Your right ankle was predictably necrotic; the way the spokes from the external fixation device poked the ischemic tissue turned my stomach, but when I looked at your face as I placed my hand on the dead foot, you seemed totally unfazed. I discovered that your left foot was also in a boot, and when I asked you why, you said, "That used to be my bad side." For a few years you'd had a diabetic neuropathy that caused pain and difficulty in walking. "Now," you said, "that's my good side."

Davidai and Gilovich give several examples of the ways our perceptions can skew toward misfortune, despite the many "boosts" we've received. It's not only that challenges naturally have greater salience because they must be overcome, it's also, the psychologists note, that "informational disparities often make headwinds more available than tailwinds." For example, because we spend longer hiking up the trail than cruising down, it actually seems that "the trail itself" has more uphill than downhill segments. Davidai and Gilovich don't comment on how the asymmetries of our individual perceptions may be amplified at the level of the group, but my own sense is that the headwinds we face as a profession are increasingly writ large. To a certain extent, they should be: we would be remiss if we didn't constantly and exactingly focus on addressing all of medicine's shortcomings. But how to balance fixing what's wrong with holding on to all that's right?

Stories aren't for everyone, and surely they can't solve all our professional woes, be they practical or existential. But one thing we do all share is that, every day, we witness people facing what is often the greatest headwind of their lives: illness. To the extent that stories capture the grace so many people summon when facing these challenges, I suspect they can help us pause, if only briefly, to feel the wind at our backs.

As I walked out of your room, you called after me, "Doc, do you think I'll be able to walk again?" The problem was, I really didn't know, and I didn't want to lie. But you answered for me: "That's what I'll do," you said. "I'll learn to walk again." And I said something like, "Yes, that's what people do."

Disclosure forms provided by the author are available at NEJM.org.

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The Inevitable Math behind Entitlement Reform

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The projected growth in Medicare and Medicaid spending, which exceeds projected aggregate economic growth, is pushing policymakers to seriously consider further entitlement reform. At some point, Americans will probably be unwilling to pay higher taxes or increase borrowing to fund public health care programs. Capturing this view, House Speaker Paul Ryan (R-WI) has emphasized the importance of reining in spending on such programs, stating (accurately) that "it's the health care entitlements that are the big drivers of our debt."[1]

Any reform will be constrained by the basic math of spending growth (see table). Specifically, growth in inflation-adjusted Medicare and Medicaid spending reflects increasing numbers of beneficiaries and growth in spending per beneficiary. The latter, in turn, reflects both price inflation (relative to general inflation) and growth in utilization per beneficiary. The importance of each of these factors has changed over time because of demographic shifts and policy actions. Current approaches to reform may therefore have to be different from past strategies.

Projections from the Centers for Medicare and Medicaid Services suggest that inflation-adjusted Medicare spending will grow by 5.33% annually between 2016 and 2026. Nearly half of that growth (2.82 percentage points) is due to projected increases in the number of Medicare beneficiaries. The story is similar for Medicaid: 1.16 percentage points of its projected 3.31% annual growth rate can be attributed to increasing numbers of beneficiaries. To contain spending, the number of beneficiaries could be reduced by raising the Medicare eligibility age or tight-

Decomposition of Forecasted Spending Growth.*

Variable	Projected Average Annual Health Care Spending Growth Rates, 2016–2026 (%)	
	Medicare	Medicaid
Real GDP	2.91	
Total expenditures	5.33	3.31
No. of beneficiaries	2.82	1.16
Per-beneficiary expenditures	2.44	2.12
Price	–0.30	—
Utilization	2.75	—

* Data are from the Centers for Medicare and Medicaid Services, National Health Expenditure Tables, 2017. GDP denotes gross domestic product. Data on price and utilization of services are not available for Medicaid.

ening Medicaid eligibility rules. Such reforms would shift spending to patients or to other publicly funded programs, such as the Veterans Health Administration or Affordable Care Act marketplaces. Savings associated with eligibility restrictions would therefore be at least partially offset by increased spending in other programs, but total savings could still be substantial. Given widespread resistance to such changes, however, cost-containment efforts focused on spending per beneficiary are more likely to be politically successful.

Health care prices in the United States, even in the public sector, exceed those in other countries. Policies that could reduce prices include equalizing payments for the same services delivered at various sites and reducing payments for overpriced services.[2] Yet much of the low-hanging fruit has already been harvested. For example, after adjustment for inflation, Medicare physician fees are scheduled to fall by more than 10% in total by 2026, and overall fees are projected to fall by an average of 0.3% per year over the same period. Even drug prices after rebates have grown more slowly in recent years, though growth in spending on reinsurance payments in Medicare Part D has been particularly rapid. Given existing fiscal pressures, price growth in Medicaid is also likely to be minimal. Since price inflation is already low in the public sector, there will be pressure to raise, not lower, prices. We believe there is more that could and should be done to reduce public-sector prices, but substantial price reductions would be needed to alter the trajectory of spending on public health care programs. Making these cuts would be politically difficult.

Much of the projected increase in inflation-adjusted spending on health care entitlements, particularly for Medicare, stems from assumed increases in utilization (e.g., 2.75 percentage points of the 5.33% annual projected growth for Medicare spending). Strategies for holding utilization growth below projections (and more in line with very recent historical growth) will thus be central to the success of any attempt at cost containment.

Four broad utilization-reduction strategies might be considered. The first is to dissuade patients from seeking care by charging them more at the point of service. About 85% of Medicare beneficiaries have supplemental plans (e.g., Medigap) that reduce their out-of-pocket costs. Policies that limit the generosity of such plans could reduce Medicare spending considerably. However, such strategies would increase beneficiaries' financial risks, reduce access to care, and probably exacerbate health disparities.

A second strategy is to help beneficiaries improve their health by enhancing long-term care management and preventive services with the goal of avoiding more expensive services. Evidence suggests that although this type of approach is probably beneficial to patients and may be cost-effective, it is generally not cost saving.

A third strategy involves relying on private health plans to help reduce utilization. Evidence on the effectiveness of this strategy in Medicaid is mixed; research suggests that Medicaid managed care may have little or no effect on spending.[3] Medicare Advantage plans, however, have reduced utilization by about 5 to 10%.[4] These savings could be captured by taxpayers and could increase if the government capped payments to plans and required beneficiaries to pay the portion of premiums above the cap. Such a policy could pressure plans to further control spending, but beneficiaries would probably be forced to pay more, depending on the amount of government support. In the current Medicare Advantage program, savings are realized by Medicare only if government payments to plans — which are tied to spending in traditional Medicare —

fall accordingly. Thus, continuing to improve efficiency in the traditional program is crucial.

A final approach for reducing growth in utilization is to change incentives for providers who are part of alternative payment models, such as accountable care organizations (ACOs) and episode-based payment. Such models aim to improve efficiency by severing payments from the specific mix of services provided. Population-based payment gives organizations the most flexibility to achieve that goal. Under alternative payment models, metrics of success move from admissions, bed days, or visits to measures of efficiency, such as spending and quality of care. Providers participating in such programs can essentially transform projected increases in volume into profit if they eliminate wasteful services. Yet although recent evidence suggests that such models can reduce spending, their effects are generally small. For example, by reducing utilization of acute inpatient services and post-acute care, ACOs were able to generate savings of about 2.6% after 2 years.[5]

Given the limited success of ACOs, some members of the health policy community advocate abandoning them. Our view is that instead of changing focus yet again, we should refine rules for payment plans, harmonize them among programs (e.g., ACOs, episode-based payment, and Medicare Advantage), and exercise patience. For example, an ACO's target spending amount (its benchmark), which determines its bonuses or penalties, shouldn't fall in future years if the organization reduces spending — a policy that essentially penalizes organizations for success. In addition, benchmarks could be more predictable, and the amount of risk (and risk adjustment) involved could be revised to support participation by small practices. The application and oversight process for ACOs could also be simplified.

Outside alternative payment models, other policy initiatives addressing utilization would be useful, such as refining the Medicare benefit package so that it offers better financial protection and supports efficient use of services. Eliminating incentives for providers to use drugs inefficiently and bringing down drug prices (while retaining incentives for manufacturers to innovate) will also be important.

Because the proportion of Americans who are 65 years of age or older is projected to continue increasing for decades to come, entitlement reform will probably remain on the agenda even if the low rate of per-beneficiary spending and utilization growth persists. Given these trends, policymakers should have no illusions about how easy it will be to reduce growth in Medicare and Medicaid spending. Increased growth in gross domestic product could improve this outlook by reducing the number of Medicaid recipients and increasing tax revenue, but inaction could lead to major problems if hopeful scenarios don't materialize. Thus, although there are opportunities to reap more savings by using targeted initiatives to reduce prices, slowing per-beneficiary utilization growth will probably also be necessary. Policy tools already exist to reduce utilization, and we should continue to refine and harmonize them. Doing so will require a long-term commitment and patience from policymakers.

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