National Health Expenditures, 1982

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Rapid growth in the share of the nation's gross national product devoted to health expenditure has heightened concern over the survival of government entitlement programs and has led to debate of the desirability of current methods of financing health care. In this article, the authors present the data at the heart of the issue, quantifying spending for various types of health care in 1982 and discussing the sources of funds for that spending.

The United States spent an estimated $322 billion for health care in 1982, an amount equal to 10.5 percent of the Gross National Product (GNP). Highlights of the figures that underly this estimate include the following:

- Health care expenditures grew 12.5 percent between 1981 and 1982—a diminished, but still rapid, rate considering that the economy as a whole was in a recession at the time (Figure 1).
- Health care expenditures amounted to $1,365 per person in 1982, $140 more than in 1981 (Table 1). Of that amount, $579 came from public funds.
- Hospital care accounted for 42 percent of total health care spending in 1982 (Figure 2). These expenditures increased 14.9 percent from 1981, to a level of $136 billion (Table 2).
- Spending for the services of physicians increased 12.8 percent to $62 billion—19 percent of all health care spending.
- Public sources provided 42 cents of every dollar spent on health in 1982. Federal payments amounted to $93 billion, and $44 billion came from State and local governments (Table 3).
- Consumers paid $175 billion for health care in 1982, either directly or together with employers, in the form of health insurance premiums.
- All third parties combined—private health insurers, governments, private charities, and industry—financed 68 percent of the $287 billion in personal health care in 1982 (Table 4), covering 88 percent of hospital care services, 63 percent of physicians' services, and 43 percent of the remaining health services (Tables 5 through 8).
- Outlays for health care benefits by the Medicare and Medicaid programs totalled $83 billion, including $48 billion for hospital care. The two programs combined paid for 29 percent of all personal health care in the nation (Table 9).

This article continues a series of reports begun in the Department of Health, Education, and Welfare (Reed and Rice, 1964). The series, now the responsibility of the Health Care Financing Administration, presents the National Health Accounts of the United States.

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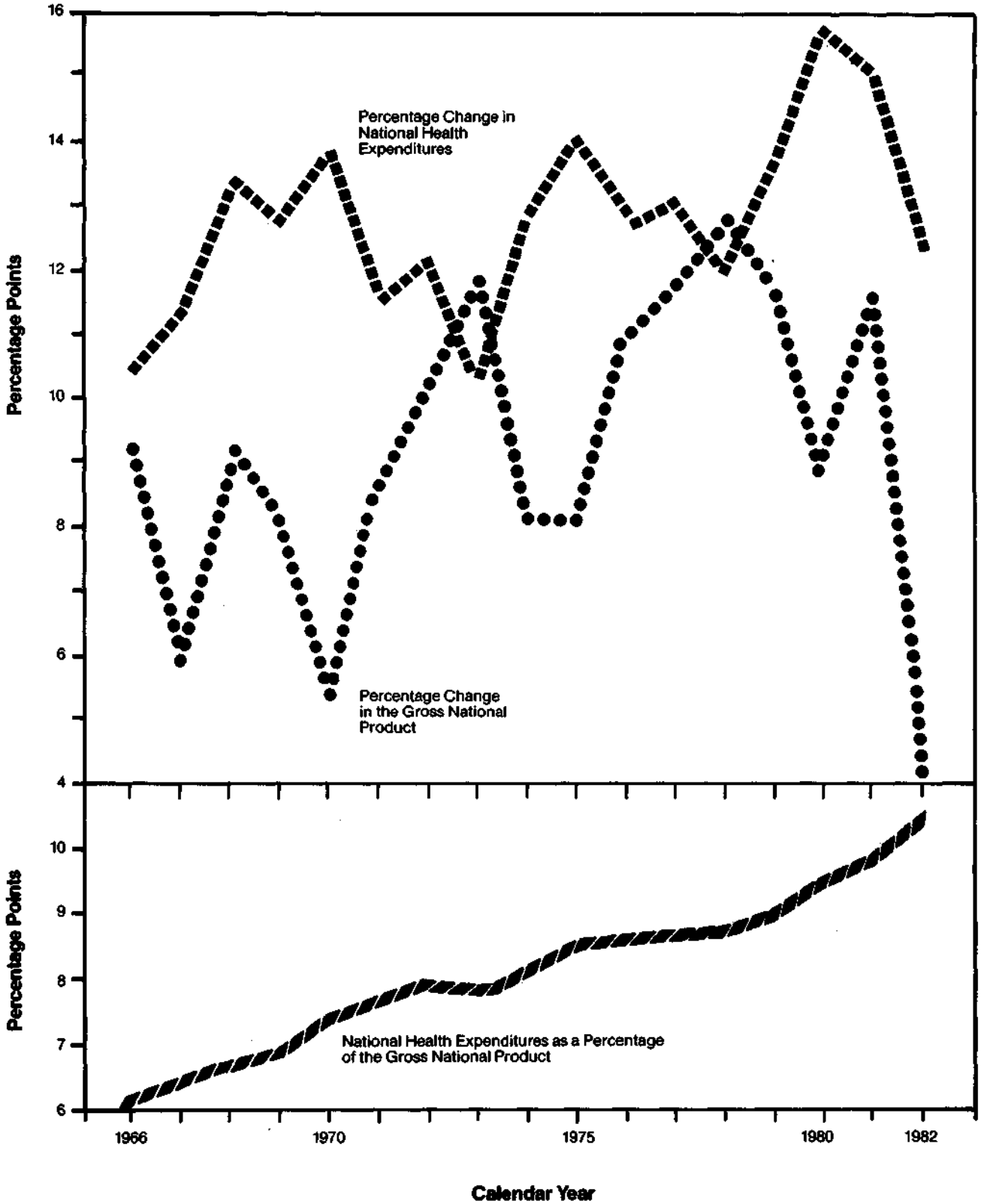
Overview

Expenditures for health care reached $322 billion in 1982, a 12.5 percent increase from 1981 levels and an amount equal to 10½ cents of every dollar of the Gross National Product. The rapid growth of spending for health, together with growing government deficits and the increasing burden both place upon the economy, has led to a national debate of the philosophy of health care financing and to substantive changes in the methods by which the Federal government pays for health care.

The health care sector of the economy was more robust in 1982 than was the economy as a whole; evidence of that strength can be seen in Figure 3. The dollar value of the provision of care, whether measured before or after inflation, grew at twice the rate of personal income, from which the bulk of spending for health care is financed. Employment and workhours scored solid gains in the private segment of the health care industry, compared to actual declines in the private nonfarm economy as a whole; the unemployment rate for health-related workers and professionals was less than half the aggregate U.S. civilian unemployment rate. Payroll growth in private health establishments was at a rate of 15.1 percent—seven times as great as total private nonfarm payroll growth—and consumer medical prices increased at almost twice the rate of the Consumer Price Index for all items. Thus, in these aspects of "production"—output, labor, and prices—the health care industry registered stronger performance in 1982 than did the economy as a whole.

FIGURE 1

National Health Expenditures and Gross National Product: Growth and Relative Sizes, 1966–1982



Source: Bureau of Data Management and Strategy, Health Care Financing Administration.

TABLE 1

Aggregate and *per capita* National Health Expenditures by Source of Funds and Percent of Gross National Product
Selected Calendar Years, 1929-1982

	1982	1981	1980	1979	1978	1977	1976	1975	1974	1973	1972	1971
National Health Expenditures (billions)	$322.4	$286.6	$249.0	$215.0	$189.3	$169.2	$149.7	$132.7	$116.4	$103.2	$93.5	$83.3
As a Percentage of the GNP	10.5	9.8	9.5	8.9	8.8	8.8	8.7	8.6	8.1	7.8	7.9	7.7
Sources of Funds:	185.6	164.4	143.6	124.4	109.8	99.1	86.7	76.5	69.3	63.9	58.1	51.6
Private Expenditures	136.8	122.2	105.4	90.6	79.5	70.1	62.9	56.2	47.1	39.3	35.4	31.7
Public Expenditures	93.2	83.7	71.1	61.0	53.9	47.4	42.6	37.1	30.4	25.2	22.9	20.3
Federal Expenditures	43.7	38.5	34.3	29.5	25.7	22.7	20.4	19.1	16.7	14.1	12.5	11.3
State/Local Expenditures												
Per Capita Expenditures[1]	1365	1225	1075	938	836	755	674	604	535	478	438	394
Sources of Funds:												
Private Expenditures	786	703	620	543	485	442	391	348	318	296	272	244
Public Expenditures	579	522	455	395	351	313	284	255	216	182	166	150
Federal Expenditures	394	358	307	266	238	211	192	169	140	117	107	96
State/Local Expenditures	185	165	148	129	113	101	92	87	77	65	59	54
Percentage Distribution of Funds	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private Funds	57.6	57.4	57.7	57.9	58.0	58.6	57.9	57.7	59.5	61.9	62.1	62.0
Public Funds	42.4	42.6	42.3	42.1	42.0	41.4	42.1	42.3	40.5	38.1	37.9	38.00
Federal Funds	28.9	29.2	28.5	28.4	28.4	28.0	28.5	27.9	26.2	24.4	24.5	24.4
State/Local Funds	13.5	13.4	13.8	13.7	13.6	13.4	13.6	14.4	14.3	13.7	13.4	13.6
Addenda:												
Gross National Product (billions)	3,059.3	2,937.7	2,633.1	2.417.8	2,163.9	1,918.3	1,718.0	1,549.2	1,434.2	1,326.4	1,185.9	1,077.6
Population (millions)	236.2	234.0	231.7	229.1	226.6	224.2	222.0	219.9	217.7	215.7	213.6	211.3
Annualized Percentage Changes												
National Health Expenditures	12.5	15.1	15.8	13.5	11.9	13.1	12.8	14.0	12.8	10.3	12.3	11.5
Private Expenditures	12.9	14.5	15.4	13.3	10.7	14.3	13.3	10.5	8.4	10.0	12.5	10.1
Public Expenditures	12.0	15.9	16.4	13.9	13.4	11.4	12.0	19.2	19.9	10.9	11.9	13.9
Federal Expenditures	11.4	17.7	16.5	13.3	13.6	11.4	14.8	21.8	20.9	10.0	12.6	15.0
State/Local Expenditures	13.3	12.2	16.2	15.0	13.1	11.5	6.6	14.6	18.2	12.4	10.6	12.0
Gross National Product	4.1	11.6	8.9	11.7	12.8	11.7	10.9	8.0	8.1	11.8	10.1	8.6
Population	1.0	1.0	1.1	1.1	1.1	1.0	1.0	1.0	.9	1.0	1.1	1.3

See footnotes at end of table.

(continued)

TABLE 1 (continued)

Aggregate and *per capita* National Health Expenditures by Source of Funds and Percent of Gross National Product
Selected Calendar Years, 1929-1982

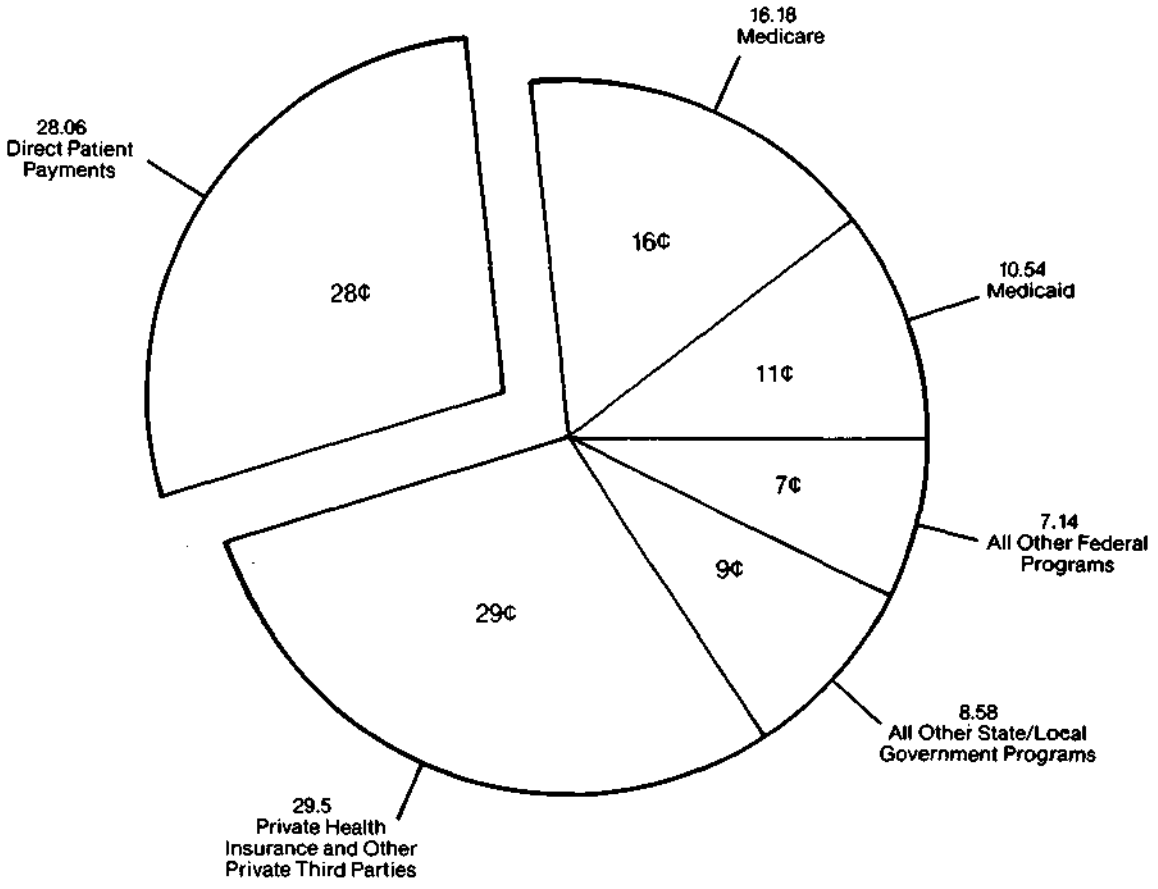
	1970	1969	1968	1967	1966	1965	1960	1955	1950	1940	1929
National Health Expenditures (billions)	$74.7	$65.6	$58.2	$51.3	$46.1	$41.7	$26.9	$17.7	$12.7	$4.0	$3.6
As a Percentage of the GNP	7.5	7.0	6.7	6.4	6.1	6.0	5.3	4.4	4.4	4.0	3.5
Sources of funds:											
Private Expenditures	46.9	40.7	36.1	32.3	32.5	31.0	20.3	13.2	9.2	3.2	3.2
Public Expenditures	27.8	24.9	22.1	19.0	13.6	10.8	6.6	4.6	3.4	.8	.5
Federal Expenditures	17.7	16.1	14.1	11.9	7.4	5.5	3.0	2.0	1.6	n/a	n/a
State/Local Expenditures	10.1	8.8	8.0	7.1	6.1	5.3	3.6	2.6	1.8	n/a	n/a
Per Capita Expenditures[1]	358	318	285	254	230	211	146	105	82	30	29
Sources of Funds:											
Private Expenditures	225	197	176	160	163	156	110	78	60	24	25
Public Expenditures	133	121	108	94	68	55	36	27	22	6	4
Federal Expenditures	85	78	69	59	37	28	16	12	10	0	0
State/Local Expenditures	49	43	39	35	31	27	20	15	12	6	4
Percentage Distribution of Funds	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private Funds	62.8	62.0	62.0	63.0	70.6	74.1	75.3	74.3	72.8	79.7	86.4
Public Funds	37.2	38.0	38.0	37.0	29.4	25.9	24.7	25.7	27.2	20.3	13.6
Federal Funds	23.6	24.6	24.3	23.3	16.1	13.3	11.2	11.3	12.8	n/a	n/a
State/Local Funds	13.6	13.4	13.7	13.7	13.3	12.6	13.5	14.4	14.4	n/a	n/a
Addenda:											
Gross National Product (billions)	992.7	944.0	873.4	799.6	756.0	691.0	506.5	400.0	286.5	100.0	103.4
Population (millions)	208.6	206.4	204.4	202.3	200.1	197.9	183.8	168.4	154.7	134.6	123.7
Annualized Percentage Changes											
National Health Expenditures	13.8	12.8	13.4	11.3	10.4	9.2	8.7	7.0	12.2	.8	n/a
Private Expenditures	15.1	12.9	11.5	−.6	5.1	8.8	9.0	7.4	11.2	.1	n/a
Public Expenditures	11.6	12.7	16.5	39.7	25.7	10.2	7.8	5.8	15.5	4.6	n/a
Federal Expenditures	9.8	14.0	18.4	60.1	34.5	12.9	8.5	4.3	n/a	n/a	n/a
State/Local Expenditures	14.7	10.5	13.3	15.0	16.5	7.8	7.2	7.0	n/a	n/a	n/a
Gross National Product	5.2	8.1	9.2	5.8	9.4	6.4	4.8	6.9	11.1	−.3	n/a
Population	1.1	1.0	1.0	1.1	1.1	1.5	1.8	1.7	1.4	.8	n/a

[1]Based on mid-year population estimates including outlying territories, armed forces, and Federal employees overseas and their dependents.
n/a Data not available.
SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

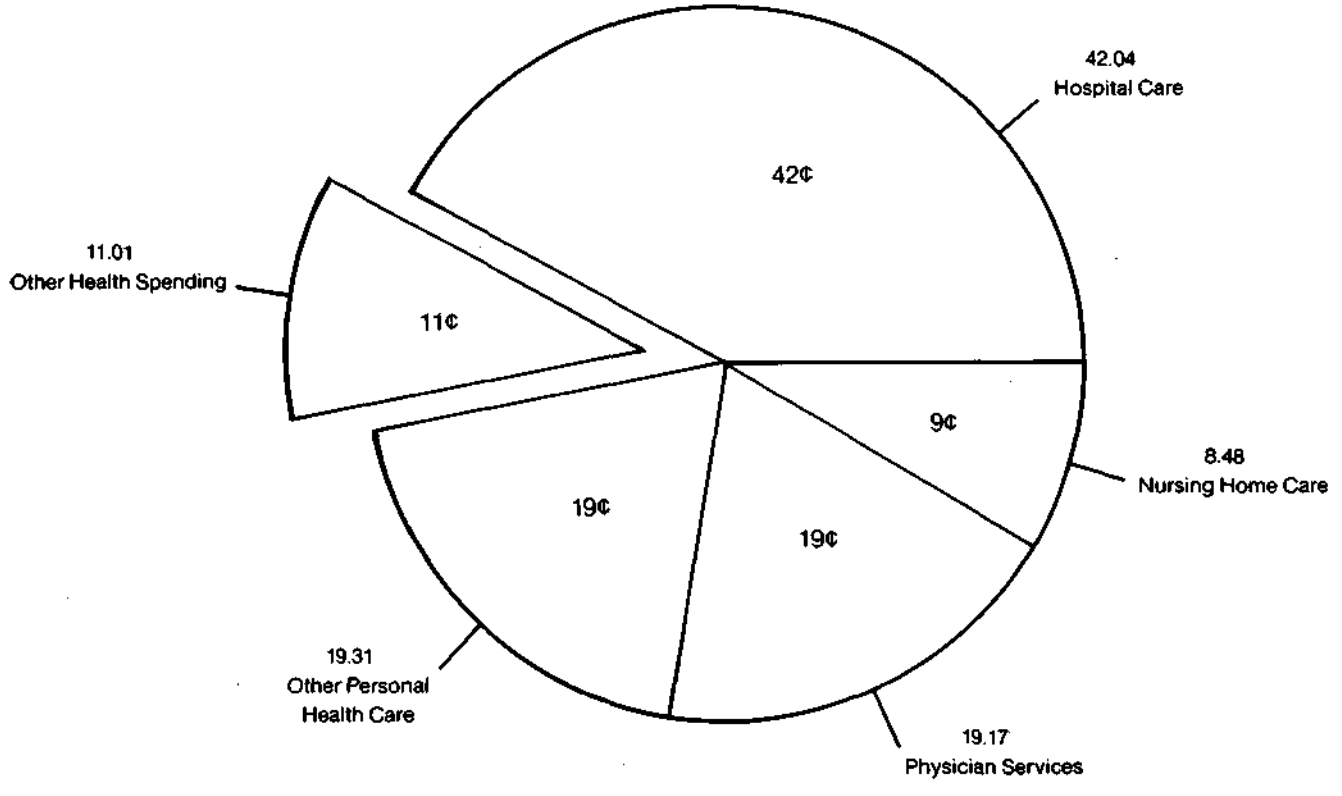
FIGURE 2

The Nation's Health Dollar in 1982

Where it Came From...



...And Where it Went



Source: Bureau of Data Management and Strategy, Health Care Financing Administration

TABLE 2

National Health Expenditures by Type of Expenditure, Selected Years 1929-1982
(in billions of dollars)

	1982	1981	1980	1979	1978	1977	1976	1975	1974	1973	1972	1971
Total	322.4	286.6	249.0	215.0	189.3	169.2	149.7	132.7	116.4	103.2	93.5	83.3
Health Services and Supplies	308.3	273.5	237.1	204.5	179.5	160.1	140.6	124.3	108.9	96.3	86.9	77.2
Personal Health Care	286.9	254.6	219.4	188.9	166.7	148.7	131.8	116.8	101.0	88.7	80.2	72.0
Hospital Care	135.5	118.0	100.4	86.1	75.7	67.8	59.9	52.1	44.8	38.7	34.9	30.8
Physicians' Services	61.8	54.8	46.8	40.2	35.8	31.9	27.6	24.9	21.2	19.1	17.2	15.9
Dentists' Services	19.5	17.3	15.4	13.3	11.8	10.5	9.4	8.2	7.4	6.5	5.6	5.1
Other Professional Services	7.1	6.4	5.6	4.7	4.1	3.6	3.2	2.6	2.2	2.0	1.8	1.6
Drugs and Medical Sundries	22.4	21.3	19.3	17.2	15.4	14.1	13.0	11.9	11.0	10.1	9.3	8.6
Eyeglasses and Appliances	5.7	5.7	5.1	4.6	4.1	3.7	3.4	3.2	2.8	2.5	2.3	2.0
Nursing-Home Care	27.3	24.2	20.6	17.6	15.2	13.2	11.4	10.1	8.5	7.1	6.5	5.6
Other Health Services	7.6	6.9	6.0	5.1	4.5	4.1	3.8	3.7	3.1	2.7	2.6	2.3
Program Administration and Net Cost of Insurance	12.7	11.1	10.7	9.3	7.5	7.1	5.0	4.4	5.2	5.4	4.7	3.4
Government Public Health Activities	8.6	7.7	7.0	6.2	5.3	4.3	3.8	3.2	2.7	2.2	2.0	1.8
Research and Construction of Medical Facilities	14.1	13.1	11.8	10.5	9.8	9.2	9.0	8.4	7.5	6.8	6.6	6.1
Research[1]	5.9	5.7	5.3	4.8	4.4	3.9	3.7	3.3	2.8	2.5	2.4	2.1
Construction	8.2	7.5	6.5	5.7	5.3	5.3	5.3	5.1	4.7	4.3	4.2	4.0

	1970	1969	1968	1967	1966	1965	1960	1955	1950	1940	1929
Total	74.7	65.6	58.2	51.3	46.1	41.7	26.9	17.7	12.7	4.0	3.6
Health Services and Supplies	69.3	60.8	54.0	47.5	42.4	38.2	25.2	16.9	11.7	3.9	3.4
Personal Health Care	65.1	56.9	50.2	44.4	39.6	35.8	23.7	15.7	10.9	3.5	3.2
Hospital Care	27.8	24.1	21.0	18.3	15.7	13.9	9.1	5.9	3.9	1.0	.7
Physicians' Services	14.3	12.6	11.1	10.1	9.2	8.5	5.7	3.7	2.7	1.0	1.0
Dentists' Services	4.7	4.2	3.7	3.4	3.0	2.8	2.0	1.5	1.0	.4	.5
Other Professional Services	1.6	1.5	1.4	1.3	1.2	1.0	.9	.6	.4	.2	.3
Drugs and Medical Sundries	8.0	7.1	6.4	5.8	5.5	5.2	3.7	2.4	1.7	.6	.6
Eyeglasses and Appliances	1.9	1.7	1.5	1.3	1.3	1.2	.8	.6	.5	.2	.1
Nursing-Home Care	4.7	3.8	3.4	2.8	2.4	2.1	.5	.3	.2	—	—
Other Health Services	2.1	1.9	1.7	1.6	1.5	1.1	1.1	.7	.5	.1	.1
Program Administration and Net Cost of Insurance	2.7	2.7	2.8	2.2	2.0	1.7	1.1	.8	.5	.2	.1
Government Public Health Activities	1.4	1.2	1.0	.9	.8	.8	.4	.4	.4	.2	.1
Research and Construction of Medical Facilities	5.4	4.8	4.1	3.8	3.7	3.5	1.7	.9	1.0	.1	.2
Research[1]	2.0	1.9	1.9	1.8	1.6	1.5	.7	.2	.1	—	—
Construction	3.4	2.9	2.2	2.1	2.1	2.0	1.0	.7	.8	.1	.2

[1]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures," but are included in the expenditure class in which the product falls.

SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

TABLE 3

National Health Expenditures by Type of Expenditure and Source of Funds, 1980-1982 (billions of dollars)

Type of Expenditure	Total	Private					Public		
		Total	Consumer			Other[1]	Total	Federal	State & Local
			Total	Patient Direct	Health Insurance				
					1982				
Total	322.4	185.6	174.7	90.4	84.2	10.9	136.8	93.2	43.7
Health Services and Supplies	308.3	179.5	174.7	90.4	84.2	4.8	128.7	87.5	41.2
Personal Health Care	286.9	171.2	167.0	90.4	76.6	4.2	115.7	83.7	32.0
Hospital Care	135.5	63.5	61.3	16.4	44.9	2.2	72.0	54.6	17.4
Physicians' Services	61.8	44.8	44.7	23.1	21.7	—	17.0	13.4	3.6
Dentists' Services	19.5	18.7	18.7	13.4	5.2	—	.8	.4	.4
Other Professional Services	7.1	4.9	4.9	3.6	1.3	.1	2.2	1.7	.5
Drugs and Medical Sundries	22.4	20.4	20.4	17.6	2.8	—	1.9	.9	1.0
Eyeglasses and Appliances	5.7	4.8	4.8	4.4	.4	—	.8	.7	.1
Nursing-Home Care	27.3	12.3	12.2	11.9	.2	.2	15.0	7.9	7.1
Other Health Services	7.6	1.7	—	—	—	1.7	5.9	4.0	1.9
Program Administration and Net Cost of Insurance	12.7	8.3	7.7	—	7.7	.6	4.4	2.4	2.0
Government Public Health Activities	8.6	—	—	—	—	—	8.6	1.4	7.3
Research, and Construction of Medical Facilities	14.1	6.0	—	—	—	6.0	8.1	5.7	2.4
Research[2]	5.9	.3	—	—	—	.3	5.6	5.0	.5
Construction	8.2	5.7	—	—	—	5.7	2.5	.7	1.9
					1981				
Total	286.6	164.4	155.3	82.1	73.2	9.2	122.2	83.7	38.5
Health Services and Supplies	273.5	159.3	155.3	82.1	73.2	4.0	114.2	78.2	36.0
Personal Health Care	254.6	152.4	148.9	82.1	66.8	3.5	102.2	74.4	27.8
Hospital Care	118.0	54.2	52.4	13.1	39.4	1.7	63.8	48.5	15.3
Physicians' Services	54.8	39.7	39.7	20.7	19.0	—	15.1	11.7	3.3
Dentists' Services	17.3	16.6	16.6	12.3	4.3	—	.7	.4	.3
Other Professional Services	6.4	4.7	4.7	3.5	1.1	.1	1.7	1.3	.4
Drugs and Medical Sundries	21.3	19.5	19.5	17.1	2.4	—	1.9	.9	.9
Eyeglasses and Appliances	5.7	5.1	5.1	4.7	.3	—	.7	.6	.1
Nursing-Home Care	24.2	11.0	10.9	10.7	.2	.1	13.2	7.3	5.8
Other Health Services	6.9	1.6	—	—	—	1.6	5.3	3.7	1.7
Program Administration and Net Cost of Insurance	11.1	6.9	6.4	—	6.4	.5	4.2	2.5	1.7
Government Public Health Activities	7.7	—	—	—	—	—	7.7	1.3	6.4
Research, and Construction of Medical Facilities	13.1	5.1	—	—	—	5.1	8.0	5.5	2.6
Research[2]	5.7	.3	—	—	—	.3	5.3	4.8	.5
Construction	7.5	4.8	—	—	—	4.8	2.7	.7	2.1
					1980				
Total	249.0	143.6	135.7	72.1	63.6	7.8	105.4	71.1	34.3
Health Services and Supplies	237.1	139.3	135.7	72.1	63.6	3.6	97.9	66.0	31.9
Personal Health Care	219.4	132.2	129.1	72.1	57.0	3.1	87.2	62.7	24.5
Hospital Care	100.4	46.1	44.6	10.9	33.7	1.5	54.3	41.1	13.2
Physicians' Services	46.8	34.3	34.3	17.8	16.5	—	12.5	9.5	3.0
Dentists' Services	15.4	14.8	14.8	11.2	3.6	—	.6	.3	.3
Other Professional Services	5.6	4.2	4.2	3.3	.9	.1	1.4	1.0	.4
Drugs and Medical Sundries	19.3	17.7	17.7	15.7	2.0	—	1.6	.8	.8
Eyeglasses and Appliances	5.1	4.6	4.6	4.3	.3	—	.5	.5	.1
Nursing-Home Care	20.6	9.1	9.0	8.8	.2	.1	11.5	6.2	5.3
Other Health Services	6.0	1.4	—	—	—	1.4	4.6	3.2	1.4
Program Administration and Net Cost of Insurance	10.7	7.1	6.6	—	6.6	.4	3.7	2.0	1.7
Government Public Health Activities	7.0	—	—	—	—	—	7.0	1.3	5.7
Research, and Construction of Medical Facilities	11.8	4.3	—	—	—	4.3	7.5	5.1	2.4
Research[2]	5.3	.3	—	—	—	.3	5.0	4.5	.5
Construction	6.5	4.0	—	—	—	4.0	2.5	.6	2.0

[1]Spending by philanthropic organizations, industrial in-plant health services and privately financed construction.

[2]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures," but are included in the expenditure class in which the product falls.

SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

TABLE 4

Aggregate and *per capita* Amount and Percentage Distribution of Personal Health Care Expenditures, by Source of Funds, Selected Years, 1929-1982

Year	Total	Patient Direct Payments	All Third Parties					
			Total	Private		Public		
				Health Insurance	Other	Total	Federal	State and Local
				Amount (in billions)				
1929	$ 3.2	$ 2.8	$ .4	[1]	$ .1	$ .3	$ .1	$ .2
1935	2.7	2.2	.5	[1]	.1	.4	.1	.3
1940	3.5	2.9	.7	[1]	.1	.6	.1	.4
1950	10.9	7.1	3.8	$ .9	.3	2.4	1.1	1.3
1955	15.7	9.1	6.6	2.5	.4	3.6	1.6	2.0
1960	23.7	13.0	10.7	5.0	.5	5.2	2.2	3.0
1965	35.8	18.5	17.2	8.7	.8	7.7	3.6	4.1
1966	39.6	19.5	20.1	9.1	.8	10.1	5.3	4.9
1967	44.4	18.8	25.5	9.6	.8	15.1	9.5	5.6
1968	50.2	20.5	29.6	11.0	.9	17.7	11.4	6.4
1969	56.9	22.9	34.0	13.0	.9	20.1	13.2	7.0
1970	65.1	26.0	39.1	15.6	1.0	22.5	14.5	7.9
1971	72.0	27.8	44.2	17.3	1.2	25.6	16.8	8.8
1972	80.2	31.0	49.2	19.1	1.3	28.8	18.9	9.9
1973	88.7	34.2	54.5	21.1	1.3	32.0	21.1	11.0
1974	101.0	36.4	64.6	24.5	1.5	38.6	25.8	12.8
1975	116.8	39.0	77.8	30.1	1.6	46.1	31.4	14.7
1976	131.8	43.0	88.8	35.5	1.8	51.5	36.1	15.4
1977	148.7	48.7	100.0	40.0	2.1	57.9	41.0	16.9
1978	166.7	54.1	112.6	45.0	2.2	65.3	46.4	18.9
1979	188.9	61.8	127.1	50.2	2.6	74.3	53.3	21.0
1980	219.4	72.1	147.3	57.0	3.1	87.2	62.7	24.5
1981	254.6	82.1	172.6	66.8	3.5	102.2	74.4	27.8
1982	286.9	90.4	196.4	76.6	4.2	115.7	83.7	32.0
				per capita Amount[2]				
1929	$ .26	$ 23	$ 3	[1]	$ 1	$ 2	$ 1	$ 2
1935	21	17	4	[1]	1	3	1	2
1940	26	21	5	[1]	1	4	1	3
1950	70	46	24	$ 6	2	16	7	8
1955	93	54	39	15	3	21	10	12
1960	129	71	58	27	3	28	12	16
1965	181	94	87	44	4	39	18	21
1966	198	97	100	46	4	51	26	24
1967	219	93	126	48	4	75	47	28
1968	246	100	145	54	4	87	56	31
1969	276	111	165	63	4	98	64	34
1970	312	125	188	75	5	108	70	38
1971	341	132	209	82	6	121	79	42
1972	376	145	230	89	6	135	89	46
1973	411	159	253	98	6	149	98	51
1974	464	167	297	112	7	177	118	59
1975	531	177	354	137	7	210	143	67
1976	594	194	400	160	8	232	163	69
1977	663	217	446	178	9	256	183	75
1978	736	239	497	199	10	288	205	84
1979	825	270	555	219	11	324	233	92
1980	947	311	636	246	13	376	271	106
1981	1088	351	738	285	15	437	318	119
1982	1215	383	832	324	18	490	354	135
				Percentage Distribution				
1929	100.0	88.4	11.6	[1]	2.6	9.0	2.7	6.3
1935	100.0	82.4	17.6	[1]	2.8	14.7	3.4	11.3
1940	100.0	81.3	18.7	[1]	2.6	16.1	4.1	12.0
1950	100.0	65.5	34.5	9.1	2.9	22.4	10.4	12.0
1955	100.0	58.1	41.9	16.1	2.8	23.0	10.5	12.5
1960	100.0	54.9	45.1	21.1	2.3	21.8	9.3	12.5
1965	100.0	51.8	48.2	24.4	2.2	21.6	10.1	11.4
1966	100.0	49.2	50.8	23.0	2.1	25.7	13.3	12.4
1967	100.0	42.5	57.5	21.7	1.8	34.0	21.4	12.6
1968	100.0	40.9	59.1	21.9	1.8	35.4	22.7	12.7
1969	100.0	40.2	59.8	22.8	1.6	35.4	23.1	12.3
1970	100.0	39.9	60.1	24.0	1.6	34.5	22.3	12.2
1971	100.0	38.6	61.4	24.1	1.7	35.6	23.3	12.3
1972	100.0	38.6	61.4	23.8	1.6	36.0	23.6	12.4
1973	100.0	38.6	61.4	23.8	1.5	36.1	23.8	12.4
1974	100.0	36.1	63.9	24.2	1.5	38.2	25.5	12.7
1975	100.0	33.4	66.6	25.8	1.4	39.5	26.9	12.6
1976	100.0	32.6	67.4	26.9	1.4	39.1	27.4	11.7
1977	100.0	32.8	67.2	26.9	1.4	38.9	27.6	11.4
1978	100.0	32.5	67.5	27.0	1.3	39.2	27.8	11.4
1979	100.0	32.7	67.3	26.6	1.4	39.3	28.2	11.1
1980	100.0	32.9	67.1	26.0	1.4	39.7	28.6	11.2
1981	100.0	32.2	67.8	26.2	1.4	40.2	29.2	10.9
1982	100.0	31.5	68.5	26.7	1.5	40.3	29.2	11.1

[1]Included with direct payments: separate data not available.
[2]Based on mid-year population estimates including outlying territories, armed forces, and federal employees overseas and their dependents.
SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

TABLE 5

Aggregate and *per capita* Amount and Percentage Distribution of Expenditures for Hospital Care, by Source of Funds, Selected Years 1950-1982

Year	Total	Patient Direct Payments	All Third Parties					
			Total	Private		Public		
				Health Insurance	Other	Total	Federal	State and Local
			Amount (in billions)					
1950	$ 3.9	$ 1.2	$ 2.7	$ .7	$ .1	$ 1.9	[1]	[1]
1955	5.9	1.3	4.6	1.7	.2	2.7	[1]	[1]
1960	9.1	1.8	7.3	3.3	.2	3.8	[1]	[1]
1965	13.9	2.4	11.5	5.8	.3	5.4	$ 2.4	$ 3.0
1966	15.7	2.5	13.2	6.0	.3	6.9	3.5	3.4
1967	18.3	1.8	16.4	6.2	.3	10.0	6.3	3.7
1968	21.0	2.1	18.9	7.1	.3	11.5	7.3	4.1
1969	24.1	2.4	21.6	8.3	.3	13.1	8.5	4.5
1970	27.8	2.8	25.0	9.9	.4	14.7	9.5	5.2
1971	30.8	2.8	28.0	11.1	.5	16.5	10.9	5.6
1972	34.9	3.8	31.1	12.0	.5	18.6	12.4	6.2
1973	38.7	4.6	34.1	13.0	.5	20.5	13.7	6.8
1974	44.8	4.7	40.1	14.9	.6	24.6	16.8	7.8
1975	52.1	4.3	47.9	18.4	.6	28.8	20.3	8.6
1976	59.9	5.0	54.9	21.6	.7	32.7	23.8	8.8
1977	67.8	6.3	61.5	23.9	.9	36.8	27.2	9.6
1978	75.7	6.5	69.2	27.1	.9	41.2	30.6	10.6
1979	86.1	8.5	77.6	30.1	1.2	46.3	34.8	11.5
1980	100.4	10.9	89.5	33.7	1.5	54.3	41.1	13.2
1981	118.0	13.1	104.9	39.4	1.7	63.8	48.5	15.3
1982	135.5	16.4	119.2	44.9	2.2	72.0	54.6	17.4
			per capita Amount[2]					
1950	$ 25	$ 7	$ 17	$ 4	$ 1	$ 12	[1]	[1]
1955	35	8	27	10	1	16	[1]	[1]
1960	49	10	40	18	1	20	[1]	[1]
1965	70	12	58	29	2	27	$12	$15
1966	78	12	66	30	2	35	18	17
1967	90	9	81	30	1	49	31	18
1968	103	10	92	35	2	56	36	20
1969	117	12	105	40	1	63	41	22
1970	133	13	120	48	2	70	46	25
1971	146	13	133	52	2	78	51	26
1972	164	18	146	56	2	87	58	29
1973	179	21	158	61	2	95	64	31
1974	206	21	184	69	3	113	77	36
1975	237	19	218	84	3	131	92	39
1976	270	22	247	97	3	147	107	40
1977	302	28	274	106	4	164	121	43
1978	334	29	305	120	4	182	135	47
1979	376	37	339	132	5	202	152	50
1980	433	47	386	145	6	234	177	57
1981	504	56	449	168	7	273	207	65
1982	574	69	504	190	9	305	231	74
			Percentage Distribution					
1950	100.0	29.9	70.1	17.7	3.5	48.9	[1]	[1]
1955	100.0	22.3	77.7	28.5	3.0	46.2	[1]	[1]
1960	100.0	19.8	80.2	36.3	2.5	41.3	[1]	[1]
1965	100.0	17.2	82.8	41.8	2.2	38.9	17.5	21.3
1966	100.0	15.6	84.4	38.2	2.0	44.2	22.6	21.7
1967	100.0	10.0	90.0	33.7	1.5	54.8	34.4	20.3
1968	100.0	10.0	90.0	33.9	1.5	54.6	34.9	19.7
1969	100.0	10.0	90.0	34.5	1.2	54.3	35.5	18.8
1970	100.0	10.0	90.0	35.8	1.4	52.9	34.3	18.6
1971	100.0	9.2	90.8	35.9	1.6	53.4	35.2	18.2
1972	100.0	10.9	89.1	34.3	1.4	53.3	35.5	17.8
1973	100.0	11.9	88.1	33.7	1.3	53.0	35.5	17.5
1974	100.0	10.4	89.6	33.3	1.4	54.9	37.5	17.3
1975	100.0	8.2	91.8	35.4	1.1	55.3	38.9	16.4
1976	100.0	8.3	91.7	36.0	1.1	54.6	39.8	14.7
1977	100.0	9.3	90.7	35.2	1.3	54.3	40.1	14.2
1978	100.0	8.6	91.4	35.8	1.2	54.4	40.4	14.0
1979	100.0	9.9	90.1	35.0	1.3	53.8	40.4	13.4
1980	100.0	10.9	89.1	33.5	1.5	54.1	40.9	13.1
1981	100.0	11.1	88.9	33.4	1.5	54.1	41.1	13.0
1982	100.0	12.1	87.9	33.2	1.6	53.1	40.3	12.8

[1]Disaggregation not available.

[2]Based on mid-year population estimates including outlying territories, armed forces, and federal employees overseas and their dependents.

SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

TABLE 6

Aggregate and *per capita* Amount and Percentage Distribution of Expenditures for Physicians' Services[1] by Source of Funds, Selected Years 1950-1982

Year	Total	Patient Direct Payments	All Third Parties					
			Total	Private		Public		
				Health Insurance	Other	Total	Federal	State and Local
			Amount (in billions)					
1950	$ 2.7	$ 2.3	$ .5	$ .3	$.0	$ .1	[1]	[1]
1955	3.7	2.6	1.1	.9	.0	.2	[1]	[1]
1960	5.7	3.7	2.0	1.6	.0	.4	[1]	[1]
1965	8.5	5.2	3.3	2.7	.0	.6	$ .2	$ .4
1966	9.2	5.5	3.7	2.8	.0	.8	.3	.5
1967	10.1	5.1	5.0	3.0	.0	2.0	1.4	.7
1968	11.1	5.2	5.9	3.4	.0	2.5	1.8	.7
1969	12.6	5.9	6.8	4.0	.0	2.8	2.0	.7
1970	14.3	6.5	7.9	4.9	.0	3.0	2.1	.9
1971	15.9	7.1	8.8	5.3	.0	3.5	2.5	1.0
1972	17.2	7.3	9.9	6.0	.0	3.9	2.7	1.2
1973	19.1	8.0	11.1	6.7	.0	4.4	3.1	1.4
1974	21.2	8.1	13.2	7.9	.0	5.3	3.7	1.6
1975	24.9	9.0	15.9	9.4	.0	6.5	4.6	1.9
1976	27.6	9.7	17.9	10.8	.0	7.1	5.2	1.9
1977	31.9	11.4	20.5	12.4	.0	8.0	5.9	2.1
1978	35.8	13.1	22.7	13.5	.0	9.2	6.9	2.3
1979	40.2	15.0	25.3	14.6	.0	10.7	8.1	2.6
1980	46.8	17.8	29.0	16.5	.0	12.5	9.5	3.0
1981	54.8	20.7	34.1	19.0	.0	15.1	11.7	3.3
1982	61.8	23.1	38.7	21.7	.0	17.0	13.4	3.6
			per capita Amount[2]					
1950	$ 18	$15	$ 3	$ 2	$0	$ 1	[1]	[1]
1955	22	15	7	5	.0	1	[1]	[1]
1960	31	20	11	9	.0	2	[1]	[1]
1965	43	26	17	14	0	3	$ 1	$ 2
1966	46	27	18	14	0	4	2	3
1967	50	25	25	15	0	10	7	3
1968	54	26	29	17	0	12	9	4
1969	61	28	33	19	0	13	10	4
1970	69	31	38	23	0	14	10	4
1971	75	34	42	25	0	16	12	5
1972	80	34	46	28	0	18	13	5
1973	88	37	51	31	0	20	14	6
1974	98	37	61	36	0	24	17	7
1975	113	41	72	43	0	30	21	9
1976	124	44	81	49	0	32	23	9
1977	142	51	91	55	0	36	26	9
1978	158	58	100	60	0	41	30	10
1979	176	65	110	64	0	47	35	11
1980	202	77	125	71	0	54	41	13
1981	234	88	146	81	0	64	50	14
1982	262	98	164	92	0	72	57	15
			Percentage Distribution					
1950	100.0	83.2	16.8	11.4	.3	5.2	[1]	[1]
1955	100.0	69.8	30.2	23.2	.2	6.7	[1]	[1]
1960	100.0	65.4	34.6	28.0	.2	6.4	[1]	[1]
1965	100.0	61.4	38.6	31.7	.1	6.9	1.8	5.1
1966	100.0	59.9	40.1	30.8	.1	9.3	3.4	5.9
1967	100.0	50.3	49.7	29.4	.1	20.2	13.6	6.6
1968	100.0	47.0	53.0	30.4	.1	22.5	15.8	6.7
1969	100.0	46.4	53.6	31.6	.1	21.9	16.2	5.8
1970	100.0	45.1	54.9	33.9	.1	20.9	14.9	6.0
1971	100.0	44.9	55.1	33.3	.1	21.7	15.5	6.3
1972	100.0	42.4	57.6	34.8	.1	22.8	16.0	6.7
1973	100.0	41.8	58.2	34.9	.1	23.2	16.0	7.1
1974	100.0	37.9	62.1	37.0	.1	25.0	17.6	7.4
1975	100.0	36.2	63.8	37.6	.1	26.2	18.6	7.6
1976	100.0	35.1	64.9	39.1	.1	25.8	18.8	7.0
1977	100.0	35.7	64.3	39.0	.1	25.2	18.6	6.7
1978	100.0	36.6	63.4	37.7	.1	25.7	19.2	6.5
1979	100.0	37.2	62.8	36.2	.1	26.6	20.1	6.5
1980	100.0	38.0	62.0	35.2	.1	26.7	20.4	6.4
1981	100.0	37.7	62.3	34.7	.1	27.5	21.4	6.1
1982	100.0	37.3	62.7	35.1	.1	27.6	21.7	5.8

[1]Disaggregation not available.

[2]Based on mid-year population estimates including outlying territories, armed forces, and federal employees overseas and their dependents.

SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

TABLE 7

Aggregate and *per capita* Amount and Percentage Distribution of Other Personal Health Care Expenditures,[1] by Source of Funds, Selected Years 1950-1982

Year	Total	Patient Direct Payments	All Third Parties					
			Total	Private		Public		
				Health Insurance	Other	Total	Federal	State and Local
			Amount (in billions)					
1950	$ 4.3	$ 3.7	$ .6	[2]	$ .2	$ .4	[3]	[3]
1955	6.1	5.2	.9	[2]	.2	.6	[3]	[3]
1960	8.9	7.5	1.4	$ .1	.3	1.0	[3]	[3]
1965	13.4	10.9	2.5	.3	.5	1.7	$ 1.0	$ .7
1966	14.7	11.5	3.2	.3	.5	2.4	1.4	1.0
1967	16.0	11.9	4.1	.5	.5	3.0	1.8	1.2
1968	18.1	13.2	4.9	.5	.6	3.8	2.3	1.5
1969	20.2	14.6	5.6	.7	.6	4.3	2.6	1.7
1970	23.1	16.8	6.3	.8	.6	4.8	2.9	1.9
1971	25.2	17.8	7.4	1.0	.7	5.7	3.4	2.2
1972	28.1	19.9	8.2	1.1	.8	6.3	3.8	2.5
1973	30.9	21.6	9.3	1.4	.8	7.1	4.3	2.9
1974	34.9	23.7	11.2	1.7	.9	8.7	5.2	3.5
1975	39.7	25.7	14.0	2.3	1.0	10.8	6.5	4.3
1976	44.3	28.4	16.0	3.1	1.1	11.7	7.1	4.6
1977	49.1	31.1	18.0	3.7	1.2	13.1	7.9	5.2
1978	55.2	34.5	20.7	4.4	1.3	14.9	8.9	6.0
1979	62.6	38.3	24.3	5.5	1.4	17.4	10.4	6.9
1980	72.1	43.3	28.8	6.8	1.6	20.4	12.0	8.3
1981	81.9	48.4	33.5	8.4	1.8	23.4	14.2	9.2
1982	89.6	51.0	38.5	9.9	1.9	26.7	15.7	11.0
			per capita Amount[4]					
1950	$ 28	$ 24	$ 4	[2]	$1	$ 3	[3]	[3]
1955	36	31	5	[2]	1	4	[3]	[3]
1960	48	41	8	$ 1	2	6	[3]	[3]
1965	68	55	12	1	2	9	$ 5	$ 4
1966	74	58	16	2	2	12	7	5
1967	79	59	20	2	3	15	9	6
1968	88	65	24	3	3	19	11	7
1969	98	71	27	3	3	21	13	8
1970	111	80	30	4	3	23	14	9
1971	119	84	35	5	4	27	16	11
1972	132	93	38	5	4	30	18	12
1973	143	100	43	6	4	33	20	13
1974	161	109	52	8	4	40	24	16
1975	181	117	64	10	4	49	30	19
1976	200	128	72	14	5	53	32	21
1977	219	139	80	17	5	58	35	23
1978	243	152	91	20	6	66	39	27
1979	273	167	106	24	6	76	46	30
1980	311	187	124	30	7	88	52	36
1981	350	207	143	36	8	100	61	39
1982	379	216	163	42	8	113	66	47
			Percentage Distribution					
1950	100.0	86.2	13.8	[2]	4.2	9.6	[3]	[3]
1955	100.0	85.6	14.4	[2]	4.1	10.3	[3]	[3]
1960	100.0	83.9	16.1	1.1	3.3	11.6	[3]	[3]
1965	100.0	81.6	18.4	1.9	3.5	13.0	7.8	5.2
1966	100.0	78.4	21.6	2.2	3.4	16.1	9.6	6.5
1967	100.0	74.6	25.4	3.1	3.3	19.1	11.4	7.7
1968	100.0	73.1	26.9	2.8	3.1	21.0	12.6	8.3
1969	100.0	72.3	27.7	3.4	3.0	21.4	12.8	8.5
1970	100.0	72.8	27.2	3.6	2.8	20.8	12.5	8.3
1971	100.0	70.7	29.3	3.9	2.9	22.5	13.7	8.8
1972	100.0	70.8	29.2	4.0	2.8	22.5	13.5	9.0
1973	100.0	69.9	30.1	4.5	2.6	23.1	13.8	9.2
1974	100.0	67.8	32.2	4.8	2.5	24.8	14.9	9.9
1975	100.0	64.7	35.3	5.7	2.5	27.1	16.4	10.7
1976	100.0	64.0	36.0	7.1	2.5	26.5	16.1	10.4
1977	100.0	63.3	36.7	7.6	2.5	26.7	16.1	10.6
1978	100.0	62.6	37.4	8.0	2.4	27.0	16.1	10.9
1979	100.0	61.2	38.8	8.8	2.3	27.7	16.7	11.0
1980	100.0	60.1	39.9	9.5	2.2	28.2	16.7	11.6
1981	100.0	59.1	40.9	10.2	2.2	28.6	17.3	11.2
1982	100.0	57.0	43.0	11.1	2.2	29.8	17.5	12.3

[1]Dentists' services, other professional services, drugs and medical sundries, eyeglasses and appliances, nursing home care, and other personal health care.
[2]Included with direct payments: separate data not available.
[3]Disaggregation not available.
[4]Based on mid-year population estimates including outlying territories, armed forces, and federal employees overseas and their dependents.
SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

TABLE 8

Personal Health Care Expenditures by Selected Third-Party Payers and Type of Expenditure, 1980-1982 (billions of dollars)

Source of Payment	Personal Care	Hospital Care	Physicians' Services	Dentists' Services	Prof. Services n.e.c.	Drugs Etc.	Eyeglasses Etc.	Nursing Home Care	Other Care
1982									
Total	$286.9	$135.5	$61.8	$19.5	$7.1	$22.4	$5.7	$27.3	$7.6
Patient Direct Payments	90.4	16.4	23.1	13.4	3.6	17.6	4.4	11.9	—
Third-Party Payments	196.4	119.2	38.7	6.0	3.5	4.7	1.2	15.4	7.6
Private Health Insurance	76.6	44.9	21.7	5.2	1.3	2.8	.4	.2	—
Philanthropy and Industrial In-Plant	4.2	2.2	—	—	.1	—	—	.2	1.7
Government	115.7	72.0	17.0	.8	2.2	1.9	.8	15.0	5.9
Federal	83.7	54.6	13.4	.4	1.7	.9	.7	7.9	4.0
Medicare[1]	50.9	36.3	11.4	—	1.3	—	.6	.5	.8
Medicaid[2]	16.9	6.2	1.5	.3	.4	.9	—	6.9	.8
Other	15.9	12.1	.5	.1	—	—	.1	.5	2.5
State and Local	32.0	17.4	3.6	.4	.5	1.0	.1	7.1	1.9
Medicaid[2]	15.5	5.6	1.4	.3	.3	.8	—	6.3	.7
Other	16.5	11.8	2.2	.1	.2	.2	.1	.8	1.2
1981									
Total	$254.6	$118.0	$54.8	$17.3	$6.4	$21.3	$ 5.7	$24.2	$6.9
Patient Direct Payments	82.1	13.1	20.7	12.3	3.5	17.1	4.7	10.7	—
Third-Party Payments	172.6	104.9	34.1	5.0	2.8	4.2	1.0	13.5	6.9
Private Health Insurance	66.8	39.4	19.0	4.3	1.1	2.4	.3	.2	—
Philanthropy and Industrial In-Plant	3.5	1.7	—	—	.1	—	—	.1	1.6
Government	102.2	63.8	15.1	.7	1.7	1.9	.7	13.2	5.3
Federal	74.4	48.5	11.7	.4	1.3	.9	.6	7.3	3.7
Medicare[1]	43.5	31.3	9.7	—	.9	—	.5	.4	.6
Medicaid[2]	16.2	5.9	1.6	.3	.3	.9	—	6.5	.8
Other	14.7	11.3	.5	.1	.1	—	.1	.4	2.3
State and Local	27.8	15.3	3.3	.3	.4	.9	.1	5.8	1.7
Medicaid[2]	12.8	4.7	1.3	.3	.2	.7	—	5.1	.6
Other	15.0	10.7	2.1	—	.2	.2	.1	.7	1.0
1980									
Total	$219.4	$100.4	$46.8	$15.4	$5.6	$19.3	$5.1	$20.6	$6.0
Patient Direct Payments	72.1	10.9	17.8	11.2	3.3	15.7	4.3	8.8	—
Third-Party Payments	147.3	89.5	29.0	4.2	2.3	3.6	.8	11.8	6.0
Private Health Insurance	57.0	33.7	16.5	3.6	.9	2.0	.3	.2	—
Philanthropy and Industrial In-Plant	3.1	1.5	—	—	.1	—	—	.1	1.4
Government	87.2	54.3	12.5	.6	1.4	1.6	.5	11.5	4.6
Federal	62.7	41.1	9.5	.3	1.0	.8	.5	6.2	3.2
Medicare[1]	35.7	26.0	7.8	—	.7	—	.4	.4	.5
Medicaid[2]	13.8	5.1	1.3	.3	.3	.8	—	5.5	.6
Other	13.2	10.1	.4	.1	—	—	.1	.4	2.1
State and Local	24.5	13.2	3.0	.3	.4	.8	.1	5.3	1.4
Medicaid[2]	11.8	4.3	1.1	.2	.2	.7	—	4.7	.5
Other	12.7	8.8	1.8	—	.2	.2	.1	.7	.9

[1]Represents total expenditures from trust funds for benefits. Trust fund income includes premium payments paid by or on behalf of enrollees.

[2]Includes funds paid into Medicare trust funds by States under "buy-in" agreements to cover premiums for public assistance recipients and for persons who are medically indigent.

[3]Based on mid-year population estimates including outlying territories, armed forces, and federal employees overseas and their dependents.

SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

TABLE 9

Expenditures for Health Services and Supplies Under Public Programs by Program, Type of Expenditure, and Source of Funds 1982

Program Area	Health Services and Supplies											
		Personal Health Care										
	Total	Total	Hospital Care	Physicians' Services	Dentists' Services	Prof. Svcs. n.e.c.	Drugs Etc.	Eyeglasses Etc.	Nursing Home Care	Other Care	Administration	Public Health Activities
	Amount (in Billions)											
Total Health Services and Supplies	$308.3	$286.9	$135.5	$61.8	$19.5	$7.1	$22.4	$5.7	$27.3	$7.6	$12.7	$8.6
All Public Programs	128.7	115.7	72.0	17.0	.8	2.2	1.9	.8	15.0	5.9	4.4	8.6
Total Federal Expenditures	87.5	83.7	54.6	13.4	.4	1.7	.9	.7	7.9	4.0	2.4	1.4
Total State and Local Expenditure	41.2	32.0	17.4	3.6	.4	.5	1.0	.1	7.1	1.9	2.0	7.3
Medicare[1] (Federal)	52.2	50.9	36.3	11.4	—	1.3	—	.6	.5	.8	1.3	—
Medicaid[2]	34.0	32.4	11.8	2.9	.6	.7	1.7	—	13.3	1.5	1.5	—
Federal Expenditures	18.0	16.9	6.2	1.5	.3	.4	.9	—	6.9	.8	1.0	—
State and Local Expenditures	16.0	15.5	5.6	1.4	.3	.3	.8	—	6.3	.7	.5	—
Other Public Assistance Payments for Medical Care	2.1	2.1	.8	.2	—	—	.1	—	.8	.1	—	—
Federal	—	—	—	—	—	—	—	—	—	—	—	—
State and Local	2.1	2.1	.8	.2	—	—	.1	—	.8	.1	—	—
Veterans' Medical Care	7.1	7.0	5.8	.1	.1	—	—	.1	.5	.5	.1	—
Department of Defense[3]	5.6	5.5	4.5	.1	—	—	—	—	—	.8	—	—
Workers Compensation	6.0	4.6	2.4	1.9	—	.1	.1	.1	—	—	1.4	—
Federal Employees	.2	.2	.1	—	—	—	—	—	—	—	—	—
State and Local Programs	5.9	4.4	2.2	1.9	—	.1	.1	.1	—	—	1.4	—
State and Local Hospitals[4]	8.6	8.6	8.6	—	—	—	—	—	—	—	—	—
Other Public Expenditures for Personal Health Care[5]	4.6	4.5	1.8	.3	—	.1	—	.1	—	2.2	.1	—
Federal	3.2	3.1	1.7	.2	—	—	—	—	—	1.2	—	—
State and Local	1.4	1.4	.1	.1	—	—	—	—	—	1.1	.1	—
Government Public Health Activities	8.6	—	—	—	—	—	—	—	—	—	—	8.6
Federal	1.4	—	—	—	—	—	—	—	—	—	—	1.4
State and Local	7.3	—	—	—	—	—	—	—	—	—	—	7.3
Exhibit: Medicare and Medicaid	85.7	82.9	48.1	14.3	.6	2.0	1.7	.6	13.7	1.8	2.8	—

See footnotes at end of table.

TABLE 9 (continued)

Expenditures for Health Services and Supplies Under Public Programs by Program, Type of Expenditure, and Source of Funds 1981

Program Area	Health Services and Supplies											
		Personal Health Care										
	Total	Total	Hospital Care	Physicians' Services	Dentists' Services	Prof. Svcs. n.e.c.	Drugs Etc.	Eyeglasses Etc.	Nursing Home Care	Other Care	Administration	Public Health Activities
	Amount (in Billions)											
Total Health Services and Supplies	$273.5	$254.6	$118.0	$54.8	$17.3	$6.4	$21.3	$5.7	$24.2	$6.9	$11.1	$7.7
All Public Programs	114.2	102.2	63.8	15.1	.7	1.7	1.9	.7	13.2	5.3	4.2	7.7
Total Federal Expenditures	78.2	74.4	46.5	11.7	.4	1.3	.9	.6	7.3	3.7	2.5	1.3
Total State and Local Expenditures	36.0	27.8	15.3	3.3	.3	.4	.9	.1	5.8	1.7	1.7	6.4
Medicare[1] (Federal)	44.8	43.5	31.3	9.7	—	.9	—	.5	.4	.6	1.3	—
Medicaid[2]	30.5	29.0	10.5	2.8	.6	.5	1.6	—	11.6	1.4	1.5	—
Federal Expenditures	17.3	16.2	5.9	1.6	.3	.3	.9	—	6.5	.8	1.1	—
State and Local Expenditures	13.3	12.8	4.7	1.3	.3	.2	.7	—	5.1	.6	.4	—
Other Public Assistance Payments for Medical Care	1.8	1.8	.7	.2	—	—	.1	—	.7	.1	—	—
Federal	—	—	—	—	—	—	—	—	—	—	—	—
State and Local	1.8	1.8	.7	.2	—	—	.1	—	.7	.1	—	—
Veterans' Medical Care	6.7	6.6	5.5	.1	.1	—	—	.1	.4	.5	.1	—
Department of Defense[3]	5.0	5.0	4.1	.1	—	—	—	—	—	.7	—	—
Workers Compensation	5.7	4.4	2.2	1.9	—	.1	.1	.1	—	—	1.3	—
Federal Employees	.2	.2	.1	—	—	—	—	—	—	—	—	—
State and Local Programs	5.6	4.3	2.1	1.8	—	.1	.1	.1	—	—	1.3	—
State and Local Hospitals[4]	7.7	7.7	7.7	—	—	—	—	—	—	—	—	—
Other Public Expenditures for Personal Health Care[5]	4.2	4.2	1.7	.3	—	.1	—	.1	—	2.0	.1	—
Federal	3.0	3.0	1.6	.2	—	—	—	—	—	1.1	—	—
State and Local	1.2	1.2	.1	.1	—	—	—	—	—	.9	—	—
Government Public Health Activities	7.7	—	—	—	—	—	—	—	—	—	—	7.7
Federal	1.3	—	—	—	—	—	—	—	—	—	—	1.3
State and Local	6.4	—	—	—	—	—	—	—	—	—	—	6.4
Exhibit: Medicare and Medicaid	74.9	72.2	41.8	12.5	.6	1.4	1.6	.5	12.0	1.6	2.8	—

See footnotes at end of tables.

TABLE 9 (continued)

Expenditures for Health Services and Supplies Under Public Programs by Program, Type of Expenditure, and Source of Funds 1980

Program Area	Total	Health Services and Supplies										
		Personal Health Care										
		Total	Hospital Care	Physicians' Services	Dentists' Services	Prof. Svcs. n.e.c.	Drugs Etc.	Eyeglasses Etc.	Nursing Home Care	Other Care	Administration	Public Health Activities
	Amount (in Billions)											
Total Health Services and Supplies	$237.1	$219.4	$100.4	$46.8	$15.4	$5.6	$19.3	$5.1	$20.6	$6.0	$10.7	$7.0
All Public Programs	97.9	87.2	54.3	12.5	.6	1.4	1.6	.5	11.5	4.6	3.7	7.0
Total Federal Expenditures	66.0	62.7	41.1	9.5	.3	1.0	.8	.5	6.2	3.2	2.0	1.3
Total State and Local Expenditures	31.9	24.5	13.2	3.0	.3	.4	.8	.1	5.3	1.4	1.7	5.7
Medicare[1] (Federal)	36.8	35.7	26.0	7.8	—	.7	—	.4	.4	.5	1.1	—
Medicaid[2]	26.8	25.5	9.4	2.5	.5	.5	1.4	—	10.2	1.1	1.3	—
Federal Expenditures	14.6	13.8	5.1	1.3	.3	.3	.8	—	5.5	.6	.8	—
State and Local Expenditures	12.2	11.8	4.3	1.1	.2	.2	.7	—	4.7	.5	.5	—
Other Public Assistance Payments for Medical Care	1.6	1.6	.6	.2	—	—	.1	—	.7	.1	—	—
Federal	—	—	—	—	—	—	—	—	—	—	—	—
State and Local	1.6	1.6	.6	.2	—	—	.1	—	.7	.1	—	—
Veterans' Medical Care	5.9	5.9	4.9	.1	.1	—	—	.1	.4	.4	—	—
Department of Defense[3]	4.2	4.2	3.4	.1	—	—	—	—	—	.6	—	—
Workers Compensation	5.0	3.9	2.0	1.6	—	.1	.1	.1	—	—	1.1	—
Federal Employees	.1	.1	.1	—	—	—	—	—	—	—	—	—
State and Local Programs	4.9	3.8	1.9	1.6	—	.1	.1	.1	—	—	1.1	—
State and Local Hospitals[4]	6.2	6.2	6.2	—	—	—	—	—	—	—	—	—
Other Public Expenditures for Personal Health Care[5]	4.1	4.1	1.7	.3	—	.1	—	—	—	1.9	.1	—
Federal	3.0	3.0	1.6	.2	—	—	—	—	—	1.1	—	—
State and Local	1.1	1.1	.1	.1	—	—	—	—	—	.9	—	—
Government Public Health Activities	7.0	—	—	—	—	—	—	—	—	—	—	7.0
Federal	1.3	—	—	—	—	—	—	—	—	—	—	1.3
State and Local	5.7	—	—	—	—	—	—	—	—	—	—	5.7
Exhibit: Medicare and Medicaid	63.3	60.9	35.4	10.3	.5	1.2	1.4	.4	10.5	1.2	2.4	—

[1]Represents total expenditures from trust funds for benefits and administrative costs. Trust fund income includes premium payments paid by or on behalf of enrollees.

[2]Includes funds paid into Medicare trust funds by States under "buy-in" agreements to cover premiums for public assistance recipients and for persons who are medically indigent.

[3]Includes care for retirees and military dependents.

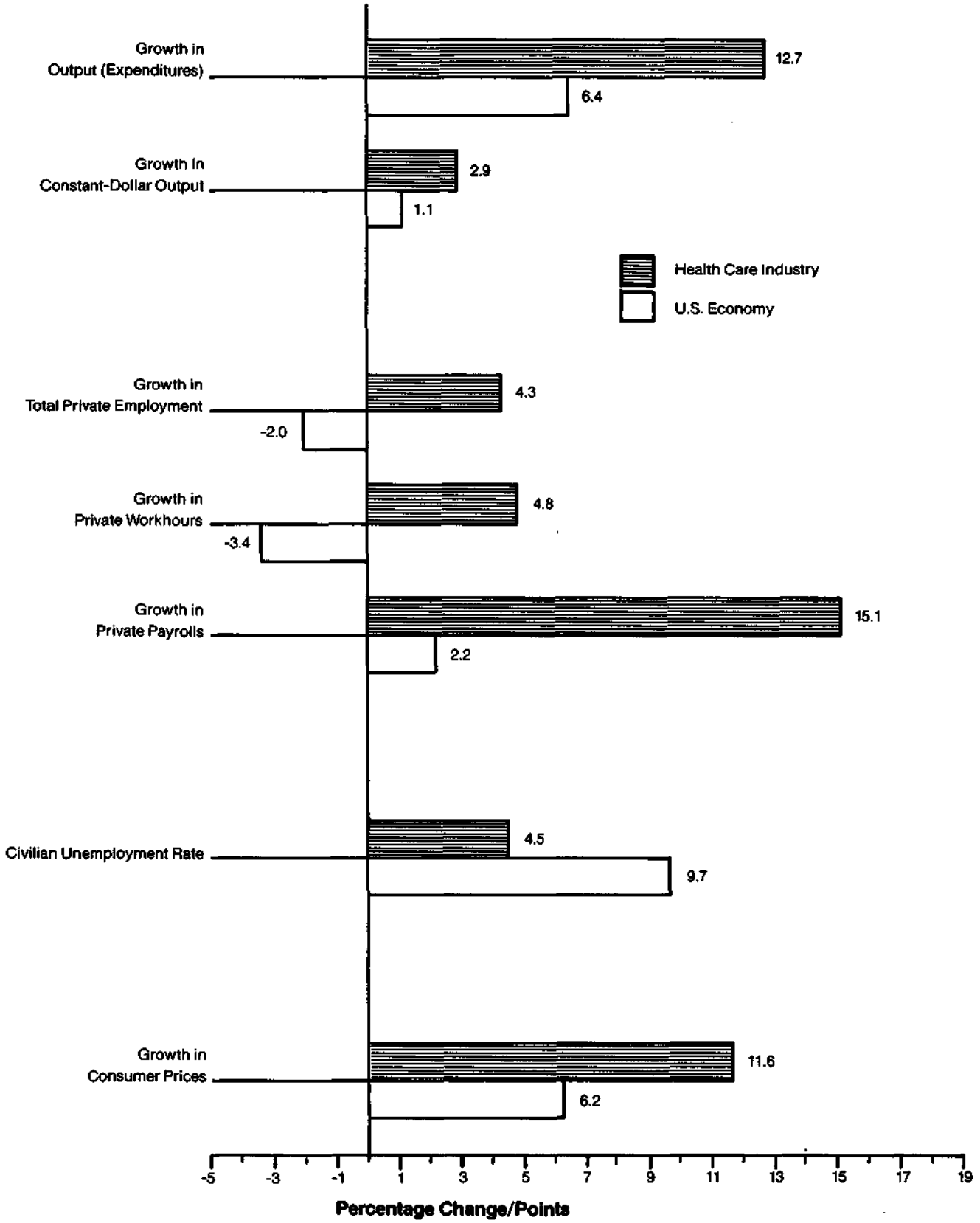
[4]Expenditures for State and local government hospitals not offset by other revenues.

[5]Includes program spending for maternal and child health; vocational rehabilitation medical payments; temporary disability insurance medical payments; PHS and other Federal hospitals; Indian health services; alcoholism, drug abuse, and mental health; and school health.

SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

FIGURE 3

Aspects of the Health Care Industry Compared to the Economy as a Whole, 1982



Source: Bureau of Data Management and Strategy, Health Care Financing Administration.

There are a number of explanations of the difference in growth between health spending and the output of the general economy. First, it is generally accepted that, as an economy matures, consumers desire an increasing proportion of services, such as travel, health care, dining, and so on. Second, one theory of economic growth (Baumol, 1967) holds that industries with slower-growing productivity will experience more rapid price inflation than will industries with faster-growing productivity. Health care, despite recent advances in technology, is still quite labor-intensive, and is among the slower industries in terms of productivity growth. Third, rapid advances in, and proliferation of, medical technology have expanded the treatment of disease to previously unattainable breadth and depth. This has resulted in more consumption of health care *per capita*; in addition, oversaturation of some markets may well have created greater price inflation, through the need to carry unused capacity. Fourth, the population of the United States gradually is aging; although each age group is healthier than its counterparts in previous decades, one consequence of more older Americans is a need for more health care, as older people require more hospital and nursing-home care (for example) than do younger people. These four sources of growth in the relative size of the health sector can be categorized as evolutionary in nature.

A fifth cause of increases in the share of Gross National Product going to health care is the way in which that care is financed. Two factors are important in this regard: third-party reimbursement, and government subsidies of health care spending.

More than in any other market for consumer goods and services, third parties, rather than consumers themselves, pay for consumption of health care. The extent of third-party reimbursement ranges from 88 percent of hospital care to 22 percent of spending for consumer medical durables and nondurables (including drugs and eyeglasses).

Third-party reimbursement, as it is practiced currently, leads to greater consumption of health care for two reasons. The first reason is that when a third party pays for a service, the act of consumption and the act of paying are separated in time and place: the true cost of the service is obscured for the consumer. Because the perceived price of consumption is lower than the actual price, consumers tend to use more health care services than they would otherwise use. Second, most third-party reimbursement is "cost-based" or "retrospective" in nature. When the insurer pays a proportion of costs, whatever those costs may be, there is little incentive for consumers or providers of care to be cost-conscious. This feature reflects directly the original intent of health insurance, which was to guarantee access to health care regardless of the cost. However, with consumption growing more rapidly than the supply of funds from which we pay for care, the cost-based aspect of third-party reimbursement has generated increasing pressure for reform.

Another important force acting upon the financing of health care is the tax treatment of health insurance premiums and out-of-pocket payments for health care. Under current law, employer contributions for health insurance policies (more than three quarters of the premiums earned in 1983) are excluded from employees' taxable income, and from earnings subject to payroll taxes. In addition, up to $150 of an employee's share of health insurance premiums could be deducted directly from taxable income (until 1982); and the balance of those premiums, along with other consumer medical expenses, were tax-deductible to the extent that they exceeded three percent of adjusted gross income (five percent after 1982). The tax treatment of premiums alone cost the Federal government $26 billion in foregone revenue in fiscal year 1983 (Congressional Budget Office, 1982). The tax-exempt status of health insurance premiums encourages employees, and does not discourage employers, to substitute more comprehensive insurance coverage for higher money wages. Many consumers view such expanded coverage as a "use or lose" benefit, and tend to overconsume health care services, despite the fact that overconsumption raises the price of health insurance in the long run. Tax treatment of health care spending, and the extent of third-party coverage of health care, can be considered structural causes of rising health expenditures.

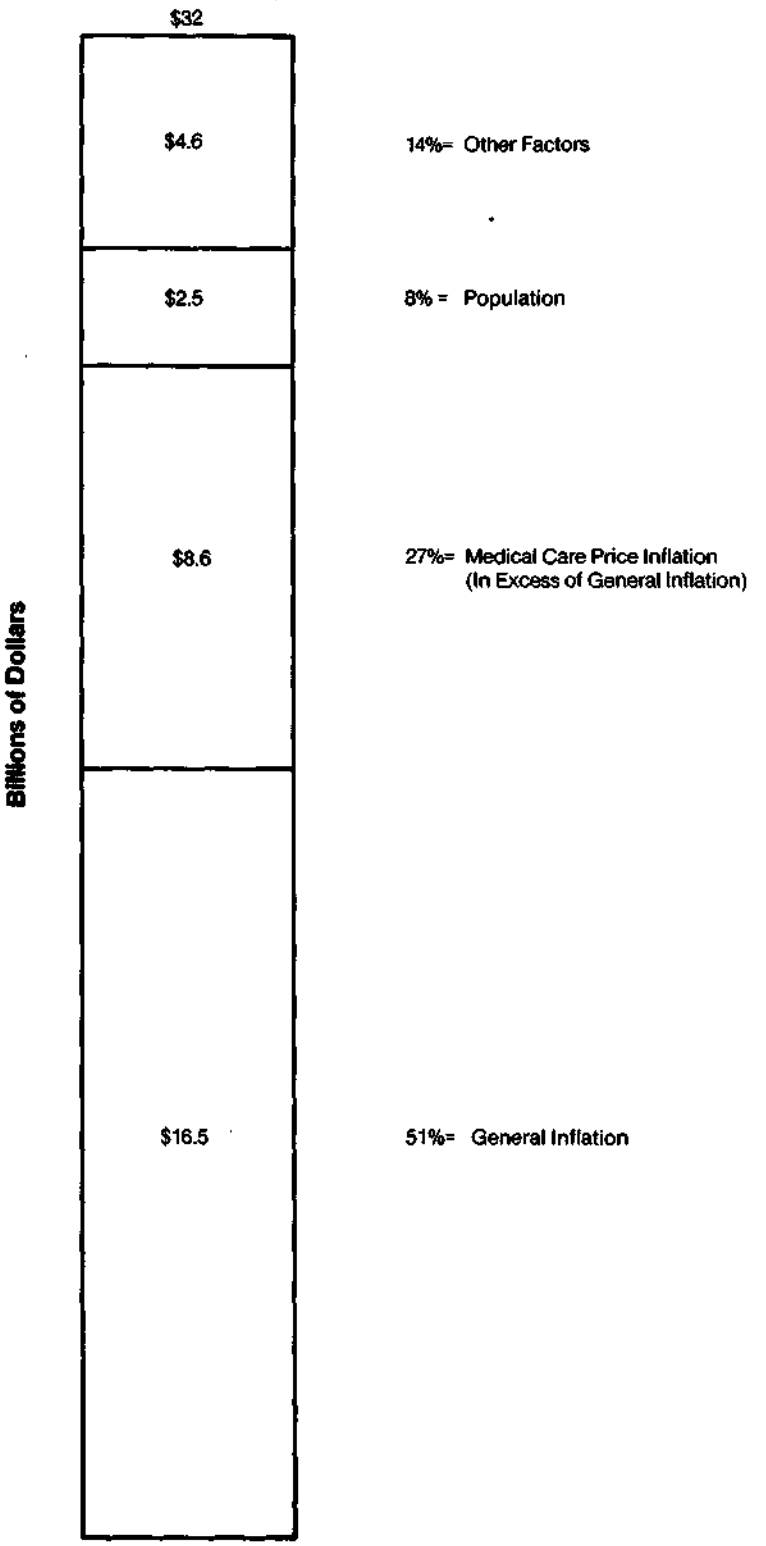
Government response to increasing health care expenditures, which comprised 12.6 percent of Federal outlays in 1982, centered on the structural causes mentioned above. Attempts were made to reduce the extent of third-party coverage: States were authorized to limit the services and populations covered by Medicaid, and to institute copayments for Medicaid services. California has instituted a system in which hospitals bid for Medicaid "business." A proposal was made to restructure the copayment for hospital services covered by Medicare, raising the copayment for a moderate length of stay and providing full coverage for the latter part of very long stays. A major break from retrospective reimbursement was begun with the introduction of diagnosis-related hospital payments under Medicare, to take effect gradually between fiscal years 1984 and 1986. This form of prospective payment, in which a hospital knows at the time of admission how much Medicare will pay for treatment of the patient, is expected to force providers of care to become more cost-conscious. Other measures included a proposed brief freeze of Medicare physician fee schedules. Regarding the tax treatment of health insurance premiums, the direct exemption of $150 of premiums was eliminated, and proposals have been made to tax employees on employer contributions in excess of $175 per month ($70 per month for an individual). It is hoped that these and other actions will result in greater recognition of the actual cost of care, both by consumers of that care and by its providers, and that growth of expenditures will slow.

Goods and Services Purchased in 1982

"National health expenditures" are defined to include all spending for health care of individuals, the administrative costs of non-profit and government health programs, the net cost to enrollees of private health insurance, government expenditures designed to promote health in general, noncommercial health research, and construction of medical facilities. The definition excludes spending for environmental improvement, a category which often is categorized with health in Federal budget documents. (For further information, see the section on definitions, concepts, and data sources later in this article.)

FIGURE 4

Factors in the Increase of Personal Health Care Expenditures 1981-1982



Source: Bureau of Data Management and Strategy, Health Care Financing Administration.

National health expenditures are divided into two categories: health services and supplies, and research and construction of medical facilities. Health services and supplies, in turn, consist of personal health care, program administration and the net cost of insurance, and government public health activities.

Personal Health Care

A total of $287 billion was spent for personal health care in 1982—up 12.7 percent from spending in 1981. Personal health care expenditures accounted for nine-tenths of all national health expenditures. On a *per capita* basis, $1,215 was spent in 1982—an increase of 11.7 percent from the 1981 level.

Most of the growth in this spending for health care is attributable to price inflation. As shown in Figure 4, 78 percent of the increase in spending between 1981 and 1982 was due to price inflation; another eight percent was due to population growth. The remainder was due to a variety of influences, among them the aging of the population, increased consumption *per capita,* and changes in the types of services provided.

Personal health care consists of a number of different goods and services.

Physicians' Services

Physicians are the most influential group in determining the size and shape of the health care sector. They affect personal health care expenditures much more than is indicated by the 22 percent share of spending devoted to their services[2]: by some estimates, they influence 70 to 80 percent of health care spending (Blumberg, 1979; Somers and Somers, 1977). Physicians have a dominant role in determining who will be hospitalized and what type and quantity of services the hospital patient will receive. Expenditures for prescription drugs are influenced similarly.

Expenditure for physicians' services reached $62 billion in 1982—an increase of 12.8 percent from the previous year. This spending accounted for 21.5 percent of personal health care expenditures and for 19.2 percent of all national health expenditures. Price inflation and increased intensity of service were responsible for most of the growth in expenditures. Public funds—mostly Medicare and Medicaid—paid for one-quarter of spending for physicians' services; private health insurance and direct patient payments divided the balance almost evenly.

Price inflation was a significant contributor to the growth of expenditures for physicians' services. Measured by the Consumer Price Index (CPI), physicians' fees rose 9.4 percent in 1982, compared to an increase of 6.1 percent in the CPI for all items.

The number of office visits has not had much effect upon the growth of spending for physicians' services, because the total volume and *per capita* number of physician office visits have changed very little in recent years. For example, the National Center for Health Statistics (NCHS) Health Interview Survey indicates that visits to physicians by the noninstitutionalized population remained relatively constant between 1971 and 1981, at around one billion visits per year.

Although the number of visits to physicians has not changed substantially, the number and types of services provided during the visits—the intensity of care—appears to be increasing. In the last 10 years, the number of surgical operations performed in community hospitals has increased an average of 2.4 percent per year, a rate faster than the growth of the U.S. population. The volume of tests in independent clinical labs has been increasing at a 15 percent annual rate in recent years (Bailey, 1979). Rising surgical rates and increased out-of-hospital laboratory testing have contributed to the increase in intensity of care per physician visit, and thus to rising expenditures for physician care.

Hospital Care

Expenditures for hospital care in 1982 were $136 billion—an increase of 14.9 percent from 1981[3]. Hospital care accounted for 47.2 percent of total personal health care expenditures and for 42.0 percent of national health expenditures. As was true for all of the categories of health care services, price inflation was responsible for the major part of the increase in spending over the past three years; community hospital admissions were virtually unchanged between 1981 and 1982, and the number of inpatient days actually fell slightly.

The Federal government funded 40.3 percent of spending for hospital care in 1982, private health insurance paid for 33.2 percent, and State and local governments paid for 12.8 percent. Thus, patients paid just over one-tenth of the cost of hospital care directly.

The hospital sector has undergone a substantial change in structure since 1965. As shown in Table A, expenditures for care in community hospitals (which provide primarily acute care) rose from 70 percent of total hospital spending to 76 percent between 1965 and 1971, and reached 84 percent in 1982. The share of expenditures accounted for by State and local government-run psychiatric hospitals declined from 11 percent in 1965 to less than 5 percent in

TABLE A

Percentage of Hospital Expenditures, by Type of Hospital, for Selected Calendar Years

	1965	1971	1982
Total			
Community	100.0%	100.0%	100.0%
State and local	69.6	76.1	83.9
psychiatric	11.1	8.7	4.5
Federal	12.8	9.8	8.0
Other	6.5	5.4	3.6

SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

[2]In the National Health Accounts—the framework within which these estimates fit—expenditures for physicians' services encompass the cost of all services and supplies provided in physicians' offices, expenditures for services of private practitioners in hospitals and other institutions, and diagnostic work performed in independent clinical laboratories.

[3]In the National Health Accounts, hospital care includes all inpatient and outpatient care in public and private hospitals and all services and supplies provided by hospitals. Except for the services of hospital staff physicians, expenditures for physician care provided in hospitals are included in the physician category described above.

1982. The relative size of expenditures in Federal hospitals—operated mainly by the Veterans Administration and by the Department of Defense—also declined, but to a lesser extent: from 13 percent of total hospital expenditures to 8 percent.

As mentioned earlier, price inflation was responsible for a major portion of the increase in hospital expenditures in 1982. Using the National Hospital Input Price Index (Freeland, Anderson, and Schendler, 1979) to approximate the prices faced by hospitals, two-thirds of the growth in expenditures can be attributed to input price inflation.

Nursing Home Care

Nursing home care cost $27 billion in 1982—an increase of 12.9 percent from 1981[4]. This expenditure accounted for 9.5 percent of personal health care expenditures and 8.5 percent of total national health expenditures. Major factors in the growth of nursing-home spending include continued rapid expansion of Medicaid-funded intermediate care facilities for the mentally retarded (ICF-MR), as well as growth of prices and days of care in other types of settings. Public programs pay for more than half of the total, and patients directly finance most of the rest.

Increasing longevity, changing social patterns which deemphasize family responsibility for the elderly, and the availability of public funds (primarily Medicaid) underlie much of the growth in nursing home care.

Excluding the special Medicaid ICF-MR category mentioned earlier, spending for other nursing home care more than doubled between 1976 and 1982, growing from $11 billion to $24 billion. During that 6-year period, prices paid by nursing homes for the goods and services needed to provide care increased at an average annual rate of 8.7 percent. We estimate that nursing home days of care increased in excess of 3 percent annually, while the U.S. population 65 years of age and over grew 2.6 percent per year. These factors have combined to generate the rapid growth in spending for nursing-home care, although that growth began to slow somewhat in 1981.

Drugs and Medical Sundries

This category accounted for 7.8 percent of personal health care spending ($22 billion) in 1982, and includes spending for prescription drugs, over-the-counter drugs, and medical sundries dispensed through retail channels. Expenditures for drugs purchased or dispensed by hospitals, nursing homes and other institutions, physicians, and dentists are counted elsewhere.

Drug therapy constitutes a significant factor in the treatment of illness. Approximately 58 percent of the noninstitutionalized population received at least one prescription for medication in 1977 (Kasper, 1982). About 57 percent of all dollars for drugs and medical sundries are estimated to be spent for prescription drugs alone, and 31 percent are spent for over-the-counter drug products.

From 1965 to 1982, spending for retail drugs and sundries increased about 9.0 percent annually, a rate significantly below that for other major health care services. Consequently, its share of personal health care expenditures has declined from over 12 percent in 1965 to 7.8 percent in 1982. The growth of drug spending, impelled by more rapid price inflation, grew at rates above the long-run trend between 1979 and 1981. In 1982, however, due to a decrease in demand attributable to the recession, the growth rate slowed, to 4.8 percent.

Other Personal Health Care Goods and Services

Expenditures for all other types of personal health care goods and services were $39.9 billion in 1982—an increase of 9.8 percent. That spending amounted to 14 percent of all personal health care expenditures and to 12 percent of national health expenditures. A quarter of the expenditures in this group of services was financed through government programs in 1982, and health insurance covered 17 percent; consumers paid for 54 percent directly. The principal expenditure in this category was for dentists' services, but the category also includes spending for services of other health professionals (including most home health agencies), for eyeglasses and orthopedic appliances, and for provision of care in industrial settings. Growth of this composite component was influenced significantly by the growth of spending for dentists' services, and, to some extent, by the growth of spending for other professional services.

Spending for dentists' services, which reached $19 billion in 1982, increased not only because of price inflation, but also because of recent increases in the extent of third-party dental coverage. Traditionally, use of dental services fluctuated with the business cycle. However, despite a 12 percent increase in the CPI for dental care in 1980 and a slump in the general economy in 1981 and 1982, "price-deflated" expenditures *per capita* for dental services increased in all three years. This departure from tradition reflects the increased extent of third-party dental coverage.

Other Health Services and Supplies

The cost of operating third-party programs in 1982 rose 14.5 percent, to $12.7 billion. This estimate includes $4.4 billion in administrative expenses for those public programs which identified administrative expenses. It also includes a small amount estimated to be the fund-raising and administrative expenses of philanthropic organizations. The largest part of the component is the net cost of private health insurance, the difference between earned premiums and incurred claims. Estimated at $7.7 billion for 1982, net cost reflects administrative expenses, additions to loss reserves, and profits or losses of Blue Cross/Blue Shield plans, mutual and stock carriers, and prepaid and self-insured health plans.

Public health activities of various levels of government amounted to $8.6 billion in 1982. Public health activities are those functions carried out by Federal, State, and local governments to support community health, in contrast to care delivered to individuals. Federal expenditures of $1.4 billion included the services of the Centers for Disease Control and the Food and Drug Administration, as well as grants to States.

[4]In the National Health Accounts, nursing home services are those provided in skilled nursing facilities (SNFs), in intermediate care facilities (ICFs), and in personal care homes which provide nursing care. In addition, most of the care for mentally retarded Medicaid recipients provided in what are designated "Intermediate Care Facilities for the Mentally Retarded" (ICF-MR) is included as nursing home care. The relatively small amount of nursing-type care provided in hospitals (including ICF-MR care) is included with expenditures for hospital care.

Other National Health Expenditures

National health expenditures devoted to non-profit research and to construction of medical facilities were $14 billion in 1982, an amount equal to 4.4 percent of total health spending.

Expenditures for noncommercial health care research and development were $5.9 billion in 1982. The Federal government financed by far the largest amount for research, with funds totalling $5.0 billion, most of which was spent by the National Institutes of Health. Expenditures by State and local governments, exclusive of Federal grants, were $500 million, and private philanthropy funded an even smaller amount.

The $5.9 billion in spending for research in the National Health Accounts excludes research performed by drug companies and by other manufacturers and suppliers of health care goods and services (an estimated $2.8 billion in 1982 by pharmaceutical manufacturers alone). As this type of research is treated as a business expense and is financed through sales of goods or services, its dollar value is implicitly included in personal health care expenditures; to include it again in this line would result in double-counting.

Of the $8.2 billion spent on construction of medical facilities in 1982, 31 percent was funded from public sources. Grants from philanthropic organizations funded 4 percent, and the remainder came from internal funds or from the private capital market. This estimate does not include spending for capital equipment, because there is no source of data to yield a reliable, consistent time series of data on spending for equipment.

Financing Health Care

Health care can be financed directly by the consumer through out-of-pocket payments. Alternatively, consumers can reduce the risk of incurring major medical costs by acquiring third-party coverage. The third party may act as the financial intermediary between the health provider and the consumer of health care, or may reimburse the consumer for the cost of care, or may hire the provider of care. In any case, an insured consumer pays less or none of the cost of care at the time of service.

The health care market differs from the perfect market for goods and services depicted in standard economic theory. First, it is dominated by third-party payers: in 1982, two-thirds of personal health care expenditures were made by the government or by private health insurance. Second, unlike most other markets, the consumers of health care lack full information when decisions are made to purchase health care. For example, hospital admission is usually made upon the decision of a seller of health care (a physician) rather than by the consumer of hospital services (the patient), or by the purchaser of the service (the government, private health insurers, or the patient). Whether the patient with complete information would choose the same types and quantities of care is an issue yet to be answered empirically. To the extent that the patient would not make the same choices, the industry plays a role in determining its "sales."

A corollary to these theories is that the absence of the "usual" market forces limiting health care expenditures may generate political (nonmarket) bargaining between payers and providers; where the government is the payer, this takes the form of regulations or rate-setting (Feder and Spitz, 1980). In practice, those parts of the health care sector for which government pays the highest proportion of costs (hospitals, for example) are also parts of the sector with the greatest degree of cost regulation.

Third-Party Financing

Unlike other goods or services for which the consumer pays the provider directly, health care payments often are handled by a financial agent—a "third party." The details of the payment method may vary: the consumer may pay the provider and apply for reimbursement from the third party, or the provider may bill the third party directly, or the provider may be employed by the third party (as in the case of Defense Department hospitals, for example). In the case of Medicare, institutional providers bill "financial intermediaries," private health insurers acting as agents for the Federal government, and physicians may bill either the financial intermediary or the patient.

The existing third-party coverage of health care may have contributed to a healthier population, but it has exacted a price as well. Insurance has increased access to care, resulting in treatment of patients who had been shut out of the orthodox medical market by price considerations. However, the structure of insurance benefits encourages use of inpatient rather than outpatient facilities, and encourages overuse of tests and procedures rather than underuse. The financial incentives embedded in the prevailing reimbursement structures may encourage effective medical care, but they do not encourage efficient care.

Private Health Insurance

Blue Cross and Blue Shield plans, commercial insurance companies, and prepaid and self-insured plans paid an estimated $77 billion in 1982 in the form of medical benefits, an amount equal to 26.7 percent of personal health care expenditures. They earned an estimated $84 billion in premiums, 48 percent of all consumer spending for health, resulting in a net cost to enrollees of insurance equal to $7.7 billion.

The size of the private health insurance industry has been growing, reflecting the perceived desire for its services. By 1982, 46 percent of private expenditures for personal health care—the amount not covered by public programs—was reimbursed by private insurance. In 1980, three quarters of the U.S. population was covered by private health insurance for hospital care, compared to one half of the U.S. population in 1950. Fifty years ago, it was noted that only a handful of the population had the financial resources to pay directly and fully for the medical care associated with a major illness (Falk *et al.*, 1933); that observation remains valid today. The relatively rapid rate of growth of insurance premiums—14 percent per year since 1950, compared to an increase of 11 percent in total personal health care expenditures—reflects the desire for the prepayment and risk-sharing offered by private health insurance.

The advent of Medicare and Medicaid slowed the growth of the private health insurance share of personal health care expenditures. However, it did so primarily by introducing new consumers to the market rather than by shifting privately insured people to public programs. The insurance share of spending doubled between 1950 and 1965, reaching 24 percent. In the ensuing years, the insurance share of spending stabilized at about 27 percent.

A large proportion of spending for hospital care and physician's services is paid by private health insurance. In 1960, private insurance paid for 36 percent of hospital care, the first type of service to be covered extensively; that share reached 42 percent by 1965. When Medicare and Medicaid were established in 1966, hospital care spending increased dramatically, and the portion paid by private insurance, while growing in dollar terms, dropped to less than 34 percent by 1967. It has remained between 33 and 36 percent since that time. Extension of coverage beyond surgical procedures in recent years has led to a higher share of physicians' services being reimbursed by private insurance. This share rose from 32 percent in 1965 to 35 percent in 1982.

For other health care services, insurance coverage has been extremely limited. Dental care is one area in which coverage is growing. Enrollment for dental benefits rose over 50 percent between 1976 and 1979 to a total of 60.3 million persons (Carroll and Arnett, 1981). Insurance paid for about 27 percent of all dental expenditures in 1982. Vision care benefits, although not large in dollar terms, also has experienced significant growth in recent years.

Public Expenditures

Government programs spent $116 billion for personal health care spending in 1982, a 13.1 percent increase over 1981. Public programs financed more than 40 percent of all personal health care expenditures, including 53 percent of all hospital care, 28 percent of all physician services, and 55 percent of all nursing-home care.

Federal expenditures of $84 billion for personal health care accounted for more than two thirds of the public outlay. The 12.5-percent increase in spending was less than the 17.3-percent increase registered in 1981, due primarily to reduced growth in the Federal share of Medicaid and to the introduction of block grants.

State and local governments financed $32 billion of personal health care services in 1982, 15.0 percent more than in 1981. The trend has been for States to concentrate their expenditures in the Medicaid program, where State expenditures are matched with Federal dollars: almost half of State and local government spending in 1982 was directed through the Medicaid program.

Public financing for health care services comes from a number of Federal, State, and local programs (Table 10). Some, such as the Veterans Administration and the Department of Defense, provide services directly through networks of hospitals, clinics, and nursing homes. The same agencies also pay public and private facilities to provide services. In the Medicare program, which accounts for 61 percent of all Federal spending for personal health care, the Federal government acts as an insurer, providing funds for medical care for eligible aged and disabled people. In other programs, Federal funds flow to State governments, which contribute additional funds. States may administer a medical program, as in the case of Medicaid, or may let funds flow through to local government agencies, as is done with maternal and child health and other community-related grants. States also fund health programs independently in State-run hospitals, or through public assistance vendor payments for individuals not covered by Medicaid.

MEDICARE AND MEDICAID In 1982, Medicare and Medicaid financed 29 cents of every dollar spent for personal health care in the United States. The two programs expended $83 billion[5] in benefits to 48 million people—one fifth of the U.S. population.

The introduction of these two programs, which accounted for almost three quarters of all public spending in 1982, has dramatically increased the Federal government presence in the health care market. Currently, the two programs pay 35 percent of all hospital expenditures, 23 percent of all physician expenditures, and 50 percent of all nursing home expenditures.

Nearly 29.5 million people, 90 percent of whom are 65 years of age or over, are enrolled in **Medicare.** 1982 program expenditures totaled $52.2 billion; $50.9 billion represented benefit (personal health care) payments, and the remainder was for administrative expenses. About $2,700 per person was paid in 1982 for the 18.9 million people receiving benefits. Medicare spending for personal health care increased 17.7 percent in 1982, up $7.4 billion from 1981.

In 1982, Medicare spent an amount equal to 44.0 percent of the public share of personal health care expenditures, and 17.7 percent of total spending for personal health care. Over 70 percent of Medicare benefits were for hospital care; another 22 percent paid for physicians' services.

Medicare was created by Title XVIII of the Social Security Act. It began on July 1, 1966, as a Federal insurance program to protect the elderly from the high cost of health care. Rather than providing health care directly, Medicare reimbursed for care received from private sector providers. In July 1973, coverage was extended to permanently disabled workers and their dependents eligible for Old Age, Survivors and Disability Insurance (OASDI) benefits, and to persons with end-stage renal disease.

Medicare has two parts, each with its own trust fund. The Hospital Insurance (HI) program, also called Part A, pays for inpatient hospital services, post-hospital skilled nursing services, and home health services. The Supplementary Medical Insurance (SMI) program, also called Part B, covers physician services, medical supplies and services, home health services, outpatient hospital services and therapy, and a few other services.

[5]This figure does not include the $393 million paid by the Medicaid program to purchase Medicare Supplementary Medical Insurance for eligible Medicaid recipients. This "buy-in" amount is reported both as Medicaid expenditure and as Medicare expenditure, but is counted only once in the combined figure.

TABLE 10

Health Care Expenditures by Source of Funds: 1965-1982
(millions of dollars)

	1982	1981	1980	1979	1978	1977	1976	1975	1974
Total National Health Expenditures	322,392	286,616	248,967	214,962	189,312	169,248	149,655	132,720	116,379
Private Health Expenditures	185,563	164,420	143,553	124,389	109,785	99,140	86,718	76,540	69,263
Health Services and Supplies	179,529	159,309	139,264	120,627	106,251	95,674	83,205	73,205	65,958
Patient Direct Payments	90,446	82,079	72,068	61,806	54,089	48,707	43,007	38,979	36,419
Insurance Premiums	84,245	73,184	63,624	55,859	49,679	44,619	38,172	32,437	27,777
Other	4,838	4,046	3,552	2,962	2,483	2,348	2,026	1,788	1,762
Medical Research	333	339	322	302	282	273	267	264	252
Medical Facilities Construction	5,701	4,772	3,967	3,460	3,251	3,193	3,246	3,072	3,053
Government Program Expenditures	136,830	122,196	105,414	90,573	79,528	70,109	62,937	56,180	47,116
Health Services and Supplies	126,745	114,161	97,875	83,835	73,274	64,404	57,421	51,115	42,953
Medicare[1]	52,172	44,772	36,828	30,333	25,932	22,524	19,303	16,317	13,099
Temporary Disability Insurance	56	54	52	58	80	74	71	73	71
Workers' Compensation (Medical)	6,054	5,713	5,042	4,494	3,476	3,129	2,756	2,430	2,175
Public Assistance Medical Payments	36,048	32,325	28,473	24,340	21,118	18,858	16,852	15,096	12,079
Medicaid[2]	33,967	30,520	26,828	22,867	19,812	17,721	15,836	14,153	11,287
Other Public Assistance Medical Payments	2,081	1,806	1,645	1,473	1,307	1,137	1,016	945	793
Defense Dept. Medical Care[3]	5,567	5,031	4,233	3,779	3,441	3,062	2,964	2,830	2,893
Maternal & Child Health Programs	896	861	812	767	726	683	641	589	547
Veterans Medical Care	7,086	6,659	5,941	5,313	4,984	4,400	4,152	3,495	3,000
Medical Vocational Rehabilitation	318	285	281	279	259	250	224	224	203
Other Personal Health Care Programs	11,907	10,763	9,206	8,229	7,930	7,105	6,646	6,901	6,155
ADAMHA[4,5]	695	749	791	636	681	574	529	649	202
Indian Health Service[5]	493	456	403	344	318	260	226	204	88
OEO Health and Medical Care[6]	—	—	—	—	—	—	—	—	—
State & Local Hospitals[7]	8,600	7,747	6,213	5,615	5,418	4,950	4,688	5,050	4,890
School Health	737	636	582	532	495	432	377	361	332
Other Public Programs n.e.c.[8]	1,382	1,174	1,218	1,102	1,018	890	826	637	643
Other Public Health Activities	8,641	7,699	7,007	6,243	5,327	4,320	3,813	3,157	2,731
Medical Research	5,555	5,314	5,006	4,483	4,162	3,646	3,434	3,071	2,538
Medical Facilities Construction	2,530	2,721	2,532	2,255	2,092	2,059	2,083	1,994	1,625
Federal Program Expenditures	93,173	83,675	71,085	61,032	53,851	47,399	42,562	37,075	30,445
Health Services and Supplies	87,505	78,198	65,960	56,452	49,406	43,578	38,888	33,813	27,837
Medicare[1]	52,172	44,772	36,828	30,333	25,932	22,524	19,303	16,317	13,099
Workers' Compensation (Medical)	180	162	140	117	93	76	70	59	42
Public Assistance Medical Payments	17,966	17,259	14,578	13,028	11,161	10,044	9,010	7,937	6,398
Medicaid[2]	17,966	17,259	14,578	13,028	11,161	10,044	9,010	7,937	6,398
Other Public Assistance Medical Payments	—	—	—	—	—	—	—	—	—
Defense Dept. Medical Care[3]	5,567	5,031	4,233	3,779	3,441	3,062	2,964	2,830	2,893
Maternal & Child Health Programs	335	395	358	350	343	321	312	286	253
Veterans Administration	7,086	6,659	5,941	5,313	4,984	4,400	4,152	3,495	3,000
Medical Vocational Rehabilitation	251	228	224	223	207	200	180	178	167
Other Personal Health Care Programs	2,570	2,379	2,412	2,082	2,017	1,723	1,581	1,490	933
ADAMHA[4,5]	695	749	791	636	681	574	529	649	202
Indian Health Service[5]	493	456	403	344	318	260	226	204	88
OEO Health and Medical Care[6]	—	—	—	—	—	—	—	—	—
Other Public Programs n.e.c.[8]	1,382	1,174	1,218	1,102	1,018	890	826	637	643
Other Public Health Activities	1,378	1,314	1,265	1,227	1,230	1,229	1,316	1,221	1,054
Medical Research	5,017	4,822	4,538	4,048	3,762	3,284	3,109	2,772	2,268
Medical Facilities Construction	652	655	567	532	681	537	566	490	340
Net State and Local Program Expenditures	43,656	38,521	34,328	29,540	25,677	22,709	20,375	19,105	16,671
Health Services and Supplies	41,240	35,964	31,895	27,383	23,866	20,625	18,533	17,301	15,116
Temporary Disability Insurance	56	54	52	58	80	74	71	73	71
Workers' Compensation (Medical)	5,874	5,551	4,901	4,378	3,384	3,053	2,685	2,371	2,133
Public Assistance Medical Payments	18,082	15,066	13,894	11,312	9,957	8,814	7,842	7,161	5,682
Medicaid[2]	16,001	13,261	12,249	9,839	8,651	7,677	6,826	6,216	4,689
Other Public Assistance Medical Payments	2,081	1,806	1,645	1,473	1,307	1,137	1,016	945	793
Maternal & Child Health Programs	560	466	454	417	383	362	330	303	294
Medical Vocational Rehabilitation	67	57	56	56	52	50	44	46	36
Other Personal Health Care Programs	9,337	8,384	6,795	6,147	5,913	5,382	5,064	5,411	5,222
State & Local Hospitals[7]	8,600	7,747	6,213	5,615	5,418	4,950	4,688	5,050	4,890
School Health	737	636	582	532	495	432	377	361	332
Other Public Health Activities	7,263	6,385	5,742	5,016	4,097	3,091	2,497	1,936	1,678
Medical Research	538	492	469	435	401	362	325	299	270
Medical Facilities Construction	1,879	2,066	1,965	1,722	1,411	1,522	1,517	1,505	1,285
Private Health Expenditures	63,878	58,067	51,623	46,871	40,716	36,067	32,337	32,533	30,950
Health Services and Supplies	60,603	54,839	48,736	44,311	38,526	34,452	30,892	31,017	29,482
Patient Direct Payments	34,211	30,992	27,805	26,024	22,876	20,523	18,836	19,479	18,522
Insurance Premiums	24,845	22,358	19,475	17,075	14,596	12,868	11,090	10,555	9,993

(Continued)

TABLE 10 (continued)

Health Care Expenditures, by Source of Funds: 1965-1982
(millions of dollars)

	1973	1972	1971	1970	1969	1968	1967	1966	1965
Total National Health Expenditures	103,161	93,493	83,284	74,663	65,629	58,169	51,305	46,107	41,749
Other	1,547	1,489	1,456	1,213	1,053	1,061	966	982	966
Medical Research	232	227	233	215	213	208	198	186	176
Medical Facilities Construction	3,043	3,001	2,655	2,345	1,978	1,407	1,247	1,330	1,292
Government Program Expenditures	39,283	35,426	31,660	27,792	24,913	22,102	18,968	13,574	10,799
Health Services and Supplies	35,720	32,061	28,426	24,952	22,266	19,592	16,580	11,403	8,754
Medicare[1]	10,135	9,114	8,284	7,500	6,916	5,974	4,726	1,135	—
Temporary Disability Insurance	69	65	71	66	59	55	53	54	52
Workers' Compensation (Medical)	1,882	1,574	1,440	1,408	1,262	1,146	1,011	910	798
Public Assistance Medical Payments	10,349	9,119	8,055	6,321	5,500	4,617	3,635	2,732	2,112
Medicaid[2]	9,676	8,541	7,076	5,471	4,556	3,950	2,982	1,512	—
Other Public Assistance Medical Payments	673	578	979	850	944	667	653	1,220	2,112
Defense Dept. Medical Care[3]	2,304	2,210	1,786	1,782	1,733	1,606	1,454	1,211	853
Maternal & Child Health Program	482	508	464	429	451	389	338	300	255
Veterans Medical Care	2,741	2,380	2,051	1,764	1,520	1,381	1,301	1,198	1,145
Medical Vocational Rehabilitation	177	178	174	149	123	113	84	56	40
Other Personal Health Care Programs	5,349	4,905	4,337	4,114	3,474	3,267	3,089	2,981	2,686
ADAMHA[4,5]	—	—	—	—	—	—	—	—	—
Indian Health Service[5]	—	—	—	—	—	—	—	—	—
OEO Health and Medical Care[6]	77	149	179	158	124	115	102	83	23
State & Local Hospitals[7]	4,142	3,733	3,377	3,347	2,888	2,748	2,620	2,578	2,373
School Health	307	290	277	260	236	215	192	166	150
School Public Programs n.e.c.[8]	822	733	504	349	225	188	175	154	140
Other Public Health Activities	2,233	2,006	1,764	1,420	1,229	1,045	888	825	814
Medical Research	2,291	2,126	1,883	1,754	1,709	1,668	1,568	1,443	1,340
Medical Facilities Construction	1,272	1,240	1,351	1,086	938	843	821	728	705
Federal Program Expenditures	25,178	22,879	20,319	17,667	16,067	14,112	11,918	7,444	5,535
Health Services and Supplies	22,836	20,612	18,203	15,715	14,164	12,233	10,142	5,781	3,984
Medicare[1]	10,135	9,114	8,284	7,500	6,916	5,974	4,726	1,135	—
Workers' Compensation (Medical)	34	29	26	23	18	16	15	13	12
Public Assistance Medical Payments	5,462	4,637	4,214	3,244	2,776	2,221	1,765	1,463	1,359
Medicaid[2]	5,462	4,637	3,841	3,001	2,409	1,979	1,469	734	—
Other Public Assistance Medical Payments	—	—	373	243	367	242	296	729	1,359
Defense Dept. Medical Care[3]	2,304	2,210	1,786	1,782	1,733	1,606	1,454	1,211	853
Maternal & Child Health Program	209	249	190	159	196	172	149	117	84
Veterans Administration	2,741	2,380	2,051	1,764	1,520	1,381	1,301	1,198	1,145
Medical Vocational Rehabilitation	144	142	139	120	95	84	63	40	26
Other Personal Health Care Programs	899	883	683	507	350	303	277	237	163
ADAMHA[4,5]	—	—	—	—	—	—	—	—	—
Indian Health Service[5]	—	—	—	—	—	—	—	—	—
OEO Health and Medical Care[6]	77	149	179	158	124	115	102	83	23
Other Public Programs n.e.c.[8]	822	733	504	349	225	188	175	154	140
Other Public Health Activities	908	967	830	615	561	476	392	367	344
Medical Research	2,042	1,889	1,670	1,571	1,552	1,537	1,455	1,340	1,245
Medical Facilities Construction	302	378	446	381	371	342	321	322	308
Net State and Local Program Expenditures	14,105	12,547	11,341	10,125	8,825	7,990	7,050	6,130	5,264
Health Services and Supplies	12,886	11,448	10,223	9,237	8,102	7,359	6,437	5,621	4,770
Temporary Disability Insurance	69	65	71	66	59	55	53	54	52
Workers' Compensation (Medical)	1,848	1,545	1,414	1,384	1,244	1,130	996	897	787
Public Assistance Medical Payments	4,887	4,483	3,841	3,077	2,724	2,396	1,870	1,269	753
Medicaid[2]	4,214	3,904	3,235	2,470	2,148	1,971	1,513	778	—
Other Public Assistance Medical Payments	673	578	606	607	577	425	357	491	753
Maternal & Child Health Programs	273	258	274	270	255	217	190	183	171
Medical Vocational Rehabilitation	32	36	35	29	28	29	20	16	14
Other Personal Health Care Programs	4,449	4,023	3,654	3,607	3,124	2,963	2,812	2,744	2,523
State — Local Hospitals[7]	4,142	3,733	3,377	3,347	2,888	2,748	2,620	2,578	2,373
School Health	307	290	277	260	236	215	192	166	150
Other Public Health Activities	1,326	1,039	934	805	668	569	495	458	469
Medical Research	250	237	213	183	157	131	113	104	95
Medical Facilities Construction	970	862	906	705	567	501	500	405	399

[1]Total expenditures from trust funds for benefits and administrative costs. Trust fund income includes premium payments paid by or on behalf of enrollees.
[2]Includes payments by States into the Medicare trust funds to cover Part B premiums of eligible public assistance and medically-needy Medicaid recipients.
[3]Includes care for retirees and military dependents.
[4]Alcohol, Drug Abuse, and Mental Health Administration.
[5]Not separately estimated prior to 1974.
[6]Office of Economic Opportunity. Programs transferred to the Department of Health, Education, and Welfare in 1974.
[7]Expenditures for State and local government hospitals not offset by other revenues.
[8]Not elsewhere classified.
SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

Unlike other Federal health programs, Medicare is not financed solely by general revenues. In 1982, 90 percent of the funding for the Hospital Insurance program came from a 1.3-percent payroll tax levied on employers and on employees for the first $32,400 of wages. Payroll contributions to the HI program increased 12.8 percent in fiscal year 1982, while HI benefit payments jumped 18.8 percent. The SMI program was financed by monthly premium payments of $12.20 per enrollee and by general revenues (appropriations from general tax receipts). The general revenue share of SMI funding has grown significantly, from about 50 percent in 1971 to 70 percent in 1982. By law, SMI premiums may not increase more than the increase in monthly cash retirement and survivor benefits, requiring a proportionately greater amount of general tax revenues to maintain the trust fund. As shown in Table B, $14.3 billion of Federal tax revenues was used in fiscal year 1982 to finance the Medicare program. The current administration is seeking to increase the SMI premium, in order to restore the original balance between contributions and general revenue contributions to the SMI trust fund.

TABLE B

Payments into Medicare Trust Funds for Selected Calendar Years

	1971		1982	
	Billions of Dollars	Percent of Total	Billions of Dollars	Percent of Total
Total	$8.5	100.0%	$55.2	100.0%
Payroll Taxes	5.0	58.1	34.7	62.9
General Revenues	2.1	24.8	14.3	25.9
Premiums	1.3	14.7	3.9	7.1
Interest	.2	2.3	2.3	4.2

SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

Efforts to curb rapidly growing Medicare expenditures resulted in changes in reimbursement policies late in 1982. The limits on daily routine inpatient hospital costs were replaced by limits on total inpatient costs per admission. In addition, Congress permitted prospective *per capita* payments to HMOs and other medical programs which contracted to provide comprehensive medical services to Medicare beneficiaries. During fiscal year 1984, further initiatives in prospective payment will be implemented, in the form of predetermined reimbursement rates for over 400 different diagnosis-related groups (DRGs). Under DRGs, hospitals will be reimbursed based upon diagnosis of the patient's illness, regardless of services provided or of length of stay (initially, DRG rates will vary for urban and rural areas and among the nine census regions). The aim of DRGs is to force hospitals and attending physicians to consider the economic consequences of prescribed courses of treatment—a facet from which they often are insulated.

In addition to reimbursement reforms, other changes are being made in the Medicare program. Coverage of Federal employees became effective in January of 1983 and mandatory coverage of employees of nonprofit organizations is slated for 1984. Also in 1984, self-employed people will be required to contribute the equivalent of both the employer and the employee share of the HI tax, doubling their contribution to the HI trust fund.

When Medicare began in 1966, 9.4 percent of the population was 65 years of age and over. By 1982, the Census Bureau estimated that 11.6 percent of the population was elderly. Because of this shift toward an older population, the percentage of the total population potentially eligible for Medicare on the basis of age has increased 23 percent. That increase in the proportion of the population eligible for Medicare, coupled with significant rises in medical care prices, has put the solvency of the Medicare HI trust fund in jeopardy: the Medicare trustees believe that unless additional changes in the program are instituted, the HI trust fund will be unable to meet its obligations by 1990 (Medicare Trustees, 1983).

Nearly all Medicare HI hospital benefits are for care in community hospitals. Because days of care provided in community hospitals to persons age 65 and over increased 1.7 percent in 1982, while days of care provided to persons under age 65 dropped 2.1 percent, and because almost all persons 65 years of age and over are enrolled in the Medicare HI program, total Medicare hospital outlays grew faster than did community hospital expenses.

Medicare outlays for physicians' services also increased as a share of total expenditures for physicians' services in 1982. This was related in part to increased hospitalization rates for Medicare beneficiaries (especially aged beneficiaries). Between 1971 and 1977, charges for physicians' services provided on an inpatient basis to aged beneficiaries increased from 57 to 61 percent of all allowed physicians' charges—a trend which probably continued through 1982.

Medicare payments for skilled nursing facility (SNF) care as a percent of total nursing home revenues have declined in recent years. In 1968, Medicare provided more than one-tenth of total nursing home revenues; by 1982, that share had dropped to less than 2 percent. Most of the decrease occurred between 1969 and 1971, following a reinterpretation of Medicare nursing-care coverage.

Medicare reimbursement for home health agency services has grown significantly. Home health care reimbursements in fiscal 1982 were $1.3 billion, compared to $464 million for SNF care. In contrast, Medicare spent $60 million for home health care in fiscal year 1968, compared to $344 million for SNF care. Most of Medicare payments for home health agency care are included in "other professional services." The remainder, which was used to reimburse care provided by hospital-based agencies, is reported under "hospital care."

In 1982, **Medicaid** cost $34.0 billion in combined Federal and State funds, providing benefits equal to 11.3 percent of personal health care spending. Medicaid expenditures for personal health care were 11.7 percent higher than in 1981, and averaged about $1500 for each of its 21.7 million recipients. Hospital care accounted for more than a third of program benefit expenditures, and nursing home care accounted for more than 40 percent.

Medicaid finances more long-term, non-acute, institutional care than does Medicare. Long-term care is provided by nursing facilities, psychiatric hospitals, and home health

agencies. Long-term care benefit expenditures amounted to almost half of all 1982 Medicaid program spending. Nursing-facility expenditures include spending in SNFs, intermediate care facilities for the mentally retarded (ICF-MR), and all other ICFs. Medicaid has paid for 42 percent of all non-ICF-MR nursing home care in recent years.

Medicaid was established in 1966 by Title XIX of the Social Security Act as a joint Federal-State program to provide medical assistance to certain categories of low-income people. These include aged, blind, and disabled people, and members of families with dependent children. The program is run by the State, but the Federal government, through what are called "matching funds," contributes a portion of the cost of providing medical benefits to the categorically eligible. In addition, if the State chooses, Federal matching funds are available for medical benefits for the "medically needy"—people in one of the categories listed above who have incomes too high to qualify for cash assistance but not adequate to pay their medical bills.

Federal law requires that States participating in Medicaid provide a minimum set of services for their recipients. These services include inpatient and outpatient hospital care; laboratory and x-ray services; skilled nursing home care and home health services for those 21 and older; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning services; and rural health clinic services. In fiscal year 1982, approximately 50 percent of Medicaid expenditures went for services mandated by Federal law.

Increases in Medicaid expenditures have outpaced increases in revenues in most States. Since large portions of service expenditures and eligibility are determined by Federal law, States have been attempting to curb Medicaid's growth through those aspects of the program they can control (Intergovernmental Health Policy Project, 1982). During 1981, States employed such strategies as reduction of the number and scope of optional services, tightening of the qualifications for the medically needy program and restructuring of reimbursement policy. Among the changes instituted by States were the imposition of limits on days of hospitalization and on hospital emergency and outpatient facility services, introduction of or increases in copayments for prescription drugs, tightening of eligibility requirements and curtailment of coverage to 18- to 21-year olds, adoption of prospective reimbursement policies, and increased application by States for waivers from Federal requirements. In some States, services were added to include less expensive alternative care, as in the case of home- and community-based services.

A recent survey of State Medicaid programs (Intergovernmental Health Policy Project, 1983) indicates that States are shifting their focus away from restrictions on eligibility and reductions in services, and toward longer-term reform. Included in these reforms are establishment of rate-setting programs, increase review of patient use patterns, and more stringent certificate-of-need review.

The Federal share of Medicaid has dropped almost four percentage points since calendar year 1979, shifting a larger proportion of Medicaid funding to the States. This decline is caused by revisions in formula match ratios which occur every two years (the latest is for fiscal year 1982); by the changing proportions of total Medicaid expenditures accounted for by each state, most with different match ratios; by implementation of laws reducing Federal contributions to Medicaid; and by the way in which Federal expenditures are estimated.

The basic Federal share of Medicaid payments to a given State is based upon a formula which incorporates the State's *per capita* personal income. The Federal "formula match ratio" currently ranges from 50 to 77 percent, 83 percent being the maximum payable by law. Changes in the total Federal share occur each year as States with varying match ratios account for a different share of total national Medicaid expenditures. For example, when States with low matching ratios experience more growth in program expenditures than do States with high matching ratios, the weighted average Federal share of Medicaid expenditures falls.

The Omnibus Budget Reconciliation Act of 1981 (OBRA) implemented a reduction in Federal Medicaid reimbursement to States of three percent in fiscal year 1982 and four percent in fiscal year 1983. States could regain, or "offset," one of those percentage points for each of three conditions: if the State operated a hospital cost review program, if the State had an unemployment rate one-and-a-half times the national average, or if the State operated a fraud and abuse program that recovered at least one percent of the Federal payment. In addition to these three offsets, a State could regain up to the original loss of Federal money by reducing the growth of its program expenditures to a target rate. It is estimated that these OBRA reductions saved the Federal government over $400 million in fiscal year 1982, costs which had to be borne by the States.

Another reason for the decline of the Federal share of Medicaid expenditures—particularly in fiscal year 1982—is the use of outlay data to measure Federal expenditures. While combined Federal and State expenditures in this report reflect the timing of payments to providers of care, the Federal portion alone reflects the timing of fund transfers to States to reimburse those payments. This difference in timing results in year-to-year fluctuations in the Federal share of Medicaid: a higher share in 1981 and a lower share in 1982.

HEALTH CARE FOR VETERANS The Veterans' Administration (VA) provides compensation and pensions for military veterans and their survivors, as well as medical care for veterans. Nearly 28.5 million people are eligible to receive some medical care from the VA, although not all of them apply for benefits. In fiscal year 1982, hospital and other medical care for veterans accounted for 29 percent of the $23.9 billion in outlays of the VA. In the 1982 National Health Accounts, VA expenditures for personal health care are estimated at $7.0 billion. Of that amount, $5.8 billion, or 82 percent, was spent to provide care in the 172 VA medical centers (and other hospitals). VA medical centers provided care for 1.3 million inpatients and supplied care during 18.0 million outpatient visits.

In fiscal year 1982, 24.5 million inpatient days of care were financed by the Veterans' Administration in VA and non-VA hospitals. An additional 8.9 million inpatient days were provided in VA nursing homes or financed by the VA in State or community operated nursing facilities.

HEALTH CARE FOR THE MILITARY AND DEPENDENTS The Department of Defense (DOD) assumes responsibility for the health care needs of the nation's active and retired military forces and their dependents and survivors. Approximately $5.5 billion (9.6 percent of DOD expenditures for salaries and benefits) was spent for health care in fiscal year 1982, including care for more than 2.1 million active personnel. The DOD health care system includes 165 hospitals which provide 5.3 million inpatient days of care in fiscal year 1982. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the program which finances care required outside the DOD facilities (primarily for dependents and retirees), financed another 2.5 million inpatient days of care.

INDIAN HEALTH SERVICE The Federal Indian Health Service provides personal health care and public health services to approximately 885,000 Indians and Alaskan natives, through a network of hospitals and clinics. In 1982, $488 million was spent by the Indian Health Service in the delivery of health services.

HEALTH BLOCK GRANTS During fiscal year 1982, Federal block grants were introduced for maternal and child health; preventive health; and alcohol, drug abuse and mental health. A fourth health block grant, primary care, will be implemented in fiscal year 1983, furnishing grants for community health centers to provide care for the medically needy population. A total of $1,088 million in fiscal year 1981 health expenditures were consolidated into three block grants amounting to $887 million in fiscal year 1982. This represents an 18 percent decrease in spending. The objective of these block grants is to moderate the levels of Federal funding and to reduce regulatory involvement, while offering States flexibility in responding to their diverse health needs and priorities.

Despite the reduction in Federal *appropriations* for these block grants programs, the full reduction in Federal *outlays* may not be seen until 1983. Many of the health programs falling under block grants awarded project grants during the last quarter of fiscal year 1981, funding projects for up to twelve months under fiscal year 1981 budget authority. When these projects terminate, further reductions in Federal outlays will occur. This extension of Federal outlays for project grants has eased the transition to block grants for many States.

Maternal and child health programs promote the health of medically-underserved mothers and children and of crippled children. State and local governments spent $831 million, including Federal block and special project grants of $330 million, for a variety of physician and other clinical services and for infant intensive care.

Federal preventive health block grants are included in Federal public health expenditures, funding various prevention and detection programs. This grant program requires a 20-percent match in funds by States, which is included in State and local public health activities.

The alcohol, drug abuse, and mental health block grants provide funds for prevention, treatment, and rehabilitative programs. Outlays for block grants and special projects, along with funding for St. Elizabeth's hospital in Washington, D.C. amounted to $695 million in 1982.

An initial report by the Government Accounting Office (GAO, 1982) indicates that few program changes occurred during the early part of fiscal year 1982 as a result of the health block grants. States relied upon the same mechanisms to handle block grants as were used in the supplanted categorical programs, since States had little time or money to institute change. The expectation is that States will begin to reexamine their needs, prioritize expenditures, and start to shift funds within the health sector in response to reduced Federal funding and to increased State budget constraints.

WORKERS' COMPENSATION Workers' compensation programs, except for the program for Federal workers, are independent State-administered income maintenance programs that provide benefits for work-related disability and death. Approximately 29 percent of the benefits paid by these programs in 1982 was for medical services for workers, and the remaining 71 percent was for income-loss payments for workers and survivors. Health and medical benefits amounted to $4.6 billion in 1982. Since workers' compensation programs are required by law, they are treated as public programs in the National Health Accounts. In some States, workers' compensation is run by private insurance under State oversight; others use State-operated insurance funds, or a combination of both (Price, 1980, 1981).

STATE AND LOCAL GOVERNMENT HOSPITALS State and local governments traditionally have operated hospitals in order to provide health care to their citizens. In 1982, the cost of providing that care, after deduction of receipts from Medicare, Medicaid, other government programs, and patient payments, was $8.6 billion.

Medicare and Medicaid have altered significantly the financing patterns of these hospitals, providing reimbursement for services that would have been provided previously as charity care. Thus, the net cost of care in State and local hospitals declined from 61 percent of total operating expenses in 1965 to 25 percent in 1977, and has remained at about that level since then.

Approximately 1,750 community hospitals, accounting for 21 percent of all community hospital beds, are operated by State and local governments (primarily local). Expenditures for services in these hospitals amounted to $19.2 billion in 1981, having increased at an annual rate of 15.0 percent since 1965.

State governments and some large local governments have cared for the mentally ill in psychiatric hospitals, where 1981 expenditures amounted to $5.3 billion. Care for the chronically mentally ill has undergone substantial change since 1955. A shift toward community-oriented care reduced the resources devoted to psychiatric hospitals. From 1965 to 1981, spending in these hospitals increased at an 8.1 percent annual rate—substantially below the 14.3 percent annual rate for hospitals as a whole. In 1955, the 275 State and county mental hospitals had 558,922 resident patients. That number fell to 337,619 in 1970, and to 215,573 in 1974 (National Institute of Mental Health, 1977). Operation of these hospitals is financed mostly from State and local governments' own funds, with relatively little patient revenue.

OTHER STATE AND LOCAL GOVERNMENT PROGRAMS State spending for medical care for the poor who are not eligible for Medicaid, and State spending which is not eligible for Federal matching funds, are classified as "other public assistance payments for medical care." In 1982, this spending amounted to $2.1 billion. Another $1.1 billion was spent in 1982 through temporary disability insurance, school health, and vocational rehabilitation programs.

Philanthropy and Industrial Inplant Services

Some health care is provided to industrial employees through in-plant health services. Expenditures for these services, classified as "other health services," are estimated at $1.7 billion for 1982. Private philanthropic organizations' funds for personal health care are classified by type of care, and totaled over $2.5 billion in 1982. Administrative and fund-raising expenses of private charities and philanthropic support of research and construction are included with the respective expenditure categories.

Direct Patient Payments

The portion of personal health care expenditures not paid by third parties is known as "direct patient payments" or "out-of-pocket" costs. This amount excludes premium payments for Medicare and/or private health insurance, but does not include deductible and coinsurance amounts. In 1982, direct patient payments amounted to $90 billion—$383 per person. There has been a relative decline in out-of-pocket payments for health care, from a little over one-half of personal health care spending in 1965 to less than one-third in 1982, because of the rapid growth in third-party payments.

The share of expenditures borne directly by the patient varies enormously by type of service (see Table 6). In 1982, patients paid 12.1 percent of hospital expenditures directly, and they paid 37.3 percent of expenditures for physicians' services. For dentists, the direct share was 69.0 percent, and for drugs and drug sundries it was 78.8 percent. As shown in Table 5, the direct payment share for hospital and physicians' services has been cut nearly in half since 1965. For all other services, however, private health insurance and public programs have not assumed as great a share of the cost of care.

Definitions, Concepts, and Data Sources

This report is the latest update of the national health expenditure estimates from the National Health Accounts. Provisional estimates of spending for health care in the nation are presented for calendar year 1982, with selected historical data extending back to 1929.

The National Health Accounts provide a framework to help understand the nature of spending for health care. Going beyond a simple collection of numbers, the accounts employ a classification matrix with a consistent set of definitions to categorize health care goods and services and the manner in which their purchase is financed.

The framework of the National Health Accounts provides a more definitive picture of health care spending than do other systems, such as the National Income and Product Accounts (source of the GNP). However, care is taken to assure that the classification used, and the estimates of levels generated, are consistent with those underlying the GNP. (Cooper *et al.*, 1980).

Different aspects of the National Health Accounts are explored in other work performed in HCFA (Fisher, 1980; Freeland and Schendler, 1983; Levit, 1982).

Hospital Care

The estimates of expenditures for hospital care are based upon data on hospital finances collected by the American Hospital Association (AHA) as part of the Annual Survey of Hospitals and the monthly National Hospital Panel Survey. The data from the monthly survey are used to estimate levels of community hospital expenditures for periods more recent than the latest annual survey and to adjust the annual survey data to correspond to the various time periods for which estimates are made.

The composite estimate represents all spending for hospital services in the nation for both inpatient and outpatient care, including spending for drugs and other supplies and all services by hospital staff, including physicians salaried by the hospital.

Services of self-employed physicians in hospitals (surgeons, for example) are not counted as hospital expenditures. Anesthesia and x-ray services sometimes will be classified as hospital care expenditures and sometimes as expenditures for physicians' services, depending on billing practices.

This category measures outlays for hospital services rather than the cost of providing service. Total revenue data are used for community hospitals; for other types of hospitals, where revenue data are not available, total expenses are used. Certain adjustments are made in the AHA data: additions are made to allow for a small number of hospitals not included in the national totals; and for Federal hospitals, estimates are based on figures obtained from the responsible agencies.

Nursing Home Care

Expenditures for nursing home care encompass spending in all facilities or parts of facilities providing some level of nursing care. Included are all nursing homes certified by Medicare and/or Medicaid as skilled-nursing facilities, those certified by Medicaid as intermediate-care facilities for regular patients as well as solely for the mentally retarded, and all other homes providing some level of nursing care, even though they are not certified under either program.

The estimates for total nursing home expenditures other than those intermediate-care facilities serving the mentally retarded are derived from data on facilities, utilization, and costs. Sources for these data are the National Center for Health Statistics National Nursing Home Survey and the Internal Revenue Service statistical reports. In years for which no data are available, estimates are based on measures of utilization and indexes of prices paid by nursing homes for labor and nonlabor resources. The nonhospital portion of Medicaid expenditures for intermediate-care facilities for the mentally retarded is added to regular nursing home expenditures.

Services of Physicians, Dentists, and Other Health Professionals

Expenditures for the services of these practitioners are based primarily on statistics compiled by the Internal Revenue Service from business income tax returns and published in *Statistics of Income—Business Income Tax Returns.*

Business receipts, which exclude nonpractice income, are summed for sole proprietorships, partnerships, and incorporated practices to form the core of the physician component. To that sum is added a portion of spending for outpatient independent laboratory services that is assumed to be billed directly to patients and not included with physicians' business receipts. An estimate of fees paid to physicians for life insurance examinations is deducted, and an estimate of the expenses of nonprofit group practice prepayment plans is added.

Expenditures for non-profit group-practice dental clinics are added to the IRS total estimate of dentists' business receipts. No separate adjustment is necessary for dental laboratories, since all billings are assumed to be made through dentists' offices.

The incomes of salaried physicians, dentists, and other practitioners are included with the expenditures for the employing provider, such as hospitals or hospital outpatient facilities. If they are serving in field services of the Armed Forces, their salaries are included with "other health services." Whenever possible, expenditures for the education and training of medical personnel are considered as expenditures for education and excluded from health expenditures.

The Internal Revenue Service statistics provide estimates of the income of other health professionals in private practice. These include private-duty nurses, chiropractors, optometrists, and other health professionals. Estimates for home health agencies that are not hospital-based are added to the private income of other unspecified health professionals. The portions of optometrists' receipts that represent the cost of eyeglasses are deducted, since they are included under spending for eyeglasses and appliances. Expenditures for home health agencies that are hospital-based are included.

Drug and Medical Sundries, Eyeglasses and Orthopedic Appliances

Expenditures in these categories include only spending for outpatient drugs and appliances purchased from retail trade outlets by consumers. The category excludes spending for goods provided to patients in hospitals and in nursing homes, and for those dispensed through physicians' offices. The basic source of the estimates for drugs and drug sundries and for eyeglasses and appliances is the estimate of personal consumption expenditures compiled by the Bureau of Economic Analysis of the Department of Commerce as part of the National Income and Product Accounts (NIPA). The two series that are used are "drug preparations and sundries," representing nondurable medical goods and "ophthalmic products and orthopedic appliances," which are durable medical goods. Payments by workers' compensation programs are deducted from the NIPA series to derive a private spending figure for drugs and for appliances. Combined with expenditures by public programs for these products, the data yield an estimate of the total of expenditures for the nation.

Other Personal Health Care

Personal health care expenditures that do not clearly fit into a category of spending, or that are for unspecified purposes, are aggregated here. Public expenditures aggregated here include school health services, identified but unclassified expenses such as ambulance services reimbursed by Medicare, and public spending for which no service category can be identified. A substantial portion of the total is for care provided in Federal units other than hospitals, a residual amount that reflects the cost of running field and ship-board medical stations and military outpatient facilities separate from hospitals. The only private expenditures in this category are for operation of industrial on-site health services.

Government Public Health Activities

The Federal portion of government public health activities consists of outlays for the organization and delivery of health services, the prevention and control of health problems, and similar health activities administered by various Federal agencies, chiefly within the Department of Health and Human Services. Expenditures by the Food and Drug Administration and the Center for Disease Control within HHS represent the largest single agency expenditures in the Federal government for public health activities.

The State and local portion represents expenditures of all State and local health departments, less intergovernment payments to the States and localities for public health activities. It excludes expenditures of other State and local government departments for air-pollution and water-pollution control, sanitation, water supplies, and sewage treatment. The source of these data is *Governmental Finances,* an annual statistical series of the Bureau of the Census, and the periodic *Census of Governments.*

Program Administration and the Net Cost of Insurance

The net cost of insurance is the difference between the earned premiums or subscription income of private health insurers and claims or benefit expenditures incurred (in the case of organizations that provide services directly, the expenditures to provide such services). In other words, it is the amount retained by health insurers for operating expenses, additions to reserves, and profits.

Administrative expenses in the National Health Accounts include non-personal health expenditures of private charities for health education, lobbying, fund-raising, and so on. In addition, it includes administrative expenses of the Medicare, Medicaid, Veterans Administration, Department of Defense, Workers' Compensation, Indian Health Service, and maternal and child programs.

Medical Research

Expenditures for medical research include all spending for biomedical research and research in the delivery of health services, by private organizations and public agencies whose primary object is the advancement of human

health. Research expenditures of drug and medical supply companies are excluded, since they are included in the producer price of the product.

The Federal amounts are derived from agency reports collected and compiled by the National Institutes of Health. The amounts shown for State and local governments and private expenditures also are based on estimates prepared by the National Institutes of Health (NIH, 1982).

Construction of Medical Facilities

Expenditures for construction are the "value put in place" for hospitals, nursing homes, medical clinics, and medical research facilities, but not for private office buildings providing office and laboratory facilities for private practitioners. Also excluded are amounts spent for construction of water-treatment or sewage-treatment plants and Federal grants for these purposes. The data for "value put in place" for construction of publicly and privately owned medical facilities in each year are taken from Department of Commerce reports.

Government Program Expenditures

All expenditures for health care that are channeled through any program established by public law are treated as a public expenditure in the National Health Accounts. For example, expenditures under workers' compensation programs are included with government expenditures, even though they involve benefits paid by insurers from premiums that have been collected from private sources.

In order to be included, the primary focus of a program must be on the provision of care or the treatment of disease: nutrition and antipollution programs are not included. For example, a Department of Agriculture grant program, the Women, Infants and Children (WIC) program, provided $903 million to supplement the diets of low-income pregnant women and mothers and their infants and children in fiscal year 1982. WIC, along with "Meals on Wheels" and similar programs, is not included in the National Health Accounts, because it is viewed as a nutrition program rather than a health service program.

Coinsurance and deductibles in the Medicare program are included among patient direct payments, but premiums paid by enrollees in the Medicare Supplemental Medical Insurance (SMI) program ($3.9 billion in 1982) are not treated as private expenditures.

In 1982, an additional $393 million was spent by the Medicaid program to purchase Medicare SMI coverage for eligible Medicaid recipients. This "buy-in" amount is reported both as Medicaid expenditure and as Medicare expenditure.

Federal Expenditures

Federal program expenditures are based in part on data reported by the budget offices of Federal agencies. Several significant differences exist from spending reported in the Federal budget, however, because of the conceptual framework on which the national health expenditure series is based. Expenditures for education and training of health professionals are excluded from national health expenditures. The majority of these expenditures comprise direct support of health professional schools and student assistance through loans and scholarships. Payments by agencies for health insurance for employees are included with other private health insurance expenditures, rather than as government expenditure.

Outlays of Federal programs by the type of health care provided are based on information obtained from the agencies that administer each program.

State and Local Expenditures

In general, all spending by State and local government units for health care that is not reimbursed by the Federal government through benefit payments or grants-in-aid, nor by patients or their agents, is treated as State and local expenditures: State and local spending is net of Federal reimbursements and grants-in-aid for various programs. The amounts received from the Federal government as revenue sharing funds and used for health programs are not deducted from State spending since there is not adequate information to make this adjustment. During the fiscal year 1978, States used $706 million in revenue sharing funds for health care purposes, much of which is reflected in "government public health activities."

As with Federal expenditures, payments for employee health insurance by State and local governments as employers are included under private health insurance expenditures.

Private Health Insurance

Estimates of the amount of health care expenditures financed by private health insurance are derived from the data series on the financial experience of private health insurance organizations compiled and analyzed by the Health Care Financing Administration (Carroll and Arnett, 1981).

Price Indexes for Personal Health Care Expenditures

To quantify the effect of price inflation upon growth of spending for health care, it is necessary to construct a measure of inflation of medical prices.

The measure used in this article is the "personal health care expenditure fixed-weight price index." The index is a market-basket, or Laspeyres, index with 1977 as its base year. To a price index for each commodity or service is attached a weight proportionate to purchases of the commodity or service in 1977. The price proxies used and the weights attached to each are shown in Table C.

This index is a better measure of inflation than are its two main substitutes. The medical-care component of the CPI places less weight on institutional care than is warranted by expenditures, because of its emphasis on consumer payments as the criterion of importance. Similarly, the medical-care component of the personal consumption expenditures fixed-weight price index (itself a component of the GNP fixed-weight price index) fails to include spending by Medicaid and other public programs when the price weights are determined, and includes a piece for the net cost of health insurance.

TABLE C

Derivation of the Personal Health Care Expenditure Fixed-Weight Price Index

Commodity/Service	Price Proxy	Weight[2]
All Personal Health Care	–	100.0
Hospital care	National Hospital Input Price Index	45.6
Physicians' services	CPI[1], physicians' services	21.4
Dentists' services	CPI[1], dental services	7.1
Other professional services	CPI[1], professional services	2.4
Drugs and medical sundries	CPI[1], medical care commodities	9.5
Eyeglasses and appliances	Weighted average of CPI[1], other professional services and CPI[1], eyeglasses	2.5
Nursing home care	National Nursing Home Input Price Index	8.9
Other care	CPI[1], medical care	2.7

[1]Consumer Price Index for all urban consumers, Bureau of Labor Statistics (U.S. Labor Department). Indexes are scaled so that the 1977 value is 100.0.

[2]Rounded.

SOURCE: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration.

Although the purpose of the index is a measure of output prices, we have used input-price indexes to approximate inflation of institutional-care prices. The choice was dictated by the lack of alternatives: no single CPI component has measured hospital prices fully, consistently, and over an extended period of time; and no index of nursing home output prices exists. In the absence of productivity growth, and to the extent that an institution uses an across-the-board markup and passes price increases through to patients, input-price index movement will equal that of the unobtainable output-price index.

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