

Virtual Mentor

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Op-Ed

Medical Care for the Elderly: Should Limits Be Set?

Responses by Daniel Callahan, PhD, and Kenneth Prager, MD

Editor's note: Predictions abound that, when baby boomers become eligible for Medicare, the program—which pays for medical goods and services for the elderly—will go broke. Here two experts examine the weaknesses of the Medicare system and suggest how it might be made viable.

Response 1

Daniel Callahan, PhD

The trustees of the Medicare program have projected that Medicare will, in effect, go bankrupt in 10 years [1]. It faces a projected annual cost increase of some 7 percent, which will raise the program's cost from \$427 billion in 2007 to \$844 billion in 2117 [2]. Many policy analysts have determined that, for the program to survive in a viable way, the government will need to double the taxation for it, cut its benefits in half, or combine these two approaches in some way [3]. Doubling the taxation would be a great burden on the young, who will have to pay those taxes, while cutting benefits in half would harm the old, whose medical treatment Medicare reimburses.

How do we get out of this dilemma, particularly in the context of (a) a bipartisan resistance these days to large tax increases of any kind, and (b) the imminent retirement of the baby boom generation—one that has shown every inclination to expect generous medical care of the highest quality. If that is not enough of a dilemma, consider the fact that Congress has resolutely refused, since Medicare's initiation in 1965, to allow actual costs to be taken into account when determining the medical benefits the program will provide. "Reasonable and necessary" has been the only acceptable standard.

But those are not the only problems. Thirty or 40 years ago it was taken for granted that the elderly were not good candidates for organ transplantation, dialysis, or advanced surgical procedures. That has changed. Age alone is no longer considered a reason to deny necessary care. It is widely assumed that equity demands that the elderly be treated like everyone else; that is, age has become irrelevant in treatment decisions.

Unfortunately that last sentence must be qualified in light of Medicare's financial situation. Under the best of circumstances, age should be irrelevant in the Medicare program. But so far, cost of care has not been considered, and it can hardly remain irrelevant in a program strapped for money; cuts will have to be made. There are a

number of ways the program can put off making cuts that would directly limit the medical care of individual beneficiaries.

- A universal health care system might well lower the overall costs of health care by means of strong regulatory interventions, as has been done successfully in Europe.
- Congress could allow the program to take cost into consideration when it creates the benefit structure—and refuse to cover expensive treatments that have marginal benefits.
- Medicare beneficiaries with large incomes could be forced to pay high deductibles and copayments (already being done with Part B coverage for physician services and proposed for pharmaceutical coverage).
- Higher deductibles and copays could be extended to those in the middle range of income.
- Cuts could be made in physician and hospital reimbursements.

With the possible exception of universal health care, none of these suggestions would be sufficient to keep the Medicare inflationary costs in line with the projected growth of the GDP (gross domestic product), that is, in the vicinity of 3-4 percent a year—a significant drop from Medicare’s present 7 percent annual rate of inflation. But nothing less than such a drop would keep Medicare financially sustainable. There are no good solutions in sight, and little is served by unrealistic talk about cutting waste and inefficiency (a 30-year failed refrain), hoping for research breakthroughs that will eliminate costly diseases such as cancer and heart disease (which would have a much less dramatic effect than most people think), or more consumer-directed medicine, which forces patients to make more cost-savvy choices (of little use for complex multi-organ failures common to the elderly).

Given all those obstacles, I believe we need to confront three questions. The first is a matter of the philosophy of modern medicine: is there an obligation to keep the elderly alive as long as possible, regardless of the cost of doing so? I would argue that, in the face of such economic pressure, there is a duty to help young people to become old people, but not to help the old become still older indefinitely. A more reasonable goal is maintaining a high quality of life within a finite lifespan.

One may well ask what counts as “old” and what is a decently long lifespan? We can generally agree that the present Medicare and Social Security eligibility criteria of 65 years is quickly becoming outdated. My own answer is that someone is old when it can be said that he or she has had a “full life,” by which I mean enough time to do most (though not necessarily all) of the things that a life makes possible: education, family, work, and so on. As I have listened to people speak of a “full life,” often heard at funerals, I would say that by 75-80 most people have lived a full life, and most of us do not feel it a tragedy that someone in that age group has died (as we do with the death of a child).

A second question might be a matter of justice: since it is the young who pay the taxes used to care for the old, are there some limits to what they should be asked to pay? As matters now stand, there are about four working people for every retired person (known as the dependency ratio). As the baby boomers retire, that ratio will decline to 2.5 younger workers for every retiree. To keep the Medicare program at its present level of benefits would require a tax increase for the young of a magnitude that would threaten their ability to care for their families and children [3]. No doubt more of the elderly can continue to work and thus be less dependent, but there are likely limits to how far that can be pushed. There are some, like me at age 77, who continue to work, but the numbers drop off rapidly by 80 (and of course those who do hard manual labor rarely continue into their 70s).

The third question is a matter of broad health care policy: can we deal with the Medicare cost problem separately from the overall costs of our health care system? The answer is no, a point agreed upon by every health policy expert [4]. The costs of Medicare are, in great part, caused by the cost of overall health care in this country—and Medicare's coverage benefits affect those overall costs. The reason for this symbiotic relationship is simply that Medicare finances coverage benefits, but it is the private sector that mainly provides the actual care.

We are left then with the question of universal care. The American private sector has historically been unable to control costs and shows little potential for being able to do so. The European universal health care systems manage to control costs by heavy government regulation—limits on technology, negotiated physician fees, national and hospital budget caps, and price controls on pharmaceuticals. All of this sounds obnoxious to many Americans, but the hard truth is that what sounds acceptable in the U.S.—rejecting strong government interventions—simply won't work to control costs. There are, to be sure, many happy-face scenarios available that say otherwise, but few if any have a track record of success.

I add a caveat. The European systems themselves are now under economic strain, though far less than our own. Their strain comes from the underlying dynamic of developed countries: aging societies, rising technology costs, and increased public demand. Those factors are just exacerbated in our country. In the long run, all countries will have to rethink the idea of endless medical progress and technological innovation, aspirations that are turning out to be incompatible with finite budgets.

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Response 2

Kenneth Prager, MD

“Elderly people who are terminally ill have a duty to die and get out of the way.”
—Colorado Governor Richard D. Lamm in a 1984 address to the Colorado Health Lawyers Association

“Do not cast me off in old age; When my strength fails, do not forsake me!”
—Psalms 71:9

When the baby boomer generation reaches senior citizenship in 3 years, their growing appetite for the health care dollar and the increasing pressure it puts on the American economy will surface in an ever more dramatic form. The U.S., already strained by the world's highest per capita spending for health care, is about to inherit a huge wave of elderly citizens who will need (and want) their share of the health care dollar. The explosion of this demographic time bomb, coupled with the cost of increasingly sophisticated and expensive medical technology, will result in an unsustainable economic burden that might not only bankrupt Medicare but also have a devastating impact on the American economy.

It is doubtful that any politician will have the temerity Governor Lamm had when he stated in 1984 that old, terminally ill Americans “have a duty to die and get out of the way.” But underlying Lamm's heartless statement is a feeling probably held by many Americans: old folks who have lived their lives should not be allowed to place a huge economic burden on the young by using a disproportionate amount of limited financial resources for medical care.

There is an implied and fallacious assumption in this line of reasoning, which is that by spending less on the aged we will have more money for those who might put the funds to “better” use. Medicare money is not fungible, and a decrease in its budget will not result in more money being allocated elsewhere. This does not exclude the

possibility, however, that the Medicare budget could be spent more wisely on the elderly, a point I will get to later.

Not too long ago, some societies actually treated their elders as second-class citizens when it came to health care. During a trip to the Soviet Union in 1986, I was told that elderly patients in Soviet hospitals were badly neglected because they were felt to be nonproductive elements of society. I was also told how, in an Eastern European communist country, people lied about their ages when calling an ambulance because emergency services were not dispatched to older patients.

These extreme and repugnant examples of ageism should serve as dramatic reminders that age should not be used as the sole criterion for allocating health care resources. Whereas age may play *a* role in selecting recipients for certain treatments, for example scarce organ transplants, it is difficult to think of instances where age *by itself* should play an exclusionary role.

Besides, how would such determinations be made (and by whom)? Should patients above a certain age be excluded from ICU care? Should octogenarians not be offered coronary bypass surgery? Should we withhold aggressive chemotherapy from patients above a certain age? The inhumanity of such suggestions is self-evident.

The reason elderly patients use a disproportionate share of medical resources is obvious—they are sicker and need the care. They are also entitled to the care, inasmuch as most have paid Medicare taxes all their working lives on the understanding that this program would provide for them when they needed it.

The real question isn't whether our elderly are entitled to these resources, but how the money can be spent wisely, and whether there are reforms that, if carried out, would decrease expenditures that do not promote the health of Medicare recipients.

It is often stated that 27-30 percent of all annual Medicare expenditures are spent on caring for people in their last year of life [1], with the implication that this is too large a portion of the Medicare budget and that much of this money should be spent on health care for the non-dying. Firstly, this percentage has been remarkably stable over many years [2]. Secondly, the suggestion that this is excessive assumes that we can know ahead of time which patients will die so that less money would be “wasted” on their terminal care. This, of course, is incorrect. Many elderly patients, treated aggressively, survive for years with a good quality of life. And even if we could reasonably predict which of these patients were in their last year of life, we would still have to provide them with palliative care that is not inexpensive.

Medicare statistics do, however, point to glaring discrepancies that call for further investigation and corrective measures. A 2003 study found that per-capita Medicare expenditures in certain areas of the country were more than double those in others, without any appreciable difference in the quality of care. In fact, the data showed that “low-use [Medicare services] states tend to have higher quality services relative

to high-use states” [3]. The reasons for such variability may lie in a complex mix of differences in beneficiaries’ propensities for seeking care, area-specific practice patterns, and the racial and ethnic mix of the over-65 population. Finding explanations for these data holds a promise of decreasing medical expenditures without sacrificing the health care of the elderly.

Another topic that should be mentioned is the medically responsible use of technology. For example, the finding that life expectancy of patients with severe heart failure can be prolonged with the placement of implantable cardiac defibrillators has resulted in thousands of elderly patients with CHF receiving these very expensive, sophisticated devices without corresponding evidence that people in this advanced age group benefit from them.

A third reform that might save Medicare funds without sacrificing the quality of health care is reversal of the trend towards specialization among medical school graduates. By closing the income gap between medical practices that are procedure-based and the so-called cognitive specialties, we might encourage more graduates to become general internists, whom geriatric patients depend upon most. Skilled geriatricians can not only prevent excess expenditures on the unnecessary tests and procedures favored by specialists, they might also provide better overall care for the elderly than the fractionated pattern of specialist-centered care that many senior citizens receive.

Finally, one promising statistic is that Medicare expenditures in the last year of life decreases for those aged 85 years or older [4], in large part because the aggressiveness of medical care decreases with advanced age. As a greater percentage of the elderly population reaches their mid-80s (and if they have not had expensive, life saving interventions up until then), Medicare expenditures may actually drop.

In short, the proper approach to an aging population that consumes ever more health care dollars is not to cut their access to care arbitrarily but to develop a multifaceted approach that emphasizes patient and physician education about what medical care is helpful and what is not; promotes research into which procedures help the elderly and which do not; and endeavors to revive the increasingly neglected practice of general internal medicine with a focus on the geriatric population.

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