Samuelson: The Monster at Our Door

Uncontrolled health spending poses ugly choices: raise taxes, gut other programs or run ever-larger and dangerous deficits.

By Robert J. Samuelson  

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Sept. 18, 2006 issue - Unless you're a news junkie, you probably missed Mark McClellan's announcement that he'll resign in early October, after two grueling years as head of CMS. What's CMS? Well, it's the Centers for Medicare and Medicaid Services, which spent $515 billion in 2005—21 percent of the federal budget and about $21 billion more than all defense spending. Leaving government presents McClellan with a golden opportunity: he can tell us what to do about Medicare. It's the monster in our future—and no one knows it better than McClellan, who is a medical doctor, a Ph.D. economist and since 2004 Medicare's chief bureaucrat. Moreover, he's not a rabid partisan. He also worked for Bill Clinton.

If "monster" seems like rhetorical overkill, then recall what the aging baby boom does to government. Federal spending on the elderly is plausibly projected to double from 2000 to 2030 as a share of national income. About three quarters of that increase will be health spending—mostly Medicare, but also Medicaid (70 percent of Medicaid spending goes to the old and disabled). The rise in health spending exceeds all of today's discretionary domestic spending on schools, the FBI, the environment and much more. If the "aging problem" involved only higher Social Security spending, we could handle it easily.

We all know that runaway health spending is already driving up the number of uninsured (latest count: 46.6 million), because insurance is increasingly too expensive for employers to cover low-skilled workers. Now, uncontrolled health spending will dominate the federal budget and pose ugly choices: (a) raise taxes sharply, (b) gut other programs and (c) run ever-larger—and more dangerous—deficits.

Some economists believe that we've gotten our money's worth from higher health spending. Since 1960, life expectancy at birth has risen from about 70 to 77. Harvard health economist David Cutler attributes about half the increases to medical advances—new drugs, surgeries and therapies. (Candidates for the other half: less smoking, less punishing jobs, fewer accidents.) Academic studies suggest that people value an extra year of life at about $100,000, says Cutler. That's how much they'd pay—in theory—to live a year longer. On average, the extra health spending needed to increase life expectancy a year has cost less than $100,000 per person. Therefore, we've gotten value for money.

By this logic, higher health spending is nonthreatening. In a recent paper, economists Robert Hall of Stanford and Charles Jones of the University of California, Berkeley, suggest that health spending may reach 30 percent of national income by 2050, up from 16 percent today and 5 percent in 1950. But they are unperturbed, because as Americans get richer, they prefer more health spending—longer and better lives—to a "third car [or] yet another television."

I'm not in this camp. Yes, much health spending has been beneficial and cost-effective. In the future, biotechnology or stem cells may produce large gains against Alzheimer's disease, Parkinson's and cancer at reasonable costs. But the present health-spending explosion is increasingly wasteful and socially corrosive. It may ultimately lower economic growth—a side effect of the high taxes needed to pay for Medicare and Medicaid—and already depresses take-home pay, squeezes other public services and redistributes income from the young to the old. Meanwhile, the extra health benefits are dwindling.

Today's waste transcends excess paperwork (an easy rhetorical target) and mainly involves unnecessary or harmful care. Using Medicare records, Dr. John Wennberg and colleagues at Dartmouth Medical School have documented huge variations in care—with few, if any, benefits. One study examined 4.7 million Medicare patients with any of 12 chronic illnesses who died from 2000 to 2003. In New York, some hospitalization rates were twice as high as at the Mayo Clinic. (Indeed, Cutler's latest calculation sends the same message; by the 1990s, it cost about $145,000 to increase an average life one year for those 65 and older.)

We should overhaul Medicare, but just how is unclear. To know, we need to answer three questions: (1) How much health spending can the economy absorb without having higher taxes or depressed wages reduce economic growth? (2) Who should pay for Medicare—that is, should older people pay more (lessening the burden on the young)? And (3) how can we pay physicians in hospitals for better outcomes and not just for more tests, hospitalizations and visits? These questions apply to any system we might adopt—from a government-run "single payer" system to more "consumer driven" health care.

Carrying out President Bush's agenda—including the new drug benefit—McClellan couldn't pose these basic questions. Now he says he plans to settle at a think tank or university, where he can. He has a huge chance to help define the needed debate. Most studies of Medicare have had a narrow and technical focus, evading the truly central issue. It isn't, "What's good for Medicare beneficiaries?" Rather, it's, "What's good for America?"