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## There is No Entitlement Crisis

Health Care, Medicare, Medicaid, Social Security, Fiscal Policy

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FEBRUARY 23, 2009 — The White House has just concluded a conference intended to focus attention on large anticipated budget deficits. No, not the current deficits. The fiscal problem on which the White House meeting will focus lies further in the future and is much more serious. It is widely described as an "entitlement crisis." *But there is no "entitlement crisis."* Yet, the repeated and mindless invocation of a nonexistent "entitlement crisis" threatens to divert national debate from the real problem—how best to avoid the explosive growth of spending on our exorbitantly costly health care system—and waste time on a bogus one.

Entitlements include federal payments for health care (principally through Medicare and Medicaid), for pensions (principally through social security and public employee retirement benefits), and several other programs including food stamps, cash income for the poor, and veterans benefits.

That the United States faces daunting long-term budget challenges is indisputable. But the very projections—those of the Congressional Budget Office—cited to document the long-term budget challenge, show that there is no general entitlement problem. Rather, the nation faces a daunting health care financing problem that bedevils private insurers and public programs alike.

The distinction is critical. How the problem is defined will determine whether the debate on how to solve it has any real chance of succeeding.

Here is what the projections indicate. Over the next four decades, government spending on all entitlement programs other than Medicare and Medicaid will increase negligibly as a share of national output—by only about 1 percentage point of GDP. That change is the difference between a projected increase of roughly 2-percentage points in the share of income going to pay social security benefits and a nearly 1-percentage point drop in spending on other non-health entitlements.

Meanwhile, Congressional Budget Office projections indicate that national health care spending will skyrocket, rising from 16 percent of gross domestic product to 37 percent by 2050. Aging of the baby-boomers explains some of the increase—the old cost more to care for than do the young—but not much. If population aging were all that is going on, national health care spending would rise by less than a quarter as much as current projections indicate.

Most of the increase is expected to come from the continuing—and, on balance, highly beneficial—proliferation of new ways to diagnose and treat disease. This lengthening menu has caused health care spending to take every larger bites out of total income for more than four decades. The gap has

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averaged about 2.5 percentage points a year. That difference sounds small, but it has been inexorable and accounts for most of the projected increase in Medicare and Medicaid spending. Furthermore, it shows no signs of ending. It also drives projected increases privately financed spending on health care that are so large that room for growth of non-health consumption will be squeezed and could actually stop.

If all of this spending were for care worth more than it costs and if health services were efficiently produced, the additional spending would be good news, even if paying the bills required major adjustments. But the United States spends twice as much per person on health care as the average of the ten other richest countries. And our health system is rated as inferior to most of theirs. Patients receive only a little over half of recommended care during typical contacts with doctors or hospitals. Huge amounts are spent on interventions that yield negligible benefits, while opportunities to achieve sizeable health improvements at little cost go unexploited. And as the projections indicate, at least on the cost front, things will get worse. And there is also that continuing national shame—that 46 million people are uninsured and lack adequate financial access to standard care.





These numbers tell a simple story. The nation faces a health care financing and organization challenge. The challenge is to design ways to pay for and produce health care services, private and public, so that spending goes for services expected to produce benefits worth what they cost, are produced as efficiently as possible, and are available equitably to all Americans. Then, the nation must decide how best to pay for that care—through premiums, out-of-pocket charges, and taxes.

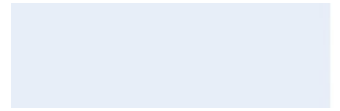
The public fiscal challenge and the private health care financing problem reflect the same underlying force. The public fiscal challenge cannot be met effectively without addressing the private consumption squeeze. Not, that is, unless the nation is willing to betray its commitment to assure the elderly, disabled, and poor health care of approximately the same standard available to everyone else.

Some analysts argue that there are sizeable sums to be saved from curtailing inefficiencies in Medicare and Medicaid. And they are surely right that there are some ways to save money in Medicare. However, serious gaps in Medicare coverage also demand attention. Any net savings will be far smaller than enormous projected increases in Medicare spending. Few savings are possible in Medicaid because benefits in many states remain inadequate and because the program already pays providers so little that many doctors refuse to see Medicaid patients. Bigger savings are possible from overall reform of the entire health care system. But these cannot be achieved by tinkering with just the programs that pay for care for the elderly, disabled, and poor. And they cannot be implemented humanely without the universal coverage that would assure everyone access to essential care.

Dwelling on an imagined 'entitlement crisis' is triply misleading. It directs attention to pensions and other non-health programs that pose no serious budgetary challenge. It diverts attention from health care reform, the problem which—if addressed effectively—will remove the long-term fiscal challenge. And it suggests that the health care problem is just in the public sector, when the real challenge—and the only way to meet it—is to reform the whole health care system. That is the nation's long-term fiscal challenge.

None of this suggests that health care reform will be easy or quick. The failures of past presidents of both parties and of past Congresses do not permit such naivete. Republicans and Democrats still disagree on how best to reform the delivery of health care and best to pay for it. In fact, no consensus exists within either party on the best course to follow. But this debate is the right one to have because it can improve the quality of care we receive, cover the uninsured, and solve the nation's long-term fiscal challenge. In the end, the solution will require increased taxes, as well as measures to slow the growth of health care spending. Reaching agreement will be difficult and slow. But a debate about a bogus 'entitlement crisis' misdirects public discussion. Not incidentally, it would threaten the adequacy of social security benefits that during the current financial turmoil have proven to be the only source of income on which the retired and disabled can count with absolute security.

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