

# Bailing Out Medicare

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**BOSTON** — All evidence suggests that until incentives are devised to restrain physicians' economic behavior, Medicare's coming fiscal crisis will not be resolved. So far, neither the Administration nor Congress has confronted this politically sensitive issue.

The Congressional Budget Office offers sober conclusions, to which the Administration takes only minor exception: Medicare, the Federal program of health benefits for the elderly, is fast approaching a major crisis. Its trust fund for hospital insurance, financed through payroll taxes, will go broke in 1988. The fund's cumulative deficit will reach \$300 billion by 1995, driven by a projected 13.2 percent annual increase in hospital costs.

Reagan Administration proposals pending in the Congress would merely delay the fund's deficit by perhaps one year. The proposals, among other things, seek to transfer a growing proportion of Medicare's costs to the personal budgets of elderly people. The President would shift \$16.8 billion in costs to the elderly over a five-year period, through higher deductibles, co-payments (patients' daily share of hospital costs) and monthly contributions.

President Reagan argues that larger out-of-pocket payments by Medicare patients would instill greater cost-consciousness on their part. The elderly, however, already personally pay about one-fourth of the rapidly rising costs of Medicare-covered services. On average, they spend 20 percent of their annual incomes for medical care. The elderly, moreover, rely heavily on physicians' advice about the care they receive. It is not realistic to expect hospitalized elderly patients to challenge and influence doctors on important, and costly, medical matters. Out-of-pocket payments will shift costs, not reduce them.

The long-term implications of Mr. Reagan's cost-transferring strategy should be understood.

The Congressional Budget Office estimates, for example, that to eliminate the projected trust fund deficit by imposing a new premium on Medicare hospital insurance would require that each beneficiary pay \$167 monthly by 1995. If, instead, daily co-payments for hospital care were relied upon to cover the deficit, by 1995 Medicare patients would pay more than one-third of the average daily cost of hospitalization. Either approach, the Congressional Budget Office stated, "would require even greater cuts in benefits each year after 1995."

The solution to a Medicare shortfall lies not in manipulations of cash flow,

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as President Reagan proposes, but in examining the forces driving the medical care delivery system itself — an engine running out of control. This examination must focus on physicians.

The doctor is the key decision-maker — recommending hospitalization and surgery, ordering laboratory tests, deciding when a patient is discharged and influencing adoption of new technology. Typically, the physician is a private entrepreneur who mobilizes hospital resources yet bears no financial responsibility for the ensuing costs. In no other industry are senior decision-makers so unaccountable for the economic consequences of their actions.

Fee-for-service reimbursement rewards physicians for using as many resources as possible. This powerful incentive is reinforced by a professional ethic to do everything possible for a patient, and a human desire to respond to patients' expectations. These forces encourage doctors to order services that may be only marginally beneficial, independent of the costs.

To rectify this imbalance in incentives, Congressional action is needed. Earlier this year, with strong Administration support, Congress enacted Medicare reforms designed to motivate hospital administrators to con-

## Physicians' role

serve resources. However, the legislation did not touch on the basic obstacle to cost control — the physicians. Consequently, hospital administrators face an uphill struggle to alter physicians' thinking, relying largely on exhortation.

Until the Congress deals directly with the physician issue, it is likely that Federal reforms will have a negligible effect on rising hospital costs.

One approach is to pay physicians a set amount, varying by diagnosis, for the care of a hospitalized patient — rather than, as now, a separate fee for each particular item of service. This reform would parallel the change in hospital reimbursements that Congress enacted earlier this year, and would give physicians an incentive to hold down costs.

This policy should be accompanied by administrative changes and educational initiatives in hospitals to strengthen physicians' fiscal accountability. Additional incentives are needed to discourage the use of medical technologies when the expected benefit to a patient is slight.

In sum, physicians themselves must help to resolve Medicare's coming crisis.