FEDERAL GRANTS MANAGEMENT

A State Health Officer's View

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PUBLIC HEALTH WORKERS share a common concern over a critical issue of our time: Federal grants—where are they leading public health? It may be as Jonathan Swift once said, "We are so fond of one another because our ailments are the same." This does not imply that we regard Federal assistance as an ailment. On the contrary, we recognize the grant as a prescription for our public health problems—but a prescription with side effects that warrant our critical attention.

I am deeply concerned with the present administration of Federal grants. This issue strikes at the roots of our political system. The manner in which the Federal Government wields its unrivaled fiscal resources has a profound impact, for good or for ill, on the very quality of American democracy.

We on the State and local operating levels are aware of the rush of history which has compelled the Federal Government to perform in a larger arena. We know that the old lines of responsibility have faded under which Washington simply fought the wars and delivered the mail, State government built the roads and locked up the more important criminals, while local government provided water and schools and picked up the trash.

The face of the nation itself has changed. At the turn of the century we were still essentially a rural people. Today, more than half our population lives in some 200 gigantic urban centers with king-sized public health problems that spill over city limits and even State borders.

Two World Wars and the Korean conflict have thrust the Federal Government into a more powerful position. The cold war keeps it there, propped by a budget of $55 billion for defense alone.

Federal dominance of atomic energy development and radiological protection clearly illustrate Washington's carryover of wartime authority.

The States themselves have contributed to extended Federal power. When some States have been unwilling or unable to resolve complex problems, like water and air pollution, the Federal Government has filled the vacuum.

In the public health field the very excellence of the Public Health Service is responsible in part for enlarging the Federal Government's health horizons. The zeal of this remarkable organization has no doubt occasionally made it impatient of the pace of progress at the State level.

The admirable performance of the Children's Bureau through the years has also exerted a force for better maternal and child health among the States.

Yes, we at the State and local levels accept the imperative for a forceful Federal public health program—though we may have questions as to degree and direction. At the same time, we stress the continuing requirement for vigorous and creative public health enterprises on the State level. I take deep pride in the public health initiative we have displayed in New York State.

New York's Activities

We have significantly buttressed Federal aid for sewage plant construction. We will pay the full cost of community sewage studies. We will provide our communities with aid identical to Federal assistance for sewage plant construc-

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tion when Federal aid is exhausted. And, after they are built, we'll pay one-third of the cost of operating these plants.

We initiated in 1964 a system of air purity standards.

We have taken several steps to check the mounting cost of medical care, including review of hospital planning to make sure that any new hospitals planned are actually needed.

We have launched a medical audit to assure uniformly high-quality medical care in our State.

We are overseeing the critical function of medical laboratories through a new licensing program. We have also set minimum standards of qualifications for directors of these laboratories.

We have formed two new bureaus to focus our efforts on heart disease and other chronic illnesses.

We are establishing a statewide network of rehabilitation centers. And we have extended State aid for rehabilitative treatment to several additional diseases of childhood: cystic fibrosis, muscular dystrophy, diabetes, chronic asthma, and others.

We take special pride in our system of State aid to local government. New York State pays 75 percent of the first $100,000 and 50 percent of anything above that amount spent by county health departments, as well as 50 percent of the expenditures of city health departments. We provide this aid with minimal controls that respect the intelligence and initiative of our local health officials.

New York, along with so many of its sister States, is pursuing an imaginative public health program that reflects our conviction that the State is ultimately responsible for the direction of public health within its borders. But State governments need help—financial help for the most part—to meet this responsibility. And we look to the Federal grant-in-aid program to bridge the gap between our means and our aims.

Failings of Federal System

However, the present Federal grant structure comprises five elements that trouble State health agencies: (*a*) the Federal Government's overpowering taxing advantage, (*b*) serious failings in grant administration, (*c*) the divisive impact of direct Federal aid to communities, (*d*) the unnecessary rigidity of categorical grants, and (*e*) discrimination against health departments in Federal support of general research.

George Bernard Shaw was essentially correct: lack of money is the root of most evil. The States currently cannot match Federal revenue-raising power. Washington has largely monopolized the rich-yielding tax fields on incomes and corporate profits. Most States are left with taxes on real property which cut inequitably across the public spectrum or sales taxes which are regressive and unpopular.

Since most States lack the taxing base to raise all the revenue they need, they must depend on Washington. This dependence accentuates the second problem, the serious administrative failings in the present Federal grant program.

Congressional tardiness in appropriating funds for grants-in-aid makes a shambles of intelligent State planning. Grants are generally effective on the first day of July and run for 1 year. Yet, States do not usually know until September or October, with any certainty, how much money they will receive. Any State official who has administered Federal grants knows what this situation produces: desperate recruitment and planning for a new 1-year program, of which 4 to 6 months may already be lost; a feverish scramble to commit funds before the fiscal year runs out; the desperate scraping for State funds or painful releasing of trained personnel when a Federal program is suddenly cut back or cut out. One member of my staff has aptly described Congress's tardiness as "the plot against planning."

Next, I am deeply troubled by the growing use of project grants through which the Federal Government bypasses the State to deal directly with communities and even voluntary agencies.

Some rural-dominated legislatures have invited this intrusion by showing little concern for metropolitan problems. The flight to the suburbs has also aggravated the situation by impoverishing the core city.

Consequently, mayors of large cities have followed a path that bypasses the State house and leads directly to the White House, where they get a sympathetic hearing and hard cash.

This emerging pattern troubles State health administrators—and with reason.

Intelligent State planning must be done statewide. Statewide planning is not served by Federal enticements which lead some of our cities off in independent directions.

Direct Federal intervention denies the State's superior knowledge of what its salient problems are and where additional resources should be channeled.

Finally, direct Federal assistance introduces a divisive wedge which undercuts the State's authority to lead its communities along a path of common benefit.

My next concern is with the continuing rigidity of categorical grants. Since we cannot transfer any part of a categorical grant to another program, no matter how compelling our need, we find ourselves doing strange things. A State with high infant mortality may, for example, launch a new cancer program of lesser priority because it can get funds for one program and not for the other.

We may perpetuate programs and practices for no better reason than that Federal money is available for them.

Under rigid categorical grants, the imagination is exercised in Washington, but the administrative load is borne on the backs of State and local health officials. Abraham Lincoln once said, "I go for all sharing the privileges of government who assist in bearing its burden." State and local health officials heartily concur.

Lastly, I am concerned with the narrow share of Federal research funds awarded to health departments—particularly for general research. The case for vigorous public health research programs is compelling.

Public health departments need to carry out research to close the gap between our medical knowledge and techniques for bringing this knowledge to people.

Health department programs must be based on sound epidemiologic reasoning, which in turn grows out of sound research.

Research funds represent investment capital for public health agencies. A health department, just like a private business, must plow back a share of its assets into research to improve its products.

Perhaps most important, a first-rate research program acts like a magnet to draw able personnel into public health. We need research enterprises that will capture the imagination of men and attract men of imagination.

I have now completed the simpler half of my task—to catalog the wants and lacks of the grant program. To stop at this point would be to escape lightly, if not nobly. However, the rules of the game now require me to match my criticisms with some constructive ideas.

Proposed Reforms

How can we reorder the tax structure to give the States a fairer chance to raise revenues to support their own health programs? Gov. Nelson Rockefeller, in a recent talk to county officials, had some thought-provoking ideas on this subject. He called for: (*a*) crediting certain taxes paid to State and local governments against Federal taxes, (*b*) a transfer of certain excise taxes from the Federal Government to State government, and (*c*) continued collection of certain excise taxes by the Federal Government, but redistribution of these revenues to the States.

These reforms would reduce the degree of State dependence on Federal aid and the Federal controls that this aid implies.

To remove the greatest obstacle to sound grant administration, I urge the Federal Government to notify States of the amount of aid they will receive with at least 2 months' lead time. States should also be given a 2-year grace period before Congress eliminates any grant program entirely, so that a State can phase the program out or develop State plans to support it.

As for the growing use of project grants made directly to local governments, any short-term profit that this device offers the central government must be paid for eventually in a weakened Federalism. Everyone concerned with the proper distribution of powers among our three levels of government will endorse a sharp curtailment of this divisive practice.

State health departments also deserve a far greater share of Federal research funds. To promote this objective, public health officials on State and local levels must be imaginative in dramatizing the ultimate benefits of general

research. In this way we can supply the Public Health Service with arguments to place before Congress which will compete in persuasiveness with the appeal of disease-control programs.

As for the undesirable rigidity of categorical grants, various solutions have been voiced. Ten years ago, a report made to the Association of State and Territorial Health Officers recommended up to 20 percent interchangeability between categories. Later, a subcommittee of the Joint Federal-State Action Committee recommended giving States the authority to transfer up to one-third of a grant from one category to another.

At this point I want to propose a more far-reaching plan to reduce the excessive Federal controls that currently thwart the wisest investment of grants-in-aid. I propose a system designed to satisfy both Washington's concern for proper use of its moneys and the State's pleas for greater flexibility.

There is a hierarchy of desirability among the various kinds of grants. At the pinnacle is the block grant, as yet untried. It requires only that a grant be spent for a broad purpose, such as public health. The State is free to plan the use of this money within the limits of broad rules and regulations.

Next most desirable is the general health grant. At present, it resembles the garter snake—flexible, but quite small. Third in the hierarchy are categorical grants, checked by reins held tightly in Washington. At bottom is the project grant awarded directly to the State, the community, or voluntary agency by the Federal Government.

I propose a system of State public health agency ratings through which the kind of grants awarded would depend on the level of a State's public health development.

The state of development could be measured by determining the ratio of per capita income in a State to its per capita expenditures for public health.

The rating could be further refined by bringing into play the incidence rates for various diseases within the State.

To illustrate this concept in action: A State whose level of expenditures for public health in relation to its per capita income is high would continue to receive Federal grants-in-aid, perhaps in an amount similar to what it now receives, but the grant would be of the block or general health kind. In other words, the vigor and initiative of this State's public health program would be respected and rewarded by a greater degree of autonomy in the use of Federal grants.

Another example is a State with middling expenses for public health, but a high incidence of a particular disease. This State might receive some of its aid for general health purposes, but would receive a more closely controlled categorical grant for attacking the high-incidence disease.

The avowed objective of the grant-in-aid program is to establish minimum patterns of health service across the nation and to provide special funds to fight front-running problems. The program of State-rated grant categories described here would meet these objectives. At the same time, this concept would free the most advanced States of unwarranted Federal encroachment and would set a tempting standard of independence for the less-developed State health agencies to strive for.

I believe that the general direction of health services within our States remains a primary responsibility of State government.

The people of this nation will not be served best by having their State governments reduced to field outposts for a monolithic Federal bureaucracy.

The idea of 50 State laboratories of thought and action is still valid. It deserves to be nurtured, not starved, by Washington.

The English political philosopher, John Stuart Mill, clearly foresaw the perils of overcentralization a century ago. The nation, he said, which "sacrifices liberties to a little more administrative skill . . . or semblance of it," or "which dwarfs its men in order that they may be docile instruments . . . even for beneficial purposes, will find that with small men no great thing can ever be accomplished."

Then let us foster a program of Federal assistance to the States that promotes greatness in men so that we can continue to accomplish great things in public health.