Deficits Haunt Science Budgets

Congress is on the way to passing a relatively generous budget for NIH, but nothing is certain because it has yet to agree on how to meet the Gramm-Rudman goals

A few hours before Congress adjourned on 16 August for a 3-week break, the Senate Appropriations Committee approved a $6.081-billion budget for the National Institutes of Health in fiscal year 1987. If that sum is approved by Congress, and if it all gets spent, NIH would end up with about $1 billion more than the Administration requested and $820 million more than it had this year—a 15.5% increase at a time when almost every other area of the federal budget is being severely squeezed.

The sum is, however, far from being money in the bank. NIH, like all other claimants on the federal budget, is going to find itself caught in a desperate battle to cut the federal deficit when Congress returns on 8 September. As a consequence, no government agency yet has a clear picture of what resources it will have in FY 1987, which begins on 1 October, a scant few weeks away.

The uncertainty rests in part on the fact that when Congress finally adjourned in the early hours of Saturday morning, it had completed work on only three appropriations bills (none of which has much direct relevance to R&D). Equally important, members left Washington deeply divided on how to meet the targets specified in the infamous Gramm-Rudman-Hollings deficit reduction act, which could require some major cuts in federal spending.

Congress will be faced with a monstrous fiscal problem when it returns. Gramm-Rudman requires the deficit to be shrunk to $144 billion next year, a huge drop from this year's projected record shortfall of $230 billion. According to an estimate by the Congressional Budget Office, the FY 1987 deficit may exceed the Gramm-Rudman target by as much as $30 billion. Something clearly has to give.

One result is that there is going to be a lot of pressure to cut appropriations bills. However, virtually everybody agrees that Congress is unlikely to complete action on many appropriations bills before FY 1987 starts, so much of the federal budget is expected to end up in a so-called continuing resolution—a catchall spending bill that will be approved by Congress in late September, in the waning moments of FY 1986. The continuing resolution will be an intensely negotiated composite of the appropriations bills that have not made it all the way through the congressional mill.

What will happen if, come 1 October, Congress has still failed to bring the projected FY 1987 deficit below $144 billion? That question is likely to be at the center of an interesting political dogfight over the next few weeks.

Under the Gramm-Rudman law, automatic across-the-board cuts would have been made in October. The starting point for the cuts would be each agency's newly approved budget, contained either in regular appropriations bills or in the continuing resolution, and the amount would be determined by a deficit projection made by the Congressional Budget Office and the Office of Management and Budget. However, the Supreme Court has ruled that the mechanism specified in the original law for applying the knife is unconstitutional. When Congress returns, it will have to decide whether to institute some other way of making automatic cuts to reach the Gramm-Rudman target. Alternatively, it could decide, with some justification, that the deficit is on the way down, declare victory, and leave to fight the election.

The decision to build a fourth orbiter has done nothing to ease uncertainty over NASA's budget.

Given all these uncertainties, nobody should count on the increases approved so far for NIH holding up entirely. However, at this point NIH looks in better shape than many other science agencies. The House has already passed its version of the NIH appropriations bill, and it has even been slightly more generous than the Senate Appropriations Committee. It approved a total budget of $6.153 billion, enough to fund some 6200 new and competing grants. According to Senate staff members, the $6.081 billion in the Senate bill would fund about 6100 new grants, about the same as this year.

The expectation is that NIH will end up at the beginning of FY 1987 with a budget in excess of $6 billion—whether in a regular appropriations bill or as part of a continuing resolution—compared with some $5.3 billion in FY 1986. Some of this increase could, however, be quickly sliced off if Congress does agree to make across-the-board cuts to meet the Gramm-Rudman target.

One thing that is certain is that spending on AIDS research and education will increase sharply next year. The House has budgeted a total of some $337 million for AIDS, while the Senate bill contains $355 million. The comparable figure this year is $234 million. Congress also is likely to reject an Administration proposal to channel all AIDS funding through a central office in the Department of Health and Human Services; both bills appropriate the money directly to individual agencies.

In contrast, the National Science Foundation could end up with considerably less than the Administration requested. The Administration wanted to give NSF a 15.6% increase, but the House Appropriations Committee has said it can do no better than 6%. In a bill approved on 31 July, but which has not yet gone to the floor of the House, the committee included $1.55 billion for NSF—$136 million less than the Administration wanted but $92 million more than the foundation's FY 1986 budget. NSF officials are hoping for more generous treatment from the Senate, but the Senate Appropriations Committee has not yet acted on its version of the bill.

The bill is stalled in the Senate Appropriations Committee because of uncertainties about the budget for the National Aeronautics and Space Administration. (NSF and NASA are included in the same bill.) The problem is that Congress has been waiting for months for the Administration to send up a revised NASA budget detailing how it plans to finance the recovery from the Challenger disaster. The Administration, meanwhile, has been deeply split on whether a replacement orbiter is required, and if it is, how it should be paid for.

President Reagan's announcement on 15

August that NASA will be given the go-ahead for a new orbiter does not do much to relieve the uncertainty. Reagan said that the orbiter would be paid for from savings in NASA and from unspecified unspent funds in other agencies. Some $272 million will be required in FY 1987, rising to $665 million the following year, $715 million in 1989, $515 million in 1990, and $180 million in 1991. Several key legislators immediately said they would not permit the funds to be taken from other NASA programs, however, and presidential spokesman Larry Speakes promised that NASA's main big-ticket item, the space station, would not suffer. Where the money will come from is thus anybody's guess, but space scientists fear the worst.

All will become clearer by early fall. Between now and then lie some interesting politics. ■ COLIN NORMAN

For-Profit Hospitals Loom Large on Health Care Scene

An across-the-board need to contain costs affects traditional not-for-profit hospitals as well as for-profit institutions, blurring distinctions among medical care providers

It was only a few years ago that the for-profit hospital industry burst on the national scene with surprising force. Ever since the early part of the century, there have been for-profit hospitals in this country, usually small, often physician-owned establishments that blended into their communities without standing out in any particular way as "businesses." But during the 1970's, the definition of what it means to be a for-profit hospital changed as large investor-owned corporations began buying up individual hospitals and linking them nationwide in an imposing chain. The idea that, from a business point of view, owning a chain of hospitals is not unlike owning a flourishing chain of fast-food eateries took hold in the public imagination—and bothered a lot of people.

In 1975, only 378 hospitals in the United States were in the hands of investor-owned corporations—just about 6% of all the hospitals in the country. Only 9 years later, the figure had jumped to 878 hospitals or 13% of the total. Furthermore, the investor-owned or for-profit hospital industry quickly came to be dominated by a handful of giant corporations with assets in the billions of dollars and a seemingly insatiable appetite for expansion through the acquisition of more hospitals. The colossal reach of the investor-owned health care industry became widely recognized, and hospitals, never a big item on the stock market, became the talk of Wall Street.

The new reality came up hard against a long-held belief that hospitals benevolently serve the needs of the community, not a bunch of anonymous stockholders, and fears about the potential distortion of an idealized health care system were expressed. Nowhere were these fears expressed more consistently and vociferously than within academic medicine. The case of the never completed sale of Harvard's McLean Hospital to the giant Hospital Corporation of America is a dramatic case in point (*Science*, 21 March, p. 1363). Arguing that medicine and big business should not mix, the Harvard Medical School faculty blocked the planned sale of McLean, which would have continued as a Harvard teaching hospital under its new owners; HCA was prepared to pay $35 million up front.

Medical care as big business has been a hotly debated phenomenon for the past 5 or 6 years. In 1981, the Institute of Medicine (IOM) sponsored a workshop on the topic and subsequently a major study was launched in an attempt to "understand the provision of health care by investor-owned organizations and to illuminate the issues that are involved." The study, which took 3 years to complete and was recently released,* examined not only factual matters but also questions of value. "These value conflicts color people's interpretation of data and persist after all empirical studies have been reviewed," the IOM report acknowledges. Indeed, the 22 committee members themselves (drawn from medicine, hospital administration, business, ethics, law, and economics) never did reach total agreement on value-laden issues even though they did achieve consensus on the majority of questions before them (see box, p. 929).

Walter McNerney. *For-profits and not-for-profits alike will have to respond to new cost-cutting forces in the marketplace.*

But one inference to be drawn from the study data seems clear: the for-profit enterprise is not quite the menace it has been cracked up to be. Furthermore, as committee chairman Walter J. McNerney, former chairman of Blue Cross, says, "Today, the country as a whole tends to be a little more commercial in its attitude toward health care than it was in the sixties, for instance. Maybe medicine is viewed a little less ecclesiastically and a little more pragmatically."

The IOM report speaks of the differences between for-profit and not-for-profit organizations that have led to a number of assumptions about the attitudes of each type of institution toward quality of medical care, cost, service to the poor, involvement in research and education, and the role or primary loyalty of physicians. One assumption was that "something essential will be lost if a service ethos . . . is abandoned or replaced with a principle based on economic goals." The committee reported that its "examination of the evidence shows that many

*Institute of Medicine, *For-Profit Enterprise in Health Care*. Available for $39.50 from the National Academy Press, 2101 Constitution Avenue, NW, Washington DC 20418 (1986).