August 4, 1995

To: Molly Brostrom
From: Katie Smeltz
Subject: Summary of packet provided by Robert N. Butler, M.D.

"The Links Among the Generations"
Robert N. Butler

The Anniversary of the Older Americans Act should remind older Americans as well as younger generations that we must work hard not to lose the social and economic advances we have made in Social Security and Medicare.

"In My Opinion: We Must Lead the Crusade to Insure Kids"
(AARP Bulletin, 3/95)

Dr. Butler recommends a national Grandpersons' Initiative for Kids First. All organizations representing older people should make helping younger people a priority. After the institution of Kids First, the next logical step in health-care reform would be to meet the need for home, community and institutionally based long-term care.

"Caring for the Elderly In an Age of Limits"
(Washington Post, 4/25/95)

This article discusses the need to change the Medicare system. Older people need to care about younger people in order to bridge the generation gap.

Butler feels that the baby boomer generation is the key to changing elderly issues. "The baby boomers are a transformational generation. When they catch on to what old age is, they're going to demand things."

"Doctors Are Refusing To Treat Medicare Patients"
(Washington Post, Health, 5/12/92)

Doctors are not treating Medicare beneficiaries the same as all patients, they are not seeing them as frequently. Medicare reimburses only 80 percent of what Blue Cross and Blue Sheild and commercial carriers pay for similar services. A striking contrast to the fee for service system is the one in the United Kingdom , which has had long experience in using the capitation method of paying for health care.

"The Importance of Basic Research in Gerontology"
Robert N. Butler

The ultimate health-care service and the ultimate health-care cost containment mechanisms result from fundamental research.

"Dispelling Ageism: The Cross-Cutting Intervention"
Robert N. Butler

The war against ageism is largely showing signs of success. Possible interventions are to tap sources responsible for maintaining a dignified and healthy old age. These include the individual to maintain a productive and healthy lifestyle in old age, as much as possible. Government needs to be involved at all levels. Legislation such as the Age Discrimination in Employment Act and various other protections, including entitlements and long-term care, are antidotes for ageism.

Ageism allows the younger generation to see the older generation as different from themselves. Current manifestations of ageism are seen in medical schools among the residents toward their treatment of the elderly.

"Here's How to Take Charge of Old Age Now"
Dr. Robert N. Butler

People who lead purposeful lives live longer than those who do not.
*Exercise
*Low-fat diet
*Drink alcohol in moderation
*Eliminate tobacco

People must continue to adapt to stay healthy, both mentally and physically. Failure to adapt to changes and losses as they occur can result in physical illness at any age.

"International Longevity News" (Newsletter)
Articles include:

"In A Global Career, Shigeo Morioka Blends Business and Productive Aging."

"Winning Resolutions: Save Medicare, Help Kids"

"New Jersey Companies Tailor Benefits, Work Conditions to Fit Stages of Life and Career Cycles."

"Serving Japan's Senior Citizen Market"

Mount Sinai

The Mount Sinai Medical Center

The Mount Sinai Hospital
Mount Sinai School of Medicine

One Gustave L. Levy Place
New York, NY 10029-6574

The Henry L. Schwartz Department of Geriatrics and Adult Development

Robert N. Butler, M.D.
Brookdale Professor & Chairman
Director
International Leadership Center on Longevity and Society (ILC-US)

Box 1070

Tel (212) 241-4633
Fax (212) 860-9737

June 23, 1995

Fax: (202) 456-7028

Ms. Molly Brostrom
White House Old Executive Office Building

Dear Ms. Brostrom:

Thank you so much for seeing me. It was a pleasure to have a chance to talk to you about older people and their health care today.

Please know I am prepared to be of any possible help I might be. I am enclosing a few papers that might be of interest to you.

Sincerely yours,

Robert N. Butler

Robert N. Butler, MD

RNB/mm

Enclosures

Some Recent ILC Accomplishments:

• **U.S.-Japan Commission on Aging.** The ILC is represented on this ongoing commission created by the governments of U.S. and Japan to stimulate collaborative research on issues relevant to the aging of both nations.

• **Almanac on Longevity and Society.** This almanac, a compendium of comparative data about aging populations, eventually will cover 46 nations. Compiled in collaboration with the United Nations, this almanac can assist leaders in business and government with key facts about worldwide population aging.

• **Project Linkage.** Illustrating a commitment to the concepts of productive aging and intergenerational cooperation, the ILC and community partners developed and obtained funding through the U.S. Department of Housing and Urban Development for a model project in New York City's East Harlem. It will provide housing for lower income elderly and bring them together with "latch-key" children after school hours. Health care services for the residents and the children will be provided as well.

• **Symposium and Book on Strategies to Delay Dysfunction in Later Life.** This was the first in a series of ILC conferences designed to give leaders in business and the media access to cutting-edge biomedical research presented by the researchers themselves. One goal of these meetings is to stimulate new products, procedures, and cost-containing measures in health care and related industries.

• **Comparative Health Economics and Cost Effectiveness Research.** These studies by the ILC's team of health economists in the U.S. and Japan are expected to identify and track methods and systems that yield effective services for older people at lower costs.

• **Perspectives on Health Care Reform.** Starting with the requirements of sound geriatric care, a recently published ILC book, *Beyond Medicare*, shows how effective long-term care can be achieved and financed in systems along with acute care. Implications are drawn for national health policy, personnel development, and public education.

Mount Sinai

International Longevity Center
Box 1070
The Mount Sinai
Medical Center
N.Y., N.Y. 10029-6574

Tel. (212) 241-1472
Fax. (212) 860-9737

Designed and Produced by
COMMUNICATIONS SERVICES
Warner-Lambert Company

International Longevity Center

Charting a Course for the 21st Century

The ILC Mission

"It took 5,000 years of human history to expand average life expectancy by 25 years. In this century alone, we have added almost as many years to people's lives in the industrialized world and have made substantial gains in the developing world as well. That's a remarkable achievement. We're undergoing a *longevity revolution.*"

Robert N. Butler, M.D., Director

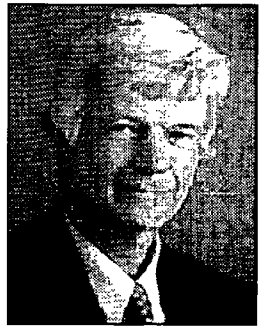
The ILC is the first private, non-profit organization devoted exclusively to research, policy analysis, and public education regarding the *longevity revolution* — the substantial increase in life expectancy and the rapid growth in the number and proportion of older people worldwide. The ILC was founded in 1990 by Robert N. Butler, M.D. and Shigeo Morioka. The ILC (U.S.) is directed by Dr. Butler, and the ILC (Japan) is directed by Hideo Ibe, Ph.D. The ILC is supported by private donations and private as well as governmental grants and contracts.

The ILC provides leadership by:

- Researching and analyzing the problems and opportunities stemming from population aging in the U.S. and abroad, such as productive aging, silver markets, and long-term care;
- promoting collaboration among researchers in science, business, and government;
- stimulating the development of informed public and private sector policies regarding longevity; and
- disseminating information to the mass media and the public at large.

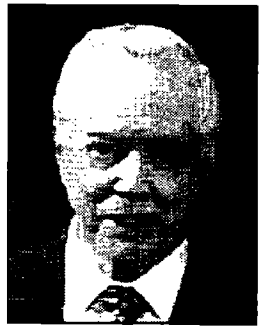
The ILC: Helping to Shape New Attitudes and Policies

"In my many travels over the past few decades, I have heard the same concern expressed by many professional, business, and governmental leaders: Can we afford all these older persons? The truth is that as longevity has increased, so has productivity. At the ILC, we try to show that there are many benefits connected with the greater number and proportion of older persons. And we believe that when older persons remain productive, it's good for them, and it's good for society as well."



Robert N. Butler, M.D., Founder and Director, ILC (U.S.)

"By the year 2000, there will be 410 million older people in the world. This is a staggering development, and every part of society will be affected by it. The key is how we repond to increased longevity, as a world, as a nation, and as people. That's why the ILC was founded. The ILC works on a worldwide scale to identify cutting edge issues linked to longevity and to develop dynamic, innovative, and workable strategies for change."



Hugh Downs, TV personality, Host of ABC's 20/20

"It's time to change the public's mindset about what it means to live longer, to see these new 25 years of life as a new stage of human development — new possibilities and problems, too, but to see the new age as adventure. The ILC is leading us toward this goal."

Betty Friedan, Author and Social Commentator

"In Congress, we're constantly under pressure about how to allocate scarce resources to the different generations — young vs. old. Sometimes it seems like the battlelines have been drawn. We need to know what works and what doesn't as we try to ensure our children's future. The work of the ILC can help us chart a course for the 21st century."

John Glenn, U.S. Senator (D–Ohio)

"Business must play a key role in the *longevity revolution.* Demand for goods and services is changing drastically as the population ages. To prosper, smart businesses must be prepared to react accordingly. We want to make sure we're out in front capitalizing on these golden opportunities to the fullest extent, and the ILC can show us how."

Peter Hannaford, Chairman, The Hannaford Company, Inc.

INTERNATIONAL LONGEVITY CENTER
PROJECTS ADVISORY GROUP

William B. Abrams, M.D., Pharmacology
Merck Manual of Geriatrics

Robert N. Binstock, Ph.D., Political Science
Case Western Reserve University

James E. Birren, Ph.D., Psychology
UCLA Center on Aging

Marjorie H. Cantor, Social Gerontology
Fordham University

Christine Cassel, M.D., Ethics
University of Chicago

Betty Friedan, Psychology & Social Criticism
Author

Rose Gibson, Ph.D., Social Research
University of Michigan at Ann Arbor

Mary Grace Kovar, Ph.D., Health Statistics
National Opinion Research Center, University of Chicago

Peter Libassi, Law
University of Hartford

Robert Myers, Social Insurance
Former Chief Actuary
Social Security Administration

Bernice Neugarten, Ph.D., Human Development
University of Chicago

Masako Osako, Ph.D., Sociology & Finance
Industrial Bank of Japan

Martha N. Ozawa, Ph.D., Social Welfare
Washington University at St. Louis

Victor Regnier, FAIA, Architecture
USC School of Architecture

Janet S. Sainer, Public Policy and Aging Services
Former Commissioner on Aging, New York City

James Schulz, Ph.D., Economics
Brandeis University

Ursula Springer, Ph.D., Communications & Publishing
Springer Publishing Company

Cynthia Taeuber, Ph.D., Demography
U.S. Bureau of the Census

Peter J. Whitehouse, M.D., Ph.D.,
Neurology/Neuropsychology
Case Western Reserve University

T. Franklin Williams, M.D., Medicine
University of Rochester Medical Center

Kathleen Woodward, Ph.D., Humanities
University of Wisconsin

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

Reprint from:

THE ANNALS OF THE AMERICAN ACADEMY
OF SOCIAL AND POLITICAL SCIENCE

"Dispelling Ageism: The Cross-Cutting Intervention"

by Robert N. Butler

SAGE PUBLICATIONS, INC.
2111 West Hillcrest Drive
Newbury Park, California 91320

SAGE PUBLICATIONS LTD
28 Banner Street
London EC1Y 8QE, England

The Importance of Basic Research in Gerontology

ROBERT N. BUTLER

We can all feel encouraged when new investigators, including young scientists, contribute to basic research in gerontology and longevity science since we must increasingly contend with problems affecting the growing number of older persons. Gerontology and longevity science are surely magnet fields of the 21st century.

The very term gerontology was introduced by Elie Metchnikoff at the beginning of the 20th century. George Sacher emphasized the importance of understanding the mechanisms of longevity and death as well as ageing within his broadened definition of gerontology. As the 20th century nears its end, the Japanese are talking about longevity science.

Modern science arose in the 16th century with both the questioning of ancient dogmas and the introduction of new ideas and information by such great figures as Copernicus, Vesalius, and Paracelsus. But it was not until the Industrial Revolution in the 18th century that science began to accelerate and become professionalized. Medical science evolved too, especially in the last century. The germ theory of disease began to be applied towards the amelioration of health and sanitation. This helped launch the remarkable triumph of survival we have seen in this century with significant reductions in maternal, childhood, and infant mortality rates. Survival was increased primarily through the understanding of pathogens, namely infectious agents (such as bacteria, protozoa, viruses, fungi, rickettsia) and, more importantly, means of their prevention (immunizations) and treatment.

But now, as we approach the 21st century, we are moving into areas of further elucidation of the underlying mechanisms of apparently non-infectious chronic disease, such as atherosclerosis and neoplasia. By their nature these diseases of old age require us to appreciate better the interrelationship of genes, the environment (broadly defined to include our lifestyle as well as the quality of air, water, and exposure to various pathogens, carcinogens, and toxins), and ageing itself. Research on ageing variables has received less attention so far compared with research involving environmental and genetic factors.

Fortunately, this is changing. In 1974 the US Research on Aging Act established the National Institute on Aging. This led to the identification of major new priorities for research in the US: Alzheimer's disease, osteoporosis, the impact of grief and retirement on body and mind, nutrition, pharmacology, and, of course, the basic biology of longevity and ageing.

In order to utilize resources prudently, efforts have been made to develop major research plans. The National Institute on Aging itself developed two plans entitled: *Our Future Selves* (1977) and *Toward an Independent Old Age* (1982). Recently the National Academy of Sciences' Institute of Medicine completed its National Agenda for Research on Aging entitled *Extending Life, Enhancing Life* (1991). Each of these has furthered interest in ageing by the broad scientific community. The most recent plan highlighted fifteen major priorities including proliferative homoeostasis (cell replacement and repair), clinical geriatric syndromes (such as 'failure to thrive'), social and behavioural research (including health-care incentives), health services delivery research (including emphasis on interventions in long-term care), and analytical and empirical ethics research (for example, to deal with the profound issues related to end-of-life decisions).

Underlying all of this planning is the realization that the ultimate health-care service and,

Age and Ageing 1993;**22**:S53-54

indeed, the ultimate health-care cost containment mechanisms result from fundamental research. Research is much less expensive than dealing *after the fact* with growing numbers of diseased and disabled elderly people. Alzheimer's disease alone illustrates the enormous problem that already exists, but which will become even greater in the next century if we fail to ask basic questions to understand fundamental neurobiology better. Alzheimer's disease and the other dementias are much more complex than poliomyelitis, but the latter disease is illustrative of how fundamental knowledge can lead to the near eradication of a disease. Although we all know the names of Sabin and Salk, the public is less familiar with the names Enders, Weller, and Robbins. Yet it was they who discovered how to grow the polio virus, which was the necessary basis for the development of vaccines.

The importance of basic research in gerontology and longevity science cannot be overestimated. We have moved into the era of what I have long called the 'new gerontology', which contains the following components. First, stereotypes, myths, and images of old age are being replaced by more factual information, such as that 'senility' is not an inevitable consequence of ageing, but due to various diseases. Cardiac output does not decline as a function of ageing *per se*, but as a function of atherosclerosis which remains occult without thallium scanning.

Second, we have a better appreciation of the underlying mechanisms of ageing thanks to the work of Leonard Hayflick (the 'Hayflick limit') and the work of Anthony Cerami (glycation of proteins in ageing). Third, we have also seen the introduction of preventive and therapeutic interventions. Note the importance of postmenopausal oestrogen therapy on the biomedical side and, in the psychosocial sphere, the valuable Widow-to-Widow programme of the American Association of Retired Persons, which helps newly widowed persons deal with grief.

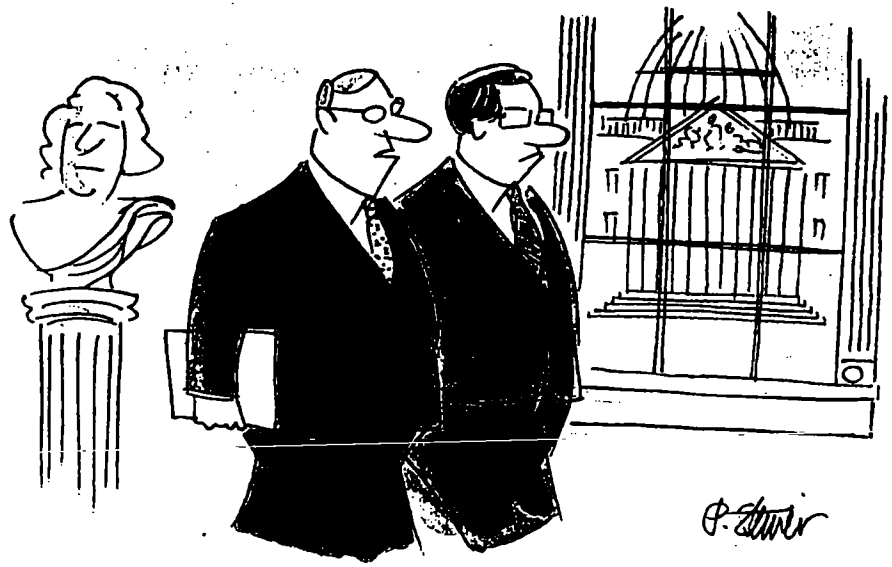
A fourth aspect of the new gerontology is the empowerment of older persons to feel greater self-respect, strength and energy through the growth of productive ageing—in other words, the mobilization of the continuing contributions of older persons to their families, their communities, and society. The simple premise of productive ageing is that it is good for both the individual and society for older persons to remain vigorous and contributory.

Finally, a word about the word *basic*. Both historically and contemporaneously, we tend to think of basic in terms of underlying biological mechanisms, and these are certainly of enormous importance. But *basic* also encompasses our understanding of human character and behaviour which will be advanced, of course, by the understanding of basic neurobiology, but also by theoretical and empirical understanding of the realm of human consciousness and behaviour.

By *basic*, then we mean here *fundamental* efforts directed to explaining major human phenomena, whether they be biological, behavioural, or social, in the simplest yet most comprehensive of terms. If we do not undertake basic studies in all spheres of human life, we will fail to grasp the most significant basic questions of all, those prompted by the new longevity. Why have we devoted ourselves to gaining some control over the universe, some appreciation of nature's regularities, some opportunity to extend human life with freedom from disease, unless we have certain goals concerned with human betterment and enrichment?

HALP BULLETIN
MARCH 1995

We must lead the crusade to insure kids



"Sure I want to put kids first, as long as I'm still in charge."

Last year's hopes for health-care reform may have been dashed, but the fact remains that millions of Americans are un- or underinsured, including an estimated 18 million children. This, the world's wealthiest country, can't afford to keep its children at risk.

Future health-care reform will likely occur in steps. Modest insurance market reforms will probably include ending denial of health insurance on the basis of pre-existing conditions and providing portability of health insurance for employees.

But the most critical step in reform should be universal access to health care for America's children.

This is not a new idea. The late Sen. Jacobs Javits, R-N.Y., suggested Medicare for children, or "Kiddie Care," some years ago.

The Kids First initiative, led by pediatrician Irwin Redlener, singer/songwriter Paul Simon, editorial cartoonist Garry Trudeau and others, joined by the Children's Defense Fund, the American Academy of Pediatrics and the National Association of Children's Hospitals, all seek coverage of children by various means. Their financing proposals differ, but this should not obstruct the goal, which, I suspect, would be acceptable to everyone along the political spectrum. Were we to begin a national campaign to provide health care for children, I believe the vast majority of Americans would support it.

Older people care deeply about children—their grandchildren and other children. They also care about the future of the country and continue to contribute to their communities—and their families—through donations of time and money.

In keeping with these concerns and speaking as an older person, geriatrician and grandfather, I recommend a national Grandpersons' Initiative for Kids First. All organizations representing older people should take the lead in calling for a health insurance program for all children like the one older persons themselves enjoy. This effort would go a long way toward eradicating the image of older people as "greedy geezers."

After the institution of Kids First, the next logical step in health-care reform would be to meet the need for home-, community- and institutionally based long-term care. Forty percent of persons needing such care are under age 60, including many disabled children.

We older folks have the responsibility to help maintain our society and support younger generations. I very much hope that elders and the great organizations that represent them will lead a Grandpersons' Initiative for Kids First in America.

Robert N. Butler, Director
International Longevity Center (U.S.)

BY ABIGAIL TRAFFORD

Caring for the Elderly In an Age of Limits

COMMENTARY

Perhaps it all began with his grandparents. He was less than a year old when his parents split up and he went to live with his grandparents on a chicken farm in New Jersey. He remembers his grandfather's blue overalls, white hair and his stories about the "olden" days. And he remembers his grandmother who, after her husband died, lost the farm in the Depression and took care of him by working in a sewing room run by the WPA.

His love of old people led him to want to specialize in geriatrics in medical school. By 1961, when the first White House Conference on Aging was held, Robert N. Butler was a young researcher in neuropsychiatry at the National Institutes of Health. Delegates came to the conference from across the country to discuss issues affecting the elderly—and Butler was one of them.

Out of that landmark conference came the recommendation for a national health care program for the elderly, a major step toward the enactment of Medicare in 1965.

By the second White House conference in 1971, Butler was on the medical school faculty at George Washington University and Howard University and chair of the D.C. Commission on Aging. Once again, he was a delegate.

Out of that conference came the establishment of the National Institute on Aging to focus research on diseases of the elderly and the aging process itself. Ten years later, Butler attended the third White House conference in 1981 as the director of the Aging Institute.

Now the fourth conference is about to begin, and Bob Butler will be one of the major voices. After a lifetime devoted to studies of the aged, he is one of the nation's most respected gerontologists. He is author of the Pulitzer Prize-winning book "Why Survive? Being Old in America" and chair of the department of geriatrics and adult development at Mount Sinai School of Medicine—the only medical school with a geriatrics department.

Butler has seen national health policy for the elderly grow from nothing to today's intricate web of health and social programs. But now, the political tide has turned. No longer do the elderly have a blank check to draw on public sympathy or funds. Congress is looking for ways to reduce government spending, and Medicare is a prime target. The goal is to slow the rate of growth in Medicare spending so that the country can save an estimated $100 billion or more during the next five years. Just how—and how much—Congress will chip away Medicare is not yet clear, but as Richard J. Davidson, president of the American Hospital Association, told a group of health reporters in Washington recently: "We're going to see one hell of a fight in this town."

The irony is not lost on Butler that the battle over Medicare is heating up just as the White House is holding its fourth conference on aging. Like Butler himself, who is 68, Medicare has grown older. It is now one of the most entrenched of federal government programs. And with time has come the recognition that the program needs to be modified. As Butler knows from his research on how people age, the ability to change is the key to survival.

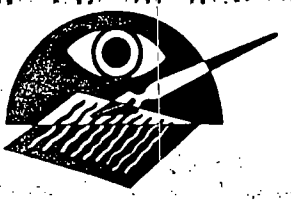
This is not the moment for seniors to "just say no" to any change in Medicare. Better to seek out changes that would make the program more responsive to their needs—and in the process perhaps more cost-effective. Delegates to the fourth White House Conference on Aging intend to propose a restructuring of Medicare, says Butler, with more emphasis on services to support people with chronic illness. Most important to many seniors is coverage of drugs and long-term care, which are not included in Medicare. In return, the elderly may have to give up unlimited choice of physicians and join health plans that coordinate services. They may also have to pay more for coverage and services.

Senior citizens also need to close the Generation Gap. Conference delegates are likely to propose a health program to cover all children and thus forge an alliance between the young and the old. "We believe that children—who are the future of the country—ought to have health care just as older people have Medicare," says Butler. This is also a way of fighting the stereotype of the "greedy geezer" who takes away resources from the rest of society. It doesn't help in the political battle over Medicare and Medicaid to have old people "simply saying I want, I want," says Butler. Besides—unlike Medicare—a program to cover children would be relatively cheap, because kids are generally pretty healthy.

Most of all, Butler wants to galvanize the baby boomers. History shows that Medicare passed in 1965 largely because it had support of middle-aged people who were worried about their parents. To protect the Medicare program in the 1990s, Butler believes aging has to become a midlife issue—not just a concern for the elderly. "People other than older people will see that there is something in it for them," says Butler. "The baby boomers are the transformational generation. When they catch on to what old age is, they're going to demand things."

That's why in the current fight over Medicare, Butler is taking the long view. After all, he's now a grandfather himself. ■

US POST 4/25/95



Doctors Are Refusing To Treat Medicare Patients

By Robert N. Butler
Special to The Washington Post

COMMENTARY

The debate over affirmative action has generated much talk about quotas, but there is one in the medical world that has received virtually no attention. It is the growing practice of physicians to limit the number of Medicare patients that they are willing to see. It is becoming common for appointment secretaries in medical offices to ask people who call for an appointment how they plan to pay for the doctor's services. When the caller indicates that he or she (usually she) is a Medicare beneficiary, the doctor's schedule suddenly becomes very tight.

Or, says the secretary, "the doctor is not taking any new patients at this time." The older the patient, the "busier" the doctor is portrayed to be.

The reasons for this avoidance of older patients are obvious. First, Medicare reimburses only 80 percent of what Blue Cross and Blue Shield and commercial carriers pay for similar services. Second, the amount of time, skill and effort required to care for older, frailer patients is extensive, given that they often have multiple medical conditions combined with psychological and social complications.

Sixty-five percent of these frail, older persons are women. About half live alone and are at greater risk for being placed in a hospital or nursing home.

Physicians are not to blame for this state of affairs; indeed, they deserve some words of defense. The financial realities of medical practice today are such that the older patient population has become an undesirable one.

The combination of excessive bureaucratic paperwork and reduced payments for Medicare patients undermines efforts to care for older people, who require a far greater investment of time than that required by younger patients. These financial conditions reduce incentives for physicians to take on older patients.

The Physician Payment Review Commission (PPRC), established in 1986 to assist Congress in physician payment reform, was intended to improve primary care—the core of geriatrics. In reality, however, the PPRC reforms have actually become counterproductive. In the process of establishing pay parity among primary care physicians and specialists, the reforms have raised fees for some and lowered them for others. Geriatricians, for example, stand to lose as much as 17 percent in earnings.

The original studies upon which these physician payment reforms were based looked at actual resources required (such as skill, time and effort) to provide care to patients. The resource-based relative value scale (RBRVS)—which is intended to pay doctors more for communicating with patients and less for surgery, tests and other "procedures"—was one result of these studies.

However, frail, elderly subjects were omitted from the studies. Thus, not reflected in the new payment system are the complexity and intensity of care that this elderly group requires.

A striking contrast to this fee-for-service system is the one used in the United Kingdom, which has had long experience in using the capitation method of paying for health care. That is, the government makes a single annual payment to primary care physicians for each patient that covers all care.

The government does not have to know each item of service received by the patient. Thus, the system is less bureaucratic, easier to administer and less costly than ours.

The average British general practitioner, for example, cares for approximately 2,000 patients in any given year. About 240 of them are over 65—perhaps 120 of these are between 65 and 74; 70 might be between 75 and 84; and about 50 are usually 85 and older.

Under this system, an additional 10 pounds, or about $17.50, is provided annually for each patient in the first group; an additional 10 pounds is provided per patient in the second group; and still another 10 pounds per patient in the third group. No more than 20 percent of all the elderly patients make major demands on the physician's time. But every physician agrees to do an annual examination of all patients, including appropriate preventive care, such as flu shots and counseling.

It is important to note that, unlike the American system, the British system allows a patient to consult only those physicians in one's own defined geographic area, unless he or she is prepared to pay out of pocket rather than rely on the national health service. Thus, their method is not directly transferable to ours.

In the long run, however, the capitation method, when applied to older patients, would be less costly and less bureaucratic than our present RBRVS-based method.

Coupled with the introduction of a standard payment to physicians, whatever the source of payment, these reforms would reduce a physician's avoidance of older patients simply because they are perceived as being a drain on time and income. ■

Physician Robert N. Butler is Brookdale professor of geriatrics and adult development at Mt. Sinai Medical Center in New York.

Second Opinion is a forum for points of view on health policy issues.

WASHINGTON POST HEALTH MAY 12, 1992

The Links Among the Generations

By Robert N. Butler, M.D.
Chair, Advisory Committee for the 1995 White House Conference on Aging, May 3, 1995, Washington, D.C.

Over 2,000 delegates are assembled here at this, the fourth White House Conference on Aging. Our theme this year is "America Now and into the 21st Century: Generations Aging Together with Independence, Opportunities, and Dignity." Our conference will be both forward-looking and intergenerational and will serve not only today's older Americans but younger generations who will one day be old. We must understand there are not only biological links among the generations. There are social links and moral links as well.

Yesterday was the 30th anniversary of the Older Americans Act, which has aided millions of older Americans over the years. This anniversary should remind the older generation as well as younger ones that we must work hard not to lose the social and economic advances we have made. Social Security and Medicare -- two popular programs under intense attack today -- do not serve only one age group. Social Security is a life-course system of protections, not just a retirement program for older persons. It provides for the disabled and for children: indeed, some 3 million children are covered by Social Security. The reason Medicare was passed in 1965 was because adult children wanted such coverage for their older parents. So it is not simply an advantage for the older generation, but for their middle-aged children as well. And let us not forget that Medicare covers the disabled as well as the old. We must preserve and strengthen Social Security and Medicare and cover long-term care, including community care, and medications. We must also undertake major cost-containment reforms. But every penny saved in Medicare must go to Medicare. We must not balance the budget at the expense of Medicare beneficiaries. No means testing.

In keeping with our conference theme, we should vote our genuine concern about the links among the generations and call for health insurance for all Americans and begin with the children of America. It is unconsciounable that here in the U.S., the world's most productive nation, there are 18 million children without health care insurance. Whatever the mechanism for financing such insurance, we cannot afford to let the future of our country -- our children -- be without health care coverage.

Like me, many of you are parents of children who belong to that huge generation known as the Baby Boomers. The first wave of baby boomers will turn 50 years old in 1996. We cannot wait until these first Baby Boomers reach Golden Pond in the year 2011 before we devise ways to assure their economic security and develop a health system that knows how to take care of them. There are some things we cannot do overnight; we need lead time. Thus I would like to see major resolutions come from this conference that support the advancement of biomedical, social, and behavioral research so that we may learn how to improve the quality of late life by preventing, reducing, and delaying the onset of physical and mental frailty. This means that we need to find ways to prevent, postpone, or cure dementias such as Alzheimer's -- a disease that robs people of their sense of self and their ability to recognize loved ones, while requiring costly and often inadequate long-term care. This means that support for the National Institute on Aging must be increased significantly.

We must also support the development of geriatrics-oriented medicine as well as palliative medicine and end-of-life decision-making that can help relieve needless pain and suffering at the time of death. It is hard to believe that among the 140 U.S. medical schools, there are only about 20 significant programs in geriatrics and only one full-fledged department of geriatrics! What a contrast to Great Britain, where the third largest specialty is geriatrics and where every medical school has a department of geriatrics. Without a concerted effort

to integrate the principles of geriatrics within all of primary care and specialty medicine, we will surely not be ready to meet the needs of the Baby Boomers when they grow old. End-of-life or palliative medicine is a specialty in Great Britain, but not here. In order to support geriatric medicine and palliative medicine, renewed support must be given to the Veterans Administration and the National Institute on Aging. In addition, the graduate medical education funds provided under Medicare, which have given major support for medical residency education in all kinds of specialty and primary care medicine, but not in significant amounts to geriatrics, should now be directed to this field, particularly since Medicare is intended to provide access to health care for the old. What I have said about medicine must also apply to nursing, social work, and the other health professions.

The present elders of our society struggled through the Depression of the 1930's, fought in two world wars and Korea, and led this nation in its "golden age" from the end of WWII to the beginning of the 1980's. Although they worked hard all of their lives, 27% of older people are still poor or near poor, that is within 150% of the poverty level ($6,930 for an individual and $8,741 for a couple). Only 3% of older persons 65 years and above have incomes in excess of $50,000 a year, and 83% have incomes under $25,000. Social Security is the major source of income for 40% of older Americans, and the only source of income for many. All too many, especially older women and members of minority populations, live in stark poverty.

And at the same time, more private dollars flow from the old to the young rather than the other way around. Older persons still provide enormous amounts of voluntary time to their nation, communities, and families, taking care of their children and grandchildren when needed. The notion that older people are enjoying the good life at the expense of society and taking away the opportunities of our children is simply wrong and outrageous.

We, the older generation, do assume responsibilities and we will not be complacent about social institutions. It is always important to re-examine institutions and find new and better ways to accomplish the same goals. Among these goals is the need to provide protections against the vicissitudes of human existence over which we have no control -- disease and accidents to an individual and economic and other disasters that can befall a nation. But this protection must come with the understanding that all individuals, including older persons, have specific responsibilities to society. We delegates must find ways for older persons to continue to contribute productively to our society. It will help defuse the undeserved anger that has been directed against the elders of our society. Vital and productive aging must go along with increased life expectancy.

We cannot and should not depend upon Social Security alone, but must build up our own personal endowment for the future. We should not depend upon the family alone, although we should forge strong family ties. We should not depend upon the community alone, our jobs alone, or on the government alone. If you ask the question, who is responsible for our old age?, the answer should be that responsibility must be shared among all of these.

This is a millennial conference -- the last White House Conference on Aging before the 21st century. There is much to consider in the four areas identified for deliberation at the conference: promoting economic security, housing and support services, health care and long-term care, and quality of life. You will find your voice and speak out on all these issues. But remember, we must not only adopt strong resolutions to support older persons but give attention to the needs of Baby Boomers and to children as well. We must continue to act long after this conference ends, long after the resolutions have been voted upon. As elders of our society, it is our responsibility to set an example by working to achieve a humane and decent

society for all the generations. All of us need to remember that there is unity and continuity to life.

Finally, apart from public policy *per se*, we all must and do seek meaning in our lives through love, work, spiritual fulfillment, and involvement with the arts and humanities. Music, art, dance, and literature often help us find that purpose, as well as the moral roots of our lives and our moral links to one another. Thank you. Good health!

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

INTERNATIONAL
LONGEVITY NEWS
FORMERLY PRODUCTIVE AGING NEWS

NUMBER 2 • JUNE 1995

From the Editor's Desk...

This issue is strictly business.

First, we want to recognize one of Japan's leading businessmen for his devotion to the concept of "productive aging," the idea that the later adult years are not throw-aways but rather socially and personally useful and satisfying. Indeed, Shigeo Morioka, the chairman of the board of Yamanouchi Pharmaceuticals Ltd. and Executive Vice-President of the ILC (Japan), champions the concept and exemplifies it. This issue honors Morioka-san for his leadership. To know him better, see our lead article (at right).

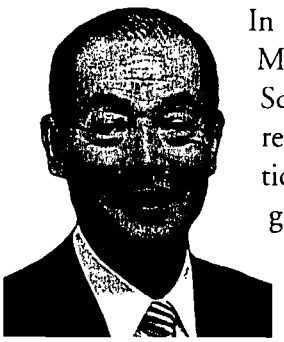
Elsewhere in this issue we present business aspects of the Longevity Revolution, a term coined by Robert N. Butler, M.D., director of ILC-US. On page three is a compilation of "silver industries," by which we mean products and services for older adults and their families.

As an example of the growth of silver industries, we report on

(continued on p.2)

Energizing the ILC-Japan

IN A GLOBAL CAREER, SHIGEO MORIOKA BLENDS BUSINESS AND PRODUCTIVE AGING



In 1945, in a Japan exhausted by World War II, Shigeo Morioka was graduated from the University of Tokyo's School of Agriculture and went to work, at age 23, as a researcher on penicillin at the Yamanouchi Pharmaceutical Co., Ltd. In the ensuing 50 years, as the company grew in Japan and abroad, he served in marketing, research planning, and other activities of the company, becoming chairman of board, president and chief executive officer in 1980.

Developing into one of the largest global research-oriented pharmaceutical companies under Mr. Morioka's leadership, Yamanouchi had sales in its drug and other business of $4 billion in the year ending last March. The company is respected for its entrepreneurship, far-sighted research programs, product innovations, and marketing ability as well as for its sense of responsibility to its patrons, stockholders, industry and society.

Mr. Morioka led the way in establishing the International Longevity Center (ILC) in Japan in 1990, in attracting government interest and in persuading major corporations to help finance it. Mr. Morioka is devoted to productive aging as a matter of principle and personal practice. "Productive aging" emphasizes the positive characteristics of older individuals as social and economic resources rather than as burdens.

(continued on p.2)

IN THIS ISSUE...

Graying Travel Market p.2
U.S. Silver Industries p.3
Bermuda Senior Games ... p.4
Social Security p.4
Tailoring Benefits p.5
Baby Bust and Markets p.6
Japan's Senior Market p.6

International Longevity Center (US)
Henry L. Schwartz Department of Geriatrics and Adult Development, Box 1070
The Mount Sinai Medical Center
New York, N.Y. 10029-6574
Mount Sinai

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

VOLUME 12
NUMBER 13
JULY 15, 1991

Bottom Line PERSONAL

Incorporating Privileged Information

Personal Points

☐ **Improve your decisions** by breaking them into four parts: *Framing...intelligence gathering...coming to conclusions*...and *learning from experience.* Decide how much time to devote to each part. Review recent good and bad decisions to see the effect of sticking to your model—or deviating from it. Then make adjustments in the model. *Key:* This self-audit process should be continuous.

Decision Traps by J. Edward Russo, professor of marketing and behavioral science at the Johnson Graduate School of Management, Simon & Schuster, 1230 Avenue of the Americas, New York 10020. $9.95.

☐ **The job you choose** may be determined by the amount of testosterone in your body. Highest levels of this hormone—linked to aggression, sensation-seeking and antisocial behavior—were found in actors and lawyers...lower levels in nurses and teachers...lowest in ministers.

Study by the Georgia State University psychology department, reported in *Health*, 3 Park Ave., New York 10016. Monthly. $22/yr.

☐ **Mid-afternoon picker-uppers.** Spend 20 minutes napping or meditating...or take a short walk. Avoid sugar and heavy foods for lunch. Save easier jobs such as routine paperwork and correspondence for the midday slump.

Neil B. Kavey, director, Sleep Disorders Center at Columbia-Presbyterian Medical Center in New York, quoted in *Working Woman* magazine, 342 Madison Ave., New York 10173. Monthly. $18/yr.

☐ **Sunscreen savvy.** In a bathing suit, you need at least one-half teaspoon of sunscreen for the face and neck, one-half teaspoon for each arm and shoulder, one-half teaspoon for the front and back of the torso and one-half teaspoon for each leg and foot.

Safe in the Sun by Mary-Ellen Siegel, senior teaching associate, department of community medicine, Mount Sinai School of Medicine, City University of New York, Walker and Company, 720 Fifth Ave., New York 10019. $21.95.

In this issue

☐ Legal ways to hide income from Uncle Sam...3
☐ Opportunity stocks.....4
☐ GIC dangers.....4
☐ Portfolio for intelligent cowards.....5
☐ Job strategies for tricky times.....6
☐ The American family is in trouble—how to protect yours.....7
☐ Fertility miracles.....8
☐ Great new cookbooks....8
☐ Lessons from Socrates...9
☐ Cool summer drinks...10
☐ Better picture taking.....10
☐ Life planning.....11
☐ Terrorism self-defense: An update.....12
☐ How to take charge of old age—now.....13
☐ Best cordless phones...14

From Harvard Psychologist Ray Flannery The Secrets of Stress-Resistant People

Most people in America live incredibly hectic lives. We push ourselves to manage successful careers, families and relationships.

We're constantly pushing for more ...and more...and more.

Result: Most of us are up to our necks in stress—and that stress is climbing.

To find out more about stress and how we can better cope with it, *Bottom Line/Personal* asked a Harvard psychologist who has studied stress and stress-resistant people for the past 12 years...

What exactly is stress?

Stress is the physical and psychological distress that we experience when our day-to-day problems exceed our abilities to solve them.

While most of us think of stress in emotional terms, it also causes dramatic physiological changes. It floods the body with adrenaline, speeds up the heartbeat, deactivates the immune system and focuses our thinking.

When we are in genuine danger—facing an automobile accident or being attacked by a vicious dog, for instance—stress-induced physiological changes can be lifesavers.

But when stress becomes chronic, persisting even without the threat of physical danger, it serves only to damage our physical and emotional health.

Stress forces the body to go into overdrive, sapping our energies, making our lives joyless and sending us to early graves.

Is life more stressful today than in years past?

Probably so. Life was hard prior to 1900, but stress as we know it did not become a particular problem until the past few decades.

In fact, stress wasn't a problem for earlier generations precisely because life was so hard. Our ancestors worked long hours at hard physical labor just so that they could procure adequate food and shelter. They were physically exhausted at day's end.

Now, thanks to the ready availability of most consumer goods and to the proliferation of telephones, TVs and countless other labor-saving devices, we can choose to work fewer hours and have more leisure time. Yet today's faster pace of life leaves us frantic.

Result: We've stopped focusing on the truly important things in life—good relationships with the people that we love, for example—and stress ourselves trying to acquire and make use of everything that's in sight.

It's ironic that although America has the greatest array of consumer goods in the history of the world, instead of mak-

Bottom Line/Personal interviewed Raymond B. Flannery, Jr., PhD, assistant professor of psychology, department of psychiatry, Harvard Medical School, Cambridge Hospital, 1493 Cambridge St., Cambridge, Massachusetts 02139. He is the author of *Becoming Stress-Resistant*, Continuum, 370 Lexington Ave., New York 10017. $17.95.

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

THE MOUNT SINAI JOURNAL OF MEDICINE

VOLUME 60 NUMBER 6 NOVEMBER 1993

Education, Clinical Services, and Research on Treating Older People:

The Department of Geriatrics and Adult Development, The Mount Sinai Medical Center—A Decade of Experience

Myron Miller, Rein Tideiksaar, and Carol Capello, guest editors

From the Department of Geriatrics and Adult Development,
The Mount Sinai Medical Center