

National Health Expenditure Projections, 1994–2005

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Using 1993 as a baseline and assuming that current laws and practices continue, the authors project U.S. health expenditures through the year 2005. Annual spending growth has declined since 1990, and, in the scenario reported here, that trend continues in 1994. Growth of health spending increases thereafter, but remains below the average experience of the past decade. Even so, health expenditures grow faster than the gross domestic product (GDP), and by 2005, account for 17.9 percent of the GDP. Unless the system changes, Medicare and Medicaid are projected to pay for an increasing share of total spending during the next decade.

INTRODUCTION

Since 1990, growth of national health expenditures (NHE) in the United States has been progressively slower than in past years. By calendar year 1993, the year-to-year growth of NHE was 7.8 percent, the second-lowest increase in the past 33 years (Levit et al., 1994). As a result of this experience, the long-term picture for the health sector is somewhat better than predicted in earlier estimates. Health care spending as a percentage of the total economy, however, is expected to continue to increase in the future (Table 1).

Preliminary data for 1994 offer further signs of encouragement: Provisional estimates indicate that national spending for health care reached \$938 billion in 1994, 6.1 percent higher than in 1993. This is the

smallest percent increase for any year since 1960. NHE is estimated to be 13.9 percent of the Nation's GDP (the total value of goods and services produced in the United States) in 1994. This is the same share of GDP as in 1993, only the fourth time since 1965 that the share has failed to rise from one year to the next. The leveling off in 1994 was in part because the Nation experienced moderate growth in NHE and in part because of fairly strong growth in GDP.

The new projections of NHE reported here assume a gradual return to higher growth rates beginning in 1995.

- In 1995, NHE is projected to reach \$1.0 trillion and account for 14.2 percent of GDP.
- In the year 2000, NHE is projected to be \$1.5 trillion, an amount equal to 15.9 percent of GDP.
- In 2005, the final year of our projections, NHE is estimated at \$2.2 trillion—17.9 percent of GDP.

Between 1996 and 2005, growth is projected to stabilize at about 8 percent per year. This is lower than the 11.5 percent average for 1965 through 1993, partly because of lower price inflation during the projection period and partly because of lower growth in use and intensity of services provided.

Our new figures are somewhat lower than projections published 3 years ago (Burner, Waldo, and McKusick, 1992), before the recent deceleration of health care prices and spending. Although the new figures reflect those slowdowns, we

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feel that it is too early to assume that the shift is permanent. In particular, the differential between health care price inflation and general price inflation is little different today than it has been in the past.

It is also important to recognize the uncertainty associated with these projections. Future changes in the laws and regulations governing the delivery and financing of health care would almost certainly result in differences in actual experience from what we have projected. The figures shown here represent an estimate of what would occur, were current laws to remain in force and the trends in current practices of delivery and financing to continue. The scenario is consistent with the projections of Medicare and Medicaid outlays included in the President's 1996 budget submission and, as such, incorporates the overall economic assumptions of that submission.

Tables at the end of this article show details of our new NHE projections by type of service and source of funds.

PROJECTION MODEL

The projections presented here were made using a model that can be described as actuarial, demographic, and constrained. The model is actuarial in nature because it relies primarily on trend analysis to project the factors accounting for the growth in spending. However, in using this model, we have not simply extrapolated from past trends. Instead, we have used the model as a framework to incorporate certain actuarial, statistical, economic, and judgmental factors.

The model is demographic in nature. It explicitly recognizes the effects of the aging of the population on the demand for health care. It is framed in terms of use and expenditure per capita and assumes that there will be a sufficient supply of providers to meet any additional demand

without significant changes in price inflation trends.

As described earlier, the model produces a constrained scenario. It is tied to the President's 1996 budget economic assumptions (Table 2) and to the Medicare and Medicaid projections in that budget. We used population estimates from the intermediate assumptions of the 1994 Old Age, Survivors, and Disability Insurance (Social Security) trust fund report (Board of Trustees, 1994). In addition, Health Resources and Services Administration projections of the number of physicians and dentists were used in estimating the expenditures for these professionals.

The projection model is linked to the national health accounts (NHA). The scenario presented here is based on historical estimates of NHE through 1993 (Levit et al., 1994). Estimates are made for 18 types of goods and services using a series of identity equations. In a typical identity, aggregate historical expenditures are broken down into seven factors accounting for their growth:

Exogenous factors:

- Population.
- Price growth in the general economy, proxied by the GDP implicit price deflator.

Factors relating to the demographic composition of the population:

- Use per capita, by age and sex.
- Intensity of services, by age and sex.

Service-specific factors:

- Use per capita, exclusive of age-sex effects.
- Intensity of services, exclusive of age-sex effects.
- Change in medical care prices relative to the GDP deflator.

A more detailed explanation of these factors can be found in Freeland and Schendler (1984) and Sonnefeld et al. (1991).

After each of the 18 expenditure levels was projected using the applicable identity equation, it was compared with a projection of funds available to pay for that service. The projections were refined through an iterative process until both sides were in balance. We also compared projections of services that are either substitutes or complements (for example, physician services and prescription drugs) to ensure that the scenario we developed was internally consistent.

Exogenous Assumptions

The economy is projected to grow steadily at moderate rates throughout the 1993-2005 projection period. In the President's budget, growth in real GDP is projected to slow from 3.9 percent in 1994 to its post-1972 historical average of about 2.5 percent by 1996 and to maintain that growth rate for the remainder of the projection period. Price inflation, as measured by the implicit price deflator for the GDP, is projected to grow 2.8 percent in 1995 and then to stabilize at 3.0 percent per year through 2005. This assumption represents an increase from the very low growth rates of 2.2 percent in 1993 and 2.1 percent in 1994 but not a return to the much higher rates experienced during the 1970s and early 1980s.

Total population growth is projected to decline gradually, from 0.9 percent in 1994 to 0.7 percent in 2005. In addition to experiencing slower growth, the population is projected to age somewhat, on average. The proportion of the population 65 years of age or over is projected to remain almost constant at about 12.5 percent, but the proportion of the population 75 years or over is projected to increase from 5.5 percent in 1994 to 6.1 percent in 2005.

The aging of the population is often cited as a significant factor in the growth in health care spending, but it does not have a significant effect during our projection period. To measure the effect, we developed indexes of use per capita and cost per use for most of the components of personal health care. Based on these indexes, we estimate that between now and 2005, the aging of the population will add less than 1 percent per year to the growth of personal health expenditures. The aging of the population will not have a major effect on spending until after the current projection horizon, when the "baby boom" generation begins to reach 65 years of age (around the year 2010).

Endogenous Assumptions

As previously mentioned, preliminary estimates for 1994 indicate the smallest growth in NHE in any year since 1960. Most of this slowdown occurred in the private sector and appears to be attributable to the continuing move to managed care, possibly in conjunction with provider restraint in the face of last year's health care reform efforts. Given the uncertainty about managed-care's ability to control health care costs in the long term, we have produced what we describe as a "moderate" set of projections. That is, we assume neither that the recent slowdown will continue nor that growth will return to the high rates that characterized the 1970s and 1980s.

Reflecting the slowdown in overall price inflation already discussed, we have projected price inflation in the medical sector to be slower than in the historical period. Medical care inflation, net of overall price inflation, is projected to grow one-half of 1 percent per year slower between 1993 and 2005 than during the previous 10 years. Growth in real expenditure per capita, which includes changes in utilization and intensity, is projected to average 2.4 percent per year for

the projected period. This is only one-tenth of 1 percent less than the growth during 1983-93, but more than 1 percent less than the average growth for 1965-93.

In producing this scenario, we have created three projection periods. The "short term" includes 1994 and 1995, which we assume to be influenced heavily by recent trends. During the "intermediate term" (1996-2000), trends in sector-specific price inflation, use per capita, and intensity of services per unit of use converge to their ultimate assumed growth rate. These ultimate growth rates characterize the "long term" (2001 and later).

Factors Affecting NHE Growth

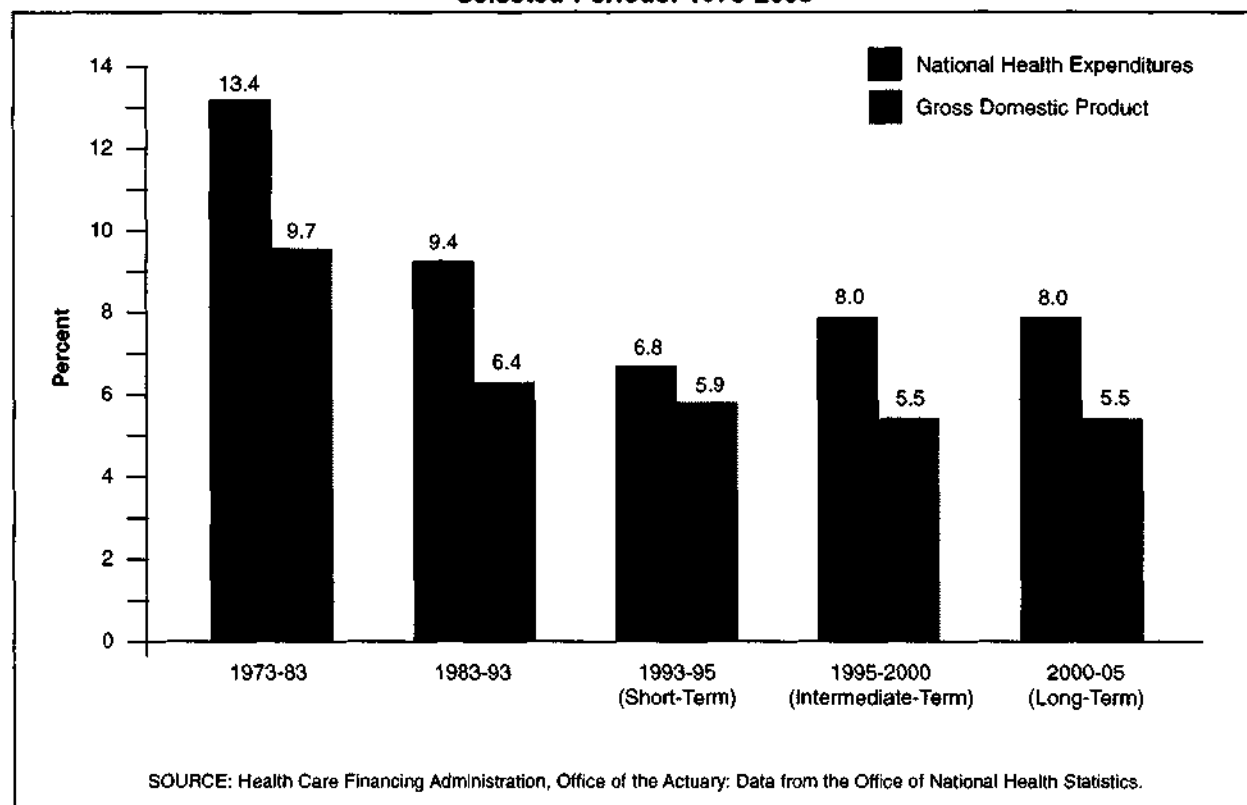
During the past 30 years, NHE has typically grown faster than GDP, and we pro-

ject little change in that relationship during the next decade. During the decade from 1973 to 1983, NHE growth averaged 13.4 percent per year, 3.7 percentage points faster than the GDP growth (Figure 1). During the 1983-93 decade, annual NHE growth averaged 9.4 percent, 3.0 percentage points faster than the comparable GDP figure. Over the projection period (1993-2005), our figures place NHE growth at an average of 7.8 percent per year, 2.2 percentage points faster than projected GDP growth.

There are several causes of the difference between NHE growth and GDP growth. First, the health sector is predominantly a service industry, and the service sector generally grows faster than the rest of the economy over the long term—especially when national income is rising.

Figure 1

Average Annual Growth in National Health Expenditures and Gross Domestic Product for Selected Periods: 1973-2005



Second, technological change in the health sector tends to increase spending by creating new products, rather than to reduce the price of existing products. Even where that change reduces the price of existing products, the elasticity of demand appears to be greater than unity, leading to increased spending. Third, much of health spending is prepaid through insurance premiums, insulating that spending from economic upswings and downswings. Further, there is evidence that the presence of health insurance raises not only the level of health spending but the growth of that spending as well (Peden and Freeland, 1995). Finally, the aging of the U.S. population raises the aggregate demand for health care services: People 65 years of age or over consume four times as many health care goods and services as do those under 65 years of age (Waldo et al., 1989). (As noted earlier in this article, however, we believe that aging of the population will not play a significant role in health expenditure growth until well after the end of our projection period.)

When examining the growth of NHE, it may be useful to identify growth attributable to increases in population, to price inflation, and to all other factors. The latter category includes the effects of national income levels and distribution, technological change and dispersion, changes in morbidity and mortality, and changes in financing mechanisms, as well as other influences such as time, cost, and consumer awareness. These various influences are lumped together principally because it is virtually impossible to separate their effects at a national level with information available today. It may also be useful to divide the inflation factor in two: economy-wide inflation (generally outside the control of agents in the health sector) and sector-specific inflation. Several authors have pointed out that this distinction may

not be wholly accurate (e.g., Aaron, 1994), but it does indicate the rough magnitude of factors endogenous to the health sector, as opposed to those exogenous to the sector.

The relative effects of these four factors—population growth, general price inflation, health sector price inflation, and “other”—are projected to be roughly the same during the projection period as during the past decade. During 1973-83, general price inflation averaged 7.8 percent, accounting for 60 percent of the growth in NHE (Figure 2). Deceleration of the GDP deflator during 1983-93, unaccompanied by significant changes in growth of other factors, reduced its relative contribution to aggregate NHE growth. In fact, compared with overall inflation, average growth rates for industry-specific inflation, population, and “other” factors have changed fairly little during the past two decades, and in the intermediate term and long term of our projections, they continue to grow at about those historical rates. The deceleration of all factors during the short term was mentioned previously and is discussed later in this article.

“Real” Growth in NHE

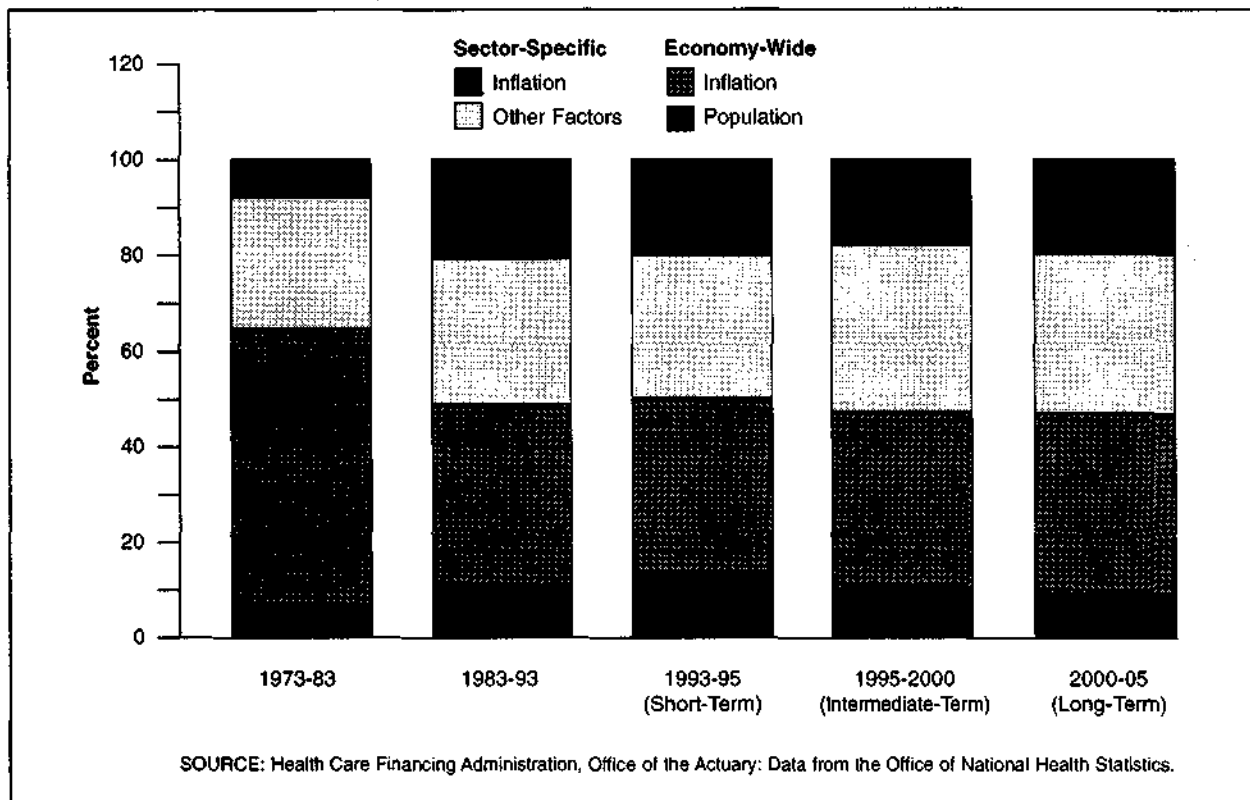
Among the concerns over rising levels of health expenditure is the effect of those levels on non-health sectors of the economy. One aspect of those effects is the pressure of rising employer-sponsored insurance costs on costs of production; another is the effect on government deficits. A discussion of these effects is outside the scope of this article, but has taken place in other settings (Monaco and Phelps, 1994). However, there are several ways in which the trend in health expenditures can be viewed in an aggregate economic sense.

One such way is to look at growth of constant-dollar expenditures and GDP. The

constant-dollar figure for each component of health expenditures and each component of the GDP is found by deflating nominal dollar spending by a price index specific to the component. These deflated components are summed to a constant-dollar total for NHE or GDP. In an ideal world (from the statistician's standpoint), growth of these measures roughly approximates growth of the quantity of goods and services produced, together with changes in the quality of those goods and services. As mentioned earlier, there is considerable doubt about the ability of existing price measures to separate quality change from pure price change; to the extent that some quality improvements are expressed as price inflation, then the growth of constant-dollar NHE or GDP would understate the true case.

However, such measures can be used to show roughly the capacity of the economy to absorb increased health expenditures. During 1973-83, constant-dollar NHE increased 3.2 percent per capita annually, a rate that declined to 2.5 percent during 1983-93. Our projection methods produce an annual growth rate of 2.4 percent for 1993-2005. One of the key results of this analysis is that a rising share of GDP going to health does not necessarily translate into fewer non-health goods and services being consumed: From 1973 to 1983, per capita constant-dollar GDP, excluding NHE, increased 0.6 percent per year; the rate rose to 1.6 percent from 1983 to 1993 (Figure 3). In the projection period 1993-2005, the rate is 1.7 percent. In the scenario we constructed, NHE would rise as a share of the GDP, from 13.9 percent to 17.9

Figure 2
Relative Contribution of Factors Accounting for Average Annual Growth in National Health Expenditures for Selected Periods: 1973-2005



percent, without causing a reduction in growth of real per capita non-health GDP. Of course, it is perfectly valid to argue that the non-health growth rate would be even higher, were health expenditures reduced. Further, we draw no conclusions as to whether social welfare would be greater or less, were health expenditure growth slower. The point made here is simply that NHE can rise as a share of GDP without reducing the level of real consumption per capita.

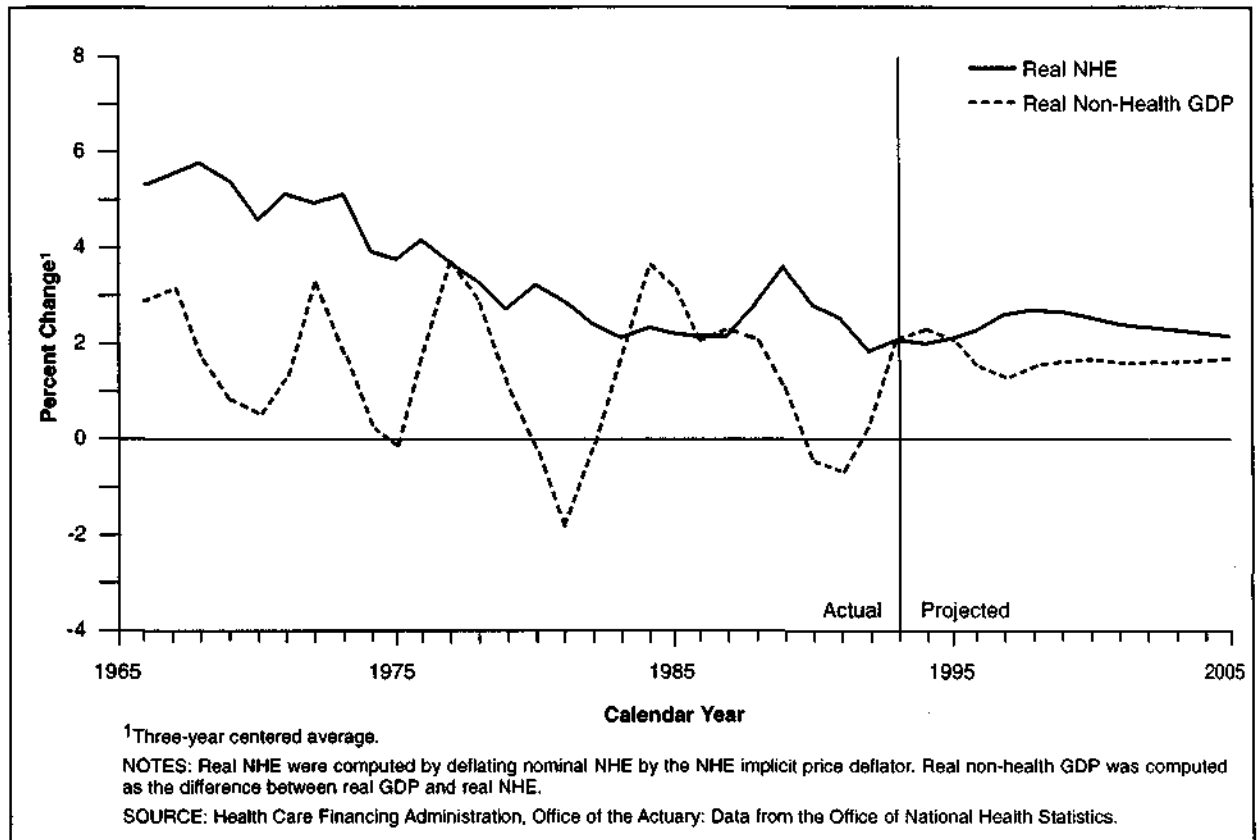
Another way to look at the magnitude of health expenditure growth is through the real opportunity cost of that expenditure. Economists define the opportunity cost of a purchase to be the value of other goods or services that could have been bought with the same money. The real opportunity cost is the value of those other goods and serv-

ices adjusted for changes in their prices. Growth in the real opportunity cost of NHE, therefore, equals the growth of current-dollar NHE divided by the growth of the GDP deflator that excludes NHE categories. During 1973-83, real opportunity cost averaged 4.4 percent per year, and during 1983-93, it averaged 4.8 percent (Figure 4). In recent years, the rate has begun to diminish a little, and in our projection scenario, that trend continues: The annual average growth of the opportunity cost of NHE between 1993 and 2005 is 4.2 percent.

Summary of Projection Scenario

Over time, an increasing share of NHE has been devoted to the direct provision of health care goods and services to

Figure 3
Percent Growth in Real National Health Expenditures (NHE) Per Capita and Real Non-Health Gross Domestic Product (GDP) Per Capita: Calendar Years 1965-2005



patients. Personal health care expenditures (PHCE) exclude administration expenses, research, construction, and other spending that is not directed to a specific individual. PHCE accounted for 85.6 percent of NHE in 1965, rising to an 88.5-percent share in 1993. Excess hospital capacity (in aggregate) has resulted in fairly small amounts of health-facility construction over the years, and construction price inflation has been much slower than price inflation of medical goods and services. In addition, since 1973 research expenditures have grown more slowly after adjustment for price inflation than have PHCE. In our projection scenario, these trends continue, and the ratio of PHCE to NHE reaches 90.8 percent in 2005.

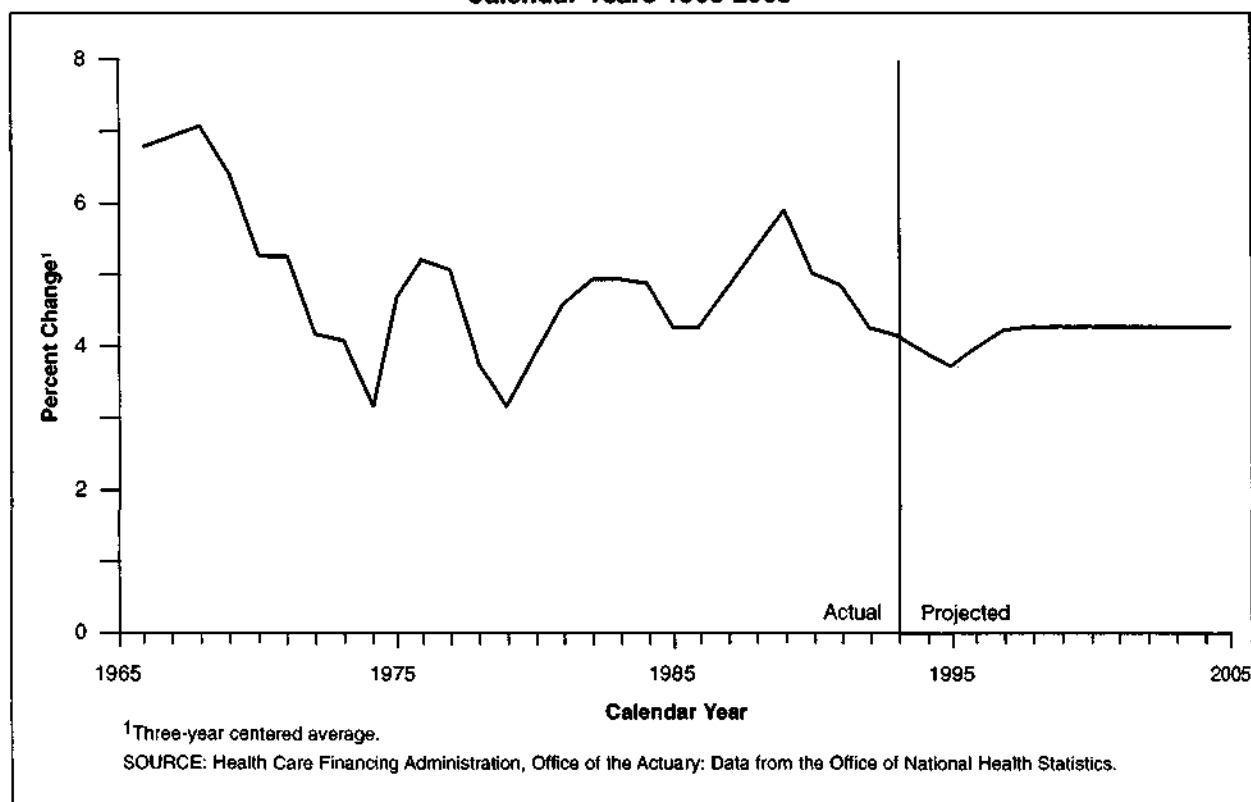
PHCE are projected to reach \$897.7 billion in 1995, \$1.3 trillion in 2000, and \$2.0 trillion in 2005 (Table 3). These dollar lev-

els imply an average annual growth rate of 8.0 percent during the projection period, compared with 9.5 percent for 1983-93 and 13.6 percent for 1973-83. The projected slowdown is mostly a function of lower price inflation, although 1973-83 was characterized by higher growth of use and intensity than later years.

Our projections show an expected continuation of the shift in composition of personal health care from inpatient care to ambulatory services. Inpatient community hospital revenues are projected to grow at an average annual rate of 6.0 percent during the projection period, compared with 9.7 percent for community hospital outpatient revenues and 9.0 percent for physician services. Home health care, which is financed in large part by the Medicare program, has the highest projected growth, averaging 10.4 percent per year.

Figure 4

**Percent Growth in Real Opportunity Cost of National Health Expenditures Per Capita:
Calendar Years 1965-2005**



The shift of services away from institutional settings is reflected in the average growth rates by type of service in our projection scenario, as shown in Figure 5. The shifts show up as increases in use or intensity per capita, which are included in the "other factors" category. These average growth rates also reflect the projected differential trends in price inflation.

Total hospital care is projected to grow at an average annual rate of 7.0 percent during the projection period. The projected growth rate for hospitals being slightly lower than for the rest of NHE, the hospital share of NHE declines from 36.9 percent in 1993 to 33.9 percent in 2005.

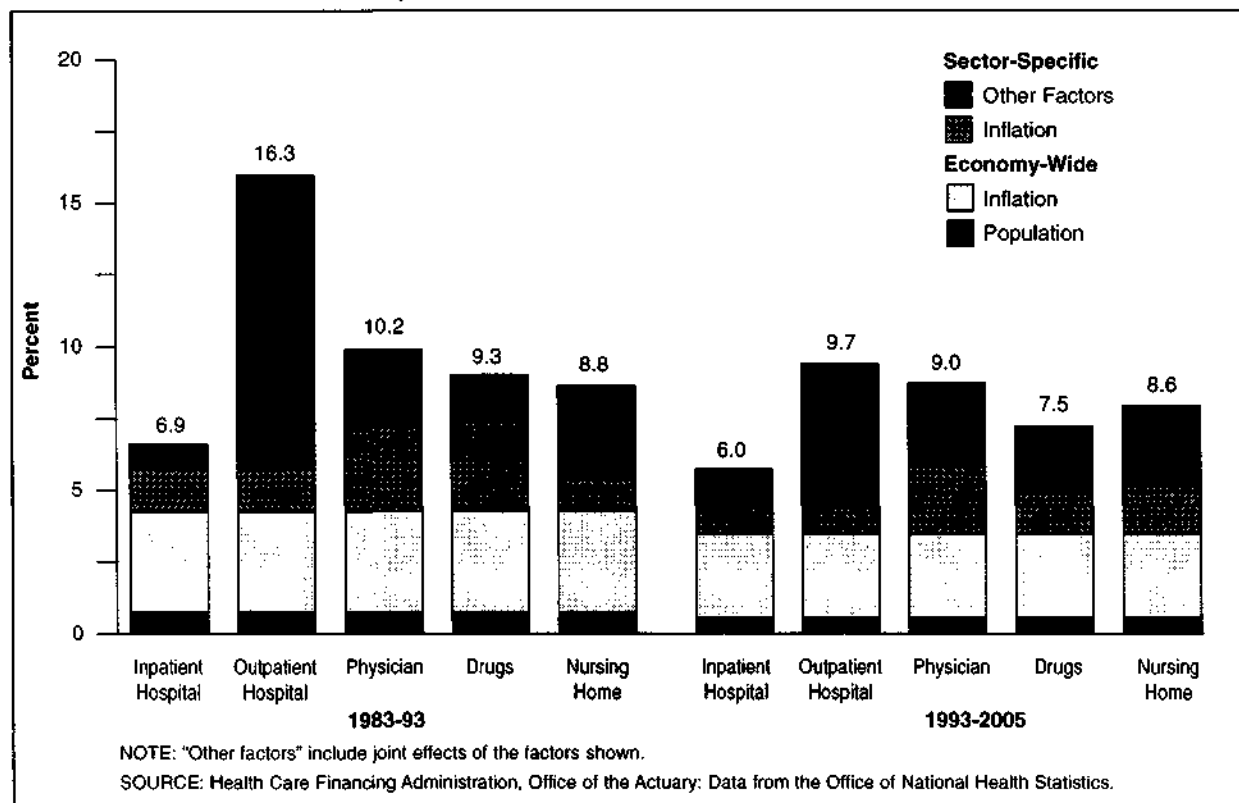
The short term is characterized by a sharp deceleration of community hospital revenues. Partial data for 1994 suggest that community hospital inpatient revenues (which account for about 60 percent of all

hospital spending) grew less than 3 percent (Donham, Sensening, and Heffler, 1995). This is the smallest increase on record—even smaller than the 1985 figure that coincided with the implementation of Medicare's prospective payment system.

We believe that the hospital experience in 1994 was a function of several forces, including the health reform debate and increased use of managed-care plans, and that growth is likely to increase once again after these factors play out. However, the projected growth of inpatient revenue remains well below historical rates in the future, for three reasons. First, the number of hospital days per capita has been declining since 1982, and we project this trend to continue (but at a slower rate). Second, the difference between hospital prices and overall price inflation is projected to average about 0.5 percent lower per year than

Figure 5

Factors Accounting for Average Annual Growth in Selected Types of National Health Expenditures: Selected Periods 1983-2005



for 1983-93. Third, we project intensity growth to average 2.1 percent less per year than for the previous 10 years.

In contrast to community hospital inpatient revenues, outpatient revenues are projected to increase as a share of NHE during the next 12 years. In recent years, growth of these revenues has surged as providers responded to initiatives by Medicare and other payers of health care to find cost-effective alternatives to inpatient care. We project that trend to continue, but at a slower rate, as providers continue to shift care from inpatient to outpatient settings and from outpatient to non-hospital settings.

Expenditures for physician services are projected to increase at an average annual rate of 7.6 percent during the short-term projection period (1993-95) and then to increase to 9.3 percent per year for the remainder of the period. As a result, the average growth during the projection period is about 1 percentage point slower than during 1983-93. All of the reduction is the result of lower price inflation; real growth has averaged 3.3 percent per year for the past 20 years and is estimated to maintain that rate during the projection period.

As mentioned earlier, spending for home health services is projected to grow faster than any other component of NHE during the next 12 years. Technological change has made it possible to deliver many services in patient homes that previously were delivered in institutional settings. Also, changes in Medicare provisions resulted in expanding coverage of home health services as cost-effective alternatives. We expect that the former factor will continue to operate in the projection period but that the effects of the Medicare expansion will become fully phased in within the short term.

SOURCES OF FUNDS

Our projection scenario shows an increasing emphasis on public programs to finance health care. The private share of NHE decreases from 56.1 percent in 1993 to an estimated 53.9 percent in 2005 (Table 4). This decrease in the private share is distributed about equally across the three components of private spending—private health insurance, out-of-pocket, and other private payments. Medicare and Medicaid benefits account for the rising public share of total spending. Within the public sector, the Federal share is projected to continue to increase and the State share to decline (Figure 6). Most of the shift to the Federal Government has been the result of States' use of "tax and donation" (T&D) mechanisms to shift more of the Medicaid burden onto the Federal Government, as described later.

Medicaid

Total Medicaid benefit outlays are projected to increase at an average annual rate of 9.0 percent during the projection period. This is significantly lower than the 12.9-percent rate for 1983-93 and the 14.0-percent rate for 1973-83. During the late 1980s, Medicaid outlays grew rapidly. In part this was because of eligibility expansions and mandated higher payments to certain providers, particularly nursing homes. But the largest factor was increased payments to disproportionate-share hospitals (DSH), which were often financed by provider-based taxes and voluntary donations. To slow the rapid growth of Medicaid outlays, Federal regulations were passed to cap the amount of DSH payments and to limit States' ability to use T&D mechanisms to obtain additional Federal funds. In our projections, these regulations contribute sig-

nificantly to the slowdown in the growth of the Medicaid program.

Although the regulations have been effective in stopping the ability of States to continue to shift more of the burden onto the Federal Government, the changes are not applicable retroactively. Thus, it appears there has been a permanent change in the effective Federal match rate. When 1993 State and local Medicaid payments are adjusted to remove DSH payments estimated to have been offset by T&D funds, the effective Medicaid Federal match rate increased from 57.3 percent to 64.5 percent (Levit et al., 1994). The projections of State and local Medicaid payments have been adjusted to reflect this higher match rate.

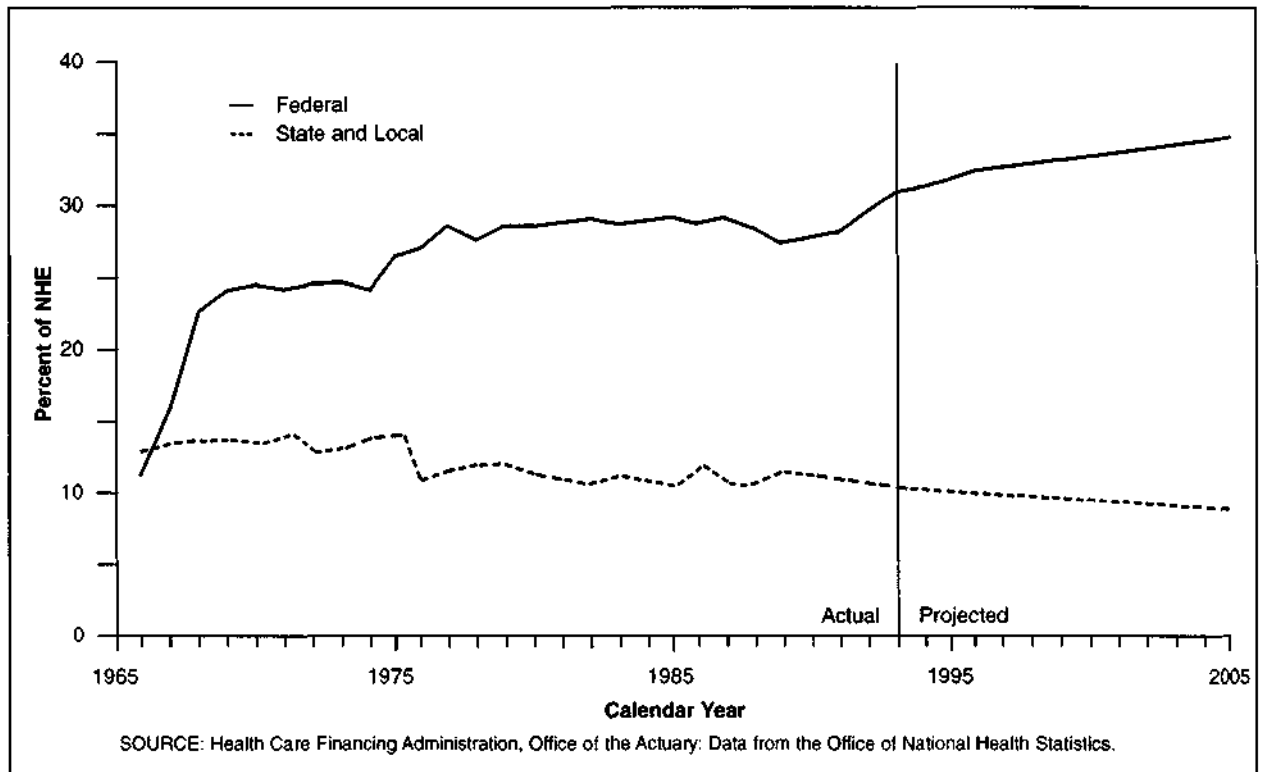
Another factor contributing to the recent slowdown of Medicaid spending appears to be the increasing number of recipients

enrolled in managed care plans. According to statistics from the Health Care Financing Administration (1994) Office of Managed-Care, almost one-quarter of all Medicaid recipients in 1994 were enrolled in some kind of managed-care plan. This trend is projected to continue, and third-party premiums are projected to be the fastest-growing component of the Medicaid program.

Medicare

Medicare is projected to pay for an increasing share of personal health care expenditures between 1993 and 2005. In 1993, Medicare benefits covered 19.3 percent of PHCE; in 2005 that share is projected to be 22.6 percent. Within the Medicare program, the shift from hospital inpatient services to other services is projected to continue. This is primarily the result of the

Figure 6
Percent of National Health Expenditures (NHE) Funded by Public Sources:
Calendar Years 1965-2005



ability of the Medicare prospective payment system to limit increases for hospital inpatient services.

The Medicare projections also incorporate an assumption that the recently enacted physician reforms will continue to be effective in holding down increases in payments to physicians. Because of the conversion from Medicare to NHA categories, this slowdown is difficult to see in our tables. The NHA physician category includes three types of Medicare Part B services: physician services, group practice prepayment plans (GPPP), and independent laboratory services. However, physician payment reform does not affect the spending in the latter two categories. In fact, growth in GPPP is projected to average almost 20 percent per year during the projected period, attributable primarily to assumed continuing growth in enrollment in such plans. Although Medicare enrollment in managed-care plans has almost doubled in the past 5 years and is projected to continue to increase, it does not appear that Medicare is as effective in realizing savings from managed care as is the private sector. This is attributable to the statutory payment methodology, under which Medicare pays capitated health maintenance organizations at 95 percent of the average costs of Medicare enrollees in fee-for-service plans in the same geographic area.

The projected rates of increase for both skilled nursing facility and home health benefits under Medicare are dramatically lower than those experienced during the past 10 years. Liberalization of the requirements for eligibility for these two services resulted in annual growth rates of as much as 30 percent during the past several years. These growth rates are not projected to continue but rather to slow significantly by the year 2005 as the system adjusts to the new rules (Figure 7).

Private Insurance

We have not projected any dramatic changes in the breadth or depth of private health insurance coverage during the next 12 years. That is, we assume that the types of services covered and the proportion of costs for those services paid by insurance will remain fairly constant.

Preliminary data for 1994 and 1995 indicate that growth in private health insurance premiums is at an all-time low. According to a survey of employers conducted by the consulting firm of Foster Higgins (1995), the average cost of health benefits per employee actually declined by 1.1 percent from 1993 to 1994. However, the report also showed increases in costs for each of the four types of plans shown—traditional indemnity, preferred provider organizations, point-of-service plans, and health maintenance organizations. Therefore, the decrease in aggregate costs is entirely attributable to the shift from traditional indemnity plans to managed-care plans.

Currently, there is great uncertainty and disagreement about the ability of managed care to effectively control costs over the long term. In our projections, we have assumed that the move to managed care produces a one-time savings, but that the savings are spread over several years. As this movement tapers off, we have projected a return to higher growth rates for private insurance premiums—about 8.0 percent per year, still significantly lower than the double-digit rates of the 1970s and 1980s.

SUMMARY

The scenario we have reported here shows only one of many possible paths the U.S. health sector may take in the coming years. Potential reforms in the private

insurance industry, although not as sweeping as those proposed by the Clinton Administration's Health Security Act, seem quite likely; but the effect of those reforms on access to insurance and premium costs is not at all clear. Legislative changes to the Medicaid program and even to the Medicare program add additional wild cards to the outlook for health expenditure growth. So, too, does the move toward managed care, both under Medicaid and under private coverage: Can the cost savings accomplished to date through managed care continue as more and more consumers and more and more providers enter that part of the system?

Our scenario can be seen as a baseline. That is, it can be used as a point of comparison for alternative views of the future. For example, other scenarios could be constructed in which managed care is even more successful than in the past; or in which Medicare is capitated; or in which some form of global cost containment is achieved. However, we sound a cautionary note to those who believe that the United States could never spend 17 percent of its GDP on health without a revolution: Many noted health economists of the 1960s firmly believed that we would never spend 10 percent of our GDP on health without a consumer revolution.

Figure 7

Average Annual Growth in Medicare Benefit Outlays: Selected Periods 1973-2005

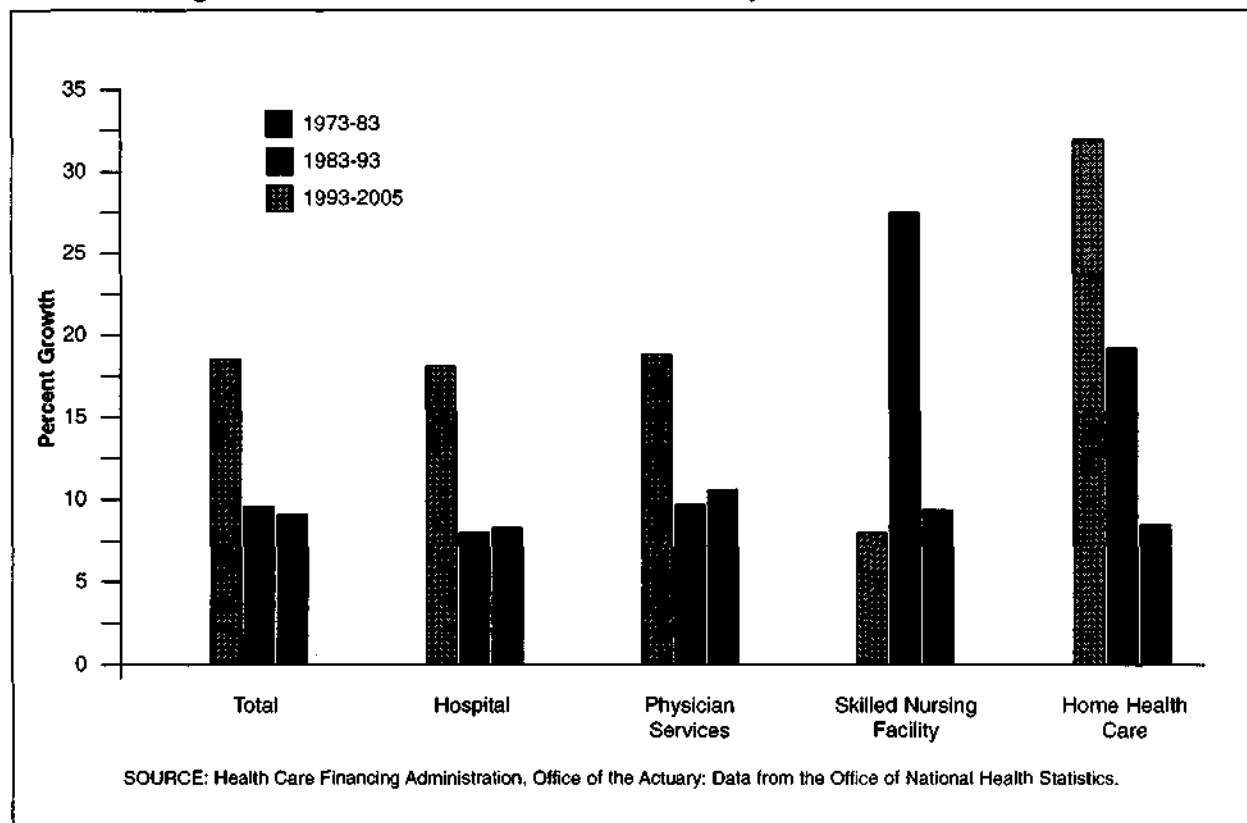


Table 1
National Health Expenditure Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds:
Selected Calendar Years 1980-2005

Source of Funds	Historical						Projected		
	1980	1990	1991	1992	1993	1994	1995	2000	2005
Aggregate Amount in Billions									
All Sources	\$251.1	\$696.6	\$755.6	\$820.3	\$884.2	\$938.3	\$1,007.6	\$1,481.7	\$2,173.7
Private	145.8	410.0	432.9	462.9	496.4	518.1	552.7	807.9	1,171.3
Public	105.3	286.5	322.6	357.5	387.8	420.2	454.9	673.7	1,002.4
By Program									
Medicare	37.5	112.1	123.3	138.3	154.2	171.4	190.0	293.5	450.9
Medicaid	26.1	75.4	93.9	108.0	117.9	128.5	138.4	214.5	333.4
Other	41.6	99.0	105.5	111.2	115.7	120.3	126.5	165.7	218.1
By Government Level									
Federal	72.0	195.8	224.7	254.3	280.6	306.7	334.1	502.5	756.7
State and Local	33.3	90.7	98.0	103.2	107.3	113.5	120.8	171.2	245.7
Percent Distribution									
All Sources	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private	58.1	58.9	57.3	56.4	56.1	55.2	54.9	54.5	53.9
Public	41.9	41.1	42.7	43.6	43.9	44.8	45.1	45.5	46.1
By Program									
Medicare	14.9	16.1	16.3	16.9	17.4	18.3	18.9	19.8	20.7
Medicaid	10.4	10.8	12.4	13.2	13.3	13.7	13.7	14.5	15.3
Other	16.6	14.2	14.0	13.6	13.1	12.8	12.6	11.2	10.0
By Government Level									
Federal	28.7	28.1	29.7	31.0	31.7	32.7	33.2	33.9	34.8
State and Local	13.3	13.0	13.0	12.6	12.1	12.1	12.0	11.6	11.3
Average Annual Percent Change From Previous Year									
All Sources	—	10.7	8.5	8.6	7.8	6.1	7.4	8.0	8.0
Private	—	10.9	5.6	6.9	7.2	4.4	6.7	7.9	7.7
Public	—	10.5	12.6	10.8	8.5	8.3	8.3	8.2	8.3
By Program									
Medicare	—	11.6	10.0	12.2	11.5	11.1	10.9	9.1	9.0
Medicaid	—	11.2	24.5	15.0	9.2	9.0	7.7	9.2	9.2
Other	—	9.1	6.5	5.5	4.1	4.0	5.2	5.5	5.6
By Government Level									
Federal	—	10.5	14.8	13.2	10.3	9.3	8.9	8.5	8.5
State and Local	—	10.5	8.0	5.3	3.9	5.8	6.4	7.2	7.5

See footnotes at end of table.

Table 1—Continued
National Health Expenditure Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds:
Selected Calendar Years 1980-2005

Source of Funds	Historical						Projected		
	1980	1990	1991	1992	1993	1994	1995	2000	2005
Gross Domestic Product (Billions)	\$2,708.0	\$5,546.1	\$5,724.8	\$6,020.3	\$6,343.3	\$6,735.0	\$7,116.5	\$9,310.1	\$12,155.5
U.S. Population ¹	235.1	259.4	262.8	265.8	268.4	271.0	273.5	285.0	295.7
National Health Expenditures Per Capita	\$1,068	\$2,686	\$2,875	\$3,086	\$3,294	\$3,463	\$3,685	\$5,198	\$7,352
National Health Expenditures as a Percent of Gross Domestic Product	9.3	12.6	13.2	13.6	13.9	13.9	14.2	15.9	17.9

¹July 1 Social Security area population estimates.

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

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

Table 2
Historical and Projected Gross Domestic Product and Population: United States, Selected Years 1980-2005

Year	Gross Domestic Product			Population by Age Group		
	Current Dollars in Billions	1987 Dollars in Billions	Implicit Price Deflator	All Ages	65 Years of Age or Over	75 Years of Age or Over
	Number in Thousands					
Historical						
1980	\$2,708	\$3,776	71.7	235,071	26,128	10,411
1990	5,546	4,897	113.3	259,357	31,918	13,527
1991	5,725	4,868	117.6	262,757	32,540	13,923
1992	6,020	4,979	120.9	265,802	33,113	14,282
1993	6,343	5,135	123.5	268,429	33,592	14,620
Projected						
1994	6,735	5,337	126.2	270,971	33,997	14,932
1995	7,117	5,488	129.7	273,453	34,363	15,283
2000	9,310	6,203	150.1	285,025	35,476	16,975
2005	12,156	6,987	174.0	295,662	36,843	18,017

SOURCE: 1996 President's Budget Submission and (Board of Trustees, 1994).

Table 3
Aggregate Amount and Average Annual Percent Change in National Health Expenditures, by Type of Service:
Selected Calendar Years 1980-2005

Source of Funds	Historical						Projected		
	1980	1990	1991	1992	1993	1994	1995	2000	2005
Aggregate Amount in Billions									
National Health Expenditures	\$251.1	\$696.6	\$755.6	\$820.3	\$884.2	\$938.3	\$1,007.6	\$1,481.7	\$2,173.7
Personal Health Care	220.1	612.4	670.8	729.7	782.5	832.5	897.7	1,334.3	1,973.4
Hospital Care	102.7	256.5	282.3	306.0	326.6	341.7	364.5	518.3	736.8
Physician Services	45.2	140.5	150.3	161.8	171.2	182.7	198.0	309.8	483.6
Dental Services	13.3	30.4	31.7	34.7	37.4	40.0	42.9	59.1	79.1
Other Professional Services	6.4	36.0	40.4	46.4	51.2	56.7	62.9	103.3	166.4
Home Health Care	1.9	11.1	13.2	16.8	20.8	24.2	27.9	45.9	68.0
Drugs and Other Medical Non-Durables	21.6	61.2	67.1	70.8	75.0	79.0	84.7	122.3	178.6
Vision Products and Other Medical Durables	4.5	10.5	11.3	12.0	12.6	13.2	13.9	17.9	22.6
Nursing Home Care	20.5	54.8	60.8	65.5	69.6	74.2	80.2	121.2	179.6
Other Personal Health Care	4.0	11.4	13.8	15.8	18.2	20.9	22.7	36.5	58.7
Program Administration and									
Net Cost of Private Health Insurance	12.1	38.3	37.0	39.5	48.0	50.3	51.9	74.1	107.3
Government Public Health Activities	7.2	21.6	22.9	23.7	24.7	26.1	27.9	37.2	48.6
Research	5.5	12.2	12.9	14.2	14.4	15.4	15.9	19.6	24.4
Construction	6.2	12.1	11.9	13.2	14.6	14.1	14.2	16.5	20.0
Average Annual Percent Change From Previous Year									
National Health Expenditures	-	10.7	8.5	8.6	7.8	6.1	7.4	8.0	8.0
Personal Health Care	-	10.8	9.5	8.8	7.2	6.4	7.8	8.2	8.1
Hospital Care	-	9.6	10.0	8.4	6.7	4.6	6.7	7.3	7.3
Physician Services	-	12.0	7.0	7.6	5.8	6.7	8.4	9.4	9.3
Dental Services	-	8.6	4.2	9.6	7.7	7.0	7.2	6.6	6.0
Other Professional Services	-	18.9	12.3	14.8	10.4	10.6	11.0	10.4	10.0
Home Health Care	-	19.4	19.2	27.4	23.8	16.2	15.5	10.5	8.2
Drugs and Other Medical Non-Durables	-	11.0	9.5	5.5	5.9	5.4	7.1	7.6	7.9
Vision Products and Other Medical Durables	-	8.9	7.2	6.4	5.3	4.3	5.5	5.1	4.8
Nursing Home Care	-	10.3	10.9	7.8	6.3	6.6	8.0	8.6	8.2
Other Personal Health Care	-	11.0	21.4	14.4	15.0	15.0	8.7	10.0	10.0
Program Administration and									
Net Cost of Private Health Insurance	-	12.2	-3.3	6.6	21.5	4.8	3.2	7.4	7.7
Government Public Health Activities	-	11.5	6.4	3.4	4.2	5.6	6.9	5.9	5.5
Research	-	8.4	5.6	10.3	1.1	6.8	3.5	4.3	4.5
Construction	-	7.0	-1.9	11.4	10.8	-3.4	0.5	3.0	4.0

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

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

Table 4

National Health Expenditures, by Source of Funds and Type of Expenditure: United States, Selected Calendar Years 1993-2005

Year and Type of Expenditure	Private						Government				
	Total Public and Private	All Private Funds	Consumer				Total	Federal	State and Local		
			Total	Out of Pocket	Private Insurance	Other			Medicare ¹	Medicaid ²	
1993	Amount in Billions										
All Expenditures	\$884.2	\$496.4	\$453.6	\$157.5	\$296.1	\$42.8	\$387.8	\$280.6	\$107.3	\$154.2	\$117.9
Health Services and Supplies	855.2	484.3	453.6	157.5	296.1	30.7	370.9	268.6	102.4	154.2	117.9
Personal Health Care	782.5	445.5	415.5	157.5	258.0	30.0	337.0	259.0	78.1	151.1	112.8
Hospital Care	326.6	143.7	126.9	9.1	117.8	16.8	182.9	149.2	33.7	92.7	42.4
Physician Services	171.2	113.1	110.3	26.2	84.1	2.7	58.1	45.0	13.1	34.8	12.5
Dental Services	37.4	35.6	35.5	18.7	16.8	0.2	1.7	1.0	0.8	—	1.5
Other Professional Services	51.2	40.6	37.0	21.2	15.8	3.6	10.6	7.3	3.3	5.6	1.4
Home Health Care	20.8	9.4	6.9	4.3	2.5	2.5	11.4	9.8	1.5	8.1	3.2
Drugs and Other Medical Non-Durables	75.0	65.8	65.8	47.4	18.4	—	9.2	4.7	4.4	—	7.7
Vision Products and Other Medical Durables	12.6	8.5	8.5	7.6	0.9	—	4.2	4.0	0.2	3.7	—
Nursing Home Care	69.6	26.0	24.7	23.0	1.7	1.3	43.6	28.3	15.3	6.1	36.0
Other Personal Health Care	18.2	2.8	—	—	—	2.8	15.3	9.5	5.8	—	8.1
Program Administration and Net Cost of Private Health Insurance	48.0	38.8	38.1	—	38.1	0.7	9.2	6.3	2.8	3.1	5.1
Government Public Health Activities	24.7	—	—	—	—	—	24.7	3.3	21.4	—	—
Research and Construction	29.0	12.1	—	—	—	12.1	16.9	12.0	4.9	—	—
Research	14.4	1.2	—	—	—	1.2	13.1	11.1	2.1	—	—
Construction	14.6	10.9	—	—	—	10.9	3.8	0.9	2.8	—	—
	Percent Distribution										
All Expenditures	100.0	56.1	51.3	17.8	33.5	4.8	43.9	31.7	12.1	17.4	13.3
Health Services and Supplies	100.0	56.6	53.0	18.4	34.6	3.6	43.4	31.4	12.0	18.0	13.8
Personal Health Care	100.0	56.9	53.1	20.1	33.0	3.8	43.1	33.1	10.0	19.3	14.4
Hospital Care	100.0	44.0	38.9	2.8	36.1	5.2	56.0	45.7	10.3	28.4	13.0
Physician Services	100.0	66.0	64.4	15.3	49.1	1.6	34.0	26.3	7.7	20.3	7.3
Dental Services	100.0	95.3	94.9	50.0	44.9	0.4	4.7	2.7	2.0	—	4.1
Other Professional Services	100.0	79.3	72.3	41.3	30.9	7.0	20.7	14.2	6.5	11.0	2.7
Home Health Care	100.0	45.2	33.1	20.8	12.2	12.2	54.8	47.4	7.4	38.8	15.5
Drugs and Other Medical Non-Durables	100.0	87.8	87.8	63.2	24.6	—	12.2	6.3	5.9	—	10.2
Vision Products and Other Medical Durables	100.0	67.0	67.0	60.0	7.0	—	33.0	31.8	1.2	29.6	—
Nursing Home Care	100.0	37.4	35.5	33.0	2.5	1.9	62.6	40.7	21.9	8.8	51.7
Other Personal Health Care	100.0	15.5	—	—	—	15.5	84.5	52.5	32.0	—	44.6
Program Administration and Net Cost of Private Health Insurance	100.0	80.9	79.4	—	79.4	1.5	19.1	13.2	5.9	6.5	10.6
Government Public Health Activities	100.0	—	—	—	—	—	100.0	13.2	86.8	—	—
Research and Construction	100.0	41.7	—	—	—	41.7	58.3	41.4	16.9	—	—
Research	100.0	8.7	—	—	—	8.7	91.3	77.0	14.3	—	—
Construction	100.0	74.2	—	—	—	74.2	25.8	6.4	19.4	—	—

See footnotes at end of table.

Table 4—Continued

National Health Expenditures, by Source of Funds and Type of Expenditure: United States, Selected Calendar Years 1993-2005

Year and Type of Expenditure	Private						Government				
	Total Public and Private	All Private Funds	Consumer			Other	Total	Federal	State and Local	Medicare ¹	Medicaid ²
			Total	Out of Pocket	Private Insurance						
Amount in Billions											
1994 (Projected)											
All Expenditures	\$938.3	\$518.1	\$474.4	\$163.7	\$310.7	\$43.7	\$420.2	\$306.7	\$113.5	\$171.4	\$128.5
Health Services and Supplies	908.8	506.3	474.4	163.7	310.7	31.9	402.6	294.0	108.6	171.4	128.5
Personal Health Care	832.5	465.9	434.7	163.7	271.0	31.2	366.6	283.8	82.9	168.1	123.1
Hospital Care	341.7	146.8	129.6	8.5	121.1	17.2	194.9	160.3	34.6	100.7	45.0
Physician Services	182.7	119.1	116.3	26.9	89.4	2.7	63.6	50.0	13.6	39.0	13.7
Dental Services	40.0	38.1	37.9	20.0	18.0	0.2	1.9	1.1	0.8	—	1.7
Other Professional Services	56.7	44.8	40.8	23.3	17.5	4.0	11.9	8.3	3.6	6.5	1.5
Home Health Care	24.2	10.3	7.5	4.7	2.8	2.8	13.9	12.0	1.9	9.8	3.9
Drugs and Other Medical Non-Durables	79.0	68.8	68.8	49.2	19.6	—	10.2	5.3	5.0	—	8.6
Vision Products and Other Medical Durables	13.2	8.6	8.6	7.8	0.9	—	4.6	4.4	0.2	4.1	—
Nursing Home Care	74.2	26.6	25.2	23.4	1.8	1.4	47.6	31.4	16.3	7.9	38.3
Other Personal Health Care	20.9	2.9	—	—	—	2.9	18.0	11.0	6.9	—	10.4
Program Administration and Net Cost of Private Health Insurance	50.3	40.4	39.7	—	39.7	0.7	9.8	6.7	3.1	3.3	5.4
Government Public Health Activities	26.1	—	—	—	—	—	26.1	3.5	22.6	—	—
Research and Construction	29.5	11.9	—	—	—	11.9	17.6	12.7	4.9	—	—
Research	15.4	1.3	—	—	—	1.3	14.0	11.9	2.2	—	—
Construction	14.1	10.5	—	—	—	10.5	3.6	0.9	2.8	—	—
Percent Distribution											
All Expenditures	100.0	55.2	50.6	17.5	33.1	4.7	44.8	32.7	12.1	18.3	13.7
Health Services and Supplies	100.0	55.7	52.2	18.0	34.2	3.5	44.3	32.3	11.9	18.9	14.1
Personal Health Care	100.0	56.0	52.2	19.7	32.5	3.7	44.0	34.1	10.0	20.2	14.8
Hospital Care	100.0	43.0	37.9	2.5	35.4	5.0	57.0	46.9	10.1	29.5	13.2
Physician Services	100.0	65.2	63.7	14.7	48.9	1.5	34.8	27.4	7.5	21.3	7.5
Dental Services	100.0	95.2	94.8	49.9	44.9	0.4	4.8	2.7	2.1	—	4.3
Other Professional Services	100.0	79.0	72.0	41.2	30.8	7.0	21.0	14.6	6.4	11.6	2.6
Home Health Care	100.0	42.6	31.1	19.6	11.5	11.4	57.4	49.7	7.8	40.7	16.3
Drugs and Other Medical Non-Durables	100.0	87.1	87.1	62.2	24.8	—	12.9	6.7	6.3	—	10.9
Vision Products and Other Medical Durables	100.0	65.4	65.4	58.8	6.6	—	34.6	33.4	1.2	31.4	—
Nursing Home Care	100.0	35.8	33.9	31.5	2.4	1.9	64.2	42.2	22.0	10.6	51.6
Other Personal Health Care	100.0	14.0	—	—	—	14.0	86.0	52.9	33.1	—	50.0
Program Administration and Net Cost of Private Health Insurance	100.0	80.4	79.0	—	79.0	1.4	19.6	13.4	6.2	6.6	10.8
Government Public Health Activities	100.0	—	—	—	—	—	100.0	13.3	86.7	—	—
Research and Construction	100.0	40.2	—	—	—	40.2	59.8	43.1	16.7	—	—
Research	100.0	8.7	—	—	—	8.7	91.3	77.2	14.1	—	—
Construction	100.0	74.4	—	—	—	74.4	25.6	6.0	19.5	—	—

See footnotes at end of table.

Table 4—Continued

National Health Expenditures, by Source of Funds and Type of Expenditure: United States, Selected Calendar Years 1993-2005

Year and Type of Expenditure	Private						Government				
	Total Public and Private	All Private Funds	Consumer			Other	Total	Federal	State and Local	Medicare ¹	Medicaid ²
			Total	Out of Pocket	Private Insurance						
Amount in Billions											
1995 (Projected)											
All Expenditures	\$1,007.6	\$552.7	\$506.5	\$175.2	\$331.3	\$46.2	\$454.9	\$334.1	\$120.8	\$190.0	\$138.4
Health Services and Supplies	977.5	540.7	506.5	175.2	331.3	34.2	436.8	321.1	115.7	190.0	138.4
Personal Health Care	897.7	499.4	465.9	175.2	290.8	33.4	398.3	310.2	88.1	186.7	132.3
Hospital Care	364.5	155.4	137.2	8.8	128.4	18.2	209.2	172.8	36.4	109.0	48.7
Physician Services	198.0	126.9	124.2	28.0	96.1	2.8	71.1	56.4	14.7	44.5	14.8
Dental Services	42.9	40.8	40.7	21.4	19.2	0.2	2.0	1.1	0.9	—	1.8
Other Professional Services	62.9	49.6	45.2	25.7	19.4	4.4	13.3	9.3	4.0	7.4	1.7
Home Health Care	27.9	11.8	8.6	5.4	3.2	3.2	16.1	14.0	2.1	11.6	4.4
Drugs and Other Medical Non-Durables	84.7	73.6	73.6	52.1	21.5	—	11.0	5.7	5.3	—	9.3
Vision Products and Other Medical Durables	13.9	8.9	8.9	8.0	0.9	—	5.1	4.9	0.2	4.6	—
Nursing Home Care	80.2	29.3	27.7	25.7	2.0	1.6	50.9	33.9	17.0	9.5	39.9
Other Personal Health Care	22.7	3.1	—	—	—	3.1	19.6	12.0	7.5	—	11.6
Program Administration and Net Cost of Private Health Insurance	51.9	41.3	40.5	—	40.5	0.8	10.6	7.2	3.4	3.3	6.1
Government Public Health Activities	27.9	—	—	—	—	—	27.9	3.7	24.2	—	—
Research and Construction	30.1	12.0	—	—	—	12.0	18.1	13.0	5.1	—	—
Research	15.9	1.4	—	—	—	1.4	14.5	12.1	2.3	—	—
Construction	14.2	10.6	—	—	—	10.6	3.6	0.9	2.8	—	—
Percent Distribution											
All Expenditures	100.0	54.9	50.3	17.4	32.9	4.6	45.1	33.2	12.0	18.9	13.7
Health Services and Supplies	100.0	55.3	51.8	17.9	33.9	3.5	44.7	32.8	11.8	19.4	14.2
Personal Health Care	100.0	55.6	51.9	19.5	32.4	3.7	44.4	34.6	9.8	20.8	14.7
Hospital Care	100.0	42.6	37.6	2.4	35.2	5.0	57.4	47.4	10.0	29.9	13.4
Physician Services	100.0	64.1	62.7	14.2	48.5	1.4	35.9	28.5	7.4	22.5	7.5
Dental Services	100.0	95.3	94.8	50.0	44.9	0.4	4.7	2.7	2.1	—	4.2
Other Professional Services	100.0	78.8	71.8	40.9	30.9	7.0	21.2	14.8	6.4	11.8	2.6
Home Health Care	100.0	42.3	30.9	19.5	11.5	11.4	57.7	50.1	7.5	41.5	15.8
Drugs and Other Medical Non-Durables	100.0	87.0	87.0	61.6	25.4	—	13.0	6.7	6.3	—	11.0
Vision Products and Other Medical Durables	100.0	63.6	63.6	57.3	6.3	—	36.4	35.2	1.2	33.2	—
Nursing Home Care	100.0	36.5	34.5	32.0	2.5	2.0	63.5	42.3	21.2	11.8	49.7
Other Personal Health Care	100.0	13.8	—	—	—	13.8	86.2	53.0	33.2	—	51.2
Program Administration and Net Cost of Private Health Insurance	100.0	79.6	78.1	—	78.1	1.5	20.4	13.8	6.6	6.4	11.8
Government Public Health Activities	100.0	—	—	—	—	—	100.0	13.2	86.8	—	—
Research and Construction	100.0	39.9	—	—	—	39.9	60.1	43.2	17.0	—	—
Research	100.0	9.0	—	—	—	9.0	91.0	76.3	14.6	—	—
Construction	100.0	74.4	—	—	—	74.4	25.6	6.1	19.5	—	—

See footnotes at end of table.

Table 4—Continued

National Health Expenditures, by Source of Funds and Type of Expenditure: United States, Selected Calendar Years 1993-2005

Year and Type of Expenditure	Private						Government				
	Total Public and Private	All Private Funds	Consumer				Total	Federal	State and Local	Medicare ¹	Medicaid ²
			Total	Out of Pocket	Private Insurance	Other					
Amount in Billions											
2000 (Projected)											
All Expenditures	\$1,481.7	\$807.9	\$743.1	\$256.4	\$486.7	\$64.9	\$673.7	\$502.5	\$171.2	\$293.5	\$214.5
Health Services and Supplies	1,445.6	793.7	743.1	256.4	486.7	50.6	651.9	487.0	164.9	293.5	214.5
Personal Health Care	1,334.3	734.5	685.0	256.4	428.6	49.6	599.7	472.3	127.5	289.5	205.1
Hospital Care	518.3	214.6	189.5	12.1	177.4	25.1	303.8	256.3	47.4	166.5	73.4
Physician Services	309.8	193.0	189.2	40.8	148.4	3.8	116.7	93.1	23.7	73.1	25.7
Dental Services	59.1	55.9	55.7	29.4	26.3	0.3	3.1	1.8	1.4	—	2.8
Other Professional Services	103.3	80.5	73.3	41.0	32.3	7.1	22.8	15.9	6.9	12.6	3.6
Home Health Care	45.9	21.4	15.7	9.8	5.9	5.8	24.4	20.8	3.6	16.6	7.6
Drugs and Other Medical Non-Durables	122.3	105.0	105.0	71.5	33.5	—	17.4	9.1	8.3	—	14.9
Vision Products and Other Medical Durables	17.9	10.6	10.6	9.6	1.0	—	7.3	7.1	0.2	6.7	—
Nursing Home Care	121.2	48.9	45.9	42.3	3.6	2.9	72.3	48.7	23.6	14.0	55.7
Other Personal Health Care	36.5	4.7	—	—	—	4.7	31.9	19.4	12.4	—	21.4
Program Administration and Net Cost of Private Health Insurance	74.1	59.1	58.1	—	58.1	1.0	15.0	9.9	5.1	4.0	9.4
Government Public Health Activities	37.2	—	—	—	—	—	37.2	4.9	32.4	—	—
Research and Construction	36.1	14.2	—	—	—	14.2	21.8	15.5	6.3	—	—
Research	19.6	1.9	—	—	—	1.9	17.7	14.6	3.0	—	—
Construction	16.5	12.3	—	—	—	12.3	4.1	0.9	3.2	—	—
Percent Distribution											
All Expenditures	100.0	54.5	50.2	17.3	32.8	4.4	45.5	33.9	11.6	19.8	14.5
Health Services and Supplies	100.0	54.9	51.4	17.7	33.7	3.5	45.1	33.7	11.4	20.3	14.8
Personal Health Care	100.0	55.1	51.3	19.2	32.1	3.7	44.9	35.4	9.6	21.7	15.4
Hospital Care	100.0	41.4	36.6	2.3	34.2	4.8	58.6	49.5	9.1	32.1	14.2
Physician Services	100.0	62.3	61.1	13.2	47.9	1.2	37.7	30.0	7.6	23.6	8.3
Dental Services	100.0	94.7	94.3	49.7	44.5	0.4	5.3	3.0	2.3	—	4.8
Other Professional Services	100.0	77.9	71.0	39.7	31.3	6.9	22.1	15.4	6.7	12.2	3.5
Home Health Care	100.0	46.7	34.2	21.3	12.9	12.6	53.3	45.4	7.9	36.2	16.6
Drugs and Other Medical Non-Durables	100.0	85.8	85.8	58.4	27.4	—	14.2	7.4	6.8	—	12.2
Vision Products and Other Medical Durables	100.0	59.4	59.4	53.6	5.8	—	40.6	39.5	1.1	37.6	—
Nursing Home Care	100.0	40.3	37.9	35.0	3.0	2.4	59.7	40.2	19.4	11.5	45.9
Other Personal Health Care	100.0	12.8	—	—	—	12.8	87.2	53.2	34.1	—	58.5
Program Administration and Net Cost of Private Health Insurance	100.0	79.8	78.4	—	78.4	1.4	20.2	13.3	6.9	5.5	12.7
Government Public Health Activities	100.0	—	—	—	—	—	100.0	13.1	86.9	—	—
Research and Construction	100.0	39.5	—	—	—	39.5	60.5	43.1	17.4	—	—
Research	100.0	9.8	—	—	—	9.8	90.2	74.6	15.5	—	—
Construction	100.0	74.8	—	—	—	74.8	25.2	5.5	19.7	—	—

See footnotes at end of table.

Table 4—Continued

National Health Expenditures, by Source of Funds and Type of Expenditure: United States, Selected Calendar Years 1993-2005

Year and Type of Expenditure	Private						Government				
	Total Public and Private	All Private Funds	Consumer			Other	Total	Federal	State and Local	Medicare ¹	Medicaid ²
			Total	Out of Pocket	Private Insurance						
Amount in Billions											
2005 (Projected)											
All Expenditures	\$2,173.7	\$1,171.3	\$1,080.2	\$370.6	\$709.6	\$91.1	\$1,002.4	\$756.7	\$245.7	\$450.9	\$333.4
Health Services and Supplies	2,129.2	1,153.6	1,080.2	370.6	709.6	73.4	975.6	737.8	237.8	450.9	333.4
Personal Health Care	1,973.4	1,067.3	995.3	370.6	624.6	72.0	906.1	718.1	187.9	446.5	318.8
Hospital Care	736.8	295.9	261.4	16.9	244.6	34.5	440.8	377.9	63.0	252.7	107.9
Physician Services	483.6	288.8	283.2	59.2	224.0	5.7	194.8	156.4	38.4	122.2	45.8
Dental Services	79.1	74.3	73.9	39.1	34.9	0.4	4.8	2.7	2.1	—	4.4
Other Professional Services	166.4	127.9	116.5	63.8	52.7	11.4	38.5	26.8	11.7	20.5	7.4
Home Health Care	68.0	32.7	23.9	14.7	9.2	8.8	35.3	29.4	5.9	22.5	12.5
Drugs and Other Medical Non-Durables	178.6	151.2	151.2	99.2	52.0	—	27.4	14.5	12.9	—	23.8
Vision Products and Other Medical Durables	22.6	12.2	12.2	11.0	1.2	—	10.4	10.2	0.2	9.8	—
Nursing Home Care	179.6	77.4	72.8	66.7	6.1	4.6	102.1	68.9	33.3	18.9	79.1
Other Personal Health Care	58.7	6.8	—	—	—	6.8	51.9	31.4	20.5	—	38.0
Program Administration and Net Cost of Private Health Insurance	107.3	86.3	84.9	—	84.9	1.4	21.0	13.2	7.7	4.3	14.6
Government Public Health Activities	48.6	—	—	—	—	—	48.6	6.4	42.2	—	—
Research and Construction	44.5	17.6	—	—	—	17.6	26.8	19.0	7.8	—	—
Research	24.4	2.5	—	—	—	2.5	21.9	18.0	3.9	—	—
Construction	20.0	15.1	—	—	—	15.1	4.9	1.0	4.0	—	—
Percent Distribution											
All Expenditures	100.0	53.9	49.7	17.1	32.6	4.2	46.1	34.8	11.3	20.7	15.3
Health Services and Supplies	100.0	54.2	50.7	17.4	33.3	3.4	45.8	34.6	11.2	21.2	15.7
Personal Health Care	100.0	54.1	50.4	18.8	31.7	3.7	45.9	36.4	9.5	22.6	16.2
Hospital Care	100.0	40.2	35.5	2.3	33.2	4.7	59.8	51.3	8.5	34.3	14.6
Physician Services	100.0	59.7	58.5	12.2	46.3	1.2	40.3	32.3	7.9	25.3	9.5
Dental Services	100.0	93.9	93.5	49.4	44.1	0.4	6.1	3.4	2.7	—	5.5
Other Professional Services	100.0	76.9	70.0	38.4	31.7	6.8	23.1	16.1	7.0	12.3	4.5
Home Health Care	100.0	48.1	35.2	21.7	13.5	12.9	51.9	43.2	8.7	33.0	18.4
Drugs and Other Medical Non-Durables	100.0	84.7	84.7	55.5	29.1	—	15.3	8.1	7.2	—	13.3
Vision Products and Other Medical Durables	100.0	54.1	54.1	48.8	5.3	—	45.9	44.9	1.0	43.2	—
Nursing Home Care	100.0	43.1	40.6	37.2	3.4	2.6	56.9	38.3	18.5	10.5	44.0
Other Personal Health Care	100.0	11.5	—	—	—	11.5	88.5	53.5	35.0	—	64.7
Program Administration and Net Cost of Private Health Insurance	100.0	80.5	79.2	—	79.2	1.3	19.5	12.3	7.2	4.0	13.6
Government Public Health Activities	100.0	—	—	—	—	—	100.0	13.2	86.8	—	—
Research and Construction	100.0	39.7	—	—	—	39.7	60.3	42.7	17.6	—	—
Research	100.0	10.4	—	—	—	10.4	89.6	73.8	15.8	—	—
Construction	100.0	75.4	—	—	—	75.4	24.6	4.8	19.8	—	—

¹ Subset of Federal funds.² Subset of Federal, State, and local funds.

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

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

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REFERENCES

- Aaron, H.J.: Thinking Straight About Medical Costs. *Health Affairs* 13(5): 8-13, Winter 1994.
- Board of Trustees: *1994 Annual Report of the Board of Trustees of the Federal Old-age and Survivors Insurance and Disability Insurance Trust Funds* Washington. Social Security Administration, April 1994.
- Burner, S.T., Waldo, D.R., and McKusick, D.R.: National Health Expenditures Projections Through 2030. *Health Care Financing Review* 14(1):1-29, Fall 1992.
- Donham, S., Sensening, A., and Heffler: Health Care Indicators. *Health Care Financing Review* 16(4):243-272, Summer 1995.
- Foster Higgins: Employer Health Benefit Cost Drops in 1994; Jump in Managed Care Enrollment Abates Cost Spiral. Press release. New York. February 14, 1995.
- Freeland, M.S., and Schendler, C.E.: Health Spending in the 1980's: Integration of Clinical Practice Patterns with Management. *Health Care Financing Review* 5(1):1-68, Spring 1984.
- Health Care Financing Administration: *1994 Medicaid Managed Care Enrollment Report*. Office of Managed Care, Medicaid Managed Care Office. Baltimore, MD. 1994.
- Levit, K.R., Sensenig, A.L., Cowan, C.A., et al: National Health Expenditures, 1993. *Health Care Financing Review* 16(1):247-294, Fall 1994.
- Monaco, R.M., and Phelps, J.H.: *Will Comprehensive Health Care Reform Help or Hurt the Economy? An Empirical Assessment*. Inforum Working Paper 94-014. Interindustry Forecasting Project. College Park, MD. University of Maryland Department of Economics, August 1994.
- Peden, E.A., and Freeland, M.S.: The Impact of Insurance on the Growth of Medical Spending. *Health Affairs* 14(1):235-247, Summer 1995.
- Sonnefeld, S.T., Waldo, D.R., Lemieux, J.A., and McKusick, D.R.: Projections of National Health Expenditures Through the Year 2000. *Health Care Financing Review* 13(1):1-27, Fall 1991.
- Waldo, D.R., Sonnefeld, S.T., McKusick, D.R., and Arnett, R.H., III: Health Expenditures by Age Group, 1977 and 1987. *Health Care Financing Review* 10(4):111-120, Summer 1989.

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