INTERNATIONAL FORUM

Meeting the Health Needs of the Elderly

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Abstract

In addressing health care practitioners and researchers at the Brookdale Institute, Robert N. Butler, Professor of Geriatrics and Adult Development, Mount Sinai Hospital, New York, and former director of the National Institute of Aging, spoke candidly about changes in attitudes and practices needed in medical care. He called the American health care system to task for permitting people to "fall through the cracks" of the system and go without care; for spending too little money and effort on research in geriatrics; and for accepting the "quicker and sicker" discharges which result from offering financial rewards to hospitals for "curing" people quickly.

Butler called his fellow physicians to task for failing to practice collaborative medicine, which includes the patient, as well as other professionals in the care process. He criticized physicians for seeing human being as "cases" that need to be "managed".

He emphasized four aspects of the "new gerontology" which he believes must be incorporated into geriatric and gerontological practice:

* the movement toward revisionism – treating the diseases of the elderly rather than viewing aging as a disease
* movement away from description to an understanding of underlying mechanisms
* the opportunity to directly intervene in the processes of aging as well as diseases and disabilities associated with aging
* empowerment of older persons. The author sees Israel as being one step ahead of the U.S. in that health care is considered an entitlement and all citizens have access to care. Too many U.S. legislators and business persons are still emphasizing the "disproportionate" share of the health care dollar going to the elderly.

MEETING THE HEALTH NEEDS OF THE ELDERLY

My presentation provides an overview of health care of the elderly from the U.S. perspective. There are certain aspects of the Israeli scene that impress me greatly. One is the provision of primary care in which Israel appears to have been much more successful than the United States, at least in ensuring every Israeli an opportunity for health care. It is shocking that some 40,000,000 Americans do not have access to health care; they do not have any kind of insurance mechanism, though half of them are working people.

This is so different from the philosophy of Kupat Holim (Israel's major provider of health care) which is that you help yourselves through helping others. From my perspective this provides a basis on which to describe and define a major world-wide cultural crisis which is in the making, and I will return to this point.

Israel has, I think, some of the same critical problems as the U.S. especially in relation to long-term care. There is a barrier to fully and satisfactorily developing a program for home care and a whole range of services to us as we grow older, especially for those who are often called "the very old"—aged 75, 85 and above. Moreover, I find the same critical issue in the U.S. and Israel in the development of geriatrics, which is mainly focused on a kind of political or turf struggle that involves internal medicine.

Since this seminar is taking place in the holy land, I think I can speak of the apostolic attitude of the doctor, the fact that the physician thinks of himself in too grandiose a manner. The medical profession must be less zealous in protecting its power base and operate in a much more effective and egalitarian manner in cooperation with a variety of the other services, disciplines and specialties. In fact, it is the interdisciplinary perspective that has always motivated Myrna Lewis' and my work. Our efforts have been to try to describe the phenomena from broad psychosocial and biomedical, as well as cultural perspectives. In some respects, I think one of the key issues that is causing all societies to have difficulties in confronting the challenge of age is that we are divided into specific departments, specialities. We do not have the imagination to break down departmental barriers and function together. This is part of the cultural crisis —the world-wide cultural issue.

In every nation I have visited, every society, regardless of its culture, socioeconomic basis or political system, the following three issues arise:

1) The burden of costs that is "imposed" or "posed" as a consequence of population aging. Can we afford our elders in a world that is increasingly confronted by a changing view of the welfare state? Can we afford not only older people but children, disabled people, unemployed people and poor people? We have seen, I think, an extraordinary and painful division developing in various Western and industrialized societies with regard to the "haves" and the "have nots".

2) The issue of intergenerational conflict. There is a notion that war will develop among the generations; even though the polls of Louis Harris, Yankolovitch, White and others refute such a view. Nonetheless, the press, TV, radio and print media in the U.S. enjoy emphasizing a growing conflict among the generations.

3) The concept of stagnation in society, which is prevalent in various places, including the People's Republic of China, the Soviet Union, Sweden, Romania, France, Great Britain, Mexico and Japan. This concept claims that if we have more older persons, there will be industrial, societal and productive weakening. In some nations there is even a notion that with population aging will come a weakening of military power and strength. This is expressed by Alfred Sauvy of France, the great demographer and a very great pessimist on the topic of aging, as a "gray peril".

From our perspective, we believe that the basic barrier is really a failure of social imagination, a lack of commitment to social equity, and in some ways, difficulty in being able to transform our mind sets and bring them more in line with the realities of what we call the longevity revolution. The term longevity revolution has been introduced to move us beyond concepts that sound potentially negative or disturbing, such as the "graying of America", the graying of nations" or "population aging". We prefer to stress the unprecedented increase in average life expectancy in this century which has occurred throughout the industrialized world, namely about 26 years, which is nearly equal to what had been attained during the preceding 5,000 years in history. As often as I have made that comment, I am still struck with what a remarkable increase in life it represents.

Many people, including the U.S. Department of Health and Human Services where I have the great privilege of serving, really do not understand the mechanism underlying this increase in the number and proportion of older persons. There have not only been remarkable reductions in maternal and childhood mortality rates, which account for about 80% of

those 25—26 years, but 20% are due to increased active life expectancy from base year 65. This is late life survival as a result of reduction of deaths from heart disease and stroke. The extraordinary longevity revolution will continue to affect not only the industrialized world, since by the year 2000, 60% of all people over sixty will be living in the developing world.

No one would want to live long if this would mean living disabled and debilitated lives. In the corridors and meeting rooms of the planning organizations of the American Government one still hears terms like the "disproportionate" health costs associated with age. Would they wish us to return to the days of high mortality rates of mothers, of illnesses and disease and infectious disease of children? What has happened, of course, is that there has been a postponement or a movement forward in time of health and social costs that were related to earlier years of life in the past. Now death is the harvest of old age; 80% of all deaths occur after the age of 60. We do not have that continuing punctuation of life by the grim reality of early death. So there has been a dramatic change.

It seems, too, that there has been little recognition, at least within American medicine, of what has these days been called the new gerontology, which I will define, and which I think becomes an important basis for rational planning of health care for the elderly. The new gerontology, which has developed in the United States since the 1940s, comprises at least the following four concepts:

1. Movement towards revisionism;
2. Movement away from description to an understanding of underlying mechanisms;
3. Opportunity to directly intervene in the processes of aging as well as diseases and disabilities associated with aging;
4. Empowerment of older persons.

Revisionism

When I became involved in gerontology in 1955 in the National Institute of Health, we endeavored to capitalize on the method Keddy and Schmidt had developed at the University of Pennsylvania which had begun to consider whole-brain physiology, oxygen consumption and glucose utilization. It was expected that there would be a dramatic drop in these values with increasing age. We discovered that selected vigorous and healthy older persons did not demonstrate inevitable decline of intellectual functions, but rather decline was attributable to a variety of

disease states. Indeed, to our surprise, and in fact it even held up publication of our book *Human Aging*, we found a relationship between social deprivation, displacement in the environment and cerebral physiology. Those of us who were biomedically oriented, and I include myself among them, questioned this phenomenon. Now the new techniques of positron emission tomography which provide the opportunity for quantitative discrete measurement of cerebral physiology in different portions of the brain, have reconfirmed that there is no decrease with age in cerebral physiological values among normal health, community-residing elderly.

In the National Institute on Aging's Baltimore Longitudinal Study of Aging, it was shown that cardiac output does not decline inevitably with aging, that glomerular filtration rate, which is the measurement of kidney filtration, not only often does not decline with age but in some 30% of the elderly, it is stable or even increases. Glucose tolerance tests, which are usually a measure of the body's capacity to handle a challenge dose of glucose, are bound to be impaired with age, but are not diagnostic of diabetes, specifically type II diabetes which is associated with age. Senility is not inevitable with aging, as was often thought in the 1940s and 1950s but rather is a function of a variety of diseases, including Alzheimer's disease and multi-infarct dementia.

The notion of sexlessness, that somehow as people grow older their desire, their capability, the degree of satisfaction they experience will inevitably end, is not correct.

More recently during work that was stimulated by discussion between Hans Popper, one of the great liver experts in the world, and myself, it became clear that the liver does not age in the same manner that other body parts age, and even then I'm putting "age" in quotes. This has led to the practical result that one can accept for donor transplants, livers from people far beyond the original maximun of forty-five years —up to 60 years in the United States. In addition since the liver is a regenerative organ, one can cut the adult liver into parts and use them for children. So there are many practical implications of the revisions of our views with respect to what is attributable to age, and what is attributable to disease and social adversity. In conclusion, the first part of the new gerontology is the revision of views.

Moving Away from Description

The second aspect of the new gerontology is movement beyond description, i.e., pure phenomenology, to begin to better understand the underlying mechanisms of senescence. Here I would broaden this to in-

clude not only biological senescence, but also the underlying issues of the relationships among generations, dynamics of such relationships, characteristics of different stages of life and life-span psychology that identifies the notion that there are different developmental tasks and programs. This refers back to Havighurst, and, in the area of biology, to the extremely interesting and provocative possibilities that are now before us with the advent of the new biology, recombinant DNA or cloning with hybridoma technology, and monoclonal antibodies that can be created for studying and testing a variety of theories of aging. The error– catastrophe theory states that when cells make a mistake, a chain reaction of mistakes continues to be made. This theory does not appear to be valid, but it has contributed to a still newer theory that relates to the disposal system. This theory proposes that cellular metabolic products are disposed of with greater difficulty as people grow older. The free-radical damage theory concerns the relationship of DNA repair mechanisms in connection with the length of species' life. We have too, the neuroendocrine theory and the immune-senescence theory. In short, we are beginning to get behind the broader concepts that are part of all of Western civilization's wear and tear theory. On the one hand, there is the impact of environmental or random events, and on the other hand, the role of intrinsic, fundamental aging.

Intervention

The third part of the new gerontology relates to the capacity to intervene, which has been evident on the behavioral side. First of all, we know that since 1965, with the introduction of Medicare and Medicaid, as imperfect as those systems are in providing finance and access to health care for older people, there has been a steady increase in average life expectancy. Also, we know that social network support systems for the bereaved, for example, have important impact. The American Association of Retired Persons, now 26,000,000 members strong, has adopted a system, invented by Boston social worker Phyllis Silverman, called the widow-to-widow program, whereby widows who have come to terms with their widowhood help those who are freshly widowed to cope with the profound impact of bereavement.

Svanborg of Sweden, who has visited Israel, recently reported that within the first three months after the death of a spouse, there is a 50% increase in mortality rate in the case of widowers and 22% in the case of widows. Though this last figure is significant, there is a dramatic difference related to gender as far as the capacity to deal with both the morbid

and mortal aspects of the loss of a loved one is concerned.

From studies at Mount Sinai by Marvin Stein, in Sweden by Svanborg and in France by Lambert, we gain an increasing understanding of the relationship of the immune system to bereavement. This demonstrates the importance of interdisciplinary or multidisciplinary approaches in studying the whole person and interrelationships among physiological, psychological and environmental events. Thus we know that sociobehavioral interventions can play a part.

Not more than four years ago, it was found that some 80% of women surveyed in the U.S. had never heard of osteoporosis, which accounts for wrist fractures, crushed vertebrae, so-called dowager's hump and hip fractures. In the U.S., hip fractures occur at the rate of some 200,000 per year, at a cost of more than two billion dollars per year. From the perspective of peoples' lives, particularly women's, that means the end of freedom, mobility and the opportunity to enjoy life. Yet through simple measures of exercise, calcium intake and, when there is no family counterindication and when judiciously and appropriately employed, the use of estrogen, we can now intervene in the process of ostenopenia, which is the bone-thinning that occurs prior to osteoporosis.

Before us we see the extraordinary possibilities of plasticity, biological plasticity, including neuroplasticity. By virtue of the outstanding work of people like Carl Cotman at the University of California and Irvine, who has been able to show in specific animal models, through predictable, repeatable types of lesions, that healthy cells can make new circuitry to compensate for the damage that has been created by the death of specific cells, we may begin to understand better the fundamental biochemistry of neurochemistry of the central nervous system that will give us power to control the recircuitry, reconnectivity of the central nervous functions.

Certainly part of intervention is rehabilitation itself. We were impressed by the work at Beth Rivkah near Tel Aviv, and certainly have heard much about Levinstein and the prospect of being able to introduce a variety of rehabilitative functions. With the new high technology, the opportunity to find means for providing prosthetic environments and prosthetic arrangements that will help people deal with the many communicative, sensory and mobility deficits that many older persons may develop is really within our power, as are possibilities of robotry, of sensory devices and other means that would introduce such help in the care of older people.

Empowerment

Empowerment is the fourth, but perhaps not least, of the issues in the new gerontology. Cicero made a great statement many centuries ago about the need for older persons to stand up, speak up and be themselves, and not feel intimidated or crushed by the overall majority or by the young. With the increasing power of the American Association of Retired Persons, there are increasing opportunities to negotiate on behalf of older persons to protect that which they have gained and to advance that which they may need. But at our own particular level of interest in the health care of the elderly, there is a need to have older persons participate much more equally and collaboratively in the process of their own care.

As I have been saying in the U.S. recently, when I get to be 85 and 90, I do not want to be the object of what is called "case management". I do not regard myself as a "case" and I do not want to be "managed". I think it is important that we develop *collaborative care.* Collaborative care suggests a much more egalitarian relationship between the physician and the patient. The original Latin word for doctor means teacher, and while I do not for a minute fail to recognize the special body of knowledge that is medicine and the important contribution the physician has to make, the physician must shed his or her apostolic function and, instead collaborate directly with the patient or, to put it more broadly, the person. In turn, the person has to gain more and more power over the situation and, in doing so, he or she will improve his or her own health. There is a scientific basis for this. During our studies at NIH, we found that those who survive have clear goals in life. This conclusion is not based on conjecture because we had in-depth protocols and hours of interviews with each of the subjects in the study. We had independent raters evaluate the people, and we paid attention only to items for which the interrater agreement was beyond 0.83.

Some of you may have seen in *Science* magazine a remarkably good summary article by Judith Rodin of Yale University about the importance of the individual person's having some manner of control over his or her own life, even in the nursing-home situation, a situation where autonomy is profoundly destroyed; having some sense of control is adaptive and life-enhancing. So I am leading up to the fact that we need a broad transformation of social organization and the way in which health services are rendered. Notice I did not say medical, because medical is just one part of it, and health is a much broader concept.

When I say health and social services, I refer to the fact that we still have in the U.S., in Great Britain, and I have indications that it is also true in Israel, difficulty in integrating social and health services. Certainly in Great Britain this seemed to be very much evident when I was taken on tours and introduced to U.K. geriatric medicine. As for the American situation, with which I am more familiar, Medicare will be undergoing a major reconstruction.

Medicare was created in the political atmosphere of the 1960s to bring some financial relief to older persons, but, in fact, it was designed for people who were employed and became ill with an acute, hospitalizable illness. If any of us had then sat around the table, we would have designed a very different system of Medicare. Medicare does not provide for checkups, for outpatient medications, dietary counseling or dentistry. It does not provide for home care to any significant degree. In short, it is really an acute, high technology model, and therefore, an expensive model. So in the U.S., we must undertake a restructuring of Medicare, moving from health promotion to disease prevention to rehabilitation, to de-emphasize institutionalization and to provide a more realistic, affordable and sensible type of system.

In the meantime, we have certain frightening elements that have affected us. One is the so-called DRGs, the diagnosis-related groups, which are 467 diagnostic categories under prospective payment, meaning that the hosptial will be paid *x* number of dollars for a specific illness. If they are able to care for the patient for less than *x* number of dollars, they keep the difference. If, in fact, it costs the hospital more than that, the hospital loses. Well, hospitals are brilliant and administrators are fantastic. Thus, hospitals made a fortune last year. At the same time, we have "sicker and quicker", that is, people who are prematurely discharged from the hospital. In addition, though it is much more subtle and difficult to measure, we have "exclusion at the gate". This is the case of an older person, a "proper" older person, who is behaving just like an older person. She is 75–80 and has multiple, complex and interacting physical and psychological problems. She is complex and difficult, and she is not for admission. It is much better to have someone with a single, nice, clean diagnosis.

I like to tell medical students that taking care of young people is simple, "Peter Pan medicine" —a single illness, usually something straightforward. When one gets into geriatrics, however, one gets into some really interesting medicine, diagnostic problems that are really worthy of one's intellectual gifts. I also tell them that if they are not interested in old persons they have only two other choices, obstetrics or

pediatrics, because the wave of the future is geriatrics, and we might as well face this fact.

We are trying to integrate geriatrics within American medicine, and we are trying to do it without the creation of a new practice specialty, but rather, an academic specialty. In this way we will have the teachers, the innovators and the researchers that will ensure that none of the 16,000 medical students who graduate each year from 127 medical schools will lack some fundamental understanding of how and why we age, how medications behave differently in our bodies as we grow older, how to differentially diagnose dementia, how to deal with the multiple, complex, social and behavioral elements in the presentation of the patient, how to recognize how different the presentation may be in an older person because of the changed host, how an increased white cell count may not emerge in the case of appendicitis, or how immune senescence may result in a recrudescence of a Ghon tubercle of tuberculosis, which may be the basis of infection of a grandchild. It is a fact that in the inner cities of the U.S., the most common transmission of tuberculosis to children is via grandparents.

We are trying to point out that geriatrics is a cross-cutting discipline. There cannot be geriatric medicine alone, or geriatric psychiatry alone, or geriatric gynecology alone. We must recognize that no specialty can be absolved, nor can primary medicine be absolved from the responsibility of caring for older persons. We must mainstream and integrate the rapidly growing body of knowledge. Next year, for the first time, there will be examinations for certificates of competence in family medicine and in internal medicine, and we hope, soon in psychiatry.

We are nonetheless confronted with a great problem. Dr. Leslie Libow and I worked to create the first department of geriatrics in an American Medical School, the Mount Sinai School of Medicine. There are maybe twelve of us with gray hair in the U.S. who are among the senior geriatricians or gerontologists. We have a remarkable number of bright and exciting young people who are coming onto the scene but there are very few in the middle. In American academic life, to move from instructor to assistant professor to associate professor to chairman of a division of a department takes ten or more years, so that much of the present politics of geriatrics, at least in the U.S. at the Senate and Congressional levels, involves finding the funds for manpower development.

However, there are other obstacles to the development of geriatrics. When patients are treated in our out-patient clinic the two and a half hours of work involving the physician, the social worker, the pharmacist,

the physcial therapist and the neuropsychologist, will cost some 87 dollars. This is simply insupportable, so one of our problems with Medicare is the payment structure of physicians and other health care workers. I am pleased to have been asked to serve on a commission for the U.S. Congress called the Physician Payment Review Commission. Part of our task will be to examine the financing of geriatrics.

As I have already mentioned ours is the only department of geriatrics in the country. We try to meet the three major goals of any academic department: medical education on the undergraduate, postgraduate and continuing medical education levels; the introduction of services; and finally, a strong research program. The Department will be four years old on July 1, 1987. On the education side, we are, I believe, the only school in the States that requires all our students to go through a clerkship with us. During the clerkship, which lasts one month, they have to spend two weeks working in long-term care, primarily with Dr. Libow. During those two weeks, they also make house calls, which is a significant aspect of their training because these are probably the last house calls they will ever make during their careers. Through these house calls we want them to become acquainted with living conditions of older people: what is in the refrigerator, what kind of medications are in the medicine chest, what are the safety features of the bathroom and kitchen, might the older person slip and fall, how do you analyze the environment? In addition, a series of some 13 lectures ensures that the basic body of knowledge is presented to the students. We also have a large fellowship program comprising six fellows in their first year and six in their second, namely people who have had three years of internal medicine and are either board eligible or have passed their boards. They become important teachers because often the model for the medical students is really the house officer or the fellow. We have begun to experiment with continuing medical education, which will enable the many thousands of physicians in the New York area to gain an introduction to geriatrics at Mount Sinai. We also have government support for a Geriatric Education Center, for teaching nursing-home directors and others.

We have an outpatient clinic that now serves a thousand patients, which in our terms and in the medical school setting, is very large. The average age of those thousand patients is 82, so we are talking about real geriatric patients with complex, multiple problems. Without exception, they have multiple problems, although an acute event usually brings them to our attention. Seventy percent of them are women who live in our area, and given the fact that New York City alone has over one million people over 65, we have just about every socioeconomic, ethnic and

religious group. Finally, we have research professorships in molecular biology of aging and neurobiology. Now that we have our molecular biologists on hand, we can inform the rest of the medical world that gerontology and geriatrics have a science base, that we can learn new things in previously unexplored territory that can lead to innovative applications.

Moving from Mount Sinai back to the national issue, we are now involved at a national level in trying to reform the basic research agenda. So far, the National Institute of Health devotes about 2% of its dollars to research on aging. Only after the establishment of the National Institute on Aging was attention given to Alzheimer's disease, which probably accounts for half of the people in American nursing homes. Health promotion and disease prevention are other national concerns related to the health care of the elderly. The push for health promotion and disease prevention began not out of generosity of heart and a desire to see people enjoy a higher quality of age, but out of pressure to contain costs as a major national, political and public policy strategy, i.e., that people should cost less money. I suggest that Schopenauer was right when he said that not being born at all is the best way to have cost containment.

Personally, I think that health promotion and disease prevention are very anemic terms; I prefer self-responsibility. We really do have to participate in that collaborative relationship with the physician. We have to know what to do to take better care of ourselves. We have to totally eliminate tobacco use, which plays a role in one out of every three deaths in women. It is inexcusable for any of us to smoke. I know that such talk does produce tension, like discussing sex; sex and tobacco both create a certain provocation. But the truth is that smoking is really dangerous. In the U.S., but not in Israel, we also have the very serious problem of alcoholism. Self-responsibility has to include not only these more medical aspects, but also attention to the physical characteristics of the environment, for example, the toe-catching rugs that can lead to falls and broken hips.

As I approach my conclusion, I would like to turn to the long-term care issue. In our country, it is handled through humiliation, particularly for women because women outlive men, since the elderly have to utilize their assets and income in order to have access to long-term care. There is still the unsolved problem of home care. In February 1987, I was consulting in Japan. As you know, Japan seems often to be number one, and it is number one in terms of life expectancy, too. It has the fastest aging population in the world. When I met with the Ministry of Health and Welfare, I learned to my amazement, that they are planning to provide up to three hundred thousand nursing home beds between now and the

year 2000, more than fifteen thousand per year. Japan is engaged in a multi-billion dollar domestic economy stimulation to deal with its trade deficit, and some of America's commercial nursing home chains, such as Beverly Enterprises, are in Japan building residential housing for older persons. My question is, why not home care? You know, it is interesting that despite the richness of the Japanese family life, they do not have highly developed, informal networks of caregiving such as those of the People's Republic of China and the U.S.

We also have an existential issue. In the U.S. the suicide rate for older people is the highest. Some 25% of all suicides are committed by people over 65, particularly white men in their 80s. The incidence of the suicide of women tends to be more bell-shaped with the peak in the middle years. There are existential issues that are not being picked up by our new diagnostic manual of psychiatry in the U.S. There is lower recognition of what we call the somatic equivalent, that is the bodily representation of depression. There is little understanding of the internal sense of despair about the way in which one's life has been led, or one's relationship with one's children. The existential issues tend to disappear as we move into a more formalistic psychiatry in the U.S.

This leads me to my concluding remarks. As Myrna Lewis and I have discussed so often, there is a feeling that population aging could result in a major worldwide cultural crisis. Such a feeling prompted an ex-governor of Colorado, Richard Lamm, to challenge me to a debate that was recently held in Washington, D.C., in which he called for the rationing of health care for the terminally ill and for older people. Yet we are not at war; there is no battlefield in the U.S. and we are not in a severe economic depression. Nevertheless here is an American politician with many followers, including some from the U.S. Congress, such as David Durenberger, Republican from Minnesota, and James Jones, the Democrat from Oklahoma (although he was not re-elected), who have created the Americans for Generational Equity (AGE) and suggest that the future is being mortgaged by older people, that older people are depriving the youth of the country. They do not recognize that there is unity and continuity to life, that yesterday's children are today's older people and that today's children will be the old people of the 21st century. Failing to really analyze the significance of these issues yields talk about rationing. I have always been positive towards notions of death with dignity and of hospice practices, but become increasingly concerned about how slippery the slope is to euthanasia, particularly to active euthanasia, and how attractive it can become to policymakers. Since I do not trust governments, my own opinion is that we really need to have a strong

private sector, a public initiative, that assures us that any decisions that are made about who should live and who should die would not be the decision of government alone or those who are concerned with budgets. When you recognize the fact that older people are largely women, we are talking about the potential killing of older women.

So how do we handle all these issues? Here I will become obviously superficial. First we have to find ways of continuing the productive capacity of older people. A seminar was held at Salzburg some years ago at which much time was devoted to the problem of how to maintain the productivity of older persons. Recently, in the halls of the U.S. Congress, we held a major symposium, "The Promise of Productive Aging", where we discussed ways to protect older persons, and their continuing empowerment and productivity.

Second, we must consider the politics of aging. There is safety in numbers. We see the growing power of the American Association for Retired Persons and others, but we need to adopt an intergerational strategy. We cannot only be advocates for the old; we must take a life-cycle, human development perspective. Kupat Holim says it very well: we help ourselves by helping each other. I think that this is really an important issue, as is individual responsiblity, which I have already stressed insofar as health promotion and disease prevention are concerned.

פורום בינלאומי

התמודדות עם צורכי הבריאות של קשישים

רוברט נ. בטלר

המחלקה לגריאטריה והתפתחות האדם
בית־החולים "הר סיני"
ניו־יורק

ג'וינט ישראל
מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה

גבעת-ג'וינט ת.ד. 13087
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התמודדות עם צורכי הבריאות של קשישים

רוברט נ. בטלר

המחלקה לגריאטריה והתפתחות האדם

בית־החולים "הר סיני"

ניו־יורק

ירושלים מאי 1988

פב–15–88

תמצית

ב- 24.6.1987 נערך במכון ברוקדייל בירושלים סמינר לחוקרי המכון ולאנשי מקצוע מתחום הטיפול הרפואי. רוברט נ. בטלר, פרופסור לגריאטריה ולהתפתחות האדם בבית־החולים "הר סיני" בניו־יורק והמנהל לשעבר של המכון הארצי לחקר הזיקנה בארה"ב, נשא דברים כנים על השינויים שיש לחולל בגישות לטיפול הרפואי ובטיפול עצמו.

הוא ציין, שבמערכת הבריאות בארה"ב אנשים "נופלים בין הכיסאות" ואינם מקבלים טיפול רפואי; מעט מדי מאמצים ומשאבים מושקעים בגריאטריה; ושחרור החולים מבתי־החולים נעשה במקרים רבים מוקדם מדי, כתוצאה ממדיניויות התיגמול לבתי־חולים, המעודדות "ריפוי מהיר". הוא ביקר גם את עמיתיו הרופאים על שאינם פועלים מתוך עבודת צוות, הכולל גם את החולה עצמו נוסף לאנשי מקצוע אחרים הקשורים לתהליך הטיפול, ועל שהם מתייחסים אל החולה כאל "מקרה" שיש "לנהל" אותו.

הוא הדגיש ארבעה היבטים של ה"גרונטולוגיה החדשה", שחייבים לשלבם בגרונטולוגיה ובגריאטריה:

* התייחסות למחלות של זקנים במקום ראיית הזיקנה כמחלה.
* הבנת מנגנונים בסיסיים במקום תיאורם.
* הזדמנות להתערב באופן ישיר בתהליך הזיקנה ולא רק במחלות ובמוגבלויות הקשורות לזיקנה.
* הגברת כוחם של הזקנים. להערכתו של בטלר, ישראל מקדימה את ארה"ב, שכן היא מכירה בזכותו של כל אזרח לטיפול רפואי ומאפשרת טיפול רפואי לכל. בארה"ב נשמעות עדיין טענות רבות מפי מחוקקים ואנשי עסקים על הקצבה "לא פרופורציונלית" של משאבים לטיפול רפואי בזקנים.