system: the dynamics of growth. Washington, D.C., June 1981, vols. 1–11.
17. Final report. Evaluation of the impact of PHS programs on State health goals and activities. DHEW Publication No. (HRA) 77–604. U.S. Government Printing Office, Washington, D.C., May 1977.