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Longevity and the Future: Challenges of Health Policy

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Longevity and the Future Challenges of Health Policy

The physical extension of life may be the single greatest accomplishment of the 20th century.

By John D. Blum

Not long ago an article appeared in the *New York Times* detailing the experiences of older people who in their 70s and 80s were all leading active, vital lives, and in many cases were pursuing second, and even third, careers. The *Times* article recounted an anecdote told by Florida Senator Bob Graham, who was to give a talk at a picnic for 45 centenarians, but the event had to be postponed because half the group was away on vacation! According to Nobel laureate Gary Becker, the physical extension of life may be the single greatest accomplishment of the 20th century, and could prove to be the most significant factor of the new century. There are some who suggest that the concept of midlife may be extended as far as age 85. The implications to society of growing numbers of people living longer are profound and, indeed, have an impact on all areas of social endeavor. Few sectors of activity are more significantly affected by the increases in life span than health care. While living longer presents our society with exciting possibilities, it also comes with a price, as it is quite clear that medical costs for older people far exceed those incurred earlier in life, and that long life isn't always equated with

good health. We are challenged now by the realities of aging in currently existing health programs, most notably Medicare, and those challenges will only be compounded as physical life spans increase. The purpose of this essay is to explore some of the primary challenges in health care, such as economic limitations, politics, the impact of markets, and the inevitability of scientific progress, which must be confronted in light of an expanding population of older individuals. While the focus of this article is the effects of aging on the future of the American health care system, the challenges noted have equal applicability to other Western health care systems as well.

Economics, Longer Life, and Resource Allocation

A review of recent American health policy leads to the conclusion that since the enactment of Medicare and Medicaid in the mid-1960s, U.S. health policy has been dominated by economics. So many of the recent federal and state regulatory efforts have been directed toward imposing fiscal controls over a sector that has had a history of high inflation and dramatic cost escalation. Certainly, aging and the costs of treating elderly patients are frequently voiced reasons for the high cost of health care, but the reasons why health care is so costly are complex and involve the confluence of multiple factors, well beyond the scope of this article. Still, the prospect of having increased numbers of older Americans will undoubtedly force greater expenditures on health care services, and will only serve to add to fiscal pressures in this area. Stripping away all of the complexity surrounding health care cost issues leaves us with a naked truth: There is a limit to what can be spent for health and medical care services. As a wealthy society, our limits on health care expenditures may far exceed what other countries in the world can spend, but ultimately, there is an end point to how many resources can be devoted to the health care sector. To date, we have been fortunate as a society in that we have not had to make conscious decisions about how to limit expenditures on health (even if so much of our government health policy concerns that point), but the collision of demographics and science will likely force the issue.

Recognition that health care expenses are ultimately limited leads us to a difficult reality, one that will require that careful and deliberate decisions be made about how to allocate dollars for medical expenditures. While politicians may shy away from even using the term rationing, it is likely that health care services in this century will need to be allocated in a more carefully thought-out scheme in order to meet the pressures for access to services. The fact is that both individual physicians and public/private health care systems already ration health care services. In fact, the most volatile disputes about our current managed care system tend to be those centering on coverage issues, which are ultimately controversies about medical care service rationing decisions. With greater demands on the system, there will be a need for a more public and structured process to evaluate questions concerning the viability of providing payment for existing and developing medical care, similar to what has occurred in Oregon with that state's Medicaid program. It will be a difficult step to move government policy makers at the federal level to devise schemes of formal rationing, but cost pressures will necessitate that the health system adopt a more rationalized structure generally, and that will require considerable political courage.

Longevity, Politics, and Future Trade-Offs

Beyond cost, politics represents the next major challenge to the future of health care, and that challenge is profoundly affected by the demographics of aging. The recent presidential race demonstrated that health care issues are heavily laced with political overtones as questions about patient rights, Medicare solvency, prescription drug benefits for elders, and the implementation of the children's health program became subject matter of national debate. The election also demonstrated that there is still a residual fear of large-scale government intervention in health care, which has persisted since the demise of the Clinton Health Security Act. As might be expected, a significant number of the most prominent health policy issues concern matters that deal with the elderly and

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typically are geared toward changes in the Medicare program. With a projected drain on the U.S. Treasury of $1.1 trillion over the next decade (*NEJM*, Vol. 338, No. 18), it is impossible for politicians to ignore Medicare. At the same time, with the politicization of health care, it seems equally impossible to envision a major overhaul of this program, short of averting a total fiscal meltdown. Since the dramatic demise of the Medicare Catastrophic Coverage legislation in the late 1980s, Washington has been skittish about embarking on highly visible changes in Medicare. With the exception of the Balanced Budget Act of 1996 addition of Medicare + Choice, an expanded managed care option, recent programmatic changes have flowed through the administrative process, removed from the spotlight of congressional activity. In the late 90s, the National Bipartisan Commission on the Future of Medicare was created in an attempt to correct defects in the Medicare program and forge future directions, but this effort reached an impasse, hopelessly split along partisan lines.

Of even more recent vintage are the ongoing debates over the addition of a prescription drug plan to the Medicare program. During the presidential election, the Republicans' proposed drug coverage plan rested on the involvement of private insurance. In turn, the Democrats touted a plan for drugs that entailed a major, government-controlled addition to Medicare. Neither party's drug expansion platform was candid when it came to a discussion of the potential cost of a drug benefit addition. For any major drug benefit to work, some type of cost control mechanism would need to be developed, possibly a system of pharmaceutical price controls. According to the Kaiser Family Foundation, Americans spent $91 billion on prescription drugs in 1998, and as a result of advances in the pharmaceutical area and increased usage, that price will grow to $243 billion in 2008. A third of this expenditure is attributed to the elderly.

The dramatic expansion in longevity will cause serious financial challenges for Medicare and other public/private health care programs, bringing even greater cost pressures into the political forum. Recent history doesn't bode well

Childers Still Victorious in Court

Photo by Keith Myers.
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Jesse Childers—who will soon be 90—has achieved celebrity as a tennis player. The Kansas City lawyer has recently returned from Rancho Mirage, California, with a silver ball trophy. He finished second in doubles and fourth in singles at the USTA Men's 90 Hard Court Championships. These wins have attracted interviews by *The Kansas City Star* and CBS Channel 9 television. A stroll with Bobby, his wife of 24 years, now draws greetings from strangers.

Childers is an original member of the Senior Lawyers Division. He was admitted to practice in Missouri in 1934 and retired in 1995. During his most recent years in practice, he was a partner of the late Don Jackson, who was a founder of the SLD and its chair in 1988–89.

His serious interest in tennis began at the age of 65. Without any lessons, he developed his natural skill for the game. Ten years ago, at the annual Florida getaway for members of his club, he played and won more matches than any of the 50 other players. His daily regimen includes 30 minutes of calisthenics that he learned while serving in the Navy. He plays doubles three days a week at the Carriage Club and has an extended workout on the other days.

"There are several activities seniors can enjoy—mine is tennis," says Childers. "I hope good health allows me to keep playing several more years." ■

for bipartisanship in forging new directions in health policy, but perhaps the future pressures of demographics and science will be such that politicians may have to forgo partisanship to maintain the integrity of government health programs. It is interesting to note that the United States is hardly alone in its experiences with the politicization of health care. In Britain there was a major overhaul of the National Health Service in response to strong political criticism that the NHS was deteriorating, forcing the Labor government to act and implement a series of changes and provide an infusion of cash to modernize the delivery system. In Canada as well, the Liberal government was forced to increase federal transfer payments to the provinces to bolster sagging provincial health insurance plans, and the issue of the future of government-sponsored health care was a very prominent one in Canada's recent national election.

Politicians will be forced to make hard choices about how many resources will be put into health care, pitting health expenses against other obligations of government, such as defense and welfare. Within the health care field, the realities of the growing number of older Americans will lead to allocation decisions, which will result in choices that could lead to intergenerational conflicts. Policy makers will be forced to determine how many resources should be spent to extend life, and those determinations may have real impacts on dollars that are available for newborns and childhood diseases, as well as broad public health measures. Entering into this intergenerational tension over appropriate priorities in health care is interpretation of societal value, which has traditionally favored no limitations on expenditure of resources to save lives. However, that value system has never faced serious challenge wrought by the realities of limited resources, and the concept of rationally dealing with resource limitations is alien to federal politicians.

Market-Based Health Care: The Need for Questioning

During the dramatic movement of health coverage into managed care, we have witnessed the acquiescence of policy makers

On the Brink of a Brand-New Old Age

By Laura L. Carstensen

[. . .]

Old age, historically, was an experience for the few. Arguably, its transformation into an experience most of us will share—because of collective efforts to improve sanitation and prevent disease—represents the most important adaptive change in human history. In the 20th century, 30 years were added to average life expectancy. Yet this enormous gift is not only little celebrated, but even viewed as a crisis in the making, a change that could paralyze the nation, break the bank, destroy opportunities for younger people and place undue burdens on the middle-aged.

In fact, we have before us the opportunity to rethink and reshape our lives so that these extra years are not only meaningful for the individuals who live them, but nonburdensome and productive for the society around them. Research shows that most people already function very well until just a few short years before death: better than 60 percent of people over 80 live independently. If we make the right investments in science, technology and cultural change, life for the elderly can be not only longer but healthier and richer. [. . .]

Our national conversation about aging must expand beyond discussing how to care for a graying population. Encouraging passivity among healthy older people is not only bad for their health but bad for the country. There is nothing inherently wrong with an older, more mature society. It can be wonderfully adaptive for infants to be born into families that include multiple older generations who are invested in their survival. It's potentially wonderful to have a highly skilled and knowledgeable work force that only experience can deliver.

We have a choice. We can sit back and let the advances in life expectancy create problems—and, mind you, if we continue to encourage older people to step out of the mainstream, the problems will be horrific—or we can actively and deliberately decide what this new phase of life should mean for individuals and societies. [. . .]

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The coming biological revolution will open an array of possibilities for enhancing human health during an increasing life span.

to the use of the private marketplace as the appropriate forum for the delivery of health care and the establishment of applied health policy. Undoubtedly, America has had a long tradition of using private markets for the provision of most basic services, and with our jaundiced attitude toward government programs generally, it is no wonder that health care should be no different. Any notion of a broadly based government health plan has been thwarted by political opponents throughout the 20th century and seems to have all but expired with the demise of the Clinton Health Security Act in the mid-90s. Interestingly enough, the Clinton plan was based on market competition, and while underpinned by a heavier hand of government, it nevertheless was rooted in a notion that marketplaces would yield productive competition, benefiting consumers.

While managed care health coverage is based on use of private plans, which in turn have spawned dramatic realignment of local health care providers, the fact is, government regulation of all sorts is very much in evidence in health care delivery. Still, there is no unifying regulatory scheme in health care; rather, a bizarre quilt of federal and state initiatives, and the pressures of the market, are allowed to work to both deliver services and structure the composition and types of agents providing those services. The trade-off of using markets is that economic failures will be allowed, and already we are confronted with news of HMOs that have canceled Medicare coverage or experienced significant profit downturns that have affected their services. While government may rush in to protect consumers and providers from the worst abuses of the marketplace, markets operate to enhance business, and that may not always be compatible with public health. In the future, blind faith in markets will need to be reexamined, and, as difficult as it may be, some type of structured system may need to be developed to ensure effective health delivery, particularly if health is elevated to a basic legal right.

Science, the Driving Force

Perhaps the most significant variable affecting the future of health policy and aging is scientific development. It is impossible to predict where science will take us in the 21st century, but if the past is our guide, it is likely that the progress to be made in medical sciences will be dramatic. On June 26, 2000, President Clinton announced that scientists had completed a rough sketch of the human genome, mapping the complete set of human genes. In a matter of a few years, we have come from knowing very little about our genes to knowing a great deal. While knowledge of the genome won't erase medical uncertainties overnight and lead to immediate cures to illnesses, such information will go a long way toward solving many complex medical dilemmas. Already genetics is leading to new and exciting research about prolonging life, harnessing new tools and ideas from molecular biology and genomics. While science poses great potential for enhanced life, that potential is not without a price. Scientific progress will open the door to serious legal questions about confidentiality, discrimination, and equitable access, and will force politicians and lawyers to develop new laws and new approaches to integrating scientific progress into existing policies. While some new treatments and drugs will lower the costs of delivering medical care, many will not: many new technologies will be expensive. With costly new therapies, there will be an increasing number of difficult issues about equitable access to resources both in our health system and in a global context, as well.

Concluding Thoughts

Economics, politics, and science in the health policy arena present challenging and complex problems as they are linked to the extension of physical life, and are matters that influence us, individually and collectively. Undoubtedly, those who shape the law—practitioners, judges, legislators, and academics—will be at the center of deciphering how best our institutions can meet the profound challenges future health policy issues will present. The coming biological revolution will open an array of possibilities for enhancing human health during an increasing life span. Our legal institutions must be poised to facilitate such progress, but in ways that are equitable and responsive to human dignity. ■

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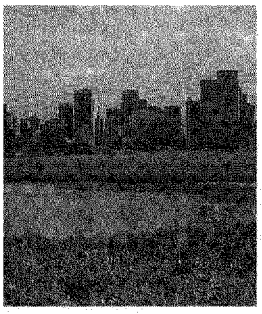

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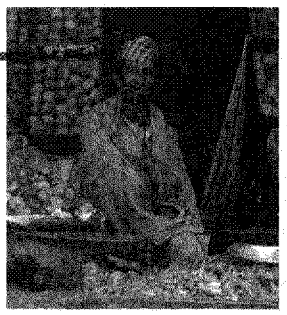

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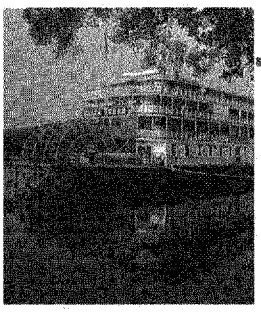

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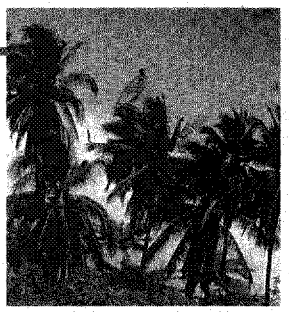

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