Federal Health Spending Passes the $50-Billion Mark

John Walsh

Since World War II, the federal government's role in health care has expanded steadily. With the enactment of Medicare and Medicaid legislation in 1965, the costs of federal health programs became the fastest growing major component in total national expenditures on health. Federal outlays for health in 1977 amounted to an estimated $49.6 billion in total spending of $160.6 billion (*1*). In addition to their impact on health care financing, federal programs have strongly affected patterns of service. Particularly in recent years, the federal government has moved from a policy of restricting its actions to the provision of financial support to one of also exerting more overt policy influence on health programs.

Until World War II, federal health activities were limited largely to traditional public-health functions—notably the control and prevention of infectious diseases—to low-level support of medical research, and to provision of medical care for the military, for veterans, and for merchant seamen who were cared for in Public Health Service hospitals. A wider federal role was inhibited by a general sentiment that federal aid would entail federal control, similar to the attitude which blocked expansion of federal aid to education. In the case of health care, the medical profession applied strong pressure to limit the federal role.

In the postwar period, modification of these attitudes permitted a step-by-step increase in the variety and scale of federal programs. This article will describe this progression through a summary of important programs in four main categories—construction of facilities, funding of services, and support of manpower training and of research.

Construction

The first major break in the prewar pattern of federal health spending came in 1946 with legislation which led to creation of the Hill-Burton program for construction and modernization of hospitals (*2*). This program of federal grants won acceptance in part because funds for "bricks and mortar" were viewed as the least compromising form of federal aid. A strong early argument for the program was that it was intended to aid construction of hospitals in rural areas as a means of upgrading medical services in such areas. Passage of the Hill-Burton legislation also reflected the recognition at that time of the difficulties public and other nonprofit hospitals were experiencing in raising capital funds for construction.

Hill-Burton funds played a major part in the expansion and modernization of the nation's hospitals during the 1950's and 1960's. By the early 1970's, however, the rationale for the program was being questioned. Not only had the need for hospitals in rural areas been largely met, but there were signs that overbuilding of hospitals generally was creating an excess of beds and contributing significantly to inflation in health-care costs.

Outlays under Hill-Burton peaked at $283.6 million in 1970 and have declined since then. More important, perhaps, the program was redirected into the financing of health facilities other than hospitals and forms of funding were altered. The financial situation of hospitals, by and large, has improved. A major factor in this improvement is that Medicare and Medicaid as well as private health insurance programs provide funds for depreciation and interest on construction loans for hospitals. Federal construction programs now emphasize loan guarantees and interest subsidies rather than grants.

Service

By far the largest and fastest growing sector of the federal health care budget has been the support of health services under the Medicare and Medicaid programs. In 1965, before the programs for financing of health services for the aged and the poor went into effect, federal expenditures on health amounted to about $4.4 billion. In 1970 the total was $18 billion. Current federal budget figures show that "indirect" health services, in which Medicare and Medicaid are the dominant elements, cost $35.7 billion in a total health budget of $49.6 billion in 1977. (Costs of provision of *direct* services by federal agencies such as the Department of Defense and the Veterans Administration through their own health care systems is put at over $6 billion a year, in addition to the $35.7 billion in indirect services. For fiscal year 1979, the President's budget projects the cost of services as $47.4 billion in a total federal health spending of $63.4 billion.

Medicare benefits were initially available to those over age 65, but in 1973 coverage was extended to two other groups, the disabled and those suffering from chronic kidney disease. In 1975, the program covered about 23 million aged and 2 million people who had qualified for disability payments under Social Security for at least 2 years. The latter group included some 28,000 eligible for Medicare payments for hemodialysis treatments or kidney transplant operations. In the past year, costs of the program for kidney patients alone reportedly passed $1 billion.

The federal government's share of total national spending on health services amounts to some 28 percent. This includes 39 percent of hospital expenses, 32 percent of nursing home expenses, 19 percent of physicians' expenses, and 5 percent of drug expenses.

Medicare and Medicaid account for about two-thirds of federal outlays for health services. The Department of Defense and the Veterans Administration spend substantial sums for indirect health services through a variety of programs. The Department of Health, Education, and Welfare is a major spender on programs other than Medicare and Medicaid. These range from the Maternal and Child Care Program established before World War II to the phalanx of community-oriented health care programs generated by the social legislation of the 1960's. Many of these latter programs are administered by the Alcohol, Drug Abuse, and Mental Health Administration. Budget estimates for fiscal year 1979, for example, put spending on community mental health services at $243 million, drug abuse services at $211 million, and alcohol abuse services at $142 million.

The author is a member of the News and Comment staff.

0036-8075/78/0526-0886$00.50/0

Research

Funding of health services has been the most controversial and has proved to be the most costly of federal health activities. Support of medical research enjoyed a period of virtually uncontested and very rapid expansion in the postwar period, but in the past decade the rate of growth of funding for research has been much slower than that for either support of services or manpower programs.

In 1950, federal spending on biomedical research was less than $100 million. By 1970, the total was some $1.5 billion, with about $860 million of that in the budget of the National Institutes of Health. Expenditures on research increased to $2.4 billion in 1975, and the NIH budget to $1.6 million, but inflation reduced the impact of these increases drastically and concentration of new funds in research on cancer and heart disease during this period resulted in a decline, in real terms, in funding for research in several other areas. Recent federal budgets have shown a return to a broader distribution pattern and provided some growth in constant dollars.

Manpower

Until the 1960's, federal support of health manpower training was mainly indirect through research grants or through the funding of medical residencies by agencies such as the Veterans Administration, Public Health Service, and National Institute of Mental Health. However, prompted by concern about a shortage of physicians, the Congress in 1964 passed a Health Professions Educational Assistance Act intended to encourage expansion of the training of physicians and other health professionals. The act provided construction funds for medical schools and loans for students conditional on expansion of enrollments.

The HPEA and its successor legislation were effective in promoting a major expansion of enrollments in the next decade, but during that period there was a change in policy-makers' perceptions of manpower needs. In addition to creation of a larger supply of health manpower, it was deemed necessary that the flow of professionals be increased into medically underserved areas—primarily rural and inner city areas—and that the numbers of physicians training in certain specialties be raised. To accomplish these aims, Congress provided incentives such as "capitation" grants for medical schools and direct aid to students. A National Health Service Corps was created which offered generous federal scholarships to medical students in return for a commitment to practice for a term in medically underserved areas after completing training. Expansion of training in so-called primary care specialties was made a condition of institutional support. And concern about the heavy reliance of hospitals on foreign medical school graduates led to restrictions on entry and participation in residency training programs of foreign-trained students. Some of these measures encountered stiff resistance from the medical schools and medical profession, but the imposition of these requirements occurred during a period when medical schools were under severe financial pressure and when, for example, tuitions were rising very rapidly, and the schools had come to rely heavily on federal support. Relations between medical schools and the government can be described currently as uneasy. Federal support of health manpower training in 1977 was put at some $1.7 billion.

The federal view is that medical education and health manpower training generally is subsidized heavily by the government and that, therefore, the government has a responsibility to ensure that health resources are managed in the best interests of the public which has provided the funds. Similar reasoning underlies measures taken in recent years to evaluate the quality and control the costs of health services paid for by the government. These latter efforts are grouped generally under the category of "planning" activities.

Review of patient care has been a matter of concern to federal officials since the start of the Medicare and Medicaid programs. Requirements for such review procedures were in the original legislation, but dissatisfaction continued over how the review function was being performed. This led to enactment of the so-called Professional Standards Review Organization Act in 1972. This law mandated the formation of groups of physicians to review service to Medicare and Medicaid patients in the physicians' area. A lack of professional enthusiasm for the PSRO idea slowed its implementation and has caused a questioning of its effectiveness.

A major effort to consolidate planning activities came with passage of the National Health Planning Act of 1974, which was designed to assure development of a national health policy and insure a more rational use of resources by existing planning legislation, such as the Comprehensive Health Planning Act, Health Maintenance Organization Act, and Regional Medical Programs Act. Federal expenditures for planning and statistics amounted to $378 million in 1977.

Another major category of health programs can be said to have emerged since the late 1960's with the buildup of programs for environmental control, consumer protection, and disease prevention. To a marked degree these programs follow the model of federal regulatory activity set, for example, by the Food and Drug Administration. But the new programs differ in that they are designed to deal with the difficult problems of long-term effects on human health of pollutants and, particularly, of toxic substances found in small quantities in the environment. Agencies such as the Environmental Protection Agency, Occupational Safety and Health Administration, and Consumer Products Safety Commission, in their research, monitoring, and regulatory activities, are engaged in what amounts to a new range of public health activities.

The major health programs established over the past three decades were created to serve particular needs and not according to any systematic design. For the most part, these programs have supported activities for which other funding was not available, or provided services to groups of people who would otherwise have been excluded. These federal programs now cost over $50 billion a year and obviously exert a significant impact on the economy as well as on health care. Federal programs, by and large, reinforce the fee-for-service principle which undergirds American medical care. Rapidly rising costs of health care have inevitably prompted government efforts to control cost and quality. These efforts have not been strikingly successful, but, with national health insurance programs under serious discussion, control efforts can be expected to continue and to increase tensions in the health care field, which in the United States has become a highly complex, mixed public-private enterprise.

References

1. *Special Analysis, Budget of the United States Government. Fiscal Year 1979* (Government Printing Office, Washington, D.C., 1978).
2. Main sources of data and analysis for this article were: L. B. Russell, B. B. Borque, D. P. Borque, C. S. Burke, *Federal Health Spending 1969-74* (National Planning Association, Washington, D. C., 1974); M. S. Koleda, C. Burke, J. S. Willems, *The Federal Health Dollar: 1969-1976* (National Planning Association, Washington, D.C., 1977); L. B. Russell and C. S. Burke, *Int. J. Health Serv.*, **8** (No. 1), 55 (1978); R. M. Gibson and M. S. Mueller, *Soc. Security Bull.* (April 1977), p. 3.