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Assault on Seniors

OPINION

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Since Medicare was established in 1965, access to care has enabled older Americans to avoid becoming disabled and languishing in nursing homes. But legislation now being rushed through Congress—H.R. 3200 and the Senate Health Committee Bill—will reduce access to care, pressure the elderly to end their lives prematurely, and doom baby boomers to painful later years.

The Congressional majority wants to pay for its \$1 trillion to \$1.6 trillion health bills with new taxes and a \$500 billion cut to Medicare. This cut will come just as baby boomers turn 65 and increase Medicare enrollment by 30%. Less money and more patients will necessitate rationing. The Congressional Budget Office estimates that only 1% of Medicare cuts will come from eliminating fraud, waste and abuse.

The assault against seniors began with the stimulus package in February. Slipped into the bill was substantial funding for comparative effectiveness research, which is generally code for limiting care based on the patient's age. Economists are familiar with the formula, where the cost of a treatment is divided by the number of years (called QALYs, or quality-adjusted life years) that the patient is likely to benefit. In Britain, the formula leads to denying treatments for older patients who have fewer years to benefit from care than younger patients.

When comparative effectiveness research appeared in the stimulus bill, Rep. Charles Boustany Jr., (R., La.) a heart surgeon, warned that it would lead to “denying seniors and the disabled lifesaving care.” He and Sen. Jon Kyl (R., Ariz.) proposed amendments to no avail that would have barred the federal government from using the research to eliminate treatments for the elderly or deny care based on age.

In a letter this week to House Speaker Nancy Pelosi, White House budget chief Peter Orszag urged Congress to delegate its authority over Medicare to a newly created body within the executive branch. This measure is designed to circumvent the democratic process and avoid accountability to the public for cuts in benefits.

Driving these cuts is the misconception that preventative care can eliminate sickness. As President Obama said in a speech to the American Medical Association: “We have to avoid illness and disease in the first place.” That would make sense if most diseases were preventable. But the two most prevalent diseases of aging—cancer and heart disease—are largely caused by genetics and their occurrence increases with age. Your risk of being diagnosed with cancer doubles from age 50 to 60, according to the National Cancer Institute.

The House bill shifts resources from specialty medicine to primary care based on the misconception that Americans overuse specialist care and drive up costs in the process (pp. 660-686). In fact, heart-disease patients treated by generalists instead of specialists are often misdiagnosed and treated incorrectly. They are readmitted to the hospital more frequently, and die sooner.

“Study after study shows that cardiologists adhere to guidelines better than primary care doctors,” according to Jeffrey Moses, a heart specialist at New York Presbyterian Hospital. Adds Jeffrey Borer, chairman of medicine at SUNY Downstate Medical Center: “Seldom do generalists have the knowledge to identify the symptoms of aortic valve disease, even though more than 10% of people over 75 have it. After valve surgery, patients who were too short of breath to walk can resume a normal life into their 80s or 90s.”

While the House bill being pushed by the president reduces access to such cures and specialists, it ensures that seniors are counseled on end-of-life options, including refusing nutrition where state law allows it (pp. 425-446). In Oregon, the state is denying some cancer patients care that could extend their lives and is offering them physician-assisted suicide instead.

The harshest misconception underlying the legislation is that living longer burdens society. Medicare data prove this is untrue. A patient who dies at 67 spends three times as much on health care at the end of life as a patient who lives to 90, according to Dr. Herbert Pardes, CEO of New York Presbyterian Medical Center.

What is costly is when seniors become disabled. In a 2007 Health Affairs article, researchers reported that surgeries to unclog arteries and replace worn out hips and knees have had a major impact on steadily reducing disability rates. And nondisabled seniors use only one-seventh as much health care as disabled seniors. As a result, the annual increase in per capita health spending on the elderly is less than for the rest of the population.

Nevertheless, Medicare is running out of money. The problem is the number of seniors compared with the smaller number of workers supporting the system with payroll taxes. To remedy the problem, the Congressional Budget Office has suggested inching up the eligibility age one month per year until it reaches age 70 in 2043, or asking wealthy seniors to pay more.

These are reasonable solutions—reducing access to treatments and counseling seniors about cutting life short are not. Medicare has made living to a ripe old age a good value. ObamaCare will undo that.

Dr. McCaughey is chairman of the Committee to Reduce Infection Deaths and a former lieutenant governor of New York State. To learn more about the status of health care legislation, visit www.defendyourhealthcare.us.