

TAKING CARE OF AMERICA'S FIFTH CHILD

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This is a moment of enormous opportunity for us to get together and to do what is fair for our children. I know that, over the next five years, this country can make a commitment to seeing that every child has the health and income security that every 66-year-old has. I do not believe for a moment that we cannot.

I am proud that we lead the world in millionaires and billionaires and have the largest gross domestic product in the world. But I am not proud that our children are the poorest group of Americans. I am proud that we lead the world in health technology, but I believe it is shameful that we do not provide health care to every one of our children. We can let their parents know what they are entitled to, get them enrolled, keep them enrolled, and make sure that they get access to a quality health care system.

And that is our opportunity and moral responsibility as we approach a new century. The time has come to transform priorities, and ask hard moral and practical questions about what kind of people we seek to be in the 21st century. What kind of people do we want our children to be? What kind of moral, personal, community, political, and policy choices are we adults prepared to make at this turn of the century and millennium? Will it be a world in which few human beings ever anticipate or experience a more just, compassionate, and less violent society in which no child is left behind?

The Fifth Child

Imagine a very wealthy family blessed with five children. Four of their children have enough to eat and comfortable warm rooms in which to sleep. One of their children does not. She is hungry and lives in a cold room. On some nights she has to sleep on the streets or in a temporary shelter or even be taken away from her neglectful family and placed in foster care with strangers.

Imagine this family giving four of their children nourishing meals three times a day and snacks to fuel boundless child energy, but sending the fifth child from the table and to school hungry with only one or two meals and never the dessert the other children enjoy.

Imagine this wealthy family making sure that four of their children get all of their shots, regular checkups before they get sick, immediate health care when they are sick, while ignoring the fifth child who is plagued by chronic infections and respiratory diseases like asthma.

Imagine this family sending four of their children to good, stimulating preschools and music and swimming lessons, and sending the fifth child to unsafe day care with untrained caregivers responsible for too many children. Or these parents having to leave this child with an occasionally accommodating relative or neighbor, or even alone.

Imagine this wealthy family reading every night to four of their children who have books in their rooms, but leaving the other child unread to, untalked to, unsung to, or propped before a television screen which feeds him violence and sex-charged messages, ads for material things, and intellectual pablum.

Imagine this family sending four of their children to good schools in safe neighborhoods (if there is such a thing anymore) with enough books and computers and laboratories and science equipment and well-prepared teachers, and sending the fifth child to crumbling school buildings, with ceilings peeling and leaks

and asbestos and lead paint and old books (and not enough of them), and teachers untrained in the subjects they teach.

Imagine four of the family's children excited about learning, looking forward to college after they finish high school, and getting a job, and the fifth child falling farther and farther behind grade level, unable to read and wanting to drop out of school, or at risk of getting pregnant or into trouble.

And imagine four of the children engaged in sports and music and arts enrichment after school and summer camps and internships as they reach adolescence, while the fifth child meets his friends on the street after school, or goes home alone because mom and dad work or have escaped parenting responsibilities and have resorted to drugs and alcohol, leaving this child hanging out all alone either at home or with their peers after school and all summer.

The Poverty of Children

This is not a stable or healthy family or a sufficiently compassionate one. It is also not a sensible one. Amid unprecedented prosperity, huge federal and state budget surpluses, hundreds of billions of dollars of tobacco settlement monies, eight years of continuous and unprecedented economic growth, and a presidential boast that the state of the union has never been better, 13-1/2 million children are poor in the wealthiest nation on earth. A child is more likely to be poor now than in any year between 1966 and 1980, and the gap between the rich and the poor is the greatest it has ever been.

Worse, in 1998, 5.8 million children lived in extreme poverty with incomes below half the poverty line of \$6,500 a year, or less than \$6 a person a day, in a three-person family. Behind presidential and gubernatorial political spin about the success of ending welfare as we know it, rampant child hunger, homelessness, sickness, insecurity, and suffering persists. This is wrong.

Dramatic drops of families from welfare rolls have not seen commensurate drops in child poverty. In fact, reductions in food stamp and Medicaid rolls in the wake of welfare changes since 1996 have increased child hunger and homelessness and have pushed many poor families into deeper poverty. A U.S. Department of Agriculture study reports an increase of 3.7 million children without enough food between 1997 and 1998. We have a community monitoring project, supported by the W.K. Kellogg Foundation, with groups like Catholic Charities and other local groups that are going around the country and finding more and more people showing up in homeless shelters and in soup kitchens. America's Second Harvest reports that one in five people in their growing food pantry lines is a child.

How long will we tolerate in a \$9 trillion economy the hunger and sickness of children, the poverty of children that gnaws at their bellies, snatches away their resilience, scratches away their sense of security and makes some of them wish they had never been born? When has the time ever been riper for us to come together and mount a massive movement and a campaign to end immoral child poverty, hunger, sickness, homelessness, and to make our nation a safe and compassionate place and home for all of our children?

Now that it is the official public policy that all poor mothers must work after a set time limit with no income safety net for children, what steps will leaders in local, state, and federal government, the private sector, and philanthropy take to ensure work at wages that lift all families out of poverty and ensure that all families have the tools of work? Seventy-four percent of all poor children today live in working families who cannot make enough to escape poverty. Yet many states are sitting on billions of unspent welfare and child health dollars designed to help parents and children grab a lifeline of hope out of poverty.

What will happen to children when their parents -- whom they do not choose -- can't feed, clothe, and care for them? And how do we make sure that state and local bureaucracies make it easier rather than harder for

parents who play by the rules, work every day, struggle to make ends meet, and care for children, to receive the food, the health care, and the child care that they are entitled to under law so that they can become more self-sufficient?

We have a profound job in changing the culture of our local and state governments, and health grantmakers can play a role. How do we create an ethic of service and sense of mission about saving the lives and health of children? If our goal now is self-sufficiency and work, how do we make sure that we make it easier rather than harder for parents to know about and get benefits? How do we simplify procedures? How do we reach out to make sure that we serve as many children and as many parents, not as few, as we can? What role can health philanthropy play in making sure the state and local government is more responsive and more efficient, that it reaches out effectively, and decreases bureaucratic hurdles?

That is one of the things I am going to come back to because I think of this as a moment of real opportunity with the State Children's Health Insurance Program (CHIP) to make the system work. It does not matter how many new laws we get: If we cannot translate them into humane, efficient, and timely services at the local level, new laws will not make a difference. So we have got to change systems to make them more responsive and create a new sense of mission to help all of our children get a healthy start. What could be a more important mission?

So how do we get that sense of urgency ourselves? How do we transmit that energy into those who are administering programs? And how do we put into place the training programs and the outside monitoring capacity to make government and all of our institutions work to serve and improve the health status of children?

We have a lot of public education to do, and health grantmakers can make a difference. Contrary to popular stereotypes, America's fifth child is much more likely to live in a working family than on welfare. That child is more likely to be white than black or Latino, and is more likely to live in a rural or suburban area than in our inner city. We've got to have overall messages, but we also need targeted efforts to reach the different children who are uninsured in different places, and in culturally sensitive ways.

America's fifth child obviously has many health deficits and is plagued by poor health and lack of hope. America's fifth child is twice as likely to be born without adequate prenatal care, at low birth weight, and to die before his first birthday; is far less likely to have a father at home, and to have the consistent affection of two parents, the stability of a married family, a steady family income, or extended family and community resources. And that fifth child is more likely to be arrested, be convicted if arrested, be tried as an adult, and to be sentenced to prison.

This fifth child desperately needs to be able to, and wants to, trust adults and the world around him or her, but is almost always afraid. Afraid of being hungry, of having no place to sleep, of having a mother, father, sister, grandparent, uncle, or friend be killed and disappear. Of being bitten in bed by a rat or crawled on by roaches, of being accosted by a mean gang member, a drug peddler in their own homes or streets. Of being too hot in the summer and too cold in the winter, being disrespected and ignored, of being lonely. Afraid of not existing in a world that is passing them by.

We can be a better country, and we can build better communities, and we can do a lot more to make all of our children feel welcome, cared for, and valued. We must not let this fifth child continue to be a fifth rail in our priorities -- in our communities, in our religious congregations, in our philanthropic efforts, and in the halls where decisions on budgets are made -- just because this fifth child cannot organize or vote.

Our fifth child would be better off if he or she lived in 23 other nations. If he or she lived in France, two out of three of our children would not be poor. They would have health security. They would have paid

parental leave. They would have some kind of income security net. I do not believe for a moment that this nation -- if it puts its mind to it, makes the spiritual and political commitment, and puts into place the range of strategies that we must put into place -- cannot change and transform these problems for our fifth child.

It is not just poor children who are in trouble in this country. There are millions of near-poor children who are poor in health care and child care and are not getting what they need. We also have millions of spiritually poor children who suffer from affluenza and a lack of a sense of purpose and connectedness, who are not being adequately parented and provided guidance. Look at Columbine. . . look at Conyers, Georgia. We are all in trouble.

Substance abuse and violence and coarseness of language drift and permeate everything. If we can come together around saving that fifth child, perhaps we will begin to focus on all of our children who are at risk: those who are at risk of the pollution of the airwaves and the Internet, with violence and materialism, and the degradation of our environment.

So how do we get ourselves prepared to be a great nation and a great leader as we face a new century and millennium? We must transform our priorities and redefine our measures of success. Child poverty and neglect are not acts of God. They are conscious, moral, and political choices. We can change them, and I think our choices have to be changed over the next years to build a nation fit for children.

We currently have a negative compact with our children. In the Children's Defense Fund's (CDF's) annual State of America's Children report, we propose a positive compact. The only thing this nation will guarantee its children is detention or a prison cell after they get into serious trouble. We will not guarantee them prenatal care to be born healthy, and we want to change that. We will not guarantee them health care, and we want to see that every one of them gets a healthy start. We will not guarantee them Head Start or quality child care to get ready for school though we know that makes a difference. We will not guarantee them a good education though we know that education affects health status just as health status affects educational achievement. We will not guarantee them the chance to get a good college education and get a job.

So how do we make a positive compact and determine that no child will go hungry or homeless or without health care in this wealthy nation? And how do we break this vision down into manageable pieces for action?

CDF will be laying out an agenda for 2000-2001. One of the first places we want to start is with health care and making sure that the 7 million children currently eligible for CHIP and Medicaid get that health care now. Let us mount whatever campaigns are needed and put into place the range of strategies to make it happen. Let us also use that example as a means to ensure that the other 4.5 million children who do not have health care get a commitment from their nation to provide it.

But I want to keep coming back to urgency and the fact that this is about individual children whose lives depend on what we do now. We have 11.9 million children still without health insurance. Even though we have made this progress enrolling 2 million kids in CHIP, private companies are still eroding health care coverage and states are dropping children from Medicaid by the tens of thousands.

Saving Antonio

In Los Angeles a couple of months ago, someone told me the story of Antonio, a baby who was born to a mother named Maria who was sent home with that baby the day he was born. But she didn't have a home. She was a single parent with no extended family support, but she loved that baby and, within the limits of public assistance, was able to find a small room to rent where she and Antonio lived.

After about three months, Maria called the health clinic to report that the baby was sick. The nurse said bring him in. Maria did not have transportation and said she could not. The nurse asked for his symptoms and, after learning that the baby had diarrhea for two days, concluded he had a flu virus that was going around. She advised the young mother to keep the baby hydrated and feed the baby liquids such as Pedialyte or apple juice every hour. Maria went to her refrigerator. She certainly did not have Pedialyte and she did not have apple juice and she did not have orange juice. Her refrigerator did not even have ice.

But she did have in her cupboard some tomato sauce so she filled the baby's bottle with tomato sauce and stayed up all night feeding him every hour on the hour. The sodium content of the tomato sauce accelerated his dehydration, and by morning, Antonio's tiny body was lifeless.

Was this mother a murderer? Was she even a neglectful parent? Had she done everything possible within the resources available to her and within the limits of her parenting knowledge? The one thing that worker said to me is that she loved her baby and was devastated about the loss. This goes on a lot in this nation, and we need to stop it with a sense of urgency.

I have a seriously asthmatic child, but always have had good health care. I had a good pediatrician and, when my son had an attack, I could rush him off to the pediatrician or to the emergency room and get a shot of adrenaline. I was very moved when I read about a Texas mother with an \$8-an-hour job and no health insurance having her 11-year-old wake her up in the middle of the night gasping for breath saying, "Mom, my inhaler is broken." The mother rushed her child in panic out to the car in the middle of the night. But all along, she debated whether she was going to go to the emergency room that would cost her at least \$100, which she could not afford, or whether she was going to go find an all-night drugstore and try to find an over-the-counter remedy and hope that it would work. She said she realized the next day that -- for \$88 -- she was gambling with the health of her child.

No parent in the wealthiest nation on earth, and the world's leader in health technology, should have to make these kinds of choices, and you and I have got to figure out how to change that. We can if we garner the will.

A few weeks before he was assassinated, Dr. Martin Luther King Jr. spoke at the National Cathedral in Washington. He told us the story of the rich man Dives and the beggar Lazarus. He said there was nothing in that story that says the rich man went to hell because he was rich. He went to hell because he allowed his brother to become invisible. Just as the rich man did not realize that his wealth was his opportunity, so America may not realize its opportunity and could make the same mistake, Dr. King said.

Dr. King called for a poor people's campaign and saw it as America's opportunity to help bridge the gulf between the haves and the have-nots. The question, he said, is whether America will do it. There is nothing new about poverty, Dr. King said. What is new is that we now have the techniques and the resources to get rid of poverty. The real question is whether we have the will.

That is still the real and most urgent question today in our \$9 trillion economy, with huge budget surpluses and tobacco settlement monies. This is the time, when we have quadrupled in wealth since Dr. King spoke, to decide whether we are not going to let 13.5 million poor children and many millions of other Americans remain poor. It seems to me that is what we have to confront. We have to build a sustained forceful movement, and the philanthropic community needs to step out of its traditional boxes of funding and support it.

Healthy Beginnings

I think we can make an enormous difference, and I think we can begin with health. You've got all the resources you need in this room to transform our health care system for children. The theme of this meeting, *Spanning the Generations*, provides an opportunity to focus on how we do make sure that there is a healthy continuum from the dawn of each life to the final stages.

We know that what happens early in life -- the access a very young child or a pregnant woman has to adequate health care, nutrition, and interestingly enough, to education -- profoundly affects an individual's health at the end of life. We know a lot more today than we did many years ago about child development and how a child's brain is developed through the first few years. We know of the importance of screening early for hearing and vision problems so children get the glasses and the hearing aids to be able to see and to hear and do well in school. We know that making sure pregnant women, especially low-income pregnant women, receive adequate prenatal care and nutrition and WIC makes a difference -- and we know what a difference Medicaid made on infant mortality. We know a lot about how to make a positive difference.

Again I come back, why don't we do it? Why don't we figure out how to put together and sustain the range of strategies to make it happen and to really protect the quality of life and potential for all of our children to develop?

Building Coalitions

I recently met again with Horace Deets at the American Association of Retired Persons (AARP) with whom we have an intergenerational coalition. We have begun to work with him collaboratively to reach out and make sure that every one of the children living in the 3.7 million grandparent-headed households gets health care. I hope AARP will help us figure out who they are and figure out how to reach them.

We have got to have a lot of different strategic targets. What are the coalitions we have to begin to build? How do we work with juvenile court judges to reach all those children coming into the juvenile court system? How do we make sure that every child who comes to an emergency room or is born in a hospital does not leave without being signed up for health care? That every child that comes into a child care center or school health clinic or any clinic is signed up for CHIP or Medicaid? There is so much we can all do in different ways. We have got to figure out how we play our own role in ensuring that every child gets health care.

Mr. Deets reinforced the important interest all of us have as we age in investing in our children. He said not to address the health needs of children means that we are risking developing a generation of frail elderly. If children do not get health care when they are young, they may not be able to enjoy the good life when they are older. He repeated again to me what he said in many instances as we have worked together, that the increase in the average life expectancy in the 20th century is due to decreases in infant and child mortality rates. So that when we say that Americans are living longer and are in better health today, that is often because the improvements in children's health manifest themselves at the end of life.

Now when I talk to the AARP board, I always address them as grandparents (not as senior citizens) about how we build a world that is fit for our grandchildren. Many grandparents are struggling to raise grandchildren without adequate supports, and with difficulties getting them health care and registered in school.

We have made a lot of progress. Life expectancy is much longer. We have had enormous success on vaccinations. We can learn much from that. We have had improvements in infant mortality, but it is not acceptable that we still lag behind about 20 other nations in low birth weight and infant mortality. We can do better, and we must not remain the only wealthy industrialized nation that does not assure our children and all of our adults a good quality health care system.

Bringing up the CHIP Enrollment Rate

We know that children bear this consequence more than any other. We have an enormous opportunity with the CHIP but how do we make it work?

We know that race and class and neighborhood all make a difference. We have seen the increase in asthma. A recent study at Mount Sinai Medical Center in New York City in the emergency room visits for asthma showed how dramatically they varied by zip code, reflecting economic and racial differences. Spanish Harlem had 223 visits for every 10,000 residents while some parts of lower Manhattan had none. We know about the problems of asthma among our homeless children because many of their parents cannot afford the inhalers and the things that middle-class parents can, and they live in housing that just breeds these kinds of problems.

We know that public policy is crucial. The children's vaccines program, which was enacted in 1992, has made an enormous difference. But you have to go out in these communities and knock on doors and help people enroll to make the system respond. We learned a lot in New York City where we mounted a campaign with the New York City Health Department, Chase Manhattan Bank, the Robin Hood Foundation, and NYNEX and put in an 800-number with every possible language that the family could call and with the providers also in place. We learned from focus groups that we needed to call it vaccinations because too many citizens associate immunization with immigration. Over three years we were able to move from 52 percent preschool vaccination rates to more than 80 percent. We want to similarly bring up the rate of CHIP enrollment. To do so, we have got to put all the pieces of the puzzle together. Public media campaigns without community networks and infrastructures, without the capacity to get people services, will not work.

What can we learn from some of the success of these efforts? We need now to do a number of things because, after two years, the CHIP program is one of the best kept secrets in America. I go to a lot of audiences, whether it is women business owners or faith-based organizations, and I say, "How many of you know about the new \$48 billion State Children's Health Insurance Program?" And almost nobody does. So our outreach has not yet scratched the surface, and we are going to have to figure out how we get out to hairdressers, barber shops, laundromats, congregations, disc jockeys, undertakers, malls, and wherever people are. We must make people understand that this program is there for working parents.

We must convince women business owners and other employers who do not often cover their own children that they need to do so. They have a self-interest in coverage. So we have got a long way to go in mounting effective outreach strategies. You need to help figure that out with us and others. We have got to get the word out and make it easier, rather than harder.

Secondly, we need to focus on the whole system and how we can make that change. In New York, we have a model called SHOUT which has worked very well. In New York City, CDF staff went through eligibility training. We convinced the city and state to let us become outreach workers and eligibility workers, and we learned how hard it is for parents to get through the system. We engaged high school, college, and medical students to knock on doors and help people fill out applications and navigate them through the bureaucratic hurdles. The American Medical Student Association has agreed to take on CHIP and Medicaid enrollment as its project with us for the next couple of years.

We had a 100-percent no-error rate working with a local provider helping people fill out these forms. In many states, we have been able to get the forms shorter but in some states you still have to be a lawyer and a certified public accountant to get through these forms. One of the kinds of projects that I would like to see everywhere is Child Watch projects where we take the media, local officials, and others and have them be a

poor mother trying to get assistance through the system. This is a real opportunity to help people understand the inefficiency and the barriers that poor working families face.

We have been doing a lot of outreach, knocking on doors, helping people fill out the forms. But that is not enough if we don't work them through the system. We've got to change the way the system works. Changes we are working for in Congress for the CHIP program are presumptive eligibility, continuous enrollment and mail-in applications. New York State has now issued \$10 million in grants for more community-based outreach and enrollment so that people do not have to go to a welfare office and bring all of their papers or lose days of work.

So here is a great opportunity if we can put together the capacity using students, senior citizens, and faith communities. We are working with AARP now to see how we can do some senior volunteer projects to help people get through the system and to fill out these forms, and to attain and keep their health care. We would like to now extend the SHOUT model to medical and nursing students, social work students, college students, and high school students.

What an opportunity to train young people in how the health and welfare systems do or do not work. What an opportunity to get children health care. I love the health enrollment issue because the only thing that matters is how many children are actually getting health care. We can measure it, and then if they are not getting it, figure out why they are not getting it, and then systematically change those barriers.

We would love to have more local capacity. The W.K. Kellogg Foundation has given us pass-through grants in some places. We need to do them in many places so that we can train folk on how to get through the system and learn about the system. We would love to have more stipends for young people who are eager to serve. We are begging. In a meeting with Davidson College in North Carolina, the president has agreed to call together other colleges and use their service learning and Bonner Scholars to become outreach and enrollment workers.

Why could we not recruit tens of thousands of students to get children enrolled, and to learn about the health system? They are turned off politics. But here is a chance to help them learn how to serve and how to advocate and how to become engaged in serving children. So you can play an enormous role in increasing that capacity and training, and getting outside our usual networks of child advocacy.

We are trying to think about other nontraditional partnerships to ensure children health care. Stand for Children Day every June will encourage health fairs everywhere under the theme, "Building Healthier and Safer Communities for Children," in all 50 states. Kmart has become a wonderful partner with *Martha Stewart Living*. We have had 150 health fairs in Kmart stores in New Jersey, Connecticut, and New York, and thousands of children have been enrolled. The pharmacists, the loudspeakers, make a difference.

We've been doing health fairs with medical students, college students, and in children's museums. So we need to look at all the community resources and say, how do we attach students or seniors to child care centers so when parents come to drop off or pick up children they can get help enrolling their children? In fact, many child care workers are eligible for these benefits but do not know about them. Everywhere in the child welfare system, how do we see that people get enrolled?

Let's do as massive a campaign as we did to eradicate polio to give every child a healthy start, to overcome and change many of the bureaucratic hurdles, and to insist that local governments be more responsive. Let's have big back-to-school pushes with enrollment on site.

Why can we not, on Children's Sabbaths every third weekend in October where tens of thousands of congregations conduct worship services, have health enrollment in every congregation? Have health enrollment forms in every bulletin insert?

We have to figure out how we get out of our comfort zones and push our country forward to catch up with other industrialized countries, and use our enormous resources to make sure our children get what they need, and to make this country commit to seeing that every child is healthy, ready for school, and safe after school. We can do that, working together.

A Prayer: I Care and I Am Willing to Serve

I always end everything with a prayer, so let me end this one with a prayer. I think if we can all get out of our narrow roles as philanthropists, professionals, and researchers, and just say, how can I -- as a parent, or as a member of a congregation, or as a member of civic association, or as a member of an organization -- be a part of building a movement and mounting a crusade to see that all of our children get a healthy start? How can I look at all of my grantees and figure out whether they have a role to play in reaching every child who is currently eligible for health care and in building a base for broader health security for our children?

So I hope that we will not wait around for Dr. King to come back. We are it, and we have these problems. Our children are suffering and we can figure out how to make a difference. We must all make a new commitment to serve, and to seize this enormous opportunity on the cusp of a new century to make a difference, and to overcome our own sense of inadequacy.

So this is a prayer for each of us to serve in whatever way we can. I certainly tell this to myself every morning when I get up and say:

Lord, I cannot preach like Martin Luther King, or turn a poetic phrase like Maya Angelou, but I care and I am willing to serve. I do not have Fred Shuttlesworth's and Harriet Tubman's courage, or Andy Young's political skills, but I care and I am willing to serve. I cannot sing like Fannie Lou Hamer, organize like Ella Baker or Bayard Rustin, but I care and I'm willing to serve. I am not holy like Archbishop Tutu, forgiving like Mandela, or disciplined like Gandhi, but I care and I am willing to serve. I am not brilliant like Dr. DuBois or Elizabeth Cady Stanton, or as eloquent as Sojourner Truth and Booker T. Washington, but I care and I am willing to serve. I have not Mother Teresa's saintliness, Dorothy Day's love, or Cesar Chavez' gentle, tough spirit, but I care and I am willing to serve.

God, it is not as easy as it was in the 1960s to frame an issue and forge a solution, but I care and I am willing to serve. My mind and body are not so swift as in youth and my energy comes in spurts, but I care and I am willing to serve. I am so young nobody will listen. I am not sure what to do, but I care and I am willing to serve. I can't see or hear so well, can't speak good English, stutter sometimes and get scared when I have to stand up before people or risk criticism, but I care and I am willing to serve. Use me as Thy will to save our children today and tomorrow, and to build a nation and a world where no child is hungry, or sick, or is left behind, and where each is made welcome.

From the bottom of my heart, I know we can do this, but each of us has to make a personal and professional commitment to say, I care and I am willing to serve, and I am willing to use every ounce of my resources to do what is necessary to give all our children hope and health.

ENHANCING HEALTH IN LATER LIFE

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As you are all aware, previously unimagined numbers of individuals are living to be very, very old in America. But we are also well aware that demography is not destiny. The numbers by themselves do not tell the story. The health and the functional status of the elderly, and the availability and the affordability of their health care, will be influenced by a number of factors:

- c the strength of the economy (often overlooked by those of us in health care);
- c advances in medical science and technology;
- c hoped-for increases in health promotion and disease prevention in later life; and
- c the pace of change in the elderly population, such as decreasing disability rates and growth of the oldest old.

We have been told it is a risky and faulty strategy to assume that a child's eligibility for a health program assures health security. The fact that we have a children's vaccinations program and a WIC program and a Medicaid program and now a \$48 billion State Children's Health Insurance Program (CHIP) does not assure that children eligible for those programs benefit from them. It is equally faulty to assume that an elderly person eligible for Medicare has health security.

Most discussions about health care assume that people have access to appropriate health care late in life, and focus on the eligibility and costs of benefits, copayments, deductibles, coinsurance, and so forth. When I joined the Medicare Payment Advisory Commission (MedPAC) and began to listen to the debates about how to reform the Medicare program, it became strikingly clear to me that the Medicare program is a health insurance program, not a health program. The time has come for us to shift the focus of discussion and debate from Medicare finances to health care for the elderly.

Three Targets for Enhancement

Now as we approach health care and enhancement of function for tomorrow's elderly, I consider it important to focus on three separate targets: the diseases of old age, usual aging, and senescence.

The first target is age-related diseases. Past decades have seen great advances in the management of acute and chronic diseases in frail older persons. Scores of new, more effective treatments have been developed for heart disease, cancer, and other disorders. For instance, a peptic ulcer, a common disorder previously requiring major surgery, is now effectively treated with outpatient oral antibiotic therapy. Diseased gallbladders and cancers of the colon are now removed through a tube in laparoscopic surgery without opening the abdomen. Individuals with fractured hips are up and about the day after surgery. And in many cases, severe coronary artery disease can be effectively treated without surgery at all or with surgery that results in a band-aid on the chest. And one has the sense that many additional dramatic treatments are just over the horizon. It's an exciting time.

But while treatment advances, prevention is neglected, despite the fact that the most common causes of death in old age -- heart disease, cancer, stroke, chronic lung disease, pneumonia, and influenza -- are all potentially preventable.

Our unforgivable neglect of health promotion and disease prevention in late life seems based on two myths. The first myth is that age-related changes reflect an inevitable, intrinsic process that is largely genetically determined. In other words, the secret to successful aging is to choose your parents wisely. This is wrong, but it is the way people feel. Approach someone in the street and ask, "How are you going to age?" You'll be told, "Well, my mother lived to be 96," or "No male in my family has lived past 52." Whatever their predecessors' story is, they assume that also is their destiny.

While heredity is important, studies indicate that it only accounts for about one-third of the physical changes of aging, and about half of the mental changes in aging. Other factors, including lifestyle, are dominant.

The second myth is that the aged body has little plasticity, that it cannot respond to lifestyle changes. I have told older men to quit smoking. They say, "Doc, I've had a million of these cigarettes. Talk to my grandson." But the fact is if an older man quits smoking, there will be a prompt and sustained reduction in his risk of heart disease and stroke and cancer, and an improvement in his pulmonary and cardiac function. The science indicates a remarkable and perhaps surprising capacity for the aged body to respond positively to exercise, to smoking cessation, and the like.

A growing body of knowledge about disease prevention in later life indicates that the time has now come for this issue to be placed firmly on our national health agenda. While some effective primary prevention strategies are currently available, they are underutilized in the elderly. Vaccination against hepatitis B, pneumococcal infection, and screening for breast, colorectal, and cervical cancer are all covered by Medicare.

Perhaps the most obvious example of our failure in this regard is the deplorably low utilization of influenza vaccinations. Currently, only half of elderly individuals on Medicare receive influenza vaccinations. Now if you had come to a hospital in Manhattan in January of this year, you would have seen an emergency room clogged with acutely, desperately ill elderly individuals with high fever, shaking chills, shortness of breath, clinging to life, infected with influenza A. If you came down from Mars and you looked at that scene you would have said, "This must be a terrible disease. It certainly cannot be prevented. Or if it can be prevented, the prevention must have serious side effects. Or maybe it is expensive. Or maybe it is rare and it is not available."

How would you explain to that person that, in fact, the cabinets in the emergency room are lined with vials filled with the vaccine that is inexpensive, safe, and effective in preventing that disease? I am tired of playing this scene year after year after year. Do not tell me that those people do not get the influenza vaccination because they are on Medicare. They are not getting immunized. It is available. It doesn't cost them anything. Why do we not give it to them?

This is not the only example. Sixty percent of elderly individuals who should have mammograms get them, even though it is covered for Medicare. Ten percent of elderly women who should have a Pap smear have it, even though it is covered by Medicare. And, less than 1 percent of Medicare beneficiaries in 1999 had screening for colorectal cancer, although it is covered by Medicare.

Recently, the Health Care Financing Administration (HCFA) has begun to turn more attention to prevention in old age. The current Healthy Aging Project has recommended interventions to increase utilization of Medicare-funded preventive services. But much more work needs to be done, and a much more intensive effort and a deep commitment needs to be made to assure that these available, effective preventive measures, already in place, are used more effectively.

There's more to successful aging than the avoidance of age-related disease. Successful aging also requires the maintenance of physical and cognitive function. This leads me to the next two targets. The second target is usual aging, a term that describes characteristics of the elderly who are functioning well, yet are at substantial

risk for disease or disability. These characteristics are modest increases in blood sugar, insulin, body fat, and increases in systolic blood pressure. These usual aging characteristics increase the risk of diseases in late life and are often considered normal by many health care providers.

The risk here is that labeling these things as “normal” suggests to everyone, including the patient, that they are harmless, they cannot or should not be modified, it is the way God meant it to be. I have caught myself and my students saying to elderly women, "Your blood pressure is a little high, but it's okay for your age, my dear. Your blood sugar is a little high, but it's okay for your age, my dear. Your weight is a little high, but it's okay for your age, my dear."

This statement, while meant to encourage rather than alarm, implies that the increases in blood sugar and body weight and blood pressure carry no risk. Nothing could be farther from the truth. These abnormalities carry substantial risk of heart disease and stroke. These and other usual aging factors can be modified with positive shifts in lifestyle including exercise and diet. A healthy lifestyle adopted late in life can increase active life expectancy, decrease disability, even reduce health care costs, but HCFA doesn't care.

Do not think that lifestyle changes are just about reducing physiological risk factors. We have long underestimated the importance of social and behavioral factors to health and survival among the elderly, and we know more now than ever before about their value. Several studies have shown that isolation from active, effective social connectedness is a significant risk factor for mortality, an even more important factor than smoking.

This is dramatically underlined by the recent findings by Tom Glass and his colleagues, Lisa Burkman and others, at the Harvard School of Public Health. They followed a group of elderly individuals for 13 years and showed that engagement in social activity -- such as church attendance, visits to the movies, restaurants, sporting events, day and overnight trips -- or productive activities -- such as gardening, preparing meals, shopping, and paid or unpaid community work -- were as beneficial in reducing the risk of mortality as swimming, walking, or physical exercise that increased physical fitness. Here again I think is another tremendous opportunity for the private sector, and particularly for community-based foundations.

Now the importance of social and behavioral factors is not limited to survival effects. It can also be seen in health status and the maintenance of mental and physical function. The MacArthur Foundation studied the predictors of successful aging by following for eight years more than 1,300 initially high-functioning individuals who were between the ages of 70 and 79 years at the study's outset. One of the strongest predictors of the maintenance of cognitive function was a sense of self-efficacy or mastery, the feeling that one can influence what happens in one's life.

Furthermore, in studying predictors of the maintenance of physical function, emotional support was found to be important, especially in men. And finally, also from the MacArthur studies, self-efficacy again emerged as a very important factor in the study of the predictors of productive activities. Self-efficacy and mastery can be enhanced in individuals, but we have not been able to get the interventions to influence these kinds of factors onto the national research agenda.

To extract the true power of prevention, we must overcome the common bias that preventive measures are only marginally effective and represent, at best, a temporizing measure of some use until the magic anti-aging, antidisease bullet arrives on the scene. People waiting for this simple fix will die waiting. There will be no magic bullet but preventive measures are remarkably effective.

Armed with this new knowledge regarding prevention, we must act to broaden our preventive efforts through the Medicare program and the efforts of private foundations. We must work to develop a

comprehensive behavioral management program to fully engage older individuals in the lifestyle changes that will advance our major national goal of increasing not only their life span but also their health-span.

In addition to diseases and usual aging, the third target of our efforts to increase successful aging is senescence. By senescence, I refer to the age-related reductions in functional capacity that we characterize as the core of aging.

The senescence syndrome includes stiffening in our vessels and reductions in our muscle mass and muscle strength, in memory, in vision, in hearing; impairments in our kidney function, in our lung and our heart and in our immune function. We see these as the core aging effects that occur in the absence of disease. Core changes represent why it is that, as we are older, we function less well. I see the senescence syndrome as the brave new world of aging research. For after we reduce the burden of disease and reduce or eliminate the prevalence of risk-laden usual aging, we may begin to be able to push back on senescence.

Several exciting recent findings lead me to this optimism. These include a recent study in the *Proceedings of the National Academy of Sciences* by Smith and his colleagues in San Diego. They documented that gene therapy with human nerve growth factor in the brains of monkeys nearly completely reversed the age-related reductions in the number and in the size of brain cells felt to be responsible for age-related losses in cognitive function.

Many of you have heard of the studies of neurogenesis. When I went to medical school, the dogma was that there were not many things we knew for sure, but one of them was that there were no new brain cells created after birth. That is wrong. Everybody who reads the newspaper knows that is wrong . . . that we are creating new brain cells every day.

This occurs throughout adulthood and it has also recently been documented to occur in late life, and it has been documented to be modulated by a number of factors including hormonal manipulation. We can now enhance the daily production of new brain cells late in life. This is an extraordinary finding that has the promise of offering a significant pathway to the prevention or treatment of neurodegenerative disease in late life. And if not that, perhaps at least combat senescence in the brain in late life.

Now some approaches are already available to modify brain senescence. Administration of estrogen to elderly women, while maybe not effective in preventing or changing the course of Alzheimer's disease, has been shown to significantly mitigate senescence-related impairments in verbal learning and in memory.

And exciting studies also suggest that senescent changes in muscle can be reversed. Now as we grow older, our muscles change. They get smaller and less strong and also, if you look at them under the microscope, they have fewer of the so-called fast fibers and more of the so-called slow fibers.

Investigators at the University of Pennsylvania have now shown in animals, using gene therapy, that they can prevent these well-defined, age-related changes in muscle. These are extraordinary findings which could not have been imagined just a few years ago.

If we are able to reduce the incidence and the severity of age-related diseases and be effective in prevention. . . if we can modify usual aging and begin to push back on senescence, it begins to feel like the eighth day of creation.

Beyond Health: Successful Aging

So where does that leave us? Well, I would ask one final question: New brains for what? New muscles for what? New years of healthy life for what? True attainment of successful aging requires more than the

avoidance of disease, and the maintenance of cognitive and physical functioning. The final component of successful aging is engagement with life.

Our society has a structural lag. We have not kept up with the science. Longevity has not been accompanied by social adaptation. We have not developed approaches to incorporate older individuals effectively in our society and to give them meaningful roles.

We need to begin right now integrating the social and the behavioral sciences with our medical and our biological advances to develop those roles. We must take advantage of the wisdom and the potential productivity and the contributions of older individuals by engaging them more effectively. There are exciting opportunities before us in health care, in the treatment and the prevention of disease. But none can be more exciting, more full of promise, more likely to have a greater impact on our society than the prospect, much of it within our grasp, of enhancing the health and the function and the productivity of previously unimagined numbers of older Americans.

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THE ART OF AGING

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We are at a new turning point in the field of aging. The past 25 years have witnessed two major conceptual turning points that have fundamentally influenced the course of research, practice, and policy deliberations. The first one occurred in the mid-1970s when the major federal research programs on aging were launched. This is interesting as, in many ways, research into aging became a phenomenon only in the last quarter of the century.

A conceptual turning point occurred at that time. Many of the negative changes that people had attributed to aging instead came to be seen as problems with aging.

The second major turning point, which we are just entering now, is the idea of potential in later life. This is an idea where individuals, communities, and policymakers are far from up-to-speed. And until one fully understands potential in later life, individual motivation is stifled in terms of planning for one's future. Creative community program planning is inhibited. Enlightened social policies are stymied unless one sees what is truly possible in aging.

So the challenge now, in addition to dealing with the problems, is to look at potential. When I headed the National Institute on Aging, I had the wonderful opportunity to interview the comedian George Burns, who was 97 years old at the time. I was there as a public health official representing the federal government, presenting him a certificate acknowledging his positive contributions to images of aging when he staged a joke on me. To fully appreciate the context of the joke, you have to understand the timing of the meeting. It was during the height of the Surgeon General's campaign against smoking, and I was there as a public health official. So as I'm presenting him the certificate, he hands me this illegal Cuban cigar. At which point I said, "Not to worry, I don't inhale." And he said that he didn't either. And the more he thought about it, he was going to run for president.

Then he went on to explain how he was adapting to his own advanced age. He said he had begun to ask for his applause in advance, just in case. And that he no longer purchased green bananas. I asked him, "What does your doctor say about your smoking and your drinking?" He said, "My doctor is dead."

That meeting with him was one that best captured the changing face of aging in the late 20th century, and now the 21st century. His agent was, understandably, very protective of him. But what we did not realize until we got there was that his agent himself was 85 years old. And the joke writer was in his 70s. The only young person was the car driver. But it was a remarkable picture of the changing face of aging in contemporary society. We ended up doing a public service message that a number of you may have seen. The point of this message was to get people's attention to write into the National Institute on Aging for information.

Examining potential and looking at creativity in later life is critically important, not only from the quality-of-life standpoint but from a health perspective. Some of the latest findings, looking at productivity in terms of older people, are associated with an increase in health, a reduction of illness, and improvement in response to procedures like bypass surgery. So people who are socially connected and involved in some productive activity not only have important payback, in terms of how they feel in general from a life satisfaction

standpoint, but in terms of health. And of course, there is a broader opportunity here in terms of the potential contributions to family and society.

Franklin Delano Roosevelt pointed out that no society, however rich, can afford to waste its human resources. And he could have easily made that statement about our older human resources.

Defining Creativity in Aging

In understanding creativity in aging, the definition that I use is really deceptively simple. It is bringing something new into existence that is valued.

Two other aspects are important to appreciate creativity, because I see this as a universal phenomenon. One, building upon Howard Gardener's concepts, is it is important to look at creativity with a capital "C," which is the typical type of creativity that we look at, the type of creativity that can influence the course for a community or culture.

But equally important is creativity with a little "c," the type of creative acts that can change the course for an individual or their family, and bring something new into existence in terms of how they deal with their job, a hobby, a new career, interpersonal relationships, family life, community, and volunteer work. These are areas ripe for opportunities for creativity with a little "c."

Related to that, also building upon Howard Gardener's concepts of multiple intelligences, is the importance of looking at diverse forms of creativity, not just in terms of the artistic realms, but also in the social realm. Across the history of civilization, older people have, in many ways, been keepers of the culture, and have shown remarkable social creativity. We see this in many roles today -- older university professors, judges, and diplomats -- and in areas where the opportunity for age and its relationship to accumulating wisdom and emotion and intelligence is important.

The Biological Basis of Creativity

The whole focus on creativity in later life is not just an anecdotal one. Indeed, there's a neurobiological foundation for understanding the capacity for ongoing learning and creative potential in later life.

Picture two neurons, nerve cells of higher intellectual functioning in the brain. Humans have more than 15 billion neurons that are involved in memory and intellectual function. These cells communicate with one another in two fundamental ways: one, through their anatomy or their architecture, extensions known as dendrites (analogous to limbs on trees), and also through the release of neurotransmitters, or chemicals, from one nerve cell to the other.

A remarkable set of studies done initially by Marian Diamond and colleagues looked at the impact of an enriched and challenging environment on the anatomy and physiology of the brain. And what the researchers found startled the scientific community and, in many ways, turned upside down the way that people looked at the brain. They found that animals that were exposed to a more challenging environment, compared to a control group of animals, sprouted considerably more dendrites than those that were not exposed to this challenging environment. It was like a tree sprouting new branches. A given nerve cell can sprout hundreds or even thousands of these dendrites.

So if you picture these cells and their extensions analogous to a tree with limbs, and you picture the neurotransmitters like squirrels, a tree that has more branches makes it easier for a squirrel to jump from one tree to another. In effect, these cells that sprouted more branches or dendrites made it easier for neurotransmitters to move from one cell to another. What was also discovered in these experiments of the

animals that were exposed to a more challenging environment is that they produced more of the transmitter acetylcholine, which is the neurotransmitter involved with memory and intellectual functioning. This is the neurotransmitter that is found to be at deficit levels in Alzheimer's disease.

So here -- in response to only environmental challenge, nothing physical, nothing pharmacologic -- these animals responded dramatically with a change in their anatomy. They actually had an increase in their brain-cell bodies. Brain weight itself increased with these animals, and they increased production of this neurotransmitter. But even more exciting and relevant to this discussion is all of these changes, all of them, continued independent of age. The older animals showed the same responses.

Subsequent research found that the length of these dendrites grew to their greatest length in humans from their early 50s to their late 70s. These changes turned upside-down our understanding about the capacity of the brain to respond to challenge and its modifiability. They set the stage for the beginning of our biological understanding of the capacity for ongoing learning and, indeed, the capacity for creativity independent of age.

Another major confounder came into play, and we perhaps saw this at its greatest height in the late 1960s and the early 1970s where, in our culture, images of aging were probably at their lowest. This was the time when you often heard the phrase, "You can't trust anybody over 30." Today you are more likely to hear the phrase in reverse. But at that time, it was quite powerful and people talked about the generation gap and the age gap. But what was missed, the more fundamental explanation of what was going on, was not an age gap but an education gap. The late 1960s was the beginning of the space age. Sputnik had been launched, and a revolution in education was going on. And this affected the young first.

It is important to realize that, in 1970, the median years of education for persons beyond the age of 65 was only 8.7 years. That is less than a high school education. Twenty years later, in 1989, that same middle group of those over 65 had gone from under a high school education to over a high school education. And one of the most rapidly growing groups of college graduates and graduate students became the 50 and older age group. In that 20-year period, the sociologic literature shows an unparalleled increase in positive, constructive intergenerational relationships.

Stages in Later Life

In terms of changes that are going on biologically and educationally, we are witnessing some profound changes. But we also have not fully understood basic psychological developmental capacity in later life. And here theory has been thin. In Eric Ericson's stage theory of the life cycle, he only had one stage in later life.

In my book, I introduced another stage theory based on 30 years of research. I describe four stages. The separation line between all of these is not absolutely rigid -- there is some overlap -- but they generally follow chronologically. One is the mid-life reevaluation phase that goes on throughout the 40s and the 50s. What happens in both genders, once one enters his or her 40s, is people begin to think about how much time is left, as opposed to how much time has gone by. Children are always measuring their situation from birth. But then all of a sudden that changes. And when that occurs, a profound psychological change occurs where one begins to think, where have I been? Where am I? Where am I going?

In some, that triggers a mid-life crisis. But in a much larger group, it triggers constructive mid-life reevaluation, sort of the situation with Odysseus or Ulysses or with Alex Haley, who began in his mid-40s with a 12-year quest through Africa and ended up with the writing of *Roots*.

This is followed by what I describe as the liberation phase. Contrary to stereotypes about aging, many people, when they reach their 60s, know who they are. They know that, if they make a mistake, it is not

going to undo the view others have of them. And more importantly, they know it is not going to undo the view they have of themselves. So they often feel free to do something that they have never done before. It is sort of an "If not now, when?" phenomenon.

Now let me illustrate this, building upon some of the earlier points that I mentioned about looking at creativity from a social standpoint, and give you a contemporary example. Think of the Mideast Peace Agreement. This astounded everyone, that these lifelong archenemies from Israel and Palestine could get together. Not just the countries, but the players. How could this happen?

Well, I feel that one of the key dynamics was a social creativity phenomenon in the liberation phase, because all of the major players were in their mid-60s and early 70s. For the Israelis, Itzhak Rabin and Shimon Peres were in their early 70s. Arafat was approaching 65. I feel, in the liberation phase, their age gave them the courage to finally do the right thing: If not now, when? And following the whole history of social creativity -- of older people as keepers of a culture -- if they did not do that, they could lose their cultures. They were in jeopardy. It is a powerful dynamic.

This is followed, as one gets into the 70s and early 80s or beyond, by a summing-up phase. We see a tremendous increase in storytelling and autobiography across all fields. And in the process of looking back and summing up, many people think about what they have gained in life, and they give it back not only in storytelling but through volunteerism and philanthropy. They deal with unfinished business.

I always try to test these theories. I was once attending a talk on opera and the speaker was noting the fact that Verdi had composed *Falstaff* at 80. I rose from the audience and said "That, in itself, is remarkable. Why do you think Verdi wrote *Falstaff* when he was 80 years old, as opposed to anything else?" And so the lecturer, like a psychiatrist, turned it back on me and asked me why I thought Verdi had done this.

I had just finished developing this theory about the summing-up phase and what's left undone. Here Verdi is in his 80s. He is in the top of his field. He is looking back and thinking, what is unfinished? And he realizes there is one area that he has never really done right, and that is comic opera. When he was in his 20s, he composed his only comic opera and it was a terrible flop. If I were Verdi and at the age of 80, I would want to set that picture straight. And sure enough, he composed *Falstaff*, a comic opera.

Then I said that if I were Verdi, I would want to stage the opera in the same theater where the original opera flopped, if it still existed. The lecturer did not know the answer, but she had these reference books with her. So she looked it up, and it was the same theater, La Scala. And so the theory holds up.

And then you go to the encore phase. People used to describe this phenomenon as swan song. That always bothered me in two ways. There is a certain sadness about the swan song, and it implies a single event. Rather, I describe this as encore, a more uplifting quality, and often you see more than one encore. An illustration of the encore stage is George Abbott, the playwright. It was remarkable that he wrote *Damn Yankees* when he was 68. But as an encore, he revised it when he was 107. So it gives you a sense of these different stages that are operating.

The Dynamics of Aging

Despite this new knowledge in aging and these findings, we still have just this proliferation or this legacy of negative stereotypes and negative images. And they are often combined together. Three that you often hear together is, with aging, there is an inevitable decline in creative vision. There is a disappearance of risk-taking where people are becoming conservative, restrictive, and cautious. And motor skills are going fast.

Let us look at these three dynamics -- creative vision, risk-taking, motor skills -- in the great Renaissance portrait painter, Titian, particularly his remarkable painting of *Man With A Glove*, painted when he was 39 years old. It is a great portrait in the history of art. There are many things that one can say about this work but, for purposes of our discussion what I'd like you to focus on -- in addition to the beauty, the power, the poignancy of the painting -- is how well-defined it is along the edges.

Now let us double Titian's age and consider what he was doing at 78 years old. A self-portrait that he did then was considered by art historians to be an equally great work of art, but a little controversial in the eyes of some who said that the portrait is not quite as well-defined as *Man With A Glove*. A little less defined, a little more amorphous along the edges, but he was 78 years old, people said, and you have to factor that in.

Let us push this point a little further and consider what Titian was doing when he was 83 years old in his famous painting of *The Rape of Lucretia*, the event that brought down the Roman Empire. This is a great painting, but quite controversial in the eyes of the critics of the 16th century. People were saying this is just not a typical Titian portrait. It is very amorphous, but he is 83 years old.

Now in any area, before one reaches a conclusion, you need a control group, as in the earlier example that I gave with dendrite sprouting and the control group of laboratory animals. And Titian here remarkably provides his own control. He does a second painting of Tarkin and Lucretia at the same age of 83. Now I researched this very carefully. Titian did both of these paintings. This was not a matter of the master doing a sketch and having his students complete the work, to explain the difference in the form of the painting. He did both of them.

One is indistinguishable from the qualities of *Man With A Glove*, in terms of how well-defined it is. So he showed he could still do the same type of work, in terms of form. But what the other illustrates is -- very often with an older person, as opposed to a younger person -- if something is not understood, there is a rush to judgment. And they say "Well, he is getting older, he is kind of losing it, his marbles are rolling out." Whereas a younger person at least gets the benefit of a doubt -- they are either a genius or crazy -- to explain something that is not understood.

So then how do you explain the differences in the paintings? Put yourself in the shoes of the greatest portrait painter of the Renaissance. Anybody who could afford a painting by Titian at that time typically wanted the type of painting that made him famous. This is a problem that many artists have that locks them into a style.

But it was as if Titian, in his 80s, in his ninth decade, said, "I want to do something that I want to do. I want to explore new territory." I think you can then look at the painting and rather than call it amorphous, you can make a point that it shows great creative vision, great risk-taking, and boldly anticipating by three centuries impressionist art of the 19th century.

When you focus on Titian and Picasso, some may say, aren't these exceptions rather than the rule? Isn't this a bit of a *Ripley's Believe it or Not?* And those are fair questions. But my own views and research in this area were profoundly affected following a show that I saw in 1980 at the Corcoran Gallery of Art in Washington, DC. This show was a formal study of American folk art from 1930 to 1980. What the curator and art historian who put on the show were struck by was that almost half of the outstanding work during that time was by minorities, and particularly African Americans, many of them living along the Mississippi-Alabama corridor.

I went to the show not only with the eyes of somebody who appreciates art, but with those of a gerontologist, and I saw something they had not described. They put together a show of 20 of the outstanding black artists during that 50-year period, many of whom had died. But what they had not described of these 20 artists, and what struck me, was that 16 of them, or 80 percent, were over the age of

65 when they either first began their work or reached their mature phase. Thirty percent were older than the age of 80 when they either began their work or reached their mature phase.

Following the show, I did my own in-depth study of folk art and I found that this pattern continued independent of racial and ethnic diversity in this country. It is a field dominated by older persons.

When you have any field that is dominated by older persons, then you can no longer trivialize interesting examples as outliers or exceptions rather than the rule. It says something inherently profound about the basic underlying potential for creative production on the part of older persons. Folk artists are particularly interesting because they close the gap between the Picassos and everyday people, and they bring the point home even stronger.

Take, for example, work done by Bill Traylor, who did his first work when he was 85 years old. Traylor had been a slave and, following emancipation, continued to live on the plantation where he worked. He had a large family and wanted to stay there until all his children reached maturity and independence, which finally happened, and then his wife died and he was the only person in his family left there. He was 84 years old. And he felt he no longer had a reason to stay.

So he moved to Montgomery, Alabama, and got a job in a shoe factory where he worked for a year until they let him go because he had developed arthritis to the point that he could no longer do the quality of work demanded of him. And he basically became a street person and tried all kinds of things to survive. And one of them was drawings, which he began to hang on clotheslines, and almost overnight he was recognized as an extraordinary artistic talent. Within a year, his work was being shown regionally and then nationally.

The liberation phase often intersects with retirement, which I feel for many people acts like a patron. It gives people time to focus on activities other than having to meet ends. So you have this external freedom and this internal freedom, this liberation aspect, that creates a powerful partnership.

Somerset Maugham was not only a gifted writer but he was a medical school graduate. He made an interesting observation in his own late life work that he wrote in his 60s called *Summing Up*. And in looking at older persons, he brought to bear the intuitive insights of a gifted writer with the trained observations of a health professional. And in *Summing Up*, he wrote, "When I was young I was amused at Plutarch's statement that the elder Cato, who was a Roman statesman, began at the age of 80 to learn Greek. I am amazed no longer. Old age is ready to undertake tasks that youth shirked because they would take too long."

And in this, Maugham captures the wonderful twin paradox about the capacity to change and the significance of time in health. Life expectancy at birth in Rome during the great Roman Empire was only 22 years. That did not mean that people did not reach old age, but there was a tremendous falloff from death due to disease, famine, war, complications of childbirth, and poor public health. Today, in contemporary America, life expectancy is approaching 65 years, with the fastest growing group being centenarians.

Shortly after I read *Summing Up*, I interviewed a woman who was 81 years old who had just graduated from high school. And she said she finally had the time and the opportunity to get involved with her lifelong passion. She had a large family and spent her earlier adulthood raising them. And three of her children had problems, two severe health problems and one marital problems. And finally she turns 80, things are settled down, and she was able to turn to her passion of reading historical and biographical novels, these huge 1,000-page books. And she had read 18 of them over the previous seven months. Again, it was this idea of finally having enough time.

The psychoanalysts have weighed in on this as well. Basically, from psychoanalytic research, they find -- contrary to stereotypes -- that older persons are more in touch with their dynamic psychological inner life. That is a tremendous asset for anybody who is an artist or going to be creative in any area to draw upon one's inner life.

Going back to the Corcoran show, there was another artist, William Edmundson, who was a janitor in the 1930s, working in a women's hospital at that time in Nashville, Tennessee. The 1930s was the period of the Great Depression, and hospitals were under great trouble then, as many are today. That hospital folded, and Edmundson was out of work.

As he later described to a reporter, he had the inspiration to carve. A photographer saw these new carvings and was totally captivated by them and sent a portfolio of Edmundson's work to the Museum of Modern Art (MOMA) in New York. And in 1937, at the age of 67, Edmundson's work became the basis of the first solo exhibit by a black artist in the history of the MOMA, in effect opening the doors up to a generation that followed.

Another artist in the Corcoran show, Sister Gertrude Morgan, was a nun who established in the mid-1940s a highly regarded and well-known orphanage called Gentilly, in New Orleans. Over 20 years, the orphanage grew and thrived and made tremendous contributions to the community. But in 1965 tragedy struck. Hurricane Betsy swept through New Orleans and leveled the orphanage. Sister Gertrude Morgan was devastated. She felt her life's work was destroyed. And in trying to cope with that depression, she turned to an earlier talent that she never really had time to pursue: painting. Ten years later, in her mid-70s, she reached her mature phase, and any national show that you see of Southern art will have her work in it.

At a different folk artist exhibit, the Hemphill Folk Art Collection at the National Museum of American Art, I found the best work in the show by Irving Dominick, which he did in his late 60s. In this work, Dominick brought something new into existence. He drew upon his preretirement skills of making ductwork for a heating and air conditioning company, and began to create cylindrical sculptures. He did not totally reinvent himself; he took this skill and, going back to that definition of bringing something new into existence, he turned it in a slightly different direction, and it opened up a whole new world for him.

There is another dynamic going on with a number of these artists, and it has been captured in the late-life work and poetry of Carlos Williams. Most people know Carlos Williams as a poet, but he was also a physician. He was still practicing pediatrics in his 60s when he suffered a stroke. Those of us in the health field know that we examine patients who have suffered from a stroke along multiple domains: cognitive, physical and emotional functioning. Fortunately, Carlos Williams did not have significant cognitive changes. He did have major motor and muscle changes, to the point that he could no longer continue the practice of medicine. As for emotional changes, he developed severe depression, to the point that he was hospitalized for a year at the age of 69. He came out of that and began a new phase of his poetry that culminated 10 years later, at the age of 79, with the publication of *Pictures from Brueghel* which was awarded a Pulitzer Prize.

What is Added, What is Taken Away

The third dimension is the relationship between what is added in the later life and what is taken away. There is nothing romantic about loss. But when loss occurs and you can only go so far in dealing with it, it is part of the human condition to want to transcend it in a certain way. In his poetry in late life, Carlos Williams wrote about an old age that adds as it takes away.

But later life has much more loss, and so you see this much more commonly, and you see many more examples of people dealing with loss and trying to transcend it. . . Bill Traylor, whom I mentioned earlier with the arthritis, William Edmundson in losing his job, Carlos Williams with the stroke.

And it also points out that just because there is loss does not mean it is over. Instead, for many people, it just moves them in an entirely new direction. This concept about old age that adds as it takes away is not new to modern medicine or poetry, but it is actually captured in a major theme from Greek mythology over 25 centuries ago in the myth of Tyresius. Tyresius was walking through the woods one day thinking great thoughts, and had the misfortune of being in the wrong place at the wrong time. His eyes inadvertently moved in the direction of the goddess Athena and fell upon her as she was bathing in the nude. She caught the eyes of a mortal seeing her bathe in the nude. She went into a rage, and in her fury she blinded Tyresius. The other gods and goddesses said, "Why did you do that? Tyresius was a great man. He was just in the wrong place at the wrong time. He is certainly not a voyeur. Reconsider." Athena did reconsider but she did not restore Tyresius' outer eyesight, but instead gave him great inner vision. Tyresius later went on to predict the plight of Oedipus. And so it is again this idea about old age that adds as it takes away.

Henri Matisse, in his early 80s, suffered from multisystems disease -- cardiovascular disease, pulmonary disease, and gastrointestinal disease -- that sapped his energy so that he could no longer paint the way that he did before. It was not enough for him to paint less well than the way he had. And so as a result, he moved in a new direction and launched his work with cutouts, which art historians describe as closing the gap between color and form. What Matisse's shift in his art shows is that, in the midst of all of these limitations, there is the tremendous power, strength and reserve of the human condition, independent of age. And so Matisse, in the midst of all that restriction, turned a new page in the history of art.

Aging and Social Policy

I am going to wind up with a few more anecdotes to show how these negative images can, in fact, short-circuit social policy. The idea that you are over the hill, it is too late to change, tremendously interfered with Medicare coverage of mental health services. This culminated in 1987 with hearings on Medicare. Medicare had been operational at that time for more than 22 years. During that time, there had been few changes in coverage for mental health, which was virtually nonexistent.

And so Medicare continued to severely limit mental health coverage. This outcome was a cynical rationalization that all of the people who did not want mental services did not seek them because they could not afford them and they did not want to be humiliated. And people said, "Why offer them anyway? Can you really do anything about depression in later life? Doesn't it go with the territory of aging? And psychotherapy? Come on, does that really have a role in later life?"

I was the first witness. And I said I am astounded that the Congress in the late 20th century is asking if you can treat depression in later life, and whether psychotherapy works with older people. I am astounded because Western civilization has known the answer to both of these questions in the affirmative for almost 150 years: Every December, with the annual arrival of the winter holidays, celebrates the ability to treat depression in the elderly and the role of psychotherapy.

At which point they thought *I* needed psychotherapy. And I went on to present the famous case of 1843 of this well-known London figure described as mean-spirited, miserable, misanthropic, making the lives of all around him miserable. But basically, rather than reflecting the ravages of aging, he had an undiagnosed depression causing all these problems. But then he was the fortunate beneficiary in 1843 of a home visit by a multidisciplinary team. This was more than 100 years before the community health movement. And they employed psychodynamic dream work. This was more than 50 years before Freud's classic work on the interpretation of dreams. This, of course, was Charles Dickens famous case history of Ebenezer Scrooge, also known as *A Christmas Carol*.

I pointed out that the real reason that Dickens wrote this case history was several-fold. First, he wanted to show it was never too late to change in later life. Secondly, he wanted to show how often the diagnosis of

depression was missed. Thirdly, he wanted to show that chronic illness, regardless of age, often presents a window of opportunity to make an intervention, sometimes profound. Fourth, and most important, he wanted to show the efficacy of psychotherapy, including dream work, in dealing with depression of the elderly. And finally, he wanted to show that when you treat the problems of the elderly, it need not be at the expense of other age groups. Witness the impact on the community of London, Bob Cratchit, and Tiny Tim.

This was the real reason that Dickens wrote this case history. Western civilization has celebrated the ability to treat depression and the efficacy of psychotherapy every Christmas for 150 years; wasn't it time for Congress to do the same?

This, coupled with some Washington-style, behind-the-scenes lobbying, helped contribute to changes in mental health coverage in 1987. But it shows how these negative images can not only stifle individual motivation, community planning, but also social policy. This was the happy outcome.

Looking for New Metaphors

There is a need for new metaphors about aging. We often hear about the autumn of your life, the winter of your years, the trees becoming barren, the sky clouding up. Georgia O'Keeffe, in her mid-70s, had reached great fame as a painter. Over her life, she had a number of fears and one of them was a fear of flying. As her work came under greater demand, she was forced to fly more and more. One day, looking out the window of the airplane, she realized she no longer had a fear of flying. She felt this tremendous exhilaration, launched a whole new body of work -- which I will give her full credit that she understood the double meaning, the double entendre of the title -- *Sky Above Clouds*.

And she did this work and it was huge in number, almost 100 pieces. What she is pointing out, which I think captures the changing face of aging, is rather than looking just at the clouds that can occur, she saw blue sky above those clouds. And I feel that is a much more accurate picture of aging today in the 21st century.

Speaker Profiles

Marian Wright Edelman, J.D.

Marian Wright Edelman is founder and president of the Children's Defense Fund (CDF), overseeing its mission to educate the nation about the needs of children and encourage preventive investment in children before they get sick, drop out of school, experience a family breakdown, suffer the hardships of a teen pregnancy, or other problems. A graduate of Spelman College and Yale Law School, Mrs. Edelman began her career in the mid-1960s when, as the first black woman admitted to the Mississippi Bar, she directed the NAACP Legal Defense and Educational Fund office in Jackson, Mississippi. In 1968, she moved to Washington, DC, as counsel for the Poor People's March that Dr. Martin Luther King, Jr. began organizing before his death. She also founded the Washington Research Project, a public interest law firm and parent body of CDF. For two years, Mrs. Edelman served as director of the Center for Law and Education at Harvard University and in 1973 began CDF. She was a MacArthur Foundation Prize Fellow, and has received many honorary degrees and awards, including the Albert Schweitzer Humanitarian Prize and the Heinz Award. She was a trustee of Spelman College, serving as chair from 1976 to 1987, and is the author of five books.

John W. Rowe, M.D.

John Rowe is president and CEO of Mount Sinai NYU Health. Prior to the Mount Sinai-NYU Medical Center merger, Dr. Rowe was president of the Mount Sinai Hospital and the Mount Sinai School of Medicine in New York City, where he is a professor of medicine and geriatrics. Before joining Mount Sinai in 1988, Dr. Rowe was a professor of medicine and founding director of the Division on Aging at Harvard Medical School, and chief of gerontology at Boston's Beth Israel Hospital. He has authored more than 200 scientific publications, mostly in the physiology of the aging process, and a leading textbook of geriatric medicine. Dr. Rowe has received many honors and awards for his research and health policy efforts regarding care of the elderly. He was a director of the MacArthur Foundation Research Network on Successful Aging and is a coauthor of the book, *Successful Aging* (Pantheon, 1998). He served as president of the Gerontological Society of America, and is on the Board of Governors of the American Board of Internal Medicine. He also is a member of the Institute of Medicine of the National Academy of Sciences and the Medicare Payment Advisory Commission.

Gene Cohen, M.D., Ph.D.

Gene Cohen is the first director of the Center on Aging, Health & Humanities, established in 1994 at The George Washington University, where he also holds the positions of professor of health care sciences and professor of psychiatry. He also cofounded the Creativity Discovery Corps, whose mission is to identify and preserve the creative accomplishments and rich histories of under-recognized older adults, especially those who are isolated and homebound. In addition, he is founding director of the Washington, DC Center on Aging, also established in 1994. Dr. Cohen served as acting director of the National Institute on Aging and was chief of the Center on Aging of the National Institute of Mental Health. He also coordinated the U.S. Department of Health and Human Services' planning and programs through its Council and Panel on Alzheimer's Disease, and

was awarded the Public Health Service (PHS) Distinguished Service Medal, the highest honor of the PHS. He is the first editor-in-chief of *The American Journal of Geriatric Psychiatry*, has authored more than 100 publications, and is completing a new book on creativity and aging entitled *The Creative Age: Awakening Human Potential in the Second Half of Life*. He is also working on a PBS broadcast series on creativity and aging. Dr. Cohen is a graduate of Harvard and the Georgetown University School of Medicine, and holds a doctorate in gerontology from The Union Institute.

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