EDITORIALS

Health, Make It Last A Lifetime

The theme of Older Americans Month, "Health, Make It Last A Lifetime," is particularly appealing today because we are living in a time of unprecedented longevity. To a large extent, good health habits determine the quality of life in the later years. As a society we have superb public health practices. Increasingly men and women, by their own lifestyles, are learning how to prevent life-threatening diseases, including some forms of cancer and heart disease. Medical science, too, has progressed incredibly in the last few years. The fruits of this progress have given us the possibility of long, productive lives. Men today can expect to live an average of *73* years; women *78* years.

If we live to age 65, we can expect an additional "bonus" 16 years of life. Can we afford to waste that time? Often we focus only on the problems of this rapidly increasing population group and ignore the triumph before us. Think of the 26 million Americans over 65 and the 32,000 over 100 years of age. What an achievement this longevity represents. Consider what their experience and wisdom contribute to the enrichment of our society.

Fortunately, the vast majority of older Americans enjoy basic good health. Only a small fraction, 5 percent, are in long-term care in institutions at any time, although 20 percent will need such care at some point in their lives. Nevertheless, almost 80 percent of the people over age 65 have such chronic disorders as arthritis, hypertension, hearing loss, visual loss, and heart problems. And although most report little or no difficulty in living their daily lives, many older people suffer from disorders which could be prevented or relieved with such simple measures as earlier care, regular exercise, and sound nutrition.

Health promotion—the carrying of information to people of all ages, but particularly to the elderly—is emerging as an extremely important movement. We have learned through studies being conducted by the Office of Disease Prevention and Health Promotion that the elderly are a receptive and appropriate audience for health information. We have learned also that older people can and do make changes in living patterns to promote or protect their health. It appears, indeed, that this older group has an uncommon interest in health and a strong commitment to taking good care of themselves and remaining active in their later years. Older Americans have been touched by the health revolution of the 80s just as surely as have the younger generations.

How do we respond to this need, to this challenge? How do we reach and teach older Americans to help them protect their health and vitality? Does it truly make a difference to change life patterns when you are in your 60's or 70's? Current scientific research supported by the Public Health Service brings optimistic news that even the wheelchair- or bedbound can experience improvement in muscle strength and bone density with modest exercise. We have learned that combinations of calcium, vitamins, and exercise are powerful weapons in preventing the beginnings of osteoporosis, the thinning and weakening of the bones that often results in hip fractures in older women. We know that diet plays a role not only in maintaining vitality, but it may help prevent heart disease and cancer.

In 1977 the Surgeon General issued a report entitled "Healthy People." Among the objectives it mentioned was the intent to reduce the average annual number of days of restricted activity among the elderly by 20 percent, to fewer than 30 days per year. Implicit is the goal of delaying the onset of illness and doing all possible to maintain the functioning of the people already ill.

We do not anticipate eliminating disease or disability, but it is realistic to think of curbing such human events. The elderly, 11 percent of the population, consume 25 percent of the drugs sold in the United States. Some experts estimate that the older person uses an average of 13 medications a year. The contribution that our superb pharmaceutical products have made to longer and healthier lives is undoubted, but there are also risks associated with drug use. Consider that 1 to 3.5 percent of all hospital admissions are a direct result of adverse drug reactions, with the elderly suffering 15 times the admissions of those in younger groups. There are also injuries caused by drug-induced unsteadiness, and confusion—often mistaken for irreversible dementias—that make us think that management of drugs is an even more serious problem than these figures suggest. However, better understanding of the changes that occur in the body with age, of the therapeutic ramifications of treating an older person who may have not one, but several chronic health problems, and of the complexity of coordinating medications when several physicians are treating the same patient—carrying the added risk of drug-drug interactions—would improve the planning of drug regimens. Additionally, better education of the older person about illness and treatment goals and methods would help to reduce hospital admissions. Education for health can bring immediate benefits.

Death rates for accidental injuries are higher for persons 75 and older than for all other age groups. At 166.7 deaths per 100,000, the rate for people 75 and older is about four times the rate of all Americans (47.9 per 100,000) and almost three times higher than the rate for the next highest group (63 per 100,000 for people 15 to 24 years).

Older Americans are harmed by fires, falls, and motor vehicle accidents, among other sources of injury. Accidents in 1977 accounted for almost 43 million days of bed disability among the elderly. While the elderly are quite knowledgeable about the risks of accidents, they are also vulnerable. We need community programs to add environmental safety to the innate caution of the elderly. Theoretically, all such injuries could be prevented; none are inevitable.

What we should *not* do is rest on our longevity laurels. We can—through education—cut the accident rate even as we emphasize the importance of nutrition, good preventive care, and exercise. The potential gain is clear, for us as individuals and for society. Both science and statistics point to still unconquered frontiers. There is a growing, willing, and receptive audience of older Americans who are ready to learn all that they can about making their health last a lifetime.

Margaret M. Heckler
Secretary of Health and Human Services

See the poster theme of Older Americans Month on cover 3.

Epidemiology and Health Policy—United States and Israel Share Experiences and Perspectives

In 1980, an agreement was developed and signed by the United States and Israel for the promotion of cooperative activities in health between the two countries. One activity planned under the agreement was meetings to be attended by scientists from both countries to discuss topics of mutual interest. The first such symposium was held in Tel-Hashomer, Israel, in March 1981, on the subject of "Regionalization of Health Services"(*1*). Participants at the second binational symposium, held October 17–19, 1983, at the National Institutes of Health, Bethesda, Md., discussed the "Interrelationships of Epidemiology and Health Policy." The interrelationships of epidemiology—its limitations and contributions in the formulation of health policy—were explored from the perspective of the rich and varied experiences of health professionals, researchers, and decision-makers in the United States and Israel.

Following an initial plenary session, the conference participants divided into three workshops. The first workshop was entitled "The Role of Epidemiology and Preventive Initiatives"; the second workshop, "The Role of Epidemiology and Assessment of Need, Program Development, Resource Allocation"; and the third, "The Role of Epidemiology and Regulatory Programs." The individual workshop members met in three one-half-day sessions and discussed papers that were introduced by designated speakers. These presentations were followed by open discussions. At the final plenary session, the chairpersons of the three workshops reported on the presentations and discussions at their individual sessions.

The papers given at the workshops and a summary of the final discussions will be presented in three consecutive issues of *Public Health Reports,* beginning with papers from the first workshop, which are published in this issue. Presentations from the third workshop will appear in the July-August issue, and the presentations at the second workshop and summary discussions will be published in the September-October 1984 issue. Publication of those papers and the summary discussions will permit a much larger audience to benefit from this stimulating symposium. I believe this larger audience will find revealed in these reports, as did the participants, more evidence of the utility of epidemiologic data in formulating health policy.

On behalf of myself and all the American members of the organizing committee for this symposium, I wish to thank all the participants, and especially our Israeli guests, for their participation.

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Reference

1. Slater, P.E., and Davies, A. M., editors: Binational U.S.–Israel Symposium on the Regionalization of Health Services. Israel J Med Sci 18: 321–432 (1982)