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ABSTRACT

This report assesses the impact of federal child health policy under Titles V and XIX of the Social Security Act upon the states of Connecticut and Vermont for the years 1935 to 1975, and analyzes the reasons for the discrepancy between policy intent and state execution. Two simultaneous approaches are used for data analysis: a cross sectional perspective using data collected from one time segment across different areas, and an historical approach for analysis of the development of policy and administrative change. Specific research methods comprise a review of Congressional intent, Department of Health, Education and Welfare (HEW) regulations, state legislation, administrative performance, services with special references to urban/rural variations, and the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. Overall findings indicate that federal agencies interpret federal law diversely, and that states faced with uncertain policy, short funds, and external pressures fail to comply with even the federal EPSDT mandate. In addition, since HEW has failed to monitor its programs, states face no loss of funds or penalties. Recommendations include (1) that Congress provide sufficient funding to assure state cooperation and monitor state performance with continuous reporting systems; (2) that Congress be specific as to populations to be served and services to be provided; (3) that administrative agencies be consolidated to avoid interbureaucratic confusion; and (4) that child health advocacy groups become more involved in legislation and in monitoring programs. (Author/CM)

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RESEARCH DIGEST SERIES

Uncertainties of Federal Child Health Policies: Impact in Two States

U S DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
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National Center for Health Services Research Research Digest Series

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Abstract

This report assesses the impact of federal child health policy under Titles V and XIX of the Social Security Act upon the states of Connecticut and Vermont for the years 1935 to 1975, and analyzes the reasons for the discrepancy between policy intent and state execution. Research methods comprised a review of Congressional intent, HEW regulations, state legislation, administrative performance, services with special reference to urban/rural variations, and EPSDT. This study offers a basis for a methodology for policy evaluation studies in other states or the country as a whole. *Findings:* federal agencies diversely interpreted federal laws; states faced with uncertain policy, short funds, and external pressures failed to comply even with the federal EPSDT mandate. Since HEW failed to monitor its programs, states faced no loss of funds or penalties. *Recommendations:* that Congress provide sufficient funding to assure state cooperation, and monitor state performance with continuous reporting systems; that Congress be specific as to populations to be served and services to be provided; that administrative agencies be consolidated to avoid interbureaucratic confusion; and that child health advocacy groups become more involved in legislation and in monitoring programs.

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by Anne-Marie Foltz
April 1978

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This issue of the NCHSR Research Digest Series by Anne-Marie Foltz draws on her work and that of Yale Health Policy Project colleagues, Christa Altenstetter, James Warner Bjorkman, and Milton Chen under the leadership of Dr. George A. Silver, principal investigator. The research was performed for NCHSR under Grant HS 00900.

Mrs. Foltz is Research Associate and Lecturer at Yale. Dr. Silver is Professor of Public Health at Yale.

The final report of the grant, *Impact of Federal Health Policies in the States of Connecticut and Vermont*, 397 pages, is for sale to the public from the National Technical Information Service, Springfield, VA 22161 (tel.: 703/557-4650), and may be ordered as PB 262 959 in either paper or microfiche.

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Foreword

This report reviews two federally supported child health care programs from the original statement of Congressional intent to its questionable delivery at the local level in two states. While other studies have documented the variance between Congressional intent and local performance, this provides the in-depth analysis necessary to identify and weigh its causes. The particular value of this study is that its findings and recommendations can be used to assess the prior effects of national health care policy as well as to guide the formulation of health care legislation and interest group participation in the future.

Gerald Rosenthal, Ph.D.
Director

April 1978

Preface

The extraordinary interest in health policy during the past decade reflects both public and professional concern. Political scientists, long preoccupied with purely theoretical formulations, increasingly have seized opportunities to test theories in the marketplace. The public, disappointed in political solutions that did not solve social problems, increasingly turned to the academic community for answers. Health care, particularly in recent years, has been a source of public discontent and academic inquiry. However, evidence of public dissatisfaction and demand for action can be traced back as far as the Republican Party platform of 1912, when national health insurance was one of the Bull Moose planks. Academic concern goes back as far as the 1916 report of Edgar Sydenstricker and Rollo Britten to the Public Health Service designing a National Health Insurance program. But the attack on the process of public and private medical care financing and delivery is more recent, and the investigation of the policy process, from program inception through implementation, is also relatively new.

Many studies have been directed at the policy formation process whereby public concerns are turned into laws. Fewer studies have been directed at the obstacles, flaws and miscarriages between the passage of a law and its implementation. Yet it is the visible effects of the law, success and failure in the light of the Congressional intent, that cry out for study.

In the case of child care, we wanted to find out why there were few services, and lagging examinations and immunizations, despite heavy federal investment.

The path of study led through many interesting ramifications. Addressing ourselves to the federal/state interface, the Yale Health Policy Project reviewed the relevant papers and reports affecting Connecticut state child health activity and, later, Vermont activities over the past 40 years, and interviewed present and former officials, interest group leaders and public figures along the way. It was a monumental task, fascinating in the history it revealed and a bit disheartening in the pattern of social policy it displayed.

In this report interested readers can find some explanation of the puzzling contradictions in our public posture and program shortfall, evidenced in the federal/state programs affecting child health. Neither the conclusions nor recommendations can be generalized because the information is drawn from only two states. In any case, the project findings indicate that more federal concern, more federal supervision, and better reporting, would seem to be needed. Until the Congress and the American people reach some consensus as to what they want in the way of a child health program, what the goals are and how they might be reached, conclusions drawn from policy studies can only be tentative, at best. It seems that for the foreseeable future, federal health (and child health) actions will be crisis generated and not derived from reasoned construction and judicious long-term planning. The lessons of these programs therefore ought to be taken to heart.

George A. Silver, M.D.

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Introduction

In 1972, the Yale Health Policy Project undertook a study of the impact of federal health policy on the states. Child health policy was chosen as the focus of the study; and two New England states, Connecticut and Vermont, were chosen as the sites. The purpose was to analyze the implementation of federal policy to explain the gap, often noted in the literature, between federal intent and state performance. The research questions were: What was the intent of federal child health policy; did federal programs stimulate states to carry out federal policies; if not, what were the major causes of this failure; and finally, which of these causes was amenable to change?

The rationale for this ambitious undertaking was that few studies of this kind had previously been undertaken and none existed in the field of health even though federal involvement and commitment in health through grant-in-aid programs had increased notably since the 1960's. Such a study could thereby provide valuable information about the operation of federal health programs.

This NCHSR Research Digest reviews the methodology and findings of the project. The findings have been presented in published papers, project working papers, and in the final report (3) submitted to the National Center for Health Services Research, which supported the four-year study. Since a report of this size cannot do justice to so diverse a project, publications and reports are cited to assist the reader in finding original sources.

Methodology

Model and framework

For this study, we adopted a model based on a definition of policy as "a projected program of goal values and practices." Policy in our model is a dynamic process and hence subject to changing or diverse conceptions both within one level of government and also through the various levels of government from inception and regulation to implementation. It is recognized that policy may be formed as much from informal administrative practices as from laws, regulations and rules. The flow of policy is not necessarily one way; decisions taken at lower levels of government can affect those at higher levels. Nor can the various levels of government be considered autonomous or closed, as the model presupposes permeability of governmental institutions. We proposed, then, a project which would follow more closely the format of implementation studies than program evaluations.

To analyze the flow of the policy process requires a detailed knowledge of shifting events and actors. To make this task manageable, the scope of the project was limited to cases which would be studied comprehensively. These cases were limited by: (1) geographic area, (2) target population, (3) policy content, and (4) the way in which impact was assessed.

Connecticut, an urban state, was chosen as the original site for the implementation study. As the project progressed, we chose Vermont, a rural state, as a second site to test hypotheses generated by the Connecticut study and to verify that we were not dealing with unique relevant characteristics. Any state, in some sense, is unique, and in case studies, generalizations, from a sample of two, must be made with a certain caution. The case studies provided the opportunity for the careful analysis of interrelationships which would not be available in cross-sectional and survey analyses alone.

Children were chosen as the target population because the effects would be easier to assess when the federal program was aimed at a particular population than when it was more diffuse in intent. The study of child health was particularly compelling. We suspected that despite the mythical primacy of the child in the American "child-oriented" society, there was sufficient evidence in terms of the prevailing higher health risks for poor children, that children, and particularly poor children, were not getting their fair share in American society.(1, *27-32*) Moreover, health policy toward children constitutes major social policy since children comprise 40 percent of the United States population. Public interest, or at least public rhetorical interest, in children is high, exemplified by the White House Conferences on Children held every decade since 1909. Other studies on child health programs had focused on surveys, cross-sectional analyses, and inventories, but none had examined the processes of child health policy itself.

Many different child health programs were considered, but it was clear we could not study all federal programs and policies affecting child health. The criteria for inclusion in the study were that the program had to be directed mainly toward the health of children, and had to be broad in scope, affecting as many children as possible. From these criteria, two programs, both legislated under the Social Security Act, emerged as the logical choices:

Title V : Maternal and Child Health (1935)
Crippled Children's Services (1935)
Maternity and Infant Care Projects (1963)
Children and Youth Projects (1965)
Title XIX: Also known as Medical Assistance, or Medicaid (1965).
Early and Periodic Screening Diagnosis and Treatment (EPSDT 1968).

These were the major child health programs of DHEW and accounted for the greatest proportion of federal funds expended for child health and for children served. By 1970, the latecomer, Title XIX, had outstripped even Title V in both dollars and services. (Table 1) Both Titles V and XIX involved grants-in-aid to the states, but they provided also a series of contrasts. Title V was a system of formula grants to the states, and project grants to localities: Title XIX was open-ended reimbursement to the states for medical vendor payments. The formulae used to allocate grants among the states were different. Title V allotments were determined by a ratio to favor poor and rural states with each state required to match federal funds with equal state funds; Title XIX reimbursements were made on the basis of a matching formula intended to favor poorer states. The categorical formula grants of Maternal and Child Health (MCH) and Crippled Children's Services (CCS) could be considered the forerunners of health revenue sharing since their mandates were broad and they provided wide latitude for the states. The Title V projects were so specialized and localized that we chose to consider their impact only in the context of the larger Title V formula grants and the Title XIX programs. Title XIX was a system of vendor payments for health services which reimbursed the states for certain types of health services for three categories of persons: (1) those eligible for public assistance; (2) those categorically eligible whose incomes made them medically needy; and (3) all financially eligible children. (2)

In both Titles V and XIX, states could choose whether or not to participate. In the case of title V, within a few years of its passage, all states elected to participate. For Title XIX, only two states, Arizona and Alaska, were not participating by 1972.

During the first year of our study, we spent considerable time defining quantifiable indicators of impact and obtaining data on them. As we learned more about federal-state administration and the service arena, it became clear that the sketchy nature of the data available would not in most cases provide reliable quantifiable indicators to demonstrate federal impact. Moreover, any causal connection between federal policy and service, or health outcome, could not be presumed from any change that appeared subsequent to federal legislation. Many other factors, perhaps not quantifiable, might intervene. Impact, was not to be demonstrated on the health outcome of children, but to be described through an analysis of the state level and service level changes which took place during a period of increasing federal investment in child health programs.

Four major areas of research became the focus for the qualitative assessment of impact: (1) administration and relations among and within different levels of government; (2) health services delivered by the federally sponsored programs; (3) expenditure patterns for child health, both federal and state; and (4) private interest group activity in the states in relation to federal policy. We also expanded our time frame to provide for historical analyses of the Title V programs which date back to the 1930s. Their implementation provided the administrative framework within which the developments of more recent years must be viewed.

Procedures

Given the broad framework of the policy process model, data gathering was of necessity eclectic, using techniques mainly from the fields of public health and political science. Two approaches were used simultaneously: the first was a cross-sectional perspective using data collected from one time segment across different areas; and the second was an historical approach for analysis of the development of policy and administrative change. Federal intent for titles V and XIX was analyzed first through legislative intent, by the study of Congressional reports, hearings, and debates, the *Congressional Quarterly,* and interviews with relevant actors. Federal executive intent was then examined through regulations, guidelines, informal Department of Health, Education, and Welfare (HEW) memos, and letters, and also through interviews with those in the executive agencies charged with promulgation of regulations (which have the force of law), and implementation. The distribution of Titles V and XIX funds among the states was also collected as well as whatever data were available on services provided by the programs under study. The HEW Region I office provided data in the form of memos and interviews as to its role in the policy process.

State activities were analyzed from legislation, debates, reports, hearings and newspaper files; from health and welfare department reports on services and administration; and from financial statistical data from the fiscal office. In addition, demographic data were calculated for the states, including density of population; proxies for need, such as infant and neo-natal mortality rates; poverty levels; and distributions of health resources. As for the federal level, relevant actors were interviewed.

During two summers, surveys were held in Connecticut and Vermont to assess the impact of the Medicaid-EPSDT program on health providers and children's services, and to assess its relation to the earlier established Title V MCH and CCS services and projects. These surveys included inventories of child health resources in the states and interviews with providers.

The role of private interest groups was examined through studies of voluntary health and advocacy organizations, as well as the professional associations, with particular attention to the medical societies. These groups were studied through their publications and interviews.

Out of the materials and interviews the staff prepared a chronology of events describing state activities prior to and following federal legislation. From the descriptive material, a series of analytic working papers was prepared to serve as mutual information sources and for testing hypotheses. These papers and additional materials then became the basis for publications and the project reports.

Findings

The states of Connecticut and Vermont

Connecticut and Vermont were chosen as contrasts for this study: they are respectively high and low income, urban and rural, industrial and agricultural. (Table 2) Politically, Connecticut has seen continuous changes and competition between the political parties, while Vermont remained long a Republican stronghold. In administrative structures the states differ too: Vermont has fewer autonomous agencies, and has an integrated human resources agency, while Connecticut has maintained separate government agencies for different functions and even for different populations cutting across functional lines.

However, the two states were markedly similar in several surprising respects. Both states have more physicians per capita than the national average and rank in the top ten states for per capita Medicaid expenditures. Infant mortality is lower in Connecticut and Vermont than in the nation as a whole, but Connecticut has a higher non-white population (6 percent) and sharply divergent mortality rates for this latter group.

In social policy, at least policy directed toward child health, we found the states differed markedly. Vermont has tended to apply universalist solutions to its problems, while Connecticut focused on assistance only to certain selected needy groups. Thus, the Vermont legislature produced more progressive legislation than its Connecticut counterpart although Connecticut's financial resources were greater. (3, 256) When dental services for children were required under the EPSDT program, the Vermont legislature initiated a dental insurance program for all low to middle income children while Connecticut served only those required under Medicaid and, in fact, decreased the services available to children. (4, *17*) Administratively, means tests for CCS services were never adopted in Vermont, but were established in Connecticut.

It is not clearly evident what accounts for these divergent social policies. What accounts for Vermont, a poor state, spending as much per capita as Connecticut? The usual quantifiable indicators, such as health needs, health resources, or fiscal resources, do not explain the differences. More likely it stems from a self-selected population which is more committed to social goals, despite its relative poverty, and which on ideological grounds, performs differently from its equally poor counterpart states.

Intent of federal policy

"Ambiguous" was the word we used most frequently to describe federal intent for child health policy. Some of the confusion as to intent can be attributed to excesses of rhetoric raising hopes and expectations which cannot be met in the practical implementation of a program. Congress, in its legislation, was the main creator of ambiguity, but the problems were compounded as policy moved from the legislative arena to the executive branch and then to the states and localities for interpretation and reinterpretation.

The stated Title V—MCH goal of "promoting the health of mothers and children" was broad and clear in intent. However, since 1935, the funds allocated for this purpose by Congress have been so low per capita that no observer realistically can expect the states to initiate major child health programs on the basis of the additional federal funding. Moreover, another goal also underlay the original Title V legislation. The prevailing philosophy among health professionals of the day was to build up health resources which were lacking in the country as a whole by building up public health agencies. (3, *33–38*; 1, *36–38*) Title V required the establishment of a single-state agency (health department) to administer the federal grant programs. The public health interest groups felt that only fully formed public health departments could carry out a federal mandate to promote the health of mothers and children. Thus, the administrative base would have to precede any federal attempts to provide direct services to children. This philosophy prevailed until the 1960's when Title V instituted projects in selected localities which would provide direct services, but these were not of a scope to have national impact. Yet, the service orientation of Title V did exist from the beginning in the Crippled Children's Program, the other major part of the Title V legislation. This program required states to identify and treat children suffering from handicapping conditions.

The potential for conflict and uncertainty as to goals was built into the original Title V legislation. In addition, the Children's Bureau, which administered the program, over the years elaborated policy which was not always consonant with the original Congressional goals, imprecise as they may have been. (3, *147*)

Title XIX (Medicaid) intent was hedged with restrictions. "As far as practicable under the conditions" in each state, the states were to furnish medical care to welfare recipients and the medically needy. As with Title V, a single state agency had to be designated to receive funds. Each state could determine what was practicable for itself. There were no obligations in the law if the states chose not to accept Title XIX. Even if a state chose the program, the procedures spelled out in the Handbook of Public Assistance (no regulations were published until late in the 1960s) were not limiting. Moreover, the states quickly learned, as they had with Public Assistance, that the federal government would not enforce its own rules. In Medicaid's ten-year history, no state had been found out of compliance. The law and regulations were therefore unclear since states that did not conform, even when the subject of Medicaid scandals, were not penalized.

A major confusion of intent in the Title XIX program arose in 1968 after Congress had added a requirement that each state was to provide its eligible children under 21 with early and periodic screening, diagnosis, and treatment (EPSDT). This amendment could be read as a mandate for comprehensive care for every Medicaid-eligible child. However, the scope of the screening and care, and the definition of the children eligible to receive services were hardly mentioned by Congress in its hearings or debates. Estimates of cost were applied separately for Title XIX and CCS programs, which were also part of the amendments, with no mention of how the two implementing agencies would carry out these programs or reimburse one another, if at all. Another amendment requiring agreements between different agencies did not clarify matters much. It was not clear whether health or welfare would be responsible for the program. Moreover, HEW's long delay in issuing regulations confused matters more because the states began to recognize that HEW itself was not much interested in enforcing Congressional intent. HEW, in regulations which finally emerged in late 1971, defined the narrow scope of treatment services following screening. However, the regulations did not clarify the ambiguity in administrative direction. To compound matters, in 1972 Congress reaffirmed its intent by requiring states to inform all eligible persons of the program and thereby engage in outreach services at the risk of incurring a one-percent penalty against state AFDC funds. (5, *40–64)* Again, HEW delayed several years before issuing penalty regulations. Thus, in the case of EPSDT, HEW and Congress each were providing different interpretations of federal intent to the states.

Further confusion in intent was created by frequent HEW reorganizations. The Children's Bureau, the original administrator of the Title V programs, was eventually dismembered, while the major expenditures and services for child health were administered under Title XIX by the Medical Services Administration, whose major concerns were not children but services for the adult poor which took up more than 80 percent of its expenditures.

Despite these ambiguities, federal policy intent can be seen as both stimulative and redistributive. The purpose was to stimulate states to spend their own funds on federal goals and to redistribute funds from wealthier to needier areas both within states and among states. The Title V program was to stimulate the states to increase their expenditures for child health through the required matching mechanism, to build health agencies, and to provide services, particularly for handicapped children. The Title XIX program was to stimulate the states to pay for medical assistance to all persons eligible for welfare and for the medically needy as well as for financially eligible children if the states chose the option of including these two latter categories. (2, *3–5*) In addition, the EPSDT program was to stimulate states to provide for preventive health and treatment services for all children eligible under Title XIX and to search out these children and bring them in to care. As with Title V, states would be expected to increase their expenditures in order to match federal grants.

Federal policy was also directed toward the redistribution of funds among the states. The Title V legislation targeted rural and poor areas and the administrators carried out this policy by adopting an allocation formula which would favor states with these characteristics. Title XIX matching grants also favored poor states by adopting a matching formula which matched federal to state funds on a sliding scale from 50 to 83 percent, depending on the state's wealth.

Within the states as well, the policy was also redistributive. Title V was targeted to rural and poor areas while Title XIX, through its tie to the welfare programs, directed its services to the poor and near poor.

Were federal policies stimulative?

Federal policy intent to stimulate the states could result in four possible outcomes: (1) states could increase their funds allocated for federal purposes; (2) states could provide services required by the federal policy; (3) states could build up their administrative capacity to handle the federal programs; (4) private interest groups could be stimulated to participate more in the state-federal policy-making process.

Fiscal stimulation. The fiscal stimulation was expected to take place mainly through the federal matching ratio, although the fact that the Title XIX funds were open-ended gave the states potential for limitless funding as long as they were willing to spend some of their own funds as well. In the case of Title V, neither Connecticut nor Vermont appreciably increased its state funds for child health when it began its programs. Since both states were already supporting child health and crippled children's services before 1935, these programs were used as the matching funds to obtain the additional federal funds. (3, *315–316*) Federal administrators never examined closely how the states arrived at their matching fund figures.(6) Today, this practice is so ingrained that state matching in Title V formula funds is only an accounting procedure. Any personnel and activities in state and local health departments which are in the field of child care all qualify as matching funds. The minimal stimulation effect of the matching requirement may be attributed partially to the fact that the overall state child health programs represent only a small fraction of the state budget. (3, *315–317*)

In the case of Title XIX, earlier researchers had found that no stimulation effect had taken place. Our study (7, *13*) indicated that Medicaid expenditures from state and local sources could be explained mostly by factors such as fiscal capacity and urbanization. The federal matching ratio of between 50 and 83 percent did not provide strong incentives for generating state fiscal effort. Yet, both Connecticut and Vermont, despite this lack of incentive, increased their spending for Title XIX. Between 1968 and 1973, Connecticut's Title XIX expenditures rose from $58 million to $119 million while Vermont's rose three-fold from $8.6 million to $24 million. Thus, although the matching ratio did not of itself stimulate spending, the availability of federal funds did stimulate Connecticut and Vermont to increase their expenditures for health services to the poor.

Impact on services. Table 3 shows that both Connecticut and Vermont experienced a decline from 1940 in the proportion of the population served through well child clinics, and an overall decline in MCH direct services. (Data were not available for the years prior to the implementation of Title V in 1935.) In the CCS program, Vermont consistently provided services for at least that proportion of the population that might be considered poor and near poor while in Connecticut the proportion of children served declined to far lower than the proportion below the poverty level. (3, *220–225*)

Over the years, both states had been providing fewer direct MCH services and Connecticut alone decreased crippled children's services. If the original intent of Title V was mainly to build up an infrastructure to assist in child health services, then the services should not have declined, as they did, long after the structure was in place. We concluded that the goal of services, although not explicit in the Federal intent, was one that was accepted by the states, at least in their early implementation. The later move from direct services must be explained by shifts in state views of the role of public agencies toward the private sector and particularly their reluctance to compete with physicians whose numbers greatly increased during the forty-year period under study.

In Medicaid and EPSDT programs, the numbers of children served in both states increased over the years. Unfortunately, data were reported separately for the two services so that there may well be duplications. Table 4 shows the growth of these services and the increasing proportion of the population covered. Prior to EPSDT, almost all these services were for acute episodic care. EPSDT was intended to bring the children into regular and periodic care. However, we found in both states, that many of these EPSDT children had been served earlier through free clinics. (4, 8) Moreover, screening services were likely to be highest in those two or three areas where states had established Title V projects.

The EPSDT services reported only screenings. Neither state could document whether children who were screened and needed treatment were followed and received the required care. Moreover, the states reported each screening as a separate child, so that an infant who received several screenings in a year would be counted several times, inflating the number of children who received care during the year. In the case of Medicaid-EPSDT, the program, rather than competing with the private sector, provided reimbursement for it without interfering with prevailing private patterns of health care. Nevertheless, for ESPDT, both states exhibited reluctance to proceed with implementation of the program as evidenced by the low proportion of eligible children who received services during the first two full years of implementation, fiscal 1974 and 1975. The particular format of the Title XIX grant system was a weak instrument to stimulate the states to increase services (4, *20–21*)

Impact on administration. The federal requirement to designate a single state agency for both Title V and XIX programs strongly stimulated the development of state administration. This administrative device required changes in state laws after 1935 to allow health and welfare departments to accept and administer federal funds under Title V and the welfare titles of the Social Security Act.

Under Title V, Connecticut already had its Bureau of Child Hygiene which qualified for MCH funding, but it had to create a separate crippled children's division. Vermont reconstituted an MCH unit and brought in a privately-funded infantile paralysis division as the basis for a state crippled children's division (3, *239–241*) The funds were then used to build up personnel in the two divisions.

The single state agency requirement had affected welfare agencies in the 1930s and had permitted them gradually to take over the welfare functions of localities.(9) By 1965, the welfare agencies in both Connecticut and Vermont had grown considerably. In Connecticut and Vermont, as in most states, the welfare department was designated as the single state agency for Title XIX. (A few other states designated health departments.) The states took on little administrative staff to carry out Medicaid. By 1973, Vermont had one staff person and Connecticut had three staff persons administering a program of $24 million and $119 million, respectively. Thus, even though federal matching funds were available for administration as well as for vendor payments, in contrast to the Title V programs, state Title XIX programs were, if anything, underadministered. This problem became particularly evident when the states were required to carry out the EPSDT program. The paperwork of the officials at times seemed to overwhelm them (10, *3–19*) Even though federal funds were available with the usual matching by the state, states did not take advantage of these funds to build up their managerial capability for these large programs. In this case, the federal stimulative policy did not work.

The single-state agency requirement turned into its own kind of administrative headache for the states as it developed state agencies with overlapping functions. States were not allowed to consolidate their MCH and CCS divisions until as late as 1974 even though the divisions' functions overlapped. (3, *239*) More confusing was the overlap of functions where the welfare departments had to provide for services under Medicaid, and then for preventive health services for children through EPSDT. The health and welfare agencies were asked to "enter into agreements" but the agency with the service capacity (health) was not the agency with responsibility (welfare). Federal policy stimulated both health and welfare agencies to develop overlapping functions within the state.(8)

Impact on interest groups. The existence of federal policy, particularly in crippled children's services and EPSDT, stimulated interest groups which used the federal policy as a focus for their activities. In Connecticut, associations were formed on behalf of children with cystic fibrosis, cerebral palsy and cardiac disease. Within a few years the state legislature required that these diseases be included in the state's coverage of its crippled children's program (3, *253*). In Vermont, a public interest group lobbied successfully for a dental insurance program for children at the time that the state became required to provide dental care to Medicaid-eligible children. (4, *16–17*)

Poverty lawyers working on behalf of Medicaid-eligible clients filed suits to oblige states to implement federal law and provide preventive health services to children under EPSDT. Such suits were filed in Connecticut and Vermont as well as nine other states by the end of 1974. These suits indicated that the existence of the federal law was a stimulus to the interest group which provided a secondary stimulus to the state to comply. The resolution of the suits also showed that courts were willing to intervene in issues of positive government programs if the state's deviation from the standards set by the statute was sufficiently great. Moreover, state agencies submitted willingly to judicial orders requiring specific administrative actions. (11, *44–45;* 8, *635*)

The state medical societies reacted strongly to the implementation of Title XIX but were less of a secondary stimulus to the state than a hindrance. Their concerns centered very closely on the question of fees and reimbursement. In Vermont, they succeeded in having the issue settled privately and getting their chosen type of reimbursement. (3, *381–387*) In Connecticut they were obliged to enter the public arena to achieve a usual and customary fee system, only to have it rescinded by the legislature within a year because of its high costs. (3, *391–394*) Through their societies physicians were a secondary stimulus to the program by instigating fees which physicians would accept. The physicians would thereby be more likely to care for Medicaid patients, facilitating implementation of federal policy. However, when physicians did not receive the fee rates they wanted, many, particularly in Connecticut, refused Medicaid patients.

The stimulative effects of federal policy were very different for Title V and Title XIX. Title V did not stimulate the states to increase their funds for child health services, nor to increase substantially those services themselves. The federal policy did stimulate the states to build administrative capacity in maternal and child health. Title XIX, on the other hand, stimulated state funds for medical vendor payments and services, but did not stimulate states to build administrative capacity to deal with these large programs. Both Title V and Title XIX stimulated interest groups acting as secondary stimuli, particularly to enforce the implementation of federal intent.

Was federal policy redistributive?

Federal allocation formulae were intended to redistribute federal funds among the states to favor poor and rural states in the case of Title V, and the poor in the case of Title XIX. We analyzed this redistribution, first in terms of the net inflow or deficit of federal Title V and XIX grants received by each state in relation to its tax burden. (Table 5) The redistributional patterns differed substantially among the different child health grants. Title V formula grants tended to equalize interstate distribution; Title V project grants favored wealthy and urban states with localities which had the capacity to apply for project grants; Title XIX open-ended funding favored wealthy and urban states with liberal programs. (3, *310–314*) Vermont, although poor and rural, developed a liberal program because of its ideology and therefore deviated from the prevailing pattern of grant distribution.

Title V funds could be targeted to rural and poor states, but they did not necessarily distribute equitably for poor persons. However, as Table 6 shows, the variation in Title XIX expenditures, ranging from $7.54 (Mississippi) to $280.82 (Massachusetts), indicated that the poor in wealthy states with liberal policies were favored to the detriment of the poor in other wealthy states and in poor or rural states. (3, *320–321)* The pattern of redistribution among states was thus inequitable and discriminatory.

Within the states as well, distribution of health resources did not follow the expected pattern of federal intent. In the case of Connecticut, we examined the distribution of health resources among towns in relation to socioeconomic factors and health needs. (12) Private health resources, such as physicians, were concentrated in wealthier towns. Federal policy attempts to equalize access through Title V grants and EPSDT funds did not have the intended effect. In neither case were public resources such as Title V services or EPSDT providers allocated by state administrators to towns where health needs were greatest as measured by poverty levels, Aid for Dependent Children rates and five-year infant mortality rates. Health planners were not distributing resources to needy areas, even assuming imperfect information. Thus, there was little evidence that a rational planning model was operating in Connecticut in the early 1970s. Rather, a "bureaucratic politics" model may be more appropriate for explaining the variations in the distribution of health resources. Planning programs may have improved information available to decision-makers but they did not necessarily change the patterns of decision-making which resulted not from agreed-upon strategies or goals such as equalizing health resources, but from different understandings of what the goals were and from differing organizational and personal interests. (12)

However, we should note that at least for CCS the redistributive intent for rural services under Title V formula grants was met. Both the states of Connecticut and Vermont placed CCS clinics in predominantly rural areas. (3, *208–209*)

Reciprocal impact

Since the policy model we employed assumed permeability of institutions, we found that while policy was moving downward through federal-regional-state levels, other policy was moving upwards. Many such instances of reciprocal impact took place during the period under study.

Under title V-CCS programs in the early years, states determined that all children under 21 were eligible for services, but federal policies did not formally incorporate this practice until 1949, and Congress not until 1968. Although most states by 1939 appointed physicians as their MCH and CCS program directors, this did not become a federally required practice until 1951. (13, *33*)

States influenced federal programs which they did not want to implement. The proposed regulations for EPSDT published in 1970 required states to provide EPSDT regardless of the limitations of the state plans. Thus, states which did not previously pay for certain types of services would have to pay for them under the new rules. The states objected vigorously and effectively. When HEW published final regulations nearly a year later, the scope of requirements had been considerably decreased to meet state demands. (5, *54*)

States also influenced the Regional Offices of HEW. We had selected two states within the same HEW Region to mitigate the effects of differential directives from different regional offices. Instead, we found that the regional office itself reflected more often the opinions of the state rather than the federal policy it was supposed to administer. (14, *40–41*)

The gap between intent and performance: policy fragmentation

The Federal Title V and XIX programs did not necessarily stimulate the states to spend more for child health programs but merely to take on the federal programs as part of what they had been doing earlier. The federal programs, as administered by the states, failed to redistribute services to poor and rural persons. In addition, at least in the case of Title XIX, the funds failed to be redistributed equitably among the states. What accounts then for these failures?

Ambiguity of intent. Our first finding about the hypothesized gap between intent and performance is that it was not always as great as purported to be. Close analysis of federal intent revealed ambiguous language and internal conflicts even before the law had left Congress. Congressmen with particularistic interests geared toward election-day success did not give child health policy, which was of low political salience, the care which a well-thought out policy required. Thus, the original ambiguity of goals created some of the gap between intent and performance.

Federal ambiguity of intent may appear as flexibility, but it also left the policy vulnerable to fragmentation by bureaucracies and private interest groups among different levels of, and between different agencies within, government. Thus arose the possibility for different interpretations by bureaucrats and private interests depending upon their own particular interests and narrower goals.

Intergovernmental problems. A first source of fragmentation in federal child health policies came from the multiplicity of interdependent governmental levels. In 1935, the states we studied had maternal and child health programs similar to those mandated by federal law. Rather than expand their own programs, they substituted. This behavior was made possible by the weakness of the federal position and by the flexibility that had been built into the provisions for federal-state relations. The state legislature of Connecticut, particularly, had never devoted much attention to child health, so it was not surprising that the state did not seize the opportunity to increase its expenditures for children.

States had extraordinary discretion in how they interpreted Title V formula grants: these funds should therefore best be viewed as prototypes of revenue sharing. (15, *217–237*) Title XIX, as a reimbursement grant, prevented states from collecting federal funds, unless they paid out first to health providers. Thus, the Title XIX mechanism theoretically provided greater control by the federal government. However, since states still had discretion in eligibility, scope of services, and payment fees, the program developed more according to what the states wanted than the federal intent. States could refuse to participate; if they participated, they could refuse to conform even to their own state plan. (3, *197*) The states were particularly reluctant to initiate the EPSDT program because of the increased costs it would engender. The federal government had to proceed by negotiation with the states rather than to order them directly to implement. Even threats of penalties did not move state officials who believed the penalties would never be applied, just as in the case of Title XIX. Moreover, the states were right. Although the first penalty recommendations for EPSDT were handed down in 1975, no penalties had been applied by 1977.

Intragovernmental problems. Another major cause of fragmentation of policy was confused bureaucratic assignment. No one agency was in a position to build bureaucratic solidarity behind that policy. This issue was mainly a problem in the case of Title XIX and EPSDT. Since this program provided the greater part of health services to poor children, this problem was of major consequence. Title XIX was a policy that grew out of welfare legislation, but in fact it was health policy. Health and welfare agencies, however, have differing ideologies, professional personnel, clientele, types of services, control over functional areas and hierarchical relations relative to higher and lower levels of government. (3, *194–199*) Ideologies of welfare agencies prevailed so that discussions of Title XIX more often revolved around issues of fiscal probity than whether services should be provided. Welfare is a field in which the government has a virtual monopoly over its functions and the state welfare agencies have increased their functional control over localities during the years. However, only a small proportion of the health sector is controlled by the public sector and only a small proportion of these functions are controlled by health departments. Table 7 shows the proportions of state health and welfare functions of Vermont and Connecticut which were actually administered by their respective departments. One should also note that during recent years, at least in Connecticut, both the health department and health functions have received a declining share of the state general fund. (3, *187–190*)

The federal requirement of bureaucratic assignment to a single-state agency without control over its functional area negatively affected policy implementation. (3, *196*) Although close cooperation between agencies had been mandated under Title XIX in 1965, health and welfare agencies were unable to agree as to who would pay whom for what. Connecticut, for example, resolved the issue by having neither agency pay for the other and in fact, no contacts or cooperation developed between welfare and the crippled children's program. (2, *16–19*)

Inadequate information systems. Symptomatic of this fragmentation of policy were the information systems established by federal and state governments to manage the Title V and Title XIX programs. Federal surveillance of state performance can at best be termed inept, (3, *244*) and information feedback was poor. (1, *81–83*) There were two problems: the types of information requested by the federal government; and the time lag allowed to states to report.

States reported children who received physician's services from Title V-CCS but not those who received CCS care from other persons; they reported well-child services if the state-federal MCH funds paid any part of the services regardless of what other sources provided the services. Matching funds did not have to appear as a specific line-item in the state budgets and states never had to document in detail their matching accounting for formula grant funds. Under Title XIX, states reported financing and services, but no accurate figures were available on how many children were actually eligible for these services. (10) For Title XIX-EPSDT, the federal government did not require states to report follow-up care of children screened although that should have been the main purpose of screening. Moreover, the state of Vermont claimed that children were receiving preventive care from private physicians through regular Medicaid reimbursement. However, state officials were unable to document this claim because their reporting system was not equipped to deliver the information.

The federal government tolerated long delays by the states in reporting: nearly two years in the case of mandatory Title V reports (3, *242*), and similar delays in Title XIX, as in Connecticut's failure to submit Title XIX reports for fiscal 1975, even as late as mid-1977.

The information system which should have provided the federal agencies with information about state implementation, in fact, tended to obscure activities rather than reveal them. It may be that HEW did not want to know; in that case, the information system was most successful in preventing federal surveillance of the states.

Salience of child health. The final source of fragmentation was the low salience of child health in public policy. For the most part, child health was outside the glare of public attention which left both federal and state health and welfare bureaucrats a relatively free hand in the shaping of the policy. Title V had been only a very small section of the major social policy of the day, the Social Security Act, and had consequently received very little attention; Title XIX had never been intended as a child health program; the EPSDT provisions of 1967 passed through Congress as a miniscule part of massive revisions in the Social Security Act, receiving very little attention in hearings and debates. (5, *49–50, 59–60*) One could characterize Title V and Title XIX as programs without strong constituencies. (8) Children did not vote and since they were poor, were unlikely to have voting parents either.

Child health was also not of great salience at state levels, as noted by the low legislative input in the bills related to child health. The interest groups concerned with child health were themselves fragmented into different aspects of a disease or of the policy itself. Thus, interest groups formed to lobby for children with cystic fibrosis or cerebral palsy, rather than for preventive health services for all children. The only exceptions were the cases of the poverty lawyers, but even their efforts were limited to those children eligible for Medicaid services in the state in which they were suing. Their categorical concern did not allow them to apply their interests to other poor or needy children. Thus, the lobbies which might have counteracted the effects of policy fragmentation were themselves fragmented or non-existent.

In summary, the ambiguity of the original federal intent set the scene for the further fragmentation of policy. Different federal and state bureaucracies interpreted the policy according to their own needs; health and welfare agencies vied with one another as to who had the responsibility for child health. Quarrels at the state level were sent to higher levels for adjudication with no better results. Thus, those at lower levels made *ad hoc* decisions to carry out policy, or as in the case of Title XIX and EPSDT, when the policy was expensive, and time-consuming to administer, they made policy by avoiding implementation. This became easier because the federal government did not require the management information that would enable it to evaluate the implementation of its own policy.

The one force which could counter the effect of this fragmentary process was the interest groups which, operating from outside the governmental process, could intervene at whatever level necessary to enforce their own interpretations of child health policy. This process could have been particularly effective if the interest group had been involved in the policy formation. However, in the case of federal child health policy under Title V and Title XIX, the interest groups themselves fragmented. Thus, the one potential cohesive force in federal policy-making was not operating and the policy decisions were controlled by those who held power closest to the delivery points and who were responsive not to issues of child health but to particularistic bureaucratic and private interests.

Recommendations

These findings on the gaps, failures, and fragmentation of federal child health policy suggest several recommendations for policy-makers.

First, on the issue of ambiguous policy: given that Congressmen are rewarded not for their attention to detail but for their espousal of popular programs, it is unrealistic, without changing our electoral system, to expect Congressmen to change considerably. However, Congress can demonstrate more concern for child health policies by assuring, at least, that in hearings and debates, the issues are debated and the intent, even if conflicting, is voiced. Moreover, even though the temptation is always to let the Secretary of HEW work out the details, Congress should consider that some of these details will be so important that they may change entirely the original intent. Thus, Congress should be more specific in targeting the populations to be served by a particular piece of legislation, the types of services expected, the costs, and the administrative framework.

In intra-governmental relations, particularly in the question of health-welfare agencies, we recommend that Congress examine the issues of bureaucratic assignment. If Title XIX is to remain predominantly a welfare program, tied to welfare by eligibility restrictions, the welfare agencies will have to develop capabilities in case management in health. In so doing, they may, in the many states where the Title XIX agency is not the health agency, be in conflict with the health agency as to who has jurisdiction over what areas. The bureaucratic assignment of a policy to a single-state agency does not make much sense if that agency has little functional or hierarchical control. (3, *199*) Nor is a health department necessarily a solution since these agencies also have little control even over the public funds expended for health. Thus, the assignment of policies by Congress may be crucial in determining whether that policy can be implemented. Moreover, interbureaucratic confusion at the federal level spills over into confusion at lower levels of government. We recommend that Congress consider carefully either creating new agencies for its child health policies or requiring consolidations of existing ones to assure stronger agencies with capabilities in their own fields. This recommendation applies both to federal and state agencies.

In inter-governmental relations, we recommend first that Congress maintain a closer watch on the executive branch for enforcing its own policies, and secondly, that the states be given greater incentives to cooperate with federal policies by increasing the funds available to them. States, particularly in recent years, have increasingly faced budget cutbacks; to induce states to take on new programs or even to carry out their present programs will require positive incentives, such as considerably higher matching funds with a concomitant requirement of maintenance of effort of present services and expenditures.

Fourth, DHEW must develop reporting systems which will provide data consonant with intent so that federal officials can know whether a particular program is in fact reaching its goals. Reporting data should be monitored and checked on a random basis. In addition, inducements for improved management should be added for Title XIX's child health programs; otherwise, the present situation will continue in which even HEW does not know how many children were actually served by EPSDT and Medicaid combined.

The final and most important recommendation consists of raising the salience of children and child health as a political issue. As noted earlier, the legislation we studied had received scant attention from advocacy groups. When Title V was passed, children at least had the remnants of a lobby from the earlier heady days when the Children's Bureau was formed. However, this influence quickly waned. During the period under study, there was no well organized general child health advocacy group. The existence of such a lobby is the one force that can prevent the fragmentation of policy as it moves through the layers of government and among different agencies. The children's advocates, to be effective, however, would have to mobilize for child health in general rather than themselves being fragmented as they were by concerns for specific diseases or particular needy children. Such a lobby would have to oversee policy not only as it were being formed, but also as it were being implemented.

The experience of Titles V and XIX indicate that even such major health policy for children cannot provide care for the intended children unless the groups which should be looking out for their interests are mobilized to supervise that policy every step of the way. Policies do not happen just because Congress passes a law. Policies are shaped by the entire implementation process. Those who would be concerned that children receive the best health care through federal assistance, must then supervise that process.

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*"Working Papers" and "Reports."

Table 1: Federal expenditures for children under 21, Title V and Title XIX Programs, and numbers served as a percentage of U.S. population under 21

	1940	*1955*	*1970*
Federal Expenditures			
Title V	$8,058,000	$22,532,351	$223,504,648*
Title XIX	—	—	481,063,000
Children Served			
Title V	1,698,529 (3.5%)**	3,905,657 (6.2%)**	6,074,675 (7.5%)**
Title XIX	—	—	7,614,000 (9.4%)

* May include child welfare funds of approximately $20 million as well as the maternal and child health, crippled children's, special projects, and research funds.

** Excludes immunizations and school health examinations as data are not comparable. May include duplicate counts.

Source: (5) *38* and (8) *631*

Table 2: Population and health characteristics of Connecticut and Vermont

	Connecticut	*Vermont*
Population, 1973	3,080,000	466,000
Rural population, 1970	22.3%	65.2%
Per capita personal income, 1972	$5,931	$4,185
Percent of persons below poverty level, 1969	7.2%	12.1%
Expenditures for education per capita, 1973	$276	$297
Infant mortality per 1,000 live births, 1973		
White	13.3	16.2
Other	24.9	—
M.D. Population/Active physician per 100,000, 1970	191	187
Hospital beds per 100, 1970	3.34	4.51
Medicaid (Title XIX) expenditures per capita, 1972	$34.67	$37.93

Source: (3) *121* and *212*

Table 3: Children served by Connecticut and Vermont Maternal and child health and crippled children's services

	Children served by state-sponsored well-child conferences as a percentage of all children aged 0–5		*Children served by state crippled children's services as a percentage of handicapped children * aged 0–21*	
	Connecticut	*Vermont*	*Connecticut*	*Vermont*
1940	8.5	**	7.1	**
1950	2.5	**	8.0	15.8
1960	1.3	11.0	5.5	22.9
1970	1.0	7.0	3.9	21.8

* Handicapped children estimated as seven percent of the population.

** Data not available.

Source: (3) *220–224*

Table 4: Children served by Title XIX and its EPSDT Screening Programs: Connecticut, Vermont and United States

	CY 1968	*CY 1970*	*FY 1974*	*FY 1975*
Title XIX children served				
Connecticut	83,594	95,617	112,299	**
Vermont	7,611	17,675	20,226	24,949
United States	5,910,000	7,614,000	10,110,317	10,329,000
Title XIX children served as a percentage of population under 21				
Connecticut	7.3%	8.2%	10.1%	**
Vermont	4.3	9.6	11.1	13.8%
United States	7.3	9.5	12.7	13.1
EPSDT: percentage of Title XIX eligible children screened *				
Connecticut	—	—	3.9%	21.3%
Vermont	—	—	5.5	8.1
United States	—	—	7.7	14.1

* The federal government and the states count separately children receiving regular Title XIX services and those receiving screenings. At present, there is no way of knowing whether the same children are included in each count.

** Data not available.

Source: (4) *32*

Table 5: Interstate redistribution effect of federal health grants to states, FY 1972 (in thousand dollars)

State	*(1) Maternal and child health, formula*	*(2) Maternal and child health, project*	*(3) Maternal and child health, total*	*(4) Total health excluding Medicaid*	*(5) Medicaid*	*(6) Total health including Medicaid*
Alab	+1,481	+3,206	+4,687	+5,415	+19,329	+24,744
Alaska	+216	−122	+94	+281	−6,374	−6,093
Ariz	+165	−424	−259	+2,223	−30,276	−28,053
Ark	+933	+497	+1,430	+2,350	+546	+2,896
Calif	−4,974	−5,317	−10,291	−47,790	+161,464	+113,665
Colo	+14	+2,748	+2,762	+11,583	−1,548	+10,035
Conn	−1,156	−1,158	−2,314	−12,337	−37,673	−50,010
Del	+71	−376	+305	−865	−10.318	+11.183
D.C.	−6	+5,601	+5,595	+23,450	+3,524	+26,974
Fla	−55	+1,617	+1,562	−6,866	−78,903	−85.769
Ga	+1,504	+880	+2.163	+2.133	+26.902	+29.035
Hawaii	+83	+251	+334	+383	−4,478	−4,095
Idaho	+280	−5	+275	+1,865	−243	+1,622
Ill	−3,170	−1,095	−4,265	−45,572	−72,692	−118,264
Ind	+384	−2,351	+1,967	−5,364	−44,004	−38,640
Iowa	+411	−1,224	−813	+555	−30,722	−30,167
Kans	+134	−139	−5	+3,252	−5,416	−2,164
Ky	+1,328	−250	+1,078	+5,301	+8,600	+13,901
La	+1,363	−1,411	−48	+11,725	+611	+12,336
Main	+334	−369	−35	+899	+4,001	+4,900
Md	−307	+5.876	+5,589	+6,705	−25,530	−18,825
Mass	−1,444	+2,122	+678	+13,194	+60,971	+74,165
Mich	−649	+176	−473	−12,014	−14,416	−26,430
Minn	+340	+313	+653	+20,485	+14,638	+35,123
Miss	+1,601	+136	+1,737	+4,930	+21,445	+26,375
Mo	+150	−29	+121	+5,985	−48,029	−42,044
Mont	+214	+15	+229	−758	−1,968	−2,726
Nebr	+158	+621	+779	+4,195	−5,033	−838
Nev	+80	−276	−196	−4,095	−8,739	−12,834
N.H.	+134	−272	−138	−1,180	−8.200	−9,380
N.J.	−2,082	−4,536	−6,618	−30,884	−65,428	−96,312
N. Mex	+337	+139	+476	−1,510	−756	−2,266
N.Y.	−6,065	+2,493	−3,572	−10,986	+417,448	+406,462
N.C.	+2,195	+133	+2,328	+12,172	+3,157	+15,329
N. Dak	+283	−240	+43	+472	+3,234	+3,706
Ohio	−850	+164	−386	−3,293	−117,940	−121.233
Okla	+367	−1,112	−745	+4,142	+32,112	+36,254
Oreg	+191	−51	+140	+2,158	−18,742	−16,584
Penn	−521	−905	−1,426	+15,776	−72,177	−56,401
R.I.	+65	−325	−260	+347	+6,060	+6,407
S.C.	+1,490	−203	+1,287	+4,610	−4,956	−346
S. Dak	+278	−264	+14	+547	−410	−957
Tenn	+1,230	+670	+1,900	+7,343	−15.899	−8,556
Texas	+621	−1,433	−812	−91	−20,529	−20,620
Utah	+382	−203	+179	+6,588	+1,364	+7,932
Vt	+214	−228	−14	+4,423	+6,085	+10,808
Va	+772	−929	−157	−3,039	−27,991	−31,030
Wash	−49	−207	−256	−1,971	−17,078	−19,049
W. Va.	+737	−132	+605	+2,027	−6,079	−4,082
Wisc	+286	−1,735	−1,449	−7,401	+14,795	+7,394
Wyo	+233	−103	+130	−1,082	−3,752	−4,834

Note: Items may not add to the total because of rounding
Source (2) *330*

Table 6: Federal Grants-in-Aid ($) per poor person, FY 1970

	Title V total	*Total health excluding Medicaid*	*Title XIX (Medicaid)*	*Total health including Medicaid*
U.S.	6.62	36.12	93.20	129.32
Alab	7.17	30.23	32.04	62.27
Alaska	10.20	63.00	0	63.00
Ariz	4.43	54.73	0	54.73
Ark	4.47	20.01	5.89	25.90
Calif	5.39	32.64	240.94	273.58
Colo	15,47	66.60	85,82	152.42
Conn	9.47	67.71	193.88	261.54
Del	7.76	37.76	40.57	78.33
D.C.	37.41	109.75	103.45	213.20
Fl	7.31	26.53	16.01	42.54
Ga	5.74	28.80	56.93	85.73
Hawaii	16.67	112.45	109.62	222.07
Idaho	7.97	39.18	63.10	102.28
Ill	8.15	33.47	90.44	123.91
Ind	4.97	38.15	23.73	61.88
Iowa	4.83	41.20	44.68	85.88
Kans	5.50	42.76	89.35	132.11
Ky	4.04	28.27	55.46	83.73
La	2.91	21.82	39.77	61.59
Maine	5.24	35.30	55.78	91.08
Md	15.58	50.59	101.95	152.54
Mass	13.86	65.32	280.82	346.14
Mich	10.28	56.37	133.47	189.84
Minn	7.92	38.61	160.79	199.40
Miss	3.31	17.89	7.54	25.43
Mo	6.33	41.15	48.82	89.97
Mont	7.73	46.16	64.13	110.29
Nebr	11.16	43.10	53.42	96.52
Nev	11.91	39.14	87.91	127.05
N.H.	7.95	46.03	60.48	106.51
N.J.	4.06	36.28	45.93	82.21
N.M.	5.55	43.70	41.61	85.31
N.Y.	8.71	40.67	273.69	314.36
N.C.	5.71	35.45	19.89	55.34
N.D.	4.86	40.59	87.84	128.43
Ohio	9.32	43.78	51.17	94.95
Okla	2.63	26.20	133.64	159.84
Oreg	7.51	41.56	41.89	83.45
Penn	6.20	50.86	99.38	150.24
R.I.	6.54	41.35	170.80	212.15
S.C.	4.49	24.39	38.98	63.37
S.D.	3.81	28.94	42.04	70.98
Tenn	5.09	30.46	15.60	46.06
Texas	4.23	22.52	43.54	66.06
Utah	6.65	61.92	88.88	150.80
Vt	7.27	75.60	163.19	238.79
Va	5.88	28.23	26.14	54.37
Wash	8.61	34.87	115.71	150.58
W. Va	4.27	26.23	32.91	59.14
Wisc	5.30	39.43	194.71	234.14
Wyo	9.32	57.42	24.32	81.74

Source: (3) 333

Table 7: Health and welfare functional and department expenditures as a percentage of the state's general fund, Connecticut and Vermont

	State expenditures on health functions	*Expenditures by health department*	*State expenditures on welfare functions*	*Expenditures by welfare department*
A. *Connecticut*				
1935	6.3%	0.4%	4.3%	0.3%
1940	5.7	0.6	10.0	4.1
1950	15.7	4.7	18.8	18.7
1960	13.3	3.3	15.8	15.8
1970	9.4	2.0	19.6	19.6
B. *Vermont*				
1935	*	*	*	*
1940	1.4%	1.0%	15.2%	6.4%
1950	7.8	1.7	13.2	11.2
1960	1.9	1.3	13.0	7.0
1970	4.9	1.6	13.2	13.0

Source: (3) *189*

*Data not available

Current NCHSR publications

National Center for Health Services Research publications of interest to the health community are available on request to NCHSR, Office of Scientific and Technical Information, 3700 East-West Highway, Room 7-44, Hyattsville, MD 20782 (telephone: 301/436-8970). Mail requests will be facilitated by enclosure of a self-adhesive mailing label. These publications also are available for sale through the National Technical Information Service (NTIS), Springfield, VA 22161 (telephone: 703/557-4650). PB and HRP numbers in parentheses are NTIS order numbers. Publications which are out of stock in NCHSR are indicated as available only from NTIS. Prices may be obtained from the NTIS order desk on request.

Research Digests

The *Research Digest Series* provides overviews of significant research supported by NCHSR. The series describes either ongoing or completed projects directed toward high priority health services problems. Issues are prepared by the principal investigators performing the research, in collaboration with NCHSR staff. Digests are intended for an interdisciplinary audience of health services planners, administrators, legislators, and others who make decisions on research applications.

(HRA) 76–3144 Evaluation of a Medical Information System in a Community Hospital (PB 264 353)

(HRA) 76–3145 Computer-Stored Ambulatory Record (COSTAR) (PB 268 342)

(HRA) 77–3160 Program Analysis of Physician Extender Algorithm Projects (PB 264 610, available NTIS only)

(HRA) 77–3161 Changes in the Costs of Treatment of Selected Illnesses, 1951–1964–1971 (HRP 0014598)

(HRA) 77–3163 Impact of State Certificate-of-Need Laws on Health Care Costs and Utilization (PB 264 352)

(HRA) 77–3164 An Evaluation of Physician Assistants in Diagnostic Radiology (PB 266 507, available NTIS only)

(HRA) 77–3166 Foreign Medical Graduates: A Comparative Study of State Licensure Policies (PB 265 233)

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(HRA) 77-3176 Quality of Medical Care Assessment Using Outcome Measures (PB 272 455)

(PHS) 78-3183 Recent Studies in Health Services Research, Vol. II (CY 1976)

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