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## Larry deGhetaldi: Medicare costs can be cut

In an influential New Yorker article exploring wide variations in health care costs, surgeon Atul Gawande describes a visit to McAllen, Texas, which is both the Square Dance Capital of the World and the second-most expensive health care market in the U.S. after Miami. A group of Dartmouth Medical School researchers pegged McAllen's 2006 Medicare spending at \$15,000 per enrollee -- almost twice the national average of \$8,304, and \$7,350 more than the comparable figure for Santa Cruz County. How can our county, with its extraordinary cost of living, deliver high quality health care at less than half the cost of the same care in South Texas?

As Gawande discovered, higher spending levels haven't made the residents of McAllen any healthier hence his article's title, "The Cost Conundrum". This isn't unique to McAllen; researchers have found that both the quality of care and health outcomes are often better in regions spending less. Moreover, the culprits for rising costs are not necessarily what we'd suspect: high wages for health workers, the baby boom generational wave flowing into Medicare, or even the role of expensive technology.

Instead, factors driving up costs include overuse or misuse of scarce health care resources, such as unnecessary re-hospitalizations. In 2004, 20 percent of Medicare beneficiaries discharged from hospitals were re-hospitalized within a month -- costing \$17.4 billion of the \$102.5 billion Medicare paid to hospitals that year. Half of those re-hospitalized had no record of a follow-up outpatient visit, which may partially explain the high return rate. Five states with the highest Medicare spending had re-hospitalization rates 45 percent higher than those with the lowest rates.

What if all areas spent the same amount as the lowest-spending regions, instead of tolerating current variations? Peter Orszag, director of the federal Office of Management and Budget, thinks spending could be reduced by 30 percent \$700 billion if doctors and hospitals in high-cost areas practiced the same way that their counterparts do in low-cost areas -- without sacrificing quality and possibly boosting it. A more modest estimate comes from Oregon's a lower-spending state. If national Medicare spending per beneficiary matched Oregon's, the annual savings would be \$100 billion -- less than Mr. Orszag's estimate, but enough to shift Medicare's funding equation comfortably into the black.

Because Medicare represents the greatest threat to the U.S. Treasury since the Depression, we need to learn from areas like Oregon and Northern California if we expect to cede to our children not only health care for all, but also a financially viable federal government.

Santa Cruz County has its own cost conundrum. The high cost of living makes our hospital wage index the highest in the country; a hospitalization here costs Medicare more than any other place. Yet our Medicare expenditure per enrollee is low compared to state and national averages, hovering around the 15th percentile, despite some limitations on access to primary care. Clearly, we're doing something right. Maybe the care we collectively provide here is more integrated than elsewhere, and perhaps our specialists take on some primary care roles. Avoiding an avoidable hospitalization or needless ER visit, or not subjecting terminally ill patients to unnecessary and often harmful care are part of our success story. And we have assets like the Health Improvement Partnership HIP, a nonprofit coalition that tackles tough local health issues that affect all of us, like access to primary care.

As Congress ponders Medicare and health care reform, remember that lower spending without sacrificing quality is an attainable goal -- and a necessary one, for our nation's physical and economic health. Help Congress vote for the Santa Cruz and Oregon models, instead of perpetuating the McAllen model.

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