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Setting National Priorities—The 1974 Budget*

Administration Proposals

Many of the major grants for health services are being terminated or reduced. It is useful to think of these grants in two categories. First, there are grants under which the federal government shares the construction and operating costs of various kinds of public health services and assists state and local public health agencies in controlling communicable diseases. The administration approach seems to have been: reduce or eliminate most federal programs that support specific kinds of health services (except for the drug abuse program, which is expanded); provide continuing general support, at or slightly below prior levels, to state and local public health agencies for health services and disease control but increase state discretion as to the use of funds; and retain federal control over the programs that provide special health services for poor neighborhoods in inner cities and rural areas.

Under this approach the Hill-Burton grants for hospital construction were eliminated; grants for community mental health centers and alcoholism clinics will be phased out gradually as long-term agreements for federal support expire; and those grants for maternal and infant care under which the federal government currently selects the projects to support will be converted into state formula grants. On the other hand, the federal government will continue unchanged its project grant program for neighborhood health centers and other health services in poverty areas.

In the second category of health grants, those for planning, innovation, and development, a similar approach was followed. The $125 million regional medical program was terminated. Under this program the federal government supported, on an individual project basis, regional cooperative efforts (usually led by the major medical schools in a region) for such purposes as disseminating knowledge of up-to-date medical techniques and coordinating planning for the use of complex medical technology. On the other hand, the broad grants to state health agencies for planning their own public health programs were retained, after a slight cut, as were federal grants for research and development in health services.

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Alternative Approaches

It is impossible to discuss the future of federal grants for health services except in the context of the availability of health insurance. If a federally supported health insurance program that covered the poor and near-poor fairly comprehensively were enacted, some of the current grants for support of various kinds of health services would be unnecessary. That is, an institution that provided treatment could charge for its services and people could use their insurance to pay the charges.

With the availability of such insurance, neighborhood health centers now supported by federal grants could look to patient charges for their financing. Similarly, community mental health centers, which now receive federal grants for construction and staffing, could derive part of their support from such charges. The latter institutions perform three functions. They provide an alternative and generally preferred means of caring for many of the long-term mentally ill who were previously confined to large state hospitals; they undertake community activities such as mental health education; and they provide mental health services to a broader segment of the population who do not need long-term intensive care. It is this third service for which they could recover charges from patients supported by health insurance. The other two functions, traditionally financed by state governments, would have to continue to be underwritten by public support.

Providing adequate financing to people for the purchase of health care, however, does not eliminate the need for federal intervention. Experience has amply demonstrated that the existing medical care system does not respond quickly to new demands placed upon it and that it leaves poor urban and rural areas without adequate health resources. Without specific action by the federal government, the introduction of a national health insurance program may accelerate the rise in medical prices and divert resources away from poor areas which already suffer from a shortage of health care. Two kinds of reforms are needed: first, federal developmental support for new types of medical care delivery which promise to use medical resources more effectively and distribute them more equitably; and second, federal incentives for health care personnel to locate in areas where such care is scarce and for an increase in the number of health professionals recruited from minority groups.

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There are five major kinds of innovation in the delivery of health care which the federal government now supports through some type of separate grant. Neighborhood health centers (principally in inner cities) and community mental health centers have been mentioned. Grants are also made for projects to improve health service delivery in remote rural areas. Although the financing of their ongoing operations could be fully or partly borne by charges levied on patients under a comprehensive health insurance system, it is unlikely that new centers would spring up without federal developmental support. Health maintenance organizations (HMOs), which provide comprehensive medical services for a defined population in exchange for a fixed annual payment for each person served, are believed by many to offer a promising means of improving the efficiency and effectiveness of the health care system.[3] The administration proposes $60 million in developmental grants in the 1974 budget, a sum it estimates will assist in the establishment or improvement of about 120 HMOs.

The Hill-Burton grant program has provided financial assistance for the construction of hospital bed facilities and, increasingly in recent years, for ambulatory and outpatient facilities at hospitals. This program is terminated in the 1974 budget. Its two basic objectives should be considered separately. More hospital beds are no longer needed; indeed, there are now too many in the United States. The occupancy rate in community hospitals has been declining since 1969 and is now below 80 percent. Not only does this excess capacity drive up the cost of medical care but it encourages hospital treatment of health problems that could be taken care of more efficiently and effectively on an outpatient basis — in doctors' offices, in clinics, or at home. There is, however, a need for expansion of outpatient and ambulatory care; it is often a better way of dealing with illness and is particularly important in poor sections of central cities, where there are few private physicians. But providing such support through construction grants is inefficient. Subsidizing construction leads to overinvestment in facilities and too little support for operation and maintenance.

Instead of these five separate grant programs — some supporting initial development, some ongoing services, and some capital construction — what is needed is a single broad grant program under which the federal government can furnish the seed money for the initiation and development of more effective means of delivering health care, according to the needs of particular areas and population groups. Under a federally supported health insurance system, the institutions developed should ultimately be required to meet the test of the marketplace. After the initial subsidized years they should make it on their own, at least in providing health care covered by insurance, financing the costs of such care (including the cost of capital) from fees. As time passes, the experience of different kinds of institutions should help the federal government judge which kinds of developmental grants to emphasize and which to reduce.

For all five of the areas concerned, the 1974 budget provides about $530 million in grants. Of that amount some $125 million represents the fiscal 1974 cost of carrying out long-term (eight-year) agreements to support community mental health centers; even though the administration proposes to phase this program out as the agreements expire, funds will have to be made available for a number of years to honor the agreements. Similarly, the total includes $135 million to carry out previous agreements on hospital construction under the terminated Hill-Burton program.

Under the alternative proposed here, the grants financing the delivery of ongoing services or the construction of facilities would be replaced with a new, flexible grant program for developmental purposes. With the need for expanding the availability of services in areas where they are inadequate and the acceleration of demands on the system resulting from a new health insurance system, total annual commitments of perhaps $500 million, to be reached by fiscal 1976, would be appropriate. Further expansion thereafter might be warranted depending on how successfully the new institutions meet the needs of the population they serve. The net additional cost of the new program would be about $250 million in fiscal 1976 and $225 million in 1978, over and above the expenditures projected by the administration.[4]

The development of new institutions for the improved delivery of health care would itself attract more physicians and allied health professionals into areas where such care is scarce, but several additional steps would contribute to this end.

Members of minority groups suffer particularly from lack of medical care, in part because many of them live in low-income areas and in part because of the shortage of medical personnel willing to serve inner city areas heavily populated by blacks and other minority groups. Federal efforts to increase the supply of medical personnel from minority groups would serve three purposes: providing members of these groups with greater professional opportunities; taking advantage of an underutilized resource — bright young people from minority groups — to increase the supply of medical personnel; and training

people more likely to practice among minority groups. In a society where there were no distinctions of color or race, this last objective would be irrelevant. The problem of bringing additional health resources to the poor, whatever their race, would be the same. But until that point is reached, the availability of health care for minority groups may remain related to the availability of minority health personnel. Pursuit of these objectives would involve providing financial incentives for members of minority groups to attend medical and other health professional schools, and perhaps financial incentives to medical schools to admit a greater number of students from minority backgrounds. This effort, however, would increase the supply of medical services to minority communities only after a fairly long period of time. There is also a need, particularly in this interim period, for supporting programs training minority paraprofessional personnel to work in community health organizations. Since the cost of such training should not be part of the charges levied on insured patients, separate financial support by the federal government would be necessary. At the present time the costs of many community health organizations are higher than would be justified by the provision of medical services only, because these organizations provide on-the-job training for community residents in paraprofessional skills — efforts that should be separately financed and expanded as the number of community-based organizations increases. The additional incentives needed to support the entry into medical and dental schools of an additional 1,000 minority group members each year and paying for the training of 10,000 paraprofessional personnel a year in community health organizations would require added budgetary expenses of about $60 million.

The regional medical program (RMP), which the administration proposes to terminate, is a planning and innovation-spreading effort. There are fifty-six regional cooperative arrangements supported by $125 million in annual federal grants. According to the administration, "There is little evidence that on a nationwide basis the RMP's have materially affected the health care delivery system."[5]

It is difficult to gauge the validity of this judgment. Initially, the RMPs were established to upgrade the treatment of heart malfunction and defects, cancer, strokes, and kidney disease; subsequently, they were broadened to deal with more general improvements in the health care system. Ideally, they were to provide a mechanism by which medical schools and other leading medical centers in an area could take the leadership in improving health care in their section of the country. Performance has varied, obviously, from one to another, and performance is exceedingly difficult to measure. Moreover, health care in the United States is a $77-billion-a-year industry. That it cannot be revolutionized through the expenditure of $125 million a year on RMPs is hardly surprising, and not in itself an indictment of the program.

The planning, innovation, and knowledge-dissemination functions of the RMPs have several characteristics: (1) unlike service delivery programs they cannot be supported by the marketplace, even with insurance; (2) medical schools and other health centers have no funds to support such efforts on their own — continuing support must come from public sources; (3) the major need for improvements in health service delivery varies substantially from area to area; and (4) the funds now devoted to RMPs are large in comparison with what states budget for health planning and with other federal funds available for health planning and development purposes.

It is unlikely that RMPs will be continued with state funds once federal support is withdrawn. The federal government has provided the means of launching these new organizations. Simply withdrawing its support will virtually ensure that most of them disappear, whatever their merits. One alternative to the administration's proposal for eliminating the program is to combine RMP funds with the $148 million in federal funds now available to states and local communities for planning and carrying out their own comprehensive health service projects, thereby allowing each state a choice between continuing to support RMPs and devising other mechanisms for accomplishing the same purpose. This would add some $125 million a year to the budget proposed by the administration.

All of the above discussion assumes the introduction of a national health insurance scheme, which would, among other things, provide reasonably comprehensive coverage with zero or low deductibles and coinsurance for the poor. If such a plan is not adopted, a strategy that included termination of service grants to neighborhood health centers would not be workable, since the centers would then have few sources of financial support. Similarly, the administration's plans to terminate the Hill-Burton program and to phase out support for community mental health centers would lead to serious consequences for the centers and for the expansion of ambulatory facilities in urban hospitals.

If there is no comprehensive insurance plan, therefore, a second alternative must be considered. This would include continuation and expansion of service grants for neighborhood health centers, roughly tripling the level of support by 1978 and

making possible a substantial increase in coverage for the low-income population served by these centers; continuation of service grants for community mental health centers; expansion of the HMO development grants from the $60 million provided in the 1974 budget to $100 million in 1976 and $200 million in 1978; and conversion of the Hill-Burton construction grants into a new kind of grant costing $150 million a year and designed to encourage more ambulatory treatment in urban hospitals. Supporting health service delivery through construction grants has the disadvantages discussed earlier. As a substitute, the federal government could agree to pay a specified portion of the annual costs of any expansion in ambulatory care and outpatient treatment undertaken by hospitals serving areas with large concentrations of low-income people. Loan guarantees for construction would be made available as necessary. If these grants proved successful in substantially increasing the delivery of outpatient services, federal support could be increased in later years.

The education and training program for minority health personnel and the integration of RMP funds with state comprehensive health grants would also be incorporated in this alternative. Measured in terms of outlays this alternative would add $465 million in fiscal 1976 and $945 million in fiscal 1978 to the outlays projected by administration proposals. (This alternative costs more than the first one principally because, in that approach, health insurance would pay for some of the services financed by grants in the second alternative.)

REFERENCES

3. See Charles L. Schultze and others, *Setting National Priorities: The 1973 Budget* (Brookings Institution, 1972), pp. 232-34, for a discussion of HMOs.
4. The relatively low net cost reflects the phasing in of the new programs as some of the old programs are phased out.
5. *The Budget of the United States Government — Appendix, Fiscal Year 1974*, p. 383.

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