National Health Expenditures, 1996

Katharine R. Levit, Helen C. Lazenby, Bradley R. Braden, Cathy A. Cowan, Arthur L. Sensenig, Patricia A. McDonnell, Jean M. Stiller, Darleen K. Won, Anne B. Martin, Lekha Sivarajan, Carolyn S. Donham, Anna M. Long, and Madie W. Stewart

The national health expenditures (NHE) series presented in this report for 1960-96 provides a view of the economic history of health care in the United States through spending for health care services and the sources financing that care. In 1996 NHE topped $1 trillion. At the same time, spending grew at the slowest rate, 4.4 percent, ever recorded in the current series. For the first time, this article presents estimates of Medicare managed care payments by type of service, as well as nursing home and home health spending in hospital-based facilities.

OVERVIEW

NHE in 1996 were marked by a slow growth rate, continuing the steady deceleration since 1990. The decade that began with double-digit expenditure growth saw those rates tumble each year. Over the past 4 years, these rates have been successively slower than at any time since 1960, the earliest year maintained in the current NHE series.

To produce these dramatic results, the Nation's health care system underwent fundamental, interrelated changes. Beginning in the late 1980s, employers, spurred by the desire to hold down health benefit costs for their workers, sought relief from rapidly rising insurance costs. Insurance companies responded with managed care products as alternatives to traditional fee-for-service (FFS) insurance. Many managed care products offered lower premiums through tighter control on costs and utilization, along with emphasis on preventive care. Excess system capacity allowed insurers to aggressively negotiate discounts with providers in exchange for guaranteed access to employer-insured groups. A renewed interest in effectiveness of treatment and technological developments, designed to reduce the health system's dependence on expensive inpatient hospital care, further reduced hospital utilization and exacerbated the problem of hospital excess capacity. In the past few years, the slowing of general price inflation and the even more dramatic decline in medical price inflation have contributed to the continued deceleration in health care costs.

In this article, we describe the changes occurring in several key sectors of the health care industry, focusing on the impact of these changes 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 7 and Tables 9-18 at the end of this article. Definitions can be found in the Technical Note of this article.

Highlights

NHE in 1996 reached $1.035 trillion, a modest increase of 4.4 percent from 1995 levels. On a per person basis, health spending rose $126, from $3,633 per person in 1995 to $3,759 in 1996.

The rate of growth in spending for the last 4 years was the slowest experienced

The authors are with the Health Care Financing Administration, Office of the Actuary, National Health Statistics Group. The opinions expressed herein are those of the authors and do not necessarily represent those of the Health Care Financing Administration.

since 1960 (Figure 1). The growth in NHE has continued to decelerate since 1990. In the history of tracking NHE, this was the first instance where growth in NHE decelerated for 6 consecutive years. This was also the first time in more than three decades that NHE growth was in the single digits for 6 successive years. These growth rates contrast sharply with the period 1980-90, when both private and public sectors averaged double-digit annual growth rates (11.3 and 10.5 percent, respectively). This period of high growth preceded the most recent call for health care reform.

Health care spending as a percent of gross domestic product (GDP) stabilized over the 1993-96 period at 13.6 percent, as health spending and GDP grew at roughly the same average annual rate. This is the first time in the 37-year history of the current NHE series that the share of GDP has been stable for more than 3 consecutive years.

The portion of NHE funded through government programs continued to increase in 1996, rising 0.8 percentage points to 46.7 percent. The public share has steadily increased for 7 consecutive years, from 40.4 percent in 1989 to 46.7 percent in 1996. This resulted from public sector health spending (up an average of 9.7 percent) growing at almost twice the rate of private sector spending (5.8 percent on average) over that period.

Factors Accounting for Growth

Personal health care expenditures (PHCE) grew 4.4 percent in 1996. This year's growth rate continued a trend of deceleration in PHCE and in many specific health service categories as well. To better understand the causes of this deceleration, PHCE growth can be separated into four factors—economywide inflation, medical-specific price inflation above and beyond economywide inflation (referred to as "excess medical inflation"), population change, and changes in the use and intensity of services.

In 1996 price increases accounted for more than one-half of PHCE growth: Economywide inflation drove 56 percent of health spending growth, while medical price inflation in excess of overall inflation accounted for only an additional 5 percent. Growth in intensity of services accounted for 19 percent and population growth for 21 percent (Figure 2). Excess medical price inflation steadily declined over the past few years, and in 1996 represented the smallest share since 1979.[1] Measurement of medical inflation in this analysis was substantially affected as a result of using newly released Producer Price Indexes (PPIs) to deflate selected categories of nominal PHCE (explained later in this section).

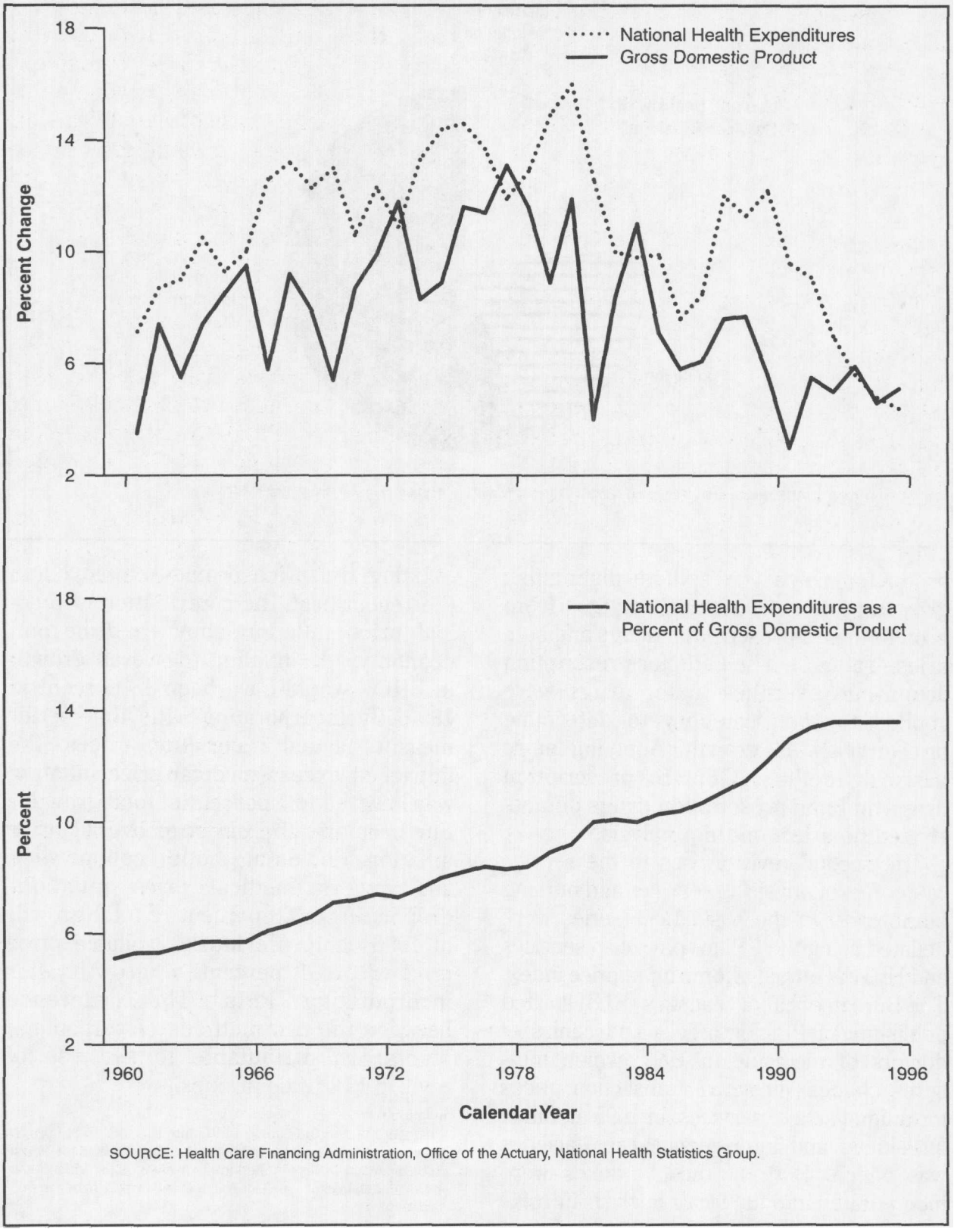
After adjusting for population, nominal PHCE per capita increased 3.5 percent in 1996. When economywide and excess medical price inflation of 2.6 percent were taken into account, real services purchased per person increased only 0.8 percent. This residual amount measures the change in intensity of service use per person, reflecting the quantity of services delivered, age/sex composition of the population, technological improvements that may allow for more efficient use of services, and the cumulation of any measurement errors in expenditures, inflation, or population.

Several revisions were added to the methodology for calculating factors accounting for health expenditure growth this year. The first revision affected the service category of non-durable medical

[1] As measured by the Consumer Price Indexes (CPIs), medical inflation increased at almost twice the rate of the all-items CPI in 1990 (9.1 and 5.4 percent, respectively); by 1996 the gap between the medical and all-items CPIs (3.5 percent and 2.9 percent, respectively) had narrowed considerably, and the overall level of price inflation was lower (Sensenig, Heffler, and Donham, 1997).

Figure 1

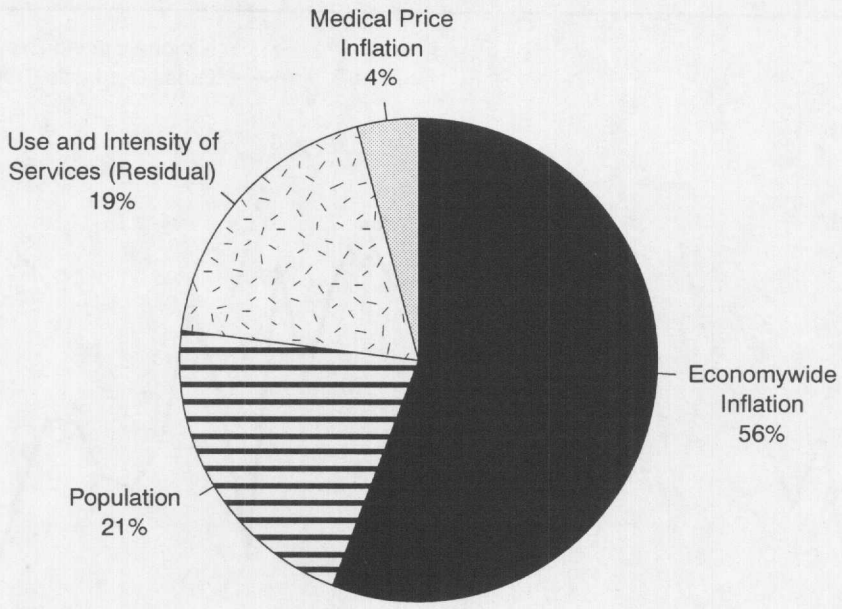
Percent Growth in National Health Expenditures and Gross Domestic Product, and National Health Expenditures as a Percent of Gross Domestic Product: Calendar Years 1960-96



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

Figure 2

Factors Accounting for Growth in Personal Health Care Expenditures: 1996



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

products, which was split to distinguish growth for prescription drugs from growth in non-prescription drugs and sundries (Table 1). The CPIs for prescription drugs and over-the-counter drugs were applied to each category to determine price impact on growth. Applying more narrowly defined CPIs to prescription drugs and non-prescription drugs demonstrated no effect on this analysis.

The second revision was to the service categories of physician services and nursing home care. In the past, these series were deflated using the CPI for physician services and HCFA's nursing home input price index. The Bureau of Labor Statistics (BLS) started publishing a PPI for offices and clinics of doctors of medicine in 1994, which measures changes in actual transaction prices for unique sets of services; in 1995 an index for skilled and intermediate care facilities was added. Both of these indexes were incorporated into the factor analysis in 1996.

Using the price proxies employed in the recent past, the contribution of medical price inflation above and beyond economywide inflation to overall growth in PHCE would have been 13 percent in 1996. By incorporating PPIs that better measure actual transaction prices, the impact of excess medical price inflation was lowered to 5 percent of total growth.[2] Furthermore, the effect of overall price inflation (including both economywide and excess medical price inflation) dropped from 68 percent of total growth in 1996 using previously available price proxies to 61 percent of growth after incorporating PPIs. The difference between the two methods (7 percentage points) is attributable to the use of revised PPI price proxies.

[2] Although the introduction of PPIs into this analysis improves the measurement of price inflation, the analysis is made worse off because of the very limited number of years for which it can be calculated, because measurement of medical PPIs began only recently.

Table 1

Price Indexes Used to Deflate National Health Accounts Personal Health Care Categories

Type of Expenditure	Price Index
Hospital Care	PPI-General Medical and Surgical Hospitals
Physician Services	PPI-Offices and Clinics of Doctors of Medicine
Dental Services	CPI-Dental Services
Other Professional Services and Home Health Care	CPI-Professional Medical Services
Non-Durable Medical Products	CPI-Medical Care Commodities
Prescription Drugs	CPI-Prescription Drugs
Non-Prescription Drugs	CPI-Internal and Respiratory Over-the-Counter Drugs
Vision Products and Other Medical Durables	CPI-Eye Care
Nursing Home Care	PPI-Skilled and Intermediate Care Facilities
Other Personal Health Care	CPI-Medical Care Services

NOTES: PPI is Producer Price Index. CPI is Consumer Price Index.

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

TYPE OF EXPENDITURES

Personal Health Care

Americans spent $907.2 billion for PHCE in 1996, an increase of 4.4 percent from 1995. All segments of PHCE decelerated in growth with the exception of non-durable medical products. In 1996 hospital and physician services were among the slowest growing segments of PHCE. Because hospital and physician services account for most of PHCE (61.8 percent), their slow growth affected the overall growth of health care expenditures. Non-durable medical products consist of over-the-counter medicines and medical sundries, and prescription drugs. In 1996 both components grew at faster rates than overall PHCE (4.7 percent and 9.2 percent, respectively).

Private health insurance (PHI) and public programs attempt to control health care costs by targeting those providers consuming the greatest expenditures—hospitals and physicians. Some of the most significant changes in health care are seen in these two providers. Hospitals and physicians were subjected to restrictions on payments by prospective payment systems and fee schedules, and to scrutiny by managed care organizations (MCOs) on the type and number of services provided. In response, hospitals devised ways to increase their revenues or improve their market position by expanding their lines of business, specializing, and merging with other hospitals; physicians are affiliating with larger practices and physician networks to increase their competitiveness. Even some of the smaller expenditure categories that have registered rapid growth in recent years (such as prescription drugs and home health care) are being examined closely by insurers for ways to restrain growth.

As a result, the distribution of PHCE has changed in recent years. The slow growth of expenditures for hospital and physician services caused these categories combined to drop almost 4 percentage points as a share of PHCE since 1990 (Table 2). Hospital expenditures as a share of PHCE went from 41.7 percent in 1990 to 39.5 percent in 1996; similarly, the share of PHCE for physician services declined from 23.8 percent in 1990 to 22.3 percent in 1996. Share declines in hospital and physician service expenditures were offset by increases in other services, particularly home health care and other personal health care (OPHC). Both of these service categories measure spending for alternative, lower cost services[3] that can substitute for more traditional physician and hospital services.

[3] Medicaid community-based waivers, the bulk of OPHC, direct care to lower cost alternative community- and home-based settings.

Table 2

Personal Health Care Services Percent Distribution: Calendar Years 1990-96

Type of Expenditure	1990	1991	1992	1993	1994	1995	1996
	Percent Distribution						
All Personal Health Care Services	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital Care	41.7	41.5	41.2	41.0	40.5	39.9	39.5
Physician Services	23.8	23.9	23.8	23.3	23.0	22.6	22.3
Dental Services	5.1	4.9	5.0	5.0	5.0	5.1	5.2
Other Professional Services	5.6	5.6	5.7	5.9	6.1	6.2	6.4
Home Health Care	2.1	2.4	2.6	2.9	3.1	3.3	3.3
Drugs and Other Medical Non-Durables	9.7	9.6	9.6	9.6	9.6	9.8	10.1
Vision Products and Other Medical Durables	1.7	1.6	1.6	1.6	1.5	1.5	1.5
Nursing Home Care	8.3	8.4	8.4	8.4	8.6	8.7	8.7
Other Personal Health Care	1.8	2.0	2.1	2.3	2.6	2.9	3.0

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

Hospital Services

Hospital care expenditures, 39.5 percent of PHCE, grew to $358.5 billion in 1996. The small 3.4-percent increase in spending halted a 5-year trend in which growth decelerated from 10.7 percent in 1990 to 3.3 percent in 1995. Community hospital expenditures are responsible for 89 percent of all hospital spending. Growth in expenditures for community hospital inpatient services[4] have also decelerated since 1990. In 1996 inpatient days declined 3.6 percent, the result of a decline (-0.4 percent) in admissions—the first decline in 3 years—and in length of stay (-0.2 days). Across the United States, hospital occupancy rates have fallen from 64.5 percent in 1990 to 58.7 percent in 1996, despite the 7-percent decrease in number of hospital beds during that period. Although also decelerating, continued strong growth in community hospital outpatient services has helped to offset decelerating growth in inpatient hospital expenditures. Hospitals succeeded in aggregate in reducing expense growth to rates approximately equal to revenue growth, thus maintaining their profit margins (American Hospital Association, 1996).

These statistics reflect the changing environment in which hospitals operate, as their traditional line of inpatient hospital services shrinks under pressure from insurers to reduce expensive inpatient hospital stays. To remain financially viable, hospitals have sought ways to improve their competitiveness, improve their negotiating positions with insurers, increase their risk-bearing ability, control a greater share of the market, and generate greater revenues. Hospitals continue to adapt to the managed care environment in a number of ways, characterized by: (1) increased merger and joint-venture activity, (2) specialization in profitable product lines, and (3) diversification into new lines of business.

Merging with existing multihospital organizations or developing collaborative agreements among facilities helps hospitals control expenses in the face of decelerating revenue growth. Increased size gives hospitals greater control over negotiating with insurers, contracting for the purchase of goods and services, and generating capital required for survival in this increasingly competitive market, while increasing hospitals' risk-bearing ability. Some observers raise concerns, however, that the merger phenomenon may be disadvantageous for consumers in markets dominated by large hospitals and may lead to reduced competition, higher prices, and/or reduced services (Alpha Center, 1997).

One type of specialized merger is the purchase of non-profit hospitals by for-profit

[4] Inpatient expenditures account for 68 percent of all community hospital revenues.

organizations. In some cases, a for-profit conversion is the only way to maintain hospital services in a community when its non-profit hospital, unable to meet expenses, faces closure. Communities worry, however, that other indirect benefits of non-profit facilities, such as charity care, research, physician education, public health functions, and accountability may shrink (Langley and Sharpe, 1996; Altman and Shactman, 1997).

Hospitals may also collaborate with other health providers to improve their competitiveness. To increase their ability to attract new customers, hospitals have joined with physicians and other hospitals to form physician-hospital organizations (PHOs), networks, health care systems, and joint ventures. These arrangements make it easier for hospitals to diversify their services, allowing them to offer comprehensive ranges of services to insurers and gain guaranteed access to patients.

Hospitals also have adapted to the new competitive hospital environment through specialization. By identifying high-profit services and developing efficient and effective treatment protocols for a narrow range of services, hospitals can effectively negotiate with insurers for a large share of specialized services. Cardiac care, cancer treatment, rehabilitation services, or women's health care are often identified as high-profit niches for hospital specialization. Facing competition from specialized hospitals, more traditional hospitals complain that revenues from their most profitable services erode while they must continue to provide less profitable services (such as trauma centers and neonatal intensive care units) and a larger proportion of care to uninsured patients (Myerson, 1997).

Finally, as the share of revenues from inpatient services declined, hospitals expanded their range of services, particularly into post acute care, where insurer payments were less restrictive. Expenditures for nursing home care and home health care services provided by hospital-based facilities, shown later in this article, have exhibited strong growth for the last 6 years. Hospital-based nursing home care and home health care expenditures accounted for 5 percent of all non-Federal hospital spending in 1996, up from just over 2 percent in 1990. This diversification of services allowed hospitals to capitalize on Medicare's payment regulations to maximize their revenues. For example, because Medicare compensation is based on a patient's diagnosis-related group (DRG), hospitals can increase profits by shortening inpatient stays and discharging the patient to a hospital-based skilled nursing facility (SNF), where the hospital can also receive cost-based payment for the patient's SNF care. A recent U.S. General Accounting Office (GAO) (1996) report found that "hospitals with SNF units saw larger decreases in the average patient length of stay than did hospitals without SNF units." The GAO also reported that the number of hospital-based SNFs increased more than 80 percent between 1980 and 1996, from 1,145 to 2,088 (U.S. General Accounting Office, 1997d).

Nursing Homes and Home Health Facilities

For the first time, estimates of expenditures for services provided to all patients by hospital-based nursing homes and home health facilities were developed and presented in this report to provide a more comprehensive picture of spending for nursing home and home health care than is available in these NHE service categories. Expenditures reported in the nursing home and home health care service components of the NHE measure free-

standing facility expenditures only. Expenditures for hospital-based facilities are included with hospital care in the NHE and are not readily identifiable. Information contained on cost reports submitted to the Health Care Financing Administration (HCFA) by hospitals, nursing homes, and home health agencies were used to develop these hospital-based expenditure estimates (Jing Xing Health and Safety Resources, Inc., 1997).

Spending for freestanding nursing home care amounted to $78.5 billion in 1996, implying an estimated cost of a 1-year stay in a freestanding nursing home in excess of $47,000. An additional $9.0 billion was spent for nursing home care provided in hospital-based facilities (Table 3). Growth in spending for nursing home care at all sites slowed from 7.1 percent in 1995 to 5.3 percent in 1996. The reason for this deceleration is, in part, a slowdown in the growth of nursing home input prices; i.e., the cost to facilities for providing services (Sensenig, Heffler, and Donham, 1997).

Expenditures for freestanding home health care reached $30.2 billion in 1996, and an additional $7.8 billion was spent for home health care provided by hospital-based home health agencies (Table 4). Annual spending growth for home health care delivered from all sites decelerated for the fourth consecutive year, from 23.4 percent in 1992 to 9.5 percent in 1996. Data from the Medicare program, the largest single payer for home health care, showed a dramatic slowdown in the growth of average number of visits per person served and persons served per 1,000 enrollees in 1996. Since 1993 Medicare has placed additional restraints on the growth in per visit payments (Sensenig, Heffler, Donham, 1997).

Annual expenditures for hospital-based nursing homes and home health care facilities grew more rapidly than their freestanding counterparts each year from 1990 through 1996. Although growth rates slowed in 1996, expenditures for care provided by these hospital-based facilities continued to increase faster than any of the national health expenditure service categories. For example, expenditures for hospital-based home health care grew 24.5 percent in 1996, compared with growth of 6.2 percent for freestanding facilities.

A growing number of hospitals are expanding their lines of business to include hospital-based nursing home and home health facility care (Jing Xing Health and Safety Resources, Inc., 1997; American Hospital Association, 1989-96). These facilities allow hospitals to provide a continuum of professional care to discharged patients not yet fully recovered from their illnesses. Moreover, such facilities enable hospitals to expand their revenue base in three ways: providing ready access to patients requiring these services (a competitive advantage in

Table 3
Total Expenditures for Nursing Home Care, by Type of Facility: Calendar Years 1990-96

Year	Total	Hospital-Based Nursing Home Facilities[1]	Freestanding Nursing Home Facilities[2]
		Amount in Billions	
1990	$54.7	$3.7	$50.9
1991	61.5	4.4	57.2
1992	67.4	5.1	62.3
1993	72.4	6.1	66.3
1994	77.6	6.7	70.9
1995	83.1	7.8	75.2
1996	87.5	9.0	78.5
		Annual Percent Growth	
1990	—	—	—
1991	12.6	17.0	12.2
1992	9.5	16.8	9.0
1993	7.4	18.7	6.5
1994	7.2	11.3	6.8
1995	7.1	16.4	6.2
1996	5.3	15.0	4.3
		Percent Distribution	
1990	100.0	6.8	93.2
1991	100.0	7.1	92.9
1992	100.0	7.6	92.4
1993	100.0	8.4	91.6
1994	100.0	8.7	91.3
1995	100.0	9.4	90.6
1996	100.0	10.3	89.7

[1] Included in the hospital spending category of the National Health Accounts (NHA).

[2] Estimated spending reported in the nursing home care category of the NHA.

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

Table 4

Total Expenditures for Home Health Care, by Type of Facility: Calendar Years 1990-96

Year	Total	Hospital-Based Home Health Facilities[1]	Freestanding Home Health Facilities[2]
		Amount in Billions	
1990	$14.8	$1.6	$13.1
1991	18.2	2.2	16.1
1992	22.5	2.9	19.6
1993	26.5	3.7	22.9
1994	30.5	4.8	25.6
1995	34.7	6.3	28.4
1996	38.0	7.8	30.2
		Annual Percent Growth	
1990	—	—	—
1991	23.4	31.9	22.4
1992	23.4	31.7	22.3
1993	18.0	28.2	16.5
1994	14.9	31.7	12.2
1995	13.9	29.8	10.9
1996	9.5	24.5	6.2
		Percent Distribution	
1990	100.0	11.1	88.9
1991	100.0	11.9	88.1
1992	100.0	12.7	87.3
1993	100.0	13.8	86.2
1994	100.0	15.8	84.2
1995	100.0	18.0	82.0
1996	100.0	20.5	79.5

[1] Included in the hospital spending category of the National Health Accounts (NHA).

[2] Estimated spending reported in the home health care category of the NHA.

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

attracting patients), attracting patients that are more likely to be covered by Medicare or PHI (both reimburse at higher rates than Medicaid), and maximizing Medicare payments (skilled nursing home services are reimbursed on a reasonable cost basis).

Medicare's share of funding for home health care has been increasing steadily since 1988. In 1996 almost one-half of spending for home health care (49.4 percent) delivered from all sites was funded by Medicare. Because of the sustained high growth rates, Medicare spending for home health care provided to Medicare beneficiaries has been under scrutiny by the U.S. Department of Health and Human Service's Office of the Inspector General (OIG). As a result of problems detected through OIG's and HCFA's fraud and abuse activities, President Clinton declared a moratorium on licensing and certification of all new home health agencies (HHAs), effective September 15, 1997, until stricter requirements for Medicare participation have been instituted (Goldstein, 1997).

Physician Services

Expenditures for physician services rose to $202.1 billion in 1996, up 2.9 percent from the previous year. Growth in expenditures for physician services has decelerated steadily since 1990 and has remained in the single digits since 1992. The slowdown in growth is in part the result of the expanding role of managed care and changes in physician practices.

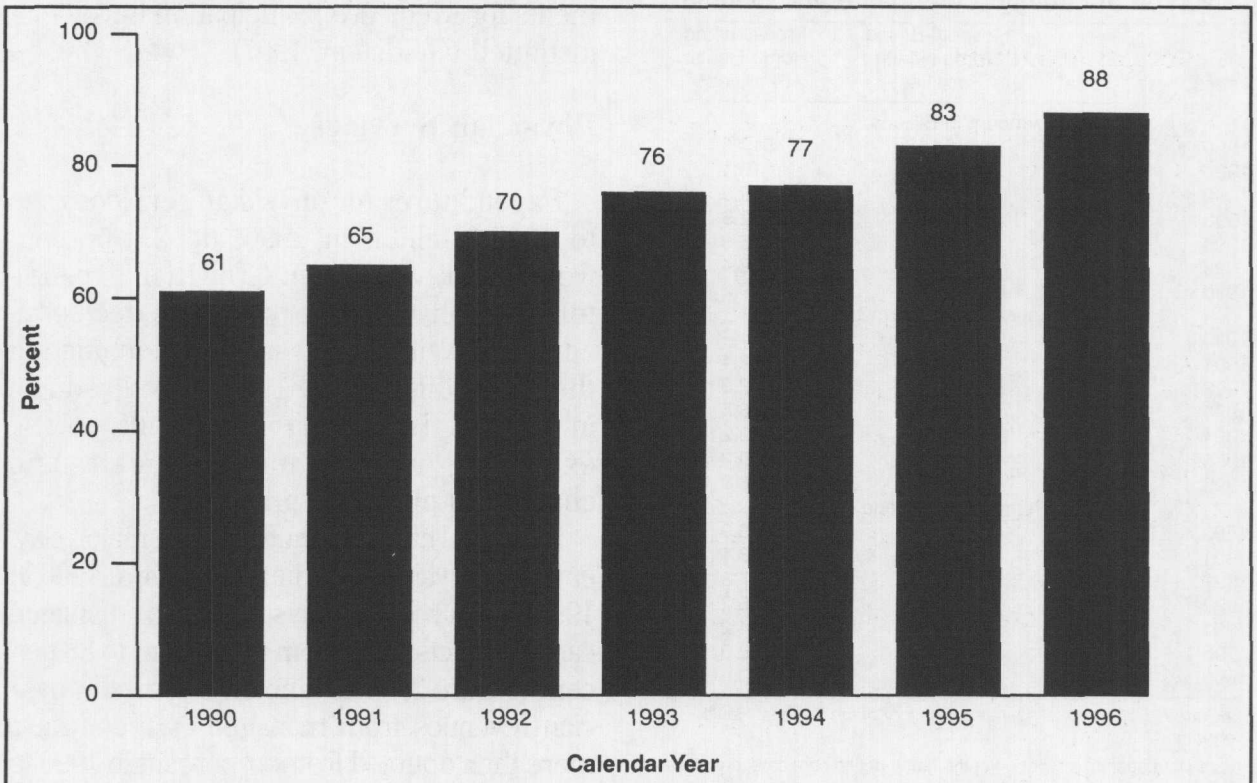
Managed care continued to be a major player in the physician marketplace. From 1990 to 1996, the percent of physicians with managed care contracts grew from 61 percent to 88 percent (Figure 3). The amount of overall physician revenues from managed care contracts more than doubled from 17 percent in 1990 to 39 percent in 1996 (Emmons and Wosniak, 1997). For roughly the same time period (1990-95), median physician net income grew at an average annual rate of 4.2 percent, a lower rate than the previous two 5-year periods (Moser, 1997).

In response to pressures in the physician marketplace, the composition of physician specialities changed. These changes were partly driven by managed care and the introduction of the Medicare payment system based on a resource-based relative value scale (RBRVS). Since 1985 the percent of office-based physicians with medical (including family practice) and hospital-based specialties grew, while those with surgical specialties declined (National Center for Health Statistics, 1997).[5]

[5] This trend could change as MCOs implement cost-containment measures that may limit the demand for primary care physicians in the future. MCOs are requiring higher physician productivity (seeing more patients per day), substituting non-physician health providers (such as nurse practitioners and physician assistants), and establishing nurse triage systems to reduce the need for primary care physician services (Terry, 1997).

Figure 3

Percent of Physicians with Managed Care Contracts: Calendar Years 1990-96



SOURCE: American Medical Association: *Socioeconomic Characteristics of Medical Practices*, 1992-97.

Physician practice characteristics also changed in recent years. The size of physician practices grew from an average of 10.6 physicians in 1990 to 14.5 in 1996 (Emmons and Kletke, 1997). The proportion of physicians in solo practices or self-employed in group practices declined (Moser, 1996), while the proportion of employee physicians grew from approximately 32 percent in 1990 to 42 percent in 1996 (Emmons and Kletke, 1997). The increased size of practices enables physicians to control costs by operating more efficiently, spreading risk, and meeting the demands of MCOs or employer contracts. In the future, this trend is expected to continue as changes in the Federal Trade Commission antitrust guidelines give more leeway for physician practices to merge and create networks to contract with health care purchasers (Kuttner, 1997).

The share of physician services funded by public sources increased from 29.7 percent in 1992 to 32.9 percent in 1996. Medicare expenditures, 21.1 percent of physician service expenditures, continued to grow at rates faster than overall physician services, despite decelerating in 1996. In recent years, Medicare implemented the Medicare Fee Schedule and Volume Performance Standards (VPS).[6] VPS is designed to reward or penalize physicians for changes in aggregate per capita utilization patterns. The reward or penalty is incorporated into the physician payment 2 years after the change in utilization pattern occurs. Because volume in 1994 grew faster than specified targets, there was a penalty incorporated into the 1996 payment rates, which accounts, in part, for the

[6] Medicare implemented the VPS in 1990 and the physician fee schedule based on the RBRVS in 1992.

deceleration in Medicare spending for physician services.

Prescription Drugs

Spending for non-durable medical products is the second-fastest-growing segment of PHCE, increasing 7.7 percent in 1966. The category of non-durable medical products consists of over-the-counter drugs and medical sundries, as well as prescription drugs. Americans purchased $62.2 billion in prescription drugs in retail outlets in 1996, an increase of 9.2 percent over 1995 (Table 5). Most third-party payers witnessed continued high expenditure growth over the past several years, rather than the decelerated growth seen in most other service sectors. For PHI and all public programs in aggregate, prescription drug expenditures increased 13.3 percent in 1996. At the same time, out-of-pocket payments continued to grow very slowly, at 1.9 percent.

Prescription drugs in 1996 continued the 3-year trend of increases in utilization (as measured by the number of prescriptions dispensed), overshadowing prices as the primary factor accounting for growth. According to several surveys, increases in utilization ranged from 4.3 to 5.8 percent in 1996, up from a historic average growth of about 2 percent (IMS America, 1996a; Schondelmeyer, 1997). Although price increases, measured by the CPI for prescription drugs at 3.4 percent, remained relatively small, they too showed an acceleration from the 1.9-percent increase observed a year earlier (U.S. Department of Labor, 1997).

Managed care and improved drug therapies are important sources of expenditure growth in prescription drugs. As evidence of this trend, insurance plans paid 34 percent more per member per month for pharmacy benefits between 1993 and 1996 (Ukens, 1997). The substitution of drugs

Table 5
Prescription Drug Expenditures and Average Annual Percent Growth: Selected Calendar Years 1960-96

Year	Levels in Billions	Average Annual Percent Growth from Previous Year Shown
1960	$2.7	—
1970	5.5	7.5
1980	12.0	8.2
1990	37.7	12.1
1991	42.1	11.9
1992	46.6	10.6
1993	50.0	7.2
1994	53.1	6.2
1995	57.0	7.4
1996	62.2	9.2

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

for other types of health care was especially evident in utilization increases in two categories of drugs: antidepressants (up 52 percent) and narcotic analgesics (up 13 percent) (Ukens, 1997). Antidepressant drugs substitute for more expensive psychotherapy and inpatient mental hospital stays. Narcotic analgesics are used in conjunction with surgery, enabling patients to avoid or shorten inpatient hospital stays. In addition, people discharged from the hospital with prescriptions for narcotic analgesics fill these prescriptions at local retail pharmacies (Vecchione, 1997); these expenditures are captured in the non-durable medical product category of NHE, rather than under NHE hospital expenditures as would have been the case had the patient received the drugs as part of an inpatient hospital stay.

The drug utilization incentives for physicians in managed care can act in opposing directions. On one hand, data on the number of pills per managed care prescription versus FFS prescription suggests physicians are keeping patients out of the office by increasing the number of pills per prescription (IMS America, 1996b). On the other hand, MCOs attempt to constrain pharmacy costs by holding physicians at risk for exceeding a pre-established drug

budget (Johannes, 1997). Increases in drug expenses were one of the biggest factors in the sluggish 1996 earnings reports of health maintenance organizations (HMOs). Drugs accounted for 10 percent of HMOs' medical budgets last year but 50 percent of their cost increases (Johannes, 1997).

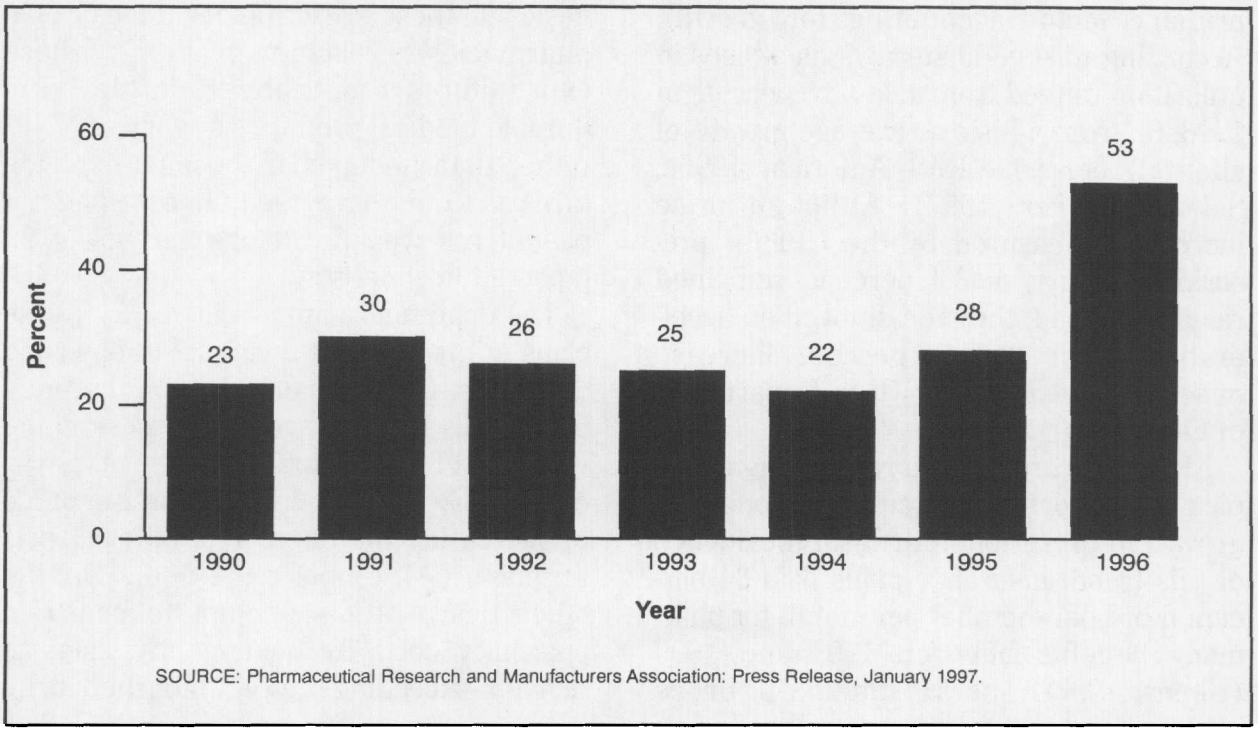
Another possible source for growth in this category may be direct-to-consumer advertisements (DTCA). Spending for DTCA doubled in 1996 from $0.3 billion to $0.6 billion and is expected to exceed $1 billion in 1997 (Ukens, 1997). The cost of advertising is a factor in price increases, adding to the growth of prescription drug expenditures. DTCA also places added pressure on physicians when advertisements encourage consumers to demand costly drugs (Vecchione, 1997).

Another source of price and utilization increase is the rise in the number of new drugs introduced during 1996. The Food and Drug Administration approved a record 53 new molecular entities in 1996 (Figure 4). New costlier drug therapies, such as two new protease inhibitors, a new class of drugs for asthma, a new treatment for multiple sclerosis, and a new schizophrenia medication, caused expenditures to rise. Net increases in product mix and the effect of new costlier therapies also added to prescription drug expenditure growth. In fact, the Federal Government credited the decrease in the number of new acquired immunodeficiency syndrome (AIDS) cases reported and a drop in AIDS-related death rates to new therapies such as the "AIDS cocktails," widely available for the first time in 1996 (Associated Press, 1997).

Whether or not this sort of growth can be sustained is questionable. Many drugs created during a pharmaceutical research boom in the 1970s and 1980s are approaching the end of their patents, resulting in a record number of profitable drugs coming off patent in a short period of time (Tanouye and Langreth, 1997). The num-

Figure 4

New Drugs Brought to Market: Years 1990-96



SOURCE: Pharmaceutical Research and Manufacturers Association: Press Release, January 1997.

ber of patent expirations may hold down pharmaceutical price increases and total expenditure growth for years to come.

SOURCES OF FUNDING

Health Services and Supplies

Of the $1.0036 trillion spent for health services and supplies (HSS) in 1996, $540.9 billion (53.9 percent) resulted from private sector expenditures, mostly through PHI (33.6 percent) and out-of-pocket spending (17.1 percent) (Table 6). Another $462.7 billion (46.1 percent) came from government expenditures. Medicare and Medicaid alone accounted for more than three-quarters of all public expenditures for health care.

Since 1990 the share of total HSS spending paid for by the Federal Government has grown steadily. Between 1990 and 1996, the Federal share rose from 27.5 to 33.5 percent, while the private share fell from 60.0 to 53.9 percent. State and local governments were responsible for 12.6 percent of health expenditures in 1996, approximately the same proportion that they paid in 1990. The shift in the shares of spending between Federal and private funds is primarily the result of a dramatic slowdown in the growth of private sources of funding, principally PHI and consumer out-of-pocket payments. Growth in Federal funding, driven mostly by increases in Medicare and Medicaid payments, also decelerated somewhat, but remained well above private growth levels during the 1990-96 period.

The effects of health system changes are evident in the contrast between private and public sector financing responsibilities (Figure 5). From 1960 to 1990, growth in spending by both the private and public sectors were 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. Although the number of people covered by Medicaid did increase rapidly between 1990 and 1994, the continued shift toward a larger public share since 1994 has not been driven, as it was in earlier periods, by public sector initiatives to add new populations or expand services. Public sector expenditure growth has continued at a slightly slower average annual rate since 1990 (9.4 percent) than it did between 1980 and 1990 (10.7 percent). However, average annual growth in private spending decelerated markedly between 1990 and 1996 to 4.9 percent, from the 13.1-percent average annual growth experienced during the 1980-90 period.

Private Health Insurance

In 1996 PHI premiums equaled $337.3 billion, up just 3.2 percent from 1995. This is the fourth consecutive year of decelerating growth and the sixth year of single-digit growth. The recent deceleration in premiums coincides with the dramatic shift by the health insurance marketplace away from traditional FFS indemnity insurance toward managed care.

The proportion of workers enrolled in managed care plans has skyrocketed in recent years, reaching virtually three-quarters of the enrolled workforce in 1995 (Jensen et al., 1997). As managed care plans have proliferated, price competition for market share has also increased. This competition greatly benefited employers, who found ways to exert additional pres-

Table 6
Health Services and Supplies Aggregate Expenditures, Percent Distribution, and Annual Percent Change, by Source of Funds: Calendar Years 1990-96

Source of Funds	1990	1991	1992	1993	1994	1995	1996
				Amount in Billions			
Health Services and Supplies	$675.0	$741.9	$809.1	$866.1	$915.2	$960.7	$1003.6
Private Funds	404.9	435.0	467.1	494.3	510.0	525.3	540.9
Out-of-Pocket Payments	144.4	151.6	159.5	163.6	164.8	166.7	171.2
Private Health Insurance	238.6	259.4	282.5	303.3	315.6	326.9	337.3
Other Private Funds	21.9	24.0	25.1	27.3	29.6	31.7	32.4
Public Funds	270.1	306.9	342.0	371.9	405.2	435.4	462.7
Federal Funds	185.5	215.1	245.2	267.6	291.0	314.7	336.6
Medicare	112.1	124.4	141.4	153.0	169.8	187.9	203.1
Medicaid (Federal)	42.7	56.8	68.0	76.8	81.5	86.3	91.8
Other	30.6	34.0	35.8	37.7	39.6	40.5	41.7
State and Local Funds	84.6	91.7	96.8	104.3	114.2	120.6	126.1
Workers' Compensation	15.6	16.6	18.4	17.9	18.0	17.6	16.7
Medicaid (State and Local)	32.7	37.1	38.4	43.7	49.5	53.9	55.9
Public Health Activity	17.2	18.7	20.4	22.0	24.7	27.7	31.6
Other	19.1	19.2	19.7	20.6	22.1	21.5	22.0
				Percent Distribution			
Health Services and Supplies	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private Funds	60.0	58.6	57.7	57.1	55.7	54.7	53.9
Out-of-Pocket Payments	21.4	20.4	19.7	18.9	18.0	17.4	17.1
Private Health Insurance	35.4	35.0	34.9	35.0	34.5	34.0	33.6
Other Private Funds	3.2	3.2	3.1	3.2	3.2	3.3	3.2
Public Funds	40.0	41.4	42.3	42.9	44.3	45.3	46.1
Federal Funds	27.5	29.0	30.3	30.9	31.8	32.8	33.5
Medicare	16.6	16.8	17.5	17.7	18.6	19.6	20.2
Medicaid (Federal)	6.3	7.7	8.4	8.9	8.9	9.0	9.1
Other	4.5	4.6	4.4	4.4	4.3	4.2	4.2
State and Local Funds	12.5	12.4	12.0	12.0	12.5	12.6	12.6
Workers' Compensation	2.3	2.2	2.3	2.1	2.0	1.8	1.7
Medicaid (State and Local)	4.8	5.0	4.7	5.0	5.4	5.6	5.6
Public Health Activity	2.6	2.5	2.5	2.5	2.7	2.9	3.1
Other	2.8	2.6	2.4	2.4	2.4	2.2	2.2
				Annual Percent Change			
Health Services and Supplies	12.3	9.9	9.1	7.1	5.7	5.0	4.5
Private Funds	11.7	7.4	7.4	5.8	3.2	3.0	3.0
Out-of-Pocket Payments	8.4	5.0	5.2	2.6	0.8	1.1	2.7
Private Health Insurance	14.5	8.7	8.9	7.4	4.0	3.6	3.2
Other Private Funds	5.7	9.7	4.6	8.9	8.2	7.3	2.0
Public Funds	13.0	13.6	11.4	8.7	9.0	7.4	6.3
Federal Funds	12.3	16.0	14.0	9.1	8.7	8.2	6.9
Medicare	9.5	10.9	13.7	8.2	11.0	10.6	8.1
Medicaid (Federal)	20.5	33.1	19.7	13.0	6.0	6.0	6.3
Other	41.2	33.5	18.1	16.0	16.0	6.6	7.7
State and Local Funds	14.6	8.4	5.5	7.7	9.5	5.6	4.5
Workers' Compensation	12.5	6.7	10.7	-2.5	0.2	-2.3	-5.0
Medicaid (State and Local)	21.9	13.6	3.3	13.9	13.1	8.9	3.8
Public Health Activity	8.3	8.6	8.8	8.2	12.1	12.3	13.8
Other	10.7	0.8	2.1	4.6	7.3	-2.7	2.3

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

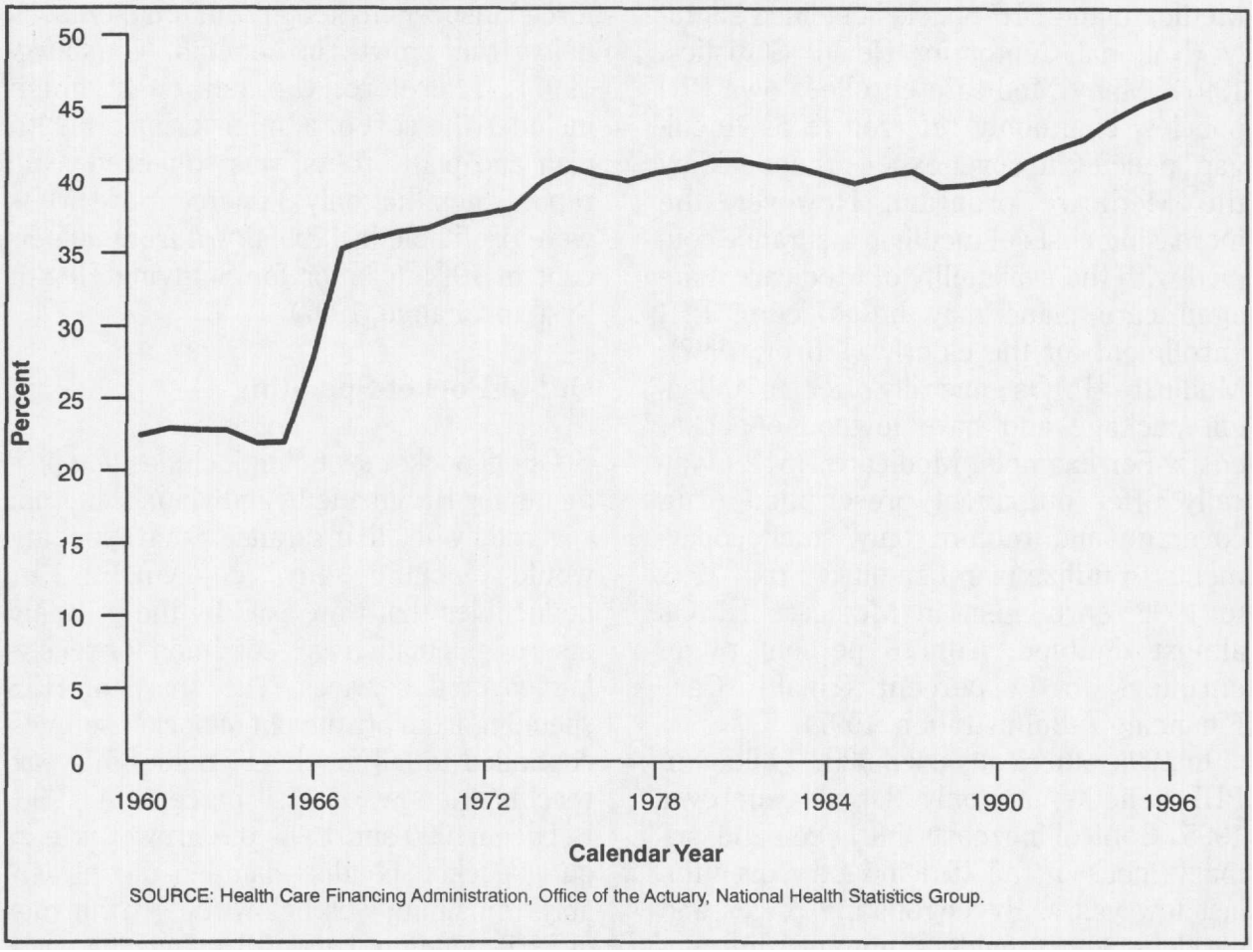
sure on insurers to limit plan price increases, including analyzing and negotiating premiums, forming purchasing coalitions, and limiting the number of insurers with which they contract (U.S. General Accounting Office, 1997b), as well as shopping for lower premiums.

In addition to efforts to control health care prices, aggregate spending on PHI premiums is affected by trends in enrollment. During the 1990s, the total number of persons with PHI appears to have leveled off,[7] which can be partly attributed to the concentration of job growth in the service sector, where workers are less likely to be offered health insurance (KPMG Peat Marwick, 1992-96). Other factors include employers discontinuing insurance coverages, or employees dropping

[7] Data from the Current Population Survey (CPS) and the National Heath Interview Survey (NHIS) indicate a modest decline in PHI enrollment from the late-1980s to the mid-1990s, followed by a slight increase in the most recent counts. However, both the CPS and NHIS made changes to their survey questionnaires (NHIS in 1993 and CPS in 1995) that make comparisons with data from earlier years difficult to interpret.

Figure 5

Public Share of Health Services and Supplies: Calendar Years 1960-96



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

their employer-sponsored coverage because of increased employee costs and changes in benefits (U.S. General Accounting Office, 1997a).

Over the last few years, employers shifted more of the health insurance cost burden to their employees by requiring employees to pay an increasing share of the premium, particularly for dependent coverage. Between 1988 and 1993, the average employee contribution rose 64 percent for single coverage and 79 percent for family coverage (U.S. Bureau of Labor Statistics, 1994). In addition, changes to employee benefit packages may have discouraged enrollment. These changes included the introduction of flexible benefit plans, as well as basing premium rates for family health policies on family size (U.S. General Accounting Office, 1997a). Flexible benefit plans, or accounts, allow employees to allocate a fixed level of employer dollars or credits to a diverse menu of benefits such as child care, life insurance, health insurance, retirement savings accounts, vacation days, or cash payments, based on their personal needs. Thus, these plans can create an incentive for healthier workers to forgo health insurance altogether or simply to eliminate more expensive dependent health coverage. Similarly, linking the required employee premium for health insurance to family size increases the costs to employees with large families and may discourage dependent coverage.

From 1993 to 1995, the number of persons over age 65 covered by both Medicare and PHI policies declined slightly (National Center for Health Statistics, 1997). Many Medicare enrollees own PHI policies, commonly referred to as "medigap" policies, to cover expenses not paid by the Medicare program. However, the increasing costs of medigap insurance coupled with the availability of Medicare managed care plans may be affecting PHI enrollment for the elderly (Jeffrey, 1997). Medicare HMOs generally offer a rich benefit package and have low out-of-pocket costs. For example, Medicare HMOs typically offer outpatient prescription drug coverage and require only small copayments to utilize plan benefits.[8] From 1992 to 1996, enrollment in Medicare HMOs almost doubled, from 6 percent of all enrollees to 11 percent (Health Care Financing Administration, 1997).

In 1996 Americans used $292.3 billion in PHI benefits, up only 3.4 percent over 1995. Controlling costs has been the primary focus of the PHI industry over the last few years. By negotiating prices and services with providers, emphasizing outpatient services rather than inpatient hospital care, providing more preventive services to enrollees, and utilizing less expensive treatment options to help patients avoid surgery and other more costly medical care procedures (Tanouye, 1997), the insurance industry has been able to slow down benefit cost growth.

Net cost of insurance (the difference between premiums earned and benefits incurred) was $45 billion in 1996. Since 1993 growth in benefits incurred has outpaced the increase in premiums earned. Competition for market share and the willingness of both employers and individuals to switch health plans to save money has forced insurers to keep premium increases below the growth in benefits (Ginsburg, 1997). Therefore, the net cost, which includes the cost of administering a health plan and plan profits, was squeezed. One report cites that only 35 percent of HMOs were profitable in 1996, down from 90 percent in 1994 (Center for Studying Health System Change, 1997).

[8] Fu Associates, Ltd. (1997), conducted a study of 1992-96 HMO cost accounting forms submitted to HCFA. The study showed that many HMOs waive coinsurance amounts and offer additional benefits at low or no additional cost to enrollees.

Out-of-Pocket Spending

Out-of-pocket spending includes any payments for HSS made by individuals and not covered by health insurance. Such spending would include any copayments or deductibles that were paid by the privately insured population as a condition for receiving covered services. The share of HSS spending from private out-of-pocket sources continued to fall for the 11th straight year, reaching a low of 17.1 percent in 1996. Between 1990 and 1996, the growth rate in out-of-pocket spending dampened considerably, remaining well below the growth rate of PHI spending. Part of the slowdown was the result of low medical price inflation. Medical care price growth, as measured by the CPI, decelerated to 3.5 percent in 1996, the result of slower price growth across health care sectors and payers (Sensenig, Heffler, and Donham, 1997).

Another factor influencing out-of-pocket spending was slow growth in the aggregate copayments and deductibles required by third-party payers (KPMG Peat Marwick, 1992-96), which failed to keep pace with third-party payments. As more privately insured persons moved from traditional FFS to managed care plans, they faced flat out-of-pocket charges per visit or copayment rates that were frequently smaller than a percentage copayment required by traditional insurance plans.

Paradoxically, HMO plans, which have traditionally minimized enrollee out-of-pocket payments, recorded the largest increases of any plan type in cost-sharing in 1996. The percentage of employer-sponsored HMO plans with no copayment decreased from 15 percent in 1995 to 10 percent in 1996, while the percentage of HMOs requiring $5 copayments increased from 18 percent in 1995 to 22 percent in 1996 (KPMG Peat Marwick, 1996). For managed care plans requiring deductibles, notable changes were found only in preferred provider organization (PPO) plans, where deductibles rose for both in-network and non-network physicians (KPMG Peat Marwick, 1996).

Medicare

The Medicare program is the largest public payer for health care services and supplies. In calendar year 1996, Medicare's Hospital Insurance and Supplementary Medical Insurance programs financed $203.1 billion of spending for the health care of its 38.1 million aged and disabled enrollees.

Annual growth in Medicare spending slowed from 10.6 percent in 1995 to 8.1 percent in 1996. This deceleration reflects, in part, slowing medical prices, legislated limits that restrain the growth in Medicare payments to providers, penalties in the form of stricter limits on the growth in physician fees imposed on physicians for exceeding the Medicare volume performance standards in 1994 (as discussed previously), provider reaction to OIG fraud and abuse detection activities, and decelerating growth in the population eligible for enrollment in Medicare.[9]

Medicare payments to managed care plans increased from 4.8 percent of total Medicare expenditures in 1990 to 10.1 percent in 1996 (Figure 6). As this proportion grew, using the managed care methodology of distributing capitation payments based on FFS information led to greater distortions in overall Medicare expenditures by service. A new NHE methodology was developed for estimating the distribution of Medicare capitation payments to the services based on Adjusted Community Rating (ACR) forms submitted to HCFA.

As a result of this methodological change, the portion of Medicare spending allocated to hospital care decreased 2.7 percentage points, while the physician share increased 0.5 percentage points, and expenses for administration and the net cost of insurance increased 1.0 percentage points. For the first time, this report presents Medicare spending for dental services and for drugs and other medical non-durables.

The most notable differences in the 1996 distributions of FFS expenditures and capitated payments were in spending for physician services and for hospital care. Physician services consumed 38.4 percent of capitated payments and only 19.0 percent of FFS expenditures. Conversely, hospital care consumed 41.8 percent of capitated payments, compared with 60.1 percent of FFS expenditures. Administration (and the net cost of insurance) accounted for 9.1 percent of capitated payments but only 1.9 percent of Medicare FFS spending. In addition, 3.5 percent of capitated payments were for prescription drugs, a service not widely covered by the Medicare FFS program (Table 7).

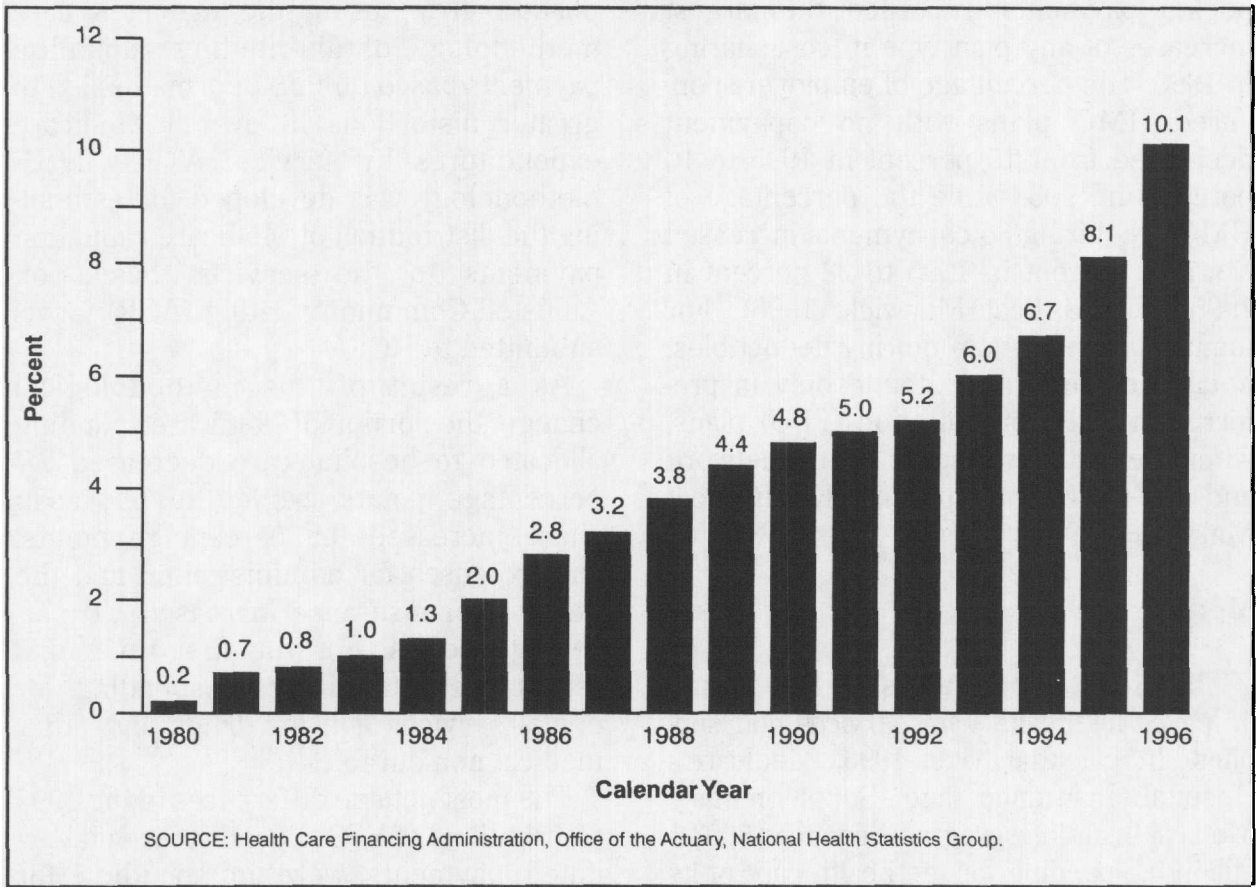
Medicaid

Combined Federal and State Medicaid spending accounted for 14.7 percent of total HSS in 1996 and largely funded insti-

[9] Since 1986 growth in the population age 65 and over has been decelerating. Annual growth in 1996 slowed by one-tenth of a percentage point over 1995. However, that trend is expected to reverse itself by the year 2002.

Figure 6

Capitated Payment Share of Total Medicare Expenditures: Calendar Years 1980-96



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

tutional services. In 1996 hospital care and nursing home care accounted for 61.2 percent (35.8 percent and 25.4 percent, respectively) of the $147.7 billion in combined Federal and State Medicaid spending for HSS. Medicaid is the largest third-party payer of long-term care, financing 47.8 percent of nursing home care in 1996. In fiscal year 1996, there were 36.1 million persons who received some type of Medicaid. Nearly one-half of all Medicaid recipients were children covered under Aid to Families with Dependent Children (AFDC) (16.7 million).

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 their programs within the constraints of the State budgetary process. One way States employ this flexibility in Medicaid program design 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 (section 1915 (c) of the Social Security Act) allow States to place Medicaid-eligible persons into alternative, non-institutional settings for certain types of medical and personal care. Freedom of choice waivers, authorized under section 1915 (b) of the Social

Table 7

Medicare Expenditures and Service Distributions, Calculated Using Old and New Methods: 1996

Type of Expenditure	Old Method[1] Total	New Method[2] Fee-For-Service Plus Capitated Payments	New Method[2] Fee-for-Service	New Method[2] Capitated Payments
		Amount in Millions		
Health Services and Supplies	$203,127	$203,127	$182,526	$20,601
		Percent Distribution		
Health Services and Supplies	100.0	100.0	100.0	100.0
Personal Health Care	98.4	97.4	98.1	90.9
Hospital Care	60.9	58.2	60.1	41.8
Physician Services	20.5	21.0	19.0	38.4
Dental Services	—	0.0	—	0.3
Other Professional Services	4.1	4.1	4.5	0.5
Home Health Care	6.4	6.7	7.3	1.6
Drugs and Other Medical Non-Durables	—	0.4	—	3.5
Vision Products and Other Medical Durables	2.4	2.6	2.6	2.2
Nursing Home Care	4.1	4.4	4.6	2.5
Program Administration and Net Cost of Insurance	1.6	2.6	1.9	9.1

[1] Distribution based on fiscal year expenditures.
[2] Distribution based on calendar year expenditures.

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

Security Act, allow States to place Medicaid beneficiaries into a mandatory managed care plan (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.[10]

During most of the 1980s, the combined share of HSS financed by Federal and State Medicaid expenditures remained fairly steady, accounting for approximately 10 percent of the total. However, beginning in 1990, the Medicaid share of HSS began to grow rapidly, increasing by 3.5 percentage points in just 4 years, to 13.9 percent in 1993. By contrast, over the last 3 years, the pace of growth decelerated considerably, with the Medicaid share increasing just under 1 percentage point, to 14.7 percent in 1996.

Remarkably, between 1989 and 1993, Medicaid spending was growing at an average annual rate of 18.0 percent. Since 1993 Medicaid spending has risen at an average annual rate of just 7.0 percent. The reasons for the rapid acceleration in the early 1990s are: (1) the rapid escalation of disproportionate share hospital (DSH) payments, (2) increases in the cost of providing services to beneficiaries (the prices paid for services and the average cost per beneficiary), and (3) the growing number of program beneficiaries (U.S. General Accounting Office, 1997c).

The 1996 growth in Medicaid spending was 5.3 percent, the lowest annual growth since the inception of the program. The slow growth rate of total Medicaid spending mirrored the overall slow growth in health care spending nationwide in 1996. Several factors accounting for the slow 1996 growth in Medicaid spending are attributable to the generally favorable economic conditions that prevailed in 1996. Low unemployment rates reduced the number of people receiving welfare and consequently the number of Medicaid-eligible persons in many States. Similarly, historically low rates of medical price inflation held down increases in the cost

[10] These projects may be statewide programs or they may target specific populations. In some cases, not all categories of Medicaid-eligible persons are covered under the waiver request. In other cases, program savings may be used to expand coverage to previously non-covered populations.

of medical goods and services, which in turn dampened the growth in nominal spending per enrollee.

The Federal share of Medicaid spending grew very slowly in 1996, masking considerable variation in the growth rate of Medicaid spending among the States. In fiscal year 1996, growth rates among States varied from an increase of 25 percent to a decrease of 16 percent. States often have large changes in spending growth from year to year because of major program changes or accounting variances that change the fiscal year in which a portion of the expenditure is reported (U.S. General Accounting Office, 1997c).

Viewed in this context, the slowdown in State Medicaid spending can be attributed primarily to three factors that affected different States' expenditures in distinct ways. These factors are not common to all States and cannot necessarily be expected to recur. First, decreases in DSH funding as a result of program caps enacted by Congress in 1991 and 1993[11] slowed spending in some States. Second, slowdowns in State-initiated eligibility expansions substantially lowered the growth in Medicaid spending in several States. For example, although Hawaii, Oregon, and Tennessee implemented eligibility expansions in 1994, the increased expenditures associated with these expansions had leveled off by 1996. Finally, because Congress was considering legislation that would have established aggregate spending levels based on 1995 expenditures (as part of the block grant proposal), a few States accelerated payments into fiscal year 1995 that would ordinarily have occurred in 1996. These accelerated payments in effect shifted payments to 1995 and therefore lowered the rate of growth in 1996.

[11] These caps limited a State's DSH program payments to a national target level of 12 percent of total Medicaid expenditures, excluding administrative costs. When a State's DSH payments exceeded this target, they were frozen until they equaled 12 percent or less of the State's medical assistance payments.

METHODOLOGICAL REVISIONS

This section contains information on revisions in methodology and data sources introduced in expenditure estimates presented in this article. Detailed information on data sources and methods can be found in previously published articles (Lazenby et al., 1992; Levit et al., 1994; Levit et al., 1996).

Medicare Revisions

The methodology for allocating Medicare spending to service categories has been revised to more accurately represent services funded by Medicare for beneficiaries enrolled in Medicare managed care plans. All Medicare enrollees receive coverage for a standard package of benefits. Medicare managed care enrollees may be covered for a wide variety of additional services such as routine physicals, preventive care, and prescription drugs. Medicare managed care funding was categorized in previous NHE estimates based on provider billings for FFS enrollees. The revised methodology provides separate service allocations for Medicare FFS and capitated payment expenditures (Table 7).

Before this project, financial information available from HCFA's Office of Managed Care reported total Medicare payments to managed care plans and separate amounts for services covered by the Hospital Insurance (Part A) and the Supplementary Medical Insurance (Part B) parts of the program. In 1996, 55 percent of the $20.6 billion Medicare paid to managed care plans covered Part A services, and the residual 45 percent covered Part B services. All of the Part A share was classified as hospital care in the national health accounts, and the Part B share was split, with three-quarters going to physician services and one-quarter to hospital care.

The revised methodology allocates Medicare managed care payments to both services and administrative expenses in the NHE estimates. These estimates represent a portion of expenditures funded by Medicare through capitation payments to managed care plans for Medicare beneficiaries who choose to enroll in managed care. Comprehensive statistics on specific services used by managed care enrollees are not reported to HCFA. Therefore, the service distribution of Medicare capitated payments was estimated from ACR forms submitted to HCFA annually by risk-type managed care plans. These forms are submitted for approval of the monthly premiums that the plan intends to charge and the services it intends to deliver to Medicare enrollees for the upcoming year.

Medicaid Revisions

Unlike Medicare, Medicaid has no national data sources useful for estimating Medicaid-purchased PHI service distributions. PHI payments continue to be allocated to services based on FFS Medicaid. Revisions incorporated this year include refinements to this FFS methodology.

The first refinement is in the estimation of the administrative portion of Medicaid PHI payments. Administrative costs were estimated by multiplying Medicaid capitation and insurance premium payments by cost-to-premium ratios calculated from PHI industry data. The resulting administrative costs were then removed from estimates of Medicaid insurance payments and added to estimates of Medicaid administration, prior to distribution to services.

The second refinement respecified the services to which Medicaid PHI[12] payments, coinsurance, and deductibles would be allocated. These refinements more accurately identified services likely to be purchased by Medicaid managed care and PHI.

Census Revisions

Expenditure estimates for nursing home care and each of the professional service components of personal health care (physician services, dental services, other professional services, and home health services) were revised to incorporate changes resulting from more recent information received from the Census Bureau. Estimates of spending for these service categories are based on business receipts of service establishments collected in the Census Bureau's quinquennial Census of Service Industries. Establishments are classified by industry according to the 1987 Standard Industrial Classification Manual (SIC) (Executive Office of the President, 1987). The most recent data available from the 5-year census are for calendar year 1992.

Information from the Census Bureau's Services Annual Survey (SAS) supplement data from the quinquennial census. The SAS provides estimates of year-to-year change in business receipts of firms by SIC classification. Annually, the SAS surveys a sample of service businesses. Every 5 years the sampling frame is changed to reflect the industry composition of each SIC component from the most recent quinquennial census. The sampling frame was revised in 1996 to reflect SIC industry compositions determined from the 1992 quinquennial census. Preliminary results from the 1996 survey altered growth rates obtained from earlier SAS surveys. To reflect these changes, the NHE estimates for 1993-95 were revised. A discussion of the SAS sample design and the sampling frame are presented in the 1996 Services Annual Survey (U.S. Bureau of the Census, to be published).

[12] Includes amounts paid by Medicaid to cover the employee share of health insurance premiums for employer-sponsored health insurance and capitated payments to managed care plans.

CONCLUSION

In 1996 NHE growth hit record lows. The effects of managed care and public program incentives, excess health system capacity, and general economic conditions, including low general and medical price inflation, were largely responsible for these dramatic, slow-growth results. Three-quarters of the employer-sponsored health plan participants and an increasing portion of public program beneficiaries and recipients participated in some form of managed care. The combination of MCOs' large market share and a marketplace experiencing excess capacity permitted extensive price discounting by insurers with providers. These discounts were reflected in recent low medical price growths.

Higher-than-expected benefit costs have been reported by managed care plans thus far in 1997, shrinking managed care profits and, in some instances, drawing on capital reserves. This will force insurers to reassess premium levels in the next few years. In one of the first indicators of this possible shift in trend, the Federal Government recently announced average health premium increases of 8.5 percent for 1998 for the Nation's largest employer-sponsored health plan, the Federal Employees Health Benefits program (Barr, 1997). This suggests that similar changes may be pending for other employer plans.

The health care system has undergone important changes during the 1990s. These changes continue to evolve, as managed care plans respond to shrinking profits and as the effects on Medicare of the Balanced Budget Act of 1997 unfold over the next few years. Although expenditure growth for 1997 appears headed for the same low growth rate observed for 1996, emerging indicators suggest that health insurance premiums will rise in 1998. The NHE will continue to track the changing patterns of services and financing as they develop in future years.

TECHNICAL NOTE: NHE DEFINITIONS

The following list is a quick reference to definitions of some of the type-of-service and source-of-funds categories used with the NHE. Table 8 contains information from the Standard Industrial Classification (SIC) Manual for health care that is used in these definitions.

Dental Services: Covers services provided by a doctor of dental medicine (D.M.D.) or doctor of dental surgery (D.D.S.) in establishments falling into SIC 802-Offices and clinics of dentists.

Durable Medical Equipment: Includes the retail sales of items such as eyeglasses, hearing aids, surgical appliances and supplies, bulk and cylinder oxygen, and equipment rental.

Home Health Care Services: Covers medical services delivered in the home by private and public non-facility-based home health agencies, including establishments falling into SIC 808-Home Health Agencies. Excluded are medical equipment sales or rentals not billed through HHAs and non-medical types of home care (e.g., Meals on Wheels, chore-worker services, friendly visits, or other custodial services) and nursing services provided by nurse registries.

Hospital Services: Covers all services provided by hospitals to patients, including room and board, ancillary charges, services of resident physicians, inpatient pharmacy, hospital-based nursing home and home health care, and any other services billed by hospitals in the United States and its outlying territories. The value is measured by total net revenue, which equals gross patient revenues (charges) less contractual adjustments, bad debts, and charity care. It also includes government tax

Table 8

1987 Standard Industrial Classification (SIC) for Health Care Services

SIC	Title	National Health Accounts Category
801	Offices and Clinics of Doctors of Medicine	Physician Services
802	Offices and Clinics of Dentists	Dental Services
803	Offices and Clinics of Doctors of Osteopathy	Physician Services
804	Offices and Clinics of Other Health Practitioners	Other Professional Services
805	Nursing and Personal Care Facilities	Nursing Home Care
806	Hospitals	Hospital Care
807	Medical Laboratories (Independently Billing)	Physician Services
808	Home Health Care Services	Home Health Services
809	Miscellaneous Health and Allied Services, NEC	Other Professional Services

NOTE: NEC is Not Elsewhere Classified.

SOURCE: Executive Office of the President, 1987; Health Care Financing Administration, Office of the Actuary, National Health Statistics Group.

appropriations as well as non-patient and non-operating revenues.

Non-Durable Medical Products: Includes the retail sales of prescription drugs, non-prescription drugs, and medical sundries.

Nursing Home Care: Covers services provided in establishments falling into SIC 805-Nursing and personal care facilities. These include services provided by skilled nursing facilities (SNF) and intermediate care facilities (ICF), as well as government outlays for care provided in nursing facilities operated by the U.S. Department of Veterans Affairs and nursing home services in ICFs for the mentally retarded financed by the Medicaid program.

Other Personal Health Care: Covers industrial inplant services, or direct services provided by employers for the health care needs of their employees, offered either onsite or offsite. It also covers government expenditures for care not specified by kind, or health care spending that is not elsewhere classified. This tends to include services offered at non-health facilities not covered by SIC 80, such as schools, military field stations, and community centers.

Other Professional Services: Covers services provided in establishments falling into SIC 804-Offices and clinics of other health practitioners (such as chiropractors, optometrists, podiatrists, and other licensed medical practitioners, not elsewhere classified), and SIC 809-Miscellaneous health and allied services, such as kidney dialysis centers and specialty outpatient facilities for mental health and substance abuse. Ambulance services paid under Medicare are also included here.

Out-of-Pocket Expenditures: Includes direct spending by consumers for all health care goods and services, such as coinsurance, deductibles, and any amounts not covered by insurance. Out-of-pocket premiums paid by individuals are not counted here but are counted as part of Private Health Insurance.

Physician Services: Covers services provided in establishments falling into SIC 801-Offices and clinics of doctors of medicine (including ambulatory surgical centers and freestanding emergency medical centers), SIC 803-Doctors of osteopathy, and a portion of SIC 8071-Medical laboratories not measured as part of SIC 801 or 803, which represents services provided and independently billed by medical laboratories. This category also includes services rendered by a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) in hospitals, if the physician bills independently for those services. Expenditures for services provided in staff-model and group-model HMO facilities are counted under physician services.

Private Health Insurance: Equals the premiums earned by private health insurers, including premiums paid to Blue Cross Blue Shield, commercial insurance, HMOs, and self-insured plans. The difference between premiums and benefits incurred is a measure of net cost, which includes insurers' costs of paying bills, advertising, sales commissions, and other administrative costs; net additions to reserves; rate credits and dividends; premium taxes; and profits or losses.

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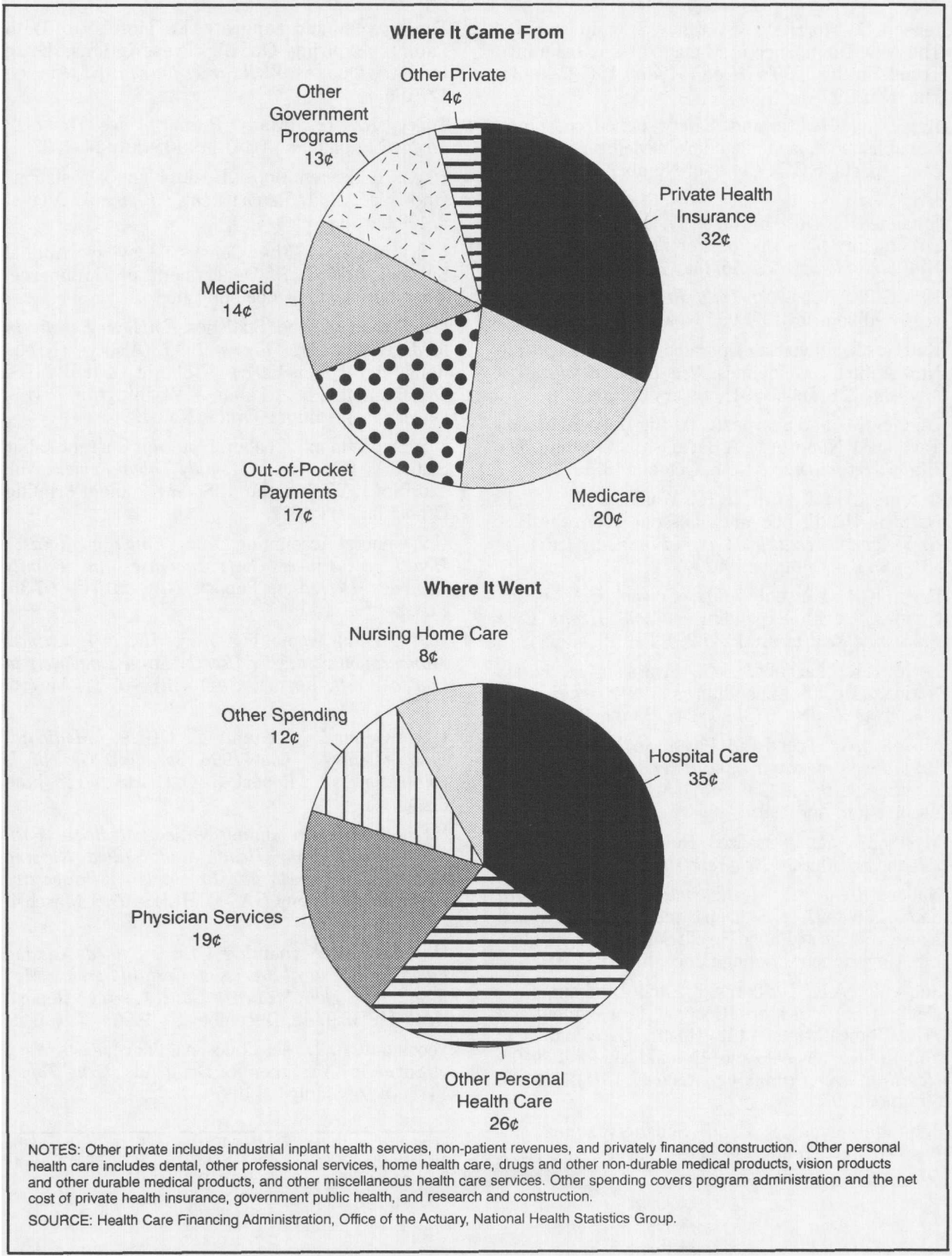
Figure 7
The Nation's Health Dollar: Calendar Year 1996



NOTES: Other private includes industrial inplant health services, non-patient revenues, and privately financed construction. Other personal health care includes dental, 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, National Health Statistics Group.

Table 9

National Health Expenditures Aggregate and per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-96

Item	1960	1970	1980	1990	1991	1992	1993	1994	1995	1996
					Amount in Billions					
National Health Expenditures	$26.9	$73.2	$247.3	$699.5	$766.8	$836.6	$895.1	$945.7	$991.4	$1,035.1
Private	20.2	45.5	142.5	415.1	445.2	478.1	506.2	521.8	536.2	552.0
Public	6.6	27.7	104.8	284.4	321.7	358.5	389.0	423.9	455.2	483.1
Federal	2.9	17.8	72.0	195.8	225.8	257.0	279.6	304.1	328.7	350.9
State and Local	3.7	9.9	32.8	88.5	95.9	101.6	109.3	119.8	126.5	132.2
					Number in Millions					
U.S. Population[1]	190	215	235	260	263	265	268	270	273	275
Amount in Billions										
Gross Domestic Product	$527	$1,036	$2,784	$5,744	$5,917	$6,244	$6,558	$6,947	$7,265	$7,636
					Per Capita Amount					
National Health Expenditures	$141	$341	$1,052	$2,691	$2,920	$3,154	$3,341	$3,497	$3,633	$3,759
Private	106	212	606	1,597	1,695	1,802	1,889	1,930	1,965	2,005
Public	35	129	446	1,094	1,225	1,352	1,452	1,568	1,668	1,754
Federal	15	83	306	753	860	969	1,044	1,125	1,205	1,274
State and Local	20	46	140	341	365	383	408	443	464	480
					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	58.1	57.1	56.5	55.2	54.1	53.3
Public	24.8	37.8	42.4	40.7	41.9	42.9	43.5	44.8	45.9	46.7
Federal	10.9	24.3	29.1	28.0	29.4	30.7	31.2	32.2	33.2	33.9
State and Local	13.9	13.5	13.3	12.7	12.5	12.1	12.2	12.7	12.8	12.8
					Percent of Gross Domestic Product					
National Health Expenditures	5.1	7.1	8.9	12.2	13.0	13.4	13.6	13.6	13.6	13.6
					Average Annual Percent Growth from Previous Year Shown					
National Health Expenditures	—	10.6	12.9	11.0	9.6	9.1	7.0	5.6	4.8	4.4
Private	—	8.5	12.1	11.3	7.2	7.4	5.9	3.1	2.8	3.0
Public	—	15.3	14.2	10.5	13.1	11.5	8.5	9.0	7.4	6.1
Federal	—	19.8	15.0	10.5	15.3	13.8	8.8	8.8	8.1	6.7
State and Local	—	10.2	12.7	10.4	8.3	5.9	7.6	9.5	5.6	4.5
U.S. Population	—	1.2	0.9	1.0	1.0	1.0	1.0	0.9	0.9	0.9
Gross Domestic Product	—	7.0	10.4	7.5	3.0	5.5	5.0	5.9	4.6	5.1

[1] July 1 Social Security area population estimates for each year, 1960-96.

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

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

Table 10

National Health Expenditures Aggregate Amounts and Average Annual Percent Change, by Type of Expenditure: Selected Calendar Years 1960-96

Type of Expenditure	1960	1970	1980	1990	1991	1992	1993	1994	1995	1996
					Amount in Billions					
National Health Expenditures	$26.9	$73.2	$247.3	$699.5	$766.8	$836.6	$895.1	$945.7	$991.4	$1,035.1
Health Services and Supplies	25.2	67.9	235.6	675.0	741.9	809.1	866.1	915.2	960.7	1,003.6
Personal Health Care	23.6	63.8	217.0	614.7	679.6	740.7	787.0	828.5	869.0	907.2
Hospital Care	9.3	28.0	102.7	256.4	282.3	305.3	323.0	335.7	346.7	358.5
Physician Services	5.3	13.6	45.2	146.3	162.2	175.9	183.6	190.4	196.4	202.1
Dental Services	2.0	4.7	13.3	31.6	33.3	37.0	39.1	41.7	44.7	47.6
Other Professional Services	0.6	1.4	6.4	34.7	38.3	42.1	46.3	50.3	54.3	58.0
Home Health Care	0.1	0.2	2.4	13.1	16.1	19.6	22.9	25.6	28.4	30.2
Drugs and Other Medical Non-Durables	4.2	8.8	21.6	59.9	65.6	71.2	75.6	79.5	84.9	91.4
Vision Products and Other Medical Durables	0.6	1.6	3.8	10.5	11.2	11.9	12.3	12.5	13.1	13.3
Nursing Home Care	0.8	4.2	17.6	50.9	57.2	62.3	66.3	70.9	75.2	78.5
Other Personal Health Care	0.7	1.3	4.0	11.2	13.6	15.4	18.0	21.9	25.3	27.6
Program Administration and Net Cost of Private Health Insurance	1.2	2.7	11.9	40.7	40.9	45.0	53.8	58.2	60.1	60.9
Government Public Health Activities	0.4	1.3	6.7	19.6	21.4	23.4	25.3	28.5	31.5	35.5
Research and Construction	1.7	5.3	11.6	24.5	24.9	27.5	29.0	30.5	30.7	31.5
Research[1]	0.7	2.0	5.5	12.2	12.9	14.2	14.5	15.9	16.7	17.0
Construction	1.0	3.4	6.2	12.3	12.0	13.4	14.5	14.6	14.0	14.5
					Average Annual Percent Change from Previous Year Shown					
National Health Expenditures	—	10.6	12.9	11.0	9.6	9.1	7.0	5.6	4.8	4.4
Health Services and Supplies	—	10.4	13.3	11.1	9.9	9.1	7.0	5.7	5.0	4.5
Personal Health Care	—	10.5	13.0	11.0	10.6	9.0	6.2	5.3	4.9	4.4
Hospital Care	—	11.7	13.9	9.6	10.1	8.2	5.8	3.9	3.3	3.4
Physician Services	—	9.9	12.8	12.5	10.8	8.5	4.4	3.7	3.1	2.9
Dental Services	—	9.1	11.1	9.0	5.6	11.0	5.6	6.6	7.3	6.4
Other Professional Services	—	8.8	16.3	18.5	10.4	10.0	9.9	8.8	7.9	6.8
Home Health Care	—	14.5	26.9	18.6	22.4	22.3	16.5	12.2	10.9	6.2
Drugs and Other Medical Non-Durables	—	7.6	9.4	10.7	9.4	8.6	6.2	5.2	6.8	7.7
Vision Products and Other Medical Durables	—	9.6	8.8	10.7	7.0	6.3	3.4	1.5	4.9	1.4
Nursing Home Care	—	17.4	15.4	11.2	12.2	9.0	6.5	6.8	6.2	4.3
Other Personal Health Care	—	6.5	12.0	10.8	20.7	13.3	17.0	21.8	15.4	9.4
Program Administration and Net Cost of Private Health Insurance	—	8.9	15.9	13.1	0.6	9.9	19.6	8.2	3.3	1.2
Government Public Health Activities	—	13.9	17.5	11.3	9.2	9.3	8.2	12.5	10.7	12.5
Research and Construction	—	12.2	8.1	7.7	1.7	10.5	5.3	5.1	0.8	2.6
Research[1]	—	10.9	10.8	8.4	5.8	9.8	2.2	9.6	5.0	1.9
Construction	—	12.9	6.2	7.1	-2.4	11.2	8.7	0.5	-3.8	3.4

[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, National Health Statistics Group.

Table 11

National Health Expenditures, by Source of Funds and Type of Expenditure: Selected Calendar Years 1991-96

Year and Type of Expenditure	Total	Private					Government		
		All Private Funds	Consumer			Other	Total	Federal	State and Local
			Total	Out-of-Pocket	Private Insurance				
	Amount in Billions								
1991									
National Health Expenditures	$766.8	$445.2	$411.0	$151.6	$259.4	$34.1	$321.7	$225.8	$95.9
Health Services and Supplies	741.9	435.0	411.0	151.6	259.4	24.0	306.9	215.1	91.7
Personal Health Care	679.6	402.4	379.0	151.6	227.4	23.4	277.1	206.4	70.7
Hospital Care	282.3	122.5	110.9	11.2	99.7	11.7	159.7	124.5	35.2
Physician Services	162.2	113.4	110.5	33.4	77.0	2.9	48.8	38.2	10.6
Dental Services	33.3	32.2	32.1	16.1	15.9	0.1	1.1	0.6	0.5
Other Professional Services	38.3	30.5	27.9	14.0	13.9	2.7	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	—	7.7	3.8	3.9
Vision Products and Other Medical Durables	11.2	7.7	7.7	6.9	0.8	—	3.5	3.3	0.1
Nursing Home Care	57.2	26.4	25.3	23.0	2.3	1.1	30.8	18.5	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	40.9	32.6	32.0	—	32.0	0.6	8.3	6.0	2.3
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
1992									
National Health Expenditures	836.6	478.1	442.0	159.5	282.5	36.1	358.5	257.0	101.6
Health Services and Supplies	809.1	467.1	442.0	159.5	282.5	25.1	342.0	245.2	96.8
Personal Health Care	740.7	431.6	407.1	159.5	247.5	24.5	309.1	235.7	73.4
Hospital Care	305.3	127.5	115.7	11.7	104.0	11.8	177.9	143.4	34.4
Physician Services	175.9	123.7	120.5	33.9	86.6	3.2	52.2	40.4	11.8
Dental Services	37.0	35.6	35.5	17.8	17.7	0.1	1.4	0.8	0.6
Other Professional Services	42.1	33.1	30.4	15.3	15.1	2.7	9.0	6.3	2.7
Home Health Care	19.6	10.8	7.9	5.0	2.9	2.9	8.9	7.5	1.4
Drugs and Other Medical Non-Durables	71.2	62.9	62.9	45.0	17.9	—	8.3	4.2	4.1
Vision Products and Other Medical Durables	11.9	8.0	8.0	7.3	0.7	—	3.9	3.8	0.1
Nursing Home Care	62.3	27.5	26.3	23.7	2.6	1.2	34.8	21.7	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	45.0	35.5	34.9	—	34.9	0.6	9.5	6.4	3.1
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

See footnotes at end of table.

Table 11 – Continued

National Health Expenditures, by Source of Funds and Type of Expenditure: Selected Calendar Years 1991-96

Year and Type of Expenditure	Total	Private					Government		
		All Private Funds	Consumer			Other	Total	Federal	State and Local
			Total	Out-of-Pocket	Private Insurance				
1993					Amount in Billions				
National Health Expenditures	$895.1	$506.2	$466.9	$163.6	$303.3	$39.2	$389.0	$279.6	$109.3
Health Services and Supplies	866.1	494.3	466.9	163.6	303.3	27.3	371.9	267.6	104.3
Personal Health Care	787.0	452.0	425.2	163.6	261.6	26.7	335.0	256.6	78.4
Hospital Care	323.0	134.0	120.9	11.9	109.1	13.0	189.0	152.2	36.8
Physician Services	183.6	128.1	124.8	32.6	92.2	3.3	55.5	43.4	12.1
Dental Services	39.1	37.2	37.0	18.6	18.4	0.2	1.9	1.1	0.8
Other Professional Services	46.3	36.3	33.3	17.5	15.8	3.0	9.9	7.1	2.8
Home Health Care	22.9	11.7	8.6	5.5	3.1	3.2	11.1	9.6	1.5
Drugs and Other Medical Non-Durables	75.6	66.2	66.2	46.8	19.4	—	9.3	4.9	4.4
Vision Products and Other Medical Durables	12.3	8.0	8.0	7.3	0.7	—	4.3	4.2	0.1
Nursing Home Care	66.3	27.6	26.4	23.4	3.0	1.2	38.7	24.9	13.9
Other Personal Health Care	18.0	2.8	—	—	—	2.8	15.1	9.2	5.9
Program Administration and Net Cost of Private Health Insurance	53.8	42.3	41.7	—	41.7	0.6	11.5	7.7	3.8
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
1994									
National Health Expenditures	945.7	521.8	480.5	164.8	315.6	41.3	423.9	304.1	119.8
Health Services and Supplies	915.2	510.0	480.5	164.8	315.6	29.6	405.2	291.0	114.2
Personal Health Care	828.5	465.7	436.8	164.8	271.9	29.0	362.7	278.7	84.1
Hospital Care	335.7	134.8	120.7	10.8	109.9	14.1	201.0	162.2	38.7
Physician Services	190.4	131.4	127.8	30.5	97.3	3.6	59.0	46.7	12.4
Dental Services	41.7	39.7	39.5	19.7	19.8	0.2	2.0	1.1	0.9
Other Professional Services	50.3	39.3	35.7	19.2	16.6	3.5	11.1	8.3	2.8
Home Health Care	25.6	12.0	8.7	5.6	3.1	3.2	13.7	11.9	1.8
Drugs and Other Medical Non-Durables	79.5	69.1	69.1	47.8	21.3	—	10.4	5.4	4.9
Vision Products and Other Medical Durables	12.5	7.9	7.9	7.2	0.7	—	4.6	4.5	0.1
Nursing Home Care	70.9	28.7	27.4	24.1	3.3	1.3	42.2	27.2	14.9
Other Personal Health Care	21.9	3.1	—	—	—	3.1	18.8	11.3	7.5
Program Administration and Net Cost of Private Health Insurance	58.2	44.3	43.7	—	43.7	0.6	13.9	8.5	5.5
Government Public Health Activities	28.5	—	—	—	—	—	28.5	3.8	24.7
Research and Construction	30.5	11.8	—	—	—	11.8	18.7	13.2	5.5
Research	15.9	1.3	—	—	—	1.3	14.6	12.3	2.3
Construction	14.6	10.5	—	—	—	10.5	4.1	0.9	3.2

See footnotes at end of table.

Table 11 – Continued

National Health Expenditures, by Source of Funds and Type of Expenditure: Selected Calendar Years 1991-96

Year and Type of Expenditure	Total	Private					Government		
		All Private Funds	Consumer			Other	Total	Federal	State and Local
			Total	Out-of-Pocket	Private Insurance				
					Amount in Billions				
1995									
National Health Expenditures	$991.4	$536.2	$493.6	$166.7	$326.9	$42.6	$455.2	$328.7	$126.5
Health Services and Supplies	960.7	525.3	493.6	166.7	326.9	31.7	435.4	314.7	120.6
Personal Health Care	869.0	480.4	449.4	166.7	282.6	31.1	388.5	301.7	86.8
Hospital Care	346.7	136.2	121.2	9.6	111.6	15.0	210.5	172.3	38.2
Physician Services	196.4	133.1	128.9	29.0	99.9	4.1	63.3	50.7	12.6
Dental Services	44.7	42.7	42.5	21.0	21.5	0.2	2.0	1.1	0.9
Other Professional Services	54.3	41.9	38.1	20.4	17.7	3.8	12.4	9.5	2.9
Home Health Care	28.4	12.4	9.1	5.9	3.2	3.3	16.0	14.1	1.9
Drugs and Other Medical Non-Durables	84.9	73.1	73.1	48.6	24.5	—	11.7	6.3	5.5
Vision Products and Other Medical Durables	13.1	7.7	7.7	7.1	0.6	—	5.4	5.3	0.1
Nursing Home Care	75.2	30.2	28.8	25.1	3.7	1.4	45.1	29.5	15.6
Other Personal Health Care	25.3	3.3	—	—	—	3.3	22.0	12.9	9.1
Program Administration and Net Cost of Private Health Insurance	60.1	44.8	44.2	—	44.2	0.6	15.3	9.2	6.1
Government Public Health Activities	31.5	—	—	—	—	—	31.5	3.8	27.7
Research and Construction	30.7	10.9	—	—	—	10.9	19.8	14.0	5.8
Research	16.7	1.3	—	—	—	1.3	15.3	12.9	2.4
Construction	14.0	9.6	—	—	—	9.6	4.5	1.1	3.4
1996									
National Health Expenditures	1,035.1	552.0	508.5	171.2	337.3	43.5	483.1	350.9	132.2
Health Services and Supplies	1,003.6	540.9	508.5	171.2	337.3	32.4	462.7	336.6	126.1
Personal Health Care	907.2	495.2	463.5	171.2	292.3	31.7	412.0	322.6	89.4
Hospital Care	358.5	137.9	122.6	9.2	113.4	15.3	220.6	181.6	39.1
Physician Services	202.1	135.5	131.3	29.6	101.8	4.2	66.5	54.2	12.3
Dental Services	47.6	45.5	45.3	22.1	23.2	0.2	2.1	1.2	0.9
Other Professional Services	58.0	44.7	40.9	22.5	18.3	3.8	13.3	10.3	3.0
Home Health Care	30.2	12.3	9.0	5.9	3.2	3.3	17.9	15.9	2.0
Drugs and Other Medical Non-Durables	91.4	78.1	78.1	50.3	27.8	0.0	13.3	7.5	5.8
Vision Products and Other Medical Durables	13.3	7.5	7.5	6.9	0.6	0.0	5.7	5.6	0.1
Nursing Home Care	78.5	30.2	28.7	24.7	4.0	1.5	48.3	32.2	16.1
Other Personal Health Care	27.6	3.4	—	—	—	3.4	24.2	14.2	10.0
Program Administration and Net Cost of Private Health Insurance	60.9	45.7	45.0	—	45.0	0.7	15.2	10.1	5.1
Government Public Health Activities	35.5	—	—	—	—	—	35.5	3.9	31.6
Research and Construction	31.5	11.1	—	—	—	11.1	20.4	14.3	6.1
Research	17.0	1.4	—	—	—	1.4	15.6	13.2	2.4
Construction	14.5	9.7	—	—	—	9.7	4.8	1.1	3.7

NOTE: The figure 0.0 denotes less than $50 million. 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, National Health Statistics Group.

Table 12

Personal Health Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-96

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	$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
1990	614.7	144.4	470.3	206.7	21.3	242.3	177.6	64.7	109.3	71.4
1991	679.6	151.6	528.0	227.4	23.4	277.1	206.4	70.7	121.1	89.6
1992	740.7	159.5	581.1	247.5	24.5	309.1	235.7	73.4	137.9	101.5
1993	787.0	163.6	623.4	261.6	26.7	335.0	256.6	78.4	149.0	114.6
1994	828.5	164.8	663.6	271.9	29.0	362.7	278.7	84.1	165.6	123.3
1995	869.0	166.7	702.3	282.6	31.1	388.5	301.7	86.8	183.4	131.4
1996	907.2	171.2	736.0	292.3	31.7	412.0	322.6	89.4	197.8	139.7
					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)
1990	2,364	555	1,809	795	82	932	683	249	(3)	(3)
1991	2,588	577	2,011	866	89	1,055	786	269	(3)	(3)
1992	2,792	601	2,191	933	92	1,165	889	277	(3)	(3)
1993	2,937	611	2,327	977	100	1,251	958	293	(3)	(3)
1994	3,064	610	2,454	1,005	107	1,341	1,031	311	(3)	(3)
1995	3,185	611	2,574	1,036	114	1,424	1,106	318	(3)	(3)
1996	3,295	622	2,673	1,062	115	1,496	1,172	325	(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
1990	100.0	23.5	76.5	33.6	3.5	39.4	28.9	10.5	17.8	11.6
1991	100.0	22.3	77.7	33.5	3.4	40.8	30.4	10.4	17.8	13.2
1992	100.0	21.5	78.5	33.4	3.3	41.7	31.8	9.9	18.6	13.7
1993	100.0	20.8	79.2	33.2	3.4	42.6	32.6	10.0	18.9	14.6
1994	100.0	19.9	80.1	32.8	3.5	43.8	33.6	10.1	20.0	14.9
1995	100.0	19.2	80.8	32.5	3.6	44.7	34.7	10.0	21.1	15.1
1996	100.0	18.9	81.1	32.2	3.5	45.4	35.6	9.9	21.8	15.4

[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, 1960-96. Numbers and percents may not add to totals because of rounding.

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

Table 13
Hospital Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-96

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	$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	36.5	5.0	55.9	42.1	13.7	26.4	10.6
1990	256.4	10.3	246.2	94.6	10.7	140.8	106.1	34.8	69.4	29.4
1991	282.3	11.2	271.1	99.7	11.7	159.7	124.5	35.2	77.0	37.8
1992	305.3	11.7	293.6	104.0	11.8	177.9	143.4	34.4	88.7	42.4
1993	323.0	11.9	311.1	109.1	13.0	189.0	152.2	36.8	93.5	47.2
1994	335.7	10.8	324.9	109.9	14.1	201.0	162.2	38.7	102.1	49.2
1995	346.7	9.6	337.1	111.6	15.0	210.5	172.3	38.2	110.7	50.8
1996	358.5	9.2	349.3	113.4	15.3	220.6	181.6	39.1	118.3	52.9
					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	58	(3)	(3)
1990	986	40	947	364	41	542	408	134	(3)	(3)
1991	1,075	43	1,032	380	44	608	474	134	(3)	(3)
1992	1,151	44	1,107	392	44	670	541	130	(3)	(3)
1993	1,206	44	1,161	407	49	706	568	137	(3)	(3)
1994	1,241	40	1,202	406	52	743	600	143	(3)	(3)
1995	1,270	35	1,235	409	55	771	632	140	(3)	(3)
1996	1,302	33	1,269	412	55	801	659	142	(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	25.7	10.3
1990	100.0	4.0	96.0	36.9	4.2	54.9	41.4	13.6	27.0	11.5
1991	100.0	4.0	96.0	35.3	4.1	56.6	44.1	12.5	27.3	13.4
1992	100.0	3.8	96.2	34.0	3.9	58.3	47.0	11.3	29.1	13.9
1993	100.0	3.7	96.3	33.8	4.0	58.5	47.1	11.4	28.9	14.6
1994	100.0	3.2	96.8	32.7	4.2	59.9	48.3	11.5	30.4	14.7
1995	100.0	2.8	97.2	32.2	4.3	60.7	49.7	11.0	31.9	14.7
1996	100.0	2.6	97.4	31.6	4.3	61.5	50.6	10.9	33.0	14.7

[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, 1960-96. Numbers and percents may not add to totals because of rounding.

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

Table 14
Physician Service Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-96

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	$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	14.7	30.6	17.1	0.4	13.1	10.0	3.1	8.0	2.5
1990	146.3	32.3	114.1	66.7	2.7	44.7	35.6	9.1	29.2	7.0
1991	162.2	33.4	128.7	77.0	2.9	48.8	38.2	10.6	30.4	9.1
1992	175.9	33.9	142.0	86.6	3.2	52.2	40.4	11.8	31.2	11.1
1993	183.6	32.6	151.0	92.2	3.3	55.5	43.4	12.1	33.2	12.7
1994	190.4	30.5	159.9	97.3	3.6	59.0	46.7	12.4	36.1	13.6
1995	196.4	29.0	167.3	99.9	4.1	63.3	50.7	12.6	39.7	14.4
1996	202.1	29.6	172.5	101.8	4.2	66.5	54.2	12.3	42.6	15.1
					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)
1990	563	124	439	257	10	172	137	35	(3)	(3)
1991	618	127	490	293	11	186	146	40	(3)	(3)
1992	663	128	535	326	12	197	152	45	(3)	(3)
1993	685	122	564	344	12	207	162	45	(3)	(3)
1994	704	113	591	360	13	218	173	46	(3)	(3)
1995	720	106	613	366	15	232	186	46	(3)	(3)
1996	734	107	627	370	15	242	197	45	(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	5.5
1990	100.0	22.1	77.9	45.6	1.8	30.5	24.3	6.2	20.0	4.8
1991	100.0	20.6	79.4	47.5	1.8	30.1	23.6	6.5	18.8	5.6
1992	100.0	19.3	80.7	49.2	1.8	29.7	23.0	6.7	17.8	6.3
1993	100.0	17.7	82.3	50.2	1.8	30.2	23.7	6.6	18.1	6.9
1994	100.0	16.0	84.0	51.1	1.9	31.0	24.5	6.5	19.0	7.1
1995	100.0	14.8	85.2	50.9	2.1	32.2	25.8	6.4	20.2	7.4
1996	100.0	14.6	85.4	50.4	2.1	32.9	26.8	6.1	21.1	7.5

[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, 1960-96. Numbers and percents may not add to totals because of rounding.

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

Table 15
Nursing Home Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-96

Year	Total	Out-of-Pocket Payments	Third-Party Payments							
			Total	Private Health Insurance	Other Private Funds	Government			Medicare[1]	Medicaid[2]
						Total	Federal	State and Local		
					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
1990	50.9	22.0	29.0	2.1	0.9	26.0	15.8	10.2	1.8	23.1
1991	57.2	23.0	34.2	2.3	1.1	30.8	18.5	12.3	2.1	27.5
1992	62.3	23.7	38.6	2.6	1.2	34.8	21.7	13.2	3.3	30.2
1993	66.3	23.4	42.9	3.0	1.2	38.7	24.9	13.9	4.8	32.4
1994	70.9	24.1	46.8	3.3	1.3	42.2	27.2	14.9	6.3	34.3
1995	75.2	25.1	50.2	3.7	1.4	45.1	29.5	15.6	7.8	35.5
1996	78.5	24.7	53.8	4.0	1.5	48.3	32.2	16.1	8.9	37.5
					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)
1990	196	84	111	8	4	100	61	39	(3)	(3)
1991	218	88	130	9	4	117	70	47	(3)	(3)
1992	235	89	146	10	4	131	82	50	(3)	(3)
1993	248	87	160	11	5	145	93	52	(3)	(3)
1994	262	89	173	12	5	156	101	55	(3)	(3)
1995	276	92	184	13	5	165	108	57	(3)	(3)
1996	285	90	195	15	5	175	117	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
1990	100.0	43.1	56.9	4.0	1.8	51.0	31.0	20.0	3.4	45.4
1991	100.0	40.2	59.8	4.1	1.8	53.8	32.3	21.5	3.6	48.1
1992	100.0	38.0	62.0	4.3	1.9	55.9	34.8	21.2	5.3	48.5
1993	100.0	35.3	64.7	4.5	1.8	58.4	37.5	20.9	7.2	48.9
1994	100.0	33.9	66.1	4.7	1.9	59.5	38.4	21.1	8.8	48.3
1995	100.0	33.4	66.6	4.9	1.9	59.9	39.2	20.8	10.4	47.2
1996	100.0	31.4	68.6	5.2	1.9	61.5	41.0	20.5	11.4	47.8

[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, 1960-96. Numbers and percents may not add to totals because of rounding.

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

Table 16
Other Personal Health Care Expenditures[1] Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-96

Year	Total	Out-of-Pocket Payments	Third-Party Payments							
			Total	Private Health Insurance	Other Private Funds	Government				
						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
1990	161.0	79.9	81.1	43.2	7.0	30.9	20.2	10.7	8.9	11.8
1991	178.0	84.0	94.0	48.3	7.8	37.9	25.2	12.6	11.6	15.2
1992	197.1	90.3	106.9	54.3	8.4	44.2	30.2	13.9	14.6	17.8
1993	214.1	95.7	118.3	57.4	9.2	51.8	36.1	15.7	17.6	22.2
1994	231.5	99.5	132.0	61.4	10.0	60.6	42.5	18.0	21.1	26.2
1995	250.7	103.0	147.7	67.5	10.5	69.7	49.2	20.5	25.2	30.6
1996	268.1	107.7	160.4	73.1	10.7	76.5	54.7	21.9	28.0	34.2
					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)
1990	619	307	312	166	27	119	78	41	(4)	(4)
1991	678	320	358	184	30	144	96	48	(4)	(4)
1992	743	340	403	205	32	167	114	53	(4)	(4)
1993	799	357	442	214	34	193	135	58	(4)	(4)
1994	856	368	488	227	37	224	157	67	(4)	(4)
1995	919	378	541	247	39	255	180	75	(4)	(4)
1996	974	391	582	265	39	278	199	79	(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	15.9	3.6	16.5	11.0	5.5	3.2	5.5
1990	100.0	49.6	50.4	26.9	4.3	19.2	12.5	6.6	5.5	7.3
1991	100.0	47.2	52.8	27.2	4.4	21.3	14.2	7.1	6.5	8.6
1992	100.0	45.8	54.2	27.6	4.2	22.4	15.3	7.1	7.4	9.0
1993	100.0	44.7	55.3	26.8	4.3	24.2	16.9	7.3	8.2	10.4
1994	100.0	43.0	57.0	26.5	4.3	26.2	18.4	7.8	9.1	11.3
1995	100.0	41.1	58.9	26.9	4.2	27.8	19.6	8.2	10.0	12.2
1996	100.0	40.2	59.8	27.3	4.0	28.5	20.4	8.2	10.4	12.8

[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, 1960-96. Numbers and percents may not add to totals because of rounding.

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

Table 17

Personal Health Care Expenditures, by Type of Expenditure and Source of Funds: Selected Calendar Years 1980-96

Source of Funds	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 Personal Health Care
					Amount in Billions					
1980										
Personal Health Care Expenditures	$217.0	$102.7	$45.2	$13.3	$6.4	$2.4	$21.6	$3.8	$17.6	$4.0
Out-of-Pocket Payments	60.3	5.3	14.7	8.8	3.3	0.5	17.5	2.7	7.4	—
Third-Party Payments	156.8	97.4	30.6	4.5	3.1	1.9	4.1	1.0	10.3	4.0
Private Health Insurance	62.0	36.5	17.1	3.8	1.1	0.4	2.4	0.4	0.2	—
Other Private	7.8	5.0	0.4	0.0	0.5	0.5	—	—	0.5	0.9
Government	87.0	55.9	13.1	0.7	1.5	1.0	1.7	0.6	9.5	3.1
Federal	63.4	42.1	10.0	0.4	1.1	0.8	0.9	0.5	5.6	2.0
Medicare	36.4	26.4	8.0	0.0	0.6	0.7	0.0	0.4	0.3	—
Medicaid	13.7	5.7	1.4	0.3	0.1	0.2	0.8	—	4.9	0.2
Other	13.3	9.9	0.6	0.1	0.4	—	0.0	0.1	0.4	1.8
State and Local	23.6	13.7	3.1	0.3	0.4	0.1	0.8	0.1	3.9	1.1
Medicaid	11.1	4.9	1.1	0.2	0.1	0.1	0.6	—	3.9	0.2
Other	12.4	8.9	2.0	0.1	0.3	0.0	0.2	0.1	0.0	0.9
1990										
Personal Health Care Expenditures	614.7	256.4	146.3	31.6	34.7	13.1	59.9	10.5	50.9	11.2
Out-of-Pocket Payments	144.4	10.3	32.3	15.4	13.7	3.6	40.4	6.7	22.0	—
Third-Party Payments	470.3	246.2	114.1	16.2	21.0	9.5	19.5	3.7	29.0	11.2
Private Health Insurance	206.7	94.6	66.7	15.1	12.0	2.2	13.0	0.8	2.1	—
Other Private	21.3	10.7	2.7	0.1	2.5	2.2	—	—	0.9	2.2
Government	242.3	140.8	44.7	0.9	6.5	5.1	6.5	2.9	26.0	9.0
Federal	177.6	106.1	35.6	0.5	4.3	4.1	3.1	2.7	15.8	5.4
Medicare	109.3	69.4	29.2	0.0	3.3	3.0	0.1	2.5	1.8	—
Medicaid	40.4	16.6	4.1	0.4	0.3	1.1	2.9	—	13.0	2.0
Other	28.0	20.1	2.2	0.1	0.7	—	0.1	0.2	1.0	3.5
State and Local	64.7	34.8	9.1	0.4	2.2	1.0	3.4	0.1	10.2	3.6
Medicaid	31.0	12.9	2.9	0.3	0.2	1.0	2.1	—	10.1	1.5
Other	33.7	21.9	6.2	0.1	2.0	0.0	1.2	0.1	0.1	2.1
1991										
Personal Health Care Expenditures	679.6	282.3	162.2	33.3	38.3	16.1	65.6	11.2	57.2	13.6
Out-of-Pocket Payments	151.6	11.2	33.4	16.1	14.0	4.3	42.7	6.9	23.0	—
Third-Party Payments	528.0	271.1	128.7	17.2	24.3	11.8	22.9	4.3	34.2	13.6
Private Health Insurance	227.4	99.7	77.0	15.9	13.9	2.5	15.2	0.8	2.3	—
Other Private	23.4	11.7	2.9	0.1	2.7	2.5	—	—	1.1	2.4
Government	277.1	159.7	48.8	1.1	7.7	6.7	7.7	3.5	30.8	11.1
Federal	206.4	124.5	38.2	0.6	5.2	5.5	3.8	3.3	18.5	6.7
Medicare	121.1	77.0	30.4	0.0	4.1	4.3	0.1	3.1	2.1	—
Medicaid	54.3	25.2	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	70.7	35.2	10.6	0.5	2.5	1.2	3.9	0.1	12.3	4.4
Medicaid	35.3	12.5	3.8	0.4	0.3	1.2	2.7	—	12.2	2.2
Other	35.4	22.7	6.7	0.1	2.2	0.0	1.3	0.1	0.1	2.2

See footnotes at end of table.

Table 17–Continued

Personal Health Care Expenditures, by Type of Expenditure and Source of Funds: Selected Calendar Years 1980-96

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					
1992										
Personal Health Care Expenditures	$740.7	$305.3	$175.9	$37.0	$42.1	$19.6	$71.2	$11.9	$62.3	$15.4
Out-of-Pocket Payments	159.5	11.7	33.9	17.8	15.3	5.0	45.0	7.3	23.7	—
Third-Party Payments	581.1	293.6	142.0	19.2	26.8	14.6	26.2	4.6	38.6	15.4
Private Health Insurance	247.5	104.0	86.6	17.7	15.1	2.9	17.9	0.7	2.6	—
Other Private	24.5	11.8	3.2	0.1	2.7	2.9	—	—	1.2	2.6
Government	309.1	177.9	52.2	1.4	9.0	8.9	8.3	3.9	34.8	12.7
Federal	235.7	143.4	40.4	0.8	6.3	7.5	4.2	3.8	21.7	7.8
Medicare	137.9	88.7	31.2	0.0	5.0	6.0	0.1	3.5	3.3	—
Medicaid	65.4	31.5	6.6	0.7	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	73.4	34.4	11.8	0.6	2.7	1.4	4.1	0.1	13.2	5.0
Medicaid	36.2	10.9	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	0.0	2.3
1993										
Personal Health Care Expenditures	787.0	323.0	183.6	39.1	46.3	22.9	75.6	12.3	66.3	18.0
Out-of-Pocket Payments	163.6	11.9	32.6	18.6	17.5	5.5	46.8	7.3	23.4	—
Third-Party Payments	623.4	311.1	151.0	20.5	28.7	17.4	28.8	5.0	42.9	18.0
Private Health Insurance	261.6	109.1	92.2	18.4	15.8	3.1	19.4	0.7	3.0	—
Other Private	26.7	13.0	3.3	0.2	3.0	3.2	—	—	1.2	2.8
Government	335.0	189.0	55.5	1.9	9.9	11.1	9.3	4.3	38.7	15.1
Federal	256.6	152.2	43.4	1.1	7.1	9.6	4.9	4.2	24.9	9.2
Medicare	149.0	93.5	33.2	0.0	5.7	7.8	0.2	3.9	4.8	—
Medicaid	73.5	34.3	7.7	1.0	0.6	1.8	4.6	—	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	78.4	36.8	12.1	0.8	2.8	1.5	4.4	0.1	13.9	5.9
Medicaid	41.1	12.9	5.0	0.7	0.5	1.5	3.2	—	13.8	3.5
Other	37.3	23.9	7.0	0.1	2.4	0.0	1.3	0.1	0.1	2.4
1994										
Personal Health Care Expenditures	828.5	335.7	190.4	41.7	50.3	25.6	79.5	12.5	70.9	21.9
Out-of-Pocket Payments	164.8	10.8	30.5	19.7	19.2	5.6	47.8	7.2	24.1	—
Third-Party Payments	663.6	324.9	159.9	21.9	31.2	20.0	31.6	5.3	46.8	21.9
Private Health Insurance	271.9	109.9	97.3	19.8	16.6	3.1	21.3	0.7	3.3	—
Other Private	29.0	14.1	3.6	0.2	3.5	3.2	—	—	1.3	3.1
Government	362.7	201.0	59.0	2.0	11.1	13.7	10.4	4.6	42.2	18.8
Federal	278.7	162.2	46.7	1.1	8.3	11.9	5.4	4.5	27.2	11.3
Medicare	165.6	102.1	36.1	0.0	6.7	10.0	0.3	4.2	6.3	—
Medicaid	77.7	35.3	8.1	1.0	0.6	1.9	5.0	—	19.4	6.5
Other	35.4	24.9	2.5	0.1	0.9	—	0.2	0.3	1.5	4.9
State and Local	84.1	38.7	12.4	0.9	2.8	1.8	4.9	0.1	14.9	7.5
Medicaid	45.6	13.9	5.5	0.8	0.5	1.7	3.6	—	14.8	4.8
Other	38.5	24.8	6.8	0.1	2.4	0.1	1.3	0.1	0.1	2.7

See footnotes at end of table.

Table 17–Continued

Personal Health Care Expenditures, by Type of Expenditure and Source of Funds: Selected Calendar Years 1980-96

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					
1995										
Personal Health Care Expenditures	$869.0	$346.7	$196.4	$44.7	$54.3	$28.4	$84.9	$13.1	$75.2	$25.3
Out-of-Pocket Payments	166.7	9.6	29.0	21.0	20.4	5.9	48.6	7.1	25.1	—
Third-Party Payments	702.3	337.1	167.3	23.7	33.9	22.5	36.3	6.0	50.2	25.3
Private Health Insurance	282.6	111.6	99.9	21.5	17.7	3.2	24.5	0.6	3.7	—
Other Private	31.1	15.0	4.1	0.2	3.8	3.3	—	—	1.4	3.3
Government	388.5	210.5	63.3	2.0	12.4	16.0	11.7	5.4	45.1	22.0
Federal	301.7	172.3	50.7	1.1	9.5	14.1	6.3	5.3	29.5	12.9
Medicare	183.4	110.7	39.7	0.0	7.8	12.0	0.5	4.9	7.8	—
Medicaid	82.0	36.2	8.5	1.0	0.8	2.1	5.6	—	20.0	7.9
Other	36.3	25.4	2.5	0.2	1.0	—	0.3	0.3	1.6	5.0
State and Local	86.8	38.2	12.6	0.9	2.9	1.9	5.5	0.1	15.6	9.1
Medicaid	49.4	14.6	6.0	0.8	0.6	1.8	4.1	—	15.5	6.0
Other	37.5	23.5	6.6	0.1	2.4	0.1	1.4	0.1	0.1	3.1
1996										
Personal Health Care Expenditures	907.2	358.5	202.1	47.6	58.0	30.2	91.4	13.3	78.5	27.6
Out-of-Pocket Payments	171.2	9.2	29.6	22.1	22.5	5.9	50.3	6.9	24.7	—
Third-Party Payments	736.0	349.3	172.5	25.4	35.5	24.3	41.1	6.4	53.8	27.6
Private Health Insurance	292.3	113.4	101.8	23.2	18.3	3.2	27.8	0.6	4.0	—
Other Private	31.7	15.3	4.2	0.2	3.8	3.3	—	—	1.5	3.4
Government	412.0	220.6	66.5	2.1	13.3	17.9	13.3	5.7	48.3	24.2
Federal	322.6	181.6	54.2	1.2	10.3	15.9	7.5	5.6	32.2	14.2
Medicare	197.8	118.3	42.6	0.1	8.4	13.6	0.7	5.3	8.9	—
Medicaid	87.4	37.1	9.0	1.0	0.9	2.3	6.4	—	21.5	9.1
Other	37.3	26.2	2.6	0.1	1.0	—	0.3	0.3	1.7	5.0
State and Local	89.4	39.1	12.3	0.9	3.0	2.0	5.8	0.1	16.1	10.0
Medicaid	52.3	15.8	6.1	0.8	0.7	1.9	4.5	—	16.0	6.7
Other	37.1	23.3	6.3	0.1	2.3	0.1	1.3	0.1	0.1	3.4

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, National Health Statistics Group.

Table 18

Expenditures for Health Services and Supplies Under Public Programs, by Type of Expenditure and Program: Calendar Year 1996

Program Area	All Expenditures	Personal Health Care											Administration	Public Health Activities
		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			
	Amount in Billions													
Public and Private Spending	$1,003.6	$907.2	$358.5	$202.1	$47.6	$58.0	$30.2	$91.4	$13.3	$78.5	$27.6		$60.9	$35.5
All Public Programs	462.7	412.0	220.6	66.5	2.1	13.3	17.9	13.3	5.7	48.3	24.2		15.2	35.5
Federal Funds	336.6	322.6	181.6	54.2	1.2	10.3	15.9	7.5	5.6	32.2	14.2		10.1	3.9
State and Local Funds	126.1	89.4	39.1	12.3	0.9	3.0	2.0	5.8	0.1	16.1	10.0		5.1	31.6
Medicare	203.1	197.8	118.3	42.6	0.1	8.4	13.6	0.7	5.3	8.9	—		5.3	—
Medicaid[1]	147.7	139.7	52.9	15.1	1.8	1.6	4.1	10.9	—	37.5	15.8		8.0	—
Federal	91.8	87.4	37.1	9.0	1.0	0.9	2.3	6.4	—	21.5	9.1		4.4	—
State and Local	55.9	52.3	15.8	6.1	0.8	0.7	1.9	4.5	—	16.0	6.7		3.6	—
Other State and Local Public Assistance Programs	5.4	5.4	3.0	0.3	0.1	0.4	0.1	1.0	0.0	0.1	0.4		—	—
Department of Veterans Affairs	16.7	16.7	13.7	0.2	0.0	—	—	0.0	0.3	1.7	0.8		0.1	—
Department of Defense[2]	13.4	13.2	10.3	1.6	0.0	—	—	0.3	—	—	0.9		0.2	—
Workers' Compensation	17.3	15.8	7.7	5.9	—	1.9	—	0.3	0.1	—	—		1.4	—
Federal	0.6	0.5	0.3	0.1	—	0.1	—	0.0	0.0	—	—		0.0	—
State and Local	16.7	15.3	7.4	5.8	—	1.8	—	0.3	0.1	—	—		1.4	—
State and Local Hospitals[3]	12.5	12.5	12.5	—	—	—	—	—	—	—	—		—	—
Other Public Programs for Personal Health Care[4]	11.1	10.8	2.1	0.9	0.1	1.1	—	0.0	0.1	—	6.4		0.3	—
Federal	7.1	7.0	1.8	0.7	0.1	0.9	—	0.0	0.1	—	3.4		0.1	—
State and Local	4.0	3.8	0.4	0.2	0.0	0.2	—	0.0	0.1	—	3.0		0.2	—
Government Public Health Activities	35.5	—	—	—	—	—	—	—	—	—	—		—	35.5
Federal	3.9	—	—	—	—	—	—	—	—	—	—		—	3.9
State and Local	31.6	—	—	—	—	—	—	—	—	—	—		—	31.6
Medicare and Medicaid	350.8	337.5	171.2	57.6	1.9	9.9	17.7	11.6	5.3	46.5	15.8		13.3	—

[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 totals because of rounding.

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