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The Carter Administration's Health Budget: Charting New Priorities with Limited Dollars

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> Jimmy Carter's budget marks the first time in this century that a newly elected Democratic President has failed to ask for major funds for a single significant new domestic welfare program.
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> —David S. Broder, *The Washington Post*
> February 15, 1978

WHEN PRESIDENT CARTER unveiled his first complete budget, he underscored a political and economic fact of government life: the virtually automatic growth in the cost of operating federal social programs not only drives the direction of the budget, but consumes most of the dollars, leaving only marginal amounts for new initiatives.

This trend, in which the allocation of tax dollars to entitlement programs is deemed uncontrollable by the budget process, has grown significantly over the last decade. But its impact is greater in the fiscal 1979 budget because, as Broder implies, many social program advocates assumed that government spending would be more expansive under a Democratic administration. Faced with an already large budget deficit and a lagging economy, Carter decided against launching major new programs and chose instead a $25 billion tax reduction plan as his prime budgetary initiative.

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President Carter opened his budget message to Congress on January 23, 1978, by saying:

> The first complete budget of any new Administration is its most important. It is the Administration's first full statement of its priorities, policies, and proposals for meeting our national needs.

The President requested new budget authority[1] of $568.2 billion for fiscal year 1979, but projected that outlays would total $500.2 billion during that period, which begins October 1, 1978. Carter estimated that tax receipts would generate $439.6 billion, leaving a spending deficit of $60.6 billion.[2] Although the President's budget is the first to exceed half a trillion dollars, the share of the Gross National Product (GNP) accounted for by government would drop from 22.6% to 22%, the Administration estimates. President Carter emphasized this reduction relative to the GNP and characterized the fiscal 1979 spending plan as "a restrained one." He added in his budget message to Congress:

> In formulating this budget I have been made acutely aware once more of the overwhelming number of demands upon the budget and of the finite nature of our resources. Public needs are critically important; but private needs are equally valid, and the only resources the government has are those it collects from the taxpayer.

The Administration requested $182.5 billion in new budget authority for the Department of Health, Education, and Welfare

[1]Several budget terms are used throughout this article; for the sake of better understanding, they will be defined at the outset. *Budget authority:* authority provided by law to enter into obligations that will result in immediate or future outlays of government funds. Requests for new budget authority most nearly reflect the program priorities of government. *Outlays:* funds government actually projects it will spend in a given fiscal year, whether or not previously authorized. *Budget justification:* detailed financial and programmatic statements submitted by Cabinet departments to the House and Senate Committees on Appropriations in defense of their respective budgets. *Budget press release:* a compilation of facts and figures on the budget prepared at the time of its release for the news media, but used extensively through the fiscal year by special interest groups attempting to influence the shape of the final budget.

[2]The projected budget deficit is a constantly floating figure. The figure released with the budget on January 23, 1978, will probably be larger by the end of fiscal 1979, as it is not likely that Congress will reduce the size of an impending Social Security tax increase, enact the Administration's proposed $1.2 billion higher education subsidy program for middle-class families, and take fiscal action on continuing government concern over the level of unemployment.

(HEW), an increase of $20.2 billion over the previous year. *Total* federal spending for health programs will be an estimated $63.4 billion in fiscal 1979, an increase of $6.5 billion (11.4%) over that in the previous year. The *proportion* of the federal budget spent on health care will rise to 12.7% in 1979, up from 12.3% in 1978 and from 9.2% in 1970. The bulk of these monies (an estimated 78.3%) will be allocated for health programs operated by HEW. The Department of Defense will spend an estimated $4.1 billion, and the Veterans Administration $5.7 billion to finance health services for active duty servicemen and women and their eligible dependents.

At HEW, the Administration's "first full statement of its priorities, policies, and proposals" translates into a budget of which 89% will be spent by ongoing programs of entitlements for people who meet specific statutory eligibility requirements (Table 1). Most of these funds are for two purposes: income support (Social Security and public welfare) and health services for the poor and elderly (Medicaid and Medicare).

TABLE 1
Composition of the Federal Budget Outlays

Outlays	1977	1978 (millions of dollars)	1979
Entitlements:			
Social Security benefits	83,861	93,050	103,081
Medicare	21,549	25,570	29,412
Medicaid	9,876	10,846	11,952
AFDC, SSI and other welfare	12,751	13,783	13,351
Title XX social services	2,404	2,583	2,610
Interest payments and other	213	844	816
Subtotal	130,654	146,676	161,222
% of Total	88.6	89.1	89.0
Discretionary Funds:			
Health programs	6,347	6,777	7,087
Elementary, higher, and other education	7,792	8,385	9,708
Human development services	2,426	2,612	3,060
Other	236	145	188
Subtotal	16,801	17,919	20,043
% of Total	11.4	10.9	11.0
Total HEW Outlays	147,455	164,595	181,265
% of Total	100.0	100.0	100.0

Source: Adapted from Executive Office of the President, Office of Management and Budget. *Special Analyses Budget of the United States Government, Fiscal Year 1979.* Washington, D.C.: 1978.

These entitlement programs[3] will require estimated outlays of $161.2 billion in fiscal 1979. In the remaining portion of HEW's vast spending plan, discretionary funds totaling $20 billion were requested by the President. Of this total, Public Health Service programs would receive $7.1 billion, a net reduction of $2 million from fiscal 1978, as Table 2 shows. Because of the large increases in spending for Medicare and Medicaid, and Carter's determination to hold spending where possible, HEW has been forced to offset the cost of new health initiatives. Thus, it proposes a sharp cut in health manpower funding, only a small increase in spending for biomedical research, and reliance on projected savings from the Administration's hospital cost containment legislation.

The HEW budget reflects a determination on the part of the Administration to target limited resources more closely on perceived national needs. This is apparent in the proposed offsets for new spending under the Public Health Service. It is also a factor in the effort by HEW Secretary Joseph A. Califano, Jr., to shift spending increases from entitlement programs, where the Department has strictly limited capacity to direct its use, to discretionary programs, where new spending can be more highly controlled. In his news conference on January 21, 1978, Secretary Califano pointed out his effort to more closely target monies:

> There is one important point I would like to make, and it goes both to the point of management and it goes to the point of targeting our money for people who are needy. The entitlement programs, basically the formula programs of Social Security, Medicare, and Medicaid, which if an individual has an entitlement he gets paid, from 1977 until 1978 the increase was 12.2% in those programs. We have held that increase from 1978 to 1979 to only 9.9%. The way we have done it is both through management, through the anti-fraud and abuse programs, which are beginning to pay off in dollars, and also through legislative changes that we are proposing [hospital cost containment]. Secondly, the discretionary funds, the funds that go to some of our neediest people, Title One [of the Elementary and Secondary Education Act] and

[3]HEW's fiscal 1979 budget press release and supporting documents refer to Social Security, Public Assistance, Medicare and Medicaid as "entitlement" programs. Traditionally, HEW's budget office referred to these programs as "uncontrollable" through the budget process, but this terminology was abandoned this year because Secretary Califano regarded this label as an expression of poor management on the part of the Department.

Head Start, for example, increased in the 1979 budget over 1978 by only 6.6%. You will note that our increase in the 1979 budget over 1978 is a substantial 12.4%, so we are hopefully, and I think with increasing assurance, learning how to target our money to provide more funds in these discretionary programs, larger increases in them, and through better management to hold down some of these big dollar entitlement programs.

TABLE 2
Winners and Losers in the PHS Budget

Outlays	1978	1979	Increase
		(millions of dollars)	
Winners:			
Adolescent health	—	60	+ 60
Community Health Centers	262	301	+ 39
National Health Service Corps	43	63	+ 20
Maternal and child health grants to states	335	348	+ 13
Family planning	135	145	+ 10
Immunization	23	35	+ 12
Health education (anti-smoking)	5	13	+ 8
Child health research	166	199	+ 33
Other NIH research	2,610	2,655	+ 44
Mental health research	112	135	+ 23
Drug abuse research	34	46	+ 12
Alcoholism research	16	21	+ 5
Community Mental Health Centers	269	284	+ 15
Health Maintenance Organizations	26	32	+ 6
All other	789	842	+ 53
Total increases			+353
Losers:			
PHS hospitals operations	177	153	− 24
Repair of PHS hospitals	15	—	− 15
Construction of NIH ambulatory research center	66	31	− 35
Renovations at St. Elizabeths	57	—	− 57
Capitation grants	144	87	− 57
Health professions student loans	20	0	− 20
Nursing	122	21	−101
Public and allied health	36	15	− 19
Other health manpower	31	10	− 21
All other health	41	35	− 6
Total decreases			−355
Net Change			− 2

Source: Adapted from U.S. Department of Health, Education, and Welfare, Office of the Assistant Secretary for Management and Budget. *Internal Briefing Book*. Washington, D.C.: 1978.

HEW's Budget: An Overview

Development of a federal budget is a fascinating, almost year-long exercise.[4] Decisions are fashioned from a panoply of political, economic, social, and sometimes emotional considerations that come into play when government policymakers divide limited dollars among a multitude of competing claims. In HEW's case, the Office of the Secretary devotes countless hours to budget development. Like most government agencies, HEW uses the budget process not only to chart its spending plan, but also to develop a legislative package for submission to Congress as part of the President's overall agenda.

The budget process starts every spring at HEW when the Department establishes internal spending ceilings for each of its operating agencies. The agencies begin work on their new budgets after receiving their ceilings. In practice, the operating agencies usually exceed these allowances, hoping thereby to increase their actual budgets. In July, the President's Office of Management and Budget (OMB) establishes its own budget ceilings for the individual departments and agencies. Between July and the following December, the Department is engaged in an internal debate over its priorities and also is involved in a similar exercise with OMB, the agency that protects and defends the President's interest in the budget process.

HEW's budget between 1964 and 1979 will have increased eightfold, and the Department's share of the total federal budget will have risen from 18% to 36%, as Table 3 shows. In the last decade, HEW's budget has quadrupled as the Department has taken on new responsibilities either proposed by the President or thrust upon it by Congress. Inflation also has taken its toll in diminishing the value of HEW's dollar as it has in the economy at large. The decade-long trend favoring massive expansion of HEW's budget is a continuing concern to other government agencies, which are forced to compete against it for tax dollars to fund programs that their stewards regard

[4]Less than 2 months after the Administration's budget for fiscal 1979 was released, Secretary Califano directed his operating agency chiefs to begin policy planning for fiscal 1980. Califano was particularly interested in getting an early start because he believed that in selected cases the Secretary's office had not been brought into the planning cycle early enough to influence decisions for fiscal 1979.

of equal importance to society. Indeed, the Carter presidency has continued this trend. In January 1977, President Ford had projected that 50.6% of the 1979 outlays would pay for human resource programs, while 26.6% would go for defense. President Carter asked for 51.8% for human resources and 23.6% for defense spending in his fiscal 1979 budget. In this comparison, human resource programs are in four budget functions: education, training, employment, and social services; health; income security; and veterans' benefits and services.

HEW's budget clearly belongs to its aggressive secretary. The new priorities of the Department are Califano's priorities. President Carter's budget office lost its director, Bert Lance, during the critical early days of the fiscal 1979 budget process. Lance, who enjoyed the President's confidence, could have served as a more effective OMB counterweight to Califano's expansionist designs. Along with Carter, Lance had been a staunch proponent of the goal that the Administration balance the federal budget by 1981. With Lance's premature departure and in the face of President Carter's strong belief in Cabinet government, OMB's power has been debilitated. As a consequence, the President's budget agency has played a less influential role in the development of HEW's budget than it has in any year over the previous decade.

TABLE 3
Trends in the Federal Budget Outlays

Outlay (in billions of dollars)	1964	1969	1974	1979	Change 1964-1979 Amount	Change 1964-1979 Ratio: 1979/1964
HEW:						
Health	2.3	11.7	21.6	48.6	+ 46.3	21.1
Education	.7	3.4	5.4	10.6	+ 9.9	15.1
Social services	.2	1.0	2.9	5.6	+ 5.4	28.0
Social Security benefits	16.6	26.2	55.9	103.1	+ 86.5	6.2
Other income assistance	2.4	4.3	7.9	13.6	+ 11.2	5.7
Total, HEW	22.2	46.6	93.7	181.5	+159.3	8.2
% of federal budget	18.0	25.0	35.0	36.0	+ 18.0	—
Total federal outlays	120.3	184.6	268.4	500.2	+379.7	4.2

Source: Adapted from U.S. Department of Health, Education, and Welfare. *1979 Budget Themes*. Washington, D.C.: 1978.

During the presidential years of Richard M. Nixon and Gerald R. Ford, OMB's role was pronounced in government budget and policymaking. Its strength was due largely to the views of the professional and political staff members, who favored a more limited government role, and to OMB's traditional institutional role of cutting spending wherever possible. These qualities squared with the philosophy of Republican presidents. At the professional level, OMB's health staff remains under the directorship of Victor Zafra, whose conservative leanings are not sympathetic to those of Secretary Califano. When OMB questioned HEW's fiscal 1979 priorities, the President sided with Califano more times than not.[5] Moreover, Carter's touted "zero-based budgeting" concept, which OMB was responsible for implementing, was of little importance in the presidential allocation of resources, according to OMB staff members involved in the process and to Havemann (1978), the only Washington reporter who covers the budget agency on a full-time basis. Havemann wrote:

> Zero-based budgeting worked major changes in the way the departments and agencies prepared their 1979 budgets. But OMB reviewed their budgets in much the same way that they have examined budgets in past years, and Carter played a role similar to Ford's.

President Carter's budget represents not only a stepping away by government from the more conservative fiscal policies of Presidents Nixon and Ford, but also a reaffirmation of the principles of

[5]Secretary Califano clearly was the major influence on HEW's budget, but not because Carter was inattentive. OMB staff members who worked with the President on the budget were impressed with his devotion to reading prepared material and with his pointed questioning during review. Carter left no doubt who was in charge when HEW's Professional Standards Review Organization (PRSO) program came up for discussion at a White House session on the Department's budget in early December, 1977. HEW had asked for $300 million for the program in fiscal 1979; OMB cut the request to $174 million, to a total that was nevertheless 16% higher than that of the previous year. But Carter asked whether OMB had ever considered abandoning the program because it had demonstrated little result in reducing the cost or improving the quality of federally-financed health care. OMB, a long-time skeptic of PSRO but recognizing the likelihood that Congress would reject its termination, readily accepted the President's casual suggestion. Thus, OMB sent HEW's budget back to the Department for its final review with *no* funds earmarked for the PSRO program. Califano appealed the decision directly to the President and persuaded Carter to restore the $174 million.

Democratic social programming, which had been attacked for so long by the Republicans. These traditions include a strong belief in categorical programs, domination of policymaking and spending decisions by Washington rather than subnational governments, and a conviction that the primary factor separating American society from solutions to its social ills is money.[6] Secretary Califano was a leading architect of President Lyndon B. Johnson's "Great Society," under which the government vastly expanded its social interventions. Thus, perhaps a return to the principles that formed the basis for programs launched under the Great Society is not a surprise. Nevertheless, after 8 years of Republican assaults on the categorical program structure and efforts to maintain a tight rein on social spending (not to mention Carter's attacks on traditional Washington ways during the 1976 campaign), social program advocates welcomed a return to the philosophical tenets of every Democratic president since the New Deal. But beliefs were not backed by budgetary action.

[6]While money is certainly an important ingredient in the expansionist designs of Califano, it is only one of a number that he regards as important in improving the health and welfare of Americans. In a private interview on January 13, 1978, Califano cited the importance of the Department's mass communication efforts to alert individuals to the dangers of everything from smoking to a declining rate of immunization of children. He said: "I feel less Washington-oriented than when I came into this job. I would cite several recent matters. Our antismoking effort made me aware that there is so little in our control. You can make people aware of it. I have no way to require, direct, or do anything in terms of what individuals do about smoking and health, but the Department can provide some material and we can say here are the facts. I'm very conscious of the need to persuade people on the merits of something that's worthwhile to them. Another example is immunization. We're adding another $13 million to the budget in fiscal 1979 in an effort to increase to 90% the immunization rate, and that's nothing compared with the payoff. What's our role in immunization? We're really working through local schools, through state public health services and city public health services. We can provide some leadership and some funds to buy the vaccine, but when we went out with that program I wrote to the governors and the Commissioner of Education wrote to the school superintendents; the Public Health Service went out through their lines. I asked the AMA [American Medical Association] and the pediatricians to work hard on this. And they've all acted very responsibly. That struck me as another experience in which Washington could direct, but not dictate. It just required thousands and thousands of people and institutions getting on board. It makes me very conscious of the importance of selecting with care the things the Department wants to do and then turn loose the informal apparatus that we use to communicate."

Health Priorities: More Services to Low-Income People

The Carter Administration identified two major priorities in its health budget: improved services for children and youth, and new efforts to both upgrade HEW's program efficiency and reduce medical care costs. Budget proposals highlighted under these rubrics include: an expansion of Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, which the Administration has renamed the Child Health Assessment Program (CHAP); an extension of Medicaid services to all low-income pregnant women; expansion of services to adolescents to prevent unwanted pregnancies; and an increase in childhood immunization efforts. The Administration also cited as important thrusts: a stepped up antismoking campaign, aimed principally at children and teenagers; increased funds for biomedical research related to pregnancy; expansion of federal efforts to develop Health Maintenance Organizations; additional funds to further the National Health Service Corps; and funds to increase the number of community health centers. The President's proposed hospital cost containment plan, cited by Carter as one of his five top legislative priorities for 1978, was identified as the major action aimed at controlling costs. This proposal will be discussed later.

All of the White House and departmental press releases and budget documents focused on these proposals as evidence of the Administration's commitment to be "responsive to people's needs," as Califano said in his statement of January 21, 1978. These proposals would require new spending of $734 million, broken down as follows: Public Health Service programs, $353 million; CHAP, $263 million; and Medicaid services for low-income women, $118 million. To underscore the stringency of current budgetmaking, however, it is important to recognize that all of these proposed increases are more than offset by proposed spending reductions. But in the uncontrollable, or entitlement, category, the projected spending increases are of a magnitude (as is the case every year) that they could not be offset (see Fig. 1). These increases are in Medicare and Medicaid, where the Department is compelled by law to finance services to eligible beneficiaries without regard to the resulting spending levels. Medicare spending would rise $3.8 billion, to $29.4 billion, and fed-

eral Medicaid costs would increase $1.1 billion, to $12.1 billion. In fiscal 1979, state and local spending for Medicaid would cost another $9.2 billion. These spending increases are dictated not by improved benefits or more beneficiaries but rather by inflation. HEW emphasized the impact of inflation on the Medicaid budget in its budget justification statement to the House and Senate Committees on Appropriations:

> As in 1978, the inflation of medical care prices is the major factor behind the increase in medicaid costs. In FY (fiscal year) 1979 inflation is expected to account for almost 89 per cent of the estimated increase. A smaller number of medicaid recipients expected in FY 1979 accounts for a very small decrease of less than 1%, and a small increase in utilization of the medicaid services by the medicaid recipients accounts for just over 11% of the increase.

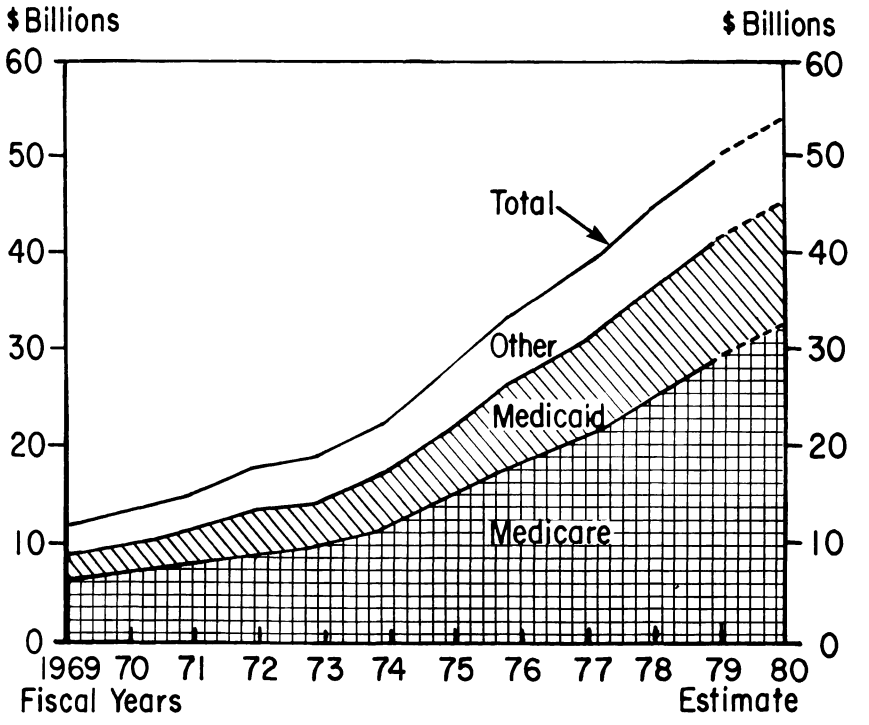

FIG. 1. HEW Outlays for Health, 1969–1980 (projected). Source: Adapted from U.S. Department of Health, Education and Welfare. *1979 Budget Themes*. 1978.

The budget targets its new discretionary health service dollars on low-income families through the proposed creation of 131 community health centers in medically underserved areas. With the requested increase of $39 million for community health centers, the program's spending level would rise to $301 million. HEW estimates that the new funds would provide services to 1 million additional individuals, bringing to 5.6 million the number of people served nationally in 705 centers. But even with the budget increase, HEW estimates that community health centers would serve only 11.4% of the individuals living in areas defined by the Department as medically underserved.

The Administration's decision to bolster community health centers provides a significant contrast to the priorities of Carter's Republican predecessors. The community health center movement was born in the mid-1960s, a creation of President Johnson's "War on Poverty." Initially, the units were called neighborhood health centers. After Nixon's election in 1968, his Administration opposed further expansion of the program; Republicans viewed the centers as poorly managed, too expensive on a per-patient basis, and without solid links to mainstream medicine. Moreover, the centers were regarded as duplicative of Medicaid.

In developing the fiscal 1979 budget, though, a number of influential figures argued for increasing federal support for community health centers, including Secretary Califano, Assistant Secretary for Health Dr. Julius Richmond, his principal deputies Ruth Hanft and Dr. Joyce Lashof, and Deputy Assistant Secretary for Health Planning and Evaluation Karen Davis. Their advocacy stems from several factors. Secretary Califano is still a believer in the Great Society programs he helped design as Johnson's chief domestic advisor. Assistant Secretary Richmond also is a long-time advocate as one of the architects of Head Start, an educational enrichment program for preschool poor children that concentrated resources on the same target population as those served by the health centers. Hanft, Lashof, and Davis believe that poor individuals will be denied access to quality medical care unless government creates federal outposts to serve them.

Expanding the number of centers also fits well with another Administration proposal—the Adolescent Health Service and Pregnancy Prevention Initiative. The centers will provide new services

under the budget plan, which HEW explained in its budget justification statement:

> Efforts under the Adolescent Health Service and Pregnancy Prevention Initiative will provide services to an additional 147,000 adolescents in 1979. This initiative involves activities designed to increase comprehensive health care services for adolescents, especially with regard to pregnancy prevention, venereal disease, drug and alcohol abuse and emotional disorders. Effective approaches reducing the incidence of these problems require that medical staff working with adolescents develop an understanding of the adolescents' behavior patterns, life styles and value systems. Together with those adolescents already being served in community health centers, a total of 944,311 adolescents will be provided care in 1979.

This particular health service proposal carries a distinct Califano label. Early in his tenure, the Secretary became aware of the growing problem in the United States of teenage pregnancy. Beyond the HEW estimate that each year one of every 10 teenagers becomes pregnant, however, is the Administration's compelling political need to develop alternatives to abortion. The President and Secretary Califano are avowed opponents of the use of public funds to finance abortions, except when the life of the mother is endangered. Peter H. Schuck, Deputy Assistant HEW Secretary for Planning and Evaluation, said in an interview (Roberts, 1978):

> There is no question that their position on abortion vastly increased the incentives to address the problem in other ways.

The pregnancy prevention proposal targets new dollars in a number of related programs, as shown in Table 4. The Administration is seeking new authorizing legislation, which must be enacted before the proposal is fully implemented. Asked in an interview how the Department developed its priorities on pregnancy prevention and children, Califano underscored his personal interest and that of President Carter in identifying alternatives to abortion by the following answer:

> The basic initiatives were designed to fulfill some of the President's campaign promises—alternatives to abortion, for instance. With limited resources, we put a lot of bucks into kids and young people through Head Start and other elementary and secondary education

programs. We've expanded CHAP [Child Health Assessment Program] to serve poor kids. And I've tried to substantially enhance the research and development capability in child health development and human development. My reason is, I am convinced that . . . whether you're pro-abortionist or anti-abortionist, whether you're for or against birth control, you've got to be interested in learning all you can out of the reproductive process . . . If we could find or discover in this country a temporary sterilization technique, or develop ways to correct deficiencies in the fetus, that would be very important. A year ago, I visited a school in the South Bronx, an elementary school in which every kid was on welfare. I asked the principal and the guidance counsellor what they'd do if they had more money. And they said, "Do you mean $20,000 more for 627 kids?" And I said, "Sure." They said they'd hire a nurse to inform mothers in the neighborhood who become pregnant how to take care of themselves because so many of those kids had learning problems related to prenatal care. Now if we could do that and also develop a birth control measure that the Catholic church and the Pope would approve, just think what that would mean for our country, for the world. So we put money there.

TABLE 4
Budget Authority Spending for Adolescent Health, Services, and Pregnancy Prevention

Budget Authority Programs	1978 Ford	1978 Carter	1979	Change
		(millions of dollars)		
New Legislation:				
Adolescent Health, Services, and Prevention Act	—	—	60	+ 60
Expanded Medicaid coverage for low-income pregnant adolescents	—	—	18	+ 18
Current Law:				
Family planning project grants	35	50	68	+ 18
Family planning reimbursement through:				
Medicaid	26	26	26	—
Title XX social services	7	7	7	—
Community Health Centers	25	45	60	+ 15
Maternal and child health	40	45	52	+ 7
Health education	—	1	3	+ 2
Research and training	13	22	44	+ 22
Total	146	196	338	+142

Source: Adapted from U.S. Department of Health, Education, and Welfare, Office of the Secretary. *Report.* January 23, 1978.

The Administration emphasized again its commitment to assessing the health needs of poor children by liberalizing a proposal it first advanced in the fiscal 1978 budget, the Child Health Assessment Program. CHAP represents an expansion and improvement in child health requirements under Medicaid's EPSDT program. The budget requests $263 million in new funds to extend coverage to low-income children 6 to 21 years of age who would not otherwise be covered. With this expansion, CHAP would make an additional 1.7 million children eligible for Medicaid services.

The Administration's first CHAP proposal limited early screening services to low-income children under 6 years of age. CHAP differs from EPSDT by offering to states a more favorable federal matching rate for health assessments and treatment. Thus, the Administration hopes that, in response to financial incentives, states will move not only to screen more children but also to provide them with continuing access to a regular source of care. Congress is now actively considering the Administration's CHAP plan.

Health Manpower: Reversing a Trend

The Administration proposed the boldest health policy change in its new budget in manpower programming. The President recommended a 38% reduction in manpower subsidies and announced plans to terminate capitation grants to schools of veterinary medicine, optometry, pharmacy, podiatry, and nursing, and to phase out over 3 years such assistance to schools of medicine, osteopathy, and dentistry.

Capitation grants are a clear example of federal assistance that is regarded by the Administration as not highly enough targeted to be in the immediate public interest. Capitation support—grants paid to schools on a per-student basis—has been used by schools for a range of purposes, including salaries and overhead. Congress first authorized such support in 1971 when the schools convinced government that, because they were producing health professionals to alleviate a shortage, they should be viewed as "national resources."

Under its policy, first articulated in the fiscal 1979 budget, the Administration proposes to reduce health manpower budget authority to $335 million, compared with a level of $544 million in the previous year. The policy reversal is based on a simple

premise—that adequate numbers of health professionals are practicing or already are in the education pipeline; thus, federal subsidies to schools that train such individuals can be reduced. The major problem now is a maldistribution of this personnel by geography and by medical specialty, HEW said in its budget justification statement:

> Earlier years addressed the need to increase the number of trained health professionals by providing fiscal incentives through health professions and nursing capitation grants. The number of physicians increased 55,400 from 1970 (323,200) to the current level (378,600). Nurses increased by 289,000 from 1970 (722,000) to the current level (1,011,100). There is now no overall shortage of these health professionals. Also because of the long range economic benefits derived by the practicing physician, it is the Administration's policy to have physicians take on more of their own educational costs, a shift of emphasis in providing just mere increases in numbers to providing health manpower in geographic and specialty medically underserved areas has taken place and is the highest priority in the health manpower budget.

The nation's 19 schools of public health were the striking exception to the Administration's general policy of phasing out or immediately terminating capitation support. The budget recommends that these schools continue to receive capitation grants totaling $5.9 million a year. The schools of public health were slated to lose this support along with the other health professional institutions, but late in the process HEW Under Secretary Hale Champion intervened, according to a ranking HEW budget official, who said in a private interview:

> It is the personal belief of Champion, for which he fought very hard, that schools of public health should be fostered. Thus, capitation grants for these schools were maintained, rather than abandoned, as HEW proposed initially. Champion was able to sell the schools' case because there is a belief in some quarters that the students they produce are oriented toward prevention, a secretarial priority.

In manpower programs, as in other parts of HEW's health budget, the Administration maintained or increased support for primary medical care and emphasized the provision of service to the nation's most vulnerable population segments. Reflections of these policies include an increase in the National Health Service Corps budget from $42.6 million in fiscal 1978 to $62.9 million and a $1

million increase to $61 million to finance 7000 family medicine and primary care residency positions. The President's spending plan also continues to support programs to train increased numbers of personnel in biostatistics, epidemiology, and health administration and planning, although it proposed a reduction for traineeships in public health to 25% of the 1978 level and terminated traineeships in allied health professions. HEW's budget press release said:

> This places the responsibility for tuition and other payments on the students who will benefit from training in these fields.

Biomedical Research: A Shift toward Basic Research

The President used the fiscal 1979 budget as the vehicle to express his view that an imbalance exists favoring government-funded applied research over the pursuits of basic science. Thus, in the budget for the National Institutes of Health (NIH), the Administration focused new money on basic research, but it did so within a framework of an almost level budget. The Department cited the shift favoring basic research in its budget justification statement:

> The 1979 budget request for the NIH reflects a substantial shift in emphasis with a greater proportion of the funds utilized for basic research, an increase to a level of $856 million in 1979, or 33% of the research and development budget, from 30% or $763 million in 1978. This change reflects a high presidential priority, and represents a continuing NIH commitment to the development of the science base, which will provide the knowledge for future clinical application, and ultimately the transfer of that knowledge into health care. In order to meet this new priority, some applied activities are being phased down, with funds redirected to basic research.

Four days before the budget was released, Gilbert Omenn, M.D., Ph.D., Assistant Director for Human Resources and Social and Economic Services in the President's Office of Science and Technology Policy, set out the Administration's reasoning for upgrading basic research. On January 19, at an oversight hearing before the Senate Appropriations Subcommittee on Labor-HEW,

Omenn testified that during its first year the Administration had conducted a broad inquiry into the state of the nation's research enterprise:

> The President, the Vice President and several Cabinet members have taken special interest in this review of basic research policy. Based upon that review of basic research in all fields, the President emphasized at the awards ceremony November 22 [1977] for the 15 recipients of the National Medal of Science that: First, the percentage of university researchers who are young, that is, 7 years' postdoctorate, has fallen from 43% in 1968 to 27% in 1975. Second, the quality of equipment in research labs has deteriorated. Third, the number of universities ranked as first-class centers in various fields has declined, and Fourth, the federal support for basic research across all fields, in constant dollars, declined 19% in the decade from 1967 through 1976 . . . The President's budget requests . . . will reflect a commitment across the Administration to invest in basic research to meet the needs of the future.

The Administration's renewed emphasis on basic research accords with the view of the science community. A distinguished cast of Nobel laureates and other researchers testified in favor of more funding for basic research on the same day that Omenn appeared before the Senate subcommittee. Senator Thomas F. Eagleton, D-Mo., who chaired the hearing, described the witnesses as:

> perhaps the most prestigious and distinguished group of physicians and researchers ever assembled at any one time before a Senate committee.

Eagleton left little doubt during the hearing that he was fully prepared to support increased funding for basic research.

The President requested budget authority of $2.9 billion for the National Institutes of Health (NIH), an increase of $42.3 million over the previous year. HEW sought in its budget justification statement to diminish the importance of what a reduction in funds for applied research would mean:

> In order to fund the new basic research priority, applied research has assumed a lower priority in 1979, decreasing by $42.3 million to a level of $1.9 billion. Within this level, it will be possible to address all of the highest priority applied research opportunities. Clinical drug trials, for which NIH obligates approximately $100 million annually, will remain a primary method of research application and will receive continued

attention during 1979. Emphasis will be placed on the development of more efficient and improved techniques for the diagnosis and treatment of human cancer through chemotherapy, radiation therapy, surgery, immunotherapy, or a combination of these treatments. Research will also focus on the development of simple, effective techniques for reducing dental caries, the development of new or improved vaccines, and treatment for allergies.

The National Institute of Child Health and Human Development (NICHHD) will receive a 20% increase in its funding to support new research in contraceptive development, fetal research, and smoking prevention. Thus, NICHHD would receive $33 million of the $42.3 million in new NIH budget authority requested by Carter. The biomedical research community will thereby play a role not only in the Administration's emphasis on children and youth but also in the drive of Carter and Califano to find viable alternatives to abortion. The NIH maintains, though, that increased funding for NICHHD has more than simply a political dimension. NIH Director Donald S. Fredrickson, M.D., testified before the House Appropriations Subcommittee on Labor-HEW that there are promising research leads that NICHHD could follow if it had a larger budget to work with.

The Administration sought a sizable increase in mental health research funding, but only after the personal intervention of Rosalynn Carter, who is honorary chairman of the President's Commission on Mental Health. HEW initially sought to increase the mental health research budget by $2 million, a level that fell considerably short of the interim recommendations of the Commission. Dr. Thomas Bryant, Commission staff director, worked inside the Administration to increase the mental health research budget, but progress was slow. The $2 million increase to a fiscal 1978 base of $112 million won the endorsement of Carter during his review of HEW's budget. After this review, which ends the formal budget debate (except for personal appeals that Cabinet officials feel compelled to make to the President), Bryant sought out James T. McIntyre, Jr., who at the time was OMB director-designate, to press for a larger mental health research budget. Mrs. Carter attended this meeting. Soon after the meeting, McIntyre directed OMB's staff to increase funding for mental health research to $135.4 million, a $23.3 million increase over fiscal 1978.

Containing Medical Costs: An Extra-Budgetary Uphill Struggle

The second major HEW priority identified by the Administration in its budget is to "improve program efficiency and reduce [medical-care] costs." The focus for this priority is the President's hospital cost containment legislation, which had been introduced 9 months before the new budget. Recognizing assumptions based on enactment of the legislation is critical to a complete understanding of Carter's spending plan. Dollars for the new social programs that Carter agreed to include in his budget flow in great part from a shaky political and economic assumption—that the Administration's hospital cost control plan will reap savings of $2 billion in fiscal 1979. The breakdown of estimated savings is $1.3 billion for private payers of medical care; and in the public sector, $630 million in Medicare and $100 million in Medicaid.

Califano noted the relationship between education budget increases and projected health savings in a statement on January 21, 1978, which accompanied the release of the budget:

> This budget—with its increase in important discretionary programs like education and its dollar saving proposals like hospital cost containment—blends an awareness that vital human services are still not reaching millions of needy Americans with a deep commitment to manage the department's massive resources in a responsible and prudent manner that will win the confidence of the Congress and our citizens.

There is no question that the Administration and Congress view with growing concern the medical cost spiral, but the agreement on how to deal with it stops abruptly there. Although the hospital cost control proposal has been in trouble almost since the day the Administration announced its intent (April 25, 1977), the President built his budget on savings estimates agreed to by HEW and OMB. Agreement, however, was an accommodation reached only after an internal debate during which HEW favored higher estimates and OMB lower ones.

To achieve the projected savings, the Administration's hospital cost control bill would impose a cap of 9% on the operating revenues of every non-federal hospital, regardless of its size, case mix, or efficiency. Federal institutions would be exempt from the ceiling, but

the Administration said even these would be subject to it indirectly through the government budget. With pass-through provisions for increases in the wages of nonsupervisory hospital employees, the cost of energy, and premiums for malpractice insurance, the effective annual cap would be an estimated 11.2%. The Carter plan also would impose a permanent annual ceiling on national capital expenditures of $2.5 billion. The capital funds would be allocated on a strict population basis state by state, but within each of these jurisdictions the health planning structure would make the resource allocation decisions.

The Administration's bill is amazingly unpopular on Capitol Hill, although the President cited it as one of his top five legislative priorities in 1978. Representative Dan Rostenkowski, D-Ill., chairman of the House Ways and Means Subcommittee on Health, one of the four congressional panels considering the hospital cost bill, depicted in a private interview the dilemma facing legislators:

> I see a need for cost containment; there definitely should be a movement for it, but it's a very unpopular issue because of the argument that cost containment means that services will be curtailed.

The only constituency intensely interested in cost containment is a varied confederation joined to oppose it. Moreover, Carter's public support for the plan has not been aggressive. Rostenkowski added:

> In the health community, you're dealing with some of the most sophisticated people in our country. In the health community, you have the philanthropist who sits on the hospital board, the doctors, the attorneys, and even the nun who can roll her eyes to the heavens and say, "Oh God, what is government doing to us now?"

Rostenkowski, who as Deputy Majority Whip is a member of the House Democratic leadership, declined to support the Administration's bill despite his standing as one of Carter's most faithful congressional lieutenants. Instead, Rostenkowski offered an alternative under which hospitals would strive on a voluntary basis to reduce their operating costs in the aggregate by 2% in 1978 and again in 1979. If the voluntary plan fails, then mandatory federal controls similar to those proposed by the Administration would be instituted.

The House Ways and Means Subcommittee on Health approved Rostenkowski's bill on February 28, 1978, but its 7-6 vote signaled a tough hearing for the measure before the full Committee.

Three other congressional committees either have already reported hospital cost control legislation or have it under active consideration. The Senate Human Resources Committee, under the prodding of Senator Edward M. Kennedy, D-Mass., reported a bill much akin to that of the President's on August 2, 1977. Kennedy has publicly denounced Rostenkowski's standby control measure as too weak a prescription. The House Interstate and Foreign Commerce Subcommittee on Health and the Environment also approved a cost bill similar to that introduced by the Administration. Finally, the Senate Finance Subcommittee on Health has held public hearings on the Administration's bill, but its chairman, Senator Herman E. Talmadge, D-Ga., has announced publicly he is opposed to the measure. Talmadge is pushing another alternative that would seek cost restraints through long-range reform of the way HEW reimburses hospitals for care. This plan would establish target rates for hospitals of similar nature and size.

Congressional Response to HEW's Budget

Congress's response to HEW's spending plan is not unlike its reaction to the Administration's hospital cost containment legislation. It is easier for legislators to approve the expenditure of new monies than it is to deny funds to active and powerful interests that resist budget cuts or new controls. A pattern has been well established in the last decade regarding the relationship between HEW's budget proposals and those of Congress. Congress, without fail, adds substantial sums to those sought by the executive branch, be the President Democrat or Republican. And early congressional consideration of Carter's budget provided no indication that legislators will deviate from this procedure.

The Department's discretionary budget is handled every year by the House and Senate Appropriation Subcommittees on Labor-HEW. These subcommittees, although still powerful, have lost influence over the Department in the last 5 years as entitlement programs have absorbed more and more funds. Funding for Social Security and Medicare do not require action by the appropriations process because their monies come from trust funds. But even Medicaid and public welfare, which do require an annual federal appropriation, never are seriously examined by the House and Senate

Appropriation Subcommittees on Labor-HEW because there is so little these panels can do to change policies dictating spending.[7]

The programmatic areas that the budget slights most significantly—health manpower and biomedical research—are two favored activities of the Congress, and particularly its appropriation panels. Since the creation of NIH, Congress has been a moving force in building the research agency into the world's largest biomedical science enterprise. Senator Warren G. Magnuson, D-Wash., chairman of the Senate Appropriations Committee and its Labor-HEW Subcommittee, was sponsor of the 1937 law creating the National Cancer Institute and he remains a staunch supporter of biomedical research. In a private interview, Terry Lierman, staff director of the Senate Labor-HEW Subcommittee on Appropriations, said that he anticipated the Senate would increase NIH's budget:

[7]Congressional money committees are subjected every year to a wide range of pressures exerted by private interests that seek to increase funding in federal health programs. No organization spends more time developing alternative budget proposals and represents a more disparate range of interests than the Coalition for Health Funding. A Washington-based operation composed of 52 private national organizations ranging from the American Academy of Pediatrics to the Association of American Medical Colleges to the United Auto Workers, the Coalition prepared a 75-page alternative to the Administration's health budget. In its opening summary the Coalition said: "President Carter's first health budget allows no growth in health service programs, makes severe cuts into certain painstakingly developed research programs, and drastically reduces the health education and manpower development programs. The Carter Administration has narrowly limited its health initiatives in the FY 1979 budget to improving health services to pregnant women, children and adolescents, and restraining the ever increasing cost of Medicare and Medicaid programs. Compared to a 15% increase in the education budget, the PHS budgets allows less than a 1% increase and the rehabilitation and developmentally disabled services budget only allows a 4.7% increase. In contrast, the January 1978 Consumer Price Index for all urban consumers places annual inflation for hospital and other medical care services at 10.8%, and for physician and dentist fees and the cost of drugs at 8.4%." The President's budget requested $7.2 billion for programs which fall within the jurisdiction of the House and Senate Labor-HEW Appropriation Subcommittees. The Coalition for Health Funding urged Congress to appropriate $8.6 billion for these same programs.

> The increase in the NIH budget becomes a matter of degree. In past years, the committee has increased the biomedical research budget 10% to 15% above the request. Last year, the increases were not as big because of the budget deficit and other more pressing claims for the money. There is an awful lot of standstill in the Administration's new research budget. Obviously, we will take a hard look at it, but I would anticipate the Senate would add dollars. The subcommittee itself is perhaps the most liberal among all of the panels of the United States Senate and that's where the funding decisions originate, at least for HEW. In short, we like the Administration's initiatives, but not their budget cuts, but the situation is not as bleak as it was under the Republicans.

Nicholas Cavarocchi, who handles the health budget for the House Appropriations Subcommittee on Labor-HEW, agreed with Lierman during a subsequent interview:

> The emphasis on basic research is fine, but to cut applied research and training programs is not a direction that will stand up in the House. The NIH is still a favored program, although legislators would like to see more results produced from the massive investment in research. NIH's budget will increase, I don't see that trend changing, but not at the rate it enjoyed during the boom years of the 1960s.

Cavarocchi predicted that the House would restore the proposed cuts in health manpower capitation support (Lierman, in his earlier discussion, thought the Senate would do likewise). Cavarocchi said:

> As long as there are pockets in the United States without doctors it will be tough for Members of Congress to cut back on the production of physicians. Members still believe there is a need for more doctors. They just don't buy the larger economic argument that, because doctors are capable of generating their own demand, medical schools should cut back on the production of physicians.

Thus, if the views of two staff members who work daily with members of Congress on shaping HEW's budget is an accurate indicator, it seems clear that few of the health spending cuts proposed by the Administration will be accepted by the legislative branch.

Summary

The President has advanced his first complete budget, a document Carter described as "the Administration's first full statement of its priorities." The budget shows that while a new administration may have different priorities, present policymakers are very much bound by decisions of the past. That is, the Administration requested $182.5 billion in new budget authority for HEW, an increase of $20.2 billion over fiscal 1978; 89% of the total will fund entitlement programs over which the President has little real control. Thus, the Administration's new health initiatives come in the discretionary programs operated, for the most part, by the Public Health Service.

The health priorities of the new budget belong distinctly to Secretary Califano. He designed them and then fought successfully for their approval with OMB. Compared with the Department's massive budget, the priorities represent little new spending, but they do impart a sense of what Carter and Califano regard as important: alternatives to abortion, more services to poor people, and a heavier concentration of federal dollars on the needs of children and youth.

The budget process showed that Democrats still believe deeply that categorical grant programs present a better opportunity to target scarce resources on social problems than do blocks of money distributed to subnational governments. The Republican administrations of Nixon and Ford favored the latter approach. Thus, the 1979 budget represents an endorsement of those principles of governance that produced the New Deal and the Great Society.

The Administration proposed its sharpest reduction in federal spending in health manpower funding. Arguing that there now are adequate numbers of health professionals practicing or in the education stream, the Administration proposed a 38% cut in federal manpower spending. The Administration also proposed only a slight increase in biomedical research funding, and the President directed the NIH and other federal research agencies to target more of their remaining budgets on basic science activity.

President Carter built his HEW budget on some shaky assumptions—that Congress will accept a reduction in spending for health manpower, only a slight increase for NIH, and that it will enact the Administration's controversial hospital cost containment legislation, thus saving an estimated $730 million in federal funds. Con-

gress, a political institution that unquestionably is responsive to the pressures of private interests, as is the pattern in any democracy, is likely to look on the Administration's cost containment measure no more favorably than it regards proposed spending cuts. While it may be too strong to predict that the Democratic Congress will respond to sharp policy changes in the Carter budget in the same fashion that it did when Nixon and Ford proposed such changes, there is no indication now that its behavior will be vastly different, even for a President of the same party.

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