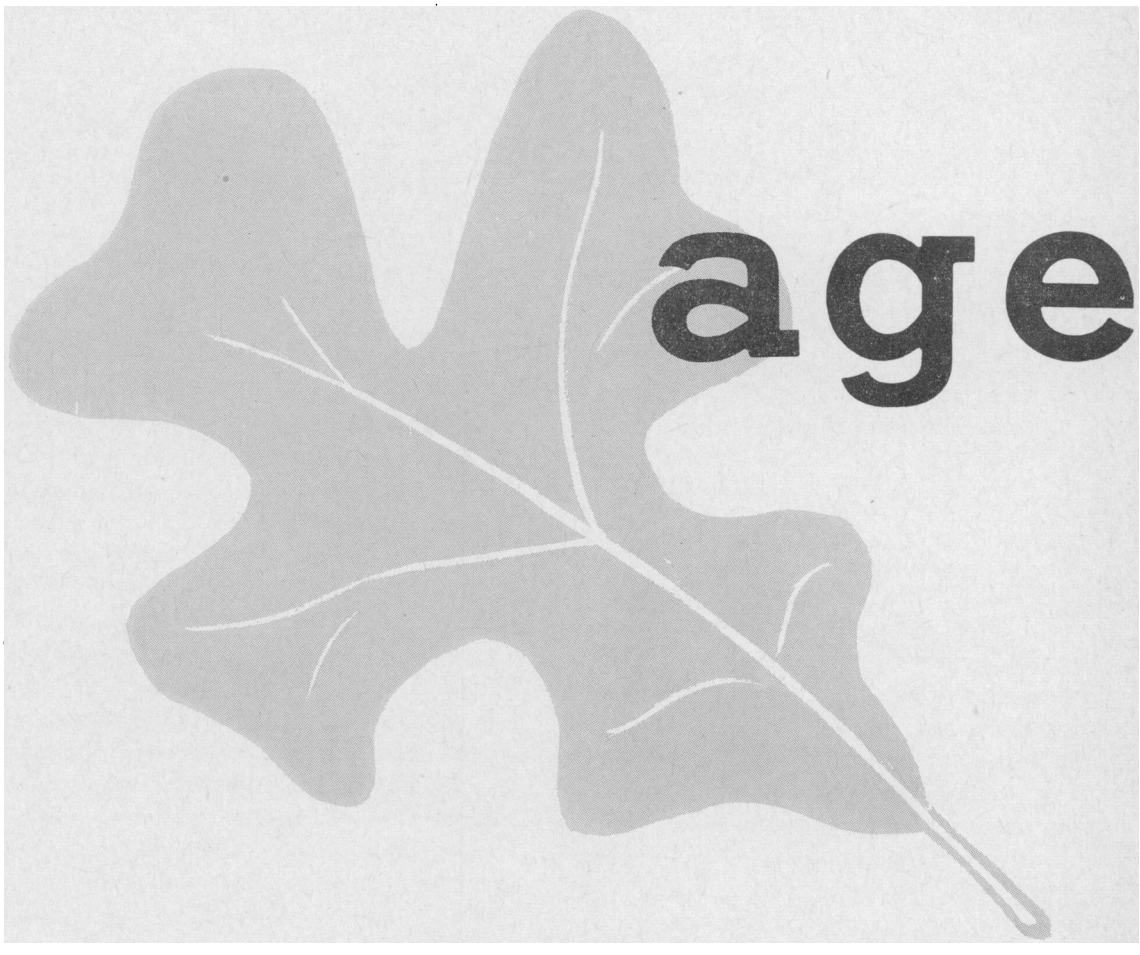

The following pages carry material selected for its relation to a single theme: the responsibility of the health professions for the aged population, identifiable less by their years than by their needs. Comments on public health programs for the aging are offered in the leading statement by Surgeon General Leroy E. Burney.

Trends in gerontology and several of its aspects are covered in five papers from the research seminar held at the University of Michigan Conference on Aging at Ann Arbor, July 1956. Reports of other sessions at that conference follow.

Certain recommendations of the first Federal-State Conference on Aging, held in Washington, D. C., in June 1956, are published for their particular value to public health agencies.

Included in the section are two privately contributed reports. Dr. Pemberton and Dr. Macleod assay the health status of a group of men over 40 in a rural area, and Mrs. Belloc reports on eyesight in the aged.

Programs for the Aged

By LEROY E. BURNEY, M.D.

The Surgeon General's address at the banquet for the State and Territorial Health Officers, November 8, 1956, Washington, D. C., was climaxed by the following strong appeal for programs for the aged.

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IT IS IMPORTANT that the public health profession develop swiftly some mutually acceptable principles upon which to base our planning in the vital and inseparable fields of aging and chronic illness.

If we do not institute constructive action to improve the health of the aged and reduce the burden of chronic illness in more communities and States, we will have failed in our plain duty to the people we serve—and that is the whole community not merely a certain segment.

I speak bluntly for the good reason that, at national and State levels, the problem of aging has become a matter of public policy with a high priority for action. It has grown over the years until now it has come to a head, presenting all the classic signs: rubor, calor, dolor, and tumor. Unfortunately, the signs of heat and irritation are observed chiefly in public and private deliberations on how to solve the problems of aging while the aged individual and his family continue to suffer the pain and our national economy, the swelling. Our communities, States, and Nation want some practical, feasible means of treatment.

As physicians and health specialists we can expect to be called in consultation. Are we prepared to give sound advice on what should be the next steps for improvement in our own field, health of the aged?

Health is a central factor in every aspect of the older person's life. It cuts across every social, occupational, and economic line. It affects every proposal for improving the lot of older people in family life, employment, recreation, and participation in community affairs.

A few specialized programs have been initiated in the past decade which, it is true, are directly related to the health of people in the fifth and succeeding decades of life. I refer to community mental health services and tuberculosis, cardiovascular disease, and cancer control. The earlier venereal disease control program also is directly related to adult health. Even if these specialized Federal-State programs were at this moment operating at peak effectiveness in all parts of the country, they could reach only a fraction of the disabilities seriously affecting the adult population of middle and later ages.

And I should be less than candid if I did not say, here and now, that our existing specialized programs reach pitifully few of the men and women who need them most: the aged. As a candidate for that category, I have a personal sense of misgiving when I realize that the age groups which have the shortest remaining life expectancy also receive the short end in health and related services. Yet, there is so much health departments could do now if they had the resources and the vision. We simply haven't begun to apply the knowledge already available.

In terms of national health and national economy, there are incalculable savings to be made through restoration of bed-bound, institution-bound older people at least to self-care

in their homes. It has been done, here and there, by the Allegheny County Institutional District in Pennsylvania, at the Goldwater Memorial Hospital in New York City, and at the District General Hospital in Washington, D. C.

The health maintenance clinic is no longer a pipe dream. This idea for the improvement of adult health is being applied in the University of Miami Medical School and, limited to recipients of old age assistance, by the Santa Cruz County Health Department in California. In New York City and Worcester, Mass., medical societies, health departments, and voluntary agencies are experimenting with "well-oldster conferences." They say the "well oldsters" don't object to the obvious "well baby" comparison, quite the reverse. Equally sporadic is the development of adequate home care programs; yet, 90 percent of the disabled 65-and-over group is at home. Almost untouched is the quality of care in nursing homes; yet, many State health departments are responsible for the licensing of such facilities. So, also, is the idea of cooperative services to the chronically ill and aged in which many community agencies, voluntary and official, participate.

Are we, the appointed guardians of public health, going to remain content with piecemeal services for the increasing millions of older people? We in the Public Health Service are going to give this problem top priority in our program planning. We have already taken some of the steps. We shall take others, assign more personnel, cooperate with the States to the fullest extent of our available resources.

I wish to add one caution. Public health practitioners and private practitioners are not miracle workers. I fervently agree that some of the improvements we could make tomorrow, with relatively simple means, might seem miraculous in their beneficial effects on the lives of many older people. But the social, economic, physical, and emotional problems of growing old in our society are complex and difficult of solution. No efforts on the part of public health and medicine to improve the health of the aged can be fully successful unless society is willing to make parallel efforts in related fields. We cannot be all things to all men. So let our planning for health of the aged be predicated upon the following assumptions:

- That continued efforts will be made to improve financial security of our older citizens.
- That parallel efforts will be made to remove arbitrary restrictions on the employment of individuals because of chronological age.
- That there will be no diminution in the Nation's current medical research effort, leading to more effective health care and control of chronic disease.
- That existing health and rehabilitation programs be sustained and progressively expanded so that maternal and child health services and other preventive and restorative programs may assure oncoming generations a foundation of better health as they reach old age.
- That the concept of Federal-State cooperation and of working together with the professions and the public will continue to inform and inspire all that we do for the better health of the aged.