* * * REMARKS OF THE SURGEON GENERAL * * *

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SURGEON GENERAL KOOP: Well thank you very much, Bob. What you hear in the way of a voice this morning is not the usual Chick Koop; that is a Swiss virus. I thought it was going to be lethal, and then I was afraid it might not be, but I did survive and here I am.

I'm very happy to be here and to see the workings of this Interagency Committee, because as I am frequently asked, as I was in an interview this morning before I came here, what have I set for my goals, one of the things that I always mention--and it might seem to you to be impertinent--is that I would like to have a role in developing a philosophy on aging in this country. And what I mean by that is that aging is a part of living, and whether or not one has to make a decision about his own aging, or about a member of his family, or about society, I think that that kind of a decision should be based on information rather than upon prejudice, and even in Government circles, as hard as we try, I find there is still a lot of prejudice and concern that doesn't have to be there. This doesn't mean that there will

ever be a document which says, "This is the philosophy of aging," but the Office of the Surgeon General, which has essentially no power, does have a lot of moral suasion and I find that in certain areas where I am asked to talk what I have to say is at least listened to, and hopefully some of the things that we discuss in the way of philosophy might eventually take hold.

You might ask how comfortable I feel in making an aging project one of my major initiatives in Government after having spent a lifetime with children, particularly with very young children. And the answer is I feel very comfortable about it because there are a lot of things that are very similar about the dependence of elderly people and the dependence of children. And I don't feel that I've taken a giant step in any direction at all. It just seemed to be a very natural evolution of the things that I was concerned about in protecting people who required protection.

My first real effort in reference to aging was a total failure. And that is, at the time of the White House Conference I tried to convince the President that it would be a marvelous gesture if he provided Dr. Butler with the six research beds he

wanted at the Clinical Center and a very fine gesture to the Conference about his own concern about these things. I almost thought, with some of the information that Dr. Gibson and Dr. Butler provided, and the response from the White House, that that might have happened, but as you know, it didn't. I hope that my next venture may prove to be more effective, and I'll say a little bit more about that later.

Let me just tell you, from the point of view of the Surgeon General, functioning in the capacity that I do now as Deputy Assistant Secretary of Health as well, how I think all this fits into the perspectives of our general Department's efforts. As you know, Secretary Schweiker is very much interested in health promotion and disease prevention, and you will be seeing something almost weekly now about a new initiative in the field of prevention. We are committed to this as a major health policy and I think this has been clear from the confirmation hearings of Secretary Schweiker right on down to his most recent press releases. In general, what we're following, are the guidelines set forth in the Surgeon General's Report on health promotion and disease prevention which was entitled "Healthy

People", and in the follow-up document which was called, "Objectives for the Nation". And you are very familiar with these things. In these two documents we really have isolated five separate categories or objectives which are goals for prevention and health promotion that we hope our society can achieve by the year 1990. They include such things as trying to lower our infant mortality rate from its present almost 12 to 9 per 1,000 live births; to assure some kind of longterm, successful control of high blood pressure by at least 60 percent of persons with the disease, and that of course impinges very definitely upon your concerns; to reduce the proportion of smoking adults to less than 25 percent of the population--the kind of effort that the smoking lobby, or the tobacco lobby is making against it at this time, that seems problematical. They have already spent in advertising this year more than our entire budget on smoking and health, and that is only 25 percent of this year's budget for lobbying against the things that we think are proper; and other such things as trying to cut down on infant fetal alcohol syndrome and such things as that, which are not part of your aging concerns.

But we believe that interagency cooperation

is absolutely essential for attaining any of these goals, and the kind of a meeting you're having this morning is certainly evidence of the fact that you understand these things as well. We need the Department of Housing and Urban Development to help achieve safety and sanitation goals for improved living environments. We need the Department of Agriculture to improve nutrition, especially in our initiatives with pregnant women and children, and as you see it, with the aging population. We certainly need the Health Care Financing Administration to help to fund demonstrations in new health care technologies and to encourage the application of the results and so on. And I'll say a few things about that in a moment.

So, many of these goals may not appear at first hand to be specifically targeted at the nation's elderly. But we also have a separate program devoted to the specific problems of longterm care which cuts across all age groups and effects all social and economic groups as well. So often longterm care is assumed by the listener to refer only to the aging population, but I certainly in my former incarnation realized that a lot of longterm care went into very young children indeed, and they had to have

it for much longer periods of time than do the aged.

You are aware of the fact that Assistant Secretary Brandt appointed me as the Chairman of a Public Health Service Task Force on Longterm Care, and we moved into that with some degree of enthusiasm only to find then that we were sort of downgraded a little bit by the whole Department of Health and Human Services getting into the same act. And you know that we shifted gears as rapidly as we could and tried to comply with Assistant Secretary Rubin's request for an inventory of what was going on in various parts of the Public Health Service. And inasmuch as what Dr. Butler and Dr. Gibson are on that task force, I won't have anything more to say about that.

I've alluded to the fact that I would mention something to you a little bit further about another opportunity we might have, and I'll just specifically mention it because it involves several agencies here, and that is a longterm concern that I have had about incontinence. One of the most fascinating diseases of childhood is Hirschsprung's disease, or aganglionic megacolon, and for every one of those that you see, you see perhaps 35 or 40 children who are thought to have that disease but

merely have the symptoms of it without the pathology, and all of these children tend to have problems in incontinence. And therefore I have been concerned about the physiologic pathology, or the pathologic physiology, of incontinence. And as I got into the Public Health Service and recognized what nursing home admissions consisted of, and realized how much longterm care was associated with incontinence, and began to get the statistics on this, I realized that if we wanted to make a really cost-effective stab at something in the future, incontinence would be a marvelous goal. If you could do all the things you wanted to do and you were 100 percent successful, you could save as much as $8 billion dollars a year in longterm care by conquering incontinence by one way or another. And there are many ways that can be done, not just by surgical means and mechanical contrivances, but most effectively by the use of biomedical feedback techniques.

And on one of the occasions when I was able to corner the Secretary, I pointed out to him that if he really wanted an initiative that would sing for him in days to come, incontinence would be it, and if we could have his support, I would be very happy to try to work with people out here at NIA to spearhead

this and get some of the answers that we'd like to have. As you know, Dr. Engle working at the Institute in Baltimore has a very high success rate among ambulatory elderly, between 65 and 90, with incontinence. And my concern is, can he get the same kind of an effective result with people who are admitted to nursing homes, especially to do it quickly enough before they get into the situation of having bed sores which make their discharge absolutely impossible from a nursing home?

And it is along those lines that I approached the Secretary and got his support to go to Dr. Carolyn Davis, and we have her promise of a substantial amount of financial support as soon as the new fiscal year arrives to try to set up a unit in Baltimore which would be a typical nursing home unit where we would not be dealing with a select population, but the run-of-the-mill, across the board, incontinent patient that comes to a nursing home, and see what these biofeedback methods might do in such a circumstance.

Now, I'm not naive enough to believe that even if you had a marvelous result with that, that you could teach the doctors of America to teach their patients not to be incontinent. It's just not exciting

enough for them. But I think there is a way that we can utilize another phenomenon in our modern medical picture today, and that is the teaching nursing home that Dr. Butler has been so instrumental in bringing about. And we have met with people from one of the teaching nursing homes here in Washington, and it would appear that if we do it just the right way that we could indeed put out a nursing initiative across this land, suggesting that this would be a major contribution and a very cost-effective one if nurses would assume to themselves the role of teaching elderly people who are incontinent how to use the biofeedback techniques to improve their situation.

And as those of you who may not know as well as I do, there is a constant friction between physicians and nurses in hospitals over the value of training, and who is going to make decisions, and I think here is a place where we could ask the nurses to step into a role of teaching and responsibility where they would not have any competition from doctors and where, because of their own particular skills and compassion, we might achieve the ends that we'd like to achieve far better than if we put this in the hands of physicians. And I say that in spite of the fact that I, myself, am one.

Finally, I've just returned from the World Health Assembly, where I did not have as much time to do the things I wanted to do on the side as I had hoped, but I did meet with Dr. Caprio and Dr. MacFadyen, who are responsible for the aging initiatives of WHO. They are very enthusiastic about the upcoming World Assembly on Aging to be held later this summer in Vienna. I think that they believe that there will now be 31 ministers of various countries who go as chief delegates to that, which I think is very important, because it means that it has a high profile and a sense of importance in those countries. And as you know, it has a very high profile and a very important role in this Department because our own Secretary is going to lead the delegation to Vienna in late July. And at the moment it appears as though both Dr. Butler and I, among others, will be accompanying him. And that might augur well for the future.

And I might just say in closing that it was very gratifying to be part of the Public Health Service in Geneva and to realize in what tremendous esteem the National Institutes of Health are held, especially the National Institute on Aging, but most especially your leader Dr. Butler.