

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**FEDERAL APPROACHES TO FUNDING  
PUBLIC HEALTH PROGRAMS**



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# **EXECUTIVE SUMMARY**

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## **PURPOSE**

To review the professional literature to determine the advantages and disadvantages of Federal categorical and block grant approaches to funding public health activities.

## **BACKGROUND**

In this report we respond to the Public Health Service's (PHS) request that we: (1) identify the advantages and disadvantages of categorical grant approaches to Federal funding, (2) determine the effects of block grant funding approaches, and (3) suggest a research and demonstration strategy for block grant funding. At the request of PHS staff, we did this by reviewing the professional literature addressing Federal grant mechanisms, federalism, and intergovernmental relations.

## **THE CATEGORICAL GRANT EXPERIENCE**

*Categorical grants have been the traditional approach to Federal grant making.*

- They have grown in number and appropriation level, and continue to be the most widely used approach for Federal grant making.
- They maximize recipient accountability to the Federal government.
- They target Federal money to precisely defined national objectives.
- They facilitate nationwide adoption of innovative programs.

*Concerns about categorical grants have become more widespread as the number of programs has grown.*

- They add administrative cost and complexity to the Federal grant system.
- They contribute to fragmented program management and service delivery.
- They inhibit program responsiveness to particular State and local needs.

*The Federal government has taken initiatives during the past three decades to increase State and local government discretion over Federal aid.*

These initiatives include the Partnership for Health Act of 1966, General Revenue Sharing in the 1970s, the Omnibus Budget Reconciliation Act (OBRA) Block Grants in 1981, and many Federal waivers of categorical grant provisions in the 1990s.

## **THE BLOCK GRANT EXPERIENCE**

Our analysis of the effects of block grants focuses on five questions commonly asked about the block grant experience.

*Have block grants promoted administrative improvements and cost-savings?*

- States reported that block grants have improved administrative efficiency.
- The extent of administrative cost-savings is unclear because data are limited.

*Have block grants facilitated services integration?*

- Studies on block grants examined services integration at the administrative rather than the service delivery level.
- The Partnership for Health Act improved intergovernmental coordination, but did not necessarily promote a system-wide approach to public health problems.
- The OBRA 1981 block grants enhanced integration at the administrative level.

*Have block grants fostered greater responsiveness to State and local needs?*

- States claimed that the Partnership for Health Act allowed them to tailor services to their own needs, but evaluators contend that the block grant did not significantly reorder State program priorities.
- States reported minor adjustments to programs under the OBRA 1981 block grants, but did not substantially alter program priorities.

*Have block grants replaced State and local funding for services?*

- Scant data exist on how the Partnership for Health block grant money was used, but studies show that it promoted new spending rather than replaced State money.
- Under the OBRA 1981 block grants, States replaced lost Federal funds in order to maintain service levels.
- Factors other than block grant status better predict whether States use funds for additive or substitutive purposes.

*Have block grants left certain client groups more vulnerable?*

- Block grants often include special targeting provisions to ensure that Federal funding is allocated to the neediest populations. The effectiveness of such provisions is unproven.
- Limited data suggest no major differences in the client populations served under the Partnership for Health Act and the former categorical programs included in it.
- The OBRA 1981 block grants contained provisions to ensure targeting, but there has been little examination of their impact on the poor.

## RECOMMENDATIONS FOR RESEARCH AND DEMONSTRATION

*The Public Health Service should develop a strategy to use performance indicators in ways that will allow grantees substantial discretion in using Federal funds and, at the same time, hold them sufficiently accountable for their performance.*

The President's Fiscal Year 1996 budget calls for the Public Health Service to make a significant commitment to program simplification by consolidating 108 programs into 16. Given the additional interest in block grants in Congress, the Public Health Service must give major attention to the development of funding mechanisms that afford grantees substantial discretion and yet hold them accountable for performance. The literature and the experiences it examines offer little guidance on how to establish such a performance based system of block grants.

It is vital, therefore, to conduct an active research and demonstration effort that examines how block grants and performance indicators can be usefully linked. Toward this end, the Public Health Service could examine ways in which block grant recipients:

- identify relevant indicators of performance,
- develop mechanisms for collecting performance data,
- present and disseminate performance data, and
- use such data to improve their performance and/or refine their objectives.

It is also important to focus attention on the Federal government's oversight role with respect to block grants and examine approaches it could use to:

- ensure adequate performance of grantees.

The thrust of this research and demonstration strategy should be directed to future efforts that could be undertaken along with the provision of block grants. To a limited extent, however, it might also encompass a retrospective look at block or categorical grant programs to identify insights they offer for the development of performance based block grants. The Maternal and Child Health Block Grant Program, which calls for States to submit performance data to the Public Health Service, could be a good candidate for such inquiry.

## COMMENTS ON THE DRAFT REPORT

The Assistant Secretary for Planning and Evaluation reviewed the report and concurred without elaboration. The Public Health Service (PHS) also reviewed the report. Its comments appear in full in appendix B.

The PHS concurred with our recommendation. In so doing, it noted two actions it has undertaken that move in the direction of our recommendation. One is the "Performance Partnership Grants" program that has been proposed to Congress. The other is an

initiative "to establish and use performance measures whether they are funded through the categorical or block grant mechanism."

We recognize the relevance and importance of these actions. In tandem with them, we urge PHS to take maximum advantage of current research and demonstration opportunities available in order to promote better understandings on just how block grants and performance indicators can be usefully linked. In our report, we suggest in some detail directions that can be taken in that regard.

The PHS suggested two technical changes, both of which we made in the final report.

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# INTRODUCTION

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## **PURPOSE**

To review the professional literature to determine the advantages and disadvantages of Federal categorical and block grant approaches to funding public health activities.

## **OBJECTIVES**

To identify the advantages and disadvantages of categorical grant approaches to Federal funding.

To determine the effects of block grant funding approaches as identified in the professional literature.

To suggest a research and demonstration strategy for block grant funding.

## **BACKGROUND**

### *Rationale for the Report*

In May 1994, when national health care reform was being considered by Congress, the Public Health Service (PHS), through the Office of the Assistant Secretary for Health, asked us to conduct a review of the professional literature to identify the comparative advantages and disadvantages of categorical and block grant funding approaches to public health programs. The PHS expected that this review would facilitate its considerations concerning how public health funds could best be distributed under a reformed national health care system.

In August 1994, we prepared a working draft of the report in response to the PHS request. By the time we met with PHS officials to review the report, Congress had decided not to carry out health care reform in 1994; thus, the initial rationale for our report was less compelling.

Yet, even without health care reform, the issue of reforming the current highly categorical approach to Federal funding remains pressing. The Office of the Vice President set the tone in this regard when it issued the report of the National Performance Review in September 1993. That report, which called for a reassessment of the Federal grant system and a reduction in the number of categorical grant programs, contended that "the current system of Federal grant making fragments the ability of government at all levels to address people's needs in an integrated manner . . . by establishing often incompatible eligibility standards and administrative rules and requirements, the proliferation of categorical grants has made government at all levels less effective."<sup>1</sup>



Throughout 1994, many States were making requests for Federal waivers from categorical programs to enhance their capacity to develop innovative approaches of their own. The Fall 1994 political campaign and the November elections reflected considerable popular support for reducing the scope of the Federal bureaucracy and giving State governments increased discretion in the use of Federal funds.

In view of these developments, PHS, during a review of our working report in November 1994, underscored the continued relevance of our review of categorical and block grant funding approaches and urged us to expand our report. Specifically, PHS asked us to offer recommendations on a research and demonstration strategy that might be undertaken in concert with block grants--one that would add to our knowledge base on how block grants could serve as an effective complement to categorical grant programs.

Our inquiry gained relevance in February 1995 when the President issued his budget for Fiscal Year 1996. That budget calls for major consolidations of programs in PHS. It proposes that 32 programs in the Centers for Disease Control and Prevention be combined into 3, that 50 programs in the Health Resources and Services Administration be lumped into 9 clusters, and that 26 programs in the Substance Abuse and Mental Health Services Administration be consolidated into 4.

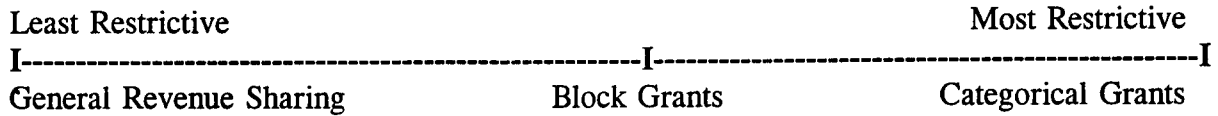
In this report we respond to the PHS requests. We start out by identifying the advantages and disadvantages long associated with categorical grants--the most traditional and prominent Federal funding approach. We then turn to an examination of the central questions typically posed about the effects of block grants. We conclude by suggesting directions PHS can take that would enable it to respond to the considerable current interest in block grants and at the same time examine how best to build in necessary accountability safeguards.

### *Types of Federal Grants*

Historically, Federal grant programs have been classified in three main groups according to level of recipient discretion: categorical grants being the most restrictive, block grants falling somewhere in the middle, and general revenue sharing (GRS) providing virtually unrestricted assistance. Currently, the most important division in the Federal grant system is between categorical and block grants. General revenue sharing was terminated in 1986 due to declining political support amidst concerns about accountability. Sometimes the differences in funding mechanisms are clearer in the abstract than in implementation, but for the purposes of definition we will use the following continuum:

FIGURE 1

Continuum of Federal Grants by Recipient Discretion



*Categorical grants* are primarily for specifically and narrowly defined purposes and are the most restrictive in terms of how much discretion they give to recipients.<sup>2</sup> Recipients of categorical grants may be State or local governments or non-profit institutions. Categorical grants typically have mandated Federal application, eligibility, and reporting requirements intended to ensure that programs and policies reflect national goals. Categorical grants are the most prominent in both numbers of programs and amount of dollars.<sup>3</sup> They are intended to support activity in particular areas, such as community mental health, hemophilia, and alcoholism.

*Block grants* are broader in scope than categoricals and have fewer Federal requirements. They allow recipients considerable discretion in determining specific activities funded within their program areas, but still maintain certain substantive goals and objectives. Administrative, fiscal, reporting and other requirements are kept to a minimum. These grants are provided chiefly to State governments. Block grants represent a small portion of Federal grants, and are designed to support activity in broader areas such as preventive health and health services, maternal and child health, and substance abuse.

It is important to point out that particular programs can fall at different points of the continuum and that, as a result, there are many programs that are hybrids of block and categorical grant approaches. An example would be the Maternal and Child Health Block Grant. When established in 1981 (as Title V of the Social Security Act), the program quite clearly belonged at the block grant point of the continuum, as it afforded extensive discretion to State grantees. In 1989, however, Congress chose to limit that discretion in various ways and to tie funding for the program in more closely with applicable health status goals and objectives set forth under the "Year 2000 Objectives" established by the Public Health Service.

It is also important to recognize that the terms "block grant" and "categorical grant" are sometimes used in different ways. For example, a program having a narrowly defined purpose but affording grantees substantial discretion might be called a block grant by some and a categorical grant by others. We have found, however, that over time, the degree of discretion afforded the grantee is the central distinguishing feature between the two types of grants. For that reason and the sake of clarity, we stress that distinction in this report.

## METHODOLOGY

This report is based primarily on a review of the policy literature on Federal grants, federalism, intergovernmental relations, and public health programs published by journals, research institutions, and government oversight agencies. To locate additional studies, we contacted academics in public health and intergovernmental relations and spoke with representatives from the National Council of State Legislatures, the National Governors Association, the Council of State Governments, and the Intergovernmental Health Policy Project.

We conducted this study in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# THE CATEGORICAL GRANT EXPERIENCE

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The following information is drawn from a review of the literature on the Federal grant system. It is meant to confirm the history and trends in Federal grant making to provide a better understanding of the context for grant reform.

## **CATEGORICAL GRANTS HAVE BEEN THE TRADITIONAL APPROACH TO FEDERAL GRANT MAKING.**

- *They have grown in number and appropriation level and continue to be the most widely used approach for Federal grant making.*

Federal grants have historically been directed at narrow, categorical programs with specific purposes and tight Federal spending requirements. Despite experimentation with other funding mechanisms, the main vehicle of Federal grant expansion over the past three decades has been the categorical grant. The total number of Federal categorical grant programs offering funding to State and local governments increased from 422 to 593 between 1975 and 1993.<sup>4</sup> Likewise, this increase was matched by similar growth in appropriations. In constant dollars, grant outlays for categoricals rose from \$77.6 billion in 1975 to \$147.4 billion in 1993.<sup>5</sup> In contrast, there were 5 block grant programs in 1975 and 15 in 1993; block grant outlays in 1975 totaled \$9.3 billion compared to \$17.6 billion in 1993 in constant dollars.<sup>6</sup>

- *They maximize recipient accountability to the Federal government.*

Categorical grants, with their extensive eligibility, planning, spending, and reporting requirements, are often viewed as the best way to make programs accountable at the Federal level. These requirements are intended to ensure both the proper use of Federal funds and effective implementation of Federally-funded programs.

The widespread perception that categoricals are most accountable to the Federal government may explain why they have been the most prolific. Congress, the Administration, Federal administering agencies, and national interest groups all play roles in designing, funding, regulating, and implementing categorical programs. But it is Congress that ultimately determines how much money to appropriate for Federal grants, and Congress generally believes that it has greater control over Federal money in a categorical system. Congress has traditionally preferred categoricals because of these tighter controls. Other proponents of categoricals, like interest groups, also favor categorical programs because they can concentrate their efforts on lobbying Congress rather than divide their time among 50 different State legislatures.<sup>7</sup>

- *They target Federal money to precisely defined national objectives.*

Categorical grants, with their strict definitions and requirements, may provide the best guarantee that Federal funds will be used to advance specific national purposes. An Advisory Commission on Intergovernmental Relations (ACIR) study that examined all sides of the debate stated that "they [categoricals] appear to offer the most efficient, direct administrative means for securing any national objective."<sup>8</sup> Historically, "categorical grants were established in response to particular needs or problems that were of national interest and concern, and Federal funds were authorized primarily to stimulate States and localities to take remedial actions."<sup>9</sup> One reason that Congress has preferred categorical grants over other approaches is because it views them as effective instruments for influencing State and local governments to provide certain services.<sup>10</sup> In addition, Congress has preferred categorical grants because they fund programs directed at specific problems, and, therefore, may find it helpful to refer to these programs when seeking constituent support.

- *They facilitate nationwide adoption of innovative programs.*

Sometimes Federal categorical grants are designed to promote widespread adoption of innovative methods for combating particular health problems. Program innovations pioneered in State or local health departments can be replicated on a national level through a Federal categorical grant to encourage States and localities to spend money on particular problems. In the past, advocates of categorical grants have credited these specific grants with fostering new programs and enlisting support from interested groups--primarily because categorical grants are created to fund *new* programs rather than *expand* general health grants.<sup>11</sup>

#### **CONCERNS ABOUT CATEGORICAL GRANTS HAVE BECOME MORE WIDESPREAD AS THE NUMBER OF PROGRAMS HAS GROWN.**

- *They add administrative cost and complexity to the Federal grant system.*

Critics claim that the existence of numerous, specialized categorical grants presents excessive administrative reporting and accounting problems for grant recipients, and inhibits efficiency and economy in distributing Federal grants.<sup>12</sup> The most outspoken critics of categorical grants have been public administrators with broad responsibility, academics, State and local government officials and service providers, and policy research institutions like the ACIR and the General Accounting Office (GAO). These groups have evaluated Federal grant programs and have documented the administrative burdens placed on recipients of categorical grants.

Many studies conducted over several decades report that State and local governments are concerned about the high administrative costs and excessive paperwork associated with categorical grants. An ACIR survey conducted almost 20 years ago found that State and local governments' chief complaints about categorical grants were the excessive paperwork and administrative complexity that they attributed to Federal involvement with these grants.<sup>13</sup>

In particular, State and local governments have been concerned about the growing number of Federal planning and reporting requirements that drain staff resources.<sup>14</sup> Many of the same fundamental difficulties remain today.

- *They contribute to fragmented program management and service delivery.*

Another lingering criticism of the categorical grant system is that it is fragmented and results in duplication and overlap of programs. According to an ACIR report, "excessive categorization and overlapping of grants create administrative problems at all levels and handicap the development of a coordinated attack on community problems."<sup>15</sup> Problems of planning, coordination, and service delivery can get especially confounded in a multi-layered bureaucracy that involves Federal, State, and local governments.<sup>16</sup>

Some critics blame fragmentation on the increase in the number of categorical grant programs.<sup>17</sup> However, the fragmentation may also result from excessive program specificity, with clusters of several grants for servicing, planning, training, and demonstrating in the same narrow program area.<sup>18</sup> This categorical specificity may be a reflection of our political system: categoricals are at the nexus in the "iron triangle" of special interest groups, Congress, and Federal program bureaus. Some contend that the prevalence of categoricals is testament that the Federal grant system is not a system at all. Instead, these programs have developed piecemeal, with little consideration for the overall needs of, or the overall impact on, State and local governments.<sup>19</sup>

All levels of government have devoted considerable attention to improving coordination of categorical grant programs over the past few decades. The Federal government has implemented a wide variety of reforms to achieve this goal, but none has had more than limited success.<sup>20</sup> Failed attempts to improve coordination among programs, the ACIR concludes, "have demonstrated that Federal agencies have few incentives to standardize, simplify, or target their activities. Their primary concern is to be able to account for and make effective use of each specific grant program they administer."<sup>21</sup>

- *They inhibit program responsiveness to particular State and local needs.*

Critics claim that the restrictive nature of categorical grants hinders Federal responsiveness to the rapidly changing and diverse needs of State and local governments. With more than 50 States and territories, and thousands of jurisdictions, opponents of categoricals contend that the Federal government is unable to respond effectively to local concerns with categorical grants. Most Federal grants assume that national concerns are complementary to State and local needs. However, there are instances when these sets of needs differ. Critics say that categorical grants lack the flexibility State and local officials need, particularly in fast-changing areas like public health, to adopt new approaches in disease control and to enact programs that reflect the needs of their populations. Critics also argue that the ability to be responsive to State and local needs is compromised by the categorical grant system with its narrow allowable uses and web of Federal requirements.<sup>22</sup>

## **THE FEDERAL GOVERNMENT HAS TAKEN INITIATIVES OVER THE PAST THREE DECADES TO INCREASE STATE AND LOCAL GOVERNMENT DISCRETION OVER FEDERAL AID.**

Amidst the growing number of categorical programs, the Federal government has experimented with several more flexible funding approaches. These experiments, which give State and local governments greater discretion over Federal funds, include block grants, general revenue sharing (GRS), and Federal waivers.

- ***Partnership for Health Act of 1966: A Block Grant***

The first modern block grant to be enacted was the Partnership for Health Act (PHA) of 1966. The PHA revised the Federal health grant system by consolidating nine categorical health service formula grants into one block grant program. Its purpose was to develop comprehensive health planning at all levels of government, to strengthen State health agencies, and to support the State and local health services in a more flexible manner.<sup>23</sup> The PHA simplified administrative procedures, which, in turn, resulted in the Department of Health, Education and Welfare assuming a "hands-off" attitude toward monitoring and implementation of the program. Throughout the 1970s, the PHA lost ground because Congress enacted numerous new categorical programs that logically could have been folded into it. The PHA block grant never became a significant vehicle for change in the public health arena, as it never accounted for more than 3 percent of State public health expenditures.<sup>24</sup> The PHA's limited financial significance coupled with political inattention ultimately resulted in its demise.

- ***General Revenue Sharing in the 1970s***

General Revenue Sharing (GRS) was an entitlement program enacted by the New Federalists to increase State discretion over distribution of Federal grant funds. State officials, not Federal administrators, determined who received Federal grants and in what amounts. The GRS was intended to consolidate Federal grant programs and eliminate the expansion of Federal program priorities, mandates, and monitoring and reporting requirements.<sup>25</sup> It required no application or granting-agency approval to receive Federal funds.<sup>26</sup> The GRS was primarily a mechanism for transferring funds from the national to the local level with little Federal decision-making.

However, the GRS never lived up to its stated goals.<sup>27</sup> The scope and number of Federal categorical programs continued to grow and minimized the impact of GRS. To compound the problems, persistent inflation throughout the 1970s produced a tax revolt which resulted in an economic slowdown and a decline in the growth of intergovernmental aid.<sup>28</sup> By 1986, these conditions converged with Congressional commitment to categorical grants, and general revenue sharing was terminated.<sup>29</sup>

- *The Omnibus Budget Reconciliation Act (OBRA) 1981 Block Grants*

Block grants reemerged as a funding mechanism in the early 1980s in response to continued administrative and political criticisms of categorical grants and the desire to curb Federal spending. Congress enacted nine block grants under the OBRA of 1981 -- four of which are administered by the Public Health Service. These public health block grants consolidated 21 categorical programs and reduced the aggregate Federal funding levels up to 25 percent. Of these block grants, three -- Maternal and Child Health (MCH), Preventive Health and Health Services (PHHS), and Alcoholism, Drug Abuse and Mental Health Services (ADMHS) -- were implemented.<sup>30</sup> Evidence on early implementation of the 1981 block grants showed that States did at least as good a job in administration of block grants as the Federal government had done formerly. Even interest groups and service providers with a large stake in maintaining a categorical system reported that they were by and large neutral toward the 1981 block grants as an administrative reform after three years of implementation experience.<sup>31</sup> Subsequent proposals for the creation of block grants failed, however, because they became identified as political instruments of domestic budget-cutting.

- *Federal waivers in the 1990s*

Recently, waivers have become an increasingly popular approach for enhancing State discretion over Federal funds. The number of State applications for Federal waivers has increased for the Medicaid and Aid for Families with Dependent Children (AFDC) programs. From April 1993 to August 1994, 17 States filed applications for Section 1115 Medicaid waivers; in the past, the Medicaid program received on average one to three waiver applications per year. During this same period, 52 applications for AFDC waivers were submitted compared to a total of 33 applications received during the preceding four years.<sup>32</sup> These waivers free States from Federal regulations, while allowing them to experiment with unconventional administrative or service delivery approaches.



# THE BLOCK GRANT EXPERIENCE

Most literature on Federal grant funding approaches was published in the 1970s and 1980s when political attention was focussed on reforming the Federal grant system. We reviewed evaluations of the shift from categorical to block grant funding for public health programs conducted by academics, the GAO, the ACIR, and various contractors hired by the Department. These evaluations focus primarily on the Partnership for Health Act of 1966 and the three PHS-administered block grants enacted under the Omnibus Budget Reconciliation Act (OBRA) of 1981.

During our search we found that few studies of public health block grants were conducted after the mid-1980s. The lack of analysis of these programs may be due to lack of data, because most Federal reporting requirements were removed when categorical programs were consolidated into block grants. Perhaps the dearth of information, coupled with almost a decade of political inattention to reforming the Federal grant system, explain why so little has been written on this topic in recent years.

It is difficult to generalize about State experiences under block grants because these grants have varied widely in structure, legislative intent, and objectives. The level of funding, the increasing categorization imposed by Congress over time, and previous State involvement in the program area have also affected block grant performance.<sup>33</sup> Nevertheless, despite these important differences among the block grants, some common lessons have emerged out of the early experiences in implementing block grants. This analysis identifies those lessons by focusing on questions commonly asked about the block grant experience.

## **HAVE BLOCK GRANTS PROMOTED ADMINISTRATIVE IMPROVEMENTS AND COST-SAVINGS?**

- *States reported that block grants improved administrative efficiency.*

The literature evaluating block grants, particularly the Partnership for Health Act of 1966 and the three PHS-administered block grants enacted by OBRA 1981, shows that most States surveyed altered their administrative systems and made management improvements in response to block grants.<sup>34</sup>

A 1977 ACIR study that examined State experiences under the Partnership for Health Act and the three other block grants (Comprehensive Employment and Training Act, Crime Control and Safe Streets Act, and Community Development Block Grant) implemented in the 1960s and 1970s "indicated that significant policy and administrative decentralization was achieved, Federal personnel and paperwork costs were reduced."<sup>35</sup> Administrative improvements resulted primarily from the requirement that State health agencies submit one comprehensive State plan for all public health activities rather than comply with many separate reporting requirements.

A series of GAO studies reported on States' experiences under the PHS-administered 1981 block grants and found that, of the 13 States surveyed, most reported having implemented management improvements as a result of the block grants. The GAO found that almost two-thirds of State respondents reported reduced time and effort spent in preparing program applications. In addition, almost three-fourths claimed that they spent less time and effort reporting to the Federal government under block grants compared to categorical programs. One-third of the States surveyed reported improving the use of personnel as a direct result of the block grants; two-thirds of the State respondents reported altering their administrative procedures in response to block grants.<sup>36</sup>

Almost all of the 13 States included in a GAO survey reported administrative improvements under the Alcohol, Drug Abuse, and Mental Health Services (ADMHS) and Maternal and Child Health (MCH) block grants. Most of these States reported reducing time and effort involved in preparing grant applications and reporting to the Federal government under ADMHS.<sup>37</sup> In an Urban Institute study of 18 States, many States reported that ADMHS enabled them to standardize administrative requirements and to improve planning, budgeting, and the use of personnel.<sup>38</sup> The GAO found that States reported improved administrative efficiency by integrating MCH planning into the overall health planning and budgeting processes.<sup>39</sup> According to the Urban Institute study, some States enhanced administrative efficiency by creating "mini-blocks" that devolved responsibility to localities. Others reported improvements and suggested potential savings at the local level from grant consolidation and streamlined application procedures.<sup>40</sup>

Some States surveyed by the Urban Institute reported that the implementation of the Preventive Health and Health Services (PHHS) block grant was time-consuming and expensive at first, but agreed that it eventually lightened their paperwork.<sup>41</sup> According to a GAO survey of 13 States, PHHS implementation was accompanied by "reduced Federal administrative requirements in such areas as preparing applications and reports."<sup>42</sup> Nine of the 18 States that the Urban Institute surveyed altered their administrative practices in response to the PHHS block grant, but many of these States reported that they passed on the burden to local grantees.<sup>43</sup> While States report benefits from administrative simplification, many may well have passed on their administrative responsibilities onto local grantees rather than actually reducing the complexity and amount of paperwork.

- *The extent of administrative cost-savings is unclear because data are limited.*

It is difficult to determine whether block grants reduced administrative costs because so little quantitative data have been collected, and existing data are of questionable reliability. The difficulties in interpreting these data are documented in evaluations conducted by the GAO, the Brookings Institution, the American Enterprise Institute, and the Urban Institute. These studies discuss both limitations in the availability of data and measurement errors in the existing data. Most pre- and post-consolidation evaluations comparing administrative costs between block grants and categorical programs have revealed no conclusive evidence to support the claim that block grants led to sizeable

reductions (10 percent or more) in administrative costs, but do not exclude the possibility that some cost savings emerged.<sup>44</sup>

Attempts by the GAO and ACIR to compare administrative costs under the Partnership for Health to the former categoricals have not yielded compelling findings. The existing data on administrative costs under the PHA suggest little difference between administrative costs for the block grant and the former categoricals. Administrative costs averaged 9.9 percent between FY 1975 and FY 1980, which falls within the range reported for categorical programs.<sup>45</sup> In part, this higher than expected administrative cost may have been because the newly created Partnership for Health Program funded grantees for a wider variety of health services than the previous categoricals. Case studies of the Partnership for Health programs suggest that the costs of applying for, allocating, and monitoring may have been as low as 2 to 3 percent, but because PHA did not restrict administrative expenditures to a set of prescribed services, State health departments funded a variety of activities with PHA money.<sup>46</sup> These confounding factors may have had independent effects on administrative costs. However, the lack of data on the Partnership for Health implementation makes it impossible to isolate them.<sup>47</sup>

While the OBRA 1981 block grants were enacted "to achieve more service at less cost," scant information documenting actual dollar savings exists.<sup>48</sup> An Urban Institute study, conducted 3 years after implementation, showed that even block grant supporters who claimed that grant deregulation "would make it possible for States to absorb as much as 20 to 25 percent of the funding reductions through administrative savings alone" admitted that savings were not that high.<sup>49</sup> Most States surveyed concluded that the block grants had substantially reduced paperwork, but had not significantly reduced administrative costs.<sup>50</sup> A series of GAO studies on the OBRA 1981 block grants corroborated these findings and reported that although States claimed reduced administrative costs, they had no documentation on the magnitude of dollar savings resulting from block grants.

## **HAVE BLOCK GRANTS FACILITATED SERVICES INTEGRATION?**

- *Studies on block grants emphasized services integration at the administrative rather than the service delivery level.*

Block grants aim to improve coordination across categorical programs, both at the administrative and service delivery levels.<sup>51</sup> They are intended to have a "system building" effect on programs. Yet, system building at the service delivery level has received little attention in evaluations of the shift from categorical to block grants. Based on the limited information in the studies on State experiences, it seems that more attention has been paid to the administrative than the service delivery aspects: focussing on economy and efficiency inherent in the consolidation of program planning, budgeting, and management operations.

- *The Partnership for Health Act improved intergovernmental coordination, but did not necessarily promote a system-wide approach to public health problems.*

The PHA was intended to create an integrated approach to the planning, financing, and delivery of public health services involving all levels of government and the private sector.<sup>52</sup> One ACIR analysis of the PHA and the three other early block grants found that significant policy and administrative decentralization had taken place and intergovernmental coordination had been facilitated.<sup>53</sup> This was most likely the result of turning over responsibility for the block grant to the State health agencies.

A second ACIR study, which included in-depth State case studies, revealed that none of the six States had implemented a system-wide approach to public health problems in response to the Partnership for Health. The PHA was not identified as an inhibitor to such an approach, but, on the other hand, neither did it generate such an approach.<sup>54</sup>

- *The OBRA 1981 block grants enhanced integration at the administrative level.*

The Alcohol, Drug Abuse, and Mental Health Services block grant prompted some improvements in integration at the administrative level. States had been heavily involved in ADMHS programs prior to enactment of the block grant, and many of the programs funded by Federal grants were quite similar to State programs. The block grant provided opportunities for administrative consolidation.<sup>55</sup> All 18 States consolidated these Federal programs into their existing State systems.

According to the GAO, integration was also enhanced under the Preventive Health and the Maternal and Child Health block grants by combining their planning components into their overall health planning and budgeting processes.<sup>56</sup> After the enactment of these block grants, decisions about use of funds were linked to broader policy decisions on State health programs, in the context of the availability of funds from Federal, State, and other sources.<sup>57</sup>

## **HAVE BLOCK GRANTS FOSTERED GREATER RESPONSIVENESS TO STATE AND LOCAL NEEDS?**

- *States claimed that the Partnership for Health Act allowed them to tailor services to their own needs, but evaluators contend that the block grant did not significantly reorder State program priorities.*

An ACIR survey of officials in all 50 States revealed that the most prized feature of the Partnership for Health was "the flexibility to use the funds where the needs are the greatest or priorities highest, and to respond to changes in health needs over time."<sup>58</sup> All but one of the States praised the flexibility of the PHA for allowing them to better meet State and local needs. Some examples of State comments include:

Delaware: The country varies in the priority of needs unmet in the public health field, and the block grant potentially provides the flexibility to meet these various priorities.

Kentucky: We are able to focus our attention on actual problems rather than expend resources on low priority areas.

Texas: Funds can be used comprehensively, with the State agency establishing its own priorities with regard to whom, how, and where the funds can be best utilized in helping satisfy the public health needs of the State's citizens.<sup>59</sup>

Another study of the Partnership for Health, conducted by a professor at Wichita State University, investigated whether the block grant resulted in substantive changes in the expenditure of State public health funds compared with expenditures under the former categorical grants. This study, based on responses from State health officials in all 50 States, found "that while there have been changes resulting from the shift to a block grant, they have generally been minimal."<sup>60</sup> It contends that increased administrative flexibility is not identical to or even related to focussing on major new priorities.<sup>61</sup>

A 1981 American Enterprise Institute study of the Partnership for Health also reported that the block grant did not lead to major shifts in States' program priorities. It concludes that because the Partnership for Health funds never accounted for more than 3 percent of State health department expenditures, the grant never exerted much influence over service priorities.<sup>62</sup>

• *States reported minor adjustments to programs under the OBRA 1981 block grants, but did not substantially alter program priorities.*

Most program areas that had been funded under the prior categorical programs continued to receive support under the OBRA 1981 block grants. Although such continuity was evident, minor changes in funding patterns emerged as States sought to assert their own priorities while dealing with funding limitations.<sup>63</sup> A GAO study of 13 States found that States recognized their greater decision-making authority to set program priorities and determine the use of funds than they had under the prior categorical programs, but did not exercise it to make substantial changes.<sup>64</sup> Freed from Federal restrictions and program guidelines, some States began to take advantage of increased flexibility and transferred small portions of funds across block grants.

Programs that fared best (financially) under the 1981 block grants appeared to be those with statewide application and histories of State as well as Federal funding. Some States reduced or eliminated funding for federally supported projects, and others realigned the types of services offered.<sup>65</sup> For example, looking at the Maternal and Child Health block grant in 18 States, the Urban Institute found that the Crippled Children's Services program, with its long history of State involvement, saw its share of funding grow in many States. In contrast, the funding for the Lead-Based Paint program--viewed as a narrowly focused, urban program with little State involvement--was cut.<sup>66</sup>

Almost all of the 18 States surveyed by the Urban Institute reported minor adjustments in their program mix in response to the Preventive Health and Health Services block grant.<sup>67</sup> To some extent, this involved creating new programs or initiatives within existing programs. However, the majority of the changes involved shifting funding among the old Federal program categories.<sup>68</sup>

The same Urban Institute study concluded that the Alcohol, Drug Abuse, and Mental Health Services block grant also resulted in limited changes across the program areas. By and large States maintained the traditional funding patterns. In part, this continuity may be due to the Federal earmarks dictating how to divide funds between services for alcoholism and drug abuse and which mental health providers to fund. Nonetheless, most States did not exercise the little flexibility afforded them.<sup>69</sup>

### **HAVE BLOCK GRANTS REPLACED STATE AND LOCAL FUNDING FOR SERVICES?**

- *Scant data exist on how the Partnership for Health block grant money was used, but ACIR studies show that it promoted new spending rather than replaced State money.*

Other than the ACIR study conducted ten years after implementation, there have been no national evaluations of the Partnership for Health Act. Little information exists showing whether funds were used to replace State funds or to add to State public health budgets. In part, the limited accountability requirements may have resulted in little reporting and data collection and led to a diminished capacity to evaluate the impact of the shift from categorical to block grant funding.<sup>70</sup> However, according to the ACIR, the minor fiscal magnitude of the Partnership for Health funds renders the issue of replacing State money with Federal funds inconsequential. The PHA funding continued to equal or exceed the total funding for the former categorical programs, and total State and local public health expenditures expanded. Based on this evidence, the ACIR suggests that PHA money was used to expand services rather than replace State money with Federal funds.<sup>71</sup>

- *Under the OBRA 1981 block grants, States replaced lost Federal funds in order to maintain service levels.*

The OBRA 1981 block grants did not result in replacement of State money with Federal funds. In fact, in many instances, the reverse was true. Public health block grants were accompanied by significant cuts in Federal funding (as much as 25 percent), so many States resorted to replacing lost Federal funds from their own treasuries for programs that they deemed important. Programs with a history of State involvement, whose benefits were spread throughout the State, or whose recipients were viewed as particularly needy, fared best.<sup>72</sup> The Alcohol, Drug Abuse, and Mental Health Services and Maternal and Child health block grants, both of which had strong State involvement, were extremely successful in securing State and local funding to make up the difference in their funding levels after Federal cuts.<sup>73</sup>

- *Factors other than block grant status better predict whether States use funds for additive or substitutive purposes.*

An ACIR analysis of States' use of Federal grants concluded that a number of factors may influence whether a particular grant program is additive or substitutive. Rather than type of grant, it proposed that the principal factor is the recipient's interest in the aided activity in relation to competing uses for funds. Other factors include the size of the recipient government, the number and variety of grant programs in which it participates, the timing and size of the grant, and the grant's requirements.<sup>74</sup> A Brookings Institution study on Federal aid contends that the type of grant is not the best predictor of whether States will use Federal funds as replacement money. It argues that "all forms of Federal aid to states and localities are fungible, no matter how ingenious the conditions placed on the use of grant moneys."<sup>75</sup>

A study published in the *Political Science Quarterly* points to a State's fiscal condition as a better determinant than type of grant in a State's decision to use Federal funds as additive or substitutive. "The more fiscally hard-pressed a jurisdiction, the more likely it is to merge Federal grant funds with its own resources, and use them to pay for the basic services it provides...If they are strong enough, fiscal pressures may cause generalist officials to use as much Federal money as they can to do what in their view must be done."<sup>76</sup>

A 1985 Brookings Institution study concluded that States and localities prefer to use Federal aid for additive purposes--to enlarge their programs--rather than substitute it for State money.<sup>77</sup> It concludes that recipient governments are aware of the costs associated with using Federal grants to support basic services. States choose to avoid risks, which include enforcement of requirements prohibiting the maintenance of existing programs with Federal funds, demands made by specialists and interest groups that Federal funds intended for their particular programs be protected, and fear of becoming reliant on Federal grants which are often unstable.<sup>78</sup>

#### **HAVE BLOCK GRANTS LEFT CERTAIN CLIENT GROUPS VULNERABLE?**

- *Block grants often include special targeting provisions to ensure that Federal funding was allocated to the neediest populations. The effectiveness of such provisions is unproven.*

Options for ensuring that block grant funds are targeted to the needy include distribution formulas, earmarking, and "hold harmless" provisions. Most block grants are allocated through distribution formulas keyed to population and financial need. Proponents argue that these formulas are more egalitarian than categorical grants because they emphasize need rather than "grantsmanship" skills. Yet, critics claim that the political compromises necessary for Congressional approval of block grant distribution formulas make targeting resources to particular client groups difficult to achieve.

Legislative earmarking is another way to alter block grants so that they channel certain amounts of money into particular program areas. A third means of targeting block grants is through inclusion of "hold harmless" provisions, which are designed to guarantee funding to former grantees over a certain period of time until they are no longer dependent on Federal aid.<sup>79</sup> Any of these mechanisms may help ensure that block grants' flexibility does not result in overlooking certain program participants and population areas.<sup>80</sup>

While these mechanisms have been used to ensure that distribution of funds through block grants does not leave any client group vulnerable, the debate about the distributional impact of block grants has generated significant controversy. Advocacy groups for the poor, contending that federally administered categorical programs are better able to target program assistance to those most in need, have expressed concerns about block grants.<sup>81</sup> They fear that block grants will prompt the elimination of services targeted to poor and minority populations over time.<sup>82</sup> This same concern has been played out in Congress. When the 1981 block grants were introduced, the Secretary of Health and Human Services maintained that freeing the States from Federal guidelines would permit them to focus their efforts more effectively on the truly needy. Some members of Congress challenged this argument claiming that, once Federal money was turned over to the State legislatures, services to the disadvantaged would be slashed.<sup>83</sup>

- *Limited data suggest no major differences in the client populations served under the Partnership for Health Act and the former categorical programs included in it.*

Because there have been no national pre-post block grant evaluations of the Partnership for Health, it is difficult to determine what impact the shift from categoricals to the block grant had on particular client groups. The only protected population were those using mental health services, for which there was a 15 percent earmark; otherwise there were essentially no restrictions on the programmatic use of funds. The little information available suggests that there was no significant change in the distribution of resources under the PHA.<sup>84</sup>

- *The OBRA 1981 block grants contained provisions to ensure targeting, but there has been little examination of their impact on the poor.*

It is difficult to assess the impact of OBRA 1981 block grants on targeting the poor. First, there has been a general lack of evaluation on the distributional impact of these block grants. Second, for programs in which income eligibility was maintained, the standards were tightened in response to Federal funding cuts. On the one hand, this move was intended to focus the reduced program benefits more narrowly on the poor, but on the other hand, it can be viewed as an attempt to limit the number of people receiving services.<sup>85</sup>

Finally, some of the OBRA 1981 block grants contained low-income targeting provisions. For example, the Maternal and Child Health block grant mandated that certain services be provided to clients with incomes below the official poverty line. However, other services



authorized under MCH were not limited to clients who met these eligibility requirements.<sup>86</sup> The Alcohol, Drug Abuse, and Mental Health Services, the Preventive Health, and the Maternal and Child Health block grants all included changes in their distribution formulas to facilitate targeting. These changes instructed the Secretary of Health and Human Services to consider States' financial resources and the size of their low-income populations when determining appropriate distribution.<sup>87</sup>

The PHHS and ADMHS block grants included provisions that required grantees to fund previously supported projects in order to ensure that low-income clients served by former categoricals would continue to be served under the block grants.<sup>88</sup> However, as States began to establish their own criteria for targeting, efforts to study the impact of targeting on a nationwide basis became more difficult.<sup>89</sup>

# **RECOMMENDATIONS FOR RESEARCH AND DEMONSTRATION**

The literature on the effects of block grants leaves many important questions unanswered. It tells us that in various settings at various times they have contributed to greater administrative efficiency, more integrated management systems, and even increased State and local spending. But the evidence in these areas is limited. It is even more limited on questions concerning the effect of block grants on administrative costs, service delivery, responsiveness to State and local spending, and targeting services to the needy.

In part, these limitations are attributable to the limited research conducted on block grants, especially in recent years. In larger part, however, they are due to other more basic factors. These include the (1) inherent difficulty in documenting the effects of a granting mechanism which aims to minimize data reporting requirements and (2) limitations of experimental design research techniques in governmental settings often experiencing rapid political, fiscal, and/or demographic change.

Yet, given the forces generating greater support for block grant approaches and given PHS' interest in responding constructively to those forces,<sup>90</sup> it is timely to delineate a research and demonstration strategy for block grants that is consistent with their inherent nature of offering grantees substantial discretion. In this concluding section, we recommend that PHS develop such a strategy.

The central question around which this strategy should revolve is the following:

**How can the Federal government enhance the discretion of grantees and at the same time hold them sufficiently accountable for their performance?**

Indeed, if block grants (whether through formally established programs or through waiver mechanisms) begin to shift from a relatively minor portion of Federal grant-making to a more significant share, finding workable answers to this question will become increasingly important. It will be vital that block grants become performance based: a direction for which experience and the professional literature provide little guidance.

Thus, we offer the following recommendation. It is directed to PHS, which requested this report. But the directions we lay out are generic enough to apply to the Department of Health and Human Services and even more broadly to the Federal government.

*The Public Health Service should develop a strategy to use performance indicators in ways that will allow grantees substantial discretion in using Federal funds and, at the same time, hold them sufficiently accountable for their performance.*

This strategy should recognize the considerable diversity across the country's political jurisdictions and should view each recipient of a block grant or Federal waiver as having both an opportunity and responsibility for contributing to the knowledge base on the central question identified above. It should focus on measuring the performance of grantees more than on reviewing their detailed plans. It should aim for continuous improvement through experiential learning and through the identification and dissemination of effective practices.

Toward this end, the Public Health Service could examine ways in which block grant recipients could do the following:

### *Identify Relevant Indicators of Performance*

Broad statements of goals and objectives and benchmarks of expected accomplishments at particular target times are useful starting points, but in themselves are insufficient bases for assessing performance. They must be supplemented by explicit indicators of performance, expressed to the maximum extent feasible in terms of outcomes--that is, actual changes in the conditions of program recipients. The process of identifying and achieving consensus on such indicators is, in itself, an extremely important and difficult one. It can contribute, however, not only to a better understanding of program results but also to more refined expressions of program intent.

The PHS has already begun moving in this direction. The Maternal and Child Health Block Grant, administered by the Maternal and Child Health Bureau, calls for grantees to develop measurable indicators of performance related to the "Year 2000 Objectives" developed by PHS. The ACCESS demonstration program, funded by the Center for Mental Health Services, seeks to identify ways in which programs serving mentally ill homeless adults can assess their performance in improving the lives of such individuals. The self-assessment instrument developed by the Federation of State Medical Boards, through funding by the Bureau of Health Professions, facilitates efforts by State medical licensure boards to compare and assess their performance.

Among the research and demonstration questions that could be posed are these:

- . What processes are most effective in facilitating consensus on pertinent indicators?
- . Given resource and data limitations, what kind of indicators are feasible? What ones facilitate comparisons over time and across jurisdictions?
- . What is a good mix of process, output, and outcome indicators?

### *Develop Mechanisms for Collecting Performance Data*

The successful application of performance indicators will depend heavily on the feasibility of the operational mechanisms to be used once they are established. A major challenge

for architects of these systems is to develop data collection approaches that are as minimally intrusive as possible to those actually delivering services. Particularly in environments where the demand for services exceeds the supply, service deliverers are unlikely to show much enthusiasm for new accountability mechanisms that call for them to devote additional time to efforts to document their activities.

Among the research and demonstration questions that could be posed are these:

- . What kind of software programs show the most promise in allowing data to be captured with maximum efficiency?
- . How are data collection responsibilities best divided between service deliverers and central staff?
- . What kind of oversight most effectively contributes to accurate and consistent data collection?

### ***Present and Disseminate Performance Data***

How performance data are displayed and disseminated affects how they will be used. The challenge is to present and distribute them in ways that facilitate understanding, not just by statisticians and program experts, but also by general managers, legislators, and the general public. In this context, the data are not intended to provide definitive measures of the success or failure of particular programs, but rather to facilitate more effective questioning about results. If the data are presented in ways that allow comparisons over time or across jurisdictions, then reviewers are likely to pose basic questions that seek explanations for the differences.

Among the research and demonstration questions that could be posed are these:

- . What kind of graphics and textual presentations are most effective in facilitating comparative analyses?
- . Are there different approaches that are suitable for different audiences? What are the most effective ways of using "report cards" for grantees and/or service providers?
- . What dissemination techniques show the most promise?

### ***Use Performance Data to Improve Performance and/or Refine Objectives***

In the continuous quality improvement approach to enhancing productivity, performance data are intended to stimulate discussion about better ways to reach desired ends and/or to a reexamination of what those ends should be. The data should be used on an ongoing basis by grantees to review and improve their own operations; they should not be viewed strictly as a mechanism for funders to assess the performance of grantees.

Among the research and demonstration questions that could be posed are these:

- . In what ways are grantees using performance data to review their operations? How do they facilitate collegial reviews? Reviews by broader publics?
- . What are the major barriers they confront in trying to use these data to improve performance? How can they best address these barriers?
- . What are the results? Are grantees making actual changes based on a review of performance data? What kind of changes are they making?

The four main components cited above--identifying relevant indicators of performance, developing mechanisms for collecting performance data, presenting and disseminating performance data, and using such data to improve performance and/or refine objectives--involve scrutiny of what happens within the jurisdictions using block grants. As important as those internal dynamics are, they are not in themselves sufficient to afford the accountability mentioned in our central question. In that context, it is also important for PHS to examine approaches it could use to:

#### ***Ensure Adequate Performance of Grantees***

Even with a block grant affording extensive discretion, a grantee must in some meaningful ways remain accountable to the Federal funders. At the same time, the Federal funders also have the obligation to carry out their stewardship responsibilities and yet remain true to the principles of a block grant. Again, there is little experience here that provides a useful road map; knowledge must be gained by conducting an active research and demonstration effort in concert with block grant funding.

Among the research and demonstration questions that could be posed are these:

- . What is the potential of performance contracting? Are there viable mechanisms of providing more or less funding based on performance as measured by agreed upon indicators?
- . How can the Federal government best ensure that performance data are accurate and consistent with established definitions? What kind of audits should be undertaken toward this end?
- . What is the role for penalties in a performance based block grant system? Under what circumstances and how might they be used?

The five strategy components offered above are presented in the context of future efforts that could be undertaken along with the provision of grants that give grantees substantial discretion in how the funds are to be used. For example, these ideas could be used in

implementing the extensive program consolidation included in the Department's Fiscal Year 1996 proposed budget for the Public Health Service (see page 2).

To a limited extent, it might also be useful to look retrospectively at both block and categorical grant programs to identify any insights they offer to the establishment of block grant mechanisms which hold grantees accountable for performance.

In this context, the Maternal and Child Health Block Grant Program could be a good candidate for inquiry. Among the changes to that program that Congress made in 1989 were those calling for States to submit to PHS data that facilitate measurement of State progress in meeting "Year 2000 Objectives." Reviews of how individual States and PHS have responded to this mandate could be quite helpful--in the sense of assessing the potential of performance indicators, the barriers faced in trying to use them, and the ways in which these barriers might be constructively addressed.

## COMMENTS ON THE DRAFT REPORT

The Assistant Secretary for Planning and Evaluation reviewed the report and concurred without elaboration. The Public Health Service (PHS) also reviewed the report. Its comments appear in full in appendix B.

The PHS concurred with our recommendation. In so doing, it noted two actions it has undertaken that move in the direction of our recommendation. One is the "Performance Partnership Grants" program that has been proposed to Congress. The other is an initiative "to establish and use performance measures whether they are funded through the categorical or block grant mechanism."

We recognize the relevance and importance of these actions. In tandem with them, we urge PHS to take maximum advantage of current research and demonstration opportunities available in order to promote better understandings on just how block grants and performance indicators can be usefully linked. In our report, we suggest in some detail directions that can be taken in that regard.

The PHS suggested two technical changes, both of which we made in the final report.

# APPENDIX A

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## ANNOTATED BIBLIOGRAPHY

This bibliography includes three major sections: general literature on Federal grants, literature on the Partnership for Health Act, and literature on the 1981 block grants. This bibliography summarizes some of the major studies that have provided frameworks for thinking about the issues included in the body of the report.

### GENERAL LITERATURE ON FEDERAL GRANTS

1. Advisory Commission on Intergovernmental Relations, *Block Grants: A Comparative Analysis*, October 1977.

**Abstract:** This report attempts to clarify the confusion surrounding the design and administration of block grants. It is based on the ACIR's assessments of the application of block grants to health, crime control, manpower, and community development. The report includes a description of the evolution of the block grant concept, its characteristics and objectives, and compares them to the reality of implementation. This report is intended to provide a foundation for recommendations on the appropriate use of the block grant by the Federal government.

2. Advisory Commission on Intergovernmental Relations, *Summary and Concluding Observations*, June 1978.

**Abstract:** This is the final report of the ACIR's 14-volume study of the intergovernmental grant system conducted between 1976 and 1978. This report: (1) summarizes the major findings, conclusions, and recommendations of the entire study, (2) analyzes the changes in the Federal grant system in terms of intergovernmental issues, (3) identifies the broad trends that characterize Federal-State-local relations and speculates on the reasons for the trends, (4) interprets the long-term impact of these trends on American federalism, and (5) recommends a five-point intergovernmental strategy to meet the challenges of the current Federal grant system.

3. Claude E. Barfield, Rethinking Federalism: Block Grants and Federal, State, and Local Responsibilities, American Enterprise Institute, 1981.

**Abstract:** This monograph examines the administrative and political results that occur when categorical grants are consolidated into block grants. It addresses questions regarding the nature and function of American federalism in the 1980s, and suggests a framework for reordering Federal, State, and local priorities. This



monograph draws on other studies conducted by the GAO, ACIR, The Brookings Institution, The Urban Institute, and The National Governors Association that examine the impact of block grants on efficiency, decentralization, planning, coordination, and generalist control. Chapter four of this book, entitled "Evaluating Block Grants: The Previous Experience and Future Expectations," examines the administrative arguments behind the creation of block grants and is most relevant to this study. It proposes recommendations for the design of future block grant legislation.

***Important Points:***

- Avoid vague language in the stated purpose of a block grant. Well-articulated goals provide clearer direction to the States and allow for more accurate evaluation later.
- Allow the States to hold separate public hearings or to integrate the block grant into their normal budgetary and legislative processes.
- Include Congressional mandates for audits that conform to existing standards such as OMB circulars or GAO Standards for Audits.
- Set a Congressional limit on overhead for each block grant. This limitation would allow flexibility for disparate administrative costs from the individual categorical grants folded into the block grant and encourage States to watch for costly, inefficient administration.
- Specify a uniform definition of low-income persons in order to target block grant funds to the neediest populations.

4. Robert Agranoff and Leonard Robins, "How to Make Block Grants Work: An Intergovernmental Management Perspective," *New England Journal of Human Services*, Winter 1982.

***Abstract:*** This article describes the characteristics of block grants, outlines how they differ from categorical grants, and discusses past experiences with block grants. It outlines the implementation difficulties and recommends how to make block grants work on the national and State levels. It includes a discussion of national goals, accountability, adequate funding, regulatory requirements, program design and coordination, administrative systems, and planning and management.

5. Lawrence D. Brown, James W. Fossett, and Kenneth T. Palmer, *The Changing Politics of Federal Grants*, The Brookings Institution, 1984.

***Abstract:*** This book recounts the history of the Federal grant system since the Johnson Administration. It explores the growth of Federal aid in the late 1960s and early 1970s and documents the efforts of successive presidents to rationalize the grant system and reduce Federal controls. This book represents the final chapter in a major Brookings Institution effort to evaluate the distributional, fiscal, programmatic, and political effects of Federal grants. It includes three essays: (1) Fossett's essay synthesizes a series of case studies on the impact of Federal grants on selected urban areas; (2) Palmer's essay explores the evolution of Federal

grant programs; and (3) Brown's essay assesses the politics of devolution of Federal grants.

6. U.S. General Accounting Office, *Block Grants: Federal-State Cooperation in Developing National Data Collection Strategies*, HRD-89-2, November 1988. (This citation and following abstract provided by the Public Health Service.)

**Abstract:** The GAO recommends that in considering future block grant data needs, the Congress may want to statutorily require the Secretary of Health and Human Services to develop a mode for State data exchange in consultation with appropriate associations of State and local officials to facilitate uniform data collection under the community services block grant.

The GAO also recommends that the Secretary of Health and Human Services work with the States through the cooperative data collection efforts to increase data comparability under the energy assistance; community services; and alcohol, drug abuse, and mental health services block grants.

7. U.S. General Accounting Office, *Developing a Federal Drug Budget: Implementing the Anti-Drug Abuse Act of 1988*, GGD-900104, August 1990. (This citation and following abstract provided by the Public Health Service.)

**Abstract:** There is no requirement that States provide expenditure data; so there is no way to determine the exact amount of funds expended on drug abuse, alcohol abuse or mental health. The GAO concludes that accounting for agency expenditures with sufficient precision to assess programs that Congress considers significant, such as anti-drug programs, is an important objective.

**Recommendation:** Agencies with drug programs be encouraged to explore options that will provide better data with which to evaluate the effectiveness of their drug program expenditures.

8. U.S. General Accounting Office, *Alcohol, Drug Abuse, and Mental Health Services Block Grant: Women's Set-Aside Does Not Assure Drug Treatment for Pregnant Women*, HRD-91-80, May 1991. (This citation and following abstract provided by the Public Health Service.)

**Abstract:** To better assure that the Congress is given a clear picture of how the funds for the women's set-aside of the block grant is used, GAO recommends that the Secretary of Health and Human Services direct the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration to specify annual reporting requirements for the States in a manner that allows for the national aggregation of reported data. States should be required to report on (1) all treatment programs for pregnant women and women with children and new or expanded treatment programs or services for women and (2) the number of drug-abusing pregnant women and women with dependent children.

9. U.S. General Accounting Office, *Alcohol, Drug Abuse, and Mental Health Services Bock Grant: Drug Treatment Services Could be Improved by New Accountability Program*, HRD-92-27, October 1991. (This citation and following abstract provided by the Public Health Service.)

**Abstract:** This report indicates that the Federal government receives limited information on the results of the Federal investment in drug treatment services. Although most of the States reviewed monitor administrative processes, their review activities have not provided information on the quality and appropriateness of drug treatment.

The GAO recommends that Congress direct the Secretary of Health and Human Services to: (1) establish reporting requirements for the States that will provide the Department with information to determine whether States are providing drug treatment program and services that are effective and (2) report to Congress by 1995 on the progress of a State Systems Development Program initiated by the Department.

10. Michael J. Rich, Federal Policymaking and the Poor: National Goals, Local Choices, and Distributional Outcomes, Princeton University Press, 1993.

**Abstract:** This book examines the relationship between Federal decision-making systems and the distributional impacts of public policies. The analysis focuses on the roles that Federal, State, and local officials play in determining the uses of Federal funds, and how, if at all, these roles change over time. The author examines two main questions: (1) Are policy outcomes different when Federal officials--as opposed to State and/or local officials--have greater influence regarding the use of Federal program funds? (2) Do Federal, State, and local governments differ in their responsiveness to the needs of the poorest citizens? This study offers a theoretical framework for analyzing the Federal grant system with an emphasis on experience with the Community Development Block Grant program.

**Important Points:**

- The capacity of governments to target Federal funds to the poor vary greatly. Government officials at all levels tend to spread program benefits widely as opposed to concentrating them where needs are the greatest.
- Benefit coalitions play an important role in shaping Federal program outcomes. Targeting is greater when strong coalitions emerge to press government officials to concentrate funds on needy places and to needy people.
- Benefit coalitions that include a strong Federal partner are more likely to be successful in obtaining targeted policy outcomes at the local level.

11. Office of the Vice President, "Strengthening the Partnership in Intergovernmental Service Delivery," *National Performance Review*, September 1993.

**Abstract:** This report outlines the current state of intergovernmental relations and Federal grant making. It recommends how the Federal grant system should allocate money to States and localities. This report calls for a streamlined approach to intergovernmental partnership through a reduction in the number of categorical grants and a decrease in the amount of paperwork required for receipt of Federal grants.

**Important Points:**

- Federal mandates and regulations that accompany grant programs are cumbersome and costly to administer; they lack a coordinated implementation strategy between levels of government, and are not achieving their intended outcomes.
- States and localities have limited ability to customize service delivery by integrating programs because of competing, often conflicting, Federal rules that accompany each grant program.
- Massive reform of the existing system of intergovernmental grant-making is necessary. Federal grant programs should be consolidated into broad funding pools, organized around major goals and desired outcomes. The goals should include: streamlining administrative mechanisms, providing flexibility to account for regional differences and the diversity of needs, ensuring accountability by measuring performance and outcomes, and driving program design and management down to the point of contact between government and the consumer.
- The number of categorical grants should be reduced and the Federal government should work with States and localities to define a more viable Federal partnership that balances flexibility and accountability.

12. Advisory Commission on Intergovernmental Relations, *Characteristics of Federal Grant-in-Aid Programs to State and Local Governments: Grants Funded in FY 1993*, January 1994.

**Abstract:** This report is part of an ACIR series that has identified, counted, and examined the characteristics of Federal grant-in-aid programs since 1975. This report is its most recent effort to identify major changes in the basic features of the grant system.

**Important Points:**

- The total number of Federal grants to State and local governments increased from 557 to 593 between 1991 and 1993.
- Grant outlays rose to \$206.4 billion in 1993 from \$152 billion in 1991, an increase of 36 percent.
- The largest number of new categorical grants were in health, education, training, employment, and social services.
- Measured by outlays, Federal grants for health have expanded more significantly than any other area, rising from 9.1 percent of the total in FY 1975 to 40.9 percent in FY 1993.
- There were 15 block grants in 1993 compared to 578 categorical grants.

- More than 70 percent of the money in the grant system has been distributed through categorical programs, while about 10-15 percent has been allocated to block grants.
- Categorical grants continue to be the main avenue of Federal grant expansion.

## THE PARTNERSHIP FOR HEALTH ACT

13. Leonard Robins, "The Impact of Converting Categorical into Block Grants: The Lessons from the 314(d) Block Grant in the Partnership for Health Act," *Publius*, Winter 1976, pp. 49-70.

**Abstract:** Data for this study were based primarily on 51 state health officials' survey responses to a 21 page questionnaire administered during the spring and summer of 1971. All of the States responded to either the letter, the written questionnaire, or the phone questionnaire.

**Important Points:**

- The PHA increased administrative flexibility for State health officials.
- State health planning agencies did not have a major influence on the PHA. State health planning agencies located in governors' offices had even less influence over the block grant.
- Congress did not significantly increase expenditures for the PHA, as initially promised.
- The PHA's influence diminished as new categorical health programs were created that logically could have been made part of the block grant.
- The block grant did not result in a reordering of State spending priorities.
- The new administrative flexibility given State officials was insufficient to produce any substantive reordering of program priorities.

14. Advisory Commission on Intergovernmental Relations, *The Partnership for Health Act: Lessons from a Pioneering Block Grant*, January 1977.

**Abstract:** This report examines the Partnership for Health Act of 1966 to determine what lessons and insights it offers for the debate about block grants. Data for this study came from questionnaires completed by 50 State public health directors, interviews with State officials and representatives of interest groups, and discussions with academics specializing in intergovernmental relations. First, the study reviews the legislative history of this block grant, tracing the emergence of criticisms of the categorical approach to health grants. It includes an analysis of the expectations of consolidation and the legislative intent of this block grant. Second, it explores major features of the Federal administration of the block grant: organizational location, staffing, and shifts in HEW and Administration policy. Third, it provides an overview of State administration and decision-making under the block grant including: patterns of public involvement, State flexibility, and State expenditure of block grant money. Finally, it concludes that the block grant is still the best intergovernmental approach to the public health area, and recommends that appropriately structured block grants replace categoricals as the primary Federal funding mechanism. The appendix includes expenditure tables and in-depth analyses of six State case studies.

15. Carl W. Stenberg and David B. Walker, "The Block Grant: Lessons from Two Early Experiments," *Publius*, Spring 1977.

**Abstract:** This article begins with a brief description of the evolution of the block grant concept and then identifies and compares the characteristics of the instrument with the realities after almost 10 years of implementation of the Partnership for Health Act (PHA) and the Safe Streets Act.

**Important Points:**

- The PHA funded a broad functional area at first, but over time, Congress authorized additional categorical health programs that detracted from its flexible servicing goals.
- The PHA's influence and scope were curtailed by its small fiscal magnitude when compared to the aggregate of Federal public health grants or to the total State-local direct expenditures.
- The PHA increased recipient discretion to the point where State dominance fostered Federal disinterest in the block grant.
- The States were the dominant players in the implementation of PHA.
- The PHA served as a "gap filler" rather than a "launching pad" for new initiatives.

16. U.S. General Accounting Office, *Lessons Learned From Past Block Grants: Implications for Congressional Oversight*, IPE-82-8, 23 September 1982.

**Abstract:** This study examined the five pre-1981 block grants--Partnership for Health, Omnibus Crime Control and Safe Streets Act, Comprehensive Employment and Training Act, Community Development Block Grant, and Title XX Social Services--and compared them to the provisions of the OBRA 1981 block grants. It focuses on: (1) how block grants attempted to balance competing goals of flexibility and accountability, (2) whether the poor and other disadvantaged groups have been served equally under block grants and categorical programs, (3) whether block grants yielded administrative savings, and (4) what evaluative information has been available to Congress under block grants.

## OBRA 1981 BLOCK GRANTS

17. George Peterson, et al., The Reagan Block Grants, The Urban Institute, 1986.

**Abstract:** This book examines the impact of the seven health and human service block grants passed by Congress in 1981. It places the block grants in policy and budgetary perspective to extract lessons for grant design after five years' implementation experience. The data for this study are drawn from a survey of State spending and program adjustments in 18 States from FY 1981 through FY 1984. Each chapter is devoted to examining a different program area and explores how the following issues were affected by the shift from categorical to block grants: State versus national program priorities, State replacement of funds, administrative changes after the block grant, and State-local relations.

**Important Points:**

- The Maternal and Child Health (MCH) block grant gave States greater flexibility to determine program priorities, services, and providers, and at the same time allowed States to streamline administrative tasks. This flexibility was tempered by Federal funding cuts.
- States made few significant structural changes in response to the MCH block grant. The most substantial change was in the creation of "mini-blocks" delegating program responsibility to the local governments.
- Despite Federal budget cuts, most States found the resources necessary in their own treasuries to sustain MCH program spending.
- Although State officials felt that consolidation of categorical programs enhanced administrative efficiency, they could not provide estimates of administrative savings.
- Almost all of the States surveyed adjusted their Preventive Health and Health Services (PHHS) block grant program mix.
- States gave counties greater responsibility for PHHS services and distributed funds for these programs more evenly across the State.
- Some States found initial PHHS implementation time consuming and expensive, but most reported that the block grant eventually lightened their paperwork.
- Because States often do not provide PHHS services themselves, they provided little information about specific changes in service delivery under PHHS.
- The Alcohol, Drug Abuse, and Mental Health Services (ADMHS) block grant limited some Federal-State program duplication.
- The elimination of the Federal alcohol and drug reporting requirements enhanced the potential for administrative savings.
- States did not take full advantage of the flexibility available under the ADMHS block grant.



18. U.S. General Accounting Office, *Maternal and Child Health Block Grant: Program Changes Emerging Under State Administration*, HRD-84-35, 7 May 1984.

**Abstract:** This report is part of the GAO series that looked at 13 States' experiences with block grant implementation. It focuses on the Maternal and Child Health block grant which consisted of eight former categorical programs.

**Important Points:**

- States continued to support programs similar to those funded under the former categorical programs.
- States assigned higher priority to programs in areas where they had considerable previous involvement.
- Due to Federal budget cuts, States shouldered a greater share of the program funds in order to maintain services.
- States' health agencies carried out block grant responsibilities, and some reported management improvements as a result of the block grant.
- Most State officials rated the block grant more flexible and desirable than categoricals.
- About half the interest groups surveyed preferred the prior categorical approach to the block grant.

19. U.S. General Accounting Office, *States Use Added Flexibility Offered by the Preventive Health and Health Services Block Grant*, HRD-84-41, 8 May 1984.

**Abstract:** This report is part of the GAO series that looked at 13 States' experiences with block grant implementation. It focuses on the Preventive Health and Health Services block grant which consolidated seven former categorical programs into one block.

**Important Points:**

- While PHHS accounted for less than 3 percent of States' total health budgets, it represented about 30 percent of financing for broader State preventive health programs.
- Carryover funds from former categorical programs helped offset the reduced Federal funding for PHHS.
- The services offered under the PHHS block grant were essentially the same as those funded under prior categorical programs.
- States slightly modified program priorities to better reflect their concerns.
- Changes at the service provider level were not directly linked to the shift from categorical to block grant funding. They may have been influenced by escalating costs and changes in other sources of funding.
- States successfully carried out their expanded management role.
- States increased public participation and involvement of State elected officials.
- State executive and legislative officials liked the increased flexibility of block grants and preferred them to the prior categorical approach.
- Most interest groups preferred the categorical approach over block grants.

- All groups surveyed believed that the advantages of block grants were tempered by the Federal funding cuts.

20. U.S. General Accounting Office, *States Have Made Few Changes in Implementing the Alcohol, Drug Abuse, and Mental Health Services Block Grant*, HRD-84-52, 6 June 1984.

**Abstract:** This report is part of the GAO series that looked at 13 States' experiences with block grant implementation. It focuses on the Alcohol, Drug Abuse, and Mental Health Services (ADMHS) block grant that consolidated 10 categorical programs into one block.

***Important Points:***

- Carryover funds from previous categorical grants mitigated Federal funding cuts and allowed States to sustain service levels into 1982.
- Program changes occurred at the service provider level, but were attributed to evolving community needs or changes in total funding rather than the shift to the block grant approach.
- State agencies carried out their expanded management responsibilities and reported implementing administrative improvements.
- States reported increased involvement by legislatures and governors' offices and sought public input through hearings.
- State officials rated the block grant program as more desirable than the categorical approach.
- Half of the interest groups surveyed preferred the prior categorical approach over the block grants.

21. U.S. General Accounting Office, *Block Grants Brought Funding Changes and Adjustments to Program Priorities*, HRD-85-33, 11 February 1985.

**Abstract:** This report is part of the series of GAO studies that looked at 13 States' experience with block grant implementation. It examines how States used their expanded decision-making authority and reacted to changes in the level of Federal funding.

***Important Points:***

- States obtained greater decision-making authority to set program priorities and determine the use of funds than they had under the categorical programs.
- States' increased programmatic discretion was tempered by requirements that they continue to fund the same grantees as under categoricals.
- States took advantage of available carryover funds from the prior categorical funds to mitigate the Federal funding reductions.
- States exercised their new discretion to transfer funds among block grants.
- To maintain service levels, States increased the use of their own funds to replace Federal funding cuts.

- Program areas that were funded under the categorical programs continued to receive support under the block grants.
- Some minor changes in funding patterns emerged as States began to put their imprint on program priorities.

22. U.S. General Accounting Office, *State Rather than Federal Policies Provided the Framework for Managing Block Grants*, HRD-85-36, 15 March 1985.

**Abstract:** This report is part of the GAO series that looked at 13 States' experiences with block grant implementation. It describes trends in States' planning and management of block grant programs.

**Important Points:**

- Decisions on how to use block grants were linked to broader decisions on related State programs for health.
- More than half of the State program officials reported that block grants led to improvements in planning and budgeting, and increased their flexibility to better allow them to integrate Federal and State activities.
- Some States consolidated offices or integrated service delivery under related programs--particularly under the ADMHS block grant.
- Due to their prior involvement in categorical health programs, States generally did not change their levels of monitoring when they shifted to block grants.
- States were given discretion to determine the form and content of block grant data collected. As a result, the information reported to the Federal government was inconsistent across the States and difficult to evaluate.
- States in 68 percent of cases reported that block grants reduced the time and effort devoted to Federal applications and reporting. Sixty-seven percent of States surveyed claimed that block grants prompted them to standardize or alter their administrative procedures.

23. U.S. General Accounting Office, *Block Grants: Overview of Experiences to Date and Emerging Issues*, HRD-85-46, 3 April 1985.

**Abstract:** This report is part of the series of GAO studies examining block grant implementation in 13 States. This report assesses whether the objectives of block grants were met through implementation. The goals of block grants were: (1) to focus program responsibility and management accountability with States, (2) to increase public involvement in the decision-making process, (3) to improve service delivery through better integration of Federal and State programs, and (4) to promote management improvements and save money.

***Important Points:***

- States adapted quickly to their new role due to their prior involvement with many of the categorical programs.
- All of the States surveyed used hearing and comment processes to obtain public input.
- Initially, States emphasized program continuity, but over time changes emerged.
- States reported management improvements prompted by the block grants.
- Administrative savings cannot be determined due to the dearth of information.
- More than half of the interest groups surveyed preferred the categorical approach over block grants.
- Eighty percent of governors, State legislators, and State program officials believed that the block grant approach was more desirable.

24. Richard P. Nathan and Fred C. Doolittle, "Federal Grants: Giving and Taking Away," *Political Science Quarterly*, Vol. 100, No. 1, Spring 1985.

***Abstract:*** This article examines how State and local governments respond to Federal aid policy changes with an emphasis on the OBRA 1981 block grants. It offers some generalizations about the conditions under which Federal aid replacement is most likely to occur.

***Important Points:***

- Replacement is most likely to occur when the community ideology is pro-spending and the fiscal condition of the jurisdiction is strong enough to replace Federal funding cuts.
- Federally aided programs most likely to benefit by replacement are those with traditional or longstanding State and local involvement that have a politically strong constituency. For example, health programs did better in these terms than other programs for the poor.
- There was more replacement at the State level than at the local level.
- There is a strong tendency for recipient governments to resist using Federal aid to substitute for their own funds because of fear of sanctions.

25. U.S. General Accounting Office, *Block Grants: Characteristics, Experience, and Lessons Learned*, HEHS-95-74, February 1995.

***Abstract:*** This report summarizes information on federal block grant programs, assesses the experience of States operating under them and identifies lessons learned that can be useful to the Congress as it considers creating a new set of block grants.

***Important Points:***

- OBRA of 1981 created nine block grants from about 50 categorical programs. The funding and other federally imposed requirements attached to the block grants were generally viewed by States as less onerous than under the displaced categorical programs.

- Where States had operated programs, the transition from categorical programs to block grants was smoother.
- States took a variety of approaches to help offset the overall federal funding reductions experienced when the categorical programs were consolidated into the 1981 block grants.
- Funding allocations based on distributions under prior categorical programs may be inequitable because they do not reflect need, ability to pay, and variations in the cost of providing services.
- Even though block grants were intended to provide flexibility to the States, over time constraints were added which had the effect of "recategorizing" them.
- The Congress needs to focus on accountability for results, and the Government Performance and Results Act may provide such a framework.
- New block grant proposals include programs that are much more expansive than block grants created in 1981 and could present a greater challenge for the States to both implement and finance.
- Today, a total of 15 block grants are in effect. Compared with categorical grants, which number 578, there are far fewer block grants.

# **APPENDIX B**

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## **COMMENTS ON THE DRAFT REPORT**

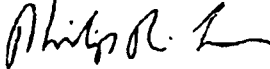
In this appendix, we present in full the comments we received from the Public Health Service.



JUN 14 1995

TO: Inspector General, OS  
FROM: Assistant Secretary for Health  
SUBJECT: Office of Inspector General (OIG) Draft Report "Federal Approaches to Funding Public Programs, "OEI-01-94-00160

Attached are the Public Health Service comments on the Subject report. We concur with the report's recommendation. Our response describes the action that we have taken or plan to take to implement this recommendation.

  
Philip R. Lee, M.D.

Attachment

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF  
INSPECTOR GENERAL (OIG) DRAFT REPORT "FEDERAL APPROACHES TO  
FUNDING PUBLIC HEALTH PROGRAMS," OEI-01-94-00160

OIG Recommendation

The Public Health Service should develop a strategy to use performance indicators in ways that will allow grantees substantial discretion in using Federal funds and, at the same time, hold them sufficiently accountable for their performance.

PHS Comment

We concur. In December 1994 the PHS began to develop a new form of grant program with the potential to bring about major changes in Federal-State relationships. It was designed to move the focus of funding to allow for much greater flexibility on the part of States to coordinate and target resources to meet local needs, while providing for accountability for the results of State expenditures using Federal funds and insuring that broad Federal priorities are addressed. This program, entitled "Performance Partnership Grants," has been proposed to Congress as a way of consolidating existing categorical and block grant programs related to substance abuse, mental health services for adults with serious mental illness and children with serious emotional disturbances, immunization, AIDS/TB/sexually transmitted diseases, chronic diseases, and preventive services.

In addition, the Health Resources and Services Administration (HRSA) has an initiative underway to establish and utilize performance measures to demonstrate the effectiveness of programs whether they are funded through the categorical or block grant mechanism. The HRSA is presently evaluating measurable goals of performance that can be reported as a part of the budgetary process for the clusters and other program activities within the agency. It is expected that this will result in an association of funding decisions with explicit performance indicators.

Technical Comments

We offer the following technical comments for OIG's consideration.

Page 2, third paragraph, third sentence states that the President's Fiscal Year 1996 Budget proposed that 50 programs in the Health Resources and Services Administration be lumped into 3. This should be corrected to state that "50 programs be lumped into 9."



Page 5, paragraph following first bullet: Block grant spending in 1993 is given in 1975 "constant dollars" as \$17.6 billion. It could be useful, especially for non-economists, to show this amount also in 1993 actual dollars (\$32 billion).

# APPENDIX C

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## ENDNOTES

1. Office of the Vice President, *Strengthening the Partnership in Intergovernmental Service Delivery*, Washington, DC, 1993.
2. Michael Reagan and Jon Sanzone, *The New Federalism*, Oxford University Press, 1981, p. 57.
3. Advisory Commission on Intergovernmental Relations (ACIR), *Characteristics of Federal Grant-in-Aid Programs to State and Local Governments: Grants Funded FY 1993*, January 1994.
4. *Ibid.*
5. *Ibid.*
6. *Ibid.*, pp. 1-7. In actual dollars, the 1993 total was \$32 billion.
7. ACIR, *The Partnership for Health Act: Lessons from a Pioneering Block Grant*, January 1977, p. 5.
8. ACIR, *Improving Grants Management*, February 1977, p. 3.
9. ACIR, *Block Grants: A Comparative Analysis*, October 1977, p. 6.
10. ACIR, *Summary and Concluding Observations on the Intergovernmental Grant System*, June 1978, p. 40.
11. ACIR, *The Partnership for Health Act: Lessons From a Pioneering Block Grant*, January 1977.
12. *Ibid.*, p. 6.
13. ACIR, *Summary and Concluding Observations on the Intergovernmental Grant System*, June 1978, p. 4.
14. Michael J. Rich, *Federal Policymaking and the Poor: National Goals, Local Choices, and Distributional Outcomes*, Princeton University Press, 1990.
15. ACIR, *Fiscal Balance*, 1977, p. 153.
16. Michael J. Rich, *Federal Policymaking and the Poor: National Goals, Local Choices, and Distributional Outcomes*.
17. Reagan and Sanzone, *The New Federalism*, p. 79.

18. ACIR, *Summary and Concluding Observations on the Intergovernmental Grant System*, June 1978, p. 4.
19. ACIR, *Improving Federal Grants Management*, February 1977, p. 3.
20. ACIR, *Summary and Concluding Observations on the Intergovernmental Grant System*, June 1978, p. 6.
21. *Ibid.*
22. ACIR, *The Partnership for Health Act: Lessons from a Pioneering Block Grant*, January 1977, p. 6.
23. Carl W. Stenberg and David B. Walker, "The Block Grant: Lessons from Two Early Experiments," *Publius*, Spring 1977.
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25. George Peterson, et al. *The Reagan Block Grants*, The Urban Institute, 1986, p. 3.
26. Reagan and Sanzone, *The New Federalism*, p. 128.
27. *Ibid.*, p. 122.
28. Claude E. Barfield, *Rethinking Federalism: Block Grants and Federal, State, and Local Responsibilities*, American Enterprise Institute, 1981, pp. 20-21.
29. George Peterson, et al., *The Reagan Block Grants*, The Urban Institute, 1986, p. 4.
30. *Ibid.*
31. *Ibid.*, pp. 28-29.
32. Department of Health and Human Services, Administration for Children and Families, *Summary of Actions on Waiver Applications*, 1994.
33. Claude E. Barfield, *Rethinking Federalism*, p. 44.
34. U.S. General Accounting Office, *Block Grants: Overview of Experiences to Date and Emerging Issues*, HRD-85-46, 3 April 1985, pp. 17-21.
35. ACIR, *Block Grants: A Comparative Analysis*, October 1977.
36. U.S. General Accounting Office, *State Rather Than Federal Policies Provided the Framework for Managing Block Grants*, HRD-85-36, 15 March 1985, pp. 44-46.

37. U.S. General Accounting Office, *States Have Made Few Changes in Implementing the Alcohol, Drug Abuse, and Mental Health Services Block Grant*, HRD-84-52, 6 June 1984, pp. 43-44.
38. *Ibid.*
39. U.S. General Accounting Office, *Maternal and Child Health Block Grant: Program Changes Emerging Under State Administration*, HRD-84-35, 7 May 1984.
40. George Peterson, et al., The Reagan Block Grants.
41. *Ibid.*, p. 118.
42. U.S. General Accounting Office, *States Use Added Flexibility Offered by the Preventive Health and Health Services Block Grant*, HRD-84-41, 8 May 1984, p. 57.
43. George Peterson, et al., The Reagan Block Grants, p. 118.
44. U.S. General Accounting Office, *Lessons Learned from Past Block Grants: Implications for Congressional Oversight*, IPE-82-8, 23 September 1982, p. 64.
45. ACIR, *The Partnership for Health Act: Lessons from a Pioneering Block Grant*, 1977.
46. *Ibid.*, pp. 150, 192.
47. U.S. General Accounting Office, *Lessons Learned From Past Block Grants: Implications for Congressional Oversight*, IPE-82-8, 23 September 1982, p. 54.
48. Claude E. Barfield, Rethinking Federalism, p. 35.
49. George Peterson, et al., The Reagan Block Grants, 1986, p. 1.
50. *Ibid.*, p. 24.
51. Department of Health and Human Services, Office of Inspector General, *Services Integration: A Twenty Year Retrospective*, OEI-01-91-00580, January 1991.
52. ACIR, *The Partnership for Health Act: Lessons from a Pioneering Block Grant*, January 1977, p. 88.
53. ACIR, *Summary and Concluding Observations*, June 1978.
54. *Ibid.*, pp. 126-127.
55. George Peterson, et al., The Reagan Block Grants.
56. U.S. General Accounting Office, *Maternal and Child Health Block Grant: Program Changes Emerging Under State Administration*, HRD-84-35, 7 May 1984, p. 9.

57. U.S. General Accounting Office, *States Use Added Flexibility Offered by the Preventive Health and Health Services Block Grant*, HRD-84-41, 8 May 1984, p. 8.
58. ACIR, *The Partnership for Health Act: Lessons from a Pioneering Block Grant*, January 1977, p. 80.
59. *Ibid.*
60. Leonard Robins, "The Impact of Converting Categorical into Block Grants: The Lessons from the 314(d) Block Grant in the Partnership for Health Act," *Publius*, Winter 1976, p. 67.
61. *Ibid.* p. 68.
62. Claude E. Barfield, *Rethinking Federalism*, p. 44.
63. U.S. General Accounting Office, *Block Grants Brought Funding Changes and Adjustments to Program Priorities*, HRD-85-33, 11 February 1985.
64. *Ibid.*, p. 1.
65. U.S. General Accounting Office, *Maternal and Child Health Block Grant: Program Changes Emerging Under State Administration*, HRD-84-35, 7 May 1984, p. 43.
66. George Peterson, et al., *The Reagan Block Grants*, 1986, p. 17.
67. *Ibid.*, p. 116.
68. *Ibid.*
69. George Peterson, et al., *The Reagan Block Grants*, The Urban Institute, 1986, pp. 124-128.
70. U.S. General Accounting Office, *Lessons Learned from Past Block Grants: Implications for Congressional Oversight*, IPE-82-8, 23 September 1982, pp. 73-74.
71. ACIR, *The Partnership for Health Act: Lessons from a Pioneering Block Grant*, January 1977, p. 127.
72. George Peterson, et al., *The Reagan Block Grants*.
73. Richard P. Nathan and Fred C. Doolittle, "Federal Grants: Giving and Taking Away," *Political Science Quarterly*, Vol. 100, No. 1, Spring 1985.
74. ACIR, *Summary and Concluding Observations on the Intergovernmental Grant System*, June 1978, p. 40.
75. *Ibid.*, p. 41.

76. Richard Nathan, "State and Local Governments Under Federal Grants," *Political Science Quarterly*, Vol. 98., No. 1, Spring 1983.
77. Nathan and Doolittle, "Federal Grants: Giving and Taking Away."
78. Nathan, "State and Local Governments Under Federal Grants."
79. Stenberg and Walker, "The Block Grant: Lessons from Two Early Experiments," p. 37.
80. *Ibid.*, p. 56.
81. U.S. General Accounting Office, *Lessons Learned from Past Block Grants: Implications for Congressional Oversight*, IPE-82-8, 23 September 1982, p. 34.
82. *Ibid.*
83. George Peterson, et al., The Reagan Block Grants, p. 18.
84. ACIR, *The Partnership for Health Act: Lessons from a Pioneering Block Grant*, January 1977, p. 98.
85. George Peterson, The Reagan Block Grants, p. 20.
86. U.S. General Accounting Office, *Block Grants Brought Funding Changes and Adjustments to Program Priorities*, HRD-85-33, 11 February 1985, p. 48.
87. *Ibid.*, p. 49.
88. *Ibid.*
89. *Ibid.*, p.50.
90. At the beginning of this report, we noted the Vice President's National Performance Review, the increasing number of State requests for Federal waivers, and the 1994 political campaigns and elections as such forces. To those might be added broader forces such as (1) the widespread movement in corporations to reduce central planning and management staffs while delegating additional authority and responsibility to the front lines and (2) the information technology revolution which makes it increasingly possible to make such delegations while top management can stay attuned to the performance of the organization on a real-time basis.