THE OTHER SIDE OF THE LEDGER: FEDERAL HEALTH SPENDING IN METROPOLITAN ECONOMIES

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EXECUTIVE SUMMARY

Federal health expenditures annually provide billions of dollars to metropolitan economies in the United States. These expenditures support vital healthcare services and have contributed to the development of numerous health services assets in metropolitan areas, including jobs, years of steady sector job growth, relatively higher wages, and multiplier effects that generate billions of additional dollars in local economies.

With these benefits, however, come well-known burdens. Besides the growing demand that health-related costs are placing on government budgets, populations in nearly every state are growing older and public hospitals around the country are struggling to maintain services. To properly manage these risks and to fully harness the tremendous benefits associated with health-related spending, state and local leaders must know more about how health programs affect their economies.

This paper addresses this need by assessing the effects of federal spending in six metropolitan areas, including Atlanta, Milwaukee, Oakland, Philadelphia, San Antonio, and San Diego. We concentrate much of our assessment on the expenditures of the major federal programs—including Medicare, Medicaid, the State's Children Health Insurance Programs—and the major programs designed to provide health benefits to the military, veterans, and federal employees, as these programs represent the bulk of federal health spending.

Overall, this paper finds that federal health spending generates a number of economic benefits to metropolitan areas. For instance:

- **Federal spending on healthcare generates billions of additional dollars to metropolitan economies.** Over $473 billion was spent by the federal government in 2002 on federal health programs. Total annual spending in metropolitan areas ranged from $10.2 billion in Philadelphia to $2.3 billion in Milwaukee, which represented an average of 4.4 percent of the metropolitan gross product in our sample. This spending generates billions of additional dollars for metropolitan economies through multiplier effects.

- **Federal health expenditures create millions of jobs in metropolitan areas.** Health services jobs numbered over 11.9 million in 2003, and accounted for between 6.6 and 12.0 percent of all jobs in the metropolitan areas in our sample. The health services industry includes establishments ranging from small private practices of physicians who employ only one medical assistant to busy inner-city hospitals that provide thousands of diverse jobs.

- **Federal health spending has contributed to the steady growth of jobs in metro areas and will continue to do so.** Between 1993 and 2002, the number of jobs in the major health employer groups grew at an average rate of 20 percent in our sample of metropolitan areas. About 16 percent of all jobs created between 2002 and 2012 are projected to be health services positions.

- **Federal health expenditures generate good paying jobs in metropolitan areas.** The majority of metropolitan workers in health services earn a higher average hourly wage than the typical worker in their metro area. A large majority of them also earn a higher average wage than that of service sector employees.

Though healthcare costs are a significant burden to all levels of government, at the metropolitan level, that spending represents a substantial economic asset and potential leverage for improving job growth and wages.

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I. INTRODUCTION

America's massive expansion in health-related spending presents an unprecedented financial challenge to government. Among the fastest-growing portions of the gross domestic product (GDP), overall healthcare spending climbed to $1.6 trillion in 2002, an increase of 9.3 percent in just one year. As a result, healthcare spending now represents 14.9 percent of GDP and is projected to increase to 17.7 percent by 2012.[1]

Such colossal increases in spending have sounded alarms at nearly every level of government, since almost half of healthcare spending is by federal, state, and local governments. As a consequence, many policy debates are now focused on how to reign in healthcare costs, find structural ways to keep Medicare and Medicaid solvent, and identify appropriate revenue sources to cover overall future expenditures.

However, a widely overlooked consequence of health spending is the substantial benefits this money provides to America's metropolitan areas. Federal health programs provide vital healthcare coverage to a range of vulnerable populations and other government beneficiaries. The $1.6 trillion spent on healthcare in 2002 also supported millions of jobs, many of which are high-paying. In fact, in many cities and towns across America, hospitals are one of the largest employers. These jobs, and the revenues they bring to communities, have proven especially important in sustaining regional economies during downturns in the business cycle.[2] They have also created a capital base for other industries to draw from, which has spurred and supported metropolitan economic development.

With these benefits, however, come well-known burdens for state and local leaders. Besides the growing demand that health-related costs are placing on state budgets, populations in nearly every state are growing older, and public hospitals around the country are struggling to maintain services. To properly manage these risks and to fully harness the benefits associated with health-related spending, state and local leaders must know more about how health spending affects their economies.

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[1] Department of Health and Human Services homepage: http://www.hhs.gov

[2] A recent report on the employment outlook in U.S. metropolitan economies, prepared for the U.S. Conference of Mayors and the Council for Investment in the New American City, examined the 10 sectors that lost the most jobs during the downturn and the 10 sectors that will lead the jobs recovery. The healthcare and social assistance industry is expected to average the second largest gain in employment (738,397 jobs) between 2001 and 2005, as the rising elderly population and national nursing shortage continue to increase opportunities and incentives for prospective workers. Many cities in the southern part of the nation are expected to record strong healthcare employment growth between now and 2005. Thus, both national and regional forecasts suggest that the health services will be a major source of new jobs in urban economies. For more information, please see "U.S Metro Economies: Types of Jobs Lost and Gained, 2001–2005." United States Conference of Mayors (2003).

One of the most important ways leaders can start learning about health spending in their metropolitan economies is to examine the role of the federal government in the health economy. The federal government is the single, largest public source of health spending, accounting for nearly 66 percent of all public health spending in 2002. It is also one of the most important overall contributors to annual health spending, representing about 30 percent of the $1.6 trillion spent on healthcare in 2002.[3] Most of this money goes to fund national programs that provide healthcare services, including Medicare, Medicaid, the State's Children Health Insurance programs, and the major programs designed to provide health benefits to the military, veterans, and federal employees.[4] By understanding these programs and the impact of the federal expenditures made on behalf of these programs, state and local leaders will go a long way toward addressing the need to understand their metropolitan health economies.

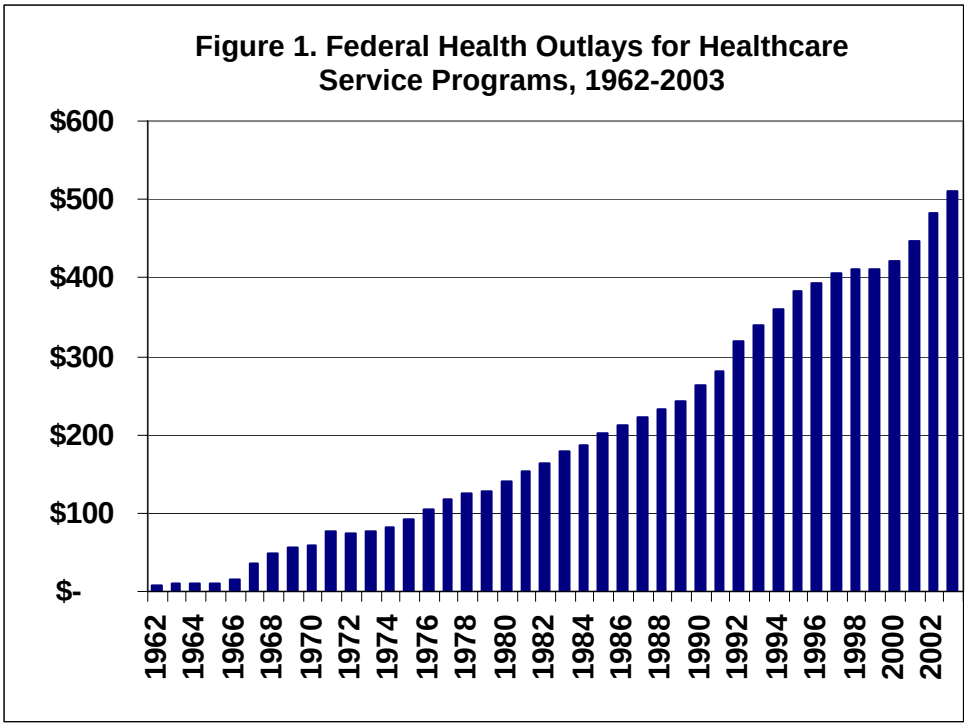
This policy brief addresses that need by reviewing and assessing the effects of federal health spending in six metropolitan areas: Atlanta, Milwaukee, Oakland, Philadelphia, San Antonio, and San Diego.[5] While there are other elements of the federal role in healthcare, such as different payment structures, provider types, and insurance plans, the sheer amount of federal health spending makes it one of the most important components of the federal role. Federal spending also translates into very vivid effects in metropolitan economies, since relatively precise metropolitan data related to that spending is available.

We begin by providing some background about federal health spending and the six major federal or federal/state programs—Medicare, Medicaid, the State Children's Health Insurance Plan (SCHIP), TRICARE, the Veterans Health Administration (VHA), and the Federal Employees Health Benefits program (FEHP)—that support such assets. Next, we review and assess the effects of federal health spending in the six metropolitan areas selected for analysis. The brief concludes with specific recommendations for how state and local leaders can effectively leverage these federal investments for further regional and community economic development.

[3] Aggregate health spending in 2002 was $1.6 trillion according to the Department of Health and Human Services; and federal health spending, according to the Office of Management and Budget, was $473 billion.
[4] We focus exclusively on spending and jobs created by programs that provide healthcare services, although there are numerous additional sources of federal health spending which are outlined in note #8.
[5] We follow the Census Bureau's definitions of metropolitan areas in determining the regions to analyze. We used the metropolitan statistical area to define cities. If a city is part of a consolidated metropolitan statistical area, we used only the city's primary metropolitan statistical area in this analysis. Analyzing and interpreting data by geographic area must be done with extreme care. In the case of the data presented here, there are 3 separate locations that are relevant: location of the provider establishment (and health services jobs), location of patient residence, and location of population (MSA). While we often think of these as being the same, they are not. There are significant flows of people in and out of MSA for jobs and for healthcare services. These flows differentiate these people from those who live in the MSA. Therefore, the people who are employed in an area are not the same as those who live there or those who use health services provided there.

II. Federal Health Spending and Programs

As shown in Figure 1, federal spending on programs that provide healthcare services has increased nearly every year since 1962, the first year of Office of Management and Budget (OMB) historical budget data. After adjusting for inflation, the federal government spent approximately $14 billion on healthcare in 1962, compared to about $483 billion in 2002, an increase of over 3000 percent. While in retrospect this spending increase seems astronomically large, it actually occurred rather gradually, albeit consistently, through out much of this period. Average annual growth in federal health spending through out this time period was about 10 percent. In fact, if we take out the year Medicaid and Medicare were enacted, 1966, average growth is trimmed to 8 percent.[6]



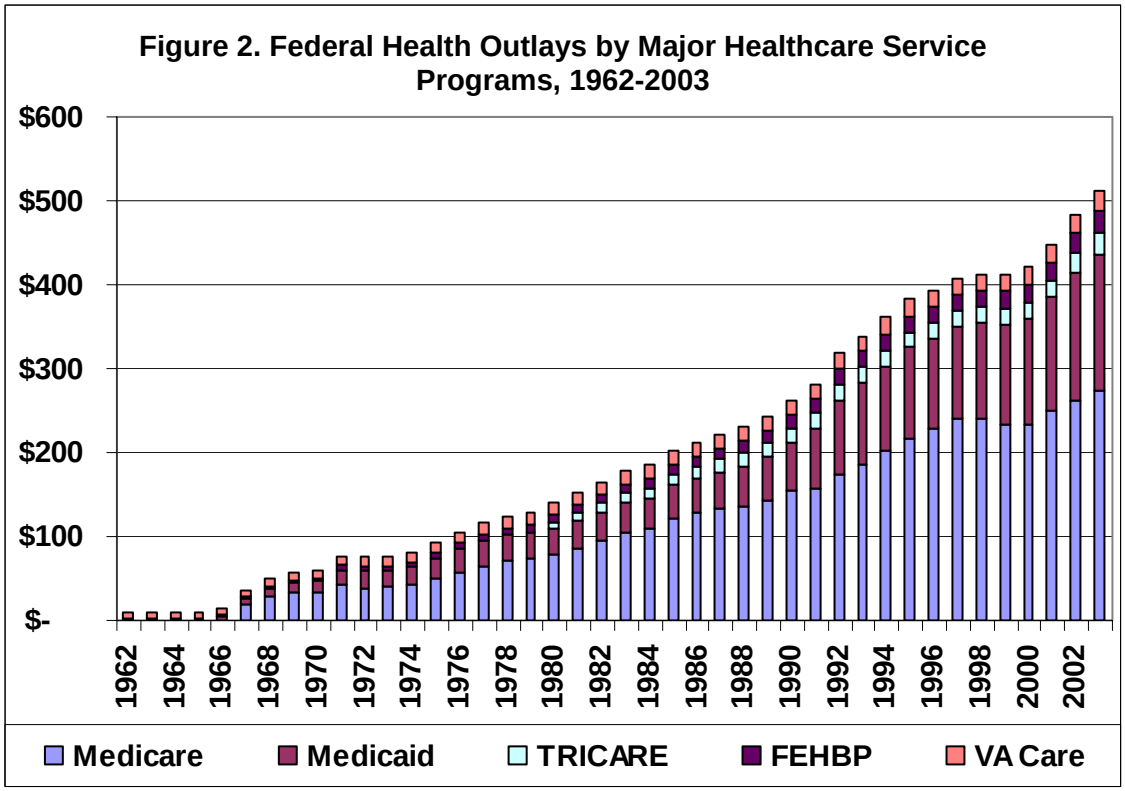
Source: Office of Management and Budget
Note: Adjusted for inflation

These historical data put the current growth in federal health spending in context. While the past decade averaged about 5 percent annual growth in federal health spending, the OMB expects an average annual growth rate of 7 percent between 2004 and 2008, reaching about $747 billion by 2008.[7] These data mean that while the federal government during the 1990s saw federal health

[6] Between 1966 and 1967 there was an 87 percent increase in federal health spending. The standard deviation around the mean of the entire series is about 14 percentage points, due in large part to the large percentage increases that occurred in the late 1960s and early 1970s.
[7] OMB reports historical outlays by major functions. Reported functions that are related to health include healthcare services, health research and training, consumer and occupational health and safety, Medicare, and hospital and medical care for veterans.

spending grow at a slower average rate than it grew for most of the past forty years, comparably large increases are in order during the next several years. As the population ages, this spending will likely continue to increase and move above its forty-year average growth rate.

These steady and potentially large future increases in federal health spending are distributed through out the United States primarily through the major programs it finances. These include Medicare, Medicaid, the State Children's Health Insurance Plan (SCHIP), the Defense Health Program (TRICARE), the Veterans Health Administration (VHA), and the Federal Employees Health Benefit Program (FEHBP).[8]



Source: Office of Management and Budget
Note: Adjusted for inflation

[8] There are numerous other programs funded by federal health spending, including the National Institutes of Health (NIH), the Centers for Disease Control (CDC), and the Health Resources and Services Administration (HRSA). For example, the National Institutes of Health (NIH) is composed of 27 Institutes and Centers whose collective mission is to sponsor and conduct medical research and research training. NIH conducts research in its own laboratories and supports nonfederal researchers working in universities, medical centers, hospitals, and research institutions. In 2002, NIH made more than 45,000 grants and nearly 5,000 training grants and awards, totaling over $19 billion. These primarily are awarded to universities, but other recipients include research institutes, independent hospitals, for-profit firms, and foreign organizations. Since elaborating on each of these programs could consume this report, and we are particularly focused on programs that fund healthcare services, we chose to focus on only these six major federal programs.

In Figure 2, we have broken up the data in Figure 1 to reflect the relative share of each of these programs in the annual federal budget commitment to healthcare. These data indicate that while Medicare has been the single largest health budget commitment since it was established in 1966, the low-income health program Medicaid has been growing at a faster rate than any other program, averaging about 10 percent between 1962 and 2002. Medicare's growth since inception was close behind at 8 percent, whereas the other major programs grew at much slower average rates. A brief review of the magnitude and type of services each of these major programs provide demonstrates that each program makes different contributions to metropolitan economies.

A. Medicare

Medicare's primary function is to provide health insurance to nearly 40 million individuals over age 65, although it also insures younger people with significant disabilities. The program provides two types of health insurance coverage: a traditional fee-for-service program and a managed care program, called "Medicare+Choice," which accounted for about 13 percent of benefit payments and 11 percent of enrollees in 2002. The traditional program has two components. Medicare Part A covers inpatient hospital services, skilled nursing facility benefits, home health visits following a hospital or skilled nursing facility stay, and hospice care.[9] Medicare Part B, which accounted for one third of benefit spending in 2003, covers physician and outpatient hospital services (i.e., mammograms and other cancer screenings), laboratory procedures, and medical equipment. Enrollees pay a monthly premium for Part B, but the premiums are heavily discounted.

Medicare also supports physician training programs by paying the salaries and fringe benefits of medical residents and faculty, covering some hospital overhead expenses, and paying indirect additional costs that teaching hospitals incur while caring for severely ill patients. Medicare also makes payments to hospitals for its share of the direct costs of nursing and allied health training programs, and pays a "disproportionate share" adjustment to hospitals that treat a high percentage of low-income patients.

Of the six major health programs, Medicare is far and away the largest, as shown in Figure 2.[10] Representing over 50 percent of all federal health expenditures, Medicare is the single largest source of income for most regions' hospitals, physicians, home care agencies, clinical laboratories, durable medical equipment suppliers, and physical and occupational therapists. It has been the largest avenue of federal health spending since its inception in 1968. As Figure 2 demonstrates, nearly all of the federal health programs have grown steadily, but spending on Medicare is now many times greater than spending on most of the other major programs.

[9] Medicare also insures patients with end-stage renal dialysis (ESRD).

[10] Our Medicare data were taken from the Consolidated Federal Funds Report compiled by the US Census Bureau. These data report Medicare Part A and Supplemental Medical Insurance spending to providers of care. Medicare spending on beneficiaries enrolled in Medicare managed care plans flows to the managed care insurers. Thus, cities that have managed care insurance company headquarters receive a greater flow of funds to the headquarters, even if the money is subsequently distributed to physicians and hospitals in other locations.

This rapid growth is expected to continue in the next decade. Medicare spending—measured as a share of the economy—is projected to nearly quadruple by 2075, growing from its current level of 2.5 percent to more than 9 percent of the gross domestic product (GDP).[11] The recently passed Medicare Prescription Drug, Improvement, and Modernization Act is likely to increase spending even more than this projection—a recent Office of Management and Budget (OMB) estimate puts the cost of this coverage expansion at $534 billion over the next 10 years.[12] If this is accurate, Medicare spending would more than triple by 2013. This evidence indicates that Medicare will continue to be the single most important federal program outlay in most metropolitan economies.

B. Medicaid

The Medicaid program, the second largest federal health program, provides health coverage for millions of low-income women, children, elderly people, and individuals with disabilities, populations including families with children, the blind, and the disabled.[13] Medicaid is jointly financed by the federal government and state governments, with the former contributing between 50 percent and 83 percent of the expenditures of the state-directed programs. The federal "matching" percentage is higher for states with lower per-capita incomes. Medicaid also has a "disproportionate share" program that requires state agencies to make allowances when determining reimbursement rates for hospitals that serve a disproportionate number of Medicaid or low-income patients. Total national health expenditures for Medicaid, excluding administrative costs, were $194.7 billion ($111.1 billion in federal and $83.6 billion in state outlays) in 2000.

States administer their own Medicaid programs and have a high degree of discretion regarding eligibility for services as well as the type, amount, duration, and scope of services provided, within guidelines set by the federal government. Many states offer only managed care insurance to recipients. Medicaid pays for long-term care through skilled nursing facilities and home health services. In 2003, there were 40.4 million beneficiaries in the program. The elderly and people with disabilities comprise one quarter of the beneficiaries but account for 71 percent of Medicaid spending for services, reflecting their intensive use of acute and long-term care services.

In 2002, over $150 billion was spent on Medicaid, which was 2nd only to the amount spent on Medicare. While most of the 1990s saw relatively modest growth in Medicaid spending, the past two years have seen relatively large increases in spending. For instance, spending on Medicaid

[11] CBO Testimony, Statement of Douglas Holtz-Eakin, Director, "Prescription Drug Coverage and Medicare's Fiscal Challenges before the Committee on Ways and Means U.S. House of Representatives, April 9, 2003, http://www.cbo.gov/showdoc.cfm?index=4159&sequence=0.
[12] Congressional Research Service, Library of Congress, "Overview of the Medicare Prescription Drug and Reform Conference Agreement, H.R. 1," December 4, 2003.
[13] Our Medicaid data were obtained from the Consolidated Federal Funds Report, which is described in reference 9. The caveat that federal payments for beneficiaries enrolled in managed care insurance plans applies to the Medicaid data. For example, Kaiser Foundation Health Plan provides Medicaid insurance to many Californians, and is headquartered in Oakland, California. Kaiser operates a significant number of hospitals and physician clinics in the Oakland MSA, but other Kaiser hospitals and medical facilities are located in other nearby counties. Thus, the Oakland figures may be somewhat overstated as compared to the locations at which care is provided.

increased 12 percent between 2000 and 2001, and about 8 percent in 2001 relative to 2002. After 2007, the Congressional Budget Office (CBO) projects that spending will increase by an average of nearly 9 percent annually, rising to $348 billion in 2014. As a result, by 2014, the federal government's Medicaid outlays are projected to reach 1.9 percent of the GDP, compared with 1.5 percent in 2003.

C. TRICARE

TRICARE is the Department of Defense (DOD) managed healthcare program for active duty family members, military retirees, and their family members.[14] The program provides three types of insurance coverage: TRICARE Prime, where military treatment facilities are the principal source of healthcare; TRICARE Extra, where an approved doctor, hospital, or other medical provider is the primary source of healthcare; and TRICARE Standard, which is a fee-for-service option (the old CHAMPUS program) where clients select their own healthcare providers. The TRICARE Network of providers and facilities is established through contracts with managed care companies.

Between fiscal years 1988 and 2003, DOD's spending on medical care almost doubled, despite large reductions in the size of the active duty military force and a substantial reduction in the size of the military's own hospital system. Adjusted for the overall rate of inflation in the U.S. economy, DOD's annual spending on medical care rose from $14.6 billion to $27.2 billion during this period. If it increases at the same rate as per capita medical spending in the United States as a whole, it could grow from $27 billion today to between $40 billion and $52 billion by 2020 (in 2002 dollars).[15]

D. Veterans Health Administration

The Department of Veterans Affairs (VA) operates the Veterans Health Administration (VHA), which has about 1,300 facilities, including 163 hospitals, 850 ambulatory care and community-based outpatient clinics, 206 counseling centers, 137 nursing homes, and 43 domiciliary facilities.[16] In 2002, there were over 6 million veterans enrolled in the VHA health insurance plan, and spending reached $22.2 billion. The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is the federal health benefits program administered by the VA. Nearly all veterans of active military service are eligible to enroll. Unless necessary services are not available in its system, all CHAMPVA services are provided through the VHA.

Of all the major health programs, spending increases on veterans has been the most anemic. Between 1962 and 2002, annual increases in health spending averaged just 3 percent, well below the average increases in the other programs. Surprisingly, these anemic annual growth rates

[14] MHS Healthcare Costs in Selected MSAs (Fiscal Year 2002) special data runs prepared by Kennell and Associates.
[15] Congressional Budget Office, "Growth in Medical Spending by the Department of Defense," September 9, 2003.
[16] VA Healthcare and the Medical Benefits Package, July 2002, http://www.va.gov/pressrel/enrollben.htm.

persisted through out the Vietnam war and the immediate years that followed that war. Although spending increases have picked up in the past few years, growth through most of the 1990s was around 1 to 2 percent every year.

E. Federal Employees Health Benefits Program (FEHBP)

The FEHBP provides health insurance coverage to over 9 million federal employees, retirees, former employees, family members, and former spouses under both fee-for-service plans and health maintenance organizations. More than 350 private health plans are offered under FEHBP. For those employees covered by an FEHBP plan and TRICARE, the FEHBP is the primary payer and TRICARE is the secondary payer. The federal government pays up to 75 percent of the premium cost.

Total federal health outlays on the FEHBP were $26.2 billion in 2002.[17] In 2002 there was the single largest increase in federal employee health spending since Ronald Reagan was in office in 1987. Federal health spending on its employees is not equal to the amount allocated to veterans, and, if past growth rates persist, will likely pass veteran spending within a few years.

F. SCHIP

The State Children's Health Insurance Plan (SCHIP) was established through the 1997 Balanced Budget Act to insure children from low-income, working families who are not eligible for Medicaid but are unable to afford private health insurance.[18] SCHIP programs provide a core set of benefits, such as inpatient, emergency, and outpatient hospital services; physician services; preventive services (including immunizations); inpatient and outpatient mental health services; X-ray and laboratory services; vision screening; and prescription drug benefits.

Congress appropriated approximately $40 billion for the program's first 10 years (FYs 1998–2007). The funds are allotted based on a formula that considers the number of low-income children and the number of low-income uninsured children residing in each state, each state's healthcare costs relative to the others', and the federal Medicaid matching rate. Federal funds for SCHIP are distributed to states as fixed-value grants, which must be used within three years. If any funds remain unused, they are redistributed to states that can use them within the year.

Like Medicaid, SCHIP is a cooperative program between the federal government and state governments. The federal government provides the bulk of the funds, but the states have primary responsibility for developing programs within federal guidelines. Unlike with Medicaid, these

[17] Our FEHBP data were obtained from a special run by the Office of Personnel Management (OPM). Data are drawn from the OPM's Health Benefit Data Files, which contain recipiency rates at the county level and premiums for participating health plans at the state level.

[18] SCHIP data were obtained from the Consolidated Federal Funds Report, which is described in note # 9. The caveat about beneficiaries enrolled in managed care plans discussed in references 9 and 12 applies to these data.

guidelines include the specification of SCHIP funding as discretionary block grants, which is one reason many states have long waiting lists for enrollment.[19]

[19] For a discussion of this see Center on Budget and Policy Priorities (http://www.cbpp.org/12-22-03health2.htm).

III. The Link Between Federal Spending and Health Services Assets

Federal funding of the six programs reviewed in the previous section goes directly to state and local governments, consumers, and a wide array of healthcare providers to cover the costs of healthcare goods and services. These "investments" in turn finance millions of healthcare jobs, make the creation of future jobs possible (and likely), and open doors to higher paying jobs in metropolitan economies.

To explore these effects of federal health spending in metropolitan economies we selected six metropolitan areas: Atlanta, Milwaukee, Oakland, Philadelphia, San Antonio, and San Diego. As shown in Table 1, these six cities represent a broad cross-section of American metropolitan areas. Philadelphia and Milwaukee are older industrial cities aggressively looking for sources of new capital to replace many moribund, older industries. On the other hand, Atlanta has recently become a major commercial center, San Diego has an established reputation as a research and development center, and San Antonio relies on a strong military presence. Oakland is more of a combination of new and old economies, bringing together an older industrial base with high-growth technology industries. While disparate in many important ways, each of these metropolitan areas benefits from the substantial amount of money invested in healthcare by the federal government.

Table 1. Demographic Profiles of Selected Metropolitan Areas

	Atlanta	Milwaukee	Oakland	Philadelphia	San Antonio	San Diego
Total Population	4,112,198	1,500,741	2,392,557	5,100,931	1,592,383	2,813,833
Federal Employees	54,784	11,839	31,942	67,451	38,582	57,899
Active Military	5,429	585	1,993	8,173	26,741	87,468
Population Growth	38.9%	4.8%	14.9%	3.6%	22.3%	12.6%
% Elderly	7.6%	12.6%	10.6%	13.6%	10.6%	11.2%
% in Poverty	9.2%	10.4%	9.5%	10.8%	14.7%	12.0%
% Elderly in Poverty	10.0%	6.9%	7.2%	9.4%	11.8%	6.8%
% Infants in Poverty	12.5%	17.8%	11.5%	15.0%	23.4%	17.0%
% Working Poor	14.2%	14.6%	11.4%	14.3%	20.2%	16.9%
% of Veterans	11.8%	12.0%	10.1%	12.3%	15.7%	14.0%

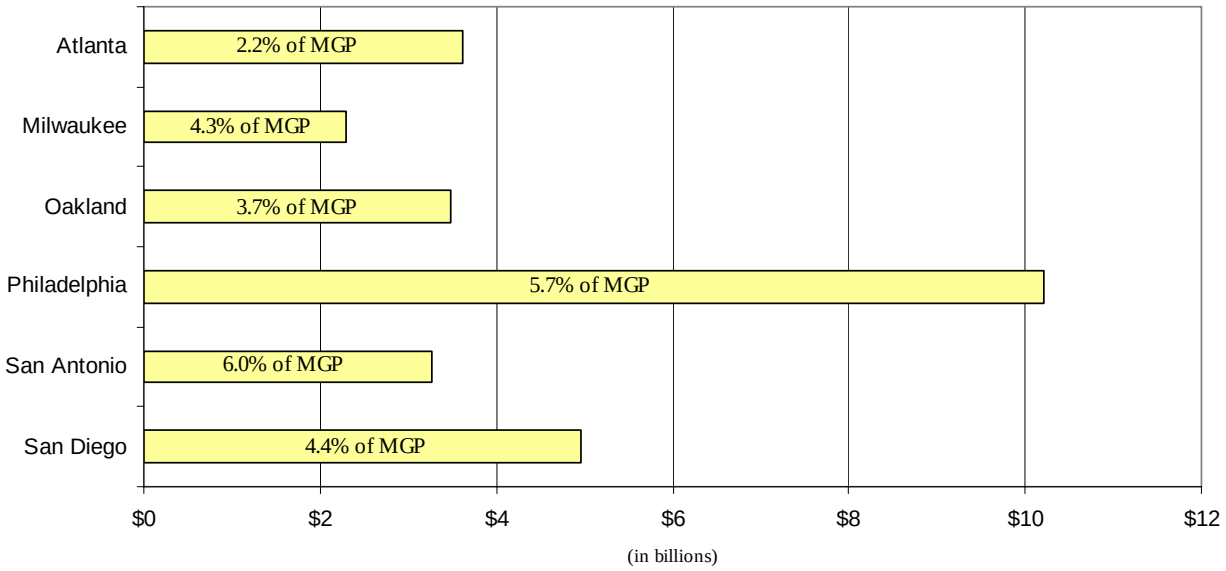
Source: 2000 Census, SF1 and SF3
Note: Population growth is measured as the change of population between the 1990 and 2000 census; working poor families are defined as annually earning $20,000–$34,999; elderly are considered all people 65 and older; and infants are all children under the age of 5.

A. Billions of Dollars in Metropolitan Economies

The federal government annually spends over $2 billion in each of these metropolitan economies. Figure 3 shows total federal health program spending for each of the six metropolitan areas and the proportion it represents in each metropolitan gross product. Total federal health

spending on these programs annually provides over $10.2 billion to Philadelphia; Atlanta receives $3.6 billion, San Diego $5.0 billion, San Antonio $3.3 billion, Milwaukee $2.3 billion, and Oakland $3.5 billion. When we control for the size of the economy in each area, these wide differences shrink in magnitude. As indicated in Figure 3, the billions of dollars transferred by the federal government comprise between 2.2 and 6.0 percent of the total metropolitan gross product in these areas. When multiplied in the economy, the federal expenditures play an even bigger role than we have directly measured.

Figure 3: Federal Health Expenditures in Metropolitan Economies, 2001

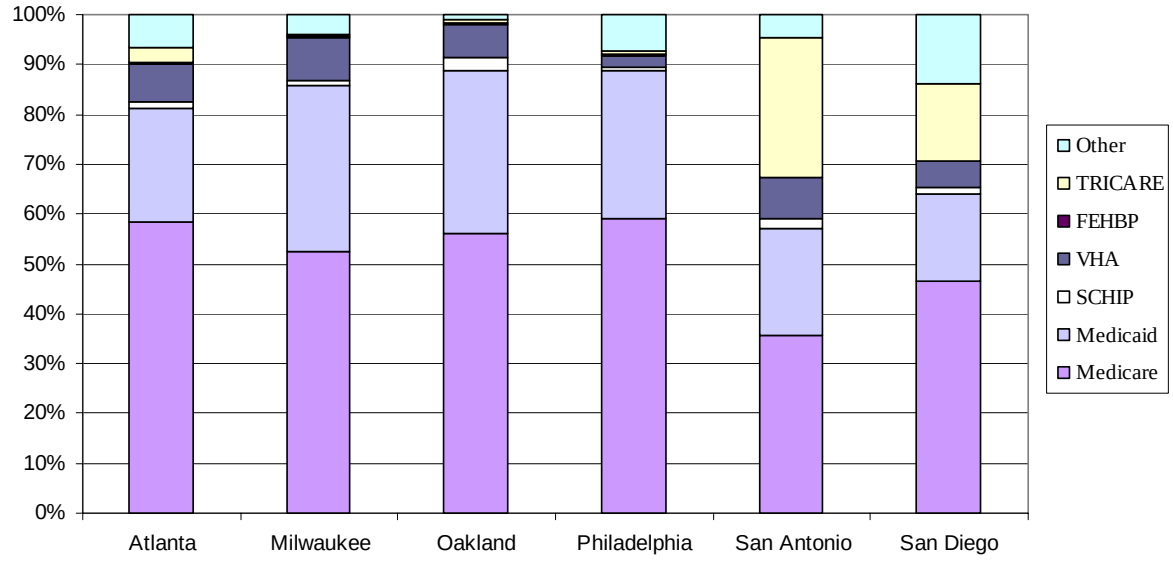


Source: Office of Management and Budget; United States Conference of Mayors.
Note: MGP stands for metropolitan gross product.

Federal funds are disbursed to these metropolitan areas through the six federal programs reviewed in the previous section. Figure 4 illustrates the proportion of spending devoted to each program in the six metropolitan areas in our sample.[20] Medicare accounts for the largest federal health program outlays for healthcare services in each city. This is the case even for Atlanta, which receives over 58 percent of its federal health funds from Medicare, even though the elderly comprise the lowest share of the population of any of the six cities, 7.6 percent.

[20] This figure is included because it provides a rough approximation based on the data that is available at the metropolitan level. Although, it must be interpreted with care, since we do not have spending data for every program in every metropolitan program.

Figure 4: Federal Health Expenditures in Metropolitan Economies by Program, 2001



Source: Office of Management and Budget

Medicaid also is an extremely important source of federal funding, averaging 20 percent of all federal health spending in these metropolitan areas. Its relative importance varies widely from region to region. Oakland has the highest share of funds coming from Medicaid, at nearly 33 percent, although its poverty rate is lower than the other areas' except Atlanta and its per capita income is higher than the other cities'. At the other end of the spectrum, 17.6 percent of San Diego's and 21.4 percent of San Antonio's federal health funds come from Medicaid, and those cities' poverty rates are the highest in the sample.

The Veterans Health Administration (VHA) delivers significant federal funding to some cities, because many large VA facilities are in urban areas. Milwaukee's VHA distributes over 8.8 percent of federal health funds, although the share of its population who are veterans is only the fourth highest of the group. The VA Medical Center in Milwaukee has more than 500 beds; its size likely explains the high share of federal spending that comes from the VHA. San Antonio has the second highest share of federal spending attributable to the VHA, at 8 percent, as well as the largest proportion of veterans in its population. San Antonio's VA is extremely large, with more than 1,000 hospital beds as well as a 274-bed nursing home facility. Over 7.5 percent of Atlanta's federal dollars come from the VHA. Oakland receives nearly $233 million from the VHA, accounting for 6.7 percent of federal health spending in the area. The VHA comprises 5.2 percent of the federal health spending delivered to San Diego, and only 2.4 percent of the federal health spending delivered to Philadelphia, although the dollar value of the funds is comparable to that received by the other cities.

TRICARE spending in Atlanta, Milwaukee, Oakland, and Philadelphia represents less than 4 percent of federal healthcare spending in these metropolitan areas. In contrast, TRICARE spending

in both San Antonio and San Diego represents over 15 percent of all federal health spending. This program provides over $900 million to San Antonio, 94 percent of which is paid to military healthcare facilities. This is not surprising given the large number of active military personnel in that city and the presence of three VA medical and health facilities. San Diego receives 15 percent of its federal funds for its TRICARE program, amounting to over $750 million.

In all six metropolitan areas, federal contributions to the State Children's Health Insurance Program (SCHIP) account for only a marginal component of total federal health spending. Oakland receives the highest share of SCHIP money from the federal government, accounting for 2.6 percent of the total. FEHBP also is relatively unimportant in terms of overall magnitude in all six metropolitan areas examined here, accounting for less than 0.4 percent of federal health spending.

As federal health spending continues to increase during the next decade, it will assume an even greater role in metropolitan economies. Led by Medicare and Medicaid, net mandatory spending will grow slightly faster than the economy, or at a rate of 5.4 percent, if current policies remain unchanged.[21] Medicare is currently about 60 percent as large as Social Security, but that proportion is projected to reach 84 percent by 2014. Spending for Medicare will then total $698 billion or almost 4 percent of the GDP. The program's share of total federal spending will have increased from 13 percent in 2003 to just over 19 percent. Federal outlays for Medicaid totaled $161 billion in 2003, making up about 13 percent of mandatory spending. After 2007, the Congressional Budget Office (CBO) projects that spending will increase by an average of nearly 9 percent annually, rising to $348 billion in 2014. As a result, by 2014, the federal government's Medicaid outlays are projected to reach 1.9 percent of the GDP, compared with 1.5 percent in 2003. The CBO projects that federal health spending will increase to nearly 15 percent of the GDP by 2030, surpassing Social Security as the largest federal budgetary outlay.[22]

B. Metropolitan Jobs

Federal health spending supports millions of health-related jobs in metropolitan areas, which represent a large proportion of all jobs in metropolitan areas. As illustrated in Figure 5, all six of the metropolitan economies in our sample rely heavily on health services jobs, although there is variance among the regions, which are divergent in size and income. Healthcare jobs in Atlanta accounted for about 6.6 percent of total employment in 2003, the lowest proportion among the six.[23]

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[21] CBO, "The Budget and Economic Outlook: Fiscal Years 2004–2013," January 2003, http://www.cbo.gov/showdoc.cfm?index=4032&sequence=5 (accessed June 9, 2004).
[22] Ibid.
[23] Employment data is from the Current Employment Statistics survey administered by Bureau of Labor Statistics. Detailed data is available for 270 metropolitan areas. The estimates in this section are made from the best metropolitan data available, although two caveats must be recognized. First, like all surveys, there is sampling error, which is especially important to consider when evaluating small area statistics. Second, we used what employment data was available to estimate an aggregate size of each metropolitan areas healthcare industry. Where possible, we used employment estimates for the social assistance industry to calculate estimates of aggregate healthcare employment. In other cases, we were able to use employment data on hospitals, nursing and residential care, and ambulatory health to create an aggregate estimate of the healthcare employment size. And, in San Antonio we imputed the hospital data based on the average

San Diego had the next lowest proportion of health services jobs - 6.9 percent - followed by Oakland - 8.2 percent - and San Antonio - 9.5 percent. Finally, healthcare jobs in Milwaukee and Philadelphia's labor markets each represented at least 10 percent of the total labor market.

Figure 5. Metropolitan Employment in the Health Sector, 2003

Source: Bureau of Labor Statistics

In general, these jobs are created by three different categories of employers: ambulatory health services (office of physicians, outpatient care centers, and home healthcare services), hospitals, and nursing and residential care. Table 2 shows the employment distribution among these groups in the six metropolitan areas in our sample. Ambulatory health services provides the largest share of jobs nationwide in this industry, about 40 percent during 2003, and between 35 and 54 percent of all health services jobs in the six metropolitan areas in our sample. Hospitals provide the next largest share, representing about 36 percent of national health services jobs and between 27 and 40 percent of health services jobs in the six metropolitan areas. Finally, nursing and residential care represents the fewest jobs, although, as we will see in the next section, they are growing at faster rates than any of the other types. In 2003, these positions represented about 24 percent of all employment in the health services, and between 18 and 25 percent of health services employment in our sample of metropolitan areas.

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distribution of employment sectors in the other metropolitan areas to arrive at an aggregate estimate. These data are available at http://www.bls.gov/industry.

Table 2. Health Services Employer Profiles in Selected Metropolitan Areas

	Atlanta	Milwaukee	Oakland	Philadelphia	San Antonio	San Diego
HOSPITALS						
Total Employment	57,200	33,500	32,400	115,300	19,000	23,100
% of Metro Workforce	2.65%	4.03%	3.16%	4.79%	2.62%	1.86%
% Increase, 1993–2003	34.59%	5.35%	26.07%	-0.60%	1.11%	8.96%
NURSING & RES. CARE						
Total Employment	*	20,900	17,100	73,300	12,500	18,000
% of Metro Workforce	*	2.52%	1.67%	3.04%	1.72%	1.45%
% Increase, 1993–2003	*	12.97%	23.91%	2.73%	4.37%	29.50%
AMBULATORY HEALTH						
Total Employment	*	31,600	34,900	101,300	37,600	44,100
% of Metro Workforce	*	3.80%	3.41%	4.21%	5.19%	3.55%
% Increase, 1993–2003	*	27.00%	9.00%	27.10%	74.07%	28.57%

Source: Bureau of Labor Statistics, Current Employment Statistics Survey.
Note: * indicates that data is not available; Res. Care stands for residential care; share of employment refers to the share of that sector component relative to all health sector jobs available in the metropolitan area; % Increase refers to the increase in the number of jobs between 1993 and 2003.

These data indicate that the health services industry employs a substantial proportion of metropolitan residents. It also provides employment in a number of different settings, from hospitals to outpatient care centers to outpatient care. These two characteristics distinguish the industry from many others that operate in metropolitan economies, making its jobs an essential component. Without the billions of dollars in federal expenditures spent in each of these metropolitan areas, both the number and the range of jobs available in those areas would likely diminish.

C. Metropolitan Job Growth and Career Ladders

As we saw in Section II, federal spending is expected to grow at a precipitous rate over the next decade. This rapid increase will help fuel the creation of millions of new health services jobs in metropolitan economies. Although local job projections are less available and reliable than national job projections, we can get a sense of what is to come by looking at the growth in recent years.[24]

There were 23 percent more healthcare jobs in 2003 than in 1993, suggesting that state and local economies across the country have seen large expansions in the number of healthcare positions in their labor economies. As data in Table 2 indicate, all three of the major employer groups experienced robust employment growth during this period. Leading the pack was ambulatory

[24] The data in this section come predominately from the Bureau of Labor Statistic's Current Employment Statistics Survey and the Occupational and Employment Survey. Data from both surveys is available on the BLS homepage, www.bls.gov. Since both surveys have different samples and sampling error, we elected to use the more widely used Current Employment Statistics survey where possible to keep metropolitan estimates of total health services employees as standardized as possible. This survey has a much larger sampling size, and is therefore considered to be a more reliable data series. This is particularly important, since the Occupational and Employment Survey distinguishes a much smaller population of health services employees than the Current Employment Statistics series.

healthcare services, which added 32 percent more jobs nationally. With the exception of San Antonio, growth in the number of positions was much slower in our sample of metropolitan areas than average national growth in this category, ranging from 9 percent in Oakland to 29 percent in San Diego. While below the national average, this growth is nonetheless impressive and signals the increase presence of ambulatory healthcare employers in metropolitan economies.

The second fastest-growing employer group in the health services industry during this period was nursing and residential care services, which increased nationally by about 23 percent, and between 3 and 30 percent in the metropolitan areas in our sample. Finally, the number of hospital positions grew the slowest, increasing by about 15 percent.

Though Philadelphia has one of the highest percentages of residents over 65 in the country, the metropolitan area actually lost about 1 percent of its hospital positions between 1993 and 2002. Atlanta, like many other Sun Belt cities, experienced tremendous population growth throughout the 1990s, resulting in a 35 percent increase in hospital positions due to increased demand for new hospital facilities and employees. As jobs in each of these health industries continue to multiply, more metropolitan workers will gain access to the lower rungs of the career ladder in the health services. The nursing profession, for instance, is structured in a clear hierarchy of nursing aides, licensed practical and vocational nurses, and registered nurses. With additional education, nursing aides can progress to LPN positions, and LPNs can progress to RN positions, with significant increases in earnings. For example, in Oakland, the average annual salary for nursing aides, orderlies, and attendants was $26,070 in 2001. The average annual salary for licensed vocational nurses was $43,930, and for registered nurses it was $71,560. This is substantially better than the growth potential in other low-paying, “dead end” service sector jobs.

D. High Wages for Metropolitan Workers

Federal spending on health programs also has helped to build a health services industry that pays higher wages for many different types of work than many other service industries. Even the lower-skill workers in health services, who make up a significant portion of healthcare employees in these metropolitan areas, tend to have higher earnings than lower-skill workers in other sectors.

Table 3 presents estimated employment levels and mean hourly wages in 2003 for three broad occupation groups in the health services industry: healthcare practitioners and technical jobs, health support occupations, and personal and home care aides. Healthcare practitioners and technical occupations includes physicians, nurses, and other skilled occupations; healthcare support occupations include home health aides, nursing aides, orderlies, and attendants and other lower-skill positions; and personal and home care aides assist elderly or disabled adults with daily living activities in the home or in a nonresidential facility.

Table 3. Health Services Occupations and Mean Wages in Selected Metropolitan Areas, 2003

	Atlanta	Milwaukee	Oakland	Philadelphia	San Antonio	San Diego
PRACTITIONERS & TECHNICIANS						
Total Employment	79,070	41,560	41,820	135,330	35,760	48,030
% of Metro Health Workforce	55.76%	48.33%	49.55%	46.68%	51.75%	56.37%
Mean Hourly Wage	$26.82	$27.15	$32.30	$27.14	$26.05	$29.72
HEALTH SUPPORT						
Total Employment	33,240	23,970	20,780	63,560	17,070	27,320
% of Metro Health Workforce	23.44%	27.87%	24.62%	21.92%	24.70%	32.07%
Mean Hourly Wage	$11.58	$11.28	$14.40	$11.66	$10.15	$12.16
PERSONAL & HOME CARE						
Total Employment	4,190	5,020	2,160	4,500	7,600	4,910
% of Metro Health Workforce	2.95%	5.84%	2.56%	1.55%	11.00%	5.76%
Mean Hourly Wage	$8.52	$9.29	$10.37	$10.50	$6.47	$8.79
Total Nonfarm Workforce	2,158,600	831,000	1,024,700	2,407,500	725,000	1,241,900
Mean Metro Hourly Wage	$18.64	$17.95	$21.59	$18.87	$15.47	$18.67
Mean Service Sector Wage	$12.62	$10.80	$12.20	$10.27	$8.05	$10.56

Source: Bureau of Labor Statistics, Occupational Employment Survey and Current Employment Statistics Survey.
Note: Proportion statistics do not sum to 100, and total health services employment does not add to the totals in Table 2, because of an 'other' category not included in this table and because of differences between the Current Employment Statistics and the Occupational Employment surveys.

The highest mean wage is paid to healthcare practitioners and technicians, who require special training or education, while, for example, an RN needs only an associate degree. The mean wage paid to these types of workers varied between San Antonio, where the average health practitioner or technician was paid $26.05 hourly, and Oakland, where the same average worker earned over $32. Once cost-of-living differences are factored in, the wage differences between these two cities, and among the other four in our sample, would likely shrink. These data indicate that the average wage paid to about half of the metropolitan workers who earn their living in the health services industry in these metropolitan areas is well over four times the minimum wage. The last two rows of data also indicate that the average wage for these same workers is well above the mean wage in the metropolitan area and the mean service sector wage.[25] In some areas, the average wage for these healthcare workers is more than 3 times the mean service sector wage.

Health support occupations, the next most populous component of the health services industry, accounted for a third of all health services jobs nationally and between 22 and 32 percent of health services jobs in each city. The largest low-wage occupations in health support are nursing aides, orderlies, and attendants; home health aides; and medical assistants. The last row of data indicate that the average wage for these positions is higher than the mean service sector wage in 5 of the 6 metropolitan areas in our sample, which includes such positions as food preparation and

[25] The service sector includes personal care and service occupations (SOC code 39).

serving, cleaning and maintenance, and personal service. Medical assistants, the higher-skilled of the three occupations, earn between 2 and 2.5 times the minimum wage in all the metropolitan areas except Oakland, where they earn even more. Lower-wage health support jobs are overwhelmingly held by women; 88 percent of workers nationwide are female. Approximately 58 percent of these women are black and 9 percent are Hispanic.

The least populous of the three major occupational categories are personal and home care aides, who are classified as personal care and service employees. Nationally, this occupation group employed 487,200 people in 2003. While the average hourly wage is only about $8.00, which is less than the average service sector wage, none of the metropolitan areas in our sample has more than 11 percent of their total healthcare workforce in this category.

The data indicate that the health services sector offers a wide spectrum of career opportunities at earnings far in excess of the average metropolitan and service sector worker. Even the average lowest-skill employee in this sector earns more than the minimum wage. This indicates that federal support of the industry brings to metropolitan areas not only millions of jobs, but also contributes to jobs that pay relatively higher wages. In turn, these wages are spent locally, which annually generates billions of dollars for metropolitan economies in multiplier effects.

In the next section, we turn to the specific implications of these findings for state and local leaders, which they can use to address the need to manage the economic risks and benefits associated with federal health spending.

IV. IMPLICATIONS FOR LOCAL ACTION

This paper has demonstrated the importance of federal health program outlays in metropolitan economies. The significance of the health services industry and of the federal health programs that contribute essential financial support to it mandates that state and local leaders actively develop policies to take greater advantage of the benefits associated with federal health spending. In this section, we propose several suggestions for local leaders to address this need.

A. Make Federal Healthcare Spending a Local Priority

When federal health program payments are augmented or restricted, the flow of funding to metropolitan economies often changes, which can substantially affect these economies. Such changes can also affect the vital healthcare coverage provided to a range of vulnerable populations and other government beneficiaries. Leaders at the state and local level must understand the importance of federal healthcare dollars to their economies and make understanding and tracking federal healthcare reform a priority.

By developing expertise in these and other programs, metropolitan leaders can prepare for and also potentially shape major changes in those programs that affect the number of jobs, the rate of job growth, the opportunities for career advancement, the adequacy of wages, and the numerous multiplier effects associated with federal health spending in their areas. Most of the national debate about health policy is related to the burgeoning costs of healthcare in America. But we have demonstrated in this paper that health expenditures, particularly at the federal level, have fostered the development of many assets in metropolitan economies.

These benefits often go unrecognized in policy debates, which instead focus on the costs associated with health expenditures. By developing a deeper understanding of these federal programs, state and local leaders can open line of communication with federal policy makers to increase the visibility of the considerable benefits, beyond providing health insurance to vulnerable populations, that federal health programs bring to metropolitan areas. This will strengthen the security of the federal role in metropolitan economies, by giving national policy makers to the resources to factor into their decisions the substantial consequences of their decisions for not only services and providers, but also metropolitan economies.

But, making federal healthcare spending a local priority goes beyond tracking and influencing federal health policy. State and local leaders also need to gather more robust data on metropolitan health spending. This report has taken advantage of the most extensive and reliable available data to demonstrate the extent and effects of federal health spending. But, we were not able to directly measure, for instance, the billions of dollars likely created through multiplier effects. We were also not able to fully quantify the amount of federal health spending flowing into metropolitan area. Such information would undoubtedly demonstrate that federal health spending plays an even more important role in metropolitan economies. It would also allow state and local leaders to make a more powerful case for federal health policy changes that will benefit their metropolitan economies.

Making federal health spending a local priority will consequently require state and local leaders to track and influence federal health policy, and to encourage the collection of more comprehensive data than currently exists. Together, these steps will allow state and local leaders to more fully understand and shape their metropolitan health economies.

B. Prepare Metropolitan Workers for Future Health Economy Growth

We have provided evidence that indicates the healthcare sector is at the beginning of a long period of job expansion, due in large part to the unprecedented number of people that are on the verge of retirement. The elderly, a group with greater than average healthcare needs and expenses, will continue to grow faster than the total population, resulting in higher demand for medical and personal services. That so many people will be retiring at the same time that more people are needed to fill healthcare positions could present significant challenges to the ability of local healthcare industries to find enough qualified labor for open positions. In fact, a recent analysis by the Center for Workforce Information and Analysis, found that there were already thousands of healthcare positions in Pennsylvania that were going unfilled because of the lack of skilled labor.[26]

We have shown in this report that the fastest employment growth is expected to occur in the lowest-skill health occupations, such as personal and home care aides. This is propitious for low-skill workers in urban areas, who are looking for skill enhancement and wage growth. By focusing on training for these occupations, state and local leaders can foster and better target employment and training opportunities.

There are a variety of specific strategies that policy makers can undertake to support expanding employment opportunities in the health services industry. One involves sector employment intervention, which represents the nexus of economic development and workforce development. These interventions target high-growth industries in the regional economy and build relationships with employers and other community stakeholders to bring about system change. For example, the Flint, Michigan, Healthcare Employment Opportunity project (FHEO) aims to address the shortage of qualified labor within the local healthcare industry and to help low-income residents attain economic self-sufficiency. An initial report on this project by the National Economic Development and Law Center (NEDLC) found that Flint's healthcare sector met four important criteria for workforce development: significant potential for job growth, accessibility of jobs within the industry to low-skill workers, opportunities within the industry to earn a "living" wage, and the potential for career advancement.

A second strategy is to take advantage of the growing demand for health workers by seeking grants to support education programs. For example, the Valley Economic Development Center in Van Nuys, California, received $1 million from The California Endowment to support a program devoted to training and placing workers in clerical jobs in the healthcare field as well as offering

[26] Center for Workforce Information and Analysis, Pennsylvania Department of Labor and Industry. http://www.supplydemand.state.pa.us

advice and support to guide them into the nursing profession. The program targets an area where about 25 percent of the population is living in poverty and 75 percent of those entering high school become dropouts.

A third strategy is involving employers in the development of recruitment and education programs. For example, Massachusetts General Hospital is working with high school and junior high school students to provide information and experience that the hospital hopes will help them consider health professions. Some employers have developed “career ladder” programs to support the ongoing education of their staff. For example, two nursing homes run by Ethica Healthcare in Atlanta have developed a program to help Certified Nursing Assistants (CNAs) study for their LPN licenses in cooperation with the Georgia Healthcare Workforce Policy Advisory Committee.

A fourth strategy is to channel non-health program funds to health worker training. In numerous states, including California, Georgia, Florida, and Massachusetts, government agencies are using Workforce Investment Act (WIA) funds to support regionally based education programs for the healthcare workforce. For example, California’s Employment Development Department has dedicated $36 million of WIA discretionary dollars to expanding the supply of nurses. Florida’s “Nurses Now” program, managed by the Florida Agency for Workforce Innovation, is providing grants for career ladder programs using WIA funds.

A fifth strategy is welfare-to-work training programs. For instance, the VHA Health Foundation established a National Healthcare Welfare to Work Task Force that identified successful practices and potential barriers to healthcare organizations employing individuals transitioning out of welfare, and determined how those lessons might be broadened to improve overall healthcare workforce development. The task force recommended that the health services industry actively partner with primary and secondary school systems to encourage students to elect healthcare careers, employers hire people into entry-level jobs and provide them with advanced training to move them into hard-to-fill jobs, and employers provide ongoing education and job training for worker retention.

Finally, union leaders also can play a in the expansion of training opportunities for current health services workers. Through partnerships with care delivery systems, organized labor has demonstrated that it understands the need to change the pattern of education and practice by providing political support, practice redesign, and educational resources. For example, Service Employees International Union (SEIU) Local 250 (Northern California) has a five-year-old labor-management partnership with Kaiser Permanente that fosters career ladder programs and improvements in the work environment.

V. CONCLUSION

Federal health spending contributes billions of dollars to metropolitan economies and supports millions of jobs for metropolitan workers, many of which are high paying relative to average metropolitan wages. Projected increases in federal health spending will also contribute to the significant projected expansion in the number of health services jobs in metropolitan areas. State and local leaders can take numerous steps to support these benefits recognizing that federal health spending plays an important role in their communities. Through various means, state and local leaders can also prepare their metropolitan economies and workers to take advantage of the significant projected growth in health spending and employment over the next decade.