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HEALTH ACTIVITIES: FEDERAL EXPENDITURES AND PUBLIC PURPOSE

ANALYSIS

SUBMITTED BY THE

SUBCOMMITTEE ON EXECUTIVE REORGANIZATION AND GOVERNMENT RESEARCH

(PURSUANT TO S. RES. 320, 91ST CONGRESS)

TO THE

COMMITTEE ON GOVERNMENT OPERATIONS

UNITED STATES SENATE

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INTRODUCTORY STATEMENT

(By Senator Abraham Ribicoff, Chairman, Subcommittee on Executive Reorganization and Government Research)

Although the Federal Government has a $20.6 billion health budget for fiscal 1971, only 20 percent of that money—$4 billion—will be spent on programs whose basic purpose is to improve and maintain the health of the general population.

This is the sum total of the Federal money that will be spent to improve the delivery of health services, develop new knowledge, and provide more manpower and facilities.

The bulk of the Federal health budget will be used for such purposes as income supplements (medicare and medicaid), medical care for special Federal beneficiaries (veterans, merchant seamen, Indians), and to support objectives other than health (AEC and NASA research and the health needs of military personnel).

These are the basic conclusions of an analysis of Federal health spending and activities prepared for the Subcommittee on Executive Reorganization and Government Research by Dr. James A. Shannon, former Director of the National Institutes of Health and currently professor and special assistant to the president of Rockefeller University in New York City.

Dr. Shannon's analysis is an outgrowth of written comments he submitted to the subcommittee last year regarding the programs of the 24 Federal agencies involved in health spending. At that time, Dr. Shannon criticized both the Federal agencies and the Bureau of the Budget for failing to present a satisfactory analysis of health spending in the fiscal 1970 budget. In particular, he stressed the absence of any aggregate "Federal health dollar" that had "real relationship to the civilian health needs of the Nation." As a result, Dr. Shannon said, the Nation lacked a "clear understanding" of the Federal commitment to health, and the Congress was "not presented with an intellectually honest analysis of Federal funds that will be expended for the health maintenance of the population."

The Shannon analysis, originally based on the health proposals of the last administration as contained in the fiscal 1970 budget, was updated when the current administration presented its budget for fiscal 1971. "Unfortunately few changes were required to adapt this text to the 1971 proposals," Dr. Shannon said.

This is a controversial analysis. But it is controversial because Dr. Shannon was precise and rigorous, not casual and careless. For example, many surely will question his decision to regard medicare and medicaid as programs whose basic purpose is not to improve and maintain the health of the general population. These two programs account for $11.6 billion—half the Federal health budget.

But Dr. Shannon is explicit:

"* * * in the longer view, Federal resources should be used to influence the operation of systems that are essential for the ultimate satisfaction of the health needs of all the people. Within this view, the Federal Establishment has identified research, education, and the provision of facilities as primary responsibilities, to be shared in varying degrees with the non-Federal sectors."

He notes that medicare and medicaid have made more medical services available to the aged and the poor. But he points out that:

"The conditions under which these services are made available do not, however, contribute to the improvement of the systems utilized. They have not had a noticeable impact on problems of maldistribution of resources and services. To the contrary, the regulations governing the operations of medicare and medicaid and some associated programs have in many ways made these programs counterproductive to the development of more effective and more economical medical services."

On a long-range basis, however, Dr. Shannon has raised questions that go far beyond the issue of health. His analysis of the data in Special Analysis K (health) of the Budget of the United States raises fundamental questions about the reliability of the Federal budget, regardless of which party occupies the White House.

In Dr. Shannon's judgment, the Bureau of the Budget's Special Analysis is essentially a "political" document, which he flatly labels as "misleading" and tending to "obscure rather than clarify the Federal commitment to health and the distribution of effort on behalf of the Nation as a whole."

According to Dr. Shannon, the budget document assembles all the proposed Federal health outlays without regard to the special purposes "for which the activity is undertaken," or the source of funds "to be utilized in their support." As a result, he says, the summary gives the "spurious sense" that the administration is presenting a coherent program proposal. Dr. Shannon thought this "a conclusion somewhat remote from the fact."

In this context, Dr. Shannon's conclusion about the Special Analysis should be noted:

"But one should view the appropriation process as a political action and the Special Analysis as a political document. In reality this is the case. The Analysis emphasizes the substantial cost of Federal health activities but does not clearly outline the general policies that have served as guides for the allocation of Federal resources. It indicates that precedence will be given to health services programs, and that increases in other high priority Federal programs will be provided. But since few general goals are established and the major health deficiencies are not defined, it is difficult to judge the reasonableness of the budget proposals of the adequacy of the devices among the available options."

Few documents are as impenetrable as the Budget of the United States Government. The result of Dr. Shannon's skillful analysis is twofold: First, to make clear our great need to learn what our Federal dollars are buying in health and what they should be buying, and second, to make us aware of the greater need to subject all the Bureau of the Budget data to rigorous and critical analysis.

HEALTH ACTIVITIES:

Federal Expenditures and Public Purpose

(By James A. Shannon, M.D.)

Preface

Health is now a socially sensitive area and the subject of quite heated public discussion. Emphasis has been given to the problems relating to a continuing and rapid rise in the cost of health services and the less than optimal arrangements for their delivery. More recently, concern has also been expressed for the serious consequences of constraints on the support of biomedical research and of education and training in the health professions. The stress within the health services system has led many to predict that, short of decisive action, the system is in danger of catastrophic breakdown. Evidence of such a breakdown is already apparent.

Our Federal programs could have significant salutary effects on the quality, cost, and distribution of health services. Yet, our current national policies and priorities are not providing adequate corrections of current deficiencies and are not contributing sufficiently to foreseeable improvements. It is urgent that the Federal involvement in health be reexamined. This need is, of course, a corollary to the similarly urgent need to reexamine the policies and priorities for the allocation of Federal funds in general.

The presentation examines some of the more important aspects of Federal health action. It is limited to generally available information about program plans and should be viewed only as one of a variety of analyses which should be undertaken. Broad deficiencies in the health care system and its scientific and educational base are noted. The proposed Federal outlays for health are then examined in the light of their contributions toward overcoming these deficiencies. Note is taken of areas where the constraints on Federal support pose serious barriers to the achievement of imperative program objectives.

The budget figures, upon which the analysis is based, are relatively rough approximations, as is the technique for categorizing the primary purposes of the outlays by activity. Nevertheless, these approximations are sufficiently precise to satisfy the general purposes of the study.

This analysis uses a fairly narrow view of health and health activities. Included are only those programs that have primary objectives. Thus, many Federal activities, with major objectives of a nonhealth nature, but with profound influence on health, have been excluded from consideration; for example, Federal activities directed toward an improvement in the physical and social environment, such as sanitation, housing, nutrition, and education programs. These activities warrant consideration for their own broad import to contemporary society and not for their "spin-off" benefits to health.

The study of the Federal health programs was originally based on the 1970 health activities proposals of the outgoing administration.[1] Unfortunately a few changes were required to adapt this text to the 1971 proposals. The important differences between the 1970 and 1971 budget proposals are identified and briefly discussed.

I. General Problems

The Federal Government is extensively involved in health through its programs in biomedical research, manpower production, the provision of facilities, and the delivery of services. The degree of Federal involvement varies, with each Federal agency undertaking such activities as are essential for the accomplishment of its mission. In a crude sense, the Federal program in health is the simple sum of all Federal agency activity. But only the Department of Health, Education, and Welfare has a mission which is specifically concerned with the general health of the Nation. It is significant that, on the whole, the systems for the actual delivery of health services to the general population are privately based, although their underpinning—by research, education, and the provision of facilities—is a mixed responsibility of Federal, State, and local governments, as well as the private sector.

Federal action, to be effective in such a complex situation, must be concentrated in areas perceived to be of special Federal responsibility. It is obvious that Federal action of an urgent nature must be directed toward the remedy of unbearable defects of national consequence. But, in the longer view, Federal resources should be used to influence the operation of systems which are essential for the ultimate satisfaction of the health heeds of all the people. Within this view, the Federal Establishment has identified research, education, and the provision of facilities as primary responsibilities, to be shared in varying degrees with the non-Federal sectors. Through mechanisms associated with income maintenance, the Federal Government has also accepted a primary role in cooperative arrangements which will secure health services for the aged, the economically disadvantaged and other special target groups, and it has committed itself to utilize its resources to obtain more equal distribution of services and to stem the rising cost of health care. Not the least of the problems of Federal involvement in the Nation's health are those derived from a combination of the complexity and breadth of the Federal programs and the fact that most individual activities require in their performance cooperative arrangements with the non-Federal sectors.

An excellent point of entry into an examination of the contributions of Federal activities to the maintenance of health is a simple statement of some of the readily perceived problems in the health area. These may be viewed as clusters around three broad functions:

The delivery of health services;
The development of new knowledge; and
The provision of resources.

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[1] The earlier analysis served as the basis for a public lecture and several seminars during November 1969, during tenure as a Regents Lecturer, University of California, San Francisco.

Delivery of health care [2]

Any statement of problems in the health services delivery systems must encompass the generally accepted, though somewhat ambiguous national commitment to provide competent health services to all, regardless of socioeconomic status. Viewed in this light, problems are apparent in the rapid and continuing rise in the cost of the services; the poor distribution of services, particularly to the urban and rural poor, and in emergency situations; the less than optimal quality of the services available to the general population; and the increasingly difficult access to services for most people. All these are accompanied by the sense of an impending catastrophic breakdown of an obviously overloaded system.

Development of new knowledge

Biomedical research and its associated science training should be viewed from the standpoint of the substance of the particular problems being investigated and from their likely contributions to the body of needed knowledge. An adequately sized and well-proportioned program of fundamental, applied, and developmental research is essential if the solution of many important health problems is to be achieved in the middle-range future. A more definitive management of health maintenance and its interruptions by episodic disease awaits such knowledge. The opportunities for such advance in knowledge are clearly apparent.

Importantly, it is also from these science based programs that faculty for any substantial expansion of the health professions educational system must be derived. But, the science base for medicine in the United States and its associated educational programs, are now undergoing progressive erosion at an alarming rate, largely from constraints on Federal support and rapidly rising costs.

The 1971 proposals involve a continuing decrease in Federal dollars available for the support of biomedical research in many highly productive and important areas. This decrease, in conjunction with the relentless increase in the price-wage structure, results in sharp cutbacks in the substance of research. Selective at first, these cutbacks are becoming more general. Concrete examples of this curtailment are clearly evident in the Federal support programs of the National Institutes of Health. (See sec. VI.)

In consequence, it is certain that a number of critically important scientific opportunities will not be pursued with vigor. These are particularly apparent in fundamental virology, in broad fields of immunology, in the disabling diseases of the central nervous system, in the behavioral and developmental sciences, in pharmacology and toxicology, and in bioengineering and engineering development. And, there are other opportunities of equal promise. Unfortunately, funds from non-Federal sources to support extensions of knowledge in these areas will probably not be forthcoming.

Provision of health resources

Adequate health resources are not available for the effective operation of many essential programs. Deficiencies are apparent in both manpower and physical facilities.

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[2] This term is roughly equated with personal health services. It includes some activities of a public health nature that may have direct impact on individuals and families, such as well-baby programs and maternal and child health programs, but it does not include public activities and services which have the environment as the primary target.

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Manpower.—Manpower deficiencies are evident in almost all categories of health personnel. These shortages are most easily perceived in the service area where they directly contribute to the increasing costs of health services, the less-than-adequate quality of many services, and their inequitable distribution. Equally important but less evident on a day-to-day basis is the shortage of faculty required for any significant expansion in manpower production.

The educational institutions [3] responsible for physician production are characterized by a high degree of financial instability due to continuing deficiencies in the direct funding of education. They cannot respond adequately to the complicated set of demands imposed upon them. These include, in addition to a need for an increase in physician production, participation in the redesign of health service systems and contributions to the solutions of health problems in their own communities. No short- or middle-range answers to these deficiencies are evident in the present programs.

The educational institutions that produce other health personnel are in comparable difficulty. Though these institutions receive support from Federal, State, and local levels, the financial base for their operation is inadequate. Further, they now consist of such a diverse and fragmented series of subsystems of education as to defy any simple modification that can be expected to produce a striking increase in the production of health manpower in the near future.

Finally, the cost of education for each of the health professions and occupations is increasing at a far more rapid rate than student subsidies. This, in conjunction with a generally inflated economy, decreases the ability of prospective students to finance their own education or training.

Facilities.—Physical facilities for most health activities are also in short supply. Modern service facilities are particularly lacking in areas that are most generally deficient in health services, that is, the inner city and rural areas. Adequate funds have not been available for meaningful renovation, for hospital replacement or for new hospital and clinic construction. Shortages are particularly apparent in the types of facilities that would be most effective in providing readily available comprehensive health maintenance and for organized long-term minimal care. Substantial progress is being made in satisfying the needs of only one special target group, the mentally ill.

Physical facilities are equally deficient in the educational, training, and research areas. These deficiencies are deterrents to the most effective use of program dollars and to program expansion and/or program modification. They pose barriers both to a rapid expansion in the number of personnel for the well-established health professions and occupations, as well as to the necessary and radical modification of the types of health professionals produced. At the same time, the shortage of resources hampers the development of new knowledge needed for the more effective management of disease and the maintenance of health.

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[3] This term is utilized in a broad sense to include schools of medicine and osteopathy and their associated educational and hospital facilities. The problems of dental schools are equally acute.

It is important to appreciate that these facility shortages are not recent in origin. During the past decade, official agencies and advisory commissions have repeatedly warned of their existence.

Program needs

Deficiencies are evident in the systems involved in the delivery of health services, in the development of new knowledge, and in the resources available for effective programs in each of these areas.

The essential interactive nature of these systems precludes the possibility of a simple correction of one, in isolation from the others. Some of the present difficulties, now so clearly apparent, have resulted from the simplistic approach adopted in the past by the Federal Establishment. The consequent Federal involvement in health has been highly fragmented, without broad Federal policy formulation and even without an expression of firm Federal intent.

Perhaps the most urgent need in any rational approach to a resolution of these complex problems would be a tentative definition of the characteristics deemed to be desirable for the Nation's health programs by 1980. It would then be easier to formulate the types of activity that should be undertaken now to facilitate the ultimate development of health systems with such desirable characteristics. Actually, quantitative and qualitative modifications of ongoing programs and the development of new activities will be most effective only if the middle-range goals to be sought (5–10 years) are clearly defined and only if the remedies undertaken result from considerations somewhat of a systems nature. Meanwhile, critical deficiencies should be remedied in a fashion which does not remove or lessen the options for systems modification in the future.

It is fully appreciated that simple yet comprehensive systems approach to more effective health planning is probably not now possible. This follows, less because the health system is complex, than because the systems approach to planning is made difficult by the many important qualitative aspects of the health activities which must be considered. Nevertheless, it is essential for reasonable program planning that each of the major functions be considered within the context of a broad, albeit crudely designed, system. Furthermore, systems analysis and modeling would be useful and can be applied in the examination of some of the more important subsystems, for example, manpower production.

II. Federal Outlays for Medical and Health Related Activities

The basic data for the analysis which follows are taken from the Special Analysis K, Federal health programs, Budget of the United States, 1971. Table I (K–2) accumulates identifiable outlays for medical and health related activities in the 1971 budget proposals.[4] It is regrettable that the Special Analyses have not been based on the President's budget proposals for "new obligational authority," the figures most essential to program planning. Instead, the special analyses are

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[4] "Special Analyses, Budget of the United States, 1971," for the data on 1969, 1970, and 1971. (In the presence of irreconcilable arithmetic errors in table K–16, it was assumed that the individual items in the table were correct. The totals have been adjusted accordingly.) The data on 1968 actual outlays were derived from Special Analysis L, Budget of the United States, 1970.

concerned with estimates of "outlays" or the sum of "expenditures" and "net loan disbursements." The use of "outlays" may be considered valid, if the overriding basis for evaluation of these proposals is the fiscal implications of the budget rather than program possibilities.

In periods, such as we are experiencing today, where there are relatively severe restrictions on expenditures, the use of "outlay figures" tends to mask the extent of the stringent constraints which are being placed on the development of new programs and the expansion of existing ones. The subsequent discussion of specific Federal activities, particularly the health research programs, will make this concept more evident.

TABLE I.—FEDERAL OUTLAYS FOR MEDICAL AND HEALTH-RELATED ACTIVITIES BY CATEGORY [1]

[In millions of dollars]

	1968 actual	1969 actual	1970 estimate	1971 estimate
Development of health resources, total	2,803	3,111	3,498	3,640
Health research	1,547	1,528	1,622	1,660
Training and education	687	805	951	1,033
Construction of hospitals and health facilities	470	612	705	712
Improving the organization and delivery of health services	100	166	220	235
Provision of hospital and medical services, total	10,764	12,794	14,486	16,096
Direct Federal hospital and medical services	2,738	2,860	3,147	3,116
Hospital and medical services, indirect	8,025	9,934	11,339	12,980
Prevention and control of health problems, total	565	651	803	866
Disease prevention and control	386	411	489	504
Environmental control	54	86	134	163
Consumer protection	125	154	181	199
Total, outlays from Federal and trust funds	14,132	16,556	18,787	20,602

[1] 1969, 1970, and 1971 data were derived from table K–2, p. 148, "Special Analyses, Budget of the United States, Fiscal Year, 1971," 1968 actual obligations were derived from table L–1, p. 148, "Special Analyses, Budget of the United States, Fiscal Year, 1970."

The health outlays in Special Analysis K have been grouped in a deceptively simple table to reflect:

(1) The development of health resources;
(2) The provision of hospital and medical services; and
(3) The prevention and control of health problems.

Table II (K–16) groups these outlays by the Federal agency conducting the program.

Together these two tables have been utilized by the Bureau of the Budget to portray outlays which in the aggregate make up "the Federal outlays for medical and health related activities" or, in traditional Bureau of the Budget terminology, "the Federal health dollar." The text of analysis K implies that a balanced Federal health program is presented which largely reflects the growing health needs of the Nation, predominant among which is the more adequate financing of health service programs. This view is summarized on pages 147 and 148:

> The major factor in the yearly increase continues to be Medicare and Medicaid, both of which are included in "Provision of hospital and medical services." Outlays from these two programs account for $11.6 billion and 83% of the

total $1.8 billion increase over 1970. In 1965, only 19% of Federal outlays for health was directed towards financing personal health care for the general population. By 1967, this proportion has risen to 48%, and in 1971, total outlays for this purpose are expected to equal $13 billion, or 63% of all Federal expenditures for health.

The large and relatively uncontrollable increases in Medicare and Medicaid tend to obscure other important directions reflected in the 1971 budget proposed by the administration. Excluding these programs, Federal health outlays rise from $8,637 million in 1970 to an estimated $8,972 million in 1971. Highlights of these increases, discussed in the appropriate sections below, will:

	1971 increase (dollars in millions)
Increase the supply of trained health manpower, principally via programs in HEW, VA, Defense, and Labor	82
Increase the construction of facilities providing care to ambulatory patients, thereby offering less expensive, but medically appropriate alternatives to hospitalization, primarily through HEW programs	18
Increase the attack on air pollution and other environmental factors principally via HEW, Agriculture, DOT and Interior programs	52
Increase family planning services and research, domestically through OEO and HEW programs, and overseas through AID programs	93
Improve the efficiency of the Nation's organization and delivery of health services through HEW, VA and OEO programs	29
Increase services offered through special and comprehensive centers for mothers and children, the poor, and the mentally ill including narcotics and alcoholics, through programs in HEW and OEO	60
Increase HEW's biomedical research, particularly in cancer, heart and lung disease and tooth decay, to exploit recent breakthroughs in our knowledge	38

Because of the time lag, a significant part of the increase in program level for ambulatory care facilities and biomedical research provided in the 1971 budget will not be reflected in higher outlays until 1972.

The tabulations show the ubiquitous nature of health activities and the high absolute Federal outlays in recent years. Table K–16 (table II in this text) shows the predominance of Department of Health, Education, and Welfare in the health area. Other data are presented in Special Analysis K (table K–1) to show the rapid rise in Federal outlays for health since 1960.

These tabulations, though accurate, obscure rather than clarify the Federal commitment to the maintenance of the Nation's health. They imply substantially higher Federal expenditures for health purposes than actually obtain. Neither the summary tables nor the text portray in a clear and unambiguous manner or origin of the funds for these activities or the end purposes for which the expenditures are made. Nonetheless, the $20.6 billion total is given prominence in considering the allocation of resources in support of the various health programs, and the consideration of these by Congress. This figure becomes of overriding importance in the development and consideration of budgets of the DHEW and its dependent Public Health Service. It is this figure which is commonly used to portray the cost of Federal health activities as being so high as to be exceeded in magnitude only by national defense outlays.

The analysis which follows makes use of the data contained in table K–16 (table II in this text), but displays as best as is possible the primary purposes for which each of the major outlays is made. Since

program information is not available in sufficient detail to make precise estimates, the allocations should be considered to be informed judgments but nonetheless close approximations of the actual programs planned.

In this view, any given Federal outlay may be considered to achieve one or more of the following four primary purposes:

The support of major Federal objectives other than health;

The satisfaction of obligations to special Federal beneficiary groups;

The supplementation of income; and

The improvement in the organization and delivery of health service to the general population.

Of the $20.6 billion which the Special Analysis K called Federal health activities, $2.2 billion was in fact directed to the support of major Federal objectives other than health; $2.1 billion intended to benefit special Federal beneficiaries; $12.3 billion, as income supplements; and only $4 billion can realistically be considered as Federal outlays primarily directed to the more general health needs of the Nation.

In the following presentation, individual programs will not be examined for excellence or even pertinence to the purposes they are devised to satisfy. But note will be taken of some of the more obvious deficiencies in major programs. Briefly, in criticism:

Except for fiscal management by the Bureau of the Budget, there is no central focus within the Federal structure where policy can be formulated, based on a proper mix of substantive and fiscal considerations, and where explicit health goals can be formulated.

In the absence of clear Federal health goals,[5] it is impossible to forecast major program development within a context of time-related cost estimates. Also, there can be no central guidance for the evolution of programs which are the common responsibility of several executive agencies.

No attempt is made in Special Analysis K to define the interaction of the Federal outlays with State, local, and private health expenditures, and to examine the extent to which the broad public purpose of adequate health services to all is indeed being accomplished.

Little attempt is made to relate the level of proposed Federal outlays to the total national cost of medical- and health-related activities (well over $60 billion) and no attempt is made to demonstrate how the proposed Federal outlays are particularly designed to improve the effectiveness of the major segments of health activities "purchased" by this large sum.

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[5] There are several program areas with quite explicit goals but these are exceptions. Examples of programs with such goals are found as elements of broader program areas, such as the development of a network of decentralized centers for the care of the mentally ill, an activity of the National Institute of Mental Health; and the provision of family planning services to the economically disadvantaged, a combined activity of programs of the Social and Rehabilitation Service, the Office of Economic Opportunity, and the partnership for health program of the Health Services and Mental Health Administration.

TABLE II.—FEDERAL OUTLAYS FOR MEDICAL AND HEALTH-RELATED ACTIVITIES BY AGENCY, 1971

[In millions of dollars]

	Health research	Training and education	Construction	Organization and delivery	Direct Federal hospital and medical services	Indirect Federal hospital and medical services	Prevention and control of health problems	Total
Health, Education, and Welfare Department	1,193.1	755.9	357.1	173.1	140.1	12,135.9	464.8	15,220.1
Health Services and Mental Health Administration	135.9	170.8	334.0	154.9	139.7	317.7	292.7	1,515.7
National Institute of Health	929.3	554.2	3.7	18.2			8.0	1,513.4
Consumer Protection and Environmental Health Service	97.3	13.4					143.1	253.8
Social Security Administration						8,774.4		8,774.4
Social and Rehabilitation Services	30.5	9.8	9.3		.4	3,034.3	20.9	3,105.3
Other		7.7	10.1			9.5		27.4
Defense Department	84.2	128.7	62.2		1,463.7	238.0	20.7	1,997.6
Veterans' Administration	63.0	99.4	54.2	25.6	1,473.5	88.1		1,803.8
Housing and Urban Development Department			178.7	2.6				181.3
Agriculture Department	44.4						175.0	219.4
Agency for International Development	9.6	6.7	6.8	22.1			110.2	155.4
Office of Economic Opportunity				12.0		165.9		177.9
National Aeronautics and Space Administration	111.8							111.8
Atomic Energy Commission	94.2	.4						94.6
Civil Service Commission						46.5		46.5
Labor Department	.3	31.5			1.7	21.0	3.6	58.1
State Department		2.8			.2	.3	28.1	31.4
National Science Foundation	25.8	3.0						28.8
Commerce Department	3.9		3.7					7.6
Other agencies	29.8	4.2	48.8		36.5	7.6	64.5	191.4
Agency contributions to employee health funds						256.9		256.9
Total outlays for health, 1971	1,660.0	1,032.8	711.6	235.5	3,115.7	12,960.2	866.9	20,582.2

Note: Tabulated data derived from table K–16, p. 171, Special Analyses, Budget of the United States, fiscal year 1971.

III. The Support of Objectives Other Than Health

Table III contains a summary of the Federal outlays for health activities which are clearly performed in direct support of another and more primary Federal objective. These amount to $2,159 million and cover expenditures for health activities contained in seven agencies. Three agencies have programs in excess of $100 million each; but the contribution of these activities to the health of the Nation is minimal.

The rationale of this categorization of Federal expenditures can be clarified by a brief comment on the activities of the dominant agency involved, the Department of Defense, whose expenditures listed in this category total $1,805 million.

The expenditure level for health activities by DOD is set by strategic and tactical considerations that relate to the physical defense of the Nation. These in turn determine the size of our Military Establishment, the deployment and activities of military forces and consequently the size and kind of support services that are required for their effective maintenance.

The health expenditures also reflect the military pay system and perquisites of the Armed Forces. This system provides a base pay, supplemented by quarters and subsistence allowances and a number of important fringe benefits. Among the latter are noncontributory retirement benefits and health care both to Armed Forces personnel and their immediate dependents. As much as 10 percent of the direct cost of operating DOD hospital installations in noncombat zones and much of the $238 million listed under indirect Federal hospital and medical services is attributable to medical care of dependents.

Rather than consider these expenditures as part of the "Federal health dollar" as in the Special Analysis, it would be more reasonable to charge the total cost of these activities to the logistical support required to satisfy the special needs of the military. This is an example of how an accurate allocation of Federal outlays by Special Analysis K of the Bureau of the Budget nonetheless misleads rather than clarifies the Federal commitment to health.

It should be noted that there are other substantial health expenditures by DOD (totaling $191.5 million), including half of the research outlays ($42.1 million), training and education ($128.7 million), and disease control ($20.7 million) that have been allocated to the category of primary health activities and not to this category of primary objectives other than health. Even though the cost of these programs are budgeted to satisfy the internal need of the military, some health benefit will accrue to the civil population. The assignment of those outlays to the more general health account reflects their potential for such a contribution rather than their current status. At the present time each program has been developed to satisfy a specific need for the Armed Forces. The ability of these programs to have more pertinence to the solution of the Nation's health problems would be substantially increased if they were developed in conjunction with comparable programs in the civilian sector. Were this done, it is likely that the satisfaction of the military needs would not suffer.

The magnitude of other outlays in this category are similarly dependent upon considerations other than those which relate to any general Federal health policy. For example:

The expenditures for the Agency for International Development and the Department of State depend on our public view of our na-

tional responsibility for and to other nations. Health activities, amounting to $186.8 million, are among a number of activities supported in the discharge of our concept of this responsibility.

The expenditures for health research by the National Aeronautics and Space Administration must also be considered to be support of activities related to goals other than the improvement of health. These expenditures by NASA are but a part of its total expenditures for research and development. The size of the NASA program in health is largely determined by the extent to which manned space flights are undertaken and NASA continues its biological explorations into exotic fields. Such activities are surely defensible in themselves but hardly relate to the more general problems of the health of the Nation. The NASA programs in health amount to $111.8 million.

In a somewhat similar fashion, the expenditures of the Atomic Energy Commission relate to the problems that must be solved in the exploitation of nuclear energy. Among these is the need to understand the hazards of ionizing radiation. The basic Atomic Energy Act and its subsequent modification also provide a base for support of research in biology and medicine. Effective work goes on at the Oak Ridge, Brookhaven National Laboratories, and at the Argonne Cancer Hospital. The categorization of these expenditures as related to objectives other than health is justified by the fact that much of the activity is not really in the health field; and that which is, is not given priority because of general health considerations. The distribution of effort and the level of program support is determined by the Bureau of the Budget only in relation to the primary missions of the agency, independently of the need for new knowledge for ultimate application in the health field. It has been assumed that as much as half of the $94.2 million the AEC budget for fundamental and applied developmental aspects of biomedical research could be classified as having general health implications. The information generally available does not permit a more detailed determination.

Implications for health

The series of health activities discussed in this section subserve essential Federal functions—but, in any general sense, they have little relation to the general commitment of the Federal Establishment to health. Consequently, little purpose is served by considering them a part of a total, designated to be the "Federal health dollar," since these activities generally bear little relation to budgets formulated to satisfy the broad health needs of the Nation. On the contrary, their size, scope, and substantive content are determined by the specific needs of these mission-oriented agencies, and the activities are generally extraneous to major problems of the health of the Nation.

Some may hold that the more general health areas benefit by the conduct of such activities and this is true in a limited sense. However, most of the benefits to be derived must be viewed as minor spinoffs of activities conducted for other purposes. The anticipation of undetermined spinoffs is hardly a serious consideration in determining the size of a budget developed to satisfy other Federal goals.

Contrary to the comment of the Special Analysis on the research programs of DOD and AEC, there are a number of cases where activities serve multiple purposes. But, information is not generally available to permit assigning with any precision portions on an activity to more than one category of objectives. It is not likely, however, that the description of the general distribution of dollars by fundamental purposes would be significantly changed, were such splits possible.

TABLE III.—FEDERAL OUTLAYS TO SUPPORT OBJECTIVES OTHER THAN HEALTH, 1971

[In millions of dollars]

	Health research	Training and education	Construction	Organization and delivery	Direct Federal hospital and medical services	Indirect Federal hospital and medical services	Prevention and control of health problems	Total
Health, Education, and Welfare Department								
Health Services and Mental Health Administration								
National Institute of Health								
Consumer Protection and Environmental Health Service								
Social Security Administration								
Social and Rehabilitation Services								
Other								
Defense Department	42.1		62.2		1,463.7	238.0		1,805.0
Veterans' Administration								
Housing and Urban Development Department								
Agriculture Department								
Agency for International Development		6.7	6.8				110.2	123.7
Office of Economic Opportunity								
National Aeronautics and Space Administration	111.8							111.8
Atomic Energy Commission	47.1	.4						47.5
Civil Service Commission								
Labor Department		31.5					3.6	35.1
State Department		2.8			.2	.3	28.1	31.4
National Science Foundation								
Commerce Department			3.7					3.7
Other agencies								
Agency contributions to employee health funds								
Total outlays for health, 1971	201.0	41.4	72.7		1,463.9	238.3	141.9	2,159.2

Note: Tabulated data derived from table K–16, p. 171, Special Analyses, Budget of the United States, fiscal year 1971.

IV. Services to Special Federal Beneficiary Groups

A second category of outlays, summarized in table IV, includes the activities undertaken to satisfy obligations, which the Federal Establishment has assumed, for the health of special beneficiary groups. The predominant expenditures support programs for the delivery of health services to veterans, merchant seamen, and American Indians, in the hospital programs of the Veterans' Administration and the Public Health Service. The budgets for these two hospital systems are generally developed independently. Aside from the fact that their intent is to cover health benefits for a defined fraction of the population, the basic activities of the two systems contribute little to the general health of the Nation.

Veterans.—An anomalous situation has developed in relation to each of these hospital systems and the beneficiaries they serve. The modern VA hospital system is a post-World War II development. The system was modified in the late forties to provide high quality medical care for the large number of veterans with service-connected disabilities, emerging from the Second World War. This load has decreased with time and the purposes of the system have changed, partly due to the changing patient load and partly due to changes in operating policy and the authorizations under which the system operates. The influence on the system of the influx of new candidates for admission as the result of Vietnam is not yet clear.

As veterans requiring hospitalization for service-connected disabilities decreased during the fifties and early to mid-sixties, an increasing proportion of patients have been admitted for non-service-connected disability. It has been estimated that currently about 75 percent of the patients in VA hospitals are hospitalized for non-service-connected disability. It is also estimated that about 8 percent of all veterans are beyond the age of 65 and most of these are eligible for medicare.[6] These should increase strikingly in the late seventies.

However, the VA system has become increasingly involved in the support of research, in the education of medical students in association with their affiliated medical schools, the training of medical specialists, the provision of specialized technical and clinical services to adjacent communities, and the training of an array of health personnel. These activities are not simply responsive to the internal needs of the system, but relate also to needs of the Nation as a whole. It was not possible, within the limited data available, to distinguish those activities that have primary relevance to the care of veterans (regardless of the case of disability) and the internal operations of the hospitals, from those with primary relevance to the improvement in the organization and delivery of health services. To maintain the most conservative interpretation of the data, the outlay for VA activities for health research, for training and for the organization and delivery of health services, the amount of $188 million has been allocated to activities considered as primarily satisfying national health objectives (table VI).

Other major expenditures in this category are by the hospitals of the Public Health Service. These programs have as their primary purposes the provision of health services to the American Indian, native Alaskans, merchant seamen, the Coast Guard, and to PHS officer personnel and their dependents. This hospital system was estab-

[6] The annual report of the Veterans' Administration, 1968, indicates that 2,093,000 of the 26,273,000 veterans are over 65. Furthermore, of the 99,978 patients in Veterans hospitals in November 1967, only 25,865 were treated for service-connected disabilities.

lished in the latter part of the 18th century to provide medical care for merchant seamen who had no firm base for medical services. It is the original element of what is now a complex health agency, the Public Health Service. Some of the resources of the system have been reduced in recent years to parallel the general reduction in U.S.-flag shipping. This reduction has been so severe that the hospital system can no longer satisfy the medical needs of merchant seamen, the primary purpose for its creation. Since health benefits have generally become a part of the fringe benefits negotiated in most industrial wage settlements, it may be argued that this special service for merchant seamen is no longer a reasonable charge to the Federal Government. The legislative base of the system could be suitably modified.

But, as in the VA experience, as the need for the primary functions lessened, new responsibilities have been added to the PHS hospital system. The major new programs are those that provide health services to the Indians and to Alaskan natives, the treatment of leprosy at Carville, the mentally ill at St. Elizabeths Hospital, and the care of narcotic victims. Also, as in the case of the VA hospitals, the PHS hospitals have developed programs of biomedical research, education, and medical training in association with affiliated university medical centers and the National Institutes of Health.

For the purposes of this analysis, the secondary activities related to research, to education, or to service have been categorized as part of the system of programs intended primarily to improve the health of the American people.

Federal hospital systems

This category of health expenditures for special Federal beneficiaries does provide for a meaningful impact on the general health of the Nation; less because of the primary purposes for which the hospital systems were established than because of the new activities that have been added. The extent of their overall contributions to general health cannot be easily calculated, but it must be substantial.

While there may well be a continuing need for a Federal hospital system external to the military, there are more suitable means to satisfy the Federal responsibilities to some of the special beneficiary groups. It is likely that the pressure for the continuation of both of these Federal hospital systems is more from political than from professional considerations. But, neither political nor professional consideration are sufficient to justify two Federal hospital systems with such a common set of purposes. It may equally be argued that the cost of caring for these special population groups are not a justifiable charge against the "Federal health dollar," whose primary purpose should be to improve and maintain the health of the entire Nation.

If it is assumed, as is realistic, that at least the VA hospital system will be continued indefinitely, and that its resources can be used to better significantly the health of the Nation, then it would only be prudent to develop the VA resources within a broader frame of reference. As a minimum, the major functions of research, manpower production, and service would benefit greatly were they reviewed in the context of their contributions to general health improvements, rather than within the context of an isolated agency.

It is important, however, that until general decisions are made to modify the purposes of these two hospital systems, their quality of services should not be reduced by short-term budgeting constraints, seeking to resolve, through attrition, some of these fundamental problems.

TABLE IV.—FEDERAL OUTLAYS TO BENEFIT SPECIAL FEDERAL DEPENDENT GROUPS, 1971

[In millions of dollars]

	Health research	Training and education	Construction	Organization and delivery	Direct Federal hospital and medical services	Indirect Federal hospital and medical services	Prevention and control of health problems	Total
Health, Education, and Welfare Department					139.7	327.2		466.9
Health Services and Mental Health Administration					139.7	317.7		457.4
National Institute of Health								
Consumer Protection and Environmental Health Service								
Social Security Administration								
Social and Rehabilitation Services								
Other						9.5		9.5
Defense Department								
Veterans' Administration					54.2	1,473.5	88.1	1,615.8
Housing and Urban Development Department								
Agriculture Department								
Agency for International Development								
Office of Economic Opportunity								
National Aeronautics and Space Administration								
Atomic Energy Commission								
Civil Service Commission								
Labor Department					1.7	21.0		22.7
State Department								
National Science Foundation								
Commerce Department								
Other agencies								
Agency contributions to employee health funds								
Total outlays for health, 1971					54.2	1,614.9	436.3	2,105.4

Note: Tabulated data derived from table K–16, p. 171, Special Analyses, Budget of the United States, fiscal year 1971.

V. Supplementation of Income

The third category of outlays, summarized in table V, includes the activities whose primary purpose is to supplement income. These amount to $12,278 million, or 60 percent of all Federal outlays for health and medically related activities. Four major activities are supported, three of which pose no problems as to purpose. These are:

The medicare programs of the Social Security Administration;

The medicaid and other health related programs of the Social and Rehabilitation Service;

Agency contributions for health benefits for Federal employees.

The fourth is:

The Community Health Centers program and related activities of the Office of Economic Opportunity.

These programs can be viewed in either of two ways:

As simple outlays by the Federal Establishment to pay for essential medical care services for the aged and the poor, or

As several sets of services or payment for services which are made available to supplement the income of the economically disadvantaged.

The latter of the two alternatives has been selected as the more meaningful way to view the fundamental purposes served by the Federal involvement in these activities.

Medicare and medicaid

The medicare program is a very special case when viewed in this manner. Importantly, and not made clear in Special Analysis K, payments for medicare benefits are derived primarily from the trust funds of the Social Security Administration. This fund is managed by the Social Security Administration for the benefit of individuals 65 or over whose income is partially protected by the general provisions of Social Security. The program, when ultimately in balance, is designed to be actuarially sound. Its philosophy is to shift the cost of medical services from the aged and their families, to society as a whole—through direct levy on employers and employees subject to social security taxes. It should be clear that this is not a Federal benefit in the ordinary sense. It should be equally clear that it is not a Federal expenditure and should not be part of a "Federal health dollar." Importantly, the costs of the medicare program is the largest single item contained in the Federal outlays cited in table II, and amounts to more than 70 percent of the costs of programs summarized in table V as income supplements.

The medicaid and related programs should be grouped for fiscal consideration with other public assistance programs of income maintenance. The neighborhood community health centers and the related programs of the Office of Economic Opportunity will be included here but require further discussion. These and other services [7]

[7] These programs cover a variety of services such as maternal and child welfare and family planning.

are made available to the economically disadvantaged to supplement the cash payments received by this segment of the population from a combination of Federal, State, and local sources. Conceptually such services or funds for the purchase of services in the health area are comparable in nature to other supplements to cash benefits such as those contained in the food stamp program, the distribution of surplus foods, day care programs, and others.

The broad philosophy which underpins the operations of this set of Federal health programs is an expression of two generally accepted judgments. The first holds that some individuals and/or family units are financially unable or insufficiently provident to accumulate the financial resources required to provide adequately for their health needs. The second holds that, given less than an adequate income, a suitable proportion of the income available cannot be set aside for personal and family health needs. In consequence, one major program has been developed to pay the cost of hospitalization and health services of a substantial segment of the population over age 65. These are the self-sustaining medicare programs. Another set has been established to satisfy the health care needs of individuals and families within the poverty sector, the working poor, and ultimately, the medically indigent. The services, purchased or provided by these programs (medicaid, OEO health programs, et cetera), supplement incomes otherwise inadequate to obtain the necessary care for health maintenance and the management of episodic disease.

There is no disagreement with the social judgments upon which these programs are based but, pertinent to this discussion, neither should there be any disagreement on the fundamental purposes for which the outlays are made. Were other devices available to satisfy the need, such as secured minimal incomes adequate for participation in some form of universal health insurance, then bookkeeping conventions would attribute these costs to other purposes.

The immediate use of medicare and medicaid funds is to purchase health services and the two programs are achieving at least a portion of their primary objective. More medical services are being made available to the poor and to the aged.

The conditions under which these services are made available do not, however, contribute to the improvement of the systems utilized. They have not had a noticeable impact on the problems of maldistribution of resources and services. To the contrary, the regulations governing the operations of medicare and medicaid and some associated programs have in many ways made these programs counterproductive to the development of more effective and more economical medical services.

The programs now provide no incentives for excellence in the services delivered or for economies in the health service system. Nor do they provide an incentive to the development of a more equable distribution of the services to the population at large. Quite the contrary,

and apart from the operational regulations, the overloading of the health care system with no parallel provision for adequate expansion, has contributed to the present shortages in health personnel and health service facilities. Such a circumstance tends to entrench more firmly the operational conventions of existing inadequate systems for health care. In the absence of health resources of an accessible nature, as is provided through the neighborhood centers programs, the simple provision of funds to purchase medical services is of lesser utility to the population served than is desirable.

The third set of programs summarized in table V are those that provide for employee health benefits within the Federal employment system. Such benefits are a normal part of the fringe benefits of Federal employment, and parallel employee benefits in private industry. These include such prerequisites as participatory life insurance and retirement. These are normal operating cost of departments and agencies and hardly qualify for inclusion in any separate listing of "health and medically related activities."

Neighborhood health centers

The fourth set of programs summarized in table V are those operated by the Office of Economic Opportunity and include the neighborhood comprehensive health centers program. They warrant additional comment. These programs are paralleled by somewhat comparable activities funded under the Children's Bureau of the Social and Rehabilitation Service and the Health Services and Mental Health Administration. Each of these programs is aimed at a special target area as described in the Special Analysis K, page 166, as follows:

> While each agency supporting health centers (OEO, Maternal and Child Health Service, NIMH and Partnership for Health) must meet certain specific objectives contained in their authorizing legislation, all are concerned with bringing into low-income areas health resources—clinics, physicians and health workers—that are either nonexistent, in short supply or not readily accessible.
>
> In addition to creating health care resources, the centers seek a comprehensive and personal approach to the delivery of medical care, the utilization of scarce resources in more effective and efficient ways, and the application of modern health technology. Many sponsor training and employment programs for residents of the communities served by the health centers and encourage participation of the poor in the planning and operation of the centers.

The Children's Bureau centers, the community mental health centers and all centers other than those of OEO have not been categorized in this report as primarily being intended as supplementation of income, but have been considered as geared toward improving the health of the general population. The distinction has been a difficult one to make, since there are multiple objectives to a'l these programs. While the programs, other than OEO, also emphasize the provision of health services to low income groups, they tend to serve a wider economic range of clients than do the OEO programs. They also possess a larger element of central design and management and potentially involve meaningful and controlled innovative studies.

The 49 comprehensive neighborhood health centers of OEO vary markedly in setting, but each serves a well-defined poverty area. Most are located in the inner city, but increasingly some will be in rural settings.

The OEO neighborhood health centers satisfy an urgent need and, in a fashion, remedy an unbearable defect in the health care systems of the Nation. In general, the recipients cannot pay for the minimal health services required; the geographic area served is grossly deficient in both health care facilities and health care personnel; and the population is disadvantaged, with limited educational achievement, poor housing, and other social barriers to healthful living.

The OEO programs themselves depart from the usual publicly sponsored medical services to poverty groups, in that they provide the equivalent of well-run prepaid health maintenance on an easily accessible neighborhood basis. They also provide additional social services that make the medical services more effective and more acceptable to the population served. This may be a re'atively simple entrance point into a broader health care system which encompasses hospital back up as sophisticated as is needed by the individuals served.

But, however the directness of Federal intervention, however direct the services rendered, and however comprehensive these services may be, these programs must be considered both philosophically and practically to be supplements to an otherwise inadequate income.

It is possible, and indeed imperative, that more adequate central management and program design be developed so that the individual programs serve as elements of field studies examining the relative usefulness of a variety of novel health practices. OEO has organized a central office for the monitoring of the substantive content of these programs during the past year, but too little time has elapsed for this to have derived much useful and transferab'e operational information.

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TABLE V.—FEDERAL OUTLAYS TO SUPPLEMENT INCOME, 1971

[In millions of dollars]

	Health research	Training and education	Construction	Organization and delivery	Direct Federal hospital and medical services	Indirect Federal hospital and medical services	Prevention and control of health problems	Total
Health, Education, and Welfare Department						11,808.7		11,808.7
Health Services and Mental Health Administration								
National Institute of Health								
Consumer Protection and Environmental Health Service								
Social Security Administration						8,774.4		8,774.4
Social and Rehabilitation Services						3,034.3		3,034.3
Other								
Defense Department								
Veterans' Administration								
Housing and Urban Development Department								
Agriculture Department								
Agency for International Development								
Office of Economic Opportunity						165.9		165.9
National Aeronautics and Space Administration								
Atomic Energy Commission								
Civil Service Commission						46.5		46.5
Labor Department								
State Department								
National Science Foundation								
Commerce Department								
Other agencies								
Agency contributions to employee health funds						256.9		256.9
Total outlays for health, 1971						12,278.0		12,278.0

Note: Tabulated data derived from table K–16, p. 171, Special Analyses, Budget of the United States, fiscal year 1971.

VI. Maintenance and Improvement of the Nation's Health

The Federal outlays for programs whose primary purpose is to improve and maintain the health of the general population are summarized in table VI. They amount to approximately $4 million. Almost 75 percent of these activities are in the Department of Health, Education, and Welfare.

As noted in each of the other chapters, some difficulties were encountered in categorizing programs which served multiple objectives but about which detailed information was not available. Some of these errors are undoubtedly self-compensating. For example, many elements of the programs in this category, as with the OEO programs discussed in section V, provide service to the economically disadvantaged and do little to improve more general systems of health services.

The programs in this category are a complex collection of discrete activities, developed and operating without clearly stated general policy guidance, without explicit general goals, and without well-informed substantive control at a central administrative point. The consequences of the lack of appropriate central mechanisms is apparent when the individual activities are considered according to three broad functions: the development of new knowledge, the delivery of health services, and the provision of resources.

The development of new knowledge

Health research activities (col. 1), directed toward the development of new knowledge required for the more effective maintenance of health and the management of disease, are proposed for funding at the substantial level of $1.46 billion. In time, a productive program could provide answers to many of the major health problems of today. Constraints on Federal support of biomedical research are placing such achievements in jeopardy—contrary to the optimistic statements in the Special Analysis which say, in effect:

> **$38 million increases in Federal health outlays "will increase HEW's biomedical research, particularly in cancer, heart, and lung disease and tooth decay, to exploit recent breakthroughs in our knowledge."**

This presentation is not intended as a special plea for more generous funding for biomedical research, but the discrepancy between the quotation and reality requires some resolution if the present criticism of Special Analysis K is to have credibility.

The outlays for health research, as proposed in the 1971 President's budget, total $1,660 million, compared to $1,622 million for 1970, $1,528 million in 1969, and $1,547 million in 1968. The administration request is less than the $1,685 million which would be required to maintain the 1969 level of activity and substantially less than the $1,790 million to maintain the 1968 level, if an annual inflation rate of only 5 percent is assumed. It is more likely that large cutbacks in important ongoing research would be required since the unit operating costs of biomedical programs have increased annually by more than 5 percent.

Substantially increased costs are particularly apparent for research involving medical care, such as in the "clinical center" programs supported by NIH. The development of new program emphasis in a number of important areas, such as fertility control, viruses implicated as

the cause of cancer, dental cavities, and environmental health sciences, will be possible only through substantial cuts in other sound and important ongoing programs and the deferral of other equally important new programs. In this light, some of the statements in Special Analysis K may be viewed as less than perceptive and objective.[8]

Quite apart from the program level of research, its general administration leaves much to be desired. Health activities, for obvious reasons, are distributed ubiquitously throughout the programs of the Federal agencies. Within such a setting, the size and scope of an agency's research program is primarily determined by the mission of the agency. For some agencies, such as NASA, the biomedical research may be too limited in scope to be generally useful. For other agencies, such as DOD, AEC, and VA, research oriented to the mission of the agency may also contribute materially to the solution of more general health and medical problems. It is reasonable to suppose that, when substantial biomedical research is undertaken either for a specific mission or for a more general purpose, the program and purposes of that activity would be subject to central substantive review in determining a suitable level of support. Present arrangements do not permit either central management or central review of the biomedical research function.

Such central consideration of biomedical research programs was less essential during the period of broad expansion of biomedical research (i.e., 1955–65). During that period, very simple program development guides were quite adequate. The areas of ignorance were so great and the biomedical research activity so modest, in contrast to the social and

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[8] As noted earlier, Special Analysis K of the budget has been based on estimates of "outlays" rather than the "obligational authority" which the budget is presumably proposing. It is extremely difficult for a budget layman to determine the method by which these outlay estimates have been prepared. It is even more difficult to understand from the outlay figures, the implications for the proposals for new Federal obligations.

Familiarity with the NIH budget made it easier to cite it as an example of the differences exhibited by the use of outlays versus expenditures. There is substantial evidence that this example is illustrative of the Federal health research experience.

NIH RESEARCH INSTITUTES, OBLIGATIONS AND OUTLAYS, 1969–71

[In millions of dollars]

	1969 comparable	1970 comparable	1971 request
Obligations:			
Research grants	575	553	546
Research training	197	179	177
Intramural research	88	95	103
Collaborative research and development	124	116	166
Other Institute direct operations	42	43	44
Total obligations	1,026	985	1,036
Total outlays	950	965	995

The table illustrates substantial cuts in obligations proposed in the 1971 President's budget.

(1) A substantial and substantive reduction in the support of research grants from $575 million in fiscal 1969 to less than $559 million in fiscal 1971. Fewer than 9,700 research projects will be funded in 1971, compared to over 12,000 in 1969;

(2) A 10 percent reduction in the research training programs during the past 2 years;

(3) The total level of obligations will have decreased by 4 percent from 1969 to 1970;

(4) Through a shift in emphasis toward the collaborative research programs, the total level of obligations proposed for the NIH Research Institutes for 1971 would be about equal to the 1969 level in absolute amount. It would be considerably less in terms of research purchasing power, when account is taken of increases in wages and prices.

On the other hand, the outlay figures, as used in the special analysis, deceptively describe a relatively steady increase from 1969 to 1970 of 2 percent and from 1970 to 1971 of more than 3 percent.

economic burden of disease, that a broad expansion of the science base for medicine became a special objective of the Federal Establishment. These circumstances were particularly valid during the first half of the decade (i.e., 1955–60). Both the executive and legislative branches were convinced that even if each competent scientist were adequately supported, the resulting program would still be inadequate. A broad expansion of resources, including both manpower and physical facilities, were undertaken. As a corollary, biomedical research was supported wherever high competence, facilities, and relevant scientific intent were clearly apparent.

These attitudes fostered the development of loosely designed Federal support for biomedical research through a number of Federal agencies (e.g., DHEW, DOD, VA, Agriculture, AID, AEC, NASA) providing support for clinical and laboratory research in both Federal and university facilities. A broad and reasonably differentiated program of fundamental and applied research had been brought into being by fiscal 1966. The need for more formal organization of public decisions on science was emerging at the time that constraints on Federal support had become more evident. At first, the restrictions limited the rate of growth in the levels of activity; later, accompanied by continuing inflation, the constraints cut increasingly into the substance of ongoing research, the training of scientists and new faculty, and they effected a virtual halt in all new construction of research facilities. The cumulative effect of these curtailments was unsettling for the achievement of the purposes of biomedical research and for the fiscally unstable educational institutions that conduct major portions of the research. Importantly, these same institutions also provide education and training of faculty and other health personnel and serve as an institutional base for innovations in the service areas.

It is now quite evident that the Federal Establishment does not have the mechanisms to manage optimally a large, complex, mutiagency research enterprise and, at the same time. accommodate to the consequences of substantial constraints on the Federal support of research. Consequently, a broad study and development of meaningful goals in the biomedical research area is in order. Out of such studies can come determinations of the level of biomedical research support it is desirable to maintain; the substantive content of the programs to be supported; the support mechanisms which can be utilized most effectively; and the relation of these to essential educational programs.

Furthermore, definitions can be established for the specific role each Federal agency could be expected to play in the further development and operation of these important Federal programs. It is quite obvious that we can no longer afford, in the name of pluralism, the luxury of a series of biomedical research programs operating in separate agencies in a more or less autonomous fashion, with the only central control being limited to the concern of the Bureau of the Budget for fiscal considerations.[9]

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[9] The forces which generated those problems, together with some consideration of how they can best be managed, is covered in earlier discussions on "Science and Public Policy," J. A. Shannon, Science, vol. 163, p. 769. February 1969. See also presentations by J. A. Shannon and by Ivan Bennett made to the Subcommittee on Science, House Committee on Science and Astronautics, July 30, 1969: "The Organization of Federal Science" and "Some Suggestions for Improving the Administration of Federal Programs of Support for Academic Science."

The counter argument has been raised that the biomedical research effort is too complex for substantive consideration at a central level and that such central program decisions would be difficult and also unproductive. Conversely, it should be recognized that quite explicit central decisions are now being made by nonprofessional groups within the Bureau of the Budget and the Congress, through the appropriation process. Such judgments transcend fiscal considerations, since they inevitably affect both the substance of the science supported and the integrity of the educational institutions which contain much of he activity. Until mechanisms are created to integrate systematically these substantive considerations into the decision process, it will be uncerain that research expenditures are managed in the best interests of the Nation.

The provision of resources

Manpower.—The manpower or training and education programs, displayed in table VI, can be subjected to much the same criticisms as those noted in relation to the support of biomedical research. The manpower programs are generally characterized by multiple agency involvement of an uncoordinated nature, with a lack of explicit goals against which individual programs may be assessed for effectiveness. Special Analysis K emphasizes the magnitude of these programs but does not attempt to evaluate the programs in terms of the qualitative and quantitative needs they are intended to satisfy.

The critically important shortage of almost all types of health personnel is generally acknowledged (also see Special Analysis I, manpower). The program proposals contained in the 1971 budget will neither remedy these shortages nor provide for a more equable distribution of health pesonnel in the middle range (5–10 years) future. Yet it is generally agreed that until the manpower shortages are remedied it will be difficult to contain rising health costs and at the same time provide for the delivery of more effective health services. The term "crisis" (though too loosely used today) can be validly applied to the current health manpower (i.e., the decisive moment; turning point: Webster). If the appropriate actions are not taken at this time and programs are not modified accordingly, even further deterioration of the health care system will most surely and rapidly ensue.

Special Analysis K indicates that "ten Federal agencies are engaged directly in the support of education programs to train medical, dental, nursing, paramedical, and other health professional personnel." More than 180,000 students and trainees will receive aid from Federal agencies for some part of their education in 1971. "The Department of Health, Education, and Welfare, principally through the health manpower programs of the National Institutes of Health, supports the training of the largest number of physicians, dentists, nurses, and other health professionals," although the DOD and VA together provide training for more medical students, interns and residents than does HEW (Special Analysis K, p. 151).

DOD and Veterans' Administration are concerned with providing for the training of manpower for the health care needs of service personnel, dependents, and veterans. But the VA programs also provide training for medical specialists and other health personnel in excess of their own personnel needs, and DOD returns to civilian status many

individuals with training in the health professions and occupations (see sections III and IV). Suitably managed, the combination of these several programs in HEW, VA, DOD, the Office of Education and the Labor Department, could contribute to the expansion of the educational and training efforts that would tend to satisfy the total needs for health personnel. Their equable distribution may require other measures.

The manpower area is one that cries out for more intelligent planning, not only because of the evident shortages of manpower, but also because of the likely changing mix of manpower that the health care systems of the future will require. Present educational systems for production of manpower in the health professions and occupations are inadequate. They are fiscally unstable; the demands for their capacity are excessive; the subsystems of education they represent are diverse and fractionated; and, significantly, they are only tentatively committed to broad innovation.

The development of suitable programs to satisfy the broad and diverse needs for health manpower will most likely require the expenditure of sums substantially in excess of those now provided by a combination of Federal, State, and local governments and by the private sector. Support must be provided for both students and their institutions, and educational innovation must be stimulated. The magnitude and the distribution of the necessary construction programs should be determined by manpower requirements. It is reasonable to expect that substantial construction funds will be needed.

The manpower area is the one area in the health field that appears particularly well suited for system modeling. Several advantages would accrue from undertaking such studies. The first would be derived from the need to define the nature of the health systems that most likely will be operational in about 10 years. This requirement must be satisfied in order to estimate the size of the manpower pool and the manpower mix required for the operation of the projected systems. The second advantage would be derived from the modeling exercise itself. The study would have to encompass a number of the options available for the modification of the health care systems, the manpower and facilities requirements of each option, and information on both costs of services and costs of manpower and facilities production under each of the options considered. Finally, interdependencies within the systems studies would be more clearly portrayed.

Such a modeling exercise could not be definitive and final within our primitive present knowledge. It most certainly could not be a part of a more complex and precise model examining the entire health system. While limited, it would be amenable to intelligent modification as we move into the future. If well done, it would provide a more reasonable guide for decisions in the complex area of health manpower, than is currently available. In the absence of such a study, there is little rational basis for the present distribution or magnitude of support.

Facilities.—The major features of any long-term plan for the provision of facilities—whether for research, for education and training, or for service, must be preceded by the development of long-range executive policy in the health area. The last Special Analysis of President Johnson's budget, 1970, acknowledged such policy as a truism, in dis-

cussing construction of health care facilities. It emphasized the sound principles of the National Advisory Commission on Health Facilities.

> . . . an interdependent, comprehensive health care system which would assure of "every citizen . . . ready access to quality health care" and "continuity of health care services." [10]

The previous administration had little time after the receipt of the report in December 1968 to reduce this general intent to concrete programs. The long-term intent of the present administration is somewhat less clear.

This year's Special Analysis of the Budget emphasizes that new conditions and changing needs make sole reliance on grant programs or emphasis on hospital beds inappropriate. . . . The 1971 budget reflects a major program shift in the medical facilities construction program: directing grants toward ambulatory care facilities; relying upon guaranteed loans with interest subsidies for construction and modernization of private nonprofit hospitals and long-term care facilities; and providing direct loans for public institutions.

The Special Analysis of Federal health care facilities programs imparts a feeling of uneasiness concerning the adequacy of the proposed Federal programs. The only general purpose that is evident is the conversion of the Federal facilities support programs to support mechanisms other than grants in order to reduce the Federal participation in costs. It is acknowledged that the present fiscal situation will not permit satisfying all urgent needs in any short period of time. Reducing Federal costs is obviously desirable, particularly if alternative mechanisms will serve to satisfy the Nation's need for health care facilities. The Special Analysis unfortunately conveys no conviction that such would be accomplished within any reasonable time.

There is a desperate need for facilities construction in all health areas to which the 1971 budget requests do not appear to be responsive. The most urgent and unsatisfied needs are: construction and renovation of research facilities involving care of animals; educational facilities to permit the broad expansion of selected educational programs, particularly medical schools; and a wide array of health care facilities. Suitably designed Federal programs in the health care area would facilitate the more vigorous entry of the private sector into prepaid health care for economically diverse (but definable) populations, including the incorporation of poverty groups and the working poor into the more general health care systems. More adequate and better distributed long-term care facilities would be a most important factor in stemming the rising cost of health care. The satisfaction of other needs, less strikingly apparent, are equally important. Included are the needs for radical renovation or replacement of inefficient hospitals in high density population areas, the development of hospital systems associated with effective outreach programs of care and facility arrangements that will encourage more modernly conceived group practices.

The reader of the Special Analysis is misled by the presentation of only the positive contributions that can be expected from the outlays forecast, without information on the broad facilities deficiences that will not be overcome. The reader is further misled by the optimistic

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[10] *Special Analysis L, The Budget of the United States, 1970*, and the cited report, report of the National Advisory Commission on Health Facilities, December 1968.

statement that the growth of third-party payments (medicare, medicaid, private insurance) would inevitably and adequately improve the borrowing ability of medical care institutions, which would, in turn, presumably increase hospital construction in areas in which it is most needed.

The Special Analysis would be more reassuring if it conveyed the conviction that the program plans had been based first on a broad study of facility requirements and secondly on a determination of the most effective manner in which Federal programs could satisfy imperative needs. Only after such study, would the decision on suitable mechanisms be meaningful.

Such study should encompass an assessment of the qualitative and quantitative facility needs—this should include the influence of desirable changes in the health care delivery system directed toward the health care system of the Nation as a whole. This analysis should define the special needs of the inner city and of rural populations. It should take cognizance of the special pressures arising through the emergence of broad health maintenance as a desirable substitute for episodic care and the consequent changes in payment systems. In fact, the facilities needed to resolve many current deficiencies may be a determining factor in whether necessary change in delivery systems will be feasible.

Without doubt, a suitable program will be costly. But, the public should not be asked to support any program—whether it involves an increase or a reduction in costs—without clear evidence of the extent to which the essential needs of the health care system will be satisfied. If there is adequate leadership and realistic programs within the Federal Establishment, private capital will be forthcoming as it has been in the past. The Hill-Burton program dominated hospital construction in the past, even though its grants bore only about 15 percent of construction costs.

The analysis uncovers several items of interest (see pp. 152–54, Special Analysis).

There are at least seven programs other than those in the Hill-Burton program which bear directly on the construction of health care facilities. Undoubtedly, these programs are less helpful to candidates for construction aid than they would be under some system of central management. Apart from DHEW's involvement in health care facilities construction through medicare (Social Security Administration), medicaid (Social and Rehabilitation Service), the Hill-Burton program, and the mental health centers (Health Service and Mental Health Administration), the following Federal agencies are also involved: HUD, OEO, Small Business Administration, Commerce's Economic Development Administration, and the District of Columbia.

The sums provided for direct medical care functions by VA, DOD, and DHEW are probably modest in relation to the demonstrated need. Yet, the funds for the construction and modernization of Federal hospitals and health care facilities is $114 million, while that for the population as a whole is $361 million. The low absolute amount for the civilian sector hardly seems a reasonable statement of the Federal responsibility for its share in the satisfaction of the Nation's need for health care facilities. (See p. 154, Special Analysis.)

The rapidly rising costs for health care are in part due to the undercapitalization of the service plant and a profound need for hospital modernization by both major renovation and replacement. The Hill-Burton program has an important role to play in such modernization, but the funds available are quite insufficient for this role to be played effectively.

The delivery of health services

It is obvious that activities to improve the organization and delivery of health services must have heavy service-oriented components. Many such activities are covered by items in columns 2, 3, 4, 5, 6, and 7 of table VI. Major exceptions are the NIH research training portion of the NIH in column 2, and most of the diverse activities of the Consumer Protection and Environmental Health Administration.

The service-oriented programs suffer the same deficiencies as those discussed above. The Special Analysis displays an array of activities, each with its own special purpose and without central substantive policy guidance toward the achievement of explicit goals. It is quite apparent that the objective of providing competent health services to all, without regard to economic status, as a right has not been achieved; and that the programs contained in these budget proposals will not do so, and would not even if funded more generously. Significantly, the barriers to the achievement of objectives are not discussed.

It would not be profitable in this analysis to discuss in any detail the health service programs, or to indicate the consequences of deficiencies in policy formulation, and in the organization and management of the particular programs. This has been touched on for other purposes in comments prepared for the Subcommittee on Executive Reorganization of the Senate Committee on Government Operations.[11] However, comment is warranted on two groups of special programs identified in the Special Analysis K of Federal health programs.

Federally funded health centers.—The Federal centers program is described in Special Analysis K, pages 166–7. (The description in the 1971 analysis is similar to that contained in the 1970 Special Analysis L, pp. 168–9:)[12]

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[11] Comments by J. A. Shannon in response to subcommittee questions, Sept. 19, 1969, pages 507–55, Senate Report No. 91–809, Federal Role in Health.

[12] While the textual description of the federally funded health centers is generally comparable in the 1970 and 1971 special analyses, there are serious unexplainable discrepancies in the statistics about the program.

The following table, comparing the two reports, illustrates the difficulties in interpreting the special analyses.

FEDERALLY FUNDED HEALTH CENTERS

	Special Analysis L, 1970			Special Analysis K, 1971			
	1968	1969	1970	1986	1969	1970	1971
Total Federal Outlays (millions)	119.7	191.5	245.1	146.5	193.7	228.7	288.5
Number of centers funded	502	622	754	318	396	444	497
Number of persons served in year (thousands)	1,125	1,742	2,400	692	1,155	1,578	1,976

It is assumed that the 1969 and 1970 figures in the 1970 analysis were estimations which were subsequently improved by the 1971 analysis. Differences in these columns are, therefore, understandable. On the other hand, for both analyses, the 1968 figures were considered "actual" data with the outlays completed. Yet for that single year, the 1970 analysis describes centers, which in number and in persons served, were more than 60 percent larger than those described in the 1971 analysis, but which were supported at almost 20 percent less cost.

These striking differences in data may suggest that different criteria were used to define the universe of health care activity, but the analysis is silent on this question. Some of the differences might involve the transfer of some of the well established OEO programs to the PHS "Partnership for Health Program", although it is hard to see how the simple transfer would affect the totals.

In recent years comprehensive community based health centers have been established to overcome the problems posed by inadequate health care resources in poor rural and urban areas. While each agency supporting health centers (OEO, Maternal and Child Health Service, NIMH and Partnership for Health) must meet certain specific objectives contained in their authorizing legislation, all are concerned with bringing into low-income areas health resources—clinics, physicians and health workers—that are either nonexistent, in short supply or not readily accessible.

In addition to creating health care resources, the centers seek a comprehensive and personal approach to the delivery of medical care, the utilization of scarce resources in more effective and efficient ways, and the application of modern health technology. Many sponsor training and employment programs for residents of the communities served by the health centers and encourage participation of the poor in the planning and operation of the centers. It is becoming increasingly evident that the care being provided through the centers is having an impact on the health status of the poor. In areas served by maternity and infant care centers of the Maternal and Child Health Service for example, reductions of up to 33% in infant deaths have occurred after the establishment of the center in the area.

In 1971, 517 health centers will be funded wholly or in part with $289 million in Federal project grants, an increase of 67 centers and $60 million over 1970. As indicated in table K–12, the majority of the centers are for the treatment of mental illness, mothers, infants and children. The number of comprehensive health centers serving the entire community will also be significantly increased in 1971 by Partnership for Health. Part of the increase derives from the transfer of a number of centers previously funded by OEO that have reached full operational status. It is estimated that all federally supported centers will serve approximately 1,976 *thousand* persons in 1971.

TABLE K–12.—FEDERALLY FUNDED HEALTH CENTERS

	1968	1969	1970	1971
Total Federal obligations (millions of dollars)	146.5	193.7	228.7	288.5
Partnership for health [1]	4.1	10.4	20.7	32.4
Maternal and child health	66.4	75.0	76.1	83.1
NIMH	43.0	56.0	58.0	83.0
OEO [1]	33.0	52.3	74.0	90.0
Number of centers funded:				
Partnership for health [1]	8	18	25	35
Maternal and child health	111	111	112	115
NIMH (operating grants)	156	218	258	298
OEO [1]	43	49	49	49
Number of persons served in year (thousands):				
Partnership for health	0	23	137	171
Maternal and child health	380	532	550	560
NIMH	177	300	391	495
OEO	135	300	500	750

[1] Some centers will be shifted from OEO to partnership for health in 1971.

The Federal center programs offer broad opportunity for centrally managed innovation and study, the results of which might later be applied to the more general health service systems of the Nation. Candidate studies, were suitable administrative arrangements in being, include the following:

The differing manpower mixes most suitable for different service situations;

The differing costs and differing benefits to be derived from the application of concepts of prepaid health maintenance versus episodic care; (The Kaiser Permanente experience is said to be biased by the special population served.)

The use of managed centers, in association with segments of the general educational system, in the production of supporting health personnel (i.e., below the M.D.);

The ultimate integration of special programs, developed for the poverty sector, with the more general health care systems;

The examination of new concepts in the delivery of health care to select population groups which might be expected to provide solid information upon which to base progressive modification of the regulations of medicare and medicaid.

The solution of a number of operating problems in the health care area would be possible with the effective utilization of the many programs that are already the direct responsibility of DHEW. It is reemphasized that the benefits from these programs would be greatly facilitated by the completion of the reorganization of the health function within DHEW and by the development of a suitable central staff.[13]

The productivity of these health center programs have much to gain from a vigorous administrative setting which provides for intimate interaction among themselves, and with other health care oriented programs, such as those of the regional medical programs and the partnership for health. It is reasonable to suppose that these activities, as well as those that relate to the administration of the medicare and medicaid programs, would benefit by the more active involvement of the National Center for Health Services Research and Development.

National Center for Health Services Research and Development.—Broader use of the already existing National Center is important for the development of an effective operational research base. (This Center is now contained within the Health Services and Mental Health Administration, which also encompasses all of the health care programs of the Public Health Service and some of the medical programs previously in the Children's Bureau.) The major thrust of the Center for Research and Development is described on page 155:

The National Center for Health Services Research and Development is the principal research arm of the national effort to improve the organization, delivery and financing of health services. In 1971, the National Center will focus its attention on developing and evaluating new organizational structures for health care and training health researchers. In addition, the Center will finance and evaluate a special series of experiments in health planning and systems organization conducted through local RMP and Partnership agencies, Budget authority to finance the expanded program will increase from $37 million in 1970 to $50 million in 1971.

The Special Analysis then makes reference to other programs in other Federal organizations and agencies which will attempt to improve the effectiveness of the health care programs.

To achieve closer coordination among the programs and accelerate efforts to improve the effectiveness of the health care delivery system, proposed legislation to continue the programs will also establish a common direction and unified set of objectives.

In other efforts to encourage efficiency and reduce costs, several studies have been initiated by HEW using Medicare, Medicaid, and Maternal and Child Health

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[13] Comments by J. A. Shannon in response to subcommittee questions, Sept. 19, 1969, pages 507–55, Senate Report No. 91–809, Federal Role in Health.

reimbursement payments to experiment with (1) the comparative advantages of prepaid group practice and fee for service care, (2) the application of industrial engineering techniques to establish performance standards for hospitals and other providers of health care, and (3) the use of financial incentives to encourage providers to operate within present target costs. In addition, the Office of Economic Opportunity will spend $12 million for projects which focus on restructuring rural health delivery systems, reorganizing hospital outpatient departments, and developing prepayment plans for the poor.

The Veterans Administration is also devoting efforts to redesigning its system of delivering health services to veterans. In 1971, the VA will spend almost $26 million in implementing management and manpower utilization techniques to improve health services for its beneficiaries and to continue development of an automated hospital information system.

The role of the Center was somewhat more broadly outlined in last year's analysis.[14] With a broad mission, the Center could be utilized with profit as a central point within DHEW for definitive operational research on the major federally funded programs. Such studies, in addition to the direct benefit to the Federal programs themselves, could solve some of the critical problems in the general health service area. It may very well be, however, that a research and development agency, within the presently structured DHEW, will operate effectively only if it becomes operational at the level of the Office of the Secretary.

Certainly, study and controlled innovation must accompany any change in the regulations of medicare and medicaid. Similarly, it is hoped that penetrating examination of the deficiencies in current health care systems will be part of the continuing operations of the regional medical programs, the "partnership for health" and the programs of the Health Services and Mental Health Administration, for the mentally ill and mentally retarded. If to these are added the opportunities available for study in the federally funded health centers program, and in the facilities and manpower area, noted above, the location of a research and development agency at a high level becomes an imperative. Viewed in this light, the coming year's legislative programs for the Department of Health, Education, and Welfare offer very broad opportunity to ameliorate the striking deficiencies of the current clumsy administrative arrangements and the limiting legislative authorizations.

Funding and administration.—Among the programs whose fundamental purposes relate to health, those summarized in this section

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[14] "The National Center for Health Service Research and Development will spend $37 million in 1970, its second year of operation. an increase of $12 million over 1969. Through research grants and contracts the Center will focus on selected priority areas. These include (1) defining the essential elements related to costs of health services, (2) study of means to improve health services to the disadvantaged, (3) developing reliable criteria for assessing effectiveness of health programs, (4) improved methodology for community health services planning and organization, and (5) basic factors in functions, design, and operation of community health facilities. A basic strategy on the Center in 1970 will be to draw upon the multidisciplinary resources of university and hospital based health services research centers. It is proposed to develop and establish common goals with leading health services/research oriented health care institutions to enable rapid assimilation of proven new techniques and procedures into ongoing health service operations." Special analysis, 1970, p. 156.

make the major Federal contribution to the improvement of health of the general population. This does not contradict the fact that other health activities, undertaken for other primary purposes, have an influence on the level of health of particular population groups. The rational management of the programs summarized in this section provides, or could provide, the most direct leverage for desired general improvements in the health area.

These programs are not adequately funded in relation to their ability to solve the problems that are outlined in this discussion. Of the funds said to reflect the outlays for health within the mystique of a "Federal health dollar," the funds purposely and primarily directed to the improvement of health account for approximately $4.0 of $20.6 billion. Contrary to any impression that might reasonably be gained from reading of the Special Analysis, there are gross deficiencies in each of the broad functions around which the individual activities can be grouped; that is—

The delivery of services;
The development of new knowledge; and
The provision of resources.

The Special Analysis would have better served the public purpose if these deficiencies were frankly admitted. It is generally recognized that fiscal constraints must be accepted as an inevitable consequence of our present national commitments and our need to stem continuing disastrous inflation. National health problems are not solvable in the present budget year. Nonetheless, an acknowledgement of the real and fundamental inadequacies of the present health programs would be an essential initial step toward remedying them when our present set of national priorities is modified. Such acknowledgement would go far to gain public confidence in the soundness of the allocation process.

The development of policies and goals for the middle- and long-range periods is even more important in times of fiscal constraint than in times of general program increases. It is easier to correct errors in program development when programs are being progressively expanded than it is to overcome program problems perceived during acute accommodations to program retrenchment.

The Federal outlays for health reflect the broad growth of research which began with the decisions of the summer of 1955, the addition of educational programs beginning in 1962, and the more recent and compelling service programs. This history is displayed in the number of legislative authorities under which the programs operate, their diversity, the relatively isolated administration of these many programs from one another, and the lack of an adequate central organizational base.

TABLE VI.—FEDERAL OUTLAYS TO IMPROVE THE ORGANIZATION AND DELIVERY OF HEALTH SERVICES, 1971

[In millions of dollars]

	Health research	Training and education	Construction	Organization and delivery	Direct Federal hospital and medical services	Indirect Federal hospital and medical services	Prevention and control of health problems	Total
Health, Education, and Welfare Department	(1,193.0)	(755.9)	(357.1)	(173 1)	(0.4)		(464.7)	(2,944.2)
Health Services and Mental Health Administration	135.9	170.8	334.0	154.9			292.7	1,088.3
National Institutes of Health	929 3	554 2	3.7	18.2			8.0	1,513.4
Consumer Protection and Environmental Health Service	97.3	13.4					143.1	253.8
Social Security Administration								
Social and Rehabilitation Service	30 5	9.8	9.3		.4		20.9	70.9
Other		7.7	10.1					17 8
Defense Department	42.1	128.7					20.7	191.5
Veterans' Administration	63.0	99.4		25.6				188.0
Housing and Urban Development Department			178.7	2.6				181.3
Agriculture Department	44.4						175.0	219.4
Agency for International Development	9.6			22.1				31.7
Office of Economic Opportunity				12.0				12.0
National Aeronautics and Space Administration								
Atomic Energy Commission	47.1							47.1
Civil Service Commission								
Labor Department	.3							.3
State Department								
National Science Foundation	25.8	3.0						28.8
Commerce Department	3.9							3.9
Other agencies	29.8	4.2	48.8		36.5	7.6	64.5	191.4
Agency contributions to employee health funds								
Total outlays for health, 1971	1,459.0	991.2	584.6	235.4	36.9	7.6	724.9	4,039.6

Note: Tabulated data derived from table K–16, p. 171, Special Analyses, Budget of the United States, Fiscal Year 1971.

VII. General Comments

This analysis has summarized the more important health needs of the Nation and how these may be modified by the program proposals of the 1971 budget. This final section is limited to comments on:

1. The nature of Special Analysis K, Federal health programs, 1971;
2. The changes in the direction of health programs;
3. Some fundamental issues bearing on the Federal health programs.

1. Special Analysis K, Federal health programs, prepared by the Bureau of the Budget, has been taken for particular examination and criticism since, more than any other document, it defines and analyzes the Federal intent in the health field for the coming year. The Special Analysis is not a policy document in the ordinary sense, but it does express, in program terms, the policies of the administration. It provides an almost unique administration summary of the absolute and relative levels of program support proposed for the forthcoming year.

The analysis is misleading. It tends to obscure rather than clarify the Federal commitment to health and the distribution of effort on behalf of the Nation as a whole. Its purpose appears to be to demonstrate the broad concern of the executive branch for the general health of the Nation, and its broad commitment to its improvement in the future.

When the Special Analysis is more carefully analyzed, however, a less rosy picture emerges. One finds health activities distributed ubiquitously within the executive agencies, lacking either central policy direction or broad program goals as a base for program development. In effect, the document clearly portrays an unsatisfactory frame of reference for an essential and important Federal function.

But one should view the appropriation process as a political action and the Special Analysis as a political document. In reality this is the case. The analysis emphasizes the substantial cost of Federal health activities but does not clearly outline the general policies that have served as guides for the allocation of Federal resources. It indicates that precedence will be given to health service programs, and that increases in other high priority Federal programs will be provided. But since few general goals are established and the major health deficiencies are not defined, it is difficult to judge the reasonableness of the budget proposals or the adequacy of the choices among the available options.

The document assembles all the proposals for Federal outlays for health activities, without regard to the special purposes for which the activity is undertaken, or the source of the funds to be utilized in their support. The outlays are analyzed within a series of frames of reference, some of which are without profound meaning. The resulting summary gives the spurious sense that the administration is presenting a coherent program proposal—a conclusion somewhat remote from the fact. These may be harsh judgments, but better this than a simple continuation of an unsatisfactory situation.

2. The 1971 budget documents reveal too few changes in program direction to provide insight into the program changes that may be expected in the immediate years ahead. More of the administration's

intentions may become evident through its forthcoming legislative proposals. Major legislation in the health manpower and health service areas will have to be submitted in the near future and such new legislation may have profound impact on the program content, the funding, and the administrative arrangements of the Department of Health, Education, and Welfare.

In sum, the 1971 budget appears to respond more to the weight of the history of the various programs than to any pressure for innovation. Nevertheless, some signs are notable:

(*a*) *Research and training*

Emphasis will be given to research in four special program areas (see pp. 23–26) in the NIH programs, at the expense of continued deterioration of the more general science base. This action appears to represent a concentration on short-range goals in contrast to middle- and long-range capability.

The willingness to sacrifice middle- and long-range capability is further represented by the continued restraints on research fellowships and training. The relatively small increases that have appeared in the funding for the institutions engaged in physician production are probably offset by the reduction in their research projects, training, and general research support grants.

(*b*) *Health resources*

Minor increases in funds, distributed over DHEW, VA, Defense and Labor Departments, will augment efforts to develop health manpower. No changes are evident in the substantive nature of these programs, nor is a coordinated plan presented.

(*c*) *Two changes have been announced in the facilities programs*

The first emphasizes the use of private capital for new construction and renovation, through Federal loan guarantees instead of direct grants; the second encourages ambulatory care and prevention in place of hospitalization. On the other hand, the proposed funds appear woefully inadequate if the intention is really to move a sluggish system in a new direction.

(*d*) *Health services*

There are administrative shifts in the regional medical programs, partnership for health programs and the National Center for Health Research and Development with modest increases in funds for each of these programs. In addition to their service functions, operational research will be performed in these programs as well as in the medical programs of the social and rehabilitation service (medicaid) and the Veterans' Administration.

Major increases appear in the special health services offered to mothers and children. These are coupled with emphasis on research and services for family planning.

3. Fundamental issues relating to the health of the Nation have yet to be presented by this administration. There has been entirely too much emphasis and discussion of the expenditure levels of individual programs. The shortages of manpower and the instability of the educational institutions have been repetitiously presented as isolated problems. Little insight has been shown in the problems of the complex system as a whole and in the particular roles which the Fed-

eral Establishment could play in maintaining the vigor and effectiveness of the Nation's health care.

Yet, the Federal Government has asserted its broad and direct responsibility with regard to the maintenance of the health of the population. It has a commitment to help solve the problems concerned with: the maintenance of personal health; the mitigation of the consequences of disease; as well as other health problems generated by the physical and social environment. The discharge of this responsibility requires that it provide the means of acquiring the knowledge and the experience which will secure for the whole population an acceptable level of health care; and which will foster the development of systems to make such health care accessible, of good quality, reasonably well distributed and at a cost which is bearable.

As explained earlier in this analysis, the Federal Establishment attempts to discharge this complex responsibility by an array of activities that relate to the development of new knowledge, the improvement in the administration and delivery of health care, and the provision of resources. The Federal outlays, proposed in the 1971 budget, for activities with these direct purposes, amount to $4 billion. Such Federal outlays, constituting less than 7 percent of the Nation's expenditures for health services, provide the bases for innovations and improvements in the health care of the entire population. These outlays support a combination of programs that should:

Provide the knowledge necessary for managing effectively the problems of health maintenance and its interruption by disease;

Provide for the development of systems of health care that are realistically directed toward satisfying the needs of major segments of the population; and

Produce an adequate health manpower pool and the essential physical facilities to contain the programs.

The successful operation of these Federal programs would be greatly aided by more critical development of public policy in health and through these means, the evolution of a series of general though explicit health goals. It is also likely that the discharge of the Federal responsibility would require more adequate provision for the satisfaction of critical needs in the facilities area; substantial modification of the regulations of medicare and medicaid; the use of federally funded health care programs to foster reasonable innovative applications; and the development of more intelligent central management as a base for meaningful innovation in the distribution and delivery of health care services.

A major modification in the executive organization of the management of the Federal health activities is required if reasonable health objectives are to be achieved. This modification must involve both the operating and the advisory structures for Federal health activities. Substantial changes must also be involved in the organizational arrangement within DHEW and between DHEW and the other Federal agencies maintaining activities in the health field. Such alterations should never be undertaken lightly, but they cannot much longer be delayed.[15]

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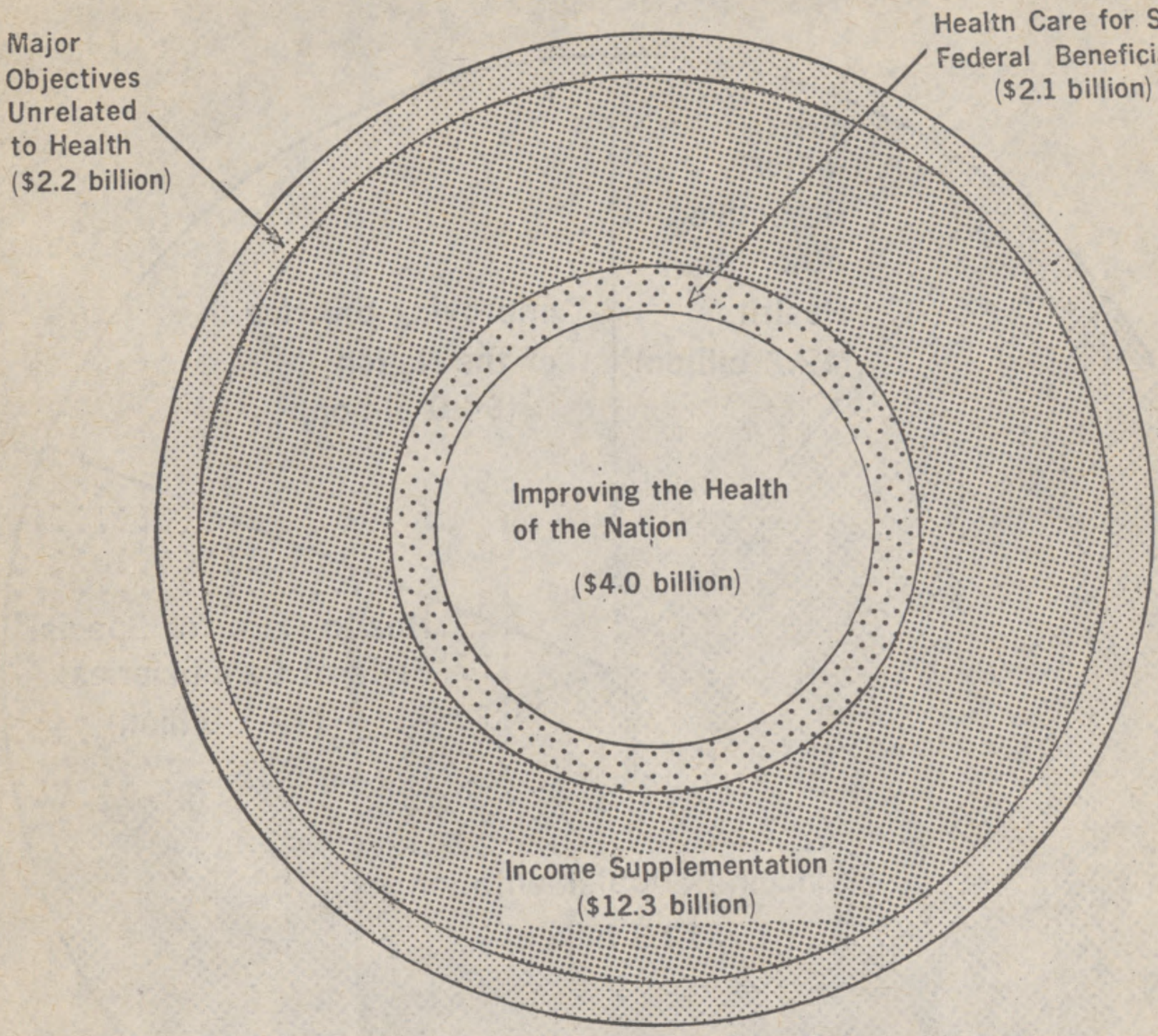
[15] More specific and detailed comments were made on Sept. 19, 1969, in response to questions developed by the Subcommittee on Executive Organization, Government Operations Committee, U.S. Senate, pages 507–55, Senate Report 91–809, Federal Role in Health. Two sections dealt directly with the general problems of policy formulation, goal setting program development in the health area and the particular need for modification of the structure of DHEW.

CHART I



1971 FEDERAL HEALTH ACTIVITIES, $20.6 BILLION

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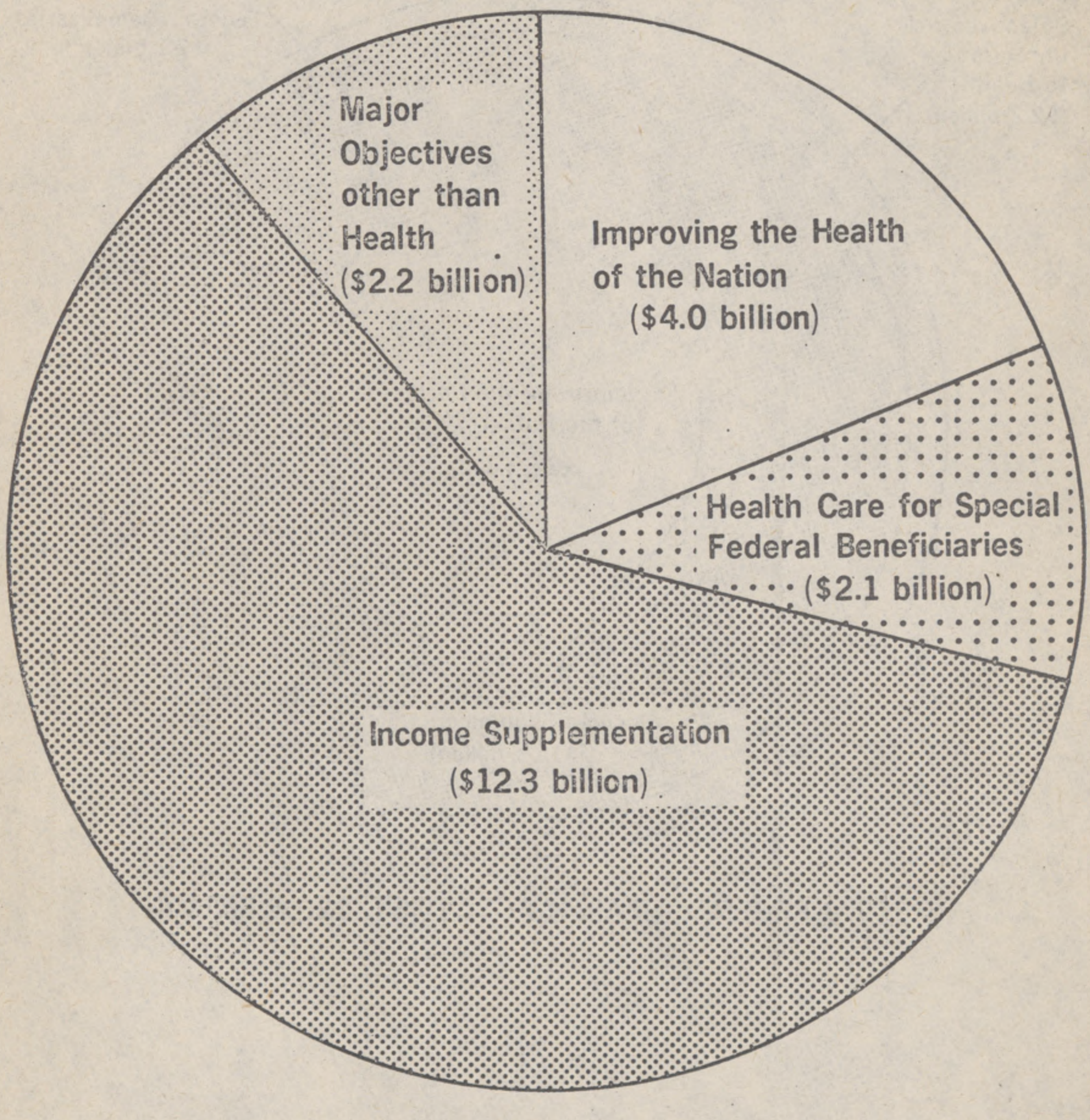
CHART II



1971 FEDERAL HEALTH ACTIVITIES
($20.6 billion)

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