# Public Expenditures and Private Control? Health Care Dilemmas in New York City

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"Sooner or later New York's problems will haunt every city in the United States of America."

*Rep. Stewart B. McKinney, Conn.,*
*"The Stricken Cities,"*
*The New York Times,*
*Dec. 27, 1976*

As a new President and a new Congress prepare to tackle the health financing and delivery issues they have inherited, attention will focus on the connection between the crisis of exploding health care costs and the financial plight of the urban areas in the nation where the poor and the elderly are concentrated and the tax base eroded by out migration and economic decline.

The Social Security Amendments of 1965 profoundly altered the parameters for the financing and utilization of health services throughout the nation. This paper describes the impact of these developments on the medical care economy of New York City. It examines the shifts that have occurred between 1965 and 1975 in the scope, characteristics, and role of the public and private sectors in paying for the medical care of New York City residents, and the changes thus brought about in the access of the old and the poor to hospital and physician services. It analyzes the effect of these changes, in the years before the city's fiscal crisis, on the expense budget of the city and on the capacity of the city to determine priorities in health spending.

While New York City, with its five boroughs each the size of a major metropolis, is unique in many ways, its very size, as well as its historic commitment to the welfare of the underprivileged and to

social innovation, serves to magnify developments and issues that are common to urban communities throughout the nation.

As will be seen, the chief significance of New York's experience lies in its attempt to use Medicare and Medicaid to transform traditional welfare medical care arrangements into an integrated health care system serving the entire population, and in the subsequent and unanticipated erosion of its capacity to control the flow of municipal funds to the health care sector and to influence the health care delivery system. In effect New York may be said to have provided the laboratory experience for anticipating what would happen if the effort to close the gap in coverage for the millions of Americans still outside the public and private benefit structures were to take the route of a revised and updated Medicaid program.

The experience of New York City has also dramatized the extent to which Medicare and Medicaid have moved the United States toward a health care system that is publicly funded and privately operated without adequate social controls that are essential to assure equity, accessibility, and prudent use of scarce resources.

## 1965—The Congressional Intent

Public Law 89-97, creating Titles XVIII and XIX of the Social Security Act, was passed by the Congress on July 28, 1965. Two days later President Johnson flew to Independence, Missouri, to sign the legislation in a nationally televised ceremony in the presence of Harry S. Truman, who, in 1948, was the first President to deliver a health message to the Congress. Title XVIII, Medicare, established uniform hospital and medical benefits, administered as part of the Social Security program, for all elderly persons regardless of income or place of residence. Less well known than Medicare, but in many ways an equally significant advance in establishing federal responsibility for the care of low income persons in need of medical services, was Title XIX, popularly known as Medicaid.

Little was said about Medicaid on the occasion of the signing of the legislation, and little is clear about the congressional intent behind it, but at the time of its passage knowledgeable observers uniformly regarded this provision of the act as a "sleeper," though they disagreed widely in predicting its outcome. Some considered that Medicaid could become the vehicle for evolving a uniquely

American pattern for providing health care coverage, a pattern suitable for this diverse and pluralistic nation. Others on the contrary predicted that it was doomed to become the first piece of social legislation in the nation to be cut back rather than expanded. Paradoxically both predictions have been borne out by subsequent developments.

The immediate objective of Title XIX was to aid and encourage the states to provide minimum health services for at least everyone receiving federally aided money payments under the categorical public assistance programs that had been established by the Social Security Act in 1935. (The federal aid share for each state was a percent of cost formula calculated in inverse relation to state per capita income, resulting in federal matching ranging from 50 percent of state outlays in New York to 83 percent, initially, in Mississippi.)

But the long range goal of Title XIX was vastly more far reaching. It envisaged progressive extension of the scope of medical assistance over a ten-year period, encouraging the states to liberalize entitlement and expand the scope of benefits with a view to providing comprehensive services for substantially everyone in need of medical assistance by 1975. To ensure accomplishment of this goal, the law specified that states which failed to develop a plan of this scope and magnitude by 1975 would thereafter forfeit federal matching on any state expenditures for medical assistance.

This proviso of the original legislation was first postponed and eventually eliminated. As the federal government and the states attempted to confront runaway costs and rising numbers of eligible beneficiaries, they began to take measures to reduce expenditures under the program, to lower fees to providers, to eliminate optional benefits, and to reduce the number of medically indigent persons eligible for enrollment in the program. Old problems in paying for the care of low income persons reappeared as a consequence of these cutbacks. In addition, many new problems emerged as experience with the new programs accumulated—discrepancies in the services received by equally entitled beneficiaries and arbitrary notches in entitlement to benefits that left the working poor saddled with the tax costs of subsidized care for the welfare population, yet without relief from the burden of rising costs of their own care paid for out of earnings or through increasingly expensive and often meager private insurance coverage. The new programs also created opportunities for fraud and abuse that had not been anticipated and that administering agencies were unequipped to cope with. All of these

problems were compounded by the economic decline and rising unemployment which marked the years following enactment of the legislation and by the increasing cost of a health care system that the Social Security legislation left virtually unchanged.

By 1972, a federal task force appointed to examine what was already being referred to as "the Medicaid mess," reported that the problems extended far beyond the Medicaid program itself to the entire health care system, its lack of organization and its widespread financing, productivity, and access shortcomings. The report recommended establishment of uniform federal benefits available throughout the nation and urged improved management and administration of the program at all levels of its operation. It reiterated the belief that fragmented, separately legislated, and separately funded programs required restructuring into an integrated system.

Against the backdrop of this nationwide experience, the particular scenario of New York's experience with Medicare and Medicaid unfolded.

## Tax Supported Medical Care in New York City Prior to 1966

Before enactment of the 1965 Social Security Amendments, federal aid to the states and localities was limited to gradually increasing matching on the cost of vendor payments for public assistance recipients and, after 1961, for the aged medically indigent under the provisions of the Kerr-Mills legislation. But for many decades New York City had a much broader program of medical services for the needy.

Our earlier study of health expenditures in New York City showed that in 1961, five years before enactment of Medicare and Medicaid, public funds already paid for half the hospital care and a third of total personal health care received by New Yorkers. Three hundred and fifty thousand persons on the city's welfare rolls in that year comprised the chief beneficiaries of public sector outlays, but city-supported medical services also provided for the medically indigent. In fact, only one out of every four city-charge patients in municipal or voluntary hospitals was a recipient of cash assistance. The rest were persons who could meet their ordinary living expenses, but who lacked the margin in earnings and savings to pay for

the cost of physician and hospital care. The clinics of municipal hospitals and of the Department of Health provided six million ambulatory care visits for children and adults in that year. Nearly half the newborn infants in the city received health supervision and preventive services in the city's ninety-eight well-baby stations. Thirty-five district health centers treated and monitored tuberculosis, tropical disease, and venereal disease patients. New programs were being started to adapt Health Department services to the changing patterns of illness, as communicable diseases were brought under control and chronic illnesses became prevalent—glaucoma testing, rehabilitation services, and cancer detection. All of these services were provided without charge and without a means test, except for in-hospital care for which patients or relatives were charged on a sliding scale related to family income.

By fiscal 1966, on the eve of implementation of Medicare and Medicaid, public and private expenditures for health care in the city had risen to $2.5 billion. Expenditures for health care in the city expense budget reached $534 million, but the health component still accounted for about 13 percent of the total city budget.

## A Decade of Change

With passage of the Social Security Amendments, New York moved rapidly to implement a broad and comprehensive program. The state legislature, with gubernatorial concurrence, set Medicaid entitlement at the highest income-eligibility level of any state in the nation—$6,000 net income for a four-person family—a standard estimated to entitle approximately 45 percent of the population to the benefits of this new program. More than half the population in many upstate areas became eligible.

Initially covered benefits for both cash assistance recipients and the medically indigent included all services, mandatory and optional, for which federal matching funds were available: care in hospitals, nursing homes, clinics and physicians' offices; services of dentists, nurses, optometrists and other health care personnel; routine dental care, drugs, sickroom supplies, eye glasses, prosthetic appliances; physical therapy and related rehabilitation services; laboratory and x-ray services; and transportation when essential to obtain medical care.

In New York City, a new municipal administration, taking office in a time of great social turbulence and unrest, saw in this legislation an opportunity, at least in the health sector, to extend the benefits of "the affluent society" to "the other America." Shortly after the state plan went into effect, the city initiated a vigorous campaign to enroll the three million New Yorkers presumed to be eligible for the new services. Car-card posters in English and Spanish appeared in the city's subways and buses with this message: "Do you need to see a doctor? Do you have medical bills that you cannot pay? The new Medicaid program can help you. Enquire at your nearest welfare office." While the program never reached the goal of enrolling three million residents for preventive as well as episodic medical services, at its peak the program was estimated to cover 1,700,000 enrolled persons, 450,000 of the medically indigent in addition to 1,266,000 recipients of cash assistance. Together with the 800,000 aged covered by Medicare, the combined programs provided benefits and federal sharing in the cost of services, for 2,500,000 New York City residents.

*Soon after the enactment of the new programs, costs and expenditures began to escalate at a far faster pace than anticipated. By fiscal year 1975, total public and private expenditures for health care in the city rose to $6.7 billion, three times the $2.5 billion spent in 1966, and nearly four times the $1.8 billion aggregate public and private outlay in 1961* (Table 1).

Surprisingly, personal health expenditures in New York have increased at about the same rate as in the nation as a whole since the advent of Medicare and Medicaid. Many factors have contributed to the increase, not all of which are well understood: increased utilization, changing patterns of care and new technology, wage increases and an expanded labor force in the health industry, increases in the cost of goods and services purchased by the industry, and changes in the composition of the population and the increasing prevalence of chronic illness.

In the last decade private spending rose at a faster rate in the United States than in New York City, 118 percent compared to 54 percent. *Private* per capita expenditures in New York are currently quite close to the national figure, $356 compared to $311. In contrast, the per capita *public* outlay, twice as high in New York as in the United States in 1966, is now more than two and a half times higher.

## The Public Sector

The public sector of medical care for the residents of the city is composed of a complex web of federal, state, and municipal appropriations and it provides services administered by more than two dozen different government agencies for a variety of public purposes (Tables 2 and 3). Some funds are spent and some services are provided directly by each level of government. Other funds move in intergovernmental transfers from one level of government to another, and are further re-allocated at the city level from one agency to another. Some appropriations are open ended; for others the size of each contribution is regulated by statutory ceilings. Some are in the form of lump sum grants, leaving to the providing agencies the determination of entitlement and scope of benefits. Still other funds are governed by complex matching formulas, and specify in minute detail the scope of services and conditions of entitlement. The expansion of the federal role in paying for personal health care services has included not only an assumption of new responsibilities for the provision of care to the elderly and the disadvantaged, but also has encompassed new areas, particularly services for the mentally ill, the mentally handicapped, and the addicted. The conditions attached to the components of this complex flow of funds determine what options the localities have with regard to public outlays and which options are foreclosed.

*By fiscal 1975 public outlays by all levels of government accounted for 60 percent of total medical spending in New York City, compared to a 30 percent public sector component prior to Medicare and Medicaid.*

The increase in the size of public sector medical care expenditures in New York was accompanied by a striking shift in the relative contribution of federal, state, and local taxes to the total (Table 4). Municipal dollars, which provided nearly half of all tax support for personal health care services in 1966, now make up only 30 percent of total government expenditures for city residents. Federal dollars, in contrast, increased from 1% to 44 percent of the total public sector by 1975. Today, however, as in the past, the federal contribution to the public sector is greater on the national level than in New York City. Federal spending accounted for 70 percent of public sector medical spending in the nation in 1975, compared to the 44 percent in New York City. Part of this differen-

tial is due to the formula in federal matching programs like Medicaid which links the federal share in inverse ratio to per capita personal income in the states, so that the large industrial states receive relatively lower matching percentages. The federal share in New York is 50 percent of total Medicaid outlays, compared to 78 percent in Mississippi at the present time.

Of the $4.0 billion total public expenditures for the health of New York City residents, $850 million was spent directly by the federal government for payments to hospitals and physicians in the city for Medicare beneficiaries. An additional $750 million was spent directly by the federal and state governments for the care of New York City's veterans and other beneficiaries in federal hospitals, and for the care of city patients in state mental hospitals.

Two-thirds of total public expenditures ($2.8 billion), including federal and state transfer funds and city tax levy revenues, was spent for services provided or paid for by New York City agencies to "promote the public health and care for the needy sick." These funds make up the health care component of the Expense Budget of the City of New York.

*Expense Budget appropriations for all New York City purposes have tripled since 1966, rising from $4 billion to nearly $12 billion in 1975, but city-budgeted health spending has increased five times, and nearly 25 percent of the expense budget of the city today is allocated to personal health care services provided or administered by city agencies, compared to 13.5 percent in the pre-Medicare and Medicaid fiscal year (Table 5).*

With the enactment of Medicare and Medicaid, federal and state contributions to city-budgeted health services increased significantly, rising from a combined 35 percent of city-budgeted health care appropriations in fiscal year 1966 to 54 percent by fiscal 1975 (Table 6 and Fig. 1). These increases are the more remarkable in view of the fact that the municipal budget is now relieved of a substantial portion of hospital and physician costs for the care of the indigent elderly, which formerly comprised nearly a third of city-budgeted health expenditures. Such monies now go directly from the federal government to providers or beneficiaries, with the important exception of Medicaid outlays for the indigent elderly for services not covered under Medicare, nursing homes, co-insurance and deductibles, and so on.

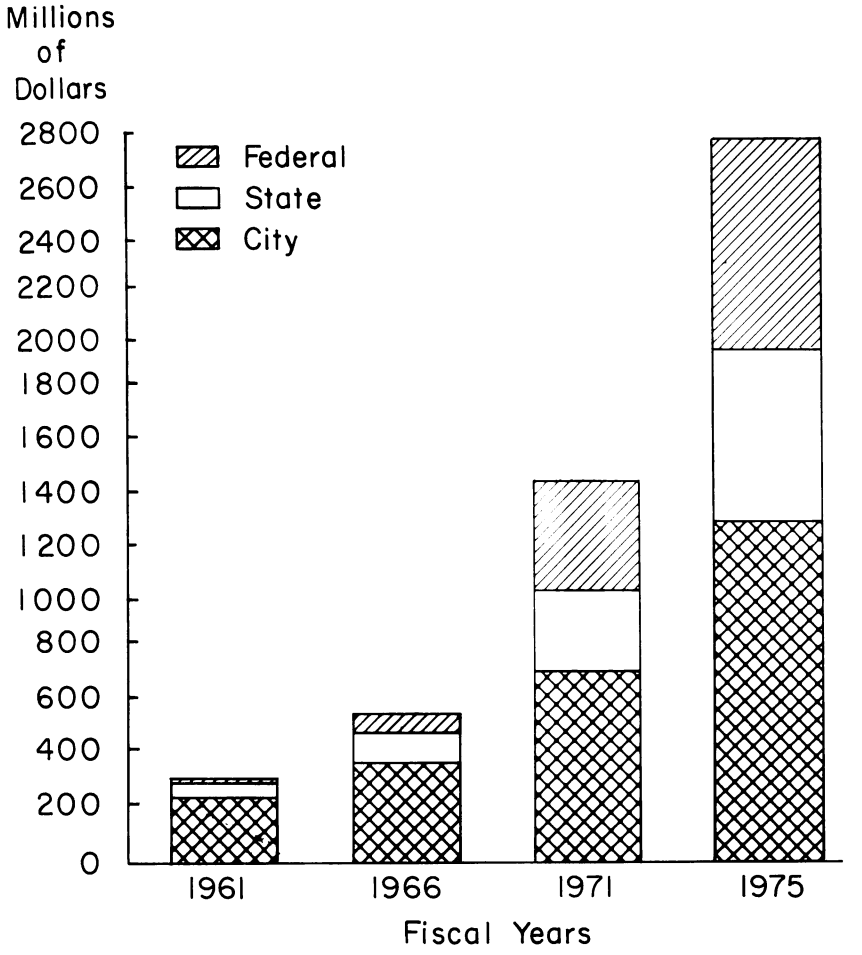


FIG. 1. City of New York Expense Budget Appropriations for Personal Health Care by Source of Funds, Fiscal Years 1961, 1966, 1971 and 1975.

*Despite vastly increased federal and state matching for local public medical care expenditures, the health sector of the city expense budget co-opts a greater share of city tax levy funds today than it did in fiscal 1966, prior to implementation of the Social Security health titles.* In this ten-year period the net city share has fallen from 66 percent to 46 percent of total city-budgeted health allocations. While federal and state aid has increased dramatically, health care costs have risen so sharply that the net amount of city tax levy funds earmarked for health in the expense budget in 1975

was more than double the combined federal, state, and city funds in the 1966 expense budget of the city. Thus, by 1975, 17 percent of city tax levy funds were allocated for personal health care purposes, compared to less than 13 percent in 1966. This increase imposes a rising burden on limited municipal sources of revenue, in sharp contrast to the fiscal relief that the city anticipated in 1965 (Table 7).

National health expenditures are customarily shown as a proportion of the Gross National Product, currently more than 8 percent. No comparable measure of total economic activity can be used for state and local areas, but an approximation of the changing relation between public outlays for personal health care services and the economic capacity of the city can be seen by showing health expenditures as a proportion of personal income.

*In fiscal year 1966 total public and private health care expenditures in New York City amounted to 8.3 percent of total personal income. By fiscal 1975 health care expenditures accounted for 13.9 percent of the city's $48.3 billion personal income.*

New York State, which requires localities to pay half of the nonfederal share of Medicaid, is one of only 13 states requiring local sharing. If matching were not required, the net savings to the city budget would be in the neighborhood of $400 million. In contrast to other localities where the local share tax base includes affluent suburban areas, in New York City the local share falls heavily on low income residents. Unemployment and the increasing concentration of low income families in the city have increased the proportion of residents needing medical assistance, while the tax base for supporting the services has diminished. Working people who are not eligible for the same benefits are bearing the increasing costs of subsidized care for the poor.

## Changes in the Pattern of Public Spending

Once Medicare and Medicaid were implemented, there was a significant change in the pattern of public sector spending in the city, a change which weakened the leverage of the city government to control utilization, costs, and expenditures while at the same time accomplishing one of the basic social purposes of the Social Security Amendments, and one of the basic objectives of the city, namely to provide access for low income persons to physicians and hospitals of their choice.

Prior to 1966, three out of every four city-budgeted health dollars were spent for services provided in hospitals and clinics operated by municipal agencies, and supported by municipally determined appropriations. By 1975 nearly half of city health appropriations were allocated for vendor payments to purchase services from the private sector. Under the provisions of Medicaid legislation in New York State, the city has little control over the volume of services. It is mandated to reimburse private sector providers at rates established by the state, with 25 percent of whatever costs are incurred coming out of municipal revenues. These outlays are subject only to the city's responsibility to monitor eligibility of the persons to whom services are rendered and the validity of claims submitted for payment.

The fraudulent practices that have crept into the program have received wide attention, and at the city, state, and federal levels steps are being taken to improve the surveillance.

In addition to city-budgeted Medicaid payments to private providers in the city, another $700 million is disbursed to the private sector directly by the federal Medicare program. Co-insurance, deductibles, and specified limitations on benefits tend to provide a brake on Title XVIII expenditures. Additional mechanisms such as Professional Standards Review Organizations (PSRO) seek to further control Medicare costs. Of greatest consequence is the fact that no procedures exist to address the problem of equitable allocation of these large sums of money according to individual medical need or public health priority, or to encourage the prudent use of scarce resources.

Medicaid, which accounts for more than 60 percent of New York City budgeted expenditures for health, covers more than a million public assistance recipients and 200,000 medically needy persons. *Of total Medicaid expenditures in the city, 41 percent is for the 9 percent of beneficiaries who can meet ordinary living expenses, but require assistance to meet hospital and doctor bills (Table 8).*

This 9 percent is largely made up of the aged and disabled who require services not covered by Medicare, such as nursing home care, or who could not meet co-payments and deductibles, or who had exhausted Medicare hospital benefits. When these expenditures are subtracted from total Medicaid outlays, the remainder which goes to provide for the average annual medical needs of the 261,500 children and 345,200 adults on public assistance more closely resembles average medical care outlays in the private sector. This does not

signify that New York City children in welfare families, likely to be at special risk for many reasons, are receiving adequate services. What it does indicate is that the Medicaid program serves, to a substantial extent, as catastrophic health insurance for the disadvantaged population.

The pathways by which medically indigent persons acquire Medicaid benefits further emphasize this catastrophic coverage aspect. Following cutbacks on entitlement at the beginning of 1967, efforts to pre-enroll eligible needy persons in the program came to a halt. Not until a patient requires nursing home or hospital care does the question of arranging Medicaid coverage gain attention. The practice followed by voluntary hospitals in New York City prior to enactment of Medicaid had been to forward to the city Welfare Department's Bureau of Collections the bills of inpatients without private insurance and unable to pay the full costs out of pocket. The bureau reimbursed the hospital and then undertook to recover such collections as could be made from the patient or his responsible relatives. The practice for recovering the cost of care provided to indigent persons not on categorical public assistance remains essentially the same. Thus by 1975, the "medical assistance only" caseload was largely made up of persons whose entitlement to Medicaid coverage had been established at the time of an episode of inpatient care, with the institutional provider initiating the process of establishing eligibility. While the same procedure theoretically is followed for outpatients who receive services in hospital clinics and emergency rooms, the rapidity with which the patient moves in and out of the institution, and the sheer volume of clerical effort involved, means that only a fraction of potentially eligible outpatients are directed into the Medicaid caseload, even when their medical expenses might have qualified them for coverage under the "spend-down" provisions of entitlement.

## Type of Expenditures

Three components of health care—hospitals, physicians, and nursing homes—make up the major portion of both public and private medical spending. The private health care dollar is spent in a different way for these components than is the public health care dollar (Tables 9 and 10).

In 1975, hospital care accounted for 37 percent of private dollar

outlays and 63 percent of public spending; physicians' services for 20 percent of the private and 9 percent of the public medical dollar; nursing home care for 2 percent of private outlays and 9 percent of public outlays.

The rise in expenditures in the decade since 1966 also varied among the components of care, and the pattern of increase was different in New York than in the United States as a whole.

Aggregate hospital outlays tripled in both the city and the nation. Nursing home spending was four times greater in New York at the end of the period, six times greater in the nation as a whole, reflecting the more extensive provision for long term care in nursing homes and public home infirmaries in New York City prior to 1966. Aggregate physician expenditures, which were more than twice the 1966 amount in the United States, rose only 50 percent in the city.

Changes in the cost, utilization, and expenditures for these services merit more detailed discussion.

## Expenditures for Hospital Care

Expenditures for hospital care in New York, as in the United States, are the largest single component of both public and private health care spending. They account for a larger proportion of total outlays in the city than in the nation—53 percent of the New York health care dollar, 42 percent of the United States health care dollar. By 1975 public funds paid for a larger share of hospital care in New York than in the nation—72 percent compared to 53 percent. Federal and state hospitals account for about 17 percent of the total hospital outlays for city residents.

The major portion of hospital care today, as in the past, is provided by 118 voluntary, proprietary, and municipal institutions in New York City. Total expenditures by these hospitals have tripled since 1966, and public appropriations currently offset close to 70 percent of all expenditures by these hospitals, compared to 40 percent in the earlier year.

Medicare and Medicaid have profoundly altered the relative roles of these three hospital systems in the city (Tables 11 and 12). In 1966 nearly four out of every five public hospital-care dollars were spent for care provided by municipal institutions. Only one out of five public dollars went to the voluntary hospitals for the care of city-charge patients. By 1975 the flow of public dollars was com-

pletely reversed. *More than half of the aggregate public outlay for hospital care goes to voluntary and proprietary hospitals today, compared to only 22 percent in 1966. As a result of this shift, 55 percent of the expenditures of private sector hospitals in this city is now offset by revenues from public sources, compared to less than 15 percent prior to Medicare and Medicaid. By 1971, 50 percent of Medicaid hospital outlays, and 87 percent of Medicare hospital funds, went to private sector hospitals (Figs. 2 and 3).* In addition, in 1971 more than 90 percent of pay-outs by Blue Cross (essentially a quasi-public trust fund) also went to private sector hospitals.

Expenditures for municipal hospitals, which cover the cost of physician services as well as all hospital charges (in contrast to separate billing for physician services customary for voluntary hospital inpatients), amounted to just over a billion dollars in 1975, including debt service costs of $63.4 million. Receipts from Medicare and Medicaid, including the city's 25 percent Medicaid match, offset 56 percent of total municipal hospital outlays. About 7 percent was recovered from patient payments and private insurance. An additional 37 percent ($382 million) of total municipal hospital expenditures remained to be supplied out of municipal revenues in order to make up the difference between collections and total outlays in that fiscal year.

Why does a deficit of this magnitude arise in the municipal system? Discriminatory rate-base determinants, failure to make collections from patients or third parties, and long standing inefficiencies alleged to be inherent in the system are cited in numerous studies as reasons for the deficit. Others view the deficit as arising largely because the municipal hospital system must serve as provider of last resort for city residents who do not have public or private coverage.

The need to reassess the role and relationship of public hospitals, developed in an earlier era of charity medicine, is not confined to New York City. In the nation's twenty-five largest cities, 22 percent of all short-term general care hospital beds are in local public institutions. For example, 22 percent of the short-term beds in Columbus, Ohio, 26 percent in Los Angeles, 32 percent in Indianapolis, and 37 percent in New Orleans are in city or county institutions, compared to New York City's 25 percent. In each of these communities these hospitals provide a higher-than-average

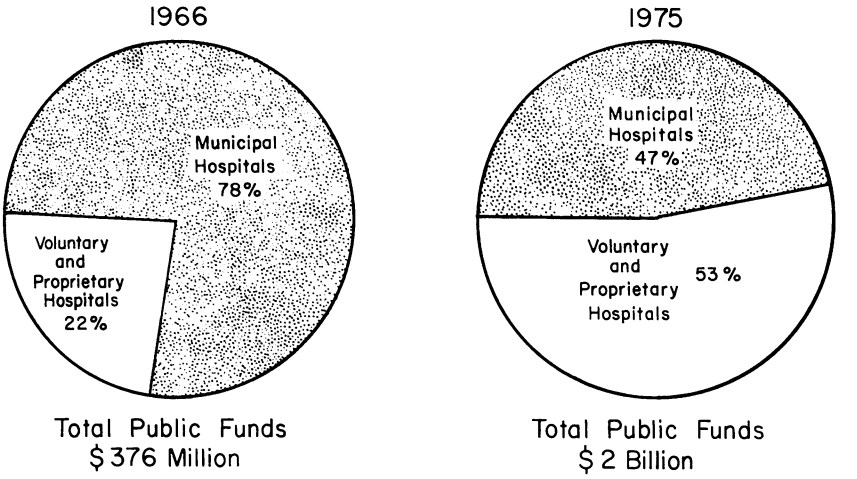


FIG. 2. public Funds Disbursed to Municipal Hospitals and to Voluntary and Proprietary Hospitals, New York City, 1966 and 1975.

ratio of outpatient and emergency room services to inpatients than do hospitals under voluntary or proprietary auspices (Table 13).

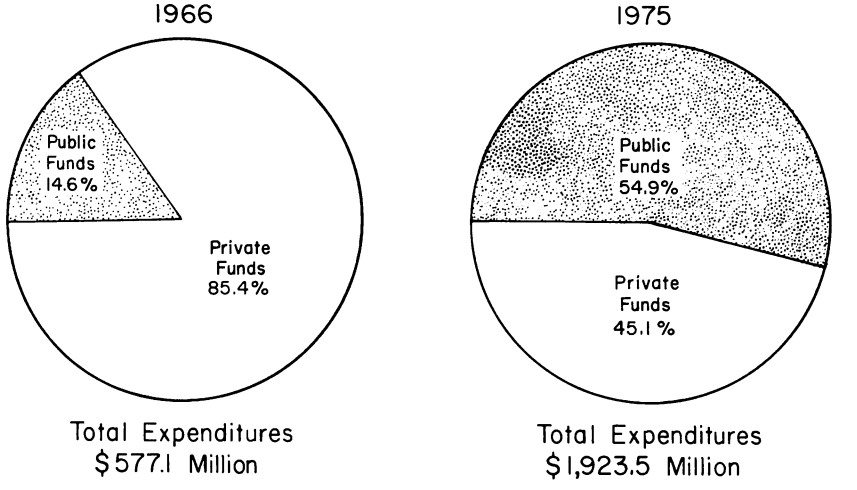


FIG. 3. Voluntary and Proprietary Hospital Expenditures, by Source of Funds, New York City, 1966 and 1975.

## *Physicians' Services*

Expenditures for physicians' services today, as in the past, are the second largest component of the health care dollar in the United States and in New York City. Total expenditures for physicians' care increased 150 percent in the country as a whole, but rose only 50 percent in New York since 1966.

Prior to that date, except for house calls by welfare panel physicians, almost no private practitioner services were paid for under public medical care programs in New York. The poor relied on clinics for outpatient services, house staff for hospital care, or on the charity of individual physicians. Today Medicare and Medicaid cover private practitioner services, as well as hospital outpatient and emergency room visits.

The pattern of spending for physicians' services in New York City has changed radically. Total public and private outlays for this component rose by $300 million, but the proportion of the aggregate health care dollar spent for physicians' services in the city dropped from 25 to 13 percent. Expenditures for physicians' services account for only 20 percent of the private medical care dollar in the city—a decline from 35 percent in 1966. In contrast, the portion of the public dollar in New York City spent for physicians' services has skyrocketed. Annual per capita public expenditures have increased from less than one dollar to forty-eight dollars. Payments from Medicare account for about 54 percent of the total public outlay for physician care, Medicaid accounts for 45 percent.

Studies in New York and elsewhere indicate that Medicare has improved the access of elderly persons to private practitioners of their choice. However, only a small portion of private physicians in New York City provide a substantial volume of office-based care to Medicaid patients. About 10 percent of those private practitioners in the city who bill Medicaid account for two-thirds of the Medicaid expenditures for physicians' services.

Changes in the size and composition of the physician supply in the city have also influenced the changing expenditure pattern. The number of office-based physicians has dropped 20 percent in the last 10 years, a drop only partially offset by the increase in the number of hospital-based physicians (Table 14). Medicaid expenditures for care provided in hospital clinics and emergency rooms were more than double the total payments to office-based physicians in 1974.

The Medicaid provisions regarding utilization and reimbursement of office practitioners, coupled with the shortage of primary care providers in low income neighborhoods, has given rise to the phenomenon of the "Medicaid mill." How to bring these market-generated provider organizations under social controls has been a problem in New York since the start of the program. The problem is emerging in other localities as well.

There is no exact definition of a Medicaid mill and, unlike hospitals and nursing homes, there is no agency of government clearly responsible for auditing performance. Review now occurs only on an ad hoc basis, often in response to some scandalous exposé. Yet these providers are serving a function and filling a vacuum in availability of primary care service. If they are to fill this gap in a constructive fashion, some systematic format for their regulation and governance must be developed.

## *Nursing Home Care*

Medicare and Medicaid created a powerful incentive for expansion of the nursing home industry. Other forces at work—the increase in the aged population, the statutory exclusion of relative responsibility, and changing patterns of urban housing and family life—all contributed to this expansion. Heavy private investment in the industry occurred in anticipation of this increase in effective demand. Bed capacity in the city rose from 16,700 in nursing homes and infirmaries for the aged in 1965 to 28,000 skilled nursing home and health-related facility beds by 1972.

The city's aged population rose 16 percent during the decade, but the nursing home population went up a striking 65 percent, and nursing home expenditures in the city quadrupled. By 1975, public funds offset 90 percent of the total in contrast to 43 percent earlier. During the same period the nationwide aggregate outlay for nursing homes increased fivefold, but the public share, which was 43 percent in the United States as in New York City in 1966, rose to 58 percent in the nation by 1975 compared to the 90 percent public sector role in New York in that year.

It is not clear why nursing home care receives substantially more public funds in New York than in the country as a whole. However, it is clear that the availability of these benefits under Medicare and Medicaid contributed to the rapid expansion of this

sector of the health industry. Undoubtedly, another factor was the "deinstitutionalization" of large numbers of aged patients from state mental hospitals in these years, resulting from a combination of new diagnostic classifications, therapeutic developments, and advocacy-law approaches to institutionalization. However, there was no adequate provision for alternative community care for discharged elderly patients who often were without families or homes to return to. In addition to those patients discharged from state hospitals, new cohorts of elderly men and women who require congregate care and who in the past might have been directed to state mental hospitals may now instead be occupying nursing home beds in the city.

Also during these years, the bed complement of the municipal hospital system was cut from 17,000 to 12,000, and average length of stay from 20.5 to 14.3 days. This decrease in long term patients in the municipal system also contributed to the rise in the number of nursing home residents.

Thus for each chief component of medical care, the public sector underwrites a greatly increased share of the cost of services and, for each component, public funds increasingly purchase care for public beneficiaries from private sector providers. At the same time there has been little progress toward developing adequate mechanisms for monitoring the cost, appropriate use, and quality of services. No single agency is charged with the responsibility to appraise the aggregate cost effectiveness of the $4 billion in public outlays for the medical care of city residents, and there is no coordinated approach to directing these sums in a more efficient, prudent, and equitable fashion.

## In Conclusion

With Medicare and Medicaid, New York City undertook to move from a traditional welfare medical care system toward the goal of health protection for all its citizens. Some of that goal has been realized. Medicare, despite co-payments and deductibles, has brought a large measure of security to the elderly and to their families. Under Medicaid, in an average month, more than half a million people, out of a pool of some two million uninsured, poor New Yorkers, obtain needed care. By 1971, 60 percent of all

patients in hospitals in New York City on an average day were covered by public programs, including nearly all the elderly patients and 45 percent of those under age 65. Moreover, access of public program beneficiaries to hospitals of their choice had been expanded; by 1971, 65 percent of patients covered by public programs were in voluntary and proprietary institutions, compared to only 20 percent a decade earlier.

But despite these gains, the complex provisions of this program and the arbitrary income eligibility cutoff provisions result in quite arbitrary access to its benefits. The programs, both by intent and by chance, have failed to benefit many persons, particularly the working poor whose medical and fiscal needs can equal those of categorical public assistance recipients. The price of achieving even these gains has been very great in terms of the burden on the taxpayers, especially those who must meet health costs or supplement skimpy insurance benefits from meager after-tax earnings.

With 25 percent of the city's total expense budget and 17 percent of the tax levy portion of this budget co-opted for support of this limited health benefit structure, there is also concern about what economists call "opportunity costs," that is, the sums that perhaps could have gone to education, housing, nutrition, and other needs, had the cost of health care services consumed a smaller share of both the public and the private health care dollar.

Today, ten years after the enactment of the Social Security Amendment, even these gains are threatened. Recession and unemployment, a decline in the population of prime working age along with an increase in the population of dependent young and elderly, and a lag that puts the increase in median family income in the city below the national rise, have all contributed to the erosion of a tax base that had for decades generously supported health, education, and welfare services in the city. At the same time, increases in the cost of medical care in New York, as in the nation, have outpaced the overall inflation.

Prior to 1965, tax-supported health services in the city, which accounted for 30 percent of total health expenditures of city residents, were contained within a framework of tight fiscal controls. Appropriations for ambulatory and inpatient services rendered in municipal hospitals and clinics, and allocations earmarked for reimbursement to private sector hospitals for care of city-charge patients were established by the budget process within the limits of

each year's total city spending authorization. In contrast, Medicare and Medicaid, as presently written and administered, provide for open-ended public payment for services incurred by the covered population. These programs have moved the city, as they have moved the nation, toward a medical care system that is privately owned and publicly financed, without adequate public policies to deal with this changed relationship, and only a beginning has been made in developing the instrumentalities, institutions, and mechanisms to protect the public health and promote the public interest in these new and unprecedented circumstances.

The significance of New York's experience in trying to build an equitable and responsive health care system, on the basis of the provisions of Medicare and Medicaid, is the attention it focuses on two issues central to health policy in the nation today: removing the barriers that exclude millions of Americans from the nation's health benefits structure; and the search for ways to accomplish this without further compounding the inflationary spiral and the fiscal burden on the public treasury. Clearly this search centers on the organization and governance of the health care system.

The localities where the poor—urban or rural—are concentrated lack the resources to subsidize their care, and runaway costs cannot be controlled through reimbursement mechanisms alone. Other measures will be required to move the country toward a health care system that can provide adequate protection for all Americans within tolerable fiscal bounds. That system will have to be flexible enough to accommodate variations in the needs and capacities of the localities and to encourage the development of services to levels of adequacy.

It is easy, in hindsight, to see the shortcomings in the design of Medicare and Medicaid legislation as the gaps between promise and performance become apparent. It is not as easy to say how these shortcomings could have been avoided by measures that could have gained consensus in 1965. These very measures remain to be designed and to gain consensus today. The experience in the nation as a whole, and in the localities which have responded in various ways to the opportunities offered by Titles XVIII and XIX, should enable a purposeful nation to approach the design of these measures in a sophisticated as well as a courageous fashion.

The history of reform in America has been cyclical—1913, 1935, 1948, and 1965. Each of these historic moments of new in-

itiatives for strengthening and broadening industrial and social democracy has been followed by periods of accumulating experience on the basis of which Congress and the executive agencies have gradually amended and perfected the mechanisms for implementing the basic intent of legislative innovations. At the same time, history cautions that it can take so long for a new social concept to achieve statutory formation that, like generals equipped to fight the last war rather than the current one, public policies may be inappropriate and inadequate for the circumstances that prevail by the time they are implemented. New York City's experience with Medicare and Medicaid has dramatized the basic problems in the health care system that must be considered by the new president and the new Congress in developing feasible, adequate, and comprehensive health care protection for all Americans. Included in these considerations is the challenge to develop social controls over scarce resources without jeopardizing the initiative and vitality which have characterized American medical institutions.

## Methodology: Sources and Limitations of the Data

The study of health expenditures in New York City, on which this paper is based, was undertaken to provide a fiscal frame of reference for considering health planning and policy issues in the city similar to that provided at the federal level by the Social Security Administration's annual series on national health expenditures, the chief source of information on health spending in the nation.

Objectives of the study were twofold. The first was to identify changes in the roles of the public and private sectors in paying for the health care of city residents between 1966 and 1975, and to provide a basis for comparison with aggregate and per capita changes in other urban areas and in the nation as a whole. The second purpose was to assess the impact of changing public sector health outlays on the expense budget of the city and to examine the connection between tax outlays for health and the fiscal predicament of New York.

Personal health care expenditures were defined as expenditures for care rendered to an individual patient by or under the direction of a physician or other health professional, including appropriately allocated costs of administrative, overhead, and other supportive

services. Estimates were compiled for each category of expenditure as described below, for fiscal year 1966, the last year prior to implementation of Medicare and Medicaid and for fiscal year 1975, the most recent year for which data was available at the time of the study. (The New York City fiscal year begins July 1.)

To the extent possible the New York City analysis follows the methodology employed in the Social Security Administration's compilation of national health expenditure data and is subject to the same limitations. While there is reasonable confidence that the aggregate estimates for New York City as for the nation as a whole are not far from the "true" value, users of these data should realize that, as Dr. Harold Luft points out in a recent issue of *Inquiry*, there is no massive computer network that monitors the nation and records every health care transaction, and the published estimates are drawn from a number of different primary sources of differing reliability and validity.

The general method in the New York City study, as in the Social Security Administration's analysis, is to estimate total outlays for each component of care, to identify, allocate, and deduct the amounts spent from tax funds, and to treat the private sector—out-of-pocket, private insurance, and philanthropy—as the residual for each type of service.

All the difficulties in developing national health expenditure estimates are also encountered in compiling flow of funds information at the local level—locating and assembling data from many different sources, reconciling data based on different definitions, different age breaks, and different fiscal year reporting periods. Estimates of public sector outlays, for care of city residents, which can be built up from detailed published and unpublished information available from federal, state, and local agencies, are probably as reliable as public sector estimates for the nation as a whole. The same is true of the aggregate hospital component, which is derived in the New York study as in the Social Security Administration report from American Hospital Association data.

Additional problems occur at the local level in estimating for components where no primary local area data are available and it becomes necessary to disaggregate or adapt national or regional data in order to arrive at local expenditure estimates. Finally, for elements where it has not been possible to replicate the Social

Security Administration methodology, the national aggregates have been adjusted to permit N.Y.C.—U.S. comparisons. Where such adjustments have been made, for example in the case of Workmen's Compensation and Temporary Disability Insurance expenditures, they are footnoted in the tables.

In the text, and in the tables that follow, the hospital component comprises expenditures by all hospitals in New York City and the proportion of expenditures by Veterans Administration, Public Health Service, and Department of Defense hospitals and New York State Department of Mental Hygiene and Department of Health facilities, estimated to be for the care of New York City residents. These estimates include the cost of care for non-City residents who probably comprise 9 to 10 percent of hospitalized patients, a cost which might be offset by care furnished city residents by private institutions outside the city. Salaries of staff physicians, dentists, and other health professionals are included in the hospital component.

Estimated expenditures for physicians' services—gross income of private practice office-based physicians in New York City—were derived from physician income data by specialty and region published in *Medical Economics* and from American Medical Association data on the distribution of physicians in New York City.

The dentist component represents gross receipts of private practice office-based dentists in the city estimated from data published in Internal Revenue Service reports and information on the distribution of dentists in New York City obtained from the American Dental Association.

Expenditures for care in skilled nursing facilities, health related facilities, and public home infirmaries are based on unpublished data obtained from the New York State Department of Health.

The drug component consists of estimated expenditures for prescriptions and proprietary drugs in New York City retail drug outlets. These estimates are based on unpublished information furnished by Market Statistics, the publisher of *Drug Topics*. Expenditures for drugs dispensed by institutions, agencies, and professionals are included in those categories.

Government public health activities include the cost of clinic and other services provided by state and city Departments of Health, Education, Social Services, and other public agencies.

The remaining components, about 5 percent of aggregate public and private outlays in the city, were estimated from national figures.

TABLE 1
Public and Private Expenditures for Personal Health Care, New York City and United States, Fiscal Years 1961, 1966, and 1975

| TYPE OF EXPENDITURE BY YEAR | EXPENDITURE AMOUNT | | | | | |
|---|---|---|---|---|---|---|
| | Aggregate (in millions of $) | | Per Capita (Actual $) | | % DISTRIBUTION | |
| | *New York City* | *United States* | *New York City* | *United States* | *New York City* | *United States* |
| 1961: Total | 1,769.0 | 26,766.0 | 227.32 | 145.66 | 100.0 | 100.0 |
| Public | 514.4 | 6,049.1 | 66.10 | 32.92 | 29.1 | 22.6 |
| Private | 1,254.6 | 20,716.9 | 161.22 | 112.74 | 70.9 | 77.4 |
| 1966: Total | 2,455.0 | 38,990.0 | 308.42 | 198.01 | 100.0 | 100.0 |
| Public | 699.9 | 8,000.9 | 87.93 | 40.63 | 28.5 | 20.5 |
| Private | 1,755.1 | 30,989.1 | 220.49 | 157.38 | 71.5 | 79.5 |
| 1975: Total | 6,700.0 | 111,250.0 | 885.41 | 513.56 | 100.0 | 100.0 |
| Public | 4,006.7 | 43,681.4 | 529.49 | 201.65 | 59.8 | 39.3 |
| Private | 2,693.3 | 67,568.6 | 355.92 | 311.91 | 40.2 | 60.7 |

*NOTE:* Workmen's Compensation, Temporary Disability Insurance, Government Employee Health Benefits exclusive of expenses for prepayment and administration, and private reimbursement to public agencies have been allocated to the public sector for both the United States and New York City.

*SOURCES:* Cooper, Barbara S., and Worthington, Nancy L., "National health expenditures, 1929–72", *Social Security Bulletin*, January 1973.

Mueller, Marjorie Smith, and Gibson, Robert M., "National health expenditures, Fiscal year 1975." *Social Security Bulletin*, February 1976.

U.S., Bureau of the Census, *Statistical Abstract of the United States: 1966; 1969; 1975.*

TABLE 2
Public Expenditures and Intergovernmental Transfers, by Agency, New York City, Fiscal Year 1966
(millions of dollars)

| Agencies | Budget | Source of Tax Funds | | |
|---|---|---|---|---|
| | | *City* | *State* | *Federal* |
| Total All Agencies | 775.3 | 349.9 | 292.3 | 133.1 |
| New York City: Total | 533.6 | 349.9[a] | 117.8 | 65.9 |
| Department of Hospitals | 266.2 | 193.2 | 48.3 | 24.7 |
| Payments to charitable institutions | 80.8 | 50.2 | 16.0 | 14.6 |
| Department of Health | 22.6 | 11.3 | 11.3 | |
| Community Mental Health Board | 48.3 | 24.0 | 24.3 | |
| Department of Welfare | 53.2 | 13.3 | 13.3 | 26.6 |
| Department of Education | 8.6 | 4.3 | 4.3 | — |
| Miscellaneous departments | 0.7 | 0.4 | 0.3 | — |
| Employee health benefits | 31.8 | 31.8 | — | — |
| Debt service | 21.4 | 21.4 | — | — |
| New York State: Total | 175.8 | — | 174.5[b] | 1.3 |
| Department of Health | 4.2 | — | 3.0 | 1.2 |
| Department of Mental Hygiene | 161.5 | — | 161.4 | 0.1 |
| Department of Correction | 8.0 | — | 8.0 | — |
| Department of Education | 0.2 | — | 0.2 | — |
| Employee health benefits | 1.9 | — | 1.9 | — |
| Federal Government: Total | 65.9 | — | — | 65.9[c] |
| Veterans Administration | 40.0 | — | — | 40.0 |
| Department of Health, Education, and Welfare | | | | |
| Public Health Service Hospitals | 9.7 | — | — | 9.7 |
| Department of Defense, Medicare | 11.4 | — | — | 11.4 |
| Employee health benefits | 4.8 | — | — | 4.8 |

[a]Includes $20.7 million private reimbursement in the Dept. of Hospitals; $2.8 million private reimbursement in the Community Mental Health Board; and $27.6 million employee health benefits paid out by private insurors.

[b]Includes $18.4 million private reimbursement in the Department of Mental Hygiene and $1.7 million employee health benefits paid out by private insurors.

[c]Includes $4.2 million employee health benefits paid out by private insurors.

*SOURCES:* New York City Expense Budget, New York State Budget, Federal Budget and Supporting Documents, and Departmental Reports, various years.

TABLE 3
Public Expenditures and Intergovernmental Transfers, by Agency, New York City, Fiscal Year 1975
(millions of dollars)

| Agencies | Budget | Source of Tax Funds | | |
|---|---|---|---|---|
| | | *City* | *State* | *Federal* |
| Total All Agencies | 4,306.7 | 1,284.4 | 1,143.3 | 1,879.0 |
| New York City: Total | 2,801.9 | 1,284.4[a] | 689.7 | 827.8 |
| Health and Hospitals Corporation | 893.6 | 463.8 | 136.9 | 292.9 |
| Payments to charitable institutions | 326.1 | 97.8 | 97.8 | 130.5 |
| Department of Health | 140.2 | 92.3 | 44.2 | 3.7 |
| Department of Mental Health & Mental Retardation | 145.3 | 69.7 | 71.0 | 4.6 |
| Department of Social Services | 985.2 | 317.2 | 286.3 | 381.7 |
| Department of Education | 13.7 | 7.6 | 6.1 | — |
| Addiction Services | 83.6 | 25.1 | 46.8 | 11.7 |
| Miscellaneous departments | 8.4 | 5.1 | 0.6 | 2.7 |
| Employee health benefits | 142.4 | 142.4 | — | — |
| Debt service | 63.4 | 63.4 | — | — |
| New York State: Total | 551.2 | — | 453.6[b] | 97.6 |
| Department of Health | 19.9 | — | 7.0 | 12.9 |
| Department of Mental Hygiene | 444.8 | — | 368.1 | 76.7 |
| Department of Correction | 14.5 | — | 14.1 | 0.4 |
| Department of Education | 0.5 | — | 0.1 | 0.4 |
| Department of Social Services | 12.8 | — | 7.8 | 5.0 |
| Narcotics Addiction Control Commission | 40.3 | — | 38.1 | 2.2 |
| Employee health benefits | 18.4 | — | 18.4 | — |
| Federal Government: Total | 953.6 | — | — | 953.6[c] |
| Veterans Administration | 116.5 | — | — | 116.5 |
| Department of Health, Education, and Welfare | | | | |
| Public Health Service Hospitals | 20.4 | — | — | 20.4 |
| O.E.O. and 314E | 7.7 | — | — | 7.7 |
| Children and Youth | 6.9 | — | — | 6.9 |
| Medicare | 745.8 | — | — | 745.8 |
| Department of Defense, Champus | 23.1 | — | — | 23.1 |
| Employee health benefits | 33.2 | — | — | 33.2 |

[a]Includes $72.0 million private reimbursement in the Health and Hospitals Corp.; $18.2 million private reimbursement in the Dept. of Mental Health and Mental Retardation; and $132.4 million employee health benefits paid out by private insurors.

[b]Includes $29.4 million private reimbursement in the Dept. of Mental Hygiene and $17.1 million employee health benefits paid out by private insurors.

[c]Includes $30.9 million employee health benefits paid out by private insurors.

*SOURCES:* New York City Expense Budget, New York State Budget, Federal Budget and Supporting Documents, and Departmental Reports, various years.

TABLE 4
Expenditures by Each Level of Government for the Personal Health Care of New York City Residents, Fiscal Years 1961, 1966, 1971, and 1975

| Source of Funds | 1961 | | 1966 | | 1971 | | 1975 | |
|---|---|---|---|---|---|---|---|---|
| | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions of Dollars* | % |
| Total public dollars | 529.2 | 100.0 | 775.3 | 100.0 | 2,480.0 | 100.0 | 4,306.7 | 100.0 |
| City | 235.5 | 44.5 | 349.9 | 45.1 | 685.2 | 27.6 | 1,284.4 | 29.8 |
| State | 200.2 | 37.8 | 292.3 | 37.7 | 687.1 | 27.7 | 1,143.3 | 26.5 |
| Federal | 93.5 | 17.7 | 133.1 | 17.2 | 1,107.8 | 44.7 | 1,879.0 | 43.6 |

*SOURCES:* New York City Expense Budget, New York State Budget, Federal Budget and Supporting Documents, and Departmental Reports, various years.

TABLE 5
New York City Budgeted Appropriations for all Purposes and for Personal Health Care, Fiscal Years 1961, 1966, 1971, and 1975

| Category of Expense | 1961 | | 1966 | | 1971 | | 1975 | |
|---|---|---|---|---|---|---|---|---|
| | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions of Dollars* | % |
| Total expense budget | 2,345.5 | 100.0 | 3,964.7 | 100.0 | 7,744.8 | 100.0 | 11,895.0 | 100.0 |
| Appropriations for personal health care | 302.4 | 12.9 | 533.6 | 13.5 | 1,457.9 | 18.8 | 2,801.9 | 23.6 |

*SOURCES:* New York City Expense Budget, Supporting Schedules and Departmental Reports, various years.

TABLE 6

New York City Budgeted Appropriations for Personal Health Care by Source of Funds, Fiscal Years 1961, 1966, 1971, and 1975

| Source of Funds | 1961 | | 1966 | | 1971 | | 1975 | |
|---|---|---|---|---|---|---|---|---|
| | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions of Dollars* | % |
| Total appropriations | 302.4 | 100.0 | 533.6 | 100.0 | 1,457.9 | 100.0 | 2,801.9 | 100.0 |
| City | 235.5 | 77.9 | 349.9 | 65.5 | 685.2 | 47.0 | 1,284.4 | 45.9 |
| State | 59.4 | 19.6 | 117.8 | 22.1 | 355.9 | 24.4 | 689.7 | 24.6 |
| Federal | 7.5 | 2.5 | 65.9 | 12.4 | 416.9 | 28.6 | 827.8 | 29.5 |

*SOURCES.* New York City Expense Budget, Supporting Schedules and Departmental Reports, various years.

TABLE 7

New York City Tax Levy Appropriations for all Purposes and for Personal Health Care, Fiscal Years 1961, 1966, 1971, and 1975

| Tax Levy[a] | 1961 | | 1966 | | 1971 | | 1975 | |
|---|---|---|---|---|---|---|---|---|
| | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions of Dollars* | % |
| Total tax levy | 1,822.6 | 100.0 | 2,580.8 | 100.0 | 4,580.6 | 100.0 | 6,996.0 | 100.0 |
| Tax levy for[b] personal health care | 217.7 | 11.9 | 326.4 | 12.6 | 640.6 | 14.0 | 1,194.2 | 17.0 |

[a]Tax levy is defined as real estate taxes and revenues from the general fund.

[b]Net of collections from patient charges and other private sources.

*SOURCE:* New York City Expense Budget, Supporting Schedules and Departmental Reports, various years.

TABLE 8

Medicaid Expenditures for Public Assistance Recipients and for the Medically Needy in New York City, 1967, 1971, and 1973

Percentage Distribution of Beneficiaries and Expenditures, by Age and Category of Assistance

| Category of Assistance by Age | 1967 | | 1971 | | 1973 | |
|---|---|---|---|---|---|---|
| | *Expenditures* | *Beneficiaries* | *Expenditures* | *Beneficiaries* | *Expenditures* | *Beneficiaries* |
| Monthly Average | $30,893,810 | 185,789 | $93,379,866 | 605,804 | $111,294,250 | 663,034 |
| Percentage Distribution: | | | | | | |
| All Beneficiaries | 100 | 100 | 100 | 100 | 100 | 100 |
| Children | 25 | 42 | 26 | 45 | 23 | 41 |
| Other adults | 47 | 37 | 31 | 35 | 26 | 36 |
| Blind and disabled | 7 | 4 | 18 | 7 | 23 | 10 |
| Persons 65 and older | 21 | 17 | 25 | 13 | 29 | 13 |
| Recipients of Categorical Assistance | 38 | 59 | 62 | 88 | 59 | 91 |
| Children | 12 | 27 | 20 | 39 | 17 | 39 |
| Other adults | 12 | 21 | 21 | 33 | 18 | 34 |
| Blind and disabled | 6 | 3 | 14 | 7 | 16 | 10 |
| Persons 65 and older | 8 | 8 | 7 | 9 | 7 | 8 |
| Medically Needy Only | 62 | 41 | 38 | 12 | 41 | 9 |
| Children | 13 | 16 | 7 | 6 | 5 | 2 |
| Other adults | 35 | 16 | 10 | 2 | 8 | 1 |
| Blind and disabled | 1 | 1 | 4 | 1 | 6 | 1 |
| Persons 65 and older | 13 | 8 | 18 | 4 | 22 | 5 |

*SOURCE:* New York State Department of Social Services

TABLE 9

Selected Data on Personal Health Care Expenditures, New York City and United States, Fiscal Year 1966

| Type of Expenditure | Aggregate Amount (Millions) | | | Per Capita Amount | | | % Distribution | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Total* | *Public* | *Private* | *Total* | *Public* | *Private* | *Total* | *Public* | *Private* |
| Total expenditures, N.Y.C. | $2,455.0 | $699.9 | $1,755.1 | $308.42 | $87.93 | $220.49 | 100.0 | 100.0 | 100.0 |
| Hospital care | 1,112.2 | 580.2 | 532.0 | 139.72 | 72.89 | 66.83 | 45.3 | 82.9 | 30.3 |
| Physicians' services | 612.8 | 4.4 | 608.4 | 76.98 | .55 | 76.43 | 25.0 | 0.6 | 34.7 |
| Dentists' services | 188.1 | 2.0 | 186.1 | 23.63 | .25 | 23.38 | 7.7 | 0.3 | 10.6 |
| Nursing home care | 95.3 | 40.4 | 54.9 | 11.97 | 5.08 | 6.90 | 3.9 | 5.8 | 3.1 |
| Drugs | 169.2 | 2.1 | 167.1 | 21.26 | .26 | 20.99 | 6.9 | 0.3 | 9.5 |
| Other professional & appliances | 153.8 | 1.6 | 152.2 | 19.32 | .20 | 19.12 | 6.3 | 0.2 | 8.7 |
| Other health services | 123.6 | 69.2 | 54.4 | 15.53 | 8.69 | 6.83 | 5.0 | 9.9 | 3.1 |
| Total expenditures, U.S.A. | $38,990.0 | $8,000.9 | $30,989.1 | $198.01 | $40.63 | $157.38 | 100.0 | 100.0 | 100.0 |
| Hospital care | 14,157.0 | 5,019.7 | 9,137.3 | 72.28 | 25.66 | 46.62 | 36.3 | 62.7 | 29.5 |
| Physicians' services | 8,864.8 | 217.7 | 8,647.1 | 45.26 | 1.13 | 44.13 | 22.7 | 2.7 | 27.9 |
| Dentists' services | 2,865.8 | 42.7 | 2,823.1 | 14.63 | .22 | 14.41 | 7.4 | 0.5 | 9.1 |
| Nursing home care | 1,407.0 | 603.0 | 803.9 | 7.18 | 3.08 | 4.10 | 3.6 | 7.5 | 2.6 |
| Drugs | 5,031.9 | 154.1 | 4,877.9 | 25.69 | .80 | 24.89 | 12.9 | 1.9 | 15.7 |
| Other professional & appliances | 2,449.0 | 37.8 | 2,411.2 | 12.50 | .19 | 12.31 | 6.3 | 0.5 | 7.8 |
| Other health services | 4,214.5 | 1,925.9 | 2,288.6 | 20.47 | 9.35 | 11.12 | 10.8 | 24.1 | 7.4 |

*NOTE* Workman's Compensation, Temporary Disability Insurance, Government Employee Health Benefits exclusive of expenses for prepayment and administration, and private reimbursement to public agencies have been allocated to the public sector for both the United States and New York City.

*SOURCES* Published and unpublished data from public and private agencies. See Methodology.

TABLE 10

Selected Data on Personal Health Care Expenditures, New York City and United States, Fiscal Year 1975

| Type of Expenditure | Aggregate Amount (Millions) | | | Per Capita Amount | | | % Distribution | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Total* | *Public* | *Private* | *Total* | *Public* | *Private* | *Total* | *Public* | *Private* |
| Total expenditures, N.Y.C. | $6,700.0 | $4,006.7 | $2,693.3 | $885.41 | $529.49 | $355.92 | 100.0 | 100.0 | 100.0 |
| Hospital care | 3,526.6 | 2,538.0 | 988.6 | 466.04 | 335.40 | 130.64 | 52.6 | 63.3 | 36.7 |
| Physicians' services | 900.8 | 362.0 | 538.8 | 119.04 | 47.84 | 71.20 | 13.4 | 9.0 | 20.0 |
| Dentists' services | 483.8 | 44.1 | 439.7 | 63.93 | 5.83 | 58.11 | 7.2 | 1.1 | 16.3 |
| Nursing home care | 386.8 | 347.3 | 39.5 | 51.12 | 45.90 | 5.22 | 5.8 | 8.7 | 1.5 |
| Drugs | 324.4 | 81.7 | 242.7 | 42.87 | 10.80 | 32.07 | 4.8 | 2.0 | 9.0 |
| Other professional & appliances | 282.0 | 51.3 | 230.7 | 37.27 | 6.78 | 30.49 | 4.2 | 1.3 | 8.6 |
| Other health services | 795.6 | 582.3 | 213.3 | 105.14 | 76.95 | 28.19 | 11.9 | 14.5 | 7.9 |
| Total expenditures, U.S.A. | $111,250.0 | $43,681.4 | $67,568.6 | $513.56 | $201.65 | $311.91 | 100.0 | 100.0 | 100.0 |
| Hospital care | 46,600.0 | 24,667.1 | 21,932.9 | 215.12 | 113.87 | 101.25 | 41.9 | 56.5 | 32.5 |
| Physicians' services | 22,100.0 | 5,060.7 | 17,039.3 | 102.02 | 23.36 | 78.66 | 19.9 | 11.6 | 25.2 |
| Dentists' services | 7,500.0 | 414.8 | 7,085.2 | 34.62 | 1.91 | 32.71 | 6.7 | 0.9 | 10.5 |
| Nursing home care | 9,000.0 | 5,201.3 | 3,798.7 | 41.55 | 24.01 | 17.54 | 8.1 | 11.9 | 5.6 |
| Drugs | 10,600.0 | 867.2 | 9,732.8 | 48.93 | 4.00 | 44.93 | 9.5 | 2.0 | 14.4 |
| Other professional & appliances | 4,400.0 | 515.9 | 3,884.1 | 20.31 | 2.38 | 17.93 | 4.0 | 1.2 | 5.7 |
| Other health services | 11,050.0 | 6,954.4 | 4,095.6 | 51.01 | 32.10 | 18.91 | 9.9 | 15.9 | 6.1 |

*NOTE:* Workman's Compensation, Temporary Disability Insurance, government employee health benefits exclusive of expenses for prepayment and administration, and private reimbursement to public agencies have been allocated to the public sector for both the United States and New York City.

*SOURCES:* Published and unpublished data from public and private agencies. See Methodology.

TABLE 11
Public and Private Expenditures for Hospital Care in New York City, Fiscal Years 1966 and 1975

| Type of hospital | Fiscal Year 1966 | | Fiscal Year 1975 | |
|---|---|---|---|---|
| | *Millions of Dollars* | % | *Millions of Dollars* | % |
| All hospital expenditures | 889.5 | 100.0 | 2,944.9 | 100.0 |
| Total public | 375.9 | 42.3 | 2,005.0 | 68.1 |
| Total private | 513.6 | 57.7 | 939.9 | 31.9 |
| Municipal hospital expenditures | 312.4 | 100.0 | 1,021.4 | 100.0 |
| Total public | 291.7 | 93.4 | 949.4 | 93.0 |
| Medicaid | — | — | 456.7 | 44.7 |
| Medicare | — | — | 110.0 | 10.8 |
| Other public | 291.7 | 93.4 | 382.0 | 37.5 |
| Total private | 20.7 | 6.6 | 72.0 | 7.0 |
| Voluntary and proprietary hospital expenditures | 577.1 | 100.0 | 1,923.5 | 100.0 |
| Total public | 84.2 | 14.6 | 1,055.6 | 54.9 |
| Medicaid | — | — | 501.2 | 26.1 |
| Medicare | — | — | 521.3 | 27.1 |
| Other public | 84.2 | 14.6 | 33.1 | 1.7 |
| Total private | 492.9 | 85.4 | 867.9 | 45.1 |

*SOURCES:* American Hospital Association, New York City Expense Budget and Unpublished Data from the New York City Human Resources Administration, the New York State Department of Social Services, and DHEW (Region II).

TABLE 12
Expenditures by Municipal, Voluntary and Proprietary Hospitals, by Source of Funds, New York City, Fiscal Years 1966 and 1975

| Type of Hospital | Fiscal Year 1966 | | | | | | Fiscal Year 1975 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total | | Public | | Private | | Total | | Public | | Private | |
| | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions of Dollars* | % | *Millions Dollars* | % | *Millions of Dollars* | % |
| All hospitals | 889.5 | 100.0 | 375.9 | 100.0 | 513.6 | 100.0 | 2,944.9 | 100.0 | 2,005.0 | 100.0 | 939.9 | 100.0 |
| Municipal hospitals | 312.4 | 35.1 | 291.7 | 77.6 | 20.7 | 4.0 | 1,021.4 | 34.7 | 949.4 | 47.4 | 72.0 | 7.7 |
| Voluntary and proprietary hospitals | 577.1 | 64.9 | 84.2 | 22.4 | 492.9 | 96.0 | 1,923.5 | 65.3 | 1,055.6 | 52.6 | 867.9 | 92.3 |

*SOURCES:* American Hospital Association, New York City Expense Budget and Unpublished Data from the New York City Human Resources Administration, the New York State Department of Social Services, and DHEW (Region II).

TABLE 13
Public Beds as Percent of Total Community Hospital Beds, United States and Twenty-Five Largest Cities, 1974

| Localities | Number of Beds | | Public Beds as % of Total |
|---|---|---|---|
| | *All Community Hospitals* | *Community Hospitals under Public Control*[a] | |
| United States | 925,996 | 207,096 | 22.4 |
| Baltimore | 7,565 | 1,232 | 16.3 |
| Boston | 6,686 | 817 | 12.2 |
| Chicago | 19,159 | 2,272 | 11.9 |
| Cleveland | 6,568 | 565 | 8.6 |
| Columbus | 4,392 | 955 | 21.7 |
| Dallas | 5,204 | 854 | 16.4 |
| Denver | 4,674 | 781 | 16.7 |
| Detroit | 9,045 | 435 | 4.8 |
| Houston | 8,946 | 728 | 8.1 |
| Indianapolis | 3,808 | 1,233 | 32.4 |
| Jacksonville | 2,253 | 354 | 15.7 |
| Los Angeles | 9,900 | 2,575 | 26.0 |
| Memphis | 4,270 | 697 | 16.3 |
| Milwaukee | 4,816 | 580 | 12.0 |
| New Orleans | 4,450 | 1,642 | 36.9 |
| New York City | 43,062 | 10,887 | 25.3 |
| Philadelphia | 11,455 | 1,224 | 10.7 |
| Phoenix | 3,373 | 495 | 14.7 |
| St. Louis | 9,315 | 1,280 | 13.7 |
| San Antonio | 3,795 | 482 | 12.7 |
| San Diego | 2,275 | 0 | — |
| San Francisco | 5,064 | 579 | 11.4 |
| San Jose | 1,768 | 498 | 28.2 |
| Seattle | 3,398 | 546 | 16.1 |
| Washington | 5,071 | 730 | 14.4 |

[a]Excludes federal hospitals, state mental hospitals, and other special hospitals.
*SOURCE:* American Hospital Association.

TABLE 14
Hospital-Based Physicians as Percentage of Patient Care Physicians in United States, Selected Cities, and New York City by Borough, 1963, 1966, and 1974

| Localities | 1963 | | 1966 | | 1974 | |
|---|---|---|---|---|---|---|
| | *Patient Care Physicians* | % *Hospital-Based* | *Patient Care Physicians* | % *Hospital-Based* | *Patient Care Physicians* | % *Hospital-Based* |
| United States | 227,027 | 21.0 | 243,333 | 23.1 | 278,517 | 26.8 |
| Nashville | 745 | 41.2 | 791 | 40.1 | 1,018 | 40.9 |
| Denver | 1,444 | 30.7 | 1,630 | 35.4 | 1,977 | 42.7 |
| Jacksonville | 495 | 18.2 | 538 | 22.5 | 679 | 27.5 |
| St. Louis | 2,069 | 38.0 | 2,150 | 40.3 | 2,359 | 44.1 |
| New Orleans | 1,526 | 40.7 | 1,521 | 36.9 | 1,495 | 36.9 |
| San Francisco | 2,613 | 30.0 | 2,775 | 32.1 | 2,934 | 35.2 |
| Indianapolis | 1,115 | 32.8 | 1,195 | 34.6 | 1,408 | 38.1 |
| Washington, D.C. | 2,312 | 35.5 | 2,456 | 38.1 | 2,408 | 41.5 |
| Baltimore | 2,678 | 41.4 | 3,072 | 48.7 | 3,134 | 50.5 |
| Philadelphia | 4,599 | 37.9 | 4,710 | 41.9 | 4,328 | 49.3 |
| New York City | 19,283 | 29.6 | 20,789 | 36.1 | 19,291 | 45.8 |
| Staten Island | 276 | 18.5 | 354 | 27.7 | 476 | 41.8 |
| Bronx | 2,408 | 40.3 | 2,622 | 46.6 | 2,400 | 58.3 |
| Manhattan | 9,326 | 30.5 | 9,967 | 36.0 | 8,924 | 41.8 |
| Queens | 2,698 | 18.8 | 3,030 | 28.8 | 3,150 | 41.6 |
| Brooklyn | 4,575 | 29.0 | 4,816 | 36.0 | 4,341 | 30.7 |

[a]Independent cities or cities whose municipal boundaries are coterminous with county boundaries.

*SOURCE: Distribution of Physicians in the United States*, American Medical Association, Chicago.

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