

## Health Care Costs & the Entitlement Crisis Stephen Gorin

In their 2006 book *Aging Nation*, Jim Schulz and Robert Binstock referred to “merchants of doom”—academics, political figures, and journalists who mistakenly believe that we cannot afford the aging of the population. A central concern of these doomsayers is the cost of entitlements, i.e., Social Security and Medicare, which they argue will “require massive tax increases, cause immense deficits or crowd out other important government programs” (<http://tinyurl.com/me3h2c>).

Talk of a general entitlement crisis is misleading, however, because Social Security and Medicare face very different problems. According to the best estimate of the Social Security and Medicare Trustees, the Social Security Trust Fund will remain solvent until 2037, and between now and 2050, spending for Social Security will increase from 5 percent of GDP to 6 percent (<http://tinyurl.com/r6wm7z>). This is an issue, but a relatively manageable one (<http://tinyurl.com/kmpnsg>).

In contrast, Medicare’s Hospital Insurance Trust Fund will run out in 2017, and, at current rates of spending, total Medicare spending will “grow from 2.7 percent of GDP in 2007 to 8.4 percent in 2050” (<http://tinyurl.com/danjjd>). Between now and 2050, spending per person on Medicare and Medicaid will increase from 5 percent of GDP to 20 percent. The entitlement problem is actually a Medicare (and Medicaid) problem.

It would be a mistake to assume that costs are an issue only for Medicare. Between 1970 and 2006, Medicare had a slightly better record controlling cost than private insurers (<http://tinyurl.com/myme38>). The underlying problem is health care inflation. According to Peter Orszag, Director of the Office of Management and Budget, “Health costs are the real deficit threat.” To address Medicare, and provide affordable health care for everyone, we must succeed in “bending the curve,” i.e. flattening out the growth of health care costs (<http://tinyurl.com/kol55r>).

As the current debate in Washington shows, this is easier said than done (<http://tinyurl.com/mx98q5>). A central challenge for reform, both of Medicare and our system generally, is the widespread difference in spending among and within geographical areas, what Orszag called “the massive regional variation in cost and health outcomes” (<http://tinyurl.com/nayayp>). John Wennberg and his colleagues at Dartmouth have found wide differences in practice patterns and spending “in different regions across the country, different cities, and even among different hospitals in the same city.” Although there is some disagreement about the cause of or best way to address these variations, there is widespread agreement that they exist, even after controlling for a range of factors (<http://tinyurl.com/l8vj2p>; <http://tinyurl.com/lz7gpj>). Ironically, “higher spending does not result in better quality of care” but often leads to “worse access” and “lower quality” (<http://tinyurl.com/ntfgg3>).

Further insight into cost and outcome variations was provided by Atul Gawande, in a widely-discussed article in *The New Yorker* (<http://tinyurl.com/q5krj3>). Gawande visited McAllen, Texas, the second most-expensive health care market in the nation (Miami is first). “In

2006, Medicare spent fifteen thousand dollars per enrollee here, almost twice the national average.” In contrast, in El Paso County, Texas, which “has essentially the same demographics,” Medicare spending is about half that in McAllen. Despite this, McAllen’s outcomes are similar to El Paso’s and the national average.

Gawande went on to contrast McAllen with high-quality, low-cost systems, such as the Mayo Clinic and Geisinger Health System, and concluded “we are witnessing a battle for the soul of American medicine.” “McAllen and other cities like it have to be weaned away from their untenably fragmented, quantity-driven systems of health care” to systems “in which doctors collaborate to increase prevention and the quality of care, while discouraging overtreatment, undertreatment, and sheer profiteering.” This of course would amount to a fundamental transformation of our health care system. Elliott Fisher, a Dartmouth researcher, estimated that changing higher-cost practice patterns to lower-cost ones could save enough money to move Medicare “from red to...black” and provide health care for everyone (<http://tinyurl.com/n33vf7>).

Unfortunately, making these changes will not be easy. Because practice patterns and costs can vary within cities and even hospital systems, we simply cannot cut physicians’ fees “across the board in a given region” (<http://tinyurl.com/nkxdlp>). President Obama took a first step toward dealing with cost disparities when he provided funding for comparative effectiveness research. The simple—and unsettling—fact is that we often don’t know what works and what doesn’t, and even when we do know this information is not always communicated to providers. The president’s initiative on comparative effectiveness will help close these gaps. Its purpose is not to ration care but to give providers the information they need to treat their patients. In his speech to the AMA, President Obama explicitly stated that “identifying what works is not about dictating what kind of care should be provided.” As other steps toward reducing the quantity, and increasing the quality, of services, the president advocated bundling payments, giving incentives to physicians to work in teams, and providing “bonuses for good health outcomes” (<http://tinyurl.com/mzkrz9>). Medicare, and the public health insurance plan proposed by the president, could serve as vehicles for introducing these changes.

Health care inflation lies at the root of both our entitlement and health care crises. To preserve Medicare for current and future generations and provide quality, affordable health care to everyone, we need to make fundamental changes in the way we deliver health care. President Obama and his advisors clearly recognize this challenge. We have an unprecedented opportunity to bring about these changes. We must act now and let Congress know we want to move beyond petty politics and solve our health care crisis.