**Medicare..50 years and counting.. from the New York Times**

We are fast approaching the 50 year anniversary of the passage of Medicare, and we are all acutely aware of this phenomenon, regardless of political affiliation.  To summarize several points made in the article, and to serve as takeoff points for discussion, let me present several pieces in the package for thought and discussion...

1. It is obvious that the numbers of those over 65 have grown enormously, and will continue to do so.. Consequently the strains on our medical system have and will continue to grow considerably. Consider the strains of the numbers alone. How do we, and will we cope with dollars and facilities for me elderly??

2. Because of the change in communications, mainly due to the Internet, the medical sophistication of the patients has grown accordingly. The days of Paternalistic Medicine... "Do what you are told Medicine" ... Are gone. What has this change in attitude wrought in terms of strain on this system, including how care is delivered and costs therein associated...?.

3. Treatment capabilities, including advanced technical sophistication, surgical techniques, have made for many changes, involving increased costs, as well as increased longevity. The latter has and continues to have enormous dollar and resource costs. How do we as a country cope, and continue to cope with these ongoing changes?

4. And as a consequence of the changes made in longevity, many social and cultural aspects, and responsibilities are present now and in the future, which were not thought of in days gone by. To wit, how and who provides the care of the older persons? Where, and from whom comes the dollar resources necessary for the care of the older person? And how does the individual and/ or society consider the practicality/ethics and morality of newly considered (not present in days gone by) of "end of life" situations??

And many more questions....

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The 50th anniversary of Medicare next month is an opportunity to consider what the goals of medicine should be in our aging society and how we want to live in relation to medicine’s evolving tools.

There has been a revolution in medicine and in patient expectations since President Lyndon B. Johnson signed Medicare health insurance into law on July 30, 1965, setting off the often contentious debates about cost control, rationing and privatization now dominating the public conversation about health care. To craft Medicare’s best possible future, however, it may be more productive to focus on the kinds of health care older Americans are actually receiving and are claiming to want.

Consider how much patients, doctors and treatments have changed since 1965:

The United States population is growing and aging. In 1965, fewer than 10 percent of Americans were 65 and older; fewer than 1 percent were 85 and older. Today those figures are 13 percent and 2 percent, respectively, and the latter cohort is the country’s fastest-growing age group. By 2030, people 65 and over are [projected to represent 20 percent](http://www.aoa.gov/Aging_Statistics/future_growth/future_growth.aspx) of the total United States population.

Our aging population has become increasingly medically sophisticated, risk aware and demanding about treatments. The paternalistic physician who knew the patient and family and “made the decisions” into the 1960s has been succeeded by a culture of patient autonomy, hospital-centered medicine and the new importance of medical teams.

Treatment capabilities, and thus disease trajectories, have changed enormously with the expansion of medical technology and the proliferation of diagnostic tools that enable earlier diagnosis of many problems. More diseases can be treated effectively with drugs and devices that didn’t exist or were in their infancy in 1965, and more kinds of risks can be controlled. Simpler surgical techniques now enable swifter recovery, making older, frail patients candidates for surgery. Cardiac valve replacement, kidney and liver transplants, and the implantable cardiac defibrillator have become unremarkable for those in their seventh and eighth decades, as are renal dialysis and treatments for advanced, metastatic cancers. Some of these therapies are now offered, wanted and employed among patients in their 90s. Such advances have greatly increased the need for decision-making by doctors, patients and their families regarding which treatments to choose and how long to continue them.

Cultural sensibilities about normal old age, a normal life span and the ability to control the timing of the end of life have [changed significantly](http://www.newrepublic.com/article/economy/magazine/88631/american-medicine-health-care-costs). In 1965, few people age 65 expected an additional 30 years of good health. Today, “80 is the new 60,” and most people in their 60s anticipate additional decades with the aid, if needed, of medicine’s increasingly powerful and increasingly expensive tools.

This dramatically changed sense of what normal aging, especially in very late life, should look and feel like has happened almost without our notice. In hindsight, it seems that medical practice and the Medicare reimbursement system that allows and encourages today’s treatments are major contributors to our altered — and still altering — expectations. As more people live longer and healthier lives, doctors have pushed ever-upward their own sense of the “normal” age boundaries for employing new, improved and standard treatments, and patients and their families have learned to accept and demand that they do so.

Medicare is the gatekeeper: It both determines what doctors recommend and prescribe and sets the bar for what we, the patients and families, come to need and want. And that need and desire arise not only from the transformations in the now multi-billion-dollar medical-industrial system and successful clinical interventions but also from escalating societal expectations about medicine’s potential and health in later life.

This state of affairs has its dark side, as many are aware. Treatment developments that prolong life also pave the way for longer periods of chronic disease, debilitating frailty, more therapeutic options and greater patient and family uncertainty about which option is best. Prolonged old age has enabled dementia to emerge as a profound problem. Discussions about who controls the time to die and how to die have become a societal preoccupation, leading to legislation for assisted suicide, the death-with-dignity movement and the widespread conversation about too much medicine and not enough personal control at the end of life.

Where is this linkage of medical techniques, Medicare reimbursements of them and our altered sense of ordinary health care and normal aging leading us as a nation? Doctors offer and recommend those therapies that will be reimbursed by insurance, that have become standard-of-care, ultimately, because they are reimbursed. Medicare leads the way in deciding what is reimbursable, and private insurance companies generally follow Medicare’s lead, including paying for organ transplants and defibrillators, extensive surgeries and [expensive drugs to prolong life](http://www.nytimes.com/2012/10/15/opinion/a-hospital-says-no-to-an-11000-a-month-cancer-drug.html), though sometimes by only a few weeks or months. When a cardiac defibrillator that costs Medicare about $25,000 is no longer strong enough to fix hearts that are in the end stages of their ability to function, a left ventricular assist device can be implanted — at a cost to Medicare of about $250,000.

Our nation, in which individual rights remain the supreme value, finds itself in the midst of a perfect storm comprising an aging society, an astounding array of high-tech, exorbitantly costly treatments and a powerful, profit-driven drug and device industry that churns out new therapies at an unprecedented rate. In this light, Medicare’s original reimbursement strategy — to pay for acute care services loosely labeled “[reasonable and necessary](http://muse.jhu.edu/login?auth=0&type=summary&url=/journals/journal_of_health_politics_policy_and_law/v027/27.5foote.pdf)” — now seems glaringly misguided.

How, in the next half century, can we use Medicare as a resource to assist our aging society, to enable the best possible last years, months and days for the greatest number of people — that is, for the millions of us who will live into our 80s and beyond?

Plenty of observers of medical practice and health care delivery — from economists, policy analysts and ethicists to journalists, doctors, patients and families — have noted that the necessity of cost control sits in tension with the value we place on open-ended choice, individual rights and always-escalating need. The need for cost control and the tension between cost control and rationing have dominated the political debates, but some, including myself, argue that costs should not be the focus.

A successful approach to deep Medicare reform — above and beyond cost control — would also have to consider the dominant values that are directing reimbursement and standard making. These include our collective political, economic and, indeed, ethical decisions that, together, have enabled private industry’s heavy-handed influence respecting not only costs but also the kinds of treatments that become standard and, as a result, foster our expectations about medicine’s capabilities as we grow old. Those decisions — judgments that are hidden from plain view — are what underlie ordinary health care delivery, especially for older Americans.

Focusing on the cost issue alone deflects us from considering larger problems such as high-tech treatments run amok and the low priority given to the kinds of social and low-tech services that would enable people to continue living and finding meaning in their lives as long as possible. Paying greater attention to everyday needs — emphasizing palliative (instead of rescue) care, providing household help and companionship, focusing clinical training on what’s at stake for our oldest citizens and their families — and placing less value on market-dominated, high-tech fixes for the medical problems of later life, would go a long way toward creating successful Medicare guidelines for the next 50 years.

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