United States General Accounting Office
Washington, D.C. 20548

FOR RELEASE ON DELIVERY
EXPECTED AT 10:00 A.M.
MARCH 7, 1984

STATEMENT OF

RICHARD L. FOGEL, DIRECTOR

HUMAN RESOURCES DIVISION

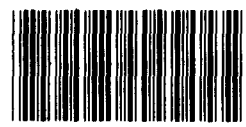
BEFORE THE

COMMITTEE ON LABOR AND HUMAN RELATIONS

UNITED STATES SENATE

ON

STATE IMPLEMENTATION OF THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT



Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the implementation of the preventive health and health services block grant. During the past year we have visited 13 states (California, Colorado, Florida, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, New York, Pennsylvania, Texas, Vermont, and Washington) to examine a wide range of issues that were of interest to your committee as well as other committees of the Congress. These states include a diverse cross section of the country and account for about 40 percent of the national preventive health block grant appropriations and about 48 percent of the nation's population. Our draft report, which was provided to you last week, provides a comprehensive picture of block grant implementation in these 13 states.

Today, I would like to focus on four major areas:

--states acceptance of their expanded management role under the block grant,

--funding trends in state preventive health programs between 1981 and 1983,

--changes in state preventive health services since block grant implementation, and

--perceptions about the block grant from different state officials and interest groups.

Before highlighting our observations in these areas, it would be useful to briefly discuss two key factors which have greatly influenced the outcome of block grant implementation; (1) how states fund and plan for preventive health services and (2) the

degree of states' involvement in administering the prior categorical programs.

The preventive health block grant is clearly a separate program at the federal level. However, when block grant funds are received by the states that distinction becomes somewhat obscured, and those funds essentially represent one of several funding sources for state preventive health programs. Typically, preventive health block grant funds account for less than 3 percent of the states' total health budgets, although they generally represent 30 percent or more of the financing for certain preventive health programs. As a result, decisions on how to use block grant funds are integrated into states' overall health planning and budgeting processes and are made in the context of the overall availability of funds from all sources. These integrated planning responsibilities, together with states considerable administrative experience under most of the prior categorical programs provided an established framework for assuming their expanded block grant management role.

STATES INVOLVED IN MANAGING PROGRAMS SUPPORTED WITH BLOCK GRANT FUNDS

All 13 states generally assigned preventive health block grant responsibilities to their state offices which had administered the prior categorical programs. As a result, states found it necessary to make only minimal changes to their organization as well as the structure of the service provider network. Also, states were taking their expanded management role seriously by establishing program requirements, monitoring grantees, providing technical assistance, collecting data, and

auditing funds. These efforts, like planning, were often integrated with ongoing state efforts for state or other federal programs.

While we were not able to quantify any cost savings associated with managing preventive health programs using the block grant approach, there were indications of administrative simplification. According to state officials, the block grant enabled 12 of the 13 states to reduce the time and effort involved in reporting to the federal government, 10 to reduce the time and effort associated with preparing grant applications, 8 to change or standardize their administrative requirements, 7 to improve planning and budgeting, and 3 to better use state personnel.

States were also obtaining input for making decisions on how to use block grant funds from several sources. In addition to conducting the mandated legislative hearings and preparing required reports on the intended use of block grant funds, 10 states held executive hearings and 8 states used one or more advisory groups. Many program officials reported that input from advisory committees, together with informal consultations, often had the most influence on program decisions. Also, program officials noted that governors and legislatures had become more involved in program decisions in 5 states and 7 states respectively.

TRENDS IN OVERALL EXPENDITURES MIXED

As states implemented their management responsibilities, a central concern was attempting to maintain funding for

preventive health programs. However, trends in total expenditures for program areas supported with preventive health block grant funds varied considerably among the states. Of the 11 states that have administered the block grant since October 1981, total expenditures increased in six states between 1981 and 1983 while declining in 5 states. New York and California began block grant administration in July 1982 and both increased total expenditures between 1982 and 1983 bringing the number of states with increases in total expenditures to 8 of 13. The growth in half of these states, however, was modest, ranging from four to six percent. Also, after adjusting for inflation, total expenditures increased in only 3 of the 13 states.

Changes in total expenditures were varied even though each state received a 12 percent reduction in federal preventive health funding levels in 1982 from the 1981 levels. This was primarily due to two key factors (1) ongoing outlays from prior categorical awards and (2) changes in state funding.

Categorical Outlays Lessen Impact of Federal Funding Reductions

Ongoing categorical outlays were an important source of preventive health funds because almost all of the categorical programs included in the block grant were project grants having awards that extended into 1982 and in some instances into 1983. Therefore, even though states had block grant funding, many service providers were able to continue operations using categorical funds. Categorical funds comprised 61 percent of total 1982 expenditures of categorical and block grant funds in the 10

states where complete data was available. Categorical outlays decreased in 1983, but still accounted for 11 percent of total grant expenditures. Because categorical outlays overlapped with block grant allocations they helped offset the reduced federal appropriations and enabled states to carry block grant funds into future years. States carried forward an average of 43 percent of their 1982 preventive health block grant awards into 1983.

Most States Increase Their Contribution To Total Expenditures

Increased expenditures of state funds were also an important factor influencing changes in total expenditures. Eight of the 11 states administering the block grant between 1981 and 1983 increased the expenditure of state funds in program areas supported with preventive health block grant funds as did New York and California between 1982 and 1983. Eight of the 10 states that increased state expenditures also experienced a growth in total expenditures.

STATES STRESS CONTINUITY BUT MOVE TO MODIFY PROGRAM PRIORITIES

While trends in total expenditures were mixed, states reported that the services offered under the preventive health grant are essentially the same as those funded under the prior categorical programs. However, to better reflect their views and accomodate limitations on available funds, states modified certain program priorities and some of the services offered. The scope and dimensions of changes, however, varied considerably by program area and by state. States gave higher priority

to those program areas where they previously had considerable involvement in making funding and program decisions.

States had considerable involvement in prior health incentive, hypertension, fluoridation, and health education and risk reduction categorical programs. Although there were variations across the 13 states, the percentage of total expenditures for these program areas was generally maintained or increased. The percentage of total expenditures decreased by more than one percent in only one state for fluoridation, two states for hypertension, three for health incentive, and three for health education and risk reduction. In addition, states found little reason to adjust the types of services provided in these four program areas as a result of block grant implementation.

In contrast, states had more limited control over federal emergency medical services and rodent control funds, and under the block grant many assigned these program areas a lower priority. The percentage of total expenditures decreased by more than one percent in 8 of the 13 states for emergency medical services. Two of these 8 states had discontinued or planned to eliminate funding for emergency medical services because state officials believed it to be a local responsibility. Officials often cited the restriction on the purchase of equipment as a contributing factor to decreased expenditures because communications equipment was a major expense under the categorical program. Six states did, however, use their new flexibility to broaden the coverage of emergency medical services. These states have primarily opted to support

more geographical locations throughout the states as opposed to concentrating funds in a few locations to develop sophisticated systems. In some instances, this is being done by making grants to more regional systems or channeling funds to local entities for the first time.

The percentage of total expenditures decreased by more than one percent in 4 of the 8 states where rodent control activities were funded between 1981 and 1983. In 2 of the 4 states, rodent control funding was eliminated in 1983 because officials believed that rodent control was a local responsibility. According to officials in these states city and county funding will continue to support two of the three previously federally funded grantees.

While the 13 states were adjusting program priorities, the service providers we visited experienced a wide variety of changes in their operations. These providers were diverse in their organization, reliance on different sources of funds, range of services offered, and the size of their operations. The service provider situations varied considerably. Some reported stable or increased funding and expansion of program operations, while others expressed funding declines. Of those where funding had declined, changes ranged from reduced staffing and services to sustained operations by increasing fees and other sources of funds, improving efficiency, cutting costs, or obtaining increased volunteer support. Certain changes were attributed directly to block grant implementation, but usually providers pointed to an array of factors influencing their

operations, particularly escalating costs and changes in other sources of funding.

OVERALL PERCEPTIONS OF BLOCK GRANT DIFFER

Almost all state executive and legislative branch officials liked the increased flexibility provided by the block grants and the reduced administrative requirements. Generally, they viewed it as a more desirable way to fund preventive health services than the prior categorical approach. Conversely, about half the interest group respondents tended to view the block grant as a less desirable funding approach while 28 percent viewed it as more desirable and the remainder perceived no impact. Also, about 48 percent of the interest group respondents believed that changes states have made to preventive health programs adversely affected individuals or organizations that they represent.

While interest groups and state officials had differing views, both expressed concern about the federal funding reductions that accompanied the block grant, which from their perspective tended to somewhat diminish its advantages. It was often difficult, however, for individuals to separate block grants--the funding mechanism--from block grants--the budget cutting mechanism.

27624