COMMENTARY

Coda: Where Have We Been and Where Are We Going?

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There are few topics of such social and policy significance for the state of North Carolina as the impending challenge which a rapid increase in the size and diversity of our older adult population will present. Over the coming decade, much of the attention of state and local public sector officials will necessarily be focused on issues related to these socio-demographic changes in our state. In thinking about these issues, there is both "good news" and "not-so-good news."

First, the "Good News"

Over the past 20 years or so, we have become more aware of the fact that in addition to positive changes in life expectancy in our country there have been dramatic changes in the prevalence of physical disabilities as adults enter late life. Scientists who have studied these phenomena at Duke University, such as Kenneth Manton and his colleagues,[1,2] have shown that the prevalence of physical disabilities (particularly those that limit activities of daily living involving mobility) have declined significantly among US older adults.

Another researcher who has studied these same phenomena is James Fries at Stanford University, who has postulated the "compression of morbidity" hypothesis.[3] Fries argues that expansion of the number of years that adults live with few activity-limiting disabilities is occurring faster than increases in overall life expectancy. For this to occur, the age-specific incidence of chronic and disabling conditions must decrease more rapidly than age-specific mortality rates. Because of these trends, the majority of older adults experiencing disabling conditions are experiencing them later in the life cycle and living for most of their lives with few activity-limiting conditions; mortality is occurring more frequently after a shorter period of disability. The result of these trends is improved health, a more positive life experience in one's later years, and potentially lower overall health care costs for individuals and the general society.

> *"The development of a viable social policy offering support for the intrinsic ideas embedded in the notion of 'healthy aging' will require both new ideas for how to operationalize the programs and social insurance arrangements to support these ideas."*

Lester Breslow, one of America's leading epidemiologists working in the field of aging, proudly boasts of his 93 years of good health and active professional life, has been arguing for years that the majority of older adults in this country, even in their 70s and beyond, live with few if any disabling conditions and most would rate their own health as either "excellent" or "good." Breslow has argued that we need to change the way in which "aging" is defined and certainly dispel the inappropriate "negative" connotations of chronological age.[4]

Such a reorientation of our thinking to incorporate these more up-to-date and accurate profiles of America's older adult population is not easily achieved. As recently as August 3, 2008, the *New York Times* included in its Sunday edition an article

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describing the way in which staff of contemporary nursing homes and other residential facilities serving older adults, as well as students in schools of medicine and nursing, had participated in "sensitization" training and exercises in which they simulated the sensory reductions of aging, claiming that this type of training was increasing the empathy of staff of these facilities while improving the quality of care these residents would receive.[5] Letters to the Editor of the *Times* reprinted a week later (Sunday, August 10, 2008)[6] emphasized one of 4 themes:

1) A realistic simulation should also include a set of corollary experiences, e.g., negotiating the health care bureaucracy, dealing with public transportation when going for health care appointments, or the problems of hiring reliable and affordable personal assistants to fill particular service gaps in one's daily routine.
2) *Functional* age is not equivalent to *chronological* age. As chronological age increases, the variability in functional age also increases. Meeting one 85-year old person is not a good basis for generalization to another person of the same chronological age.
3) The major problem faced by older adults in the most senior years is not health or functionality, but instead it is not having enough money to live on. Retirement income adequate for a 65-year old may not be adequate by the time that individual reaches age 85 due to the impact of inflation, decline of the stock market, mandatory minimum distributions from 401(k) plans, and other financial factors.
4) These simulated sensory deprivations associated with advancing age tend to reinforce stereotypes of older adults, making it seem as if there are few older adults without these deprivations in sight, sense/touch, hearing, or other bodily or cognitive functions. The person expressing this type of response to the use of simulations made the suggestion that every example of sensory deprivation should be balanced by an example of a healthy older adult fully active in some sphere of their daily life (e.g., as a volunteer in a local homeless shelter or as a participant in the North Carolina Senior Games). In other words, these physical and cognitive limitations should not be allowed to be defined as "natural consequences of aging;" persons are not disabled because they are old, but they happen to experience these limitations as they happen to be growing older. The terms "healthy aging" or "successful aging" are ones used with the intent of offering a distinctly positive notion of what the older adult years can and should mean for those fortunate enough to live to these ages.

Now for the "Not-So-Good News"

As these letter writers in response to the *New York Times* article have suggested, negative stereotypes of people of advancing chronological age tend to obscure the variability among seniors in terms of both physical and cognitive capacities. These stereotypes often make it seem less productive to invest in programs and opportunities for older adults since people in these age groups may seem less capable of benefiting from such investments or that society could realize fewer gains were these investments made.

It is true that older adults at advanced chronological ages account for the greatest burden of societal expenditures for health and medical care, even though catastrophic medical care expenditures are tending to occur later in life, as Fries has argued.

These demographic trends have the added implication that larger numbers (and proportions) of our population will be living longer after retirement, which means that there will be proportionally fewer persons in the younger age groups who are fully employed. As the so-called "dependency ratio" in our society changes in this direction, there will be even more reluctance to spend valuable public funds on programs and activities that support a growing segment of the population who are no longer contributing to the overall societal economy.

All of this is to say that programs and initiatives that promote the general concept of "healthy aging" and longevity will not always meet with a warm and positive response, at least from those most concerned about the entitlements expected by these populations in health care and in social services among those in these advancing years. The development of a viable social policy offering support for the intrinsic ideas embedded in the notion of "healthy aging" will require both new ideas for how to operationalize the programs and social insurance arrangements to support these ideas. It will also require a substantial effort in affecting a general attitudinal support for greater societal investment in these programs of benefit to our senior citizens.

What is Encompassed by the Terms "Healthy Aging" or "Successful Aging?"

The terms "healthy aging" or "successful aging" are terms that raise questions about both individual and societal preparation for advancing years. On the one hand, these terms suggest the need for "prospective" approaches to aging and make the case for the establishment of health-oriented lifestyle patterns as early as possible (though there is evidence to support the notion that "it is never too late to start, and always too soon to cease" these healthy lifestyle patterns).[7] On the other hand, there is recognition that certain "opportunity structures" in the general society make these personal choices less available as options or offer few incentives for their longer term adoption. In other words, the achievement of the promised benefits of healthy/successful aging will require both *personal* and *societal* efforts to make these goals attainable. In espousing the notion of "healthy or successful aging," we are talking about a national effort to promote more individual responsibility for "healthward" personal decision-making regarding lifestyle, while at the same time encouraging a new concept of societal responsibility to and for our older citizens.

Taking the notion Jim Fries advanced using the concept of the "compression of morbidity" as a framework for thinking about healthy/successful aging seems like a useful starting point

for all of us who are concerned about these issues in North Carolina. Fries has enabled us to see the words "healthy aging" as less a contradiction in terms, and more of a programmatic agenda for how to go about addressing some of the more important health issues of our total population. It's really a simple idea: We want to reduce the total amount of lifetime disability population-wide mainly by postponing, for as long as possible, the onset of specific disabling conditions.

This offers a new way of looking at what has, since the early 1970s, been the major thrust of the health promotion and disease prevention movement in America. We are not just talking about changing lifestyles because of some nonspecific, personal search for a higher quality of life. We are talking about concrete efforts each of us may make to delay or eliminate particular symptoms of disability and activity-limiting disease. We are trying to minimize the number of years people suffer from chronic and potentially disabling diseases and conditions.

Fries is not making the case that efforts to delay the onset of disabling conditions will greatly increase longevity; he is stating that we can expect to significantly reduce overall health care costs while improving the lives of persons living for additional years without the burden of these illnesses. Many have seen Fries' paradigm as the dominant and underlying model of what we now view as the "healthy aging" movement.

So, Where Are We Now? And Where Should We be Headed?

It would be easy to conclude the deliberations represented in this special issue of the *North Carolina Medical Journal* with the admonition that all we have to do is to encourage North Carolinians to follow the latest and most up-to-date advice on diet, exercise, sleep, and other lifestyle choices, all part of what we have come to define as a "healthy lifestyle," and one's prospective health status as an older adult will be improved. However, nothing is quite so simple. It is true that reducing any of the many known risks to positive health (such as smoking, excessive alcohol consumption, sedentary lifestyle, or unsafe driving patterns) will have both personal and societal benefits. But many other factors are important in delaying the onset of debilitating chronic conditions. Pharmacologic therapies for hypertension, diabetes, congestive lung disorders, and heart failure, as well as surgical interventions for the relief of back, knee, and hip pain, and ophthalmologic surgery for cataracts have all reduced the activity-limiting effects of serious health conditions, making them less likely to be defined as disablements.

Healthy aging requires, at a minimum, an attitude that embraces a positive notion of maintaining an active and vigorous lifestyle for as many years as possible. But it also requires a societal effort to assure the accessibility of programs and services that make these goals individually attainable. A societal goal of promoting healthy aging will require the reinvention of new models for the provision of care for persons with various forms of disablement to facilitate the maximum feasible levels of independence, mobility, and other aspects of participation of persons in these age groups.[8] Efforts to assure the availability and accessibility of appropriate and high-quality preventive, diagnostic, and curative professional health care services, without the barrier of lack of insurance, for everyone regardless of age is a necessary component of any effort we may make to assure the health of all of us in our senior years. For that reason, we should no longer define "healthy aging" as a program of activities for seniors alone. These are ideas for everyone, for they require the persistence of a lifetime in the quest for the benefits of good health. **NCMJ**

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