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# AGEISM IN THE HEALTH CARE SYSTEM: SHORT SHRIFTING SENIORS?

## HEARING

BEFORE THE

## SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

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# AGEISM IN THE HEALTH CARE SYSTEM: SHORT SHRIFTING SENIORS?

**MONDAY, MAY 19, 2003**

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, DC.*

The Committee met, pursuant to notice, at 2 p.m., in room SD–628, Dirksen Senate Office Building, Hon. John Breaux, presiding.

Present: Senators Breaux, Dole, and Wyden.

The CHAIRMAN. The Committee will please come to order. I thank all of our guests for being with us, and Senator Dole as well.

## OPENING STATEMENT OF SENATOR JOHN BREAUX, CHAIRMAN

The Special Committee on Aging is special in a sense, that it also sometimes alternates between the chairmen of the committee, and this may be the only committee in the U.S. Senate where you have a Democrat chairing a committee today. So we kind of alternate because it's really nonpartisan.

I think the committee has a very unique responsibility in defending America's seniors. As we all prepare for the pending wave of 77 million aging "baby boomers", our responsibility is to help our country rethink and really to redefine so many of the ways we think about growing older in this country.

Outdated thinking about aging leads to outdated public policies, and also public health risk. Today's hearing is important not just because seniors are falling through the cracks in our health care system, but because it serves as a brutal reminder of how ageism is presented in our country. We must, in my opinion, rethink our attitudes and policies toward the elderly.

Too many people assume that since seniors have Medicare, their own health care system, that their health care needs are being adequately met. I have said time and again that Medicare is broken. In addition to the antiquated nature of the program, the system designed to care for our seniors also discriminates against them. Part of this discrimination is due to the lack of doctors, pharmacists, physical therapists, or mental health professionals who are trained in geriatrics.

But another reason is the underlying age bias in modern medicine. We all know the stereotypes about seniors that say, "well, they're difficult" or "they're all going to die anyway" or "they're all a bunch of old geezers." This afternoon we're going to explore that ageism bias in health care, or as I refer to it as "medical ageism". Across the spectrum of the United States health care system is a

potential to save more lives, to save millions in health care dollars, increase access to better health care, and also to improve the quality of life of seniors by removing the systematic bias from our health care system.

This Committee has looked at the entire health care system and identified specific areas where medical ageism exists: in mental health, in preventative health screenings, in clinical trials, and in treatment for hospital-borne infections. For example, cancer continues to be the second leading cause of death. Nearly 80 percent of all cancers are diagnosed at ages 55 and older. Yet most people do not receive the screening tests that they should. In fact, only one in ten seniors are up-to-date in their preventative Medicare screenings. In contrast, 95 percent of 5 year olds are up-to-date on their immunizations because we conduct immunization programs and run major public awareness campaigns. Why not try to get something similar done for our seniors?

While the Food and Drug Administration, the FDA, now mandates that children be included in clinical trials for new prescription drugs, seniors are almost always left out. This is ironic because the average 75-year-old has three chronic medical conditions and regularly uses about five prescription drugs. Changes with aging can also alter how the body metabolizes, absorbs and clears these drugs from the body.

Though much progress has been made to eradicate the stigma and the shame of mental illness, seniors have also been left behind in this area. Older Americans have the highest suicide rate in our country, a rate four times the national average. Many assume that symptoms of depression are a part of the normal aging process, but they are not. In fact, over 70 percent of suicide victims saw their doctor within 1 month of their suicide. They were not treated or referred for treatment for their depression. Our health care system simply failed them.

We found age bias in so many aspects of our health care system that this hearing can really not address all of them. Today is just a beginning. We plan to further investigate areas where medical ageism exists and to use this committee to highlight these areas over the next few months.

Now, today I learned of a terrible case of an elderly woman in my State of Louisiana who died from oral neglect. Why? Because no one bothered to look into her mouth. Gum disease is treatable, not a death sentence for the elderly. I was astonished to learn of numerous other egregious cases just like this one. Apparently, many do not see dental care for the elderly as a priority. Again, one questions why we should bother with trivial things like dental cleaning. Cleaning is too late for seniors. Oral disease can seriously compromise the general health of seniors and place them at increased risk for infection.

[The prepared statement of Senator John Breaux follows:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX

I believe this Committee has the unique responsibility to defend America's seniors. As we prepare for the pending wave of 77 million aging baby boomers, our responsibility is to help this country re-think and re-define how we age. Outdated thinking about aging leads to outdated public policies and public health risks. Today's hearing is important, not just because seniors are falling through the cracks

in our health care system, but because it serves as a brutal reminder of just how present ageism is in our country. We must rethink our attitudes and policies toward the elderly.

Too many people assume that since seniors have Medicare—their own health care system—their health care needs are being met. I have said time and again that Medicare is broken. In addition to the antiquated nature of the program, the system designed to care for our seniors also discriminates against them. Part of this discrimination is due to the lack of doctors, pharmacists, physical therapists or mental health professionals trained in geriatrics, but another reason is the underlying age bias in modern medicine. We all know the stereotypes about seniors, that, "They're difficult." "They're going to die anyway." "Old geezers."

This afternoon we're going to explore the ageism bias in health care or, as I refer to it, "medical ageism." Across the spectrum of the U.S. health care system is a potential to save more lives, save millions in health care dollars, increase access to better health care and to improve the quality of life of seniors by removing this systemic bias from our health care system. This Committee has looked at the entire health care system and identified specific areas where medical ageism exists—in mental health, preventive health screenings, clinical trials, and treatment for hospital-bourne infections.

For example, cancer continues to be the second leading cause of death. Nearly 80 percent of all cancers are diagnosed at ages 55 and older, yet most people do not receive the screening tests they should. In fact, only one in ten seniors are up to date in their preventive Medicare screenings. In contrast, 95 percent of five year-olds are up-to date on their immunizations because we conduct immunization programs and run major public awareness campaigns. Why not try something similar for seniors?

While the FDA now mandates children be included in clinical trials for new prescription drugs, seniors are almost always left out. This is ironic because the average 75-year old has three chronic medical conditions and regularly uses about five prescription drugs. Changes with aging can also alter how the body metabolizes, absorbs and clears these drugs from the body.

Though much progress has been made to eradicate the stigma and shame of mental illness, seniors have been left behind. Older Americans have the highest suicide rate in America—a rate four times the national average. Many assume that symptoms of depression are a part of the normal aging process, but they are not. In fact, over 70 percent of suicide victims saw their doctor within one month of their suicide, but were not treated or referred for treatment for their depression. Our health care system simply failed them.

We found an age bias in so many aspects of our health care system, that this hearing can not address it all. Today is just the beginning. I plan to further investigate areas where medical ageism exists and to use this Committee to highlight these areas over the next few months.

Just the other day, I learned of a terrible case of an elderly woman in Louisiana who died from oral neglect. Why? Because no one bothered to look in her mouth. Gum disease is treatable—not a death sentence for the elderly. I was astonished to learn of numerous other egregious cases just like this. Apparently, many do not see dental care for elderly as a priority. Again, many question why we should bother with trivial things like a dental cleaning, claiming it is too late for seniors. But oral disease can seriously compromise the general health of seniors and place them at increased risk for infection.

I want to thank our witnesses for being here today and I look forward to their testimony.

I want to now ask if she has any opening comments, Senator Dole, our distinguished colleague from North Carolina.

Senator DOLE. Senator Breaux, thank you very much for your leadership in chairing the hearing today.

I do not have an opening statement, except to say, "How much I look forward to hearing the testimony of our panel today," because my interest in these issues dates back throughout my career in public service to my days on the Federal Trade Commission, when I led several investigations at that time, and because this week, my own dear mother celebrates her 102d birthday. So I look forward to your testimony today. Thank you.

The CHAIRMAN. Thank you, Senator Dole.

Senator Wyden, any comments?

**STATEMENT OF SENATOR RON WYDEN**

Senator WYDEN. Thank you, Mr. Chairman. I am very pleased that you're continuing these hearings and it's good to have some old friends and passionate advocates, before us today particularly Dr. Butler, who years ago was crying out in the wilderness that our country get serious about these issues.

Like Senator Dole, I really come at these issues from personal experience. For a number of years, I was Director of the Gray Panthers before I was elected to Congress, so I have taken a special interest in these concerns.

I believe that ageism is an immoral stain that cheapens our country's health care system, and it's time to get some fresh policies that wipe it out. Let me be specific about what I'm especially concerned about, and that is something that Dr. Butler has written about for years.

I think it really starts with medical education for so many of the practitioners in the field. I remember years ago, when I ran the legal aid office for the elderly, I was often invited to speak at medical schools. I was struck at how few of those who were studying medicine were taking geriatrics, or even a course. We did a review of the current requirements and apparently only 14 medical schools in the country require a course on geriatrics. Most schools now seem to offer an elective on the topic, but only 3 percent of the students are even enrolling.

So my sense is, and to pick up on what Chairman Breaux is talking about, the country is not going to be ready for this demographic tsunami that is coming in 2010 and 2011. I hope that some of you will talk to us about what it's going to take to really shake up, once and for all, the system of how students are educated for health care professions.

I was struck, when I was giving discussions on gerontology and taught courses on the subject, that the medical education model was simply out of sync for older people. It was almost as if the ideal was to diagnose the problem, determine the cause, treat it, and then cure it so that a young person would then go on to play tight end for the Chicago Bears. That was sort of the model.

Well, a lot of our constituents, and Mrs. Dole's 102-year-old mother, isn't going to go play tight end for a football team. There needs to be a medical education model that works for those kind of people. We are going to have an extraordinary number of people who are going to live to 100. The challenge here is just staggering, and that's why I think it is so good that Chairman Breaux is continuing this.

This committee has always worked in a bipartisan way, and I remember Mrs. Dole's work on the Federal Trade Commission and how helpful it was. So I look forward to working with my colleagues.

The CHAIRMAN. I thank both of my colleagues, and thank the very distinguished panel of witnesses who are going to be with us this afternoon. We would ask that each of you try, to the extent you can, summarize your statements and we will proceed to questions.

Our first witness will be Dr. William Payne. Dr. Payne is a retired radiologist from Nashville, TN, and we're delighted to hear of his experiences.

Dr. Payne.

**STATEMENT OF WILLIAM FAXON PAYNE, M.D., RETIRED RADIOLOGIST, NASHVILLE, TN**

Dr. PAYNE. Thank you, sir. Good afternoon, Senators.

I am pleased to be invited to appear here today and hope that I can convince you to enact legislation to abolish aging. We who are elderly could do without it. [Laughter.]

I am a retired radiologist and medical school professor emeritus from Vanderbilt University. I turn 78 this month, and I live in Nashville, TN.

On February 5, 1999, I was treated for an early cancer of the prostate under general anesthesia. I was discharged that day, and a few days later developed "walking pneumonia." I was treated with antibiotics, but as it turned out, the treatment was inadequate.

Approximately a week after my surgery, I was up very early to go to work at the hospital and was working a crossword puzzle in our bedroom. I looked up and asked my wife who was the man in the doorway. Since there was no man in the doorway, she knew I was hallucinating. My brain was oxygen deprived.

My wife immediately called my internist and was told to take me to the ER—now! When we arrived at the ER, I walked in and collapsed in cardiac and respiratory arrest. I underwent CPR for 10 minutes, then was placed on a respirator, where I remained for the next 12 days in a coma. During those 12 days on life support, I lost 30 pounds. I was treated with antibiotics, blood transfusions, steroids, and both IV and tube nutrition.

I had developed sepsis, or as we used to call it, "blood poisoning." Sepsis is an extremely serious and often deadly bacterial infection. It can start with any common infection, more often in the lungs, and rapidly progresses to multiple organ failure. It must be recognized in its earliest stages for treatment to be successful. Seniors are even more at risk of contracting sepsis because the majority of people in the ICU are above the age of 65. They must be treated aggressively right away because their immune system response is reduced.

Dr. Wes Ely of Vanderbilt University medical center is a physician who has done extensive research on sepsis. Luckily for me, he just happened to be in the emergency room when I collapsed. He recognized my condition as sepsis and immediately began aggressive treatment for it. I was a lucky one. Other seniors have not been so fortunate. Some doctors misdiagnose sepsis in seniors, but worse yet are the doctors who recognize it and don't treat it aggressively.

Luckily for me, I survived sepsis and lead a happy, active and productive life. I work out daily at the gym and, with my wife's excellent cooking, I now weigh 50 pounds more than when I entered the hospital. [Laughter.]

Before I close, I want to share these thoughts with you. Many times the health complaints of seniors are brushed off as, "well,

you should expect this at your age." Why? Why should an older person not expect to have the same treatment as someone half his or her age? We are still human beings with feelings, and we have skills to offer society. We do not like to be shunted aside as worthless hulks or has-beens. I think all of the health profession should stop and think before dismissing the health concerns of the elderly with comments like "you have to expect this at your age." Thank you.

[The prepared statement of Dr. Payne follows:]

OPENING STATEMENT FOR DR. FAXON PAYNE

Good Afternoon Senators:

I am pleased to be invited to appear here today and hope that I can convince you to enact legislation to abolish aging. We who are elderly could do without it. I am a retired radiologist and medical school professor emeritus from Vanderbilt University. I turn 78 this month and I live in Nashville, Tennessee.

On February 5th of 1999 I was treated for an early cancer of the prostate while under general anesthesia. I was discharged that day and a few days later developed "walking pneumonia." I was treated with antibiotics, but as it turned out, the treatment was inadequate. Approximately a week after my surgery, I was up very early to go to work at the hospital and was working a crossword puzzle in our bedroom. I looked up and asked my wife who was the man in the doorway. Since there was no one in the doorway, she knew I was hallucinating. My brain was oxygen deprived. My wife immediately called my internist and was told to take me to the ER now! When we arrived at the ER I walked in and collapsed in cardiac and respiratory arrest. I underwent CPR for 10 minutes, then was placed on a respirator where I remained for the next 12 days in a coma. During those 12 days on life support I lost 30 pounds. I was treated with IV antibiotics, blood transfusions, steroids, and both IV and tube nutrition.

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and we have skills to offer society. We do not like to be shunted aside as worthless hulks or has-beens. I think all of the health profession should stop and think before dismissing the health concerns of the elderly with comments like "you have to expect this at your age."

Thank you.

The CHAIRMAN. Dr. Payne, thank you very much for an excellent statement. We will have some questions for you.

Next we're going to hear from Rabbi Gerber. He comes to us from Philadelphia, PA. Rabbi Gerber will describe to us his mother's experience with depression.

Rabbi, we're delighted to have you with us.

**STATEMENT OF RABBI ZALMAN GERBER, PHILADELPHIA, PA**

Rabbi. GERBER. Thank you.

I would just like to make a few points of what has happened over the past few years in my mother's experience, that I think will outline how it was more fate than attention to her needs, luck more than attention to her needs, that actually helped her back on the road to recovery.

My mother, in 1996, was about 70 years old. Don't tell her that I don't remember exactly when she was born. She started to suffer from depression. At that point she would go from time to time to a doctor and the doctor at that point was not able to aggressively treat her. Her condition deteriorated and they put her on some strong medications but at that point there wasn't much she really needed. Actually, in retrospect, we found out she was suffering from an acute medical condition of hypothyroidism, which many times leads to depression, but she was going undiagnosed and untreated.

That started her to deteriorate, and then when my father passed away in January 1999—he was very sick in December and passed away in 1999—she sunk into a deep level of depression, to the point of being completely non-communicative and was unable to speak.

At that point, one thing that was extremely difficult—she has quite a few children, and I'm one of them, and my father had insights so as to "squirrel away" some money for her care. But we were left at that point scrambling for what to do. We felt at that point there was no real guidance, nowhere to turn. We couldn't get any solid answers on what her problem was and what should we do. So, for the lack of a better word—we ended up finding a facility to put her in—but it ended up basically of putting her in a warehouse. Her problems were not being diagnosed, nothing treated, so she had to go somewhere.

We found an assisted living facility, which is actually a facility that was not compatible to her condition. She needed aggressive care, and no one knew that.

When that wasn't working—that was in California where she lived—I and my wife ended up bringing her to Philadelphia and we quickly decided to put her into a local hospital. There she was treated for the medical condition, her hypothyroidism, but still her mental condition, her depression, had basically gone untreated. She was still unable to communicate.

From the hospital she was transferred to a nursing home, where she became extremely depressed, to the point of being self-damaging. She started to hurt herself. The nursing home at that point, for lack of ability to—again, her mental condition still going undiagnosed. The only alternative they had at that point was to—she was misdiagnosed at that point in the nursing home. They

thought she was suffering from dementia and they moved her to a dementia unit, which was basically the end of the road. It would have been the end of the road for her. She would be unable to communicate, unable to speak, and she was deteriorating rapidly. She would have lasted for a short time in the dementia unit.

At that point, because she was still self-damaging, still hurting herself, the dementia unit didn't know what to do with her. They were looking for more answers and, luckily, Dr. Streim was able to step forward. They turned for a higher level of expertise and they were able to correctly diagnose her. At that point, when they were able to correctly diagnose her, it turned out she was not suffering from dementia at all. She was suffering from deep depression, so they moved her from the dementia unit to a hospital at the University of Pennsylvania, and she received intense care and treatment for her depression.

In the course of 6 weeks, the doctor who was in charge of the ward said, "That she was the worst case of depression he had ever seen on his ward." Because of her correct diagnosis and treatment, in the course of 6 weeks she was able to sit down and have a conversation with me. She was able to recognize me and stopped her self-damaging behavior. At that point she moved back into my home and was able to start volunteering in the local library, attending an outpatient therapy program.

She is now a functioning person. I feel that was the turning point, that once she got the correct diagnosis and treatment, we basically got our mother back. Until that point, we could project that she would not have lived very long and would have ended her days misdiagnosed in a dementia unit, in a nursing home.

Now both me and my wife, and my siblings and her grandchildren—she has 30 grandchildren—they have their "Bubby" back. They have their grandmother back.

The couple of points I wanted to bring out is that my father had the foresight to "squirrel away" some money for her, but even with—there's an old saying, "That if there's a problem, throw money at it." But even though we tried to throw money at the problem, her money, at the beginning that wasn't enough. When my sister and I were speaking before I came here, she said that, you know, she had money, and still the diagnosis was not there, so what would it be as with many elderly citizens that don't have the money to throw at the problem? What would it have been with them? That's my summary.

[The prepared statement of Rabbi Gerber follows:]

**TESTIMONY OF RABBI ZALMAN GERBER**
**Before the U.S. Senate Special Committee on Aging**
**May 19, 2003**

Brief historical sketch of Penny Gerber's illness and ongoing treatment, as recorded by Rabbi Zalman Gerber, her son.

Penny Gerber and her husband, Solomon, were married for 46 years, and lived in Long Beach, CA.

1996 –Penny started to exhibit early signs of depression at approximately the same time that Solomon's health started to decline.

mid-1998 – Penny was exhibiting advanced signs of deep depression. Solomon was himself too ill to deal appropriately with her illness, but refused repeated offers of assistance from their children.

January 1999 – Solomon died. Penny's situation rapidly deteriorated into very deep depression, being unable to speak or communicate, and behavior turning psychotic and self-damaging. Her children were at a loss as to how to proceed and where to turn. They decided to follow their parents expressed wishes to keep Penny at home with a hired companion. 2 of her daughters who lived in Southern CA made Herculean efforts to try to tend to her ongoing needs. They took her periodically to a psychiatrist, who prescribed an extremely strong antidepressant medication. She continued her rapid deterioration.

October 1999 – Her children decided that Penny must be institutionalized, but had nowhere to turn for guidance. They found an assisted living facility in Los Angeles that was willing to accept her; however, in retrospect, the facility was completely incapable of tending to her urgent need of intense psychiatric treatment. Penny continued her rapid deterioration.

February 2000 – In order to relieve his emotionally exhausted sisters in CA, her son in Philadelphia brought her for a visit / long term stay to his home. Within days, he and his wife decided that she was incapable of tending to her own physical needs, and was immediately hospitalized. She stayed in the hospital for approximately 3 weeks, being treated for severe hypothyroidism and malnutrition. These medical problems had gone undiagnosed and untreated, possibly for years.

March 2000 – Penny was moved to a nearby assisted living facility just outside of Philadelphia. She was still unable to speak or communicate, and her behavior was still psychotic and self-damaging. Unable to care for her, she was transferred from the assisted living floor to the Alzheimer's unit.

April 2000 – It was determined by the attending psychiatric staff that Penny urgently needed more intensive psychiatric care, and must be moved from their facility to a

psychiatric ward in a hospital for intense treatment. She was transferred to the Hospital at the University of PA.

She stayed on the floor of the ward for approximately 6 weeks and underwent biweekly shock treatments and daily therapy. By June, she was able to recognize and hold a simple conversation with her son.

July 2000 – Penny moved back to her son's home, where she continued daily outpatient therapy throughout the summer. She started to volunteer at the local library.

December 2001 – Penny had a minor stroke, leaving her weakened on the left side of her body. She was hospitalized for intense physical therapy. She was then transferred to a local nursing home.

April 2002 – She returned to her son's home, being aided daily by a private nurse.

October 2002 – Penny was moved to a local, better equipped nursing home, where she is now able to socialize, make friends, and participate in most activities, including computers, art, and bingo.

The CHAIRMAN. Thank you very much, Rabbi, for that very personal story. It was very helpful.

Next we're going to hear from Dan Perry of the Alliance for Aging Research. Dan, welcome back. He is Executive Director of the Alliance and is here to tell us about the new report that the Alliance is releasing today on ageism, how health care fails the elderly. It's a very detailed and solid report and we're glad to have you back.

**STATEMENT OF DANIEL PERRY, EXECUTIVE DIRECTOR, ALLIANCE FOR AGING RESEARCH, WASHINGTON, DC**

Mr. PERRY. Thank you very much, Senator Breaux. I also want to extend my appreciation to the other members of the committee, Senator Dole and Senator Wyden. Thank you very much for bringing this issue to such prominence.

Senator Breaux, it was a year ago that you held a similar hearing on the ageist bias in other aspects of our society, and especially as it surfaces in the media. Today's hearing appropriately focuses on the health care setting, where older patients tend to predominate and where the ageist assumptions about what is good for them can have very deadly consequences.

As you know, Mr. Chairman, the Alliance for Aging Research is a not-for-profit organization, working to ensure that older Americans receive quality health care, informed by the best geriatric practices, as well as to have access to the newest and most effective medications, treatments, therapies, and medical technologies, without any discrimination based on age.

Today the Alliance is releasing its new report, entitled "How American Health Care Fails Older Americans." Ageism is a deeply rooted and often unconscious prejudice against the old, an attitude that permeates our culture. It is a particularly apparent and especially damaging frame of mind that surfaces in health care settings. Like other patterns of bias, such as racism and sexism, these attitudes diminish us all, but they can be downright deadly to older persons in receiving health care.

In our latest report, we document with scores of citations from the recent medical literature showing that older patients too often do not receive preventative treatments, such as vaccines and screening tests, that could potentially prevent diseases from becoming life threatening.

Lack of generally accepted standards of care for geriatric patients means older patients are more likely to face inappropriately invasive procedures, such as multiple heart surgeries, while others may be denied a life-saving surgery out of the mistaken concern that the older person's age alone rules them out.

Medical neglect of the aged begins with failures to screen older people for the early signs of incipient disease. Very few screening guidelines have been developed that even refer to people age 65 and over, even though the vast majorities of fatal heart attacks and cancer deaths occur after that age.

The short shrift that is given to older people begins even earlier, in a sense, with the training—or rather the lack of training—of America's health professionals in good geriatric medicine. As you have stated, Senator, only about one in ten U.S. medical schools re-

quire substantial course work or rotation in geriatric medicine. It's not physicians' training only. Our schools of nursing, pharmacy and other allied health professions do no better, with less than one percent of accredited professionals in those fields having advanced work in geriatrics.

Scant exposure to the techniques of geriatric medicine can foster ageist assumptions that "it's too late" to change the habits of older people, or worse, that serious and chronic health problems are somehow a "natural" part of getting older.

Too little effort is made at preventive care in the elderly, despite proven advantages for improving their quality of life. In our report, we call attention to ageist defeatist attitudes when it comes to counseling older smokers to quit the tobacco habit, or to engage in regular physical activity. When it comes to standard HIV and AIDS treatment and prevention efforts, as well as substance abuse protocols, there is a blind spot of ageism when it comes to people in their sixties and older.

Our report also notes that older people are systematically excluded or discouraged from participating in the clinical trials that determine the safety and efficacy of the medications for which Older Americans will be the largest end users.

Ageist assumptions that distort the quality of health care for such a large and growing group hurts everyone, because it leads to premature loss of independence on a giant scale, and it increases the mortality, disability and depression in older adults who might otherwise lead productive, satisfying and healthier lives.

Older people themselves unconsciously embrace unfounded assumptions that to be old is to be sick, or that they shouldn't bother their physician by bringing up their health concerns, or that "you can't teach an old dog new tricks", which gets in the way of adopting healthier behaviors.

The Alliance for Aging Research especially thanks this committee for its attention to ageism in health care as the threat that it is to the well-being of older Americans and to all of us. Ageism is not something that we can just accept or ignore, and unfortunately, it's not something that is just going to go away. However, our report does submit these key recommendations for getting at the root of the problem:

First, we should have reform in health professions' education so that every doctor, nurse, and allied health profession graduates with at least some exposure to geriatrics.

Researchers should target their studies on the benefits to older people of common health screening protocols and preventive measures, so that we have a baseline from which to recommend more aggressive prevention and screening.

Congress and health agencies should raise the awareness, as this hearing is doing, of the availability of experimental drug trials and consider legislation creating appropriate incentives to include older subject in clinical trials.

Last, we should all work to educate and empower older adults and their families to be effective advocates in the health care delivery that too often fails America's elderly.

Thank you very much, Senators.

[The prepared statement of Mr. Perry follows:]

Testimony of
Daniel Perry
Executive Director,
Alliance for Aging Research
before
The Senate Special Committee on Aging
May 19, 2003

Chairman Craig, Senator Breaux and distinguished members of the Special Committee on Aging, thank you for this opportunity to address the prevalence of ageism in American health care.

Senator Breaux, last fall you also presided over a hearing of this Committee raising awareness about the bias against older people in other aspects of American society, especially in the way they are portrayed by the media. Today's hearing appropriately focuses on health care, where ageist assumptions of what is good for older patients can have momentous consequences.

The Alliance for Aging Research is a not-for-profit organization, working to ensure that older Americans receive quality health care, informed by best geriatric practices, as well as have access to the newest and most effective medications, treatments, therapies and medical technologies, without any discrimination based on age.

Today the Alliance is releasing a new report titled ***How American Health Care Fails Older Americans***. This is the second time in ten years that our organization has raised evidence of a systematic medical bias against the elderly. Once again we are citing scores of current and recent scientific studies, reports, surveys and medical commentaries to make our point.

Ageism is a deep and often-unconscious prejudice against the old, an attitude that permeates American culture. It is a particularly apparent and especially damaging frame of mind that surfaces all too often in healthcare settings where older patients predominate. Like other patterns of bias – such as racism and sexism – these attitudes diminish us all, but they can be downright deadly to older people in receiving healthcare.

In the Alliance's latest report we document how older patients too often do not receive preventive treatments such as vaccines and screening tests that could potentially prevent diseases from becoming life threatening. Indeed, due to insufficient research on older patients, there is very little clinical agreement what constitutes normal lab results in older people.

Lack of generally accepted standards of care for geriatric patients means older patients are more likely to face inappropriately invasive procedures, such as multiple heart surgeries, while others are may be denied a life-saving surgery out of the mistaken concern that the patient's age alone rules them out for certain procedures.

Medical neglect of the aged often begins even before illness strikes. It starts with the failures to screen older people for the early signs of incipient disease. Very few screening guidelines have been developed that even refer to people over age 65, even though the vast majorities of fatal heart attacks and cancer deaths occur after that age. We are still waiting for the research to show whether common health screening protocols for measuring cholesterol or colorectal cancer exams catch problems early enough in the elderly to save lives.

The short shrift given to older people begins even earlier, with the training of America's health professionals – or more accurately the *lack* of training in the basics of good geriatric medicine. Only about 1 in 10 U.S. medical schools requires a rotation or substantial coursework in geriatrics for physicians in training. Our schools of nursing, pharmacy and

other allied health professions do no better, with less than 1% of the accredited professionals in those field having advanced work in geriatrics. The fact that so few U.S. pharmacists are specifically trained in geriatric pharmacology likely contributes to frequent over-medication, under-medication, and mis-medication of the elderly, a serious and growing public health problem.

Until a few years ago there was only one medical school in the U.S. with a full Department of geriatric medicine. Then, thanks to the leadership of the Donald W. Reynolds Foundation and a couple of state governments, that number increased to three very recently. And now, within the past year, newly inaugurated Departments of geriatrics in Florida and Hawaii raise the number to five. That may be some progress, but 5 Departments of geriatrics out of 145 allopathic and osteopathic medical colleges in the U.S. is still embarrassingly few.

Scant exposure to the principles of goods geriatric medicine can foster ageist assumptions that "it's too late" to change the health habits or older people, or worse, that serious and chronic health problems in older patients are a "natural" and therefore acceptable part of the aging process. Our report cites a survey of physicians involved in health care of the elderly in which 35 percent of doctors considered elevated blood pressure to be a normal process of aging and 25 percent considered treating hypertension in an 85-year-old patient to have more risks than benefits.

In our report we cite authoritative studies demonstrating that too little effort is made at preventive care in the elderly, despite proven advantages for improving quality of life. We call attention to ageist, defeatist attitudes when it comes to counseling older smokers to quit the tobacco habit, or to engage in regular physical activity. When it comes to standard HIV/AIDS

treatment and prevention efforts as well as substance abuse protocols, there is a blind spot born of ageism when it comes to people in their 60s and older.

Our report also notes that older people are systematically excluded or discouraged from participating in the clinical trials that determine the safety and efficacy of new therapeutic drugs, even though older people predominate as the end users of pharmaceutical therapies. That means many of the side effects and other attributes of these drugs are not recognized until they may have harmed some older patients following approval and marketing.

The bias that underlies these shortcomings would be unacceptable if the elderly were a small percentage of the patient population in our country. But currently Americans over the age of 65 comprise half of all physician time. By 2030, almost 1 in 4 of the entire population of the U.S. will be in this age group. Ageist assumptions that distort the quality of healthcare for such as large and growing group hurt everyone, because they lead to premature loss of independence on a giant scale, and they increase mortality, disability and depression in older adults who might otherwise lead productive, satisfying and healthier lives.

Older people themselves often unconsciously embrace unfounded assumptions that to be old is to be sick, that they shouldn't "bother" their physician by bringing up health concerns, or that "you can't teach and old dog new tricks," regarding changing health behaviors.

Mr. Chairman, we thank the Special Committee for its attention to ageism in healthcare as a threat to the well being of older Americans. Ageism is not something that we can just accept or ignore, and unfortunately, and it is not something that will just go away. However, the Alliance's report does submit these key recommendations for getting to the root of the problem:

- There should be reform of medical and healthcare professional education so that every doctor, nurse and allied health provider has received some training in geriatrics prior to graduation;
- Researchers should target studies on the benefits to older people of common health screening protocols and preventive measures; Medicare and private insurance should help educate providers and patients alike on benefits established by medical evidence;
- Congress and health agencies should raise awareness of the availability of experimental drug trials and consider legislation creating appropriate incentives to include older subjects in clinical trials;
- We should all work to educate and empower older adults and their families to be effective advocates in healthcare delivery that too often fails the elderly.

Thank you.

The CHAIRMAN. Thank you, Mr. Perry, and thank you for the excellent report.

Our next panelist will be Dr. James Marks of the Center for Disease Control. Dr. Marks is the Director of the CDC's National Center for Chronic Disease Prevention and Health Promotion. He will describe, as I understand it, prevention measures for the elderly and whether they're being properly utilized.

Dr. Marks, welcome.

**STATEMENT OF JAMES S. MARKS, M.D., DIRECTOR, NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Dr. MARKS. Thank you, Senator Breaux, and members of the committee, for this opportunity to address a critical priority for CDC and for public health, preventing disease, and preserving health among our Nation's growing number of older adults. I would like to submit my full written statement for the record.

The CHAIRMAN. Without objection.

Dr. MARKS. The unprecedented aging of the U.S. population will present societal and economic challenges unlike anything our society has ever seen. We cannot begin to slow the skyrocketing health care costs or control serious health problems without much more aggressively working to prevent disease, injury and disability among older Americans.

You've heard from Dan Perry that older Americans have not been fully involved in disease research, and that treatment of disease is not pursued as aggressively among older Americans as it is among their younger neighbors. Likewise, and especially in the areas of maintenance and promotion of health and disease prevention, those areas have not been addressed as strongly as they should among our older adults.

It is CDC's role and public health's challenge to see that what we know is effective is much more broadly applied, and to help conduct the research to learn more about what will work to help older adults maintain an active, enjoyable life as they age. Much of the research on prevention was conducted on adults less than 65. Yet, increasingly, the science tells us that even for older adults it is never too late to receive substantial health benefits from improving health behaviors and from receiving preventive health services. But they and their providers have not been getting that message, and so their care and their health have both suffered. Further, public health practice in this Nation has not had an emphasis on older adults, although that it beginning to change.

CDC has identified several critical priorities for addressing the health of our Nation's seniors. First, we must promote healthy lifestyles for our seniors. It is very clear that healthy lifestyles are tremendously influential in helping older people avoid the deterioration traditionally but inappropriately associated with aging. Adults who are physically active, maintain their weight and do not smoke, delay the onset of disability by 7 to 10 years, a tremendous improvement in a society where the costs of long-term care are overwhelming each State's ability to provide basic services to their poor

and uninsured. Yet there is little systematic effort to encourage these behavior changes among our older populations.

Second, we must increase the use of clinical preventive services, such as screening for chronic disease and provision of flu and pneumonia immunizations. We know that older adults are less likely to get cancer screenings, less likely to be treated fully for high blood pressure and elevated cholesterol than their younger neighbors. Despite coverage for flu vaccine and pneumonia vaccine for the last 20 years, arguably the simplest of our interventions, less than two-thirds of adults over 65 get these as needed, and in African Americans, it's less than 40 percent. Coverage is important, but it does not ensure use. Education of providers and older adults themselves is needed, and coordination of the services is important.

Third, we must reduce hazards and risks for injuries. 250,000 people are hospitalized for hip fractures each year, and about half will be unable to go home or live independently afterwards. Simple measures in homes, like reducing furniture and throw rugs that increase their risk of tripping, or installing grab bars in houses can greatly reduce this risk of injury.

I would like to highlight a small local program that CDC is helping to support, that offers evidence that we can close these gaps between what we know works and what we actually do in our communities.

The Sickness Prevention Achieved through Regional Collaboration project, or SPARC, is conducted by a non-profit organization serving a critical role as a local bridge between health care providers, aging services providers, and seniors in a four-county area at the intersection of Connecticut, New York, and Massachusetts.

SPARC has shown remarkable results. It increased pneumonia vaccine in Dutchess County, NY by 94 percent, doubled the use of breast cancer screening among women attending flu clinics, where SPARC made mammography appointments also available, and it doubled the rate of pneumonia vaccinations in Litchfield, CN, an increase that was twice as large as that in surrounding counties. It's an outstanding example of a successful science-based program that should be happening in communities nationwide.

I would like to thank the committee for inviting me to talk about this issue of critical importance to the American people, the public health, and the CDC. It is in all of our best interests to assure that the golden years are healthy, quality years, and that older adults get what they want most—their best chance for staying independent, active members of society, for as long as possible.

We, as a society, must recognize that the increasing number of older adults makes the urgency of this vision much more compelling than it has ever been before.

Thank you very much.

[The prepared statement of Dr. Marks follows:]

**Testimony**
**Before the Special Committee on Aging**
**United States Senate**

# Preventing Disease and Preserving Health Among Our Nation's Aging

*Statement of*
**James S. Marks, M.D., M.P.H.**
*Director*
*National Center for Chronic Disease Prevention and Health Promotion*
*Centers for Disease Control and Prevention*
*U.S. Department of Health and Human Services*

**For Release on Delivery**
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Thank you, Mr. Chairman, Senator Breaux, and Members of the Committee, for the opportunity to address a critical priority for our society, the Department of Health and Human Services, the Centers for Disease Control and Prevention (CDC), and public health – that of preventing disease and preserving health among our nation's growing number of older adults. CDC shares the priority that this Committee has placed on ensuring that the health of our nation's seniors receives appropriate and equitable attention as reflected in the scheduling of this hearing.

In my remarks today, I would like to focus on the opportunities of known prevention measures to reduce unnecessary illness, disability, and premature death among older Americans, including the critical role that Medicare-covered preventive services play in helping to preserve health and the quality of life for our nation's seniors. I would also like to highlight an innovative local model program that has demonstrated remarkable success in ensuring that seniors receive potentially life-saving preventive services.

Implications of an Aging Society

In 1900, only three million people in this country were over the age of 65. As you well know, that picture has changed dramatically a century later. Eight short years from now, the leading edge of the baby-boomers will reach age 65 and the number of older adults will increase rapidly. In the next 25 years, the population over age 65 will more than double, to 70 million older adults. This unprecedented aging of the U.S. population will present societal and economic challenges unlike anything our society has ever had to address.

Current health and aging trends have enormous implications for public health, the health care system, and our existing network of social and aging services. In terms of

health care, a look at a few numbers makes the point clear: a 65-year-old costs four times what a 40-year-old costs in terms of health care dollars. Seniors already account for one-third of all health care dollars spent in the United States -- over $300 billion each year. The ongoing debate about how to rein in the growth in health care costs including Medicare has occurred during the phase of a slow, gradual increase in our number of older adults. We will soon be paddling against a relentlessly rising tide, when the first wave of 76 million baby boomers reaches Medicare age. These numbers are sobering, compelling, and require urgent action.

We cannot begin to stem skyrocketing health care costs, much less adequately ameliorate priority health problems, without addressing in a fundamentally more aggressive manner the **prevention** of disease and disability among older Americans. Increased emphasis on disease prevention and health promotion opportunities for aging and older adults is one of the few avenues available to address the looming impact of chronic disease and other illnesses, disabling injuries, and long-term health care costs among older Americans.

Recent CDC projections of just one major disease—diabetes—illustrate the magnitude of what we face if we do not take action now. The number of U.S. adults with diagnosed diabetes (including women with gestational diabetes) has increased 61 percent since 1991 and is projected to more than double by 2050. Diabetes costs the nation nearly $132 billion a year. The average yearly health care cost for a person with diabetes was $13,243 in 2002, compared with $2,560 for a person without diabetes. Diabetes costs represented 11 percent of national health care expenditures during 2002. Even more alarming for our health care system and for Medicare is that the greatest increase in diabetes cases over the next 50 years will be among those 75

years of age and older—a projected increase of 336 percent. This is just one example of how the aging of our nation could greatly increase national health care costs if we do not identify and apply preventive measures now.

The Role of Public Health and CDC

The 35 year increase in life expectancy for Americans in the 20th century represents a remarkable societal achievement. The same effort that led to these unprecedented gains needs to be mobilized to make added years of life for Americans as healthy and independent as possible. The goal of public health in aging, and that of CDC, is to extend health, functional independence, and health-related quality of life for as long as possible, and compress and delay periods of illness and disability so that individuals can maximize their senior years in good health, and families can maximize the years they enjoy with their senior family members. Research has shown that poor health does not have to be an inevitable consequence of growing older. Death is inevitable, but, for many people, it need not be preceded by a slow, painful, and disability-ridden decline. Our nation will continue to age – that we cannot change - but we can delay and in many cases prevent illness and disability.

Older Americans today are likely to either need to or want to work past "retirement age." They must be healthy to do so and workplaces must promote continued health. As the U.S. population continues to age, the number of workers 55 years and older will also increase dramatically. These workers will be more susceptible to a variety of occupational illnesses and injuries. Therefore, we need to better understand this increased susceptibility and what can be done in the workplace to reduce the increased risk. For example, older workers are at greater risk of a fatal accident because of a slip

or fall than younger workers. Prevention strategies need to focus on how these types of injuries can be reduced.

While continuing to pursue technologic advances and assuring access to health care are essential, there is also much to be gained from more widely applying prevention strategies with demonstrated effectiveness. The evidence is convincing if not overwhelming that prevention is worth the investment for the health and safety of older adults. A recent Institute of Medicine report noted that the return on investment in medical care for cardiovascular disease reaped benefits at 4 to 1, but investment in behavioral change returned a remarkable 30 to 1 advantage. It is imperative that we bring the health advantages of prevention to older adults around the country.

CDC has identified the following critical priorities for the agency in addressing the health of our nation's seniors:

- Increase the use of early detection services (e.g., screening for chronic diseases such as cancer, cardiovascular disease, diabetes and its complications)
  Chronic diseases account for nearly 75 percent of all deaths in this country. Additionally, they are by far the leading causes of disability and long-term care needs, and represent nearly 75 percent of all health-related costs. Although chronic diseases are in no way limited to older adults, these conditions, such as cancer, heart disease, diabetes, and arthritis, are heavily concentrated in adults aged 50 or older. Early detection and appropriate follow up care saves lives and may reduce costs. However, over ½ or 50 percent of older Americans (50 years of age or older) have not had recommended colorectal cancer tests within appropriate screening intervals, even though Medicare covers the cost for all

eligible Americans over age 65. Among women aged 65-69, over 30 percent have not had a mammogram within the recommended time interval; yet another Medicare-covered benefit that is underutilized.

- Increase the use of adult immunization

  Influenza and pneumonia (invasive pneumococcal disease) contribute to over 42,000 deaths each year. Despite the fact that Medicare covers immunizations for these two diseases, more than a third of individuals age 65 and older do not receive an annual flu shot at the recommended interval and 40 percent have not ever received a pneumonia vaccination.

- Promote healthy lifestyles

  Research has shown that healthy lifestyles are more influential than previously thought in helping older people avoid the deterioration traditionally associated with aging. People who are physically active, eat a healthy diet, do not use tobacco, and practice other healthy behaviors significantly reduce their risk for chronic diseases and can delay the onset of disability by 7 to 10 years. Research has shown that the rate of disability among individuals who practice healthy behaviors is one-fourth the rate of those who do not. A person is never too old to benefit from improved nutrition, being physically active, or quitting smoking.

- Reduce hazards and risk factors leading to injuries

  Falls are the most common cause of injuries to older adults. Half of the 250,000 older adults hospitalized each year for hip fractures cannot return home or live independently afterwards, and one-quarter die within the first year after fracture.

Simple measures such as removing tripping hazards and installing grab bars in the home can greatly reduce older Americans' risk for falls and related fractures.

- Increase the use of disease self-management techniques
  Programs that teach older adults how to better manage chronic illness can reduce both pain and health care costs. Arthritis is the leading cause of disability among American adults. The Arthritis Self-Help Course, developed by the Arthritis Foundation to help people with arthritis better manage their disease, has been shown to reduce arthritis pain by 20 percent and visits to physicians by 40 percent. However, less than 1 percent of Americans with arthritis who could benefit participate in such programs, and courses are not available in many areas.

CDC and the public health community in our states and communities have a continued role to play in bringing the benefits of prevention to our nation's seniors. Working closely with other federal agencies, such as the Administration on Aging, public health brings the focus on health, the knowledge of what works, and the links to the clinical community. What CDC brings to the table is its well-recognized scientific expertise, long-standing experience in prevention research, ability to evaluate health promotion programs and identify those that work, established public health network and ability to work with states and communities to implement disease prevention and health promotion programs, and unique surveillance capacity to better guide programmatic efforts.

- CDC is currently working closely with the Administration on Aging (AoA) to bring together the respective strengths of the public health and aging networks.

Whereas the public health network provides sound expertise and capacity to implement effective prevention and health promotion programs, the aging network has a long history of providing aging-related services to seniors. CDC and AoA recently supported an assessment of the health promotion needs of state health department and state units on aging in relations to older adults. Results included a clear message that the aging network is looking to public health for science-based health promotion and disease prevention strategies that are tested and proven effective. State units on aging also expressed that they do not have the time, resources, or expertise to develop and test health promotion interventions. CDC's strength is its ability to demonstrate the effectiveness of a prevention strategy or program and help states and communities put it into practice. CDC is also uniquely positioned to take the results of research conducted through is Prevention Research Centers program, by the National Institute of Health's National Institute on Aging (NIA), or other venues; to build public health interventions based on the results of that research; and to make these interventions available widely in terms that local communities and area agencies on aging can understand and easily apply.

- The growing science base for the benefits of prevention among seniors needs to be shared and implemented widely in public health practice. CDC is poised, through its leadership role in the public health community, to ensure that the growing body of evidence that we can change the health of seniors is applied throughout public health practice. To a certain extent, it is as if we have not fully engaged in applying public health practice to older populations. For example, a 2-year-old girl is more likely to be "up-to-date" on needed preventive services than is her 65-year-old grandmother. We have sometimes not recognized that

healthy behavior choices can improve the health of older Americans *even when those healthy choices are begun later in life.* CDC can play a key role in raising much-needed attention to the critical needs of seniors on our national public health agenda.

- CDC can help increase the use of preventive services by seniors through public education, changing the way we offer preventive services to seniors, and influencing changes to medical practice. The Congress and the Centers for Medicare & Medicaid Services (CMS) have emphasized the value of selected prevention measures – chronic disease screening and adult immunization -- by ensuring that they are covered benefits under the Medicare program. However, coverage alone does not ensure use. CDC data from the states have shown that very few older adults have received all recommended covered services. In some states, as few as one in nine seniors is up to date on covered services. Despite payment by Medicare for more than 20 years, delivery of pneumococcal vaccination – arguably on of the simplest of clinical preventive services – has reached less than 56 percent of those aged between 65 and 74. Among African-Americans, the delivery rate is less than 40 percent -- less than four out of ten. Medicare-covered preventive services are available, they are effective, and they are provided at little to no cost for the beneficiary. Yet, they are under-utilized. Clearly, there is a gap to be bridged.

  CDC working with other DHHS agencies and public health, can help close that gap. We can provide public education about the value of preventive services to seniors. We can identify how to modify national delivery of preventive services to make services more accessible to seniors (for example, providing services at

times and in places that are convenient for seniors taking into account their transportation needs and combining services to minimize the need for multiple visits). We can influence help educate physicians to promote use of preventive services by seniors. When a 68-year-old woman visits her doctor's office, she is generally there for a specific complaint--her arthritis, her heart disease, her diabetes, or perhaps some combination of chronic or other conditions. The question of whether she has had her flu and pneumonia vaccine may never come up. The recommendation that she be screened for colorectal cancer may not enter into the conversation during what is likely to be a very brief office visit when other health matters are more urgent. Specific recommendations from a physician are critical in increasing use of preventive services by seniors.

An Example of Success

There is good news in that many of these challenges are being successfully addressed by small programs operating on minimal dollars in limited geographic areas of the country. Among the most innovative models is a program covering a 4-county area in portions of Connecticut, Massachusetts, and New York. The Sickness Prevention Achieved through Regional Collaboration -- or SPARC -- program is conducted by a non-profit organization that acts as a local bridge among local public health departments, the medical community, and community-based organizations to increase the use of Medicare's clinical preventive services -- chronic disease screenings and adult immunizations -- among the older population. One of SPARC's especially effective strategies has been to promote and help the medical community to combine preventive services for ease of access. SPARC has demonstrated great success in enhancing the provision of preventive services within clinical practices, facilitating public access to prevention, and establishing local accountability for the delivery of services.

SPARC does not deliver preventive services but helps local communities do a better job of providing the services themselves. SPARC's advantages include:

- Improves access to preventive care across governmental jurisdictions;
- Establishes new points of access for preventive services;
- Provides local prevention outreach and patient education tailored to diverse and underserved communities;
- Assures community-wide access to vaccine supplies and monitors local outcomes;
- Capitalizes on economies of scale;
- Creates a central locus of accountability, and;
- Provides a forum for key and varied players to jointly address critical issues and challenges.

One local provider in a SPARC community has said of the program, "SPARC frees us to take care of sick patients." Local health departments see the benefit as well. One local health department staffer commented to my staff, "The program is well-thought out and grounded in science. They provide so much of the infrastructure and keep us focused on preventive strategies in the midst of so many competing priorities. SPARC expands our ability to do good public health work."

Through rigorous evaluation supported in part by CDC, SPARC achievements include:

- Increased by 94 percent pneumococcal vaccinations delivered in Dutchess County, NY (as demonstrated by Medicare reimbursement data);

- Doubled the use of breast cancer screening among women attending flu clinics where SPARC made mammography appointments available; and
- Doubled the rate of pneumococcal vaccinations in Litchfield County, CT, representing twice the increase seen in surrounding counties where SPARC was not available.

SPARC's mission in relation to older adults is clear and well-defined. It does not provide a new service; it does not compete with the medical care system. Rather, its one overarching aim is to increase the use of Medicare-covered clinical preventive services. It does so by providing critically needed coordination and linkage between the clinical care world, the social services world, and the older adults themselves in the communities that it serves. In a very fragmented system, SPARC provides the focal point and the glue to ensure that the Congress' intent is fulfilled -- that the nation's older adults receive potentially life-saving preventive services. SPARC represents a particularly noteworthy catalyst for enabling an effective community-based response to a national priority.

SPARC is currently available on an extremely limited basis in a very specific geographic area. There is nothing unique about the area that SPARC serves. These same results can be achieved elsewhere. In fact, its impact may be even greater in more rural and isolated communities.

SPARC is a good example of the role that public health and CDC plays nationally in supporting local efforts to change the course of health for our seniors. CDC is just beginning to do in aging what we have done in so many other public health areas. We evaluate public health programs in the field (as we did with SPARC), identify those that

work, and make these programs available to states and local communities throughout the country.

Current CDC Efforts

In recent years, CDC has placed increased priority on addressing the health of seniors and collaborated closely with its sister agencies--AoA, CMS, NIH, the Health Resources and Services Administration (HRSA), and the Agency for Healthcare Research and Quality (AHRQ). Recently, CDC and AoA, through state-based counterparts--the state Chronic Disease Directors and the National Association of State Units on Aging--conducted an assessment among state-based staff in the public health and aging networks to better determine priorities, needs, and collaboration around older adult health in the states. Respondents indicated that support at the national level for science-based, health promotion/disease prevention programs for older adults is a key priority for the states. CDC can play a critical role in identifying, disseminating, and implementing effective programs in states and local communities.

Support to States and Communities

In response to this assessment, CDC and AoA have jointly funded 10 states to have their state public health and aging offices work together on projects designed to improve older adult health. Thirty-one states applied for an average of $10,000. The ten funded states are now targeting such issues as promoting regular physical activity and increasing the use of clinical preventive services. A key requirement of our grants is that state units on aging and state health departments must work together, a first in many of the funded states.

To further support efforts in states and communities, CDC has initiated work with

several key national organizations, such as the National Council on the Aging, the American Society on Aging, and the Center for Medicare Education at the American Association of Homes and Services for the Aging to establish national-level resources on which states can readily draw. Among anticipated outcomes of work with these organizations are the development of a "best practices" compendium for older adult health; web-based modules addressing key health issues for older adults; and effective communication tools related to Medicare-covered preventive services for the public, caregivers, and providers.

CDC also supports 36 states to improve the quality of life for people with arthritis. Arthritis is the leading cause of disability affecting almost 70 million Americans. CDC-funded states are developing action plans with partners such as Arthritis Foundation affiliates, conducting pilot projects, and building arthritis programs. In many states, such programs are geared towards increasing the number of Americans who can take advantage of the demonstrated benefits of the Arthritis Self-Help Course and physical activity programs for people with arthritis. In addition, CDC and NIH co-funds research to better determine why arthritis occurs and progresses. CDC is supporting research to find effective strategies to improve the quality of life among persons with arthritis.

Determining what works in prevention and getting it out to states and communities

A critical role of public health is to move research from "the bench to the trench," i.e., to communities that are distant from our best universities and medical schools, to ensure that promising research findings and effective intervention strategies reach the individuals they are designed to benefit. To that end, CDC is investing in research that

helps not only to identify what works in prevention, but to ensure that such research is put into practice in communities.

- CDC is supporting the "Healthy Aging Research Network," a network of centers located at 7 academic institutions around the country conducting public health research on effective strategies for improving older adult health. Recently, the network has initiated collaboration with the National Council on Aging to better delineate and disseminate information on "best practices" for prevention and health promotion for older adult health. Traditionally, prevention research has focused on those under age 65; the Healthy Aging Research Network is changing that.

- CDC continues to evaluate, identify, and disseminate programs that work, like SPARC. Another example of a program CDC has evaluated and disseminated is the "Senior Wellness Project," partially supported through CDC's Prevention Research Center program, which was developed at the University of Washington in Seattle in collaboration with the state's largest non-profit agency serving seniors, the local HMO, and other partners. Working through the network of senior centers to engage participants in activities tailored to the needs of seniors with chronic illnesses (e.g., chronic disease self-management education and tailored physical activity) this program has reduced hospitalizations and improved functional status among its participants.

- CDC joined with the Robert Wood Johnson Foundation, AARP, NIA, and over 40 other key national health and aging organizations to develop the *National Blueprint: Increasing Physical Activity Among Adults Age 50 and Older.* This

landmark report delineates for the first time key science-based strategies for promoting physical activity in this age group. CDC is now working with partners to disseminate and implement strategies identified in the Blueprint.

- CDC participated in updating the Transportation Research Board's National Academy of Sciences Report, "Transportation in an Aging Society," and will continue to work with organizations such as the National Safety Council to assess knowledge, attitudes, and perceptions related to older driver safety.

- CDC is providing leadership to eliminate racial and ethnic disparities among people 65 years and older. The Racial and Ethnic Adult Disparities in Immunization Initiative (READII) is a two-year demonstration project to identify best practices in eliminating influenza and pneumococcal vaccination disparities among African-Americans and Hispanics 65 years and older. A Department of Health and Human Services priority, CDC is implementing the READII project in five sites (Chicago, Illinois; Rochester, New York; San Antonio, Texas; Milwaukee, Wisconsin; and the Mississippi Delta region) with the support of AoA, CMS, HRSA, and AHRQ. Local READII sites are working with public health professionals, medical providers, and community organizations to identify interventions that eliminate these vaccination disparities, such as improving the healthcare systems' provision of influenza and pneumococcal vaccination to seniors, increasing public awareness and demand, and enhancing access to vaccination services for seniors in a variety of settings.

Monitoring Health Status and Risk Factors Among Older Adults

The aging network, state health departments, and national health and aging

organizations need critical surveillance data on older adult health to better target their programmatic efforts. CDC currently provides information to health and aging professionals on how to use its web-based surveillance data on older adults. However, the nation's rapidly changing demographics require new thinking about key health indicators for this population. To advance efforts in this area, CDC is committed to developing better measures of older adult health and quality of life, providing critically-needed data analyses and reports to states and communities, and better delineating existing and projected health disparities.

In conclusion, I would like to thank the Committee again for its leadership and commitment to the health of our nation's seniors. Positively impacting the health of older adults offers some of our most promising prevention opportunities. We know that even the oldest of the elderly can benefit from prevention.

While quality medical treatment for diseases is critically important, our nation needs a better balance between treating diseases and preventing them. There is much we can do to prevent diseases and conditions that contribute so heavily to disability, the need for long-term care, and to our spiraling health care costs. Older adults have never had a more urgent need for prevention, nor has our society. We look forward to working with you to have the healthiest older adults in history.

Thank you.

The CHAIRMAN. Thank you very much, Dr. Marks, for those remarks.

We will now hear from Dr. Robert Butler of the International Longevity Center, a good friend of the Aging Committee. He is going to talk about the under representation of seniors in clinical trials.

Dr. Butler, welcome back. It's good to see you.

**STATEMENT OF ROBERT N. BUTLER, M.D., PRESIDENT AND CEO, INTERNATIONAL LONGEVITY CENTER-USA**

Dr. BUTLER. Thank you, Senator Breaux, and Senator Dole and Senator Wyden. I would like to speak briefly and then submit my full statement for the record.

Ageism, pervasive in our culture and within medical practice, affects all of us who plan to grow old. Today, however, I will just focus upon under representation in clinical trials and leave with you also a report which the International Longevity Center recently completed on this topic.

The consequences of under representation are more than considerable, with an impact with respect to adverse drug reactions, the inappropriate dosage and the misperception that older persons cannot tolerate certain medications, or perhaps not even benefit from them.

There is ample evidence that there is inadequate representation in clinical trials. For example, in one large cancer trial with 16,000 patients, only 25 percent were of the 65-plus representation, and yet, 50 percent of everybody who develops cancer is over 65 years of age. Similarly, only 9 percent of one sample with breast cancer were represented.

With respect to heart disease, the other great killer in old age, in one study of the 75-plus population, only 9 percent were of the older age group, although 40 percent of all heart attacks occur among those 75 years of age and older. Of course, the complexity grows with age, in particular in the 85-plus population.

It is very important to note also that the National Center of Health Statistics has estimated that, in any given year, something like 17 percent of all persons over 65 years of age wind up in a hospital with the very strong possibility that drug reactions were involved. This is staggering. There have been estimates that this costs our country and people $20 billion a year.

So why aren't older people included in these clinical trials? For one thing, there is the notion they do not want to participate, which we know is not true, and also it should be pointed out they constitute a huge pool of some 35 million people to whom investigators could turn.

Second is the notion that the confounding variables of complex illness would make the findings too difficult to interpret. But, in fact, the world of reality is the number of older persons with complex illnesses that are on so many medications, as you indicated, Senator Breaux, in your opening remarks. Therefore, we are, in a sense, protecting from the fruits of research individuals whom we really need to know more about, for both quality of life reasons and with respect to cost.

Moreover, physicians do not refer older people, perhaps in part because they, too, do not comprehend the extent to which it is valuable to do so. There are no regulations to require appropriate representation. I think back on the days in which that was true also of women and of minorities, and there are always explanations. For example, in women it was explained because of the menstrual cycle, and it would simply be too confounding and too complicated. There has also been the misunderstanding that Medicare will not cover the clinical costs associated with clinical trials.

So what might we do? Briefly, we have advanced the idea, borrowed actually from a senatorial suggestion some number of years ago, that it might be well now to have a national clinical trials and evaluation center. It might be divided into ten Health and Human Services regions, with competition among medical centers to carry out such studies, that the funding would come from conventional sources—NIH, the Federal Government, pharmaceutical companies, academia—and also would provide great opportunities to follow patients after a drug has entered the market. For example, on average, only about 5,000 patients have been studied when a medication is available, and yet, the population base that might make evident the extent of untoward side effects is considerably more. So a national clinical trials and evaluation center is something that should be considered.

Moreover, regulation, so that just as women and minorities have required representation, so will older population. Then the provision of some incentives—for example, motivations to pharmaceutical companies perhaps by extending patents.

Finally, the importance of medical education. If we have well-trained physicians, well-trained nurses and other health providers, they can play a much more significant role in both mobilizing the representation of older people within clinical trials and undertaking the appropriate observations necessary to note untoward and other side effects.

Thank you very much.

[The prepared statement of Dr. Butler follows:]

INTERNATIONAL LONGEVITY CENTER - USA

**Testimony of**

**Robert N. Butler, M.D.**
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and
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## Before the U.S. Senate Special Committee on Aging

United States Senate

"Ageism in the Health Care System: Short Shrifting Seniors?"
May 19th 2003

Thank you very much for the opportunity to appear at this hearing highlighting the problem of ageism in our nation's health care system. My comments today will focus on the underrepresentation of older persons in clinical trials. Clinical trials are the processes that have been established to test the safety and efficacy of new drugs and treatments. Unfortunately, people aged 65 and over are woefully underrepresented in or even excluded from these trials, despite the fact that they are the ones who generally take the most medications. The result is a lack of understanding of how drugs and treatments will work in older persons, which can lead to adverse reactions and inappropriate dosages or treatments, and the misperception that older people cannot tolerate or benefit from new drugs and procedures. As Congress debates the addition of a prescription drug benefit for Medicare beneficiaries, it becomes increasingly important that we have a proper understanding of how drugs affect the older population. Today I will discuss the lack of representation of older persons in clinical trials in more depth, explore some of the reasons why this is the case, and offer some suggestions to increase their participation. The current situation is reflective of ageism in the health care system and is unacceptable.

The underrepresentation of older persons in clinical trials is well documented. Three extensive studies highlight the problem particularly well. One study[1] involving over 16,000 people in cancer clinical trials found that only 25% of the enrollees were 65 and over, although this population accounts for over 60% of all cancer cases. The trials involving breast cancer treatments were particularly dramatic – with only 9% of participants 65 and over, while women that age account for almost half of all breast cancer cases.

Another study[2] of clinical trials focused on treatments for heart disease and also found that older people were not well-represented in such trials, or were even excluded. Moreover, this problem is exacerbated as the population grows older. For example, the study found that between 1991 and 2000, only 9 percent of patients enrolled in clinical trials were 75 and over, but almost 40 percent of people who suffer heart attacks are in this group. So, we really don't know the effectiveness of all these new cholesterol-reducing drugs on older people!

Most recently, a large study conducted by RAND[3] looked at participation in clinical trials funded by the National Cancer Institute (NCI), totaling over 59,000 patients from 1997 to 2000, which also confirmed that older people are underrepresented in clinical trials relative to their disease burden. This study also analyzed the criteria that exclude older people and found that such exclusions had a significant impact on the low participation. Relaxing the exclusions would significantly increase participation by older people.

This lack of representation increases the likelihood of adverse drug reactions and inappropriate treatments. Older people tend to be more complex medical cases, involving multiple chronic conditions and medications and they commonly exhibit responses to medications that differ from those of younger patients, with people 85 and older particularly sensitive to typically prescribed drug dosages. It has been estimated by the National Center for Health Statistics that medication problems may be involved in as many as 17 percent of hospitalizations of older Americans annually, and another study by

the GAO has estimated that drug misuse by older persons costs approximately $20 billion a year in hospital stays.

In addition, the lack of older people in clinical trials can lead physicians to make an assumption that their older patients are unable to tolerate a specific treatment and will simply not make it an option. This ageist view of older people has persisted despite a significant body of evidence, dating back to the 1960s, that older people can tolerate powerful drugs and interventions to treat cancers and other diseases and to improve quality of life. Indeed, there is no reason to assume that a person would not benefit from a drug or treatment based simply on his or her age.

There are several reasons why older people are not appropriately represented in clinical trials.

1. There is an ageist misperception that older people do not want to participate in such trials or are less likely to adhere to the research protocol. However, evidence suggests that older people can be successfully recruited and are compliant subjects in clinical trials. Moreover, with more than 35 million people aged 65 and over, a large pool of potential quality subjects is available.

2. Researchers may exclude older people, many with multiple conditions, because these subjects can make it harder to interpret the results or because they are afraid the patients may suffer negative effects. Yet people with complicated medical histories are common today, and we must learn something about older people as they live and age. Trying to "protect" them from the fruits of research is unrealistic, counterproductive, and ageist.

3. Practicing physicians may not refer older patients to clinical trials, erroneously assuming that these individuals would not receive any benefit or be effective participants. This misperception that older people can not handle the treatments associated with clinical trials is ageist, and as previously noted, not based on any evidence.

4. There are no regulatory standards governing the inclusion of older persons in clinical trials, as there are for women and minorities.

5. There is some confusion about Medicare coverage of health-care costs during clinical trials, though this has been somewhat lessened by an Executive Order clarifying Medicare payment policy to specifically allow for the reimbursement of routine patient care costs of clinical trials (such as office visits and tests).

6. The high cost of traveling to receive the treatments and other transportation-related barriers preclude older persons from being able to effectively participate in trials.

So what can be done?

There are a variety of initiatives that can be undertaken to increase the participation of older persons in clinical trials. This includes efforts by both the government and by private organizations.

I would like to briefly discuss one comprehensive way to address the current lack of representation, which involves taking a fresh look at the clinical trials system. This would entail the creation of a national clinical trials and evaluation center, which would actually consist of several centers around the nation, perhaps organized similar to how HHS is organized into 10 different regions. This would be an entity focused solely on conducting clinical trials. It could be funded by those institutions that are already engaged in sponsoring clinical trials, such as the federal government, the pharmaceutical/medical industry, academia, and others. The benefits would be a more efficient, cost-effective, centralized approach with consistent standards, benefiting all parties involved. This could also enhance efforts to strengthen Phase IV clinical trials, which is basically post-marketing surveillance. Better post marketing surveillance is critical in detecting adverse drug events in the older population, given all the complicating factors associated with them. It would also help us better understand the effectiveness and cost-effectiveness of different drugs that treat the same condition. This would greatly complement any effort to increase representation of older people in clinical trials. The ILC is planning on producing an Issue Brief focused specifically on this issue in the next several months.

Other possible ways to address the lack of representation of older persons include:

1. Enacting legislation encouraging more appropriate representation of older persons in clinical trials, as has been done for women and minorities.

2. Exploring the feasibility of legislation to motivate drug makers to test medications and devices on older persons, similar to what is done to encourage pediatric studies.

3. Advocacy groups for older people should highlight the importance of clinical trials - disseminating information to their members and encouraging them to enroll.

4. Public awareness campaigns could be initiated to alert older people and their families to the existence of clinical trials and how to participate in them. Medicare could incorporate this information in its annual communications with beneficiaries, the Administration on Aging could incorporate it into a variety of its programs, and the National Institute on Aging could also be effective in highlighting the issue.

5. Programs could be established at the local level to assist older participants in clinical trials to travel to the site, provide moderate stipends, and explore ways to increase the use of community-based sites, which are more accessible.

6. Last, but certainly not least, exposing all physicians to the field of geriatrics during medical school would dispel many of the myths among medical students about older people, promote the understanding that the older population is diverse and dynamic, heighten the sensitivity of those who become clinical research investigators to the need to include older people when designing clinical trials, and increase the likelihood that practicing physicians will recommend to their older patients that they enroll in them.

In order to ensure that older people receive appropriate, evidence-based medical care, it is critical that they be better represented in clinical trials of drugs and treatments. The simple fact is that all drugs need to be tested in all populations that might be taking the drugs. The ILC has published an Issue Brief entitled "Clinical Trials and Older Persons: The Need for Greater Representation," on which my testimony is based. There are copies of this Issue Brief on the table and on our website.

Thank you again for this opportunity to discuss this important issue. I am happy to answer any questions you may have.

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[1] Lee PY, Alexander KP, Hammill BG, Pasquali SK, Peterson ED. 2001. Representation of elderly persons and women in published randomized trials of acute coronary syndromes. *JAMA* 286: 708-713.

[2] Hutchins LF, Unger JM, Crowley JJ, Coltman CA, Albain KS. 1999. Underrepresentation of patients 65 years of age or older in cancer-treatment trials. *New England Journal of Medicine* 341: 2061-2067.

[3] Lewis JH, et al. 2003. Participation of Patients 65 Years of Age or Older in Cancer Clinical Trials. *Journal of Clinical Oncology* Vol. 21, No. 7: 1383-1389.

The CHAIRMAN. Thank you, Dr. Butler, once again for some very important remarks and a great contribution.

We will hear from our final panelist this afternoon, Dr. Joel Streim, President of the American Association for Geriatric Psychiatry. He will discuss the effects of age discrimination against the elderly in the arena of mental health.

Doctor, we're glad to have you.

**STATEMENT OF JOEL E. STREIM, M.D., PRESIDENT, AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY**

Dr. STREIM. Thank you.

Mr. Chairman and members of the committee, I appreciate the opportunity to testify here today about the effects of age discrimination in our health system on older adults with mental disorders.

We know that psychiatric illness in older persons is a serious public health problem. Research has shown that mental illness is associated with poorer health outcomes and increased costs for elderly patients with co-occurring medical conditions that are highly prevalent in late life, such as hip fractures, heart attacks and cancer. In older adults, the interaction of concurrent psychiatric and medical conditions causes excess disability and increased mortality, creating unique treatment needs that have been largely ignored by our health system.

Geriatric mental illness brings together two of the most damaging elements of discrimination in America: the stigma of advanced age, and the stigma of mental illness. These twin discriminatory burdens are evident not only in a lack of research, but also in inadequate access to treatment and appropriate services. Community mental health facilities often lack age-appropriate services and staff trained to address medical needs; and Medicare, with its primary mission of funding health care for seniors, perpetuates the bias against mental health care by requiring a 50 percent copayment for most mental health services, rather than the 20 percent copay that applies to all other medical conditions. That's not just an insurance carrier's coverage decision. It's the law.

Most older adults with mental illness receive their care in primary care settings. The problem with this can be summed up with one stunning statistic, which you referred to before, Senator Breaux: one-third of older adults who commit suicide have seen their primary care physician in the week before completing suicide, and 75 percent have seen their doctors within the prior month.

Because of the disconnect between primary care and mental health care, older adults are too often misdiagnosed or improperly treated. Research has demonstrated that older adults are more likely to receive appropriate mental health care and to have better clinical outcomes when mental health services are integrated with general medical care within the primary care setting. Multiple appointments with multiple providers in multiple settings add up to an unacceptable burden to persons for whom chronic illness and physical disability are serious constraints.

There is also less stigma associated with receiving psychiatric services when they're an integral part of general medical care.

There are other research advances in geriatric mental health that, in practice, could and should have life-altering effects. For in-

stance, it's been clearly demonstrated that symptoms of pain and depression are treatable, even in old age, even in the face of chronic disease and disability, and even for those living in nursing homes. But our health system hasn't done enough to translate this scientific knowledge into clinical practice.

The pervasive attitude among clinicians, and among many patients and society at large, is that getting old means living with pain and depression; and so older adults don't get the treatment they deserve.

Beyond the failures of recognition, diagnosis, and initiation of treatment, recent research has revealed the next generation of problems facing older adults with mental illness: poor quality of follow-up care. Studies have shown that among elderly nursing home residents who are receiving antidepressant medication, approximately half continue to have symptoms, yet they don't get needed changes in their treatment to ensure that they get well.

In 1999, the Centers for Medicare and Medicaid Services introduced a quality indicator for depression care in nursing homes that unwittingly recognizes the simple prescription of antidepressant medication as a reflection of good care, even when failure to provide proper follow-up care leaves the patient with unremitting symptoms.

There are few areas where there is a more serious dearth of research and services than in the area of late-life alcohol and substance abuse. The standard definitions of alcohol abuse don't adequately reflect the problems of older adults. Older adults who are abusing alcohol may not be driving cars or fighting in bars, making them less likely to be identified as having a problem by the usual social or legal parameters that typically bring younger drinkers to attention.

Some older adults consume alcohol in quantities or patterns that don't usually suggest abuse or dependence, but their drinking may be causing falls, with the attendant risk of hip fractures and other injuries, institutionalization, and even death. Yet this category of "at-risk" drinking doesn't even exist in current definitions; so the problem in older adults goes unnoticed.

In the area of treatment, we don't have age-appropriate services in settings acceptable to seniors. Existing approaches to the treatment of alcohol and substance abuse are geared toward younger adults, and don't address the problem of comorbidity from medical illness and depression, as commonly seen in the geriatric population. This is yet another example of neglect of older adults and their unique needs, both in our national research agenda and in the design of clinical services.

In conclusion, mental disorders of late life are treatable. However, ageist attitudes and health care policies that discriminate against older adults prevent those individuals from getting the treatment they need and deserve. This is a shameful tragedy, and the time has come to right the wrongs against so many older Americans.

I would like to thank the committee for the opportunity to testify here today, and will be happy to answer any questions.

[The prepared statement of Dr. Streim follows:]

**Testimony of Joel E. Streim, MD**
**President, American Association for Geriatric Psychiatry**
**Before the Special Committee on Aging**
**United States Senate**
**Age Discrimination in the Health Care System**
**May 19, 2003**

Mr. Chairman and Members of the Committee:

I am Joel Streim, president of the American Association for Geriatric Psychiatry. AAGP is dedicated to the mental health and well being of older Americans and the care of those with late-life mental disorders. AAGP's membership consists of 2,000 geriatric psychiatrists and other health professionals in clinical practice, education, and research.

AAGP appreciates this opportunity to testify before this Committee on the effect of age discrimination against older adults with mental disorders. My testimony will first address the impact of the problem. I will then speak to four specific areas that warrant the Committee's attention: the integration of mental health care and primary care, the translation of geriatric research into clinical practice, the quality of treatment for depression in late-life, and alcohol and substance abuse among older adults.

**Impact of the Problem**

Epidemiological studies have shown that more than 20 percent of Americans aged 65 years and older—approximately 7.5 million seniors—have a mental illness. As the population aged 65 and older is projected to double from the current 35 million to 70 million in the year 2030, the number of older adults with mental illness is expected to increase proportionately to 15 million persons. These disorders include dementia due to Alzheimer's disease and other neurodegenerative disorders, 30 to 40 percent of which are complicated by depression or psychosis, as well as mood disorders such as depression and bipolar illness, anxiety disorders, severe mental illness such as schizophrenia, and alcohol abuse.

We know that psychiatric illness in older persons is a public health problem, as accumulating evidence shows that mental illness is associated with worse health outcomes for elderly patients with co-occurring medical conditions, as well as higher health care costs. Research has shown that depressed older adults have worse clinical outcomes for a variety of conditions that are highly prevalent in late-life: hip fractures, heart attacks, and cancer. Depression increases mortality rates after heart attacks and among elderly residents of long term care facilities. In fact, depression is a stronger predictor of mortality among heart attack victims than a second heart attack. After surgical repair of hip fractures, depressed patients have poorer recovery rates during rehabilitative care compared to those who are not depressed. Among cancer patients, those who are depressed have worse pain control, increased hospitalization rates, poorer physical function, and poorer quality of life. Persons over age 65 have the highest suicide rate of any age group, and among those over 85, the rate is twice the national average.

Older adults with severe mental illness, a rapidly growing segment of the population, are falling through the cracks of an already stressed mental health system. Community mental health facilities often lack age-appropriate services and staff trained to address medical needs, which are almost always present among older adults who suffer from mental illness. Less than three percent of older adults receive outpatient mental health treatment by specialty mental health providers—and only one-third of older persons who live in the community and who need mental health services receive them. In fact, most older adults with mental illness receive their care from primary care practitioners and long term care facilities. Nursing homes are the primary providers of institution-based care for older persons with mental disorders, with 80 to 94 percent of nursing home residents having a diagnosable mental disorder. But studies have demonstrated that only a small percentage of them actually receive mental health services, with the oldest and most physically impaired residents being least likely to receive services. Older adults with mental disorders who receive their care from primary care practitioners often receive poor quality care—one in five of them is given an inappropriate prescription, they are less likely to be treated with psychotherapy, and they receive a lower quality of general health care, leading to excess disability and increased mortality.

Geriatric mental illness brings together two of the most damaging elements of discrimination in America: the stigma of advanced age and the stigma of mental illness. An old person in our society is often invisible, just because of advanced age. Worse than being invisible, an old person suffering from depression or dementia is devalued and dismissed. The National Institute of Mental Health has disbanded its aging research branch and has actually reduced funding levels in the area of geriatric psychiatry, even while its budget has grown over the last several years. And this has taken place in the face of projected exponential growth in this segment of our population.

These twin discriminatory burdens are evident not only in a lack of research, but also in inadequate access to treatment and appropriate services. Mental health care services in our country are designed for young and middle-aged adults in good physical health, ignoring the unique needs of older adults who typically have concurrent medical conditions that complicate their care. Instead of a system that provides coordinated care to manage the complex interactions of psychiatric and medical conditions—and the multiple medications used to treat them—older adults are subject to a system of fragmented care that falls far short of what we should consider to be a minimum standard of care. Even Medicare—with its primary mission of funding health care for seniors—carries the bias against mental health care that afflicts the nation's health care system more generally. That is, most mental health services under Medicare require a 50 percent copayment as opposed to the 20 percent requirement for treatment of all other medical conditions. And that's not just an insurance carrier's coverage decision—it's the law.

**Integration of Mental Health Care and Primary Care**

The problems associated with the fact that most older adults receive their mental health care from primary care practitioners can be summed up with one stunning statistic: one-third of older adults who commit suicide have seen their primary care physician in the week before completing suicide, and 70 percent have seen their doctors within the prior month. Because of the disconnect between primary care and mental health care, older adults seen by their primary care physicians

are too often misdiagnosed or improperly treated, and they continue to suffer from depression and other mental illnesses that complicate their medical conditions and lead to excess physical disability.

Better tools for screening and diagnosis by primary care practitioners are absolutely critical for better mental health among seniors. A major obstacle to improved care for mental illness is the lack of training of primary care practitioners in identifying mental disorders in their geriatric patients, as well as the absence of mental health professionals working collaboratively, on-site in primary care settings.

There is important research now underway, with early findings demonstrating great promise for innovative approaches to delivery of mental health care in primary care settings for older adults. Specifically, it has been demonstrated that older adults are more likely to receive appropriate mental health care if there is a mental health professional—a psychiatric nurse or social worker—working and coordinating care within a primary care setting than if they are referred to a mental health specialist located outside the primary care setting. Multiple appointments with multiple providers in multiple settings add up to an unacceptable burden to persons for whom concurrent chronic illnesses, immobility and other physical disabilities, and limited transportation options are serious constraints. There is also less stigma associated with receiving psychiatric services when it is an integral part of general medical care. Preliminary results from other studies have shown significant improvements in treatment response rates for elderly patients who receive coordinated mental health care integrated within primary care sites, compared to those who receive "usual care."

If every primary care clinic with a substantial geriatric patient population had a mental health professional to attend to the needs of these elderly patients, their access to mental health care and their treatment outcomes—and many other aspects of their care—would be improved.

For the last two years, Congress has appropriated $5 million to the Substance Abuse and Mental Health Services Administration (SAMHSA) for mental health outreach and treatment for the elderly. Representative Patrick Kennedy has introduced the "Positive Aging Act," which would build on that grant to provide authorization for projects that integrate mental health screening and treatment services at community health centers and other public or private nonprofit primary care clinics. It would also support geriatric mental health outreach teams in settings where seniors reside or where they receive social services, such as senior centers, adult day care programs, and assisted living facilities. This proposal, if enacted, would provide an important advance in assuring that elderly Americans actually receive the mental health services they need.

**Translation of Research into Clinical Practice**

The 1999 Surgeon General's Report on Mental Health and the 2001 Administration on Aging Report on Older Adults and Mental Health underscore both the prevalence of mental disorders in older persons and the evidence that research is developing effective treatments. Scientifically tested treatments are effective in relieving symptoms, improving function, and enhancing quality of life. These interventions reduce the need for costly hospitalizations and long-term care without simply shifting the burden to the family. However, there is a pronounced gap between the

emergence of effective treatment and subsequent implementation by health care providers. This gap can be as long as 15 years. If we delay the provision of new treatments to the present four million Americans with dementia the way we delayed the treatment of depression, a generation of seniors will be prematurely admitted to nursing homes. The Surgeon General and Administration on Aging reports emphasize the need for translational and health services research to identify the most cost-effective interventions, as well as effective methods of care delivery.

Special attention needs to be paid to emerging findings from investigations of serious late-life mental disorders such as schizophrenia, bipolar disorder, and other psychotic illnesses. Despite the fact that these conditions take a major toll on elderly patients and their families, clinical treatment often has not kept pace with scientific advances. Effective treatments are not getting to those who need it most. AAGP's members are at the forefront of research on Alzheimer's disease, depression, and psychosis among the elderly, and we believe that more science must be focused in these areas. But it is equally important to ensure that new medical knowledge is rapidly translated into clinical care. Improving the treatment of late-life mental health problems will benefit not only the elderly, but also their children, whose lives are often profoundly affected. Caregiving itself is an enormous drain on the financial security and health of family members, many of whom become depressed as a result. Research has clearly demonstrated the benefits of formal caregiver interventions and services, improving mental and physical health of family caregivers, and delaying nursing home placement of dependent family members. However, many caregivers still do not receive the mental health care and support that they need.

There is important research on geriatric mental health that could and should have life-altering effects in practice. But getting the information to practicing clinicians in a way that is useful to them and to their patients is an ongoing challenge in all areas of health care. For instance, new research has shown a strong correlation between chronic pain and major depression. Do practitioners know this? And how will they use it? Both pain and depression are underdiagnosed and undertreated in elderly patients. The pervasive attitude in society—and among many clinicians and patients themselves—is that getting old necessarily means living with pain and living with sadness. As such, many older adults mistakenly believe that being sad or having pain is an expected, normal part of aging, so they don't talk about it; instead, they accept it and suffer with it. Furthermore, they don't want to be stigmatized by others—or to perceive themselves—as weak or lazy. But we know that they are not weak or lazy; they are suffering from a clinical illness. Symptoms of depression and pain, like symptoms of diabetes and Parkinson's disease, are treatable. And they deserve to be treated and relieved.

**Quality of Depression Treatment**

A colleague of mine describes the disparity in quality between follow-up treatment for geriatric depression and follow-up care for other medical illnesses this way: A patient comes to a physician with a fever, and the physician prescribes an antibiotic to treat the infection that is thought to be causing the fever. But the fever persists, and therefore diagnostic tests and changes in treatment continue until the cause is found and the appropriate treatment prescribed, and the symptom (the fever) is relieved as the underlying illness remits. He contrasts it with a story he was told by the director of nursing in a nursing home. Making rounds with her staff, the head of

nursing remarked that Mrs. Jones seemed to be depressed. And the staff nurse responded that Mrs. Jones was being treated for her depression, and prepared to move on to the next patient. Unfortunately, in far too many instances of geriatric care, that's the end of the story. In this case, the head of nursing intervened, insisting that if the patient is being treated for depression and she's still depressed, then something's wrong with the treatment.

Over the past 15 years, the field of geriatric psychiatry has worked hard in the battle to increase public and professional awareness about late-life mental illness, conveying the message that depression is not a normal part of aging and that there are effective treatments available for depression in older adults. The battle is not yet won: there are still many unrecognized cases of depression in late-life. However, with the increasing availability of newer and safer antidepressant medications, more primary care physicians are initiating treatment in their older patients. Recognizing depression, making the diagnosis, and initiating treatment represents an incremental step toward improving the quality of care. But recent research has begun to reveal the next generation of problems related to the treatment of depression in older adults: poor quality of follow-up care. In nursing homes nationwide, more than one-third of patients now receive antidepressant medications; but half of these patients remain depressed. One-third are receiving doses less than the manufacturer's recommended minimum effective dose. Others might benefit from the addition of psychotherapy. Some may need more effective treatment for concurrent medical illnesses that complicate the course of their depression, or interfere with their with response to treatment. In all of these scenarios, the current treatment is inadequate, and the quality of follow-up care must be questioned. When follow-up assessment indicates a lack of treatment response, principles of good clinical practice dictate that the treatment should be modified, with the goal of getting the patient better.

Ironically, a quality indicator introduced by CMS in 1999 to assess the quality of depression care in nursing homes only serves to perpetuate this problem. According to this indicator, when patients with depressive symptoms are receiving antidepressant drugs, the nursing home gets credit for delivering good quality care. Here we see the same flawed assumption that simply initiating treatment is sufficient, disregarding the fact that the presence of persistent symptoms is actually an indicator of treatment failure. Thus, CMS policy has unwittingly codified neglectful care in a regulatory indicator that was intended to ensure quality of care. Neglect of the ongoing care needs of frail older adults, especially those in nursing homes, is too often the norm, both in clinical practice and in federal policy and regulations. We need to improve the quality of geriatric mental health care by translating scientific and clinical knowledge into health care policy and regulations, and put an end to warehousing misery in long-term care and other treatment settings.

**Geriatric Alcohol and Substance Abuse**

Earlier in my testimony, I spoke to the need for more targeted research in geriatric mental health. There are few areas where the knowledge base is more deficient and where there is a more serious dearth of research than in the area of alcohol and substance abuse in older adults. Is Grandfather quietly drinking himself to death or risking a fall with a disabling injury, and the consequent need for more care and a greatly reduced quality of life? How much is too much? Is it the reason for his memory difficulty? His unsteady gait? How does the alcohol affect his heart

disease, and how much does it matter? Does he need treatment? What kind of treatment is available, and how can it be presented in a way that is acceptable to him?

Or, an elderly woman who lives alone is becoming more confused and neglecting her personal grooming and hygiene. Is this the early stage of a dementia? But there is reason to suspect that she is taking tranquilizers, and nobody is really paying attention to that. If she stops these drugs, will she get better? Who knows how much she's taking? She may be taking analgesics for arthritis, too, or antihistamines for her insomnia, and some of her symptoms may be related to drug-drug interactions. Her hypertension had been well controlled with prescription medication, but lately she forgets to take this. Will her medical condition worsen as a result?

There are few studies of substance abuse among older adults, but what we do know suggests the areas we need to explore. We know that the prevalence of alcohol dependence is not far from that of depression – the figure for "at risk" drinking is about 15 to 16 percent. And there is substantial alcohol abuse co-occurring with depression, an association that increases with advancing age. Due to neglect of research on late-life substance abuse, there is little data about the misuse of prescribed and over-the-counter medications, both of which may be major problems among older adults. We need research on abuse/misuse of all addicting substances in the elderly, including over-the-counter medications. We need comprehensive studies of what substances seniors utilize, who is utilizing what, and the impact of that use on mental and physical health, functional status, service utilization, and quality of life.

The standard definitions for alcohol abuse don't necessarily apply to older adults. A major question in the field is whether to base definitions on the amount of alcohol consumed or degree of functional impairment. For example, older adults who are consuming alcohol in significant amounts may not be driving or fighting in bars, making them less likely to be identified as having a problem by the usual social or legal parameters that typically bring younger drinkers to attention. Alternatively, older adults may be consuming alcohol in quantities or patterns that don't normally suggest dependence. But falls may be a huge problem – and this "at risk" category doesn't even exist in current definitions. And the effect of alcohol consumption among the elderly is different in its impact on families. It may not be loss of work and income that is at stake, but rather the result of falls and consequent dependence on family caregivers. We also should look at the effect on younger generations in terms their own use or abuse of alcohol from the example that is set and assumptions that are made about acceptable consumption.

We especially need to pay attention to cohort effects. We need to know whether and to what degree the attitudes of aging baby boomers toward alcohol consumption and drug abuse may change the future incidence of addictive disease and alter the risk of developing other late-life mental health problems.

In the area of treatment, we need to identify age-appropriate services that can be effectively combined with therapy, including detoxification and prevention interventions. SAMHSA and the Department of Veterans Affairs have sponsored a major research effort to address co-occurring mental illness and substance abuse, and this is commendable. Preliminary findings show that elderly "at-risk" drinkers who have access to mental health care integrated in the primary care setting are twice as likely to see a mental health specialist, compared to those who are referred to

a specialty facility, such as a drug and alcohol rehabilitation center. We also need geriatric research that examines the relationship of substance use problems and medical illnesses that commonly occur in older adults. Existing strategies for research and treatment of alcohol and substance abuse among younger adults do not adequately address the problem of comorbidity from medical illness seen in the geriatric population. This is yet another example of neglect of older adults and their unique needs, both in our national research agenda and in the design of clinical services for the treatment of alcohol and substance use disorders.

**Conclusion**

Treating mental illness among older persons presents a set of fascinating challenges—and we have the tools to succeed, both in research and clinical care. But if we fail to meet the challenges because of prejudiced beliefs and misconceptions about old age and mental illness, then we will have consigned our parents, ourselves, and our children to living the late stages of life unnecessarily beset by frailty, cognitive and emotional distress, and a concomitant loss of independence and quality of life. Mental disorders of late life are treatable; but ageist attitudes and health care policies that discriminate against older adults prevent them from getting the treatment they need and deserve. This is a shameful tragedy. It calls upon all of us to right the wrongs against so many older Americans.

The CHAIRMAN. Thank you very much, Doctor, and I thank all of the members of the panel. I think you all have been very helpful in pointing out what this hearing is all about, and that is the fact that ageism discrimination exists and it exists in the health care area in particular, which is one of the biggest concerns, obviously, of seniors and older Americans, whether it's in psychiatric care, clinical trials, or whether it's in the recognition of a problem that is more typical perhaps in older Americans, and they don't recognize it because there's not enough attention being paid in the medical profession to some of these problems.

Dan Perry, you had given us some suggestions. We know there's a problem. I think you all made the case that there's a serious problem of discrimination in America against seniors in how they get their health care and how they don't get their health care, because of a lack of concentration on particular problems.

The question then becomes, if we've got the problems and we know what they are, what do we do about them? You have given us some recommendations which maybe we can elaborate on. You can pass a law not to discriminate in health care against seniors, but obviously that's not enough to solve the problem. So the question really becomes, what can Congress do? How do we approach this?

I will ask you first, and if anybody else has some ideas about this, I would like to hear them.

Mr. PERRY. I think raising this to this issue of ageism in health care level of attention is a good first start. It is how we've dealt with other forms of bias in our society. We have thrown the bright light on it and we have shown how this diminishes all of us. We have made it so that people think twice in our society about indulging in sort of easy, sloppy thinking when it comes to what an older person can do. So I think that's an excellent first step.

Then let's realize that it's the Federal Government that does provide the health insurance coverage for this whole population. That's a pretty big stick to wield when it comes to reforming health care. That includes medical education. As a number of us have pointed out, the way we train, the way we orient health providers in our society, has a lot to do with their expectations of what an older person can or can't do when they're out there actually practicing. Suggestions such as Dr. Butler and others have made about changing the population of those that are part of the clinical trial, these are very doable, whether it's offering incentives to manufacturers or creating national clinical trials and evaluation center under some Federal leadership.

These are all levers that you, as policymakers, have at your disposal to try to identify the evil that is ageism, as with other forms of prejudice, and to make some structural changes in how we teach, how we develop our new drugs, and how we encourage people to get into trials and to use the testing that's available.

Last, the part that is somewhat more ephemeral is this business of empowerment. It's a matter of speaking to people and telling them it's all right to be a "squeaky wheel" in the system, and, in fact, that's the best way to make sure that you're going to get the attention that you deserve, and not for the patients themselves to have these attitudes that "I'm 85, I have no right to feel any better,

and why am I going to push back on the system". So I think you're taking a big step in the right direction.

The CHAIRMAN. If you look at the statistics—I mean, I don't know how we got into the situation that we're in, because we didn't do it overnight. But the numbers, by the year 2010, 50 percent of all doctor visits in the United States are going to be made by Americans over the age of 65. Yet, only five of the 125 medical schools in the country have full-time geriatric departments. There is simply not enough geriatricians in the country, in the Nation. Out of 650,000 physicians, only 9,000 are geriatricians, compared to about 42,000 who are pediatricians for children.

It seems like society is ignoring this huge group of people that are going to be older Americans. Yet the doctors are not moving in that direction, and not utilizing clinical trials to look at this huge growing population. Yet it happens not only in health care, but in everything else, and advertising and everything else. There is a huge group of people that are getting ready to be here for a very long period of time and we are not prepared, professionally, from a health standpoint, to address what's going to happen unless some changes are made.

I don't know how we do that. Do we pass a law that we need more geriatricians? We tried to do that with specialists and we ended up with too many specialists and not enough general practitioners, and now we have 42,000 pediatricians and only 9,000 geriatricians, and that's where the numbers are going to be increasing.

Dr. Butler, do you have any thoughts on this?

Dr. BUTLER. Yes. My view has always been that no one, but no one, should graduate from medical school, or any residency program or, in fact, be in practice, and be subject to continuing medical education, without properly trained teachers in geriatrics. If we don't have the teachers, we're at a loss.

So our Center came up with a very simple algorithm, which is extraordinarily inexpensive. We know that it takes roughly ten physicians for every one of the 145 allopathic and osteopathic schools of medicine, to create a teaching cadre, a core group, that can assure us of proper teaching. We calculate that between now and the time the "baby boomers" reach 65 en mass, about 2022 to 1923, it will only cost the country about $22 million a year. Since there are 100,000 faculty members in medical schools, and we're talking about 1,450 academic geriatricians, it's really a very modest proposal.

It's doable and a running program already exists within the Federal Government. You do have, within HRSA, the Health Resources and Services Administration, the Geriatric Academic Career Award.

The CHAIRMAN. Can anybody give me an answer as to why medical schools have not tried to keep up with where the population is going?

Dr. BUTLER. For this very reason: there haven't been the teachers. If you don't have the leaders, the academicians, then you don't have the figures for students to emulate, you don't have the knowledge base to do the teaching. If you said to an obstetrician or a urologist, "you've got to teach geriatrics", it wouldn't really be very constructive. So you have to have the teacher base.

When the Heart Institute started, it was fortunate to be able to train, in the first 22 years of its existence, 16,000 cardiologists, which is probably why we have excellent training in cardiology and a 60 percent reduction in deaths from heart disease and stroke. But we've had nothing comparable in the field of geriatrics. You have to have teachers in order to really transform the schools.

The CHAIRMAN. Is geriatrics a profession? Some may make the argument that, "all right, we don't need to have a geriatrics department. We have a cardiology department and we train heart doctors, and heart doctors see a lot of elderly people. We're training specialists in disease areas that older Americans are going to be suffering from, so we don't need a specialty for older Americans because we have all these specialties in medical diseases that, in fact, older Americans get. So we don't need a geriatrics department. We have a cardiology department."

Dr. BUTLER. That confirms my point, that you have to have the teachers to make sure those cardiologists or urologists or whatever have a proper understanding of the nature of the older person.

The same issue arose in the 1920's with respect to pediatrics. The view of organized medicine was that children were just miniature adults, and we certainly did not need pediatricians. We overcame that. So we have to have that teacher base. Once we have that, we can be sure then that, whatever field one goes into in medicine, they've had proper training.

The CHAIRMAN. I think we certainly have the ability to move in that direction, I would say to my colleague, Senator Wyden, because the teaching hospitals are funded through Medicare. Yet, Medicare has never insisted that the hospitals that train doctors that are funded by Medicare, which is for older Americans, have any requirement whatsoever that a certain percentage of the operations deal with older Americans.

Dr. BUTLER. Absolutely, although Medicare does provide, fortunately, fellowship programs, supported by the graduate medical education money, but only for one year, when it should be a 2-year program to really launch the young academic geriatrician.

The CHAIRMAN. But it's also optional. You can ignore it.

Dr. BUTLER. You can. You're absolutely right.

The CHAIRMAN. Dr. Streim.

Dr. STREIM. Actually, we have a "catch 22" here, because if we are going to be successful in training the geriatric educators who will train the generalists and the specialists in issues related to aging, we have to first attract early cohorts of medical students and residents to geriatric fellowship training. The problem is, because of ageist attitudes, it's very difficult to recruit some of the best and brightest to choose careers in geriatrics, to become the teachers of the future.

There are some legislative remedies that I think can help. One is, to address the cap that CMS has placed on GME positions at medical centers. That cap was introduced primarily to limit the number of specialists we train. A few years ago, provision was made so that, instead of only paying for half of a FTE for specialty training in the fellowship years, there was an exemption made for geriatrics fellowship training, so that those trainees would be reim-

bursed—that their salaries would be supported at a full FTE. That's helpful——

The CHAIRMAN. What's the FTE for, non-Washingtonians?

Dr. STREIM. The full time equivalent salary for residents in a teaching hospital, which is part of graduate medical education funding that comes from the Medicare program.

But the fact is that all medical centers that have teaching residency programs are still capped at their 1996 levels, again to limit specialty care training. Many medical centers are therefore reluctant to increase the number of physicians available to train physicians in geriatric medicine and geriatric psychiatry because of that cap. This is an area where I think we can help medical centers encourage or create more opportunities for clinical training in geriatrics.

The CHAIRMAN. A very good suggestion.

Dr. STREIM. There is one other suggestion I would like to make at this point, too, if I might.

The fact that we really aren't attracting enough people to pursue training in geriatrics has to do with misconceptions about careers in geriatrics and what geriatrics is all about, and that's where trying to teach this to medical students in the earlier stages of their training is so important. The Bureau of Health Professions at HRSA can play a major role in helping us to train those who will go to medical schools and really make the case for careers in geriatrics to those who are in the earliest years of training.

That's really what we need to do to prime the pump, so that we can get trainees attracted to geriatric careers, to become the teachers of future medical students and residents.

The CHAIRMAN. Thank you.

Senator WYDEN.

Senator WYDEN. Thank you, Mr. Chairman. You asked so many key kind of questions, I just want to amplify a number of the points you made.

It seems to me that the acute lack of practitioners is a very serious problem, but what seems even more serious to me is how little has changed in really a couple of decades. I think about this panel, and going back to the days when I was Director of the Gray Panthers, most of what you all have said today is very similar to what was said 20 years ago.

Dan, would you disagree with that?

Mr. PERRY. No, you're absolutely right. The big difference is that we're now a little more than 7 years away from when the first "baby boomer" is going to join the Medicare rolls. Fifteen or 20 years ago, it might have been a bit abstract, but there is literally no time left to delay.

Senator WYDEN. So we could have had this debate 20 years ago. I think what is really needed is a revolution in medical education, and that nothing short of that is really going to turn this around.

I share Chairman Breaux's view. You can't just wave your wand and, by fiat, decree from Washington, DC, that this is all going to happen, that people are going to flock to geriatric education.

Has anybody asked medical students recently, through some kind of survey or other kind of exercise, what it would take to get them to be serious about geriatrics? Have they been asked?

Dr. BUTLER. I think they've been asked indirectly by the electives, which only——

Senator WYDEN. By who?

Dr. BUTLER. Indirectly through the electives they've been asked. Namely, only 3 percent apply, and that's because they don't have the teachers, they don't have——

Senator WYDEN. That's the result, Bob, and we know what the result is. I'm curious whether anybody has like shown up at the Harvard Medical School and said, "Look, here's the bottom line here. Nobody is going into geriatrics. What would it take to get you folks into this?"

Dr. BUTLER. I don't think anybody has done that, except as I've said, in a way, that they've voted with their feet by virtue of not even taking the electives, which is an expression of their sense that it's too depressing, that the rewards are minimal because there are no high-paying aspects in terms of a procedure, there are no teachers that will really lead them. They don't see the positive aspects because they haven't been taught because they haven't had the teachers to do so.

Senator WYDEN. It's been a while since I got an invitation to speak at the Oregon Health Sciences Center, and we had Dr. Chris Cassel until recently, who, of course, was a leader in the field. But because of what you all are saying, I'm going to go back to the Oregon Health Sciences Center shortly and really start asking the students what it would take to get them interested in this, not just the medical students, but the nursing students and a whole host of them, because clearly, what's going on now, isn't working. The recommendations today are good and useful, but they really aren't very different than, as Dan said, those made years ago.

Dan, do you want to chime in here?

Mr. PERRY. I would add to what Dr. Butler said, that there is nothing that attracts and succeeds like success. Just a few years ago, we had a grand total of one department of geriatrics that really did interdisciplinary work and was really a success. Dr. Butler happened to head that at the time.

Now, in the last 4 or 5 years, we're up to five. Out of 145 allopathic and osteopathic medical schools, five out of 145 still is not a great success, but it's something.

If we had more examples, such as those being funded by private foundations—the Donald W. Reynolds Foundation has funded these full departments at the University of Arkansas, the University of Oklahoma, and they're attracting people into the field. They are cross-fertilizing between physicians, nurses and social workers. If we had more examples of that, physicians, nurses and others in training would see that this is an attractive field and they would be attracted to success, in my opinion.

Senator WYDEN. How are these associations doing in terms of making this a priority? Say AAMC, the Association of Medical Colleges, are they using their bully pulpit to make this a priority?

Dr. STREIM. Not sufficiently.

Dr. BUTLER. Not to my knowledge. I think it goes back, unfortunately, to finance. They do not have the financial basis upon which to operate, and there hasn't been that type of public/private initia-

tive which I think we've enjoyed with the Reynolds department, that I enjoyed at Mount Sinai with the Brookdale Foundation.

You need to have the funding in order to be able to support the physical space, the teaching equipment, the faculty salaries, and that's where the geriatric academic career work in HRSA that Dr. Streim mentioned is so vital and important.

Senator WYDEN. How are the medical school presidents doing? I haven't seen a medical school president, a dean, the leaders, speak out about this in any significant way. Am I missing something? Maybe I'm not reading the literature——

Dr. BUTLER. I think Dr. Cassel did, Dr. Rowe, both at Mount Sinai in the second instance and Chris Cassel in the first at Oregon. But again, there are so few geriatricians that very few of them have achieved the status of becoming deans or becoming the presidents of medical centers.

Dr. STREIM. The leadership is sitting in this room, unfortunately. It doesn't go much beyond.

Senator WYDEN. I think what you all have had to say, in terms of recommendations, is important.

I hope we can set in place now, through legislation and through the work that you're doing, something that's going to really jar a system that has changed very little in the last 20 years. I think what Dan was talking about is a relevant point. Certainly it was harmful that the situation didn't change over the last 20 years, and I think it produced the kinds of accounts that the Rabbi and others have talked about.

If it doesn't change now, and it doesn't change quickly, we are going to get engulfed by these problems. When that demographic tsunami hits, then you are going to see the extraordinary price that this country pays for what I call the immoral stain of ageism.

Mr. Chairman, I guess we have several who want to comment.

Dr. BUTLER. The revolution I would suggest is that, just as there are national cancer centers, Alzheimer's disease centers, that the Federal Government, in cooperation with the private sector, initiate departments of geriatrics within American medical schools. That would be the revolution. There would be a revolt, people would be upset, but in the long run, it would be the kind of result that I think you're speaking to.

The CHAIRMAN. Dr. Marks.

Dr. MARKS. I would like to comment a little bit and refer to Senator Wyden's question, the first one. When I was training, I trained in pediatrics, but you see that I'm speaking on the issues of aging because I recognize how critical it is to our society. The areas that people were staying away from was oncology, because there wasn't much hope in it. I think that's part of the sense of what people feel about an aging population.

Part of what we have to recognize is framing that hope is going to be critical. That is not just about repair work on badly damaged bodies, but it's about, in fact, helping people to stay healthy and active as long as they can.

I saw a gentleman on TV who had finished last in his race. It was a 100 meter race. He was 102. He wasn't discouraged by this because the oldest age category was 75 to 79. That's a very different view of the next 20 years after age 80 than most of us have.

We do not have to have the outcomes we currently have, and if we just train people to treat those outcomes and not to prevent, them we will have limited ourselves as a society and we will have limited our view of what older age can be. That is part of what we think public health needs to bring. Just like you talked about no geriatrics programs in medical schools, almost every school of public health has a maternal and child health program. Very few have any programs for dealing with an aging population.

When we see what can happen in a program like the SPARC program, we see that we can dramatically change the preventive services and the attitudes of community agencies around an older population.

The CHAIRMAN. Thank you very much.

Dr. Payne and Rabbi Gerber, these other gentlemen have been commenting on how to resolve the problem. You have given two excellent examples of the problem and what the problem is, a lack of recognizing clinical depression in a somewhat older American which led to a lot of problems over a number of years, and Dr. Payne, fortunately for you, you had someone in the emergency room who just happened to recognize it, but you almost died because of what you got.

Did you indicate that that particular problem is more serious perhaps with the elderly?

Dr. PAYNE. Yes, I think it is, because of the reduced immune system response in the elderly.

The CHAIRMAN. It's easier for them to be susceptible to that.

Dr. PAYNE. Sir?

The CHAIRMAN. It's easier for them to be susceptible to that because of their age?

Dr. PAYNE. Right.

I think there is one other thing, Senator, that hasn't been touched on very well. I think there should be some public education, which is fairly cheap, insofar as the elderly are concerned, that they should seek medical help when they first need it, not when they desperately need it. I don't know how you get this done, but maybe through public education, like we've had with smoking and alcoholism, et cetera, that when you're sick, go to your doctor.

The CHAIRMAN. One of the most exciting things in medical care is the whole concept of preventative care. Everybody says we have to have more preventative care. People don't see a physician until they're sick. In reality, we ought to have a complete analysis and profile on every American, looking at their case history, their parents, their genetic makeup, to determine what they're susceptible to later on in life, so that a proper course of preventive medical care can be instituted earlier to delay the inevitable results of what that person may likely develop later on in life, whether it's coronary heart disease or diabetes or any of the diseases that affect so many of us. That really is what preventative care is, not waiting until you're sick to go get treated, but to do the things that are necessary now to prevent that sickness from ever occurring and delaying it later and later.

This has been a terrific hearing. I thank all of our witnesses for being here. Your suggestions are good, your examples are so very

important for us to be able to take to the general public and begin the next step.

This is a huge problem, but it's also a huge opportunity. It's a huge opportunity for our medical schools to begin looking at institutes on aging and to do more, like you all are doing in your areas. This is something that really represents the future in health care.

Speaking of Senator Dole's mother being 102, we would like to recognize today the clerk for our committee, Patricia Hameister, that it's her 100th hearing. She's not 100 years old. [Laughter.]

This is her 100th hearing, and we want to congratulate her for her great service as well.

With that, our committee will stand adjourned.

[Whereupon, at 3:12 p.m., the committee adjourned.]

# APPENDIX

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**Testimony of the American Psychological Association for the hearing record of the Senate Special Committee on Aging**

**Ageism in the Health Care System: Short Shrifting Seniors?**

**May 19, 2003**

**Submitted by**

**Henry Tomes, Ph.D.**

**Executive Director, Public Interest Directorate**

On behalf of the American Psychological Association, I would like to commend the Senate Special Committee on Aging for directing your attention to the health care needs of older adults. The American Psychological Association (APA) shares your commitment to improving the quality of life experienced by older adults across gender, race/ethnicity, and geographic areas. Our 150,000 members and affiliates include a sizable number of psychologists who provide an estimated 52,000 hours of care weekly to older adults. We would like to take this opportunity to share the contributions of psychological research and practice to understanding and reducing prejudice against older Americans.

As you well know, issues of prejudice and discrimination have been at the forefront in our country over the past several decades. While a great deal of attention has been focused on understanding and combating racism and sexism, little focus has been directed to the third "ism," ageism. Ageism is a term developed by Robert Butler (the first director of the National Institute on Aging) in 1969 and is defined as "a systematic stereotyping of and discrimination against people because they are old" (Achenbaum, 1985). Ageism can be exhibited in a variety of ways, including discriminatory attitudes and behaviors, prejudicial comments, poor treatment, and discriminatory institutionalized practices and policies against older adults.

Ageism is often based on a variety of stereotypes related to behavioral factors associated with older adults. These negative stereotypes often attribute qualities to older adults, such as poor psychological functioning, anxiety, tremors, fatigue, confusion, and irritability, without sufficient assessment (Zarit, 1980; Goldstein, 1985; Edelstein & Kalish, 2000). In addition, there are also positive stereotypes that may deny real psychological changes that occur during adult development, e.g., "Aging is just a state of mind." (Cherry & Smith, 1998; Gatz & Pearson, 1988). These inaccurate stereotypes can lead to discrimination toward older persons in the workplace, politics, and in the health care arena, ultimately reducing their opportunities and negatively impacting their quality of life.

Psychology has long been committed to promoting the health and well being of older adults and remains dedicated to ensuring that all individuals, regardless of their age, live free of prejudice and discrimination. Psychologists are particularly well equipped to address both the prevalence and impact of ageism on individuals and our society at large. As researchers, psychologists have provided evidence of the impact of ageism on psychological assessment (Edelstein & Kalish, 2000) and treatment of older adults (Zarit, 1980). As educators, they have used the research base to promote accurate information about psychological aging, and finally, as practitioners, psychologists have utilized the research base and expertise to provide the mental health services that older individuals need.

As the largest organization representing psychologists worldwide, APA has taken a leadership role in providing accurate information about advancing age to reduce stereotypes and to eliminate decision making based on faulty information about the aging process. One of the ways in which APA and its members have worked to promote equal treatment for older Americans is through our advocacy efforts regarding the training of health care providers to work with older adults. As America's population ages, the need for well-trained mental health care professionals with an expertise in aging continues to grow.

Although most older adults enjoy good mental health, nearly 20% experience some type of mental disorder. The most prevalent disorders are anxiety, cognitive impairment and depression. Symptoms of depression in older Americans are often overlooked and untreated because they may coincide with other medical illnesses or life events. In fact, older adults currently have the highest suicide rate of any age group in our country.

Researchers estimate that up to 63% of older adults with a mental disorder do not receive the services they need. The Department of Health and Human Services reports that only 3% of older adults report seeing mental and behavioral health professionals for treatment. Most older adults seek mental and behavioral health services from their primary care physician who may not have the time or training to recognize or appropriately treat mental or behavioral health issues.

The number of health care professionals available to treat the growing number of older persons with mental and behavioral disorders is inadequate. The National Institute on Aging has estimated that 5,000 doctoral geropsychologists working full time with older adults will be needed by 2020. Presently there are less than 1,000 identified geropsychologists who provide clinical services to older adults. There is also insufficient support for high quality program development in the area of geropsychology. Only about 10% of psychology doctoral programs offer in-depth training with older adults, which is not enough to meet the need nation-wide.

It is essential that we work to increase the number of practitioners well trained to address the growing mental and behavioral health needs of older adults. This can be achieved in part through continued support of the Graduate Psychology Education (GPE) Program in the U.S. Department of Health and Human Services. This program provides funds to train geropsychologists who provide health care services to older persons as well as health service psychologists to work with other health professionals in the provision of services to underserved populations (e.g., children, rural persons, chronically ill, and victims of abuse and trauma).

In closing, the American Psychological Association commends the Senate Special Committee on Aging for highlighting the issues of prejudice and discrimination against older adults. We look forward to working with members of Congress as a resource to combat ageism and promote the health and well being of older Americans.

**Ageism in the Health Care System: Short Shrifting Seniors?**

**Hearing before the Senate Special Committee on Aging**
**May 19, 2003**

Discrimination in health care on the basis of old age is common. But some geriatricians contend that age cannot predict the appropriateness of providing health care to old people from a medical point of view. "Age is not an independent variable" is how Christine K. Cassel, M.D. (now Dean, School of Medicine, and Vice-President for Medical Affairs, Oregon Health and Science University) made this point at a 1989 conference, *Health Care for an Aging Society*, in Houston, Texas. There is considerable evidence that older people can benefit medically from health care and that they should not be denied health care on the (untrue) argument that the care will do them no good. The Senate Special Committee on Aging should be commended for bringing this important issue to greater public attention.

*Although discrimination in health care on the basis of age is common, numerous studies confirm that older people can benefit from health care*

"Study Backs Drugs and Surgery for Elderly with Colon Cancer," *The New York Times* (Oct. 11, 2001) describes the successful use of chemotherapy after surgery for people over age 65 with colon cancer. Doctors from the Mayo Clinic and six other health care centers in North America and Europe "pooled seven studies [involving 3351 patients] comparing surgery alone for colon cancer with surgery followed by chemotherapy, the standard treatment."

"Study Says Age Should Not Determine Who Gets Joint Replacements," *The New York Times* (Feb. 11, 2001) reports the findings from a Canadian study that "healthy people age 80 and older can benefit significantly from having [total hip or knee replacement surgery] and may do just as well after surgery as younger patients." The authors of the study found that "older patients in their study did not have a higher rate of complications" from the elective surgeries than younger patients. The study looked at 454 patients who had total hip or total knee replacement surgery at two Edmonton hospitals.

"US Study Endorses Surgery for Those over 100," (Reuters, Oct. 24, 2000) describes successful surgery involving anesthesia for people over 100, according to study by Ramesh Paladugu of New York Methodist Hospital in Brooklyn. Reviewing 61 general surgeries at the hospital in people over age 100, Dr. Paladugu said in a report to the American College of Surgeons, "'A patient's physiological age is more important than his or her chronological change. Therefore, as long as one's overall health is good, a centenarian should be able to undergo surgical procedures without having any problems.'"

Verne G. Kopytoff, "A Faulty Heart, A New Change," *The New York Times* (Jul. 17, 1996) describes successful heart transplants in people over age 65, the usual age cut-off for heart transplants, at the Medical Center of UCLA, "using hearts that are considered to have a higher-than-usual chance of failing and that would otherwise be discarded." "[T]he program has a one-year survival rate comparable to the national rate for younger and healthier recipients." The

article reported:

> Dr. Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, a said U.C.L.A.'s results posed serious ethical questions like this one: How can age discrimination in allocating heart transplants continue if it is proved to have no practical basis?

Timothy L. Kauffman, et al., "Rehabilitation Outcomes after Hip Fracture in Persons 90 Years Old and Older," *Arch Phys Med Rehabil*, Vol. 68 (Jun. 1987) reports on a retrospective study that found successful outcomes (i.e., recovery of independent ambulation) for patients over 90 who received rehabilitation following hip fractures. The study looked at the therapy provided to 18 residents of six skilled nursing facilities in Southcentral Pennsylvania between March 1, 1983 and February 29, 1984.

The Center for Medicare Advocacy, Inc. is a national, non-partisan education and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare and quality health care. The Center for Medicare Advocacy's national office is in Connecticut, with offices throughout the country, including in Washington, DC.

Toby S. Edelman
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