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THE 1978 BUDGETS: FORD, CARTER, CONGRESS, HEALTH

A Staff Paper

by Milton Turen

August 1977

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THE 1978 BUDGETS: FORD, CARTER, CONGRESS, HEALTH

Introduction

Just before leaving office, President Ford submitted his budget recommendations for the fiscal year 1978, which begins October 1, 1977.

In February, one month after his inauguration, President Carter submitted his recommendations for the 1978 budget by proposing revisions of President Ford's budget. In April, President Carter withdrew the $50 tax rebate he had proposed earlier, and also the special tax cuts that were designed to encourage hiring by business. In addition, he revised slightly his economic forecasts for calendar year 1977 and 1978; actual spending trends and other developments also required changes of the estimate prepared in February. Receipts are expected to be higher in both years, while spending is seen as reduced in 1977 and increased in 1978.

The Office of Management and Budget issued a revised set of 1977 and 1978 budget estimates on April 21. Those April estimates--which do not include the effects of President Carter's subsequent Social Security financing and energy proposals--are used in this report as the Carter budget. In instances that require a distinction between the February and April budgets, the tables in this report will separately identify the April revisions.

Congress adopted its first concurrent resolution for the 1978 budget on May 17. This resolution established expenditure limits, revenue goals, the size of the deficit, and other guides for committees in their subsequent detailed action on the Budget. The first concurrent resolution is an interim guideline; the final binding resolution must be adopted by the Congress by September 15.

This year's Institute of Medicine staff paper on the budget differs from the earlier reports in that it compares three budget recommendations rather than two. It contains the changes proposed by a new Administration, under a new party, replacing an outgoing one. It compares a presidential and congressional budget developed by members of the same political party. The paper also indicates where President Carter's budget continues policy decisions recommended by President Ford, and identifies budget recommendations made by the Democratic-majority Congress that differ from those proposed by President Carter.

This paper opens with an overall comparison of the three budgets, then develops in greater detail the comparison between the Ford and Carter recommendations for 1978. The remaining part of the report compares Carter and congressional budget recommendations for 1978.

Unless otherwise indicated, all years are fiscal years. Before 1977, fiscal years began July 1 and ended June 30. Beginning in 1977 the fiscal year is October 1 to September 30. The period July 1 to September 3 is called the transition quarter and covers the interim between the old and

the new fiscal year periods. Budget totals for the transition quarter, shown below, have been excluded from subsequent text and tables.

Total Receipts	$81.8 billion
Total Outlays	94.7
(Outlays for Health)	(8.7)
Deficit	-13.0

Rounding of the numbers in the text and the tables may preclude their adding to the stated totals. Unless indicated otherwise the source documents are: The Budget for Fiscal Year 1978 for President Ford's recommendations; Fiscal Year 1978 Budget Revisions and the April 21, 1977, Current Budget Revisions, issued by the Office of Management and Budget for President Carter's recommendations. The congressional estimates are derived from House and Senate Budget Committee reports (House Report No. 95-189, Senate Report No. 95-90) and from the May 11, 1977 Joint Conference Report, House Report No. 95-291 on the 1978 First Budget Resolution.

In the coming months, and probably by October 1977, both the President and the Congress will have updated their 1978 recommendations and include the impact of proposals on energy, Social Security, welfare reform, and perhaps tax reform. In October, a very short resume will be prepared comparing the President's and the Congress' update. This resume will be mailed to readers who write and request it.

Different Views of the Budget

A budget for the U.S. Government embodies three major objectives. First, it is a fiscal plan, whose spending and taxing proposals are designed to affect the general state of the economy--to stimulate if it is lagging or to restrain if it is booming. Second, the budget is a plan to apportion the nation's resources as between public and private direction and within the federal area. Third, the budget provides leverage for future changes in federal programs. Over 70 percent of the budget outlays in any year are committed because of previously incurred obligations and because of entitlements embodied in the law. Except for dependence on the level of the economy, an even larger share of federal receipts are automatic and require legislative changes to raise or lower them. Accordingly, to bring about future year changes in receipts or outlays, policy revisions must be introduced in the pending year's budget. These changes usually have a relatively small impact in the budget year but gather size in ensuing years.

Table 1 presents the key numbers that summarize the Ford, Carter, and congressional budget recommendations for 1978.

The Ford recommendation was based on two major propositions: (1) that economic recovery would be sustained without the need for large stimulus by the federal government, and (2) that the 1978 budget should begin to slow down and reduce the federal share of the nation's resources, leaving more to the private sector. By proposing further permanent reductions in federal income taxes and cutbacks in existing spending programs, the Ford budget results in the lowest 1978 deficit along with the lowest levels of receipts and spending of the three budgets being compared. The "cost" is a 6.6 percent rate of unemployment and a slower rate of real growth in the economy during calendar year 1978. The "benefit" forecast in the Ford proposal is a lower rate of inflation in calendar 1978 and in the general budget projections for 1981. Federal expenditures as a percent of GNP in 1981 are reduced by about two percentage points and federal receipts are prevented from rising. The Ford 1978 budget plan would be in balance in 1980 and would provide a surplus in 1981.

Both the Carter and Congress budgets reject Ford's basic aim to lower the federal share and thus do not recommend large spending cutbacks nor the large permanent reduction in income taxes. By 1981 these two budgets would have larger federal receipts and outlays and would provide surpluses to finance new federal programs. The Carter and Congress budgets do not differ greatly from the short-run economic outlook and assessment forecast in the Ford budget. The economic outlook projected by President Carter is somewhat more optimistic. The economic forecasts used by the Congress are almost identical to those used by President Ford and led the Congress to forecast lower receipts and a $6.7 billion higher deficit than estimated by Carter. In its first resolution, the Congress did not set higher outlay targets to stimulate the economy. It chose to wait till September 15, when the second budget resolution is due, to assess the progress of economic recovery.

The receipts and surplus by 1981 that are implicit in the Carter and congressional 1978 budget plans are primarily a result of coupling high economic growth with the income tax laws enacted in May 1977. President

Table 1. Ford, Carter, and Congress Budget Estimates and Projections

	(In billions of dollars)		
	Ford	Carter	Congress
1978 Budget Recommendations			
Receipts	$393	404.7	396.3 (397.2) 1/
Outlays	440	462.6	460.9 (461.8) 1/
Deficit	47	57.9	64.6
Economic Forecasts--Calendar Year 1978			
GNP in current prices	2,092	2,103	2,088
Real growth in GNP:			
Percent Increase over C.Y. 1977	5.1	5.6	5.1
Percent increase in Consumer Price Index over C.Y. 1977	5.4	5.7	5.4
Average rate of unemployment(%)	6.6	6.4	6.5
Projections for 1981 based on 1978 policies and trends. 2/			
Receipts	553.1		594
Outlays	527.0	Not	567
Surplus	26.1		27
GNP in current prices	2,784	Avail-	2.828
Annual rate of unemployment (%)	4.8		4.5
Annual increase in C.P.I. (%)	3.8	able	5.4
Federal receipts as percent of GNP 3/	19.8		21.0
Federal outlays as percent of GNP 3/	18.9		20.0

1/ Figures in parenthesis treat earned income tax refunds as outlays rather than reduction in receipts for comparability to treatment in Ford and Carter presentation.

2/ Estimates for Congressional budget are those shown in House Budget Committee Report (House Document No. 95-189, p. 98-100). These are figures based on high economic growth averaging 5 percent per year during 1977-81. A 4 percent economic growth reduces the surplus to $12 billion. As of time this report was prepared, the Administration had not released 1981 projections; these would probably be close to Congressional projections.

3/ Comparable figures for 1977 are: Receipts 19.1%; Outlays 21.7%.

Source: The Budget for F.Y. 1978, April 21 Current Budget Estimates and the Reports of the Congressional Budget Committees.

Carter's longer range permanent income tax reform proposals are not expected until later in calendar 1977 and probably will not affect revenues in fiscal 1978. It is not clear whether his reform proposals will include significant reductions as well as shifts in the distribution of the tax. If tax reductions are included in his reform proposal then the size of his 1981 surplus will be reduced. Carter's proposal to utilize income tax receipts to help finance the Social Security system, if adopted, would further reduce the surplus available for major new programs.

There are similar uncertainties about projecting the 1981 receipts implicit in the congressional 1978 budget. The Congress in the past has usually revised the income tax system to lower its revenue yield. Should it take similar action in the near future, the 1981 tax yield and the accompanying surplus would be significantly reduced.

Comparing the Ford and Carter Budget Recommendations

The Ford budget message emphasized: "I have proposed and reproprosed this year a marked slowdown in the rate of growth in government spending... We need to put the burden of proof on the government to demonstrate the reasons why individuals and business should not keep the income and wealth they produce...[we should no longer presume] as has been the practice in the past, that positive margins of receipts over expenditures that show up in projections are surplus or fiscal dividends that must be used primarily for more federal spending..."

The Carter budget for 1978 does not represent a completely developed position. The short time in which President Carter's revision had to be made, the omission of the effect of his energy and Social Security proposals, and the scheduled studies and task forces whose reports during calendar year 1977 will help develop his Administration's proposals prevent his 1978 budget from being a full expression of his program. Accordingly, the Carter budget--except for the limited economic stimulus package--aims primarily at bringing federal outlays and receipts closer to "current service" levels--the amount of outlays under existing federal policies and programs. Tables 2 and 3 show the major changes in receipts and outlays to the Ford proposal which were recommended by President Carter.

President Carter sought to ensure higher receipts in the future, particularly to enable a balanced budget in 1981 without major reductions in outlays for existing social programs. Thus he rejected Ford's large and permanent reduction in income taxes and proposed instead a much smaller reduction through changes in the standard deduction and a one-year extension of the temporary income tax reductions enacted in 1976. Larger changes await his permanent tax reform program to be proposed later. President Carter also rejected the traditional Social Security payroll tax increase shared equally by employers and employees as proposed by Ford, recommending instead a lower payroll tax increase on employees and a higher increase on employers (effective after 1978) coupled with an $11 billion contribution from the general fund. This contribution makes up for the receipts lost by the Social Security cash benefit system because unemployment exceeded 6 percent in the calendar years 1975-1978. Finally, to assist the aged, Carter proposed that the monthly premium paid by them to cover physician services, under Medicare, be frozen at $7.20 rather than rise to $7.70 on July 1, 1977 and to $8.10 in 1978.

President Carter's 1978 outlay estimates exceed Ford's by $22.6 billion. The increase is designed to restore the outlay reduction proposed by President Ford and to strengthen various economic stimulus measures. Carter's budget would exceed the recent 10 percent increase in the annual rate of growth of federal outlays whereas Ford proposed lowering that rate to 7 percent.

In the 1978 budget submitted by Ford, the Office of Budget and Management estimated that federal outlays would be $445.4 billion under a current service policy. Table 4 summarizes and contrasts the changes from this current service estimate in the Ford and Carter budget recommendations. The lower half of

Table 2. Carter Revisions to Ford Budget Receipt Recommendations

	(In billions of dollars) Fiscal Year	
	1977	1978
Ford budget receipt estimates	$354.0	$393.0
Carter changes:		
Revised economic assumptions		
February estimates	-.9	1.9
April revision	.7	1.2
Proposed freeze in Medicare monthly premium at 7.20 per month	-	-.2
Rejection of Ford's proposed increase in social security taxes	-	-1.3
Rejection of Ford's proposed permanent reduction in individual and corporate income taxes	6.9	23.8
Economic stimulus proposals:		
$50 rebate..proposed in February	-8.2	-
withdrawn in April	8.2	-
Simplified standard deduction		
February estimate	-1.5	-5.6
April revision 1/	.3	-.3
Reduction in business taxes		
proposed in February	-0.9	-2.4
withdrawn in April	0.9	2.4
Extension of 1976 temporary tax reductions ($35 tax credit per exemption, earned income credit, etc.)	-	-7.8
President Carter's April budget receipt estimates	359.5	404.7

1/ Delayed enactment shifts some of the reductions from 1977 to 1978.

Source: Fiscal Year 1978 Budget Revisions p. 21-24 and April 21, 1977 Current Budget Estimates Issued by Office of Management and Budget.

Table 3. Carter Revisions to Ford Budget Outlay Recommendations

	(In billions of dollars) Fiscal Year	
	1977	1978
Ford budget outlay estimates	$411.2	$440.0
Carter changes:		
a) Re-estimates		
Unemployment insurance	-1.0	-1.2
Mortgage credit programs	-.4	-
Interest	.3	2.0
Offshore oil lease receipts	.3	-.3
Re-estimates made in April 1/	-6.0	3.4
b) Extensions of programs which Ford would allow to expire		
Employment and training	-	1.3
Earned income credit payments	-	.9
Counter-cyclical revenue sharing grants to state and local government	.2	.9
Federal supplemental unemployment insurance payments	.5	.4
c) Restoration of program reductions proposed by Ford		
Food stamps and nutrition	.7	2.1
Health care	.3	1.3
Education	-	.5
d) New program increases		
Veterans benefits including cost of living adjustment	-	.9
Energy programs - accelerate petroleum storage	-	.8
Transportation	-	.4
Special services and day care	-	.3
Foreign economic assistance	-.2	.6
Child and rural health programs	-	0.2
e) New program cutbacks		
Water resource development	-	-.3
Defense	-	-.3
f) Economic Stimulus Proposals (in addition to items under extension of expiring programs)		
$50 payment to social security beneficiaries and other low-income people	3.2	-
Public service employment and expanded training	1.0	5.0
Public Works	.2	2.0
Increase in counter-cyclical revenue sharing	.7	.7
April withdrawal of part of stimulus package	-3.2	-.2
g) All other net revisions	.4	1.2
President Carter's April budget outlay	408.2	462.6

1/ Some of these changes apply to items listed below but the April 21 report did not provide sufficient data for distribution.

Source: Developed by IOM staff based on FY 1978 Budget Revisions, p. 13; April 21, 1977 Current Budget Estimates issued by Office of Management and Budget.

Table 4 repeats most of the changes presented in Table 3. But the upper part highlights that Carter accepted with some modifications many of the changes from the current service budget proposed by Ford.

Major Ford outlay increases accepted by Carter would:

- o Increase real defense spending for supplies, weapons system procurement, and research and development ($1.5 billion)

- o Provide capital replenishment for international financial institutions, participate in the balance-of-payments loan program for Portugal, increase economic development assistance to less-developed countries and other international affair activities ($0.5 billion)

- o Upgrade the nation's parks and wildlife refuges, increase funding for energy conservation and research development programs, increase production of enriched uranium and other natural resources, environment, and energy items ($1.2 billion)

- o Fund the airport grants program at the full authorized level, increase the number of mass transit grants, increase Coast Guard activities to improve navigation and marine safety, increase funding for the Federal Aviation Administration and for the Northeast Corridor railway improvement program ($0.8 billion)

- o Provide full funding for the basic education grant program and increase funding levels for other education and related activities ($0.6 billion)

- o Increase low income housing assistance programs from 235,000 to 394,000 households; although 1978 outlays increase by $100 million, future outlays will be much higher

- o Step up support for VA hospitals, nursing homes, etc., adding $100 million to 1978 outlays

Major Ford outlay reductions accepted by Carter would:

- o Limit aid to schools enrolling children of federal employees to those school districts where federal activities impose a real economic burden; 1978 outlay savings of over $300 million

- o Reduce student benefits under Social Security, convert the Social Security retirement test to an annual rather than monthly basis, and make other benefit changes to produce 1978 outlay savings of over $750 million

- o Limit increases in hospital reimbursements financed by Federal programs, which would lower 1978 outlays by about $700 million

Table 4. Summary of Ford and Carter Changes in 1978 Outlays from Current Service Policy (CSP)

	(In billions of dollars)		
	Ford	Carter	Comment
Base estimate under CSP	$445.4	$445.4	Includes Section (b) Table 3
Reductions proposed by Ford and amount accepted by Carter	-12.4	-4.1	See discussion
Increases proposed by Ford and amount accepted by Carter	7.0	6.4	See discussion
Re-estimates by Carter	-	3.9	Section (a) Table 3
Economic stimulus by Carter	-	7.5	Section (b) Table 3
New program increases by Carter	-	3.2	Section (d) Table 3
New program decreases by Carter	-	-0.6	Section (e) Table 3
Miscellaneous changes (net)	-	.9	Section (g) Table 3 with modification
Recommended 1978 Outlays	$440.0	$462.6	

Source: Developed by IOM staff based on The Budget F.Y. 1978, p. 9-25; Fiscal Year 1978 Budget Revisions p. 13; a March 10, 1977 release No. 178 and the April 21 release by the Office of Management and Budget.

- o Require private health insurance reimbursement for VA hospital treatment of non-service-connected disabilities, eliminate duplicate burial benefits for veterans, and reduce over-payments under the GI bill by reinstituting attendance certification; a 1978 outlay saving of over $400 million

- o Reform housing allowances, blue-collar pay scale systems, etc., in defense budget to yield 1978 outlay savings of $200 million

- o Reduce health resource support programs for medical facilities construction, aid to educational institutions and concentrate on selected health professions education programs; estimated 1978 outlay savings of about $150 million

- o Tighten review and control to minimize erroneous payments in the Supplementary Security Income program and in federal public assistance grants; 1978 savings estimated at over $100 million

Table A and B in the Appendix group the Ford and Carter estimates of 1978 receipts and outlays by major categories. To sharpen the contrast their estimates are contrasted with estimates under a current service policy. Table B, dealing with receipts, compares Ford's proposal to reduce income tax receipts to $171 billion with Carter's proposal that would yield $183 billion. This table also contrasts the yield from Social Security payroll taxes. Ford proposed increases to yield $126 billion; Carter's payroll tax increase is deferred until after 1978, and his estimate of receipts from this source is $124 billion in 1978.

Table A, dealing with outlays, indicates that Carter's total defense outlays are essentially comparable to Ford's and that the major difference is in benefit payments to individuals and in grants to state and local governments. In these two areas--representing the domestic social programs--Ford proposed revisions under a basic policy to reduce or limit the growth in outlays, a policy that Carter rejected.

Ford and Carter 1978 Recommendations for Health Programs

Table 5 highlights the differences between President Carter and Ford in federal health programs.

The biggest difference is in their handling of Medicaid and Medicare. President Ford again recommended combining Medicaid and other grant in aid programs into a closed-end block grant to the states. He was willing to continue the current service level of federal financial assistance to the states (unlike his block grant proposal last year, which reduced federal aid by one billion dollars) but essentially leaves the problems and the remedies to the states. President Carter rejected the block grant and endorsed Health, Education, and Welfare Secretary Califano's proposal to create a new Health Care Financing Administration which would be responsible for both Medicare and Medicaid. Federal approaches toward cost-containment, quality control, and fraud prevention would be consolidated for both programs. Both Ford and Carter urged limits on spending increases for hospital services. Ford proposed that the limits only apply to payments made by federal financing programs—notably Medicare and Medicaid. Carter wants the limitations also to apply to reimbursements by private insurance plans. Carter presents these actions as essential preparatory steps to a later proposal for national health insurance. Ford in his January 18, 1977 Economic Report emphasized greater reliance on individuals, business, and labor unions to curb cost escalation in medical care and expressed the "hope we will not choose to fund these costs through a comprehensive national health insurance system..." (p. 10).

President Ford repeated his recommendation to extend Medicare to cover catastrophic medical costs (defined as annual costs over $500 for hospital care and over $250 for physician services) but coupled it with increased sharing by Medicare beneficiaries in costs below the catastrophic levels. President Carter rejected this proposal. His rejection does not rule out subsequent coverage of catastrophic costs but strongly suggests a position against increased cost-sharing by Medicare beneficiaries.

In addition to the block grant and Medicare, Ford made other recommendations on health programs. These proposals and the reactions by Carter are listed below.

Ford Proposal	Carter Position
o Set limits on increase in physician fees to be reimbursed under Medicare.	Reject
o Close or transfer to the local communities the existing eight Public Health Service hospitals.	Reject but subject to later review
o Transfer St. Elizabeth's Hospital to the District of Columbia.	Endorse

o Consolidate under one appropriation to the Assistant Secretary many separate appropriations for health services and for health resource development.	Reject
o Shift support for medical education from emphasis on increasing number of graduates to emphasis on better geographic distribution and on selected specialities.	Endorse
o Discontinue capitation grants to schools for veterinary medicine, optometry, podiatry, and pharmacy.	Endorse
o Eliminate HEW's program to assist federal agencies in the operation of their employee health programs.	Reject
o End special support grants designed to to improve biomedical research potential of educational institutions.	Endorse
o Fund in full a newly enacted $500-million loan guarantee fund to support private loans to students in the health professions, relying on this program to replace direct federal loans or scholarships.	Endorse

As indicated in Table 5, President Carter proposed legislative changes and modest increases to improve health care services to poor children and to Medicare beneficiaries in rural areas, and for alternatives to abortion.

In January 1977, the Office of Management and Budget estimated that under a current services policy, 1978 outlays for health would total $45.3 billion, the same estimate made by the Congressional Budget Office in December 1976. Both Carter and Ford saw the need to contain medical care costs to gain leeway for other health programs and still remain below $45.3 billion.

In recent years, there has been growing recognition that the health of our population is strongly affected by environmental and behavioral factors. Neither the Ford nor the Carter budgets recommend any real changes in money or priorities for programs aimed at these health determinants.

Table 5. Carter Revisions to Ford's 1978 Budget for Health

	(In millions of dollars)
Ford recommended outlays for health	$43,305
Carter rejection of Ford proposals:	
In Medicare - to add protection against catastrophic costs	-594
- to put ceiling on reimbursement increases coupled with increased cost-sharing by beneficiaries	2,378
In Medicaid and 19 other grants to be replaced by a single block grant	80
New Carter proposals:	
Extend Medicare's coverage in rural health services (25) and Medicaid's child health services (180)	205
Increases in abortion alternative (15), mental, drug, and alcoholism (4), Indian health (10), immunization (2), health manpower training (21), and research (3)	55
Cost containment proposals in Medicare (-695)' Medicaid (-134) unaccompanied by greater cost-sharing by beneficiaries	-829
Revised Carter outlay recommended in February 1977	44,485 1/
April revisions	
Re-estimates of outlays in various Public Health programs	130
Re-estimate of Medicare outlays	13
	$44,628

1/ President Carter also proposed that the Medicare monthly premium rate be frozen at $7.20, and that the scheduled increases to $7.70 on 7/1/77 and to $8.10 on 7/1/78 not be implemented. This freeze doesn't affect Medicare outlays but saves beneficiaries $37 million in 1977 and $182 million in 1978 which will be made up by increased payments from general revenue funds.

Source: FY 1978 Budget Revisions and April 21, 1977 Current Budget Estimates, issued by OMB.

Trends and Projections in Budget Receipts and Outlays

In the 1960s, federal spending began to shift from defense to human service programs. At the beginning of that decade defense spending accounted for 47 percent of the total federal budget; spending for human resources took 29 percent. Table 6 shows that defense spending had declined to 40 percent of total outlays in 1970 and dropped to about 25 percent currently. Spending for human resources which rose to 37 percent in 1970 was further accelerated and reached about 52 percent currently. The rise in human resource spending stemmed from the introduction of new programs--particularly Medicare and Medicaid--and from improvements and the growing maturity of existing programs.

The shift in the internal make-up of federal spending was accompanied by an increase in the share of GNP directed by the federal government. In the 1970s, federal spending rose from 20 to 22 percent of GNP (Table 6); in the early 1960s, total federal spending hovered around 19 percent of GNP. Currently one percent of GNP is worth about $20 billion. During periods of economic recession, federal spending takes a larger share of GNP partly because it rises to fund recession-induced spending and partly because the GNP levels off or declines.

Federal receipts have also experienced an internal shift, although not much of a change as a percent of GNP. Table 6 shows that social insurance taxes and contributions rose from 23 percent of total receipts in 1970 to more than 30 percent currently. In 1960 social insurance accounted for $15 billion or only 16 percent of all receipts, whereas individual and corporate income taxes totaled $62 billion or 65 percent of receipts.

Total federal receipts, however, remained relatively level around 19 percent of GNP, and except for 1969 and 1970 never reached 20 percent. Periodic reductions in the income tax rates and tax liabilities more than offset increases in the social insurance tax and held down income tax receipt increases otherwise expected from the increase in GNP and personal income levels.

What can be expected over the next few years? Both President Carter and the Congress have endorsed the goal of a balanced budget. The President has set this target for the 1981 budget. The Congress has not set any specific date but probably will agree to a 1981 dateline. The Senate Budget Committee has coupled a balanced budget, assuming a prosperous economy, with the goal of "limiting the federal sector to about one-fifth of GNP" (Report No. 95-90, p. 15). While neither the President nor the Congress has, as yet, issued any 1981 projections to accompany the 1978 budget estimates cited in this staff paper, it is possible to adapt five-year projections made by the House Budget Committee (Report No. 95-189, p. 98-100).

These figures, for 1981, are presented in Table 1. They indicate the 1981 budget would be in balance and would show a surplus, assuming no major new programs and continued economic recovery. Total federal outlays would be about 20 percent of GNP. Federal receipts, assuming no further reductions

Table 6. Percentage Distribution of Outlays and Receipts by Major Categories Selected Years

		Actual			Estimated	
	1970	1975	1976	1977	1978P	1978C
	Percent Distribution					
Total Outlays	100	100	100	100	100	100
Defense	40.3	26.6	24.6	23.8	24.4	24.8
International Affairs	1.8	1.8	1.4	1.6	1.6	1.6
Human Resources, total	36.9	51.6	53.9	53.2	51.6	51.9
Health	6.6	8.5	9.1	9.6	9.6	9.6
Income Security	21.9	33.3	34.8	34.0	32.1	32.0
Educ. training, Employment and Soc. Serv.	4.0	4.7	5.0	5.1	5.8	5.9
Veterans benefits and services	4.4	5.1	5.0	4.5	4.1	4.4
Physical resources and	.7					
general science 1/	13.2	10.9	11.9	11.6	12.8	12.7
Interest, general government, etc. 2/	15.0	13.4	13.0	13.5	12.9	13.2
Undistributed offsetting receipts	-3.3	-4.3	-4.0	-3.7	-3.5	-3.5
Total Receipts	100	100	100	100	100	100
Indiv. Income taxes	46.7	43.6	43.9	44.5	45.2	44.7
Corporate income taxes	17.0	14.4	13.8	15.3	15.1	14.7
Social ins. taxes contrib.	23.4	30.7	30.9	30.0	30.7	31.3
Excise taxes 3/	8.1	5.9	5.7	5.0	4.6	4.6
All other 4/	4.8	5.3	5.8	5.1	4.4	4.7
Total dollars and relation to GNP						
GNP ($ in billions)	959.0	1450.6	1609.5	1877	2103	2088
Total budget outlays ($ in billions)	196.6	326.1	366.5	408.2	462.6	461.8
Total budget receipts ($ in billions)	193.7	281.0	300.0	359.5	404.7	397.2
Percent outlays of GNP	20.5	22.4	22.8	21.7	22.0	22.1
Percent Receipt of GNP	20.2	19.8	18.6	19.1	19.2	19.0

Note: P is President Carter's recommendation; C is congressional. Figures for 1977 are President Carter's estimates. GNP estimates for 1977 and 1978 are for calendar rather than fiscal years; outlay and receipt ratios to GNP are therefore slightly overstated.

1/ Includes agriculture, natural resources, environment, energy, commerce and transportation, general science, space and technology and community and regional development.

2/ Includes law enforcement and justice, revenue sharing and general purpose fiscal assistance and allowances.

3/ Includes highway and airport trust funds.

4/ Includes estate and gift taxes, customs duties and miscellaneous.

Source: Developed by IOM from Carter and congressional budget reports and documents.

in the income tax laws, would grow to 21 percent of GNP. The 1981 figures are projections rather than forecasts and are especially sensitive to small changes in the underlying economic assumptions. The important point shown by the 1981 projection is the level of receipts and outlays as a percent of GNP rather than the exact dollar numbers.

Introduction to Comparison of Carter and Congressional 1978 Budgets

The remainder of this staff paper concentrates on the Carter and congressional recommendations. But first, some background information and technical points are in order.

This year's first concurrent resolution by Congress on the budget treats earned income payment made to low income taxpayers ($.9 billion) as a deduction from budget receipts. The President's budget classifies this payment as an outlay under the income security function. For purposes of comparison, this report follows the presidential pattern and thus increases both outlays and receipts in the first budget resolution by $.9 billion.

The President's budget figures reflect revisions made at the end of April. The first budget resolution sought to incorporate many of those revisions, especially those concerning lagging 1977 spending, which now is expected to occur in 1978. But there may have been some revisions that the first resolution did not incorporate, or circumstances for which the congressional budget committees forecast somewhat lower outlays. Accordingly, a more current congressional figure for 1978 would perhaps be $1 to $2 billion higher than $461.8 billion in total outlays shown on Table 7.

The President's budget and the first budget resolution develop overall outlay totals and allocate these totals to various functional areas. But within each functional area, the binding nature of the two budgets differ. The President's intrafunctional estimates are controlling on the agencies and departments and reflect his Executive branch position. The intrafunctional distribution developed by the congressional budget committees and discussed in their reports accompanying the first budget resolution is suggestive or advisory to the appropriation and legislative committees of the Congress. Until the budget resolution is amended, these latter committees are expected to abide by the totals for each function. While the congressional budget committees often recommend specific changes for programs within a function, the appropriation or legislative committees are not proscribed from internal functional changes which differ from the Budget Committee position.

Finally the appropriation committees may estimate that an automatic entitlement program in a functional area may entail lower expenditures than estimated by the President or by the congressional budget committees. These "savings" can then be used to support higher appropriations and outlays for other programs in the same function. Under these circumstances, the President can claim that the congressional appropriations will exceed his estimates because supplemental appropriations will be required later to fund the "savings" in the entitlement programs. This confrontation is possible even where the functional total embodied in the first budget resolution is less than the President's recommendation. This process also may result in a dispute between the congressional budget committees and the various appropriation or legislative committees. The latter dispute generally is resolved in action on the subsequent budget resolutions.

Nevertheless the Budget Committees of the Congress have canvassed the various appropriation and legislative committees and received their reactions to the President's proposals. The report of these Budget Committees and their conference reports do highlight the significant areas of agreement or disagreement with the President's proposals.

Carter and Congressional Budget Estimates

The 1978 budget estimates by President Carter and Congress as shown in Table 7 are less than one billion apart in total outlays. At present the major dollar differences that reflect an actual difference in program choices rather than technical differences are limited to defense, community and regional development, natural resources, education, health, and veterans benefits and services.

In the defense budget, the Congress believes that the Administration can tighten managerial controls and carry out its program with lower outlays. In community and regional development, the Congress wants more antirecession public works programs and rejects Carter's proposal to end special categorical grants and rely only on a block grant; the Congress proposes to fund both types of grants. The Congress estimates a lower outlay for natural resources, because the savings from its proposal to go slower in building up the strategic petroleum reserve are only partially offset by increases in water resource development projects. The President proposes cutting out some of these dams and other water projects. In education, the President proposes no new funds for the National Direct Student Loan Program--letting that program make new loans with funds received from repayments of loans on prior years. The Congress proposes to appropriate new funds. The President also proposed sharp reductions in "impact-aid" funds--grants made to local governments to offset the presumed extra costs imposed on their schools by the children of federal employees. The Congress opted for a much slower phaseout of this program. For veterans benefits, the congressional figure provides a larger buildup in VA medical care and rejects the cost-saving proposals on some other benefits urged by the President. On debt service the Congress projects an increase in interest rates above current levels, while the President's budget continues the tradition of using current interest rates.

The figures in Table 7 do not demonstrate the congressional agreement that exists for a large number of cost reducing reforms recommended by President Carter. Some of these major reductions and their estimated savings are:

Reduction	Estimated savings
Reform of the Wage Board salary determination principles used in the Defense Department.............	$.2 billion
Higher charges for enriched uranium...................	.1 billion
Repeal of an appropriation trigger provision that automatically raises federal education grants.....	.2 billion
Ceilings on reimbursement for hospital care in Medicare and Medicaid................................	.6 billion
Revisions in the Social Security cash benefit program..	.8 billion

In summary, the first budget resolution endorses the need to move toward a balanced budget in the near future. It contains few funds for new programs, and its accompanying reports and discussions emphasize that its 1978 outlays are $15 and $20 billion below targets suggested by the Senate and house appropriation and legislative committees.

Table 7. Comparison of Carter and Congressional Estimates of 1978 Outlays by Functions

	(In billions of dollars)		
	President	Congress	Difference
Total	$462.6	$461.8	$ -.8
National Defense	112.8	111.0	-1.8
International Affairs	7.2	7.3	.1
General science, space, and technology	4.7	4.7	-
Natural resources, environment, and energy	20.9	20.0	-.9
Agriculture	4.4	4.3	-.1
Commerce and transportation	19.9	19.4	-.5
Community and regional development	9.9	10.8	.9
Education, training, employment, and social services	27.0	27.2	.2
Health	44.6	44.3	-.3
Income security	148.7	147.6	-1.1
Veterans benefits and services	18.8	20.2	1.4
Law enforcement and justice	3.8	3.8	-
General government	4.0	3.8	-.2
Revenue sharing and fiscal assistance	9.7	9.7	-
Interest	40.9	43.0	2.1
Allowance for contingencies	1.2	.9	-.3
Undistributed offsetting receipts	-16.0	-16.3	-.3

Source: April 1977 Current Budget Estimates; Conference Report (House Doc. No. 95-291).

Health Spending: National and Federal

Total national expenditures for health reached $139.3 billion in 1976; a hundred billion dollars more than in 1965 (Table 8). These figures published by the Social Security Administration show a rise in health expenditures from 5.9 percent of GNP in 1965 to 8.6 percent in 1976. The federal share of those expenditures rose from 13 to 28 percent over the same period.

The increase in total national and federal expenditures is primarily due to increased expenditures for personal health care--service and supplies for specific individuals--from $33.5 billion in 1965 to $120.4 billion in 1976. Of this $86.9 billion rise, the Social Security Administration calculates that 7.6 percent was due to population growth, 34.8 percent resulted from changes in services, and 57.6 percent was the result of price increases. Accompanying these increases was a growth of personal health care spending paid through third-party systems, from 47 percent in 1965 to 68 percent in 1975. Among third-party payment systems, the most growth occurred in federal programs, mostly Medicare and Medicaid.

The federal budget documents use two definitions of health expenditures. Both are somewhat broader than the Social Security Administration's definition because they include "medical training and education." The definition used in the budget document excludes health-related outlays covered in other functions, mainly defense and veterans benefits. But the health definition used in the Special Analysis accompanying the budget document includes those health-related expenditures.

The congressional budget follows the more restricted functional definition used in the President's budget and excludes defense and veterans medical care. Accordingly, the remainder of this report uses that definition.

Under the more restricted definition used in the budget document, total federal health expenditures were $33.4 billion in 1976 or 9.1 percent of the total federal budget. Comparable figures in 1965 were $1.7 billion and 1.4 percent. Using the broader Special Analysis definition, federal health and health-related expenditures in 1976 reached $43.6 billion or 11.9 percent of total federal expenditures. In 1965 the comparable figures were $5.2 billion and 4.4 percent of the total federal budget. In 1978 about 13 percent of total federal expenditures will be for health and health-related activities.

Although there has been significant growth in all federal health spending, the major increase has been in programs to finance personal health care. If current trends continue, total national health expenditures would be about 10 percent of GNP or $265 billion by 1981. While some policymakers view the trend as our society's choice for the allocation of resources, a majority of them are troubled by the rising costs and share of GNP. Constraining the costs in personal health care has become a major factor in developing a national health strategy. This strategy would cover not only personal health care programs, but also other areas that determine health status, such as environmental and behavioral factors, and would release some resources for other social purposes.

Table 8. Total Health Expenditures and Personal Health Care Expenditures, Selected Fiscal Years 1950-76

Types of Expenditures and Source of Funds	1950	1960	1965	1970	1975	1976
Total Health Expenditures:						
Amount (billions of dollars)	12.0	25.9	38.9	69.2	122.2	139.3
Percent of GNP	4.5	5.2	5.9	7.2	8.4	8.6
Percent funded by public	25.5	24.7	24.5	36.7	41.6	42.2
Personal Health Care Expenditures:						
Amount (billions of dollars)	10.4	22.7	33.5	60.1	105.7	120.4
Percent distribution by source of funds:						
Total	100.0	100.0	100.0	100.0	100.0	100.0
Direct payments	68.3	55.3	52.5	40.4	33.6	32.5
Third party payments	31.7	44.6	47.5	59.7	66.4	67.5
Private insurance	8.5	20.7	24.7	24.0	25.4	26.0
Other private	3.0	2.3	2.0	1.5	1.3	1.3
Federal	9.4	9.2	8.5	22.3	27.3	28.0
State and local	10.8	12.4	12.3	11.9	12.4	12.2
Per capita amount (dollars)	67.75	124.50	170.32	289.76	488.23	551.50
Non-personal Health Expenditures: (in billions of dollars):						
Research	0.1	0.6	1.4	1.8	2.9	3.3
Medical facility construction	0.7	1.1	1.8	3.3	4.6	5.0
Government public health activities	0.3	0.4	0.7	1.4	2.9	3.3
Expenses for prepayment and administration	0.4	1.0	1.5	2.5	5.9	7.3

Source: Gibson and Mueller in the Social Security Bulletin, April 1977

Total Health Outlays in the 1978 Budget

The congressional budget target for health in the first budget resolution has three major components--Medicare, Medicaid, and All Other. The Congress did not attempt to further divide All Other into health research, manpower, prevention and control, or various other health services, planning, or statistical activities. The presidential and congressional outlays for total health and for these three groupings are compared in Table 9.

For Medicare and Medicaid, the Congress endorsed President Carter's objective to control increases in hospital costs, and his proposals to improve child health services, and to extend Medicare coverage to services in clinics, even though those services are not directly supervised by physicians, as in rural areas served by nurse-practitioners and physician assistants. The child health proposal provides extra grants to the states to facilitate screening, immunization, and follow-up corrective health services. The differences in outlays for these legislative changes, shown in Table 9, are due to timing. The Congress felt that these legislative proposals would not be enacted in time to take effect on October 1, 1977--as proposed by the President. Congress assumed an effective date of January 1978.

The more significant difference between the President and the Congress in Medicare and Medicaid is reflected in the current service policy estimate. The Congress projected that the existing Medicare and Medicaid program would require $650 million less than did the President. It is this lower projection which the Congress utilizes to provide $300 million more for All Other and still come up with an overall health target $300 million below the President. Should actual experience approach the President's base estimate for Medicare and Medicaid, the congressional target would probably be adjusted upwards in later budget resolutions and would then exceed the President's total health estimate.

Although it is not reflected in Table 9, reports of the budget committees indicate that the Congress rejected the President's proposal to freeze the Medicare monthly premium rate at its July 1977 level of $7.70. The House report cites opposition by the Ways and Means Committee and said that 40 percent of the $220 million in premiums lost in the freeze would benefit Medicare recipients with annual family incomes of $10,000 or more, and that for most of Medicare beneficiaries with much lower family incomes, the monthly premium is paid by the Medicaid program.

For all other health programs, the President essentially proposed continuations of the total 1977 level. Special increases, as in counselling and family planning as alternatives to abortion, are offset by reductions in existing programs, particularly health manpower training. The congressional budget committees agree that federal support for health manpower programs can be reduced and that the need no longer is for more physicians but rather for their better geographic and specialty distribution. Nevertheless, the congressional budget figure recommends a slower reduction in manpower programs. The Congress also wants increased funds for biomedical research and for special health service programs for Indians, migrants, and mental health patients.

Those differences not withstanding, the Congress and the President share an overriding objective to control the rise in medical care costs.

Table 9. Comparison of Presidential and Congressional 1978 Outlay Estimates for Health

	(In millions of dollars)	
	President	Congress
Total	$44,600	$44,300
Medicare		
Current Services Policy	26,081	25,778
Proposed: Hosp. Cost Control	-695	-620
Payments to clinics	25	25
Other		1
(Subtotal)	(25,411)	(25,184)
Medicaid		
Current Services Policy	11,816	11,469
Proposed: Hosp. Cost Control	-134	-106
Child health and other	180	177
(Subtotal)	(11,862)	(11,540)
All Other Health	7,300	7,600

Note: Congressional figures are rounded for total and All Other Health. For comparison, similar figures in Presidential estimates also have been rounded.

Source: 1978 Budget Revisions and April Current Budget Estimates; Joint Conference Report on First Concurrent Budget Resolution; House explanation in May 17, 1977 Cong. Record p. H4558 and House Budget Committee Reports.

The Administration's Hospital Cost Containment Proposal

The Administration's proposal concentrates on hospital care for obvious reasons:

> Size Hospital care is the largest single cost component. In 1976 it required $55 billion or 40 percent of all health expenditures and 46 percent of all expenditures for personal health care.
>
> Annual rate of price increases The price for hospital services increased at a faster annual rate than other medical care prices or prices generally. In 1976 hospital service charges rose 13.4 percent compared with 10.2 percent for the total medical care component in the Consumers Price Index (CPI) and with 7.1 percent for all items in the CPI.
>
> Services and technology More than other medical care, hospital services are markedly affected by the introduction of new technology and services which increase rather than reduce costs and which require additional personnel. It has been estimated that in calendar year 1975 almost 45 percent of the increase in cost per patient was due to changes in hospital services and technology.

Most of these characteristics of hospital care have accompanied and have been stimulated by a basic difficulty under the present third-party payment system for hospital charges: an open-ended source of funding which blunts incentives for either the hospitals or the patients to keep costs down or to assess the utility of in-hospital services. The current system encourages unnecessary hospitalization, unnecessary services, and necessary services, but in hospitals where the equipment and required skills apply to such a small number of patients that suitable utilization never is achieved. About 91 percent of hospital expenditures are paid by third-party systems--private insurance or public agencies. Only 9 percent is paid directly "out of pocket" by the patient.

Recent Administrations have urged approaches aimed primarily at controlling Medicare and Medicaid hospital costs. Those approaches sought to increase cost sharing by the patients, set percentage limits on price increases, and require state or local health planning agencies to certify the need for hospital construction or large equipment expenditures. But except for "certificate of need" and experiments with prospective reimbursements, none of those proposals was enacted. Nor has the Congress enacted its own proposals beyond some broad limits on increases in the hospital room and board.

President Carter's proposal takes a different approach. It includes all hospital revenues, including reimbursement from private insurers or patients, and is not limited to payments from Medicare and Medicaid. His proposal concentrates on revenues received by hospitals* not on setting limits for prices,

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*Phase IV of the Nixon Wage Control effort in 1973 embodied an effort to limit the increase in a hospital's revenue. Furthermore, controls during the 1971-73 period applied to all patients and third-party payers, not only federal government reimbursements.

wages, or charges for specific services. Incentives for operating within the revenue limits are concentrated on the hospital management and affiliated physicians, and the formula for establishing a hospital revenue ceiling is based on available data. The Carter proposal also gives substantive tasks and judgments to state health planning agencies.

More details of President Carter's proposals are presented in Table C in the Appendix.

Along with the revenue ceilings, the President's proposal puts tight limits on capital expenditures by acute care hospitals. Current plans call for an annual ceiling of $2.5 billion--about one-half of the nation's present actual expenditure. Until more precise formula factors are developed, the national capital expenditure limit would be allocated to the states on the basis of population. No reimbursement would be made by Medicare or Medicaid for services in hospitals created or increased in size from capital expenditures outside the state's share of the national limit. Finally, the proposal would bar any certificate of need for hospital construction in health planning areas where hospital beds now exceed 4 per one thousand population or where the average occupancy rate is below 80 percent. The bed-to-population ratio is the same as one of the recommendations of the Institute of Medicine's policy statement of October 1976, "Controlling the Supply of Hospital Beds."

The Administration urges its proposals as a temporary measure, for which the Secretary of HEW is directed to develop a permanent replacement by March 1978.

The congressional first budget resolution strongly endorsed the cost constraining objective of President Carter's proposal. But Congress left the details to be worked out by its legislative committees. That raises some potential problems, because the House and Senate each have two substantive committees that can claim jurisdiction: Ways and Means and the Subcommittee on Health and Environment of the Interstate and Foreign Commerce Committee in the House, and the Committee on Finance and the Subcommittee on Health and Scientific Research in the Senate.

Additional problems* are suggested by recent history. Although the Congress has repeatedly endorsed cost containment, it has been reluctant to enact tough constraining legislation--particularly when the legislation was not endorsed by health care providers. Whether a Democratic Congress with a Democratic Administration will act differently is yet to be seen.

In addition the major bill, to control hospital costs, pending in the prior sessions of Congress was developed by Democratic Senator Herman Talmadge from President Carter's home state of Georgia. He reintroduced in this session his bill to control costs another way. The Senator wants to classify and group hospitals by bed size, type, or other appropriate criteria, and then

*At least one constitutional issue is raised by the Administration's proposal: does the federal government have authority to regulate revenues or limit construction of nonfederal hospitals, particularly where the regulation affects nonfederal funds?

direct Medicare and Medicaid to prospectively reimburse each hospital on the basis of the average cost for the group. Efficient hospitals with costs below the average make more money, while hospitals with costs above the average would lose money until they managed to reduce their costs. This reimbursement method would apply initially only to routine hospitals costs--bed and board. Once some experience was acquired, this reimbursement method could be extended to other hospital services.

Budget for Other Health Programs

The first budget resolution proposes a ceiling of $8.0 billion in budget authority and $7.6 billion in outlays for health programs other than Medicare and Medicaid. The budget authority ceiling is 10 percent above the 1977 level. President Carter recommended $7.3 billion in budget authority—about the same level as in 1977. The congressional ceiling allows for selected program increases—particularly those urged by the President--without offsetting reductions elsewhere. The President, however, proposed selected reductions which offset his proposed increases.

As the congressional figure is not distributed among the component programs, it is not possible to compare the details in the President's recommendation with the congressional resolution. Consequently this section concentrates on the President's recommendations.

Table 10 lists the 1978 budget authority recommended by President Carter for the Department of Health, Education, and Welfare which account for $6.3 billion in budget authority. The remaining $1.0 billion is spread among various other agencies and departments. The table identifies those programs for which the President wants changes from the 1977 level.

The table indicates the overall generalization that President Carter sought to maintain the 1977 level in 1978. (President Ford recommended a lower 1978 budget authority of $6.0 billion for these HEW health programs).

President Carter recommended:

- increases for family planning, birth control education, reproductive research, maternal health care, and adoption—all as alternatives to abortion;
- increased immunization for children;
- phasing out federal support to health education institutions;
- shifting support to students in these institutions away from direct federal scholarships or loans and towards federally guaranteed private loans;
- holding to about the 1977 levels of support for biomedical research in the well-funded heart and cancer programs;
- providing small increases for some components of the National Institutes of Health that, unlike heart and cancer, have not had increases in recent years.

As indicated by the asterisks on Table 10, the Congress is likely to propose further increases in NIH particularly for cancer and heart research and in grants to the states for disease prevention programs under the Center for Disease Control. It is also likely that the Congress will reject the Carter decreases which begin phasing out federal support in the various health-manpower training programs.

Table 10. Budget Authority for Other Health Programs in HEW. Fiscal Years 1976-78 (in million dollars)

	1976	1977	1978	Comments on change from 1977
Total	5,793	6,198	6,257	
Food and Drug Adm.	210	253	279	Expand program on safety and efficacy of medical devices.
Health Services Adm.	1,324	1,516	1,587	
Community Health Services	781	837	895	Increase in alternatives to abortion (family planning, community health centers). Also increase in national health service corps.
Quality Assurance	53	66	79	Increase for operating PSROs.
Public Health Service Hospitals	115	131	135	To meet mandatory cost increases pending resolution of status of hospitals.
Indian Health	339	433	442	Principally scholarship support to Indians entering the health professions.
*Center for Disease Control	150 1/	180	187	
Child Immunization Programs	5	13	19	To increase state and local child immunization efforts.
Health Education	4	5	7	Educational programs or alternatives to abortion.
*National Institutes of Health	2,302	2,531	2,576	
Institute of Allergy and Infectious Diseases	127	141	153	Catch up in neglected areas.
Institute of General Medical Sciences	187	205	220	" " "
Institute of Child Health and Human Development	137	145	156	To increase research in reproduction as part of alternatives to abortion.
Institute of Environmental Health Sciences	38	49	58	Catch up in neglected areas.
*Research Resources Grants	130	138	102	Phase-out grants to build up research capability in biomedical schools.
Alcohol, Drug Abuse and Mental Health Administration	881	940	947	
Health Resources Administration	722	699	588	
Health Planning and Medical Facilities Construction	188	146	137	Zero out grants for construction.
Capitation Grants to Schools of Medicine, Osteopathy and Dentistry	83	91	114	Formula increase required due to increased student number.
*Capitation Grants to Schools of Optometry, Podiatry, Pharmacy and Veterinary Medicine	18	7	0	Phase out this institutional support program.
*Aid to Students in the Health Professions	65	58	47	Phase down federal loans and scholarships; rely instead on federally guaranteed private loans.
*Capitation Grants to Nursing Schools	46	49	0	Phase out institutional support.
*Aid to Nursing Students	40	46	9	Phase out, rely instead on private loan program.
*Special Educational Aids Other Than Primary Care, Physician Attenders, Geographical Distribution and Aid to Minorities	56	37	8	Phase out special aid except for identified areas.
Office of Assistant Secretary for Health	69	79	93	Increase for mandatory retirement benefits and for scientific activities overseas. Latter funded by special foreign currency funds available to U.S. government.

* Indicates program areas in which congressional budget probably will be higher.

1/ Excludes one-time budget authority of $135 million for Swine-flu immunization program.

Source: Special tabulation dated February 21, 1977 released by the Department of Health, Education, and Welfare.

Summary and Observations

Not surprisingly, there is a marked contrast between President Ford's budget recommendations and those proposed by President Carter and the Congress. President Ford's recommendations sought to contain the growth in federal social programs; his tax and expenditure proposals aimed to reduce federal command of the nation's total resources; President Carter's and the Congress' do not. Yet there is general agreement among the three budget recommendations on what the government should do to further economic recovery and to contain inflation. All three foresee continued economic improvement through private action and do not propose major increases in the 1978 outlays to stimulate economic growth. While the congressional budget committees are somewhat less optimistic about economic improvements in the private sector, they have gone along with President Carter's plan, leaving open the possibility that in September or later economic developments may necessitate a major fiscal stimulus effort. All three budgets express concern about inflation as well as a favorable assessment of economic recovery and growth, and therefore set targets for a balanced budget in the near future and project a surplus in 1981 of around $30 billion.

But even if that optimistic expectation of economic growth comes true, there probably won't be much money available for new programs--particularly if the goal of a balanced budget is attained. That surplus in 1981 is projected on existing income tax laws; changes in tax laws traditionally lower the tax yield, and would reduce that surplus.

In addition, the effect of a new energy policy on the economy could be to increase the costs of energy-intensive production, slow economic activity, and therefore reduce federal revenue yields.

Neither are cutbacks in existing programs expected to produce much in the way of funds for new programs. Both President Carter and the Congress have expressed a need for increases in defense spending. In non-defense spending, the President has endorsed reductions in many programs--such as farm price supports and veterans' benefits--that Congress usually regards as necessary for the contentment of its constituency.

Some of the leading proposals for new programs--national health insurance, urban mass transit, financial aid to cities, and the like--are expensive. Even with a brisk economic growth and no reduction in federal revenues, a balanced budget means that new programs of that magnitude would probably have to be introduced gradually as the money became available.

For health programs in 1978, the first Carter budget and the first budget resolution indicate some new directions.

In the matter of controlling costs, President Carter has not adopted previous proposals for increased cost-sharing by patients or transferring to the states Medicaid and its problems. Instead he has opted for cost control through efforts aimed at providers. To presidents Nixon and Ford, soaring health care costs and expenditures after 1967 were mainly a development that inveighed against mandatory universal national health insurance. To President Carter the rise in health care costs is something to be stopped so that national

health insurance can be put into place. The congressional majority, by and large, agrees.

President Carter has proposed limiting the supply of hospital beds and capital equipment, arguing that increased supply creates unnecessary use. Although he has not yet proposed limiting health manpower supply, he has asked for reductions in federal grants that encourage increases in supply. These proposals are acceptable to the Congress except in manpower supply, where it is reluctant to accept cutbacks.

President Carter's position on abortion also is a new direction. Previous presidents preferred to let the courts and the states decide on the right to abortion and on the use of federal funds for it. President Carter says he is opposed to abortion and has urged alternative educational, family planning, and adoption programs. The Congress supports this position and will probably limit the use of federal Medicaid funds to pay for abortions--particularly now that the Supreme Court has ruled that this use of health funds is a legislative rather than a constitutional issue.

Congressional action and the accompanying debate focuses primarily on the use of Medicaid funds to finance abortions for poor women. Probably an equal number of abortions are financed through medical care insurance programs offered by employers to women who are employees or dependents of employees. These programs are either directly financed by the federal government--for federal military or civilian employees and their dependents--or indirectly encouraged through favorable federal tax treatment. Action on Medicaid ignores a more basic social policy issue: paying for abortions directly with federal funds or with private funds encouraged by tax laws.

In the mid-1960s, federal health care legislation sought only to alleviate financial barriers to care; the new Medicare and Medicaid laws specified that the legislation did not authorize interference in the practice of medicine. But today concern centers on the efficacy of medical care and the cost with which it is delivered. A decade ago, expansion in the supply of health care resources was pushed to lower prices. Now increases in supply are seen to increase use and total expenditures without any automatic presumption that the increased use is medically effective or necessary.

Controlling hospital costs, whether through prospective reimbursements around an average cost, or through a cap on annual hospital revenues, requires firmer standards and judgments, acceptable both to providers and the public, in two major areas. The first is the determination of diagnostic and treatment services that are medically necessary and would therefore be reimbursed by a third-party payer. The recently established Professional Standards Review Organizations (PSROs) in more than 200 health service areas across the country are aimed at this determination. So are such studies as the recent Institute of Medicine report on Computed Tomographic Scanning. Another move in this direction was the May 1977 announcement by Blue Shield that it will not pay for 18 surgical procedures and 10 diagnostic tests because they are medically questionable or ineffective. Should the physician and his patient still want to go ahead, the cost will be borne by the patient, not the insuror.

The second area requiring firmer knowledge or guidelines has to do with the decision to hospitalize a patient. The national hospital admission rate has risen steadily from 149.8 per thousand population in 1967 to 161.7 in 1973. A provision in the Administration's bill exempts hospitals from the revenue cap if at least 75 percent of their revenues are from health maintenance organizations (HMOs). While there are a number of reasons for this exemption, one major factor is that the HMO, with its prepaid capitation system, has a lower hospital admission rate. Comparisons of HMO experience with fee for service systems show however that the HMOs do not differ significantly in the average length of stay once a patient is admitted.* There is no published information comparing HMO and fee for service utilization of professional services within the hospital after admission. If comparisons of hospital services after admission show no significant differences, it would suggest that HMOs also need firmer knowledge about diagnosis and treatment.

If containing the rise in existing health care expenditures is a prelude to mandatory universal national health insurance, the cost problem moves to the center of national health policy. But resolving this problem requires increasing our knowledge of what is medically necessary. Otherwise approaches through regulation, HMOs, or other systems may leave us with doubts whether we are depriving individuals of needed medical care or whether certain care is so unnecessary that it need not be reimbursed by our insurance.

*A recent report published by HEW's National Center for Health Service Research [DHEW Publication No. (HRA) 75-3125] compared the experience in the Washington, D.C. areas for matched single members and families under the Federal Employees Health Benefits Plan. Those enrolled under an HMO plan had an admission rate of 69 per 1000 members and an average length of stay of 6.5 days. Those enrolled under the fee for service Blue Shield-Blue Cross plan had an admission rate of 121 and an average length of stay of 6.6 days.

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A P P E N D I X

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Table A. Comparison of Ford and Carter Budget Outlays in FY 1978 by Major Categories

	(In billions of dollars)		
	Current Policy Base	Ford	Carter
Total	$450 3/	$440.0	$462.6
National Defense	112	112.3	112.8
Benefit payments for indiv. 1/	197	193.6	199.3
Grants to state and local govts. 2/	51	46.1	56.6
Net Interest	34	31.1	32.3
All other	57	56.9	61.8

1/ Excludes military retired pay which is included under National Defense.

2/ Excludes payments for individuals which are channeled through state and local governments, e.g., public assistance, Medicaid, food stamps, etc. These are included in benefit payments for individuals.

3/ Larger than $445.4 shown in Table 4 because it includes discretionary inflation adjustments.

Source: Developed by IOM from FY 1978 Budget Revisions, April 1977 Current Budget Estimates, and from December 2 and 3, 1976 Testimony by Alice Rivlin of Congressional Budget Office before the Joint Economic Committee.

Table B. Comparison of Ford and Carter Budget Receipts in FY 1978

	(In billions of dollars)		
	Current Policy Base	Ford	Carter
Total	$404.0	$393.0	$404.7
Individual income taxes	185	171.2	183.0
Corporate income taxes	59	58.9	61.3
Social insurance taxes and contributions	123	126.1	124.1
All other 1/	37	36.8	36.3

1/ Excise, estate and gift, customs duties and miscellaneous.

Source: Same as Table A.

Table C. Provisions of the Administration's Hospital Cost Containment Bill Relating to Hospital Revenues

Coverage. All short-term acute care and specialty hospitals. Excluded are: chronic care hospitals, hospitals less than 2 years old; federal hospitals, and hospitals getting at least 75 percent of their revenues from Health Maintenance Organizations.

Basic Focus. To limit increases in the annual hospital in-patient revenues derived from third-party payers or from direct payment by patients. For the first year the limit on revenue increases would be about 9 percent above the 1976 base year experience for the hospital.

Setting the Basic Limit. Derived from two broad formulas designed to adjust revenues to reflect general price trends in our economy (the GNP deflator published by the Department of Commerce) and a formula calculated allowance as a cushion for above average increases in prices for items hospitals buy and for limited expansion in services within the hospital. The basic formula has two parts:

- the increase in the GNP deflator for the most recent past 12 months.
- plus one-third of the difference between the average annual increase in hospital costs in the preceding two years and the increase in the GNP deflator in those two years.

Formula Adjustments to Basic Limit. Would be provided for major changes in patient load as measured by the number of admissions where the admission increased by more than 2 percent or declined by more than 6 percent. Within the 2 to 6 range, there would be no adjustment. Beyond the 2 to 6 range, hospitals would receive

- for increased admissions beyond 2 percent, revenue increases of one-half of the average revenue per stay in the base year for each admission.
- for decreased admissions over 6 percent, a similar reduction in revenues per admission.

A second formula adjustment is also provided for pass-through of actual increases in pay to non-supervisory hospital employees.

Special Adjustments. Beyond those listed above require special review by state and local health planning agencies and by the Secretary of HEW. These would be possible if there were exceptional changes in patient load or major increases in types of service or major renovation or replacement of the physical plant.

State Programs. The federal cost containment program would be waived if a state has a program which meets federal requirements.

Enforcement. Payments above the limits would be disallowed under Medicare and Medicaid. Payment by other third parties in excess of limits would be taxed at 150 percent. The hospital receiving reimbursement above the limit would be taxed at 150 percent unless the hospital agreed to rebate the excess to its payers--generally via reducing charges in the following year.

Public notice would be required publicizing the hospital's violation of the revenue limit.

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