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OPINION

How Medicare Fails the Elderly

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HERE is the dirty little secret of health care in America for the elderly, the one group we all assume has universal coverage thanks to the 1965 Medicare law: what Medicare paid for then is no longer what recipients need or want today.

No one then envisioned the stunning advances in medicine that now keep people alive into advanced old age, often with unintended and unwelcome consequences. Indeed, scientific reports have showed the dangers, not merely the pointlessness and expense, of much of the care Medicare is providing.

Of course, some may actually want everything medical science has to offer. But overwhelmingly, I've concluded in a decade of studying America's elderly, it is fee-for-service doctors and Big Pharma who stand to gain the most, and adult children, with too much emotion and too little information, driving those decisions.

In the last year alone, and this list is far from complete, here is what researchers have found both useless and harmful, according to leading medical journals:

• Feeding tubes, which can cause infections, nausea and vomiting, rarely prolong life. People with dementia often react with agitation, including pulling out the tubes, and then are either sedated or restrained.

• Abdominal and gall bladder surgery and joint replacements, for those who rank poorly on a scale that measures frailty, lead to complications, repeat hospital stays and placement in nursing homes.

• Tight glycemic control for Type 2 diabetes, present in 1 of 4 people over 65, often requires 8 to 10 years before it helps prevent blindness, kidney disease or amputations. Without enough time to reap the benefits, the elderly endure needless dietary limits and needle sticks.

Yet Medicare, which pays for all of the above, does not, except in rare instances, pay for long-term care in a supervised, safe place for frail or demented old people, or for home aides to help with shopping, transportation, bathing and using the toilet.

Nationwide, the median annual cost of a nursing home in 2010 was $75,000; room and board in an assisted living facility, with no additional help, was $37,500; and the most basic category of home health aide, who can perform no medical tasks, like the dispensing of medication, was $19 an hour. These expenses are left to the elderly (and their adult children) to pay for out of pocket until their pockets are all but empty.

Then they are eligible for Medicaid, the state-run safety net for the poor. While Medicare, a federal program, is financed by payroll taxes, and thus is an "earned" benefit, Medicaid is "charity," in the minds of the formerly middle class who worked their whole lives and never imagined themselves destitute.

In the case of my mother, who died at 88 in 2003, room and board in various assisted living communities, at $2,000 to $3,500 a month for seven years, was not paid for by Medicare. Yet neurosurgery, which I later learned was not expected to be effective in her case, was fully reimbursed, along with two weeks of in-patient care. Her stay of two years at a nursing home, at $14,000 a month (yes, $14,000) was also not paid for by Medicare. Nor were the additional home health aides she needed because of staffing issues. Or the electric wheelchair after strokes had paralyzed all but the finger that operated the joy stick. Or the gizmo with voice commands so she could tell the staff what she needed after her speech was gone.

She paid for the room. My brother and I paid for the private aides and bought her the chair and the "talking board." What would her life have been like without the skilled care she required and the ability to get around her floor and communicate her needs? I shudder to think. But none of this was Medicare's responsibility.

Yet Medicare would pay for "heroic" care for a woman who was dying of old age, not a disease that could be treated: Diagnostic tests. All manner of surgery. Expensive medications. Trips to the emergency room or the hospital — had she not refused all of them, in the last year of her life. So, in less than a decade, by my low-ball estimate, my mother spent $500,000 of her own money and uncalculated sums from her two children before winding up what she considered, with shame, "a welfare queen."

A recent state-by-state study of long-term care, the first of its kind, by a consortium of researchers, has found that this kind of essential help costs anywhere from 166 percent to 393 percent of the average annual income of America's elderly.

BY now, you may be wondering if your parents have a half million dollars for old age. Or if you or your children do. You may be counting on quick and easy deaths. Shoot me, so many

people say. Alas, 70 percent of the elderly will need extended care before they die. Denial is powerful but doesn't pay the bills.

This mismatch between what is covered and what is actually useful is the central flaw in Medicare today, a shock to families who have no clue, until they're smack in the middle of it, about how this system works.

This mismatch tortures our elderly, drains the Medicare trust fund and leaves adult children with depleted retirement reserves. Yet in all the debate about the national debt, medical inflation and the need to pare Medicare costs by such means as raising the eligibility age, why is nobody, outside the insular community of long-term care providers, even mentioning the difference between acute and chronic care and how each is paid for (or not)?

Why is nobody enraged that our taxes are paying for hip replacements, for example, for people with advanced Alzheimer's disease, who are incapable of physical therapy? Why is nobody saying out loud, like it or not, that one of our great challenges is figuring out what to do about our elderly people, our fastest growing-population cohort, which will grow exponentially when 76 million baby boomers join the ranks?

The current system is unsustainable, but the alternative is the third rail of health care policy. President Obama's original legislation included Medicare reimbursement to doctors for discussion of end-of-life issues. These are what Sarah Palin called "death panels"; days later, they were cut from the legislation. An Independent Payment Advisory Board will make recommendations to Medicare about what works and what doesn't, beginning in 2015, but its proposals are not binding, as intended. A long-term-care insurance provision — with an average daily benefit of a mere $50 — is under siege.

Reading the history of the Medicare law, which was not intended for long-term care because today's technology and demographics were unimaginable then, one is struck by the battles and ultimate compromises between President Lyndon B. Johnson and Wilbur Mills, the head of the House Ways and Means Committee, who originally opposed Medicare.

That the crafting of that legislation was so difficult leaves one despairing that this pillar of the Great Society could now be rewritten, given our partisan incivility. But right now, according to the health economist Marilyn Moon, there are 47 million Medicare beneficiaries, costing a half trillion dollars a year, or one-fifth of the nation's health spending. In 2050, the population on Medicare will number 89 million. How scary is that?

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