A STUDY OF THE FORMULAE FOR GRANTS-IN-AID IN THE WAGNER BILL

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The Wagner Bill, although officially entitled the "National Health Act of 1939," might more accurately be called the "Federal Aid to Health Act of 1939." Aside from the provision of small sums for research and for the administration of the Act, the Wagner Bill does not contemplate any extension of the direct health activities of the federal government. It is primarily a grant-in-aid measure, that is, a detailed set of specifications covering the conditions under which the several states may, if they so desire, receive funds from the federal government to assist them in providing specified health services and facilities under their own state-devised and state-administered plans.

To carry out the purposes of the Act during its first year of operation, the Wagner Bill authorizes the appropriation of some $98,000,000 of federal money. Of this amount $89,000,000, or over 90%, is authorized to be paid to the states in the form of grants-in-aid.[1] The amount of federal grants actually paid out, however, will depend on the ability and willingness of the states to raise, through their own taxes or otherwise, the matching funds required under the Act. As the state health programs expand, increased federal appropriations sufficient to carry out the purposes of the Act are authorized.

Assuming full cooperation on the part of the states, it is estimated that some ten years hence, when the program reaches its maximum, federal grants for various public health services, for medical services to the needy, and for the construction and maintenance of hospitals, but excluding grants for state sickness insurance claims, will reach a total of $425,000,000 per annum. This will involve the raising of an approximately equal sum by the states and localities, bringing the total maximum cost of these three phases of the Wagner Bill to $850,000,000 per annum.[2] This sum will, for the most part, represent a net addition to the $571,000,000 of federal, state

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[1] Preliminary Report of Sub-Committee of Senate Committee on Education and Labor ("Establishing a National Health Program"), SEN. REP. No. 1139, 76th Cong., 1st Sess. (1939) 31.

[2] Message from the President of the United States Transmitting the Report and Recommendations on National Health Prepared by the Interdepartmental Committee to Coordinate Health and Welfare Activities, H. R. Doc. No. 120, 76th Cong., 1st Sess. (1939).

and local funds which it is estimated are now being spent on public health services and on hospital care in the United States.[3]

The National Health Bill, which is in the nature of an amendment to the present Social Security Act, authorizes federal grants to the states for five general purposes. Title V authorizes grants for maternal and child-health services and for medical services for children, including crippled children. Title VI authorizes payments to the states for public health work and investigations. Titles V and VI are not new, having been parts of the Social Security Act since its original enactment in 1935. The Wagner Bill, however, greatly increases the federal grants authorized under these two titles and alters the formulae for distributing the grants among the several states.

The remaining three titles of the Wagner Bill are new. Title XII authorizes grants to the states for the construction and improvement of needed hospitals and for assistance over a period of three years in defraying the operating costs of such added facilities. Title XIII authorizes grants to the states for medical care, or, to quote the exact language of the Bill, "For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and among individuals suffering from severe economic distress, to extend and improve medical care (including all services and supplies necessary for the prevention, diagnosis and treatment of illness and disability) . . ." Finally, under the provisions of Title XIV, federal grants are authorized for the purpose of assisting the states in the development, maintenance, and administration of plans for temporary disability compensation.

Although the formulae for determining the amounts of federal grants to be paid to the several states under the various titles of the Wagner Bill differ as to detail, all of them, with the exception of those provided under Title XIV, are characterized by certain uniformities of principle and procedure. These uniformities, as well as some of the major differences between the various titles of the Bill, are set forth in condensed form in Table I.

The first step in the process of making a grant under any title or sub-title of the Bill is, of course, an appropriation for that purpose by the Congress. The Wagner Bill merely authorizes appropriations within certain limits for the first three years of operation of the Act. Thereafter it authorizes whatever appropriations shall be necessary to carry out the purposes of its various titles. Within the limits of these authorizations, the actual amounts appropriated for any year will be entirely dependent upon the current action of Congress.

Once an appropriation for a grant under any of the titles or sub-titles has been made, the next step provided by the Bill is the allotment or apportionment of this appropriation among the several states on the basis of criteria specified in the Bill. The Bill provides that state allotments under Title V shall be made by the Chief of the Children's Bureau. Allotments under Titles VI and XII are to be made by the Surgeon General of the Public Health Service. Allotments under Titles XIII and XIV become a responsibility of the Social Security Board.

[3] U. S. TREAS. DEP'T, BULLETIN, Aug. 1939, p. 4.

TABLE 1. ANALYSIS OF SALIENT PROVISIONS OF NATIONAL HEALTH BILL

Purpose	Authorized Federal Appropriation for Federal Year 1940*	Allotting and/or Administering Agency	Basis of Allotments to States	Required Disposition of Federal and State Matched Contributions	Matching Ratios (Per cent Federal Contribution to Total Cost of Plan)
Title V:					
Part 1: Maternal and child-health services	$ 8,000,000	Children's Bureau	1) No. of births; 2) No. of mothers and children in need of services; 3) Special problems of maternal and child health; 4) Financial resources.	To finance approved State plans for *extending and improving* specified services.	33-1/3% to 66-2/3% depending on average per capita income of State.
Part 2: Medical services for children, including crippled children	13,000,000		1) Child population; 2) No. of children in need of services; 3) Special problems of medical care of children; 4) Financial resources.		
Part 5: Administration, investigations, and demonstrations, etc.	2,500,000				
Title VI: Public health work and investigations:					
Part 1: Payments to States	$15,000,000	Public Health Service	1) Population; 2) No. of individuals in need of services; 3) Special health problems; 4) Financial resources.	Same as above.	Same as above.
Administration, studies, demonstrations, etc.	1,500,000				
Part 2: Investigations	3,000,000				
Title XII:					
Grants for general hospitals	$ 8,000,000	Public Health Service	1) The needed additional hospitals; 2) The financial resources.	To finance approved State plans for constructing and improving needed hospitals.	Same as above.
Grants for mental and tuberculosis hospitals	†				
Administration, etc.					
Public Health Service	1,000,000				
Public Works Administration (etc).	†				
Title XIII:					
Grants for medical care	$35,000,000	Social Security Board	1) Population; 2) No. of individuals in need of services; 3) Special health problems; 4) Financial resources.	To finance approved State plans for extending and improving medical care.	16-2/3% to 50% depending on average per capita income of State.
Administration	1,000,000				
Title XIV:					
Grants for temporary disability compensation	$10,000,000	Social Security Board	No provision for State allotments.	To finance approved State plans for temporary disability compensation.	33-1/3%
Administration	250,000				
Total	$98,250,000				

*SEN. REP. No. 1139, 76th Cong., 1st Sess. (1939) 31.
†A sum sufficient to carry out the purposes of (this part of) this title.

As will be seen from Table 1, the factors or criteria to be taken into consideration in allotting appropriations for grants among the states vary according to the purpose of the grant. Thus, in determining the allotments for maternal and child-health services, the Bill directs that the following factors for the respective states be taken into consideration: (1) the total number of births in the latest calendar year for which the Bureau of the Census has available statistics; (2) the number of mothers and children in need of the services; (3) the special problems of maternal and child health; and (4) the financial resources. Grants for the construction of hospitals under Title XII are apportioned among the states on the basis of only two factors: (1) the needed additional hospitals; and (2) the financial resources.

The sum allotted to any state is not necessarily the sum it will actually receive. An allotment represents merely the maximum amount which a state may receive provided it fulfills certain conditions laid down in the Bill. It is not necessary to enumerate all of these conditions. For the present purpose, it need only be pointed out that in order to receive any funds at all, a state must submit a plan or plans for extending and improving its services and facilities along lines specified in the Bill. These plans, moreover, must be approved by the designated federal administrative agency, namely, the Children's Bureau, the Public Health Service, or the Social Security Board, as the case may be.

Most important of all as determining the amount of federal funds actually received by a state is the stipulation that the state must itself contribute from its own resources certain proportions of the total cost of each of its approved plans. The amount allotted to a state for any given purpose represents the maximum federal grant it may receive for that purpose. Within this limit, however, the amount which it actually receives is wholly dependent on the sum which it is able and willing to raise through its own efforts for the purpose of financing its plan.

As regards all of the titles of the Bill except Title XIV, the proportion of the total cost of a state plan which the federal government undertakes to contribute is a variable one determined for each state by its relative financial resources. The greater the relative financial resources of a state the smaller will be the proportion of the total cost of its approved plans which the federal government will undertake to finance and the larger will be the proportion of the cost which the state will be obliged to finance through its own efforts.

Section 1101(e) of the Bill directs that "the 'financial resources' of the several states shall be measured by per capita income accruing to the inhabitants thereof as determined jointly by the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board, between January 1 and July 1 of each year on the basis of data for the most recent three-year period for which satisfactory data are available. . . ." As regards state plans submitted under Titles V, VI and XII of the Bill, the federal government undertakes to pay from a minimum of 33⅓% to a maximum of 66⅔% of the cost of such plans, depending on the per capita income of the states concerned. As regards plans submitted under Title XIII, the ratio of

federal support ranges from 16⅔% to 50% according to each state's per capita income. The principle of variable matching of grants is not followed in Title XIV which provides federal aid for temporary disability compensation plans. Here the proportion of federal support remains fixed at 33⅓% for all states irrespective of their per capita income.

Mississippi ranks lowest among the states on a per capita income basis. The federal government will, accordingly, undertake to defray 66⅔% of the costs of all approved plans submitted by Mississippi under Titles V, VI and XII; 50% of the costs of any plan it may submit under Title XIII; and 33⅓% of the cost of its plan, if any, under Title XIV. The District of Columbia, which for the purposes of the Bill is treated as a state, ranks first on a per capita income basis. The federal government will, accordingly, defray only 33⅓% of the cost of the District's approved plans under Title V, VI and XII; only 16⅔% of the cost of its plan under Title XIII; but 33⅓% of the cost of its plan under Title XIV. The ratios of federal support for other states will range between the above two sets of extremes, the ratios for each state being determined by its rank on a per capita income scale.

To illustrate more concretely the procedure by which the amounts of federal grants to the states would be determined under the terms of the Wagner Bill, it may be worth while to follow step by step the way in which a grant to a particular state, say Indiana, for a specific purpose, say maternal and child-health services, would be calculated. The Wagner Bill authorizes a first-year appropriation of $8,000,000 for grants to the states for the extension and improvement of maternal and child health services. It will be assumed that Congress actually appropriates this amount. It will then devolve upon the Chief of the Children's Bureau to allot this $8,000,000 to the states. In determining the amount to be allotted to each state, the Bill requires that the following factors be taken into consideration: (1) the total number of births in the latest calendar year for which the Bureau of the Census has available statistics; (2) the number of mothers and children in need of the services; (3) the special problems of maternal and child health; and (4) the financial resources. The Bill does not specify how factors like "the special problems of maternal and child health" and "the financial resources" shall be given objective and quantitative expression. Neither does it specify the respective weightings which shall be given to each of the four factors prescribed. The Chief of the Children's Bureau with the approval of the Secretary of Labor is empowered to exercise her own discretion and to prescribe her own rules and regulations on questions of this kind.

For illustrative purposes only, the Children's Bureau has worked out a preliminary formula for allotting appropriations for maternal and child-health services to the states.[4] This formula is, of course, highly tentative and it would probably be improved as experience developed. According to the formula, 25% of the appropriation would be allotted to the states on the basis of the number of live births in each state.

[4] Hearings before a Subcommittee of the Senate Committee on Education and Labor on S. 1620, 76th Cong., 1st Sess. (1939) pt. 3, p. 751. (Hereinafter cited as "Hearings").

With certain exceptions which may be disregarded for the present purpose, the remainder of the appropriation (somewhat less than three-quarters) would be allotted to the states by means of a composite index based on four statistical measures weighted as follows: average income per capita, 3; infant mortality rate, 1; maternal mortality rate, 1; and sparsity of population (square miles per 1000 population in excess of the average for the most densely populated quartile state), 1.

Application of the formula which has just been described would give to the State of Indiana an allotment of $156,349 out of the total appropriation of $8,000,000. But in order to receive any money at all from the federal government, Indiana would be obliged to match each dollar of federal contribution with a certain number of cents contributed from its own resources, the required matching ratio being determined by its per capita income.

According to the estimates of the United States Department of Commerce, the average income of the inhabitants of Indiana for the three calendar years ending with 1937 was $441 per capita. Mississippi at the bottom of the income scale had an average income for the same period of $196 per capita, while the District of Columbia at the top of the scale had an average income of $1,165 per capita. Indiana's per capita income of $441 exceeds the per capita income of Mississippi by $245, which represents approximately a quarter of the $969 by which the per capita income of the District of Columbia exceeds that of Mississippi. Indiana's matching ratio, or the proportion of federal funds which it might count on to finance an approved plan of maternal and child-health services, would, therefore, be 58.3% (the maximum ratio of 66⅔% minus one quarter of 33⅓%, the latter figure being the difference between the maximum and the minimum statutory ratios).

With a matching ratio of 58.3%, Indiana would be obliged to contribute 41.7 cents out of its own funds toward every dollar spent on its child-health program. To obtain its full allotment of $156,349 the state would, accordingly, be required to raise the sum of $112,292 from state and local sources. Any reduction in the amount of state and local support would be paralleled by a corresponding reduction in the amount of the federal contribution. Thus, if Indiana were willing to put up only $50,000 of its own money toward the purposes in question, the amount of its federal grant would be reduced to $69,904 $\left(\frac{50{,}000}{.417} - 50{,}000\right)$. In this event some $86,445 of Indiana's federal allotment would remain unobligated and unpaid at the close of the fiscal year. This unused balance would be available for reallotment to all of the states for the succeeding fiscal year in addition to the amount appropriated for that year.

The Senate Committee on Education and Labor held extensive hearings on the National Health Bill during the months of April, May, June and July of this year. The published records of these hearings reveal two types of criticism. On the one hand are the criticisms of those who appear to be out of sympathy with the Bill's major purposes, or at least with the proposed method of accomplishing those purposes. On the other hand are the criticisms of those who support the Bill's objectives

and the method of federal aid which it embodies, but who raise questions concerning particular features of the Bill. The present study deals only with the latter type of criticisms and specifically with criticisms of the formulae for distributing federal grants among the several states.

The formulae for grants-in-aid under the Wagner Health Bill have been questioned on four main counts which may be summarized briefly as follows: First, it has been said that the formulae are too indefinite and leave the determination of the amounts of individual state grants too much to the discretion of the federal authorities charged with the administration of the Act.[5] Second, it has been claimed that the proposed methods of distributing federal funds will operate to penalize progressive states which have already gone beyond the average in providing health and hospital services through their own unaided efforts.[6] Third, it has been intimated that the proposed methods of allocating grants among the states do not give sufficient weight to the needs of the several states for health and hospital services relative to their respective abilities to support such services from their own resources.[7] Fourth, differences between the formulae to be used in distributing specific types of aid have raised questions whether the various formulae are properly correlated with reference to their combined effect in promoting a comprehensive and balanced social welfare program.[8] Each of these points will be considered in turn.

That the formulae for determining allotments to states under the various titles of the National Health Act lack definiteness and leave much to administrative discretion is evident from Table 1. In determining the amounts of allotments the responsible federal officials are directed to take certain factors into consideration. They are not limited to these factors, however, nor does the Act contain any specifications as to how much weight each factor is to be accorded. Some of the factors specified such as "population," "child population," and "number of births" are definite statistical concepts which are matters of current record. Other factors such as "number of mothers and children in need of services," "special health problems" and "financial resources" have no recognized statistical counterparts. At present, at least, the selection of quantitative measures of such factors must involve personal judgments which may change from time to time.

The discretionary formulae of the National Health Bill contrast sharply with the strictly objective formulae used in apportioning federal highway aid. Under the Rural Post Roads Act of 1916, allotments to the states for highway construction are automatically determined on the basis of population, area, and mileage of rural delivery routes as certified by the Postmaster General. Similarly, the Federal Aid to Education Bill,[9] introduced by Congressman Larrabee last year, provides for the distribution of federal aid for schools by means of a definite formula which leaves no room for administrative discretion.

In defense of the discretionary bases for making allotments provided in the Wag-

[5] Hearings, 144, 448, 495.
[6] *Id.* 128-129, 144-145.
[7] *Id.* 92, 96, 159, 500.
[8] *Id.* 502, 708.
[9] H. R. 3517, 76th Cong., 1st Sess. (1939).

ner Bill, it may very well be argued that health and hospital needs are too varied and diverse to be measured by any objective formulae which will be valid for all states. If objective formulae which are merely crude approximations are tentatively used, they will undoubtedly have to be changed as experience develops and as techniques of measurement improve. But changes of this kind may be difficult to make once a particular formula has been frozen into a statute. Finally, it may be pointed out that the methods of determining state allotments under the National Health Bill are essentially the same as some of the methods now prescribed under Titles V and VI of the Social Security Act and that these methods are apparently giving satisfactory results.

In this connection, however, it must be borne in mind that the Children's Bureau, despite its discretionary powers in the matter of allotting certain funds under Title V of the present Social Security Act, has actually chosen to apportion those funds by means of objective formulae of its own devising.[10] It must also be remembered that the sums subject to discretionary allotment under the present provisions of the Social Security Act are relatively small in comparison with the sums which would have to be apportioned among the states were the National Health Bill enacted.

The chief advantage of making allotments to the states by means of objective formulae plainly written into the law is that such formulae are easier to administer and protect the administering agency against accusations of arbitrariness and discrimination. From the standpoint of the states, definite statutory formulae have the advantage of enabling each state to make its own advance calculation of the amount of federal aid it may count upon receiving, thus facilitating financial planning.

The criticism that the matching provisions of the Wagner Bill discriminate against progressive states which are already taxing themselves to the limit in order to provide health and hospital services is tied up with the question of what, according to the intent of the Act, is an approved state plan. In order to qualify for federal funds a state must first submit plans for the approval of designated federal agencies. As will be seen from Table 1, all of the titles of the Act with the exception of Title XIV specify plans for *extending and improving* health, medical and hospital services or facilities. It is plans of this particular description which the federal government agrees to finance in specified proportions, but only to the extent that the states themselves finance the remainder of the cost of such plans.

Do the above provisions of the National Health Act mean that all state and local money to be acceptable for matching purposes must be "new" money, that is, money which is additional to what the states and localities are already raising and spending for health and hospital purposes? If so, the Act might conceivably lead to the type of discrimination illustrated in the following example:

State A, a progressive state, has been taxing itself heavily in order to improve its health and hospital services. In consequence, its state supported services of this nature have reached a standard considerably above the national average. State B, although

[10] Hearings, 148, 149.

possessing greater taxable resources than A, has neglected its health and hospital services, with the result that its standards are below the national average. Upon the enactment of the National Health Bill, State B submits to the appropriate federal agencies plans for extending and improving its services and facilities in order to bring them up to the level which State A is already maintaining through its own taxing efforts. From 16⅔% to 66⅔% of the cost of supporting State B's improved services will be contributed by the federal government.

State A, on the other hand, may find itself unable to raise the matching funds required further to improve its already high standard of service. In this event it will receive no aid from the federal government. Thus, State B, the wealthier state, will be assisted by the federal government to maintain the same standards of health and hospital services which the poorer State A is obliged to support entirely through its own efforts.

The possible unfairness which has just been illustrated arises, of course, from the circumstance that a state to receive any federal money at all must raise a certain proportion of matching funds through its own taxes and from the further circumstance that these state funds must apparently be used in *extending and improving* health, medical, and hospital services. In other words, state and local taxes spent in maintaining already existing services and facilities are apparently not to be counted for matching purposes. This limitation on the use of state matching funds represents a departure from the present provisions of Titles V and VI of the Social Security Act. Under the present Act, the state plans in respect of which there is a matching requirement are not "state plans for *extending and improving*" maternal and child-health services, etc., as specified in the Wagner Bill, but merely "state plans for such services." Moreover, Titles V and VI of the present Social Security Act authorize certain types of grants to the states without the requirement of matching.[10a]

One of the most serious of the criticisms voiced at the hearings respecting the grant-in-aid provisions of the Wagner Bill concerns their alleged failure to distribute federal aid among the states in accordance with the need of each state as related to its financial ability. This criticism was concisely expressed by Mrs. H. W. Ahart, President, Associated Women of the American Farm Bureau Federation, in the following language:

"The Wagner bill recognizes this need of the rural areas by specifying in each case in connection with the grants to the states that these funds are to be utilized for the purposes specified especially in rural areas and in areas suffering from severe economic distress. This recognizes where the principal need exists, but in addition we feel it would safeguard and improve the effectiveness and usefulness of this program if a more definite formula and mandate were written into the bill with respect to the apportionment of funds to the states so as to require the distribution of funds on the basis of need and the inability of the states to supply these services."[11]

Except for the reference to "rural areas" and "areas suffering from severe economic distress," there is nothing in the text of the National Health Act which expressly

[10a] Social Security Act Amendments of 1939, Pub. No. 379, 76th Cong., 1st Sess., §§502(b), 512(b), 602.

[11] Hearings, 96.

indicates a purpose to equalize health, medical and hospital services, or the state and local tax burden incident to supporting a minimum of such services throughout the United States. In this respect the National Health Bill differs markedly from the Federal Aid to Education Bill, the stated purpose of which is "to assist in equalizing educational opportunities among and within the states."

Despite any express reference to equalization in the text of the National Health Bill, it is clear from the hearings that some at least of the Bill's sponsors considered it an equalization measure. This is indicated by the following statement of Senator Wagner with reference to the Bill's grant-in-aid provisions:

"Federal encouragement and cooperation will be effected through the traditional method of grants-in-aid allotted and distributed in a manner to bring the greatest measure of federal aid to the states which are in the greatest need of the services, and which are least able to meet those needs by their own financial resources."[12]

In another connection Senator Wagner said:

"We are trying to help the states which, because of their lack of wealth, are not able to give as much aid, medical aid, as the wealthier states. Their aid is higher than the wealthier states; the apportionment is from one-third to two-thirds, depending upon the per capita income."[13]

Will the formulae for grants-in-aid under the National Health Bill distribute federal funds among the states on the equalizing principle? An equalizing formula must not only operate to level up interstate inequalities in standards of health and hospital services, but it must at the same time exert an influence in the direction of leveling down interstate inequalities in the state and local tax burdens incident to financing such services.

For illustrative purposes at the hearings, the Children's Bureau prepared a sample tabulation showing how a hypothetical federal appropriation of $8,000,000 for maternal and child-health services would be allotted to the states in accordance with the Bureau's interpretation of the terms of Title V of the Wagner Bill. It will be recalled that allotments to states are determined on the basis of factors which reflect each state's relative need for the services.

The tabulation also showed the respective ratios in which each state would be required to match its federal funds. These ratios range from a lower limit of 33⅓% to an upper limit of 66⅔% and depend on each state's average income per capita, which may be taken as a measure of financial ability. On the basis of the above data, reflecting both need and financial ability, the Bureau calculated the amount of matching funds which each state would have to raise from its own resources in order actually to receive its full federal allotment.

By expressing each state's quota of matching funds as a ratio of the total income received by the inhabitants of the state, it is possible to secure an approximate idea of the relative weight of the new taxes which each state would have to impose in order to secure the share of federal funds corresponding to its need. These ratios of

[12] *Id.* 111. [13] *Id.* 129.

required additional state and local taxes to total private income are given in Table 2 of the present study.

TABLE 2. REQUIRED RATES OF STATE AND LOCAL TAXATION TO ENABLE EACH STATE TO SECURE ITS FULL ALLOTMENT OF FEDERAL FUNDS UNDER AN EIGHT MILLION DOLLAR FEDERAL APPROPRIATION FOR GRANTS TO THE STATES FOR MATERNAL AND CHILD HEALTH SERVICES

State	Total income received by inhabitants, 1937* (In millions)	Amount of matching funds required to receive full allotment from Federal Government†	Tax rate (in cents per $1,000 of income) required to raise matching funds	State	Total income received by inhabitants, 1937* (In millions)	Amount of matching funds required to receive full allotment from Federal Government†	Tax rate (in cents per $1,000 of income) required to raise matching funds
1	2	3	4	1	2	3	4
Alabama	671	159,951	24	Nebraska	578	55,156	10
Arizona	238	41,087	17	Nevada	92	27,593	30
Arkansas	435	95,178	22	New Hampshire	257	27,571	11
California	5,153	253,192	5	New Jersey	2,706	109,074	4
Colorado	608	58,277	10	New Mexico	176	47,570	27
Connecticut	1,335	47,648	4	New York	11,138	429,231	4
Delaware	241	31,243	13	North Carolina	997	190,891	19
Dist. of Columbia	789	58,904	7	North Dakota	223	37,789	17
Florida	806	78,325	10	Ohio	4,206	223,076	5
Georgia	887	163,026	18	Oklahoma	824	102,629	12
Idaho	240	34,869	15	Oregon	586	45,321	8
Illinois	5,063	233,186	5	Pennsylvania	5,899	330,408	6
Indiana	1,715	112,292	7	Rhode Island	471	32,067	16
Iowa	1,090	95,431	9	South Carolina	490	107,646	22
Kansas	810	72,711	9	South Dakota	217	36,449	17
Kentucky	860	129,238	15	Tennessee	862	124,042	14
Louisiana	783	115,850	15	Texas	2,538	307,262	12
Maine	423	43,910	10	Utah	251	38,651	15
Maryland	1,092	59,735	5	Vermont	171	24,927	15
Massachusetts	2,955	129,354	4	Virginia	968	120,782	12
Michigan	3,259	189,481	6	Washington	1,018	62,892	6
Minnesota	1,382	113,061	8	West Virginia	762	91,210	12
Mississippi	419	140,476	34	Wisconsin	1,652	117,537	7
Missouri	1,839	131,648	7	Wyoming	145	26,407	18
Montana	318	37,904	12				

*U. S. DEP'T OF COMMERCE, STATE INCOME PAYMENTS, 1929-37, p. 2.
†Hearings, 755, col. (10).

It will be seen from the table that the state and local matching funds necessary to assure each state the amount of federal aid commensurate with its need will impose very unequal tax burdens on the various states. At the one extreme are the non-industrial states which would have to tax themselves with relative severity in order to secure their full allotment of federal funds. Thus, if the state matching funds were raised through a flat-rate exemptionless income tax, Mississippi would find it necessary to levy a tax of 34 cents per $1,000 of income in order to raise its matching quota. Alabama would have to levy a tax of 24 cents per $1,000; South Dakota, a tax of 22 cents; Idaho, a tax of 15 cents; and Montana, a tax of 12 cents per $1,000 of income. The industrial and commercial states, on the other hand, could raise their quotas of

matching funds and thus secure their full allotment of federal aid with a relatively mild increase in their rates of taxation. As will be seen from the table, the required rates in California, Illinois, Massachusetts, New Jersey and New York would be less than 5 cents per $1,000 of income.

It would appear from Table 2 that if federal funds for health and hospital services are actually distributed among the states according to their need for such services, the matching provisions of the bill will have the effect of exaggerating rather than of reducing existing interstate inequalities of tax burdens. This outcome may seem strange in view of the fact that the bill provides for variable matching ratios which favor the poorer states. To equalize the state and local tax burden incident to raising matching funds, however, it would be necessary to extend the present range of matching ratios beyond the maxima and minima now specified in the Bill.

It is possible that some of the poorer states would be unable or unwilling to raise their full quotas of matching funds because of the relatively heavy rates of state and local taxation involved. To the extent that this occurred, the federal aid received by the states in question would fall short of their full allotments, and the actual distribuion of federal funds among the states would not correspond to a distribution based on need. The poorer states would receive less from the federal government relative to their needs than would the wealthier states.

Despite their failure to equalize the state and local tax burden incident to raising matching funds, it should be borne in mind that the variable matching grants of the Wagner Bill go much farther in the direction of equalization than do the fixed 50-50 matching grants now specified in the Social Security Act for Old-Age Assistance, Aid to Dependent Children, and Aid to the Blind. Measured by the standards of these public assistance grants, the Wagner Bill, with its variable matching provisions, represents a distinct triumph for the principle of equalization. On the other hand, Titles V and VI of the present Social Security Act authorize the distribution of certain funds to the states for maternal and child-health services, services to crippled children, and public health work solely on the basis of relative need and financial ability and with no requirement of state matching. These latter types of grants are more effective for equalizing purposes than any matching grant, even of the variable kind. The non-matching grants of the present Social Security Act are, however, not continued in the Wagner Bill.

A final question raised at the hearings concerning the grant-in-aid formulae of the Wagner Bill was whether these formulae were properly correlated with reference to their combined effects on the promotion of a balanced, well-coordinated health, medical care and hospital program. The feature of the Bill which gives point to this question is the lack of uniformity in the matching ratios specified under its several titles.

It is apparent from Table 1 that the states with the lowest per capita income will receive $2 from the federal government for every $1 of their own funds which they spend in child-health services, public health work or hospital construction. On the