

OPENING PLENARY SESSION

Keynote Address

Presented by C. Everett Koop, MD
Surgeon General, United States Public Health Service
Sunday evening, March 20, 1988

Thank you, Dr. Abdellah.

I want to personally welcome you and thank you all for coming to this Surgeon General's Workshop on Health Promotion and Aging.

We have three days of serious deliberation, illuminating discussion, and—I sincerely hope—innovative thinking ahead of us. The outcome should help point us—and society—in worthwhile directions for the future.

Many people have worked long and hard to make this workshop happen. If I had an extra hour or so, I would gladly name and thank each one of them personally.

That's not possible. However, with your understanding and permission, let me—at the very least—extend a word of special thanks to Dr. Faye Abdellah, Deputy Surgeon General of the U. S. Public Health Service, whose guiding hand has been subtle but essential throughout the planning process, and to Senior Pharmacist Steven Moore, lent to us from the Food and Drug Administration, who accomplished all the thousands of planning and administrative details that enabled us to get here today—equipped and on time.

To both of you ... thank you very, very much.

I do not want to monopolize the podium and steal time away from my good friends and colleagues, Commissioner on Aging Carol Fraser Fisk, and Dr. Frank Williams, Director of the National Institute on Aging. So I will limit my remarks to a brief review of how we got here ... and why ... and for what purpose.

Early in 1984 the Department of Health and Human Services launched a major initiative to encourage the public and private sectors—at all levels, national, regional, state, and local—to work together on promoting the health of America's older citizens.

The U.S. Public Health Service and the Administration on Aging shortly thereafter signed an agreement in which we pledged to do a number of things together in order to invest this health promotion initiative with increased momentum and importance.

And there *has* been a great deal of momentum generated throughout the country on behalf of older Americans:

- Every state now has a lead agency of its own to spearhead the health promotion effort...

- There are some 35 state interagency coalitions at work to promote the health of older Americans...
- A National Public Education Program, called the "Healthy Older Persons Campaign," has raised the consciousness of tens of thousands of older men and women concerning the benefits of promoting their own health, instead of just passively waiting and hoping for the best...
- At the Federal level, the agencies and offices of the U. S. Public Health Service itself have been actively engaged in this cooperative effort, but chief among them has been the work of the Office of Disease Prevention and Health Promotion, directed by Dr. Michael McGinnis. You'll hear more about that tomorrow morning.

A key element of this P.H.S.—A.O.A. cooperative venture is our mutual pledge to do what we can to help prepare all health professionals—physicians, nurses, dentists, nutritionists, social workers, pharmacists, and so on—for the eventual "graying of America."

I don't have to repeat the demographic projections. I'm sure you're quite familiar with the numbers.

But those projections are much more than mere numbers. Those are projections about the lives of real people—flesh-and-blood men and women who will be old and who will need a certain level and type of health care that, I'm afraid, is still not very well understood, much less practiced, in our society today.

And that's why seven components of the Public Health Service and the Administration on Aging agreed to jointly plan and conduct a "Surgeon General's Workshop on Health Promotion and Aging."

I'm delighted to add that the Henry J. Kaiser Family Foundation and the Brookdale Foundation are supporting the workshop.

Also, we have included six graduate and professional students who will be pursuing careers in geriatrics and will serve as working group members.

We wanted it to be a workshop in which the spectrum of health care disciplines would be well represented and all of them would be challenged to think creatively and pro-actively about ways to promote good physical and mental health among people age 65 and older.

That's the kind of workshop we wanted—and, I'm pleased to say, that's the kind we got.

The emphasis here is emphatically upon the promotion of good health. But let's be clear on at least one point.

We don't believe health promotion needs to take place *at the expense of* good curative medical care.

And it ought not to occur at the expense of good rehabilitative medicine.

And certainly not at the expense of good research into the disease processes and disabling conditions that often interfere with the normal and healthful processes of aging.

Rather, we believe that health professionals can put much greater emphasis on health promotion without compromising *in any way* the more traditional and still effective approaches to health care.

We believe that this *must* be done ... we're here to say that it *can* be done ... and by noon on Wednesday, we will tell the health community *how it might be done* on behalf of the elderly and the very old.

I don't expect us to be prescriptive in this workshop. But I *do* hope that the recommendations generated by the work sessions tomorrow and Tuesday are clear enough and direct enough that health professionals everywhere can immediately see the relevance of the health promotion concept to their own particular disciplines or practice.

What then should we keep in mind?

First, we ought to focus on ways to sensitize the health professions to the specific risk factors of older people—and then how to reduce or even eliminate those risk factors from the lives of one's patients.

Second, we need to re-examine the way we organize and deliver our medical, dental, nursing, and other health-related services to see if we can change—once and for all—their built-in *post facto* bias. Health care ought to be just as effective—or even *more* effective—*before* illness strikes.

And third, we need to do these things with some sense of what we hope to accomplish *overall* for our country's older citizens.

Older people—like people of all ages—do not live in a vacuum:

- They work in places that are pleasant—and in places that aren't so pleasant...
- Their human relationships may be loving and caring, or difficult and stressful ...
- They may have financial independence, or they may be totally dependent on family or Government to provide all their basic needs ...
- And finally, the phrase "the graying of American" can be misleading. *More* of us will have gray or white hair—(or no hair at all). But *most* Americans—about 80 percent of the population—will be young or middle-aged. Hence, older people will still be living in a society in which *all* age groups compete for attention ... and for resources.

I was reminded of this just the other day, when I read that the rock star Bruce Springsteen is going on a nationwide tour that will earn him millions and millions of dollars.

And while he's singing to enthusiastic audiences of young people, another group will also be on a national concert tour of their own. In fact, I saw them on TV last night in New Orleans. They're the so-called "Rat Pack"—Frank Sinatra, Dean Martin, and Sammy Davis, Jr.. We are told that these gentlemen also expect to earn millions of dollars from the enthusiastic sextagenarians who will show up at *their* concerts.

It was an interesting juxtaposition of news items. And whether or not you'll attend either or neither of those concerts, you still have to be impressed by the inter-generational vitality that is already emerging in our society ... a vitality that is, in itself, a reflection of generally good physical and mental health among the American people.

In other words, we have every reasons to be optimistic and adventurous in our thinking at this workshop, because we're not here to *reverse* the direction of America's health status, but rather to be built on—and

accelerate—the progress in health that Americans have achieved over the past decade or two.

This is an exciting period in the history of health care in America:

- The yield of the research community has been prodigious, with much more yet to come.
- The nation is more health-conscious and more *pro*-health than at any time in our history.
- And it's a period in which *all* Americans are more sensitive and more responsive to the health needs of their fellow citizens ... regardless of race, sex, ethnic origin, *or age*.

We have, therefore, an extraordinary opportunity to help our citizens not only to live a few years longer, but also to make those extra years—and indeed *all* the years of their lives—good and healthful years.

Now it's time to hear from my two distinguished colleagues, Commissioner Carol Fraser Fisk and Dr. Frank Williams. But rest assured, I'm not ducking out. In fact, I'll be back at this podium tomorrow to present my "charge" to the working groups.

Then, on Wednesday, Commissioner Carol Fraser Fisk, Dr. Williams, and I will return to hear your recommendations and speak to the next phase of this initiative. But we will not be inactive meanwhile.

You will also note from your agenda that things don't end there either. Following the close of the workshop on Wednesday morning, there will be an afternoon public hearing, one of a series of such hearings that have been held throughout the country.

At this Washington, DC hearing, our workshop recommendations will become part of the development of our National Public Health "Objectives for the Nation for the Year 2000."

Thus, we will make sure that aging concerns are given the prominence they deserve in the evolution of those national objectives.

You're all invited to that open hearing and I hope many of you will attend.

Between now and then, we've got a lot of work to do.

So let's do it. Let's do it together. And let's start now.

Dr. Abdellah, the microphone is yours.

Thank you.

Address

Presented by Carol Fraser Fisk
Commissioner of Aging, Administration on Aging
Sunday evening, March 20, 1988

Good afternoon. It's a pleasure to join in welcoming you to this important meeting. This conference is a very significant event, for through it I hope we will help more older Americans have a healthy old age.

Over the past several years, we have made significant progress in making health and social service providers more aware of the concepts of health promotion. Through this joint AoA/PHS initiative, countless numbers of older persons have participated in health promotion activities. Now it is time for us to take a look at what we have learned from these and other activities and to chart a course for future action.

It is a special pleasure to join Surgeon General Koop and Dr. Williams in this venture. The vision of the Surgeon General has helped mobilize the Public Health Service and all of us to undertake health promotion activities, including those which led to our having this conference. The creativity of Dr. Frank Williams has helped us forge even stronger collaborative ventures. And, the vigilance of the Deputy Surgeon General, Dr. Faye Abdelah, has helped us produce practical results time and time again. It is indeed an honor for me to join these distinguished national leaders here today.

As Dr. Koop has already said, we know a good deal about the older population. Let me highlight just a few statistics that may startle you. Today, one in nine Americans is over sixty years old. By the year 2030, one in four persons, or twenty-five percent of our population will be over sixty. In fact, in the next twenty-five years, the population over sixty will more than double. Among the elderly, the fastest growing segment will continue to be that over eighty-five years. Today, one in fifteen is over 85. By the year 2030, one in ten will be over 85 years old.

The impact of those demographic changes in society today is significant, and that impact will continue to grow as the numbers of older Americans continues to increase. All segments and institutions of our society will need to change as our population ages. As I look into my crystal ball, I see various areas of our lives which will need to change as more and more of us live longer lives.

The lengthening of the lifespan will cause a continual increase in the size of the general population. The average age and the median age of the population will continue to move upward. Of necessity, there will be more focus on the needs and the talents of our mature citizens. Older

people, even a growing and a vocal force, will keep reminding us of the challenge and opportunities they offer.

The increase in longevity already has and will continue to have an impact on American families. There will be more generations, and new roles for them in the family. In some families, more grandparents will become caregivers for their grandchildren while the middle aged generation is working. In many other families, adult children will continue to serve as caregivers for their parents and even their grandparents.

The graying of America has many implications for the production and allocation of resources, too. Both the work force and the marketplace will be affected.

People will have longer working lives, although they may have several different careers, different working hours, shared jobs and different working places in their later years. Changes that allow elders to stay in the work force will be essential. With fewer well trained younger workers as well as with more older people who want or need to be employed in later life, the work environment will need to change. By the year 2000, we will have an equal number of persons entering and leaving the work force. We will not be able to waste the talents of our older citizens.

Work force benefits will have to change accordingly. Employers will have to structure benefit packages differently because of different assumptions about retirement, health care, and caregiving responsibilities, to name just a few considerations. Corporations will have to expand their efforts to help keep current workers, young, middle aged, and old, productive and healthy. They will also increasingly look for ways to reduce health care expenses incurred by retirees.

An aging society will also mean that different types of products will be demanded and consumed. For example, one change could be in the packaging of food products. Instead of microscopic labeling, manufacturers should soon realize that older persons will be more likely to buy their products if they could read the package contents. Large print will be more common, as will better lighting.

Other changes might include affordable long-term care insurance, cars with mirrors to compensate for the loss of visual acuity, personal convenience and comfort items, home shopping services, grocery delivery services, and better timed street crossing lights.

Health care and social service delivery systems must change too. Current institutions and organizations may not be appropriate or adequate for the needs of an aging society.

We are already seeing changes in the use of acute hospital beds and increasing needs for long-term care services and facilities. Community caregiving organizations will be severely strained by the increasing patient load, *especially* if they must care for AIDS victims simultaneously. To combat this pressure, we must find ways to reach people more effectively in their homes. Such progress would be particularly important in isolated rural areas.

Our manpower needs will certainly change as we will need more persons in new types of careers. Technology will cause changes in the way

we deliver care and our needs for various types of care changes with age. But that new technology won't address all the issues of an aging America.

Families and friends will continue to serve as caregivers, and they will need training as well as respite services. They may also need innovative ways to cover the costs of health care expenses. Individuals will need to begin planning earlier and personally take more steps to assure a financially secure old age. Perhaps we will even see more incentives for those who pursue healthy lifestyles.

With an increased older population, society's attitude toward longevity and the quality of life in later years will continue changing. The assumption that being old means being sick and frail is disappearing. It is being replaced by the notion that most older persons are healthy, vital, and want to stay well and functioning as long as possible.

More and more of us will realize that we have the ability to choose how we live. The relationships between such factors as nutrition, exercise, preventive health and disease mean that we can take a more active part in our own health care. Each of us will need to be more pro-active in working with health professionals, staying well, and when ill, taking part in our recovery and rehabilitation.

This brief glimpse into the future reinforces my strong conviction that it is *our* job to take the message of the value of health promotion and wellness for older persons to the leaders and citizens of our communities. Our society must stay healthy. Our elders must stay healthy.

Dr. Koop has challenged us in three areas:

First, we need to assist doctors, nurses, and other health professionals to incorporate health promotion into their regular plans of patient care. Older persons are particularly sensitive to messages from their doctors. Why not begin here? What recommendations can we develop that makes that a reality?

Second, we need to educate older persons to the value of health promotion and wellness at any age. We must get the message out that changing habits, even in later life, will produce significant and tangible benefits. I ask you, how can we reach more mature citizens with this important message?

Third, we need to build partnerships to help educate people of *all* ages to get ready for later life. Public, private, and voluntary groups must combine their strengths in each community across the nation. What better place is there to start than taking care of one's health.

The legacy of this conference must be manifested in several areas: new directions in program areas; sharing of information about methods of prevention and treatment; the development of a health promotion and wellness agenda for older persons for the coming decade; and a commitment to implement these recommendations. We have a lot of work to do over the next three days.

You have a unique opportunity to bring your knowledge and expertise to the forefront of this effort. Over the next few days, I ask you to develop

recommendations which you will take back of your communities, your organizations and your colleagues. I urge you to develop ways to assist your designed State coalitions on health in achieving their agendas. I encourage you to organize local coalitions which sponsor health promotion and wellness activities for older persons. Finally, I challenge each of you to personally set a good example of health promotion practices.

You are here because you are leaders in your field and I congratulate you on all that you have done thus far. But I urge you to do more. The needs of our older population today are significant. The talents of older people today are exciting. In the future, both those needs and that talent pool will grow. What makes a difference to each of us as we age is what happens in the community and neighborhood where we live and work. I urge you to seize the opportunities that are before you to help make those communities better places for all of us to live and to mature today and in the future.

Working together—we can do it! Thank you.

Address

Presented by Assistant Surgeon General T. Franklin Williams
Director, National Institute on Aging
Sunday evening, March 20, 1988

Dr. Abdellah, Dr. Koop, Commissioner Fisk, and colleagues:

It is indeed an honor to be part of this important Surgeon General's Workshop in Health Promotion and Aging. I am particularly glad that Dr. Koop has focused attention on these very significant public health issues.

In the 1970s, the orientation toward age and aging of many persons in fields of medical research and health policy began to assume new directions. This change in focus was primarily due to three growing realizations. The first, and perhaps most apparent, was the tremendous growth in the number of people who were living—and living well—past their 65th birthdays. As a result of this phenomenon new questions arose. Would this trend continue? What would be the far-reaching implications of such a demographic change in the United States, and perhaps around the world?

The second realization was that, regardless of how many people were achieving healthy old age, aging was still looked upon with dread. If you were turning 50 or 60 you expected physical and mental declines. Just as unfortunate, so did your physician. Myths about aging prevailed. Many in our youth-oriented society even viewed 30 as being past prime. The question: What could reasonably be expected from people as they age?

The third realization was that many older people did, in fact, suffer physical and mental declines. But, considering the large number of healthy older people, it became apparent that some illnesses might be avoided.

There were many gaps in our scientific knowledge of the aging process. On May 31, 1974, to respond to growing concerns in this area, Congress enacted the Research on Aging Act creating the National Institute on Aging (NIA) with a mandate "to conduct and support biomedical, social, and behavioral research and training related to the aging process and diseases and other special problems and needs" of older persons. In July 1975, the Adult Development and Aging Branch and the Gerontology Research Center were separated from the National Institute of Child Health and Human Development and were made the core components of the new NIA.

Investigators now had the direction from Congress to discover which aspects of aging processes might benefit from medical intervention. The goal was, and still is, to be able to understand normal aging processes and develop ways to improve the quality of life for all people as they grow

old. Irrational myths and fears needed to be replaced by reliable data on physiological, psychological, and social changes which often take place during one's lifetime.

NIA research is conducted by scientists at the Gerontology Research Center in Baltimore and in the National Institutes of Health (NIH) Clinical Center in Bethesda, and through multidisciplinary grant programs which give support to research institutions throughout the United States and, to a limited degree, in other countries. Additionally, several interagency agreements, for example with National Center for Health Statistics and the Bureau of the Census, have expanded our ability to develop more precise information about the older population.

Since its inception, NIA has developed priorities based upon the concerns which led to the Institute's formation. Research on aging is potentially unlimited in scope, so judgments must favor areas which show scientific promise or which society deems to be important public issues.

Priorities, of course, evolve over time but a continuing major emphasis at NIA is to understand aging processes and how aging is *distinct* from disease. The passage of time imposes change on everyone but it is vital to understand which changes are inevitable and which are open to modification. The Baltimore Longitudinal Study of Aging, conducted at the NIA Gerontology Research Center, was initiated in 1958 to permit repeated observations of the same subjects over time. Results of numerous studies there have shown that if one can identify and separate out people with disease conditions and focus study on healthy aging, changes with age are far fewer than previously thought. Increasingly, studies demonstrate that older people do not necessarily suffer heart and kidney problems, nor do their personalities change with the passing of time [Rodeheffer, Lindeman, Costa]. In fact, these studies show that very few, if any, changes occur uniformly to all people as they age. Aging is highly individual. It is for this reason that I object to and do not use the term "the elderly" as it implies, erroneously, that older people are all alike—a stereotyping term.

Other research results from around the country support this perspective. For example, Dr. K. Warner Schaie at Pennsylvania State University and others, in evaluating intellectual and cognitive changes over time, have found that many people do not suffer loss of intellectual function, and those who do can often benefit from cognitive training programs that reverse or decrease their intellectual decline [Schaie, Baltes, Rodin].

Epidemiologic studies have contributed greatly to our understanding of the aging population. Data from the Established Populations for Epidemiological Studies of the Elderly (EPESE), supported by NIA, includes information on over 13,000 participants in four communities: New Haven, Connecticut; East Boston, Massachusetts; two rural counties (Iowa and Washington) in Iowa; and an enrolled predominantly black population in the vicinity of Durham, North Carolina [Cornoni Huntley]. These studies are presenting detailed, longitudinal information on healthy older people living in the community.

Once we accept the notion that people do not inevitably become frail or demented as they grow old, we can examine ways to maintain a person's health, independence, and function into later years. This, then, is another priority at NIA. Can positive changes in a person's attitude and lifestyle affect health and vitality later in life? In many areas we are just now beginning to collect data. In the area of nutrition, for example, we generally support the Dietary Guidelines of the National Research Council, but these guidelines are based on studies of persons under the age of 51, and we simply do not know whether or how nutrient requirements differ for older people. NIA is participating in a seven-institute collaborative follow-up of the National Health and Nutrition Examination Survey (NHANES). This survey should provide key information—and the largest archive of data to date—on patterns of health and disease related to nutritional habits.

Careful research studies have given us some answers to questions about health promotion and disease prevention. John Holloszy of Washington University in St. Louis and his colleagues have shown that when previously sedentary older people enter a fitness program, approved by their physicians, their aerobic capacity improves as much as that for younger people. There also are accompanying improvements in blood lipids and glucose tolerance. Studies by Gail Dalsky, also at Washington University, show that in women between the ages of 55 and 70, the typical decline in bone mineral content of the spine can be minimized or eliminated by following a sensible exercise regimen [Holloszy, Seals, Dalsky]. This finding has important implications for prevention of fractures in older people. We also know that smoking cessation, good medical and dental care, moderate, if any, alcohol use, a good mental outlook, and a knowledge of drugs and their possible adverse effects can benefit a person's health. At the same time, much further research and program development at NIA and other agencies, such as the Office of Disease Prevention and Health Promotion, Office of Technology Assessment, the Food and Drug Administration, the National Institute of Mental Health, and other Institutes of NIH, are critical to our full understanding of what is possible in health promotion for older people.

The NIA also focuses its research, training, and information dissemination efforts on the common disabling conditions of older people—those which threaten loss of function and loss of independence. Rehabilitative efforts, i.e. restoration or improvement in function in these situations to the maximum extent possible, are also a part of health promotion.

Probably the greatest threat to personal independence in older people is dementia. Between 5 and 10 percent of all people over 65 suffer from Alzheimer's disease, with the numbers increasing substantially among the oldest age groups. Research on the etiology and pathogenesis of dementia is crucial to eliminating this terrible affliction. Through sophisticated techniques researchers are beginning to gain a better understanding of the changes that take place in Alzheimer's disease. Diagnostic capabilities have been increased. In response to Congressional legislation, the NIA now

supports ten Alzheimer's Disease Research Centers which bring together some of the best basic and clinical research in the field. Congress also has directed NIA to establish an Alzheimer's Disease Education Center and Clearinghouse to assist families, health care professionals and the general public in obtaining the most up-to-date research results. We also are working with the World Health Organization (WHO) which has made this area a top priority.

Other problems which often threaten loss of function as people age include incontinence, falls and hip fractures, osteoarthritis and osteoporosis, and losses of hearing and vision. We have made some progress. For example, studies by Drs. Bernard Engel, Kathleen McCormick and their colleagues in the Gerontology Research Center have shown that urinary incontinence can be controlled through pelvic floor exercises and related strategies in about 80 percent of affected women living within the community [Burgio]. In the area of falls and fractures, we now have better understanding of the multiple risk factors that can lead to repeated falls in older people [Radebaugh, Tinetti]. More attention is being given to research on deafness, blindness, osteoarthritis and osteoporosis in older people.

In relation to all these efforts we need to expand the training of personnel in geriatrics and gerontology. The recently completed study on personnel for health needs of older people through the year 2020, conducted at the request of Congress by NIA, the Bureau of Health Professions, and other federal agencies, documents these needs and in particular the urgent need for more academic leaders and teachers in these fields [Personnel]. The Institute of Medicine of the National Academy of Sciences has recommended that NIA support development of "Centers of Excellence" for research and training in geriatrics, to help meet this need.

The Institute on Medicine has also recently proposed a study of "Health Promotion and Disability Prevention for the Second Fifty" [Report]. The purpose of the study would be to establish a solid body of knowledge on selected health risk factors for older people and measure the efficacy of health promotion and disease/disability prevention interventions beginning in the middle years and extending on through the last half of life—a purpose quite congruent with that of this workshop. These workshop sessions should provide current information on health promotion in older people in relation to medications, alcohol, dental health, preventive health services, mental health, nutrition, physical fitness and exercise, smoking cessation, and injury prevention. Further research on these topics is of immense importance if we are to gain a full understanding of what it means to grow old healthfully and vigorously. Old myths about aging are being replaced by fact. Sessions such as this should help us all to develop a realistic picture of what growing old is all about.

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PLENARY SESSION

"Health Promotion and Surgeon General's Workshop"

Presented by Assistant Surgeon General David Sundwall
Administrator, Health Resources and Services Administration
Monday morning, March 21, 1988

Thank you, Dr. Abdellah. And thank you, Dr. Koop, for calling together this group of distinguished professionals.

It's a pleasure, as well as an honor, to be a participant in these workshops on health promotion and aging. I want you to know I respect the work you're doing here and elsewhere around the country. And I admire your concern for older Americans and your dedication to their welfare and health.

This forum provides a unique opportunity to focus on health promotion and disease prevention in aging individuals. You've heard Carol Fraser Fisk describe what the Administration on Aging is doing in this area and Dr. Frank Williams describe the activities of the National Institute on Aging.

I've been asked to review some of what we're doing for older Americans in the Health Resources and Services Administration, particularly as it relates to health promotion and disease prevention.

That HRSA should be involved in health promotion activities is appropriate in light of our designated mission. So that you'll better understand how we fit into the Public Health Service and, particularly, into health promotion activities, let me briefly outline what that mission is. It comes in two parts. Simply put, the first half has to do with resource building and the second with service delivery.

We're charged with helping to assure that this nation has the necessary resources, both facilities and health professionals, to meet the nation's current and future needs.

In this capacity, we support the education of health professionals through guaranteed student loans, scholarships for minorities and the disadvantaged, and a variety of grants to institutions for developing and supporting health education and training programs.

We also administer the Hill/Burton indigent care program. Much of the hospital construction that took place between the end of the Second World War and 1973 was financed with Hill/Burton funds. Even though Congress discontinued funding for the construction portion of the program, many Hill/Burton facilities retain their obligation to provide free care to qualifying low income individuals.

Our new Office of Rural Health Policy is another good example of what we're doing to help build the nation's health care resources. Congress

appropriated \$1.2 million for FY'88 for grants to develop Rural Health Policy/Research Centers. These Centers will collect, develop and disseminate current information on rural health and conduct policy research and analysis of rural health issues of national significance.

We also support organ transplantation activities and 7 regional educational centers for training health professionals in the prevention and care and treatment of patients with AIDS. Taken together, these programs are instrumental in developing essential health resources across the nation.

Now, the second half of HRSA's mission is to support the delivery of health services to special populations and those who, because of lack of resources or geographic location, are unable to obtain appropriate services for themselves.

America's homeless population is a prime example. HRSA recently awarded \$46 million to 109 communities that demonstrated the ability to provide comprehensive health services to homeless individuals.

Another population of Americans having difficulty obtaining appropriate services is that infected with the AIDS virus. HRSA's AIDS related activities bridge the two segments of our mission. Whereas, our 4, soon to be 7, area education centers fall under the resource building portion, the 11 AIDS Services Demonstration Projects that are designed to build on existing resources to provide comprehensive services for AIDS patients fall under the health services portion.

The homeless initiative and the AIDS Service Demonstration Projects are relatively new compared to our participation in maternal and child health programs. We've had a long history of involvement in this area. HRSA administers the MCH Block Grant as well as numerous other initiatives, some of them designed to reduce the incidence of infant mortality.

Many of the services provided by HRSA's nearly 600 Community and Migrant Health Centers are for mothers and their children. And although they provide traditional curative medical care, increasing emphasis is being placed on preventive health services as a means of improving the health status of their clientele.

There's a lot of truth in the old saying—an ounce of prevention is worth a pound of cure. Frankly, I believe it's worth more than a pound, both from the standpoint of cost as well as from pain and suffering.

Now, if preventive medicine is important to the general population, it's of even greater significance to senior citizens because of its potential for improving the quality of life during the senior years while conserving scarce health resources.

Right now those 65 or older are 12 percent of the population but account for more than 30 percent of the total cost of health care. This percentage is projected to increase as the number of older Americans, and particularly those 85 years of age and older, increases through the end of this century. Therefore, the topic of these workshops is of utmost importance, not just for senior citizens, but for the health and well-being of the U.S. treasury that will spend about \$145 billion on health care this year.

About \$1.5 billion of that will go for HRSA programs—many of them having geriatric components.

At HRSA, we recently established a Committee on Aging-Related Issues. Because many of the bureaus and divisions administer programs with geriatric components, the Committee's goal is to coordinate these internal initiatives in addition to coordinating with other governmental agencies that administer programs for senior citizens. It will also develop a plan to increase relevance and accessibility of HRSA programs to the aging population. It will keep abreast of aging-related activities within the private sector. And it will develop and maintain an inventory of HRSA aging-related activities.

Many of these aging activities are found in Community and Migrant Health Centers. Nearly ten percent of their clientele is over 65. And, although the percentage is remaining relatively constant, there is an increase in the number of elderly obtaining services at CHC's that parallels the expansion of the older population.

Traditionally, Community Health Centers have emphasized primary and preventive care, but recently they've been more aggressive in efforts to actively incorporate prevention activities into their service regimes for senior citizens.

In 1984, we awarded \$1.7 million in supplemental funds to 57 Community Health Centers to assist these Centers in developing and implementing preventive health programs to serve as models for other Centers.

To build on this, HRSA and the Administration on Aging are jointly sponsoring a networking initiative between State Primary Care Associations and State Agencies on Aging. For those who are unfamiliar with State Primary Care Associations, they're made up of Community Health Centers and other nonprofit organizations, including some state health departments, that provide primary care services.

State Units on Aging working with State Primary Care Associations will develop an action plan that correlates with local circumstances and health care needs. To help participants formulate these plans, we sponsored a series of 10 planning seminars that were completed in December of last year.

Now that the first stage of the program is completed with the working plans—hopefully—"signed, sealed and delivered" we're in the process of contracting for a study to evaluate their implementation and effectiveness.

We hope to improve collaboration and cooperation among the various administrative and management levels of the aging and primary care network, whether they're local, state or federal, so that we'll be better prepared to meet the health care needs of the expanding older population.

By linking Community Health Centers to the aging network and making the Centers more sensitive to the unique health care needs of older individuals, we'll enhance our ability to provide appropriate, comprehensive Geriatric care.

We're so confident that this networking relationship between HRSA and the Administration on Aging will prove to be effective—that it will improve accessibility and quality of care for aging citizens—that we're in the process

of drafting a Memorandum of Understanding that will cement our official ties and build and expand upon our earlier collaborative efforts.

The Memorandum has 5 stated objectives. They are:

- To support states and communities in the development of improved health care systems serving older persons;
- To promote expanded education and training opportunities for health personnel serving the elderly;
- To collaborate with the private sector to improve health care for the elderly; and
- To promote the maintenance and expansion of health services for older persons living in rural areas.
- To support model programs for older HRSA and AoA employees and employees providing care to older family members.

Although it's still in the negotiation stages, we hope to soon finalize the formal agreement even as we continue our joint objective to improve quality and accessibility of health care services for older Americans.

One of the real stumbling blocks to doing this is the documented shortage of health professionals with geriatric training. At the request of Congress, we recently conducted a study entitled "Personnel for Health Needs of the Elderly Through Year 2020." The study was jointly sponsored by the Bureau of Health Professions and the National Institute on Aging.

Congress specifically requested that the report contain recommendations on—first, the number and training needs of primary care physicians and other health and human services personnel required to provide adequate care—and second, the necessary changes in Medicare and other third-party reimbursement programs to support such training.

The published report to Congress contains 16 findings and 5 comprehensive recommendations. Even though they're vitally important to the aged and their health care, I don't intend to review them individually because they all don't relate directly to health promotion. However, one of the more sobering is that the demand for services for older Americans will double by the year 2020 if current utilization rates are maintained. Approximately 2 out of every 3 patients will be over 65. Geriatric personnel requirements will greatly exceed the current supply.

That's the bad news, ladies and gentlemen. The good news is that the increasing demand for geriatric services will coincide with an anticipated growth in the supply of health care practitioners. Our challenge is to make sure that they will be prepared and well-trained in geriatric medicine.

That's not going to be easy because one of the reasons we don't have a cadre of health professionals trained in geriatrics is that we don't have the faculty to train them. In fact, the report estimates that we only have from 5 to 10 percent of the faculty we'll need to train the number of health professionals that our projections estimate will be needed to meet the health care needs of the expanding aging population.

At HRSA, we have several initiatives specifically designed to address both shortages.

Over the years, our Bureau of Health Professions has supported the education of health professionals in a variety of ways, including scholarships, student loans and grants to educational institutions.

Now that we have a surplus of physicians in most medical specialties, we no longer indiscriminately support medical education. We now target our limited resources toward shortage areas—those where the greatest needs occur. Our sole remaining scholarship program is for minorities and the disadvantaged. And most of our grants support programs in family medicine, primary care and geriatrics with requirements that recipients implement aspects of disease prevention and health promotion into their curricula.

We fund grants to schools of medicine and osteopathy; teaching hospitals; and graduate medical education programs to train physicians and dentists who plan to teach geriatric medicine or geriatric dentistry. The institutions themselves then award fellowships in geriatric retraining programs for physicians who are faculty members in departments of internal medicine and family medicine.

In addition, we're funding several programs to develop curriculum models in geriatrics, all of which contain elements of health promotion.

One of our grants funded a program where over a six-month period, 22 family medicine physicians participated in a 4 week mini-fellowship program in geriatric medicine. The participants were then required to evaluate the program. Using the feedback from the mini-fellowships, a curriculum resource package is being prepared and will be made available nationally to assist family medicine faculty or faculty in other specialties involved in teaching residents.

We also support geriatric training in dentistry, family medicine, general internal medicine and preventive medicine. A number of programs support the development of geriatric nurse practitioners and physician assistants.

In addition to these grants, HRSA funds 31 Geriatric Education Centers that are strategically located around the country. The Centers are generally a consortia of several academic institutions, a broad range of health professions schools and a variety of clinical facilities. They will be funded at about \$9 million for FY'88.

The Centers stress the multidisciplinary approach with an emphasis on health promotion. Their main objective is to train and prepare faculty to teach geriatrics to various health care providers. However, they do participate in continuing education for practicing health professionals.

Now that I've given you a sketch of what HRSA's doing in geriatrics and health promotion, I want to assure you we are practicing what we preach. HRSA's Division of Federal Occupational and Beneficiary Health Services is the federal focus for health promotion programs for federal employees right through the time of retirement.

The Division functions primarily as a consultant for the various federal agencies. It conducts studies, advises management on health promotion activities, and sets up programs for employees.

For example, right in HRSA we sponsor a annual health fair for all employees. Among other things, we have nutrition analysis and counseling, weight reduction counseling, and high blood pressure, cardiovascular and cholesterol screening.

We also operate health units and employee counseling units in many federal agencies. These units offer a wide range of counseling services and routine physicals and health screening programs for federal employees so that we can incorporate the principles of health promotion into the lives of federal employees.

I want to reemphasize that health promotion is a vital element in each of HRSA's geriatric programs. With increasing longevity and rising health care costs, wellness is becoming more and more important to our financial as well as our physical health.

We believe that by combining health promotion activities with miraculous new technology and curative powers, we can help assure that the last years of life are spent in better health than ever before. We have the tools to help change what once were "the declining years" into "the golden years."

HRSA is dedicated to this objective. And our geriatric programs are targeted toward this end. We want to work with related government agencies and those of you in the private sector to promote the health and well-being of America's senior citizens.

I look forward to this joint endeavor and to reviewing the conclusions of this workshop. Thank you again for inviting me to participate.

“Year 2000 Health Objectives for the Nation”

Presented by Assistant Surgeon General J. Michael McGinnis
Director, Office of Disease Prevention and Health Promotion
Monday morning, March 21, 1988

I would like at the outset to pay special tribute to the Surgeon General for his insight and timing in convening this workshop. As you—the experts in health promotion and aging—know, one of the gravest challenges this Nation faces is how to ensure the vigor of its expanding aging population. I am here today to tell you that much of our success in meeting that challenge will depend on what we do now—and in the intervening years before the baby boom retires—to prevent disease and promote health.

My job this morning is to discuss with you a framework within which we can collectively channel our thoughts on how we would take on those challenges—within the context of the Year 2000 Health for the Nation objectives setting initiative.

The application of the tenets of health promotion/disease prevention to older adults is a relatively new notion. This workshop, however, is one of the signals of the growing recognition that there are benefits to be gained through the adoption of healthy practices and behaviors at most any age.

Part of this recognition comes from learning how to see aging for what it is—and isn't. Many of the so-called signs of old age are actually the sequelae of disease. And the most prevalent diseases, furthermore, are those which derive from lifestyle and environmental factors, factors within our control. The interplay of these factors as we age accounts in large part for the wide variation between chronological and physiological age we see in the older population.

In addition to separating aging from disease, the scientific evidence is building a strong case that preventive practices and healthy behaviors can have a substantial impact on the quality of later life, through less premature disability, shortened periods of acute illness, and less need for long term care. While research in prevention is just starting to address older people, a substantial body of knowledge has been developed over the past 20 years linking personal behavior to health status.

I would like to review briefly, if I may, some of the milestones bringing us to this point today—with the humble acknowledgment that some of the foremost experts and scientists who have contributed to these efforts are amongst us.

A pioneering study to demonstrate the correlation between cardiovascular disease and the risk factors of smoking, obesity, and hypertension

was the Framingham study, begun back in 1948. This study continues to provide valuable scientific support for health promotion and disease prevention programs. For example, researchers found that the rate of coronary disease for men with sedentary lifestyles is about three times higher than that for active men.

In the mid-1960s, Lester Brewlow and his colleagues looked into the personal habits of 7,000 people living in Alameda County, California, and found seven health habits to be related to physical health status and mortality. The longest living turned out to be those who followed most or all of seven common sense practices: they did not smoke; maintained a reasonable weight; ate breakfast; rarely snacked between meals; drank alcohol in moderation, if at all; slept seven to eight hours a night; and took part in some sort of regular physical activity. Between 1965 and 1974, the death rate for men observing all seven good health practices was only 28 percent that of men who followed three or fewer. For women, the comparable statistic was 43 percent. What's more, the survival rates were substantially the same for those age 65 and above, as well as for those in younger age groups.

In the 70s, new ground was broken by the Stanford Three Community Study—setting the benchmark for the public education campaigns we see today. They took on a problem which has often confounded the public health community—that of how to bridge the gap between getting people to know what is a health risk and getting them to actually reduce their risk through behavior change. The Stanford field study in three California towns found that cardiovascular risk scores were reduced through a combination of mass media appeals and were further reduced in those people who received both mass media and personal communications.

Prompted by the new insights into the links between risk factors and disease, Federal policy-makers both here and in Canada began paying parallel attention to the relative importance of lifestyle factors to health status. The Canadians came first, issuing a report in 1974 which held up the modest gains in health status attributable to medical care against the potential gains from changes in environmental or lifestyle factors.

The next year, the Fogarty International Center of the National Institutes of Health and the American College of Preventive Medicine co-sponsored a National Conference on Prevention here in the U.S. A growing consensus was developing around the need for a national focus on disease prevention and health promotion. The next year, the Office of Disease Prevention and Health Promotion was created to coordinate Federal health promotion programs.

As other research initiatives were launched, including the Hypertension Detection and Follow-up Program, the Multiple Risk Factor Intervention Trial (MRFIT), the Lipid Research Clinics Coronary Primary Prevention Trial and many others, prevention climbed up the national agenda.

The evidence linking lifestyle factors and health led to the conclusion prominently emphasized in the 1979 Surgeon General's report *Healthy People* that further improvements in the health of the American people

would not be achieved from increased medical care and greater health expenditures alone—but through a renewed national commitment to efforts designed to prevent disease and promote health. Broad goals were set to reduce death and disability rates by 1990 in the different age groupings.

For older people, however, the explicit goal was to improve the health and quality of life and reduce the average annual number of days of restricted activity by 20 percent, to fewer than 30 days per year. Implicit was the goal of allowing each individual to seek an independent and rewarding life in old age, unlimited by many health problems within his or her capacity to control.

The approach chosen to achieve these national goals outlined in the Surgeon General's report was to draft a comprehensive national prevention strategy based on 226 measurable objectives in 15 separate priority areas. Specific targets were set to be achieved by 1990 for improving health status and reducing risk for disease, disability, or death in areas encompassing preventive interventions, health-related behaviors, and changes in the physical environment.

Over the past eight years, the so-called 1990 health objectives have been used to spotlight problems, set priorities, and allocate resources at the local, State, and national levels. And we have shown some progress.

Midway, in 1985, we were pleased to report that despite problems in pregnancy and infant health, family planning, and violent behavior, about *half* of the objectives had either been achieved or were on the path to success. The greatest progress was made in areas such as high blood pressure control, prevention of injuries, smoking reduction, immunization, and control of infectious diseases. In the past 15 years, we've seen a 25 percent reduction in tobacco use, a 15-20 percent decline in the consumption of saturated fat and cholesterol, a 40 percent drop in salt consumption, and a two- to three-fold improvement in blood pressure control.

But, perhaps the more dramatic conclusion which can be drawn from the mid-course review is that people are not dying as they did before. There has been a 55 percent decline in stroke deaths and a 40 percent drop in heart attack deaths. With five years left to 1990 at midway, we were already 70 percent on the way to our goal of reducing infant deaths, 90 percent on the way for child mortality, 90 percent for adolescent mortality, and 70 percent for adult mortality. This is good news, to be sure.

But what does all this mean for older Americans? Indeed, some claim that the factors which have led to reductions in mortality will not yield overall improvements in health status. Prolonged longevity by itself, goes the argument, could simply mean that more people will spend longer proportions of their lives afflicted with chronic and degenerative diseases.

I join those who posit another view. It is exactly the elders of the Year 2000 who will be the beneficiaries of healthier lifestyles and behaviors in their early and middle years and of advances from research in treatment and rehabilitation. So it is quite reasonable to expect that the benefits of a lifetime of healthy practices, carried into the later years, will lead to fewer chronic diseases and ameliorate those which do occur. Certainly that constitutes a worthy goal.

So where do we go from here? As I mentioned at the outset, we are now beginning to set new health objectives for the Year 2000 and a special concern is setting targets for older Americans. The 1990 objectives did not adequately address this population because of the attention given to premature mortality and morbidity. But the Year 2000 gives us the opportunity to make such adjustments. This time we know more about the aging process, we know more about the aging population, and we know more about the value and effectiveness of a variety of health promotion strategies in general, and for this age group specifically.

Furthermore, we are compelled to take special notice. Between 1985 and the Year 2020, the population 65 and older is likely to increase by almost two percent a year, an average of about 750,000 additional older persons per annum. The oldest-old—the 85-plus generation—are projected to increase at an even faster rate, at about three percent a year. In contrast, the total United States population is anticipated to grow each year by less than one percent.

While the rate of growth of the 65-plus population is expected to be somewhat greater after the Year 2000, between 1985 and Year 2000, the oldest-old will grow faster, at an average rate of about four percent a year. Then, as the baby boomers ease into the elderly category, we can expect a nearly three percent growth rate in the young-old, the 65 to 74 age range.

Although the majority of older adults in the future are expected to be relatively healthy, most will develop one or more chronic health problems. Many of these conditions should cause few difficulties but others could result in severe disabilities. A widely used measure of disability among older persons is the number of persons with activity of daily living limitations (ADL). Data from the 1984 Health Interview Survey aging supplement show that over 22 percent of older persons living in the community have some degree of disability.

We also know that the impact of chronic health problems increases with age. More than 60 percent of those age 85 and over reported some degree of limitation. Since we will have more people living longer in the Year 2000, NCHS projects a 30 to 50 percent increase in the numbers of older persons with some limitations in activities of daily living, if current patterns of disease continue.

The sum of these trends, then, is that we have a growing high risk group whose only option to health care currently is expensive, and not always appropriate, acute care medical treatment. So clearly, one national strategy must be to balance the prevailing focus on curative medicine with attention to preventing disease and promoting and maintaining health.

The leading chronic conditions afflicting older people—arthritis, hypertension, hearing and visual loss, and heart problems—are conditions we know have the potential in many cases to respond to health promotion interventions such as exercise, healthy diet, and early care. And at least two of the three most debilitating conditions which lead to a need for long term care—stroke and hip fracture—could be prevented.

For those people already ill, our goal should be to maximize function and prevent further deterioration. Changes in diet, exercise, and other health behaviors—may have an impact on function and ability to cope with the demands of daily life, even beyond their gains in health status.

So when planning for the Year 2000, we must broaden the perspective which has been applied to the younger ages of preventing morbidity and premature mortality. The challenge is not how to prolong life, but how to extend *active* life expectancy. What can be done to delay the onset of disease? How can we maintain function and independence in those older adults with chronic and degenerative diseases? How can we *measure* functional independence? How do we set priorities amongst preventable problems? What do we know about the *effectiveness* and *efficacy* of such strategies in the 65-plus group?

Over the next few days you are going to be giving a close look to the range of behaviors and practices identified to be of the most benefit to the health of older people. It is my hope that we will be able to take the work you will be doing here and use it as the groundwork for designing Year 2000 objectives which address the specific preventable problems of older Americans.

Let me just touch briefly on how that will actually happen. First, you should know that the Public Health Service is collaborating in the Year 2000 effort with the Institute of Medicine, under the guidance of a steering committee representing all the PHS agencies who will have the ultimate responsibility for carrying out the objectives. The first step of this process has been one of gathering information. Regional hearings are being held around the country to solicit grassroots testimony about preventive health priorities in the coming decade. Special hearings are also being sponsored by interested organizations at their annual meetings. In addition, we are convening a special hearing to focus on the needs of older people following this workshop on Wednesday afternoon. If you are not already planning to attend, I invite you to do so. We are expecting to hear first from Dr. Koop—who will be sharing the recommendations from this workshop with us and entering them into the record. We'll also hear from the American Association of Retired Persons, the National Council on the Aging, the ... and many other interested groups. There should be time following the scheduled testimony to hear from you and I encourage you to come forward.

Once all the hearings have been held, the task of drafting the actual objectives will be assigned to those agencies within the Public Health Service who will have the lead responsibility for a given area. We anticipate that a draft of the objectives will go out for review and comment by the end of this year and that the final Year 2000 objectives will be issued at the end of 1989.

In closing now, I'd like to thank you for the opportunity to share with you what we are doing and I certainly am looking forward to hearing your recommendations two days hence.

As we rise to the challenges of our demographic destiny, we must acknowledge that neither knowledge nor change come easy. But with the collective spirit, wisdom, and commitment of people like you, I believe we will be successful. If I may, I'd like to close with a quote from the last line of *Healthy People*, the Surgeon General's report on health promotion and disease prevention which got us started, with one alteration:

"If the commitment is made at every level, we ought to achieve our goals, and *older* Americans, who might otherwise have suffered disease and disability, will instead be healthy people."

Thank you.
