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HEALTHY ELDERLY AMERICANS: A FEDERAL, STATE, AND PERSONAL PARTNERSHIP

HEARING

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HEALTHY ELDERLY AMERICANS: A FEDERAL, STATE, AND PERSONAL PARTNERSHIP

FRIDAY, OCTOBER 12, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Albuquerque, NM.

The committee met, pursuant to notice, at 9 a.m., at the Main Library, Albuquerque, NM, Hon. Jeff Bingaman presiding.

Present: Senator Bingaman.

Also present: Merry Halamandaris, legislative assistant to Senator Bingaman; and Jane Jeter, minority professional staff member.

OPENING STATEMENT BY SENATOR JEFF BINGAMAN, PRESIDING

Senator BINGAMAN. First of all, I want to welcome everybody to the hearing and indicate that this is a field hearing under the auspices of the Senate Special Committee on Aging, which is a committee that I have been assigned to this year for the first time. The idea of the hearing is somewhat innovative as far as the activities of the Special Committee on Aging goes. It is a hearing to focus on the activities that are taking place which promote health and well-being among our older citizens. Rather than focusing on what can be done to deal with the problems of sickness once they occur and the tremendous funding problems in that area, we are trying to focus instead on the other end of the spectrum and say what can we do and what is being done to keep these problems from occurring and to keep people healthy.

Let me start by thanking the many people who have helped us put this hearing together—and there are many. Vince Murphy, who is my coordinator here in the State, has worked hard on this and has done a terrific job. Jack Waugh, who is head of our press operation, has done an excellent job in getting the message out that this hearing would occur. Ed Jayne, who is the director of our legislative effort in Washington, is here with me today. He has been very instrumental in getting this hearing organized.

Merry Halamandaris works in our office and particularly focuses on problems involving aging issues. She is here and has done a tremendous amount of work. Jan Scheutz, who is on sabbatical from the University of New Mexico and working with us in Washington this semester, has also done a tremendous amount of work, which I appreciate.

Liz Gallegos, who heads our office here in Albuquerque, has done a tremendous job for us. Becky Bustamante in our Santa Fe office, who does a great deal of work with senior citizens in the State, has

worked hard on this as well. Lynn Ditto from our Roswell office has done an excellent job and we appreciate her help.

I particularly appreciate Jane Jeter, who is from Senator Glenn's staff, the Democratic staff on the Senate Committee on Aging.

The goal of the hearing is to identify the preventive health opportunities that exist for older Americans. Today, as we all know, there are more and more people who are classified as older Americans, and there is a great deal of attention being given to the health care issues that affects this group. Unfortunately, there has not been as much attention given to the health promotion efforts, some of them very impressive, that are going forward to help senior citizens.

I think the general public has an interest in this hearing today, for the very simple reason that health care costs have risen dramatically over the last decade. They have risen constantly at twice the rate of inflation, and it is now over $200 billion a year in Government programs alone, not to mention the tremendous cost to individuals, to families, and to our economy in general.

Obviously, older Americans consume a disproportionate share of these health care costs. Almost a third of public spending on health is devoted to servicing the older citizens.

As birth rates decline and life-extending medical technology improves, older people are rapidly becoming a larger share of our population, which is now 11.5 percent, or 1 in every 9 Americans who are today over 65.

Today, we are going to first of all concentrate on the issue of what is being done in existing programs for health promotion for older Americans. Second, this panel will concentrate on new strategies for improving and expanding these important public programs. Our final panel will explore the personal opportunities that exist for people to build better health through changes in their own lifestyles.

Before I introduce the first panel, I want to acknowledge the help and the cooperation of Senator John Heinz of Pennsylvania, who is chairman of the Senate Special Committee on Aging. He has indicated a strong interest in receiving the report that we are producing today from this hearing. Additionally, I appreciate the interest and the help of Senator John Glenn, who is the ranking minority member of the Special Committee on Aging.

I hope that today's testimony will help us to realize both the needs and the opportunities that exist for improved health opportunities for our senior citizens. This is a subject that is of great interest to me, as I am sure it is one of great interest to you, as witnessed by your presence here.

In the interest of saving time, I will not read my prepared statement. I will insert it into the record at this time.

[The prepared statement of Senator Bingaman follows:]

PREPARED STATEMENT OF SENATOR JEFF BINGAMAN

Good morning. My name is Jeff Bingaman and it is my pleasure to welcome all of you to this field hearing of the Senate Special Committee on Aging.

Our work this morning focuses on forging a partnership between people and government—to promote the health and well-being of the Nation's older citizens.

This goal, to identify preventive health opportunities for older Americans, is a very unusual theme for a public hearing of this type. In fact, according to the

Senate Committee on Aging, it is the first known of it's kind ever held. Usually we talk of the health problems of advancing age and the treatments for infirmity. Today, we are going to explore the promise of growing old, and how to stay well.

So, our underlying understanding today is that growing old is not a disaster, as it is too often seen by our society, but that aging is the time when for many, life can be lived to its fullest.

A few days ago, George Burns, who I believe is 87 years old, was on his way to an appearance on the Johnny Carson show. On his way to the studio, he was waylaid by a young photographer who wanted to take his picture. While this young man was getting ready he asked George, "I wonder if I'll be able to take your picture 20 years from now?" "I don't see why not," George said, "you look healthy enough to me."

That is our goal today; to make sure we can all have this hearing again 20 years from now—how older people can live longer, healthier, happier lives.

The general public has an interest in our proceedings here as well. The public cost of health care has risen dramatically over the past decade, rising constantly at twice the rate of inflation, and it is now over $200 billion a year just in government programs, not to mention costs to individuals, familes, and the economy.

Older people consume a disappropriate share of these costs, almost a third of public spending on health, twice their proportion of the general population.

And, as birth rates decline and life-extending medical technology improves, older people are rapidly becoming a larger share of our population—now 11.5 percent, that is one in nine of all Americans are over age 65.

Some people refer to this as the "graying" of America. It makes more sense to call it the "maturing" of the American population. The perception of our youth-oriented culture, that growing old is just one big problem, just doesn't fit the facts. The truth is, based on research of the National Center for Health Statistics, that eight out of every ten people over 65 are healthy enough to live their normal lives without medical assistance. And that pleasant statistic includes the 5 million who are over 80.

"Oldness" in itself is an individual perception to begin with. Somebody once took a survey among senior citizens who were between the ages 70 and 79, and many of them thought "old" was being in your eighties.

So, the truth is, "we're as old as we feel." Today, we will be addressing in this hearing the opportunities for older people to feel as well as they possibly can.

Of course, many older and younger Americans do require health care which is often costly. We certainly must do everything we can to prevent escalating health care costs.

Today, we will review the existing public programs for health promotion for older people: examine in our second panel, new strategies for improving and expanding these important public programs; and, then in our last panel, explore the personal opportunities for people to build better health through changes in their own life-styles. Then we are all going to take a lap around the building.

We are very fortunate to have a distinguished group of panelists to assist us—both from here in New Mexico and from around the country—who I will introduce as we go along.

In his letter authorizing this special hearing, Senator John Heinz of Pennsylvania, chairman of the Senate Special Committee on Aging, indicated his strong interest in receiving the report of our work today. I appreciate his interest, and also want to extend my thanks to Senator John Glenn, the ranking minority member of the committee.

I hope what will come out of today's testimony will be the realization that older Americans both need and are entitled to, the same opportunities for fitness and well-being which are extended to all the other age groups in our population.

This is a subject of great interest to me, as I am sure it is to you, and we will begin with our first panel on what the overall status is today of health promotion for older citizens.

Senator BINGAMAN. Our panelists on the first panel today are Dr. Samuel Lin, who is the Deputy Assistant Secretary of Health, who has come here from Washington to tell us the position of the Federal Government on many of these issues and the activities taking place. He is joined by Stephanie FallCreek, director of the Institute for Gerontological Research in Las Cruces; by Nina Mervine, New Mexico State director, American Association of Retired

Persons; and by George Ellis, who is head of the New Mexico State Agency on Aging. We greatly appreciate their presence here today.

To speed the progress of the hearing, the entire panel will testify, and then I will ask questions about different statements they have made. Then, we will continue with our second panel.

So, Dr. Lin, you may begin your testimony. Again, we greatly appreciate your presence here today and we are looking forward to your testimony.

STATEMENT OF DR. SAMUEL LIN, ASSISTANT SURGEON GENERAL AND DEPUTY ASSISTANT SECRETARY FOR HEALTH, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICE, ACCOMPANIED BY VIRGINIA TANNISCH, HEALTH CARE FINANCING ADMINISTRATION OFFICE, ALBUQUERQUE, NM

Dr. LIN. Thank you and good morning, Senator.

I would also like to introduce, to my right, Virginia Tannisch, who is our Health Care Financing Administration representative based here in Albuquerque.

I want to thank you in particular, Senator Bingaman, for inviting Secretary Heckler to testify at this hearing. I bring you her personal greetings, as well as an appreciation for your interest and commitment to improving the quality of life for our senior citizens. Secretary Heckler regrets that she is unable to be here herself. However, the statement I will present is her own and details the range of involvement and commitment of her Department to promote wellness in our senior populations.

Many of us are aware that the average lifespan of Americans has significantly increased during the past century. In 1900, only 4 percent of the population was age 65 and older, whereas today 11 percent of the population is 65 years or older. By the year 2030, it is anticipated that persons in this age group will constitute 21 percent of our population. Clearly, these gains in longevity are important. However, we must go beyond this measure of health and consider also the quality of life.

Although most persons age 65 and over consider themselves to be in good health, approximately 80 percent of them suffer from at least one chronic condition. These older Americans, on the average, experience 39 days of restricted activity and 14 days confined to bed rest each year. Yet, these chronic conditions can often be avoided or alleviated if a person practices certain health habits.

Health promotion activities can educate people about the associations between lifestyle and health habits and the leading causes of death and disability. Programs can assist people in changing behaviors that may lead to illness. While all illness and disease cannot be eliminated, the well-being of older Americans can be improved through the adoption of good health practices.

Health care costs of the elderly now exceed, as the Senator has mentioned, $120 billion per year. Efforts aimed at avoiding illnesses that require costly medical care are desirable to reduce costs in addition to making life more rewarding for older persons.

My message to you from the Department of Health and Human Services is that it is not too late to improve the health of older

Americans. Several studies indicate that older people are very concerned about the high costs of health care and maintaining their functional independence. They are very interested in their health and indicate a willingness to change their behavior to improve their health. Some even believe their willingness to adopt healthy behavior exceeds that of any other age group.

Within the Department of Health and Human Services, several health promotion efforts for the elderly are now in progress. In the forefront is the joint Public Health Service and Administration on Aging health promotion initiative which is drawing attention to the need for health promotion for older persons and helping National, State, and local agencies and organizations create their own programs.

Initiated by Surgeon General C. Everett Koop and Commissioner on Aging Dr. Lennie-Marie Tolliver, several HHS agencies are involved in this campaign, and some of their effort will be briefly described. First, however, let me provide a brief review of the background that led to the development of this initiative.

"Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention," published in 1979, states that—

> The long term goal of health promotion and disease prevention for our older people must not only be to achieve further increases in longevity, but also allow each individual to seek an independent and rewarding life in old age, unlimited by many health problems that are within his or her capacity to control.

A more specific objective concerning the quality of life was also developed, that being able to—

> By 1990, to reduce the average number of days of restricted activity due to acute and chronic conditions by 20 percent, that is, to fewer than 10 days per year for people age 65 or older.

In 1983, our National Institute on Aging published a health promotion agenda that had similar goals for the elderly. Though many activities are underway to achieve these goals, special attention is currently being given to health promotion. Activities directed toward this goal include issuing a general prevention-oriented program announcement to solicit research designed to specify how psychosocial processes, interacting with biological processes, influence health and effective functioning in the middle and later years. More recently, two new programs have been released to further our knowledge on factor related to health promotion and disease prevention.

The NIA is calling for research and research training to specify how particular behaviors and attitudes influence the health of people as they age, and how particular social conditions affect the development and potential modification of these behaviors and attitudes. Not only are the health behaviors and attitudes of middle-aged and older people themselves involved, but also those of formal health-care providers and of family and friends. These behaviors and attitudes include medical beliefs about the nature of the aging processes. They also include behaviors believed by older people to promote health and functioning, as well as "illness behaviors" that involve how older individuals monitor their bodily functioning; how they define and interpret symptoms perceived as abnormal; whether they take or fail to take remedial action, utilize formal health-

care systems, comply with prescribed regimens; and how they approach death.

Over 30 grants have already been funded in this newly emerging area which is called behavioral geriatrics research. There is a Special Emphasis Career Development Award to provide behavioral scientists with needed biomedical, clinical, or epidemiological training to successfully engage in careers in behavioral geriatric research. Additionally, the NIA is encouraging research on social environments influencing health and effective functioning in the middle and later years. Research is needed on how the quality of aging is affected by the subtle and continuing interplay between individuals growing older and the beneficial or adverse circumstances in the day-to-day social situations they face in a changing society.

We are also working to find out what activities have the most potential for improving the health of people in this age group. A study entitled "Aging and Health Promotion: Market Research for Public Education" conducted by our Office of Disease Prevention and Health Promotion, the National Institute of Aging, and the National Cancer Institute in the Public Health Service and the Administration on Aging was undertaken to help provide answers. This study reviewed the literature on the health problems of older people and assessed through qualitative research the actual concerns reported by older people. The study also examined the interest of the older people in their health and their ability and desire the change their behavior. Focus group discussions were held with older people from different parts of the country to understand their views and to learn from their insights.

Because this portion of our testimony deals with what our senior citizens have said, I will take the opportunity to expand on this issue.

The results revealed that while older persons are very interested in maintaining and improving their health, knowledge about specific habits and their association with chronic diseases and conditions was limited. Six primary areas were identified as significantly related to conditions prevalent in the elderly and having the potential for change: Fitness and exercise, nutrition, safe and proper use of medicine, accident prevention, preventive services, and smoking.

We have learned a great deal about how to address these issues. Physical fitness improves cardiovascular fitness, strength and flexibility, while reducing the risks of heart attack, falls, broken bones, and lower back pain. Since physical activities make people feel better in general, people often adopt many other healthful behaviors as well. Unfortunately, too few older Americans know about proper exercise and the accompanying benefits. Fifty-seven percent of those 65 and older do not exercise on a regular basis according to national surveys. Some programs have already been developed that address the exercise needs of older Americans, even for those who are confined to wheelchairs and beds.

The importance of nutrition in maintaining good health is important for all age levels. Recently, many links have been established between diet and disease; for example, osteoporosis or brittle bones is associated with a lack of calcium and exercise. Over 30 percent of cancers have been linked to diet. In the focus groups, it became evident that many people knew what not to eat, but that they were

unable to describe what constituted a balanced diet. Some educational programs have been created, but there is a need for simple and well-integrated information on what a healthy diet is, rather than only what ingredients or foods are to be avoided. We suspect that this is true for all age groups, not just older people.

Proper use of drugs and alcohol is another crucial factor in the maintenance of health. Older Americans consume 30 percent of all prescription drugs and disproportionate amount of over-the-counter medicines. Several people in the focus groups expressed concern over the interactive effects of the different drugs they are taking. They expressed a need for more information and guidance from health care providers. Efforts should be directed toward the training and education of health professionals about the special needs of the elderly. More research is needed that focuses on the effects of drugs on the elderly, and prescription guidelines need to be developed.

Another major cause of disability and death is accidents, particularly falls and automobile accidents. One of the reasons that the elderly sustain so many injuries during automobile accidents is that only 10 percent of them report that they regularly use their safety belts. While the exact cause of the many falls that result in or are associated with hip fractures has not been established, falls are attributable in part to unsafe living environments and poor physical condition. While there is clearly a need for improvement in the utilization of seat belts, many older people are aware of the risk of falling and have taken steps to make their home environments safe. Community programs should be created to reinforce this behavior and to provide additional information, especially to those persons who may not be aware of their high risk for accidents.

There are two other areas of importance in health promotion for older people—preventive services and smoking. Guidelines with respect to screening procedures and tests are developed by various professional groups. The appropriate application of these recommended procedures should be encouraged. All people should be advised to stop smoking and never to start the habit at any age. Evidence now suggests that even if people quit smoking at age 50, their risk for cancer decreases.

Another central purpose of the survey was to determine whether older people are a suitable audience for health promotion activities. The focus groups revealed that older persons are very conscious of their health and that they try to figure out ways to stay healthy. Other studies also indicate that when educated about health habits, older persons had higher levels of compliance and behavioral change than the other age groups. This leads us to the conclusion that older people are an interested and enthusiastic audience for health information.

Let me describe, then, some of the special features of our health promotion initiative for the elderly.

At the Secretary's request, the Governors of almost every State have named individuals in their States to coordinate health promotion activities for older people. Generally based in the State health department or State office on aging, these individuals will receive resources to help make programs in their States a reality.

To provide support and technical assistance to State and local agencies, the Administration on Aging developed a publication distribution plan consisting of over 30 publications in the 4 priority areas of injury control, proper drug use, better nutrition, and improved physical fitness. One document, "A Healthy Old Age: A Source Book for Health Promotion With Older Adults," has already been printed for this initiative. AOA sent over 15,000 copies to State agencies on aging, community and migrant health centers, Indian tribes, service units of the Indian Health Service, and to OASIS projects—which are minisenior centers located in department stores.

AOA will develop two other new documents for this initiative—the first, a process guide for use by State and local health aging units to set up health coalitions and programs, and the second, an annotated bibliography on health promotion.

AOA sponsors nutrition programs that provide meals to older persons. Over 3.5 million persons participated in 1983. The cost was $381 million. In the same year, AOA served over 9 million older persons through its programs, many of which include health promotion activities.

In conjunction with several other agencies, the Food and Drug Administration has created a seminar series addressing the issue of geriatrics and drugs. Also, a series of articles on the elderly and nutrition is now appearing in their magazine called the FDA Consumer. Guidelines for geriatric drug testing are under development. A coordinated effort to investigate many of the issues related to geriatric drug use is ongoing. In addition, they are involved in major consumer education initiatives on sodium labeling, patient education on prescription medications, and health fraud. The agency conducted two consumer outreach programs designed to teach economically disadvantaged black elderly how to reduce sodium in their diets and to make the rural elderly more aware of health promotion messages on nutrition, medications, and medical devices. With regard to health fraud, a special unit is being established to address this specific issue in the drug area. FDA's consumer affairs officers, located throughout the country, continue to work with State and local organizations to bring priority health education messages to the elderly.

Accident prevention for older Americans has received attention also from our centers for disease control. They recently produced "Prevention of Injury for Older Adults," a selected bibliography providing an overview of the magnitude of injuries among older adults and the types of health education methods and programs being conducted to reduce them. The CDC has also initiated a project with the Department of Public Health in Dade County, FL, to assist the county in designing and conducting an epidemiologic population-based study of the elderly in order to determine the causative factors of non-work-related injuries. We believe this project will develop, implement, and evaluate a model prevention program designed to reduce the incidence of injuries and their associated costs.

As part of this initiative, the department has just awarded over $1 million in grants to 51 community and migrant health centers in 29 States for health education projects aimed at the elderly.

In 1983, Secretary Heckler assembled a special task force to evaluate the current medical knowledge of Alzheimer's disease, an incurable condition that affects approximately 2 million older Americans. In September of this year a report on the current knowledge, promising directions and recommendations, was issued. In conjunction with this departmental effort, AOA has launched a major campaign for the development of family support groups for families of older persons with Alzheimer's disease. The goal of this effort is to inform the aging network about the nature of Alzheimer's disease and to encourage the development of support groups to help families cope with the problems created by the disease. Additionally, AOA has developed a four volume technical assistance handbook on Alzheimer's disease to provide background materials and to assist States and local governments, professionals, and families in grappling with this problem.

Secretary Heckler is also very pleased to announce that, as a centerpiece of this initiative, the department will be providing materials and technical assistance to States to assist them in conducting public education programs on health promotion for older adults in their States. Under the direction of the Public Health Service, a variety of radio, television, and print materials will be produced for local distribution, including public service announcements and broadcast materials for talk shows. Print materials will provide in-depth information on specific health topics and alert the public to the campaign. Regional workshops will be convened to familiarize participants with public education materials and to give assistance on how to work with the media and provide health promotion services for older people.

A program of this magnitude is a major undertaking and one that we, the Federal Government, cannot conduct alone. We are very pleased to announce that we have already been joined by a number of organizations that share our interest in the health promotion needs of older people. The following organizations will participate in this effort:

The American Association of Retired Persons [AARP] will produce the public service announcements in collaboration with us and distribute them along with HHS-developed materials to the State contacts. AARP is working with the ODPHP on all aspects of materials development for the public education program.

The American Hospital Association will sponsor with us a teleconference for health care providers to increase professional attention given to meet the needs of older Americans. This teleconference will follow a series of regional training sessions.

The National Council on Aging and its many member organizations have already begun to urge their members to participate actively in these programs. We believe that this type of support will be essential to the success of the program.

In our Health Care Financing Administration efforts, the Medicare Program has several initiatives underway designed to promote better health and prevent illness among the elderly. We are preparing to implement a law that fosters greater participation of health maintenance organizations and competitive medical plans in the Medicare Program. The structure of HMO's give them incentives to provide comprehensive services and promote healthy life-

styles. Provision of preventive procedures and education on appropriate practices to promote good health assist HMO members in avoiding expensive hospital stays. We know that health education of patients is effective in decreasing their use of ambulatory health care services as well. A recent demonstration conducted by the Health Care Financing Administration found that health education provided by an HMO resulted in a significant decrease in total medical visits and minor illness among the HMO members. We are convinced that, because of their preventive focus, HMO's offer great potential to the elderly as high quality, cost effective health care delivery systems.

Nearly 900,000 Medicare beneficiaries now receive their health care from HMO's. The new law will make HMO's and CMP's an even more attractive alternative by allowing them to pass on cost savings to beneficiaries in the form of increased services or reduced premiums. When the law goes into effect shortly, we expect a dramatic rise in HMO enrollment by Medicare beneficiaries, up by as many as 600,000 beneficiaries in the next 3 to 4 years, with a 50- to 100-percent increase in the number of contracts between HMO's and Medicare.

Medicare also has an active program to encourage beneficiaries to obtain second opinions before undergoing elective surgery. Avoidance of unnecessary surgery is an important component in the promotion of good health. Medicare will pay for the opinion of a second physician to assist beneficiaries in deciding if an operation is necessary or if it might be avoided in favor of an alternative medical treatment. HCFA has also encouraged private insurance companies and State Medicaid Programs to pay for second opinions for their members.

If a patient is reluctant to ask his or her physician for a referral to another physician, we have established a national toll-free number to call to help locate in the patient's area. Medicare beneficiaries may also obtain that information from their local Social Security office or carrier. Helping people decide whether surgery is necessary, advisable, or avoidable, will discourage inappropriate procedures and any needless risks associated with them.

Other recent laws have expanded the Medicare benefit package to include coverage for pneumococcal and hepatitus B vaccines. These two vaccines have demonstrated their cost effectiveness and ability to prevent illness.

We are also funding several other research projects involving preventive services. We are studying how the opportunity to obtain preventive services relates to individuals' decisions to join HMO's rather than participating in the traditional fee-for-service system; the effect of this type of insurance coverage on the amount of preventive care used; the amounts of preventive care used in prepaid systems versus fee-for-service settings when there are no out-of-pocket charges; the responsiveness of consumer demand to changes in the price of preventive care; and the effects of preventive services on the cost of care in the clinic setting.

In conclusion, many health promotion programs for older Americans have begun within the Department of Health and Human Services. Public and private organizations have been very responsive to the aging initiative, and they are continuing to develop new

programs that serve the needs of the elderly. Continued public-private collaboration can ensure that the impact of this initiative is not short lived. Resources can be directed at the development of programs at the State and local levels. On a national level, we can continue to stimulate health promotion activities for older persons. All of these efforts will contribute to the maintenance and improvement of the health of the elderly, enabling them to enjoy more satisfying lives.

Again, Senator Bingaman, on behalf of Secretary Heckler, whose testimony I have delivered, thank you for your interest and this opportunity.

Senator BINGAMAN. Thank you, Dr. Lin. We appreciate your testimony, as I have said before.

Ms. Thannisch, do you wish to make any statement at this time? We are glad to have you here and would be anxious to hear from you if you have a statement.

Ms. THANNISCH. Thank you, Senator. I do not have a statement. Dr. Lin spoke on behalf of the Department.

Senator BINGAMAN. Thank you very much.

I will have a few questions for you after the other two witnesses on this panel testify.

Our next witness is George Ellis, who is the director of the New Mexico State Agency on Aging in Santa Fe. He is coordinator of the regional offices of Area Agencies on Aging. This year his agency is involved in promoting health among senior citizens as part of a nationwide project to encourage older citizens to become more active and responsible for their own health care. As I understand it, Mr. Ellis, you're going to testify about that initiative.

I want to add that our office in Washington has had excellent cooperation from Mr. Ellis in working on issues affecting older citizens. We greatly appreciate his cooperation with us on all these issues and we appreciate your being here today.

You may proceed.

STATEMENT OF GEORGE ELLIS, SANTA FE, NM, DIRECTOR, NEW MEXICO STATE AGENCY ON AGING

Mr. ELLIS. Thank you.

Senator Bingaman, staff members of the special committee, staff members of your office, distinguished panelists, senior citizens, and members of the audience: May I express my appreciation for the invitation to speak before you today.

Senator, your leadership has been crucial to our State, and your advocacy for our elderly has been second to none. May I, or behalf of Gov. Toney Anaya, thank you for the assistance you have provided the State and the aging network during your tenure in the Senate. Whether fighting unfair disability determination regulations, helping preserve our rural primary health care system, working for just changes in the reauthorization of the Older Americans Act, or arranging for the House Committee on Aging's hearing under the Chair of the Honorable Claude Pepper, you have made a permanent difference in the lives of our elderly. We are grateful for and indebted to your unselfish and effective public service.

I am part of a panel giving a general overview of health promotion for the elderly. My viewpoint can best be conveyed by providing the committee with three documents: Governor Anaya's testimony [1] before Chairman Pepper's subcommittee in August of 1983; the Governor's welcoming speech [2] at our last annual conference on aging; and the spring 1983 issue of Generations,[3] the quarterly journal of the Western Gerontological Society.

Governor Anaya's testimony and speech represent the official position of the State of New Mexico on the whole subject of health care, costs, and financing; long-term care; disease prevention; and health promotion. This issue of Generations, edited by Dr. Ken Dychtwald, is perhaps the most concise, yet comprehensive statement on wellness and health promotion for elders in print. These documents, added to the testimony of the excellent panelists scheduled today, far surpass anything I could say on the subject. Still, there are comments that I would like to share with you and the audience.

The demographic picture here in New Mexico is both an exciting and a frightening one. The over-60 population grew by almost 60 percent between 1970 and 1980. If this rate of growth continues—and there is every reason to believe it will—by the year 2000 there will be almost one-half million elderly in New Mexico. We are the sixth fastest growing State in percentage of the population over 60, and our rate of growth of the over-75 population exceeds the national average.

The reasons for our rate of growth are our environment and lifestyle. Native New Mexicans exceed the national life expectancy in almost every racial and ethnic category, with Hispanas having a life expectancy of almost 80 years of age. The flow of elderly into our State is steadily increasing.

That is the good news. The bad news is that we have neither the primary- or long-term-care systems in place, nor do we have the revenue sources to fund such systems, given the current economic and tax structure. And even if we froze health costs at today's rates, if the rate of chronic illness maintains at current levels, it is doubtful that the State could fund its part of the costs. If the State is to be rational about its future, then it must undertake health promotion, disease prevention, and a community and in-home-based care system.

The medical system we have been blessed with since the late 19th century has done a magnificent job wiping out certain diseases. It has done so by research into the cause and treatment of disease. Thus, we have had marvelous victories over acute illnesses. The diseases that plague us today are not caused by outside agents, such as micro-organisms. These chronic diseases are caused primarily by our lifestyles and our environments. And our medical model of health care is inadequate, in and of itself, to cure our behavior and our environment.

In relation to costs, the main difference between our "afflictions of civilization" and diseases at the turn of the century is that our

[1] See app. 1, item 1.
[2] See app. 1, item 2.
[3] Retained in committee files.

illnesses kill us gradually rather than quickly. Therefore, the cost of treating but not curing them is extended over decades. We must develop a holistic health system to go with our medical system that will prevent or retard chronic disease to the end of our life expectancy. Fortunately, there is a great consensus as to what this system should be:

First, it should view aging and dying as natural processes and not as diseases which are to be avoided or prevented at all costs, regardless of the quality of life.

Second, it should not spend its resources on extending the lifespan of the human species, but on achieving a vital and vigorous life throughout our life expectancy.

Third, it should foster individual responsibility for one's health from an early age and engender the skills necessary for self-healthcare at every age.

Fourth, it should promote exercise, proper nutrition, only moderate alcohol use, nonsmoking, stress reduction, and a healthy work home, and play environment.

Fifth, it should educate and alter the support systems of the elderly so that health promotion and disease prevention is seen as a societal as well as an individual responsibility.

Sixth, it should address the "social carcinogens" of poverty, racism, sexism, and ageism, as well as environmental carcinogens and pathogens.

Seventh, it should give equal status to mental and emotional health treatment and promotion.

Eighth, it should restructure our entire health financing system, public and private, so that disease prevention, health promotion, mental health treatment and promotion, nontraditional medical systems, in-home and community-based care, case management, and social services are reimbursed on at least an equal basis with medical and institutional care.

Ninth, it should conceive health as more than the absence of disease, but as a state of complete physical, mental, and social well-being which lets one carry out daily tasks with vigor and alertness with enough energy left to pursue interests and leisure activities and to meet life's emergencies successfully and intact.

Tenth, it should, in the words of Governor Anaya, "achieve a vision of aging as the crowning achievement of the life process, as a status that all other generations can look forward to."

To me, Senator, both as an individual and as a professional, the great news is that the consensus articulated above is already rampant in our society. Our laws, regulations, and bureaucracies just haven't caught up yet. But with the impetus of leadership such as yours, they will. Good health among the current generations of elderly is possible today. And in your and my lifetime, it will be possible to live a vigorous, alert, undiminished, unimpaired life right to the last days of our lifespan, if we and our society start right now.

We have our own health prevention initiative instituted in 1983 by the State Agency on Aging. I am going to reserve comment on that because Dr. Stephanie FallCreek has been the project coordinator and will cover that in her remarks.

I am also appreciative of the chance to be the lead agency for the Administration on Aging's Health Initiative Program. We think that program holds great promise. The only problem with the initiative is that it does not have any Federal funds to back it up. But because of our 1983 appropriation from the State of New Mexico, we are able to pursue the initiative at a substantial level.

Thank you, Senator.

Senator BINGAMAN. Thank you very much, George. We appreciate your testimony.

The third witness that we have today is Nina Mervine. Mrs. Mervine is the State director of the American Association of Retired Persons. AARP, of course, has designated 1984 as the year to focus on health, and they have developed a campaign for their members to educate, train, and mobilize senior citizens to become more responsible for their own health and to become more involved at the community, State, and Federal level with legislation that involves the health and well-being of senior citizens.

As I understand it Nina, you're going to explain to us exactly what this organization is doing, particularly what you're doing to promote health among senior citizens.

STATEMENT OF NINA M. MERVINE, DEMING, NM, STATE DIRECTOR, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mrs. MERVINE. Senator Bingaman, staff members of the committee, and audience. Thank you for inviting me to testify before this field hearing on behalf of the American Association of Retired Persons. I am here today to discuss health promotion and wellness for older adults. AARP is involved in several health education and promotion programs on the National, State, and local levels. These programs are part of a larger health care campaign that AARP is undertaking, aimed at saving the Medicare Program from insolvency, and reducing skyrocketing costs of health care.

Our health care system is out of control. Medicare and Medicaid are in serious financial trouble. Businesses must cope with huge increases in the cost of health insurance benefits for their employees. Workers and their families are facing cutbacks in their health insurance protection. Health programs for children are running out of funds.

All Americans should have access to appropriate health care at a fair price. But unless we work together to bring our health care system under control, adequate medical care will soon become a luxury only the wealthy can afford.

That is why AARP has launched a major national campaign to cut the cost and keep the care in our health care system. This campaign, entitled "Healthy US", is designed to achieve these general goals:

To reduce the rate of cost escalation in health care; to preserve and strengthen the Medicare and Medicaid Programs and to assure the availability of affordable health care for all citizens; to encourage the development of alternative health delivery systems, such as health maintenance organizations, home health and ambulatory care services, that can be more responsive to consumer needs and more efficient in the delivery of services than the current institu-

tional systems; to provide information to consumers on health care costs and options; and to encourage Americans of all ages to adopt and practice more healthful lifestyles.

The immediate priority of the campaign is to preserve Medicare and Medicaid and other health care programs by reducing the rate of growth of health care costs. At first, this will require legislative action.

While the immediate goals focus on Medicare, AARP believes that encouraging healthy lifestyles is crucial. A great deal of the illness in this country is a result of personal behavior and environmental conditions. The American Medical Association estimates that 55 percent of all disease is lifestyle related.

Poor heath habits also affect our financial health. More than 30 million workdays are lost each year due to illnesses caused by high blood pressure. Lost work days due to alcoholism cost $19 billion a year.

Health promotion and wellness activities will not save Medicare or immediately change our health care system; only legislative action can do that. Good health habits can help to reduce personal health costs, as well as help older adults lead more active and vital lives.

I would now like to discuss an overview of health promotion for older adults.

The time is right for a health promotion program with older people whose numbers are steadily growing. Today there are 26.6 million people aged 65 or older, and by the year 2000 it is estimated that 20 percent of all Americans will be over age 55. Projections for the next several decades show that the population 75 years of age and over is expected to increase four times faster than that of persons under age 65. The proportion of the elderly who are aged 75 and older is important because the incidence of chronic disease and impairment and the utilization of medical services tends to increase with age, and increase dramatically after age 75.

The aging of America presents serious questions regarding the future. Will we remain an active and vital population? What will be the quality of our lives as individuals in our later years and as we live longer? Will we be able to contain health care costs? Will more and more of our national resources need to be directed toward caring for an increasingly infirm or chronically ill population?

The answers to these questions are important to the future well-being of the Nation. Steps to encourage the preservation and maintenance of good health among all adults, including older adults, are important. Millions of lives have been saved from acute heart attacks, strokes, early death from cancer, diabetes, and other acute conditions. Information exists which can help older persons learn how to prevent or control disease and to better manage chronic, degenerative diseases which have tended to become the dominant pattern of illness. Not only is there a real need for health promotion among older adults, but many are very interested in health, have the time to engage in activities that may enhance their health, and may be particularly responsive to health promotion.

Prevention, health promotion, and early detection of disease in early, treatable stages can reduce the overall cost of health care,

which can help individuals keep down out-of-pocket health expenditures, but it will not solve the crisis in Medicare. Appropriate health education can also help older adults be more independent and take control of their lives, contributing to a higher quality of life.

During the early months of 1984, research was undertaken by the Office of Disease Prevention and Health Promotion, the Administration on Aging, the National Institute on Aging, and the National Cancer Institute to determine the interest of older people in acquiring health information and their ability and desire to make changes to improve their health. A review of health promotion topics and a series of 15 focus group discussions were conducted. Across all of the focus groups there was an overwhelmingly positive response regarding the importance of health and participants' interest in issues related to health. A significant concern and dread over health care costs was expressed as either the first or second issue in each group conducted. Related to the issue of health care costs were concerns about being incapacitated and alone.

In addition to health care costs and independence, the following issues were stressed repeatedly by participants: Nutrition—including diet and overweight—exercise, staying active; high blood pressure and salt intake; cardiovascular health; arthritis and mobility; vision problems; hearing problems; medication problems; dementias and Alzheimer's disease; and diabetes.

The results of this and other studies confirm that older adults are generally health oriented, seek health information, and are concerned with the notion of staying well.

As individuals, older adults can reduce their personal health care costs with good health habits by developing a healthy exercise routine, maintaining a well-balanced low-salt and low-fat diet, regular checking of blood pressure levels, drinking alcohol in moderation, and stopping cigarette smoking.

As members of communities, older adults can help to initiate and attend health promotion events in their area. AARP has several plans and programs in this area that are going on at the present time.

Preventive health services and health promotion programs must be made available and accessible to older adults in all States of this country in order to keep the quality in the life of our aging population.

There is a need for more emphasis on health promotion for all ages. Relatively few health dollars are spent on health promotion in this country. While 97 percent of the health care dollar is spent on treatment of disease and 2.5 percent is spent on the detection of disease, only one-half of 1 percent is spent on health promotion. Moneys to support and expand health promotion programs are desperately needed, as well as to support research into this area. Many myths exist about health promotion and wellness. Research is needed to establish a scientifically sound data base on which programs can be developed.

There is a need to educate professionals. Few medical and other professionals receive training in geriatrics in general, and fewer

still in health promotion for older adults. Moneys are needed to stimulate the development of professional education programs.

There is a need to educate older adults. Just as health and other professionals need to be educated about the value of health promotion for older adults, older persons themselves need to be convinced of its importance. Many individuals past a certain age adopt a too late attitude about their health and their ability to change.

There is a need for long-range planning. Interest in health promotion, especially for older adults, is a relatively recent phenomenon. A concrete strategy for continuing emphasis on health promotion for all aged persons should be developed. Health activities and programs designed specifically for older populations, addressing lifelong patterns, should be a part of a continuum of services and programs. Legislation to stimulate the development of health promotion programs for older adults is needed at the National, State, and local levels.

There is a need for development and testing of model health promotion programs. Information alone will not bring about behavior change. Programs must be developed to encourage and support desired health related behaviors.

Coordinated and effective health promotion programs that develop and support healthy lifestyles among older adults are vital to their quality of life and the well-being of our entire Nation. AARP congratulates Senator Bingaman on his efforts to explore avenues of improvement through self-help and legislation for the promotion of wellness for older adults in New Mexico and the United States. We offer our congratulations and assistance in this effort.

Thank you very much.

Senator BINGAMAN. Thank you very much, Nina. I appreciate that excellent testimony.

I will ask a few questions to different members of the panel. If any of you want to respond and the question isn't directed at you, please feel free to do so.

Dr. Lin, concerning the initiative that Secretary Heckler is taking, Mr. Ellis was indicating that although the program was well intentioned, there is no funding for it. Is that because your agency did not ask for it, or that the Congress didn't give it to you?

Dr. LIN. Well, may I say that one of our intents was to encourage the State and local health authorities to also put resources into their own programs. As Mr. Ellis mentioned, the State of New Mexico did make the initiative a priority to fund. We are hoping that that is a means which will cover costs of these types of programs.

Certainly the costs that we have incurred have had to deal with both the areas of biomedical research and of information distribution and technical assistance, which we are always willing to provide.

Senator BINGAMAN. Is it your intention not to request Congress to fund this health promotion effort but instead to depend upon the States to provide the funding necessary to implement it?

Dr. LIN. Yes, sir. I believe, where possible, with our health promotion/disease prevention activities—and we have some 227 objectives that we are promoting—for improved morbidity and mortality, improved quality of life, et cetera, by the year 1990, we are

seeking to conduct these within the context of our current funding and attempting to carry these on without additional funds at this point.

Senator BINGAMAN. But are you going to shift any funds from the existing programs to health promotion? I notice Nina referred to the fact that—I think the statistic you quoted was that one-half of 1 percent of the funds that go into health care are spent on health promotion. I'm just wondering if that is a relationship or fraction that is intended to change in the coming years, or is the position of the Secretary that this should be done at the State or local level?

Dr. LIN. Well, I think it is expected to be a cooperative effort, each side—that being the Federal, State, and local bearing its share of responsibilities and costs. Within our Department, for example, as part of the overall initiative in health promotion and disease prevention, each of our operating divisions, and within those divisions, agencies, such as the National Institutes of Health, the Centers for Disease Control, Alcohol, Drug Abuse, and Mental Health, et cetera, each one of those was directed to create an office, without additional funding, of health promotion and disease prevention, to provide the agency an overall direction of activities, whether they be services or research-type projects, toward health promotion and disease prevention. It's done within the current context of our funding. I believe the circumstances are dynamic enough that anything is possible in the future.

At this point we are intending to do it within our given fiscal limits.

Senator BINGAMAN. Dr. Lin, much of your testimony and much of what you discuss deals with plans to produce additional educational materials, plans to produce public service announcements on radio and television, et cetera. I just wondered if there is a timetable that you have in mind for the preparation of these types of educational materials.

Is this something that will happen in the 1985 fiscal year, or is it a long-term plan? What is your understanding?

Dr. LIN. I could answer that generically. If we are following the "Objectives for the Nation," the book that I mentioned earlier that has health status objectives for the year 1990 as a target date, we are shooting for 1990 as far as accomplishing a number of these efforts relative to different rates of morbidity, mortality, et cetera.

Next year, 1985, is the midpoint between the beginning of this 1990 objective target. We will be reassessing at that point where we stand, and we also are going to be proposing objectives for the Nation for the year 2000. So there will be midyear or midstream modification as we see the data collect.

Senator BINGAMAN. I am still unclear, though, because you state that radio and television public service announcements will be prepared as part of this program. When would you expect that to happen?

Dr. LIN. I expect they will be forthcoming fairly shortly. Now, as I mentioned, we have a total of 227 objectives under our health promotion and disease prevention initiative, ranging from health care for the elderly to improved occupational health, to improved immunization targets for school age children, et cetera. It is our

intent to accomplish as many of those at the same level of priority as best as possible. We are accomplishing this. I cannot tell you exactly when they—the service announcements—will be out on the market, but I believe they will be forthcoming.

Senator BINGAMAN. I introduced in the Senate a bill that has already been passed out of committee on the House side, to establish a monitoring system for nutrition, a national monitoring program. The way we have drafted the bill, it would have a directorate cochaired by the Secretaries of Agriculture, Health and Human Services, and Defense, and then would establish an executive director and really put in place a 10-year program to develop a good data base on what the nutritional situation is with American citizens.

I just wanted to know if this is a piece of legislation that you're familiar with and, if so, whether you have any thoughts as to whether this kind of data is needed or useful or if it's already available.

Dr. LIN. Sir, I am aware, but not of the specifics. I do not know what our current position is relative to your bill. I would imagine, relative to collection of national data in order to improve further directions relative to policy or programs, we certainly would have an interest in being a part of the discussion.

Senator BINGAMAN. But is it your view that the data that is presently available is adequate or inadequate, or do you have any strong feelings on that?

Dr. LIN. I really am not able to comment on that, but we would be happy to provide a position for the record.

Senator BINGAMAN. OK. I would appreciate that.

Let me also ask, you indicate that one part of the initiative is the awarding of a million dollars in grants to health education programs aimed at the elderly, and these are going to 51 community and migrant health centers in 29 States.

Do you know if any of those grants have come to New Mexico?

Dr. LIN. I believe we're in the process of making a distribution via our regional offices, and I think our regional offices are in the process of determining awards' priorities relative to community health centers. I don't have the specifics for you because this is something that the Secretary announced only within the last several days. Again, we would be happy to provide those for the record.

Senator BINGAMAN. Are those grants that have been made?

Dr. LIN. Not that I'm aware.

Senator BINGAMAN. They have indicated they will make a million dollars' worth of grants.

If education of the elderly on these health promotion issues is important, it strikes me that the extent of the distribution of published material that you referred to may not be adequate for the purpose. For example, there have been only 15,000 copies of a publication called "A Healthy Old Age: A Source Book for Health Promotion."

Is that a publication? I have not seen that publication. Is it one that is intended for the use of a senior citizen, or is that intended more for the use of a person administering a senior citizen facility? What is the nature of that publication?

Dr. LIN. First, I will personally be sure that you get a copy.

Senator BINGAMAN. I would appreciate that.

Dr. LIN. Second, as far as its use, it really is for setting up programs. What we again hope to do through the initiative, as I mentioned initially, is that the first part of the initiative was the Secretary requesting that each Governor designate a pivot person, if you will, within each State with whom we would be in contact. Mr. Ellis is the pivot person for the State of New Mexico. We believe that these folks will help us reach the appropriate clientele within the States. I don't think that we ourselves have the capacity to do it just within the federal system. It has to be done in a cooperative fashion with the State and local health authorities.

Senator BINGAMAN. Are there any publications that your agency is producing or has produced which are intended as guides to an individual citizen who wants to improve his lifestyle as far as health promotion goes?

Dr. LIN. Yes, sir. Every one of our agencies that has a part in this initiative, including the National Institutes of Health, and, in particular, the National Institute on Aging, have publications that are written for the consumer, for the clientele, if you will. The Food and Drug Administration has pamphlets that are geared directly to the consumer. They are available through our public relations offices of each of our agencies.

Senator BINGAMAN. Could you try to put together some information as to how widely those are distributed, how many copies are distributed, and through what sources they are distributed? I think that would be interesting information, just so we know the extent to which that information is available.

Dr. LIN. I would be happy to do that.

Senator BINGAMAN. Mr. Ellis, you have a very interesting statement, and I would like to have you elaborate about item No. 8 on page 2 of your testimony. You say one of our priorities should be to restructure our entire health financing system, public and private, so that disease prevention, health promotion, mental health treatment and promotion, nontraditional medical systems, in-home and community-based care, case management, and social services are reimbursed on at least an equal basis with medical and institutional care.

Could you elaborate on that? That sounds like a fairly tall order.

Mr. ELLIS. Senator, it is a very tall order. It relates to the statistics that Nina gave earlier, that 96 percent of our health care dollars are spent on institutional acute disease treatment—the medical model, as it's referred to.

What we must do, in my opinion, in everything from Medicare and Medicaid, to State employee health coverage, to the private sector, is put wellness and health promotion and community-based and in-home care on an equal basis with the cure of disease.

Let me give you examples. Medicare will only pay 50 percent, for example, for mental health treatment, which puts mental health automatically on a lower pedestal than physical health in our system. We pay for hospitalization, but we do not pay, either in public or private financing for in-home care.

We are in the midst of having a Medicare Waiver Conference, sponsored by the Human Services Department, in Santa Fe right now. The waiver is a great idea. But it is so restrictive that it is almost impossible to carry it out and not invoke sanctions. That is

because as a society we see paying for home care, paying for community-based care, as exceptions. The fact that it is a waiver to the Medicaid Program treats it as an exception. We have to treat health promotion and community-based care as the rule and not as the exception. In my opinion, we may need to restructure Medicare and Medicaid to finance two different but equal systems, one an acute-care system and one a long-term care system.

We need to pay for the detection of diseases, not just their cure. Our whole system is set up around the disease model and we have to shift so that community-based, in-home, prevention, and health promotion models receive equal attention and equal funding.

That is a very tall order, but it is not as tall an order as raising the revenue to pay for our current model in the year 2000.

Senator BINGAMAN. Are you aware or can any of the panelists answer this—if you're aware of any system for reimbursement for health care costs that includes reimbursement for physical examinations on an annual or periodic basis? Is that something which is built into any of the systems that we have in place?

Dr. LIN. Not in Medicare or Medicaid that we're aware of, no.

Senator BINGAMAN. Is it in any of the Federal programs?

Dr. LIN. No.

Senator BINGAMAN. Mr. Ellis, would you indicate how much—if the Federal Government is putting no money into the initiative health promotion, how much is the State putting in?

Dr. ELLIS. The State legislature in 1983, before the AOA initiative, appropriated $50,000 for us to do a health promotion project. Dr. FallCreek is, through contract with New Mexico State University, in charge of that project. So we have been underway since 1983.

When the AOA initiative came along, we simply took that appropriation for this year and directed it toward accomplishing the objectives in the initiative.

The initiative is an excellent idea. The information that is published through the initiative is quality information. In fact, Dr. FallCreek is responsible for the authorship of a good portion of that material.

I think the problem that I see in all our efforts is that we tend to assume, at a bureaucratic level, that publications, PSA's, and information will solve the problem. But bad health is primarily a behavioral problem. What Dr. FallCreek and I have attempted to do, using some of our title V slots, is to put a role model in each senior center so that there is a senior citizen who practices health promotion who can teach the active practice of good health to other senior citizens.

We will not change our lifestyles by information alone. We will only change it by doing. When senior citizens, at whatever gathering place, become actively engaged in good health practices, then we start addressing the problem. So long as we keep health promotion at an informational level only, it is not going to change the health patterns of our senior citizens.

Senator BINGAMAN. I appreciate very much the efforts you have put into preparing your testimony and your answers to these questions.

Our intention is to have a second panel and then break for about 15 minutes before we go to our third panel. Thank you.

The second panel is going to concentrate on what we have defined as "strategies for health promotion". We have four members of the panel.

let me begin first by apologizing to Dr. FallCreek. In my opening statement that had been handed to me, we indicated that she was in Roswell. She is not. She is at New Mexico State, which I knew. She is the director for Institute for Gerontological Research there.

Let us start with Dr. Lamy, who is with the Center for the Study of Pharmacy and Therapeutics for the Elderly at the University of Maryland. He has traveled here to be with us today. He is well known for his expertise in this field and has testified at several hearings before the Senate and the House.

Dr. Lamy, I should just say as a personal note before you start, your last name is a very famous name in New Mexico. I don't know if you're aware of Archbishop—we refer to him here as "Lamee". I don't know if there is any direct relationship there, but I think you should definitely claim it. He is a very popular historical figure in this State and is very beloved for all that he contributed here.

We're happy to have you here today. We appreciate you coming.

STATEMENT OF PETER P. LAMY, PH.D., BALTIMORE, MD, DIRECTOR, CENTER FOR THE STUDY OF PHARMACY AND THERAPEUTICS FOR THE ELDERLY, UNIVERSITY OF MARYLAND AT BALTIMORE

Dr. LAMY. Senator, thank you for inviting me. I will speak to the area of medicines and medications that the elderly take.

He is 83 years old; he is a veteran; he fought or his country in two wars and he came to us last week completely confused and depressed. He was on 15 medications. The response of the health care system was to give him an antidepressant. That's what we do.

I was delighted to hear Dr. Lin speak on behalf of Secretary Heckler and say we need to look at the safe and proper use of medicines. I am delighted because I would state unequivocally that we need to handle them safely and properly. They are looking for prescription guidelines for drugs for the elderly. We are still discussing how drugs should be tested, so that we know how drugs will act in the elderly. We have no idea. We have tested them for 3 months in young people and we give them for 10 or 15 years to old people. We don't know what drugs do when given chronically, and 60 percent of all drugs used are given chronically.

We do hear that 50 percent of all medical schools now have a component in geriatrics, and that is in surveys that are published and cited most frequently. But if you look, only 2 percent of the medical students took these courses because they are elective and not mandatory.

After my mother-in-law passed away I tried to find out what happened. The key, I think—and it was mentioned this morning—was that she had always said "But my doctor didn't ask me" and he afterwards said "She didn't tell me." We may know a lot, but we're not using it. It is that behavioral aspect, the lack of communica-

tion. We have much more content knowledge than we use. The elderly may be afraid to ask. We, as health care providers, certainly do not take the time to ask them.

We need to make the elderly an active participant in the health care process and not passive participants. That's important because while durgs are beneficial to the elderly, they may, indeed, adversely affect the elderly's functional status, the elderly's nutritional status, the physiologic status, and the mental status. If there is one thing that is a keystone to wellness and independent living, it is mental acuity. Drugs that are used incorrectly often impact very adversely on the mental status of the patient, causing confusion, depression and drug-induced dementia, known as pseudodementia, which we then either treat as disease entities or we ascribe to the symptomatology of old age. We expect the elderly to be confused and possibly depressed.

We do seem to take two steps forward and, as Dr. Lin reported, the initiative is exciting. And then we take a step backwards. The FDA is working on guidelines for drugs and the elderly, and then they approve a new drug such as Advil, a nonsteroidal, and nonsteroidals are known to cause confusion in the elderly and a whole host of other things.

But the key is to look at the Advil package. This panel is full of small writing. I would challenge anybody, if they can read it, to understand it. I wear trifocals and I can't read it any more. We pay for that, and yet we have new packaging available that State Medicaid will not pay for because it's new.

So, quite obviously, we know a lot more about drugs and their use than is being used in day-to-day prescribing. There is testimony by the American Society of Clinical Pharmacology and Therapeutics that much of it has to do with nonrecognition of the possible and potential toxicity of drugs by the prescribers, the physicians. Therefore, about 20 percent of the elderly are thought to be admitted to acute care hospitals because of adverse drug effects, at an estimated cost of $3 billion a year.

A major factor still often overlooked in drug action is nutrition. The elderly may be undernourished, with infection, and have a mortality rate of 28 percent, whereas well-nourished elderly have a mortality rate of only 4 percent, a sevenfold difference.

Another factor that is quite often overlooked is the elderly's ability to follow directions, or our ability to give directions. We say "take two drops in each eye twice a day." Well, let's think about an elderly patient with a Parkinsonian tremor and visual impairment. How in Heaven's name are they ever going to get two drops in each eye. They're not going to do that. It's going to fall all over their cheeks and the forehead, but certainly not into the eyes.

So this question assumes great importance, that the elderly can read and understand directions, and that we give directions.

We keep hearing that we need to develop new things. We developed 8 or 10 years ago a simple medication record that the physician and the pharmacist and patient would fill out what the patient is taking at any one time, so at least somebody knows what they're taking. Yet they are not often used.

The elderly make major medication errors and we have addressed that in many of our programs. I am pleased to say that

Secretary Heckler has given us an award of excellence for community-based programs, a program in which we prepare pharmacists, then students, and training them to talk with the elderly. This is our elderly program.

If I may digress for a minute, it's fun to talk to the elderly, but you have to know what's going on. I gave my first talk and I was very happy and I thought I was very effective. Then everybody got up and walked out. "General Hospital" came on and I wasn't aware of the soaps. So we need to understand the elderly. We go out and use a whole host of written material, "The Care Giver," "Vitamins Are Not Enough," and others, and have distributed 400,000 across the Nation.

In concert with the concern of the previous panel, we tell the elderly not only that they need to know about their diseases and deficiencies. We change their behavior. We get the elderly to ask questions and demand answers. That's their right and they're paying for it.

The second program we have is a visitation program, where we take our students, incoming pharmacy students. They must select an elderly in the community. They're telling us it's not in the catalog and why should they do it. We make them do it anyhow. They learn, No. 1, the aging network, and No. 2, they begin to learn that not all elderly are sick and sickly, that many are very sweet and many are very healthy. But some do need help, and students learn how to respond to that need.

Then we have the Care-Giver Program. I think it is probably the most important program in view of the developing health care system. The home health care market is exploding. I don't think we really know how to handle it. So what we are doing is we are sending people into the homes—and they're not getting paid for it. There is no Government program that will do that. We're looking at the medications they take and the nutrition they have or don't have, because quite often the elderly must make a decision on whether to buy a prescription drug or to buy food for nutrition.

We have good data that shows that only about 70 percent of all prescriptions, indeed, are filled, and 30 percent are not filled. This is because they bought food that week.

The Care-Giver Program is important, I think, because the care-giver is changing. There is a perception of the care-giver being a 40-year-old female taking care of a 65-year-old mother, but it may be 73-year-old son taking care of a 93-year-old father. So what we are doing, we are teaching the care-giver, so that when they get to older age they won't make the mistakes the current generation is making, and we are helping the elderly.

There are a whole host of other programs. We are helping industry in developing programs. Parke-Davis developed an Elder-Care Program which addresses the need of the pharmacist and physician to talk to the other.

But I am sorry to say that there are problems coming. I feel that while the FDA is looking at how drugs should be handled by the elderly, they are also giving out lists of generic equivalents and State Medicaid programs mandate their dispensing, not taking into consideration that there are special patients and special diseases and special drugs.

We have heard about mental disease. For psychotropic drugs, the FDA will accept as an equivalent to the innovator drug, a generic if in 70 percent of the patients it is 70 percent equivalent. I don't think that's good enough.

We need to look at many things. We need to look at new kinds of packaging, and we need to reimburse for it so that we can keep the elderly at home where they want to be and where they would like to be because they are independent.

I thank you, Senator.

Senator BINGAMAN. Thank you very much, Doctor. We appreciate that testimony. I will ask you a question or two after the other panelists have completed their testimony.

Dr. FallCreek, as I indicated before, is director for the institute for gerontological research at New Mexico State. She recently authored a book about healthy lifestyle in the elderly. As I understand it, she will focus on some of the same things she discussed in that book and what they are doing at the institute.

Please go right ahead. We're happy to have you here.

STATEMENT OF STEPHANIE FALLCREEK, D.S.W., DIRECTOR, INSTITUTE FOR GERONTOLOGICAL RESEARCH, NEW MEXICO UNIVERSITY, LAS CRUCES, NM

Dr. FALLCREEK. I want to thank you, Senator Bingaman, the Senate Special Committee and your staff, for the opportunity to address the committee and also this distinguished audience of older persons and other interested people.

Physical fitness is a vital ingredient in any prescription for a healthy old age. Dr. Robert Butler, former director of the National Institute on Aging, has said, "If exercise could be packaged into a pill, it would be the single most widely prescribed and beneficial medicine in the Nation." Unfortunately, or maybe fortunately, it can't be packaged into a pill. It is important to remember that an "exercise prescription" does not necessarily have longivity as its goal, rather maximum function and independence throughout life is the goal.

Many excellent programs and several good models exist in fitness with elders, in senior centers, in health centers, in churches, in recreational programs, and in many other settings across the country. North Carolina, for example, has a statewide fitness program called AHOY—Add Health to Our Years. This program, which is 4 years old, has already trained more than 6,000 older people in basic physical fitness programs for themselves. New Mexico's own health promotion with elders project has 25 older persons working with their peers in senior centers across the State. This represents only one of New Mexico's several activities which give life to the spirit of the Federal initiative of the Public Health Service and the Administration on Aging.

Other model programs, such as Senior Olympics, Senior Games, "body repair shops," Growing Younger, and Growing Wiser, represent some of the kinds of activities and programs taking place across this country. But they are taking place in scattered locations rather than offering fitness opportunities to all elders. Those who

may need exercise the most are likely to be neglected in many of these programs.

Despite the existence of these types of programs, and despite the evidence in support of the benefits of exercise to elders, evidence suggests that elders participate in regular exercise less than most other age groups. In fact, it looks like our youngest citizens and our oldest citizens are those least likely to engage in physical fitness programs. A recent study of the President's Council on Physical Fitness in Youth, for example, found that youth between the ages of 7 and 17 are more overweight than they ever have been in the history of this Nation. In some respects, that finding is comparable to what we have been seeing in terms of physical fitness in older persons. I think that we might consider these intergenerational issues as we develop physical fitness programs, in order to develop fitness strategies which reach across the lifespan.

It looks like older women participate in exercise less than even older men. Low-income older persons and ethnic minorities appear to engage in and experience the benefits of exercise programs even less frequently.

Why is it that this seems to be the case when the benefits are so clear? First of all, I think the fact is that in spite of many good information dissemination efforts, many people are not aware of the real benefits of exercise to older persons. I therefore will briefly suggest some of them.

Improved cardiovascular fitness and reduced risk of heart attack. Research suggests that not only can cardiovascular and muscular decline be slowed down, but with regular exercise in many cases oxgen transport and vital capacity can actually be improved. The process can be slowed down and in some can be reversed.

Second, in the prevention of osteoporiasis fractures, exercises which involve weight bearing on the muscles and bones of the body are one good way to reduce calcium loss, particularly among older women. Not only does exercise slow down the loss of calcium from the bones, but it increases muscular strength and serves to protect the joints and the bones so that when falls do happen, the consequences may be less serious. Exercise which focus on flexibility and strength minimize the risks of falling in the first place.

Third, reducing the risk and impact of hypertension. Research suggests that exercise can reduce hypertension, particularly those with moderately elevated blood pressure and those who have serious problems with obesity.

Fourth, minimizing the impact of arthritis. Exercise certainly will not cure arthritis. It is probably the strongest measure that we have to control the symptoms and to maintain range of motion and flexibility. Aquatic exercises, for example, which do not place strain on arthritic joints and tensed muscles, may be particularly recommended for older persons.

Fifth, coping with insomnia. Older persons have identified difficulty with sleeping and inability to sleep as a major health concern. Exercise has been shown to reduce insomnia and to result in people going to sleep more easily and sleeping for a longer period of time.

Sixth, increased energy. A regular exercise program usually results in people having more energy to do the things that they want to do with their lives.

Seventh, reduction and/or control of anxiety and mild depression. Incidentally, that may be particularly significant in a State like New Mexico, where our problems with alcoholism and suicide rate are many times the national average. If we can prevent those things before they become a problem, we will be doing everybody a favor.

Eighth, an improved self-concept or self-image. Maintaining a high level of fitness, feeling like one is in control of one's own body, contributes greatly to an individual's sense of independence and ability to exercise self-responsibility.

Finally, it appears that motivation to improve health behaviors in other areas such as nutrition, stress management, communication skills, may be increased with exercise. Therefore, exercise may be an ideal starting point for a comprehensive personal health promotion program. Often those individuals who undertake an exercise program find themselves almost unconsciously beginning to make healthful changes in other areas of their life. For example, people who begin a strenuous walking program, who engage in regular walking exercises, often find themselves more ready to quit smoking than if they had not undertaken such a program

A second major reason why we don't see older persons beginning to get into exercise programs has to do with attitude, not just the attitude of elders themselves, but the attitudes of those who work with elders and those who care for elders.

Most elders in the market study that was mentioned earlier indicated that poor health was the primary reason that they had not been involved in a regular exercise program. The fact of the matter is that poor health should be a primary reason for beginning to undertake an exercise program. We are sometimes literally killing our elders with tender loving care when we do for them what they could do for themselves, and that applies to very simple things. For example, when the "Meals on Wheels" volunteer delivers the meal to that person in their own home, it would have been the tradition for that person to get up and walk, however haltingly or slowly, that "Meals on Wheels" delivery person to the door. And what does the person say? "No, no, Mrs. Jones. I can see myself out," rather than allowing that person to do for themselves what they could and get the exercise benefit of getting up out of that chair and walking to the door.

Along with those attitudes may be a belief that engaging in physical exercise is dangerous to the health of older persons. Ninety-nine percent of the time that is simply not the case. An exercise program can be developed for and undertaken by someone in any level of health at any age.

There are certain medical conditions that suggest exercise should be undertaken under a doctor's supervision. There are other conditions that suggest that some kind of a physical examination or a screening should take place before an exercise program is undertaken. It is important for people to know those conditions; it is also important for people to be aware that for most persons medical su-

pervision and medical intervention is not necessary in order to have a healthy exercise program.

Physician attitudes and level of knowledge about health in elders may be one of our greatest challenges to getting exercise programs going for older people. Research suggests that doctors prescribe or recommend exercise for elders as part of a treatment package less than for any other age group. In fact, they may actively encourage elders in reduced levels of health to undertake a more sedentary lifestyle.

Again, exercises designed to respond to the needs and abilities of even severely disabled individuals can be developed. A very significant study undertaken in Wisconsin, which institutionalized elderly persons, involved having people do a series of exercises while they were seated in a chair. These were primarily nonambulatory nursing home residents. After participation in this program, the elders who participated had significantly less—approximately 4 percent less calcium loss than those elders who did not participate in the exercise program. I think you can see the importance of something like that when it is translated even to those who are already in an institutional setting.

Numerous projects within the last 5 years have indicated that not only are older people interested in exercise, but they are willing and able to begin exercise programs. I think that that was again validated by the market study that was referred to by Dr. Lin and Mrs. Mervine, which said that older people may even have a stronger interest in undertaking health promotion behaviors than people in other age groups.

If we recognize that exercise programs are beneficial to older people, I think it's important for us to specify what constitutes a balanced exercise program; that is, what is an exercise program that will result in the kinds of benefits that we're talking about. Basically, an exercise program for elders would include the same components that an exercise program for younger persons would include. It would include flexibility exercises, strengthening exercises, endurance building and cardiovascular exercises, and balance and coordination building exercises.

The benefits that we talked about before are sort of abstract. Improved cardiovascular fitness. What does that mean to an older person? Well, there are some tangible benefits that aren't up there in the realm of the abstract. Flexibility exercises are needed for maintaining the range of motion needed to dress one's self, feed one's self, reach for objects on shelves and pick up one's house. Strength is important to carrying one's groceries, picking up a grandchild, maintaining proper posture to avoid backache or muscle strain. Endurance is required for holding down a part-time job, keeping up with one's partner in ceremonial dances, being able to walk to the grocery store or senior center, and being able to travel to visit relatives of friends. Balance and coordination are needed to prevent falls, play sports, and do your favorite dances, drive a car or board a bus.

I want to emphasize in these comments that it is primarily the exercise class of life that we're talking about, not necessarily some specific popular exercise routine or regular costly trips to the "Skinny Lady Health Spa."

No one was ever institutionalized because they couldn't do jumping jacks and calisthenics. It is the ability to undertake the activities of daily life that keep an older person independent, dressing one's self, feeding one's self, and taking out the garbage. Inability to accomplish those activities can in the extreme case lead the individual into an institutional care setting. In any case, reduced ability to engage in these everyday life requirements seriously limits the individual's ability to care for him or herself and enjoy life to the fullest extent possible.

In order for us to begin to make these benefits of exercise programs available to and experienced by a majority of elders, several things must occur. First of all, we do need additional dissemination of information about exercise and aging, including use of commercial media outlets, which focus on the benefits of fitness, common sense, and low-cost approaches to exercise programs, and the appropriateness and safety of exercise for elders.

Second, we need additional State and federally supported research and demonstration activities to develop a variety of best practice models for elder fitness programs which respond to the distinct and different needs, interests and abilities of culturally, ethnically, economically diverse groups of elders in all levels of health.

We need educational programs in fitness and aging for students preparing for careers in aging.

We need training programs in fitness and aging for professionals, paraprofessionals, and volunteers who are already working with elders in a variety of settings.

Finally, we need training and technical assistance as well as financial incentives for agencies and organizations who want to initiate or expand fitness activities with elders.

In conclusion, I would like to emphasize three important considerations in supporting health promotion programs with elders.

First, it is important to design and use sound, sensible approaches to exercise which have been demonstrated to be effective, safe, and based on scientific knowledge. It is equally important to realize that given good training and backup, elders themselves can deliver safe, successful, and effective physical fitness programs with their peers in a variety of settings.

Second, interventions and programs to promote health are lifespan strategies. To be most effective, they must cross age categories and touch people of all ages in different levels of health. Fitness can be an intergenerational and/or family affair. Although there may be specific techniques and special emphases which apply to elders, the underlying principles and benefits of fitness apply to people throughout the life cycle. Programs which actively involve elders themselves and their families will promote not only the health of elders, but also other family members, and the health of the family unit itself.

Finally, the benefits of a good fitness program with elders are compounded dramatically when combined with participation and healthful changes in other health-promoting activities, such as nutrition, stress management, communication skills, medication management, accident prevention, and preventive screening services. All of these areas are critically important if we are to achieve the goal of optimum health and maximum independence for older

adults in this country. Many of the programs that are needed in research, model development, education and training apply equally to all areas of health promotion. An integrated strategy of encouragement and support for these health promotion activities with older persons will ultimately be the most effective.

Thank you.

Senator BINGAMAN. Thank you very much. We appreciate that. Again, I will have a few questions when the other witnesses have completed their testimony.

Our next witness is Pat Cleaveland, who is with the nutrition division of the department of health and environment for the State of New Mexico. She is going to explain the nutritional needs of the elderly and propose some guidelines about nutrition that will contribute to more healthy lifestyles for senior citizens.

Pat, thank you for being here. We look forward to your testimony.

STATEMENT OF PAT CLEAVELAND, M.S., SANTA FE, NM, HEAD, NUTRITION SECTION, HEALTH SERVICES DIVISION, HEALTH AND ENVIRONMENT DEPARTMENT, STATE OF NEW MEXICO

Ms. CLEAVELAND. Thank you, Senator Bingaman, staff members, panelists and audience. As the United States and world population ages, one of the major challenges to the health care professions will be to understand the relationship between nutrition, aging, and health.

Malnutrition may be one of the major health problems of the aging. Based on major nutrition surveys, it is estimated that half of the aged consume diets containing less than the recommended levels of nutrients. The unknown is what effect inadequate diets have on the aging process.

Chronic diseases such as coronary heart disease, hypertension, diabetes, and obesity are recognized to be closely linked to malnutrition or chronic overnutrition. Because 85 percent of those persons 65 years of age and older have some form of chronic disease, many of the nutritional problems of the aged are closely associated with chronic disease. Inadequate or excessive nutrition contributes to the development of chronic disease, hastens the development of degenerative diseases of the aged, and increases susceptibility to and delaying of recovery from illness. Conversely, changing eating habits to improve nutrient intake is also looked upon as a possible means of therapy for some conditions.

A person's nutritional status is influenced by numerous factors. Loneliness, depression and isolation may cause a person to lack the incentive to prepare meals and may cause a loss of appetite. Lack of physical activity will reduce a person's overall sense of well-being and may reduce the efficiency of the body's absorption and metabolism of nutrients. Emotional stress or physical trauma seem to increase the body's need for nutrients. Many drugs and medications interact with nutrients to make them less available to the body or increase the body's needs for these nutrients. Inadequate incomes characteristic of a large number of our older citizens reduces the person's ability to purchase a nutritious variety of foods.

Food habits learned early in life tend to remain a cherished part of the person's life, even though those habits may be inappropriate.

Approximately 80 percent of adults in the United States suffer from some form of periodontal bone loss. Untreated periodontal disease leads to dental problems for the elderly person which may make the foods that the person likes and are affordable difficult to eat. A reduced sense of taste and smell may further reduce food intake. Difficulty in getting out to purchase foods may cause inadequate food intake for many persons. Americans are bilked of over half a billion dollars a year by food quackery through appeals to their fears of illness and ill health. Older persons are especially vulnerable targets for promoters of expensive miracle foods and supplements. The result is a further reduction in the person's ability to acquire the foods they need.

In spite of all of this information, health care experts don't really know about nutritional needs of the elderly. We have recommendations defined for persons 51 years of age and older by the National Research Council. However, those are based on extrapolated figures from the normal adult, whoever that is. Little is really known about what is actually needed for the older person.

We do know that, as persons get older, their total calorie intake tends to decline as their basal metabolic rate declines. But sometimes that decline in food intake isn't enough, so then we end up with obesity problems. Conversely, we also have persons whose energy intake is inadequate to meet their needs, particularly the person over age 70. As the quantity of food the person takes decreases, the nutrient intake also decreases.

What we find happening then is the person obtains enough calories for their needs, but then doesn't obtain enough other nutrients to meet their needs.

Although protein intake is normally adequate in the U.S. population, among the older persons who may have a reduced income or difficulty in chewing, meat consumption may be reduced. So protein intake may be a problem for those persons.

The average America diet tends to be fairly high in fat. We know there is a definite relationship between the development of cancer, heart disease and obesity to high fat intake.

Many studies of the diets of older persons indicate inadequate intake of B vitamins and vitamins A and C. That is because fruit and vegetable consumption tends to be lower in older persons because of food habits, cost, or difficulty in getting to the store frequently. At the same time drugs and medication can increase the person's need for vitamins.

Calcium and iron are frequently consumed in inadequate quantities. Another one of the foods that people frequently don't use during the later years is milk. We now have increasing evidence that osteoporosis is a result of lack of exercise and lack of calcium, the two together. Iron deficiency anemia is a problem for a significant number of older persons, simply related to an inadequate intake of iron, which frequently is the result of low intakes of meat, also. On the other hand, sodium is often consumed in larger quantities than is needed by older persons, especially those whose sense of taste may be affected by the aging process. For persons with hypertension, high sodium intake may be harmful.

There are numerous other vitamins and minerals about which we have real questions as to whether the normal person is getting enough. It is clear that poor food habits compounded by over- or under-nutrition, over-or under-consumption of calories, and difficulties with access to adequate food result in increased susceptibility to disease, greater debilitation as a result of that disease, and possibly more rapid degeneration as a result of the aging process.

Now, what do we need to do to improve that situation? First, we recommend that prevention of a problem is always preferable to dealing with the problem after it occurs. It is clear that a lifetime of positive food habits is the best preparation for healthy later years. Nutrition education should be required as a component of all food and nutrition programs and health programs with adequate funding to support qualified nutrition educators.

One of my personal gripes is that we often define nutrition services as giving food to people, and that is only a small part of it. It limits the number of people who can receive nutrition services. Nutrition education through the person's lifetime can have a far greater impact on a person's health.

Periods when a person is most receptive to nutrition education include childhood when food habits are being formed, during pregnancy and early parenthood when concern for the child's health is a strong motivating factor, and during adulthood and later adulthood when health problems or concerns begin to arise. Nutrition programs should build on these times of interest to encourage improved food habits through nutrition education efforts.

One of the projects of the nutrition section of the health and environment department in the area of adult nutrition has been the development of a comprehensive weight management program for use in public health offices by public health staff to teach the importance of diet and exercise to the adult population. Many people are concerned about weight. They don't recognize that there is a relationship between weight and adequate nutrition and exercise. This is a method then of teaching the importance of nutrition and exercise while dealing with a problem that is perceived by many people as a serious one, while it is also a way of helping to prevent many of those chronic diseases that we're concerned about in the older population. This program is now being offered in many county health offices within the State.

The USDA Nutrition Education and Training Program provides nutrition education to teachers, school food-service workers and students. However, funds have been reduced during the 7 years of the program. A stronger nutrition education component in food stamp and senior nutrition programs is badly needed to improve program effectiveness.

Second, in order to better monitor the nutritional status of the population and to better target food and nutrition programs, an improved system of nutrition monitoring and surveillance is needed. The system should provide timely data; data from different surveys should be planned to be compatible so that data can be linked and compared; data should be available by population subgroups and by geographic area; the data reported should be accessible, and the system should identify warning signs to help us recognize at-risk populations before health problems occur.

Better information is needed about the nutritional status of the elderly and the nutritional needs unique to this population. A research program to determine food intake and nutrient needs specific to the older population, other than a perceived belief about what people are doing, is needed.

The National Nutrition Monitoring and Related Research Act of 1984, as Senator Bingaman mentioned awhile ago, if enacted, could significantly improve the status of nutrition monitoring and research. We certainly appreciate Senator Bingaman's interest in this bill.

Third, we must reveiw our programs to assure that limited income does not result in limited food intake. Food assistance programs must emphasize outreach and build a more positive image with the public so that there are no barriers for the needy person to prevent program participation.

We know that less than half the people who are eligible for food stamps ever apply, even.

Fourth, for those persons with special dietary needs, information on nutrient content of foods should be more available. Although significant advances in food labeling have been made, it is still difficult for a person to really know what is in the package when they're in a grocery store.

Fifth, the importance of the nutritionist/dietitian as part of the health care team must be recognized. Medicare reimbursement for nutrition services is limited. Better training in nutrition for all health care professionals is needed as well.

The nutrition section of the health services division of health and environment department is committed to providing nutrition information to all citizens of New Mexico as a means of preventing health problems later in life. We appreciate this opportunity to discuss nutrition problems of the elderly with you.

Thank you.

Senator BINGAMAN. Thank you very much, Pat. I appreciate that excellent testimony.

Before we go on to a few questions, let's hear the testimony from Catherine Salveson, who works for the department of health and environment for the State of New Mexico. She serves those who have some type of illness and also particularly focuses on the rural elderly. As I understand it, she is going to discuss strategies that can be used to promote health among those in the rural areas of this State in particular, and we are very happy to have you here, Catherine.

STATEMENT OF CATHERINE SALVESON, R.N., M.S., SANTA FE, NM, HEAD, ADULT HEALTH SECTION, HEALTH SERVICES DIVISION, HEALTH AND ENVIRONMENT DEPARTMENT, STATE OF NEW MEXICO

Ms. SALVESON. Thank you, Senator Bingaman. I, too, appreciate the opportunity to share our thoughts on strategies for health promotion. My comments are not availabe to you in written form today because I have spent the last 3 days traveling throughout the southern part and eastern part of the State meeting with rural primary care providers of local county health offices, looking to exact-

ly the issues we're talking about here today. I have included their remarks in what I will be sharing with you this morning.

The necessity to pay closer attention to the continuing care needs of the elderly was documented in the 1980 New Mexico State Health Plan. The increasing prevalence of chronic and disabling conditions, coupled with the aging of our population, urged a response by health care providers to ensure that persons with such conditions were able to function at an optimum level for as long as possible. This is the essence of health promotion.

Today, more Americans are living to age 65 than ever before. The life expectancy increased from 47 years in 1900 to 73 years in the late 1970's. In 1900, 4 percent of the U.S. population was 65 and older, while this group now comprises over 11 percent of our population.

The health condition of this growing population is not necessarily favorable, as we have heard here today. Based on a 1976 health interview survey conducted by the U.S. Center for Health Statistics, 45 percent of the people over 65 have more than one chronic condition that causes some activity or functioning limitation in their daily lives, and 10 to 20 percent are functionally disabled who may still be at home. It is these individuals who need the continuing health promotion that we are talking about here today in order to maintain their independence.

These kinds of services can be provided in a great variety of ways. The New Mexico Statewide Health Coordinating Council adopted a definition of continuing care services as those services which are provided to individuals with persisting physical and mental ill-health conditions in order to prevent deterioration of the condition, as well as services provided to individuals in need of assistance in their activities of daily living. This is the promotion of their present situation.

Unlike young people, who look at health promotion as something that will make them feel better than they feel today, in many ways looking at the rural and the frail elderly, health promotion needs this status quo, to stay where you are now is to promote your health. Not to have that health promotion is to encourage and facilitate one's eventual demise.

Now, I wanted to talk specifically about people in rural areas, which is what I have been doing all week. Here in New Mexico, which is basically a rural State, we have a great many older people living in rural areas where it is difficult to get coordinated community care. The service are often not there. In 11 counties, we have over 10 percent of our population over the age of 65. In one county we have 50 percent of the population over 65 during the winter months—the snowbirds that come to visit New Mexico.

Other counties have very high rates, and most of these are rural counties. De Baca County, 18 percent of the population currently; Union and Harding Counties, over 15 percent of the population is over the age of 65. I might add that these are counties which in the last census showed a decline in population, so at a time when we have more older people living in rural areas, we find that the young people are moving into urban areas in order to find jobs. These are the young people who are often the ones who are available to provide the continuing care that these older people need.

Of particular concern to us are the frail elderly. These are people over the age of 75. They are at a time in their life where they are both experiencing a decline in their health and a decline in their income. In New Mexico, we have 2.5 percent of our population that falls within this age range. Only nine counties in the State fall below this 2.5 percent. And yet, in many rural areas these old, old people are continuing to maintain themselves independently: 5.2 percent of the population in Colfax County; 4.8 percent in Quay; and 9.2 percent in Sierra County. These are the folks who need our adult care services for their health promotion, to maintain the status quo, to stay in their homes, as we have heard today, is their wish. We are looking at them as those who need the most support.

Now, I would like to take a few minutes to just look at what are the realities of health promotion. Current chronic conditions are the result of a lack of health promotion over the past 50 years. Health has become very popular in the United States in the last 15 years. Fifty years ago we saw physicians advertising cigarettes in the Nation's leading magazines. So the results of health promotion were not available to many older people who now suffer from chronic conditions because their health wasn't promoted. We find, then, that there are four general factors which affect an individual's health status. These have been identified to be their environment, both social and physical. And I might add that housing has been identified as a major factor in a person's health status.

The second is availability of health care resources, and this is what the majority of my comments are focused toward.

Third is the genetic makeup. If you have diabetes or heart disease in your family, you are at greater risk.

And fourth is your lifestyle, which both Pat Cleaveland and Stephanie FallCreek have addressed very specifically, in terms of what people eat and how much exercise they get.

Of these four factors, the one which makes a significant contribution to an individual's well-being or lack of is their lifestyle. This is also the area over which the individual has the greatest amount of control. Thus the state of health in which people find themselves when they become older can be, to a large extent, attributed to their health habits that they developed and practiced during their younger years.

In New Mexico, the prevalence of low incomes, rural areas, and the inability of health care resources throughout our history further impacts these older people who live in rural areas. An analysis of the leading causes of death in 1976 in the United States indicated that one-half of the deaths could be attributed to our unhealthy behavior and lifestyles. According to the 1978 Public Health Service's report on disease prevention and health promotion, the incidence of 7 of the 10 leading causes of death could be reduced if healthier habits were promoted and practiced.

We talk about the public health revolution. We once had a public health revolution in this country, which was for the control of contagious disease, so that we could have clean water, control tuberculosis, and the flu. Now we are moving into the second public health revolution where we're talking about this prevention effort, that our lifestyle is really what we need to change.

Unfortunately, most of those efforts are aimed at younger people. As the director of the adult health section in the Health Department, I face competition for funding with programs for younger people. We look to see that 85 percent of our activities in the Health Department are directed at child health, to provide family planning to young women who want to control their childbearing, to provide risk reduction to people in their middle years so that they don't face chronic disease. Fifteen percent of our activities are addressed toward chronic disease and toward adult health promotion, so we are looking at a move in this country where many of our health-care dollars are directed to prevent disease in the population. However, for people who already have those diseases, that weren't prevented by our public health departments 40 years ago, they continue to have to live with as problems.

The next point I would like to make is that the whole concept of health among older persons is different than it is for a younger person. For an older person, health often means independence. To be healthy is not necessarily to get up in the morning and be willing to go out and jog for 2 miles, but to be able to get up in the morning, fix your breakfast, and visit your friends; to maintain one's independence is to be healthy. Therefore, any effort to keep the person in their home and in their community is health promotion.

We heard spoken of earlier our efforts here in New Mexico toward a coordinated community care effort. We feel very proud that over the last 3 years many agencies have gotten together to face what our future would be in terms of institutionalizing people for care, and that we need to find ways to keep these people in their communities.

This New Mexico response is also seen within the State health department. Our new director, Dr. Fitzhugh Mullan, who recently came to us from the National Institutes of Health and was prior director of the National Health Service Corps, is calling for what he calls a community-oriented primary care system which works toward a comprehensive care system built on the local level that is acceptable and accessible to people, culturally, economically, and geographically that is coordinated between all agencies. We are currently working, which I have been doing for the last 3 days, with primary care centers in very rural areas—in Hatch, in Loving, in Portales—coordinating what's going on in the county health office, coordinating them, what's happening with emergency medical services, with the State agency on aging, with the local county commission, the extension clubs and church groups.

We find here that $50,000 has been set-aside for these primary care centers to apply for grants for the specific purpose of showing a coordinated effort at the local level to provide health promotion in their local communities. I am very happy to be part of that effort.

Finally, we are looking at the problems in health promotion that have to do with reimbursement support. As was already alluded to, less than one-half of 1 percent of the Medicaid budget has been going toward the support of home care. We would call for in rural areas, where we do not have the same kind of providers that are available in urban areas, that these amounts of funds be expanded,

as home care is the way we will be promoting rural people's health.

What are the needs of these rural people in their own minds? A survey was done in Dona Ana County, and when older people were asked what their biggest worries were, respondents indicated the following: of course, the first one was money, 25 percent; the second was health, 20 percent; the next two were families, problems with their families, 13 percent, and not seeing enough of their families, 10 percent. And fourth was transportation, almost 9 percent.

Another key factor and the most significant to measure health status of the elderly is the chronic conditions' effect on their functioning ability. The major causes of limitation that these people had included arthritis and rheumatism, which responds to exercise, heart condition, which responds to both diet and exercise, and visual impairment, which is certainly a preventive health activity.

For New Mexico, it is estimated that 36 percent of the population, age 65 and over, suffer limitations in activities due to the presence of conditions which could be corrected with preventive health care.

Looking at the PSRO data, which is our New Mexico Professional Standards Review Organization, we look at our cost of reimbursement. They listed what they saw as the major problems of older people. They came up with diabetes, hypertension, heart disease, arthritis, respiratory problems, and falls, all of which respond to preventive health care as we have addressed here today.

Finally, I would like to address access to care. We live in a cultural State. We are rich in both Hispanic tradition and native American tradition. In rural areas people practice their personal medicine through a variety of providers. We have found that in our health manpower shortage areas that it is often cost effective to send in midlevel providers, such as physician assistants and nurse practitioners. These people often work very closely with the local parish priest or the local curandero.

We currently face a problem, where financing for these individuals is being limited and being restricted. We are going to our New Mexico State Legislature to try to convince the legislators to allow physicians' assistants to continue to provide medications in rural areas. The State pharmacists feel this is not an appropriate activity. Yet if these medications are not available to be provided by midlevel providers, an older person in Hatch may have his blood pressure diagnosed by the clinician and have to drive 45 miles to pick up his pills. We all know whether or not that will be the life of those pills being purchased.

We finally look at the area of transportation, in that New Mexico, being a very large rural State, faces problems in these rural areas for primary care clinics. If their funding is jeopardized, people will have to drive from 1½ to 2 hours in order to get a physical assessment. Support for these clinics is definitely needed in rural areas.

In terms of the availability of services, I would like to just look at what we currently have. In New Mexico we have 43 field health offices and our services to older people basically come through the preventive health block grant. We much appreciate this Federal

support and look to it increasing in the future, as this is where our hypertension services, our cancer screening programs are supported. Much of this is used for older people.

Our primary care sites are in jeopardy as we look at health manpower service areas being redistricted and the National Health Service Corps having its funding reduced. We need these local clinics in rural areas as the rural areas cannot support themselves. Federal dollars that put doctors, nurses, pharmacists, and dentists in rural areas are the key to our health promotion for rural people.

Our visiting nursing and home health care services need to be given the waivers for Medicare that allow them to make their extended visits and to bring in occupational therapists to help an elderly woman who has had a fall stay in her home. Our senior citizen centers that provide meals need continuing support. Churches in rural areas need to be eligible to provide these kinds of services and expand who is able to apply for these moneys. And most importantly, volunteers. Here in New Mexico we place a lot of appreciation and support to volunteers who take blood pressures, deliver meals, go in and help a person with range of motion, or help someone with their activities of daily living.

Finally, through the Department of Labor, through the ACTION program, through senior visits, it is essential to the health promotion in rural areas.

In conclusion, I would like to look at what we would request for our legislative support. We know that financial incentives help. Could we not provide more to volunteers to use their own cars, perhaps a tax deduction, as they move throughout their community to provide health promotion.

Tax incentives for families who are willing to care for an older person at home, who would otherwise have to be institutionalized.

Matching funds for communities that are willing to build coordinated case management systems to take care of their older people.

Again, the medicaid waivers need to be continued and expanded, especially in rural areas, and to provide funding for nonparaprofessionals and for midlevel providers who go in and provide the majority of home care in low-income areas.

The creativity on the Federal level, through special incentives such as health promotion, is the key in New Mexico for the continuation of our development of coordinated community care, community-oriented primary care, and all of us working together to keep the older person at home, where they really want to be.

Thank you.

Senator BINGAMAN. Thank you very much, Catherine, for that excellent testimony.

Let me just ask a very few questions here, since we do have one additional panel. Dr. Lamy, I want you to answer a very general question, and in doing so, to add whatever additional thoughts you have.

If you had to identify one thing that the Federal Government should do, or could do, to help older people to remain healthy, would you describe what that would be? There are so many aspects to this problem that it's difficult for me to focus in and say there is one thing that the Federal Government could play a constructive role in.

Dr. LAMY. I would be glad to address that issue.

I think over the years we have looked at aging as a medical issue. We have had enormous amounts of money available to medical schools, medical merit awards and everything else. Aging is not a single health profession issue. It is not medicine, and aging is not a medical issue. We have to have a concentrated and concerted effort by many of the health professionals that we just heard, and the same advantages or opportunities that have been given to medical schools ought to be given to the other health professions such as pharmacists, dietitians, nurses, dentists, and whatever, because aging needs to be addressed on an interdisciplinary level.

Senator BINGAMAN. Thank you very much.

Dr. FallCreek, could you just tell me that status of the State and Federal funding that is available to promote the kind of exercise programs that you're describing and advocating here?

Dr. FALLCREEK. There is a tremendous variance from State to State, first of all. For example, New Mexico is practically unique among the 50 States in having appropriated funding specifically for health promotion for elders, to be administered through the New Mexico State Unit on Aging.

The State of North Carolina funds a position within their State Unit on Aging, for a health and recreation specialist, who supports these kinds of programs both with State and Federal dollars. Most States do not have any State-supported funds to do that, which focus on elders.

The Federal Government, through the Older Americans Act, as the money flows down into the area agencies on aging, provides an opportunity for area agencies on aging to designate some of their funding to go towards supporting physical fitness programs. At this time, however, very little of that money is used within area agencies in this country for physical fitness programming, and that is primarily because it goes to other services—to transportation services, to nutrition services, and to other equally important kinds of programs.

There is money, bits and pieces of demonstration grant money, occasionally available through the Federal Government to support projects in fitness and aging, although I notice in the most recent solicitation from Health and Human Services, under the discretionary grant program, there was no specific priority assigned to health promotion or to fitness/nutrition kind of programs with elders, which I thought was somewhat strange, given the Federal initiative, which has recently been promoted by that Department.

Senator BINGAMAN. Are you aware of the extent to which these types of physical fitness programs for older citizens are made available today in New Mexico? I know when I was in Farmington 6 months ago we saw posters there and discussed with the city the program that they have there, a physical fitness program for citizens over 50, I believe.

Is that a unique program or is that going on in many places?

Dr. FALLCREEK. It is going on in many places in the State of New Mexico. Again, I think in some ways that New Mexico can consider itself a leader in promoting physical fitness programs with elders.

For example, here in Albuquerque there is a very large and a very well organized aquatic exercise program. I think it serves sev-

eral thousand senior citizens within the Greater Albuquerque area. Many small towns throughout the State have fitness programs. There are still many which do not. My rough guess is—and this is just a ballpark guess—is that maybe between 20 and 30 percent of the senior centers in the State have some kind of organized, ongoing fitness program. Again, the project that George Ellis mentioned, that we have used State legislative funds to support, has made an initial step toward addressing this need. We are beginning to address that deficit by utilizing older persons themselves as the trainers and providers of fitness programs.

I think there are some important cautions that we need to be aware of in terms of training and screening, which we will do more of in the future. I think the peer trainer model may provide one very cost-effective vehicle for increasing the quantity and marketability of elder fitness programs. It also addresses a point that Catherine brought up, and that is, how do we support volunteers through stipends or reimbursement of expenses to begin to deliver for us those services, particularly in rural areas, where we will never be able to afford the kind of extensive, highly trained ongoing professional involvement in service delivery that we might like under ideal circumstances.

Senator BINGAMAN. Thank you. Pat Cleaveland, I was interested in your comment that nutrition promotion or nutrition education should be part of a nutrition program.

To what extent is that going forward, for example, in senior citizen centers, where they have meals available? Are there efforts in most senior centers, in this State or nationwide to also provide some instruction or education to people?

Ms. CLEAVELAND. There's a wide variety of efforts there. It is not a mandated part of the program as it is in a few of the other food and nutrition programs. George Ellis can probably answer this better than I as far as what's happening all over the State. My experience is somewhat limited to the senior areas, the geographic areas, in which I have worked.

In many cases the services have to be provided through volunteer efforts or through a person coming in from another program, not a regular part of the routine senior nutrition program in that center. So it varies widely.

I would guess—again, a ballpark guess—that probably 50 percent of the senior mealsites do provide some form of nutrition education, although the great majority of them do so on not a regular basis. You know, the extension worker is invited to come in, the district nutritionist may come in from public health, a nurse may come in, someone from the Diabetes Association may come in, so that it tends to be more of a one-shot deal when there is services there.

However, there is an effort in this State I know—but I don't know a great deal of detail about it—to hire nutritionists to work in geographic areas around the State, so it is something that they are working toward, the area agencies on aging, within the State.

Senator BINGAMAN. Let me ask one other question along these same lines.

You also referred in your testimony to the need to put a nutrition education component into the Food Stamp Program. Could you

be more specific as to what kind of a nutrition education component you are talking about and how you believe it should be implemented?

Ms. CLEAVELAND. There has been a lot of pilot projects, kinds of efforts to look at nutrition education as part of the food stamp program, and even before we had the food stamp program and we had the commodity food distribution program. But again, it tends not to be a routine part of the program that impacts on large numbers of people.

The kinds of things that are feasible includes, if the food stamps are mailed out to people, inserts into the envelope. In many cases there have been nutrition displays and demonstrations set up within the sites where persons are certified for food stamps or when they were coming in and got food stamps, if we were to use the WIC program as a model for the way to provide nutrition education within a food program, then we would plan it so that when people came in to pick up their food stamps, if that was the way food stamps were provided, then they would be scheduled for nutrition education at the same time. Their visit would consist of half an hour, longer than might otherwise be necessary, to sit in on a small group class, hear a film, hear a program on a distinct topic, be part of a food demonstration, that sort of thing. It could be done.

But at this point, having a program that organized requires money and staff.

Senator BINGAMAN. Let me ask Miss Salveson pretty much the same question that I addressed to Dr. Lamy at the beginning of the questions. If there was one thing you had to identify that the Federal Government could do to help in this area of health promotion for the elderly, what would you say that would be?

Ms. SALVESON. I think that the most important thing, certainly for the rural elderly, and all the elderly in general, would be to provide funds in a way such that they are accessible to a wide variety of providers, to a wide variety of communities.

Many times the eligibility criteria to apply for Federal funds are so limited that there is not really good creativity, where you don't have a community center but a church might want to apply, where you don't have a home health care agency but you might have a local nurse working out of a public health agency who would be willing to provide the service. But the restrictions in the legislation are that it can only go to an agency.

The need to be creative in small communities cannot be overemphasized, and also the importance of funding an appropriate provider. Most of the services that we talked about today do not require a physician. A midlevel provider, a physician's assistant, a nurse practitioner, a nutritionist, third-party payment and funding for this level of professional person is often limited unless they are under the auspices of an agency or physician. The waivers that have been provided, that allow a greater amount of home care, that allow other providers such as occupational therapists and physical therapists to go in over a period of time are very effective in terms of maintaining a person and are often much more cost effective.

Senator BINGAMAN. OK. Thank you very much. I think that was excellent testimony from all of you. I greatly appreciate your being here.

We will take about a 5-minute break so that everybody can stretch or use the restroom or whatever. Then we will have our third panel.

[Whereupon, a short recess was taken.]

Senator BINGAMAN. Let's resume our processing.

Before we introduce the next panel or start with their testimony, I want to recognize several people who are here or have been here in the audience because of their involvement in these issues, and because of the great distance some of them have come for this hearing.

Let me first thank our court reporter, Ms. Hill, who is doing an excellent job for us. I want to thank State Representative Ed Sandoval, who is chairman of the Health and Aging Committee for the State Legislature here in New Mexico. I don't know if Ed is here right now or not. Ed, stand up. We appreciate your interest. [Applause.]

All of these commendations you have been hearing, about how the State of New Mexico is out in front on some of these issues, I think certainly should be music to your ears.

Let me also indicte that Richard Brusuelas of the New Mexico Health Systems Agency was here earlier. Although Richard had to leave, we appreciate his help on these issues and in this hearing.

Elaine Monihan of UNM Hospital is here. Pat Johnson and Romona Flores Lopez of State HED are here. Winifred Conner from Clovis is here.

Frank Lopez from Nambé is the AARP State legislative chairman, we appreciate you being here. Larry Waterman, who is with the retired public employees, thank you for being here, Larry. Ray Batagalini with the American Heart Association, is here and we appreciate his interest.

Pete Madrid from the Espanola Senior Center is here. And Ersel Cordelle, who is with the National Association for Retired Federal Employees. We worked with Ersel on a lot of different projects and we appreciate his interest and his presence today very much.

Lyn Anher, with the Catholic Social Services, is also here today with us. We appreciate her presence.

Let me go ahead, then, with the final group of panelists and their testimony. We will try to finish today by 1 o'clock. Each panelist can present his testimony, and then I will ask a few question if there is additional time to do that.

The first witness on this panel is Dr. James Goodwin. Dr. Goodwin is associate professor of medicine and chief of gerontology at the University of New Mexico Medical Center. He is doing research on the factors that contribute to wellness in senior citizens, investigating psychological, sociological, and physical traits of senior citizens who consider themselves satisfied with their current state of health.

We are looking forward very much to your testimony, Dr. Goodwin, and we appreciate your being here today.

STATEMENT OF DR. JAMES S. GOODWIN, ALBUQUERQUE, NM, ASSOCIATE PROFESSOR OF MEDICINE AND CHIEF, DIVISION OF GERONTOLOGY, UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE

Dr. GOODWIN. Thank you, Senator Bingaman.

I guess I would like to start out by borrowing a line from one of my brothers. My brother Fred is scientific director of the National Institutes of Mental Health and he has to do a lot of testifying. One of the things he always tries to impress upon committees he is testifying before is that the American medical industry spends less money as a percent of its total costs in research and development than any other industry in the country. So that while we are expending huge amounts to promote health and to treat disease in this country, we are not spending an adequate amount of money or a comparable amount of money as do other industries in asking the questions of "where should our spending go; what health should we be promoting and how should we do it?"

One way of looking at that is—I have a quibble with Catherine Salveson who talked earlier about how all the smoking-related problems today are a result of the failure of health promotion 50 years ago. Well, 50 years ago no one knew that smoking caused disease. Some people had the opinion that smoking caused disease. But it is very difficult to set up large-scale programs based on opinion, as many people had the opinion 50 years ago—in fact, more people had the opinion 50 years ago, a strongly held opinion, that masturbation caused mental illness. So had there been an allocation of funds 50 years ago for health promotion, more money would have been spent perhaps in tucking little boys' hands behind their back than in telling people not to smoke. [Laughter.] So I think we need the knowledge. We know that smoking causes disease now and we can go out and promote health.

I would like to talk about some of the studies we are doing at the University of New Mexico involved in longitudinal study of healthy elderly people. This involves 300 people over the age of 70 which we have been following now since 1978.

In order to get into this study, they had to say they had no medical illnesses at all, and they also had to be taking no prescription medications. It turns out that some of those people, when we did a comprehensive physical screening on them, turned out to have chronic illesses and we included more until we could come up to 300 totally healthy people.

The overall question we were asking in this study is what keeps healthy old people healthy. The best way to do a study like this would be to take people at birth and follow them, but I didn't think I would be able to live long enough to do that type of study. So I took healthy people, most of them over age 70, and wanted to follow them at least over a 10-year period to be able to look at the characteristics of this population when they come into the study, to see what are the characteristics of some of these people that keeps them healthy versus characteristics of other of these people that leads them to go on to develop chronic diseases.

We were looking at many different attributes, and let me just go over a couple of them.

The first was what we call the immune function, which is how the white blood cells in the body work. The reason this became important is because it has been known for many years that older people have depressed immune function. The white blood cells in the body, which are responsible for rejecting infections, rejecting cancers, they fail as we get old. It turns out that they fail even in healthy old people. It isn't because some old people are sick. Even in healthy old people, some of them have rather terrible white blood cell function.

Now, my research and the research of many immunologists in this country over the past 15 years has been directed at the mechanisms of why these white blood cells fail and then what we can do about it. Several intervention programs have been successfully developed so that we now have medicines which can successfully stimulate the white blood cells of older people so that they act more normal.

The question became, is it important? I mean, we have these medicines, but should we be giving them? Maybe treating is worse than not treating. We didn't know for a fact that having poor white blood cell function was actually bad for you. So the overall question we were first asking in this study is, when we take these 300 people, follow them over 10 years, we separate them by a bunch of immunological tests at the beginning and those with poor white blood cell function and those with good white blood cell function and ask the very simple question: Does that matter? The people with poor white blood cell function, do they, indeed, get more infections; do they indeed get more cancers? If so, then we can go back with our intervention program and say, if we intervene with medication in this group to promote their white blood cell function, does this prevent these infections. But first we have to know whether they actually are at risk for getting infections.

We are asking a lot of other questions really in an analogous fashion. They are different questions, but we asked them pretty much the same way. For example, perhaps the major thrust of our study now is looking at nutritional function in the elderly. I should add that these studies are funded by the National Institute on Aging and also by the AARP-RTA Andrus Foundation and by several private contributors. We have a grant now from the National Cancer Institute also to fund this type of longitudinal study.

We turned in 1979 to begin to address nutritional issues. As Pat Cleaveland said this morning, there is just not much knowledge about nutrition. There is a tremendous number of opinions. But when you come in and try to develop a nutritional intervention program, a nutritional educational program, you have to have facts. You can't tell people your opinions because your opinions may change. Whereas if you have well-defined facts, they won't change.

So it is important to get information. There is very little information. We have things called recommended dietary allowances in this country, the RDA. On the box of Total it tells you that you're getting your recommended dietary allowance of 17 different vitamins and minerals for the day.

Now, many of the studies on nutrition for the elderly talk about whether older people who are free-living or who are in nursing

homes get their recommended dietary allowance, and it turns out that they, indeed, do not. This is not my work. This is work from several studies around the country.

Especially people in nursing homes, where I think all of us would agree that institutionalized people have a real hard time getting their recommended dietary allowance, even though it's in their diet, they don't eat their diet and they're at great risk for malnutrition.

It is somewhat ironic that Medicaid will not pay for multivitamins for people in nursing homes because no one has shown them that that's an important point, that vitamin supplement is an important aspect of being in an institution.

In any case, these requirements that we have, these recommended dietary allowances that we have, are all set on young people. They are all set on volunteers during World War II, conscientious objectors in their twenties, young men, also Quaker volunteers during the 1950's, where some very helpful and courageous people volunteered for these studies. But the one thing they all had in common was that they were all under the age of 30.

Now, the question is, Is any of this data relevant to people over the age of 70 or 80? That is one of the questions we are trying to address in our study, in that we are getting comprehensive nutritional information on these people in terms of how much vitamins and minerals they take in; we're getting blood levels of vitamins and minerals they take in.

We are identifying people who are getting less than their so-called recomended dietary allowance, which may be set too high or too low, or it may be just right, depending upon how similar a 70-year-old is to a 30-year-old in terms of their requirements. But we are getting all that information and then we are able to ask similar questions to the questions of white blood cell function. We are able to ask the question, is someone who is getting half as much vitamin C as we think they ought to be getting, are they really at risk for anything. Does getting half as much vitamin C put you at greater risk for anything.

I can just go over a couple of our findings there. One thing that startled us somewhat was that we had a well-educated population, a financially well-off population, a mobile population—this is a free-living population, where 48 percent are college graduates, which is very unusual for people in their seventies in this country, so it is an unusual population. Their nutritional intake would not be limited by income. In other words, this was not a poverty-stricken population. So they could get as much as they wanted, essentially.

Yet we still found some nutrients—for example, folic acid and pyridoxine, which they weren't getting enough of. They we asked the question, does this put them at risk for anything? Well, another aspect of this study is too look at their memory function, their intelligence, their abstract thinking ability, many aspects of what we call their cognitive function. What we found was that, indeed, when we separated out those people who were in the lowest 5 or 10 percent, in terms of either intake or blood levels for certain of these nutrients, particularly vitamin C, folic acid and vitamin

B-12, that these people did significantly worse on these tests of mental function and tests of memory.

Now that we have that information, we are developing an intervention program where we can ask the question, it we take a bunch of healthy old people and supplement half of them with multivitamins, and the other half with a placebo, does this have a significant effect on mental function. So, given that information, we can now ask the more practical question.

We have other findings that I could mention in the last minute or so. We found out a very unusual finding, one we totally unexpected, which is that our healthy old people are deficient in vitamin D. Now, vitamin D is supplemented in all dairy products. We can make vitamin D in our own bodies because of sunlight. We can cause conversion of cholesterol into vitamin D in the skin, and certainly New Mexico has a lot of sunlight. So the last thing I would have expected was to have vitamin D deficiency in our healthy old people, and yet we found that one-third of them had almost immesurable levels of vitamin D intake in their diet, and also levels in their blood.

It turns out that it is one of the side effects of another nutritional issue, which is that we have been telling people to cut down on fat and cholesterol in their diets. My people are very health conscious and, therefore, they have been avoiding cholesterol like the plague. They have been avoiding dairy products, which is where vitamin D is fortified. So one of the unwanted and unexpected side effects of them cutting down on their cholesterol intake—which has been the message of health intervention studies over the past 30 years—has been that they have cut down on their vitamin D and also their calcium intake.

Another health intervention project has been to get people to avoid sunlight so that they won't develop skin cancer, and that has the unwanted side effect of them wearing these huge hats and covering up on the sun so that they don't even make their own vitamin D.

Sometimes when we have very good intentions of health promotion, we have unwanted side effects.

We have also been studying psychological function in these people. We have been studying patterns of medical care of these people. I'm just listing these now rather describing them.

I want to finish by just mentioning that the University of New Mexico really has a variety of projects, not just through me but through many independent investigators at the university studying the problems of aging, either at a basic level—the chairmen of two of our departments, Dr. Bob Anderson of pathology and Dr. Bob Kelley of anatomy, are both internationally recognized as looking at aspects of agings.

Then in epidemiology, Dr. John Samuet and I are looking now at patterns of cancer care in New Mexico in the elderly, because there is an issue of the fact that sometimes older people with cancer don't get the same treatment as younger people because physicians may be afraid that they might not stand up to the treatment. We have just gotten a grant from the National Cancer Institute to look at that.

So there is a lot of ongoing research in aging, both at a basic level and at a more clinical level at the University of New Mexico.

Thank you.

Senator BINGAMAN. Thank you very much, Doctor. I will ask you a question or two after we hear from the other panelists.

Our next witness is Larry Curley, who is the executive director for the Laguna Rainbow Nursing Center and the Elderly Care Center at New Laguna here in New Mexico. Larry has been involved in issues affecting native Americans, Indian elderly, for many years. We appreciate his being here today and look forward to your testimony.

STATEMENT OF LARRY CURLEY, EXECUTIVE DIRECTOR, LAGUNA RAINBOW NURSING CENTER AND ELDERLY CARE CENTER, NEW LAGUNA, NM

Mr. CURLEY. Good morning, Mr. Chairman, Senator Bingaman. It is a pleasure to be here. Again, I would like to reiterate that my name is Larry Curley.

I think, before I go any further, what I would like to do is to introduce to you, Senator Bingaman, my grandmothers and my grandfathers from the Pueblo of Laguna who have come up here to check into what I have to say to you and make sure what I am telling you is the truth. Could I have the people from Laguna stand up, please. [Applause.]

Senator BINGAMAN. Let me thank all of them for being here. But many of these same people from Laguna have been in my office in Washington on issues affecting the elderly and the Indian citizens of this country. We are very pleased to see them here again today.

Mr. CURLEY. Thank you.

First of all, I am a member of the Navajo Tribe. I am working for the Pueblo of Laguna, working for the elderly of the Pueblo of Laguna, and as you have all heard earlier, I am the executive director of the Laguna Rainbow Corp. This corporation is an umbrella organization created by the tribal council of the Pueblo of Laguna to provide comprehensive services to the elderly Pueblo of Laguna. I think in that respect we have learned a lot in the providing of services for our elderly people. I am hopeful that we can continue to look to the Congress of the United States and the various administrations in the development of what I think is a model program for elderly people, specifically Indian elderly people.

It has been the philosophy of the Laguna Rainbow Corp. and the Pueblo of Laguna that our elderly people are very vital and very sacred resources in the community and that they need to be protected. This protection, we believe, is through the provision of services that meets their needs. We believe these needs can be met through the provision of services that meets the continum of care concept. It's a brandnew concept and this concept envisions the delivery of services that meets the whole need of the individual and not just an isolated fragment of their lives.

Therefore, the corporation has for the past 2 years been embarking upon the development of programs and services that does meet the total needs of the elderly community in our area.

We have, for example, a 25-bed intermediate care facility. We have a congregate housing project that provides also services to the elderly who reside within the congregate housing program. We provide them with meals, transportation, and personal assistance, with the idea that we will keep them out of the nursing home for as long as possible.

We are also beneficiaries of a program under the Older Americans Act Program called title VI. That particular program has enabled us to provide meals on wheels, congregate meals, an ombudsman program, transportation programs, for our elderly people in the community.

We recently received funding from the Department of Health and Human Services to develop a home health agency within our facility. We are currently in the process of implementing those. I think, for anyone who has ever decided to develop a home health agency, we all know the kinds of regulations and the various things that pop up left and right in implementing it.

We have also more recently—and I think this is a concern of not only the Pueblo of Laguna but of a lot of Indian tribes in the country today—and that is the development of intergenerational programs that bring young people and old people together, hoping to preserve and enhance the culture of that particular community for at least one more generation.

We have received funding to develop a child day care center within our nursing home using our elderly people as resources, as counselors, and hopefully as bearers of the continuation of the history of that community.

There are 109,000 elderly Indians in the United States today. Ten years ago, that was 64,000. That's an increase of 71 percent. We anticipate very easily that by 1990 that population will exceed 200,000. Pueblo of Laguna currently has 610, which is approximately three-tenths of 1 percent of this 109,000.

This hearing is on the promotion of wellness for the elderly through proper nutrition, and it seems to me that we in the Indian community need to present to you and the other people out there our reality, our perspective, on what wellness actually means. We believe that an Indian person is well when that person has a balanced relationship with the Great Spirit, respect for the environment and with all humanity. This, we believe, is good health.

Among the Laguna people, to eat and share food is a prayer and a thanksgiving. Food is used to physically sustain the body and as a means of relating to the Great Spirit and as a way to provide remembrance to those who have journeyed forth to the greater silence. And does it meet one-third of the RDA? [Laughter.]

I would like to think so. In a way, it probably exceeds the requirement because it has a much larger significance.

Over 50 percent of our Indian elderly in the United States today are living on incomes below the low-income level. Twenty-five percent of our Indian elderly take care of grandchildren in one way or another. Twenty-five percent of the Indian population age 45 today will never see their 60th birthday.

As a matter of fact, in a study performed by the National Indian Council in 1981, that study determined that Indian people, at the

age of 45, begin to exhibit physical characteristics of non-Indians age 65-plus. So, in effect, Indian people get older quicker.

Alcoholism is a major source of health problems among our Indian people. Just as a matter of record, 20 percent of our elderly people who are residing within the Laguna Rainbow Nursing Center are there due to the fact that in their younger years there was a lot of alcohol abuse. Yet, when I look around, I find that prevention efforts are minimal, if at all.

My own people, the ones that just stood up, are very concerned about the direction our country is embarking upon. A good diet? I firmly believe that missiles are not good for your health, nor can it be substituted for food. We need to maintain that relationship with the Great Spirit and more so to the remembrance for the people who have gone on before us.

Some of the Indian elderly in this country do not even have dentures nor the food processors nor the electricity to run the food processors to eat the food that they already have. Why? Because it seems to me that the Indian Health Service and this current administration has decided that they don't need the resources. Funds are being cut back. The Indian Health Service does not have the resources to provide prosthetic devices. Health education is a very needed program and is done minimally. So it does paint a very stark picture for the Indian community.

I would like to state that the Indian community is very thankful for the existence of the title VI program of the Older Americans Act, all 83 of us out of the 200 tribes and some other tribes don't have it. This program, in 1982, met the needs of an estimated 19,000 Indian elderly in the United States. This 19,000 is roughly 20 percent of the 109,000 that I earlier referred to. At Laguna, it met 25 percent of our elderly population's needs. Obviously, there are shortages.

Laguna health, as I indicated earlier, is an all-encompassing term in the community. Not only is diet a part of this term, but it also includes good mental well-being, good economic well-being, and good spiritual well-being. This requires the provision of services designed to meet these needs. We have always believed that the total person's needs must be met concurrently. I think the non-Indian community now refers to it as holistic health.

I am proud of the fact that the Indian people have been very patient with you all. [Laughter.] Specifically the medical community, for your enlightenment. We believe that exercise and physical activity is also necessary. As a matter of fact, I believe that the State of New Mexico is the only State in the Union that has an all-Indian senior olympics. Each year for the past 2 years our Indian elderly have taken to the fields, to huff and puff their way to gold medal glory. In the process, I believe they have learned the value of physicial activity and promoting healthy well-being.

As we try to meet the holistic needs, more aptly we find that our resources are not enough. I think you will hear that again and again across the country; that it often falls exceedingly short of the need. We believe that our treaties with the Federal Government require their assistance. Most often what happens when we begin to press those issues, our Federal agencies feign ignorance, nonresponsibility, and a fantastic amount of finger pointing.

We believe it is time, Mr. Chairman, that the Congress of the United States develop and implement a national Indian aging policy. This has been promised to the Indian communities, to the Indian elderly, in the winter of 1981 when Commissioner Tolliver indicated that this policy would be on the books by fall of 1982. I have yet to see that policy, and I think that one of the things that I have is a tremendous amount of patience. But when my hair starts turning whiter and whiter, I know I don't have that much patience much longer. I think a lot of our elderly here don't have the luxury of time. As a result, we have in the past 3 months—representatives from Arizona and New Mexico and the Navajo Nation—have proceeded to develop our own national Indian aging policy, and we should have that process completed by November, next month.

Obviously, you will be one of the first to receive copies of this policy, to you and your colleagues, and we have every reason to believe, Mr. Chairman, that by the fall of 1985 this will be a national policy.

Mr. Chairman, when you do receive the document, please review it in juxtaposition with what you have heard here.

On behalf of our Indian elderly in the State of New Mexico, and specifically the Laguna elderly, I would like to thank you for your efforts in the establishment of an Indian focal point within the Administration on Aging during the reauthorization of the Older Americans Act this past year. Mr. Chairman, we who work for our Indian elderly know that we do lack much. We lack a lot of services that we would like to have. We do need your help.

But I would like to say one thing. We are proud of the fact that we are Indian people. Let us continue to be Indians. We do have that right, and this country does have that moral responsibility to ensure that.

Thank you. [Applause.]

Senator BINGAMAN. Thank you very much, Larry. I think that was excellent testimony. We appreciate your participation in the hearing today. I will also have a question or two when we finish with the other two witnesses.

Our next witness is Dr. Marjorie Trujillo, who is a psychologist, who has done research on the mental health of elderly in New Mexico, focusing particularly on the Hispanic population. She is going to address issues related to mental health and how this facet of wellness has been promoted among New Mexico senior citizens.

Thank you very much for being here.

STATEMENT OF DR. MARJORIE TRUJILLO, PSYCHOLOGIST, SOCORRO, NM

Dr. TRUJILLO. Thank you, Senator.

As you have heard many times today, the comprehensive examination and study of healthy lifestyles of the elderly is long overdue. Certainly a number of programs on national, State and local levels address the emotional well-being of the elderly. Unfortunately, these efforts are often attached to other program endeavors such as nutrition programs, mental health centers, or nursing homes, and are offered only as ancillary services.

While these services represent a much needed function, it is important to note that the designated role of these staff members is within the context of other functions. Because of this, they seldom receive the administrative support or possess the level of expertise that the psychoemotional needs of the elderly demand.

In addition, service in any given community may be fragmented or duplicated. Undoubtedly, the spectrum of social and medical support services available to the elderly in many of our communities is often inadequate.

Addressing the issues of healthy lifestyles for elderly can be a complex matter, as you know. I have grouped the topic into three basic areas, including, No. 1, the psychological issues and mental illness issues in late life. No. 2, the effects of physical illness upon emotional well-being, and No. 3, the effects of social economic factors upon emotional well-being.

A distinction needs to be made between psychological issues and mental illness. Psychological issues refer to adjustment problems and late life changes and stressful life events. These problems are seen as a function of increased stress that is not medicated by social supports or effective strategies in coping. While these problems are typically distressing and even debilitating, they are often transitional and seldom require psychiatric hospitalization. They may include concerns such as family dynamics, sexuality, psychosomatic disorders, hypochondria, loss of loved ones, and substance abuse.

Mental illness in late life refers to disorders such as organic brain disease, schizophrenia, depression, and suicide. The rates of diverse forms of severe mental illness of the elderly living in communities have been estimated to be between 5 and 10 percent, and we believe this is a low estimate, with a additional 10 to 40 percent of the elderly exhibiting milder forms of psychiatric impairment.

It should be noted, however, the percentages of impairment are much greater for the aged in institutional facilities. In considering these late life issues, it is important to note that the vast majority of the elderly are women; hence, special attention must be paid to the psychological problems unique to elderly women.

Poverty, which is a major risk factor in mental health problems, is especially prevalent among this group as well. Thus, it stands to reason that the Hispanic elderly are more likely to be a high-risk group, experiencing the incidence of mental illness and psychological problems.

Psychological problems of the Hispanic elderly are often significantly compounded by the physical and socioeconomic factors noted previously. The idea of retirement may be used as an example. For many elderly Americans, there is a period of transition into retirement where one may look forward to a slower and more relaxed pace in life. However, for the Hispanic elderly, there is often no retirement at all because, until recently, Hispanics, especially in the rural areas, had limited access to jobs which offered retirement programs, pension plans, or extended insurance policies. Hence, adjustment to retirement may not include leisure activities and time to pursue a favorite interest, but is characterized instead by more stringent and critical issues of adequate housing, nutrition, and health maintenance.

The Hispanic elderly are also affected by events that now affect the Hispanic population of the Southwest in general, that of rapid social change. This includes variations in family structure and general lifestyles. While the Hispanic family tradition formerly upheld intergenerational living, one now finds younger Hispanics participating in ever-increasing numbers, as they should, in the social mobility of the mainstream American population. Thus, as the family oriented communal pattern of life disintegrated rapidly for Hispanic Americans, so may the financial and emotional security and tradition that the elderly would share in an intimate and instrumental role in family solidarity.

Programs to deal with the maintenance of healthy lifestyles for the rural Hispanic elderly need to incorporate a realistic assessment of the poverty in which this group of people exists.

It may be important to designate staff to the specific task of recruiting or identifying elderly persons that qualify for special program assistance, such as food stamps, Social Security benefits, et cetera. Because, as you know, Hispanics tend to underutilize benefit and social service programs in general. We generally feel that there are two reasons for this. One is that the Hispanic people, like the Indian people and many Americans, are a very proud and independent people. They tend not to ask for assistance and would rely rather on close family ties for their needs.

Second, we believe that Hispanics cannot often negotiate the bureaucracy in order to receive the benefits that they deserve and are entitled to. Likewise, appropriate programs need to offer specialized services in addressing the needs of the elderly. Of particular importance here is the utilization of medical and mental health personnel who possess expertise in geriatric care and can produce truly therapeutic treatment plans for recovery from mental illness and psychological problems.

I will emphasize this, in that today we have talked about depression, we have talked about malnutrition, organic brain disorder, and there is a difference among these illnesses and what needs to be done in order to alleviate the distress the elderly suffer from. This takes very well-framed medical and mental health personnel. It is unfair of us to delegate these kinds of responsibilities and referrals to the well-intentioned social workers and nutritional aides that we now have in the communities. They do their job well, but it is unfair for us to lay this kind of expertise on them.

Last, I will comment on the need for persons in decisionmaking positions, Senator, to pursue the issue of Federal policy regarding the elderly. Toward this end a most urgent need exists, to view from a very comprehensive perspective the medical, housing, and social service condition of this group. Programs can no longer be expected to withstand the pressures of on again/off again funding and regulation changes that have to date plagued them. This pattern can contribute to only the breakdown of services and inefficient use of Federal dollars. Instead, programs need to be designed in a fashion that can accommodate the compounded needs of persons who may be at higher risk as are rural Hispanics.

Thank you very much.

Senator BINGAMAN. Thank you very much for that excellent testimony. I will have a question after Dr. Follingstad's testimony.

Dr. Follingstad is a practicing physician of internal medicine at the Lovelace Medical Center, the Senior Services Program there, as I understand it. He is going to explain some of the activities at the Lovelace Medical Center, which are designed to promote health among the elderly.

We appreciate you being here, Dr. Follingstad, and look forward to your statement.

STATEMENT OF DR. THOMAS H. FOLLINGSTAD, DIRECTOR, SENIOR SERVICES, LOVELACE MEDICAL CENTER, ALBUQUERQUE, NM

Dr. FOLLINGSTAD. Thank you, Senator, and thank you to this audience which has patiently ignored their lunch and nutritional needs so far. [Laughter.]

The Lovelace Medical Center is a hospital-based group practice with a multitude of specialists. We have developed a program, called the Senior Services Program, and we hope it does just that, serves our seniors. I would like to tell you about it and, in so doing, express our philosophy of health care delivery for this group of people.

First let me say that the emphasis is on wellness—it would have to be, of course, at this hearing—and on the delivery of excellent cost-effective diagnosis and treatment for those elderly who are unfortunate enough to be unwell.

First, what is "wellness"? I personally believe it is a state of mind and body such that an individual is able to function to their satisfaction in spite of the changes of aging and some chronic diseases. In other words, a wellness approach does not anticipate an unrealistic return to the full function of youth. This, after all, has been sought for many centuries and never found. We do wear out. Our bodies do have a finite end point upon which medical science, I am sad to say, has had almost no impact.

It is true that modern medicine has done a good job of curing many acute illnesses and of treating many chronic illnesses. It is for this reason that the average lifespan has almost doubled in the last century. Therefore, it stands to reason that we have many people who are making it into their eighth decade and more. What has not changed is your expectancy and mine, that we will last much beyond our 10th decade. In other words, as I said before, we all wear out. A concept of wellness seems to be a strange thing to try to fit into this rather grim sequence of aging, but it can, I am happy to say.

To realistically understand the well senior, we must cease considering the infirmities of aging as disease. The older individual whose aging eyes need glasses to read is no more diseased than the individual whose older joints have developed osteoarthritis through wear and tear. What we physicians frequently forget is that not everything we treat in the elderly is disease. This, of course, comes about because of the basic disease approach to medical training.

What we need is a program to help the elderly to gracefully progress through their later years with as much dignity and well-being as possible. I think the key to this is to involve the senior as much as possible in his or her health maintenance.

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This is best done, I think, by first assessing the individual's needs and health problems. At Lovelace Medical Center we accomplish this with a health questionnaire and a physical examination which is done by a physician's assistant. Following this initial assessment, the senior may elect to do nothing. We hope, of course, they don't do this. Ideally, they will elect a health manager or primary care physician to continue their health maintenance. We hope that this establishment of a primary care physician will make the health care system more "user friendly," if I may use that term from computer science.

If this does not work out, however, to the senior's satisfaction, we have a built-in patient advocate to fall back on. In this way, we hope to make a perfect match between the primary care practitioner, or health manager and the senior.

I need to add that this primary care practitoner need not be someone trained in geriatrics, at least in my opinion, as long as he or she is interested and knowledgeable in that area. Most often, the senior will find their health manager is a general internist or family practitioner.

I think the next step in continuing wellness is to further the health education of the elderly—and that has been discussed a lot this morning. That there is an interest in education is evidenced by the large health section in any bookstore. Unfortunately, much of this information may be too general, or in some cases downright dangerous.

I also find it sad that—in part due to lack of education—that so many of our misinformed elderly are spending large sums of their scarce income on dietary supplements and other gimmicks of questionable usefulness.

Our answer to this problem at Lovelace is threefold: Education by the primary care practitioner—the health manager—or education in regard to a specific problem by a trained nurse educator or dietitian, and seminars provided at no charge to the general public. We are quite proud of these seminars.

The subjects vary from a discussion of diseases and infirmities of the aging process to more general things like nutrition, exercise, and safety. Many of these topics have been and will be presented to various groups in the community also.

Let me go on to something perhaps a little more controversial and say that emphasizing wellness and health education sound very virtuous and very logical. However, you might ask if there is any proof of effectiveness. The answer, of course, is no. That which appears to be logical may not be when the variable of human nature is included in the formula. In fact, a recent article on the front page of the Albuquerque Journal reported on an article in the October American Journal of Public Health. This research shows that changing bad habits after age 65 makes no difference in longevity. Even though I may believe in this article, I intend to continue to encourage my senior patients, and the younger ones, too, to change their bad health habits. It also makes sense to me that a well-informed senior with or without bad habits should be able to make better choices as a health care consumer.

Making good decisions in the purchase of health care is difficult for anyone in this day of modern and complicated medicine. This

brings us to the important job of the senior services coordinator. Not everyone who participates in a wellness program remains well. When sickness strikes, the coordinator is available to guide the patient through the maze of health care. Hopefully, this leads to more efficient, cost-effective, and compassionate delivery of that health care.

Obviously, this role is traditionally played by the primary care physician or health manager for those patients who have established such a relationship. For those who do not have a primary care physician, and for those who are not established at Lovelace, the coordinator serves as a patient advocate, who is an R.N., skilled in dealing with patient problems.

What can we look for in the future? This is my wish list, I guess. We can hope for an HMO for the elderly sometime in 1985. I think this is ideal for those on a fixed income as the monthly expense is constant and frequently less than the expense of doing business in any other way. By its nature, an HMO emphasizes wellness, and coordination of efforts for those who are unwell. We would anticipate a small enrollment, of course, but hopefully this would grow considerably over the first few years.

There are other areas that need emphasis also, such as an expanded home health care delivery system at Lovelace Medical Center for those chronically ill and those recently discharged from the hospital. This same homebound health care system might also be utilized for home health assessment for those elderly people who are too feeble or frightened to leave their home.

Another alternative to bringing health care to the individual would be to make it easier for that individual to get to their health care provider. Many of our elderly find transportation to be a major stumbling block. This is for a variety of reasons, that of finances, physical impairment to driving, or just plain embarrassment at asking for help from a friend or neighbor. I think it would be very nice if there could be a small van or bus dedicated to transporting any senior patient for a minimum fee.

I feel that there is a vast number of seniors who are chronically ill and in need of nursing home or ICF placement who find this totally out of reach financially. There must be a better alternative to financial ruin for their families who must foot the bill.

Finally, for a long time the medical profession and our seniors have had a guarded relationship, at best. On one hand, the seniors are becoming increasingly aware of the benefits of being a health care consumer—and that's good. However, the physicians are faced with the continuing goal of helping chronically ill seniors maintain their health. I hope that with more time and mutual respect, together we can work it out.

Thank you.

Senator BINGAMAN. Thank you very much, Doctor. I appreciate your testimony.

I have a few questions before we conclude the hearing.

Dr. Goodwin, the study that you referred to, which I gather is now complete—it's not complete, but you have some preliminary findings; is that the situation?

Dr. GOODWIN. The original questions we were asking, in terms of, say, does white blood cell function matter, does nutritional status

matter, involved a 10-year followup period looking at morbidity and mortality, death and disease. So our statisticians tell us that we can't analyze the data as we go along because that's cheating. If you analyze the data as you go along, your chance of coming up with something which looks real but isn't it much higher—in other words, your chance of coming up with a positive finding saying this matters when it actually doesn't because it's an artificial finding by chance alone.

So the major questions which we're asking, which we can only answer by looking at death and disease development in our population, we haven't yet answered. What we have done is a cross-sectional analyses of saying "do people with low vitamin C intake tend to do poorer on this other test that we gave them? Do people with poor hearing tend to be more socially isolated?" In other words, it is a one-time-only cross-sectional analysis where we have all the data gathered at one point. But the longitudinal analysis, which is do people at this point in time, when you divide them up, do they do poorer over a 10-year followup, that data will not be available for another 4 years.

Senator BINGAMAN. If there are preliminary findings that you think are at this stage appropriate for submittal in this committee report, we would be glad to include them.

Dr. GOODWIN. My preliminary findings, which are important, are in agreement with the current wisdom of the medical community in this country now. So I think you could get them not only from my preliminary findings but from asking any geriatrician.

Three findings I would emphasize. One, I think, is exercise, as people have been talking about this morning. It is critically important in terms of maintaining health. It is not really a medical issue. It's bigger than a medical issue. But it is clear that exercise and promoting exercise is critically important, not only in the health of the elderly but in the chronically impaired elderly you can do it. We have a program at the university where we take chronically impaired people, people who are almost in wheelchairs, and start putting them on aggressive exercise programs.

Second, from a nutritional point of view, I think people over the age of 65 probably ought to be taking a one-a-day vitamin. There is enough data in now—and, once again, I think the overwhelming majority of geriatricians would agree with me—that a multiple vitamin is a good idea for older people. There is enough data showing that they may not be getting enough vitamins and minerals. Clearly, anyone in an institution ought to be doing that.

Third, probably the No. 1 nutritional problem of the elderly in this country is a calcium deficiency in women leading to probably the No. 1 public health problem in older women, osteoporosis, which is a thinning of the bones, and breaking their hips. Our data is in agreement with many, many other studies—once again, this is not unique—many other studies showing that women just don't take in enough calcium in their diets and that this is a major contributor to what people call osteoporosis or thinning of the bone which leads them to have very, very fragile bones in later life.

Those would be my three.

Senator BINGAMAN. Let me just ask one followup question. You indicated that one of the surprising things in your study was that

there is this vitamin D deficiency in a third of the people that you consider well and who are going through this study.

Have you gone the next step? Do you know what the effect of that vitamin deficiency is on their ability to function?

Dr. GOODWIN. Well, the effect we would predict—I just talked about calcium deficiency causing osteoporosis. The other major bone disease which can afflict the elderly is true vitamin D deficiency, where they do not lay down new bone. If you have calcium deficiency, you don't put enough calcium in the bone; if you have vitamin D deficiency, you are not constantly putting down new bone, which is what we're all doing all the time. Really, all the time our bones are being constantly repaired.

So everyone had thought that the only problem with elderly was not enough calcium. Everyone assumed that since vitamin D is supplemented in many groups, particularly all the dairy products—you know, when you go to the supermarket, the milk has vitamin D on it, the cottage cheese has vitamin D on it—and that there would not be a problem with vitamin D. But if the vitamin D deficiency is causing a major problem in old people, it would be contributing to the same type of thing that the low calcium is, making their bones more fragile, making them more liable to have collapse of their spinal cord as they get older, and breaking their hips.

Senator BINGAMAN. Thank you very much.

Larry, your reference to the health education being minimal with regard to programs particularly affecting elderly Indian people. Could you just elaborate on that? To what extent in your program there at Laguna is there a component of health education, or is that a priority in the way that help is provided to people?

Mr. CURLEY. I think, as an indication of where health education comes in, at the Indian Health Service facility at Laguna, from which we get a lot of nutritional experts and so forth, there is only one nutritional expert; there is one dietitian for the entire area of Laguna. That particular person not only has to deal with developing the menus in our nursing home, for example, but also has to deal with developing the menus in the Headstart programs, the local elementary schools, so that particular individual is stretched to the limit and cannot give the amount of time necessary to provide our elderly with the kind of information they need to make good, sound choices regarding nutrition.

I think, second, the other thing, there used to be a larger program called the community health field nurses, which is also under the auspices of the Indian Health Service. That particular group of people has dwindled down to, I believe, about four people now to cover that large area. In addition, the community health representatives program, their priorities are in the area of helping those who are younger essentially. So a lot of the elderly are missing and falling through the cracks.

In the area of health nutrition, there is at this particular time—I am not aware of an Indian person in the country, especially in New Mexico, who is a trained or registered dietitian. That, in itself, is I think a major problem.

Senator BINGAMAN. If there is not a single Indian person in this country who is a trained dietitian, that would be an amazing statistic. I think we should look into that and see if that's the case.

Mr. CURLEY. We only have one Indian person in the country who is trained at a master's degree level to be a nursing home administrator.

Senator BINGAMAN. Who is that?

Mr. CURLEY. You're looking at him. [Laughter.]

Senator BINGAMAN. You're it. You should toot your own horn here more loudly.

An issue that you referred to in your testimony was fascinating, and that is the All-Indian Senior Olympics. Could you describe that a little for us? I'm not—I know of the Senior Olympics Program here statewide. I did not realize there was a separate one that was all-Indian.

Mr. CURLEY. What has happened in the past 2 years is that a lot of the Indian communities, due to the fact there is not enough money to do the transportation and stuff like this, that a lot of us thought there might be another alternative, which is let's get this senior olympics specifically for Indian elderly people, which would allow a larger number of the elderly to participate. That particular activity in the past 2 years has grown from about 100 participants to this past year I believe it was over 300 participants.

We are finding now, for example, our elderly in the Pueblo of Laguna comparing themselves to the non-Indian community. In the non-Indian community you see 70- and 80-year-old people running in marathons. Our elderly do not want to be outdone, and now they want to be able to train year round, to begin to compete with the non-Indian elderly and try to win some of their marathons. So this is basically where it is now. More Indian elderly are interested in becoming more involved in these kinds of physical activities. I am also amazed at the growth of that program.

Senator BINGAMAN. Thank you very much for your testimony.

Dr. Trujillo, the focus of your testimony and the focus of your work is with rural Hispanic elderly.

Dr. TRUJILLO. That's correct.

Senator BINGAMAN. I would just ask you to what extent there is any kind of health education effort at any level—Federal, State, or local—which is directed at this group as you understand the situation today.

Dr. TRUJILLO. Well, sir, there are a number of initiatives. First of all, you have your State Agency on Aging and other health organization, such as health and environment, which do provide a lot of information and quite a bit of service.

It gets lost, however, and what I'm very concerned with is in the transition to the rural areas. We designate into regions, and then there is a regional center. Then we have three or four counties spread out over 200 or 300 miles sometimes from the regional center. You simply do not have adequate access to that information for persons trained on the local level.

Mr. Curley talked about the public health nurse and the resource that that can be. We have one public health nurse in Soporro and she does outreach work to other counties, for example. She simply cannot handle things like adequate information about birth control, nutrition to the elderly, et cetera, et cetera, et cetera. It's just not there. It cannot be handled with the limited resources that we have in the rural areas.

So it is a multidisciplinary kind of shortage, I would say. And as I say, through the nutrition centers there is some effort, it's just not adequate and people can simply not be stretched to that limit.

Senator BINGAMAN. I have been at other meetings with you where I know you are familiar with the meal programs that occur through the senior centers here in the State.

Is there a component there for providing sufficient vitamins? I know Dr. Goodwin was saying one of their findings, or one of his findings and recommendations is that there should be a multivitamin included in the diet of seniors, at least those in institutions.

Is this something that is included as part of the meals program at your senior centers?

Dr. TRUJILLO. Not to my knowledge, no.

Senator BINGAMAN. Dr. Follingstad, could you briefly tell me the extent to which you think the program you have described at Lovelace, concentrating on health promotion, is unique among hospitals in this country? Or is it an exception? Is this something that is being done more and more? Is there anything the Federal Government should be doing to provide incentives for this to be done by hospitals?

Dr. FOLLINGSTAD. I don't think what we're doing is unique. There are several large clinics that are doing the same things. I think more and more this sort of thing will happen because we have a very good health care delivery system if it can be utilized by the elderly. That's the whole crux of the problem, I believe.

Second, we are looking forward to having an HMO which I think will increase the accessibility to good health care and education.

Senator BINGAMAN. And you indicated that would happen in 1985?

Dr. FOLLINGSTAD. We hope.

Senator BINGAMAN. There is not an HMO today that is directed toward elderly in this community?

Dr. FOLLINGSTAD. Only our HMO is available to Federal employees who retire, and that's all.

Senator BINGAMAN. I appeciate the testimony. I again want to thank the witnesses and the many people that have helped to put this hearing together, all the people on my staff and all the others who have come just to participate in the hearing and to watch it. I think it has been very educational to me and I hope it has been educational to each of you. If you signed a registration form at the desk, we would be glad to get you a copy of the transcript of the hearing once it's complete, and we hope that some of the things that have come out here can be implemented and can be focused on for implementation, both in the Congress and in the administration in Washington.

Thank you again for coming. We hope also to do some followup on this hearing. Thank you.

[Whereupon, at 1:20 p.m., the committee was adjourned.]

APPENDIXES

APPENDIX 1

MATERIAL SUBMITTED BY WITNESSES

ITEM 1. STATEMENT OF GOV. TONEY ANAYA, STATE OF NEW MEXICO, BEFORE THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, SELECT COMMITTEE ON AGING, U.S. HOUSE OF REPRESENTATIVES, AUGUST 1983, SUBMITTED BY GEORGE ELLIS

Mr. Chairman, Senator Bingaman, Congressman Richardson, and participants in New Mexico's Annual Conference on Aging, I feel privileged to have been asked to testify before this committee on the subject of Medicare, Medicaid, and health costs. It is a particular privilege, Mr. Chairman, to be able to offer my comments to you, as the Nation's foremost expert on these and other issues pertaining to the well being of our Nation's older citizens.

Senator Bingaman, I thank you and your staff for arranging this visit by the Honorable Claude Pepper. Timing this visit with our statewide aging conference was excellent.

Congressman Richardson, I thank you for your efforts to address issues important to our State through hearings, public meetings, and other forums that let the people speak.

Mr. Chairman, let me tell you something about our State and why the issues being addressed today are of such vital importance to me and all New Mexicans.

New Mexico is a rural State: Its 1.3 million people inhabit the fifth largest land mass in the Nation, with over two-thirds of that population residing in communities of 50,000 or less. We are a poor State economically, ranking 42d in per capita income. Almost 18 percent of our people live in poverty. With the Reagan administration budget cuts and high unemployment, that very well could be 20 percent today. We have about 165,000 elderly, almost 13 percent of the total population. Almost 30 percent of our elderly are poor or near poor. Over 10,000 live on SSI payments. We are the fifth fastest growing State in percentage of the population that is elderly, and our over age 75 population is growing at twice the national rate. One of our counties, Sierra County, has an elderly population that is second only to your Dade County in percentage of the total population.

We have 135,000 citizens on Medicare receiving $134 million in benefits. Our elderly and handicapped populations constitute only about 30 percent of our Medicaid eligible population, yet account for over two-thirds of our total Medicaid expenditures—approximately $85 million, of which about $60 million is Federal. That is, we estimate that somewhere around $200 million of Federal funds are being spent here in New Mexico to pay for health care for our elderly citizens.

We are, then, currently spending a tremendous amount of money and the question that must be asked is not whether this is too much, but whether by spending this money on prevention and related services we could both reduce the amount spent on sickness cure and treatment, but also have a healthier elderly population.

I do not believe that we are necessarily spending too much on health care for our elderly citizens, but instead that we are spending in ways that do not most benefit these citizens. In particular I am very concerned about the fact that we spend too much on the cure and treatment of sickness, and not enough on keeping people well. I firmly believe that we have come to see the aging process primarily in medical terms and have as a result inappropriately equated growing old with getting sick. In my view, most of the problems faced by our elderly citizens are not primarily medical although I certainly do not wish to underemphasize the need to provide adequate medical care when our Nation's elderly and poor are indeed sick.

Mr. Chairman, from my perspective we must shift our Federal programs away from the current system which emphasizes sickness cure and treatment to a new system that promotes wellness among our elderly.

The National Center for Disease Control estimates that 55 percent of our long-term health is determined by lifestyle: How we eat, drink, exercise, manage stress, and whether we smoke; 20 percent by environment; housing, offices, factories, heating, sanitation, safety, air, water, exposure to toxic wastes; 15 percent by genetics; and only 10 percent by medical treatment: Doctors, drugs, surgery, hospitals. This means that 90 percent of good health is determined by factors other than medical care. Yet as a nation, we spend only 6 percent of our total health care dollars on the 90 percent that affects good health. And we spend 94 percent of our health care dollars, almost $240 billion, on medical care that affects only 10 percent of our overall health.

In particular:

—We need more funding for 2176 (Medicaid waiver) type programs, but these must be extended to cover those individuals needing in-home care who have not yet deteriorated to the point where they need nursing home care. Under current standards we must turn people down who have very real needs, and must wait for them to become seriously ill before we can serve them through our waiver program. This has to be changed.

—We need more housing for the elderly.

—We need job training and retraining opportunities for the elderly.

—We need to support physical fitness programs for the elderly, including adequate nutrition and exercise programs.

—We need to support lifeline services that give the elderly a sense of security in their own homes.

—We need to support crime prevention programs so the elderly will not be fearful of walking in their own neighborhoods.

Mr. Chairman, my list of needs for the elderly could go on but here I wish to emphasize that it is my firm belief that if we increased expenditures in these areas that we could contain our expenditures in the medical arena and the ultimate costs to society in dollar terms could be less. As a minimum, the ultimate costs to society in reducing inhumane care would make this course of action wise.

Mr. Chairman, there is no question that our medical costs are skyrocketing and that they must be brought under control. I have proposed that by reallocating these expenditures towards prevention, social services and health promotion that we would be engaged in true health care cost containment. I believe that the Reagan administration instead is engaged in a course of blaming the victim and is therefore trying to curtail health care costs on the backs of the elderly and poor of this country.

The elderly and the poor are the victims of escalating health care costs, not the cause. President Reagan insists that the problem has been caused by increased inappropriate demand for medical care by the poor and the elderly. This is, in my estimation, backwards. We must address ourselves to the underlying causes of these escalating costs which include:

—A marketplace that does not operate effectively, in large measure because of the Federal reimbursement system.

—Federal programs which treat social problems with expensive medical services.

—Inappropriate concern with consumer behavior rather than with the behavior of the true decisionmakers in the health care field: Physicians, hospitals, and nursing homes.

—And, as I have already indicated, because of inadequate emphasis on prevention.

Mr. Chairman, Senator Bingaman, Representative Richardson, let me give you a concrete example of how backwards President Reagan's proposals are. He has suggested that copayments for pharmaceuticals be made mandatory. When you go to the doctor do you write your own prescription? Do you control how many prescriptions you receive and for which drugs? No, doctors write these prescriptions. It is clear that copayments on pharmaceuticals are a perverse way of punishing the victim, have no impact on the part of the health care industry that determines how much is spent on drugs; and are a clear reflection of a refusal on the part of the Reagan administration either to understand what is causing our increased health care cost or to address these underlying causes.

Rather, I believe firmly that many of the most troubling problems faced by this population are social and economic in nature. If we could only provide our elderly citizens with the financial resources they need, and could provide a host of support-

ive services to them and their families I am sure we could reduce this population's need for acute and long-term medical care.

I was very interested in your statement, Mr. Chairman, that perhaps the most effective way of keeping our elderly citizens healthy is by providing them with opportunities to continue to make constructive contributions to our society, by working, by teaching, by volunteering and by running for public office. In this way, we can provide enhanced economic opportunities for our elderly population, enrich our society through their continued contributions, reduce loneliness and feelings of being unneeded, and, I suggest, contain our health care costs.

Mr. Chairman, New Mexicans, especially the elderly and poor, face two fundamental and worsening health problems.

The primary problem is, of course, the cost of care.

The other problem is access to medical care, especially for those most at risk. New Mexico is a rural State. President Reagan preaches against overuse while we in New Mexico are still trying to provide some services—to reach all our citizens with the basics of primary care. We have New Mexicans who can't even get in to see a doctor. Our families, for whom geography, race, poverty, and cultural and language barriers put them most at risk, are not receiving sufficient care by any standard of measurement. Yet these families and the rest of our society will bear the long-term consequences of this neglect.

And what is the President's answer to our rural health care problems? He would kill the National Health Service Corps. Not openly, of course, but by policies that force the rural areas of highest poverty, highest infant mortality rate, lowest physician-to-population ratio, and greatest need for elderly services to pay back the Federal Government for service corps physicians. If these areas could have paid for a physician, it would not have been necessary to send a service corps physician in the first place. If these policies remain, New Mexico could lose 61 primary health providers, who now serve through the Rural Health Clinic Program, and we may have to close 29 primary health care clinics.

I support the legislation introduced by Congressman Richardson that will stop these outlandish payback proposals. I thank both him and Senator Bingaman for their recent letter urging Secretary Heckler to stop the paybacks and several other rural health clinic rules that could kill our Rural Primary Care Program. Mr. Chairman, I urge you and this committee to strongly support these efforts by Senator Bingaman and Congressman Richardson.

The nonpartisan Congressional Budget Office study. Released last week, showed clearly what you have been pointing out to the Nation all along. That the most disadvantaged people in this country—the ones we ought to be helping the most—are the ones that have borne the brunt of Ronald Reagan's budget. Retirement and disability benefits; health care programs; income security programs, such as Housing, Food Stamps, and Energy Assistance; Education and Social Service Programs; and employment programs have been slashed indiscriminately. Seventy-percent of all cuts are borne by families making less than $20,000 a year and most of the cuts are borne by those earning less than $10,000 a year.

At the same time, President Reagan has given enormous tax cuts to the wealthiest in the Nation. Not since the 1920's have we had a President who did everything in his power to see that the rich get richer while the poor get poorer. Such budgets and policies are a national and international disgrace. They attempt to undo the democratic rule and equal opportunity this Nation has been trying to establish for over 200 years. They attempt to create a society of two classes, the privileged rich, and the exploited poor.

Medicare and Medicaid are excellent programs doing what they were created to do: Provide acute care to the elderly and poor of this Nation. We do have a problem of medicare deficits, and we need to ask if we are getting our money's worth for the health care we do buy. We need to ask if we are spending our health care dollars in the right way.

I am not arguing that we spend less on Medicare and Medicaid. I am arguing that we spend our money in different ways, both in Medicare and Medicaid, and in other programs as I have earlier testified.

Almost all applicable Federal requirements and State systems are based upon the medical model, making it easier to pay for doctors, surgery, drugs, and instutionalized care, and more difficult to pay for case management, home care, adult day care, home visitations, clinic and out patient care, rural care, social services such as home visitation, homemakers services, home rehabilitation, heat, and weatherization; respite care, hospice care, delivered meals, companionship; and for us especially, transportation. In other words, those factors that the Center for Disease Control

tells us affect health the most, are the very ones the Federal and State systems are most reluctant to pay.

We need a nonmedical model, a social services model for overall care, a noninstitutionalized approach, and some of the funding should probably be provided for by programs outside Medicare and Medicaid.

But Medicare and Medicaid changes are also necessary to correct biases against noninstitutional medical care.

And, if a true health care system—rather than just a medical care system—needs a larger budget, then we should support it and reevaluate our national budget priorities.

This week we observed the 20th anniverary of Martin Luther King's "I have a Dream" speech, a speech that is one of the greatest statements in American history. You, Mr. Chairman, have given us the same inspiration, for your dream gives justice, dignity, and freedom to the elderly of this Nation, and the world. In my "State of the State," address in January, I pledged the following to New Mexico's elderly:

"We will not treat you as problems, as a nonproductive burden that society has to bear. You represent the best in our civilization, the highest attainment that our culture has to offer. And that is how you will be treated. With your help, we will achieve a vision of aging not as a condition to be dreaded, but as the crowning achievement of the life process; as a status that all other generations can look forward to."

That language is not just a wishful thought. No, it is a dream. One that is attainable. Now, you, Mr. Chairman, are living proof that this vision of aging is possible. My language simply describes your life. You, and the New Mexico elderly here, already know what the rest of us have yet to imagine. Our society will be eventually judged by how it treats its elderly. I, with your help, will do everything in my power to see that our New Mexican society is judged well. Thank you.

ITEM 2. SPEECH BY GOV. TONEY ANAYA, STATE OF NEW MEXICO, BEFORE THE 1984 CONFERENCE ON AGING, GLORIETA, NM, AUGUST 28, 1984, SUBMITTED BY GEORGE ELLIS

I want to welcome all of you to the 1984 New Mexico Conference on Aging. I want to congratulate the conference planning committee members for the excellent job they have done.

Since we had the honorable and venerable Claude Pepper here last year, much has happened. Of all the excellent accomplishments, I am most pleased with the new role that the elderly play in decisionmaking and advocacy, in the aging network, at the area agency on aging level, in State government, and especially in the legislative process. Some of the most innovative recommendations for legislation in the 1985 session of the legislature have come from your membership organizations: AARP, NRTA, Senior Coalition, PERA, Gray Panthers, Title VI Indian Programs Coalition, and others. Thank you for those recommendations. They will not be ignored and you will be consulted in how legislation is framed and introduced.

I want to make several important introductions. First, the new policy advisory council that I have appointed to advise me and the director of the State Agency on Aging, George Ellis. These PAC members replace pioneers in the field: C. E. "Mike" Carmichael, Clifford Whiting, Lowell Panteah, Agnes Siedel, and, of course, the late Dr. Donald MacKay. To these as well as other veteran PAC members, Lee Burns, Frances Sanchez, and Ramos Sanchez, the State of New Mexico owes a great debt for their distinguished service.

As I call the names of the new PAC members, will you stand and remain standing until all are introduced, then we will have applause for all: Dorothy Wade from Santa Fe, Rev. F. W. Wells from Hobbs, Muggins Burroughs from Albuquerque, Joseph Abeyta, Sr., from Espanola, Joseph L. Ventura from Santa Fe, Bennie L. Montoya from Santa Fe, Lou Brooke from Silver City, and Barbara Phelps Anderson from Roswell.

These people are experienced in and knowledgeable about the aging process and programs. Talk to them. Take them information and suggestions as to how we can do a better job. They are your link to the State Agency on Aging and me. I thank you all for agreeing to serve the State of New Mexico.

What of the future of the elderly in New Mexico? It can be as bleak or as bright as one imagines it. If we do nothing, then the bleak future is ours and it is graphically described by Dr. Robert Morris of Brandeis University: I quote:

"Long-term disability trends, if unattended, constitute a ticking-time-bomb threat to the health system as now constituted and to responsible public-expenditure policy

formation. This results because the volume of severe disability will increase due to basic demographic trends and improvements in human-survival techniques. This in turn will increase the net volume of demand for both institutional and at-home-care services. These demands will distort the operation of our current institution oriented health system by inflating costs. Above all current lack of attention to the needs of less disabled older citizens, whose numbers are rapidly increasing, will produce an alienation that can lead either to arbitrary reductions in support for health care or alternatively to exponential increases in expenditures for cost inefficient activities. It is possible that neglect now could lead us into a serious consideration of euthanasia as a national policy toward the older disabled since it is not clear that, as a society, we are ready to pay the price for the kind of life that our technology extends."

That is a stark statement. But you know that there are certain thinkers around proposing what Dr. Morris wants to avoid. We have dedicated ourselves to saving and preserving life and now some dare speak out saying that the elderly have a duty to die. That you cost too much and give too little. New Mexico rejects this bleak view of the future and embraces the bright one.

As with all things in the current administration in Washington, value is measured by dollars. Well, let me talk about dollars. Let me talk about health cost containment in four areas: Costs per se, long-term care systems, case management, and health promotion. These are all essential to containing health costs and achieving a high qaulity of life for all elderly.

(1) Health cost containment.—You have all heard the staggering numbers. And you will hear more here in workshops. But we must not let repetition of the numbers innure us to their reality. Let me give you a simple illustration from Medicaid statistics. Between 1972 and 1982, the number of hospital patients increased by 128 percent but the payments by Federal and State government increased by 332 percent. The number of nursing home patients increased by 199 percent but Medicaid payments increased by 810 percent. Something must be done, not to cut back on care, but to provide even better care at reasonable cost. As you know, my Cost Containment Task Force has been in operation over a year and has already shown a $1.7 million savings in Medicaid. And it is continuing to offer substantive proposals in several categories. But we must take further steps. One legislative proposal that I have received from AARP on cost containment is very interesting.

It calls for a permanent cost containment commission that would be independent of providers' financial interests; would have power to establish and enforce uniform rates for all payers; would develop a prospective payment system; would coordinate with the State's certificate of need and health planning process; and would require utilization review programs to ensure that quality of care does not suffer. I congratulate AARP for getting involved in the details of the legislative process. I would like to hear from other advocacy organizations here through George Ellis or Dan Weaks as to your thoughts on AARP's proposal. And I commit to you that I will take the steps within my power to control health costs. I will work closely with the Interim Committee on Health, Human Services, and Aging to address this problem. The health care system, for whatever reasons, is so out of control that individuals, young and old, refrain from seeking health care because they cannot afford it. That cannot be allowed to continue. But I will not propose measures like those proposed by the Reagan administration: I will not attempt to control costs by making the elderly, handicapped, and poor pay more for their care through increased deductibles, copayments, and premiums. Nor will I control costs by permitting cost shifting to the near poor and lower middle income people, such as senior citizens on fixed incomes.

(2) A part of cost control will be redefining the objectives of medicine. Dr. Alvin Tarlov in an address before the Massachusetts' Medical Society suggests a new era in medicine:

"The central objective of medicine in the coming era will be the maintenance or improvement of individual patient functioning in the patient's normal environment while he or she performs * * * the personal activities of bathing, dressing, and eating; mobility; physical activity * * * functioning in the role of homemaker, spouse, parent, employer, supervisor, community participant, or citizen. To optimize [this type] of care will be medicine's central objective for the period ahead."

Dr. Tarlov's statement brings us logically to cost containment through a good long-term care system. Long-term care is a phrase that has caused problems in interpretation, but I use it because I know it is a phrase you use. It does not mean, as I heard a former budget analyst define it, creeping socialism. Nor does it just mean nursing home care. What it means is a network of care which includes all of the health and social services that are needed to serve the elderly and handicapped,

whether in institutional, community, or home settings, so that they may lead the most independent lives possible. Perhaps there are better terms for it. But whatever we call it, it is needed, and it is not yet all in place. Society in the past has placed the highest value on quality institutional care. Payment and reimbursement systems were set up to cover institutional rather than noninstitutional care. Payment systems were set up to pay for acute care, not for preventative care and not for extended care outside of an institution. Thus, the institutional component of long-term care is in place. And it is very expensive. The parts of the long-term care system that are not entirely in place are community-based and in-home services, which can be more cost effective. We have made a start developing these services with medical home care, congregate and home-delivered meals, and advocacy programs, to name a few; but other parts are underdeveloped or entirely missing. Adult day care, for instance, is virtually nonexistent outside of Albuquerque, and yet it is a program that is sorely needed around the state. Nonmedical home care is underfunded and inconsistently delivered. And most importantly, the mechanism that makes all the parts function as a system, the mechanism called case management, is practically unknown and little understood outside of this room. I will come back to case management in a moment. This administration took a giant step forward by proposing and implementing your program, Senate Bill 123, the Coordinated Community In-Home Care Program. But now we need to take that model, we need to take that experiment, and modify it to reflect your evaluations. And, in some form, we need to expand it statewide if we are ever to have a true long-term care system in New Mexico. Until we have interwoven a range of community-based services with institutional care, we will never be able to control costs. And may I suggest this to you. Use your power at the national level also. This has to be a partnership and right now it isn't. Because right now, our national policymakers are much more interested in talking about long-range missiles than long-term care.

(3) I return now to the key to all of the above: Cost containment as case management. Long-term care services existing independently do not constitute a long-term care system. Case management is what pulls fragmented services together and makes them work for the elderly consumer and her family. Case management provides the type of assistance that is needed, at the right time, in the most appropriate setting, and in the amount that strengthens and supports the functioning of the older person and the family.

How does case management work? Very simply, it has five parts: assessment, care planning, arranging for delivery of service, monitoring of services, and periodic reassessment. First a functional assessment is made of the client to determine the level at which that person is performing tasks of daily living, taking note of existing support systems already in place. Next, the case manager develops a care plan that translates client needs into services. Delivery of services is arranged with service providers such as visiting nurses or meals-on-wheels according to the care plan. It is the job of the case manager to then monitor the delivery and quality of those services and to periodically recheck the client's functional level in case services need to be added or discontinued. Case management ensures the coordinated delivery of multiple services to clients and acts as a watchdog on behalf of the client and the taxpayer.

In order for case management to be effective, the case manager must function independently of service providers. This independent role will become more important as the private home care industry explodes in growth. It is one thing for the state to protect the right of the institutionalized elderly, for the institutions can be properly regulated and licensed. But how, outside a complete system of case managers, will we ever protect the rights of individuals in their own homes on that day when home health services are marketed as commonly as life insurance? We can't. The history of other States tells us so. One of the resolutions that the Senior Coalition will be addressing says it well.

(4) The fourth area is health promotion as cost containment. I don't want to preach to the saved on this, but you know the facts. How we live has more to do with long-term health than any medical system yet devised. What we eat, drink, think; how we exercise; and what the condition of our dwelling is: these provide the keys to good health at any age. The greatest cost containment device is to prevent disease and impairment or to delay them as long as possible.

Yes, we can all afford good health, if we look at the whole picture; if we look at cost containment, at long-term care, at case management, and prevention. And I want you to know this: be it resolved that the Anaya administration stands ready to assist you with the New Mexico Legislature to do whatever we can at the State level to bring about real cost containment, not cost shifting. This will be no easy task. We will need each one of you working every day between now and the ides of

March. We need to involve the 80,000 members that your advocacy organizations have in this State. And we will need to reexamine the way in which we operate existing programs. We will need to discuss the merits of statewide expansion of the CCIC program as it is, as well as the merits of separating case management from the Medicaid waiver. We will need to explore the possible consolidation of all social services to the elderly under one department or agency. We will need to examine the best way to deliver long-term care in rural areas, as well as what role senior centers will play in meeting the needs of the frail elderly. We must push our primary health care system to become a preventer as well as curer of disease. These and dozens of more questions must be examined. But I am not asking you to wait for another year. I am asking you to explore these questions now, so that we can take a cost-effective package into the 1985 session of the legislature. One thing that the elderly and my term of office have in common, is that neither one can afford to wait.

I was with you last year. I will be with you again next year. And, in whatever capacity, I will always share your concerns. Your mission is the greatest and most hopeful that has ever been conceived. It is to find the quality of life in the immediate future instead of conceding that it exits only in the distant past. And I wouldn't miss that discovery for anything on earth, because you are creating my future, the future of my wife and my children. I am asking that you use me as your Governor, and my office and my appointees as the executive office of your State, to use us as your instruments to help you plan, frame, and carry out your vision. There is no way we can be defeated; no way we cannot succeed.

The experts say that the growth of the elderly population through the year 2020 mandates that we must cap costs, have long-term care, provide case management, and prevent disease and disability, if we are to afford health and social services. The elderly say that health care is too expensive; that they prefer not to be institutionalized but want to stay in their homes and communities with family and friends; that they need expert guidance in negotiating our complex care system; and that they want to stay well so they don't have to be cured. I, like John Kennedy, am often wary of the experts. But when the intelect of the experts agrees with the intuition of the elderly, then the world better pay attention. Thank you.

ITEM 3. "STRATEGIES ON HEALTH PROMOTION," PREPARED AND SUBMITTED BY PETER P. LAMY, PH.D.

DRUG USE AND THE ELDERLY

Five years ago, 57 percent of all prescriptions filled in pharmacies were for chronic care drugs (duration of use: longer than 2 weeks), this percentage now having risen to 65 percent.

It is interesting to note that about 80 percent of all antiarthritic drugs and 80 percent of all cardiovascular drugs are prescribed for the elderly.

Thus, with increasing age, not only are elderly receiving more drugs, but more potentially toxic drugs.

Adverse effects

Old age sensitizes people to toxic drug effects and greater number of drugs can produce a greater number of adverse effects.

The Royal College of Physicians (England) estimates that 20 to 25 percent of all elderly admitted to a hospital suffer from an adverse drug effect. Comparable U.S. figures are estimated at 12 to 17 percent, although the argument has been advanced that the incidence is probably much higher, but adverse effects are simply not recognized or are ascribed to the "symptomatology of old age".

A major contributing factor

Estimates on noncompliance of nonadherence to an agreed-upon drug regimen vary widely. Recently, it was shown that over one-third of elderly do not comply with their antiarthritic regimen or antihypertensive regimen. This is of major concern, since it was always thought that a "silent" disease such as hypertension may induce patients to noncompliance, but that diseases, particularly those presenting with pain, would induce greater compliance.

A recent report in JAMA indicated that as many as 31 percent of the elderly may commit drug administration errors of a nature that could lead to serious clinical consequences. Drug defaulting among the elderly may occur in up to 50 percent, more and more frequently with antihypertensive medications. Forty percent of the

elderly receive prescriptions from at least two physicians, and 12 percent take drugs prescribed for others.

It has been suggested that these factors contribute to the high incidence of adverse drug reactions and, thus, by inference, to the high cost of health care.

Patient needs

In June 1982, the HHS Secretary Schweiker sent the final report of the 1981 White House Conference on Aging to the President and Congress. Based on the 600 recommendations, Schweiker developed a National Policy on Aging. A primary recommendation in the "health" section of the policy speaks to the need to develop and disseminate education materials (on diseases and drugs) for the elderly. Furthermore, the elderly should be "further educated in the safe and effective use of nonprescription drugs," a recommendation which has assumed greater urgency with the major emphasis of switching drugs from prescription status to nonprescription status.

All consumers including the elderly, want and need more information. A recent poll by the CBS Broadcast Group/CBS Economics entitled "A Study of Attitudes, Concerns, and Information Needs for Prescription Drugs and Related Illnesses," cites that more than two-thirds of those polled considered information on blood pressure, heart problems, and life-threatening diseases as well as on drugs to be highly important. Yet, slightly more than three-fourths felt only "somewhat informed" or "not informed at all."

It is reasonable to conclude that this lack can result in consumer action, albeit misdirected. Over one-third of the households polled by CBS used the Physicians Desk Reference as a means to obtain information, probably because that book is well known and better patient information, such as is not yet as well known. In our experience in the USPDI dealing with the elderly, we would conservatively estimate that elderly use the PDR more often than do younger adults. Should they have to depend on this type of information source?

ONE EFFORT TO MEET PATIENT NEEDS

Five years ago, the School of Pharmacy at the University of Maryland at Baltimore established the Center for the Study of Pharmacy and Therapeutics for the Elderly. Concurrently, the Elder-Health Program developed, with its subdivisions of Elder-Ed, Elder-Visitation Program, and Care-giver Program. Later, the Parke Davis Center for the Education of the Elderly was established and more recently, faculty, working in concert with practitioners, have established a home care program.

All of these programs have been established on a voluntary basis, through grant support from AoA, and from support by the pharmaceutical industry, as well as from alumni of the School of Pharmacy. A very active research program in drugs and the action of drugs is also taking place. Grants have been received from AoA, NIA, NIH, and other granting authorities—but more is needed to pursue our goals on behalf of the elderly.

Faculty has been called to consult on behalf of the U.S. Senate, NIA, NIH, National Center for Health Services Research, NIMH, and many others. Faculty is currently working with the FDA on problems related to drugs and the elderly.

THE CENTER FOR THE STUDY OF PHARMACY AND THERAPEUTICS FOR THE ELDERLY

A research organization of faculty with expertise and interest in problems of drugs, drug actions, and the elderly. The center has a national advisory board, chaired by Dr. Arthur Flemming, currently President, the National Council on Aging. A former president of the American Geriatrics Society is a member, as is the head of the Center on Aging of the University of Pennsylvania. The Center has also sponsored many educational programs for health care providers, including physicians, pharmacists, nurses, and social workers.

UNIVERSITY OF MARYLAND AT BALTIMORE, SCHOOL OF PHARMACY PROGRAMS FOR THE ELDERLY

The Center for the Study of Pharmacy and Therapeutics for the Elderly

The elder-health program

The program aims at wellness of the elderly, aims to help them to maintain independence as long as possible, and aims, most of all, to make the elderly an active participant in their health care, rather than remaining a passive recipient.

The elder-ed program

The Elder-Ed Program was developed in 1978 to assure appropriate drug use by the elderly. The major objective is to convince the elderly that they must play a vital and indispensable part in the therapeutic process. Health care must be viewed as a partnership between the patient and the provider(s). Emphasis is placed on the need to understand the goal of a particular therapeutic regimen. Facts which argue for the value of preventive care are stressed. Special attention is given to self-medication, if performed correctly.

Students and retired pharmacists, who have undergone a special training program (appendix A) present discussions in the community on selected topics, such as: The aging process and how it may affect your response to a medication; the wise use of medicines; selecting the right, not the wrong, nonprescription medication; nutrition and vitamin needs of older adults; how to select your pharmacy; and generic drugs.

The program has been evaluated and has been shown to raise the awareness of older adults on the need to actively participate in their health care. The program utilizes a wide variety of pamphlets, including a medication record card: How to select your pharmacy/pharmacist; how to take your nitroglycerin, some do's and dont's; you and your medicines; medicines without prescriptions; everything you ever wanted to know about generic drugs; you and your eyes; skin care; caregivers' medication guidelines; vitamins are not enough; and personal medication record.

Over 300,000 pamphlets have been distributed free of charge nationwide. Programs based on the Elder-Ed Program have been developed in North Carolina, New Jersey, Pennsylvania, Michigan, Washington State, and many others.

The care-giver program

The Elder-Ed Program can, by definition, only address those older adults who come to meetings at churches, synagogues, health fairs, senior centers, and other places. More and more elderly, however, need the help of a caregiver, i.e., family, friends, or significant others. These persons must learn how to administer medications, how to act as information source for health care providers by providing feedback on a patient's possible reaction to a particular medication regimen, and must monitor the patient's nutritional and mental status. This program currently under development, addresses the speciasl needs of the caregivers.

The elder-visitation program

Young people must learn that not all elderly are sick and homebound, or reside in nursing homes. Incoming students at the School of Pharmacy are asked to "find" an elderly person (this way they learn the aging network) and to arrange periodic visits. After an initial period of adjustment, students act as a source of information. Students meet with faculty weekly to report and to validate any information they may wish to give. Many students have elected to continue their visits throughout their 3-year stay at the School of Pharmacy.

The home care program

A faculty-based program under development, based on visits to homebound elderly. The number of elderly under home care is going to increase dramatically (increasing numbers of elderly, lack of nursing home beds, cost-containment measures, adjustment to the wishes of elderly not to be institutionalized, and other reasons). It is important that a trained person can observe drug effects and report to physicians, while noting other agents with pharmacologic action (bought in supermarkets and health food stores, for example) that the patient may use. A major aspect of the program is to recommend preventive measures (such as for prevention of pressure sores, for example). Students accompany faculty member as a learning experience.

Appendix A.—Training Material

How others do it—the elder care program

Briefly, I would like to note at least one major, nationwide program. It is the Elder-Care Program of Parke Davis, a division of Warner-Lambert Co. of Morristown, NJ.

What it is: Communications catalyst. An information system.

What it's for: To motivate patients, particularly the elders, and pharmacists to freely discuss prescription and OTC drugs.

What it does: Improve compliance, presents adverse drug interaction, and improves patient wellness.

How it's used: Two targets, pharmacists and patients. In-store announcements and reminders for patients and pharmacists, i.e., Elder-Care Kit. Pharmacists, education and motivation programs conducted at the State association level. Communication program for use by pharmacists, i.e., new slide program. Communication program for showing to professional and lay audiences, i.e., "The Medicated Generation." Advertisements in national and State journals.

In 1982, pharmacists across the Nation were contacted by Parke Davis and were asked whether they wished to become Elder Care pharmacists. Some 10,000 responded positively. They received initially an Elder Care Kit. The program was initially presented in New York City, in the presence and with support of Virginia Knauer and the Commissioner on Aging, New York City, and sometime later in Chicago, by the Lieutenant Governor of Illinois, a pharmacist. Elder Care pharmacists were then provided with background material on geriatric medicine and use of drugs for geriatric patients. In a little more than a year, the program has been presented to 20 state and local pharmaceutical associations.

Among the organizations which have expressed interest, and which were addressed are the FDA Commissioner and his staff, the Council on Better Business Bureau, and the National Council on Patient Information.

Some other concerns

A. Special packaging, to increase compliance and safety

I have already spoken to the possibly increased need of the monitoring of drug use in home care. Drugs are probably the most cost-effective modality of home health care. Yet, their benefit-risk ratio changes with patient age, the benefit decreasing, the risk increasing. Many reasons can be cited for this, including the lack of dosing guidelines, the nonrecognition of the pharmacodynamic and pharmacokinetic hypotheses of altered drug action with age, the lack of a good data base in home health care, and the very narrow therapeutic index of many drugs used in home health care.

One overriding dictum of geriatric drug use is to avoid the reduction of the patient's quality of life, and the major component of the quality of life is mental acuity. Yet drugs are common causes of delirium, depression, confusion, and other altered mental states, and drug-induced dementia, known as pseudodementia, is a more common cause of reversible dementia than is depression.

Major reasons for drug-induced depression, confusion or altered mental states, as well as many other unexpected side effects, is lack of patient understanding of the drug regimen and lack of patient compliance.

Some of this can be addressed with special packaging systems. While there is no "ideal" system, we should ask for one that has the following characteristics:

(1) It should be practical for both patient and caregiver.
(2) It should be easy to use.
(3) It should be easy to audit and, therefore, increase accountability.
(4) If it meets criteria (1), (2), and (3), it would increase compliance and safety, key provisions looked for by both providers and patients.
(5) It should be informational.

One such system, approaching the "ideal" requirements, is available from MSI, Inc., 714 C Street, Suite 2, San Rafael, CA 94901.

B. Limiting the cost of drugs: The use of generics. Are they always "equal"?

Few issues in health care have aroused more debate than the cost of drugs. Few doubt the great contribution which drugs have made in the last few decades in the fight against previously untreatable diseases. Has that "golden age" come to an abrupt halt in the dispute of costs?

Can drug costs be reduced and is there a risk to patients?

The American Medical Association House of Delegates, meeting in December 1983 in Los Angeles, accepted a report from the AMA Council on Scientific Affairs containing a number of definitions of terms that had been worked out between the American Pharmaceutical Association and the AMA. All of these terms, which incidentally differ somewhat from the terms used by the FDA, have been used in efforts to contain drug costs. The major one, and one that might well cause problems to elderly patients, is the one denoting generic dispensing.

Although pharmaceuticals represent a relatively small percentage of total health care expenditures (about 8 percent according to a 1983 Kidder Peabody Research Report), their costs are highly visible and subject to much criticism. One reason often cited is the fact that only about 20 percent of drug costs, according to Pharmaceutical Data Services, are eligible for reimbursement by most health care insurance programs.

The cost of drugs may become even more visible due to recent developments. The 1983 Consumer Price Index shows an overall increase of 3.8 percent. The medical care index rose by 6.4 percent, but prescription drug prices jumped 9.6 percent at the consumer level.

About 40 percent of the top-selling prescription drugs in the United States are now generically available and by the end of the decade, nearly all of the current top 50 drugs will be free from patient restrictions. Generics now account for about 20 percent of all domestic drug sales, and may account for 30 percent by the end of the decade.

Currently, most States deal with either a "positive" or "negative" formulary, and the physician must indicate that a generic can be used or should be used. Patients can request generic substitutes if they so desire.

This is then essentially a free market approach, an approach to health care that has been recommended. Quite often, when it comes to decide whether to purchase either the innovator drug or the generic equivalent, both provider and patient often lack data to make a rational decision, or often do not look past the price, since price differential is most often the only clearly stated fact which is easily perceived.

A free market approach may not be the answer to certain patients, prescribed certain drugs, to treat certain diseases. There are rarely, if ever, knowledgeable buyers. The sick and their relatives, who also may already have reached an elderly age, most often are in no shape to deal calmly, logically, or effectively with the complex and important choices that must be made.

This lack of information on part of the consumer, at least, has recently been highlighted by a CBS-sponsored research project. Of all households polled, 75 percent report that they are "only somewhat informed" or "not informed at all" about prescription drugs or their illnesses.

Conversely, in a survey recently published in the Journal of the American Geriatrics Society, most of the respondents agreed that "information to clinicians to assess the potential problem of therapeutically inequivalent drug products in the aged was inadequate."

It is not unreasonable to expect increased governmental efforts to increase the use of generic drugs in order to reduce drug costs under Medicare and Medicaid. It is also likely that neither of the current formats, negative or positive formularies, will be employed but that substitution with the least costly generic will be mandated.

On January 23, 1978, FDA responded to a request from the New York State Health Department to evaluate their list of drug products for therapeutic equivalence. On May 31, 1978, the Commissioner of FDA informed all States that a list was to be prepared of all prescription drug products that are approved by FDA for safety and effectiveness and the agency's evaluation of their therapeutic equivalence in case of multisource products that contain the same active ingredient and are identical in strength and dosage form. The list was published in October 1980 and has been revised since then. Products considerd to be therapeutically equivalent are coded "A" but are subdivided into those with no known or suspected bioequivalence problems and those with actual or potential bioequivalence problems resolved with adequate in vivo and/or in vitro evidence supporting bioequivalence.

Just recently, a list of drugs for which FDA's Office of New Drug Evaluation has already granted paper NDA's, has been published.

It has been suggested that approval process of equivalents often depends on too few patients. Furthermore, it is strongly suggested that so-called equivalents may not be equivalent enough:

FDA requirements for equivalency of phenothiazines (Federal Register, August 26, 1980, p. 56838) are as follows: "The test drug products meets the in vivo portion of the bioequivalence requirement in humans if the following conditions are met: "(i) The test drug and reference material do not differ by more than 30 percent . . ." "(ii) In at least 70 percent of the subjects, the test drug product is at least 70 percent as bioavailable as the reference materials . . ."

Stated somewhat differently, an antipsychotic generic is termed bioequivalent when in 70 percent of the test subjects it falls within plus or minus 30 percent of the innovator drug.

What may be the clinical implications when a severely ill elderly patient is switched from one product to another, if such a wide range of difference is permitted?

The very nature of the mental illnesses treated with phenothiazines mandates the use of bioavailability/bioequivalent drug products. These medically important drugs are typically used in the treatment of schizophrenia, organic psychosis, and the manic phase of manic depressive illness. Such patients are often so disabled by the severity of their illness that they cannot give legal consent. Because of the nature of

these disorders, toxic effects or lack of efficacy that may be associated with the use of bioinequivalent phenothiazine drug products may go unrecognized by the physicians. The 1979 final task force report of the American College of Neuropsychopharmacology (ACNP) points out that "often any aberration in clinical symptoms is ascribed to the idiosyncracies of the patient and rarely ascribed to differences in drug products." It was the task force's opinion that bioavailability/bioequivalence and pharmacokinetics should be of major importance in the clinical use of psychotropics should be out because of the nature of the patient population, the need for chronic use of such drugs, and the extensive metabolism of psychotropic agents.

Clearly, one should hesitate and give careful consideration whether a patient particularly an elderly patient (elderly females, in particular, are much more at risk to the side effects of phenothiazines which could be increased when a stronger but still equivalent product is used) should be "switched" from one product to another even from one generic to another.

A similar potential problem exists with loop diuretics, particularly furosemide. In this instance, the generic may differ from the innovator drug by as much as plus or minus 20 percent. A 40 mg tablet, therefore, may have the clinical effect of a 32 mg tablet or a 48 mg tablet. By itself, that range in potency may be unacceptable in certain elderly. However, when an elderly patient is also maintained on digoxin (one of the top nine drugs used for those 85 years and older, as are many diuretics) and lithium (in which the blood level is critical in the very old), careful consideration again must be allowed before substitution is agreed upon.

A proposal

It is most difficult to collect clinically valid data on these potential problems. First, scientific proof, of course, would demand that a patient, maintained satisfactorily on the innovator furosemide and switched, exhibits worsening of control. (This worsening is easily ascribed to a worsening of the disease.) Secondly, control must be reestablished by counterswitching, and finally there must be rechallenge. This is, obviously not going to take place. Clinical proof, as already outlined, is often difficult since loss of control and worsening of disease state most often present in a similar manner.

Thus, a different system ought to be applied. This system would revolve around the recognition that there are critical patients, critical diseases, and critical drugs for which generic substitution should never be mandated.

(i) Critical patients: Those 75 years and older, females, living alone, and with multiple pathology and on multiple drug regimens.

(ii) Critical diseases: Those diseases which are hard to stabilize and in which it has been shown that concurrent therapy can be a destabilizing factor, such as depression, asthma, CHF, diabetes, other cardiac problems, and psychoses.

(iii) Critical drugs: In view of the wide range allowed for "equivalancy", the antipsychotics and the loop diuretics would be the first drugs so designated.

It is further proposed that the consultant pharmacist following long-term care patients either in nursing homes or in home care also be extended the professional privilege to reject generic substitution if that seems indicated.

The pharmacist is proposed as an additional safety measure since the role of the consultant pharmacist, created by the Federal Government in 1974, has been found to be effective, both from an economic as well as a clinical point of view, by the Comptroller General. With the increasing number of elderly, both older and more seriously ill than the "normal" community-living elderly, in home care, the pharmacist may well be the one health care professional most closely familiar with the elder's reaction to drugs.

Needed: A concerted, unified effort

All of the measures outlined, whether individually performed or in combination with all others, will yield only marginal benefits unless a new and concerted approach is developed. This would involve and must involve several components of the health care industry.

Pharmaceutical industry

Those developing drugs must understand the variations in drug action that may be encountered by elderly patients. If necessary, they must develop new dosage forms which would address the special needs of elderly patients.

Testing of drugs for the elderly

Dr. Temple, of the FDA, is addressing this issue, although guidelines have not yet been issued. It is very important that guidelines be issued as soon as possible.

Labeling of drugs for the elderly

More information must be made available to elderly patients, so that they may more actively and intelligently participate in their health care. This is especially important in the area of nonprescription drugs. It is doubtful whether the labeling on the newly-approved non-prescription ibuprofen is of help to the elderly patient.

The use of drugs

None of these measures, in and of themselves, will be helpful unless those prescribing, dispensing, and administering drugs for elderly patients become much more familiar with drug action in the elderly. For example, the potentially fatal interaction of digoxin and quinidine was first described in 1975, yet in practice one sees this combination still ordered, indicating that the dissemination and acceptance and use of information available is still sadly lacking. Indeed, much more is known about drug action in the elderly than is used in everday practice.

New efforts needed

This lack of acceptance and use of information points out strongly that there needs to be greater emphasis on teaching and continuing education. In order to achieve that, a more balanced approach needs to be developed. Geriatric care is interdisciplinary care and can only be successful if an interdisciplinary approach is used. Thus, overdependence (as is evident from the recent past) on medical schools will not be the most effective means to alleviate problems and find solutions.

ITEM 4. "STRATEGIES FOR HEALTH PROMOTION: RURAL ELDERLY NEEDS," PREPARED AND SUBMITTED BY CATHERINE SALVESON

Senator Bingaman, staff members of the Special Committee, distinguished panelists, senior citizens, and members of the audience. May I express my appreciation for the opportunity to speak before you today. This hearing is especially timely, as health providers (both public health and primary care) here in New Mexico are currently in the process of attending a series of meetings to address our common concerns for the future of rural health care in New Mexico. We seek to create a community oriented coordinated care system for all citizens. I will limit my remarks to the special concerns of the rural elderly.

The necessity to pay closer attention to the continuing care needs of the elderly was documented in the 1980 State health plan. The increased prevalence of chronic disabling conditions, coupled with the aging of our population urged a response by health care providers to ensure that persons with such conditions are able to function at an optimal level for as long as possible. This is the essence of health promotion.

Today, more Americans are living to age 65 and over than ever before. The life expectancy increased from 47 years in 1900 to 73 years in the late 1970's. In 1900, only 4 percent of the U.S. population was age 65 or over, while this group comprised about 11.3 percent of the U.S. population in 1980. Persons age 65 and over constitute the fastest growing age group in New Mexico. Between 1970 and 1980, this age group grew by 64 percent.

The health condition of this growing population is not necessarily favorable. Based on a 1976 health interview survey, conducted by the U.S. Center for Health Statistics, 45 percent of persons age 65 and over have one or more chronic conditions which cause some activity/functioning limitation, and 10 to 20 percent are functionally disabled. It is these individuals who need continuing health services to promote their independence in their home communities.

These services are provided in a variety of ways. The New Mexico Statewide Health Coordinating Council (SHCC) has adopted the definition of "continuing care services" as those services which are provided to individuals with persisting physical and mental ill health conditions in order to prevent deterioration of these conditions as well as services provided to individuals in need of assistance in activities of daily living. The promotion of their ability to take care of themselves keeps them from having to use more costly and less accessible acute care services.

The elderly population of specific concern is located in rural areas. Eleven counties in New Mexico have 10 percent or more of their population in the over 65 age group. The county with the greatest percentage is Sierra County. It should be noted that health and other service providers in Sierra County indicate that during the winter months as much as 50 percent of the residents are over 65. Other counties with high percentages of elderly include Colfax (12 percent), DeBaca (18.1 percent), Harding (14.7 percent), Union (15.5 percent), and Catron (12.3 percent). Much of this is due to the in-migration of seniors from northern States who come for the warmer

winter weather and settle permanently. These counties are considered rural areas in health service delivery.

In examining the age distribution of the elderly population much attention has gone to the proportion who are 75 and over. Indications are that as people reach and exceed 75 their use of health resources tends to increase due to deteriorating health. This group are sometimes referred to as the "frail elderly." At this point in life people are more likely to require acute care and long-term care if their brittle health status is not maintained. Based on 1978 population estimates, this group comprises 2.5 percent of New Mexico's population. Only 9 of New Mexico's 32 counties are below this figure. Rural areas with an appreciable proportion of persons 75 and over are Colfax (5.2 percent), Quay (4.8 percent), and Sierra (9.2 percent). These are geographically isolated areas, sparsely populated, with limited health care resources. Efforts to contain costs and provide the appropriate level of care to this group often involve the use of mid-level providers who are sensitive to the needs of this group, especially in predominantly minority areas. Health promotion is the maintenance of one's status quo as long as possible.

REALITIES OF HEALTH PROMOTION

We are currently involved in the second public health revolution. The first is seen to be the attack on contagious disease and crisis care. The devastation of uncontrolled tuberculosis and flu are now history, although well remembered by many elderly people living today. We now make a frontal attack on risk reduction and health promotion. The national interest in a "smoke free America" and controversy over the rights of smokers versus nonsmokers did not exist 40 years ago when seniors who are currently suffering from respiratory disease smoked a pack a day. Recent nutritional research on the role of heavy fats in the development of heart disease and cancer was unknown. Health promotion for persons who now live with chronic disease is to develop daily health habits that prevent exacerbation of an incurable condition. A long walk every day and a nutritious diet are certainly part of maintenance care, as well as accesss to primary care when needed to monitor a diabetic or hypertensive condition.

House Memorial 51 of the New Mexico State Legislature in 1981 looked at long-term health care needs. Four general factors that affect an individual's health status were identified: (1) Environment, both social and physical; (2) availability of health care resources; (3) genetic makeup; and (4) lifestyle.

Of these four factors, lifestyle was identified as the one making the greatest contribution toward an individual's well being, or lack thereof. It is also the area where a person has the greatest amount of control. Research confirms that the state of health a person finds themselves in when they become aged can to a large extent be attributed to the health habits they practiced during their younger years. In New Mexico, the prevalence of low incomes (environment) and limited availability of health care resources further impacts on the aged's health status, especially in rural areas.

A look at the data reveals the importance of healthy lifestyles. An analysis of the leading causes of death in 1976 in the U.S. indicated that about one-half could be attributed to unhealthy behavior/lifestyle. According to the 1978 Public Health Services Report on Disease Prevention and Health Promotion, the incidence of 7 of 10 of the leading causes of death in the United States could be reduced if healthier habits are promoted and practiced. In 1976, 50 percent of deaths due to coronary disease, 50 percent of male cancer deaths and 33 percent of female cancer deaths could be linked to poor health practices.

It is within the mission of New Mexico's Health and Environment Department to provide access to early detection, education, and with primary care referral, direct intervention in the development of chronic disease. Approximately 15 percent of field office activity goes into adult health. Present efforts to develop a community oriented primary care system are directly applicable to the needs of elderly citizens requiring diagnosis and treatment that is not available through public health. The marriage of the prevention and early detection activities of public health with the access to diagnosis and treatment in the private and community primary care sector will allow for maximal care of people at all points on the age continuum.

It should be noted that for the average elderly person, health is defined as the absence of conditions that would cause one to lose their independence. Health promotion becomes health maintenance in the truest sense of the word. Recent changes in Federal Medicaid regulations both threatened the State's ability to care for its elders and stimulated the development of a coordinated community care program. The $3.3 billion decrease in funds initiated by the Reagan administration in 1981

caused a change in focus from institution based to community based long-term care services. Some positive effects arose out of what was called the "Medicaid crisis." Section 2176 of the Omnibus Reconciliation Act of 1981 authorized the Department of Health and Human Services Secretary to waive Medicaid statutory requirements in order to enable a State to provide for home and community based care.

This was the key to the implementation of both the New Mexico State Health Plan and the New Mexico Health Systems Plan goals of stressing community home based services. Health planners and SHCC members recognized that until the reimbursement focus changed, community based services could not be developed. This change is currently under scrutiny by the Health Care Financing Administration and its continuation and enlargement is critical if rural elderly people are to receive cost effective care accessible in their local areas. The funding of mid-level providers and extension of home health services allows for the maintenance care many elders need, and does not make reimbursement dependent on admission to an acute care facility. This is a very positive change that creates a new direction away from the condition in 1979 when 71 percent of Medicaid monies were spent to support acute care for 14 percent of Medicaid eligible persons over 65. During the same time period 0.5 percent was spent on home health care.

The continuation of Medicaid waivers and the development in New Mexico of a community oriented primary care system will allow elderly persons to receive care that is comprehensive in scope, accessible locally, culturally acceptable, coordinated with both private and public medicine, and ultimately accountable, The N.M. State Legislature allocated over $400,000 in 1984 to support the development of this concept in rural areas. Dr. Fitzhugh Mullan, Health Services Division Director has initiated a plan to enlarge communication among all participants providing care in rural areas. Continuation of Federal support to designated health manpower shortage areas will assist in the development of this incentive and ultimately meet everyone's goal of quality cost effective care.

MAJOR NEEDS OF THE RURAL ELDERLY

The realities of the development of a system that addresses the needs of rural elders in financially and politically complex. Their needs are more straightforward. A sample household survey of 500 Dona Ana County senior residents in 1980 revealed their biggest worries to be:

Problem area:	*Percent*
Money	24.6
Health	20.2
Family problems	13.4
Not enough family	10.6
Transportation	8.8

New Mexico data on the income of the elderly in New Mexico indicates a lower standard of living than the rest of the United States. In 1978, per capita income in New Mexico approximated $6,574; the comparable national figure indicated a level of $7,836—16 percent higher than New Mexico's per capita level. This lower standard of living for the general populace in New Mexico means that the elderly's situation cannot be favorable in contrast to their cohort nationwide. This is because nationally the elderly's income is usually only 50 percent of the 18 to 64 age groups spendable income. These figures are even less in rural areas.

The reason income is discussed here is because it not only impacts on the amount and type of health care services an individual can purchase, but it affects the quality of life the aged person will have. Lower income means less access to any kind of care. When Dona Ana County seniors were asked to detail what the main problem in acquiring medical care was, 59 percent indicated cost. When one cannot afford acute care, there is scant possibility money will be spent on prevention or promotion services.

In looking at health worries, data from the New Mexico Professional Standards Review Organization (PSRO) breaks down to common diagnoses by office visits to physicians per 1,000 population aged 65 and over. The data is comparable to conditions reported in the Dona Ana survey: diabetes, hypertension, chronic ischemic heart disease, arthritis and rheumatism, diseases of the respiratory system, and falls.

While any one of these conditions can progress to a debilitating state requiring institutionalization of an elderly patient, they all also respond to preventive health promotion. Diabetes is partially managed by diet and exercise (combined with ongoing medical monitoring). Hypertension likewise is partially controlled by weight

control and exercise, as is heart disease. Arthritis and rheumatism respond to gentle exercise. Falls deserve special mention.

Falls are a significant contributor to the decreased mobility of the aged. Elderly women are more prone than men. The most common cause of falls is vision impairments. Other national surveys indicate that an estimated 88 percent of the 65 through 74 age group have significant eye abnormalities. Of this 88 percent, 43 percent were not receiving treatment. The underlying reason for not receiving the treatment necessary was level of income. Unfortunately preventive care, for vision or dental problems, is not covered by third party reimbursement. Clearly a change in funding availability is needed.

It is important to remember that the provision of an appropriate level of health care to rural elderly persons cannot be provided in the same way that care is available in urban areas. At the outset, rural areas cannot support private practice physicians in the numbers that are needed. The National Health Service Corps has provided appropriate providers to health manpower shortage areas. Many mid-level practitioners (i.e., physician assistants and nurse practitioners) enlarge the capability of a physician to reach into remote areas to manage a frail elders chronic conditions. In many areas effective management of an elder's health may include consultation with the local Curandera (Hispanic medicine person).

Many individuals may need to be involved in a care plan. The promotion of health in rural areas to meet the needs of older persons must be a mix of subsidized professional care, family support, and community involvement. The commitment is to provide the simple necessities of nutrition, movement (physical and transportation), safety, and primary care. There is also a need for professional organizations to be responsive to the unique needs of rural areas. It is no real service to diagnose an elder's hypertension at a local community clinic, and then require him to drive 45 miles to the nearest pharmacy to fill his prescription for the needed drugs. The move by pharmacists to limit dispensing formulary drugs from rural clinic pharmacies by mid-level providers is not in the best interest of the patient; or the community at large that ends up subsidizing the Medicaid bill for the institutionalization that the stroke from unmanaged hypertension necessitated.

CURRENT AVAILABILITY OF SERVICES

Many elders maintain a long-standing relationship with a private physician who responds to their health needs. They may or may not need other services or the continuum of care. Others are dependent on public health and community clinics for their care.

The Health Services Division of the Health and Environment Department operates 43 field health offices throughout the State. Each office offers a full range of services meeting needs from womb to tomb. Services for adults include health screening for chronic conditions, education, referral to primary care for diagnosis and treatment, and long-term followup. Many of these services are available through programs funded by the prevention health block grant. Local public health nurses work closely with their senior citizen community to assist persons needing care in working their way through the system.

Primary care is available on a sliding fee scale at rural clinic sites throughout New Mexico. As designated health manpower shortage areas, clinics receive assistance in paying the salaries of their professional staff, thus allowing patient fees to be as low as possible. Some clinics receive additional support to offset their indigent care costs. The clinics are critical if the rural elderly are to be able to remain in their local community and manage their chronic diseases.

Visiting nursing services provide home care under a doctor's order for a designated period of time. The previously mentioned medicaid waivers have expanded the ability of home health nurses and providers to remain involved in an elder's home care. This ongoing supervision prevents acute situations from developing and intervenes early when they do arise. Unfortunately, home health care is not available in many rural areas as agencies are limited to a 40 mile range. If waivers were increased, this service could potentially be increased.

The importance of volunteers and community groups such as churches, granges, and extension clubs cannot be overemphasized as part of the community continuum of care providers. Emergency medical technicians, who do home safety checks or take blood pressures after church, are just one example of volunteers who promote their communities elders' health. The Governor's Office of Voluntary Citizen Participation seeks to promote volunteerism throughout New Mexico. Support to individuals who do volunteer work should be forthcoming in as many creative ways as

possible, from recognition, to tax credits, to matching funds to organizations who train them. The extended family in rural areas is not always one of blood.

In five communities in New Mexico programs of case management to keep a frail elder from premature institutionalization have been instituted. This is the Coordinated Community In-home Care Program. Operating through the State Human Services Department and the Agency on Aging it serves eligible seniors by organizaing a variety of services throughout a community. This may include health care, meals, transportation, friendly visits, or day care. Hopes are to expand the service throughout New Mexico. Here again, case managers are dependent on medicaid waivers to pay for many needed services and on local primary care providers who can accept indigent patients.

The problems of elderly care are not unique to the United States. Fortunately, there are models to look to. The Joint Committee on Long Term Care Alternatives, Austin, TX, reported in 1978 that in Great Britain and a few other western European countries, there are comparatively few institutionalized elders. By comparison the incidence of chronic diseases and disability is similar as are the living arrangements of the ederly.

The difference in institutional care is attributable to the availability of community/home based care. They estimated that 25 to 40 percent of patients in U.S. nursing homes are receiving care in excess of their needs as more appropriate alternatives are not available.

The Health Care Financing Administration Forum in 1979 reported on the La-Crosse Center in Wisconsin. It is a project operated by the State which provides a continuum of services to deinstitutionalize and to prevent institutionalization of the elderly, blind and disabled. A report at the halfway point of the project indicated that the quality of services was improved (better results) and that the cost for many clients was much less than it would have been for institutionalization. New Mexico is not the only State seeking a more coordinated cost effective elder care system.

Under the system being developed in new Mexico, the care system is one that provides access through a primary point where people enter and then flow through to the particularly needed care. At the entry point each person is screened and individual assessment made of needs for assistance with physical, social, mental, spiritual, and behavioral problems and of available or needed resources. Referral is made to appropriate services and providers; reasonable alternative found when services do not exist. Case management plans are developed with everyone involved. Staff in the primary entry point are responsible for working with individuals and agencies and for providing communities an awareness of service gaps.

LEGISLATIVE SUPPORT NEEDED

There is no way to isolate the rural elderly completely. Not providing a system that meets their health needs merely hastens their entry into the acute care and institutionalized system of care that has proven to be so costly to every taxpayer and so unacceptable to the elderly themselves.

Ongoing support to professionals in the National Health Service Corps will allow rural primary care clinics to continue functioning and meeting the needs of the rural population. Without such clinics, the barriers of geographic distance and income prevent many elders from receiving the preventive care that maintains their independence.

The Medicaid waivers that allow long-term nursing support or care at home by a physicial therapist, home health aid, or physician's assistant are crucial to the develpment of community based systems.

Incentives to agencies and families that provide volunteer support to older persons need to be developed. Matching grants to creative community projects or tax incentives help promote ongoing volunteerism. Recognition of the extensive senior citizen volunteer programs through minimal financial support has proven very valuable (i.e., Senior Vistas through the Department of Labor.)

The preventive health block grant given to States for health promotion efforts is an effective means of supporting public health programs that reach every community in New Mexico through local field health offices. Enlargement of the grant would increase the capability of public health departments to take a lead role in coordinating a community's care for older adults.

Ultimately, the essence of rural health promotion is one of necessary funding and incentives to eliminate fragmented services. With support from both Federal and State legislation, and the commitment of communities to work in coordination, we have the potential to provide the services that are needed.

APPENDIX 2

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND ENCLOSURE FROM J.M. MCGINNIS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH; DIRECTOR, OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO SENATOR JEFF BINGAMAN, DATED SEPTEMBER 6, 1984

DEAR SENATOR BINGAMAN: I am sorry my travel schedule will not permit me to testify at the October 12 field hearing on promoting the health of older Americans. As you may be aware, this office is embarking on a large-scale public education program on health promotion for older people. Enclosed for your information is a copy of the executive summary, Aging and Health Promotion: Market Research for Public Education. This project, undertaken with several other agencies, provides background on the health problems experienced by older people, findings from focus groups with older people which were conducted to determine what actions they were willing to take to improve their health, and a description of the channels of communication older people rely on for health information.

If the opportunity to testify arises again, I would be pleased to join you, schedule permitting. I would also be happy to provide additional information on the activities of this office in health promotion for older people.

With best personal regards.

Sincerely,

J.M. MCGINNIS, M.D.

Enclosure.

AGING AND HEALTH PROMOTION: MARKET RESEARCH FOR PUBLIC EDUCATION

INTRODUCTION

With the publication by the Office of Disease Prevention and Health Promotion of Healthy People: The Surgeon Generals Report on Disease Prevention and Health Promotion in 1979, of Promoting Health/Preventing Disease: Objectives for the Nation in 1980, and the publication of a health promotion agenda [1] by the National Institute on Aging in 1983, the ground work was laid for a collaborative program to educate the public, particularly the elderly, to the potential gain of controlling personal health risks.

It is impossible to escape the demographic information about the population surge in older groups. It is difficult to go a day without a confrontation with the economic problems caused by illness. The ethical and social imperatives of the needs of the fragile and ill elderly are pressing concerns in our contemporary society. One obvious course is to eliminate all possible illness and injury to the extent possible. The most evident path is to encourage and educate people of all ages to prepare for a healthy and active old age.

Any preventable injury with its attendant pain, financial cost and disability is a sad event. Any disease caused by self-controlled behavior is increasingly unacceptable. Any lack of clear communication of the established risks associated with smoking, lack of exercise, misuse of medications, or poor nutrition is a failure that can no longer be afforded. Once it was reasonable to focus on children and to accept without question that effort extended toward the elderly might be less productive than was justified. Once it was unquestioned that the elderly were "set in their ways" and unlikely to benefit from health advisories. Once it was agreed that if damage was done, say from smoking, that it was so well established by the later years that

[1] "Report of the National Advisory Council on Aging for a National Plan of Research on Aging", 1983 (a response to "Toward An Independent Old Age: A National Plan for Research on Aging," NIA.)

the gains from cessation would be negligible. Today none of this is possible to defend.

The myths were cracking when this market research was begun and should be shattered with the publication of the report of this collaborative research. Studies show that four out of five older Americans find themelves in comparatively good health. There should no longer be any doubt that the elderly are as interested in learning about maintaining and improving their health as any group in our society and that they are furthermore willing to make changes in lifestyle to be healthier.

RESEARCH OVERVIEW

Research was undertaken by the Office of Disease Prevention and Health Promotion, the Administration on Aging, the National Institute on Aging, and the National Cancer Institute to determine the interest of older people in acquiring health information and their ability and desire to make lifestyle changes, if necessary, to improve their health.

This report provides background information to help plan health promotion programs for the elderly, and identifies effective ways to communicate information to older people about maintaining health.

The study consists of three major tasks:

A review of health promotion topics.—Data concerning the health problems of the elderly, the risk factors associated with those problems and the potential of health promotion activities in six areas were reviewed. The areas are: Physical fitness and exercise; nutrition; prevention of accidental injuries; safe use of medications; smoking; and preventive health services.

Focus groups.—A series of 15 focus group discussions were conducted to explore in an indepth fashion and to encourage spontaneous comment on the health topics covered in the literature review. The purpose of the focus groups was to develop a greater understanding of the perceptions of older persons regarding health, to identify important concerns, to explore whether there concerns may vary on the basis of age, socioeconomic level, retirement status or ethnicity, and to identify areas in which more information is needed.

A focus group is a qualitative research method. It relies on a unique group discussion format lead by a moderator. The moderator guides the discussion following a predetermined topic outline while facilitating interaction among group members. Focus groups provide a rich source of information for planning public education programs. However, since this method must rely on small numbers of participants, the results must be interpreted carefully and plans made only after careful examination of other sources of data.

Nine of the focus groups were held in five different locations in the Baltimore-Washington, DC, area. The first six of these groups were exploratory in nature, examining such topics as major health concerns, health-related activities, exercise, nutrition, accidents and safety, and sources of health information. Based on the results of the groups, the topic outline was modified to probe more deeply into the subjects of nutrition and exercise and the effects of retirement on health.

The six focus groups that used the first topic guide differed in terms of participant age and socioeconomic level. Three age categories were used: 58 to 64, 65 to 74, and over 75. In addition, in four of the groups, the 58 to 64 and 65 to 74 groups were divided between "higher" and "lower" socioeconomic levels. "Higher" and "lower" are used here to compare the groups to each other and do not imply extremes of low and high income.

The second topic guide was used with the remaining three groups in the Washington, DC area. The structure of two of these groups was based on results from the first six groups in which it was generally observed that older participants (age 65 and older) were better adjusted to their life situation than their younger counterparts (ages 58 to 64), and that the younger participants appeared to be much more in transition. Since retirement was viewed as a possible watershed event in this transition period, it was decided to screen participants for the next two focus groups on the basis of retirement status rather than age, while retaining the "lower socioeconomic level, nonprofessional" makeup of the group. The third group using the second topic guide was recruited in a Federally subsidized apartment building for senior citizens.

It should be noted that although participants were not recruited specifically for race, there were a few nonwhites present in each group.

A parallel project conducted six focus groups in the Los Angeles, California area. Using the same topic guide, these groups were specifically recruited to examine the health concerns of low-income black and Hispanic elderly. Two groups of black

women (ages 58 to 64 and 65 and over), two groups of Hispanic women (ages 58 to 64 and 65 and over), one group of black men ages 58 to 64 and one group of Hispanic men aged 58 to 64 were convened.

All participants in these groups had less than a high school education and had incomes ranging from $200 to $1,200 per month. Average income was $438 per month. It should be noted some participants were "without papers" and therefore not eligible for any government benefits.

Channels of communication.—A third component of the study reviewed data on the media habits and the demographic characteristics of older Americans. The intent of this review provides information about channels of communication that may be effective in reaching older audiences. This review analyzed data from a nationally representative sample of 19,248 adults interviewed in the 1983 Study of Media and Markets conducted by Simmons Market Research Bureau, Inc.

THE NEED FOR HEALTH PROMOTION

The time is right for a health promotion program with older people whose numbers are steadily growing. Currently, 28 million people, 11 percent of the population, are 65 or older. This proportion has grown dramatically (only 4 percent of the population in 1900 was over 65) and will continue to grow. There will soon be a significant change in the age distribution of older persons in the United States. The number of people 75 or older will increase 71 percent by the year 2000 (Rice and Feldman, 1982).

Functional independence.—Health problems, especially chronic illness, frequently limit the functional independence of older people. Nearly 80 percent of those 65 or older have at least one chronic condition. The most common problems reported are arthritis (44 percent), hypertension (39 percent), hearing loss (29 percent), and heart problems (27 percent) (NCHS, 1982). Noninstitutionalized persons 65 and older reported an average of 39 days during 1980 when their activities were restricted because of health problems, and 14 days when they were confined to bed—rates that are more than two and a half times higher than those for individuals 17 to 44 (NCHS, 1982).

Health costs.—While comprising 11 percent of the population, older persons account for 30 percent of health care spending in the United States. Health care expenditures for the elderly exceed $50 billion annually. Such costs place a severe burden on the economy. They also suggest the potential cost benefits of health promotion with older Americans (Bladeck and Firman, 1983).

Not only is there a real need for health promotion among the elderly, but many older people are very interested in health, have the time to engage in healthful activities, and may be particularly responsive to health promotion.

National surveys have found that older populations are very interested in health information (NCI, 1984, Urban Behavioral Research Associates, Inc. 1981). The evaluation of the Healthstyle Campaign revealed that older adults expressed significantly greater interest and concern about health issues than did younger groups. This finding was true among white, black and Hispanic populations (Hersey, Probst, and Portnoy, 1982).

An evaluation of California's "Friends Can Be Good Medicine" public education campaign found that respondents 65 and older showed greater gains in knowledge and changes in behavior than did younger age groups (Hersey and Klibanoff, 1983).

Studies have shown the potential of older people to change their behaviors to positively influence their health status. While there is need for caution about "overpromising" the results of health promotion, the goal of maintaining functional independence for as long as possible appears obtainable. Just as importantly, changes in health practices can affect the outlook and quality of life of older people.

HEALTH CONCERNS OF OLDER PEOPLE

Of particular importance to this study was the examination of differences in responses among the various focus groups that could be attributed to differences in age or socioeconomic level or ethnicity. Overall, it was found that similarities among the age groups and socioeconomic levels and black and Hispanic groups were far more salient than the differences. However, there were a few consistent differences that should be pointed out:

—Those in the higher socioeconomic groups tended to have more information related to health than those in the lower socioeconomic groups. They also tended to be more vocal about their attempts to consolidate conflicting pieces of information. They were the only respondents who complained of an information overload, with their major difficulty being what to believe.

—Those who had living parents (either their own or their spouse's) were more likely to focus on aging with respect to their parents than with respect to themselves. Although having living parents seemed to affect one's self-image as "not being old" it did not seem to influence other perceptions or behavior related to the study topics (e.g., exercise, nutrition, safety).

—While it is difficult to analyze for participant differences within a single focus group (e.g., men versus women), one characteristic had an obvious influence on the health-related study topics. Participants who had serious medical problems, particularly heart attack victims, were much more knowledgeable about health issues and more likely to be following healthy nutrition and exercise patterns. If these individuals had been screened out of the groups, the levels of knowledge would have been significantly lower.

With the exception of the differences noted above, differences among the groups were minimal. In reading the focus groups findings contained in the following sections, the reader should assume that there are no distinctions between age categories or socioeconomic levels or ethnic groups.

Even though concerns among these groups are remarkably similar, special attention still needs to be given to making educational materials and programs attractive, credible and relevant to different economic and cultural groups.

Across all of the focus groups there was an overwhelmingly positive response regarding the importance of health and participants' interest in issues related to health. When asked "What are your most important health concerns?" each participant enumerated a number of personal as well as general concerns. Two concerns not directly related to health behavior were consistently brought up—health care costs and maintaining one's independence.

A significant concern and dread over health care costs was expressed as either the first or second issue in each group conducted. Under the heading of health care costs, respondents were most vocal about the cost of hospitalization, nursing home costs, and insurance issues. Also expressed was some concern over the possibility that Social Security and Medicare payments might soon be either reduced or terminated, further limiting the elderly person's ability to cope if serious illness strikes. It should be remembered that some group participants were not eligible for these benefits.

Related to the issue of health care costs were concerns about being incapacitated and alone. Participants frequently expressed a concern about maintaining their independence and not becoming a burden to others.

The following issues, in addition to health care costs and independence, were stressed repeatedly by participants: Diet/nutrition/overweight; exercise/staying active; high blood pressure/salt intake; heart condition/heart attacks/cholesterol; arthritis/mobility; eyesight/cataracts/glaucoma/night driving; loss of hearing; medication/side effects/lack of information; dementias/Alzheimer's disease; circulatory problems/strokes; and diabetes.

Less frequently mentioned health concerns included: Cancer; medical services/hospital conditions/availability of doctors; digestive problems; deterioration of teeth; skin changes; sleep problems; lung diseases; and crime-related injuries (low-income groups).

An overall impression was that older people have a definite orientation toward staying well and maintaining good health. This orientation can be attributed, in part, to their fear of becoming sick and their accompanying concern about rising health care costs and loss of independence. It is important to note that participants voiced a wide array of concerns related to improving or maintaining their health; they did not simply use the group forum to talk about their individual health problems.

Participants were asked to discuss the specific things that they do to stay healthy or improve their health. Interestingly, the most prominent theme that emerged dealt with the need to "stay active" and have a "good mental attitude."

By staying active, participants were more likely to mean staying busy or involved with peoople than physical activity. For example, under the rubric of "staying active" were such things as sewing, cooking and entertaining, visiting one's children, fishing with one's grandchildren, singing, doing crossword puzzles and doing things for others.

Related to staying active was participants' emphasis on the importance of one's outlook or attitude concerning life, including the need to keep interested—to have one's brain working, to have a good mental outlet.

The issue of staying active was probed in more detail in relation to retirement among participants in the two "retired" groups. As with other groups, participants felt strongly that staying busy was essential. Many felt that they were busier now

than when they were working. Overall, participants felt that retirement was a positive experience. Those who faced adjustment problems seemed to overcome them by increasing their activities through new pursuits or through "semiretiring."

As a side issue, retired participants were queried as to whether it is important to maintain a structured lifestyle after retirement. Participants were split on this issue. Some strongly agreed that a structured routine was necessary while others were adamant that now was the time to relax.

"You must have a schedule of things to do, or else you get in trouble if you sit around."

"That's the idea of retirement—you do what you want when you want."

Participants seemed to differ by age on their attitudes toward senior citizens centers as places to go for organized activity. In general, younger participants were not attracted to these centers, referring to the atmosphere as "depressing," while older participants applauded the social benefits of these centers, viewing them as a kind of "lifeline." It should be pointed out, however, that two of the older (75+) groups were recruited through a retirement center, which may have contributed to their strong positive viewpoint.

In general, the elderly seemed to be strong subscribers to the philosophy of staying active, both physically and mentally. Involvement with life was of foremost importance to them.

Besides the firm resolve of participants to stay active and maintain a positive outlook, two major categories of activities were described as means of staying healthy. These categories were exercise and nutrition.

Apart from exercise and nutrition, participants remarked upon a few other activities. These included:

—Monitoring blood pressure—a significant number of respondents mentioned using free screening programs while others lamented the fact that there was no inexpensive means for checking blood pressure (e.g., doctors visits were too costly).

—Doing things in moderation/self-discipline.

—Regular checkups/doctor's visits.

—Rest and relaxation.

In conclusion, it was clear from these discussions that the participants were active, vigorous, and health oriented. Health was a top-of-the-mind issue for them, as evidenced by their enthusiasm and interest in discussing it. Furthermore, participants were not just sickness or problem oriented; they were very much concerned with the notion of staying well. Participants sought information from one another, asked questions, and requested clarification. As a whole, their receptivity to new or additional health information appeared to be high.

Given the salience of these concerns, older adults may be one of the groups most interested in information about health. In contrast to younger age groups, older people are already seeking health information. Hence, an effort aimed at correcting misinformation and reconciling confusing advice may be valuable.

A nationwide health promotion campaign for older people should be initiated. Specific recommendations are provided regarding exercise, nutrition, accident prevention, safe use of medications, smoking, and preventive health services.

EXERCISE AND PHYSICAL FITNESS

Exercise and physical fitness can play a central role in health promotion efforts with the elderly. Evidence indicates regular vigorous exercise can reduce the risk of heart disease, improve cardiorespiratory fitness, and improve general health and morale.

In focus groups, older people were found to be proponents of exercise, with walking being the most frequent mentioned exercise activity.

While excerise was considered important, there was no consensus on the level or type of exercise that is appropriate.

"It's more important now—we're more inactive."

"At our age, any kind of exercise is good."

"Older people do not need as much exercise; but they need to make far more effort, cause the young get it anyway, regardless."

"I'm still working so I get enough exercise. When I slow down, I'll certainly think about it."

"When you been on your feet all your life you don't go looking for more exercise."

It is clear from several of the examples given by focus groups participants that for some, the concepts of "staying active" and "exercise" are interchangeable. Also worthy of note is the difference in attitude and behavior of heart patients regarding

exercise. Individuals with heart problems who paticipated in cardiac rehabilitation programs were more knowledgeable and more adamant about following an exercise regimen than were individuals without heart problems. These individuals demonstrate the ability of older people to adopt and maintain a vigorous exercise program.

While older people may be aware of the benefits of exercise, many older individuals fail to exercise regularly. The 1975 Health Interview Survey found that 57 percent of people 65 and older (and 56 percent of people 45 to 64) reported getting no regular exercise. The frequency of regular exercise was particularly low among older women, and among low income and minority groups.

Although focus group members agreed that there are benefits related to exercising, they appeared to be conscious of their own limitations as well as other obstacles to becoming more physically active. These included such things as perceived risks and environmental factors. In addition, most participants showed a relatively low level of knowledge about proper exercise which in itself can be construed as an obstacle. These areas are expanded upon below.

Physical limitations.—Focus groups participants were very open about the physical changes that they have experienced as they have become older. There was also a certain sense of acceptance of these changes, particularly among those over 65 years old. While they talked about the need to realize their limitations, they also stressed the importance of remaining physically and mentally active.

"You've got to realize your limitations and live with them. Everything wears out sooner or later.

"I get tired quicker than I used to. It aggravates me that I can't run a mile in 10 minutes. In your mind you can still do all these things."

"I've slowed down, don't have as much energy. I used to dance every dance, now I sit down after two or three dances."

"I suppose you're gearing this to the exercise we can do, not stuff we gave up years ago, like handball."

Fears and perceived risks.—Accompanying their physical limitations were an assortment of fears and perceived risks. The most frequent fears included "overdoing it", broken bones, heart attacks and strokes.

"If you feel yourself under stress don't (exercise). If you keep going after you get tired, you can bring your blood pressure up and get a stroke."

"People are either afraid or lazy. Out of the 25 women that come to the (retirement) center, only 4 go to exercise. They're afraid of hurting themselves."

"Older ladies fall and break bones and die within a year because they can't move around."

"Fear of heart attacks, stroke too, blood clots, keeps people from exercising."

As indicated in several of the comments above, there is some degree of misinformation among the elderly concerning the actual risks of exercise and particularly the relationship of exercise to heart attacks. A small number of participants also voiced the belief that any exercise is risky for an older person.

Environmental factors.—Participants also brought up various factors in the environment that affect their ability to remain physically active. These factors include social support, availability of programs geared to the elderly and proximity of facilities. Each of these factors was mentioned as either an obstacle or a "facilitator" depending upon the individual's situation. For example, some participants said that they didn't exercise because they lacked a companion, while others mentioned that having people to exercise with was a major incentive to exercise.

"I get up every day now . . . I go out, I walk for two or three hours with friends of mine . . ."

"I have a dog, I take him out walking three times a day in good weather . . ."

"I'll tell you why I quit (playing racquetball). I couldn't find someone my age to play with and I'll be damned if I'll play with someone 25 or 30."

As mentioned, the availability and especially the proximity of facilities were given as factors contributing to or hindering the physical activity of the elderly.

"If Spa Lady wasn't so close, I wouldn't do so much."

"You really don't get that much opportunity to dance, not that you don't have to go more than 5 miles or about 15 minutes to get to it."

"I think that proximity is one of the things that motivates you an awful lot. If you have to go way out of your way, it's not very likely you're going to exercise frequently."

Lack of time to exercise was cited by Black and Hispanic women with heavy family responsibilities.

Aside from exercise facilities, group members discussed the need for programs adjusted to the physical limitations of the elderly.

"There you go again, everyone can't do dance . . . maybe you can't do Jane Fonda, but you can still do the stretches."

"Aerobics can be too strenuous—but there's a program for people to do it in the water so not to get jarred."

Also mentioned was the need to participate with one's own age group and in sports where not too much quick physical activity is required.

In addition, several Hispanic women thought some exercise, specifically dancing for older women, was inappropriate in their culture.

Knowledge of proper exercise.—A consistent theme running throughout the groups was the low level of knowledge regarding "proper" exercise programs. Before reporting on the focus group findings in this area, it would be useful to review briefly some of the current facts about exercise, particularly as it relates to cardiovascular disease.

The physical and psychological benefits of exercise have been clearly demonstrated. As the heart and muscles of the body become "trained" through exercise, blood pressure is kept at a lower level, and the heart is allowed to beat more slowly while pumping a larger volume of blood with each beat. As a result of these changes, the overall demand placed on the heart during activity is decreased. Mentally and emotionally, exercise has been shown to increase energy, combat anxiety and depression, help in coping with stress, and improve sleep.

In order for exercise to improve the condition of the heart, several criteria must be met. The exercise must be brisk (raising the heart rate to 60 to 75 percent of its maximum capacity), sustained (done at least 15 to 30 minutes without interruption), and regular (repeated at least three times a week at a comfortable pace). Aerobic exercise (fast walking, jogging, rowing, bicycling, swimming) is considered more beneficial than other forms of exercise for conditioning the heart.

Although there are risks to exercising, physically active people are not more likely to have sudden, fatal heart attacks than inactive people. In fact, people who go through a physical training program after their first heart attack appear less likely to die of a second heart attack. To establish individual exercise limits, individuals are advised to monitor their pulse rates and not to push themselves beyond the point where exercise is enjoyable. In addition, it is recommended that they use common sense by listening to their body for early warning pains and by being aware of the signs of possible heart problems. Following a gradual and sensible exercise program is considered the best way to minimize the risks of exercise and maximize the benefits.

As previously discussed participants in focus groups valued "staying active" which they equated with a broad array of activities; including crossword puzzles, crocheting and housework as well as walking and swimming. People did not seem to distinguish between different levels of physical activities; for example, bowling and mopping floors were considered equivalent to exercise classes and swimming.

When probed on whether all forms of exercise are equally good, participants were basically uninformed. One individual said he thought some activities were probably better than others. Another man said, "At (our) age, any exercise is good."

Participants were only somewhat familiar with the term "aerobic." To them, aerobics implied "exercising to music." As one woman put it, "We can't do the fast ones—the Jane Fonda (ones)—but there are some for senior citizens." Participants did not spontaneously associate aerobics with increasing oxygen uptake or improving one's cardiovascular condition. However, a number of individuals were aware of the importance of walking "briskly", compared to just walking.

For the most part, group members were wary of exercises that make the heart rate increase. Their general attitude seems to be expressed by one group member who said, "You shouldn't do exercises that make the heart go too fast—maybe exercises that make the heart go, but not too fast." They also agreed that it was good to do exercises designed specifically with the intention of not making the heart go fast (e.g., stretching exercises). Only one man had any idea what his heart rate should be, and he was a heart attack patient who participates in a formal exercise program and is monitored twice a week.

"My doctor told me, you need to walk two miles—briskly, at a certain pace. I can only go (pulse rate of) 135; each individual has his own limit."

As a whole, participants were not aware that exercise must be sustained (15 to 20 minutes) and done regularly for maximum value. There were, however, some exceptions. One individual stated that he exercises at least three times a week and feels "a heck of a lot better. If you get into a regular routine, then you're into it, you get addicted to it." Another woman stated that she walks around the shopping mall and up and down stairs more than once a week ("I walk at a nice pace, but I don't run.")

Very few participants talked about following a planned exercise program (except heart patients), building up gradually, warming up (stretching) prior to exercise or cooling down after exercise. However, group members repeatedly emphasized the need to seek medical advice prior to embarking upon any strenuous exercise or physical activity.

These findings provide clear direction to formulating accurate information for older people regarding how to exercise safely and beneficially.

It will also be useful to emphasize the kinds of exercise that are appropriate for older age groups (such as brisk walking). In addition, community groups will need to increase opportunities for exercise and help provide social support for beginning and maintaining an exercise program.

NUTRITION

The importance of good nutrition in maintaining health is unquestioned and there is a growing body of epidemiological and clinical evidence suggesting a relationship between diet and many chronic diseases—heart diseases, stroke, hypertension, cancer and osteoporosis.

Nutrition, like exercise, was an issue of widespread concern among focus group participants even before the topic was raised by the moderator. Many individuals mentioned weight control (the most common manifestation of "nutrition") as one of their primary health concerns, and others included eating moderately, watching their salt, sugar, and cholesterol intake, or maintaining a good diet as one of the general things they do to stay healthy.

There were, of course, occasional dissenters who offered such observations as "I don't watch my weight because I like to eat," and "Nutrition is what you like." There was also the gentleman who ascribed his continued good health to a "bloody mary before breakfast, a martini before lunch, (and) two martinis before dinner." In general, however, most participants who had observations about drinking talked about the need to cut down on alcohol consumption for the purpose of weight control.

As a whole, the women participants seemed more concerned about nutrition than the men, at least given their greater propensity to talk about this topic.

Knowledge of nutrition

Despite the general concern expressed by focus group members about nutrition, actual concrete knowledge of what constitutes "good" nutrition or a "balanced" diet was largely lacking. Although there were the few self-confessed health nuts most of the individuals in the groups were unable to put forth a comprehensive, detailed description of what constitutes a balanced diet. Even when specifically queried about the basic food groups of importance, responses were incomplete and/or incorrect.

In general, focus group respondents tended to concentrate on individudal components of a good diet. Only in the groups where a more detailed description of the basic food groups was specifically probed for, was the following listing achieved:

—Meats (fish, poultry, pork, beef, nuts, eggs).
—Greens (spinach and yellow and green vegetables).
—Cereals (bran, dark bread, wheat, oats, rye, rice, pasta).
—Fruit.
—Dairy products (cheese, eggs, yogurt, buttermilk, butter, margarine).
—Beer, wine, whiskey.
—Other foods (desserts, sweets, pasta, soda).

As indicated by the inaccurate list which was generated, there was some confusion over the basic issue of whether the food groups are organized by category or by content. In addition, the location of certain food (eggs, pasta) in the list was in question.

It is important to note here that participants displayed a mixed level of knowledge about the elements of a good diet, with contributions to the discussion coming in a rather piecemeal fashion. While the groups were able to produce a list of food groups, such as the one above, as part of a group effort, it was clear that very few individuals had a comprehensive knowledge of what constitutes a good diet, and none seemed to be "living it."

Food selection and preparation.—In contrast to their lack of knowledge about what should be included in a good diet, participants were much more knowledgeable about what should be avoided or omitted. Prominently mentioned were:

—Lowering cholesterol intake, especially by reducing egg consumption or avoiding eggs entirely, and "cutting down" on consumption of "fatty" meats or red meats.

—Decreasing salt intake.
—Watching sugar and "sweets" consumption.
—Avoiding caffeine.
—Avoiding junk and convenience (highly processed) food.
—Cutting down in general on the amount eaten.

Also mentioned was the need to avoid eating a lot of fried foods and to obtain fresh foods (as opposed to canned foods) whenever possible.

It should be noted that there was some confusion among participants over whether red meats should or should not be included in one's diet. On the one hand, many talked about the protein found in red meat; on the other hand, some were concerned with the excessive amounts of fat/cholesterol in red meat as compared to other protein sources (poultry and fish).

Suggestions about food selection and preparation revolved mainly around the desire to preserve the nutritional value of one's food while reducing cholesterol intake. Suggestions included the following:

—Broiling foods instead of frying them.
—Selecting fresh vegetables, steaming them and then freezing them if necessary (". . . canned foods may lose nutrients, plus (they) have salt and sugar").
—Trimming the fat from meat and removing the skin from chicken.
—Substituting herbs for salt in food preparation.
—Substituting poultry and fish for red meats.
—Substituting low fat versions of milk (skim, 2 percent fat), and using margarine instead of butter.
—Selecting lean cuts of meat.

These findings parallel changes in food consumption patterns which are evident from national data. Per capita consumption of red meat dropped 6 percent between 1970 and 1979, while consumption of poultry increased 26 percent; per capita consumption of low-fat milk increased nearly four fold since the 1960's (USDA, 1981).

Knowledge of nutrients.—Knowledge of specific nutrients was probed in greater detail with two of the groups. Although most participants seemed to be convinced that a balanced diet would include all the necessary nutrients/vitamins/minerals, many admitted that they think about or take supplementary vitamins anyway.

"I take a multivitamin once in a while."
"People who live alone should take vitamin C and vitamin D."

Then, of course, there were the dissenting opinions:

"I've been to three doctors and not one wanted to give me vitamins."
"I never took a vitamin in my life."

Spontaneous discussion of calcium was not especially high.

In contrast to calcium, a number of individuals spontaneously brought up the importance of fiber in one's diet, although exactly what fiber is was not always agreed upon.

With the exception of salt and sugar, few individuals expressed concern with additives in food, although at least some in the two groups where greater detail was sought said that they read food labels partly to determine whether additives or preservatives are included, rather than to determine nutritional content.

"I've been much more conscious in recent years (of harmful things in food) . . . (it's) diverted my mind from nutrition. I'm so afraid of being poisoned from additives . . . and cancer . . . botulism . . . EDB . . ."

"I embarrass my wife reading the labels all the time. I look for no sugar, number one, and as little of the additives as possible . . . nitrites, nitrates, that stuff."

Weight control

Although many of the issues dealt with above are associated with weight gain/loss, there are others which are more closely related. In general, cutting down on the amount of food one eats was stressed by a number of people, as was eliminating sugar (sweets) and alcohol. Other observations about weight loss and being overweight included:

". . . in order to lose weight, you should stay around 1,000 calories."
"You have to eat 1,500 to 2,000 calories a day if you want to lose weight."
"I don't count calories. I just eat three good meals a day."

Rigorously counting calories does not seem to be the generally preferred method of weight control.

Whether or not to drink alcohol (and, if so, how much) constituted the issue with perhaps the most varied perspectives. There seemed to be no real consensus regarding the value of alcohol, and beliefs ranged from that of the previously-mentioned man who partly attributed his good health to four drinks a day (spaced properly) to a number of teetotalers. In one group, moderate alcohol consumption was touted as

being somewhat beneficial; benefits ranged from improving one's appetite to being good for the stomach and helping insomnia.

Obstacles to good nutrition and weight control

Participants were asked to think about those factors which affect their ability to stay on a healthy diet and maintain good nutrition. A number of barriers or obstacles were identified.

Many of the obstacles identified were psychological in nature and therefore are difficult to combat. For example, a number of individuals subscribed to an attitude best described as complacent; in other words, "do what you're doing as long as it works." Other individuals said that being weak-willed or bored made it difficult to maintain a proper diet, especially a diet for weight management. In addition, the need for support from one's spouse or family was expressed.

". . . you get so bored you want to do something daring, like eat an egg."

"I think one of the biggest problems with food is cultural patterns of eating. It's very hard for one person in the family to break patterns when the rest don't really want to."

"Wife cooks too good."

"Sweets is my downfall."

Another barrier that is difficult to deal with directly is the cost of healthy food, both in terms of price and of convenience.

"Salary . . . money. The money has got a lot to do with it."

"Food is going up, up, up, so what do you do, you eat cheaper food, something to substitute, but it's not filling your appetite or your desire."

". . . I found strawberries at the supermarket a couple of weeks ago (for) $1.79 for a little carton . . . I ate them all . . . People that are elderly, their life isn't guaranteed. They don't know when they're going. So why go away from here hungry?"

In contrast to the barriers cited above, a number of obstacles were identified relating to specific behaviors and to informational needs, both of which may be amenable to intervention. Some specific problem behaviors mentioned included:

—Keeping extra food out of the house.

—Shopping when you're hungry instead of using a shopping list.

—Dealing with the ease of use and availability of convenience foods.

—Making and eating too much when one is cooking for one's self.

—Drinking alcohol.

Informational gaps and the amount of contradictory information in existence provide a category under which a number of barriers are subsumed. For example, some people were uncertain about where they could find restaurants serving a nutritious meal for a reasonable amount of money. This is especially problematic for people with dietary restrictions and food allergies—two conditions which become more and more likely with increasing age:

"You find more and more foods you can't handle . . . so you keep cutting them out of your diet until you finally get down to where you're much more restricted . . ."

"I don't like going out to eat in the restauants, because I can't get the foods I like to eat."

The major problem related to information concerns the degree of confusion regarding specific information about nutrition. This confusion incidentially, appeared to be most acute among the better educated or higher socioeconomic class individuals—those, in fact, who specified that they tried to research the information available about nutrition.

"But I don't know, I get confused over all the advertising. They talk about margarine—you should eat low saturated fats—and yet you wonder whether that's good for you or isn't good for you and how much should you eat of it and do you have to eat it in moderation or can use it like you'd like to use it . . . it's very confusing."

". . . (information about) cholesterol goes up and down too."

A couple of individuals felt that lack of information was even at the root of the cost issue. For example:

"It's not always a question of money. With some people it's a question of proper selection . . . they'd probably spend the same amount of money for a well selected diet as they would for a diet that is incomplete. But, here again, it is a matter of information."

". . . a lot of us aren't educated to what we should eat . . ." "If people had access to more information . . . in the long run it would be better for them."

Authoritative information stated in behavioral terms (do's and don'ts) would be appreciated. One older man admonished:

"What kind of food should you actually eat and how much, how much calories of each approximately? Be specific when they're telling you what to eat. Instead of

saying 'eat carbohydrates,' tell them what foods carbohydrates are in. Because they say 'eat protein,' you say, 'now what do I get? How do I get protein?' You don't always know what food carry the vitamins you need."

In order to adequately design nutrition information for older people, a number of things must be kept in mind. It is important for older adults to have essential nutrients. However, older adults have lower energy requirements and may tend to eat less or eat foods that do not supply need nutrients. It is more important as one ages that special care be taken in selecting foods in order to meet nutritional needs. In a recent review, Harper (1981) recommended two basic dietary guidelines for the elderly:

—The best guide for meeting essential nutrient needs is based on four food groups: (1) meats, fish, poultry, and beans; (2) milk and dairy products; (3) vegetables and fruits; and (4) cereal and grain products, including breads. Daily selection of two servings from the first and second group, and four servings from the third and fourth groups will provide between 80 and 120 percent of the Recommended Daily Allowances (RDA) for essential nutrients.

—A second dietary guideline for the elderly is not to allow alcohol and purified fats and carbohydrates, which are poor sources of essential nutrients, to displace foods in the basic foods from the diet.

In encouraging healthy nutrition, it will be important to recognize the cultural aspects of food. A campaign that simply emphasizes health benefits may fail to change eating habits rooted in cultural tradition. To overcome such barriers, it may be useful to stress the good taste and appeal of desired food alternatives. An emphasis on substitutions may be particularly valuable with older adults who may express a wide range of individual food preferences. Although different groups express the same concerns, materials will need to be designed in culturally acceptable formats.

Another nutritional problem of aging is obtaining calcium, which can result in osteoporosis—brittle bones. This disease is believed to precipitate nearly 200,000 hip fractures a year, primarily in white elderly women, and is a major cause of disability in old age. It is also an illness that may be largely preventable. The American Medical Association (1979) states, "although the precise etiology is unknown, there is some agreement that adequate calcium intake and continued physical activity are important in the prevention of osteoporosis." An NIH Concensus Conference Report on Osteoporosis (April 2–4, 1984) advised 1000 mg of calcium daily for premenopausal and estrogen-treated women and 1500 mg for postmenopausal women to maintain bone strength. The report also stated increased calcium intake may prevent age-related bone loss in men as well. Only a few participants in the focus groups were aware of the relationship between calcium and osteoporosis; and awareness of the relationship between calcium retention and exercise was completely lacking. Hence, these areas might be particularly fruitful ones for health promotion messages. Dairy products are a good source of calcium, but may be high in fat. Therefore, emphasis should be on "low-fat dairy products" to avoid conflict with messages about reducing fats. Since some older adults have difficulty digesting milk, health messages should provide information about non-dairy sources of calcium. It will also be important to stress the role of exercise in the prevention of osteoporosis.

Lack of exercise and low calcium is not simply a problem of old age. The median calcium intake of American women is 40 percent below recommended levels at almost all ages (Heaney, 1982). Therefore, while messages for older people regarding the importance of adequate calcium are important, they would be valuable for other age groups as well.

In addition, in order to respond to the issues raised by older people nutrition education should also include information on the questions older people frequently asked. These include clarification of the confusing information about fats, saturated fats and cholesterol in the diet; the role of fiber and how it is best obtained; weight control; vitamins; and digestive disorders.

PREVENTION OF ACCIDENTAL INJURIES

The prevention of accidental injuries deserves to be a major theme of health promotion efforts for the elderly. The death rate due to accidents is four times higher for people 75 and older than for all others. Accidental injuries resulted in nearly 43 million days of bed disability in 1977 for people 65 and older. The nature of health promotion approaches, however, will need to vary for motor vehicles and household accidents.

Preventing motor vehicle injuries.—Motor vehicle related accidents represent a significant cause of death and disability among the elderly, and the nature of those accidents appears to be distinctly different from that characterizing the general pop-

ulation. Biological factors (such as decreasing visual acuity, night vision, auditory function, and reaction time) increase the likelihood older individuals will be involved in accidents either as drivers or as pedestrians.

Public education efforts could be targeted at three areas:

—Regular use of occupant restraints (seat belts, shoulder harnesses). It is estimated that fewer than 10 percent of drivers and passengers 65 and older regularly use seat belts the lowest rate of any age group. Use of restraints can significantly decrease the likelihood of serious injury particularly head injuries in the event of a collision. Occupant restraints may be particularly important in preventing injuries given declining biological function in older individuals.

—Pedestrian safety. Pedestrian fatalities account for 42 percent of motor vehicle deaths among those 75 and older. The majority of those deaths could probably be prevented if elderly individuals exercised extreme caution in crossing roadways particularly at night and in urban areas. Simply getting pedestrians to cross at intersections would probably prevent deaths, since only 21 percent of pedestrian fatalities occur at intersections.

—Defensive driving. Another possible area of intervention would be encouragement of informed judgment in deciding when and how to drive. Older participants in the focus groups were aware of their limitations mentioned changes in their driving habits to reduce their exposure to dangerous driving situations by avoiding driving at night or during rush hour. These ideas, along with defensive driving skills could be reinforced. Care would be needed, however, to ensure warnings about driving within individual limits do not reinforce negative stereotypes about aging.

Public education messages about traffic safety need to be motivational rather than informational in approach. Older people know about the importance of wearing seat belts, driving cautiously, and being careful about crossing roadways. They just do not always act on this knowledge.

As one focus group respondent stated, "A seat belt; I never used it in my life, but I imagine it's good safety."

The challenge of developing effective motivational messages about traffic safety with older adults might best be combined with current efforts of the National Highway Traffic Safety Administration and private sector organizations to promote seat belt use and traffic safety.

Environmental factors that can contribute to accident rates need to be addressed by committees. Poor design and placement of signs, roadway lighting, and timing and placement of traffic signals at intersections and crosswalks can contribute to accidents and increase morbidity and mortality among older people.

Preventing home accidents.—Falls and burns exact a heavy toll on older individuals. Nearly 70 percent of all deaths attributable to falls and a third of deaths attributable to burns occur among persons 65 and older.

There are a number of safety precautions that can reduce the incidence of accidents within the home. Nonetheless, the role of public education in preventing in-home accidents is less clear than on the other issues. Older adults appear well informed about safety, but, like most age groups, do not always act on the information. Participants in focus groups had no difficulty in suggesting measures to prevent falls and other in-home accidents. In addition, participants seemed to recognize their physical limitations and offered advice (e.g., "Don't hurry, be patient with yourself").

Because older people know so much about ways to prevent accidents, information alone does not hold promise. Accident prevention may be more appropriately addressed in other ways such as encouraging diagnosis and treatment of underlying medical conditions associated with accidents. For example, properly fitted eyeglasses and adequate podiatric care could reduce the risk of falls. Provider education about the importance of treating of vision, hearing, and foot conditions may also be appropriate.

It may be useful to design community programs to remove environmental hazards and make homes safe and secure. Examples of such measures might include turning down the thermostat of hot water heaters to less than 130 degrees to prevent scalds, installation of handrails on stair cases, improved lighting in hallways, and installation of smoke detectors. This areas may also lend itself to very specialized research regarding how to communicate complex information on changing positions such as getting out of bed or walking up stairs in ways to reduce the likelihood of injury.

SAFE USE OF MEDICATIONS

Older adults are particularly susceptible to adverse effects from medication use. Enhancement of appropriate drug use by the aging would be a significant health promotion achievement. Physiological changes associated with aging, high use of prescription and over-the-counter drugs, and the difficulties of coordinating prescriptions from different medical care specialists all contribute to the problems associated with drug use among the aging.

Older people expressed concern that physicians did not communicate effectively with them regarding medication regimes and possible side effects. One man commented, "Doctors are not careful enough to tell you how to take medications, and you don't always think to ask." Problems in communication are compounded by the difficulty of coordinating medical care among many specialists. One woman said, "Doctors need a comprehensive interest in the person. These people have no connection with us. If you have a problem with a car, it goes to one garage." While these concerns extend to the whole area of geriatric health care, they are particularly important in the area of medication use.

A health promotion program regarding safe use of medications must be a multifaceted effort. There is clear need for professional education. Physicians need better information about the nature of medication effects in older individuals. It may be also useful to reinforce the need for careful communication and concern for older patients. One woman commented: "I have a good doctor. He sits and talks with you and he's patient with me." Such caring and communication skills have long been a part of the healing relationships but may be overlooked in the press of the modern practice.

There may be a useful role for public education in helping older individuals to use medications safely. As one 60 year old man commented, "there's only one person who can take responsibility for your safety and that's you." A health promotion program targeted at older people regarding safe use of medication should include: information on the importance of telling the doctor about all medications being taken; asking doctors or pharmacists questions about how to take medications safely, side effects to watch for, and what each medication is for; keeping a daily record of all drugs being taken; following prescribed medication regimens; and being cautious of possible effects of alcohol/drug or multiple drug interactions.

Finally, there is a need for continuing research in areas such as the study of the aging process itself and separation of it from disease; study of the physiological changes in aging that may affect drug efficacy; drug testing among the elderly and in situations of multiple drug use; and the development of drugs to treat mental deterioration. Information from such research needs to be transmitted to health care providers and their prescribing patterns and patient compliance studied. Continued testing of patient education methods to improve adherence to various treatment regimens is needed as is the dissemination of information about the effectiveness of programs.

SMOKING

It is recommended all adults—of any age—stop smoking. Even at a late age, smoking cessation does appear to hold benefits for contributing to improvements in emphysema, bronchitis, and coronary heart disease. Some data support a reduction in cancer rates if those 50 and older stop smoking. Since smoking was not one of the topics selected for indepth examination in this research, little information was obtained on the subject from focus groups. Abstaining from smoking was not often mentioned spontaneously by group members as a "way to stay healthy."

Although the major improvements in health status may come from anti-smoking information directed at younger age groups, it is nonetheless recommended that health promotion programs continue to encourage older people to stop smoking.

PREVENTIVE HEALTH SERVICES

Preventive health services—those which can detect disease in its early stages or, like immunization, preventive disease from occurring—can contribute to a health promotion initiative. Recommendations regarding specific tests or procedures to be offered, to which population groups, and with what frequency is the province of expert scientific review panels and professional groups. For older people, there is agreement among these experts that certain procedures should be universally applied—high blood pressure checks and immunizations for influenza and pneumococcal pneumonia. Other services, principally screening procedures for cancers, are recommended for high risk persons and should be discussed with one's health care pro-

vider. In addition, older people should be encouraged to report any problems with vision, hearing, or their teeth and gums to health care providers.

Health promotion programs can include information on the existence of specific services and the value of obtaining these services in detecting and preventing disease. In addition, health care providers need to be informed regarding appropriate ways to integrate preventive services into ongoing patient care and provide opportunities for patient education.

CHANNELS OF COMMUNICATION

One of the clear lessons learned from other public education efforts is the importance of using multiple channels of communication. The more frequently and the more ways people receive health information, the greater the likelihood they will adopt good health practices. The focus group discussions and a review of data about the media habits of older people indicate that certain communication channels may be particularly appropriate for older audiences.

Older adults watch more television than younger age groups. Moreover, during the morning and the evening news, the audience is comprised heavily of older adults. Health information during these times can efficiently reach a wide audience of older people. The television watching habits of older adults correspond well to the times when public service time is most available. Public service announcements could be used to transmit brief messages on health promotion. News/talk show segments and presentations could be used to communicate more detailed information. Focus group participants indicated they particularly liked "question and answer" formats, both because of the amount of information presented and a comfortable "pace."

Although, older adults do not listen to radio as much as younger groups, there are certain stations such as those broadcasting news and talk shows which draw a high proportion of older listeners. Public service announcements—possibly in the form of announcer copy—and presentations on selected talk shows can be useful to transmit information about health promotion to older audiences.

Approximately 70 percent of older Americans read a daily newspaper. Given this level of readership, articles featuring health promotion information can be a useful way to reach older audiences. Care should be taken to assure articles are simply and clearly written.

Specific magazines, such as Reader's Digest and Modern Maturity, and Sunday newspaper supplements are widely read by older people. It may, however, be difficult to place articles in some of these magazines.

Other health promotion campaigns have made effective use of brochures and pamphlets. Respondents in focus groups attested to the usefulness of such materials. Placing brochures in physicians' offices, libraries, food stores, and pharmacies ("right up next to the drug counter where you can't miss them") may be useful. Care should be taken to ensure such materials are easy to read and attractively formatted. One 83-year-old woman admonished:

"Do not use small print with curlicues. Keep in plain and large size. It should be in the simplest form. Many people our age have not had one day of school."

The media channels are complementary. Public service announcements (PSAs) on television and selected radio stations can increase awareness of good health practices among older people. Television and radio talk show presentations can provide more detailed information about specific ways to keep healthy. Newspaper articles can provide another source of health information for older adults. Brochures, pamphlets, and articles in community newsletters can provide sources of information that can be referred to again and again.

The final element in successful dissemination of health messages is interpersonal communication. Communications by professionals (physicians, pharmacists, nurses, health educators, and others) and communications by family and friends are important in providing information about and support for health promotion activities.

Various intermediary groups can play an important role in getting messages transmitted at the community level. There is a strong role, then, for a number of key actors:

—Physicians and other health care providers credible sources of health information particularly regarding medication use and preventive health services. It should be noted, focus group particpants consistently expressed concern that physicians were not always well informed sources on fitness and nutrition and often did not, in their opinion, provide sufficient information on medications.

—National, State, and local intermediary groups play a key role in the dissemination of health messages. The number of organizations with interests in health

promotion and/or aging is impressive. One clear role of the Federal Government is to work with these various organizations to support their efforts and facilitate cooperative activities among those providing services to the aging and those with health promotion expertise.

A multiplicity of methods of communication may be the key to a successful nationwide campaign to promote the health of older people.

Channels of communication for special populations.—The media habits of older blacks and older rural residents are similar to those of all older adults. The principal differences being that these groups read less and watch television more.

Older blacks comprise only a small proportion of the television viewing audience (6 percent during the day and 3 or 4 percent during the evening hours) so it may be difficult to air specialized public service announcements (PSA's). Talk show presentations, which can be more easily tailored to a particular audience, may offer a forum for transmitting information to older blacks. Direct presentations and distribution of materials in black communities may also be useful.

Older rual audiences can be reached through community groups and via television and radio news/talk programs on stations serving rural areas. Personal communication may be particularly important in reaching older rural and minority audiences.

FUTURE DIRECTIONS

While the emphasis in this report has been on the feasibility of planning and conducting a public education program on health promotion for older people, many other related issues have been raised. These include:

—The need for long-range planning. It must be emphasized that interest in health promotion, especially for the aging, is a relatively recent phenomenon. Life long patterns must be addressed. A concrete strategy for continuing emphasis on health promotion for the aging should be developed. Current attention should be viewed as a springboard for long-range, serious efforts.

—Developing market research base. The present research was a first attempt to segment the "aging audience" on the basis of three age groups and two socioeconomic levels and ethnicity. These variables are obviusly limited and it is strongly recommended that work be continued to better understand older people and their health practices. Special attention should be paid to the needs of low income people, minorities, and those with specific health problems, and to exploring in-depth particular topics such as preventing falls.

—Encouraging development and testing of model health promotion programs. It is well understood that information alone will not bring about behavior change. It is of critical importance that programs be developed to encourage and support desired health related behaviors.

—Stimulating action. In the long run, success of health promotion programs will rely heavily on programs and services at the local level. The Federal Government is in an ideal position to foster communication among public and private groups and to stimulate their participation in developing health promotion programs for older people.

ITEM 2. LETTER AND ENCLOSURE FROM RICHARD BRUSUELAS, EXECUTIVE DIRECTOR, NEW MEXICO HEALTH SYSTEMS AGENCY, ALBUQUERQUE, NM, TO SENATOR JEFF BINGAMAN, DATED OCTOBER 22, 1984

DEAR SENATOR BINGAMAN: Your concern and interest in our elderly New Mexican citizens was evident at the public hearing you held on October 12, 1984 in Albuquerque, NM, on "Healthy Elderly Americans and Health Promotion for the Elderly."

Although we were unable to secure a position on the agenda to present testimony, we were pleased to have had the opportunity to attend the hearing. As a public health planning body our major role is to provide effective planning to health service areas in the State. We feel health promotion for the elderly is vital, in order to bring about a healthier more independant elderly population. Our focus for the elderly is to secure a continuum of care system or long-term care system which emphasizes a well-coordinated community based primary, preventive, maintenance and rehabilitative care system that will inevitably serve to promote health and increase the health status of the elderly.

We are very interested in becoming a part of any special committees that may evolve as a result of this health promotion movement.

Thank you very much for the opportunity to present this written testimony for your review.

Sincerely,

RICHARD BRUSUELAS.

Enclosure.

HEALTH PROMOTION FOR THE ELDERLY

This testimony concerning health promotion for the elderly is provide by the New Mexico Health Systems Agency in support of strategies, legislative actions and ideas that will develop a healthier more independent elderly population.

New Mexico is the fifth fastest growing State in percentage of the population that is elderly.

Elderly population grew by almost 60 percent between 1970 to 1980. By the year 2000 there will be 500,000 elderly in New Mexico.

Health care costs of U.S. elderly now exceed $120 billion per year.

Large numbers of elderly die of chronic conditions each year in New Mexico.

Health promotion for the elderly has generated a great deal of concern and support throughout the Nation. The development of programs such as exercise classes, nutrition awareness, smoking cessation, stress management, programs that foster socialization and sound mental health, and periodic screenings and immunizations are all part of the health promotion movement. Nontraditional health care services such as day-surgery centers, home health care services, community-based care programs, are also part of the health promotion movement. The health promotion effort is aimed at avoiding illnesses that require costly and extended medical treatment. The overall goal of health promotion is that we help our elderly to become a healthier, more independent population. Through our involvement in this health promotion movement for elderly health care, we as a public health planning body strive to ensure that our goals and objectives incorporate health promotion strategies, that will affect elderly populations in New Mexico.

PROMOTING HEALTHIER LIFESTYLES

Although it is not too late to improve the health of older Americans through health promotion, we are viewing health promotion for the elderly retrospectively. Recent research suggested that after a certain age, "clean living" won't help you live longer. "Eating and sleeping properly may help younger people live longer, but by the time someone reaches 65, its too late to live right" (Albuquerque Tribune, October 5, 1984, "Party at 65?") The "essence" of health promotion is a healthier lifestyle. Health promotion should begin at infancy and early childhood, and continue through adolesence, adulthood, and finally through the elderly years. Health promotion should provide health education on maintaining a healthy lifestyle. The National Center For Disease Control estimates that 55 percent of our long-term health is determined by lifestyle: How we eat, drink, exercise, manage stress, and whether we smoke. This means that 90 percent of good health is determined by factors other than medical care. Conversely, we still spend only one half of 1 percent of all health care dollars on health promotion efforts in this country. If lifestyle is the single most important determinant in our health status in later years, more emphasis must be placed on promoting healthier lifestyles and spending on health promotion must increase.

Health promotion for the elderly should develop strategies that focus on holistic health care strategies. A general consensus is that health promotion should focus:

(1) The development of a variety of exercise programs funded by State and Federal funds that will be accessible to diverse groups of elders in the State.

(2) Nutrition programs be extended to include a nutrition education component that will be introduced into the food stamp program providing information, demonstrations, and displays on better nutrition.

(3) Encouraging older adults to participate in health promotion programs that discourage smoking, alcohol, and long periods of stress.

(4) Providing an alternative health care delivery system, and encouraging elderly to utilize these services that may be more responsive to their financial needs as consumers.

(5) Incorporate case management strategies into our current health delivery system so that better coordination and cooperation may exist between private and public programs for elderly care.

(6) Health promotion must become a priority item for funding and reimbursement at Federal, State, and local government levels.

These strategies (that are not inclusive) provide some overall, general suggestions as to the focus of health promotion for the elderly.

In New Mexico there are nearly 179,000 elderly retired persons who have been part of the work force. Many elderly look fowards to their retirement years, unfortunately, many elderly are not able to enjoy retirement because of deterioration in their health status. Our statewide objective for 1983-84 is to "initiate new employee health promotion programs in New Mexico" (AIP 1983-84). Consistent with this objective is our "good health is good business" annual conference where we actively seek to perpetuate the idea that health promotion on the worksite is vital. Because many elder persons have spent many long years as part of the work force, health promotion should begin on the worksite. Many companies and businesses are beginning to incorporate fitness activities, health education programs and even provide health facilities for their employees. Many businesses are realizing that "good health means good business" and a healthy employee is often a more productive employee. Health promotion for older employees should be initiated on the worksite through a "preretirement" program. This program should focus on providing health fitness activities and health education classes that specifically address the health needs of older adults. The goal of the preretirement program is to provide annual periodic screenings to monitor older persons health status, and detect chronic conditions in the early stages so that they may be treated effectively to prevent expensive hospitalization. In developing health promotion programs on the worksite employers could save on health insurance costs, workers compensation payments and reduce employee absenteeism.

As part of our testimony we have developed recommendations on health promotion for the elderly. Congress shold consider and encourage the following:

(1) Tax incentives should be provided for employees and their families and retirees of companies who are active in worksite health fitness programs and community health programs.

(2) Tax deductions also be provided for families who provide home health care for elderly family members.

(3) Increased Federal funding through Medicare and Medicaid for alternative health care services; i.e., home health care, hospice.

(4) A differential reimbursement system be provided for alternative care services and health promotion programs.

(5) Medicaid waiver 2176, which currently provides care for seriously ill persons needing in-home care and community based care by extended and expanded to provide more care for all elderly regardless of health status.

(6) Health promotion become a priority item for the national budget, and the State budget for health care, to increasing spending on health promotion.

(7) A program in conjunction with the State and public health department be developed to complete a list of all elderly Medicare and Medicaid enrollees to provide free consultations on health status, free immunizations and screenings and information on promotion programs and alternative services available to the elderly.

(8) The State work in a coordinated effort with public and private health care services to develop an elderly resource manual on the types of alternative care services and programs that are available in the state.

(9) Federal legislation be introduced for the development of Medicaid HMO's.

(10) The U.S. Department of Health and Human Services should initiate an effort through State health planning and health systems agency at the local level to ensure that health promotion for older Americans becomes a corner store of state health plans, HSP and AIP's.

CONCLUSION

We believe that the health promotion/illness prevention movement for the elderly must focus primarily on healthier lifestyles, providing health promotion programs, and providing alternative health care services. The success of this movement towards health promotion will be determined by the cooperation between local, State, and Federal government, and their concern for elderly health care. "The long-term goal of our health promotion and disease prevention strategy for our older people must not only be to achieve further increases in longevity, but also to allow each individual to seek an independant and rewarding life in old age, unlimited by many health problems that are within his or her capacity to control." (Healthy People: Surgeon General's Report on Health Promotion and Disease Prevention.)

We believe that resources are available with health planning agencies, also agencies organizations, department of aging, and other State and Federal agencies to sig-

nificantly address comprehensive health promotion. Further by combining resources with community interest and congressional leadership health promotion and healthier older Americans is an achievable goal.

Should you feel that the New Mexico Health Systems Agency can be of help to your committee members or staff please feel free to call on us.

ITEM 3. STATEMENT OF CORINNE H. WOLFE, COCHAIR, NEW MEXICO HUMAN SERVICES COALITION, ALBUQUERQUE, NM

I am Corinne H. Wolfe, cochair of the New Mexico Human Services Coalition.

The coalition is an advocacy group made up of 400 individual members from about 60 health, social service agencies and citizens interested in human services including children, youth, families, the delinquent and the elderly. This voluntary group was formed to work with New Mexico State agencies and the legislature on human service budgets and needed legislation.

RECOMMENDATIONS

The coalition strongly supports and has been active in the requests of the elderly for adequate health care including community, in-home and pilot project to provide alternative home care for New Mexico in seven areas. The coalition recommends that the committee support changes in Medicare and Medicaid programs that emphasize and encourage less costly alternatives to traditional care such as outpatient and home health services, surgi-centers, urgent care centers, care by mid-level practitioners and extensive home care services.

The Medicaid Program is the last resort for health care for many people, particularly the elderly and children. The program now covers only a small portion of medically needy, elderly, children and families. The coalition recognizes that health care for people in the United States is one of the most urgent needs faced by this State and the country. Health care costs are rising at three times the rate of the Consumer Price Index. New Mexico costs are rising at three times the rate of the index or 29 percent faster than the rest of the Nation. The New Mexico program is only for the categorical needy and is one of the 19 States without a medically needy program. The New Mexico program is facing the possibility of about $2 million deficit for this fiscal year. Despite this deficit, the New Mexico Coalition does not think that either the New Mexico program or the national program provides adequate health care for its citizens and certainly does not meet the 1976 commitment (Public Law 93-641) for equal access to quality medical care at a reasonable cost for all citizens. Cost containment programs must be directed at methods of administration and not by limiting eligible people or by creating a two-level system of health care for the poor and the rest of the citizens. Serious study must be undertaken to determine the costs of adequate health care so that all citizens including the poor will have access to care. Now some physicians refuse both Medicare and Medicaid patients because of payment and the quantity of paper and procedures to be followed. Even though a physician may see Medicaid patients, we are fearful that person will not receive the same attention and care as paying patients. Recently, at a hearing in the Human Services Department on its budget, a representative of a physicians' association indicated that some physicians may have no qualms about keeping medicaid patients waiting longer and otherwise subtly treating them differently.

The coalition recommends that the United States committee must consider not only the present short-term needs of the elderly and the needy but the long-term health needs of all citizens. Long-term planning must include preventive measures so that future families and the elderly will not be faced with health care needs that the present population faces. Preventive measures must take into account nutrition, lifestyle related illness, alcoholism, drugs, stress, etc. 50 to 75 percent of all deaths in the United States are lifestyle related. The coalition believe that our whole health attitude is at fault. People should be given incentives for staying well, not for getting sick. We recommend preventive medicine bonuses to encourage citizens to stay well. State Medicaid programs could be given a higher level of Federal match if they bid many of their services, contract with preferred providers, organizations, or health maintenance organizations who have established wellness programs for their clients.

The coalition recommends that the committee reexamine all present programs; Medicare, Medicaid, health services, social services, aging, and rehabilitation programs to develop maximum use of present programs to systematically provide access to quality medical care. The coalition also strongly urges the committee to look at these programs in relationship to the authorizations and outlays the Reagan

administration is calling for in military spending. Last year, the "national defense" share of the federal budget had increased in the past 2 years from 25 to 33 percent of total budget authority. This represents an incredible 57 percent share of the discretionary portion of the Federal budget, for which Congress makes annual appropriations. The coalition thinks that any clear analysis of what is happening to social programs must be seen in the context of a proposed and now existing military build-up.

The coalition emphasizes the issue and need of providing access to quality medical care. Recently the New Mexico Human Services Department implementation task force for the demonstration program for coordinated in-home care program recommended to the secretaries of the Human Services Department of the Health and Environment Department to review all State and Federal funded programs to further develop health care programs for the State. The State is beginning to place increased emphasis on maintaining health and wellness.

As a final note, the coalition is aware, just as we know members of the committee are, that your colleagues in Congress on some of the appropriations subcommittees, are proposing funding figures for entitlement and other domestic programs at amounts much below those amounts actually needed. We urge you to protect these domestic programs and increase the appropriation to more nearly meet the need.

DATA SUPPORTING THE ABOVE RECOMMENDATIONS

Case for the elderly.—The elderly population is growing at a fast rate which compounds the problem. In New Mexico, it is expected that the aged will increase from the 9 percent of the population in 1980 to 24 percent of the population in the next 10 years. In addition, technological developments in medicine mean that people live longer. The availability of medicare and medicaid has made it possible to provide basic medical care. These programs, however, are already expensive and the increased number of elderly will make the cost prohibitive.

There is a need both at the state and national levels to develop a plan for a continuum of care from the well to the very frail elderly as well as plan for hospice care for the terminally ill. A systematic long-term care policy and program is necessary to provide community in-home care and to lower the number of institutional facilities which will be needed if community in-home care in not provided. The purpose of a long-term care system is to provide all elderly members of the community the assistance they individually need in order to lead as healthy, productive, and independent meaningful lives as possible.

Medicaid in New Mexico.—In 1983-84, New Mexico Medicaid expenditures were $132,700,000, an increase of 17.9 percent over 1982-83 figures. Reports indicate that about one-third of the expenditures are for families and children (AFDC) and two-thirds for the elderly, handicapped and disabled. For the budget year 1985-86, the expected expenditures will be $163,300,000 or an increase of 13 percent. The reasons may be that there has been an increase in the AFDC caseload from about 18,000 to 19,000; the unemployment rate has remained about the same for the past 2 years and there are about 100,000 poor and near poor in New Mexico who may be eligible for care.

Families and children.—Children of unemployed and uninsured workers are being hurt. Children in unemployed families face low-income levels (63 percent of workers receiving unemployment benefits have annual income below $10,000. The average unemployment insurance benefit is approximately $100 a week.) They also face loss of job-related health insurance. According to the Bureau of Labor Statistics, over 12 million people are currently unemployed. According to the Congressional Budget Office, approximately 10,700,000 people, including children and spouses, lacked health insurance coverage at the end of 1982 because of job loss. Young workers, those most likely to have young children, are most likely to be unemployed.

In some instances, unemployed families can gain health insurance through medicaid. But in 27 States, Medicaid does not cover either impoverished unemployed two-parent families or their children.

Many low-income employed families are also unlikely to have health insurance. Nearly 13 percent of workers earning between $5,000 and $10,000 have no insurance. One alternative for paying health care bills could be the Medicaid program. But budget cuts have substantially reduced the number of working poor who can get Medicaid coverage.

For more than 10 million of the poorest children in America, the Medicaid program is the only way to pay for checkups, medical treatment, dental care, hospitalization and needed drugs. For hundreds of thousands of pregnant women, the program pays for prenatal care and delivery services. Children, more than any other

age group, rely on Medicaid to pay their medical bills. Unlike older Americans, they do not have Medicare or private insurance policies. In 1979, 55 percent of the public dollars paying for children's health care was spent through Medicaid. Medicaid accounted for only 28 percent of the public health funds spent on other age groups.

In New Mexico, the infant and maternal mortality rates improved dramatically following the introduction of public assistance, Medicaid programs, and public health preventive programs in the 1930's through the 1960's. In 1982, there were 2,000 low birth-weight babies born in New Mexico. This was better than in the past. These programs have clearly helped. But we note with concern that preliminary data from some other States indicate that they are experiencing a rise in infant mortality and low birth weight. We cannot let this happen to our future citizens, either in New Mexico or in any of the States.