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# ARTICLES

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## Empowering Domestic Discretionary Spending in Federal Budget Deliberations

Bruce S. Jansson  
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**ABSTRACT.** Federal domestic discretionary spending (DDS) funds a large portion of human services in the American welfare state including mental health, child welfare, childcare, public health, job training, and education programs. Yet relatively little research has been conducted on this small but important part of the federal budget. This article examines a number of factors that have limited the size of DDS and that may imperil its existence in coming decades. The article suggests that policy theorists and researchers need to devote more attention to DDS and that policy advocates need to develop effective strategies for protecting DDS from unwarranted assaults in the budget-making process. *[Article copies*

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**KEYWORDS.** Federal spending, discretionary spending, social policy, advocacy, budget process

Conservatives contend that federal spending has risen meteorically in recent decades. They are correct when federal spending is viewed in absolute dollars: The federal budget has risen from \$104 billion in 1940 to \$1.5 trillion in 2000—or 14 times in inflation-adjusted dollars. (Unless otherwise stated, all data in this article are stated in constant 1992 dollars and are found in U.S. Office of Management and Budget, 1999.)

Yet conservatives' rhetoric greatly overstates spending realities. When expressed as a percentage of the Gross Domestic Product (GDP), overall federal spending rose from 9.8 percent of GDP in 1940 to 20.5 percent of GDP in 1969. But its current share of GDP is less than 20 percent of GDP, lower not only than in 1969 but than during the 1980s and most of the 1990s when federal spending averaged more than 21 percent of GDP. Conservatives' rhetoric masks, moreover, the fact that the portion of the federal budget devoted to the non-entitlement domestic agenda, known as domestic discretionary spending (DDS), has actually *declined* in constant dollars from 1979 to 2000, in constant per capita dollars, and as a percentage of GDP. DDS funds virtually the entire human services agenda including categorical programs (such as Head Start) and seven major block grants: the social services; community services; alcohol, drug-abuse, and mental-health services; maternal and child health services; community development services; primary health services; and preventive health services. Unlike entitlements that are funded automatically to the level of claimed benefits in a given fiscal year, DDS is funded through the politics of the annual budget process.

DDS constituted 5.8 percent of GDP in 1940 only to decline to .9 percent in 1947. It averaged 1.2 percent of GDP in the 1950s, 2.4 percent of GDP in the 1960s, and 3.6 percent of GDP in the 1970s—only to decline to 3.2 percent in the 1980s and 2.9 percent in the 1990s. As a share of GDP, then, DDS is currently funded at considerably lower levels than during the 1970s. Nor has DDS's share of the federal budget increased during recent decades. If it was 50 percent of the federal budget in 1940,

it was 10 percent in 1950, seven percent in 1960, 14 percent in 1970, 19 percent in 1980, 12 percent in 1990, and merely 13 percent in 1998. In short, whether measured as a percentage of GDP or as a percentage of total budget expenditures, DDS has declined markedly during the past two decades.

This brief chronology hardly suggests runaway domestic discretionary spending during the past seven decades. The New Deal's spurt in DDS was erased during World War II with DDS hardly existing (in contemporary terms) from 1947 through 1963. An upward increase from 1964 through 1979 was followed by a period of relative decline or stagnation in the 1980s and 1990s.

DDS is rarely discussed in policy or budget literature, much less literature in the human services (for exceptions, see Conlan, 1984; Reischauer, 1997). In literature on domestic budget priorities, DDS is overshadowed by its larger partner, entitlements. This article provides contextual information about DDS. It discusses factors that have constrained the size of DDS in recent American history. It suggests that policy theorists need to devote far greater attention to DDS—and that policy advocates need to develop more effective strategies to protect it from assaults in budget battles.

### **THREE BUDGET RIVALS**

A major reason why DDS has declined in magnitude in recent decades is that other programs and expenditures, singly and in tandem, have preempted a large part of federal outlays. Three kinds of federal spending relegated DDS to the budget sidelines in the past six decades: military, interest payments and entitlements, particularly Social Security, Medicare, and Medicaid.

*Military Spending.* Military and veterans' spending, which constituted roughly 25 percent of the federal budget in the New Deal, rose dramatically in World War II when it absorbed 80 percent of the federal budget in 1944. Military and veterans' spending similarly dominated the federal budget during the first 25 years of the Cold War from 1950 through 1975 to a remarkable degree. Rising from \$177 billion in FY 1950 just before the beginning of the Korean War in summer 1950 to \$410 billion by FY 1952, it never fell beneath \$256 billion in the next 25 years. Military and veterans' spending absorbed 68 percent of the federal budget during the Dwight Eisenhower presidency, 58 percent in the

Lyndon Johnson presidency, and more than 50 percent in the Richard Nixon presidency.

Huge military spending was particularly undermining of DDS in the period 1950 through 1975 because it—like DDS—is funded from the federal discretionary budget. Unlike entitlements and interest on the debt which are automatically funded to the level of claimed benefits or required debt payments, discretionary spending is determined in the political budget process as members of appropriations committees annually decide how to spend available revenues. The Cold War military budget was funded almost entirely from federal discretionary funds, meaning scant resources were available for DDS in the discretionary budget. Discretionary military (excluding discretionary veterans' programs) consumed 80 percent of discretionary funds in 1949, 87 percent in 1959, and 78 percent in 1969.

The dominance of military and veterans' spending on the discretionary budget was revealed in Johnson's Great Society, which might, more aptly, be described as the "frugal society." With almost 78 percent of available discretionary resources devoted to military programs (excluding veterans' programs), Johnson lacked resources for the scores of new programs that were enacted during his tenure. His tactic under these circumstances was to enact numerous new programs, but to fund them frugally. An irate Charles Schultze (his budget director) wrote Johnson that "we are not able to fund adequately the new Great Society programs . . . {leading} to frustration, loss of credibility . . . backlogs, queuing, and griping . . . only increasing the distance between legislative achievement and actual funding" (Schultze, 1966). Such programs as the War on Poverty and the Elementary and Secondary Education Act received only nominal appropriations, even though they were centerpieces of the Great Society.

Military spending (excluding veterans' programs) continued to absorb a major share of discretionary funds for the rest of the 20th century, even if it took a somewhat smaller share than in the 1960s—or 56 percent in 1981, 67 percent in 1989, and 53 percent in 1998. (The massive increase in military spending in the 1980s, when President Ronald Reagan implemented the largest peacetime military build-up in American history, placed particular pressure on DDS.) Even in 2000, more than half of discretionary funds were preempted by military and veterans' spending—meaning that advocates of greater spending on such programs as Head Start find more than one-half of discretionary funds to be preempted by the military even before they begin their lobbying.

Military spending has been a particularly potent constraint on DDS because the military is a powerful and well-organized contender for budget. Once the Secretary of Defense and the President adjudicate behind-the-scenes conflicts between the Army, Navy and Air Force over budget share, the Joint Chiefs of Staff unify behind the military budget. They are joined by hundreds of military contractors who pressure Congress to appropriate resources in the military budget—or to increase them when specific weapons or research activities are (in their view) underfunded by the president's military budget. Military contractors, in turn, give vast resources to Congressional and presidential campaigns, making certain that members of both major parties receive contributions. As many Secretaries of Defense have discovered, efforts to downsize or terminate military installations are always greeted with howls of protest from communities where they are located (Pasztor, 1995; Vistica, 1995). Advocates of DDS are much less powerful lobbyists. Divided between hundreds of programs that include human services, infrastructure, housing, transportation, public health, environmental, and other programs, they do not speak with a common voice. They do not make campaign contributions in a concerted way. They lack a centralized federal advocate analogous to the Secretary of Defense or the Joint Chiefs of Staff—and presidents rarely invest major political capital in DDS unlike military budgets and entitlements.

*Entitlements.* It would seem at first glance that entitlements, unlike military spending, do not compete with DDS because they are funded not by the discretionary budget but by the so-called mandatory or uncontrollable budget. Entitlements' costs were not included in the regular federal budget before 1967, but in separate accounts so that their expenditures were not even included in calculations used to determine whether the budget was in deficit or surplus. All this changed in 1967 when entitlements' costs were placed in a so-called unified budget, as well as their revenues from such sources as the payroll tax for Social Security and Medicare (Wildavsky, 1988). Another important budget shift occurred in 1974, when budget reforms required legislators to establish federal spending and tax goals for a given fiscal year. They had to decide, for example, the specific size of the deficit or surplus for the coming fiscal year—and then plan tax and spending legislation and appropriations that would allow them to reach this goal (Wildavsky, 1988). They used unified budgets in these plans that included both mandatory and discretionary expenditures.

These shifts in budget policy placed discretionary spending in competition with entitlements because an upward shift in spending on

entitlements required limits or cuts in DDS to achieve a specific budget target. If Congress wanted, for example, to cut deficits in a given year, they had to choose whether to cut entitlements or discretionary spending to achieve this result. As we shall see, they usually targeted DDS for cuts or freezes because entitlements' advocates possessed greater political clout than DDS's advocates.

Entitlements proved to be an even more powerful contender for budget resources than the military. They absorbed only 8 percent of federal resources in 1953 when Social Security and Unemployment Insurance dominated entitlements' expenditures. Their budget share rose to 27 percent by 1969 in the wake of Medicare's and Medicaid's enactment in 1965. But their "take-off" occurred in the 1970s as Comprehensive Employment Training Act (CETA), the Earned Income Tax Credit (EITC) and Supplementary Security Income (SSI) were enacted; as Social Security was indexed for inflation; and as technical changes in the Food Stamps program vastly increased its size. They took 51 percent of the budget by 1981, easily supplanting military spending as the largest expenditure in the federal budget. Entitlements continued their upward trajectory in the 1980s and 1990s, absorbing 52 percent of the federal budget in 1993 and 57 percent in 2000.

This dramatic upsurge in spending for entitlements was largely concentrated in three programs: Medicare, Medicaid, and Social Security. (Indeed, 73 percent of entitlements' cost derived from these three programs in 1998.) As with military spending, DDS proved a weak competitor for federal dollars when pitted against Medicare, Medicaid, and Social Security. The political popularity of Medicare and Social Security programs derives from their universal benefits: members of all social classes and from constituencies of all legislators benefit from these programs and resist efforts to downsize them (Derthick, 1979). As universal programs with huge constituencies and powerful interest groups such as the American Association of Retired Persons, Medicare and Social Security were hardly scathed in budget battles of the 1980s and 1990s (Hager & Pianin, 1997). Medicaid, in turn, was protected from cuts by county and state officials, the American Medical Association, and the American Hospital Association, as well as so-called safety-net medical institutions, such as teaching hospitals and thousands of community-based clinics (Lewin & Altman, 2000). These officials, medical practitioners and institutions realized that deep cuts in Medicaid would devastate their revenues or budgets. (Medicaid had become the largest single expenditure in many state budgets by the mid 1990s and helped

many hospitals and clinics offset uncompensated care from medically uninsured persons.)

The different power base of entitlements and DDS was well illustrated during the 1980s and 1990s when Congress sought to decrease deficits that had begun when Reagan had coupled a large tax cut with increases in military spending in 1981. On frequent occasions, Congress took entitlements “off the table” while cutting or freezing DDS (Jansson, 2001). In light of these cuts and freezes, it is hardly surprising that DDS stagnated in the 1980s and 1990s.

When legislators do want to cut entitlements, they must change their statutes, such as by cutting eligibility levels or cutting benefits. This legislative task is far more difficult than shaving appropriations of programs funded by DDS in meetings of appropriations committees. (Different DDS programs are bundled under the federal department that houses them, making it difficult for citizens to see when appropriations for specific programs are cut.)

*Interest Payments.* Interest payments on the federal debt depleted resources that might have been used for DDS during two specific periods. Because Congress rejected President Franklin Roosevelt’s plea that most of World War II’s expenses be funded by tax revenues rather than borrowing, the federal government accumulated huge wartime deficits and debt that had to be financed in the postwar period by interest payments that absorbed about 25 percent of President Harry Truman’s budgets (Jansson, 2001). The huge budget deficits incurred by Reagan meant that as much as 15 percent of the federal budget was directed to interest payments in the late 1980s and much of the 1990s (Jansson, 2001). Had the U.S. kept interest payments from 1980 through 2004 at the same percentage of GDP that existed in 1980, the U.S. would have had \$1.4 trillion in additional resources that it could have applied to DDS and other domestic needs.

### ***IDEOLOGICAL OPPOSITION TO DDS***

The size of DDS has been constrained, as well, by conservatives’ opposition to DDS. While conservatives often criticize the size of the federal government, they rarely attack the two largest manifestations of federal power: military spending and entitlements. They defend large military outlays as necessary for national security. They have usually refrained from frontal attacks on entitlements because they suffered electoral losses in the 1980s and 1990s when they supported large cuts



in Social Security, Medicare and Medicaid. Conservatives' animus to DDS is partly grounded in their belief that many of the programs funded by it, unlike entitlements and military spending, ought to fall under the purview of state and local governments. Even in the Great Depression, many conservatives contended that federal spending on work-relief programs intruded on state and local prerogatives, even exacting from Roosevelt a promise that it would be rescinded once the Depression had eased. While President Dwight Eisenhower favored expanded spending on Social Security, he staunchly resisted significant increases in programs funded by DDS (Morgan, 1990). President Richard Nixon frequently made unfavorable comparisons of DDS to entitlements. Entitlements, he argued, gave citizens tangible and useful benefits unlike the ineffective outcomes often associated with education, job training, preschool, and social-service programs (Jansson, 2001). (Nixon prematurely drew upon some negative evaluations of these programs to portray most of them as ineffective.) If Nixon waged rhetorical warfare against programs funded by DDS and impounded funds for many programs funded by it, Reagan sought and obtained deep cuts in many of them in the appropriations process (DDS fell by 15 percent from 1980 to 1989). David Stockman, Reagan's budget director, tried in vain on many occasions to inform Reagan that he could only redress the huge deficits he had created in 1981 by making substantial cuts in military spending and in entitlements, but Reagan continued to believe that most government waste derived from DDS and from the small AFDC program (Stockman, 1986).

### ***CREATING ADVERSE FUNDING ENVIRONMENTS FOR DDS BY CUTTING TAXES***

DDS is particularly vulnerable during periods of budget deficits because programs funded by it are less able to stave off cuts than military spending and entitlements. Unlike many European nations, as well as Canada, where large deficits are widely accepted as inevitable or even beneficial, the American public and Congress has often been wary of deficits (Savage, 1988). Even during the Great Depression when the New Deal had to be funded by borrowing because of the size of work-relief programs, politicians of both parties—and Franklin Roosevelt himself—often cut federal programs to diminish the size of deficits. (Work-relief programs were so underfunded that they could accommodate only one-third of unemployed able-bodied adults.) When deficits occurred in the late 1960s, the mid- and late 1970s, the 1980s, and the 1990s, legislators often convened budget summits to work out defi-

cit-reducing programs—summits that often led to disproportionate cuts in DDS as compared with military programs and entitlements.

Nowhere was this propensity to target DDS rather than other programs more obvious than during the Reagan, George Bush, and Bill Clinton presidencies. When the Gramm-Rudman-Hollings legislation (GRH) was enacted in 1987 to force across-the-board cuts (sequestration) if Congress failed to meet specific deficit-reduction targets in coming years, budget negotiators excluded most entitlements from the package. This omission meant that cuts would have to come from discretionary spending if Congress failed to meet GRH deficit-reduction targets. When Rep. Thomas Downey (D., N.Y.) wanted to increase childcare and job training spending by \$6 billion to help welfare recipients get off the rolls, he was overruled by Democratic Party leaders on grounds it might trigger sequestration (Barry, 1989). The budget summit between President George Bush and Democratic Congressional leaders in Fall 1990 led to a decision to freeze DDS through 1993. Indeed, incoming president Bill Clinton soon discovered in 1993 that he could not enact large increases in “social investments” because they would have violated the freeze on DDS enacted in 1990 (Woodward, 1994). Moreover, the Congress enacted a “hard freeze” on DDS in 1993 extending to 1998—and Clinton, now himself turned against programs funded by DDS, slashed \$261 billion from DDS programs starting in early 1996 and over a period of years. The 1997 budget negotiations extended the freeze on DDS that was due to expire in 1998 to 2002—making this freeze so harsh that DDS could not even keep up with inflation (Jansson, 2001).

In light of their dislike of DDS, it is hardly surprising that conservative legislators and presidents have often tried to create an unreceptive budget environment for it. Conservatives sought huge tax cuts after World War II with the intent of drying up revenues that the Truman Administration might have used to fund a domestic agenda. Eisenhower fought tax increases for fear that the Democratic Congress would increase DDS. Reagan sought his huge tax cut of 1981 to deplete revenues that might otherwise have been used for DDS (Jansson, 2001). President George W. Bush sought a \$1.6 trillion tax cut at the inception of his presidency partly to dry up funds for DDS during the coming decade.

### ***DOWNWARD PRESSURE ON DDS FROM DEVOLUTION***

Liberals suspected a hidden agenda when Nixon proposed his “New Federalism” in the early 1970s: He meant, they feared, to devolve fed-

eral programs to state and local governments as a ploy *also* to cut federal spending for them. Partly for this reason, the Democratic Congress only approved two small programs for devolution (Conlan, 1984). The liberals' fears were realized when Reagan persuaded Congress to fold 57 categorical programs into seven block grants in 1981, while funding the block grants at levels only 75 percent of the monies that had gone to the 57 programs.

Nor should it be surprising that devolution and diminished federal funds are likely to go hand-in-glove. Devolution proceeds from the assumption that state and local governments devise and implement programs better than federal authorities. If basic policies are established at the state and local level, why should these authorities not also fund programs established by them? Devolved programs may also lose political clout in the federal budget process. Folded into block grants, they may lose their political identities making it more difficult to rally supporters in budget battles on Capitol Hill.

The funding of block grants in the years since their enactment in 1981 has not been munificent. Funding for the Social Services Block Grant, for example, diminished from \$3.95 billion in 1981 to \$2.09 billion in 1998. Some other block grants received negligible funds in 1998 by any standards, such as \$194 million for the Preventive Health and Health Services Block Grant, \$681 million for the Maternal and Child Health Services Block Grant, and \$1 billion for the Child Care and Development Block Grant. (It takes \$1 billion per year to operate a single aircraft carrier and its accompanying ships and submarines—and the U.S. maintains 12 of them—not to mention \$5 billion to construct a new one.)

If policy devolution also becomes funding devolution, mental health, child welfare, housing, public health, employment, and education programs will be hard-pressed to maintain their current resources. The cumulative tax revenues of all state and local governments are merely one-half the size of federal revenues, so many of these governmental units will lack resources to take up the slack particularly as they have other funding commitments such as for transportation, prisons, and higher education (Rivlin, 1992).

### **DOUBLE STANDARDS**

Programs funded by DDS sometimes encounter higher standards of evaluation and justification than military programs and entitlements. A

veritable army of program evaluators based in think tanks, government agencies, and universities evaluates programs funded by DDS, such as job training, childcare, and education programs. By contrast, military programs and entitlements are subject to fewer evaluations. Since the vast bulk of military hardware and forces are not used in battles save for scattered regional conflicts, they are not systematically evaluated. Persons who urge greater forces "to protect national security" are not required to prove that sufficient threats exist to justify these forces. Stockman was surprised to find that the military decision making process "really began at the bottom of the pyramid (as) clerks decided what they wanted; the colonels what they wanted; the generals what they wanted . . . and what ended up on the Secretary of Defense's desk was a wish list a mile long" (Stockman, 1986). Even when the Cold War ended, only minor cuts in military spending were effected even though 50 percent of the military budget had been devoted to deterring a Soviet invasion of Western Europe (Kaufmann, 1992). Similarly, relatively few evaluations of entitlements exist. Increases in Social Security or Medicare benefits are usually justified on the basis of presumed need rather than evaluations (Mayer, 1997).

Programs of all kinds should be evaluated. By holding programs funded by DDS to a higher standard, legislators imperil their funding as compared to other, less evaluated programs. Positive evaluations are often difficult to obtain in programs funded by DDS, moreover, because they often assist persons who live under adverse conditions, such as extreme poverty. In such cases, it is often not realistic to assume that a single program can make a dramatic difference in their lives (Jansson, 1999). Conflicting evaluations often occur, such as when different evaluators use different outcome criteria. Nowhere is this more apparent than with respect to evaluations of educational programs where different evaluators may use an array of tests, cognitive measures, retention measures, and graduation measures. Negative conclusions, in turn, are used by conservatives to contend that you "cannot solve problems by throwing money at them."

### ***GREATER DIFFICULTIES IN MOBILIZING VERTICAL AND HORIZONTAL CONSTITUENCIES***

Advocates need to mobilize both vertically and horizontally when seeking resources in the federal budget process. They need support from persons, professions, and institutions that benefit from resources

of specific programs (vertical organizing). They need to develop coalitions, as well, so that they receive support from other interest groups and programs in return for helping them to increase the funding of their favored program (horizontal organizing).

Supporters of military programs and universal entitlements can easily mobilize vertically. If the military has scores of contractors, service-related interest groups, local communities with military bases and contracts, supporters of Medicare, Social Security, and Medicaid develop and maintain networks of beneficiaries, local government officials, and institutions that benefit from their resources. Public opinion is extensively cultivated, as well, by supporters of military programs and these large entitlements. Supporters of these programs, in turn, develop coalitions with other groups: Advocates who favor specific increases in Medicaid, for example, can ally themselves with advocates of specific increases in Medicare. In the military sector, persons who support augmentation of funding for a specific weapon system make common cause with advocates of increased funding for other weapons systems.

It is more difficult to organize support for programs funded by DDS. Their beneficiaries, institutions, and professions are divided into separate program streams making it difficult for them to congeal behind funding for DDS. Nor is it easy to organize coalitions between different programs funded by DDS since they fall into different government departments such as Health and Human Services, Commerce, Transportation, Labor, and Education.

Many presidents have used a divide-and-conquer approach to programs funded by DDS. They select specific favored programs within DDS for increases, while cutting others so that overall DDS funding remains stagnant or even declines (Jansson, 2001). (Caps placed on DDS from 1990 onward required that increases in funds for specific programs be funded by cuts in other programs to keep DDS funding with the caps.) Favored programs, now receiving additional resources, are less likely to come to the aid of disfavored programs.

### ***THE PROGNOSIS FOR DDS***

Many danger signs exist about funding for DDS in coming decades. Eugene Steuerle of the Urban Institute predicts that two-thirds of the federal budget in 2030 will be consumed by three programs: Social Security, Medicare, and the nursing home component of Medicaid (Weinstein, 1999). If his prognosis is true, DDS will hardly exist in the

federal budget since these entitlements, when supplemented by spending on military programs, means-tested entitlements and other programs will leave scant resources for DDS. We have already noted how the huge tax cut of 2001 may deplete resources that might otherwise have augmented DDS.

Domestic discretionary spending is a vital part of the American welfare state. It should receive far greater attention in policy research and theory, since DDS's erosion could have profound consequences for the human services. Advocates need to battle for DDS's budget share against military spending and even, in some cases, entitlements. They need to be more alert to the danger that policy devolution will lead to funding devolution. They need to make the case that specific kinds of investments in human resources and in communities are both humane and effective. Instead of being a minor presence in budget negotiations, DDS's advocates should become major players who often form powerful coalitions to advance their cause.

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