An Existing Aging System That Cannot be Led*

Summary

Today, most frail older adults remain at home, families shoulder overwhelming caregiving demands, and the existing system is financially unsustainable for all but the very wealthy. Digital tools can decentralize and better coordinate care, enabling older adults to remain safely in their homes while rebuilding local community responsibility. New leadership will emerge from both aging Boomers who recognize systemic failure and Millennials who will carry much of the caregiving and financial burden and are well positioned to harness technology. Ultimately, the neighborhood-level community—people within reach of one another—must become the foundation for future aging care.

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To be “hoist with his own petard,” refers to someone who has inadvertently blown himself up with his own bomb or, metaphorically, fallen into his own trap. Most people today don’t know that a petard is a 16th-century bomb, but most people do know the expression. To be blown up by one’s own bomb is an ultimate irony.

Might that describe the impact of Big Medicine has on aging? What if the apparently unsolvable problems of old age care are largely of Big Medicine’s own making. What if aging’s unmanageable dimensions are not aging at all? What if the real challenge in aging care is not in managing the many facets of aging but rather that Big Medicine can’t get out of its own trap.

Older age, in itself, it is not the bomb here. Old age is actually rather anodyne. After all, older age itself doesn’t cost much, doesn’t need a new car every two years, or new clothes or a new house (79 percent of people 65+ own their own homes).

It’s all the physical and related emotional complications associated with what longevity leads to that’s the hard part. What longevity almost always leads to is frailty—a set of late-life appearances and traits and issues that society turns away from in alarm. We don’t even like to use the word. But even frailty is merely an artifact, a byproduct of a trap of our own making.

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So, what is the bomb we're sitting on? Our own health care delivery system. Big Medicine's role in aging is at once inescapable and consistently inappropriate for the conditions correlated with older age. The result is so comprehensively harmful that we assume that its product, bad outcomes in old age, *is* older age. It isn't frailty in itself that's the awful outcome, it's how we address frailty that renders it awful. It is the artifact of an inappropriate delivery system. We are the victims of our own scheme.

What if you have four chronic conditions? This is not an outlandish hypothetical: 77 percent of those sixty-five 65+ have at least two, and the average life expectancy at age 65 is an additional 17 – 20 years. Let's assume that your diabetes, heart condition, osteoporosis and lung limitations affect one another. Yet the specialist for each condition restricts his prescriptions only to his purview, without concern, and often even knowledge, for the impacts it may have on the others. The specialists are in different locations and don't know one another. So, when something goes wrong, and it's not clear what's causing it, you don't know whom to call. And, by the way, not any of your specialists, or anyone else, helps you to comply with or adhere to any of the treatment regimens they've prescribed.

One more factor: assume that the more severe the condition, the more intensive the intervention, the higher payment for the medical providers. And wrap that into the operation of hospitals, health insurance companies and nursing homes and you have a treatment regime that benefits most the most extreme problems. Now you have a "catch and release" system; more accurately, a "catch, extract, and release" system that is designed to cure and fix and "catch" again, not to head off or maintain.

This is Big Medicine for aging. Not Big Bad Medicine, more like Big Wrong Medicine. The men and women who deliver and administer our health care are not ill-intentioned. It's the system that doesn't fit the need.

The US health care system was built to deal with infectious and acute diseases, but 90 percent of our healthcare expenditures today are for chronic conditions. Medical science and the health care industry largely defeated infectious disease in the first half of the 20th century. But ironically it is not organized to address the consequence of that success—our dramatically extended longevity that carries with it accumulating chronic conditions.

For example, most of our 1.4 million nursing home beds are in facilities designed in the industrial age, laid out along lengthy corridors where efficiencies were achieved by breaking down the care work into repetitious tasks, assembly-line style. This was

sufficient when there was little, we could do for frailty, when we simply kept residents fed, dry, and safe, hopefully providing some modicum of dignity. But this design does not accommodate the recent proliferation of interventions that can be tailored to the unique needs of each resident. Hospitals, most congregate facilities and even today's homecare delivery systems are likewise not designed to meet the expanded universe of individualized interventions in an era of extended chronic conditions.

The experience we create with this maze of ill-fitted care is much more likely to exacerbate frailty than to deal with it. And because we fear frailty, we can't look. The images are so dreadful we turn our backs on our future selves. And we wonder why ageism is so hard to combat. We just close our eyes and think about anything else. We don't try to head it off, or prepare for it, or work with it as it arrives. We treat our future frail selves, individually and societally, as we might a beggar we can walk away from. (If, on the other hand, we like our future self, we negotiate with the future, we reduce current spending, invest in diet and exercise and shape our present to deliver our imagined positive future.)

But as our days tick past, we react to the Sword of Frailty swinging ever nearer overhead with rising ambivalence and anxiety. When frailty arrives, we are overwhelmed by the challenge of getting through each day.

Initiatives to untie the various knots in our healthcare system go for naught because pushing through an initiative requires such an inordinate investment of time, energy, and money that reform efforts are twisted out of shape, distorted and most frequently stillborn. And if they survive, they have unintended consequences that in turn require new sets of mitigations.

The basic problem that cannot be innovated away is that the current health care system sits on the wrong foundation. It is built for cure—usually single-shot cure—while the actual challenges today are in multi-dimensional mitigation and management of chronic conditions. We come to play football in scuba gear.

It's expected at this point in any discussion of health care to assign blame. Health care is a target rich field. That is simply another fragment from the health care bomb. By and large, health professionals, facilities, health insurers, regulators, legislators and governors are all unhappily flailing and failing forward, locked into routines, roles and expectations they did not sign up for. Are there players who are positioned to be unduly enriched, nestled in creases of this crazy quilt? Sure. And are there players and personages whose behaviors and perhaps very beings should not be in the tableau.

You bet. But again, these are only symptoms of a health ecosystem that can no longer protect itself, much less the underlying populace, not the cause.

We got here with all good intentions. Until mid-1960s, families and community homes for the aging took care of their own aging. With the passage of Medicare and Medicaid, government stepped in to relieve (in a well-meant spirit of helping) families and communities of their historic responsibilities. In the 1960s, when the federal government started taking responsibility for aging health care, the medical health delivery system for acute disease was triumphant. Medicare was placed on that existing foundation. Little was understood about frail aging. It was viewed as the next set of maladies to be cured. But chronic diseases are generally not cured, they're mitigated.

The resulting aging delivery system is so inappropriate, so foggy, the landscape so barren, so locked down, with no footholds for outsiders, that it has been largely abandoned by the social sciences and the academy. The few observers who remain engaged tend to sit on the sidelines shouting ever more strident jeremiads about the coming age wave (that has, by the way, reached shore some time ago) to an audience of bystanders. Everyone actually working in the aging care industry is totally immersed in trouble, foraging for scraps of support. The jeremiads only make them hunker deeper down.

Some of the chaos arises from not knowing how we have achieved our new longevity. In actuality, most of the factors that brought us increased longevity at older age have not been medical at all, societal. Yes, modern medicine enabled us to survive childhood (and arrive in adulthood healthier). But the dramatic increase of years at older age, the real demographic explosion, resulted from reducing the behavioral and physical burdens of daily life. Developments in industrial and network era technologies and supply chains have revolutionized communication, food, transportation, housing, entertainment and work. We have reduced risk through tort reform, legislating safety standards legislation, and all manner of innovations responding to a public looking for protection throughout their lives. We don't smoke any longer. We don't die as often in car crashes. We breathe cleaner air. The hard edges of our physical environments are softened. We don't trip over the curb. We exercise. We don't live on butter and bacon.

Because we don't appreciate where the longevity revolution came from, rather than extending those incredibly successful cultural, social, economic systems, with all their instrumentalities, to address frailty in our midst, we drop frailty onto sterile assembly lines of care that have been abandoned in most other dimensions of American life.

Carlo Levi's memoir *Christ Stopped at Eboli*, published in Italy in 1945, describes how all economic progress stopped at the gateway to southern Italy. People on the other side were living in caves, without electricity. The book so embarrassed the Italian government that investment was redirected to the south. The recognition that the idea of aging as a fixed decline that no one can do anything about is erroneous is slowly becoming integrated across the populace. But that enlightenment stops at frailty. This is perhaps one of the more pernicious effects of the petard we've built for ourselves.

The fog that obscures the failures in our aging care system will not clear simply because we recognize that the existing delivery system will not be there for us, because it is not calibrated to the nature of frail aging. By itself, this recognition only creates more fear.

The chaos will clear only when we see the aging care bomb we've built for what it is—that chronic disease is its own, very different epidemiologic challenge requiring a very different health system—and when we recognize that we already have the components of an effective frailty care system all around us.

As our historic facilities for aging care fade, more frail older people remain in their communities. Government has insufficient resources to fund care for the present-day scale and complexity of aging. Existing healthcare providers are laden with worn, mortgaged inventory and tables of organization tethered to a system with no help on the horizon. By now, aging care facility leadership is three full generations removed from the era when communities took care of their own. Existing facilities, staff and resources are enmeshed in a mature industry that is so specialized, so far removed from the social components of care (and the community), that their total attention is myopically riveted on narrowing reimbursement streams (and away from the long-term arc of frailty). There is no way back for them and no way forward. The healthcare petard has so constricted their experience that they can't imagine that frail aging can exist safely anywhere but on their wards.

The existing aging care regime has little or no understanding of what is coming. They have neither the resources, the relationships, nor the conceptual ability to reach into the community, where long term care truly resides.

We have come full circle. It won't be necessary to attempt to reimagine and innovate in the old system. The old system will simply wither away. Community leaders who step up to make a better place for the aging among us will be working on a new canvas altogether. The future of aging care will be developed in communities that are committed to the physical and social welfare of their older members, that find the ability

to pivot to technology that can help locate, develop and orchestrate the untapped resources for a new aging care that exists in the very nature of community itself.

For the older people, the human and physical resources are the community, the community of fellow souls who are themselves all growing older. We can use technology to *extend and strengthen* community, not to replace it. The advent of technology-supported community care is happening at a time when the network era is fully ascendant. Many of the interventions that were formerly available exclusively in institutions can now be miniaturized and placed into homes. Individuals and communities now have the tools to develop decentralized, coordinated systems to address even profound accumulating chronic conditions.

The breakthrough to a new world of aging care will come when community leaders again step forward as they did 100 years ago when they created our hospitals, nursing homes and homecare, to again take responsibility for our aging. The era of outsourcing aging is over. We can do it ourselves.

This is not the Big Medicine healthcare that is so inappropriate for our family members. We are not replacing that. Rather, we are building a community framework, with our own families, friends, neighbors, and all the available programs and resources in the community. One that can sustain the fullest measure of community living. It will access, coordinate and incorporate whatever fragments of Big Medicine are available and appropriate, and bring them home to where we live.