methodology and plans prepared for gradually drawing them into the orbit of activities. Each State and local health officer can now critically examine the services of his department with the purpose of developing a coordinative and State-wide pattern which will make every use of local resources and initiative. Imagination can be applied to personnel recruiting and training problems.

Now is an ideal time for this kind of thinking. It has been demonstrated that we are in agreement on the need for expanded local health services. We are aware of the elements which have worked well so far. We have a solid background of experience and knowledge which we can apply to solving the problems before us. And that is the kind of combination which seldom fails when properly used.

Community Health Services for an Aging Population

By JOSEPH W. MOUNTIN, M.D.

One of the great emerging opportunities for public health is health services for an aging population. I am convinced that there is a great new field here for the public health profession, one that is different, more complex, perhaps more experimental than any we have known heretofore. By the same token, however, it is one which offers great rewards to the profession as well as to the community and the Nation.

The current interest in aging is shared by a great many professional and community groups. This interest is a reflection of the problems which strike deep in the hearts and minds of millions of people in this country. Certainly the vast majority of us can expect to face the hazards—and the satisfactions—of aging. Because of the conquest of the diseases to which public health programs hitherto have been addressed, more and more people will live into a period which not so long ago was regarded as very old age. They will have to face the problems of adjustment, of health, and of security that later life brings. For most people, the interest in aging is very personal and very real.

To a considerable extent, therefore, people are waiting for professional groups to take the lead in establishing suitable programs of action. Herein lies our great opportunity—to make the added years really worth while by helping older people remain productive members of society.

It would probably be repeating the obvious to go into the background of the problem or to belabor the point of its significance. The fact that we had four times as many people over 65 years old in this country in 1950 as we had in 1900 is too well known to need emphasis. Present population forecasts indicate that by 1975 there will be more than three people over 65 for every two now in that age group.

Part of the explanation for the increasing community concern can be found in the very numbers themselves. Too many people are involved, both numerically and proportionately,

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for society to remain aloof or uninterested. Part of the explanation also lies, however, in changes in our economic and social life. We are beginning to recognize that our traditional patterns, customs, and attitudes simply make no place for older people today.

I shall not go into the social and economic aspects of the problem, except to note two points: their intimate relationship to health—for the older person particularly, it is often difficult to determine where a social problem ends and a health problem begins; and the job of changing attitudes—breaking down old prejudices and fixed habits is as much the responsibility of public health as is the provision of case-finding or home-nursing services.

Health Needs of Older People

What are the health needs of older people and what can the community do toward meeting them? The needs are, in fact, no different from those of all of us: to stay well or to preserve health insofar as possible; to get prompt and effective care in the event of illness; and to regain normal or near-normal function following disability. There is another need, which is really an amplification of these three, and which makes the health problems of older persons unique. Aging persons must be encouraged to retain, to conserve, and to use all their resources, whether they are nominally free from disease, whether they are victims of a long-term illness, or even whether they are in the advanced stages of what we consider old age. They must make the maximum use of remaining capacities, however limited, if they are to realize their full potential.

This implies a positive, rational, optimistic approach. It is an approach consistent with the new concept of aging as a phase of development rather than as a period of complete deterioration. It is consistent, too, with the wishes of older people themselves.

Aging is not in itself a disease nor is it necessarily accompanied by any specific disorders. We should also bear in mind that the potential span of man's usefulness and productivity has increased along with his lengthened life. The later years need not all be declining years.

At the same time, aging does bring physical changes and a decrease in physical strength and resiliency. Long life also increases the possibility of the development of a chronic disease. And, according to present knowledge, once a person acquires a chronic disability, he will probably have to live with it for the rest of his life. The extent to which health is maintained in the later years depends a great deal, therefore, upon how health needs are met in the earlier years.

This leads to an important principle in health planning for the aging. A health program for older persons cannot start at 65 or any other given age. It must begin long before the deteriorations are marked and irreversible. It must make provision for preventive and preparatory measures throughout the span of adult life. In other words, the emphasis must be on adult health and on strengthening the health services which will enable all people to prepare for later life.

Another element that must be considered is the extreme variation in health that is found among older people. Aging is a highly individual matter, as is the propensity for disease and the severity of its effects. We all know people who are old at 45 and those who are young at 75. Less well known is the fact that we may be old in one part of our body and relatively young in another. This inconsistency in rates of change accompanies physiological processes throughout life, but it is more pronounced in the later years.

Because the health needs of older people are so varied and complex and because they are so heavily weighted by social and emotional factors, they may be met through resources far outside the traditional health setting. For example, suitable housing accommodations for the displaced elderly person may be as important in the total health program as physical facilities for care of the sick. Gainful employment which will enable the older person to participate in community life may do much more than diagnostic clinics or nursing homes for the aged. In many instances, the older person may simply need financial or legal advice to see his emotional and even his physical problems begin to wane.

Older people who become ill take longer than others to get well. This problem of extended

convalescence must be considered a special element in health planning. Rehabilitation and restorative services of many kinds—medical, vocational, psychological—thus assume an important place in community health services for the aging. Public health agencies should work with nursing and convalescent homes to raise standards and improve the quality of care. They might also promote and develop rehabilitative services in community hospitals and health centers.

To most of us, rehabilitation evokes the thought of elaborate facilities and expensive specialized equipment. Yet a satisfactory, if elementary, type of service can be developed with the use of one room in a health center and the professional services of only one or two people. Even with the aid of the simplest equipment, installed here and in hospitals and nursing homes, many older persons could recapture skills lost during illness or learn to live with a disability. In other words, the development of a point of view should precede the installation of extensive equipment.

Local Approach Needed

The question of how best to meet the varied needs of older people has been the subject of considerable discussion in recent months. Such meetings as the 1950 National Conference on Aging and the Second International Gerontological Congress in September 1951 were held in recognition of the importance of an organized attack on the problems of the aging. To a considerable extent, however, the problems can be answered only by local communities, in terms of their own particular needs and resources.

I would, therefore, lay down no blueprint of community health services for the aging. In fact, it is well nigh impossible to set down a specific program, or a set of programs, and say these would be applicable in all situations. What a community does, or can do, may be dictated by a number of considerations—the extent of the need, the amount of local awareness and popular support, the number of physicians and other health workers, the kinds of physical facilities available, and the assumption of leadership by professional and community groups.

Because of the complexity of the needs, no single community agency can by itself provide all the health services that may be necessary, to say nothing of the equally important economic, social, educational, and recreational services. Both official and voluntary organizations have important jobs to do. In fact, without the help, the stimulation, and the leadership of voluntary and professional groups, we can expect little in the way of concrete action.

What then are the responsibilities of the public health agency? As a first step, it should begin to gather and put to work the knowledge that has already been accumulated about the problems of aging. In general, the health department has two sets of jobs. It must take its place with the other organizations in the community—both official and voluntary—in working out a coordinated approach to the many needs of older people. And it must provide certain specific services in the field of health. These services might include the establishment of health guidance clinics for older people in a manner similar to the health clinics for mothers and children; the conduct of control programs for such chronic ailments as heart disease, cancer, diabetes, arthritis, and the like; the dissemination of suitable health education material; and the inspection, licensing, and improvement of nursing homes, foster homes, and other facilities for the disabled or infirm aged. The long-term interests of older people, as well as of the entire community, will best be served by a health department that affords the essential framework through which organized programs can function effectively.

Role of Professional Health Workers

What are some of the specific contributions to a program for the aging that can be made by various types of health workers? The public health nurse, to take one example, can play a very strategic role. Because the nurse knows families and their needs, she is in a very good position to help them make necessary adjustments and arrange for the correction of disabilities. Visiting nurses particularly have the opportunity to assist the family in learning the

skills necessary to care for ill or infirm older persons. In addition, bedside care should be increasingly included among the services provided by community nurses. In cooperation with other groups, nurses can advise families on how to simplify household tasks, plan and prepare adequate diets, avoid home accidents, and maintain a cohesive family relationship.

Many environmental health services may be reoriented to the needs of older people. Public health engineers, for example, may find it desirable to evaluate the home and working environments in terms of adjustments that might be necessary for an aging population. They might develop standards for the housing of older people. And they might work with police and traffic authorities to eliminate health hazards in the streets and to make travel on buses and street cars safer for the aging.

The problems of older people open up great opportunities for psychiatrists, psychologists, and other mental health workers. Growing old calls for many mental and emotional adjustments. Often it is fraught with traumatic experiences. We all realize that the transitions from a dependent to an independent status—such as from childhood to adolescence and from adolescence to maturity—are delicate ones. These can be periods of emotional stress and turmoil. The adjustments made necessary by the older person's reversion to a dependent or semidependent status are just as trying—perhaps even more so. In fact, this is the very time when suicide rates go up and when mental deterioration sets in. Yet most mental health programs are directed almost exclusively toward the child and the youth. Certainly mental health clinics and counseling services should set aside some time for meeting the needs of older people.

Perhaps the most outstanding opportunities for fruitful work with older people may be found in the field of health education. Undoubtedly the skills and techniques of health education can find a significant outlet in work with the aging. Education must not only arouse popular and community interest but must succeed in motivating older people to do things for themselves. Health educators, probably more than the rest of us, will be aware of the fact that we are working with as well as for older people. Because the older person generally has the best understanding of his own needs and because he has the ability to make his own decisions, he must be drawn in on the planning and development of suitable activities. He must neither be patronized by nor segregated from the rest of society.

A Community Makes a Start

Briefly and in very broad outline, here are the steps one community is taking to meet its problems. As a result of interest stimulated by the National Conference on Aging and the thinking of prominent citizens in the community, a general committee on aging was set up. On this committee are represented some of the official organizations in the county such as the health and the welfare departments; voluntary groups like the community chest, church organizations, and clubs of older people; and individual citizens. The committee is entirely voluntary and without official status. Nevertheless, it is a nucleus of understanding and competence and is spearheading the development of an ambitious community program for older people. Moreover, it is having a decided effect on the county's health and welfare programs and on the work of nonofficial groups.

One of its first activities was to conduct a survey of the older people in the county—their sources of income, health status, living arrangements, and interests. Out of this survey, the committee is beginning to establish guidelines for its next steps. The problems uncovered in this survey will also help the committee decide the nature of its permanent organizational structure and its budget and staffing needs.

In the meantime, however, the group is going ahead with such activities as it is able to start on its own, utilizing whatever resources are available. The surprising thing, perhaps, is the number of projects that have been started and the heartening cooperation that has been obtained. For example, the committee has stimulated "friendly visitors" services for the homebound aged, has sponsored a hobby show and recreational activities for older people, has prepared a column on aging which appears regularly in the county newspaper, and has worked with local church leaders in developing

suitable activities. Through the efforts of this group, a local banker has agreed to give financial advice to older people. Several physicians have begun to develop a special interest in geriatrics. All of this has taken place in a little over a year and with no special budget.

The community health agency has taken a prominent role in organizing this committee and in guiding its development. As suggested earlier, this is one of the ways in which the health department can become a part of a general community aging program. On the other hand, it can also launch adult health activities by conducting specific chronic disease control and related programs. Both approaches have advantages. The latter has the advantage of specificity and of utilization of the traditional experiences and competencies of health workers. The former meets the needs of the aging group on a more integrated front and provides the supporting services which enable a health program for older people to reach full effectiveness.

Eventually, of course, both methods of attack must be pursued. But the important point now is that some start be made. To be sure, public health cannot yet supply all the answers, nor meet all the needs. But it can make that start. And in doing so it can earn the gratitude and respect of older people by making an important contribution to a better life in the later years.

Public Health Nurses

More than 25,000 nurses are now engaged in public health work, according to the Fifteenth Annual Count of Nurses in Public Health, recently prepared by the Division of Public Health Nursing, Public Health Service. Although there is still a shortage of public health nurses in every State, the number has increased more than 4,000 during the last 5 years.

It is estimated that an additional 12,000 to 15,000 public health nurses are needed to meet current shortages. The 1952 Census shows that rural areas in over 650 counties still lack the services of full-time public health nurses. Thirteen towns of 10,000 or more population are also without such services.

The 1952 count of nurses also indicates that more than 35 percent of all nurses employed by State and local agencies for public health work have completed an approved program of study in public health nursing. In 1942 less than 28 percent had this training.

Number of nurses employed for public health work on January 1, 1952, by State

Alabama	217	Louisiana	241	Oklahoma	207
Alaska	58	Maine	148	Oregon	169
Arizona	178	Maryland	498	Pennsylvania	1,832
Arkansas	109	Massachusetts	1,325	Puerto Rico	397
California	2,206	Michigan	869	Rhode Island	224
Colorado	240	Minnesota	453	South Carolina	267
Connecticut	680	Mississippi	206	South Dakota	35
Delaware	104	Missouri	428	Tennessee	377
District of Columbia	200	Montana	63	Texas	869
Florida	403	Nebraska	125	Utah	130
Georgia	521	Nevada	25	Vermont	86
Hawaii	96	New Hampshire	160	Virginia	469
Idaho	75	New Jersey	1,497	Virgin Islands	17
Illinois	1,182	New Mexico	130	Washington	376
Indiana	508	New York	3,614	West Virginia	160
Iowa	277	North Carolina	484	Wisconsin	507
Kansas	206	North Dakota	53	Wyoming	36
Kentucky	288	Ohio	1,192		