DataView

National Health Expenditures, 1995

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This article presents data on health care spending for the United States, covering expenditures for various types of medical services and products and their sources of funding from 1960 to 1995. In 1995, $988.5 billion was spent to purchase health care in the United States, up 5.5 percent from 1994. Growth in spending between 1993 and 1995 was the slowest in more than three decades, primarily because of slow growth in private health insurance and out-of-pocket spending. As a result, the share of health spending funded by private sources fell, reflecting the influence of increased enrollment in managed care plans.

INTRODUCTION

In today's health care system, providers and third-party payers face intense pressures. Increases in health care spending during the late 1980s and early 1990s in relation to overall economywide growth focused the attention of purchasers on the problems of rising costs. As the Federal Government attempted to control cost increases associated with Medicare and Medicaid, employers sponsoring health insurance for their workers evaluated alternatives to conventional private health insurance (PHI) plans more intensely. Both the private and public sectors reacted with increased enrollment in managed care plans. Under heightened pressure from managed care plans to reduce cost growth, health care providers were transformed from "revenue generators" who individually orchestrated activity within the health care system to "cost centers" within a larger, managed care system (Duke, 1996). Faced with competition for patients, an increased proportion of providers are responding to incentives to minimize costs. Managed care plans negotiated rate discounts with providers in return for provider access to large groups of patients; these plans also altered patterns of care through an emphasis on preventive services and elimination of unnecessary care, and demanded cost-conscious decisionmaking by providers in the delivery of health care. Faced with lower expected revenue growth, providers were forced to find ways to reduce expense growth to remain financially viable and competitive.

Health system changes are reflected in the matrix of spending trends recorded in national health expenditures (NHE). Most prominently, growth in health spending in 1994 and 1995 reached its lowest points in more than three decades of measuring health care spending (Figure 1). Nominal expenditures grew 5.1 percent in 1994 and 5.5 percent in 1995; real (inflation-adjusted)[1] growth measured 2.7 percent in 1994 and 2.8 percent in 1995. Decelerating growth reflects changes occurring within the provider and PHI components of the health care industry during the 1990s.

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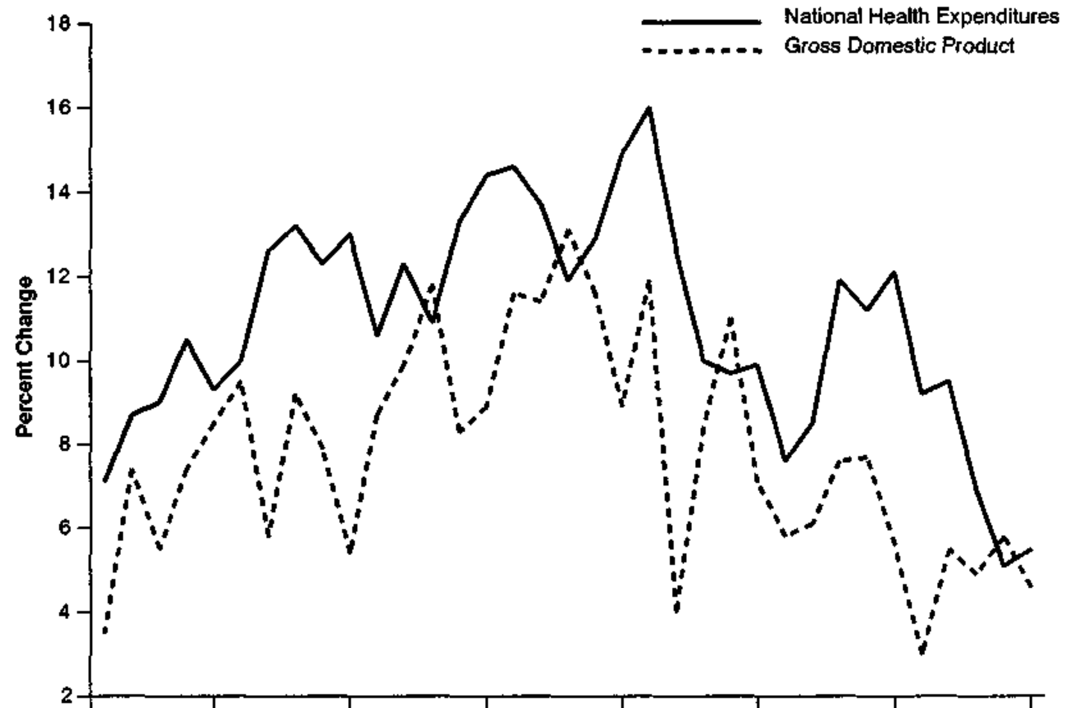
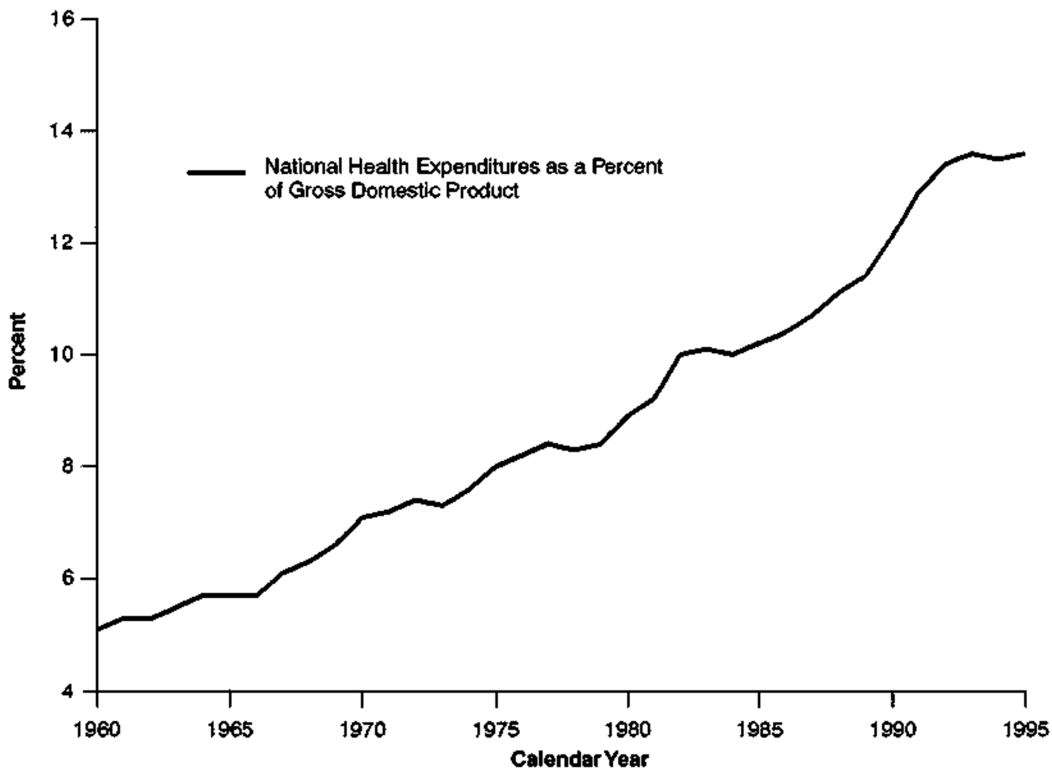
[1]Deflated using the gross domestic product chain-weighted price index.

Figure 1
Percent Growth in National Health Expenditures and Gross Domestic Product, and National Health Expenditures as a Percent of Gross Domestic Product: Calendar Years 1960-95





SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

During the 1993-95 period, health care spending as a percent of gross domestic product (GDP) exhibited virtually no change: It stabilized between 13.5 and 13.6 percent (Figure 1). There were three additional periods since 1960 when the NHE share of GDP remained stable for 3-year periods: 1964-66, 1977-79, and 1982-84. Each of these periods was characterized by strong GDP growth. For the first time in more than three decades, however, stability in NHE as a percent of GDP in the 1993-95 period was precipitated by a slowdown in the rate of growth of health care spending, rather than an upswing in overall economic growth.

The effects of health system changes are evident in the contrast between private and public sector financing. From 1960 to 1990, growth in spending by both the private and public sectors was similar, with only two notable exceptions: the period 1966-67, when Medicare and Medicaid were introduced, and the period 1974-75, which recorded the effects of the 1973 expansion of Medicare to cover the disabled population. Each of these major expansions in public program coverages produced offsetting, step-wise shifts in public and private financing responsibilities, with the share shouldered by the public sector increasing. The unique feature of the shift toward a larger public share beginning in 1990 is that it was not driven by public sector initiatives to add new populations or expand services, although the number of people covered by the Medicaid program did increase. In fact, public sector expenditure growth has continued at approximately the same average annual rate since 1990 (9.9 percent) as between 1980 and 1990 (10.5 percent). At the same time, average annual growth in private spending decelerated markedly between 1990 and 1995, to 5.2 percent, from the 11.2-percent average annual growth experienced during the 1980-90 period (Figure 2).

The disparity in growth among different types of personal health care (PHC) services narrowed in 1995. For all services except other personal health care, spending growth ranged from a low of 4.5 percent (for hospital services) to a high of 8.9 percent (for dental services). The one exception, other personal health care services, which accounts for 2.8 percent of PHC, is dominated by Medicaid home- and community-based waivers and miscellaneous services that are provided by non-health care establishments.[2] Spending for this sector grew 14.9 percent in 1995, faster than all other PHC sectors, but slower than it did in 1994 (Table 1).

The changing distribution of health care spending mirrors the impact of managed care and, to a lesser extent, changes in Medicare payment policies. The share of PHC expenditures spent on hospital and physician services has declined over the past 5 years, while spending on home health services, nursing home care, and other personal health care services has increased. These increases have paralleled increases in Medicare spending for home health and skilled nursing facility services.

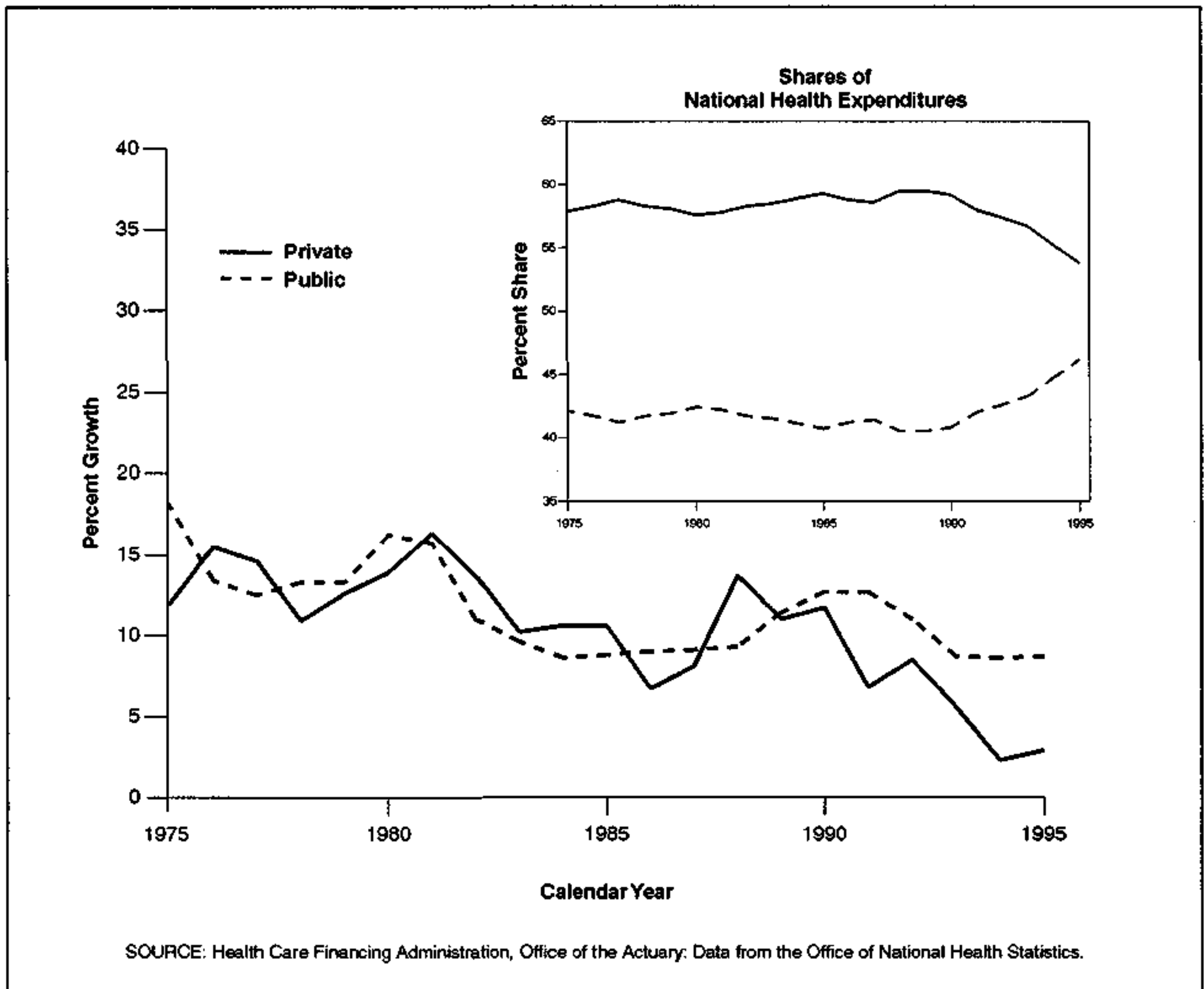
In the rest of this article, we describe the changes occurring in several key sectors of the health care industry, focusing on their impact on health care spending trends. Data cited in the remaining discussion but not shown in an accompanying table or figure can be found in Figure 9 and Tables 8-17 at the end of this article.

HOSPITAL CARE

Hospital care expenditures, the single largest component of personal health

[2]Non-health care establishments include facilities such as schools, military facilities, social services agencies, and community centers.

Figure 2
Percent Growth and Percent Share of Public and Private National Health Expenditures: Calendar Years 1975-95



spending at 39.8 percent, amounted to $350.1 billion in 1995. Registering growth of less than 5 percent in the last 2 years, spending for hospital services was among the slowest growing of any PHC services.

The American Hospital Association's (1995) panel survey of community hospitals reports that overall admissions per 1,000 population increased in 1995 by 0.4 percent, the first such increase in more than a decade. Growth in admissions per 1,000 population in 1995 comes from admissions for the population age 65 and over; meanwhile, admissions per 1,000 for the population under age 65 continued to decline but at a slower rate. Despite the slight increase in admissions per 1,000 population, inpatient days in community hospitals continued to fall by almost 3 percent overall, indicating declining overall length of stay. When the number of beds is not reduced to match the decline in days, occupancy rates fall and excess capacity grows. In 1995 overall occupancy rates in community hospitals fell to less than 60 percent (Heffler et al., 1996), the lowest rate in history. Such rates put renewed pressure on hospitals to develop new sources of revenues, to negotiate with managed care plans for access to patients,

Table 1
Personal Health Care Expenditure Aggregate Amounts, Percent Distribution, and Average Annual Percent Change, by Type of Expenditure: Selected Calendar Years 1960-95

Type of Expenditure	1960	1970	1980	1985	1990	1991	1992	1993	1994	1995
					Amount in Billions					
Personal Health Care	$23.6	$63.8	$217.0	$376.4	$614.7	$676.6	$740.5	$786.9	$827.9	$878.8
Hospital Care	9.3	28.0	102.7	168.3	256.4	282.3	305.4	323.3	335.0	350.1
Physician Services	5.3	13.6	45.2	83.6	146.3	159.2	175.7	182.7	190.6	201.6
Dental Services	2.0	4.7	13.3	21.7	31.6	33.3	37.0	39.2	42.1	45.8
Other Professional Services	0.6	1.4	6.4	16.6	34.7	38.3	42.1	46.3	49.1	52.6
Home Health Care	0.1	0.2	2.4	5.6	13.1	16.1	19.6	23.0	26.3	28.6
Drugs and Other Medical Non-Durables	4.2	8.8	21.6	37.1	59.9	65.6	71.2	75.0	77.7	83.4
Prescription Drugs	2.7	5.5	12.0	21.2	37.7	42.1	46.6	49.4	51.3	55.5
Vision Products and Other Medical Durables	0.6	1.6	3.8	6.7	10.5	11.2	11.9	12.5	12.9	13.8
Nursing Home Care	0.8	4.2	17.6	30.7	50.9	57.2	62.3	67.0	72.4	77.9
Other Personal Health Care	0.7	1.3	4.0	6.1	11.2	13.6	15.4	17.9	21.7	25.0
					Percent Distribution					
Personal Health Care	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital Care	39.3	43.9	47.3	44.7	41.7	41.7	41.2	41.1	40.5	39.8
Physician Services	22.4	21.3	20.8	22.2	23.8	23.5	23.7	23.2	23.0	22.9
Dental Services	8.3	7.3	6.1	5.8	5.1	4.9	5.0	5.0	5.1	5.2
Other Professional Services	2.6	2.2	2.9	4.4	5.6	5.7	5.7	5.9	5.9	6.0
Home Health Care	0.2	0.3	1.1	1.5	2.1	2.4	2.6	2.9	3.2	3.3
Drugs and Other Medical Non-Durables	18.0	13.8	10.0	9.8	9.7	9.7	9.6	9.5	9.4	9.5
Prescription Drugs	11.3	8.6	5.6	5.6	6.1	6.2	6.3	6.3	6.2	6.3
Vision Products and Other Medical Durables	2.7	2.5	1.7	1.8	1.7	1.7	1.6	1.6	1.6	1.6
Nursing Home Care	3.6	6.6	8.1	8.1	8.3	8.4	8.4	8.5	8.8	8.9
Other Personal Health Care	2.9	2.0	1.9	1.6	1.8	2.0	2.1	2.3	2.6	2.8
					Average Annual Percent Change from Previous Year Shown					
Personal Health Care	—	10.5	13.0	11.6	10.3	10.1	9.5	6.3	5.2	6.1
Hospital Care	—	11.7	13.9	10.4	8.8	10.1	8.2	5.9	3.6	4.5
Physician Services	—	9.9	12.8	13.1	11.8	8.8	10.4	4.0	4.4	5.8
Dental Services	—	9.1	11.1	10.2	7.8	5.6	11.0	6.0	7.3	8.9
Other Professional Services	—	8.8	16.3	21.2	15.8	10.4	10.0	10.0	6.1	7.0
Home Health Care	—	14.5	26.9	18.9	18.4	22.4	22.3	17.1	14.4	8.6
Drugs and Other Medical Non-Durables	—	7.6	9.4	11.4	10.1	9.4	8.6	5.4	3.6	7.3
Prescription Drugs	—	7.5	8.2	11.9	12.2	11.9	10.6	6.1	3.8	8.1
Vision Products and Other Medical Durables	—	9.6	8.8	12.4	9.2	7.0	6.3	5.1	2.8	7.2
Nursing Home Care	—	17.4	15.4	11.7	10.7	12.2	9.0	7.6	8.1	7.5
Other Personal Health Care	—	6.5	12.0	8.8	12.9	20.7	13.3	16.4	21.6	14.9

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

and to integrate both horizontally with other local and national hospital organizations and vertically with physicians and other health care providers and insurers (Duke, 1996).

An increasing number of hospitals are expanding their lines of business to provide more than just inpatient and outpatient hospital care. In addition to fitness facilities and home health care agencies, they are using excess bed capacity to add rehabilitation and skilled nursing or subacute care facilities to broaden their revenue base (Lewin-VHI, Inc., 1995). Creating subacute care facility units from underused inpatient units enables hospitals to compete for the followup institutional care that discharged patients often need for full recovery. Incentives exist for hospitals to discharge patients as soon as possible: Medicare's inpatient hospital payment is diagnosis-based and prospectively determined, regardless of length of hospital stay. Managed care plans, which often pay for hospitalization on a daily rate, also encourage fewer inpatient days. But community nursing homes, traditionally providing custodial services and limited medical care, are frequently not staffed and equipped to handle patients discharged from hospitals "quicker and sicker." Hospitals with a subacute care unit can discharge patients from their hospital stays quickly and admit them to the skilled-nursing or subacute care unit for their followup care, maximizing their revenue from the overall stay. Under Medicare, a hospital is compensated for the inpatient stay on a prospectively determined diagnosis-related group (DRG) basis and the nursing or subacute facility stay on a reasonable-cost basis (Anders, 1996).

With the rise of enrollment in managed care plans and falling occupancy rates, hospitals have been forced to consider the benefits of mergers and alliances with local and national hospital organizations. Squeezed by high operating expenses, competition from market-area providers, and the prices managed care organizations were willing to pay providers for services, hospitals have sought alliances with similar community facilities or with national chains. Some alliances have been based on geographic location and others on religious affiliation. Most have been aimed at integrating services, reducing competition, and increasing cooperation in order to compete effectively for managed care business (Duke, 1996). Increasingly, largely consolidated for-profit hospital organizations are buying non-profit facilities facing difficulties in the highly competitive hospital marketplace. For-profit chains strengthen the market position of acquired facilities by cutting costs. Communities worry, however, that takeovers of their local facilities will threaten the existence of hospital-provided charity and preventive services and cost jobs in their community (Langley and Sharpe, 1996; Rundle, 1996).

Expenditures for inpatient services in community hospitals accounted for 62 percent of all hospital revenues in 1995 (Table 2). Growth in inpatient expenditures has slowed since 1990, paralleling decreases in inpatient days and length of stay. Some of this deceleration can be attributed to the rise of managed care. According to the *HMO and PPO Industry Profile*, health maintenance organizations (HMOs), the most restrictive type of managed care plan, cover about 20 percent of the resident population. "HMO members experience fewer total hospital days per thousand, fewer admissions per thousand, and shorter average lengths of stay than the population at large . . . HMO members were hospitalized about two-thirds as often as the population as a whole in 1993 [and] . . . spent about half as many days in

Table 2
Hospital Revenues, Percent Distribution, and Annual Percent Growth: Calendar Years 1990-95

Type of Hospital	1990	1991	1992	1993	1994	1995
			Revenues in Millions			
Total	$256,447	$282,272	$305,357	$323,272	$334,966	$350,120
Non-Federal	238,570	262,533	284,665	301,217	312,323	326,877
Community	221,604	245,476	267,881	284,891	296,333	311,283
Inpatient	169,221	183,516	196,452	206,410	210,426	216,593
Outpatient	52,383	61,960	71,429	78,481	85,907	94,691
Non-Community	16,966	17,057	16,784	16,326	15,990	15,594
Federal	17,877	19,739	20,692	22,055	22,643	23,242
			Percent Distribution			
Total	100	100	100	100	100	100
Non-Federal	93	93	93	93	93	93
Community	86	87	88	88	88	89
Inpatient	66	65	64	64	63	62
Outpatient	20	22	23	24	26	27
Non-Community	7	6	5	5	5	4
Federal	7	7	7	7	7	7
			Annual Percent Growth			
Total	10.7	10.1	8.2	5.9	3.6	4.5
Non-Federal	10.9	10.0	8.4	5.8	3.7	4.7
Community	11.3	10.8	9.1	6.3	4.0	5.0
Inpatient	9.1	8.4	7.0	5.1	1.9	2.9
Outpatient	18.9	18.3	15.3	9.9	9.5	10.2
Non-Community	5.6	0.5	-1.6	-2.7	-2.1	-2.5
Federal	8.9	10.4	4.8	6.6	2.7	2.6

NOTE: Non-community non-Federal hospitals include long-term care hospitals (where the average length of stay is 30 days or longer), psychiatric hospitals, alcohol and chemical dependency hospitals, units of institutions such as prison hospitals or college infirmaries, chronic disease hospitals, and some institutions for the mentally retarded.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

the hospital. Growth in other types of managed care organizations (especially PPOs) and the increasing use of utilization review by indemnity health insurance plans" may also have contributed to this trend (Dial et al., 1996).

Nearly all hospital care was financed by third parties in 1995, with only 3.3 percent paid by consumers in out-of-pocket expenditures. PHI accounted for a 32.3-percent share. Total public funding accounted for a 61.2-percent share; Medicare and Medicaid, the primary subset of public payers, financed 47.0 percent of hospital care. The remaining 3.2 percent of hospital revenues came from philanthropic and non-patient sources, such as hospital gift shops, parking facilities, and cafeterias.

PHYSICIAN SERVICES

Expenditures for physician services reached $201.6 billion in 1995, an increase of 5.8 percent from the previous year. Spending for services in this sector accounted for 22.9 percent of PHC. For the last 3 years, growth in spending for physician services has been lower than the growth in overall PHC expenditures. This slow growth is linked to the expansion of managed care.

The health care system in the United States has historically been controlled by providers, with physicians typically deciding type and place of treatment. In recent years, the growth of managed care has caused the locus of control to shift from provider to insurer (Zwanziger and Melnick, 1996), with the insurer having more input into treatment plans. This fundamental change in the health care delivery system has been precipitating changes in the organization of physician practices, demand for types of physician specialties, utilization of physician services, and income of physicians. In 1993 and 1994, these changes contributed to the slowdown of growth in expenditures for physician services. By 1995 physician expenditures showed a slight upturn in growth rate, although growth was still lower than the growth in PHC spending. There is anecdotal evidence to suggest that increased utilization and referral to specialists may be part of the reason for the slight acceleration in growth (Wooton, 1996; Rice et al., 1996).

The share of physician expenditures funded by PHI rose between 1990 and 1995, consistent with managed care's emphasis on services provided by primary care physicians. Meanwhile, the share funded by Medicare remained unchanged as a result of the implementation of the Medicare Fee Schedule (MFS) to pay physicians for services and volume performance standards (VPS) to limit the effect of induced utilization increases.[3] Payment mechanisms used by both managed care and Medicare put pressure on physicians to curb expenditure growth. There is no evidence to suggest that physicians shifted costs to private insurers with the advent of the MFS because physicians were restrained by market forces from raising prices.[4] Managed care and MFS caused spending growth to drop to 5.8 percent in 1995 from 11.5 percent in 1990.

Changes in the way physicians deliver services are evident in U.S. Bureau of the Census (1996) data on revenue sources of physician offices.[5] From 1992 to 1994, the

[3]Medicare implemented the VPS in 1990 and the physician fee schedule based on a resource-based relative value scale (RBRVS) in 1992.

[4]However, physicians were able to increase the volume of services to privately insured patients and recoup some of their income by increased utilization (Rice et al., 1996).

[5]Data cited are for taxable employer firms only; they exclude information from physician establishments that are tax-exempt and/or have no employees, and from offices of osteopathic physicians. The NHE physician category is more inclusive than this subset of physician office data: The NHE category includes both taxable and tax-exempt physicians (medical doctors and doctors of osteopathy), as well as employer and non-employer physicians.

percentage of revenues earned from the delivery of inpatient hospital services fell, while those earned through the delivery of services in doctors' offices and hospital outpatient settings rose (Table 3). Part of the decline in percentage of revenues from hospital services may be associated with falling number of inpatient days.

Growth in managed care enrollment had a direct impact on physician organizations. The number of physicians signing contracts with managed care organizations is on the rise: In 1990, 61 percent of physicians had a managed care contract; by 1995 that proportion had grown to 83 percent. Although physician participation in managed care had grown substantially, the percent of revenues received through managed care contracts grew more slowly: from 28 percent in 1990 to 33 percent in 1995 (Emmons and Simon, 1996).

As the number of managed care contracts has increased, the structure of physician practices has changed. Group practices have become more prevalent. Physicians have joined together in larger group practices to offer the breadth of services necessary to attract managed care contracts and to consolidate expenses. Groups can also absorb some of the risk associated with managed care contracts. Within physician practices, the proportion of physicians who are employed has increased, while the proportion of physicians in solo practices or self-employed in group practices has declined (Kletke, Emmons, and Gillis, 1996). Employed physicians tend to work fewer hours, see fewer patients, and earn lower income than physicians who own a practice (American Medical Association, 1996). As the number of employed physicians increases, earnings of physicians on average could fall.

In 1994 physicians' income decreased for the first time in recent history. This may be a result of the growth in managed-care contracts. The decline was more pronounced for the high earners, while the income of low earners continued to rise (Simon and Born, 1996). The decline also affected primary care physicians and procedure-oriented physicians differently. Primary care physicians' income increased faster than average, while the income of procedure-oriented physicians declined or increased at a slower-than-average rate (Moser, 1996).

As the impact of managed care on the health industry has increased, there has been more emphasis on primary and

Table 3

Sources of Receipts in Physician Offices:[1] Calendar Years 1992-94

Source of Receipts	1992	1993	1994	1992	1993	1994
	Amount in Billions			Percent Distribution		
Total	$141.4	$144.5	$150.4	100.0	100.0	100.0
Patient Care and Other Professional Services	137.7	140.9	147.2	97.4	97.5	97.9
Patient Care Services	130.5	133.6	139.9	92.3	92.4	93.0
Laboratory Services	7.2	7.8	7.9	5.1	5.4	5.2
X-Ray Services	14.1	13.7	14.0	10.0	9.5	9.3
Hospital Inpatient Services	31.8	30.4	31.1	22.5	21.0	20.7
Hospital Outpatient Services	16.7	17.9	19.1	11.8	12.4	12.7
Services Delivered in Physician Offices	59.6	62.6	67.0	42.2	43.3	44.6
Other Services Delivered at Other Sites	1.0	1.0	0.9	0.7	0.7	0.6
Other Medical Professional Services	7.2	7.4	7.2	5.1	5.1	4.8
Merchandise Sales	1.7	1.6	1.6	1.2	1.1	1.1
Prescription Drugs	0.3	0.3	0.4	0.2	0.2	0.3
Other	1.4	1.2	1.2	1.0	0.8	0.8
All Other Sources	2.0	2.1	1.6	1.4	1.4	1.1

[1]Information for taxable employer firms only.

SOURCE: U.S. Department of Commerce, Bureau of the Census: Data from the Services Annual Survey, 1994.

preventive care and less on the services of specialists. Since 1990 the demand for specialists has dropped, as measured by physician recruitment advertising, while the demand for generalists has been rising (Seifer, Troupin, and Rubenfeld, 1996). This change in type of physician will also affect the future of medical schools and the type of training available to incoming students. As an indication of this trend, the percent of recently graduated residents unable to find full-time jobs in their specialties amounted to more than 6 percent in two hospital-based specialities (anesthesiology and pathology) and one surgical specialty (plastic surgery). Similar rates for various primary care specialists were 2.1 percent or less (Miller, Jonas, and Whitcomb, 1996).

Utilization of physician services remained stable over the 1993-94 period at approximately 6 contacts per person per year, after rising steadily from 5.3 contacts per year in 1989 (National Center for Health Statistics, 1996). The contribution to the increase in number of physician contacts per person differed by age group. For the population age 65 years or over, the number of physician contacts per person grew consistently between 1989 and 1994 but experienced a particularly large increase between 1990 and 1991. For the population age 15-64, utilization increased between 1989 and 1992 but has remained fairly constant since (Table 4), possibly a response to increased enrollment in managed care.

PRESCRIPTION DRUGS

Americans purchased $55.5 billion worth of prescription drugs in 1995 (Table 5). Prescription drug spending growth was slower than that of PHC in 1993 and 1994 (6.1 and 3.8 percent, respectively) but jumped to 2 percentage points faster than PHC in 1995 (8.1 percent). Surveys show that about two-thirds of the accelerated 1995 growth comes from an increase in the number of prescriptions sold. Depending on the survey used, this increase ranged from 5.7 (IMS America, 1996) to 7.8 percent (Schondelmeyer and Seoane-Vazquez, 1996).

The key to the utilization changes lies in changes in the sources paying for prescription drugs: Third parties are absorbing an increasing share of prescription drug expenditures. Between 1990 and 1995, the share of prescription drug spending paid out of pocket fell 9 percentage points, offset by larger shares paid by third-party payers: PHI share increased 5 percentage points and the Medicaid share increased 4 percentage points (Figure 3). Even smaller payers, such as the U.S. Department of Veterans Affairs and U.S. Department of Defense, through the latter's Civilian Health and Medical

Table 4

Physician Contacts[1] per Person, by Age: Calendar Years 1987-94

Age Group	1987	1988	1989	1990	1991	1992	1993	1994
				Number				
Total[2]	5.4	5.3	5.3	5.5	5.6	5.9	6.0	6.0
Under 15 Years	4.5	4.6	4.6	4.5	4.7	4.6	4.9	4.6
15-44 Years	4.6	4.7	4.6	4.8	4.7	5.0	5.0	5.0
45-64 Years	6.4	6.1	6.1	6.4	6.6	7.2	7.1	7.3
65 Years or Over	8.9	8.7	8.9	9.2	10.4	10.6	10.9	11.3

[1]A consultation with a physician (or another person working under a physician's supervision) in person or by telephone, for examination, diagnosis, treatment, or advice. Place of contact includes office, hospital outpatient clinic, emergency room, telephone, home, clinic, health maintenance organization, and other places located outside a hospital.
[2]Age-adjusted.

SOURCE: (National Center for Health Statistics, 1995).

Table 5
Expenditures for Drugs and Other Medical Non-Durables,[1] by Source of Funds: Calendar Years 1990-95

Source of Funds	1990	1991	1992	1993	1994	1995
			Amount in Billions			
Drugs and Non-Durable Medical Products	$59.9	$65.6	$71.2	$75.0	$77.7	$83.4
Prescription Drugs	37.7	42.1	46.6	49.4	51.3	55.5
Out-of-Pocket Payments	18.2	19.3	20.4	21.2	21.4	21.9
Third-Party Payments	19.5	22.9	26.2	28.2	29.9	33.6
Private Health Insurance	13.0	15.2	18.0	19.1	19.8	22.1
Medicaid	5.1	6.2	6.7	7.7	8.5	9.8
General Assistance	0.9	0.9	0.9	0.9	1.0	1.0
Other Government	0.4	0.5	0.5	0.5	0.6	0.7
Non-Prescription Drugs and Other Medical Non-Durables[2]	22.2	23.4	24.6	25.6	26.4	27.9
Out-of-Pocket Payments	22.2	23.4	24.6	25.6	26.4	27.9
		Percent Distribution by Source of Funds Within Each Category				
Prescription Drugs	100	100	100	100	100	100
Out-of-Pocket Payments	48	46	44	43	42	40
Third-Party Payments	52	54	56	57	58	60
Private Health Insurance	35	36	39	39	39	40
Medicaid	14	15	14	16	17	18
General Assistance	2	2	2	2	2	2
Other Government	1	1	1	1	1	1
Non-Prescription Drugs and Other Medical Non-Durables[2]	100	100	100	100	100	100
Out-of-Pocket Payments	100	100	100	100	100	100

[1]This class of expenditure measures spending for prescription drugs, over-the-counter medicines, and sundries purchased in retail outlets. The value of drugs and other products provided by hospitals, nursing homes, or health professionals is included in estimates of spending for these providers' services.

[2]Assumes no third-party payments for non-prescription drugs and other medical non-durables.

NOTE: Numbers and percentages may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

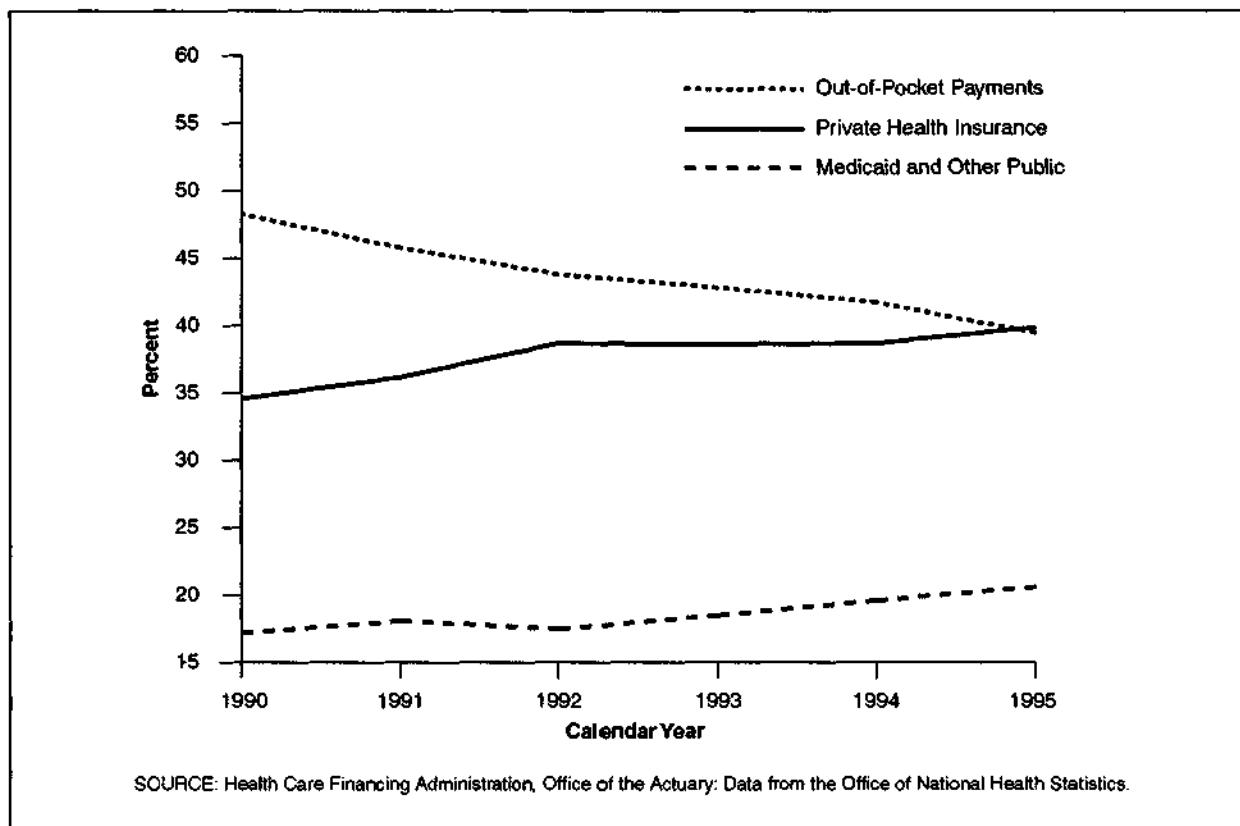
Program for the Uniformed Services (CHAMPUS), experienced impressive growth in drug expenditures.

There are several contributing reasons for high prescription drug spending growth in 1995. First, the existence of third-party coverage increases the likelihood that individuals will fill prescriptions, and the switch to managed care increases the likelihood even more. More than 9 out of 10 employees enrolled in an employer-sponsored health plan in medium and large firms had coverage for outpatient prescription drugs throughout the 1980s and 1990s (Baker and Kramer, 1995). Although most medical plans have covered outpatient drugs for many years, the shift of plan subscribers between traditional fee-for-service plans and managed care plans has had an effect on out-of-pocket payment requirements. In traditional fee-for-service plans, outpatient prescription drugs are typically covered under general plan coverages that require a yearly deductible. Under a deductible arrangement, the plan subscriber is responsible for all medical charges, including prescription drug charges, until those charges exceed the deductible.[6] By contrast, HMO plans require only a nominal dollar copayment per prescription, typically $3 or $5 (U.S. Bureau of Labor Statistics, 1994). The relatively low out-of-pocket costs of prescription drugs in HMOs and other managed care plans may help to explain the recent growth in the demand for and utilization of prescription drug benefits.

Although pharmaceutical manufacturers initially feared that managed care plans

[6]According to KPMG Peat Marwick (1995), the average single plan deductible for a fee-for-service plan was $257 in 1995, and the family deductible was $603.

Figure 3
Prescription Drug Spending, by Type of Payer: Calendar Years 1990-95



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

would restrict drugs sales, they now believe that managed care has been partly responsible for recent increases in prescription drug sales. To reduce the use of more expensive services, prescription drugs are frequently ordered as an inexpensive way to control chronic illnesses uncovered through preventive screening. Low copayments required by managed care plans also encourage patients to fill more prescriptions than they did when facing higher copayments or deductibles or the entire cost of the prescription.

Second, the sites where drugs are dispensed are changing, with more prescriptions being filled in retail outlets.[7] Fewer prescriptions are dispensed in the hospital setting (partly because of fewer inpatient days) and potentially more in the retail market. Hospital purchases of prescription drugs remained flat over the past 3 years, at $10 billion (IMS America, 1996). This differs significantly from the retail pharmacy experience, where the number of prescriptions dispensed through drug stores, mass merchandisers, food stores, and mail-order firms grew 5.7 percent from 1994 to 1995, the second-largest growth recorded in recent history. The growth of managed care has boosted sales of drugs through mail-order firms. Mail order is frequently used to purchase drugs used to treat chronic conditions, estimated to cover 60 percent of prescription drug sales in 1995 (Day, 1996). Prompted by employers interested in cutting prescription drug costs, managed care plans emphasize use of mail order.

[7]In the NHE, the prescription drug category only measures purchases in retail outlets. Sales of drugs through hospitals, physician offices, nursing homes, and other non-retail sites are captured in their respective expenditure category.

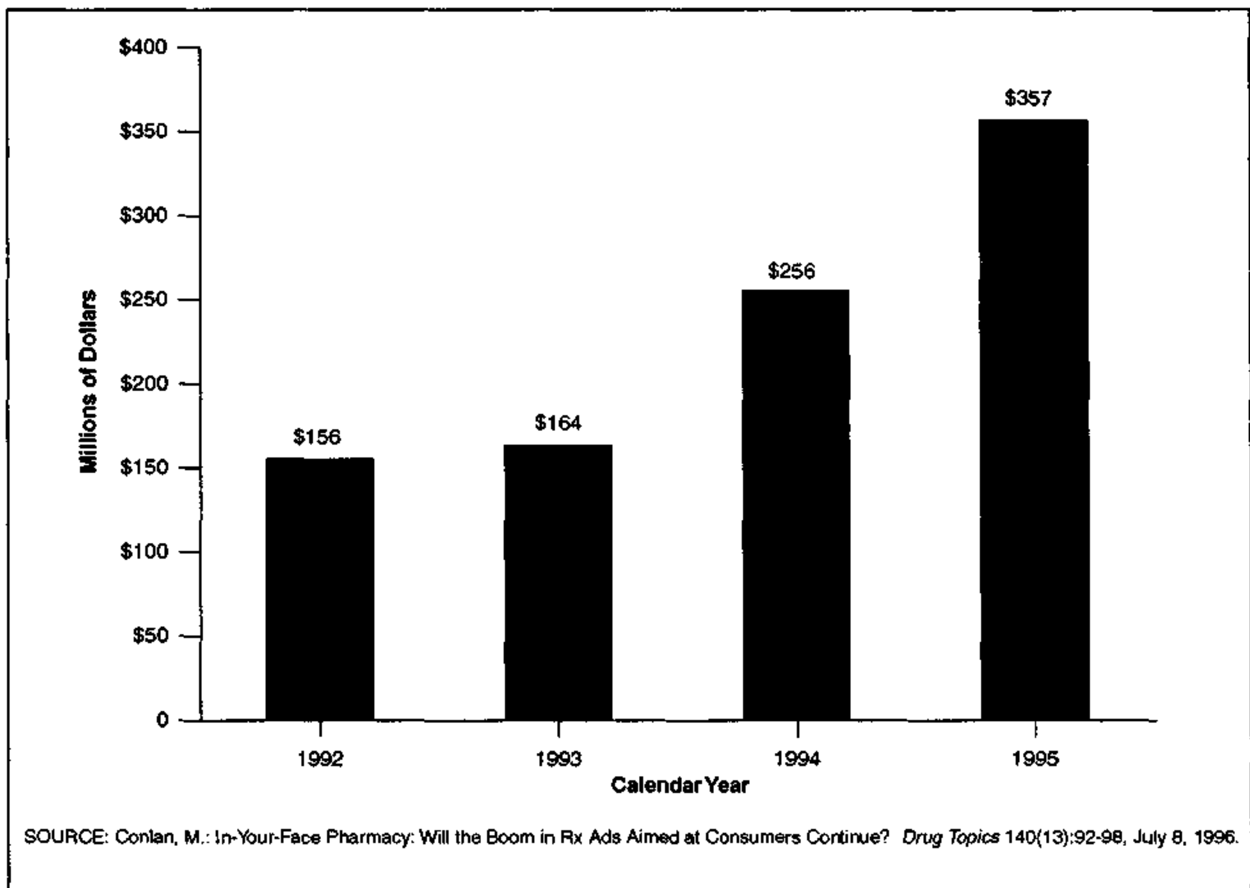
Cost savings from mail-order firms come through bulk purchasing and processing of prescriptions. However, there is concern that mail-order firms, often subsidiaries of drug manufacturers, may favor the drugs of parent drug manufacturers on their formulary list (Genuardi, Stiller, and Trapnell, 1996).

Third, increased spending on prescription drug advertisements may be influencing consumers to request specific brand-name drugs from physicians (Tanouye, 1996). Spending on direct-to-consumer prescription advertisements has more than doubled since 1992 (Figure 4).

Fourth, one obvious factor in expenditure growth is price per prescription. Prices increased 1.9 percent in 1995 as measured by the Consumer Price Index (CPI), and 2.7 percent as measured by the Producer Price Index (PPI).[8] In addition, manufacturers began to constrain the growth of rebates in 1995. NHE subtracts rebates paid by manufacturers to third-party payers, such as private insurance and Medicaid, thus decreasing the price paid by third parties. Therefore, when rebate growth slowed in 1995, price growth reflected in NHE estimates accelerated. Industry observers state that manufacturers have moved to "performance-based" rebates, where specific volume or sales quotas must be met in order for a rebate to be paid. Manufacturer rebates to Medicaid also fell as a proportion of total

[8] "The PPI is designed to measure transaction prices and is different from the CPI which in some cases measures list or full charge prices" (Heffler et al., 1996).

Figure 4
Spending by Prescription Drug Manufacturers for Direct-to-Consumer Advertisements: Calendar Years 1992-95



SOURCE: Conlan, M.: In-Your-Face Pharmacy: Will the Boom in Rx Ads Aimed at Consumers Continue? *Drug Topics* 140(13):92-98, July 8, 1996.

Medicaid drug expenditures. Because Medicaid rebates are based on best prices available to private purchasers, falling rebates in the private market affect rebates paid to Medicaid.

LONG-TERM CARE

Long-term care (LTC) includes spending for care received through freestanding[9] nursing homes and home health agencies. This sector accounted for almost one-eighth of PHC expenditures in 1995, or $106.5 billion, with public programs, mainly Medicaid and Medicare, financing 57.4 percent (Table 6). The share of LTC spending paid by Medicare more than doubled from 1990 to 1995. Growth in Medicare expenditures for home health and nursing home care[10] accelerated sharply in 1988, when Medicare relaxed its conditions for coverage and payment for these benefits. Also affecting the accelerated growth for nursing home care are lingering effects of the short-lived Medicare Catastrophic Coverage Act of 1988.

[9]In NHE, home health agencies and nursing facility services provided through hospitals are included under hospital expenditures.

[10]Nursing home coverage under Medicare is limited to care provided in a participating skilled nursing facility after at least a 3-day acute care hospital inpatient stay.

Public policy experts are concerned about the large public funding commitment to LTC that is expected to grow even larger over the next several decades. In 1995 there were an estimated 34.2 million people age 65 and over; by the year 2020 this number is expected to increase to 52.8 million (Social Security Administration, 1996). Of all people age 65 and over, 11.3 percent are age 85 or over, the age group at risk of needing nursing home care, and 44.3 percent are age 75 or over, the age group most likely to need services from home health agencies. Growth in the size of the elderly population emphasizes the increasing health care costs for LTC services that this population will generate, much of which comes from public sources.

Private sources, predominately out-of-pocket payments by patients or their families, account for the remaining 42.6

Table 6
Long-Term Care Expenditures for Nursing Home and Home Health Care,[1] by Source of Funds: Calendar Years 1990-95

Source of Funds	1990	1991	1992	1993	1994	1995
			Amount in Billions			
Total	$64.0	$73.2	$81.9	$90.0	$98.7	$106.5
			Percent Distribution			
Private Funds	51.7	49.0	46.9	44.9	44.0	42.6
Out-of-Pocket Payments	40.4	37.8	35.9	34.1	33.3	32.5
Private Health Insurance	6.4	6.3	6.1	5.9	5.8	5.5
Other Private Funds	4.8	4.9	5.0	4.9	4.9	4.6
Public Funds	48.3	51.0	53.1	55.1	56.0	57.4
Federal Funds	30.9	32.6	35.3	38.0	39.1	40.5
Medicare	7.3	8.5	11.1	13.7	15.9	17.8
Medicaid	22.0	22.6	22.7	22.7	21.6	21.1
Department of Veterans Affairs	1.6	1.6	1.5	1.6	1.6	1.5
State and Local Funds	17.4	18.4	17.8	17.1	16.9	16.9
Medicaid	17.3	18.3	17.6	16.9	16.7	16.7
General Assistance	0.1	0.1	0.2	0.2	0.2	0.2
Total Medicaid	39.3	40.8	40.3	39.6	38.3	37.9
Medicaid and Medicare	46.6	49.3	51.4	53.3	54.2	55.6

[1]Includes only those expenditures for services provided by freestanding nursing homes and home health agencies. Additional services are provided by hospital-based nursing homes and home health agencies.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

percent of funds spent on LTC. The share of LTC spending from out-of-pocket sources has been falling, mostly offset by the rising share of Medicare spending. Another segment of private funding is PHI. Private health insurers have been aggressively marketing LTC insurance policies. An estimated 3.8 million LTC insurance policies had been sold by December of 1994 (Health Insurance Association of America, to be published). However, despite evidence of increased private insurance coverage, the PHI share of total spending for LTC has changed little over the past 5 years. Consumer advocacy groups are concerned that consumers may not understand the conditions for payment of benefits established by some private health insurers. These conditions may be severely limiting consumers' chances of receiving benefits under their LTC policies. Conditions for payment are based on combinations of impairments related to the need for assistance with activities of daily living (Alecxih and Lutzky, 1996). Policyholders lose coverage when they are unable to afford continued payment of the high premiums required to keep policies in force; the Health Insurance Association of America (1996) estimates a 6-percent average annual lapse rate after the first year for all LTC policies. Also, most policyholders with active policies are healthy with no immediate need for covered services. These factors may be limiting the growth in PHI payments for benefits relative to new contract growth.

Additional expenditures for LTC are included with hospital care in NHE. In 1995, Medicare and Medicaid financed an additional $5.7 billion for hospital-based nursing home care and $6.0 billion for hospital-based home health agency services. Medicaid expenditures for a variety of home- and community-based waivers are considered to be LTC expenditures by some people. Expenditures for these services are included with other personal health care in NHE. In fiscal year 1995, Medicaid funded $2.4 billion for services covered by home- and community-based waivers.

Nursing Home Care

In 1995, spending for nursing home care climbed to $77.9 billion and accounted for 8.9 percent of total spending for PHC. Growth in nursing home care expenditures decelerated from 8.1 percent in 1994 to 7.5 percent in 1995. The nursing home expenditure estimate for 1995 implies a $127 average charge per day for care in freestanding nursing facilities. At that rate, a 1-year stay would cost more than $46,000 in 1995.

The public share of funding for nursing home care increased for the fifth consecutive year. Although Medicaid is the major public payer, funding 46.5 percent of nursing home care in 1995, increases in the public share of nursing home funding resulted from Medicare spending growth. The Medicare share, 9.4 percent in 1995, increased from 3.3 percent in 1990, with expenditures averaging growths of 35 percent annually throughout the period.

Evidence suggests that average national nursing home occupancy rates are declining, thereby creating excess beds[11] (DuNah et al., 1995). Competition from alternative forms of health care delivery, such as home health agencies and assisted-living facilities, contributes to declining occupancy and decelerating revenue growth. In response to the slowdown in revenue growth, some nursing homes are converting their unused beds into subacute care units (Lewin-VHI, Inc., 1995). The advantages to nursing facilities

[11]The adequacy or inadequacy of the nursing home bed supply compared with the size of the vulnerable population varies by State and is subject to interpretation by State officials responding to the question of adequacy.

of creating a subacute care unit are twofold. First, subacute care units are designed to better accommodate the more intensive nursing care needs of patients discharged from hospitals "quicker and sicker." Both Medicare, with its PPS, and managed care plans, receiving capitated payments for enrollees' health care needs, exert pressure on hospitals to constrain lengths of stay. Nursing homes that capitalize on this growing market of patients by establishing subacute care units bolster declining occupancy rates. Second, patients requiring these services are more likely to be Medicare or private-pay patients. Given that both Medicare and PHI pay at higher rates than Medicaid, these subacute units could help to produce higher revenue streams.

Because subacute care units require more skilled, better trained, and therefore more costly personnel and more expensive high-technology equipment, expenditures for nursing home care are likely to rise as more facilities convert beds to these type of units.

Home Health Care

Expenditures for freestanding private and public home health agencies amounted to $28.6 billion in 1995. Expenditures for the services and products provided by these agencies were 3.3 percent of PHC expenditures in 1995, a small but increasing share.

Public sources, predominately Medicare and Medicaid, financed 55.3 percent of home health care spending in 1995. Out-of-pocket payments by patients or their families funded one-half of all private spending. PHI and non-patient revenue equally funded the residual portion of private spending.

Growth in spending for home health care decelerated steadily from a high of 28.2 percent in 1990 to 8.6 percent in 1995. In 1988 Medicare relaxed its home health care coverage and eligibility criteria. The number of home health agencies providing these Medicare services grew quickly to meet increased demand by Medicare beneficiaries. Growth in Medicare home health expenditures peaked at 51.5 percent in 1990 and steadily decelerated to 17.9 percent in 1995. The more recent deceleration in growth recorded in the NHE is partially attributable to NHE measuring only payments to freestanding home health agencies as home health care; payments to hospital-based home health agencies are included under hospital care and have been growing faster than those for freestanding agencies. In recent years Medicare has sought to identify and ultimately to prosecute home health providers participating in fraud or abuse activities. This may be having some effect on the industry overall because of Medicare's status as the largest public payer.

Home health agencies seeking to maintain or boost revenue levels are also developing subacute care units (Lewin-VHI, Inc., 1995). As with nursing homes, these units or groups of more highly trained staff are designed to better serve patients discharged from hospitals but still in need of substantial home care for full recovery from their illnesses.

MANAGED CARE

In recent years enrollment in employer-sponsored PHI has shifted dramatically away from conventional fee-for-service insurance into managed care plans. Such plans typically charge lower average premiums than traditional indemnity plans (Foster Higgins, 1994; KPMG Peat Marwick, 1995) by controlling provider costs and utilization of services. In 1986 almost 90 percent of health plan participants in medium and large firms[12] enrolled in traditional fee-for-service plans; howev-

[12]Small firms and State and local governments showed similar trends.

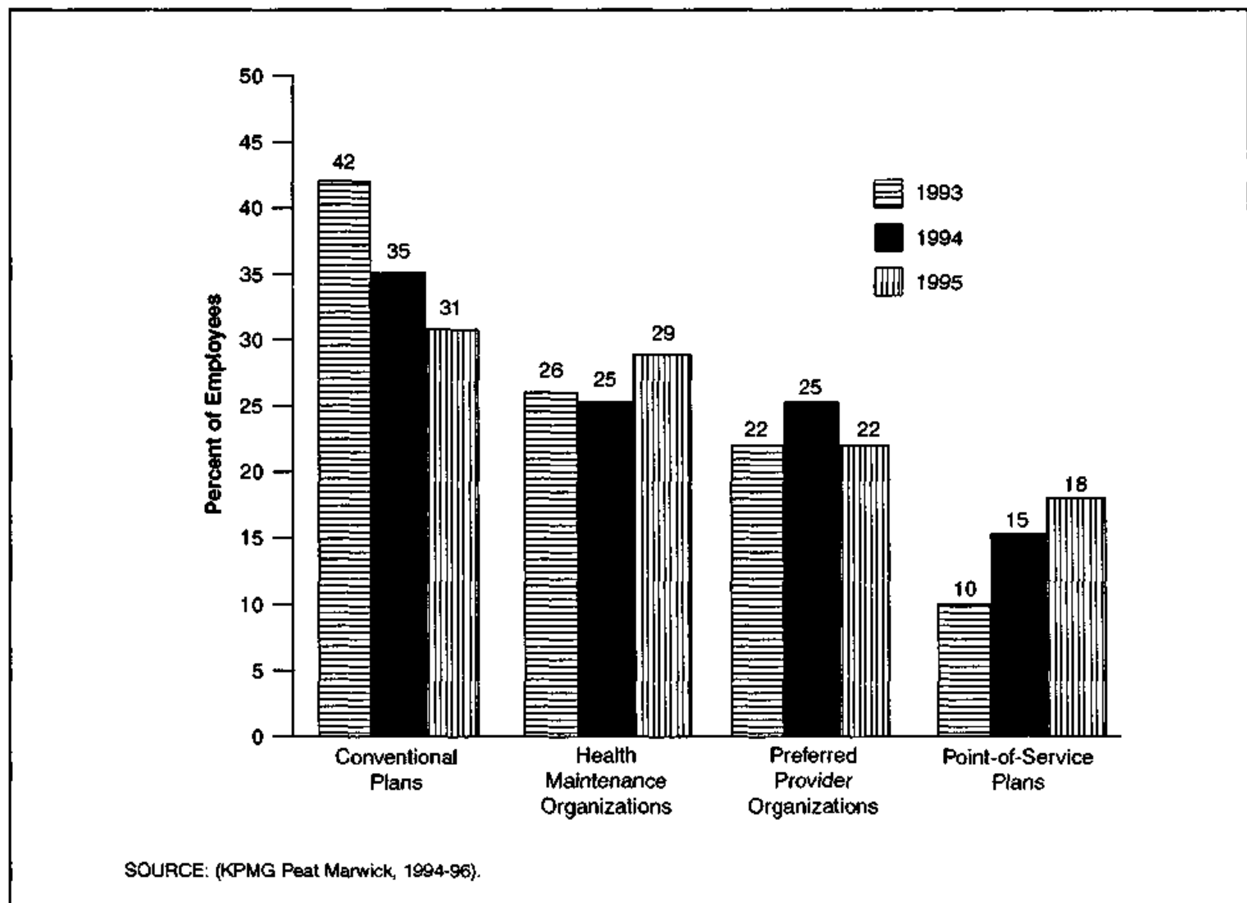
er, by 1993 the number of participants had dropped to 50 percent (U.S. Bureau of Labor Statistics, 1994). Enrollment in HMOs, typically the most restrictive of the managed care plans, grew from 13 percent to about 23 percent of all employer-plan participants between 1986 and 1993.

The fastest growing type of managed care plan was the preferred provider organization (PPO). These plans grew from 1 percent of health plan participants in 1986 to 26 percent in 1993 (U.S. Bureau of Labor Statistics, 1994). PPOs attempt to lower costs by establishing networks of providers that are paid according to negotiated fee schedules. Many traditional fee-for-service plans now also generate a list of preferred providers for participants. The advantage to the participant for using the preferred provider is lower out-of-pocket costs.

Survey data from KPMG Peat Marwick (1994, 1995) (Figure 5) indicate that employees continue to migrate away from conventional fee-for-service plans and into managed care plans.[13] In 1995, HMO enrollment in employer-sponsored plans nearly equaled the enrollment in conventional plans; it is predicted to edge ahead in 1996 (KPMG Peat Marwick, to be published). Almost one-half of the U.S. resident population was covered by an HMO or PPO plan in 1994 (Dial et al., 1996) (Figure 6).

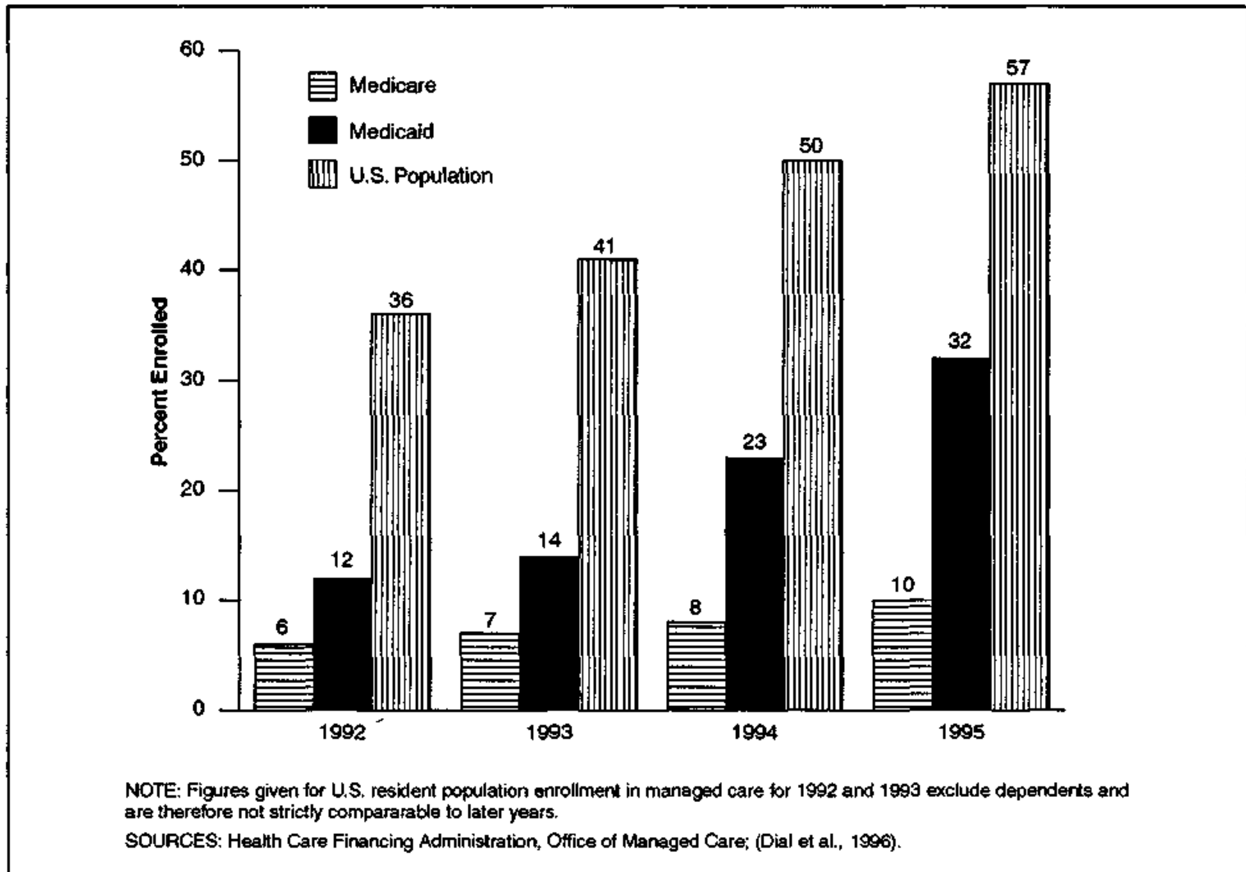
[13]This can also be a function of the plans that the employer chooses to offer.

Figure 5
Percent of Employees Enrolled in Employer-Sponsored Health Plans, by Type of Plan: Calendar Years 1993-95



SOURCE: (KPMG Peat Marwick, 1994-96).

Figure 6
Percent of Medicare Enrollees, Medicaid Recipients, and U.S. Population Enrolled in Managed Health Care Plans: 1992-95



NOTE: Figures given for U.S. resident population enrollment in managed care for 1992 and 1993 exclude dependents and are therefore not strictly compararable to later years.

SOURCES: Health Care Financing Administration, Office of Managed Care; (Dial et al., 1996).

Covered Services

Throughout the late 1980s and early 1990s, the breadth of services covered by employer-sponsored PHI greatly expanded. For example, an increasing number of insurance plans began offering home health and hospice care coverage as less expensive alternatives to hospital stays. Much of this expansion was driven by cost-containment strategies aimed at substituting lower cost services for more expensive care and by the desire to attract healthier participants.

The rise in the availability of covered services was accelerated by the migration of employers and employees toward managed care health plans including HMO, PPO, and point-of-service (POS) plans. Managed care health plans, particularly HMOs, were much more likely to provide their members with coverage for many basic preventive services, such as routine physical examinations, well-baby care, well-child care, and immunizations and inoculations. For example, data from KPMG Peat Marwick (1995) indicate that in 1995 HMO enrollees were almost twice as likely to be covered for adult physicals as enrollees in conventional plans.

Although conventional plans have been slow to catch up, many have greatly expanded their coverage during the first half of the 1990s into areas such as adult physicals and well-baby and well-child care. However, despite such increases, these conventional plans still lag most managed care plans, particularly HMOs, in the overall level of preventive services coverage.

Expansions in covered services continued in 1996. More recent survey data from KPMG Peat Marwick indicate that the biggest increases for preventive services were in POS plans. POS plan offerings for both adult physicals and well-child care coverage increased, and HMO plans were increasingly likely to cover chiropractic care. Although just over one-half the HMO plans are now offering such coverage, they still remain far behind non-HMO plans, which almost universally cover chiropractic services.

MEDICARE

Medicare's Hospital Insurance and Supplementary Medical Insurance programs funded $187 billion of spending for health services and supplies in 1995, an 11.6-percent increase over 1994 spending. Ninety-eight percent of these expenditures were for PHC services for the 37.5 million aged and disabled Medicare beneficiaries enrolled on July 1, 1995.

Medicare is the largest public payer for PHC expenditures and for each of the service components covered by the program except nursing home care. Over time, with few exceptions, Medicare has financed increasingly larger shares of spending for each service component. In 1995 Medicare funded 20.9 percent of spending for PHC, a full percentage point more than it funded in 1994. One-third of all spending for hospital care and one-fifth of expenditures for physician services are funded by Medicare. Faster growth in the Medicare population, compared with the general population, and the aging of frail elderly Medicare enrollees are contributing factors to these increasing funding shares.

Medicare expenditures for hospital care totaled $112.6 billion in 1995, 10.5 percent higher than in 1994. Expenditures for hospital care services cover inpatient, outpatient, and hospital-based home health agency and skilled nursing facility services. Relatively high growth in Medicare hospital expenditures that has continued in recent years may be, in part, the result of expansions of hospital-based, subacute units that allow Medicare patients to be discharged quickly from hospitalization and admitted into the same facility's subacute care unit. This permits hospitals to limit expenses incurred for Medicare hospitalizations, which are compensated at a fixed amount regardless of length of stay, and continue treating the patient under Medicare's cost-based reimbursement policies for skilled nursing home care (Anders, 1996).

Medicare and PHI Comparison

The 1996 Medicare Trustee's Report predicts that growth in Medicare spending will deplete the Medicare Hospital Insurance trust fund by early in 2001 and recommends that Congress act quickly to reduce the growth in program costs. Such action would extend the date of trust fund exhaustion and provide the time necessary to solve the long-term financial imbalance between costs and income (Board of Trustees, Federal Hospital Insurance Trust Fund, 1996).

The debate over how to fix the imbalance between Medicare income and expenditures inevitably involves raising taxes or lowering expenditure growth. The latter is particularly relevant in 1994-95, when spending growth in Medicare exceeded that of PHI. Between 1993 and 1995, aggregate spending under the Medicare program (benefits plus administrative costs) increased at an 11.3-percent average annual rate, while spending for PHI (benefits plus the net cost of insurance) grew only 2.5 percent annually. Part of the difference is attributable to differential growth in enrollment (Levit et al., 1996).

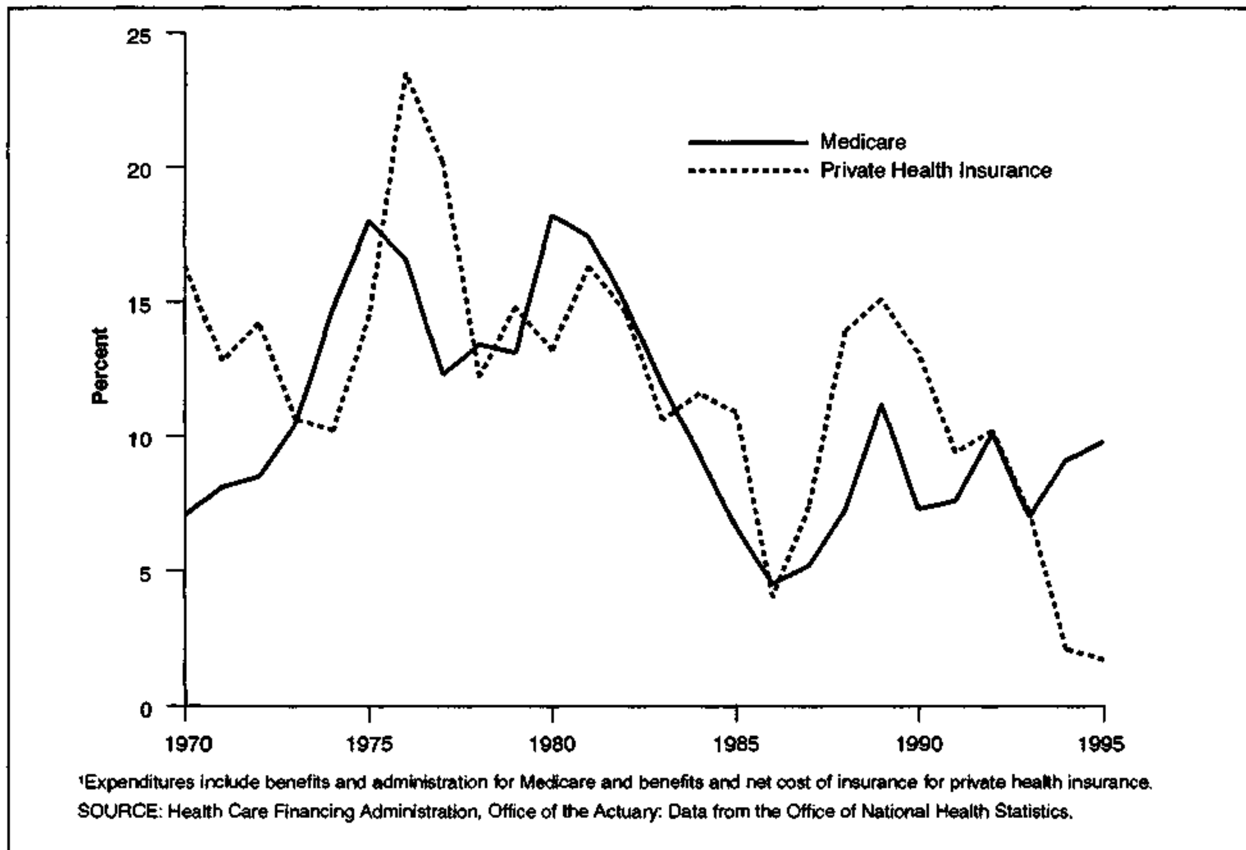
Since the inception of the program, Medicare enrollment has grown at twice the rate of PHI enrollment. In 1995 this trend continued: Medicare enrollment grew 1.6 percent, compared with PHI enrollment growth of 0.9 percent.

To remove this source of difference, we calculated spending on a per enrollee basis for 1969-95. From 1969 to 1993, per enrollee spending by Medicare and PHI grew at similar rates (Figure 7). During the 1969-93 period, average annual growth in Medicare per enrollee spending was slightly slower than growth in PHI spending overall and for each type of service except durable medical products[14] (Figure 8). In 1994 and 1995, trends in growth rates for these two payers suddenly diverged: Average annual growth in Medicare per enrollee spending for all PHC changed very little from past rates, while average annual growth in per enrollee PHI spending decelerated dramatically. Medicare spending for benefits per enrollee grew more than 2.5 times as fast as PHI spending per enrollee.

Medicare spending growth moderated slightly for each type of service except home health and nursing home care during the 1993-95 period. Expenditure growth in home health and nursing home services was affected by changes in the law and in Medicare regulations, the resid-

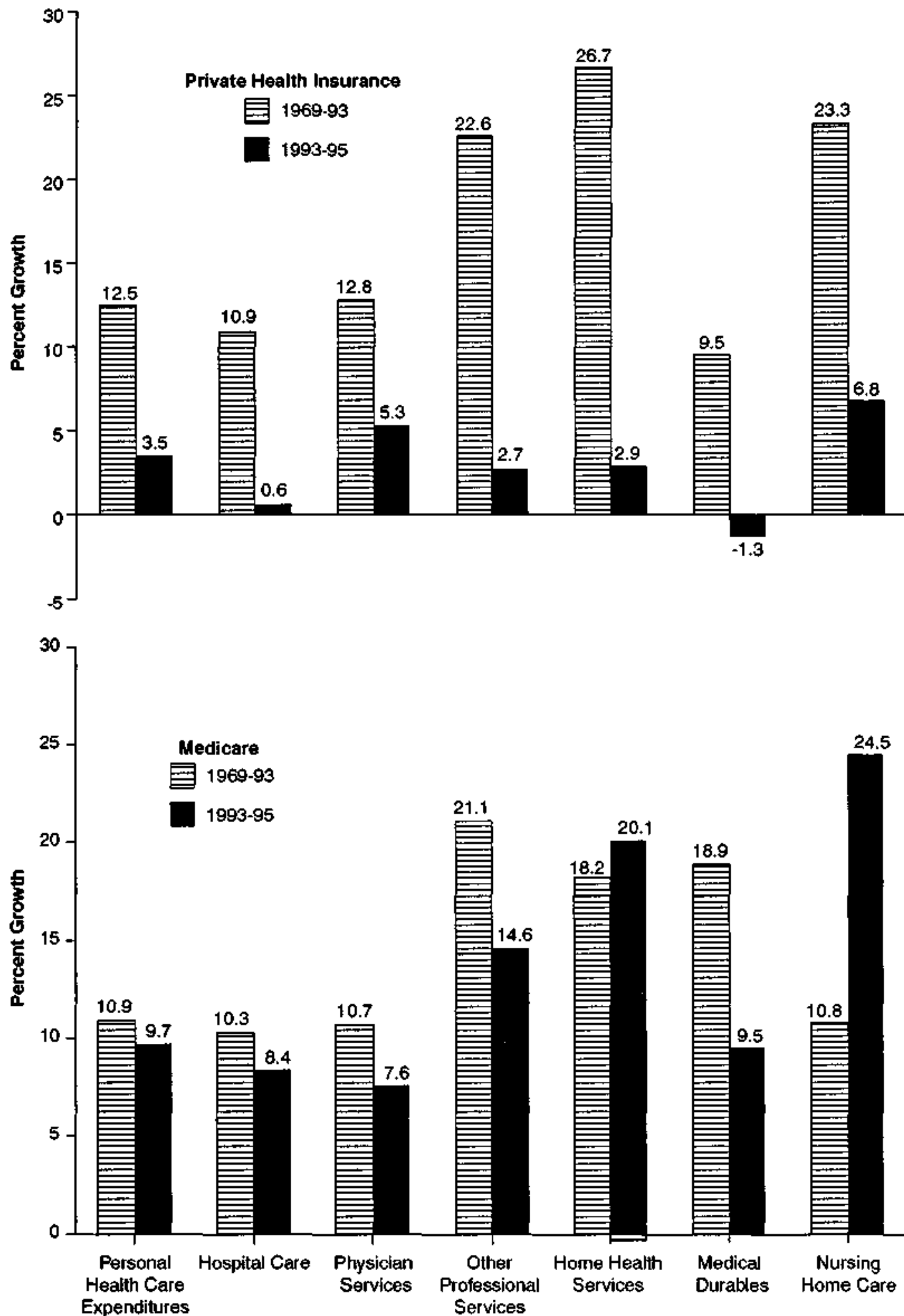
[14]The durable category covers a different product line for the elderly and non-elderly. Medical durable products purchased by the non-elderly consist primarily of eyeglasses and hearing aids, while the Medicare population uses a wide variety of durable medical equipment and supplies.

Figure 7
Growth in per Enrollee Expenditures[1] by Medicare and Private Health Insurance: Calendar Years 1970-95



[1]Expenditures include benefits and administration for Medicare and benefits and net cost of insurance for private health insurance.
SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Figure 8
Average Annual Growth in Private Health Insurance and Medicare per Enrollee Benefits: Calendar Years 1969-93 and 1993-95



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

ual effects of which were still being felt in 1995.[15] Medicare's continued strong growth in hospital services parallels the growth in admissions for the population over 65 years of age. It also reflects the NHE definition of hospital services[16] that includes not only inpatient services, but outpatient services (including those provided through hospital-based home health agencies) and services in skilled nursing home units that are compensated on a reasonable-cost basis. Strong growth in Medicare physician expenditures is somewhat misleading in that it includes bonuses paid to physicians through the MFS in 1994 and 1995 for their restraint in volume (and intensity) increases in 1992 and 1993.[17] Similarly, Medicare will incorporate penalties in its MFS in 1996 and 1997 for volume increases in 1994 and 1995 that exceeded the VPS.

One reason for the difference in Medicare and PHI expenditure growth in 1994 and 1995 is the growth in number of persons enrolled in employer-sponsored managed care plans and managed care's increased influence over providers. Managed care plans negotiate price discounts with providers in return for provider access to large groups of patients; they emphasize preventive services and elimination of unnecessary care; and they demand cost-conscious decisionmaking by providers in the delivery of health care. Each of these aspects serves to limit growth in PHI funding of services. Most Medicare enrollees are not enrolled in HMOs. Providers serving these beneficiaries are paid on a prospectively set basis (for inpatient hospital care) or on a reasonable-cost basis (for most other institutional services). For HMOs enrolling Medicare beneficiaries, Medicare pays 95 percent of the local fee-for-service average reimbursement. Thus, managed care price discounts and other factors present in the larger health care marketplace do not necessarily translate into lower Medicare costs. Because payment is set in law, Medicare has been unable to respond as quickly as PHI to changing market conditions. Experts are still investigating why managed care's costs are low. Is its success caused by elimination of unnecessary utilization, negotiated price discounts, favorable enrollee selection, or some combination of these (Newhouse, 1996)? Has managed care had an impact on quality of health care services? Some policymakers are anxious to move quickly to adopt managed care strategies in hopes of reducing Medicare costs. Other policymakers, citing the issues raised above, prefer to move more cautiously.

MEDICAID

Combined Federal and State Medicaid spending for PHC accounted for 15.1 percent of total PHC in 1995, or $133.1 billion. Medicaid largely funds institutional services. In 1995, hospital care and nursing home care accounted for two-thirds (36.9 and 25.7 percent, respectively) of combined Federal and State Medicaid spending. The program is the largest third-party payer of nursing home care, financing 46.5 percent in 1995.

In fiscal year 1995, there were 36.3 million persons who received some type of Medicaid benefit. The groups of children

[15]In 1988 Medicare eased its coverage criteria for home health benefits. This relaxation produced an expansion of benefits and accelerated growth in home health expenditures. Similarly, residual effects from the 1988 Medicare Catastrophic Coverage Act and relaxation of conditions for payment under Medicare led to accelerated growth in spending for nursing home care.

[16]Both the Federal Government (using Standard Industrial Classification codes) and the American Hospital Association collect information on an establishment basis and include revenues received for all services rendered by that establishment.

[17]Two years after performance, Medicare VPS penalizes or rewards physicians through the MFS for increases in physician volume and intensity of services used by Medicare beneficiaries.

and adults in families with dependent children represented 68.3 percent of all Medicaid recipients in 1995, yet consumed only 26.2 percent of program benefits. Nearly one-half of all Medicaid recipients were children (17.2 million), who consumed only 15.0 percent of all Medicaid benefits. These children also accounted for more than two-thirds of all family-based criteria recipients but consumed only a little more than one-half of the benefits to families. Conversely, the aged, blind, and disabled represented just over one-quarter of all recipients but consumed nearly three-quarters of program benefits (Table 7).

Medicaid is funded jointly by Federal and by State and local governments. For a State to receive Federal matching funds, it must adhere to minimum requirements for eligibility and services set by the Federal Government. Within this broad framework, State governments are afforded considerable flexibility in designing the total scope of the program within the constraints of the State budgetary process. One way States use this flexibility is through Medicaid waivers. There are two types of Medicaid waivers: program waivers (including home- and community-based service waivers and freedom-of-choice waivers) and research and demonstration waivers. Home- and community-based waivers[18] allow States to place Medicaid-eligible persons into alternative, non-institutional settings for certain types of medical and personal care. Freedom-of-choice waivers[19] allow States to place Medicaid beneficiaries into mandatory managed care plans (where beneficiaries have a choice of a minimum of two providers). Research and demonstration waivers (section 1115 of the Social Security Act) allow Federal Medicaid requirements to be waived in order to conduct experimental, pilot, or demonstration projects.

The recent slowdown in Medicaid expenditure growth from 1993 to 1994 (from 12.6 percent to 8.5 percent), which continued in 1995 (8.4 percent), was partially driven by a slowdown in the growth of overall program recipients (7.3 percent in 1993 to 4.8 percent in 1994 and 3.5 percent in 1995). In addition, the change in the proportion of the Medicaid population enrolled in managed care rather than fee for service may also have contributed to the overall expenditure slowdown. State Medicaid programs view managed care as a way to constrain cost growth. In shifting recipients to managed care plans, States also shift the risk for health care costs to the plans. As an increasing number of States employed this cost-containment option, managed care enrollment grew quite rapidly. The Medicaid managed care population represented only 9.5 percent of all Medicaid recipients in fiscal year 1991 but by fiscal year 1995 tripled in share to 32.1 percent. HMOs currently represent 62 percent of all Medicaid managed care programs; prepaid health plans, 25 percent; primary care case management programs, 12 percent; and health insuring organizations, 1 percent (Health Care Financing Administration, 1995).

The slowdown in Medicaid expenditure growth between 1993 and 1994 was also marked by a sharp deceleration in Federal Medicaid spending. (The State share of Medicaid expenditures, however, grew at a steady rate.) There was a marked increase from 1993 to 1994 in the percentage of States with higher-than-average Federal matching rates who also showed lower-than-average expenditure growth. In other words, the poorest States showed the slowest growth in Medicaid spending during this period, which slowed the growth in overall Federal matching contributions. This composition change caused the Federal percentage contribution to Medicaid spending to fall.

[18]Authorized under section 1915 (c) of the Social Security Act.
[19]Authorized under section 1915 (b) of the Social Security Act.

Table 7
Medicaid Recipients and Expenditures by Eligibility Category: Fiscal Year 1995

Category	Recipients (Thousands)	Expenditures (Billions)	Percent Distribution Recipients	Percent Distribution Expenditures
All Eligibility Categories[1]	36,282	$120.1	100.0	100.0
Aged, Blind, and Disabled	9,977	85.9	27.5	71.5
Families	24,767	31.5	68.3	26.2
Children	17,164	18.0	47.3	15.0
Adults[2]	7,604	13.5	21.0	11.2

[1] Includes children and aged and non-aged adults categorized as "other" or unknown not shown separately.
[2] Adults in families with dependent children.

NOTE: Data reported on Health Care Financing Administration Form 2082.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, 1995.

CONCLUSION

This article describes the latest shifts that have occurred within the health care system. Growth in private sector spending fell to low rates between 1993 and 1995, contributing heavily to the slow overall spending growth in those years. NHE as a share of the Nation's output of goods and services was stable for 3 years, breaking the trend of rapid annual increases registered in the late 1980s and early 1990s. Questions about whether these trends will continue and how the Federal sector (primarily Medicare) will react to current changes in the health care marketplace continue to be asked, but the answers are not clear. How will physicians react to slow or negative income growth? How will managed care plans respond to rapid increases in prescription drug use? How will issues of quality and bias selection be addressed by managed care plans? What will happen to managed care premium increases once the transition of privately insured persons to these plans has stabilized? We can watch the answers to these questions unfold in future NHE analyses.

ACKNOWLEDGMENTS

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Table 8
National Health Expenditures Aggregate and per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Years 1960-95

Item	1960	1970	1980	1985	1990	1991	1992	1993	1994	1995
Amount in Billions										
National Health Expenditures	$26.9	$73.2	$247.2	$428.2	$697.5	$761.7	$834.2	$892.1	$937.1	$988.5
Private	20.2	45.5	142.5	253.9	413.1	441.4	478.8	505.5	517.2	532.1
Public	6.6	27.7	104.8	174.3	284.3	320.3	355.4	386.5	419.9	456.4
Federal	2.9	17.8	72.0	123.3	195.8	224.4	253.9	277.6	301.9	328.4
State and Local	3.7	9.9	32.8	51.0	88.5	95.9	101.6	108.9	118.0	128.0
Number in Millions										
U.S. Population[1]	190.1	214.8	235.1	247.1	260.0	262.6	265.2	267.9	270.4	273.0
Amount in Billions										
Gross Domestic Product	$527	$1,036	$2,784	$4,181	$5,744	$5,917	$6,244	$6,553	$6,936	$7,254
Per Capita Amount										
National Health Expenditures	$141	$341	$1,052	$1,733	$2,683	$2,901	$3,145	$3,330	$3,465	$3,621
Private	106	212	606	1,027	1,589	1,681	1,805	1,887	1,913	1,949
Public	35	129	446	705	1,094	1,220	1,340	1,443	1,553	1,672
Federal	15	83	306	499	753	855	957	1,036	1,116	1,203
State and Local	20	46	140	206	341	365	383	407	436	469
Percent Distribution										
National Health Expenditures	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private	75.2	62.2	57.6	59.3	59.2	58.0	57.4	56.7	55.2	53.8
Public	24.8	37.8	42.4	40.7	40.8	42.0	42.6	43.3	44.8	46.2
Federal	10.9	24.3	29.1	28.8	28.1	29.5	30.4	31.1	32.2	33.2
State and Local	13.9	13.5	13.3	11.9	12.7	12.6	12.2	12.2	12.6	12.9
Percent of Gross Domestic Product										
National Health Expenditures	5.1	7.1	8.9	10.2	12.1	12.9	13.4	13.6	13.5	13.6
Average Annual Percent Growth from Previous Year Shown										
National Health Expenditures	—	10.6	12.9	11.6	10.2	9.2	9.5	6.9	5.1	5.5
Private	—	8.5	12.1	12.3	10.2	6.8	8.5	5.6	2.3	2.9
Public	—	15.3	14.2	10.7	10.3	12.7	11.0	8.7	8.6	8.7
Federal	—	19.8	15.0	11.4	9.7	14.6	13.1	9.4	8.7	8.8
State and Local	—	10.2	12.7	9.2	11.6	8.3	6.0	7.2	8.4	8.4
U.S. Population	—	1.2	0.9	1.0	1.0	1.0	1.0	1.0	1.0	0.9
Gross Domestic Product	—	7.0	10.4	8.5	6.6	3.0	5.5	4.9	5.8	4.6

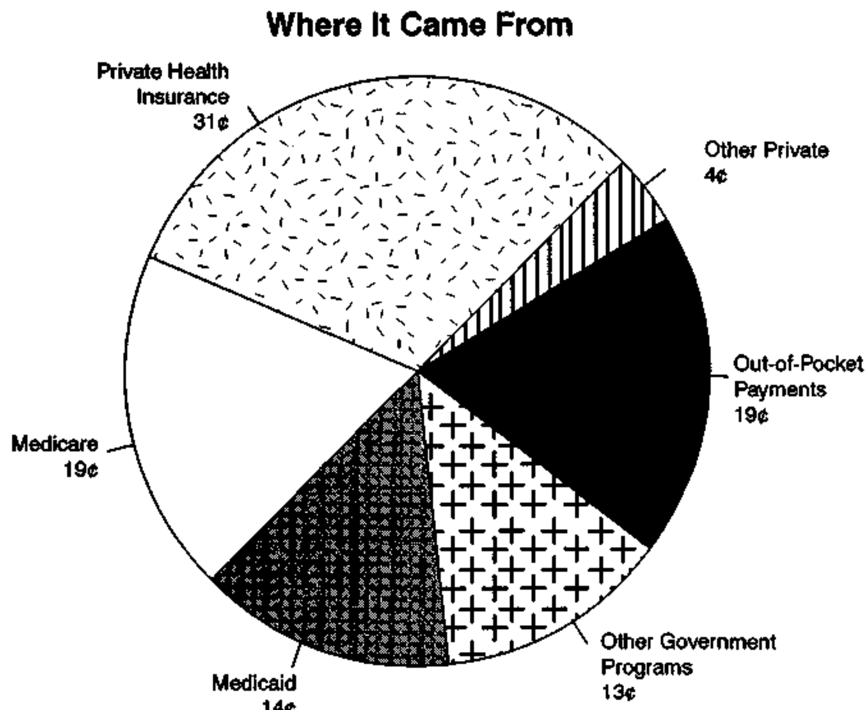
[1] July 1 Social Security area population estimates for each year, 1960-95.

NOTE: Numbers and percents may not add to totals because of rounding.

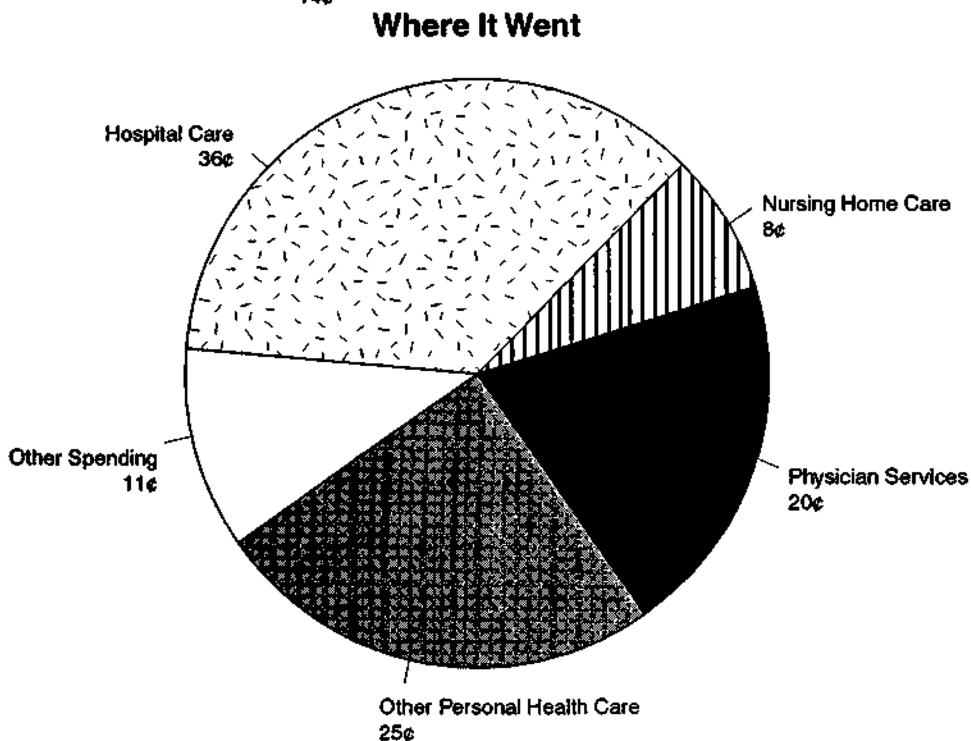
SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Figure 9
The Nation's Health Dollar:
Calendar Year 1995

Where It Came From



Where It Went



NOTES: Other private includes industrial inplant health services, non-patient revenues, and privately financed construction. Other personal health care includes dental services, other professional services, home health care, drugs and other non-durable medical products, vision products and other durable medical products, and other miscellaneous health care services. Other spending covers program administration and the net cost of private health insurance, government public health, and research and construction.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 9
National Health Expenditures Aggregate Amounts and Average Annual Percent Change, by Type of Expenditure: Selected Calendar Years 1960-95

Type of Expenditure	1960	1970	1980	1985	1990	1991	1992	1993	1994	1995
	Amount in Billions									
National Health Expenditures	$26.9	$73.2	$247.2	$428.2	$697.5	$761.7	$834.2	$892.1	$937.1	$988.5
Health Services and Supplies	25.2	67.9	235.6	411.8	672.9	736.8	806.7	863.1	906.7	957.8
Personal Health Care	23.6	63.8	217.0	376.4	614.7	676.6	740.5	786.9	827.9	878.8
Hospital Care	9.3	28.0	102.7	168.3	256.4	282.3	305.4	323.3	335.0	350.1
Physician Services	5.3	13.6	45.2	83.6	146.3	159.2	175.7	182.7	190.6	201.6
Dental Services	2.0	4.7	13.3	21.7	31.6	33.3	37.0	39.2	42.1	45.8
Other Professional Services	0.6	1.4	6.4	16.6	34.7	38.3	42.1	46.3	49.1	52.6
Home Health Care	0.1	0.2	2.4	5.6	13.1	16.1	19.6	23.0	26.3	28.6
Drugs and Other Medical Non-Durables	4.2	8.8	21.6	37.1	59.9	65.6	71.2	75.0	77.7	83.4
Vision Products and Other Medical Durables	0.6	1.6	3.8	6.7	10.5	11.2	11.9	12.5	12.9	13.8
Nursing Home Care	0.8	4.2	17.6	30.7	50.9	57.2	62.3	67.0	72.4	77.9
Other Personal Health Care	0.7	1.3	4.0	6.1	11.2	13.6	15.4	17.9	21.7	25.0
Program Administration and Net Cost of Private Health Insurance	1.2	2.7	11.8	23.8	38.6	38.8	42.7	50.9	50.6	47.7
Government Public Health Activities	0.4	1.3	6.7	11.6	19.6	21.4	23.4	25.3	28.2	31.4
Research and Construction	1.7	5.3	11.6	16.4	24.5	24.9	27.5	29.0	30.4	30.7
Research[1]	0.7	2.0	5.5	7.8	12.2	12.9	14.2	14.5	15.8	16.6
Construction	1.0	3.4	6.2	8.5	12.3	12.0	13.4	14.5	14.6	14.0
	Average Annual Percent Change from Previous Year Shown									
National Health Expenditures	—	10.6	12.9	11.6	10.2	9.2	9.5	6.9	5.1	5.5
Health Services and Supplies	—	10.4	13.2	11.8	10.3	9.5	9.5	7.0	5.1	5.6
Personal Health Care	—	10.5	13.0	11.6	10.3	10.1	9.5	6.3	5.2	6.1
Hospital Care	—	11.7	13.9	10.4	8.8	10.1	8.2	5.9	3.6	4.5
Physician Services	—	9.9	12.8	13.1	11.8	8.8	10.4	4.0	4.4	5.8
Dental Services	—	9.1	11.1	10.2	7.8	5.6	11.0	6.0	7.3	8.9
Other Professional Services	—	8.8	16.3	21.2	15.8	10.4	10.0	10.0	6.1	7.0
Home Health Care	—	14.5	26.9	18.9	18.4	22.4	22.3	17.1	14.4	8.6
Drugs and Other Medical Non-Durables	—	7.6	9.4	11.4	10.1	9.4	8.6	5.4	3.6	7.3
Vision Products and Other Medical Durables	—	9.6	8.8	12.4	9.2	7.0	6.3	5.1	2.8	7.2
Nursing Home Care	—	17.4	15.4	11.7	10.7	12.2	9.0	7.6	8.1	7.5
Other Personal Health Care	—	6.5	12.0	8.8	12.9	20.7	13.3	16.4	21.6	14.9
Program Administration and Net Cost of Private Health Insurance	—	8.9	15.8	15.0	10.2	0.4	10.2	19.1	-0.5	-5.8
Government Public Health Activities	—	13.9	17.5	11.5	11.0	9.2	9.3	7.9	11.6	11.3
Research and Construction	—	12.2	8.1	7.1	8.4	1.7	10.5	5.3	4.9	0.8
Research[1]	—	10.9	10.8	7.5	9.3	5.8	9.8	2.2	9.3	5.0
Construction	—	12.9	6.2	6.7	7.6	-2.4	11.2	8.7	0.5	-3.8

[1]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from research expenditures but are included in the expenditure class in which the product falls.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 10
National Health Expenditures, by Source of Funds and Type of Expenditure: Selected Calendar Years 1990-95

Year and Type of Expenditure	Total	Private: All Private Funds	Private: Consumer: Total	Private: Consumer: Out of Pocket	Private: Consumer: Private Health Insurance	Private: Other	Government: Total	Government: Federal	Government: State and Local
					Amount in Billions				
1990									
National Health Expenditures	$697.5	$413.1	$360.8	$148.4	$232.4	$32.3	$284.3	$195.8	$88.5
Health Services and Supplies	672.9	402.9	380.8	148.4	232.4	22.1	270.0	185.4	84.6
Personal Health Care	614.7	371.7	350.2	148.4	201.8	21.5	243.0	178.1	64.9
Hospital Care	256.4	115.0	104.3	10.3	94.0	10.7	141.5	106.6	34.9
Physician Services	146.3	101.4	98.7	35.4	63.3	2.7	45.0	35.9	9.1
Dental Services	31.6	30.7	30.6	15.4	15.1	0.1	0.9	0.5	0.4
Other Professional Services	34.7	28.2	25.6	14.2	11.4	2.6	6.5	4.3	2.2
Home Health Care	13.1	8.0	5.9	3.6	2.3	2.2	5.1	4.1	1.0
Drugs and Other Medical Non-Durables	59.9	53.5	53.5	40.4	13.0	—	6.5	3.1	3.4
Vision Products and Other Medical Durables	10.5	7.7	7.7	6.7	0.9	—	2.8	2.6	0.1
Nursing Home Care	50.9	25.0	24.1	22.2	1.9	0.9	25.9	15.7	10.2
Other Personal Health Care	11.2	2.2	—	—	—	2.2	9.0	5.4	3.6
Program Administration and Net Cost of Private Health Insurance	38.6	31.2	30.6	—	30.6	0.6	7.4	4.9	2.5
Government Public Health Activities	19.6	—	—	—	—	—	19.6	2.4	17.2
Research and Construction	24.5	10.2	—	—	—	10.2	14.3	10.4	3.9
Research	12.2	1.0	—	—	—	1.0	11.3	9.5	1.7
Construction	12.3	9.3	—	—	—	9.3	3.0	0.8	2.2
1991									
National Health Expenditures	761.7	441.4	407.3	155.0	252.3	34.1	320.3	224.4	95.9
Health Services and Supplies	736.8	431.3	407.3	155.0	252.3	24.0	305.5	213.8	91.7
Personal Health Care	676.6	400.0	376.6	155.0	221.6	23.4	276.6	205.8	70.8
Hospital Care	282.3	123.1	111.6	11.2	100.4	11.5	159.2	123.8	35.3
Physician Services	159.2	110.0	107.3	35.7	71.6	2.8	49.1	38.5	10.6
Dental Services	33.3	32.3	32.1	16.2	15.9	0.1	1.1	0.6	0.5
Other Professional Services	38.3	30.6	27.6	14.6	13.0	2.9	7.7	5.2	2.5
Home Health Care	16.1	9.3	6.8	4.3	2.5	2.5	6.7	5.5	1.2
Drugs and Other Medical Non-Durables	65.6	57.9	57.9	42.7	15.2	—	7.6	3.7	3.9
Vision Products and Other Medical Durables	11.2	7.8	7.8	6.9	0.9	—	3.4	3.2	0.1
Nursing Home Care	57.2	26.5	25.4	23.4	2.1	1.1	30.7	18.4	12.3
Other Personal Health Care	13.6	2.4	—	—	—	2.4	11.1	6.7	4.4
Program Administration and Net Cost of Private Health Insurance	38.8	31.3	30.7	—	30.7	0.6	7.5	5.3	2.2
Government Public Health Activities	21.4	—	—	—	—	—	21.4	2.7	18.7
Research and Construction	24.9	10.1	—	—	—	10.1	14.8	10.7	4.1
Research	12.9	1.1	—	—	—	1.1	11.8	9.9	1.9
Construction	12.0	9.0	—	—	—	9.0	3.0	0.7	2.3

See notes at end of table.

Table 10—Continued
National Health Expenditures, by Source of Funds and Type of Expenditure: Selected Calendar Years 1990-95

Year and Type of Expenditure	Total	Private: All Private Funds	Private: Consumer: Total	Private: Consumer: Out of Pocket	Private: Consumer: Private Health Insurance	Private: Other	Government: Total	Government: Federal	Government: State and Local
1992					Amount in Billions				
National Health Expenditures	$834.2	$478.8	$442.8	$165.8	$277.0	$36.0	$355.4	$253.9	$101.6
Health Services and Supplies	806.7	467.8	442.8	165.8	277.0	25.0	338.9	242.1	96.8
Personal Health Care	740.5	433.4	409.0	165.8	243.2	24.4	307.1	233.5	73.6
Hospital Care	305.4	129.2	117.4	11.7	105.7	11.8	176.1	141.5	34.7
Physician Services	175.7	123.1	120.3	38.2	82.1	2.8	52.6	40.8	11.8
Dental Services	37.0	35.7	35.5	18.2	17.3	0.1	1.3	0.8	0.6
Other Professional Services	42.1	33.2	30.2	16.0	14.2	3.0	8.9	6.2	2.7
Home Health Care	19.6	10.8	7.9	5.0	2.9	2.9	8.8	7.4	1.4
Drugs and Other Medical Non-Durables	71.2	63.0	63.0	45.0	18.0	—	8.2	4.1	4.1
Vision Products and Other Medical Durables	11.9	8.1	8.1	7.3	0.9	—	3.7	3.6	0.1
Nursing Home Care	62.3	27.6	26.5	24.4	2.1	1.2	34.7	21.5	13.2
Other Personal Health Care	15.4	2.6	—	—	—	2.6	12.7	7.8	5.0
Program Administration and Net Cost of Private Health Insurance	42.7	34.4	33.8	—	33.8	0.6	8.4	5.5	2.8
Government Public Health Activities	23.4	—	—	—	—	—	23.4	3.0	20.4
Research and Construction	27.5	11.0	—	—	—	11.0	16.5	11.8	4.7
Research	14.2	1.2	—	—	—	1.2	13.0	11.0	2.0
Construction	13.4	9.8	—	—	—	9.8	3.5	0.8	2.8
1993									
National Health Expenditures	892.1	505.5	467.0	171.6	295.4	38.5	386.5	277.6	108.9
Health Services and Supplies	863.1	493.7	467.0	171.6	295.4	26.6	369.4	265.5	103.9
Personal Health Care	786.9	453.0	426.9	171.6	255.4	26.1	333.9	255.9	78.0
Hospital Care	323.3	134.6	122.4	11.9	110.5	12.2	188.6	152.0	36.6
Physician Services	182.7	127.1	124.0	37.5	86.5	3.1	55.6	43.5	12.0
Dental Services	39.2	37.5	37.3	19.1	18.3	0.2	1.7	1.0	0.8
Other Professional Services	46.3	36.3	33.0	18.2	14.8	3.3	10.0	7.2	2.8
Home Health Care	23.0	11.9	8.7	5.6	3.1	3.2	11.1	9.5	1.5
Drugs and Other Medical Non-Durables	75.0	65.9	65.9	46.8	19.1	—	9.2	4.7	4.4
Vision Products and Other Medical Durables	12.5	8.4	8.4	7.5	0.9	—	4.1	4.0	0.1
Nursing Home Care	67.0	28.5	27.3	25.1	2.2	1.2	38.5	24.7	13.9
Other Personal Health Care	17.9	2.8	—	—	—	2.8	15.0	9.2	5.9
Program Administration and Net Cost of Private Health Insurance	50.9	40.6	40.1	—	40.1	0.6	10.2	6.4	3.9
Government Public Health Activities	25.3	—	—	—	—	—	25.3	3.3	22.0
Research and Construction	29.0	11.9	—	—	—	11.9	17.1	12.1	5.0
Research	14.5	1.2	—	—	—	1.2	13.3	11.1	2.1
Construction	14.5	10.7	—	—	—	10.7	3.8	0.9	2.9

See notes at end of table.

Table 10—Continued
National Health Expenditures, by Source of Funds and Type of Expenditure: Selected Calendar Years 1990-95

		Private					Government		
			Consumer						
Year and Type of Expenditure	Total	All Private Funds	Total	Out of Pocket	Private Health Insurance	Other	Total	Federal	State and Local
					Amount in Billions				
1994									
National Health Expenditure	$937.1	$517.2	$478.7	$176.0	$302.7	$38.6	$419.9	$301.9	$118.0
Health Services and Supplies	906.7	505.5	478.7	176.0	302.7	26.8	401.2	288.7	112.6
Personal Health Care	827.9	466.7	440.5	176.0	264.5	26.2	361.2	278.1	83.1
Hospital Care	335.0	134.2	122.8	11.3	111.5	11.3	200.8	162.9	37.9
Physician Services	190.6	131.5	128.4	37.3	91.1	3.1	59.1	46.7	12.5
Dental Services	42.1	40.3	40.2	19.9	20.2	0.2	1.8	1.0	0.8
Other Professional Services	49.1	38.0	34.3	19.1	15.2	3.7	11.1	8.2	2.9
Home Health Care	26.3	12.8	9.4	6.0	3.3	3.4	13.5	11.7	1.7
Drugs and Other Medical Non-Durables	77.7	67.7	67.7	47.8	19.8	—	10.1	5.2	4.9
Vision Products and Other Medical Durables	12.9	8.5	8.5	7.6	0.9	—	4.4	4.2	0.1
Nursing Home Care	72.4	30.6	29.3	26.9	2.4	1.4	41.8	26.9	14.9
Other Personal Health Care	21.7	3.1	—	—	—	3.1	18.7	11.3	7.3
Program Administration and Net Cost of Private Health Insurance	50.6	38.8	38.2	—	38.2	0.6	11.8	6.7	5.0
Government Public Health Activities	28.2	—	—	—	—	—	28.2	3.8	24.4
Research and Construction	30.4	11.8	—	—	—	11.8	18.7	13.2	5.5
Research	15.8	1.3	—	—	—	1.3	14.6	12.3	2.3
Construction	14.6	10.5	—	—	—	10.5	4.1	0.9	3.2
1995									
National Health Expenditures	988.5	532.1	493.2	182.6	310.6	38.9	456.4	328.4	128.0
Health Services and Supplies	957.8	521.2	493.2	182.6	310.6	28.0	436.7	314.4	122.2
Personal Health Care	878.8	486.7	459.3	182.6	276.8	27.3	392.1	303.6	88.5
Hospital Care	350.1	135.8	124.5	11.4	113.1	11.3	214.3	175.3	39.0
Physician Services	201.6	137.6	133.9	36.9	97.0	3.7	64.0	50.9	13.1
Dental Services	45.8	44.0	43.8	21.8	22.0	0.2	1.8	1.0	0.8
Other Professional Services	52.6	39.9	36.0	20.2	15.8	3.9	12.7	9.6	3.1
Home Health Care	28.6	12.8	9.3	6.0	3.3	3.4	15.8	13.8	2.0
Drugs and Other Medical Non-Durables	83.4	72.0	72.0	49.8	22.1	—	11.4	5.9	5.6
Vision Products and Other Medical Durables	13.8	8.7	8.7	7.8	0.9	—	5.1	5.0	0.1
Nursing Home Care	77.9	32.6	31.1	28.6	2.5	1.5	45.3	29.3	16.0
Other Personal Health Care	25.0	3.3	—	—	—	3.3	21.7	12.8	8.9
Program Administration and Net Cost of Private Health Insurance	47.7	34.5	33.9	—	33.9	0.6	13.2	7.1	6.1
Government Public Health Activities	31.4	—	—	—	—	—	31.4	3.8	27.6
Research and Construction	30.7	10.9	—	—	—	10.9	19.7	14.0	5.7
Research	16.6	1.4	—	—	—	1.4	15.2	12.9	2.3
Construction	14.0	9.6	—	—	—	9.6	4.5	1.1	3.4

NOTES: Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from research expenditures but are included in the expenditure class in which the product falls. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 11
Personal Health Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-95

			Third-Party Payments							
						Government				
Year	Total	Out-of-Pocket Payments	Total	Private Health Insurance	Other Private Funds	Total	Federal	State and Local	Medicare[1]	Medicaid[2]
					Amount in Billions					
1960	$23.6	$13.1	$10.6	$5.0	$0.4	$5.1	$2.1	$3.0	—	—
1970	63.8	24.9	38.9	14.8	1.6	22.5	14.7	7.8	$7.3	$5.1
1980	217.0	60.3	156.8	62.0	7.8	87.0	63.4	23.6	36.4	24.8
1985	376.4	100.6	275.8	113.8	14.1	148.0	111.3	36.7	70.3	39.2
1990	614.7	148.4	466.3	201.8	21.5	243.0	178.1	64.9	109.6	71.7
1991	676.6	155.0	521.6	221.6	23.4	276.6	205.8	70.8	120.2	90.1
1992	740.5	165.8	574.8	243.2	24.4	307.1	233.5	73.6	135.4	102.1
1993	786.9	171.6	615.3	255.4	26.1	333.9	255.9	78.0	147.8	114.6
1994	827.9	176.0	651.9	264.5	26.2	361.2	278.1	83.1	164.4	123.4
1995	878.8	182.6	696.2	276.8	27.3	392.1	303.6	88.5	184.0	133.1
					Per Capita Amount					
1960	$124	$69	$56	$26	$2	$27	$11	$16	—	—
1970	297	116	181	69	8	105	68	36	(3)	(3)
1980	923	256	667	264	33	370	270	100	(3)	(3)
1985	1,523	407	1,116	460	57	599	450	148	(3)	(3)
1990	2,364	571	1,794	776	83	935	685	249	(3)	(3)
1991	2,577	590	1,986	844	89	1,053	784	270	(3)	(3)
1992	2,792	625	2,167	917	92	1,158	880	278	(3)	(3)
1993	2,938	641	2,297	953	97	1,247	955	291	(3)	(3)
1994	3,061	651	2,411	978	97	1,336	1,029	307	(3)	(3)
1995	3,219	669	2,550	1,014	100	1,436	1,112	324	(3)	(3)
					Percent Distribution					
1960	100.0	55.3	44.7	21.2	1.8	21.7	9.0	12.6	—	—
1970	100.0	39.0	61.0	23.2	2.6	35.3	23.0	12.2	11.4	7.9
1980	100.0	27.8	72.2	28.6	3.6	40.1	29.2	10.9	16.8	11.4
1985	100.0	26.7	73.3	30.2	3.7	39.3	29.6	9.7	18.7	10.4
1990	100.0	24.1	75.9	32.8	3.5	39.5	29.0	10.6	17.8	11.7
1991	100.0	22.9	77.1	32.8	3.5	40.9	30.4	10.5	17.8	13.3
1992	100.0	22.4	77.6	32.8	3.3	41.5	31.5	9.9	18.3	13.8
1993	100.0	21.8	78.2	32.5	3.3	42.4	32.5	9.9	18.8	14.6
1994	100.0	21.3	78.7	31.9	3.2	43.6	33.6	10.0	19.9	14.9
1995	100.0	20.8	79.2	31.5	3.1	44.6	34.5	10.1	20.9	15.1

[1]Subset of Federal funds.
[2]Subset of Federal and State and local funds.
[3]Calculation of per capita estimates is inappropriate.

NOTES: Per capita amounts based on July 1 Social Security area population estimates for each year, 1960-95. Numbers and percents may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 12
Hospital Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-95

			Third-Party Payments							
						Government				
Year	Total	Out-of-Pocket Payments	Total	Private Health Insurance	Other Private Funds	Total	Federal	State and Local	Medicare[1]	Medicaid[2]
					Amount in Billions					
1960	$9.3	$1.9	$7.4	$3.3	$0.1	$3.9	$1.6	$2.3	—	—
1970	28.0	2.5	25.5	9.1	0.9	15.5	10.2	5.3	$5.4	$2.7
1980	102.7	5.3	97.4	36.4	5.0	55.9	42.2	13.8	26.4	10.6
1985	168.3	8.8	159.5	58.7	8.3	92.5	72.5	20.0	49.1	15.8
1990	256.4	10.3	246.2	94.0	10.7	141.5	106.6	34.9	69.7	29.7
1991	282.3	11.2	271.1	100.4	11.5	159.2	123.8	35.3	76.2	38.2
1992	305.4	11.7	293.6	105.7	11.8	176.1	141.5	34.7	86.4	42.9
1993	323.3	11.9	311.4	110.5	12.2	188.6	152.0	36.6	92.6	47.6
1994	335.0	11.3	323.7	111.5	11.3	200.8	162.9	37.9	101.9	49.9
1995	350.1	11.4	338.7	113.1	11.3	214.3	175.3	39.0	112.6	52.0
					Per Capita Amount					
1960	$49	$10	$39	$17	$1	$21	$8	$12	—	—
1970	130	12	119	42	4	72	47	25	(3)	(3)
1980	437	23	414	155	21	238	179	59	(3)	(3)
1985	681	36	645	238	33	374	293	81	(3)	(3)
1990	986	40	947	362	41	544	410	134	(3)	(3)
1991	1,075	43	1,032	382	44	606	472	135	(3)	(3)
1992	1,151	44	1,107	399	44	664	533	131	(3)	(3)
1993	1,207	44	1,163	413	46	704	568	137	(3)	(3)
1994	1,239	42	1,197	412	42	743	603	140	(3)	(3)
1995	1,283	42	1,241	414	42	785	642	143	(3)	(3)
					Percent Distribution					
1960	100.0	20.7	79.3	35.6	1.2	42.5	17.3	25.2	—	—
1970	100.0	9.0	91.0	32.4	3.2	55.4	36.4	19.0	19.2	9.5
1980	100.0	5.2	94.8	35.5	4.9	54.4	41.0	13.4	25.8	10.4
1985	100.0	5.2	94.8	34.9	4.9	54.9	43.1	11.9	29.2	9.4
1990	100.0	4.0	96.0	36.6	4.2	55.2	41.6	13.6	27.2	11.6
1991	100.0	4.0	96.0	35.6	4.1	56.4	43.9	12.5	27.0	13.5
1992	100.0	3.8	96.2	34.6	3.9	57.7	46.3	11.4	28.3	14.1
1993	100.0	3.7	96.3	34.2	3.8	58.4	47.0	11.3	28.6	14.7
1994	100.0	3.4	96.6	33.3	3.4	60.0	48.6	11.3	30.4	14.9
1995	100.0	3.3	96.7	32.3	3.2	61.2	50.1	11.1	32.2	14.8

[1]Subset of Federal funds.
[2]Subset of Federal and State and local funds.
[3]Calculation of per capita estimates is inappropriate.

NOTES: Per capita amounts based on July 1 Social Security area population estimates for each year, 1960-95. Numbers and percents may not add to totals because of rounding.

SOURCE: *Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.*

Table 13
Physician Service Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-95

			Third-Party Payments							
						Government				
Year	Total	Out-of-Pocket Payments	Total	Private Health Insurance	Other Private Funds	Total	Federal	State and Local	Medicare[1]	Medicaid[2]
					Amount in Billions					
1960	$5.3	$3.3	$2.0	$1.6	$0.0	$0.4	$0.1	$0.3	—	—
1970	13.6	5.7	7.8	4.8	0.0	3.1	2.2	0.8	$1.7	$0.6
1980	45.2	14.6	30.6	17.1	0.4	13.1	10.0	3.1	8.0	2.5
1985	83.6	24.4	59.3	33.4	1.4	24.5	19.6	4.9	16.5	3.5
1990	146.3	35.4	110.9	63.3	2.7	45.0	35.9	9.1	29.5	7.1
1991	159.2	35.7	123.5	71.6	2.8	49.1	38.5	10.6	30.7	9.2
1992	175.7	38.2	137.5	82.1	2.8	52.6	40.8	11.8	31.6	11.2
1993	182.7	37.5	145.1	86.5	3.1	55.6	43.5	12.0	33.4	12.6
1994	190.6	37.3	153.3	91.1	3.1	59.1	46.7	12.5	36.2	13.4
1995	201.6	36.9	164.8	97.0	3.7	64.0	50.9	13.1	40.0	14.3
					Per Capita Amount					
1960	$28	$17	$10	$8	$0	$2	$0	$2	—	—
1970	63	27	37	22	0	14	10	4	(3)	(3)
1980	192	62	130	73	2	56	43	13	(3)	(3)
1985	338	99	240	135	6	99	79	20	(3)	(3)
1990	563	136	427	243	10	173	138	35	(3)	(3)
1991	606	136	470	273	11	187	147	40	(3)	(3)
1992	663	144	518	309	11	198	154	45	(3)	(3)
1993	682	140	542	323	12	207	163	45	(3)	(3)
1994	705	138	567	337	12	219	173	46	(3)	(3)
1995	739	135	604	355	14	234	187	48	(3)	(3)
					Percent Distribution					
1960	100.0	62.7	37.3	30.2	0.1	7.1	1.4	5.7	—	—
1970	100.0	42.2	57.8	35.2	0.1	22.5	16.3	6.2	12.2	4.8
1980	100.0	32.4	67.6	37.9	0.8	28.9	22.1	6.8	17.6	5.6
1985	100.0	29.1	70.9	39.9	1.6	29.3	23.4	5.9	19.7	4.2
1990	100.0	24.2	75.8	43.2	1.8	30.7	24.5	6.2	20.2	4.8
1991	100.0	22.4	77.6	45.0	1.7	30.9	24.2	6.6	19.3	5.8
1992	100.0	21.8	78.2	46.7	1.6	29.9	23.2	6.7	18.0	6.3
1993	100.0	20.6	79.4	47.3	1.7	30.4	23.8	6.6	18.3	6.9
1994	100.0	19.6	80.4	47.8	1.6	31.0	24.5	6.5	19.0	7.0
1995	100.0	18.3	81.7	48.1	1.9	31.7	25.3	6.5	19.8	7.1

[1]Subset of Federal funds.
[2]Subset of Federal and State and local funds.
[3]Calculation of per capita estimates is inappropriate.

NOTES: The figure 0.0 denotes less than $50 million for aggregate amounts, and 0 denotes less than $0.50 for per capita amounts. Per capita amounts based on July 1 Social Security area population estimates for each year, 1960-95. Numbers and percents may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 14
Nursing Home Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-95

Year	Total	Out-of-Pocket Payments	Third-Party Payments: Total	Private Health Insurance	Other Private Funds	Government: Total	Federal	State and Local	Medicare[1]	Medicaid[2]
					Amount in Billions					
1960	$0.8	$0.7	$0.2	$0.0	$0.1	$0.1	$0.1	$0.1	—	—
1970	4.2	2.3	2.0	0.0	0.2	1.7	1.0	0.7	$0.1	$0.9
1980	17.6	7.4	10.3	0.2	0.5	9.5	5.6	3.9	0.3	8.8
1985	30.7	13.6	17.1	0.8	0.6	15.7	9.2	6.5	0.4	14.5
1990	50.9	22.2	28.7	1.9	0.9	25.9	15.7	10.2	1.7	23.1
1991	57.2	23.4	33.8	2.1	1.1	30.7	18.4	12.3	2.0	27.5
1992	62.3	24.4	37.9	2.1	1.2	34.7	21.5	13.2	3.2	30.2
1993	67.0	25.1	42.0	2.2	1.2	38.5	24.7	13.9	4.6	32.4
1994	72.4	26.9	45.5	2.4	1.4	41.8	26.9	14.9	5.9	34.2
1995	77.9	28.6	49.3	2.5	1.5	45.3	29.3	16.0	7.3	36.2
					Per Capita Amount					
1960	$4	$3	$1	$0	$0	$1	$0	$0	—	—
1970	20	11	9	0	1	8	5	3	(3)	(3)
1980	75	31	44	1	2	41	24	17	(3)	(3)
1985	124	55	69	3	2	63	37	26	(3)	(3)
1990	196	86	110	7	4	100	60	39	(3)	(3)
1991	218	89	129	8	4	117	70	47	(3)	(3)
1992	235	92	143	8	4	131	81	50	(3)	(3)
1993	250	94	157	8	5	144	92	52	(3)	(3)
1994	268	99	168	9	5	155	99	55	(3)	(3)
1995	285	105	181	9	5	166	107	59	(3)	(3)
					Percent Distribution					
1960	100.0	77.9	22.1	0.0	6.3	15.7	7.9	7.8	—	—
1970	100.0	53.5	46.5	0.4	4.9	41.2	24.8	16.4	3.4	22.3
1980	100.0	41.8	58.2	1.2	3.0	54.0	31.8	22.2	1.7	50.0
1985	100.0	44.4	55.6	2.7	1.8	51.1	29.8	21.2	1.4	47.2
1990	100.0	43.6	56.4	3.7	1.9	50.8	30.8	20.0	3.3	45.4
1991	100.0	40.9	59.1	3.6	1.8	53.6	32.2	21.5	3.4	48.1
1992	100.0	39.1	60.9	3.4	1.9	55.7	34.5	21.2	5.1	48.5
1993	100.0	37.4	62.6	3.3	1.9	57.5	36.8	20.7	6.8	48.4
1994	100.0	37.1	62.9	3.3	1.9	57.7	37.1	20.6	8.2	47.2
1995	100.0	36.7	63.3	3.3	1.9	58.1	37.6	20.5	9.4	46.5

[1]Subset of Federal funds.
[2]Subset of Federal and State and local funds.
[3]Calculation of per capita estimates is inappropriate.

NOTES: The figure 0.0 denotes less than $50 million for aggregate amounts, and 0 denotes less than $0.50 for per capita amounts. Per capita amounts based on July 1 Social Security area population estimates for each year, 1960-95. Numbers and percents may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 15

Other Personal Health Care Expenditures[1] Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-95

			Third-Party Payments							
						Government				
Year	Total	Out-of-Pocket Payments	Total	Private Health Insurance	Other Private Funds	Total	Federal	State and Local	Medicare[2]	Medicaid[3]
					Amount in Billions					
1960	$8.2	$7.2	$1.0	$0.1	$0.2	$0.7	$0.4	$0.3	—	—
1970	18.0	14.4	3.6	0.9	0.5	2.2	1.2	1.0	$0.1	$0.8
1980	51.5	32.9	18.6	8.2	1.9	8.5	5.6	2.8	1.7	2.8
1985	93.9	53.8	40.1	20.8	3.9	15.4	10.1	5.3	4.2	5.3
1990	161.0	80.4	80.5	42.7	7.2	30.6	20.0	10.7	8.7	11.8
1991	178.0	84.8	93.2	47.6	8.0	37.6	25.0	12.6	11.4	15.2
1992	197.2	91.5	105.7	53.3	8.6	43.7	29.8	13.9	14.2	17.8
1993	213.9	97.1	116.8	56.2	9.5	51.2	35.6	15.5	17.2	21.9
1994	229.9	100.4	129.4	59.5	10.4	59.5	41.7	17.8	20.4	25.9
1995	249.2	105.7	143.5	64.1	10.8	68.5	48.0	20.5	24.0	30.6
					Per Capita Amount					
1960	$43	$38	$5	$1	$1	$4	$2	$1	—	—
1970	84	67	17	4	2	10	6	4	([4])	([4])
1980	219	140	79	35	8	36	24	12	([4])	([4])
1985	380	218	162	84	16	62	41	21	([4])	([4])
1990	619	309	310	164	28	118	77	41	([4])	([4])
1991	678	323	355	181	30	143	95	48	([4])	([4])
1992	743	345	398	201	33	165	112	52	([4])	([4])
1993	799	363	436	210	35	191	133	58	([4])	([4])
1994	850	371	479	220	38	220	154	66	([4])	([4])
1995	913	387	526	235	40	251	176	75	([4])	([4])
					Percent Distribution					
1960	100.0	87.4	12.6	1.5	3.0	8.1	4.8	3.4	—	—
1970	100.0	79.9	20.1	5.0	2.8	12.3	6.9	5.3	0.7	4.5
1980	100.0	63.9	36.1	16.0	3.6	16.5	11.0	5.5	3.2	5.5
1985	100.0	57.3	42.7	22.2	4.1	16.4	10.8	5.6	4.5	5.7
1990	100.0	50.0	50.0	26.5	4.5	19.0	12.4	6.6	5.4	7.3
1991	100.0	47.6	52.4	26.7	4.5	21.1	14.0	7.1	6.4	8.6
1992	100.0	46.4	53.6	27.0	4.4	22.2	15.1	7.1	7.2	9.0
1993	100.0	45.4	54.6	26.3	4.4	23.9	16.7	7.3	8.1	10.3
1994	100.0	43.7	56.3	25.9	4.5	25.9	18.1	7.8	8.9	11.2
1995	100.0	42.4	57.6	25.7	4.3	27.5	19.3	8.2	9.6	12.3

[1]Personal health care expenditures other than those for hospital care, physician services, and nursing home care.
[2]Subset of Federal funds.
[3]Subset of Federal and State and local funds.
[4]Calculation of per capita estimates is inappropriate.

NOTES: Per capita amounts based on July 1 Social Security area population estimates for each year, 1960-95. Numbers and percents may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 16

Personal Health Care Expenditures, by Type of Expenditure and Source of Funds: Selected Calendar Years 1991-95

Source of Funds	Total	Hospital Care	Physician Services	Dental Services	Other Profes-sional Services	Home Health Care	Drugs and Other Medical Non-Durables	Vision Products and Other Medical Durables	Nursing Home Care	Other Personal Health Care
					Amount in Billions					
1991										
Personal Health Care Expenditures	$676.6	$282.3	$159.2	$33.3	$38.3	$16.1	$65.6	$11.2	$57.2	$13.6
Out-of-Pocket Payments	155.0	11.2	35.7	16.2	14.6	4.3	42.7	6.9	23.4	—
Third-Party Payments	521.6	271.1	123.5	17.1	23.7	11.7	22.9	4.3	33.8	13.6
Private Health Insurance	221.6	100.4	71.6	15.9	13.0	2.5	15.2	0.9	2.1	—
Other Private	23.4	11.5	2.8	0.1	2.9	2.5	—	—	1.1	2.4
Government	276.6	159.2	49.1	1.1	7.7	6.7	7.6	3.4	30.7	11.1
Federal	205.8	123.8	38.5	0.6	5.2	5.5	3.7	3.2	18.4	6.7
Medicare	120.2	76.2	30.7	—	4.1	4.2	—	3.0	2.0	—
Medicaid	54.5	25.4	5.3	0.5	0.3	1.3	3.5	—	15.3	2.9
Other	31.0	22.2	2.5	0.1	0.8	—	0.1	0.2	1.2	3.9
State and Local	70.8	35.3	10.6	0.5	2.5	1.2	3.9	0.1	12.3	4.4
Medicaid	35.5	12.8	3.8	0.4	0.3	1.2	2.7	—	12.2	2.2
Other	35.2	22.6	6.7	0.1	2.2	0.0	1.3	0.1	0.0	2.2
1992										
Personal Health Care Expenditures	740.5	305.4	175.7	37.0	42.1	19.6	71.2	11.9	62.3	15.4
Out-of-Pocket Payments	165.8	11.7	38.2	18.2	16.0	5.0	45.0	7.3	24.4	—
Third-Party Payments	574.8	293.6	137.5	18.8	26.1	14.6	26.2	4.6	37.9	15.4
Private Health Insurance	243.2	105.7	82.1	17.3	14.2	2.9	18.0	0.9	2.1	—
Other Private	24.4	11.8	2.8	0.1	3.0	2.9	—	—	1.2	2.6
Government	307.1	176.1	52.6	1.3	8.9	8.8	8.2	3.7	34.7	12.7
Federal	233.5	141.5	40.8	0.8	6.2	7.4	4.1	3.6	21.5	7.8
Medicare	135.4	86.4	31.6	—	5.0	5.9	—	3.4	3.2	—
Medicaid	65.7	31.8	6.6	0.6	0.4	1.5	3.9	—	17.1	3.7
Other	32.4	23.2	2.5	0.1	0.9	—	0.2	0.2	1.3	4.1
State and Local	73.6	34.7	11.8	0.6	2.7	1.4	4.1	0.1	13.2	5.0
Medicaid	36.4	11.1	4.5	0.5	0.3	1.3	2.8	—	13.1	2.7
Other	37.1	23.5	7.3	0.1	2.4	0.0	1.3	0.1	0.1	2.3
1993										
Personal Health Care Expenditures	786.9	323.3	182.7	39.2	46.3	23.0	75.0	12.5	67.0	17.9
Out-of-Pocket Payments	171.6	11.9	37.5	19.1	18.2	5.6	46.8	7.5	25.1	—
Third-Party Payments	615.3	311.4	145.1	20.2	28.1	17.4	28.2	5.0	42.0	17.9
Private Health Insurance	255.4	110.5	86.5	18.3	14.8	3.1	19.1	0.9	2.2	—
Other Private	26.1	12.2	3.1	0.2	3.3	3.2	—	—	1.2	2.8
Government	333.9	188.6	55.6	1.7	10.0	11.1	9.2	4.1	38.5	15.0
Federal	255.9	152.0	43.5	1.0	7.2	9.5	4.7	4.0	24.7	9.2
Medicare	147.8	92.6	33.4	—	5.7	7.8	—	3.7	4.6	—
Medicaid	74.0	35.0	7.6	0.9	0.6	1.8	4.5	—	18.7	5.0
Other	34.1	24.4	2.6	0.1	0.9	—	0.2	0.3	1.4	4.2
State and Local	78.0	36.6	12.0	0.8	2.8	1.5	4.4	0.1	13.9	5.9
Medicaid	40.6	12.6	5.0	0.7	0.4	1.5	3.2	—	13.8	3.5
Other	37.4	24.0	7.0	0.1	2.4	0.1	1.3	0.1	0.1	2.4

See notes at end of table.

Table 16—Continued

Personal Health Care Expenditures, by Type of Expenditure and Source of Funds: Selected Calendar Years 1991-95

Source of Funds	Total	Hospital Care	Physician Services	Dental Services	Other Profes-sional Services	Home Health Care	Drugs and Other Medical Non-Durables	Vision Products and Other Medical Durables	Nursing Home Care	Other Personal Health Care
					Amount in Billions					
1994										
Personal Health Care Expenditures	$827.9	$335.0	$190.6	$42.1	$49.1	$26.3	$77.7	$12.9	$72.4	$21.7
Out-of-Pocket Payments	176.0	11.3	37.3	19.9	19.1	6.0	47.8	7.6	26.9	—
Third-Party Payments	651.9	323.7	153.3	22.2	30.1	20.3	29.9	5.3	45.5	21.7
Private Health Insurance	264.5	111.5	91.1	20.2	15.2	3.3	19.8	0.9	2.4	—
Other Private	26.2	11.3	3.1	0.2	3.7	3.4	—	—	1.4	3.1
Government	361.2	200.8	59.1	1.8	11.1	13.5	10.1	4.4	41.8	18.7
Federal	278.1	162.9	46.7	1.0	8.2	11.7	5.2	4.2	26.9	11.3
Medicare	164.4	101.9	36.2	—	6.7	9.8	—	3.9	5.9	—
Medicaid	78.3	36.2	8.0	0.9	0.6	1.9	4.9	—	19.4	6.4
Other	35.4	24.8	2.5	0.1	0.9	—	0.2	0.3	1.5	4.9
State and Local	83.1	37.9	12.5	0.8	2.9	1.7	4.9	0.1	14.9	7.3
Medicaid	45.1	13.7	5.5	0.7	0.5	1.6	3.6	—	14.8	4.7
Other	38.0	24.2	7.0	0.1	2.4	0.1	1.3	0.1	0.1	2.6
1995										
Personal Health Care Expenditures	878.8	350.1	201.6	45.8	52.6	28.6	83.4	13.8	477.9	25.0
Out-of-Pocket Payments	182.6	11.4	36.9	21.8	20.2	6.0	49.8	7.8	28.6	—
Third-Party Payments	696.2	338.7	164.8	24.0	32.4	22.6	33.6	6.0	49.3	25.0
Private Health Insurance	276.8	113.1	97.0	22.0	15.8	3.3	22.1	0.9	2.5	—
Other Private	27.3	11.3	3.7	0.2	3.9	3.4	—	—	1.5	3.3
Government	392.1	214.3	64.0	1.8	12.7	15.8	11.4	5.1	45.3	21.7
Federal	303.6	175.3	50.9	1.0	9.6	13.8	5.9	5.0	29.3	12.8
Medicare	184.0	112.6	40.0	—	7.8	11.6	—	4.6	7.3	—
Medicaid	83.1	37.2	8.4	0.9	0.8	2.2	5.6	—	20.3	7.8
Other	36.5	25.5	2.6	0.1	1.0	—	0.3	0.3	1.6	5.0
State and Local	88.5	39.0	13.1	0.8	3.1	2.0	5.6	0.1	16.0	8.9
Medicaid	50.0	14.8	5.9	0.7	0.6	1.9	4.2	—	15.9	6.0
Other	38.6	24.2	7.1	0.1	2.5	0.1	1.4	0.1	0.1	2.9

NOTES: The figure 0.0 denotes amounts less than $50 million. Medicaid expenditures exclude Part B premium payments to Medicare by States under buy-in agreements to cover premiums for eligible Medicaid recipients. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 17
Expenditures for Health Services and Supplies Under Public Programs, by Type of Expenditure and Program: Calendar Year 1995

Program Area	All Expenditures	Personal Health Care: Total	Hospital Care	Physician Services	Dental Services	Other Professional Services	Home Health Care	Drugs and Other Medical Non-Durables	Vision Products and Other Medical Durables	Nursing Home Care	Other	Administration	Public Health Activities
	Amount in Billions												
Public and Private Spending	$957.8	$878.8	$350.1	$201.6	$45.8	$52.6	$28.6	$83.4	$13.8	$77.9	$25.0	$47.7	$31.4
All Public Programs	436.7	392.1	214.3	64.0	1.8	12.7	15.8	11.4	5.1	45.3	21.7	13.2	31.4
Federal Funds	314.4	303.6	175.3	50.9	1.0	9.6	13.8	5.9	5.0	29.3	12.8	7.1	3.8
State and Local Funds	122.2	88.5	39.0	13.1	0.8	3.1	2.0	5.6	0.1	16.0	8.9	6.1	27.6
Medicare	187.0	184.0	112.6	40.0	—	7.8	11.6	—	4.6	7.3	—	3.0	—
Medicaid[1]	141.0	133.1	52.0	14.3	1.6	1.4	4.1	9.8	—	36.2	13.8	7.9	—
Federal	86.8	83.1	37.2	8.4	0.9	0.8	2.2	5.6	—	20.3	7.8	3.6	—
State and Local	54.2	50.0	14.8	5.9	0.7	0.6	1.9	4.2	—	15.9	6.0	4.2	—
Other State and Local Public Assistance Programs	5.4	5.4	3.1	0.4	0.1	0.3	0.1	1.0	0.0	0.1	0.4	—	—
Department of Veterans Affairs	15.6	15.5	12.9	0.1	0.0	—	—	0.0	0.3	1.6	0.6	0.1	—
Department of Defense[2]	13.5	13.3	10.5	1.6	0.0	—	—	0.2	—	—	0.9	0.2	—
Workers' Compensation	19.8	18.1	8.8	6.7	—	2.1	—	0.4	0.1	—	—	1.7	—
Federal	0.6	0.6	0.3	0.1	—	0.1	—	0.0	0.0	—	—	0.0	—
State and Local	19.2	17.5	8.5	6.6	—	2.0	—	0.4	0.1	—	—	1.7	—
State and Local Hospitals[3]	12.3	12.3	12.3	—	—	—	—	—	—	—	—	—	—
Other Public Programs for Personal Health Care[4]	10.6	10.4	2.1	0.9	0.1	1.0	—	0.0	0.1	—	6.1	0.3	—
Federal	7.2	7.1	1.7	0.7	0.1	0.9	—	0.0	0.1	—	3.6	0.1	—
State and Local	3.4	3.3	0.3	0.2	0.0	0.2	—	0.0	0.0	—	2.5	0.2	—
Government Public Health Activities	31.4	—	—	—	—	—	—	—	—	—	—	—	31.4
Federal	3.8	—	—	—	—	—	—	—	—	—	—	—	3.8
State and Local	27.6	—	—	—	—	—	—	—	—	—	—	—	27.6
Medicare and Medicaid	328.0	317.1	164.6	54.3	1.6	9.2	15.7	9.8	4.6	43.5	13.8	10.9	—

[1] Excludes funds paid into the Medicare trust funds by States under buy-in agreements to cover premiums for Medicaid recipients.
[2] Includes care for retirees and military dependents.
[3] Expenditures not offset by revenues.
[4] Includes program spending for maternal and child health; vocational rehabilitation medical payments; temporary disability insurance medical payments; Public Health Service and other Federal hospitals; Indian health services; alcoholism, drug abuse, and mental health; and school health.

NOTES: The figure 0.0 denotes amounts less than $50 million. Numbers may not add to total because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

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