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PART 4

THE CONFERENCE

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* Select web casts were provided by Kaisernetwork.org, a free health policy news and web casting service of the Kaiser Family Foundation



**President's Letter
to the Delegates**



THE WHITE HOUSE
WASHINGTON

December 9, 2005

I send greetings to those gathered for the 2005 White House Conference on Aging.

Our seniors have earned our greatest respect. They have taught us how to persevere in the face of hardship, care for others in need, and take pride in our communities. Their patriotism, service, and leadership inspire Americans and shape the character and future of our country. This conference is an opportunity for participants to discuss initiatives for older Americans and share information on the trends and experience of aging.

My Administration is committed to improving the lives of America's seniors. We will continue to work to keep the promise of Social Security in the 21st century. This coming year, for the first time in Medicare's history, a prescription drug benefit will be available to more than 40 million seniors and disabled Americans, significantly reducing their yearly drug costs. In addition, more than a half-million seniors today are transforming their communities through the Senior Corps programs. Their dedication is changing the lives of countless Americans.

I appreciate delegates for your commitment and dedication to addressing issues that face our seniors. By treating older Americans with the dignity and respect they deserve, you honor their legacy and contributions to our Nation.

Laura and I send our best wishes for a productive conference.

A handwritten signature in black ink, appearing to read "George W. Bush".



**Letter to Delegates from
Chair of Policy Committee**

2005 WHITE HOUSE CONFERENCE ON AGING

FINAL REPORT APPENDIX



Dear Delegate:

Welcome to the 2005 White House Conference on Aging!

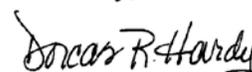
Over the next four days, you will have an opportunity to participate in one of the most historic national aging events in our nation's history. The 2005 White House Conference on Aging (WHCoA) has special significance because it is the first WHCoA of the 21st Century and the only WHCoA mandated by law to focus on the interests and issues of the aging of today and tomorrow, which includes the 78 million baby boomers born between 1946 and 1964. This emphasis on these future seniors comes at a time when many of these baby boomers are preparing to enter a new stage of life.

The 2005 WHCoA is a major milestone in a journey that has taken almost two years. Since last summer, when the first WHCoA listening session was held in Miami, Florida, I have had the opportunity to meet many delegates. I look forward to getting to know as many of you as possible in the next few days. I have been impressed with your level of commitment and passion. I know you will bring this same enthusiasm to the task we have before us, and I am very optimistic for our success.

Please know that your responsibility as a delegate will continue beyond the dates of the Conference. It is my hope that the resolutions we adopt and the implementation strategies we develop will result in meaningful recommendations for the nation which will mean a healthy, productive and better quality of life for current and future generations of older persons.

On behalf of the WHCoA Policy Committee, I look forward to working with you.

Sincerely,



Dorcas R. Hardy
Chairman, Policy Committee

4350 East-West Highway, 3rd Floor, Bethesda, MD 20814
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Annotated Agenda

2005 White House Conference on Aging Annotated Agenda** Final – November 3, 2005

I. PLANNING ALONG THE LIFESPAN

Social Security, pensions, savings, and wages each serve an important role in ensuring financial security in retirement. A cornerstone of achieving financial security in retirement is planning throughout a lifetime. Effective savings incentives and financial education are essential planning tools. Starting to save for retirement as early as possible ensures the miracle of compound interest, and provides optimum leverage. However, accumulating savings by itself does not guarantee a secure retirement. Managing those assets through longer and longer lifespans is also a key component. Americans must plan and prepare for the risk of having assets depleted because of a long term care episode or other financial crisis. Moreover, retirees must guard against becoming victims of financial fraud and exploitation. Enhanced financial literacy will help enable Americans to guard against risks and plan appropriately to achieve financial security in retirement.

A. Economic Incentives to Increase Retirement Savings

1. Individual savings; employer-based pension programs

B. Social Security Programs Now and for the Future

1. Principles to protect and strengthen Social Security

C. Protection from Catastrophic Loss

1. Long term care expenses, and ways to assist Baby Boomers and families in understanding the need to finance long-term care, through insurance and other options
2. Preventing financial fraud, abuse and exploitation: an integral part of elder and Boomer financial security

D. Financial Literacy throughout the Life Cycle

1. Financial literacy to assist Americans in learning to start saving early and to manage assets to last through longer and longer retirements

II. THE WORKPLACE OF THE FUTURE

For many decades, there has been a younger workforce on the heels of those planning to retire. With declining birthrates those demographics will change dramatically and will have a tremendous impact on the workplace of the future. In addition, Americans are living longer which means they will need more assets for longer retirements or will need to work longer so that retirement assets last a lifetime. These two factors mean the workforce of the future will have to be thought about differently. Because the workforce is shrinking, older workers will be valuable members of the job bank of the future and, older workers will need the income that working longer will provide in order to fund their retirements. To ensure that employers have the workforce they need and to provide workers with opportunities to stay in the workforce, incentives will be needed to encourage employers to retain older workers and to encourage workers to stay in the workforce. Phased retirement offered ad hoc to a few employees today must be encouraged for the benefit of the employer and employee. Strategies for overcoming current unintended barriers to reaching these goals will be an important aspect of this Agenda item. Assistive technologies are another important component of helping workers remain in the workforce.

A. Opportunities for Older Workers

1. Employer incentives for retaining older workers and current disincentives that prevent employers from retaining older workers
2. Worker incentives to remain in the workforce and current disincentives to working longer
3. Phased retirement as an opportunity for the employee who wants to retire gradually and for the employer who wants to retain older workers
4. Assistive technology to help workers remain in the workforce
5. Strategies to prevent ageism/age discrimination from affecting opportunities for older workers

III. OUR COMMUNITY

Safety, independence, access to a social network, and support by family and informal caregivers, as needed, are important components of a livable community and “aging in place” for older Americans. Aging in place means being able to grow older in the community of one’s choosing with continued access to needed social and health support services. Many Baby Boomer parents left urban residences after World War II for suburban homes and now face living in an area where services are less accessible, especially to those who no longer drive. Some possible solutions include better coordination between public health, transportation, and aging networks, better information management systems, and helping older Americans drive safely longer, and providing additional transportation options for those who no longer can or wish to drive. Longer term solutions include

building higher density neighborhoods which allow safe and convenient pedestrian access to services, better public transportation, and other transportation options. Additionally, resources and information must be readily obtainable especially during and after emergencies or disasters. Emergency preparedness and response must be given greater emphasis especially as it relates to those older individuals who face mobility challenges. Improved information management systems and coordination between health, social service, law enforcement, and other networks are especially critical in times of emergencies or disasters.

A. Coordinated social and health services that give the elderly the maximum opportunity to age in place

1. Availability of community referral resources
2. Configuration of Senior Centers to appeal to the next generation of senior citizens
3. Coordination between health and aging networks
4. Accommodation of the differences between the Baby Boomer aging population and previous generations of the elderly
5. Emergency/disaster preparedness and response as it relates to older persons

B. Promote support for both family and informal caregivers that enables adequate quality and supply of services

1. Caregiver support: training, respite, information, referral, and needs assessment for family caregivers. Training and financial support for paid caregivers

C. Livable communities that enable the elderly to age in place

1. Senior-friendly community and residential design
2. Protection from neglect and physical abuse
3. Senior-friendly roads designed to keep older drivers on the road, safely
4. Housing affordability and availability
5. Alternative modes of transportation
6. Expanded use of public transportation

IV. HEALTH AND LONG TERM LIVING

Americans are living longer. That ever increasing life span, combined with the significant increase in the population reaching age 65, as the baby boomers age, will be major factors in shaping health care policy for the next ten years and beyond. The entire spectrum of health care, physical and mental health, will be impacted by these two factors. Personal responsibility for life style choices and adherence to preventive care protocols are more important than ever in decreasing or eliminating the negative impact of preventable illnesses. When acute or chronic illnesses do occur, the issue of access to appropriate medical and mental health services will also need to address issues of coordination

of care across multiple settings and continuity of care over time. Living longer while afflicted with chronic illnesses will also require attention to choices that maximize function, quality of life, and independence in the living environment of choice for the individual.

Research, particularly more focused on issues associated with aging, and the widespread dissemination and adoption of the information that the research reveals, will be a major contributor to the quality of health care. Quality in health care includes addressing issues of health disparities, cultural competencies, language barriers, health literacy, and patient safety. The concept of health is not the sole responsibility of the individual and the formal health care system, but it also includes the support provided by the aging network, multiple community organizations, improved information management systems, and the opportunity for meaningful social engagement. Issues of health care education of the population, in order to be integrally involved in health care decisions and a health care workforce, sufficient in numbers and appropriately trained to address the special needs of the population are necessary ingredients for the success of any policy that is adopted.

A. Access to Affordable, High Quality Services

1. Development of a comprehensive, coordinated long term care strategy across the continuum of care, including benefits, living wills, end-of-life care, and health measures (in conjunction with Planning Along the Lifespan long term care issues)
2. Connecting evidence-based and comparative-based research with delivery of care
3. Aligning payment policies with the continuum of care

B. Healthy Lifestyles, Prevention, and Disease Management

1. Prevention: Education and lifestyle modifications
2. Disease management programs
3. Appropriate treatment for and education on alcohol and substance abuse and mental health
4. Provider and consumer education about disease prevention and mental health

C. Delivery of Quality Care and Promotion of Maximum Independence for Individuals with Chronic Conditions

1. Ensuring existence of a reliable, adequately trained, and culturally competent workforce
2. Providing maximum independence and non-institutional care
3. Ensuring appropriate care for seniors with disabilities
4. Addressing the shortage of paid workers for elder care and services

D. Use of Information to Improve All Health Care Services

1. Resources to make informed health care decisions
2. Medical research on aging issues
3. Appropriate use of health information technology

4. Sharing client information across multiple management systems

E. Affordable, defined health benefits, including mental health benefits, through Medicare, Medicaid, and other Federal and State health care programs

1. Ensuring adequate access to State and Federal health care programs

V. CIVIC ENGAGEMENT AND SOCIAL ENGAGEMENT

Social engagement is crucial to the physical and psychological well-being of elderly citizens. Being engaged in such activity is important for older persons in maintaining physical vigor and for getting the type of social interaction and mental stimulation necessary to continue living a full, robust life. It is an equally important way in which senior citizens can contribute to their communities. There are a wide range of available activities that may be helpful individually, to other citizens and more generally, to sustain the quality of civic life. There are opportunities for volunteers in hospitals, schools, and museums, and with religious and service organizations, as well as in many other non-institutional settings. Key questions to be addressed regarding Baby Boomers as they age are what will be their level of participation in volunteerism, what types of activities will attract them, and how to remove barriers that prevent older Americans from volunteering in their communities.

A. Integration of the elderly with the non-elderly community

1. Strategies for changing attitudes toward aging/intergenerational dynamics
2. Creation of Baby Boomer volunteer opportunities
3. Promoting expanded opportunities for companionship and leisure to reduce isolation and loneliness

B. Effective individual adaptation to the conditions of aging

1. Increasing physical activity among the elderly
2. Continuing higher education for the older learner, including computer literacy training

VI. TECHNOLOGY AND INNOVATION IN AN EMERGING SENIOR/BOOMER MARKETPLACE

There are an increasing number of new products and operational practices that intend to help the elderly cope with challenges that affect their mobility, independence, and quality of life. They include personal mobility and communication devices, housing and vehicle design, and pharmaceutical advances. Some of these are beginning to be marketed and others are in development. But some with potentially dramatic impacts on older persons, and the rest of the population, are completely unknown. For example, at the 1981 White House Conference, would it have been predicted that by 2005, cell phones, the internet, or CDs and DVDs would be in such common use? Over the next 20 years as Baby Boomers comprise the large majority of the elderly population, the marketplace affecting them will change in ways that will make their lives easier but may in other ways, make their lives more complicated.

A. Promoting new products, technology and new ways of marketing that will be helpful /useful to the older consumer

1. Developing creative products to support independence
2. Creating awareness of available technologies
3. Designing technology products that assist the broadest range of consumers
4. Assure the innovative and competitive leadership of American technology to meet rapidly-increasing global demand for aging-related products and services
5. Establishing a public, private and intergovernmental partnership to harmonize the patchwork of different Federal, State, and local policies, rules, regulations, standards, and codes that complicate and sometimes impede demand for and distribution of technology products and services
6. Assuring rational technology policies that stimulate innovation and investment

****Cross cutting issues:** Issue development should include consideration of differences among the following variables: socio-economic, disability/non-disability, rural/urban, minority, cultural, linguistic competencies/literacy, age cohort (e.g., 55-65, 65-75, 75-85, 85+), and global aging. It should also include consideration of strategies for changing attitudes toward aging. Research intending to increase the ability to cope with the conditions of aging and best practices should be identified.



Conference Program

2005
White House
Conference on Aging
CONFERENCE PROGRAM

DECEMBER 11-14, 2005

MARRIOTT WARDMAN PARK

WASHINGTON, DC



THE
BOOMING
DYNAMICS
OF AGING

From Awareness to Action

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2005 White House Conference on Aging

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Note: *The information provided in this program is current at the time of printing and subject to change.*

|| GENERAL INFORMATION

Registration and Information Desk Hours

The Registration Area is located just to the right of the hotel lobby on the way to the Grand Ballroom foyer area.

The Registration Area will be open the following hours:

- Saturday, December 10
6:00 pm – 9:00 pm
- Sunday, December 11
10:00 am – 10:00 pm
- Monday, December 12
7:00 am – 8:00 pm
- Tuesday, December 13
8:00 am – 8:00 pm
- Wednesday, December 14
8:00 am – 2:00 pm

Message Board

You may check for your messages or provide messages for other delegates at the message board located in the Registration Area of the lobby.

Resolution Voting Center Hours

The Resolution Voting Center is located in Maryland Rooms A and B down the hallway from the Grand Ballroom Foyer.

The Voting Center will be open the following hours:

- Sunday, December 11
4:00 pm – 6:00 pm
- Monday, December 12
11:00 am – 1:00 pm
5:00 pm – 6:30 pm

Badges

WHCoA Badges are required for admittance to all sessions and must be worn at all times.

Exhibit Hall

The 2005 White House Conference on Aging (WHCoA) and ZivaGuide, a technology-based health information resource organization, are co-sponsoring a 100,000 square foot Exhibition Hall. The Hall includes a Technology Pavilion, anchored by the Center for Aging Services and Technologies and the Department of Transportation. Over 100 additional exhibitors display products and services related to the field of aging.

(Exhibits are located in Exhibit Halls A, B & C of the Hotel.)

The Exhibit Hall will be open to the WHCoA participants the following hours:

- Sunday, December 11
6:00 pm – 9:00 pm
- Monday, December 12
10:00 am – 7:00 pm
- Tuesday, December 13
7:00 am – 7:00 pm

(Open to the general public on Tuesday from 9:00 am to 5:00 pm)

SeniorNet/IBM Computer Resource Center

This Center is provided for all WHCoA delegates and registered members of the press. It is located on the ground floor in Maryland Room C. The Computer Resource Center is a free computer lab where you can log on and check your e-mail, file stories, or do Internet research.

The SeniorNet/IBM Computer Resource Center will be open the following hours:

- Sunday, December 11
12:00 noon – 6:00 pm
- Monday, December 12
8:00 am - 6:00 pm
- Tuesday, December 13
8:00 am - 6:00 pm
- Wednesday, December 14
8:00 am - 3:00 pm

First Aid

A first aid room will be located in Park Tower Room 8229 near the Maryland C meeting room.

Walking Trail

The 2005 White House Conference on Aging and the Administration on Aging's "You Can!" campaign invite you to join us on the journey to wellness! A walking trail is available on the lobby level of the Hotel. The trail, which begins and ends near the lounge on the lobby level, is approximately 1/4 mile long or about 500 steps. Glow-in-the-dark footprints will light your way, so grab a fellow delegate and move one step closer to a healthier lifestyle. Every step counts!

Kaisernetwork Webcasting of the 2005 WHCoA

Select webcasts from the 2005 White House Conference on Aging will be provided by [kaisernetwork.org](http://www.kaisernetwork.org), a free health policy news and webcasting service of the Kaiser Family Foundation at http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1585. Transcripts and related resources also will be available.

|| BACKGROUND

The 2005 White House Conference on Aging

The fifth 2005 White House Conference on Aging (WHCoA) – and the first of the 21st Century – is being held in Washington, DC from December 11 to 14, 2005. White House Conferences on Aging occur once a decade and have served as catalysts for the development and enhancement of national, state and local aging policies in the United States. The 17-member bipartisan WHCoA Policy Committee appointed by the President and Congress, is chaired by The Honorable Dorcas R. Hardy.

Theme for the 2005 WHCoA

The theme for the 2005 WHCoA is “The Booming Dynamics of Aging: From Awareness to Action” which reflects the WHCoA’s legislative mandate to focus on the aging of today and tomorrow, which includes 78 million baby boomers born between 1946 and 1964. This theme urges us to acknowledge the opportunities and the challenges facing our families, communities, country and the world, and to act now to responsibly and thoughtfully shape aging policy and programs for the future.

2005 WHCoA Annotated Agenda

On November 3, 2005, the WHCoA Policy Committee adopted a final Annotated Agenda for the WHCoA. The six issue tracks of the Annotated Agenda are:

- Planning Along the Lifespan
- The Workplace of the Future
- Our Community
- Health and Long Term Living
- Civic Engagement and Social Engagement
- Technology and Innovation in an Emerging Senior/Boomer Marketplace

Public Input Process for the WHCoA – Resolution Development

The WHCoA Policy Committee has actively sought input from a wide array of stakeholders to develop the overarching agenda and plan for the Conference, including resolution development. Issues were identified and refined through public input received from more than 375 events involving 130,000 people across the nation as well as general comments received by the WHCoA. These events included listening sessions, solutions forums, mini-conferences and independent aging events. They were organized by communities, academic institutions, business and industry, national and local organizations and coalitions, non-profits, faith-based organizations, as well as Federal, State and local agencies. Comments also were received from the general public.

Resolution Development – Delegate Vote on Top 50

Resolutions provided to the delegates in advance of the WHCoA reflect the emerging issues, interests and concerns shared through the public input process. Delegates have been asked to review the resolutions in advance of the WHCoA and come prepared to select the top 50 that they believe are the most important for current and future generations of senior citizens.

Implementation Strategies

As important as the resolutions are, their implementation strategies are essential. The WHCoA Policy Committee shares a strong desire that the 2005 WHCoA produce real, positive results that will make a difference in the lives of future generations. The 50 resolutions selected by the delegates will identify what priorities the nation should address; their implementation strategies should suggest how the resolutions might be put into action. The Policy Committee believes it is critical for delegates to consider what actions must be taken over the next ten years and beyond to translate the work of the delegates into meaningful actions across the spectrum of Federal, State and local governments, as well as throughout business and industry, private and non-profit sectors, including responsibilities to be assumed by individuals.

Delegates

On August 31, 2005, the Policy Committee for the WHCoA announced the names of the approximately 1,200 delegates invited to participate in the WHCoA. Delegates will have the responsibility of voting on resolutions and developing implementation strategies that will be presented to the President and Congress to help guide aging policies for the next decade and beyond.

The delegates represent:

- Governors of all 50 States, the U.S. Territories, the Commonwealth of Puerto Rico, and the District of Columbia;
- Members of the 109th Congress;
- The National Congress of American Indians, and
- National aging and other allied organizations, academic institutions, business and industry, baby boomers, disability, non-profit and veterans' organizations, and other individuals with a stake in the aging of America.

The Policy Committee sought to ensure that the delegates represent a broad cross section of the U.S. population and worked to achieve an appropriate demographic balance by selecting delegates to fill gaps that existed after gubernatorial, congressional and Native American delegate selections had been made.

|| PROGRAM

Saturday,
December 10, 2005

6:00 PM – 9:00 PM

Conference Registration

LOCATION: Conference Registration Desk

Sunday, December 11, 2005

10:00 AM – 10:00 PM

Conference Registration

LOCATION: Conference Registration Desk

PRE-CONFERENCE EVENTS

1:30 PM – 4:00 PM

Healthy Living Celebration!

LOCATION: Cotillion Ballroom

Coordinator: *President's Council on Physical Fitness and Sports*

Presenters:

- The Honorable Dorcas R. Hardy, *Chairman, 2005 WHCoA Policy Committee*
- Melissa Johnson, *Executive Director, President's Council on Physical Fitness and Sports*
- Mollie Katzen, *renowned healthy cookbook author, "Moosewood Cookbook"*
- Mark Zeug, *Chairman, National Senior Games Association*
- Dot Richardson, MD, *Olympian and Vice-chairman, President's Council on Physical Fitness and Sports*

Simultaneous Fitness Sessions:

- Ya-La Dancing

LOCATION: Washington 4

- Thera-band

LOCATION: Cotillion Ballroom

- Tai Chi

LOCATION: Salon 1

- Line Dancing

LOCATION: Washington 5

Fitness Recognition Ceremony

LOCATION: Cotillion Ballroom

Water provided by The Coca-Cola Company

3:00 PM – 5:30 PM

Roundtable on Global Aging

(By Invitation Only)

LOCATION: Wilson Room

Moderator:

- Josefina G. Carbonell, *Assistant Secretary for Aging, Department of Health and Human Services*

Speaker:

- Richard Jackson, PhD
Director, Global Aging Initiative, Center for Strategic and International Studies, Washington, DC

Participants:

International Observers

- India — Mr. Gangadharan, *Managing Director, Heritage Hospital, Hyderabad*
- Japan — Mr. Yusuke Kataoka, *Executive Director, U.S. Foundation for International Economic Policy*
- Austria — Dr. Eveline Honigsperger, *Federal Ministry of Social Security & Generations & President of the European Federation of Older Persons (EURAG)*

- Mexico — Mr. Pedro Borda, *Director, Institute on Aging, Ministry of Social Development*
- Canada — Ms. Margaret Gillis, *Director of the Division of Aging & Seniors, Department of Health*
- Pakistan — Mr. Chaudry Abdul Ghafoor, *Secretary General, Pakistan National Centre on Aging*
- France — Dr. Francoise Forette, *Special Adviser to the Minister on Aging, Ministry of Social Security, Elderly, Family & Handicapped Persons*

Additional Speakers

- Dr. Alex Kalache, *Director, Ageing and Life Course Programme, World Health Organization*
- Mr. Todd Peterson, *Chief Executive Officer, HelpAge International*

Policy Committee/Advisory Committee Members

- Policy Committee, WHCoA, Lead Representative: Gail Gibson Hunt

The 21st Century ushers in a new era of global aging in industrialized and industrializing nations.

4:00 PM – 6:00 PM

Top 50 Resolutions Voting

LOCATION: Maryland A & B

5:30 PM – 6:00 PM

Conference Grand Opening

Exhibit Hall Ribbon Cutting Ceremony

LOCATION: Atrium at Exhibit Hall Entrance

Speakers:

- The Honorable Norman Y. Mineta, *Secretary of Transportation*
- Robert Abrams, *President & CEO, ZivaContinuum*
- Pat Conroy, *Vice Chairman and National Managing Principal, Deloitte & Touche USA LLP*

6:30 PM – 8:30 PM

Welcoming Reception

“Get Involved: A Salute to Volunteers”

LOCATION: Cotillion Ballroom

Organized by the Corporation for National and Community Service and sponsored by CVS Pharmacy and America Online

|| PROGRAM

Monday, December 12, 2005

7:00 AM – 8:00 PM

Conference Registration

LOCATION: Conference Registration Desk

7:00 AM – 8:45 AM

Continental Breakfast Buffet

LOCATION: Exhibit Hall A

Provided by several aging service organizations

9:00 AM – 11:00 AM

Opening Plenary

LOCATION: Grand Ballroom

- Presentation of Colors
- Senate Chaplain Barry C. Black, PhD
- The Honorable Josefina G. Carbonell, *Assistant Secretary for Aging*
- The Honorable Mike Leavitt, *Secretary for Health and Human Services*
- The Honorable Claude A. Allen, *Assistant to the President for Domestic Policy*
- The Honorable David M. Walker, *Comptroller General of the United States*
- Craig R. Barrett, *Chairman of the Board, INTEL Corporation*
- The Honorable Dorcas R. Hardy, *Chairman, Policy Committee, WHCoA*

11:00 AM – 1:00 PM

Top 50 Resolutions Voting

LOCATION: Maryland A & B

NOON – 1:00 PM

Box Lunch

LOCATION: Exhibit Hall A

Provided by Wal-Mart Stores, Inc.

1:00 PM – 5:00 PM

Presentation & Discussion of Policy Tracks

LOCATION: Grand Ballroom

Moderator:

- Gail Gibson Hunt, *Policy Committee Member, WHCoA*
- Robert Essner, *Chairman, President & CEO Wyeth*
- Health and Long Term Living: The Honorable Mark McClellan, MD, PhD, *Administrator, Centers for Medicare & Medicaid Services*
- Long Term Care: The Honorable Dirk Kempthorne, *Governor of the State of Idaho*
- Planning Along the Lifespan: The Honorable Hal Daub, JD, *Partner, Blackwell Sanders Peper Martin*
- The Workplace of the Future: Ken Dychtwald, PhD, *President, Age Wave*
- Civic Engagement and Social Engagement: David Eisner, *CEO, Corporation for National and Community Service*
- Our Community: Abigail Trafford, *Washington Post Health Columnist & Author*

Break refreshments provided by The Coca-Cola Company

5:00 PM – 6:30 PM

Top 50 Resolutions Voting - Final Opportunity

LOCATION: Maryland A & B

7:00 PM – 9:00 PM

Reception

AARP/National Committee to Preserve Social Security and Medicare Reception in conjunction with the Leadership Council of Aging Organizations and in honor of the 2005 WHCoA Delegates

LOCATION: Grand Ballroom

2005 WHITE HOUSE CONFERENCE ON AGING

FINAL REPORT APPENDIX

Tuesday, December 13, 2005

8:00 AM - 8:00 PM

Conference Registration

LOCATION: Conference Registration Desk

6:30 AM - 8:00 AM

Continental Breakfast Buffet

LOCATION: Exhibit Hall A

Provided by several aging service organizations

8:30 AM - 11:00 AM

Resolution Implementation Strategy Sessions (Facilitated)

- Planning Along the Lifespan
- The Workplace of the Future
- Our Community
- Health and Long Term Living
- Civic Engagement and Social Engagement
- Technology and Innovation in an Emerging Senior/Boomer Marketplace
- Cross-cutting

11:00 AM - NOON

Box Lunch

LOCATION: Exhibit Hall A

Provided by Wyeth

NOON - 2:30 PM

Resolution Implementation Strategy Sessions (Facilitated)

- Planning Along the Lifespan
- The Workplace of the Future
- Our Community
- Health and Long Term Living
- Civic Engagement and Social Engagement
- Technology and Innovation in an Emerging Senior/Boomer Marketplace
- Cross-cutting

Break refreshments provided by The Coca-Cola Company

3:00 PM - 5:30 PM

Resolution Implementation Strategy Sessions (Facilitated)

- Planning Along the Lifespan
- The Workplace of the Future
- Our Community
- Health and Long Term Living
- Civic Engagement and Social Engagement
- Technology and Innovation in an Emerging Senior/Boomer Marketplace
- Cross-cutting

7:30 PM - 9:00 PM

Dinner: The Booming Dynamics of Aging: From Awareness to Action

LOCATION: Grand Ballroom

Speaker: Roger Barnett, Chairman & CEO Shaklee Corporation

Entertainment

- Radio King Orchestra

Provided by Johnson and Johnson, Shaklee Corporation, Genworth Financial, and Aetna

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|| PROGRAM

Wednesday, December 14, 2005

8:00 AM - 2:00 PM

Conference Registration

LOCATION: Conference Registration Desk

6:30 AM - 8:00 AM

Continental Breakfast Buffet

LOCATION: Cotillion Ballroom

Provided by Ross Products, Abbott Laboratories

8:30 AM - 10:30 AM

Conference Reports from Policy Committee

LOCATION: Grand Ballroom

Presentations by members of the Policy Committee, WHCoA

11:30 AM - 1:30 PM

Closing Plenary Session and Luncheon

The Healthy Heart Luncheon

LOCATION: Grand Ballroom

- Native American Cultural Presentation
- Robert H. Eckel, MD, *President, American Heart Association*
- Karen Katen (invited) *Vice Chairman, Pfizer Inc. and President, Human Health*
- Robert N. Butler, MD, *President and CEO, International Longevity Center-USA*
- The Honorable Dorcas R. Hardy, *Chairman, Policy Committee, WHCoA*

Provided by Pfizer

|| BIOGRAPHIES

Chairmen

The Honorable Dorcas R. Hardy

Chairman, Policy Committee, WHCoA

Dorcas R. Hardy, former Commissioner of Social Security and a California and Federal official in the human services field, is President of DRHardy and Associates, a government relations and public policy firm serving a diverse portfolio of clients in the health services, disability insurance and financial industries. Ms. Hardy launched and hosted her own primetime, weekly television program, “Financing Your Future,” and has also hosted “The Senior American,” an NET political program for older Americans. She speaks and writes widely about domestic and international retirement financing issues and entitlement program reforms and is the author of *Social Insecurity: The Crisis in America’s Social Security System and How to Plan Now for Your Own Financial Survival*, Random House 1992. Ms. Hardy was formerly Chief Executive Officer of a public rehabilitation technology firm, is a Certified Senior Advisor, and a Director of several corporate and mutual fund boards, as well as the Social Security Advisory Board.

Michael McLendon

Chairman, Advisory Committee, WHCoA

Michael McLendon, appointed as the Deputy Assistant Secretary for Policy in the Department of Veterans Affairs in 2003, is the founder of McLendon & Associates, a management consulting and public policy firm providing a range of services to public and private sector clients in health services, disability, social service delivery, and technology arenas. Before coming to the Department of Veterans Affairs, he worked extensively in the international environment on a number of reform programs and since 1992, served on several task forces evaluating veteran benefits and services programs. Prior to establishing McLendon & Associates, he retired from the Department of Defense after a career in the U.S. Air Force and in the Office of the Secretary of Defense. Mr. McLendon also served as a Professor at the Defense Systems Management College.

Speakers

The Honorable Claude A. Allen

Assistant to the President for Domestic Policy

Claude A. Allen currently serves as the Assistant to the President for Domestic Policy, in which capacity he advises the President on all domestic, non-economic issues. The Domestic Policy Council handles topics that range from health care to education and job training. He previously served as the Deputy Secretary for the Department of Health and Human Services (HHS). Prior to joining HHS, Mr. Allen was Secretary of Health and Human Resources for the Commonwealth of Virginia, leading 13 agencies and 15,000 employees. Mr. Allen led initiatives for Virginia’s Patients Bill of Rights, allowing patient appeals for adverse coverage decisions made by health plans, and direct access to physician specialists. He also spearheaded Virginia’s welfare reform initiative and provided leadership to overhaul Virginia’s mental health institutions and community services. Additionally, Mr. Allen was responsible for implementing Virginia’s private health insurance program for children and families, offering lower-cost coverage options to uninsured Virginians.

Roger Barnett

Chairman and CEO, Shaklee Corporation

Mr. Barnett received his law degree from Yale Law School and his MBA from Harvard Business School. He began his career at the investment-banking firm, Lazard Freres & Co., where he identified Arcade Inc., as an investment opportunity. Mr. Barnett was also the founder, Chairman and CEO of Beauty.com. Mr. Barnett has been selected as a Global Leader for Tomorrow by the World Economic Forum and is a member of their private investment community. He has been selected as a Young Leader Forum Fellow by the U.S. Council on China Relations and is a member of the Young President’s Organization. Mr. Barnett was named as Shaklee’s new Chairman and Chief Executive Officer in May of 2004.

|| BIOGRAPHIES

Craig R. Barrett

Chairman of the Board, INTEL Corporation

Dr. Barrett was elected chairman of the INTEL Corporation's Board of Directors on May 18, 2005. Dr. Barrett is a recent appointee to the President's Advisory Committee for Trade Policy and Negotiations and to the American Health Information Community. He is a member of the National Academies Committee on Prospering in the Global Economy of the 21st Century: An Agenda for American Science and Technology. Dr. Barrett also serves as Co-chairman of the Business Coalition for Excellence in Education and is a member of the Board of Trustees for the U.S. Council for International Business. Dr. Barrett is the author of over 40 technical papers dealing with the influence of microstructure on the properties of materials, and a textbook on materials science, *Principles of Engineering Materials*.

Barry C. Black, PhD

Chaplain of the U.S. Senate

On June 27, 2003, Rear Admiral Barry C. Black (Ret.) was elected the 62nd Chaplain of the United States Senate. Prior to coming to Capitol Hill, Chaplain Black served in the U.S. Navy for over twenty-seven years, ending his distinguished career as the Chief of Navy Chaplains. In addition to opening the Senate each day in prayer, Chaplain Black's duties include counseling and spiritual care for the Senators, their families and their staffs, a combined constituency of six thousand people.

Robert N. Butler, MD

President and CEO of the International Longevity Center-USA

Professor of Geriatrics and Adult Development at the Brookdale Department of Geriatrics and Adult Development at the Brookdale Department of Geriatrics and Adult Development at Mount Sinai Medical Center. Physician, gerontologist, psychiatrist, public servant and Pulitzer-Prize winning author, Dr. Butler has long been involved in a broad array of social and health issues. He is perhaps best known for his advocacy of the medical and social needs and rights of the elderly and his research on healthy aging and the dementias. In 1975 he became the founding director of the National Institute on Aging of the National Institutes of Health.

The Honorable Josefina G. Carbonell

Assistant Secretary for Aging

Josefina G. Carbonell was appointed by the President, confirmed by the Senate, and sworn in as Assistant Secretary for Aging at the Department of Health and Human Services (HHS) on August 8, 2001. As the leader of the Administration on Aging and the National Aging Network, Ms. Carbonell oversees the largest infrastructure of home and community-based long term care services in the country. As an innovator who is result-oriented and consumer-focused, she advances her vision of improving care by enhancing access and integrating health and social service systems. Prior to joining HHS, Ms. Carbonell worked in the aging field for over 30 years and was President and CEO of the largest Hispanic geriatric health and human service organization in the nation – Little Havana Activities & Nutrition Centers in Miami-Dade County, Florida.

The Honorable Larry Craig

United States, Senator from Idaho (R-ID)

Senator Craig was elected to the U. S. House of Representatives in 1980 where he served until he was elected to the U. S. Senate in 1990. Senator Craig is currently the Chairman of the Committee on Veterans' Affairs and a member of the Committee on Energy and Natural Resources. With his appointment to the Senate Appropriations Committee, Senator Craig oversees funding on the Subcommittees of Labor, Health and Human Services, and Education, Military Construction and Veterans Affairs, and Interior and Related Agencies. He is also a member of the Special Committee on Aging, which he chaired during the 107th and 108th Congresses. In addition to his committee memberships, Senator Craig sits on a number of caucuses, including the Idaho Safe Kids Coalition (Honorary Co-Chair); the Western States Senate Coalition; and the Education Advisory Committee to the National Youth Leadership Conference.

The Honorable Hal Daub, JD

Partner, Blackwell Sanders Peper Martin

Hal Daub is a partner in the law firm of Blackwell Sanders Peper Martin in Omaha, Nebraska and Washington, DC He is former President and Chief Executive Officer of the American Health Care Association and the National Center for Assisted Living, and is currently the Chairman-elect of the Community Health Charities of America. Mr. Daub served as Mayor of Omaha from 1995-2001, and served in the U.S. House of Representatives from 1981-1989. While in Congress, he served on the House Ways and Means Committee, the Small Business Committee and the Special Committee on Aging. He has also served as an elected Board Member of the National League of Cities. Currently, Mr. Daub is serving as Chairman of the Social Security Advisory Board.

Ken Dychtwald, PhD

President and CEO of Age Wave

Over the past 30 years, Ken Dychtwald, PhD has emerged as a visionary and original thinker regarding lifestyle, marketing, and workforce implications of the "age wave." He is a psychologist, gerontologist, and author of eleven books on aging-related issues. He has recently completed a new book, *The Power Years: A User's Guide to the Rest of Your Life*, with Daniel J. Kadlec. His article, "It's Time to Retire Retirement," was recently awarded the prestigious 2004 McKinsey Award in the Harvard Business Review, tying for first place with the legendary Peter Drucker. His ideas regarding social science and marketing have been featured in many prestigious publications including: *The New York Times*, *The Wall Street Journal*, *USA Today*, *The Financial Times*, *Fortune*, *Time*, *Newsweek*, *Business Week*, *Inc.*, *U.S. News and World Report* and *Advertising Age*.

Robert H. Eckel, MD

President, American Heart Association

Dr. Eckel is Professor of Medicine at the University of Colorado School of Medicine where he holds the Charles A. Boettcher Endowed Chair in Atherosclerosis. He also has a joint appointment in the Department of Food Science and Human Nutrition at Colorado State University. Shortly after his arrival in Denver, Dr. Eckel was appointed Associate Program Director of the Adult General Clinical Research Center (GCRC) at the University of Colorado Health Sciences Center (UCHSC). In 1993 he assumed the role of Program Director, a position he continues to hold. In addition, Dr. Eckel's research has led to his involvement and presidency in a number of national organizations, including the North American Association for the Study of Obesity and the Association for Patient Oriented Research.

David Eisner

Chief Executive Officer of the Corporation for National and Community Service

The Corporation for National and Community Service administers the Senior Corps, AmeriCorps, and Learn and Serve America programs. Mr. Eisner was appointed by President George W. Bush and began serving in December 2003. Mr. Eisner is a nationally recognized leader on non-profit capacity-building, infrastructure, and organizational effectiveness, and focuses his efforts on strengthening the organization's accountability, improving customer service, and increasing public trust.

Robert Essner

Chairman, President and Chief Executive Officer, Wyeth

Robert Essner has been President and Chief Executive Officer of Wyeth (formerly American Home Products) since May 2001 and was elected the Chairman of the Corporation effective January 1, 2003. Mr. Essner is also Chairman of the Children's Health Fund Corporate Council, a member of the Board of Directors of the Pharmaceutical Research & Manufacturers of America, Massachusetts Mutual Life Insurance Company, the Board of Trustees of the University of Pennsylvania School of Medicine, and a member of the Business Roundtable and Business Council.

|| BIOGRAPHIES

Richard Jackson, PhD

Director and Senior Fellow, Global Aging Initiative

Richard Jackson is currently a senior fellow at the Center for Strategic and International Studies where he directs the Global Aging Initiative, a research and educational program devoted to exploring the long-term implications of population aging. He is also an adjunct fellow at the Hudson Institute and a senior adviser to the Concord Coalition.

Melissa Johnson

Executive Director, The President's Council on Physical Fitness and Sports

Appointed as Executive Director by President George W. Bush, Melissa Johnson is a nationally recognized leader in physical activity, fitness and health promotion. She manages the activities and operations of the Washington, DC based council, an advisory committee to the President and the Secretary of the U.S. Department of Health and Human Services (HHS).

Mollie Katzen

Healthy Cookbook Author and Speaker, "Moosewood Cookbook"

Mollie Katzen, with over 5 million books in print, is listed by the *New York Times* as one of the best-selling cookbook authors of all time. Named by *Health Magazine* as one of the five "Women Who Changed the Way We Eat." Personally selected by the Dean as a founding member of the new Harvard School of Public Health Leadership Council, Ms. Katzen holds a charter seat at the Harvard School of Public Health Nutrition Roundtable and was an inaugural inductee to the new Natural Health Hall of Fame.

The Honorable Dirk Kempthorne

Governor of the State of Idaho

Governor Kempthorne was first elected as Idaho's 30th Chief Executive in 1998, following a successful six-year term in the United States Senate and was reelected as Idaho's Governor in November of 2002. Elected by his colleagues as Chairman of the National Governors' Association in August of 2003, he launched an initiative to bring a national focus on the looming crisis of long-term care. Governor Kempthorne continues to be a national leader on issues related to long-term care.

The Honorable Michael O. Leavitt

Secretary of Health and Human Services

Michael O. Leavitt was sworn in as the 20th Secretary of the U.S. Department of Health and Human Services on January 26, 2005. He manages the largest civilian department in the Federal government, with more than 66,000 employees and a budget that accounts for almost one out of every four Federal dollars. He is a former 3-term Governor of the State of Utah where he was widely recognized as a health care innovator and welfare reformer. He was chosen by the nation's governors to represent the States before Congress on welfare reform, Medicaid and children's health insurance. He now brings his leadership abilities to the Department of Health and Human Services where he is committed to using the power of technology to improve the quality of care, reduce mistakes and manage costs.

The Honorable Mark B. McClellan, MD, PhD

Administrator, Centers for Medicare & Medicaid Services

Dr. Mark McClellan was sworn in as Administrator of the Centers for Medicare & Medicaid Services on March 25, 2004. Dr. McClellan previously served in the White House as a Member of the President's Council of Economic Advisers and later as Commissioner of the Food and Drug Administration. At Stanford Medical School, Dr. McClellan was a practicing internist and Director of the Program on Health Outcomes Research. He was also co-Principal Investigator of the Health and Retirement Study, a longitudinal study of the health and economic well-being of older Americans. Dr. McClellan's research studies have addressed measuring and improving the quality of health care, technological change in health care and its consequences for health and medical expenditures, and the relationship between health and economic well-being.

The Honorable Norman Y. Mineta

Secretary of Transportation

Norman Y. Mineta became the 14th Secretary of Transportation on January 25, 2001. As Secretary of transportation, Secretary Mineta oversees an agency with 60,000 employees and a \$61.6 billion budget. Created in 1967, the U.S. Department of Transportation brought air, maritime and surface transportation missions under one umbrella. Prior to joining President George W. Bush's administration, Mr. Mineta served as Secretary of Commerce under President Clinton and as a Vice President at Lockheed Martin Corporation. From 1975 to 1995, he served as a member of the U.S. House of Representatives from California. He co-founded the Congressional Asian Pacific American Caucus as its first chair.

Dorothy G. Richardson, MD

Vice-Chair of President's Council on Physical Fitness and Sports

Dr. Dot Richardson is currently Medical Director of the National Training Center in Clermont, Florida, a state-of-the-art facility for athletes of all levels, located on a campus with a fully staffed hospital. She is an orthopedic surgeon with Ray-Richardson Orthopedic Associates. In addition to her medical and administrative career, Dr. Richardson is a two-time Olympic Gold medalist in softball. Dr. Richardson has been the recipient of many athletic awards and was a 1999 Florida Hall of Fame Inductee in the State of Florida and was voted USA Softball's Most Valuable Player Award four times. She has appeared regularly on national television programs such as *The Today Show* and *The Oprah Winfrey Show*, and has been featured frequently in national magazines and newspapers such as *Sports Illustrated*, *USA Today*, *Time*, *U.S. News & World Report*, and the *New York Times*.

The Honorable David M. Walker

Comptroller General of the United States

David M. Walker became the seventh Comptroller General on November 9, 1998. As Comptroller General, Mr. Walker is the nation's chief accountability officer and head of the Government Accountability Office (GAO), a legislative branch agency founded in 1921. GAO's mission is to help improve the performance and assure the accountability of the Federal Government for the benefit of the American people. Over the years, GAO has earned a reputation for professional, objective, fact-based, and nonpartisan reviews of Government issues and operations. Between 1989 and 1998, Mr. Walker worked at Arthur Andersen LLP, where he was a partner and global managing director of the human capital services practice based in Atlanta, Georgia. Mr. Walker currently serves as Chair of the U.S. Intergovernmental Audit Forum, the Center for Continuous Auditing, and as a principal of the U.S. Joint Financial Management Improvement Program. He has also written numerous articles and opinion letters on a variety of subjects. Mr. Walker is frequently quoted on a range of government and management issues and has been the subject of several cover stories in various national, professional and governmental journals.

Mark E. Zeug

Chairman, National Senior Games Association Board

Mark E. Zeug is a member of the Board of Directors of the National Senior Games Association, and currently serves as its Chairman. He also is president of the Hawaii Senior Games Association and coordinator of the Hawaii Senior Olympics, an event which he founded in 1998. A retired journalist and public relations professional, Zeug has more than 30 years experience in event organization and management, corporate and non-profit public relations, advertising, and marketing. In addition to organizing the Hawaii senior games and Aloha State Games, he is an active athlete and has participated in the local games and national games when possible. He also is a certified track & field official with "national" ranking, and officiates at numerous local and national USATF competitions.

|| ACKNOWLEDGMENTS

The WHCoA wishes to acknowledge and thank the following organizations for their gifts, donations, and support of this December Conference.

| | |
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| GENWORTH FINANCIAL | WYETH |
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The WHCoA also wishes to acknowledge the following:

- Moment of Reflection on Monday, December 12, provided by Chaplin Barry C. Black, U.S. Senate.
 - Color Guard on Monday, December 12, provided by the U.S. Armed Forces Color Guard.
 - Color Guard on Wednesday, December 14, provided by the Oneida Nation, Green Bay, Wisconsin.
 - Entertainment on Wednesday, December 14, provided by the Singing Seniors of the Levine School of Music in Alexandria, Virginia, Jeanne Kelly, Director.
 - Moment of Reflection on Wednesday, December 14, provided by Joseph Garcia, Governor of Ohhay Owingeh (San Juan Pueblo, New Mexico) and President-elect, National Congress of American Indians.
 - Volunteer assistance provided by the Corporation for National and Community Service; Volunteers of America; R.S.V.P.; The Campagna Center; Generations United; and the U.S. Department of Health and Human Services.
 - Special thanks to Marty LaVor, Photographer.
-

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National Committee to Preserve Social Security and Medicare

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Health Policy R & D

Sandra Schlicker, PhD
American Society for Clinical Nutrition

Joanne Schwartzberg, MD
American Medical Association

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Deputy Executive Director

Gayle Cozens

Senior Executive Officer to the Policy Committee

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Deputy Director for Outreach

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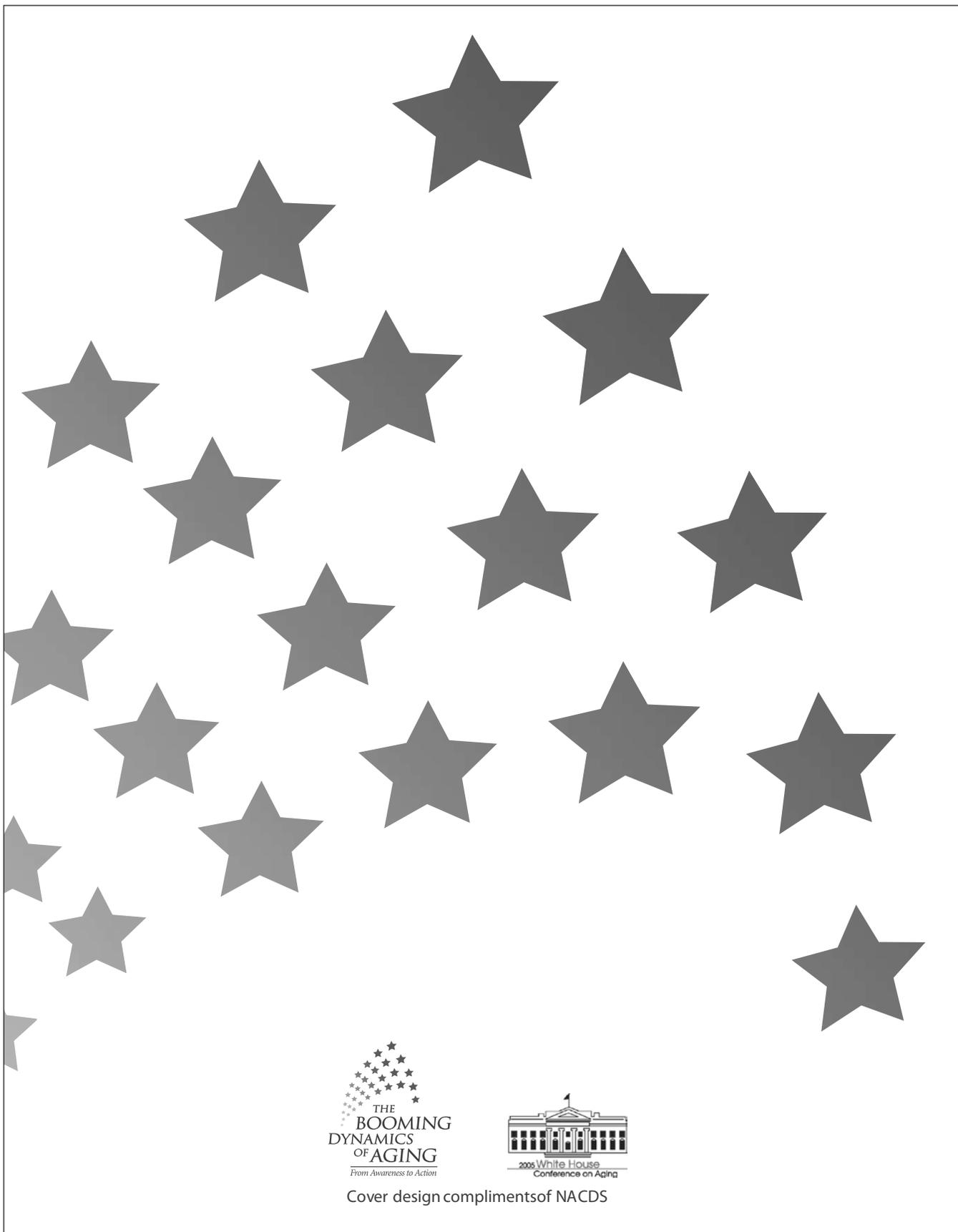
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FINAL REPORT APPENDIX

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2005 WHITE HOUSE CONFERENCE ON AGING

FINAL REPORT APPENDIX



Cover design compliments of NACDS



**Overview of Global
Aging Events**

Overview of Global Aging Events

Summary of Activities for International Observers

THE INTERNATIONAL OBSERVERS:

Forty-two International Observers attended from 23 countries. Invitations were sent to over 50 countries in Africa, Latin America, Europe, the Middle East, and Asia and Eurasia. This included a mix of developed and developing countries with large aging populations; countries with whom we have established official working relations; and countries which have expressed an interest in aging. We invited experts from ministries of health, social welfare and social security; international non-governmental aging organizations (NGOs); national aging-related NGOs; UN and other non-UN international organizations; and academicians.

PAN AMERICAN HEALTH ORGANIZATION (PAHO) RECEPTION, SATURDAY, DECEMBER 10

PAHO, the regional office for the World Health Organization, hosted a reception for the International Observers. Also attending were officials from the U.S. Dept. of Health and Human Services, the WHCoA Policy and Advisory Committee members, members of Congress, and other invited guests.

Dr. Mirta Roses Periago, Director of the Pan American Health Organization, graciously welcomed her guests and briefly discussed PAHO's aging activities. The Assistant Secretary for Aging, Josefina G. Carbonell, personally extended a welcome to all of the International Observers "who have traveled across the globe to be with us on this historic occasion."

GLOBAL AGING ROUNDTABLE, SUNDAY, DECEMBER 11, 3:00 PM TO 5:20 PM

The purpose of the Global Aging Roundtable was to learn about aging issues and best practices in the countries of the International Observers. This was a moderated session between the International Observers and members of the WHCoA Policy and Advisory Committees.

This was a very well attended session of approximately 100 people comprised of the International Observers, WHCoA Policy and Advisory Committee members, invited guests, WHCoA Delegates and members of the press.

Dr. Scott Nystrom, Executive Director of the WHCoA, introduced Josefina G. Carbonell, the Assistant Secretary of Aging. Ms Carbonell moderated the session and offered introductory remarks.

Dr. Richard Jackson, Director, Global Aging Initiative at the Center for Strategic and International

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Studies, Washington, DC, provided a global view of aging He was followed by country remarks by:

- Austria: Eveline Hönigsperger, Ph.D., Federal Ministry of Social Security & Generations
- Canada: Margaret Gillis, Director of the Division of Aging Seniors, Department of Health
- France: Françoise Forette, MD, Special Adviser to the Minister on Aging, Ministry of Social Security, Elderly Family & Handicapped Persons
- Mexico: Pedro Borda, Director, National Institute on Aging, Ministry of Social Development
- India: Gangadharan, Managing Director, Heritage Hospital, Hyderabad
- Japan: Yusuke Kataoka, Executive Director, U.S. Foundation for International Economic Policy
- South Africa: Vusi Madonsella, Director General, Ministry of Social Development

Note, Mr. Chaudry Abdul Ghafoor, Pakistan National Centre on Ageing, was unable to attend the conference but sent written remarks concerning the Centre's response to the recent earthquake in Pakistan.

Additional remarks and reflections were offered by Dr. Alex Kalache, Director, Ageing and Life Course Programme, World Health Organization, Geneva, Switzerland and Mr. Todd Petersen, Chief Executive Officer of HelpAge International.

Gail Hunt, Ph.D., WHCoA Policy Committee member and President and CEO of the National Alliance for Caregiving moderated a discussion with Policy and Advisory Committee members followed by questions from the audience.

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MEETING WITH OFFICIALS FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MONDAY, DECEMBER 12, 2005. 11:00 AM TO 1:00 PM

International Observers were briefed on aging-related activities taking place within the Department of Health and Human Services. Speakers discussed aging related programs, policies, and research, with particular attention to possibilities for foreign researchers.

The meeting was convened by Josefina G. Carbonell, Assistant Secretary for Aging.

Speakers included:

John Wren
Deputy Assistant Secretary for Management, AoA

Richard Suzman, Ph.D.
National Institute on Aging/National Institutes of Health

Sharon Hrynkow, Ph.D.
Acting Deputy Director
Fogarty International Center/National Institutes on Health

Marty McGeein
Deputy Assistant Secretary
Disability, Aging and Long Term Care Policy,
Office of the Assistant Secretary of Planning and Evaluation

Christine Williams, Director
Office of Communications and Knowledge Transfer
Agency for Healthcare Research and Quality

Lisa J. Park, MSW and Donna Rathbone, MSW
Office of Policy, Planning and Budget
Substance Abuse and Mental Health Services Administration

SITE VISITS, TUESDAY, DECEMBER 13

The morning began with a visit to Iona Senior Services, a nonprofit community organization in Washington, DC, dedicated to enabling older people to live with dignity and independence. IONA provides services and access to programs designed to meet the needs of seniors and their families. Services include information and referral, professional eldercare assessment, planning and counseling for seniors, Adult Day Health Care, mid-day meals and nutritional counseling, transportation, exercise and computer classes, health screening, and Early Alzheimer's Clubs.

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The International Observers then visited the Washington Home, a nonprofit organization providing long-term care; special care for Alzheimer's and dementia patients; rehabilitation services for patients after strokes, accidents and surgery.

AARP hosted the International Observers for lunch and a briefing of AARP activities, both domestic and global. Special remarks were made by Ms. Smith, President of the AARP Board of Directors, Mr. Dalmer Hoskins, Managing Director of Public Policy, Mr. John Rother, Group Executive Officer for Policy and Strategy and Ms. Ladan Manteghi, Director, International Affairs.

The Pan American Health Organization hosted an afternoon briefing to discuss their regional and global health activities, emphasizing the elderly. Remarks were made by:

Joxel Garcia, MD, Deputy Director

Carissa Etienne, MD, Assistant Director

Martha Peláez, PhD, PAHO Consultant in Aging

Alex Kalache, MD, WHO Geneva

In addition to the above special events for International Observers, they also had the opportunity to attend general sessions of the WHCoA, receptions, the exhibit hall and meetings with delegates.



**Overview of Healthy
Living Celebration!**

2005 White House Conference on Aging Overview of Healthy Living Events Celebration!

OVERVIEW

The 2005 White House Conference on Aging recognized the importance of leading a healthy lifestyle. A major goal of the 2005 WHCoA was to encourage healthy living for people of all ages.

This goal was achieved through the development and implementation of healthy living events and activities such as the 2005 White House Conference on Aging President's Challenge program, the 2005 White House Conference on Aging Profiles in Wellness program, the "Healthy Living Celebration!" and the 2005 WHCoA/AoA "You Can" Walking Trail. Many of these activities and events were developed with the generous assistance of other Federal agencies and departments as well as outside entities.

Each event or activity was designed to encourage, inspire and motivate delegates and all Americans, illustrating that a healthy lifestyle can be enjoyable and achievable. More than 165 delegates participated in at least one healthy living program, with many delegates participating in more than one program.

The programs received accolades from delegates and the media. Many delegates took the invitation to join the 2005 WHCoA on the journey to wellness and served as an inspiration to their fellow delegates, 2005 WHCoA attendees and all Americans.

THE 2005 WHITE HOUSE CONFERENCE ON AGING'S PRESIDENT'S CHALLENGE

A major goal of the 2005 WHCoA is to encourage healthy living for all Americans. With this goal in mind, the 2005 White House Conference on Aging (WHCoA) collaborated with the President's Council on Physical Fitness and Sports to promote physical activity/fitness and health across the lifespan. The 2005 White House Conference on Aging's President's Challenge Program was a product of the partnership.

All 2005 WHCoA delegates were invited to participate in the 2005 White House Conference on Aging's President's Challenge program, which encouraged the delegates to participate in regular physical activity before, during and after the Conference. The program highlighted the 2005 WHCoA's dedication to health healthy living. The program was also designed to draw attention to the Presidents Challenge program as a program appropriate for all Americans.

Delegates were asked to register for the program online and to electronically or manually track their amount of activity, as they strived to reach their ideal levels of physical activity. Delegates who met their goals by the commencement of the conference were awarded a certificate of completion, provided by the President's Council on Physical Fitness and Sports. The participants were also acknowledged with a reserved seat during the Healthy Living Celebration! Approximately 125 delegates reached their activity goals prior to the conference, qualifying them to receive the award.

PRESIDENT'S CHALLENGE PARTICIPANTS

| | | |
|------------------------------------|-----------------------|------------------------|
| Norman Abeles | Ramona Dover Kennedy | Julie Jow |
| Amy Ai | Gloria Duran | Ellie Jurado-Nieves |
| LaVerne Alexander | Nelson Durgin | Glenda Kane |
| Sandra Anderson | Katie Dusenberry | Vivienne Kerns |
| Georgia Anetzberger | Linda Engelbrecht | Jeffrey Kerr |
| Milton Aponte | Celia Esquivel | Esther Koch |
| Magaly Arias-Petrel | Michael Farley | Henry Lacayo |
| Bonnie Athas | Anwar Feroz-Siddiqi | Susan Lather |
| Ernest Chuck Ayala | Patricia Finder-Stone | Rebecca Liebes |
| Lt. Governor Catherine Baker Knoll | Paula Fong | Eileen Luisi-Hayward |
| Ann Bannes | Moira Fordyce | D. Jane Maloney |
| John Barnett | Naomi Fukagawa | Mary Martinez |
| Cheryl Bartholomew | Mary Furlong | Anne Mason Taylor |
| Mary Beals Luedtka | Joyce Gallagher | Gloria McCutcheon |
| Mr. AJ Benintende | Richard Gans | Mary Louise McCutcheon |
| Judy Black | David Geist | Karen McKibben |
| Eve Boertlein | Lester Gingold | Peggy Miller |
| Antonietta Boucher | Phil Godfrey | Patricia Miller |
| Elaine Brovont | Phyllis Golden | Marva Mitchell |
| Cathy Brown | Erica Goode | Stephen Montamat |
| Fran Brown | Keith Gooden | Sheri Montgomery |
| S. Ward Casscells | Harriet Goodwin | Hon Ruby Moy |
| Christine Cauffield | Richard Greenberg | Marie-Elena O Connor |
| Judy Cederholm | Cathy Grimm | Alice O Reilly |
| Lawson Chadwick | Lawrence Herman | Variny Paladino |
| Rosemary Chapin | Tom Hylemon | Michelle Park Steel |
| Frieda Clark | Jan Hively | Shelly Peterson |
| Sandra Cortese | Jeffrey Hoffmann | Jean Roesser |
| William Dailey Jr. | Warren Housley | Donald Roskopf |
| Walter De Foy | Rena Iacono | Sheila Salyer |
| Stephen Devaney | Fidela Irigoyen | Glady Schroeder |
| Anne Dickerson | Jamie Ison | Leonard Sempier |
| Marilyn Ditty | Pamela Johnson Betts | Sue Shaw |
| Bethany Dougherty | Hon. Patricia Jones | Tom Shea |

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| | | |
|-----------------|-------------------|---------------|
| Aaron Simonton | Florence Turner | Allan Zaback |
| Kathleen Spears | Michael Wasserman | Carol Zernial |
| Alice Spratley | Wilfred Watkins | Mark Zeug |
| Ernesto Stolpe | Jane Watkins | |
| Phyllis Suhar | Doug Wilkinson | |
| Louis Sullivan | Betty Wiser | |
| Fran Symms | Patricia Wojcik | |
| Mickie Timmons | Ginny Wood-Bailey | |
| Penny Troolin | Cheryl Woodson | |

WHCoA DELEGATE PROFILES IN WELLNESS

The 2005 White House Conference on Aging's Profiles in Wellness program was designed to acknowledge the healthful lifestyles and behavioral changes made by the 2005 White House Conference on Aging (WHCoA) delegates. The Profiles in Wellness program increased the awareness of delegates and the public to the importance of leading a healthy lifestyle and provided that one's lifestyle can be modified to improve the quality and length of life. Additionally, the program illustrated the 2005 WHCoA's dedication to healthy living and emphasized that lifestyle changes are achievable.

Delegates were encouraged to submit a brief story about their healthful lifestyle or behavioral change. Approximately 40 delegates submitted an entry and were approved against a set of criteria. The criterion can be found below.

- Those interested in submitting their profile must be a 2005 White House Conference on Aging (WHCoA) Delegate.
- The 2005 WHCoA and media covering the 2005 WHCoA must have permission to use the story and names of individuals mentioned in the submission before, during, and after the 2005 WHCoA.
- Submissions must be 200 words or less.
- Submissions must be true, personal accounts of positive lifestyle change.
- Positive lifestyle changes are classified as those that involve:
 - Exercise
 - Nutrition Modifications
 - Smoking cessation
 - Weight loss due to diet and/or other exercise
 - Reversal or control of a health condition through diet and/or exercise.

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Evangeline Austin

Catherine Baker Knoll,
Lieutenant Governor

Ann Bannes

Cheryl Bartholomew

Chris Baumgardner

Eileen Bostwick

James B. Conroy

Howard Cowen, DDS

Edward Creegan

Charles Crowder

Steve Devaney

Bill Dukes

Robert P. Dwyer

Eileen Hayward

Jan Hively

Cecelia Hurwich

Jamie Ison

Esther Koch

Bernice A. Morfin

Denise Nelsen

John Ortega

Judi G. Reid

Lori Ross

Sue Shaw

Ovarie Smith

Ernesto Stolpe

Dixie Taylor-Huff

Carl W. Toepel

Monica Walters

Michael R. Wasserman

Steven P. Weiniger

Gayla S. Woody

Della M. Works

Kent G. Yohe

2005 White House Conference on Aging Healthy Living Celebration!

The 2005 White House Conference on Aging Healthy Living Celebration! was held on December 11th, 2005 at the Marriott Wardman Park Hotel. This pre-conference event was designed with several goals in mind. The primary goal was to turn the attention of the delegates, and the public, to the importance of healthy living. Furthermore, the event highlighted the commitment of the 2005 WHCoA to health and wellness while demonstrating that physical activity can be enjoyable.

These goals were accomplished with the help of the President's Council on Physical Fitness and Sports, which co-sponsored the Healthy Living Celebration! The National Senior Games Association (NSGA) also participated in the event. The Chairman of the NSGA, Mr. Mark Zeug, delivered an inspirational message to the attendees. The organization also donated medals for the Profiles in Wellness participants and allowed the 2005 WHCoA to utilize extraordinary photos of Senior Olympians. Mollie Katzen, a renowned cookbook author, also shared her knowledge and experience with the delegates by speaking at the event.

Several activity sessions demonstrated that physical activity can be fun and safe. Activity leaders from around the D.C. Metropolitan area volunteered to lead group fitness classes as part of the Healthy Living Celebration! The Dancing Grannies led a low-impact, line-dancing session. The Tai Chi Chuan Study Center of the DC, Washington Metropolitan area provided several volunteers who conducted a tai chi session. Dr. Michael E. Rogers from Wichita State University led a resistance training demonstration utilizing Thera-Bands that were generously donated by the Thera-Band Corporation. Laurent Amzallag also participated in the event by leading a group of delegates in Ya-La Dancing, a form of aerobic exercise designed by Mr. Amzallag.

The event concluded with the recognition of delegates who participated in the 2005 White House Conference on Aging's President's Challenge program and the 2005 White House Conference on Aging's Profiles in Wellness program. These participants were respectively recognized by Dr. Dorothy Richardson, Vice Chairman of the President's Council on Physical Fitness and Sports and by Dorcas R. Hardy, Chairman of the 2005 White House Conference on Aging Policy Committee.

The President's Council on Physical Fitness and Sports provided every participant with a wrist-band that could be worn in support of physical activity, health and wellness at the conference and beyond.

2005 White House Conference on Aging Healthy Living Celebration!

SCHEDULE OF EVENTS | SATURDAY, DECEMBER 11, 2005

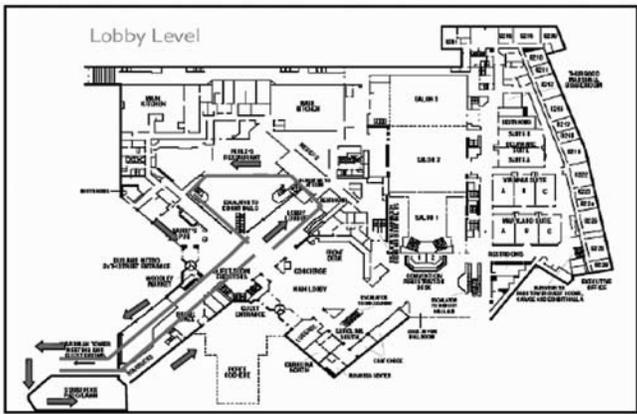
- 1:30 PM Welcoming Remarks, Dorcas R. Hardy**
Chairman, Policy Committee, 2005 WHCoA
- 1:35 PM Melissa Johnson, Executive Director**
President's Council on Physical Fitness and Sports
- 1:40 PM Delegate Mark Zeug, Chairman, National Senior Games Association**
- 1:45 PM Nutrition and Healthy Living**
Mollie Katzen, Renowned Cookbook Author
- 2:20 PM Activity Sessions I**
Dancing Grannies, Washington 5
Ya-La Dancing, Washington 4
Tai Chi, Salon I
Thera-Band, Cotillion South
- 2:40 PM Activity Session II**
Dancing Grannies, Washington 5
Ya-La Dancing, Washington 4
Tai Chi, Salon I
Thera-Band, Cotillion South
- 3:00 PM President's Challenge**
Recognition Ceremony
Dot Richardson, Vice Chairman,
President's Council on Physical Fitness and Sports
- 3:15 PM Profiles in Wellness**
Recognition Ceremony and
Charge for the Delegates
Dorcas Hardy, Chairman, Policy Committee, 2005 WHCoA
- 3:30 PM Conclusion of the Healthy Living Celebration**

2005 White House Conference on Aging/AoA “You Can” Campaign Walking Trail

The 2005 White House Conference on Aging (WHCoA) collaborated with the Agency on Aging’s (AoA) “You Can” campaign to develop a walking trail inside of the conference hotel. The trail was accessible to delegates and guests at any time throughout the conference. The trail was approximately ¼ mile or 500 steps and wound around the lobby level of the hotel.

Glow-in-the-dark feet lit the way and signs provided by the AoA “You Can” campaign encouraged delegates and increased awareness of safety issues. The trail was accessible to those with disabilities. It was available for use twenty-four hours per day, allowing delegates to exercise at any time throughout the conference.

A diagram of the trail and the rules of the road can be found at the bottom of this section.



*2005 White House Conference on Aging
Administration on Aging “YOU CAN!”
Walking Trail*

The 2005 White House Conference on Aging and the Administration on Aging’s You Can! campaign invite you to join us on the journey to wellness! A walking trail is available on the lobby level of the Marriott Wardman Park Hotel. The trail is approximately ¼ mile long or about 500 steps. The trail begins and ends near the lounge on the lobby level. Please remember to follow the ‘rules of the road’ on the reverse side of this diagram. Grab a fellow delegate and move one step closer to a healthier lifestyle. Every step counts!



WHCoA Wellness Profiles

WHCoA Wellness Profiles

AMY L. AI, PHD , Michigan

At high school, I was very athletic and ran all the time. During my doctoral program at the University of Michigan (UM), I began my research on complementary and alternative medicine and cardiovascular diseases and learned an energy exercise, Taoist longevity Qigong, from a “third-generation” Chen-Style, elderly Taiwanese Tai Chi Master.

Busy academic life since 1996, however, swallowed all my time, including that for exercise. While struggling between my two positions in both health systems, University of Washington (UW) and UM, I got five sequential ankle injuries on both sides; especially, a job-related one put me on-and-off crutches over three years and I lost my capacity for running. Ankle pain woke me up every night at 2-3 a.m., my muscles shrank considerably, and my life became miserable. The sixth ankle injury at a national convention became a wake-up call.

To prevent permanent disability, I restored my daily exercises one month afterward. I rode a bike and performed Qigong daily with a heavy cast boot and swam with a light cast boot. In a few months, I got the quickest recovery among all six incidents. Today, I sleep well, keep my muscles in shape, and have regained my capacity of running.

ANN BANNES, Missouri

I had been working in the field of aging for over 15 years and teaching many classes on healthy lifestyle. Finally, I decided that it was time for me to practice what I preached.

Six years ago in January, I joined a gym and began exercising. I worked out 4 - 5 days a week in aerobics, strength training, and stretching. I have found this routine gives me more energy, lowers my blood pressure, and keeps my once bad back from hurting. In fact, when I am traveling and away from the gym for 3 to 4 weeks at a time, I notice a big difference. My back starts hurting, my blood pressure increases and I am more tired. Even if I wanted to, I could not quit now that I have worked so hard to get into this routine cause my body would say “Oh, no you don’t – get to the gym” and off I go most mornings of the week.

BERNICE A. MORFIN, New Mexico

I never considered myself to be a serious smoker.

On the night of August 23rd, 2003 I awoke in the middle of the night, craving a cigarette. I went outside to my car to see if I had a half-smoked cigarette in my ash tray. Unsuccessful, I began searching throughout the house for a cigarette.

My husband felt bad for me and decided he would drive 12 miles into the nearest town to buy me some cigarettes. Two and a half hours later, my husband drove up with my cigarettes in his hand.

He explained that it took so long because 30 seconds before he reached an intersection, a 14 wheeler plowed into a small vehicle and he stopped to help the victims. If he had left home 30 seconds earlier, the truck probably would have hit him.

I went inside and realized that this little 4 inch cigarette was controlling me and could have changed my life and the lives of my children forever. I made up my mind that I would never smoke again.

It's been 2 years, 1 month, and 26 days. I will never smoke again and don't miss it at all.

BILL DUKES, South Carolina

I will celebrate my 63rd birthday on December 12th during the WHCoA, and I plan to celebrate many more! I can say this with confidence because of the positive lifestyle changes I have made.

Today I am healthy; I exercise regularly, am active in my business, and enjoy flying my plane.

At 55 years old I was 30 pounds overweight, lazy, stressed out and worried about having a heart attack. I had a 'wake up call'. My dad was 81, active, full of energy, driving, traveling, and working in his spare time. I realized that I could enjoy another 30 years of good life if I made changes in my lifestyle.

I joined a gym and worked with a personal trainer. I was embarrassed that I had difficulty lifting weights, doing pushups and running. My trainer, however, encouraged me. I lost 30 pounds and now I lift weights regularly, do pushups and run 10 miles per week.

My dad is now 89. His health, mental alertness and longevity inspired me to change my old lifestyle and he continues to be an inspiration as I enjoy the benefits of my new lifestyle.

DENISE NELSEN, Iowa

If I heard once "you sure like to eat, don't you Denise", I heard it a million times. I have struggled with maintaining a normal weight all of my life, at times it was more of a struggle than others. In April 1999, I had a "last straw" moment. I had come home from work sore and weary of trying to move around in small places. As the scale tipped 260 pounds, I made a decision to take the first step and joined a national weight-loss plan in my neighborhood.

As a result, my family and I started eating fruits and vegetables with every meal. The biggest

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lifestyle change was planning healthy snacks and healthy meals. After monitoring my portions and making healthy food choices, I reached my goal weight of 155 pounds in November 2000. I maintain my weight loss by continuing to “plan” healthy eating and by leading a weekly weight loss support group.

Now, I can enjoy hiking Harney Peak in the Black Hills without thinking “I am going die”. I am not embarrassed to fly on a plane – I fit into the seat. I even will opt to use the steps instead of the elevator.

CARL W. TOEPEL, Wisconsin

At Thanksgiving 2004, my son Tim in a loving way said, “Dad, what are you carrying around?” That question really bothered me, and I decided to do something about my weight. I also wanted to look trim like our former Gov. Tommy Thompson. As Secretary of Health and Human Resources, he promoted physical fitness throughout America.

Starting January 1, 2005, I gave up my morning doughnut. On rare occasions I will have dessert. I increased my swimming time and began to use the treadmill at the local YMCA. During the summer I used our pontoon pedal boat at our lake home. This Thanksgiving I am thankful to tell my son that I have lost 25 pounds.

I plan to maintain my weight control through proper diet and exercise, and my personal goal is to be the lightest weight of the men in the family by March 4, 2006.

CATHERINE BAKER KNOLL, Lieutenant Governor , Commonwealth of Pennsylvania

I have always led a very active and healthy lifestyle, but after being elected the first woman Lieutenant Governor in Pennsylvania in 2002, I knew my daily routine would change dramatically. Busy days and extensive travel make it difficult to exercise right, eat balanced meals and maintain stress-free days. But it’s not impossible. I have taken three specific steps to maintain a healthy routine even on the busiest days.

First, I eliminated all junk food from my diet. On days when snacks seem to be all that I eat as I go from meeting to event to meeting, I reach for treats such as fruit, vegetables or protein bars. No chips or caffeine for me.

Secondly, I take time to relax a few minutes each day. Once a week, I treat myself to a massage. It’s my only indulgence.

Lastly, and perhaps most importantly, I bought a dog, Boomer. I find that he not only provides me companionship, but he gets me out for exercise and fresh air.

Individually, each of the steps I take is small. But collectively, they add up to one giant step in my daily routine for good health.

CECELIA HURWICH, PH.D., California

In my late 60's the arthritis pain in my neck and shoulders was excruciating. I couldn't lift a tea kettle filled with water or open jars. When traveling I needed help pulling my small wheeled carry-on. I realized if I intended to grow older and live an active, pain free life, it was essential to make a change.

Taking action, I found a supportive trainer who advised weight training, cardiovascular exercise and walking. We started working together three times a week. At first I could barely raise a one-pound weight.

Gradually we increased the weights one pound at a time. After three months of hard workouts, the pain in my shoulders, neck and arms had subsided. Encouraged I kept up trainings and brisk walks. Nine month later I was lifting eight pounds and feeling so much stronger.

Now 85, I continue weight training, take Pilate classes, walk regularly and exercise in a swimming pool. These activities invariably improve my mood. I sleep sounder and am more alert and energetic, allowing me to enjoy life with my husband. By changing my lifestyle I discovered that it's never too late to make changes and enjoy old age.

CHARLES CROWDER, Illinois

Twenty seven years ago I decided to quit smoking for the umpteenth time.

I succeeded. Since that time I have made several other changes in life style.

Both my wife and I have become more conscious of our diet in the past ten or so years. We restrict starches and high fat foods (exception is good pie).

I changed my golfing habit from riding to walking about ten years ago.

Six years ago I purchased an electric golf cart that makes walking the course easier. About five years ago four friends and I started aerobic exercise at the gym. We meet at 5:15AM five days a week and spend about thirty to forty five minutes on the treadmill and bicycle.

Three years ago I had heart valve replacement. The amazing thing about that is I did not notice a problem while working out before the operation and do not notice a change after the operation.

I am convinced as are my friends that our workouts are a very good way too start the day.

CHERYL BARTHOLOMEW, Virginia

About seven years ago, I underwent several major foot surgeries over a period of four years. Throughout my recovery, my mobility was severely limited due to pins protruding from my toes. Physically unable to participate in my usual exercise classes, I became irritable, frustrated and depressed. My posture suffered and my back ached. I empathized with many older adults and persons with chronic conditions that restrict their fitness options.

Desperate to stay fit throughout my recovery periods, I formatted aerobic and resistance movements in a seated and supine (floor) position thereby managing to maintain my basic strength

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and stamina. Increased circulation (due to exercise) helped ease the pain and aided in the healing process. This experience triggered a career change.

The insight I gained from the struggles of surgical recovery encouraged me to respond to a “new calling”. I became a certified Senior Fitness Instructor with a goal of developing programs for persons with limited mobility, balance issues, chronic ailments, diabetes, etc. who could not or would not partake in conventional exercise. Exercise empowers older adults and improves the quality of their lives. Being proactive and exploring exercise options can change your life!

CHRIS BAUMGARDNER, Ohio

I quit smoking 12 years ago, after my mother died of lung cancer. The cause of death was as “smoking”, which sent home the message to me. With the support of my friends I was able to quit.

Since that time, I have been diagnosed with lupus and have had to take steroids for 3 years to get it under control. After that, I had one hip and knee replaced. With the joint replacements there are “restrictions”. The trick has been to find a regimen of healthy living and exercise in spite of the limitations. While my weight is not in the range it should be, I continue to try to live healthy.

I do a warm water aerobics class designed for arthritis. In my work I have talked to people with multiple sclerosis and other diseases that are living very active lives with hard jobs. It has made me a believer in not giving up. Any of us with illness and limitations in our lives should not let them take over. We should all work to be the healthiest person we can be!

DIXIE TAYLOR-HUFF, Tennessee

I am now 64 years old and exercise 1 to 2 hours per day.

From 1960 to 1963 I delivered 3 baby girls, gained about 20 lbs. after each one, and became one 5’2” rolly-polly! I decided to lose that weight because of my health and I wanted to live long enough to see those little girls to adulthood and feel well enough have fun with them.

I began to run 2 miles a day and lift weights about 30 minutes every other day. From May to November I lost approximately 60 lbs.

Today I walk between 4 to 6 miles at least 5 days a week and weight train approximately 30 minutes 3 times a week! My weight fluctuates 10 or 15 lbs. a year up and down but basically I’ve kept the weight off, and most importantly, I take no medications. I have not been to a physician, except for the annual physical, in 30 years. I have tons of energy and work 60 to 70 hours per week!

My nutritional modification was to eat less of the bad things and more of the good things...and once or twice a week eat too much of everything!

EDWARD CREEGAN, New York

Without a doubt the most important change in my lifestyle was when I decided to quit smoking.

I was a three pack a day smoker and was experiencing coughing episodes. One day about thirty-five years ago I decided to quit “cold turkey”, much to my surprise I succeeded. I had been smoking since I was about sixteen years old and I quit when I was in my late thirty’s.

Even though I quit about thirty five years ago, I still have lung damage which requires medication. However, with minimum medication, brief exercise and a substantial loss of weight I feel very good and I lead an active life as a retiree leader. There is no doubt that if I did not quit smoking when I did I would have died many years ago. Now I not only have the pleasure of helping fellow seniors but the unbelievable joy of enjoying my grandchildren for many years.

EILEEN BOSTWICK, California

When I was in my 20’s, years before cholesterol became a buzz, I learned that I had very high cholesterol (380/400). I made dietary changes only to discover that the wisdom of the day was not correct and actually worsened my condition. Years passed, I was overweight and always had very high cholesterol and very low HDL cholesterol.

Four years ago, in my mid 50’s I made a drastic change in my diet and tried to reduce my cholesterol. I changed to a mostly vegetarian diet, eating fish, vegetables, fruits, grains and added flaxseed to my diet. I buy few processed foods and frequent the Farmer’s market during the summer months.

The results were quite surprising. I started to loose weight (20 pounds) and my cholesterol numbers (216) improved dramatically, especially my HDL cholesterol which is now in the 70-84 range. This improved my cholesterol ratio and has reduced my risk of heart disease.

I try to exercise. This is not a favorite activity and I appreciate encouragement from my daughters and my dog. They make me walk. My father died at 60 from a massive coronary. Hopefully these changes will improve my health, preventing me from sharing his fate.

EILEEN HAYWARD, South Carolina

After 25 years of teaching, I was retired on a disability pension in 1976 due to allergic reactions to antibiotics. I quit smoking, and underwent a lifestyle change that included a regimen of exercises classes, taking tennis lessons, and modified my diet, with emphasis on low-fat and low cholesterol foods. In 2004, I lost 20 lbs. over a period of 6 months by changing my diet and exercising.

Having developed osteoarthritis in my 60’s, I began low intensity water exercises. Because of stenosis, I have now added walking, weights, and the exercycle 2-3 times a week. Upon awakening I do stretching exercises for mobility. In addition, I visit the acupuncturist and chiropractor on an as-needed basis.

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This modified lifestyle has given me the energy to devote the last 25 years to volunteer service, which includes forming Alzheimer's Support Groups; legislative work; serving on SC Advisory Council on Aging; MUSC Geriatric Development; and Clemson University Gerontology Research Team.

ERNESTO STOLPE, New Mexico

By the time the WHCoA conference is held I will be 58. I have had gout for the last twenty years and high blood pressure (at its highest 168/120) for the last five years, both conditions I controlled with prescription drugs.

Just short of 1_ years ago, in honor of my Godfather who passed away, I stopped drinking. Within four months I also weaned myself off of my prescription drugs. The only pills I presently take are a multivitamin and a baby aspirin. It has been over a year and I have had no bouts of gout and my blood pressure average now is 122/79 with a heart rate of 56.

My diet consists of high fiber (a lot of beans) with a lot of fresh vegetables, no fast foods, reduced-fat meat, whole grains and non-fat frozen yogurt.

I enjoy life as a grant writer. The 350 plus days of New Mexico sunshine has a lot to do with being able to walk every day in relative comfort. My walking partners are an 11-year-old beagle and my bride of 39 years.

ESTHER KOCH, California State

How I Became an Athlete at the Age of 50

It started with the Leukemia & Lymphoma Society's Team in Training (TNT) endurance event fund raising program. TNT was a great way to honor my mother who has leukemia, make a contribution to a worthy cause, and get in shape.

I completed my first 100-mile bicycle ride with TNT in 2001. I then challenged myself to complete a total of five 100-mile bicycle rides with TNT within the year of my 50th birthday. Those centuries were along the Eastern Seacoast, around Lake Tahoe, and in Las Vegas, Solvang, and Santa Fe. Then I decided to tackle California's most difficult bicycle ride, "The Death Ride", which for me was four mountain passes totaling 12,000 cumulative feet of elevation climb over 90 miles. The final birthday event with TNT was the Pacific Grove Olympic Triathlon.

I continue to make exercise a priority. This year, I hiked the Grand Canyon and took up dancing, which by the way, is a great combination of exercise, learning and coordination skills, plus social interaction as one ages. Bicycling, walking and dancing, plus two granddaughters and lots of friends, are my prescription for youthful, happy, healthy aging.

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EVANGELINE EUSTACE AUSTIN, Delaware

After my physical last year, I set a goal for walking 25 miles per week. Every morning I walk at least 2 .25 miles, and evenings I walk another two miles or so. It is exciting to return from an invigorating walk, ready to begin my workday. My evening walks allow for sharing the day's events with my neighbor and walking partner. Maintaining a walking log helps me monitor progress toward my goal. After a year and half, it feels strange to not begin the day without my morning walk. My heart rate is now in the mid 50's.

GAYLA S. WOODY, North Carolina

In July 2004 I attended the National Association of Area Agencies on Aging annual conference. I heard the Centers for Disease Control talk about obesity as the fastest growing epidemic since 1990. I heard Assistant Secretary of the US Administration on Aging, Josephina Carbonell talk about the You Can! campaign, a national health promotion campaign. I left that conference certain that health and wellness initiatives had to be a primary focus for the aging network.

At the time, I was forty pounds overweight, in my early fifties and had a high incidence of diabetes on both sides of my family. Personally, I knew I was facing a high probability of late life onset of diabetes, possibly if I lost weight, and probably if I didn't. Professionally, if I was going to "talk the talk", I had to "walk the walk."

I lost the forty pounds, changed my eating habits, and implemented a regular weight-lifting regime. It has been a year and a half and I have maintained my weight loss. So many people have noticed the change in me and commented that it has inspired them. I find it very exciting to see change happen – one person at a time!

HOWARD COWEN, DDS, MS, DABSCD, Iowa

Over the past 23 years I have been involved in competitive cycling and running. I have completed a marathon in under 2 hours, 50 minutes, and have won many 10K events for my age group. I am currently 55 years old.

In the past 10 years though, I have turned my attention to bodybuilding, although still running. I have won numerous bodybuilding competitions such as the NPC Mr. Iowa competition, and the Master's division 3 times.

I have also won the Iowa NANBF Master's crown. This past summer I was the winner of our local Gold's Gym competition for most push-ups (119), pull-ups (29), bench press (360 pounds), % of body weight, and wall squats. This was not an age discriminated competition, so I competed against all members.

I am 6 feet tall, weigh 187 pounds, with a body fat ~ 8%, total cholesterol 167 (HDL- 72), triglycerides 67, resting pulse 52, and blood pressure 110/67. I have a very strict diet, with less than

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20% fat and very little refined sugar intake. I have accumulated over 2100 hours of sick leave (at 12hrs/mo) and have not had a personal sick day in over 2 years!

JAMES B. CONROY, Iowa

I am 82 years old, 5'11" tall and weigh 170 lbs. and am in reasonably good health. I do not smoke or consume alcoholic beverages but I do maintain a regimen of exercise which includes swimming, bike riding and moderate calisthenics.

These are rather mundane points of interest regarding a healthy lifestyle, but a single personal health experience 26 years ago dramatically impressed on me the importance of knowing and caring for one's body through the use of personal discipline and medical information.

I developed an acute case of gout and after diagnosis maintained a dosage of pills which alleviated pain and reduced the number of arthritic attacks on feet, knees and other bodily joints.

On the advice of my doctor I reduced the amount of meat and seafood in my diet, and gave up all consumption of alcohol and drank only water.

Following these decisions I have had no recurrence of gout attacks and have not needed any prescription drugs.

It seems to me that informed familiarity with your body and its reaction to diet and exercise means better health and lowered health costs.

JAMIE ISON, Alabama

I climbed Mt. Kilimanjaro in September. I was invited to join a team with Erik Weihenmayer, the blind mountain climber who has climbed the 7 summits. Although I was already walking on a fairly regular basis, this trip was the motivation for me to lose the extra 20 pounds that needed to come off. I began training...walking 4 to 6 miles each morning, swimming a mile, and walking on the stairmaster, in addition to working one on one with a trainer for strength training. I traveled to Colorado to make a practice climb on a 14,000 peak in August. When I returned I knew it was time to get serious with my training and I began walking with my backpack and boots and climbing the stairs – at a local bank building and a local hospital.

Our climb took a total of 8 days – reaching the summit early on September 7th, my 52nd birthday! Climbing Mt. Kilimanjaro was a real test of endurance and strength and a wonderful opportunity to meet some real life heroes. I am continuing my walking and strength training and my next adventure is to walk in my first marathon in January.

JAN HIVELY, Minnesota

I learned that my cholesterol count was 254 in August 2004. The next month, I shifted from dairy products to soy products — using soy milk and canola margarine. I also looked for food products on the grocery shelves with labels that showed 0% or a very small % of cholesterol.

In August 2005, my cholesterol count was 212. I took no medications during the year in between, except for a daily multi-vitamin tablet.

Now, I'm so accustomed to the shift in diet that I'm sure that I'll be able to sustain the lower level of cholesterol.

JOHN ORTEGA, Iowa

In 1982, I went to the hospital thinking I was having a heart attack. The doctor found out after tests, that it was a severe case of heartburn brought about by smoking.

He suggested I get x-rays of my lungs. They found scar tissue, but it was caused from bouts with pneumonia. The doctor suggested I quit smoking to be safe.

I had a pack of cigarettes in my pocket and I finished them and have not smoked since. I quit smoking after 19 years.

JUDI G. REID, Virginia

“What do you mean I have emphysema?” I asked the doctor, in shock. “I’ve never been a smoker, there must be some mistake!”

It turns out that I did not have emphysema, but a lung disease called ‘Alpha-1 antitrypsin deficiency.’

So, once I’d received the official diagnosis of the real reason I was having difficulty breathing what were my choices? Many!

Every week, for the past 4 years, I have received an infusion of a drug to retard the deterioration of my lungs.

Recently, I participated in a pulmonary rehab program of exercising three times per week. I walk 30 minutes per day in the summer and eat healthy foods. Last year at the age of 61 I walked in the 8k race at the Richmond Marathon and experienced the thrill of crossing the finish line simultaneously with the first place runner of the marathon.

I have also had to do an ‘attitude adjustment’ from self-pity to gratitude.

I’ve acknowledged the roller coaster of emotions that automatically accompanies a chronic disease but my faith in God and a desire to serve others keeps me focused on the needs and quality of life of others.

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KENT YOHE, DC, North Dakota

January 2005 my 24 year old daughter was selected as Miss North Dakota International. As part of competition requirements she had to compete in a fitness wear competition. With an athlete's body she knew that changes needed to be made in order to look her ultimate best. She hired a personal trainer who trained her in the gym and completely changed her eating regimen as well.

With a family history of heart conditions and having my father die at age 60, I knew I had to take the future into my own hands. Witnessing first hand the changes that my daughter's body was going through and the discipline she had to cut out all sugar and processed foods, I knew I needed to change.

I have always been someone to take health seriously, and since January, I have changed my eating habits, lowered my cholesterol due to specialized vitamins formulated just for me, and increased my exercise. I not only feel better and have lost weight, but I have more energy too. Even at age 55, I can still keep up with people half my age in racquetball or softball games with 5 screws in my right ankle.

LORI ROSS, Maryland

I have made a significant lifestyle change that amazes me! My best friend learned the 2005 Marine Corps Marathon (MCM), would, for the first time, allow walkers to participate. She asked me to do it with her, mainly to help us get in the habit of exercising regularly.

When we started the training, we were not sure we would be physically capable of walking 8 or 10 miles, never mind 26 miles! We followed a training schedule, working out alone during the week alternating short walks and cross training (bike for her; Pilates for me) each day and every weekend we did longer training walks together without fail! By September, we were walking 20 miles despite a bad fall I took and knee problems.

We feel great and next weekend we will do the 26-mile MCM, followed by a half-marathon in Ft. Lauderdale on Nov. 12th. As marathon buddies, we plan to continue participating in marathons nationwide so we can keep training thus, regularly exercising. Having a buddy makes ALL the difference.

LOURDES ALVARDO-RAMOS, Washington State

I am 52 years old. I spent 22 years on military active duty where I was not only encouraged but mandated to be fit. It is not sufficient to perform all the physical demands the military imposes on you, but one must also couple them with practices such as smoking cessation, control of alcohol intake, and diet management. I am not proud of a past of smoking, excess drinking and a disastrous diet, but I am proud that through the years I have made lifelong modifications where I do not smoke, don't drink, exercise and eat sensibly.

I am currently in the Governor's Health Challenge where I have logged over 70 miles for the month

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of October. This may not sound like a lot, but it is significant to me as I am unable to run or spend a lot of time walking due to abused knees and a grueling travel and work schedule.

I intend to step up my fitness efforts and continue eating sensible. As I get older, I know that I will need every advantage to avoid illness and injury. I encourage other adults over 50 to do the same.

MICHAEL R. WASSERMAN, M.D., Colorado

As a Geriatrician, I've always believed in the importance of exercise for my patients. I was asthmatic as a child and at the age of 32, I had never run a mile and my knees would swell just playing a game of basketball. I started gradually, working my way up from a Stairmaster to a treadmill. Within a few years I'd run my first marathon. I completed my 10th Marathon a couple of years ago and have finished 4 half ironmen. A herniated disc in my spine set me back a couple of years, reducing my activity level and slowing me down significantly. I've persevered and continued to try to improve. This year, at the age of 46, I ran a mile under 6 minutes for the first time in my life! But that isn't what really excites me. I enthusiastically share with my patients the fact that 76 year old Madonna Buder and 80 year old Robert McKeague became the first woman and man of their age to complete the Ironman World Championship in Hawaii this year. There is no better way of showing that we can all improve our physical health and conditioning at any age!

MONICA WALTERS, Georgia

It was the prodding of my grandchildren to join in their activities that made me realize I was totally out of shape. When my husband and I tried to solve our sedentary empty nest syndrome with an energetic little Jack Russell terrier, my grandchildren would ask "Grandmama, why can't you help us catch your dog?" I was completely out of breath puffing after trying to run just a few yards.

I decided that in order to keep up with my grandchildren, I would have to make some changes for myself and my husband.

Out of the kitchen went the fattening snacks; in went fresh fruit. We even learned to like a bowl of oatmeal in place of a supper plate of fried chicken, french fries and buttered biscuits. Olive oil has become a staple and nutritional almonds have replaced caramels for snacks. My husband and I began walking at least 30 minutes daily and working out at the fitness center, a routine we incorporated into our everyday schedule.

With a few shed pounds and improved nutrition to keep me energetic, I'm ready for the grandchildren's challenge now!

OVARIE SMITH, California

Mrs. Ovarie Smith is a humble woman who left Texas in 1941 and moved to California with her six children. She opened her own catering service. One day while resting at home she began watching a television documentary on Developmentally Disabled persons and children. Disturbed by their treatment, she decided to become an advocate for all the underserved in Los Angeles and abroad.

Mrs. Smith's demanding schedule throughout the years led to her having a heart attack in the 80's and a stroke in 2003. She completely changed her eating habits. Instead of consuming fatty, fried foods, she acquired a taste for baked, broiled and grilled meat and vegetables. She enjoys eating hearty servings of fresh vegetables and fruits with her meals.

She also incorporated a one-mile Walking Program at 5 AM, Monday-Saturday to lose weight (25 pounds) and improve her overall wellness. Her aforementioned lifestyle changes continues to give her strength and perseverance to fight for the rights of the persons most in need of preserving their dignity, entitlement, and equality.

She is a true humanitarian and an inspiration to the world's health conscious community at the tender age of 100.

ROBERT P. DWYER, PH.D., Massachusetts

For the last 20 years, I have been battling Type II diabetes, high blood pressure and rising cholesterol. Three years ago, I injured a knee, exacerbating an arthritic condition. Shortly after this injury, I decided that I needed to do something to relieve the knee situation and my other health issues. I wanted to enjoy my family and life in ways that I wasn't able to.

At the age of 49, and nearly 340 pounds I decided upon bariatric surgery. During the preliminary process, however, I decided against the surgery.

About two years ago, my wife and I began to strive for a healthier life, eating healthier, more balanced meals. We also began walking one to two miles daily. In the winter, we snowshoe in the woods and state parks.

I experienced a weight loss of 95 pounds, a cholesterol level of 176, and significantly reduced blood sugars. Now 52 years old, my energy has increased and my life is fuller. I thank my wife for her love and support, and my family and coworkers for their encouragement.

My future is certainly brighter, and even though I still have long journey ahead of me, the road is clearer and more exciting!

STEVE DEVANEY, Massachusetts

In Pursuit Of Wellness

I do very well in moderating or abstaining from certain things that could have a direct negative impact on my wellness — except for eating too much for periods of time and thus carrying way too much excess weight. I now greatly feel the weight as I've edged over into 50+ land.

It was always easy to keep weight in check when involved in constant athletic activities during younger days. I needed to return to that method and began to join in on several of the organized group walks.

I participated in Boston's annual Jimmy Fund walk and several other walk fundraisers. I also stay active via walking, biking, golfing, and hiking. I must confess I'm too often a part of the Globesity problem and I need to always be pushing myself to get onto the solution side of this issue.

I have another goal out in the near future –that is to participate in the Ben Bulben Challenge in Ireland, an annual summertime 21 mile group hike — prep work is

needed or it won't be very much fun. I wonder what event may come into my focus after Ben Bulben? Time will tell.

STEVEN P. WEINIGER, D.C., Georgia

Around my 40th birthday I made a frightening observation:

Forget about touching my toes with knees straight, it was a strain to bend forward and barely touch my knees!

I had never been very flexible (partially because of a minor anomaly restricting mobility in the mid-back), but I knew this was not good. Since I am a chiropractor, I did not relish the idea of “moving old” in my 40s.

So, I decided to try yoga.

Over the next few years I visited many yoga and exercise studios, and took classes in various styles of yoga. I also spoke to the instructors about yoga and the mechanics of the human body.

As a doctor of chiropractic with strong grounding in anatomy, I liked most of what I heard. Despite differing philosophy and techniques, the instructors all taught students to move consciously, symmetrically, and with control- a great formula for “moving young”.

As a 40-something man with poor flexibility and tension, I loved what I felt.

Now, after 50, I practice yoga (almost) every week, and my wife and I recently converted a spare bedroom into a mirrored studio to encourage us to spend 20 minutes a day exercising.

SUE SHAW, Georgia

May 20, 1971 was quite a rewarding day. I threw out a carton of cigarettes, and became a non-smoker; from almost two packs a day to “0”. Cold turkey. Pre-nicotine patch. Wow.

In 1971, in year five of a 37 year career of teaching secondary Physical Education, I smoked. I knew it was stupid, but I still smoked a lot. I couldn’t run the length of the soccer field. My lack of endurance on the field figured heavily in my decision to quit. At age 28, my competitive spirit was alive and well! I traded smoking for jogging and never looked back. It was the best health decision I ever made.

When I quit smoking I didn’t just break a habit, I made an investment in the quality of my future. I gave myself the gift of decades of jogging and cycling; the gift of endurance with which to participate in life to the fullest.

I am so glad that I quit smoking, not only for my own health, but for the health of my students. In my health class I tell students, “If I can quit, YOU can!” And some have. It was a rewarding day, indeed.



**President's Challenge
Recognition Program**



2005 White House
Conference on Aging



2005 White House Conference on Aging *Healthy Living Celebration!*

Cotillion Ballroom
Sunday, December 11, 2005
1:30-4:00 pm
Marriott Wardman Park Hotel
2660 Woodley Road, N.W.
Washington, DC

Healthy Living Celebration!
Agenda

1:30 pm Welcoming Remarks

Dorcas Hardy
Chairman, Policy Committee
2005 WHCoA

1:35 pm Melissa Johnson

Executive Director
President's Council on Physical
Fitness and Sports

1:40 pm Delegate Mark Zeug

Chairman, National Senior
Games Association

1:45 pm Nutrition and Healthy Living

Mollie Katzen
Renowned Cookbook Author

2:20 Activity Sessions I

| | |
|-------------------------|------------------------|
| <i>Dancing Grannies</i> | <i>Washington 5</i> |
| <i>Ya-La Dancing</i> | <i>Washington 4</i> |
| <i>Tai Chi</i> | <i>Salon I</i> |
| <i>Thera-Band</i> | <i>Cotillion South</i> |

**Healthy Living Celebration!
Agenda Cont.**

2:40 pm Activity Session II

Dancing Grannies Washington 5

Ya-La Dancing Washington 4

Tai Chi Salon I

Thera-Band Cotillion South

3:00 pm President's Challenge

Recognition Ceremony

Dot Richardson

*Vice Chairman, President's Council
on Physical Fitness and Sports*

3:15pm Profiles in Wellness

**Recognition Ceremony and
Charge for the Delegates**

Dorcas Hardy

*Chairman, Policy Committee
2005 WHCoA*

3:30 pm Conclusion of the Healthy Living Celebration

***PLEASE NOTE: ALL EVENTS WILL BE HELD IN THE COTILLION
BALLROOM***

UNLESS OTHERWISE NOTED

***DON'T FORGET TO VISIT THE
2005 WHCoA/AoA "YOU CAN!" WALKING TRAIL
LOCATED ON THE LOBBY LEVEL!***

2005 White House Conference on Aging and the President's Challenge Physical Activity and Fitness Awards Program

The 2005 White House Conference on Aging (WHCoA) is working with the President's Council on Physical Fitness and Sports to promote physical activity/fitness and health across the life span before, during, and after the WHCoA scheduled for December 11 -14, 2005 in Washington, DC. We invite all delegates to consider joining us in the "2005 White House Conference on Aging's President's Challenge." The President's Challenge, a program of the President's Council on Physical Fitness and Sports, has 3 distinct program areas, is free and motivational, and is designed to help all Americans adopt and maintain an active lifestyle. What began as a national youth fitness assessment has grown into a series of programs that encourage healthier lifestyles for Americans, with or without disabilities, ages 6 to 100+. To learn more about the President's Challenge, go to <http://www.PresidentsChallenge.org>

The President's Council on Physical Fitness and Sports and the WHCoA invite all interested parties to participate and sign up for the Presidential Active Lifestyle Program (PALA) or the Presidential Champions Program. Both of these programs are designed to help individuals make and keep a commitment to staying active.

The Presidential Active Lifestyle Program helps adults and seniors get and stay active for at least 30 minutes per day, five times per week, for six weeks. Individuals who meet their activity goals earn an official President's Challenge award. Once you earn an award through the PALA Program, you can continue to earn awards through this program by increasing your segments of time to reach 30 minutes, or progress to the Presidential Champions Program.

The Presidential Champions program is designed for people who are already physically active and want to step up to a new challenge. All activity counts!! To participate in either of these programs, simply register at http://www.PresidentsChallenge.org/login/register_individual.aspx.

To learn more about the benefits of physical activity and how to become more active, go to <http://www.fitness.gov/fitness.htm>

We hope all delegates will join us in the effort to become active role models so we can walk the talk and encourage others to lead healthier lifestyles. A major goal of the 2005 WHCoA is to encourage healthy living for all, but especially for current and future generations of older Americans. Please join us on a journey toward healthy living!

Congratulations to those who completed the 2005 WHCoA President's Challenge Program!

| | |
|---------------------------------------|------------------------|
| Norman Abeles | Michael Farley |
| Dr. Amy Ai | Anwar Feroz-Siddiqi |
| LaVerne Alexander | Patricia Finder-Stone |
| Sandra Anderson | Paula Fong |
| Georgia Anetzberger | Dr. Moira Fordyce |
| Milton Aponte | Naomi Fukagawa |
| Magaly Arias-Petrel | Dr. Mary Furlong |
| Bonnie Athas | Joyce Gallagher |
| Ernest Chuck Ayala | Dr. Richard Gans |
| Lt. Governor Catherine Baker Knoll | David Geist |
| Ann Bannes | Lester Gingold |
| John Barnett | Phil Godfrey |
| Cheryl Bartholomew | Phyllis Golden |
| Mary Beals Luedtka | Dr. Erica Goode |
| Mr. AJ Benintende | Keith Gooden |
| Dr. Judy Black | Harriet Goodwin |
| Eve Boertlein | Richard Greenberg |
| Antonietta Boucher | Cathy Grimm |
| Elaine Brovont | Lawrence Herman |
| Cathy Brown | Tom Hylemon |
| Fran Brown | Jan Hively |
| S. Ward Casscells | Jeffrey Hoffmann |
| Dr. Christine Cauffield | Warren Housley |
| Judy Cederholm | Rena Iacono |
| Lawson Chadwick | Fidela Irigoyen |
| Rosemary Chapin | Jamie Ison |
| Frieda Clark | Pamela Johnson Betts |
| Sandra Cortese | Hon. Patricia Jones |
| William Dailey Jr. | Julie Jow |
| Walter De Foy | Ellie Jurado-Nieves |
| Stephen Devaney | Glenda Kane |
| Anne Dickerson | Vivienne Kerns |
| Marilyn Ditty | Dr. Jeffrey Kerr |
| Bethany Dougherty | Esther Koch |
| Ramona Dover Kennedy | Henry Lacayo |
| Gloria Duran | Susan Lather |
| Nelson Durgin | Rebecca Liebes |
| Katie Dusenberry | Eileen Luisi-Hayward |
| Linda Engelbrecht | D. Jane Maloney |
| Celia Esquivel | Mary Martinez |
| Michael Farley | Anne Mason Taylor |
| Anwar Feroz-Siddiqi | Gloria McCutcheon |
| | Mary Louise McCutcheon |

Congratulations to those who completed the 2005 WHCoA President's Challenge Program!

| | |
|----------------------|-----------------------|
| Karen McKibben | Alice Spratley |
| Peggy Miller | Ernesto Stolpe |
| Patricia Miller | Phyllis Suhar |
| Dr. Marva Mitchell | Dr. Louis Sullivan |
| Dr. Stephen Montamat | Fran Symms |
| Sheri Montgomery | Mickie Timmons |
| Hon Ruby Moy | Penny Troolin |
| Marie-Elena O'Connor | Florence Turner |
| Alice O'Reilly | Dr. Michael Wasserman |
| Variny Paladino | Dr. Wilfred Watkins |
| Michelle Park Steel | Jane Watkins |
| Shelly Peterson | Doug Wilkinson |
| Jean Roesser | Betty Wiser |
| Donald Roskopf | Patricia Wojcik |
| Sheila Salyer | Ginny Wood-Bailey |
| Glady Schroeder | Dr. Cheryl Woodson |
| Leonard Sempier | Allan Zaback |
| Sue Shaw | Carol Zernial |
| Tom Shea | Mark Zeug |
| Aaron Simonton | |
| Dr. Kathleen Spears | |

2005 WHCoA Recognizes the PROFILES IN WELLNESS PARTICIPANTS For Their Outstanding Commitment to Healthy Living!

The 2005 White House Conference on Aging (WHCoA) recognizes the importance of leading a healthy lifestyle. A major goal of the 2005 WHCoA is to encourage healthy living for people of all ages.

In addition to encouraging delegates to participate in the “2005 White House Conference on Aging President’s Challenge” program, the 2005 White House Conference on Aging would also like to commend those delegates who have already shown a dedication to health and wellbeing through positive lifestyle changes. Achievements such as lowering cholesterol through diet, adopting a regular exercise program or smoking cessation are phenomenal and deserve recognition.

The delegates profiled on the 2005 WHCoA website serve as examples to all Americans, illustrating that a healthy lifestyle is achievable!

| | |
|------------------------|----------------------------|
| Amy L. Ai, Ph.D. | Jamie Ison |
| Lourdes Alvarado-Ramos | Esther Koch |
| Evangeline Austin | Bernice A. Morfin |
| Lieutenant Governor | Denise Nelsen |
| Catherine Baker Knoll | John Ortega |
| Ann Bannes | Judi G. Reid |
| Cheryl Bartholomew | Lori Ross |
| Chris Baumgardner | Sue Shaw |
| Eileen Bostwick | Ovarie Smith |
| James B. Conroy | Ernesto Stolpe |
| Howard Cowen, DDS | Dixie Taylor-Huff |
| Edward Creegan | Carl W. Toepel |
| Charles Crowder | Monica Walters |
| Steve Devaney | Michael R. Wasserman, M.D. |
| Bill Dukes | Steven P. Weiniger |
| Robert P. Dwyer, Ph.D. | Gloria Willich |
| Lester F. Gingold | Gayla S. Woody |
| Eileen Hayward | Gella M. Works |
| Jan Hively | Kent G. Yohe |
| Cecelia Hurwich, Ph.D. | |

The 2005 WHCoA and the President's Council on Physical Fitness and Sports greatly appreciate the support and generosity of:

- **United States Administration on Aging/
“You Can” Campaign**
 - **Senior Games Association**
 - **The Dancing Grannies**
 - **Laurent Amzallag**
 - **The Tai Chi Study Center**
 - **Dr. Michael Rogers**
 - **Thera-Band**
 - **The Coca-Cola Company**
 - **Rickman Photography**

The following websites provide additional information on The President's Council on Physical Fitness and Sports, the 2005 WHCoA, and general information about leading a healthy lifestyle:

2005 White House Conference on Aging

<http://www.whcoa.gov>

The President's Council on Physical Fitness and Sports

<http://www.fitness.gov>

The Administration on Aging

<http://www.aoa.gov>

The President's Challenge

<http://www.presidentschallenge.org>

The National Senior Games Association

<http://www.nsga.com>

My Pyramid.Gov

<http://www.mypyramid.gov>

The Centers for Disease Control and Prevention

www.cdc.gov



THE
BOOMING
DYNAMICS
OF AGING

From Awareness to Action



**Transcripts of Conference
Speeches and Presentations**

2005 White House Conference on Aging

Transcripts of Conference Speeches and Presentation

Saturday, December 10, 2005

PAN AMERICAN HEALTH ORGANIZATION RECEPTION

Opening Remarks

Dr. Mirta Roses Periago, Director, PAHO

The Honorable Josefina G. Carbonell, Assistant Secretary for Aging
U.S. Department of Health and Human Services

Sunday, December 11

HEALTHY LIVING CELEBRATION!

Program and Participant Recognition

Remarks, the Honorable Dorcas R. Hardy, Chairman, WHCoA Policy Committee

Presentation, Mark Zeug, Chairman, National Senior Games Association

ROUNDTABLE ON GLOBAL AGING

Richard Jackson, Ph.D. CSIS Global Aging Initiative

Francoise Forette, MD, Innovations in the French Government Policy on Aging

Ysuke Kataoka, Executive Director, U.S. Foundation for International Policy, Japan

K.R. Gangadharan, Heritage Hospital, Hyderabad, India, Aging In India

Margaret Gillis, Director of Aging and Seniors Department of Health, Canada

Pedro Borda, Director, National Institute of Senior Citizens, Ministry for Social Development,
Mexico

Vusi Madonsela, Director General, Department of Social Development, Republic of South Africa

RIBBON CUTTING OF EXHIBITION HALL

Remarks and Introductions, the Honorable Dorcas R. Hardy, Chairman WHCoA Policy Committee

Statement, Pat Conroy, Vice Chairman and National Managing Principal

Deloitte Services, Ltd.

Remarks, the Honorable Norman Y. Mineta, Secretary, U.S. Department of Transportation

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Monday, December 12

OPEN PLENARY SESSION

Barry C. Black, Ph.D., Chaplain, U.S. Senate

The Honorable Josefina G. Carbonell, Assistant Secretary for Aging

The Honorable David M. Walker, Comptroller General of the United States

Craig Barrett, Chairman of the Board, INTEL Corporation

The Honorable Dorcas R. Hardy, Chairman, WHCoA Policy Committee

POLICY TRACKS

The Honorable Mark McClellan, Administrator, Centers for Medicare and Medicaid Services

Robert Essner, Chairman, President and CEO of Wyeth

The Honorable Dirk Kempthorne, Governor of Idaho (Audio Off-Site)

Hal Daub, President and CEO of the American Health Care Association (AHCA) and

National Center for Assisted Living (NCAL)

David Eisner, CEO, Corporation for National and Community Service (Off-Site)

Ken Dychtwald, Ph.D, Futurist

Abigail Trafford, Health Columnist, The Washington Post

Tuesday, December 13

CLOSING WHCoA DINNER: THE BOOMING DYNAMICS OF AGING

Roger Barnett, Chairman and CEO, Shaklee Corporation

Wednesday, December 14

CONFERENCE REPORTS FROM POLICY COMMITTEE

CLOSING PLENARY

Joe Garcia, Governor, San Juan Pueblo and President, National Congress of American Indians,
Moment of Reflection (English Translation)

Dr. Robert Butler, President and CEO of the International Longevity Center—USA

The Honorable Dorcas R. Hardy, Chairman, WHCoA Policy Committee

Pan American Health Organization Reception

December 10, 2005

WELCOMING REMARKS:

DR. MIRTA ROSES PERIAGO

DIRECTOR, PAHO

The Pan American Health Organization is pleased to welcome:

Josefina Carbonell, Assistant Secretary of Aging in the Department of Health and Human Services; members of the Policy Committee of the White House Conference on Aging; members of the Advisory Committee, International observers.

The Pan American Health Organization celebrated its 100th birthday three years ago and like many individuals in our new world, we continue to thrive. Our mission is to work, in collaboration with our Member States, in building better health for all throughout the Americas.

We are pleased that the White House Conference on Aging has invited the international community to be part of this important policy event for the USA. We all have much to learn and much to contribute in meeting the goals proposed by the UN for a Society for All Ages. We are pleased to host this event as an opportunity for many of you to meet and share your knowledge of aging around the world. Together we should find better ways to bring the gift of longevity to every corner of our region. This requires a vigilant fight against premature aging and disabilities caused by poverty and lack of access to quality health care; and promote a more secure world for all vulnerable populations.

Aging is a life long process that embraces all generations and impacts both individuals and families. Over 92 million persons 60 years of age and older live in the Americas; one out of every 4 homes in Latin American include an older person and families continue to provide the majority of resources for caring for the young and the old. Aging permeates the fabric of our lives. In the Americas we can celebrate that many more individuals are living longer and better; yet far too many live their old age in poverty, with poor health and in isolation. Aging has both an unfinished agenda from the 20th century and an important new challenge for the 21st century. The demographic triumph of the past century faces new and emerging epidemics of transmissible and non-transmissible diseases, pandemics, violence and terrorism. We must face these challenges.

For most of the developing nations in our hemisphere the window of opportunity for developing and implementing a compassionate, comprehensive, cost-effective aging policy is closing rapidly. Much work has to be done; many priorities with limited resources compete for attention. However, the ultimate challenge for society and policy makers is to value the life of each human being without discriminating because of age, sex, ethnic background or race. Delays in planning for our aging

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population will result in greater intergenerational dilemmas and in poorer use of limited resources.

Three years ago, the world met in Madrid to face the challenge of rapid population aging at the UN Assembly on Aging; the blueprint that emerged in the International Plan of Action on Aging has provided the guiding principles to shape policy for the international community.

For most countries in our region the rapid increase of older persons in need of services, including long-term care, is a major policy challenge. The majority of human resources in health are unprepared to meet these challenges; national budgets have not anticipated the cost of delivering health care for uninsured older adults and the health care system has to be adapted to the special needs of older populations. PAHO/WHO is working in collaboration with all our Member States in all of these areas. We are very pleased to have produced the first data base on the health of older persons in urban areas of Latin America and the Caribbean. We have developed two strong networks to support the training of both researchers and practitioners in public health and geriatrics. In collaboration with our colleagues at the World Health Organization, we have tested the framework for 'senior friendly' health centers in five countries in this region (Peru, Chile, Jamaica, Trinidad and Tobago and Suriname); and we are providing technical assistance for monitoring the response of the health system to the International Plan of Action on Aging, 2002 as requested by the World Health Assembly in 2005.

Throughout the communities in our region we have the means to promote active and healthy aging. It is time to make the decisions to guarantee that primary health care will be reoriented to provide a friendly environment with efficient services for older adults. And we must ensure that our primary health care initiatives are well coordinated with the community and the hospital to ensure continuity of care.

The goal of reducing the burden of disability in old age is a new challenge for this century and is one of the strategic objectives of the UN International Plan of Action on Aging. The USA has been successful in reducing the rate of disability. The challenge for 'poor' countries is to become old before becoming 'rich'. Aging will affect everyone, without regard to age, sex, race or social status; we hope that longevity will not be seen as the privilege of those who are rich while the poor and neglected populations become vulnerable to premature aging and disability.

On Tuesday at 2:30 p.m. PAHO/WHO will provide a briefing of WHO global and regional work in the area of aging and health. We invite you all to come and participate, ask questions, share your experiences with us.

Lastly, we thank you for joining us today. I hope that this evening, in an informal and friendly environment that we have planned for you, you find the opportunities to meet and exchange experiences with the advisory and policy committees, with delegates and other observers to the White House Conference on Aging as well as with PAHO staff. We all wish you a very productive participation in the busy agenda prepared for you.

Pan American Health Organization Reception

December 10, 2005

REMARKS BY:

JOSEFINA G. CARBONELL

ASSISTANT SECRETARY FOR AGING

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

- It is a pleasure to be here tonight.
- I want to thank Dr. Mirta Roses Periago, the Director of the Pan American Health Organization (PAHO), for graciously hosting this event.
- I also want to thank all of the other PAHO colleagues who are here and helped with this reception.
- The Administration on Aging has collaborated on a number of efforts with PAHO and we are very pleased to continue this collaboration tonight.
- Before I continue my remarks, I think this is a good time to introduce a new colleague, Alicia Diaz. I will let Ms. Diaz tell you about her new role in the Office of Global Health Affairs.
- Alicia, would you like to say a few words?
- Thank you Alicia.
- Now, I would like to personally extend a welcome to all of you who have traveled across the globe to be with us on this historic occasion.
- You have journeyed here from some 24 countries – from Asia, from Africa, from Europe and from Latin America.
- The White House Conference on Aging comes about only once every 10 years.
- These events have a tradition of diversity in participants, focus, and interests
- Each of the White House Conferences on Aging has had an impact on aging policies in the United States.
- Monday morning, you will see over 1,000 people who have gathered from across the country because they are deeply concerned and interested in the future of aging policy programs in this country.
- The 1,200 delegates participating in the Conference represent the Governors of all 50 states, the U.S. Territories, the Commonwealth of Puerto Rico, and the District of Columbia; the members of the 109th Congress; and the National Congress of American Indians.

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- This week you will see what is the culmination of several year's preparation involving input from thousands of people across the country. All of this work led to commonly agreed upon themes and resolutions to be voted upon at the conference.
- 73 resolutions were approved and sent to the Conference's delegates for their review. These resolutions are based on public input solicited over the past 15 months, obtained from testimony and reports submitted at nearly 400 Listening Sessions; from Solutions Forums; Mini-Conferences; and Independent Aging Agenda Events; as well as general public input that has been received by the WHCoA.
- The Policy Committee believes that the input received accurately reflects the emerging issues, interests, and concerns of individuals who participated in these events as well as the unsolicited input from across the country.
- Delegates will be asked to vote on up to 50 resolutions and develop implementation strategies that they believe are the most important for current and future generations of seniors. These will be presented to the President and Congress to help guide aging policies for the next decade and beyond.
- We are very pleased that so many experts from other countries have been able to join us to witness this "bottoms up" process and this historic event.
- The last conference in 1995, thirty five international observers participated.
This year we have almost 50!
- As you all well know, aging is a global issue.
- At tomorrow's global aging roundtable, we will hear from some of you on how you are dealing with aging issues in your individual countries. We look forward to this exchange since we stand to learn from each others experiences, programs and problems.
- On Monday, International Observers will have the opportunity to talk to aging experts from the Department of Health and Human Services to discuss current research, policies and programs
- On Tuesday, we will be back here at PAHO, when you will have more time to discuss health related issues, and talk about both regional PAHO activities and WHO global aging-related activities.
- For those of you who are not from the Americas, I am sure that you will find this meeting quite useful to bring back to your own regions.
- Again, my special thanks to PAHO for organizing this wonderful reception.
- Please enjoy the rest of the evening.

Healthy Living Celebration!

Sunday, December 11, 2005

CLOSING REMARKS

DORCAS R. HARDY

CHAIRMAN, WHCoA POLICY COMMITTEE

Thank you, Melissa, and thank you, Dot (Richardson) for being with us today. I know you have a lot of fans here. I commend you for your past, current and future efforts to promote fitness and health.

I would again like to extend a ‘thank you’ to Melissa Johnson and the President’s Council on Physical Fitness and Sports for their tremendous support and guidance in making today’s event possible.

I want to particularly recognize Chris Spain, Director of Research, Planning and Special Projects, who has helped us from the beginning and lent us her enthusiasm!

I would also like to recognize one of our delegates (from Hawaii), Mark Zeug, Chairman of the National Senior Games Association, and thank him and his organization for their encouragement and unwavering commitment to the promotion of physical activity for older adults.

We are grateful to renowned cookbook author Molly Katzen for sharing her thoughts with us related to nutrition and healthy eating.

Of course, we must thank the fantastic exercise leaders for sharing their time, energy and expertise with us this afternoon – what a workout!

I’d like to call your attention to the Administration on Aging’s “You Can” Campaign for sponsoring the WHCoA Walking Trail you see throughout the hotel. You can use the trail as you deliberate on your top 50 resolutions and the subsequent implementation sessions – grab a colleague and talk a walk!

For those of you who did not get a chance to participate in any of the fitness activities today, I’d like to mention that Jazzercise has a space in our exhibit hall which opens later this afternoon. They will be putting on some lively demonstrations that I think you will enjoy – join in the fun!

Most of all, I would like to say a special thank you to the 2005 WHCoA delegates for participating in the Healthy Living Celebration, and for your willingness to choose a healthier lifestyle.

Today, we have seen extraordinary examples of individuals who have taken steps towards a healthier lifestyle – those of you who participated today and those who participated in the President’s Challenge who have just been honored.

I am honored to recognize some other important people – fellow delegates who responded to the WHCoA’s Profiles in Wellness – a call for delegates to share stories of personal achievement with the WHCoA.

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Those who sent their stories to us are to be congratulated for the efforts they have made to improve their lives and health. I, for one, have been inspired by your initiative, tenacity, and in many cases, your ability to overcome significant challenges.

There were so many great stories we received, and we don't have the time to highlight them all, but I invite you to visit our website and read about them. We have individuals who stopped smoking, who took up training for marathons and triathlons, who have collectively lost hundreds of pounds. Now, we know there are a lot of people who could fall into that category!

At this time, I'd like to ask all those who had their Profiles in Wellness highlighted on our website to stand and be acknowledged by your colleagues. At the end of the today's event, you will receive a small token of appreciation from the WHCoA and from the National Senior Games Association who have contributed honorary athlete medals to honor your efforts. Thank you and keep up the good work!

Just because the WHCoA ends on Wednesday, please don't think you can't still share your stories with us or stop working on improving your health. Those of you who know me know that health – mine, yours, and our nation's – is a special passion of mine.

This afternoon we have had the opportunity to be physically active and to learn about the importance of a balanced diet. The importance of a healthier lifestyle is not a new message, but it is one we must continue to promote for the sake of our health and that of future generations.

We know that seven of every ten deaths in the U.S. are due to chronic diseases, and the number of Americans who suffer from diabetes, coronary heart disease, cancer and cognitive impairments will increase to 300% by 2049. And we all know that obesity is a major public health threat in our country.

As the Chairman of the WHCoA Policy Committee, I offer the WHCoA as a national stage — a bully pulpit — from which we can broadcast the importance of preventive health practices across the lifespan.

I want us to send a message that personal health is the responsibility of the PERSON, and that in many cases, there are steps we can take now – whether its line dancing with the Dancing Grannies or doing any of the other great activities offered today — or taking a better look at our diet — to improve our health.

As the baby boomers – all 78 million – begin to turn 60 starting in just in three weeks, it is more important than ever that we learn from the examples set by people like those we have met today — who recognize that maintaining our health throughout our lives will help to ensure a better life as we age.

As we go forth to vote on resolutions and consider implementation strategies, I challenge each of you to be leaders and to set an example for your fellow delegates and for all Americans. Thank you for joining us on the journey to wellness. Remember that the journey is un-ending and it is never too late to take the first step.

Healthy Living Celebration!

Sunday, December 11, 2005

REMARKS BY:

MARK ZEUG

CHAIRMAN, NATIONAL SENIOR GAMES ASSOCIATION

Greetings, everyone. Aloha! It's great to see all of you here. I am indeed privileged to be part of this Healthy Living Celebration! this afternoon, and enthusiastically applaud the focus on fitness in opening this event.

For I believe that proper exercise and eating habits will do more to improve longevity and quality of life for seniors than all other efforts combined. That is the mission of the National Senior Games Association, organizer of the National Senior Olympics, the largest multi-sport event in the world for seniors. We are dedicated to promoting healthy lifestyles through education, fitness and sport.

NSGA is the national organization that spearheads the senior games movement, sanctioning and coordinating efforts of senior games organizations across the country. Presently, we serve 50 member state organizations, located in 49 states and the District of Columbia.

This past June, more than 10,000 seniors from all parts of the country converged on Pittsburgh for the Summer Games, competing in 18 different sports and amassing hundreds of event records. And demonstrating again that sports provide excellent incentive for seniors to get fit and stay fit throughout their golden years.

As more and more seniors realize the value of an event like the Senior Olympics to drive their quest for fitness, our programs have grown accordingly — we are expecting around 15,000 senior athletes at our next Summer Games, set for June of 07 in Louisville, Kentucky. Two years later, we'll do it again in San Francisco, and in 011, we'll be in Houston. You can learn more at NSGA.com.

Many national games athletes began their journey to Pittsburgh by first competing in one of the more than 300 local senior Olympics events held annually around the country. In all, some 200,000 seniors nationwide participate in one or more sports competitions conducted by these state and local senior games.

And many more participate in non-competitive fitness activities such as Walk Delaware or the Hawaii Walkarama. They do it for fun. They do it for fellowship. And they do it for fitness. Because they know that fitness pays. We all know the data – you can expect to live up to 10 years longer if you stay physically active, you can expect to save about \$3,600 per year on medical and pharmaceutical costs by staying active in your senior years, you will be better able to combat illness when it does strike, you will be healthier and happier and enjoy life more if you stay physically active.

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We all know it, and our seniors prove it every time they lace up their running shoes, or pick up a tennis racquet. Our participants range in age from 50 to 103. In Hawaii, we even welcome 40-year-olds – we call them pre-seniors.

We also foster Research and Education through the NSGA Foundation --

Dr. Jenifer Mason, a trustee of the Foundation and prominent researcher who is here as a delegate is currently working with the University of Pittsburgh School of Medicine, the Texas Medical Center and the LSU Pennington Biomedical Research Center to better understand senior health problems and find ways to create better adult health and fitness through education.

We need more research like this to help us get at the problem, but we already know what the problem is – more than 50 percent of seniors are couch potatoes. They are so physically limited that they cannot walk up a flight of stairs without gasping for breath, they cannot run a few steps to catch a bus or walk across a mall parking lot without being in distress.

There's our problem folks. And we need to address it at this forum. In size, social impact and actual cost – cost in dollars and cost in reduced quality of life – it dwarfs all of the other problems identified in the list of resolutions we have before us. This is not just me talking – the Rand Corporation estimates that the social and economic costs of physical inactivity exceed the costs of smoking and drinking combined.

We need to take a serious look at these resolutions to see how implementation can be formatted to include a focus on fitness. We've got to come up with ways to encourage more seniors to be physically and mentally active, and to stay that way. We know what the outcome needs to be – we just have to figure out how to get there. But we are a powerful group of intelligent people who represent nearly every aspect of life that could possibly affect our seniors. If we can't do it, nobody can. We're here, let's do it. SENIOR POWER!

Exhibit Hall Opening/Ribbon Cutting

Sunday, December 11, 2005

5:30 p.m. Atrium Lobby

REMARKS AND INTRODUCTIONS BY

DORCAS R. HARDY, CHAIRMAN, WHCoA POLICY COMMITTEE

Good afternoon and thank you to the U.S. Coast Guard Color Guard for joining us today.

Welcome to the Grand Opening of the 2005 WHCoA Exhibit Hall – marking the first time a WHCoA has ever had an Exhibit — let alone one of this magnitude.

We are honored to have several distinguished guests to kick off this wonderful Exhibit Hall.

I don't want to steal anyone's thunder, so I will only encourage everyone to use whatever spare time they have throughout the WHCoA to visit the Exhibit hall and talk to the many participants.

It is now my distinct pleasure to introduce an exceptional individual who will serve as our MC.

Bob Abrams is President and Founder of ZivaContinuum, a technology-based health information resource organization. He is also a delegate to the 2005 WHCoA, appointed by New York Senator Charles Schumer.

Bob is truly a visionary – he put a very successful career as an eldercare attorney aside to build ZivaContinuum because he wants to provide health care consumers with the ultimate choice — to have health care information customized for them.

Just as important, Bob has become a fast and close friend of the 2005 WHCoA.

ZivaGuide, which is a subscription-based web service that provides personalized, customized and localized healthcare information to healthcare consumers and professionals, has joined with the WHCoA as our co-sponsor in putting on this grand Exhibit hall.

Under Bob's leadership he has provided the Exhibit hall participants (which include the CAST Imagine Pavilion and the Department of Transportation of the Future exhibit as well as many other innovative exhibits) with focused direction and a sense of energy you will soon witness.

I know it will be a highlight of the WHCoA and we are grateful to Bob in many ways.

Ladies and Gentlemen, Bob Abrams.

Thank you Pat (Conroy).

It is now my distinct pleasure to introduce our guest of honor

We are so honored to have Secretary Mineta join us this afternoon for the grand opening of the exhibit hall.

Secretary Mineta has enjoyed a long and outstanding career serving our country.

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He is the longest-serving Secretary in the history of the Department of Transportation, and before that enjoyed a remarkable career as Secretary of Commerce and as Vice President of Lockheed Martin.

Secretary Mineta served as a valued member of the House of Representatives for 20 years where he had an illustrious career and while there co-founded Congressional Asian Pacific American Caucus.

The Secretary was Chairman of the National Civil Aviation Review Commission and Mayor of the beautiful city of San Jose, California — a site of a WHCoA Solutions Forum on the Technology and the Marketplace earlier this year.

I could go on and on, but mostly I want to make sure that everyone here knows of Secretary Mineta's ongoing commitment to the older people of our country.

As Secretary of Transportation, he has kept his eye on the nation's future, whether it relates to security issues or to ensuring that our transportation systems and programs of the future keep in mind the needs and contributions of millions of baby boomers who will soon begin to join the ranks of our nation's senior citizens.

We are so pleased that Secretary Mineta chose to make the Department of Transportation a major partner in the historic WHCoA Exhibit hall – their presence enhances the entire exhibit along with our other wonderful partners. So we thank you Mr. Secretary!

Now it is my great honor to present: Secretary Norman Mineta.

Ribbon Cutting — Exhibit Hall

December 11, 2005

REMARKS BY:

PAT CONROY

VICE CHAIRMAN AND NATIONAL MANAGING PRINCIPAL

CONSUMER BUSINESS PRACTICE

DELOITTE & TOUCHE USA LLP

Good afternoon and thank you for the opportunity to address you here today.

This conference was convened to develop recommendations for the President and Congress in the field of aging. However, as the first wave of baby boomers prepares for retirement – and as people all around the world are living longer thanks to improved health care and nutrition – the private sector must also reassess how it serves this important consumer segment.

Consider, if you will:

- Today, there are more than half a billion people in the world who are 60 or older. This population has tripled since 1950.
- By 2050, there will be about 2 billion people worldwide over 60 – that’s 1 in 5 people, compared to today’s 1 in 10. For the first time in history, the percentage of people aged 60-plus will be about the same as the percentage of people younger than 15.
- In the United States, people over the age of 50 spend more than \$1.7 trillion on goods and services each year and account for almost half of total consumer spending. And this age group has accumulated more wealth and has more spending power than any other age group in history.

Clearly, this seismic shift will have significant implications for both the private and public sectors. How will they respond?

At Deloitte, we conducted a major study of these trends to help companies understand how they can better serve aging consumers. The report – “Wealth with Wisdom, Serving the Needs of Aging Consumers” – is available at this conference.

What did we learn? In short, that just about every industry – from consumer products to healthcare to real estate to travel & leisure... financial services, pharmaceuticals, technology and transportation... will be transformed. Aging consumers present tremendous opportunities – and tremendous challenges – for businesses.

But the aging consumer is not a monolithic concept. Like many other markets, aging consumers can vary by region, income and lifestyle, and there are obvious differences between an age-55

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consumer and one who is 85. And, the past is not always a prelude to the future; my behavior as a “senior” may depart dramatically from seniors today.

As a result of our research, Deloitte developed a framework to help companies understand the changes confronting aging consumers and target their products and services more effectively. The four key factors discussed in the report are:

- First, biological changes: as we age, our mobility, vision and hearing are often diminished. Consumers may be drawn to “easy-open” packages and larger print on labeling. Store layout and design is also critical: products on the top shelf may be less accessible. And strategically placed lighting, larger signage, and wider aisles will facilitate seniors’ shopping.
- Second, social changes: Role shifts and lifestyle changes such as grandparenthood, empty nests, and retirement can dramatically influence consumption preferences. For example, many grandparents are caregivers. And the freedom experienced by empty-nesters’ enables them to explore new choices and lifestyles.
- Third, economic changes: Seniors will need to focus on financial planning and management of money and assets, making sure that their resources match their extended life spans. And many are choosing to work well past retirement age, impacting their income and resources.
- And fourth, psychological changes: Memory and information processing change with age, and businesses need to rethink how they communicate new information to these consumers. For example, websites should be streamlined, clean and easy to navigate.

Seniors as consumers will have a large impact. But many departments and individuals within organizations will also be affected by the aging population. I alluded to the Design Department addressing some of the physical limitations of aging consumers. But other areas will be affected as well. Marketing Departments will need to alter campaigns and brand messages to include the 50-plus market. As a recent article on Advertising Age’s website referenced, “women between 50 and 70 are the golden bulls-eye of target marketing.” Chief Information Officers will need to consider the tendencies of aging consumers, even though they are more tech savvy than their predecessors. And Human Resource Departments must also take note. As boomers retire, there are fewer younger workers to replace them. Many companies will face talent shortages and skills gaps. Some companies are introducing flexible work schedules and encouraging intergenerational collaboration to keep their seasoned workers on the job and preserve their experience and expertise.

Let me give you a couple of examples of how companies are already thinking about this significant demographic shift.

Fidelity Investments, one of the world’s largest mutual fund and investment companies, interacts extensively with customers through its website. By observing and talking with older users, Fidelity

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has uncovered valuable insights. For example, older participants tend to read most of the text on a page. They tend to be more cautious in everything they do on the web, including clicking on links. They prefer larger text, and they have difficulty clicking small text links. These insights are being incorporated into an improved website design.

Whirlpool, a leading home appliance maker, specifically designed its Duet front-loading washer and dryer on a raised pedestal to reduce back strain and fatigue from unnecessary bending, stretching and reaching when loading or removing clothing.

At Ford Motor Company, engineers created something called the Third Age Suit. It looks like a cross between a beekeeper's protective gear and an astronaut suit. Wearing the suit lets engineers simulate the mobility, strength, and vision limitations of someone nearly 30 years older. The suit adds bulk and restricts movement in key areas of the body such as the knees, elbows, stomach, and back. It has gloves that reduce the sense of touch and goggles that simulate cataracts.

The suit has been used in the design of many Ford vehicles, allowing Ford to enhance product attributes for aging consumers, including ease of entry and exit from vehicles.

Real estate developers are focusing on communities for the age 55+ set. These include smaller, easier-to-maintain homes, with easy access to shopping and dining, community centers, and recreation facilities. They also offer a maintenance-free lifestyle, with lawn mowing, landscaping, snow removal and gutter cleaning all provided by the community.

And finally, LG Electronics. They market cell phones in South Korea with built in biosensors that can help individuals with medical conditions. The handsets can be specially configured to monitor blood sugar levels in users that have diabetes – a disease that strikes many aging adults. Users prick their fingers to get a blood sample and the phone reads the sample and sends the data to a doctor or relative. These handsets retail for only about \$400.

Those are just a few examples of how companies in a variety of industries are addressing this growing need. Smart companies understand that today's "longevity revolution" cannot be ignored. Just about every industry will need to change and adapt to accommodate this demographic shift. Remember, in the United States, people over 50 spend more than \$1.7 trillion on goods and services each year. That's almost half of total consumer spending. And that's just the consumer end of the equation. The talent shortage and skills gaps that employers will face will be daunting. The stakes are enormous.

I encourage you to pick up a copy of Deloitte's report – "Wealth with Wisdom, Serving the Needs of Aging Consumers" – which are on the literature table next to the registration desk, to learn more about this phenomenon.

And I thank you for the opportunity to be with you here today.

PR Contact: Laura E. Wilker , Deloitte Services LP 212-492-2871 lwilker@deloitte.com

Ribbon Cutting — Exhibit Hall

DECEMBER 11, 2005

**REMARKS FOR:
THE HONORABLE NORMAN Y. MINETA
SECRETARY OF TRANSPORTATION**

Thank you, Ms. Hardy, for that gracious introduction. But more importantly, thank you all for that very warm reception.

It's my great honor, on behalf of President Bush and Vice President Cheney, to welcome you to the opening ceremonies for the *White House Conference on Aging* here in our Nation's capital city. It's exciting to be among so many committed, thoughtful, and forward-looking Americans.

A special thanks to the United States Coast Guard for being with us today. Your grand presentation of the colors helps emphasize the significance of this very important conference.

I'm pleased to be the first United States Secretary of Transportation to be invited to speak with this dynamic group of leaders. It's hard to imagine transportation not being a vital part of the *White House Conference on the Aging*.

The vast majority of older Americans have voiced their strong preference to age in place. In other words, they want to stay in their neighborhoods and maintain their roots, with both independence and dignity. Transportation is key to this aspiration.

Don't just take my word for it. Over the past year or so, there have been nearly 400 events with nearly 150,000 individuals who have helped shape this conference's agenda. And in every corner of the country, one fact became abundantly clear: transportation is a top concern for the majority of older Americans.

That's because transportation, mobility, is critical to virtually every aspect of our quality of life in America. It's key to employment, to the food we eat, to medical and health care, to our community involvement, to what we buy, and to visiting friends and family.

President Bush recognizes the importance of mobility and access in our society. So he has challenged his Administration to close the gaps and reduce the overlaps in transportation services for those who need a little more help getting where they need to go.

Through the Administration's United We Ride partnership, the federal government is answering the President's charge by working hand-in-hand to create a one-stop shop for transportation services.

For example, instead of spending an hour getting transferred from agency to agency to find a ride to a medical appointment, a person can now call one central number, or visit our website, to find reliable transportation.

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But availability is just the first step. So we're working with state and local partners to make sure that these transportation services are acceptable, adaptable, and affordable as well.

We're confident that this common-sense approach will yield common-sense solutions. By 2030, the number of Americans 65 years and older is projected to double and reach 70 million people. So the focus must be on helping our transportation system evolve along with this dramatic population shift.

As we get older, people should not have to worry so much about getting around. We shouldn't feel trapped in their homes, or worse, be forced to move because transportation has become an impediment in their lives.

Fortunately, we're living in a time when technology is opening new avenues to help older Americans maintain their independence, especially when it comes to transportation. I come from California's Silicon Valley, so I have a natural fascination with technology. And I can tell you that it holds tremendous promise for keeping Americans moving as they age.

Today, for example, communities are using audible pedestrian signals and talking bus stops to allow those with failing eyesight to travel more safely and independently. And pedestrian detectors can adjust signal timing at traffic lights to accommodate slower moving pedestrians.

But, these advances are just the tip of the iceberg.

At the Department of Transportation, we're stepping forward to face this unprecedented mobility challenge head-on. And we believe that research and technology are key to achieving a safely mobile older population, now and in the future.

Our highway and traffic engineers, those responsible for highway design and operations, are working to make roads safer and easier for all Americans to use, including older road users.

Examples of innovation in road safety include larger and brighter roads signs, visibility improvements at intersections, adjustments to pedestrian signal timing, and brighter lines on the road.

In addition to improving road design, the Department is also committed to helping older drivers remain behind the wheel as long as they are safe to stay there. So our safety experts are researching adaptive devices that provide better control over automobiles for those who need a little extra help.

Together with law enforcement and allied health professionals, we're working to help older Americans recognize their changing abilities and adapt their transportation practices to match them.

You can learn more about the Department of Transportation's commitment to keeping Americans moving when you visit *Mobility Matters* in the exhibit hall.

Millions of Americans are now living longer, more productive lives. And many are choosing to stay active in the workforce and in the community. It's our job to make sure that they have the opportunity to do just that.

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You have a mighty big job ahead of you in the next three days as you discuss how to preserve and extend such opportunities. Your collective wisdom and experience will be vital in sorting out the many complex policy recommendations that will be presented to the President and Congress on behalf of older Americans.

So on behalf of President Bush and Vice President Cheney, thank you for your commitment to keeping older Americans moving today and in the future.

And thank you for investing both valuable time and energy to make this *White House Conference on Aging* a tremendous success. I look forward to working with all of you to make sure that your recommendations are put in place for the benefit of our senior population.

Travel safely. May God bless you and may God continue to bless the United States of America.



The Challenge of Global Aging

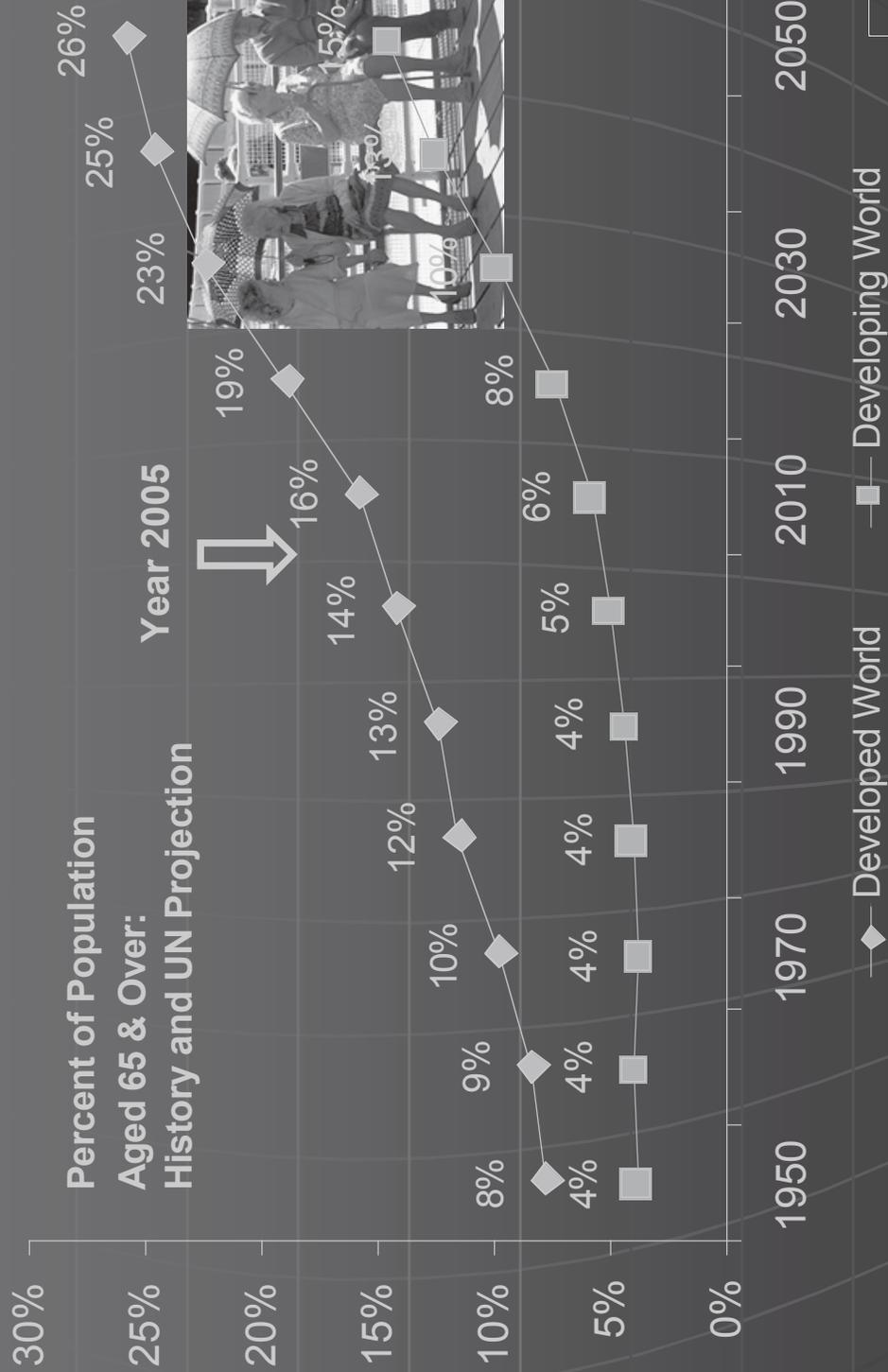
how the aging of the population will transform the world in the 21st century

Richard Jackson
CSIS Global Aging Initiative

WHITE HOUSE CONFERENCE ON AGING
Global Roundtable On Aging
December 11, 2005



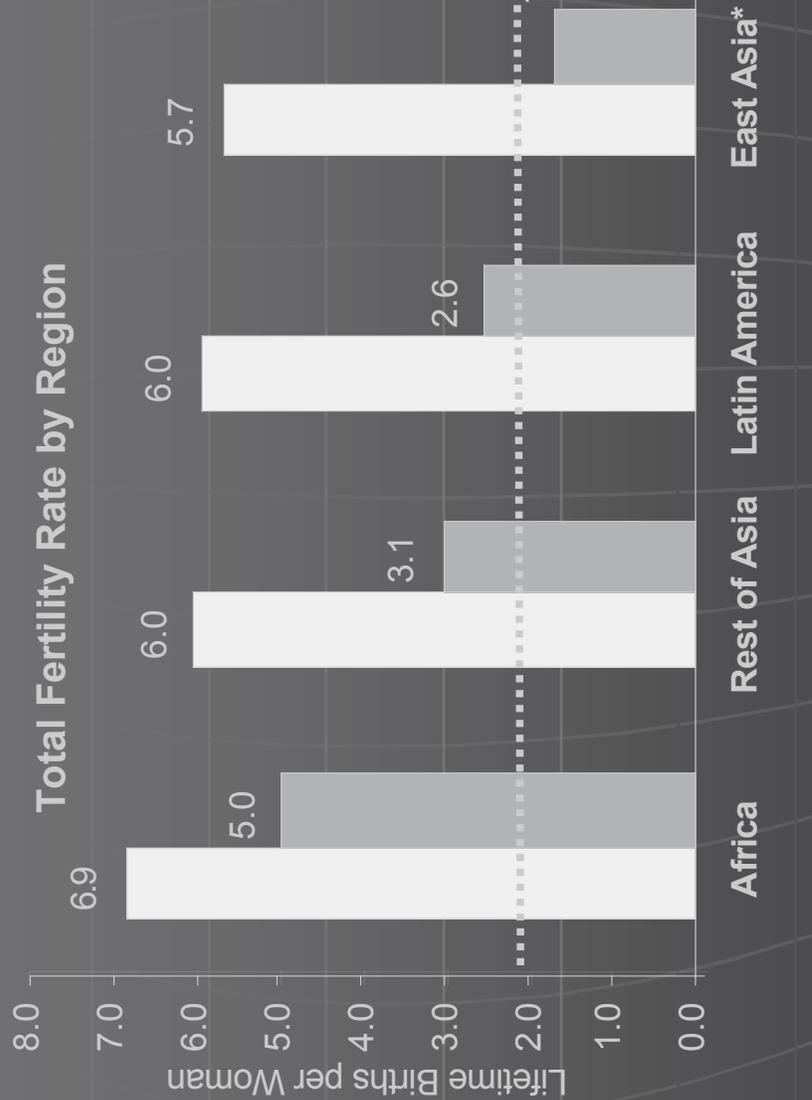
The whole world is aging—and today's developed countries are leading the way.



Source: UN (2005)



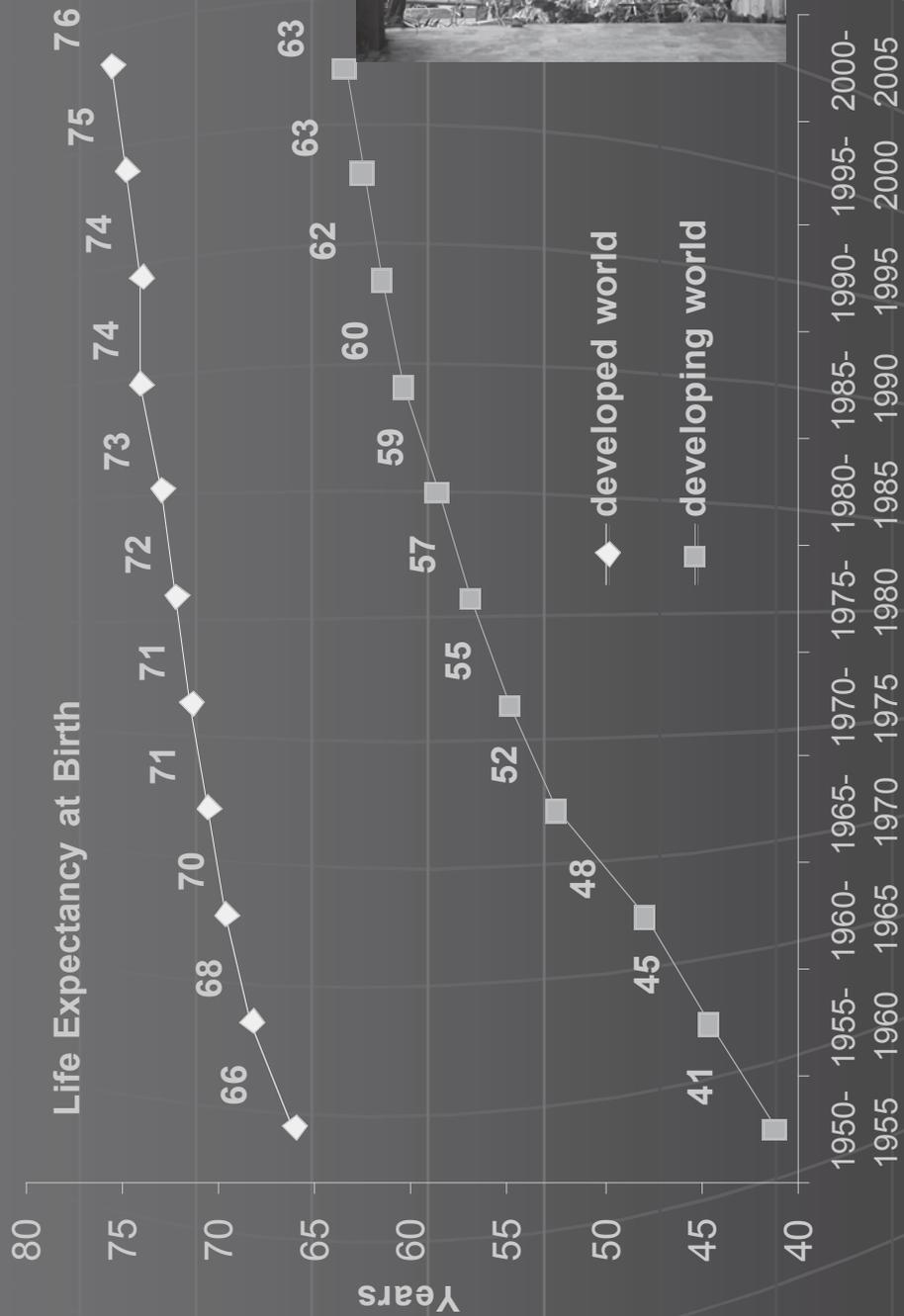
Behind the global age wave: A dramatic decline in fertility.



* Includes Oceania and excludes Japan, Australia, and New Zealand.
Source: UN (2005)



Behind the global age wave: An equally dramatic rise in longevity.



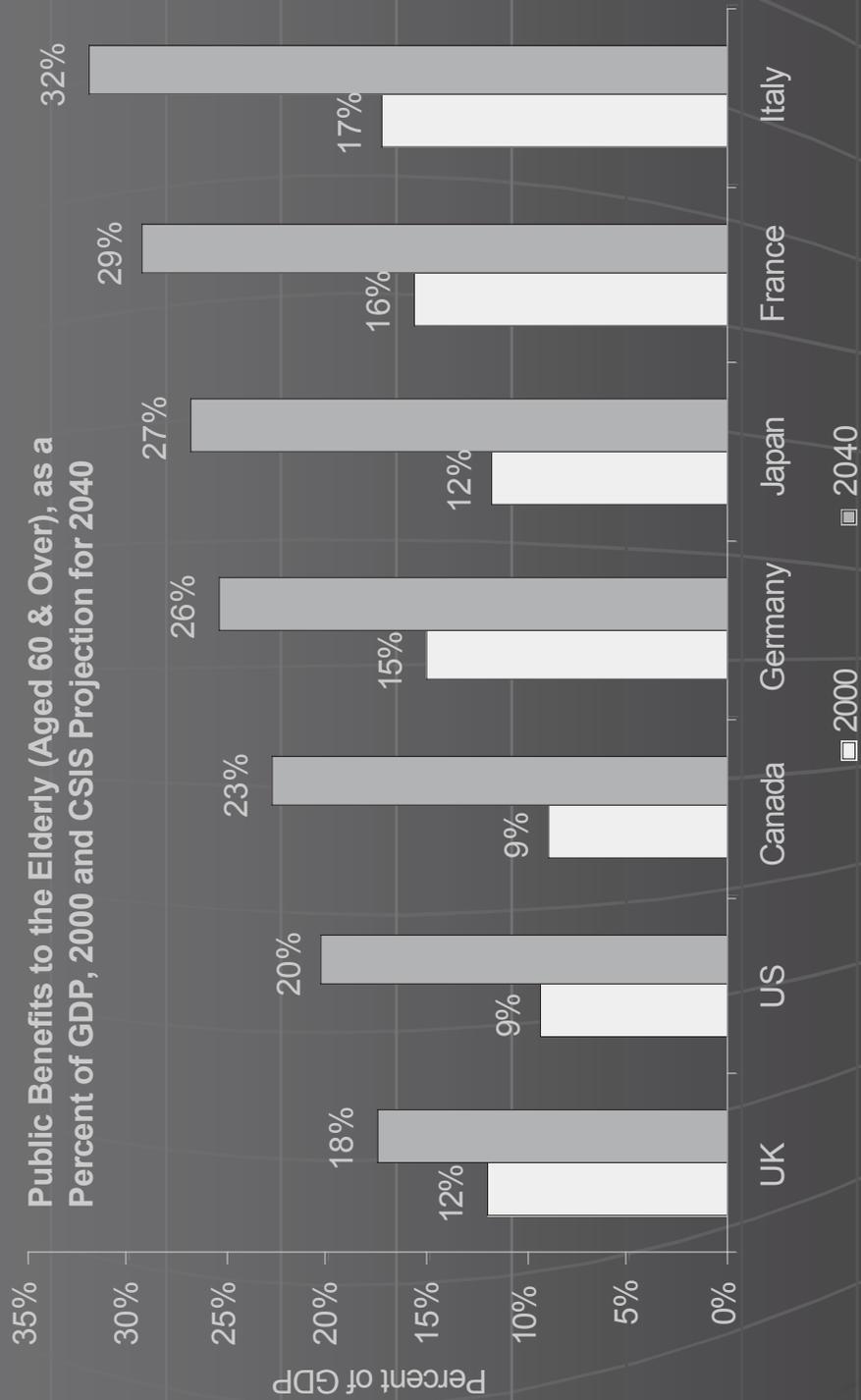
Source: UN (2005)

Three challenges for today's DEVELOPED countries.

□ *the* challenge
rising retirement costs



Rising retirement costs will impose a heavy burden on workers and taxpayers.



Source: CSIS (2003)



Three challenges for today's DEVELOPED countries.

- the FISCAL challenge
a rising retirement costs
- the LABOR challenge
a graying and shrinking workforce



In many fast-aging countries, the size of the working-age population will shrink dramatically.

Percent Change in the Working-Age Population (Aged 15-64), 2005 to 2050



Source: UN (2005)

Three challenges for today's DEVELOPED countries.

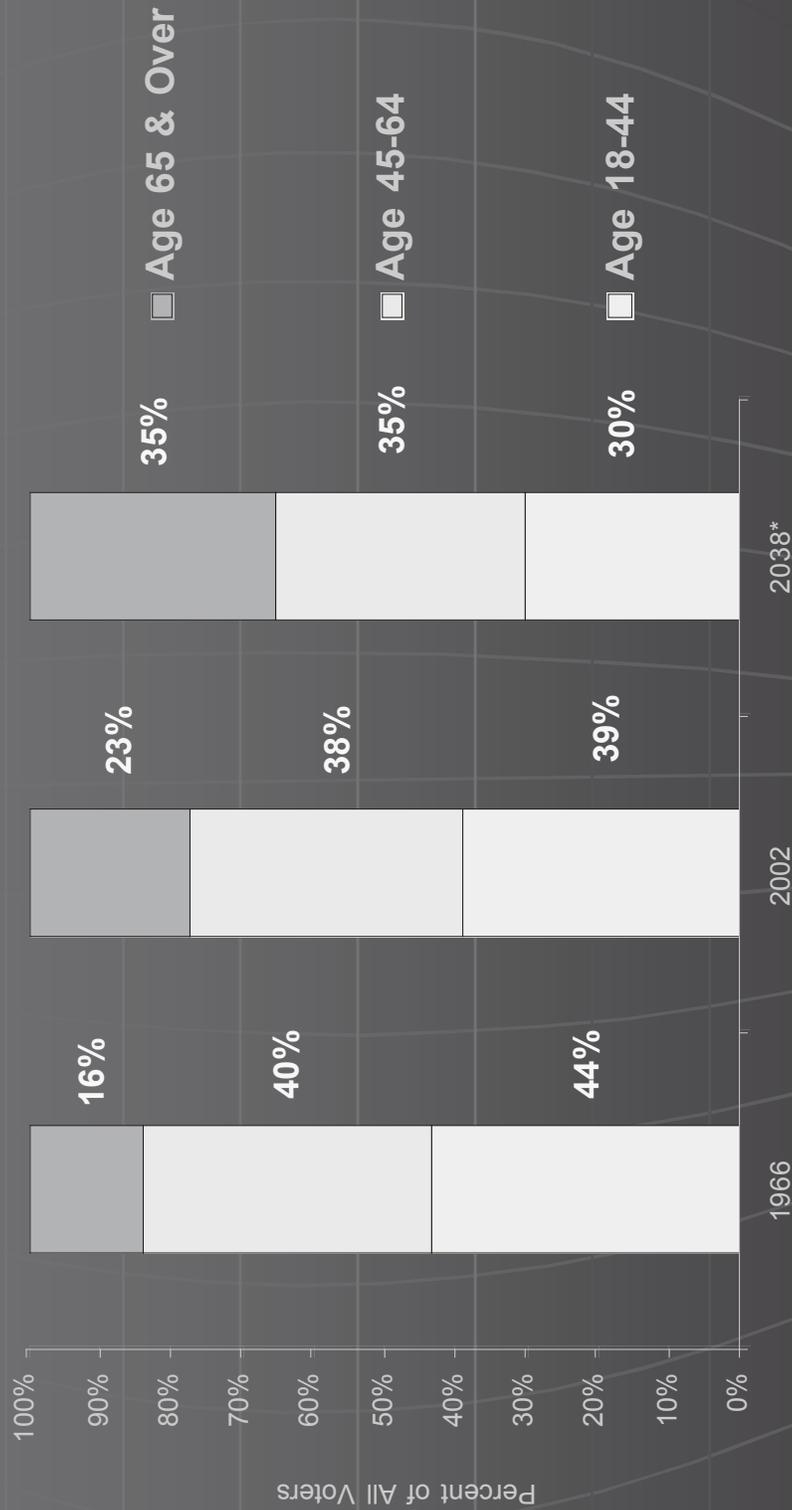


- the FISCAL challenge
rising retirement costs
- the LABOR challenge
an aging and shrinking workforce
- the POLITICAL challenge
a graying electorate

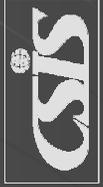


A rising share of voters will be elderly.

Voters in U.S. Congressional Elections, as a Percent of All Voters, History and CSIS Projection*



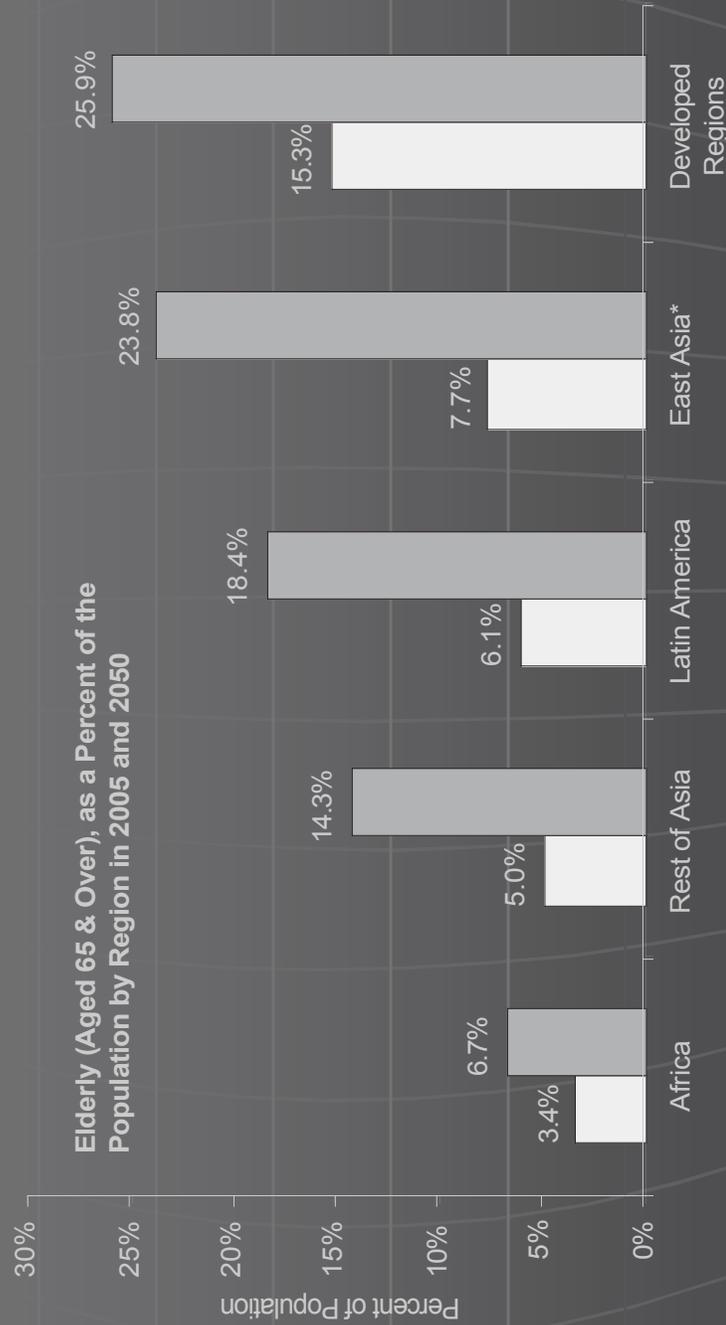
* Based on age-specific voting rates in 2002
Source: U.S. Census Bureau (2004) and CSIS (2005)



Although the developing world is still much younger than the developed world, some fast-aging developing countries will catch up by the middle of the century.



In the developing world, East Asia and Latin America face the largest age waves.



* Includes Oceania and excludes Japan, Australia, and New Zealand.
Source: UN (2005)



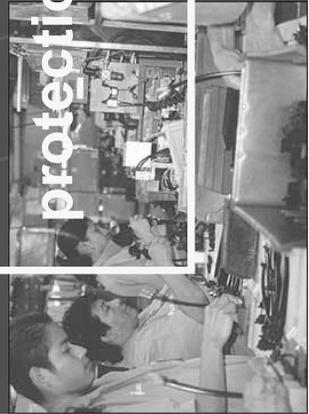
Three challenges for today's DEVELOPING countries.

- *the challenge*
limited pensions and health care
- *the FAMILY challenge*
overburdened support networks
- *the DEVELOPMENT challenge*
will countries grow rich before
they grow old?



Imperatives for an aging world.

- The **DEVELOPING** countries need to reduce the cost of their pay-as-you-go retirement systems, raise rates of labor-force participation, and extend work lives.
- The **DEVELOPING** countries need to invest more in human capital, raise living standards, and develop adequate systems of protection against a destitute old age.



Global aging is a global problem requiring global solutions.

- Immigration and outsourcing can help match jobs with workers.
- Cross-border investment can help match savers with investment opportunities.
- Bottom line: An open global economy can allow young people to help themselves by helping to support old people across international borders.





**We live in an era defined by many challenges,
from global warming to global terrorism.**

None is as certain as global aging.

And none is likely to have such a large and

enduring effect on the shape of national

economies and the world order.



Global Roundtable on Aging

December 11, 2005

INNOVATIONS IN THE FRENCH GOVERNMENT POLICY ON AGING

REMARKS BY

FRANCOISE FORETTE, MD

On behalf of Philippe Bas, Minister of Social Security, Elderly, Family and Disabled, I would like, first, to warmly thank the White House Conference on Aging organizers for allowing International Observers to participate in these very important working and brain storming sessions.

Indeed, the striking increase in longevity is a new venture of humanity and a privilege of our nations as long as the aging population remains healthy and active.

In France, in 2004, 20% of the 62 million inhabitants are 60 years old and over.

The mean life expectancy at birth is continuously progressing up to nearly 77 years for men and nearly 84 years for women.

As in other nations, there will be a continuous increase in the 65 +, 75 + and 85 + populations until 2020 but, the percentage of the population under the age of 60 years, though decreasing, remains rather high, probably thanks to the maintained fertility ratio at 1.9, one of the greatest in Europe.

France as one of the highest life expectancy but, - this is unfortunately another French paradox-, the lowest rate of activity after 60 years of age: 7% only of men and 4% of women are still in the economic circuit, as compared to 27% in the USA, 21% in the UK, 23% in Sweden, and 51% in Japan.

The predictable consequence will be a dangerous decrease in the worker to retiree ratio. This low rate of activity after 60 does not find an explanation in the health status. Indeed, 6% only of the population over 65 years of age, and 2% of the population between 60 and 69 years of age suffer from dependency due to invalidating diseases.

All people do not equally enjoy this excellent health status: There is a five year difference in life expectancy at 60 between the white collar and blue collar workers. The part of France where you live may have an influence: the life expectancy at birth is five year lower in the North than in the Paris region. But the most important probably is the activity status. The risk of mortality of unemployed people is for many reasons, of course, threefold this of the active population.

The challenge of the French Policy on Aging is to simultaneously promote health and activity as a long term perspective.

Indeed, the majority of the population will age in good conditions of health, personal autonomy and productivity in the sectors where activity is allowed. But in spite of the progress in prevention, a minority of persons is and may be victim of age-related diseases leading to dependency. As well, the oldest old, (90 years old and over) will remain a frail population whose autonomy is generally assisted.

The Government has therefore a double priority:

- 1- Promoting high quality Long Term Care systems at affordable costs for all age groups needing assistance either at home or in institution.
- 2- Improving social integration and activity of the healthy senior population.

I Promoting High Quality Long term care systems

The mortality rate observed during the 2003 heat wave, (15 000 deaths mainly among isolated elderly citizens) has certainly increased the awareness of the population and policy makers on the issues raised by the aging of the population.

Important decisions were taken to reinforce existing policies, a number of laws were voted and specific plans established.

I) 1-An Emergency Plan was drawn up

The objective was a better coordination between the different State and regional services, an improvement in the alert systems, a reorganization of the emergency services and an attempt to identify vulnerable persons and, in particular, isolated elderly who are not usual care users.

This plan intends, with specific adjustments, to cope with any emergency situation, heat waves or winter cold, terrorist attacks, bird influenza etc...

I) 2- A law called “Solidarity and Aging” was voted in 2004

By this law, a new branch of the Social Security System was created de novo. This branch covers the risk of dependency and offers part of the financing of long term care either at home or in institution.

A new Agency was set up called Caisse Nationale de Solidarit_ pour l'autonomie, CNSA.

The agency is financed by the Health System for the medical expenditures –the Health system covers all persons living in France- and by a new innovative system for the rest of the expenses (9 billion _ for the 2004-2008 period). The innovative system does not rely on general taxation or social-insurance type solution but on the product of an extra work day called “Solidarity Day” for all employees and a 0.3% tax for the employers. The CNSA is independent of any other agency and finances care needs of the dependant elderly and of the younger disabled persons. For example:

- The care costs of dependency (restrictions in Activity of Daily Living and social care such as housekeeping, meals on wheels etc...) either at home or in institutions through a specific allowance called APA (personalized allowance for autonomy). There are 850 000 beneficiaries of this allowance in France.

- The improvement of services in nursing homes (hiring of nurses, of nurses helps, social activities etc...).
- New nursing homes or new beds in existing ones (20 000 beds for the period 2004-2007).
- Day care and respite care units.

Besides the public funding provided by the agency, income-related co-payments are required. Board and lodging are not covered in nursing homes; users are charged according their ability to pay. Total expenditures on Long Term Care represent a little more than 1% of GDP (15 milliard _).

I) 3- A Geriatric Specialty was established in September 2003 and a Geriatric University Plan was implemented in 2005 in order to double le number of Professors of Geriatrics from now to 2010. The objective was to improve the geriatric training of GPs, Specialists, nursing home physicians, and all professionals taking care of frail elderly.

Measures are taken to provide a continuum of care in order to meet the needs of the elderly in all situations: Geriatric acute care units are being set up in all hospitals with emergency wards, the number of rehabilitation beds is increasing and the hospital long term care units for patient with unstable severe chronic diseases will be better staffed and equipped. Networks between hospital care and community care are strongly recommended and financed.

I) 4- Shifting the balance toward home-based care is promoted by the government to enable older citizens who need assistance to remain in their own homes. Home services are expanding to give a choice to the older persons and the number of recipients is increasing by 4000 each year. The contribution of a family member or other informal carers is often necessary and services to support carers include psychological assistance, specific information on care giving, day care centres and institutional temporary respite care.

I) 5- An Alzheimer Plan was implemented to cope with the age-related increase in the prevalence of Alzheimer's disease and related disorders. These diseases represent 70% of the causes of institutionalisation and 72% of the requests of the APA allowance.

The Alzheimer's Plan is aimed at raising the rate of early diagnosis (presently at 50%) by increasing the number of Memory Clinics (263 up to 600) and the number of Resources and Research Memory Centres (24 up to 40). The second objective is to train GPs, professionals, patients and caregivers .and to support families and informal carers (Specific Alzheimer day care centres and respite care). Another important objective of the Alzheimer Plan is to better fund Research in all aspects of Alzheimer's disease.

As a whole, these new laws and plans should greatly improve the condition of the frail and dependent elderly.

II Changing the image of aging and promoting the social integration of the healthy senior citizens in the community and the workforce of the country is another priority of the Minister's policy

The goal is to ensure people's future financial security, health and quality of life, enabling them to be productive members of society throughout their lives.

Key objectives are being pursued:

- Promoting Health prevention throughout life.
- Reforming Employment Policy after 55 years of age.
- Changing the image of aging and favouring relationships between the generations.

II) –1 Health promotion and prevention

Most of age-related diseases may be related to modifiable risk factors and then accessible to prevention. Prevention is still successful after the age of 60 but it should be started before the age of 20 years by promoting healthy lifestyles.

A National Program: "Aging Well" has been launched in 2005, based on Nutrition, Physical Activity and social integration. This program is to be implemented locally by municipalities.

A working group is considering a systematic comprehensive geriatric assessment at the age of seventy to detect all risk factors likely to lead to disabling diseases.

II) 2- Reforming Employment Policy after 55 years of age

Reforms aiming to improve the incentives and opportunities for older people to play a part in the labour market for longer are in process. A comprehensive strategy is thought over to tackle the various disincentives and barriers to employment facing older workers. This requires action by both the public authorities and social partners in the following areas:

- Reform retirement and social welfare systems to strengthen work incentives (progressive retirement, new contracts, simultaneous working/retiring)
- Encourage change in attitudes of employers and workers
- Adapt employment protection rules to promote employment of older workers
- Promote training for upgrading skills and acquiring new ones.
- Improve access to high-quality employment services for older job seeker
- Improve working conditions

II) 3- Changing the image of aging and favouring relationships between the generations.

Healthy and productive ageing brings with it enormous individual, economic and societal benefits. It bears an optimistic perception of the longevity revolution in our societies. This positive image of ageing must be spread over the media, papers, magazines, schools and university programmes. The society must stop considering the demographic evolution as a burden while it is an opportunity for all generations living together.

The government intends to favour all intergenerational experiences: Skill sharing, tutoring, and volunteering mixing young and elderly people, multigenerational projects creating suitable work for older and younger people in a wide range of forms of employment. Some experiences of “integrated lodging” including young parents and children, disabled elderly, healthy retired persons and common services for all, show how it may generate close relationships between the generations.

In conclusion, the ethical challenge of the French government is to simultaneously organize outstanding care for the frail elderly and to promote healthy and productive ageing in order to allow all people, regardless of their age, to enjoy fulfilling lives, at home, at work and in their communities.

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REMARKS BY

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Japan's Care Service Insurance Law(s) (System) as enacted in 1997 (its implementation in April, 2000) and Revisions and Amendments to the Original Law(s) enacted in May 2005; its Pros and Cons.

Japan's care services insurance law(s) as enacted in 1997 and its implementation which embarked on in the year 2000 with the stipulation attached to the original law(s) of 1979, by which the law(s) must be reviewed in every 5 years to meet the needs of the time was one of the major Social Security Policies that Japan has introduced in coping with the issue of aging, in particular, on the system of providing care services for the elderly. The fundamental philosophy and vision in the creation of this system was designed, at the time of the law(s) enacted, to make the system sustainable for years to come to cope with the rapidly accelerating population of aging who require some type of care services.

1. Outline of the System and how the system is to be restructured:

- The original law(s) enacted in 1997 was a combination of “insurance scheme” and “taxes”. The system is structured by co-sharing system whereby the Central Government is responsible for contributing 25% to the system, 12.5% by Prefectures, 12.5% by regional governments such as cities and towns, 32% by the future recipients of the care services (40 years old to 64 years old) and 18% by those who are eligible to receive the care services and who are being assessed as the one needed to receive level of care who's age is from 65 years old.
- In order to make the system carried out throughout the nation without discrepancies in terms of maintaining the quality of care to be as much as uniformly, the system has set up “Financial Stabilization Fund System” which is contributed one third each by the Central Government, Prefectures and Cities and Towns. The fund is designed to stabilize administrating and operating entities in terms of their financial condition due to some regional financial and economic condition, namely, due to changing fiscal budgetary conditions should change negatively.

- Under the original system, the level of care was classified into (5) level of care for the elderly depending on the level of care services required and plus “Supportive level of care.” Thus, the total category of care services and supportive and assistance cares combined is (6). Depending on the level of care services required, the care fees are disbursed to the recipients of care services. However, 10 % of cost of care services the elderly receives must be paid out of their pockets.

According to the Ministry of Health, Labor and Welfare, The total budget for the system in the fiscal budget in the year 2005 was \ 6.7 Trillion Yen.

Currently, those elderly who are being assessed as eligible recipients of Care services both at institutional settings such as nursing homes, the various types of care services settings and in-home care services are said to be approximately 4 million persons.

2. In view of rapidly growing population of the aged, and those elderly who require some type of care, services or supportive assistances are growing more than the government had predicted at the time of the implementation of the system in the year 2000. In particular, it is noted that the growth of level of care which have grown more than double is the level of care as classified under the original care level of Level Care (1) and Level of Supportive and Assistance, which have occupied the half of those elderly compared to those who are being assessed as the one requiring care services (from care level of (1) through (5)). This category of growing population of relatively less acute care services needed persons are those who have been receiving care and supportive assistance at in-home services. The care services and supportive assistance programs are considered not contributing to improvement of their health condition of the elderly. It is pointed out that some of services cost is used for other than direct care services and needed supportive assistances. This has contributed to the increase of care services fees

It is pointed out that miscalculation on the part of the Central Government and Ministerial Commission on Social Security Commission and its sub-committees, which were held responsible to recommend to the Minister in charge of Japan's Care Services Insurance System, was blamed in their optimistic view that the system in question could be placed as a viable and sustainable one for the years to come. At the same time, the Japanese Government has been going through the restructuring plans to make the fiscal and budgetary condition of the nation to be healthy, for which major restructuring policies and plans are underway, which is focusing on the area of social security policies including the revisions of medical insurance, pension system and now care services insurance system has become one of the targets of the government restructuring policies.

3. An Outline of Amendment of Law(s) for Japan Care Services Insurance Law(s); System as Amendments and Revisions to the Original law(s) of 1997

- With the growing population of the aged and the rapid increase of those elderly who are being assessed to require care services and supporting and assistances services under the system, the government initially wanted to included the following policies and programs so that the financial basis of the system would be enhanced as a sustainable and durable system to cope with deteriorating system in terms of its sustainability from financial point of view.
- The government had a grand design to expand and broaden the population of the payee to the system. For this task, the government had submitted a few major policies and program services which were designed for the inclusion of the key programs such as the expansion of the payee of the premium of the care services insurance in the process of review, deliberation and discussion at the Ministerial Social Security Commission for their approval and recommendation as the consensus of the Commission which will pave the way for the approval and passage of the proposed amendments and revisions at the Welfare and Labor Committee of the Lower House and the Upper House of Japanese Diet in May of 2005.

The government and the parties in power thought that some of the major policies, program services and some restructuring task of consolidating other laws such as the Disabled Support and Assistance Fees Law(s) could be in place, and lowering the starting age of the paying for the premium, all of which will enhance the financial basis of the system by the deployment of the expansion of the payee of the premium for the system. But, it did not succeed to bring about the strategies of the Ministry to included these proposed policies and services programs due to the fact that the nation was sharply divided, even among the members of the Ministerial Social Security Commission on “Revision and Amendments to Japan’s Care Services Insurance Law(s) of 1997”.

The reasons for disapproval were voiced by business groups, regional governments, professional groups (providers of care services) and people at large due to:

1. Change of starting age of paying for the premium from the originally set year of 40 years old to the proposed age ranging from 20 or 30 years old would create negative factors which will affect on the mind of the youth who may be placed in financially difficult situation and that they are not psychologically in line with the philosophy of sharing the responsibility of the cost for the care services for the elderly.

2. Secondly, business corporation and business associations decided against the proposal as their share of the burden will be increased because the employers must pick up the cost of 50% of the premium of their employees.
3. Regional governments were also against the government proposal because of the enormous burden that will be imposed on them as the administrator of the care services insurance system. They asserted further that if the Disabled Supportive and Assistance Fees Law(s) were to be consolidated with Care Services Insurance Law(s), it would create confusion because the Disabled Supportive and Assistant Law(s) were different in nature in terms of the contents of care services unless the system must be structured to cope with the way to provide special mental and medical treatment services, which will be an additional burden on the payees of the premium.
4. It is also said that the government proposal for the revisions and amendments are deviating from the vision and philosophy that the government pledged at the time of the creation of the system and there has been no unified and constant policies kept in the task of reviewing the original law(s) and that the government was trying to scale down the quality of care services for the elderly because of the fiscal difficulty by introducing some of new programs without revealing the details of services programs as well as how these programs are going to be established and consolidated with the existing system. It was also pointed out that no financial details are clearly defined for these new services programs.

The government was forced to withdraw the policy of “expansion of population of the payee of the premium” for the inclusion in the task of revisions and amendments to the original law(s) of 1997, and Instead, the following policies and services programs are included in the proposal in the form of the large framework with the details of policies and programs yet to be developed in the revised and amended law(s) which was enacted in May this year.

The followings are some of the major policies and programs that the amended and revised law(s) has included for the passage of the law(s):

- (1) Changing to prevention-oriented system(original level of care I and supportive and assistance level are going to be grouped together for receiving “preventive care services” rather than a full care which was made available under the original law(s)).
- (2) Revision of Facility Services
- (3) Establishment of new service system
- (4) Quality control and improvement

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- (5) Revision of finance and management
- (6) Extension of insured/beneficiary(additional clause)

For the details of these (6) policies and programs, please see the attached materials.

The government has decided to minimize the unproductive and wasted type of the various services programs and has placed more emphasis on “Preventive Care Services Programs” which will, in the eye of the government, reduce the cost of care services fees and that it will help the elderly become more independent. Community service programs are introduced in order to support the care services for the elderly which are designed not only for the elderly to participate in preventive care exercise to prevent them from the further progression of the health condition and frail

In conjunction with the efforts of reducing the care services fees under the system, the government decided to introduce “Rental Room Fees and Meals fees” to be charged to the residents who are residing at institutional settings such as special nursing homes and other type of facilities. The contention that the government attempted to justify this change from the original system under which rooms and meals are covered is that those elderly who are getting care services at home under the original system are not enjoying the same benefits of rooms and meals which are covered by the care services insurance compared to those who are residing at a special nursing homes and other type of the facilities.

In order that the system is to be maintained at least minimum level in order to provide appropriate care services programs, some innovative programs which are not yet implemented under the original system are going to be in place under the revised system. However, whether or not these service programs are going to improve the quality and quantity of care services are not clear in the eyes of the public.

Another major issue is the attrition rate of care givers and some irrational way of uniformed care services fees applied without consideration of regional economic condition and the factors of cost of living between the major metropolitan cities and country region. In spite of the higher wages which are required to pay for the employees at institutional facilities located in the metropolitan areas, the care services fees for the providers of care services are more or less the same with the fees disbursed to the providers in country region where the cost of living is much lower. The law(s) dictates that the uniformed standard for care services fees without consideration of the factors of cost of living which makes it difficult for the providers of care services for the elderly who are located in the metropolitan areas. It is urged that the government must implement cost of living factors as added fees for the providers of care services for the elderly in metropolitan areas to keep the providers to be able to operate the facility with quality staff to extend the good care services. Otherwise, institutional facilities in major metropolitan areas will be facing with the difficulty of operating their care services adequately and that it may be the case that they may be out of the service operation.

As it has been briefly described about Japan’s Care Services Insurance System and the revised and

amended law(s) to the original law(s) of 1997, it may be useful to summarize the pros and cons of the revised and amended law(s) to see how Japan's Care Services Insurance System will be shaping into more appropriate system by reviewing further on some of pros and cons sides to make the system to be healthy and sustainable one.

PROS & CONS of the revised and amended law(s) of 2005.

■ Pros:

1. Japan's Care Services Insurance System was designed to provide needed care services for the elderly which are supported by the combination of "tax and premium for the insurance" in the form of "co-sharing system".

This system will be available to all when they reach the age of 65 and some special measures are implemented to make it less burdensome for less-well-to-do people by reducing the fees that they have to pay for the services they are receiving.

2. By establishing institutional facilities for care services for the elderly through the financial subsidy that the government extended made number of facilities available that helped the families of the residents who are housed at facilities provided less burden in their daily lives. Particularly, those families who have less children or relatives to look after the elderly needed care services.
3. Compared to private care services being operated by profit organizations, the elderly and their families' financial burden as well as their physical and psychological burden are reduced under this care service insurance system. (Nursing homes, Health Center for Aged, Day Care Center and other type of service units are available under the system).
4. If the enhanced financial condition are improved for the system by allocating financial resources from the sales tax (consumption tax) which are now being contemplated to increase from the current 5% to 10%, it will make the system more flexible in terms of providing more various type of care services and the system will be placed as a sustainable one.

■ Cons:

1. The philosophy and vision of the system have not been implemented in full due to the lack of financial support by the government which forced the government to fail to maintain and promote constant and irrevocable policies as pledged at the time of the enactment of the original law(s).

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2. Due to the failure of expanding and broadening of the population of the payees for the premium of insurance, some of the major services programs have been not included in the revised and amended law(s), which made it difficult to improve the system as originally envisioned.
3. Because of fiscal budget tightened policies in place, it has shifted the contents of care services from full services to “preventive care” approach; some of programs which are designed to introduce “exercise and training with the use of machine” are regarded as unrealistic for those elderly whose age is 75 years old or more. Some medical experts question the contents of “preventive cares” as merits to improve the condition of the frail elderly which are proposed and being contemplated by the government.
4. Emphasis are now shifted from the expansion of care services to in-home, which will increase the burden of the families in view of the accelerating demographic changes taking place in Japan; Decline of birth rate and mobility of younger generation in their working locations; there will be less family members to look after the elderly.
5. Charging “Room & Meals fees for the elderly residing at institutional facilities” will be placed in financially difficult condition because the majority of them are depending on their incomes on national pension. It is also pointed out that those who reside at institutional facilities are less well-to-do compared to those elderly who are receiving care services at their homes.
6. The proposed reduction of service fees for the providers of care services may lead to reduction of quality of care services and the management of institutional facilities may be out of the business operation.
7. The lack of flexible policies concerning the consideration of added services fees for providers of care services operating in major populated areas will face the difficulty of recruiting qualified care givers due to the higher wages the providers of care services must pay for them, whereas the wage scale in country region is less because of the less cost of living.
8. Government has failed to develop specific contents of programs for implementation during the process of reviewing revision and amendments to the original law(s) of 1997. This has created a large degree of confusions among the regional governments, providers of care services and people at large.

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We have come full circle. During 21st Century the number of aging persons is going to accelerate more rapidly than we will be able to predict at this moment. Additionally, the decline of the birthrate will make it much more difficult to provide the adequate supporting infrastructural resources, particularly the human resources to extend personal care services to the growing number of aging people. It is important that we establish infrastructural environments to the best of our ability in order to extend opportunities not only to the elderly but also to those providing care services. However, it may be more important to think of how successful aging should be defined and follow through with it. In this sense, international collaboration on the issue of aging is as important as it will affect on the prosperity of the world unless we work together on the issue of aging.

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Working together with

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The distinguished visiting scholar

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REMARKS BY

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Aging in India

1. Government of India's programmes

With a comparatively young population, India is still poised to become home to the second largest number of older persons in the world. Projection studies indicate that the number of 60+ in India will increase to 100 million in 2013 and to 198 million in 2030. The special features of the elderly population in India are: (a) a majority (80%) of them are in the rural areas, thus making service delivery a challenge, (b) feminization of the elderly population (51% of the elderly population would be women by the year 2016), (c) increase in the number of the older-old (persons above 80 years) and (d) a large 30% of the elderly live below poverty line.

■ National Policy for Older Persons (NPOP)

The National Policy for Older Persons (NPOP) was announced in January, 1999, with the primary objectives to: encourage individuals to make provision for their own as well as their spouse's old age; encourage families to take care of their older family members; enable and support voluntary and non-governmental organizations to supplement the care provided by the family; provide care and protection to the vulnerable elderly people; provide health care facility to the elderly; promote research and training facilities, train geriatric care givers and organizers of services for the elderly; and create awareness regarding elderly persons to develop themselves into fully independent citizens. The budget allocation during 2003-2004 was INR 178 million which was revised and the allocation was INR 158 million, against which the expenditure was INR 165 million. As regards the implementation of the Scheme of Integrated Programme for Older Persons, financial assistance has been given for 323 Old Age Homes, 281 Day Care Centers and 42 Mobile Medicare Units in different parts of the country during the year 2003-04.

■ Facilities/benefits given to senior citizens by various concerned Ministries/ Departments

In order to cope with the problems faced by the aged, it is necessary that the care givers be made aware of the physical and mental conditions and problems of the elderly people so as to meet their needs as far as possible in the home setting. Under this initiative, the National Institute of Social

Defense runs a series of Programmes/Certificate Courses to educate and train persons who can provide care to older persons in the family and community settings.

2. Tradition of Caring of Elderly in India

The responsibility of caring for the elderly is traditionally that of the immediate family, and most often by the sons. However with a growing trend towards nuclear family set up, and the associated decay of the extended family structure, the vulnerability of the ageing population is increasing.

3. Heritage Hospital, a Hospital with a Difference

Established in 1994, Heritage Hospital at Hyderabad, India's only multi-specialty geriatric hospital, offers affordable medical and non-medical services to elderly patients. The caring philosophy at Heritage Hospital goes beyond treating patients and declaring them medically fit. The focus is on the overall well being of patients that include their social, emotional, psychological and physical well being. The hospital is aesthetically designed & spacious with patient-friendly interiors.

■ Heritage Home Care Services

Heritage Homecare Services is available for people who no longer need 24-hour hospital care & wish to recuperate in the comfortable environs of their own homes, under the loving care of trained nursing professionals and assistants. The care comes in the best tradition of human touch and warmth that enables and makes a recovery path a pleasure.

■ Heritage Helpline

Run and managed by a team of trained volunteers, this excellent facility is a round-the-clock service that offers top class assistance to people in distress and other various types of information and referral assistance, including healthcare services in Hyderabad.

■ Service Clubs

Having carved a niche for itself by offering world class services, we offer 'Clubs' to meet the specific needs of affiliated members.

■ Doctor-on-Call

Our trained medical personnel, on receipt of a call to this 24-hour helpline, ensure their presence at the patient's place in an ambulance with complete diagnostic/treatment equipment.

■ Heritage Seniors Club

Elderly people need proper care and succor during the evening of their lives. They need a life of dignity and respect so that the last days are well spent. That kind of environment is assured by us. Self-respect, independence and health of seniors is assured by a range of top class medical, social, legal and cultural benefits such as at-home health check-ups, supply of meals, housekeeping, regular meetings, etc.

■ Home Care Nursing Program

Studies disclose that the senior citizens pine for the warmth and care of home and family members and recover at a swift pace when they are in the familiar environs of their home. The other factor is the cost factor which is on the high side and many seniors cannot afford the same. To counter the same, we offer an innovative concept called 'Bedside Assistants (BSAs)' through our sister organization - Heritage Livelihood Services Provider. The BSAs are basically non-medical staff, who belongs to those living below poverty line. They are trained to do vital checks, monitor and administer medication, check sugar levels, attend to personal care, feeling, assist in physiotherapy, etc., with special attention to working with the elderly.

■ Food-on-Wheels

Where the sick patients are not able to cook, this useful facility is offered and the food cooked confirms to the best of hygienic norms and tastes. A continuous regular home supply of food by a cook under the eagle eyes of a qualified dietician is arranged. Heritage's cooked meals enable elderly eat and live healthy.

■ Dial-a-Driver

Available for those who are not able to drive their own cars on busy streets, a vehicle driver is arranged on call. Under this scheme, senior citizens can dial for a driver for designated periods of time and the trained drivers take them where they want to go.

■ UCH Heritage Healthcare

This is a joint programme of Heritage Hospital and United Church Homes, a leading American healthcare provider with an impeccable reputation of over 88 years. The United States faces the problem of qualified nurses and paramedical professionals. India, with its vast and excellent talent pool, is well placed to fill up this gap. Training is offered by UCH Heritage Healthcare to Indian graduate/diploma nurses in full-time courses in CGFNS/NCLEX/TSE/TOEFL/IELTS/Spoken English. In addition complete help is rendered to enable the successful candidates migrate to the US.

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REMARKS BY

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The Public Health Agency of Canada: A Strategic Approach to Advancing Active Aging

Overview

Good afternoon. I am very pleased to be here to discuss the best practices in regard to aging.

Today I will speak primarily about the Canadian federal government's response in health, which is rooted in collaborative efforts by many governments and organizations in our country.

- In Canada our population is relatively young compared to our European and Asian counterparts.
- In 2001, 13% of Canada's population was aged 65 or older - that is the definition used for seniors.
- By 2041 - the projected peak of the aging population – this percentage is expected to rise to nearly 25%.
- Though Canada has made health gains in terms of life expectancy and number of years expected to live in good health, our country faces an increasing incidence of age-related disabilities due to population aging.

Why Was PHAC Created?

- A number of factors, such as the rapid rising cost of health care in Canada and the SARS pandemic in 2003, converged to highlight the weaknesses in the public health system in Canada - not only for seniors but for all Canadians.
- With the impacts on the environment of globalization and growing populations, the threats of more virulent forms of pandemics increased and both Canadian and international experts called for greater attention to and capacity for responding to public health threats.
- In September 2004, the Public Health Agency of Canada was formed and Dr. David Butler-Jones was named Canada's first Chief Public Health Officer. Previously only our provinces, territories and major municipalities had chief public health officers.
- Obesity, chronic disease and mental health issues are expected to be among the major health

problems plaguing Canadians over the next 10 to 20 years. Alarming increases in preventable risk factors such as unhealthy eating and physical inactivity that often lead to chronic diseases have now reached epidemic proportions.

■ As the population ages, these diseases are becoming more prevalent. Canadian action in health promotion and chronic disease prevention has been disease-specific and fragmented. Establishing the Public Health Agency provides government the opportunity to make its disease and injury prevention efforts more coherent and coordinated.

Mandate of PHAC

■ The best-known function of the new Agency – undoubtedly related to the continuing wave of potential viruses such as Avian flu – is the development of the capacity to better respond to public health emergencies and infectious disease outbreaks.

■ Public health, as defined in Canada, includes activities that promote good health and prevent chronic diseases among Canadians such as immunization, nutrition and physical activity, infection control programs, earlier detection of disease, lab testing and regulations that support these activities.

■ The real change here is the focus of health management in Canada – from illness to wellness – moving upstream before people become sick, injured or vulnerable.

■ On the international stage, the Public Health Agency serves as a focal point for sharing Canada's expertise with the rest of the world and for learning from international research and development to improve Canadian public health programs and policies.

PHAC'S Approach

■ Building on these foundations, Canada has adopted an approach to health in later adult life that can be defined by some key elements:

■ First, we take a life course approach to healthy aging. As mentioned earlier, in addressing the health of older Canadians, we act “upstream” as much as possible to prevent the cumulative impact of risk factors on seniors' health, but we don't forget those whose health has already been compromised.

■ Our concerted health promotion efforts in Canada dates back 40 years so we already have some considerable experience in this area on many issues – from diet to physical activity to the needs of identifiable population groups.

■ In fact, the first International Conference on Health Promotion took place in Canada in 1986, producing the Ottawa Charter for Health promotion clearly defining the concept and urging the participating countries to make use of health promotion.

■ Our understanding of health includes physical, cognitive and mental functioning, and the sense of personal well-being that goes beyond the capacity to perform.

- We look at the health determinants - income, education, gender geographic location, genetics, diet and physical activity etc.
- Because Canada is a federal state, it is essential that we collaborate with other levels of government; it is also important to work with the voluntary sector, seniors' groups and professionals to influence seniors' health.

Recent Agency Initiatives to Promote Healthy Aging

- Canadians are very attached to their health care system, particularly its universality and accessibility. In fact, access to health care based on need rather than ability to pay is a recognized principle in this country. Any mention of a so-called "two-tier" system generally receives little sympathy, particularly from seniors.
- Canada invests in population-wide initiatives to assist children and mid-life cohorts to age well but many people still think that seniors have less potential for benefit from healthy behaviours and environments. International and Canadian evidence increasingly disputes this.
- Within PHAC, the Division of Aging and Seniors is a small group with policy, program and public education expertise. Our priority responses to this challenge for today's and tomorrow's seniors are the following:
 - Using Healthy Aging programs
 - To ensure that seniors needs are recognized and their opportunities to benefit from health initiatives are fully included, Canada is moving toward more comprehensive health promotion approaches in regard to such things as physical activity and healthy eating; and public education on oral health, safe use of medications and sensory loss issues.

Falls Prevention

- We have done extensive policy development in the past ten years and are now well positioned to foster more comprehensive strategies and action based on program experience and strong evidence. We want to ensure that seniors falls, which have huge impacts on quality of life and health system costs, are an integral part of investments in injury prevention for Canadians.

Seniors Mental Health including Alzheimer Disease and Related Dementias

- The recent establishment of the Commission on Mental Health signals concerted national action on mental health. We plan to emphasize opportunities for seniors mental health interventions, e.g., developing best practices, supporting infrastructure development. Preventing Alzheimer Disease and Related Dementias from becoming the highest economic, social and health cost over the next 25 years is also a particular preoccupation for us.

Emergency Preparedness for Seniors

■ Recent Canadian events (SARS, ice storms and floods) as well as international events like 9/11, Hurricane Katrina, the heat wave in France and the tsunami in Southeast Asia have all illustrated the special vulnerability of seniors. We are working with international partners to determine what we must do in Canada to better protect the health of a growing seniors population in the event of natural and man-made disasters.

Other Government of Canada Initiation

- Health is not the only factor that contributes to active aging.
- In December 2003, as part of the creation of a new federal Department, Social Development Canada, a Federal Minister Responsible for Seniors was named and a Seniors Secretariat was established.
- The Minister, supported by the Secretariat, will take the federal lead on seniors issues, coordinate seniors policy, and develop a National Action Plan to align federal policies, programs, and services for seniors.
- Several officials from Social Development Canada, including Susan Scotti, ADM of Income Security Programs and Gordon Roberts, Senior Director form Seniors policy will be available to you to discuss some of the innovative new programs and enhancement such as the recent increase to the Guaranteed Income Supplement that assist Canada's poorest seniors.
- To conclude, because of our efforts, we expect that more and more Canadians will not only live longer but better.

Global Aging Roundtable

December 11, 2005

REMARKS BY:

PEDRO BORDA

DIRECTOR

NATIONAL INSTITUTE OF SENIOR CITIZENS

MINISTRY OF SOCIAL DEVELOPMENT, MEXICO

At present, Mexico has a population of 7.8 million senior citizens, out of which slightly over 50% are women. All of them demand goods and services.

However, the demographic projections indicate that for the year 2025 there will be 18.4 million people 60 years of age or more, and for the year 2050 there will be 36 million.

The above numbers represent actually 7.6% of total population and for year 2050, 28% of the total population.

New Decree

To take care of the needs of our elders, a Presidential Decree was issued by President Vicente Fox on January 17, 2002 to place this institution under the umbrella of the Ministry of Social Development, and to change its name to Instituto Nacional de Adultos en Plenitud (National Institute of Adults in the Prime of Life) or Inaplen.

Legislation

The first Federal National law to protect the rights of senior citizens was enacted by Congress on June 25, 2002 to create the Instituto Nacional de las Personas Adultas Mayores (National Institute of Senior Citizens) or Inapam as a substitute of the former *Insen* and *Inaplen*.

Article 25 of this new law confirms that the governing body of the national policy to protect senior citizens by providing a scope of human integral development to its legal powers and responsibilities, because its general purpose is to coordinate, promote, support, foster, oversee and evaluate the public actions, strategies and programs derived from the currently enforced legislation.

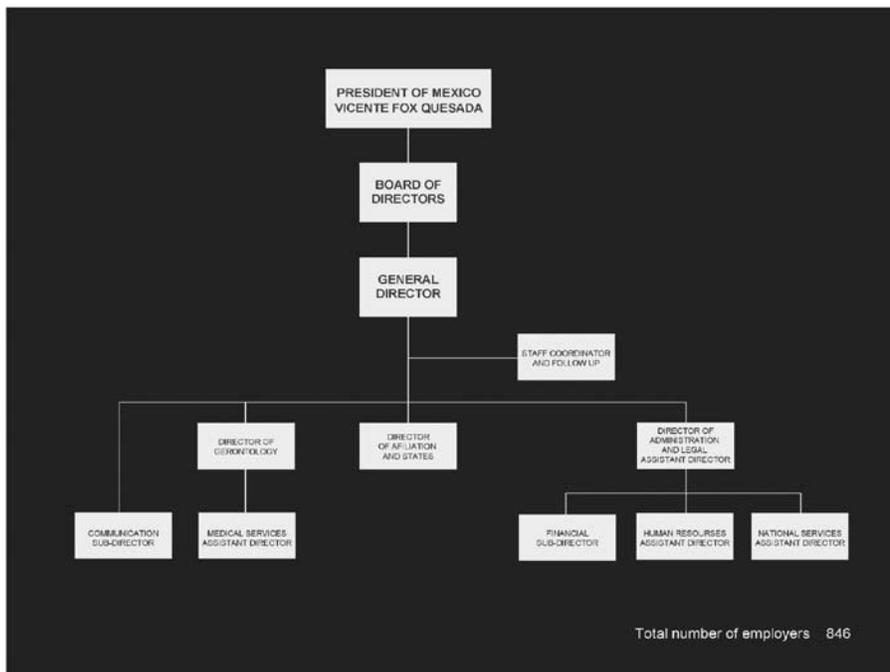
Article 28 attributes the power as the governing body for providing compulsory consultation and advisory functions to federal for government entities and, if applicable, on a voluntary basis to the institutions of the social and private sectors responsible for performing actions or programs applicable to senior citizens.

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The provisions established in Article 30 indicate that the Government Body of the Inapam is to be integrated by the Ministers of the following members of the President's Cabinet:

- Ministry of Social Development.
- Ministry of the Interior
- Ministry of Treasury
- Ministry of Public Education
- Ministry of Health
- Ministry of Labor and Social Welfare
- Social Security National Institutions
- 5 representatives of society (Elderly people)



Infrastructure

- 31 State Federal Representatives.
- 1,800 Municipal Representations and 139 Coordinating Offices.
- 6,700 Community Centers at national level.
- 4 Cultural Centers in Mexico City.
- 5 Centers of Integrated Services in Mexico City.
- 13 Gerontology Units (Mexico City, Guanajuato, Zacatecas and Oaxaca).

Priority Program

The *Program for Employment of Senior Citizens* was implemented to reincorporate senior citizens who wish to continue working and participate in the Mexican economy. This program was initiated under the support of the First Lady of the nation and the Minister of Social Development. The first meeting was in the Presidential home.

Currently more than 5,100 companies or individuals have contributed offering spaces for more than 30,000 jobs exclusively for **Gente Grande** (senior citizens).

This is one of the actions to respond to the 2nd. Assembly on Ageing that called for active employment.

Third and Final Call

2nd. action to respond to the 2nd Assembly on Ageing in Spain. Senior citizens who propose viable productive projects receive financial support from the Third and Final Call. The fund is constituted by the Ministries of Social Development and of Economy.

The Inapam Visits your Community

Mobile units bring medical and dental services, legal advice, affiliation and employment promotion to senior citizens living in marginal areas of Mexico City and rural areas throughout the country.

Youngsters Provide Support to Senior Citizens

This program responds to specific instructions of President Vicente Fox.

An exchange of values is strengthened among the girls of foster homes run by the DIF and senior citizens living at homes operated by **Inapam**.

Senior Citizens Searching for Friends

This program responds to specific instructions of President Vicente Fox.

This program promotes a get together among senior citizens and juvenile delinquents to achieve a dialogue and a transfer of values through cultural, artistic and sports activities. It is carried out jointly with the Centers for Diagnosis and Treatment of the Department of Public Security.

Senior Citizens Act Stories

This program is another action of values transmitance. It takes place at elementary schools and at parks in coordination with the Minister of the Public Function to support the *Program of Transparency and Struggle Against Corruption*.

Protection of the Economy

I.D. card for people 60 or more years of age.

Senior citizens obtain multiple benefits in the acquisition of goods and services. Discounts in products or services range between 5 to 100% at supermarkets, drugstores, transportation, restaurants, clinical studies, etc.

Agreements have been signed at more than 25,000 establishments to protect the economy of senior citizens. Since the creation of the Institute, 75 million ID cards have been issued in the country.

Department of Legal Services

Provides free legal advice to elders 60 or more years old who lack the economic means to hire a lawyer, mainly in the protection of their properties, birth certificates and wills.

Community Centers

We operate 6,700 clubs for elderly people distributed throughout the country. It is the largest social chain in the country, more than 200,000 people attend daily.

Computer Training Center

After two years of the initiation more than 2,000 senior citizens have completed an 8 week computer course. These training Center were donated by IBM (Mexico). 8 Centers are now operational.

Voluntary Programs

This program is presided over by Adriana Borda, President of the National Voluntary Organization and liaison with the Office of the First Lady.

The ladies' voluntary organization of Inapam performs various activities in favor of senior citizens, such as permanent visits to homes and day nursing homes, the sale of different goods, and the *Annual Art Crafts Bazaar*.

Arts Craft Store

The general public can purchase products created by senior citizens, who attend the clubs, cultural centers and day nursing homes.

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Main Events

This action responds to the 2nd. World Assembly on Ageing and Active Life

The traditional *National Sports and Cultural Games* promote health-related activities for senior citizens through the performance of various activities. During the national games of 2005 a total of 3,500 elderly persons participated.

This event for the 5th. Consecutive years have been inaugurated by President Vicente Fox Quesada.

National Exhibition of Art Crafts made by Elderly People

This event is organized every year with the support received from Voluntary organization, delegates, assistant delegates, senior citizens, clubs and nursing homes.

The Night for Gente Grande

Every year, more than 100,000 senior citizens enjoy the pleasures of music and dancing at an event known as *The dance to remember*.

This event is held at the Sports Palace of Mexico City and it is preceded by two major dances at different political delegations. 1,500 state events are organized in August. This dance was presided over by Mrs. Marta Fox, First Lady of Mexico.

When confronted with an increasing demographic aging rate as that recorded in the country, the challenge faced by *Inapam* is its commitment to improve the living conditions of the *Gente Grande* through the programs it has implemented.

New Actions

- Major communications program on the law and services provided for elderly people.
- Tele Care for Medical Assistance, 24 hours/365 days.
- Certification of day care centers and nursing homes (installations and human resources).
- Three new computer centers.

Global Roundtable on Aging

December 11, 2005

REMARKS BY

MR. VUSI MADONSELA

DIRECTOR GENERAL

THE DEPARTMENT OF SOCIAL DEVELOPMENT

REPUBLIC OF SOUTH AFRICA

On this occasion of the White House Conference on Aging, I bring warm and heartily greetings from my Minister, Dr. Zola Skweyiya, to the organizers of and the participants at this conference. Personally, I am singularly honoured to be the one instead of my aged Minister to make country remarks on South Africa's experience in its implementation of ageing programmes. I declare, at the outset, my country's commitment to the United Nation's salient principles on older persons, being independent, participation, care, self-fulfillment and dignity.

According to our country's first credible population census, compiled in October 1996, South Africa has a total of 40.5 million people, 6.9% of whom were aged 60 years or older. Five years later, in 2001, the population census indicated a 4% growth in population size, up to 44.8 million people, with the concomitant growth in the numbers of older persons by 3.28 million, translating into 7.3% of the total population. This proportion, we understand, is substantially lower than what obtains in the developed world, where the proportion in countries such as Italy is said to stand at 19%. South Africa's proportion of older persons is marginally lower than the average proportion, estimated at 8% in comparable developing countries, but higher than the average for Africa (5%), which has a very young population in comparison with the rest of the world.

In terms of the overall distribution of older person in South Africa, the largest concentration of older persons is in the provinces of KwaZulu-Natal and the Eastern Cape, where the proportions are (11.9%) and (18.0%), respectively. Owing to out-migration and urbanization amongst younger persons, older persons are disproportionately represented in the most rural and the poorest provinces of the country.

South Africa, as with other countries in the world, has an ageing population, which means that the proportion of older persons in the country is increasing. This South African reality calls for a concerted effort towards strengthening the capacity of older persons to play a more meaningful role in society, to enjoy active ageing, healthy and independent living, by creating an enabling environment for them. The role of older people in South African households has changed significantly over time. Traditionally, their role was to advise, direct and lead their families and communities in the

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practice of culture and tradition, in the conduct of rituals and ceremonies that defined the very being of their families and communities. They pioneered the cultivation of societal values and norms, as well as passed family and the community's indigenous knowledge from one generation to the next.

The advent of a modern way of life meant a change in the roles played by older people in society. The erosion of the status and recognition of older people has prevailed for some time. Additional factors such as urbanization, migratory labour system and the onset of chronic diseases have had a devastating impact on the structure of the family. Older people are now key to the survival of an increasing number of orphaned and vulnerable children and those adults that are frail as a consequence of the overall burden of disease, not least of which the devastating effects of AIDS. Older people play this very difficult role with limited resources at their disposal and absolutely no recognition for their efforts.

The history of South Africa prior to 1994 is well known and documented. The policy and legislative environment was not only discriminatory on the grounds of race and gender. It also did not protect the rights of older persons or even promote their independent functioning within society. Furthermore, it perceived older persons as passive recipients of services rather than as a group of persons who have a role to play in the mainstream of society. In March 2000, the Minister for Social Development established the Inter-Ministerial Committee on the Abuse, Neglect and Ill-Treatment of Older Persons to investigate the extent and causes of abuse, neglect and ill-treatment of older persons. The findings of the Committee indicated that the incidence of abuse and neglect of older persons with families, in the community and within residential facilities had grown to alarming proportions. Amongst the findings were the following:

- Abuse and neglect of the elderly were common within their families, in residential facilities, hospitals, at pension pay-points and even in government offices;
- Many older persons lived in abject poverty without any source of support, and in most cases are the main providers within their families;
- Lack of access by older persons to social services in rural areas;
- Lack of information regarding services that are available to older persons;
- Social services for older persons remained highly fragmented, poorly managed, racially divided and under-resourced.

I am delighted to say that these matters are receiving attention. Government has made significant progress in addressing these challenges that face older persons in South Africa:

Legislation: Government has two pieces of legislation that directly affect older persons. The new Older Persons Bill which is being finalized in parliament, and which is aimed at protecting and promoting the well being of older persons. The Bill encompasses the main pillars of the Madrid Plan

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of Action to which South Africa is signatory, namely older persons and development, promoting health and well being into ageing and the creation of an enabling environment; and for our purposes, amplifies the protection of the rights of older persons from abuse and neglect. The Bill thus encompasses programmes for development of older persons, to address the issues of poverty and the changing role of older persons in society.

Opening Plenary – 2005 White House Conference on Aging

Monday, December 12, 2005

REMARKS OF:

BARRY C. BLACK, PH.D, CHAPLAIN, U.S. SENATE

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BARRY C. BLACK, Ph.D.:—Psalm 92: Verse 14 states, “They shall still bear fruit in old age.” We should be productive throughout the seasons of life. And one of the purposes of a conference on aging should be to ensure that people have a chance even in life’s evening to live productively.

The first command given by the Creator to humanity was “be fruitful”; Genesis, Chapter 1, Verse 28. As we grow older we should bear the fruit of knowledge. The longer we live the more we should learn. As we grow older we should bear the fruit of integrity. There is something about the moral authority that comes from a long life well lived.

I think of Billy Graham after 9/11 in the Washington Cathedral. He personified what Aristotle called ethos. The longer we live the more we should bear the fruit of patience. A long life should remind us that life is not a sprint but a marathon.

And the longer we live the more we should bear the fruit of generosity, for the closer we get to the evening the more we should realize that our lives consist not in the abundance of the things we possess and that the Lebanese-American poet

Khalil Gibran was correct when he said, “You give but little when you give of your possessions; it is only when you give of yourself that you truly give.”

And if we bear these fruits, knowledge, integrity; if we bear the fruit of generosity and humility; if we bear the wonderful fruits, ethical fruits, in old age, the fruit of patience, what we will discover is as we and Cullen Bryant put it, we will approach our gray as one who wraps the drapery of his couch about him and lies down to pleasant dreams.

Let us pray. Eternal Lord God, Creator of the seasons of our lives, we thank you for this first White House Conference on Aging in the twenty-first century.

We praise you for the opportunity to reflect together and discuss issues that will result in

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substantive recommendations to bless those in life's evening. Guide and inspire conference delegates and participants. Open our eyes to see the light of your wisdom. Use us to assist the aging in productive and abundant living through the shadow of the night.

As we deepen our awareness of the needs of the aging, give us the courage to act.

May these efforts lead to an improvement in the quality of living for all people. Bless us today as we honor the memory of champions who have died. We thank you for the legacies of Martha Eaves, William Lehman, Arthur Fleming, Edward Roybal, Daniel Patrick Moynihan, Myrna Lewis, Rosalie Wolf, Maggie Kuhn, and Jane Kennedy. May their noble footprints on the sands of our history challenge us when we are too well pleased with ourselves, when our dreams come true because we have dreamed too little. May their courage rebuke us when we arrive safely simply because we have sailed too close to the shore. May their vision inspire us to dare more boldly, to venture on wider seas where we will do the impossible by your power. We pray in your Holy Name, Amen.

Opening Plenary Session

December 12, 2005

REMARKS BY:

JOSEFINA G. CARBONELL

ASSISTANT SECRETARY FOR AGING

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Welcome to the 2005 White House Conference on Aging!

I would like to begin — by acknowledging the Conference Committees and staff — for their leadership and hard work in making this conference a reality.

I welcome — our distinguished members of the Cabinet, elected officials and guests — our delegates and observers — and our international colleagues.

Thank you for participating in this conference.

We applaud your interest in the future of aging.

I also want to pay special tribute — to those of you who serve elderly people every day — and express my personal gratitude — for your dedication and service to older Americans.

Today represents the culmination of thousands of hours of work — that has taken place over the last 15 months — and reflects the input — of tens of thousands of people all across our nation.

As the first White House Conference on Aging in the 21st Century — we have been given an opportunity to shape the future.

We are being summoned by the unique times we live in.

We are on the threshold of a world — that will be very different than the one we have lived in.

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We are witnessing — first hand — one of the most fundamental demographic shifts in human history.

In just 20 days — the first wave of the baby boom will begin to turn 60. And — long-term living — is now a reality.

At the same time — we are seeing advances in science and technology that are transforming the way we live our lives — conduct our business — and experience the world around us — including the way we interact and communicate with one another.

And we are seeing fundamental changes in the way we think about — and deliver — health and long-term care.

These are exciting times — historic times.

Major initiatives and opportunities are underway that hold the promise to modernize and improve the future of aging and transform the world around us.

Over the next two days — we will be developing strategies to help our nation transition to that future.

Our strategies must involve every sector of society.

- every level of government
- every business sector
- every community, and yes,
- every individual.

Each generation has an opportunity — to leave its mark on the world.

Today — it is our turn.

The future of aging can not be defined as a matter of chance.

It is — a matter of choice.

Introduction of Secretary Mike Leavitt

Now, it is my distinct honor to introduce to you my boss, the Secretary of Health and Human Services, Mike Leavitt.

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He comes to the department with extensive experience in efficient management and in addressing the most significant health and human services challenges.

- As a former Governor of the state of Utah, the former EPA Administrator, a businessman, and a dedicated family man, he brings a seasoned experience, compassion and values, and a commitment to developing collaborative solutions to the Department of Health and Human Services.
- The right man to lead the Department that touches the lives of every American man, woman, child and elder.

With the vast responsibilities he has leading the largest civilian department in government, he is not only a man who HAS a mission, but is also a man ON a mission.

For instance, he has redefined “bus tours” in this country, with more than 50 Medicare tour stops since the end of June – stops like...

- Las Vegas, Nevada, where he sang with a barbershop quartet; and
- Cincinnati, Ohio, where he ate a bowl of the famous Skyline Chili; –
- In fact, he even did a little salsa dancing at Little Havana Centers in Miami, Florida.

Yes – he is a man on a mission.

And let me attest to how “effective” he is.

- He charged all of us to go home over the Thanksgiving holidays and help enroll family members in the new Medicare Prescription Drug benefit.
- And I understand that he did the same thing,

The result –

I hear that Dixie and Ann Leavitt will be saving about \$5,000 a year.

I'd say — you did pretty good, Mr. Secretary.

Mike Leavitt is a dedicated public servant who is clearly committed to the mission given to him by the President –

- to help Americans live longer, healthier, and better lives, and
- to do it in a way that protects our economic competitiveness as a nation.

Please join me in welcoming to the stage, the Honorable Mike Leavitt.

Opening Plenary Session

December 12, 2005

REMARKS BY

THE HONORABLE DAVID WALKER

COMPTROLLER GENERAL OF THE UNITED STATES

Good Morning. It's a pleasure to be with you, thank you very much. I had the pleasure of being at the 1995 White House Conference on Aging when at that point in time I was a trustee of Social Security and Medicare. Just to give you a few numbers that might help you before I go through this presentation, I am 54 years old. I am a baby boomer. I got married at 19. I have been married 34 years to the same woman. [Applause] I have two children, 32 and 28; two grandchildren, 4 and 2; and one on the way. And I am also a member of the Sons of American Revolution, having members of my family who fought and died in the revolution.

So with that, I really appreciated having the opportunity to hear the prior two speakers, but I am in the fact business. And so what you are going to hear from me is a little bit about some of the challenges and opportunities that we face with our aging society. And let me say at the outset, I don't go for the term older Americans. I would rather use the term seasoned Americans because I think we have to keep in mind that as each of us age throughout life that young gets older every year. Personally, I am always young and I hope you feel that way too, so it's something we can all deal with.

Let me share with you some information on two things I think you need to be aware of as you are going through your activities in the next couple of days. Number one, the current financial condition of the United States of America and the projected long-term fiscal position of our country; it's a sobering message. Secondly, some of the challenges and opportunities that we have, hopefully we can capitalize on our aging society, longer life spans, our knowledge-based economy, and recognizing that our most underutilized resource in this country represents seasoned citizens; so if we can let's go with the first one.

Let's start by looking back, then about where we are, and then we will look forward. In 1964, a little over 40 years ago, almost half of the federal budget was spent for defense. Fast forward 40 years, it was down to 20 percent. It would have been 17 to 18 percent but for Iraq and Afghanistan. Where did the money go? Social Security, Medicare, and Medicaid. You will notice that there is nothing in the red for '64 because Medicare and Medicaid came into effect in 1965. If you look in 1964, you will see 7 percent of the budget was for interest on the federal debt. That's what it was in 2004, but not for long because we are adding debt at near record rates and interest rates will go up over time. The past cannot be prologue.

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Looking at it differently, in 1964 when your elected representatives came to the capitol they got to decide how two-thirds of the budget was going to be spent. In 2004, it was down to 39 percent and going down every year. A significant majority of the budget is on autopilot. What is in discretionary spending? Such things as national defense, homeland security, the judicial system, education, the environment, transportation, GAO, and other important activities. Needless to say, the past cannot be prologue here as well.

If you look at trends in deficits, and this is as a percentage of the economy so inflation is taken out. The red representing the on-budget deficit, the blue representing the off-budget surplus, which largely is the Social Security surplus, and the black line representing the so-called, “unified” or “consolidated” surplus or deficit, you will see that our trend has not been positive of late until the last year. And one must keep in mind that yes, there are so-called “trust funds” for Social Security and Medicare, but there are not real trust funds. They are sub accounts of the general ledger. If you look at the financial statements of the U.S. government, you will not find a liability of the U.S. government for the bonds that are in the trust funds because the left hand owes the right hand and you eliminate it on consolidation.

Don’t get me wrong. There are bonds. I have seen them. I have touched them. They are backed by the full faith and credit of the United States government. They are guaranteed as to principle and interest. They have legal, political, and moral significance, but they have no economic significance whatsoever. When those bonds have to be cashed in, you will either have to raise taxes, cut other spending, or increase debt held by the public in order to pay benefits on time. And when you increase debt held by the public, it probably means more borrowing from China, Japan, Korea, and OPEC nations because they supplied over 90 percent of the funding for our new debt last year and it’s going up every year.

If you look in the last two years, and these numbers are in billions so you have to add nine zeroes behind these numbers. We had a \$567 billion on-budget deficit in 2004; fortunately it went down about \$100 billion. However, only about \$100 billion of the total deficit has anything to do with Iraq, Afghanistan and incremental homeland security costs, and this is before we hit the demographic tidal wave. Another way to look at it is if you look at how much our liabilities and unfunded promises for Social Security and Medicare have grown, in the year 2000 they were \$20 trillion—by the way there is twelve zeroes behind trillion. They have gone from \$20 trillion in 2000, to over \$43 trillion in 2004. More than doubling in just four years, and of that \$43 trillion plus, \$8.1 trillion was the new Medicare Prescription Drug Bill.

Yes, we need prescription drugs for seniors, but we were already in the hole \$15 to \$20 trillion for Medicare before that bill was passed; and \$8.1 trillion is more than the entire debt of the United States outstanding since the beginning of the republic in 1789. And, \$8.1 trillion is almost two times the Social Security in balance. Medicare is 7 to 8 times greater a challenge as Social Security as we look forward.

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Looking at it differently because I don't know about you, I am barely getting used to billions much less tens of trillions. If you look at it differently, the entire estimated net worth of every American in the United States including Warren Buffet, Bill Gates, every other billionaire and including all accumulated home equity, which has risen dramatically in the last several years in many parts of the country, was recently estimated to be 48.5 trillion. Therefore, if you just go on the 2004 numbers, which by the way are going to go higher later this week when I announce the 2005 numbers which are going to be about \$46 to \$47 trillion, we would have to confiscate most of the net worth of every American in order to close the hole attributable to what we have already built up in liabilities and unfunded promises.

We are not going to do that. That would be confiscatory, but frankly it wouldn't solve the problem because these numbers are going up everyday. It's roughly \$150,000 per American including each newborn, and it's over \$350,000 per full-time worker; and the average annual compensation in the United States is roughly \$50,000.

It's not just spending, it's tax preferences. The largest single tax preference in the Internal Revenue Code is healthcare, and if you add the fact that nobody pays income or payroll taxes on the value of employer provided and paid healthcare, it's over \$150 billion a year and growing rapidly; but yet tax preferences are largely off the radar screen even though they amount to \$700 to 800 billion a year in forgone revenue. By the way, your government spends over \$2 trillion a year.

Now part of the problem that we have is the way we keep score in Washington. I am not the one that decides how we keep score, the Congress does and/or other regulators, but this is a simulation of what the future looks like. The bars represent spending as a percentage of the economy, the line represents revenues as a percentage of the economy—this is only at the federal level, and inflation is taken out—if the bar is above the line then that is a deficit. You can see that based upon this simulation, which is based upon current law and Congressional Budget Office assumptions, that it looks like we have a problem going out past 2015 growing over time, but what the heck, some of us may not be here then, that's a long way out. You know, why worry about it because obviously there are variances in projections.

There is only one problem with that, for this simulation, as required by law and which is the basis under which decisions are made in Washington, four assumptions are made and none of them are realistic. Number one, no new laws will be passed in the next 35 years. Number two, discretionary spending which includes all of the vital items that I talked to you about previously, will only grow by the rate of inflation. Number three, that all tax cuts that have been enacted in recent years will expire and will not be extended in whole or in part. I am just giving the facts ladies and gentlemen; you have got your opinions. And number four, that the alternative minimum tax that bait and switch surtax that I have had an opportunity to pay in two of the last three years, and I feel confident I will have the opportunity soon again, that that will not be fixed.

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Well quite frankly, I don't know many people that believe that any of those are valid much less all four; and therefore, this is a false and misleading view of where we are and where we are headed. Let me give you an alternative scenario. There's only two differences between this scenario and the first—and I am not advocating for or against I am just giving you the numbers. As you know, there may be red and blue states, but the facts are purple. If you look at this going forward there are only two differences. Number one, discretionary spending grows by the rate of the economy and that's why the green portion stays about the same size over time, and all tax cuts are made permanent.

Ladies and gentlemen, this is an Argentina scenario—and for those of you who do not know what I mean by that—Argentina defaulted—the largest in history. Ladies and gentlemen, many people talk about Social Security's trust funds having adequate assets to pay benefits at 100 percent until 2041. Under this scenario, we are going to have to be worried about paying our bills period in 2041. One cannot look piece by piece. You also have to look at the full puzzle as well.

So what is the bottom line? The status quo is not an option. Faster economic growth can help, but there is no way we are going to grow our way out of this problem. Anybody who believes we are going to grow our way out of this situation has two problems. Number one, they have not studied economic history. Number two, they probably wouldn't pass math. The sooner we get started the better because when you are a debtor, which unfortunately our nation is, debt on debt is not good. The compounding works against you rather than for you, and we need to educate the American people as to where we are and where we are headed because very tough choices are going to be required by our elected officials. And they are not going to be in a position to make those choices unless and until the American people understand that they have to be made.

So what are some of the things we have to do? We need to re-impose budget controls and be more realistic about the affordability and sustainability of both spending and tax actions before laws are passed. It also would be great if people actually read the bills before they voted on them. We need to improve how we keep score, and we need to have some metrics to understand which federal government programs and policies are working and which ones aren't. Believe it or not, over half the federal government programs cannot demonstrate that they are making a difference. Over half on an outcome basis, and quite frankly, it would probably be that or more on the tax side.

In the final analysis we are going to have to do three things. We are going to have to restructure Social Security, Medicare, and Medicaid and frankly Social Security is going to be a lot easier than Medicare; and we can exceed the expectations of every generation of Americans if we go about it the right way. We are going to have to look at the base of discretionary and other spending, and we are going to have to look at tax policies.

Believe it or not, a vast majority of your government is based upon conditions that existed in the United States and in the world of the 1950s and 1960s. While nobody likes tax increases—including me—in the final analysis you need enough revenues to pay your current bills and deliver on your future promises.

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Ladies and gentlemen, let me tell you, I am not worried about myself, but I am very concerned about my children and grandchildren because every dollar of additional deficit today is a dollar plus the additional interest in the form of taxes on them tomorrow unless something changes. This is a document that is on our website, www.gao.gov again www.gao.gov. It raises over 200 illustrative questions to support the hypothesis that I made that a vast majority of your government is based on the 1950s and the 1960s. I would encourage you to take a look at it.

These are a few of the questions which I won't cover that deal with broad ranges of issues such as Social Security, the Pension Benefit Guaranty Corporation, the need to encourage savings and to preserve savings for retirement, the need to encourage seasoned citizens to work longer, the need to be able to look at how to restructure Medicare and Medicaid, and also how to restructure our entire healthcare system because it is fundamentally broken; and it needs comprehensive and fundamental reform.

When you look at economic security in retirement, you must look at the full picture, as well as the individual pieces. For adequate retirement income—Social Security, private pensions, personal savings, and for an increasing number of Americans, earnings from continued employment, it's affordable healthcare through Medicare and retiree healthcare for those who are fortunate to have it. It's long-term care which is a hybrid. There are a number of players who have to contribute to make sure we are successful in this area. When you look at the cash flows moving forward for Social Security and Medicare, the graph speaks loudly. We face large and growing structural deficits in those programs as well as overall. When you look at the increasing burden of Social Security, Medicare, and Medicaid to our economy and to our budget, you can see how it is projected to grow over time. We need to recognize that we face something that is unprecedented in the history of this country. It's called a demographic tidal wave or tsunami. It is the retirement of the baby boom generation which is followed by a baby bust.

You can see the tsunami in this graphic. It starts at about 2011 when the first baby boomer reaches 65 and is eligible for Medicare and it grows. Unlike most tidal waves which recede, this one will never recede and we are not prepared. These are some of the key dates for Social Security. Don't be deceived by the 2041 or 2052 date. Cash is key and we start running a negative cash flow in 2017.

There are things that need to be done in order to reform Social Security to make it solvent, sustainable, and secure for current and future generations. We have done a lot of work on it. This is just one slide; others are available on our website. We clearly have to reform our private pension system. It is broken. Companies are not delivering on their promises, and federal law allows them to evade their promises. That must be changed.

We need to make sure that we have incentives and safeguards to make sure that sponsors have to fund their plans to deliver on their promises. We have to hold them accountable for doing so, and we have to improve the transparency and timeliness of information available to workers and retirees to

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make sure that they are doing so. A number of reforms are necessary. These are some examples, but candidly, time does not allow me to go into it. This presentation will be posted on our website under the From Comptroller General's section this afternoon. So those of you who want to look at will have an opportunity to do so at your leisure.

These are the key dates for Medicare Part A. We are already in a negative cash flow situation. We went into negative cash flow in 2004, and obviously the date of projected insolvency is much quicker than it is for Social Security. As I mentioned before, the Medicare problem is 7 to 8 times greater than Social Security. This is the trend in the Part B premium as a deduction from your Social Security check. You can see it is starting to rise, but what most Americans don't understand is that when Part B SMI (Supplemental Medical Insurance) came about in 1965, it was supposed to be a 50/50 cost split. 50 percent for the taxpayers, 50 percent for the individual. It's now 75 percent for the taxpayers and 25 percent for the individual. That may or may not stay that way over the long-term.

In the final analysis for any system to work, a pension system, a healthcare system, a governance system, you name it; you have to have three elements present in order to be successful and sustainable over time. First, incentives for people to do the right thing. Second, transparency to provide reasonable assurance that people will do the right thing because somebody is looking. And number three, accountability if people do the wrong thing. We need to incorporate these principles into a number of major federal programs and policies including pensions, healthcare, and other elements that are vital to millions of Americans.

As to healthcare reform, the next two slides include a few ideas, but time does not allow me to ultimately cover them. I will say this. We are going to need to answer a fundamental question. What is in our broad-based societal interest that every American irrespective of your age, irrespective of your income and net worth, and irrespective of your geographic location, to make sure that everybody has? We need to focus our efforts on that and then provide mechanisms for people to get more than the basic and essential coverage level if they want, but they will have to do that through their employer and/or on their own because if there is one thing that could bankrupt America, it's healthcare, and it is out of control.

In summary, we also face a slowing workforce challenge, and this is also an opportunity. This is how our workforce growth is slowing. We are in a knowledge-based economy. Therefore, it's brainpower not brawn power that matters. We have a society that is healthier and living longer. Our most untapped and underutilized resource in this country are our seasoned citizens. We need to encourage Americans to work longer. And we need to provide them with means and mechanisms to do so. This can help our economy, it can help the budget, and it actually can help individuals because studies show that the longer that an individual is active, both mentally and physically, the longer they are likely to live; all other things being relatively equal.

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There are cultural barriers, there are employment barriers, there are legal barriers for us to get to where we need to be. These must be addressed and changed. Within the last month, we issued this report on our aging workforce. It contains some ideas about potential ways forward in order to be able to get us from where we are to where we need to be.

Last slide. We live in the greatest country on the face of the earth. I have had the good fortune to travel to about 90 countries and all 50 states, and I deal with my counterparts around the world on a recurring basis. We face many shared challenges. We have much to be proud of and much to be thankful for, but we have some serious challenges ahead of us, and I have showed you a few.

We need more leaders in the public sector, the private sector, and the not for profit sector, including those of you in this room who have three attributes; courage, integrity, and innovation. The courage to state the facts, to speak the truth, to tell it like it is, to do the right thing, even though it may not be popular; the integrity to practice what you preach and to lead by example, and the innovative ability to see new ways to address old problems and to help others see the way forward. Let's work together to make America even greater in the future and to provide more opportunities for our seasoned citizens. Thank you.

United States Government Accountability Office

LOOK AT



OUR
FUTURE:
WHEN BABY BOOMERS
RETIRE

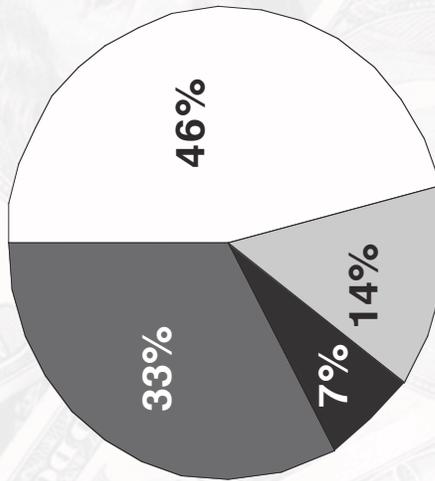
2005 White House
Conference on Aging

The Honorable David M. Walker
Comptroller General of the United States
December 12, 2005

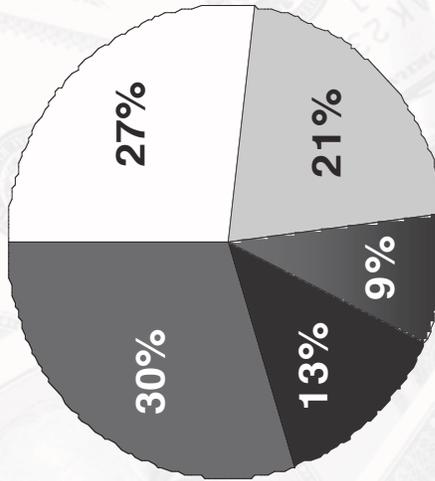


Composition of Federal Spending

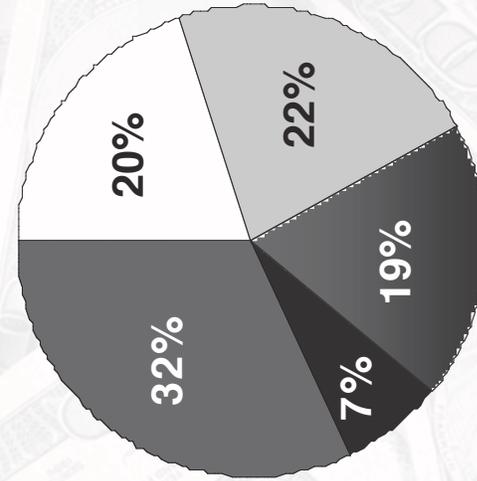
1964



1984



2004



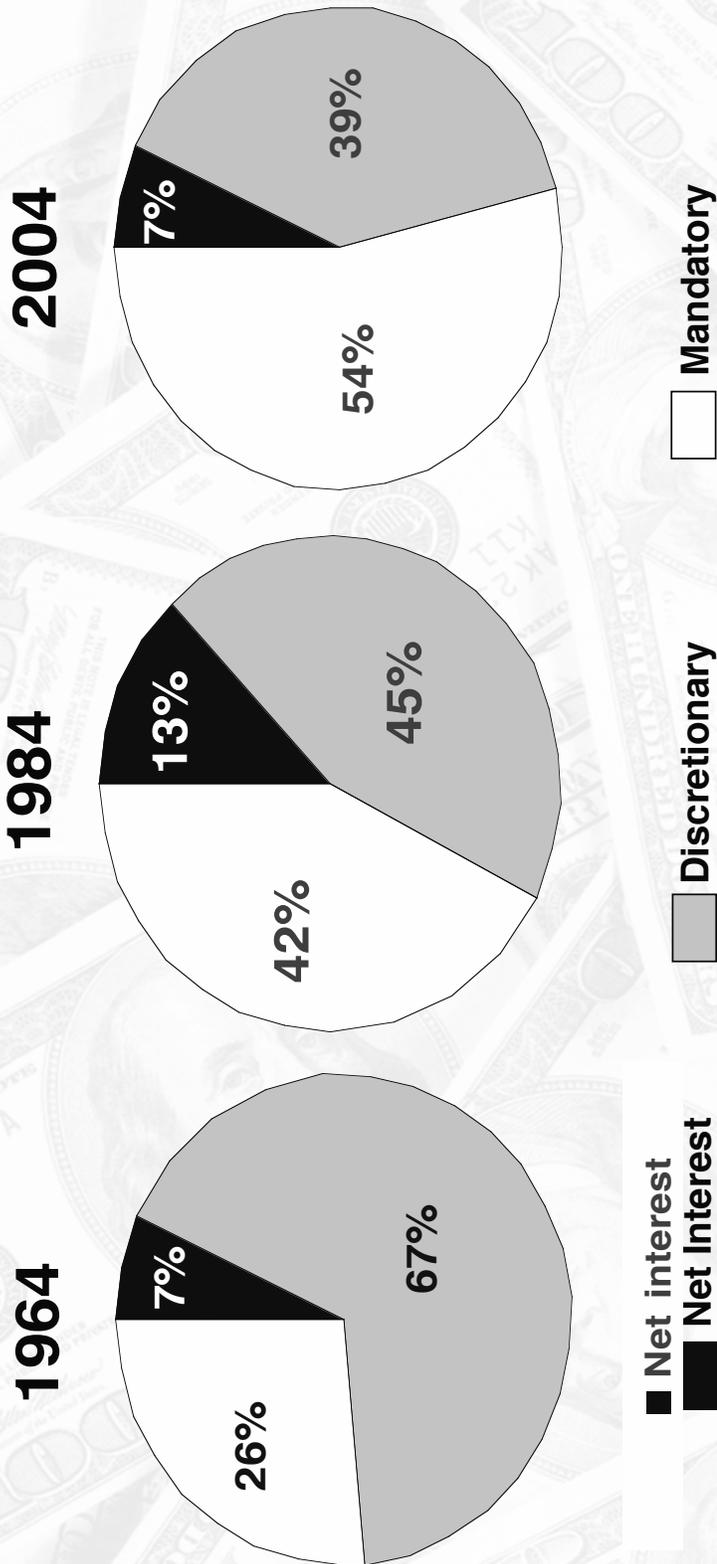
Defense
Net interest

Social Security
All other spending

Medicare & Medicaid

Source: Office of Management and Budget.

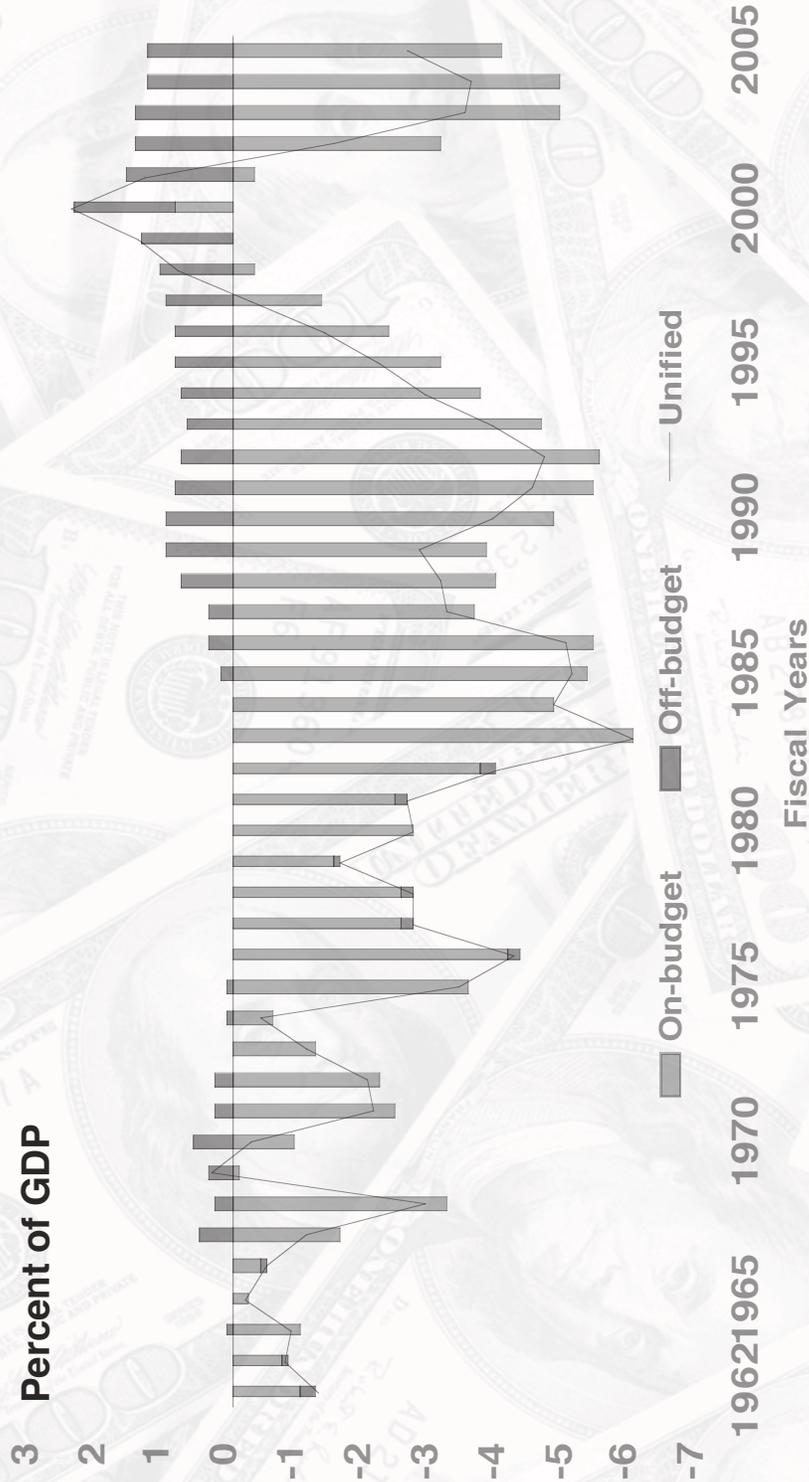
Federal Spending for Mandatory and Discretionary Programs



Source: Office of Management and Budget.

Surplus or Deficit as a Share of GDP

Fiscal Years 1962-2005



Source: Office of Management and Budget and Congressional Budget Office.

Fiscal Year 2004 and 2005 Deficits

| | Fiscal Year 2004 | | Fiscal Year 2005 | |
|---------------------|------------------|----------|------------------|----------|
| | \$ Billion | % of GDP | \$ Billion | % of GDP |
| On-Budget Deficit | (567) | (4.9) | (494) | (4.0) |
| Off-Budget Surplus* | 155 | 1.3 | 175 | 1.4 |
| Unified Deficit | (412) | (3.6) | (319) | (2.6) |

*Includes \$151 billion in fiscal year 2004 and \$173 billion in fiscal year 2005 in Social Security surpluses and \$4 billion in fiscal year 2004 and \$2 billion in fiscal year 2005 in Postal Service surpluses.

Estimated Fiscal Exposures

(in \$ trillions)

| | 2000 | 2002 | 2004 |
|---|---------------|---------------|---------------|
| <ul style="list-style-type: none"> • Explicit liabilities • Publicly held debt • Military & civilian pensions & retiree health • Other | \$6.9 | \$7.8 | \$9.1 |
| <ul style="list-style-type: none"> • Commitments & Contingencies • E.g., PBGC, undelivered orders | 0.5 | 0.8 | 0.9 |
| <ul style="list-style-type: none"> • Implicit exposures • Future Social Security benefits • Future Medicare Part A benefits • Medicare Part B benefits • Medicare Part D benefits | 13.0 | 17.8 | 33.3 |
| Total | \$20.4 | \$26.4 | \$43.3 |

Sources: Consolidated Financial Statements.

Note: Estimates for Social Security and Medicare are PV as of January 1 of each year as reported in the Consolidated Financial Statements and all other data are as of September 30. The 2005 Trustees Reports issued in March of this year show that the Social Security and Medicare exposures have increased as follows: Social Security increased to \$5.7 trillion, Medicare Part A increased to \$8.8 trillion, Medicare Part B increased to \$12.4 trillion and Part D increased to \$8.7 trillion. Totals may not add due to rounding.

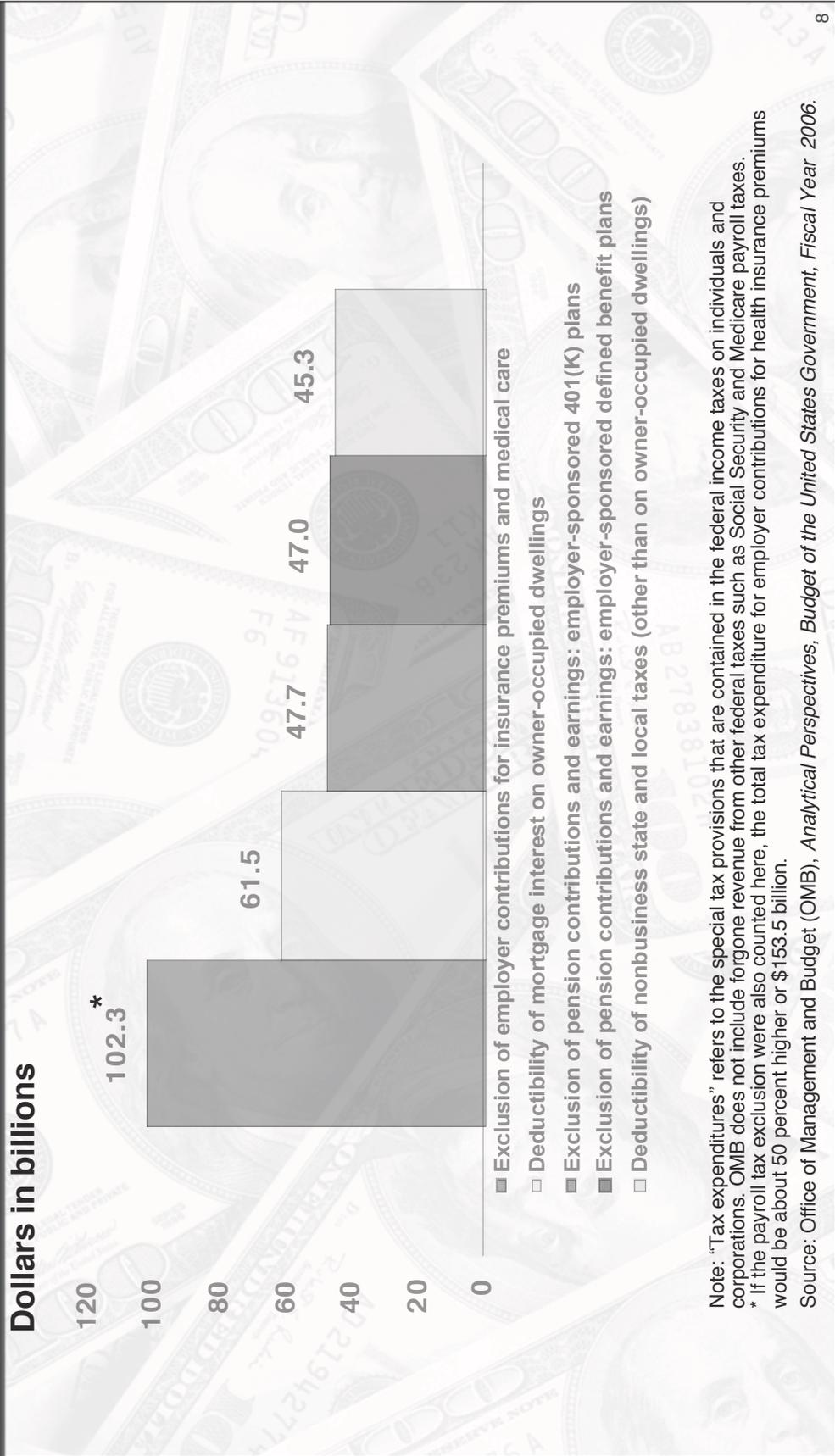
How Big is Our Growing Fiscal Burden?

Our total fiscal burden can be translated and compared as follows:

| | |
|--|------------------------|
| Total fiscal exposures | \$43.3 trillion |
| Total household net worth | \$48.5 trillion |
| Burden/Net worth ratio | 89 percent |
| Burden | |
| Per person | \$147,000 |
| Per full-time worker | \$350,000 |
| Per household | \$383,000 |
| Income | |
| Median household income | \$44,389 |
| Disposable personal income per capita | \$29,475 |

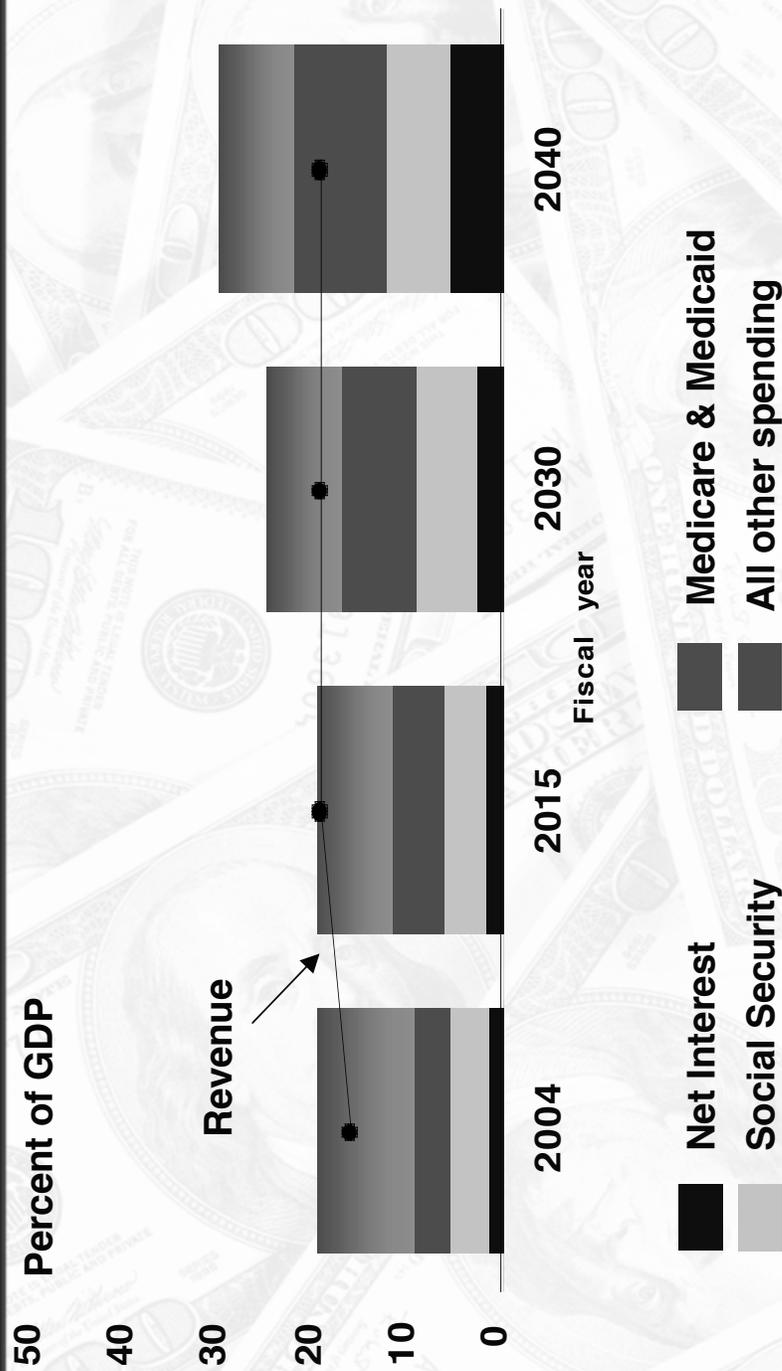
Note: Net worth and income data are calendar year 2004 levels.
 Sources: Federal Reserve Board for household net worth; Census Bureau for median household income; and the Bureau of Economic Analysis for disposable personal income per capita.

Health Care Is the Nation's Top Tax Expenditure in Fiscal Year 2004 (estimated)



Composition of Spending as a Share of GDP

Under Baseline Extended

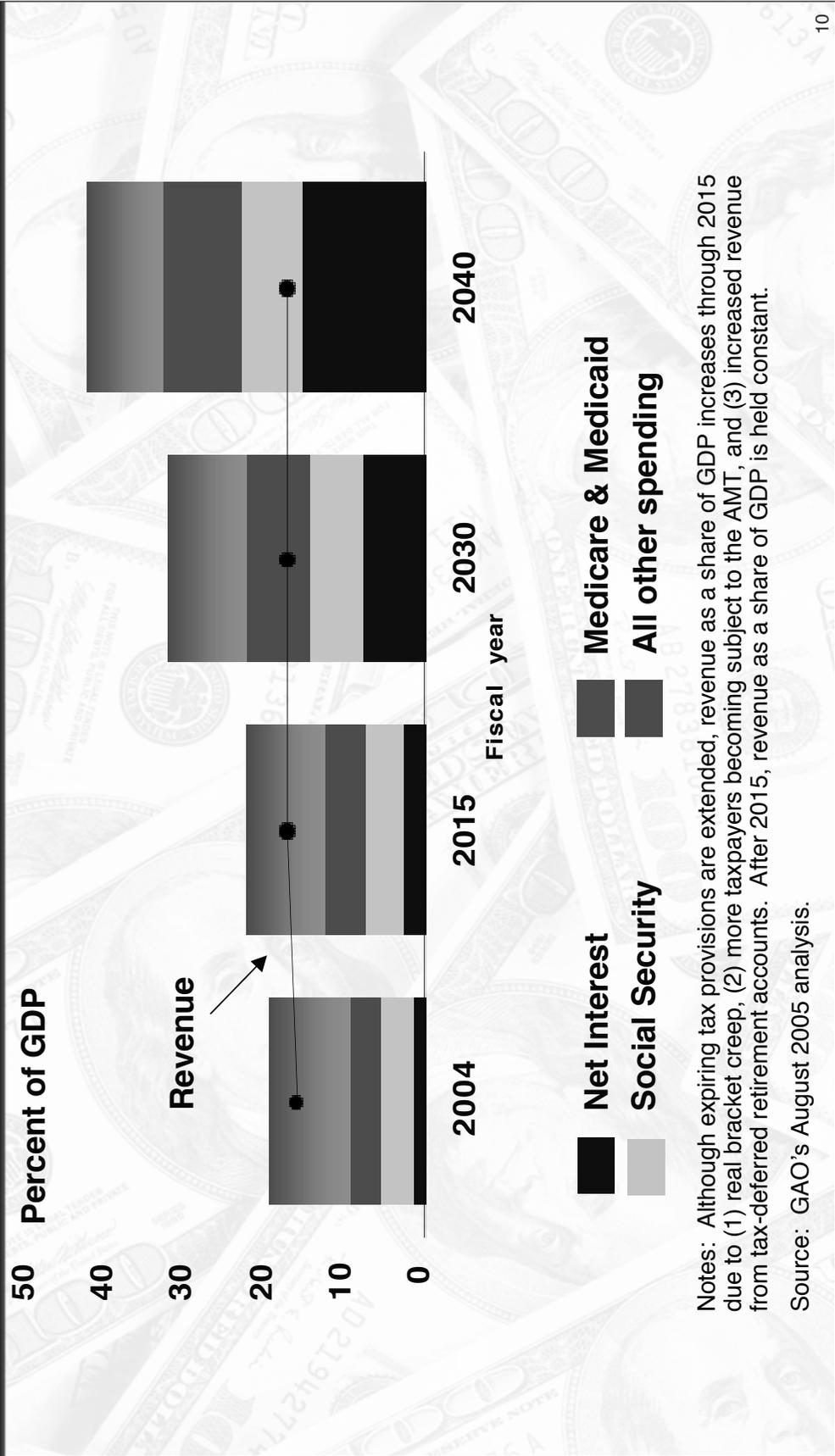


Notes: In addition to the expiration of tax cuts, revenue as a share of GDP increases through 2015 due to (1) real bracket creep, (2) more taxpayers becoming subject to the AMT, and (3) increased revenue from tax-deferred retirement accounts. After 2015, revenue as a share of GDP is held constant.

Source: GAO's August 2005 analysis.

Composition of Spending as a Share of GDP

Assuming Discretionary Spending Grows with GDP after 2005 and All Expiring Tax Provisions are Extended



Notes: Although expiring tax provisions are extended, revenue as a share of GDP increases through 2015 due to (1) real bracket creep, (2) more taxpayers becoming subject to the AMT, and (3) increased revenue from tax-deferred retirement accounts. After 2015, revenue as a share of GDP is held constant.

Source: GAO's August 2005 analysis.

Current Fiscal Policy Is Unsustainable

- **The “Status Quo” is Not an Option**
 - We face large and growing structural deficits largely due to known demographic trends and rising health care costs.
 - GAO’s simulations show that balancing the budget in 2040 could require actions as large as
 - Cutting total federal spending by 60 percent or
 - Raising taxes to 2.5 times today’s level
- **Faster Economic Growth Can Help, but It Cannot Solve the Problem**
 - Closing the current long-term fiscal gap based on responsible assumptions would require real average annual economic growth in the double digit range every year for the next 75 years.
 - During the 1990s, the economy grew at an average 3.2 percent per year.
 - As a result, we cannot simply grow our way out of this problem. Tough choices will be required.
- **The Sooner We Get Started, the Better**
 - Less change would be needed, and there would be more time to make adjustments.
 - The miracle of compounding would work with us rather than against us.
 - Our demographic changes will serve to make reform more difficult over time.
- **The Public Needs to Be Informed and Involved**

The Way Forward: Three Pronged Approach

Impose Budget Controls and Enhance Legislative Process

- Discretionary spending caps
- PAYGO rules on both sides of the ledger
- Mandatory spending triggers
- Automatic present value disclosures for legislative debate on major tax and spending bills
- Provide enhanced and integrated summaries of every key bill to Members before they vote on it, especially in connection with proposed new programs, policies, or activities

Improve Accounting and Reporting and Metrics:

- Enhanced financial statement presentation (e.g. trust fund activity, intergenerational burdens)
- Develop key national (outcome-based) indicators

Re-examine Policies and Programs:

- Restructure existing entitlement programs
- Reexamine the base of discretionary and other spending
- Review and revise existing tax policy, including tax preferences and enforcement programs

21st Century Challenges Report

- Provides background, framework, and questions to assist in reexamining the base
- Covers entitlements & other mandatory spending, discretionary spending, and tax policies and programs
- Based on GAO's work for the Congress
- Issued February 16, 2005



Illustrative 21st Century Questions: Retirement and Disability Policy

- How should **Social Security** be reformed to provide for long-term program solvency and sustainability while also ensuring adequate benefits (for example, increase the retirement age, restructure benefits, increase taxes, and/or create individual accounts)?
- What changes should be made to enhance the retirement income security of workers while protecting the fiscal integrity of the **PBGC** insurance program (for example, increasing transparency in connection with underfunded plans, modifying PBGC's premium structure and insurance guarantees, reforming plan funding rules, or restricting benefit increases and the distribution of lump sum benefits in connection with certain underfunded plans)?
- How can existing policies be reformed to **encourage income preservation strategies** so that retirement income lasts an individual's entire life (for example, benefit annuitization)?
- How can existing policies and programs be reformed to **encourage older workers to work longer** and to facilitate phased retirement approaches to employment (for example, more flexible work schedules or receiving partial pensions while continuing to work)?

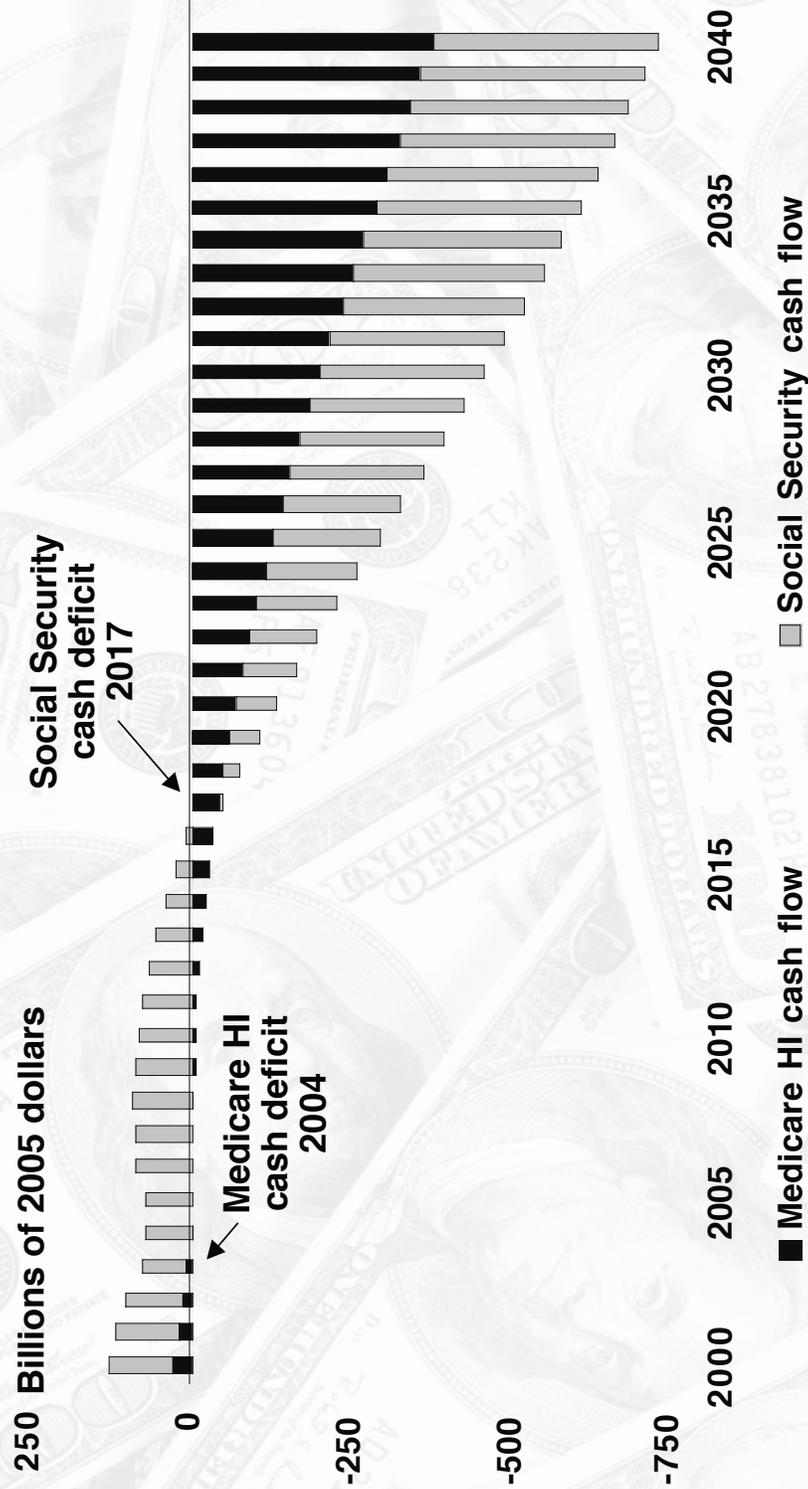
Illustrative 21st Century Questions: Health Care

- How can we make our current **Medicare and Medicaid** programs sustainable? For example, should the eligibility requirements (e.g., age, income requirements) for these programs be modified?
- How can we perform a **systematic reexamination of our current health care system**? For example, could public and private entities work jointly to establish formal reexamination processes that would (1) define and update as needed a minimum core of essential health care services, (2) ensure that all Americans have access to the defined minimum core services, (3) allocate responsibility for financing these services among such entities as government, employers, and individuals, and (4) provide the opportunity for individuals to obtain additional services at their discretion and cost?

Key Elements for Economic Security in Retirement

- **Adequate retirement income**
 - Social Security
 - Pensions
 - Savings
 - Earnings from continued employment (e.g., part-time)
- **Affordable health care**
 - Medicare
 - Retiree health care
- **Long-term care (a hybrid)**
- **Major Players**
 - Employers
 - Government
 - Individuals
 - Family
 - Community

Social Security and Medicare's Hospital Insurance Trust Funds Face Cash Deficits



Note: Projections based on the intermediate assumptions of the 2005 Trustees' Reports.
 Source: GAO analysis based on data from the Office of the Chief Actuary, Social Security Administration and Office of the Actuary, Centers for Medicare and Medicaid Services.

Social Security, Medicare, and Medicaid Spending as a Percent of GDP



Note: Social Security and Medicare projections based on the intermediate assumptions of the 2005 Trustees' Reports. Medicaid projections based on CBO's January 2005 short-term Medicaid estimates and CBO's December 2003 long-term Medicaid projections under mid-range assumptions.

Source: GAO analysis based on data from the Office of the Chief Actuary, Social Security Administration, Office of the Actuary, Centers for Medicare and Medicaid Services, and the Congressional Budget Office.

U.S. Elderly Dependency Ratio Expected to Continue to Increase

Elderly Dependency Ratio (in percent)



Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2004 Revision and World Urbanization Prospects: The 2003 Revision.

Note: Data for 2005 through 2050 are projected.

Key Dates Highlight Long Term Challenges of the Social Security System

| Date | Event |
|--------------------------|--|
| 2009 | Social Security cash surplus begins to decline |
| 2017 | Annual benefit costs exceed cash revenue from taxes |
| 2027 | Trust fund ceases to grow because even taxes plus interest fall short of benefits |
| 2041 (SSA) 2052 (CBO) | Trust fund exhausted, annual revenues sufficient to pay about 74% – 78% of promised benefits |

Sources: Social Security Administration, *The 2005 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*. Washington, DC, March 2005. Congressional Budget Office, *The Outlook for Social Security: Potential Range of Social Security Outlays and Revenues Under Current Law*. Washington, DC, June 2004 (updated April 2005).

GAO Criteria for Evaluating Social Security Reform Proposals

Reform proposals should be evaluated as packages that strike a balance among individual reform elements and important interactive effects.

Comprehensive proposals can be evaluated against three basic criteria:

- Financing sustainable solvency
- Balancing adequacy and equity in the benefits structure
- Implementing and administering reforms

Challenges Facing the Defined Benefit (DB) Pension System

- Large accumulated deficits for many active plans, the PBGC, and the U.S. Government
- Structural weaknesses in certain industries with large, underfunded DB plans
- PBGC has limited control over its risks
- Decline in the number of DB plans
- Changing demographics and workforce trends
- Legal and regulatory uncertainties
- Social Security reform initiatives

Broad Goals for Reform of the DB System

- Provide incentives and safeguards for plan sponsors to improve plan funding
- Hold plan sponsors accountable for adequately funding their plans
- Improve transparency and timeliness of plan financial information

Several Reforms Might Improve Plan Funding and Reduce the Risks to PBGC's Long-term Viability

- Strengthen funding rules applicable to poorly funded plans
- Consider additional tax deductible funding flexibility
- Limit lump sums in underfunded plans
- Modify program guarantees (e.g., phase-in rules)
- Raise and modify pension premiums (e.g., nature of risk related premiums)
- Eliminate floor/offset arrangements with significant investment concentrations in employer securities
- Increase transparency of current plan funding information
- Modify bankruptcy laws
- Address issues surrounding certain hybrid plans (e.g., cash balance plans)

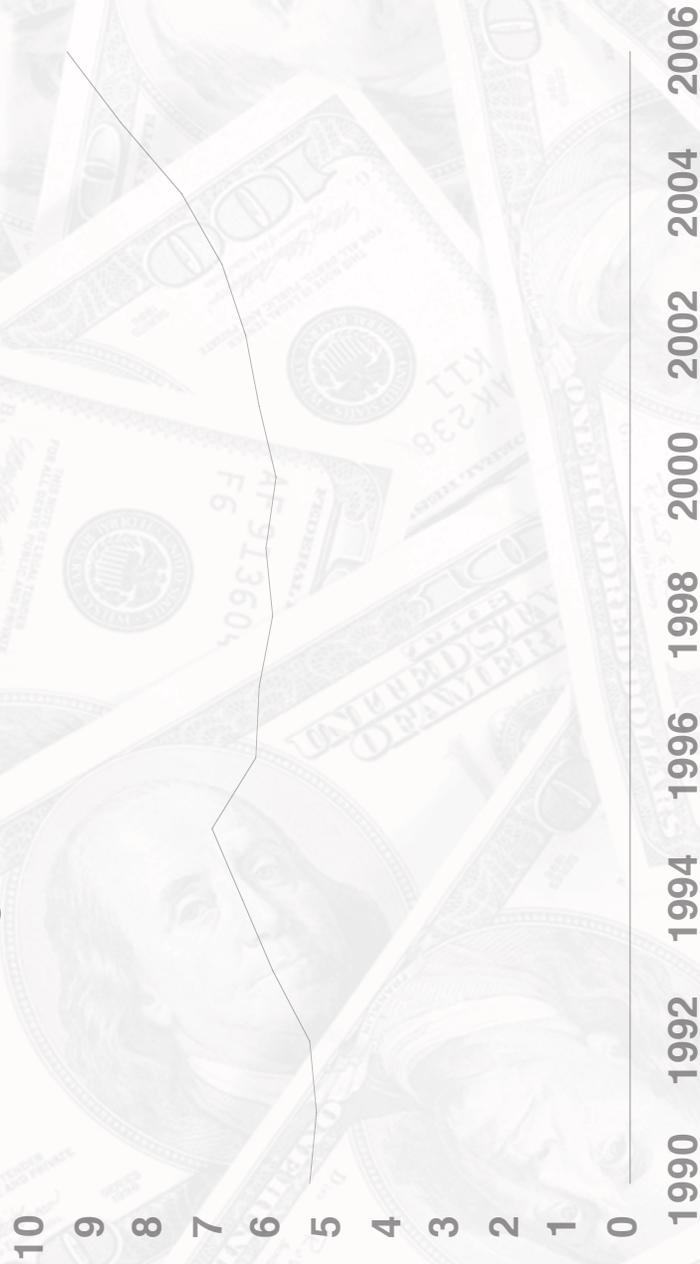
Key Dates Highlight Long Term Challenges of the Medicare Program

| Date | Event |
|------|---|
| 2004 | HI outlays exceed cash income |
| 2007 | Estimated trigger date for “Medicare funding warning” |
| 2012 | Projected date that annual “general revenue funding” will exceed 45 percent of total Medicare outlays |
| 2020 | HI (Part A) trust fund exhausted, annual income sufficient to pay about 79% of HI promised benefits |

Source: 2005 Annual Report of The Boards of Trustees of The Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds Washington, DC, March 2005

SMI Premium as Share of Average Social Security (OASI) Benefit

Percent of average OASI benefit



Note: Data for 2006 are based on the announced SMI monthly premium of \$88.50 and do not include the Medicare Prescription Drug premium. In August, the Centers for Medicare & Medicaid Services estimated that the national average monthly premium for prescription drug coverage equivalent to the Medicare standard coverage would be \$32.20.

Source: CMS, Office of the Actuary.

Issues to Consider in Examining Cost, Access, and Quality Challenges

- In reforming our health care system, the public needs to be educated about the differences between **wants**, **needs**, **affordability**, and **sustainability** at both the individual and aggregate level.
- Ideally, health care reform proposals will
 - align **incentives** for providers and consumers to make prudent choices about health insurance coverage and prudent decisions about the use of medical services,
 - foster **transparency** with respect to the value and costs of care, and
 - ensure **accountability** from health plans and providers to meet standards for appropriate use and quality.

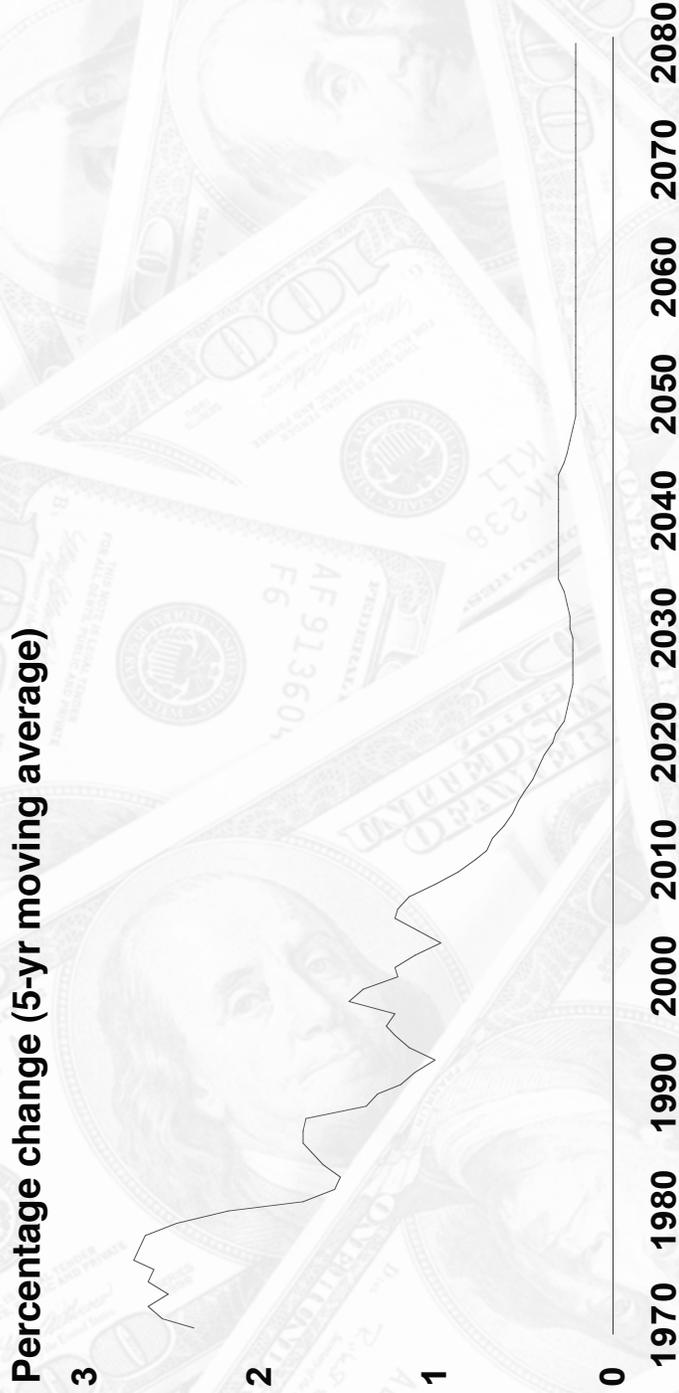
Selected Potential Health Care Reform Approaches

- Provide more transparency in connection with health care costs and outcomes.
- Employ case management approaches for people with expensive acute and chronic conditions to improve the quality and efficiency of care delivered and avoid inappropriate care.
- Leverage the government's purchasing authority to foster value-based purchasing for health care products and services.
- Foster the use of information technology to increase consistency, transparency, and accountability in health care. Use the Federal Employees Health Benefits Program (FEHBP) as a possible means to experiment and see the way forward.
- Develop a set of national practice standards to help avoid unnecessary care, improve outcomes, and reduce litigation.

Selected Potential Health Care Reform Approaches

- Revise certain federal tax preferences for health care to encourage the efficient use of appropriate care.
- Limit spending growth for government-sponsored health care programs (e.g., percentage of the budget and/or the economy).
- Pursue multinational approaches to investing in health care R&D.
- Develop a core set of basic and essential services with supplemental coverage being available as an option but at a cost.
- Create insurance pools for alternative levels of coverage, as necessary.
- Provide additional cost sharing mechanisms for individuals.

U.S. Labor Force Growth Will Continue to Decline



Note: Percentage change is calculated as a centered 5-yr moving average of projections based on the intermediate assumptions of the 2005 Trustees Reports.

Source: GAO analysis of data from the Office of the Chief Actuary, Social Security Administration.

Working Longer May Help Address the Challenges of an Aging Population

- **Impact on the Economy**
 - Larger labor force
 - Additional economic growth
- **Impact on the Federal Budget**
 - Additional tax revenue
 - Reduced expenditures: Social Security & Medicare
- **Impact on Individuals**
 - Enhanced retirement security and quality of life

Why Older Americans Don't Work Longer

- **Cultural Expectation to Retire in Mid-60s**
 - Social Security early retirement age is 62
 - Many private pensions have similar or lower eligibility ages
- **Older Americans Perceive Few Opportunities**
 - Few older workers felt they had opportunities for partial retirement
 - Most older workers and retirees saw low wage, low skilled jobs as their primary employment opportunities
- **Most Employers Do Not Make a Special Effort to Hire and Retain Older Workers**
 - Many employers say they are willing to implement policies to recruit and retain older workers, but few have actually done so
 - Employers cite barriers, such as federal pension regulations, to flexible employment options for older workers

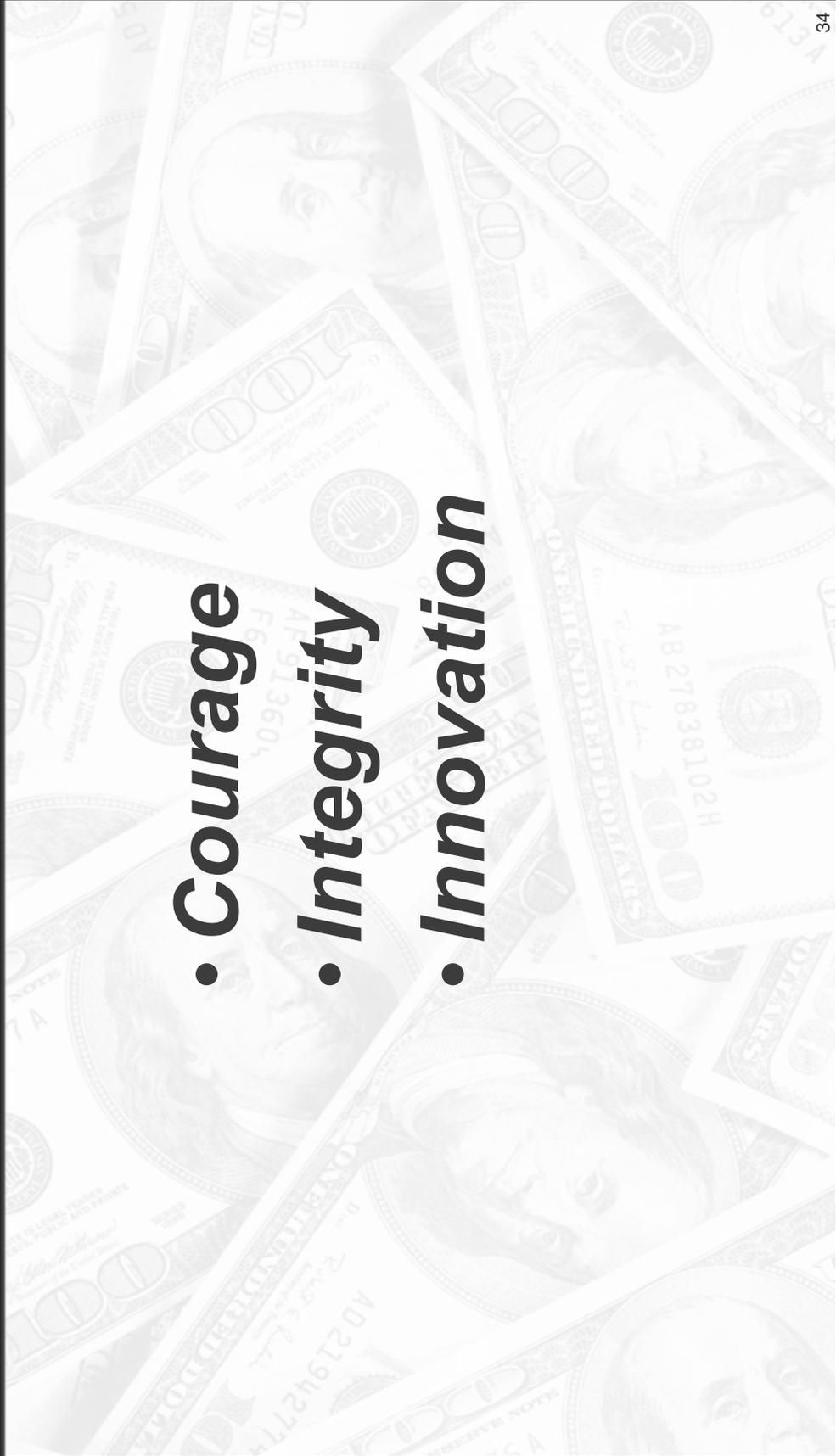
Everyone Needs to Plan for the Aging of the Workforce

- Increase public awareness both employers and employees need to understand the problem
- Encourage employers and employees to take an active role in meeting the challenges of an aging population
- Remove barriers and create opportunities for continued employment, such as phased retirement



**Three Key Ingredients Needed for These
Challenging and Changing Times**

- *Courage*
- *Integrity*
- *Innovation*



Opening Plenary Session

December 12, 2005

REMARKS BY

CRAIG BARRETT

CHAIRMAN OF THE BOARD, INTEL CORPORATION

Well, I guess I am the oldest speaker today. I have worked 66 years to get up here, and while I will talk about specific technology, what I really want to do is talk on behalf of the IT sector. I think you have heard the issues we face, and I can put them in a different perspective. Retiring baby boomers will increase healthcare spending in this country to 20% of the GDP, up from 16%. The healthcare costs alone for an employee in the United States are more than the total loaded cost of an employee overseas. Because of this, it is a simple choice for companies to go overseas to hire that individual. We need to do something about the cost of healthcare in the United States. I would like to propose to you that technology will have the ability to lower healthcare costs while providing better care.

The number of seniors has the potential to double in the next 25 years and the ratio of workers to retirees will decrease from 5:1 to 3:1. The costs associated with supporting this age wave are astronomical under today's system, but the technology to improve the healthcare system and reduce costs is still immature.

I would like to use the analogy that today's healthcare system is a little bit like the mainframe computing industry of a few decades ago. You would kind of write a program, put it on a punch card, then trusted somebody to administer it correctly. It was an inefficient system with many opportunities for error. What transformed the computer industry was in fact personal computers and giving the individual control. Today, you can buy things, access almost any kind of information, and even communicate with your friends and loved ones using a PC and the Internet. The PC has revolutionized our lives and made it easier and affordable to do tasks that once took longer and cost more. The PC has fundamentally changed how we live our lives and how we interact with the world around us; in doing so it has made information delivery more available, affordable and more personal.

Just imagine a healthcare system where personalized technology was regularly implemented. We could take the technology used in hospitals and use it in the home to ward off the unexpected onset of diseases, and to let seniors live in dignity in their own homes.

To put it another way, look at how your finances have been affected by the PC. Today you can manage all of your funds on a PC. You don't have to have a financial advisor to do that anymore. Imagine if you could just transpose the health system into this same format. You could access and

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manage your own healthcare files on your PC. The real issue here is creating a system that allows for personalized care, allows you to age in place in the comfort of your own home, and moves treatment from a generic mode to a personalized mode.

In my role as Chairman of Intel, I travel the world and have seen how other countries have implemented their healthcare. I specifically remember going to Chennai, India in 1998. I was there inaugurating a video conference system between doctors at the Children's Hospital in Chennai where they set up remote conferencing to extend their ability to care for children with heart disease and heart defects.

I went back to India just last week. They are putting up a satellite system to enhance that sort of communication and also to enhance telemedicine throughout the country. The problem I see is that even though these doctors can collaborate internationally, in the United States, a doctor in California can't advise in Nevada or New York or Florida or anywhere else in the country.

I was in South Africa a few weeks ago and telemedicine is a big deal there; unfortunately telemedicine not a deal here because rules and regulations get in the way.

What can you do with technology that is interesting? You can help prevent disease. One of the ways you do that is to entice people to exercise. You put a pedometer on them which has a wireless connection to a PC or some other monitor and you encourage them – as the president and the administration have done – to walk 10,000 steps, or four miles, a day. What this does is encourage people to exercise because you give them goals and let them monitor their performance in reaching those goals in a real-time fashion. You can detect the onset of diseases or the worsening of diseases very simply with monitors and sensors.

Today you can put sensors in the home and sense if individuals are walking around, if they are opening their refrigerator doors, if they are turning the stove on or off, if they are taking their medication, and what are they are doing on a daily basis. You can do this sensing from a remote standpoint so the caregivers, the rest of the family, can check up on their parents or their elders on a real-time basis.

You can use this for all sorts of monitoring, whether they are eating, whether they are exercising, or even for their social behavior. People who have memory problems often times don't want to answer the telephone because they are afraid they might not recognize the caller. They don't want to answer their door because they are afraid they might not recognize who comes to their door. What if you give them a very simple, enhanced call-monitoring system, which rather than just showing the number that is calling, shows them a picture, their relationship to the individual, and when they last spoke to that individual. This is very simple technology but it can have a huge impact. When an individual is given remote support, they interact in an active social way to give themselves a better lifestyle, which can be done simply with technology.

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Technology can even help those living with chronic diseases. We can constantly monitor the patient and the status of their diseases. We can get an early warning or detection if the disease is worsening. Technology can tell if a patient's gait is getting better or worse on a daily basis. It can tell if you are getting a good night's sleep or a restless night of sleep. It can even monitor your heartbeat and your breathing regularity.

All of these things are easily determined by sensors that we have today. These are very simple aspects of technology which are early in their development stage, but are not being applied for a variety of reasons which we will talk about in a few moments. However there are a number of companies who are actively investigating these technology advances; not just here in the US, but around the world.

There are a number of trends which are promoting the use of this technology. One of the trends is convergence, which is basically making user-friendly devices. User-friendly devices like cell phones which can double as a glucose monitoring system for diabetics which are being trialed in Korea today. They're not being trialed in the US because it's not allowed, but as simple a thing as a cell phone can be used to monitor a chronic disease. We can not only make consumer-friendly standard medical devices, like defibrillators, which are on sale today, but make a whole variety of devices capable of monitoring and reporting information about diseases to caregivers, to doctors, to family members, and to the individual.

We can do this using broadband Internet. You can communicate any bit of information today but what you need is good bandwidth to do that. Those of you who access the Internet realize this. As a country gets more and more broadband, the connectivity between homes, offices, and individuals becomes easier and more useful. The United States does not rank very well in this area. We are about 15th in per capita broadband penetration today. Countries like South Korea have major programs to give every citizen in the country broadband capability.

There are lots of different types of sensor today – blood sensors, skin chemistry sensors, respiratory sensors, and physical motion detector sensors. Is the individual moving around? Is the individual up? Is the individual active? There is personalized software that meets the needs of the individuals and is simple enough that they are not afraid to use. This is tailoring the software to get maximum interaction with the individual, maximum information transferred, for medication dispensing, to motivate exercise, a whole variety of topics. And lastly, there is collaboration between the major participants in the healthcare enterprise, the individual person you are monitoring, the doctor, and family caregivers. You want to have a communication channel between all three of these parties open and available, and we can do that with the sort of broadband connectivity we are talking about.

There is a bunch of Dick Tracy type of stuff associated with this and I brought my Dick Tracy watch to show you today. This is not an ordinary watch. This is called a Spot Watch, something that Microsoft put out that our researchers have been working on, with Microsoft, to enhance for

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healthcare delivery. What this watch does today is it accepts radio signals to give you stock prices, news, weather forecasts, and other information. Wherever you are, the watch receives the information that you want, but that's not very exciting from a healthcare standpoint. What is exciting from the healthcare standpoint is you can also program this watch to give you alerts to take your medication, and in addition, it even has location sensors in it relative to sensors you can put in your home. So what happens is that the sensors detect where this watch is on a routine basis in the house. If you are walking around it tracks where you are walking; if you are going to the refrigerator, to the stove, if you are lying down in bed it will track that. So it allows someone else to remotely monitor your physical activity at the same time, all just with this watch. The data is all sent back to a PC and is relayed over the internet to a third party caregiver. That's the sort of gee whiz, Dick Tracy stuff you will see downstairs. It's real. It works. It's not on the market, and we will talk about why it's not on the market in a moment.

There are a couple of things that are really important here. There's a lot of technology involved in this. The baby boomers who are aging are one of the most tech savvy groups in the world. About 50 percent of them have bought items from the internet. They are not afraid of the PC. This sort of technology can be used as this generation ages going forward. The net result is not that they use the technology, not that it's cool; the net result is that it provides preemptive, preventative medicine and cuts the total cost of healthcare. In the CAST pavilion just ask the people there what they anticipate the savings in the trials that they have done so far are using that technology. That's the only rationale for this technology. It provides better healthcare at lower cost, and if you listened to Mr. Walker's comments, I think you recognize the precarious state we are in. If you didn't listen to his comments listen to my comment that if it costs more to buy someone healthcare coverage in the United States than the total loaded salary of an employee overseas. If we don't lower healthcare costs, they will be hired in some other country and not in the United States.

So what do we need to do? It's not just about developing the technology, it's about bringing the technology into the market. It's about providing the R&D dollars to bring the technology into the market. It's about providing fast track approval for this technology to bring it into the market. Currently in the United States, we don't have fast track approval to do any of this, but Europe does. If you look to see where most of the trials are going on today they are not going on in the United States. There are license and regulatory issues, issues of reimbursement. Many of you I am sure aware of the issue. Why don't we use email to communicate with doctors? Why do we have to go to the doctor's office? The answer is simple. The doctor doesn't get reimbursed from insurance unless you go to his office. He doesn't get reimbursed for giving advice over the internet. It makes a lot of sense to somebody; unfortunately it doesn't make any sense to me. There are many, many issues of this type, which is why many companies don't want to run trials in the United States because of liability concerns. If we get coordinated, if we can have a uniform method by which to get research

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and development dollars into developing technologies which can help people live better lives in their homes at lower net cost to the medical system; I think we have got a chance to reverse some of those curves you saw in the earlier presentation.

The healthcare industry is an industry which has underinvested in information technology, not just here in the United States but generally around the world. It creates some great pieces of stand alone technology. As those of you who have had CAT scans or MRI scans know, we do a great job at introducing expensive pieces of equipment in this system, but we don't do a very good job automating the database and automating the communications between patient and doctor and family. What we are talking about here today is how to improve the communication between those three parties using very simple and straightforward technology to provide better care at lower cost. I think the need is obvious. You have seen all the numbers. We are looking at the distribution of elderly people growing over the next 10 or 20 years. We have to do something different. The current method is not sustainable. If you have to do something different then you have to think differently. What we are suggesting is to think differently by using technology in an entirely different way. About 85 percent of the medical costs are associated with 15 percent of the people, 15 percent of the people who are elderly and have chronic diseases. If we can figure out how to provide that 15 percent with much better care and much lower costs with the use of technology, we will all be farther ahead; not just for that 15 percent but for our country and the next generation growing up behind us.

Thank you

Opening Plenary Session

December 12, 2005

REMARKS BY:

**THE HONORABLE DORCAS R. HARDY
CHAIRMAN, WHCoA POLICY COMMITTEE**

GOOD MORNING TO ALL OF YOU WHO HAVE COME TO PARTICIPATE IN THE 2005 WHITE HOUSE CONFERENCE ON AGING!

ESPECIALLY GOOD MORNING DELEGATES!

On behalf of the Policy Committee, I want to welcome all of you and thank you for your enthusiasm, energy and commitment to be a part of this decennial effort to address the issues that impact the lives of today's and tomorrow's seniors.

The reality, for better or worse, is that we will all age...the graying of America is upon us and our Nation will soon look like the wonderful State of Florida! The question for all of us, and our society, is how can our twilight years be as promising, exciting and rewarding as possible?

Can we make the Fountain of Youth last longer? How can we look forward to being happy? Being healthy? And contributing? What should we do to prepare for and address our longevity? Can we avoid isolation and chronic illnesses? How can we assist those who need our help?

These kinds of questions have been discussed by nearly 150,000 persons throughout this country over the past almost year and a half....about 400 events including 40 Listening Sessions, Solutions Forums and Mini-Conferences, plus hundreds of comments through our website or mail.

From the time that the Policy Committee began its outreach for Solutions at the annual meeting of the Florida Council on Aging in 2004 to the last conversation in the historic city of San Antonio this past September, we have heard what are considered the challenges and opportunities for seniors of today and tomorrow, and we have heard suggested solutions.

Throughout this effort, members of the Policy Committee have worked diligently, and provided thoughtful input. Thank you for all you have done!

The Advisory Committee, under the leadership of Mike McLendon has also been of great counsel, and I am pleased they plan to work with us to continue our efforts beyond the days of this Conference.

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The Administration on Aging under the auspices of Assistant Secretary for Aging Josefina Carbonell, whom many of you know, and in particular Deputy Assistant Secretary Edwin Walker have been especially supportive, and I want to publicly thank them.

In several venues over the last year I have been asked: Why have a White House Conference on Aging? Can you make a difference?

I have answered that I believe WE CAN make a difference.

Our conversations will address challenges faced by current seniors AS WELL AS focus on our Conference theme: “The Booming Dynamics of Aging: From Awareness to Action.” The theme reflects the demography of our future and the possibilities that lie ahead.

This generation of baby boomers has helped define the character of our nation at every stage of their lives. From our new schools to our diverse political views to our music. And I believe we will continue to define the character of our country, from business to technology to E-bay.

We’ve rejected longstanding social mores and demanded more and better, and gone beyond demanding to inventing and solving.

We’ve spent many years in pursuit of excellence, and there is absolutely no reason to believe that our rejection of convention will give way to acceptance as we hurtle into this next stage of our lives.

And just as it has been at other stages of our lives, it is up to us to revolutionize the way in which this nation’s elders are perceived and embraced.

On January 1, 2006, the first of the baby boomers, born in 1946 will turn 60, and a 60th birthday for a boomer will continue to occur every 7.7 seconds for a LONG time!

The 2005 WHCoA has a statutory mandate (that means that Congress TOLD us) to address the issues and interests of aging today and tomorrow, which includes the 78 million baby boomers now aged 39 to 57 – that’s three out of every ten Americans.

By the time the next WHCoA convenes in 2015, the demographic, social and economic challenges that we are talking about today will be well upon us.

At that point in time, the leading edge of the boomers who turned 60 in 2006 will be turning 70, and half of the nation’s baby boomers will be over the age of 60.

What do these demographic changes portend? Well, one possibility was just laid out by David Walker who provided us with a sobering report on the future of an aging America.

I think everyone in this room knows that the sooner we get started, the better it will be for all of us and for our children and grandchildren. So we will start right now....right here.

What we do, starting today, is intended to shape the future.

Make no mistake, the 2005 White House Conference on Aging is about the future, a future that is quickly approaching. This reality makes this Conference unique...and we can contribute new ideas as to how society and individuals should plan and adapt to the changes that will accompany that future.

Mr. Walker told us that the three key ingredients needed to meet the challenges of the future are

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courage, integrity and innovation. We have to have courage to make tough choices. We must have the integrity to do that which we know in our hearts is right and FAIR...and we must free ourselves from dogmatic shackles and unleash our minds in pursuit of innovative approaches that will make the coming decade a decade of positive aging. We MUST work together.

We have the ability through this Conference to impact future political discourse.

The Conference has always been asked to make recommendations to the President and Congress. We are not being asked to resolve policy issues; we are being asked to identify issues that are important to older persons and boomers, to suggest HOW those issues be resolved and to identify WHO else, besides the federal government, can take ownership of the solutions...state, local and tribal governments, business and industry, the non-profit sector, communities, and/or the individual.

I believe, and the Policy and Advisory Committees believes, that our Conference will be a resounding success if we can frame these important issues so that they are accepted by both ends of the political spectrum. That's where our real contribution lies, and the broader that agreement, the more likely the issues will be addressed.

Just like the bi-partisan Policy Committee has done since we first met in July 2004, I know we CAN do this, we can be articulate, share our thoughts and respect each other's opinions.

We can develop fiscally responsible ideas that should be implemented sooner rather than later. We CAN make a difference in the lives of current and future senior Americans.

After all, who really thought that Policy Committee member former Democratic Congresswoman Barbara Kennelly and now Chairman of the National Committee to Preserve Social Security and Medicare and I, a former Ronald Reagan – appointed U.S. Commissioner of Social Security could work together in harmony for the last 18 months!

Now, let's look at what we will all be doing over the next three days. As you know, we have based our deliberations on an agenda that has six overarching tracks:

Planning Along the Lifespan

The Workplace of the Future

Our Community

Health and Long Term Living

Social Engagement and Civic Engagement

Technology and Innovation in an Emerging Boomer/Senior Marketplace

And, for purposes of the Conference, a Crosscutting Track that includes issues such as support of informal caregivers and integrated state and local delivery systems needed for 21st Century seniors.

These tracks have served as our foundation and helped to shape our conversations throughout the country for nearly 15 months.

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And this agenda, together with the input from all of these events, which many of us have had the honor to attend, have helped to shape the resolutions you have before you.

When we finish the work of this Conference, I expect the resolutions we select and the implementation strategies that are developed will help shape the actions and activities of the next ten years and hopefully beyond.

The Policy Committee has gone to great lengths to ensure that many pressing issues that have been presented to us over the past year or more have been in some way included, but we have also reminded ourselves that we cannot tackle every issue.

In fact, we received over 3,000 individual recommendations through the public input process. In the end, through a lively democratic process, we distilled these recommendations into 73 resolutions — and it is these 73 resolutions that now move to the center of our deliberations.

I remind you again - the resolutions before you are born out of and are representative of the richness and diversity of issues and ideas that make up our great country.

You are now being asked to vote on the 50 resolutions that you believe are the most important for current and future generations of senior citizens and that will best address the challenges that lie ahead.

HOW those challenges can be met is the crux of the 2005 WHCoA. As important as the resolutions are, it can be fairly said that the implementation strategies for the resolutions are absolutely essential if these resolutions are to mean anything. This is the work of all delegates.

It is critical that we remain creative as well as realistic in our thinking and in the approaches we consider. We must deal with the world as it is even as we seek means to change that world for the better.

Once the votes are tallied tonight, WHCoA staff will work quickly to assign rooms in which the implementation strategy sessions will be held tomorrow.

You will be notified which resolutions made the top 50 and in which rooms the resolutions will be discussed tomorrow through screens in the hotel Registration area, on your hotel room television, and through a newsletter that will be available at the Conference registration area. We will also post them on the WHCoA website so that people not able to be here can see what we have chosen. And then we will get down to work.

We are asking a lot of you tomorrow. I am confident you will rise to the task. Throughout the day we will work to translate ideas into actions. Each implementation strategy session will be guided by a facilitator (along with issue experts) who will work with you to achieve the best consensus possible on the implementation strategies being developed.

This is the first WHCoA to have this strong a focus on developing realistic action plans to ensure that delegates' efforts are successful, and I am convinced that this is the best way to achieve our objectives. It is new and different, and I believe that in the end you will very proud of your

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contributions and the outcomes.

This process reflects our commitment to the premise that the accomplishments and contributions of this WHCoA will continue well beyond December 14, 2005 when the Conference formally ends.

And it also highlights the fact that we only have a short window of opportunity before the challenges we have been talking about for decades are here with us.

I know that some of you have been involved in previous WHCoA's – we may have veterans here from as far back as 1971 – maybe even 1961? To you I say thank you for your previous work. I ask that you draw upon your experiences to help make sure that what we commit to in this conference, comes to pass.

Our task is to shape the actions and activities, policies and policy changes that will improve the quality of life for millions of older Americans. In that effort, I hope we are guided by a philosophy of George Bernard Shaw, who said “Some people look at things that are and ask why. I dream of things that never were and ask why not.”

I cannot help but think of my Father, C. Colburn Hardy, to whom I have dedicated my personal efforts as Chairman of this Policy Committee. Many of you may remember Coly Hardy. He participated in the '81 and '95 conferences from Florida. He was a professional volunteer older advocate, always had the courage of his convictions, always wanted to accomplish something and was a true visionary in every sense. His life's work and memory continues to guide me as I work to address my personal challenges,

Let me take a moment to touch on some of those challenges I have mentioned that affect many of us...and the opportunity we have to confront them.

We know that seven of every ten deaths in the U.S. are due to chronic diseases, and the number of Americans who suffer from diabetes, coronary heart disease, cancer and cognitive impairments is projected to increase 300% by 2049. That does not have to happen...and it simply can't!

We have the opportunity to educate the public about the importance of staying healthy throughout the lifespan so that we can all recognize our full potential as we age. That is why the WHCoA has focused on fitness, nutrition and health, issues I hope will be reflected in the Conference outcomes.

I want us to send a message that personal health is the responsibility of the individual person. And that in many cases, there are actions we must take now that will prevent or slow many chronic conditions affecting people now. We ALL know what causes obesity; we ALL know what a pedometer is for!

I don't know if you have had a chance to see Parade Magazine yesterday (hold up) which has a special section by Gail Sheehy called “Life begins at 60,” which she calls the Second Adulthood.”

Sheehy says that science tells us after our mid 50's, 70 percent of aging is controlled by our lifestyle. Through and throughout the WHCoA, I want us to convey that there are things each of us can

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and MUST do now to improve our lives as we age. I saw some of you at yesterday's Healthy Living Celebration — during which time we recognized several delegates for completing the President's Challenge or sharing their stories with us about lifestyle changes that have improved their health. We all need to be examples of healthy aging!

We also know that many boomers are not ready for their old age. Many are in denial that they will ever grow old...even as Chairman of this Conference I fall into that category. Many of us are just not equipped to care for an aging parent or spouse.

I became a caregiver for my Mother 3 days after I was appointed to Chair the Policy Committee. Many of you are also caregivers for your parents or spouses...it often happens suddenly; it affects Baby Boomer women to a huge degree.

And despite our best efforts, information and support for caregivers, as I have found, is often not there or not enough. We need a national long term care strategy – a public private partnership-- that includes support for caregiving across the lifespan.

And there are other issues – where we will live, how will we get around, how we will remain active and engaged, what work and volunteer opportunities exist, what technologies are available to ensure that if we have a disability or chronic illness we are able to live independently – I hope you have had a chance to visit our exhibit hall which includes some demonstrations of some of the latest technologies that will us to become or remain independent as we age.

And there is the trillion dollar question — how will we fund our longevity? Will our savings and pensions carry us comfortably into what could be a third of our lives?

Are we knowledgeable enough about the financial aspects of retirement planning to have made or to make the right choices to guarantee our financial security?

These are only some of the issues that will impact the nation in the coming years. And again, while the WHCoA cannot tackle every issue, we are working to ensure that we address them through the resolutions that we identify as the most critical to our nation's needs – now and tomorrow.

Though the Conference report will be finalized in early Summer, I want our Implementation Strategies/Action Plans to be on the minds of ALL Americans beyond the day it is presented to the President and the Congress.

I want US to create a legacy that will endure. This Conference can be a Bully Pulpit for New ideas, and its outcome a Clarion Call for the need to plan now for a better future. We want to be able to say: “We have some solutions that are fiscally responsible, bright, new...Listen to us! And Join Us!”

I would consider the WHCoA a huge success if we were to:

- Develop the foundation for a comprehensive, coordinated, affordable and accessible long term care policy or strategy that includes caregiving across the lifespan – one that is not solely the responsibility of the federal government.
- Begin a national call to action for “Healthy Aging, Healthy Living”

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- Launch an effort to integrate the delivery of systems and services at the state and local level that will facilitate aging in place as a positive experience.
- Promote a national Public Awareness Campaign to educate the public about “Don’t Get Caught Off Guard” – to be prepared to fund their longevity - through savings, financial literacy or employment opportunities.
- Develop successful, innovative model programs that highlight the tremendous resource presented by baby boomers, and provides them with meaningful opportunities in every community so that they can continue their legacy of making a difference as they age.

I know each of you has your own thoughts and ideas on which resolutions you will select and what implementation strategies will be developed. I have seen quite a few buttons on lapels urging support for certain resolutions.

Once those resolutions are selected, I look forward to hearing you articulate your ideas and hopes in the form of innovative and attainable implementation strategies at the WHCoA.

I have every confidence that the 2005 WHCoA will be successful and will be logged into history books as a WHCoA that indeed HAD the courage, integrity and innovation to tackle the big issues in order to make a difference in the lives of millions of people in this country.

I don’t know which of the 73 resolutions you have before you will end up being among the fifty we will work to accomplish.

I do know that what we do here over the next three days will be vitally important to the future of this nation. I do know that the events of the next three days will mark the end of the beginning...and signify the beginning of an historic effort to reshape the way this great nation thinks about and deals with the aging process.

Let us, together, resolve to commit ourselves to making this Conference a resounding success.

Let us commit to ensuring that the efforts we have made, and the efforts we will make in the coming days and months, will create the dawning of a new era...an era in which America’s senior citizens are more respected, valued, cared for when needed and acknowledged as among the most vital assets this nation possesses.

Thank you. Your work is appreciated!

2005 White House Conference on Aging Policy Tracks

December 12, 2005

SPEECH BY

THE HONORABLE MARK MCCLELLAN, MD, PH.D

ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES

Thank you, Gail [Gibson Hunt] for that introduction – it’s been a real pleasure working with you on effective support for caregivers’ issues related to healthy aging. I’d also like to thank Nora [Andrews] for organizing this event, and the Policy Committee for their leadership and contributions to this event. And thank you Dorcas, for all of your hard work.

I particularly want to recognize my colleague, Assistant Secretary for Aging Josefina Carbonell. Josefina has been a tireless advocate on aging issues through her career, and she’s also been a tireless advocate and educator on working with us to bring up-to-date care and coverage in Medicare.

It is really a privilege to be here at such a distinguished gathering – to have a chance to work with you on finding and developing the best ideas for bringing better health care and better health to older Americans. This is the right time and the right people for the conference theme of long-term living.

We’re in a remarkable time of medical progress. Deaths from heart disease and stroke have fallen dramatically, survival after diagnosis with cancer is increasing, and we have seen big improvements in the treatment of diseases that impair quality of life, such as effective treatments for cataracts and improving treatments for arthritis.

And even as more Americans are living longer and better lives than ever before, we still have a ways to go. The future holds the potential for even more valuable breakthroughs and our ability to use these technologies. New sciences like genomics and better information technology hold the promise of truly personalized medicine – health care that is truly effective in preventing the complications of diseases and even preventing illnesses in the first place. I got a chance to see some of this first hand downstairs in the exhibit.

Fulfilling this potential of long-term living means providing health care that is personalized, prevention-oriented, and patient-centered, based on good evidence about how to get the best health at the lowest cost for each particular patient.

This afternoon, I want to focus my remarks on how we are now working to fulfill that promise of better health and better living. We’re doing it by putting new emphasis in Medicare and Medicaid on

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prevention and on care that people can use and control to stay healthy, prevent complications, and live well.

Some of you may have heard me talk before about bringing long-term care up to date; you will hear more about this later at the conference. I feel very passionate about this, because it's a critical part of healthy long-term living. It used to be that long-term care meant institutional care, and that's why when Medicaid was created forty years ago it included a benefit for nursing home care. Since then, we've seen many improvements in institutional care, and it's still the preferred option for many people. But we are now in an era when it is possible and often desirable for millions of seniors with long-term care needs to age in place.

We are now in an era when we have seen over and over again through home- and community-based waiver programs in Medicaid that it is possible to have better health outcomes and lower costs of care per person and better satisfaction of beneficiaries and their family members. And that means it is time to change the Medicaid law so that Medicaid gives people more control over how they get their long-term care coverage. It is time to enact legislation to end the institutional bias in Medicaid. And it is time to build on the successes of everyone involved in this conference to help older Americans and their family members and caregivers to have more knowledge and more ability to control their future.

That's why those of us at Medicare and Medicaid are working closely with Josefina Carbonell and other leaders to reauthorize and enhance the Older Americans Act. It's also why we are working to reform long-term care coverage in Medicaid. And it's why we are working so hard with so many of you to implement Medicare's new benefits.

Until the Medicare Modernization Act was enacted two years ago, well over 90 percent of Medicare spending went to paying for the complications of diseases after they happened. That's because Medicare paid for the doctor bills, the hospital bills, and the rehabilitation when something went wrong. And that's understandable – that was the way health care worked 40 years ago when Medicare began, and Medicare has literally been a lifeline to help seniors and people with a disability pay the bills when they get sick.

But in an era when medical care is increasingly prevention-oriented and personalized, we can't afford simply to pay the bills when people get sick. The best way to make Medicare sustainable and to keep it up to date for the future is also the best way to support healthy, long-term living: by helping seniors take steps to stay well and to prevent complications of diseases. We're continuing to keep our promise to seniors to help pay the bills when complications happen. But it simply makes better health sense and better financial sense to help people get coverage that they control, so they can use it to stay healthier and keep their costs down. These new Medicare benefits are the biggest changes in the program's history, and they are the most important changes for healthy long-term living. They are giving people more control over their health through greater emphasis on prevention, and that includes coverage of prescription drugs.

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As a result of the Medicare Modernization Act, we've added preventive benefits to Medicare that enable us to match up well with the recommendations of the US preventive services task force, and we are working to help our beneficiaries close the big gap that still exists in using these benefits. We've started new programs to support people with frailty and with serious chronic diseases, giving them access to disease education and disease management services, and opportunities to save a lot of money through better benefits in our Medicare Health Support program and our Medicare Advantage program. And right now, we are starting the most important new benefit in Medicare in 40 years – Medicare's new, voluntary prescription drug coverage.

Today we are almost a month into the enrollment period for the new drug benefit. The level of interest in the new benefit is incredibly high. People are asking lots of questions about what it means for them. I am sure this is no surprise to many of you who counsel and assist seniors. I've talked to many of you who are experiencing a high level of interest every day, in the form of increased call volumes and demands on your trained staff.

I'd like to tell you about some of the things that we are seeing with the new drug benefit, and some of the things we are doing to help you meet this strong interest.

First, this coverage is costing less and is providing better benefits than most experts expected. For one thing, the vast majority of employers and unions are continuing their coverage for retirees and taking new subsidies from Medicare to help keep it in place. According to a major survey released last week, over 90 percent of retirees with coverage now are going to continue to get it – and in many cases with better benefits. Keep in mind that retirees have to pay all or most of the cost in some retiree plans, so that coverage isn't as good as the new Medicare coverage, it doesn't qualify for the subsidy, and the retiree is likely much better off financially as a result of using Medicare's new subsidized coverage instead.

So one important question many people with Medicare are asking is: If I have good coverage now, can I keep it? We are clearly seeing that the answer is yes, Medicare is working to support the good coverage many seniors have now. And if you like your coverage, that's all you really need to know about the new Medicare benefit.

But people who don't have good coverage and are struggling today with their drug costs – they are asking a lot of questions about what Medicare plan is a good fit for them. And it's because people have choices of plans, that we are seeing lower costs and better coverage. On average, the drug plan premiums are about 15 percent lower than independent experts had predicted, and the costs to the government will be 15 percent lower on average, as well. The plans are competing to get discounts from drug manufacturers and to take other steps to keep costs down and provide quality benefits – because they know that if they don't, people aren't going to choose their plan and stick with their plan.

By asking questions, people can get coverage that better fits their needs than if they didn't have any control over the benefits they receive. For example, many people are asking about deductibles and the

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so-called donut hole, because they want more comprehensive coverage than the basic benefit passed by Congress. And if you want coverage without a deductible or without a so-called donut hole, you can get it.

It's been a real pleasure to meet and to hear about people all over the country who are saving money. For a typical person with Medicare, the new drug coverage will cut their prescription drug expenses in half. This can make a real difference in staying healthy and staying financially secure. At an enrollment event last month in Minneapolis, 77 year old Tom Clark announced that he and his wife, Mary, had found two drug plans that would cut their costs from about \$5,550 to \$1,450 next year. Mr. Clark said that now they could celebrate their 50th anniversary next year.

I hear stories like this every day – people who are finally getting financial relief they really need. In South Carolina last week, I talked to a counselor who had helped someone enroll in a plan that was expected to lower her costs from about \$3000 a month to a little over \$3000 a year.

But others are asking why they should sign up when they aren't taking any or many drugs. For these people, a plan with a low premium that provides Medicare's basic coverage might be cheaper and better. And they can get protection against high drug costs and peace of mind from a drug plan that meets all of Medicare's standards for just a few dollars a month in many parts of the country, and for under \$20 a month just about everywhere.

And many people are asking if their drugs are covered. Now, every plan approved by Medicare must provide access to all medically necessary treatments. Because of Medicare's requirements, the plans are providing the same kind of access to medically necessary drugs that has worked for millions of Federal government retirees, for many retirees in employer and union plans, and for people in high-quality Medicaid drug plans. Every plan is required to cover essentially every drug for conditions like mental illness and cancer and immune-related conditions, where the specific drug or combination of drugs really matters.

But in areas like medicines for stomach acid problems and for hayfever, where a number of drugs work in very similar ways, every plan may not cover every single medicine, because that's how the plans negotiate the lowest possible prices. They get volume discounts, just like the Federal employees plan or the VA plan or many Medicaid plans. But unlike the VA or Medicaid, seniors can ask before they sign up for this plan whether all of the drugs they are taking right now are covered – and as you know, we have tools that people can use to find the lowest cost for the drugs that people are taking right now. This kind of personalized support in choosing coverage has never been available before, not in Medicare or anywhere else. So seniors are getting volume discounts that are leading to lower costs of coverage, but they also have the opportunity to get bigger savings on the drugs they are taking right now than if they did not have a choice of plans.

I know that many of you are getting a lot of questions like these. I salute you who are on the front lines of counseling and educating Medicare beneficiaries. I thank you for your creativity and

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ingenuity in managing this challenge. We will continue to work together with you and the new partners we have developed over the past year to meet this challenge.

When we started preparing for the biggest ever new benefit in Medicare, we knew three things would be critical to success in helping people get their questions answered. First, we knew this outreach effort would have to be historic in scope – the largest public education and outreach effort since the major education campaign that went along with the creation of Medicare forty years ago. Second, we knew that grassroots networks and partners would be critical to success. And third, we wanted to provide all our partners, beneficiaries and those who care for and about them with high tech and high touch personalized tools that they could really use.

These three critical success factors drove the development of our education and outreach strategy – a national strategy, locally executed. As you know, CMS has ten regional offices which run a campaign in each state, which in turn is organized down to the county level.

We have more than 14,000 trained partners across the country taking on a variety of roles in this effort. We think of this network as a pyramid of partners. The foundation of this pyramid is thousands of community based, public and private organizations that work with seniors and people with a disability. AARP, NCOA, and the Access to Benefits Coalition, many disease advocacy organizations, and many organizations that help our racially and ethnically diverse beneficiary population. Thousands of these partners have been responsible for educating beneficiaries about the new benefit – they and you deserve credit for a huge increase in awareness of the new coverage.

We have also developed many diverse nontraditional partners, who in addition to educating and building awareness are now providing valuable personalized counseling and assistance. For example, a few weeks ago, the students at the Massachusetts College of Pharmacy conducted an enrollment event for hundreds of people with Medicare in Worcester. We're using this as a model for future enrollments events involving pharmacy students throughout New England. Other nontraditional partners who are holding thousands of local education and enrollment events include faith based organizations and financial planners.

We've worked to put together networks of these nontraditional partners. If you didn't notice it already when you go out the main hotel entrance, take a look to the left – you'll see the Medicare mobile office. Some people might call it a bus, but I like "mobile office." It's helping us reach people across America – where they live, work, play and pray. The Medicare buses have crisscrossed America – Secretary Leavitt and I with our local partners have had mobile office events in more than 150 cities, forming more than 140 local partner networks for beneficiary education and support as well as statewide networks that reach rural areas. We have visited 45 states at least once and we're still going. With many of our new nontraditional partners and especially long standing allies, the SHIPS and Area Agencies on Aging, we are now conducting hundreds of enrollment events all over the country.

In all these efforts, the volunteers, the expertise, and the passion of these long standing partners are

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invaluable. I am truly grateful. I would like to ask anyone here who is associated with a local Area Agency on Aging, a SHIP, or a volunteer for these critical partners to stand up now. I thank you and please join me in applauding their efforts. You are a more essential part of the Medicare program than ever, and as we keep working to make our program more personalized, I think it's going to stay that way.

Recognizing that the scope of this effort would be huge, we have increased funding for our SHIP partners by more than two and a half times since 2003. While funding is critical, however, we're also listening to you and identifying best practices to meet the transformed role of our partners. This includes effective ways to collaborate and distribute workloads with our new partners and new volunteers. This is why CMS and AoA have partnered with Volunteermatch.org to launch the Medicare Rx Volunteer Initiative.

This program places volunteers with SHIPs and registered community based organizations. In just a few weeks, more than 700 volunteers have been placed with participating local organizations. If your organization could benefit from having more volunteers, please register as soon as possible at www.volunteermatch.org. All CMS Medicare RX Volunteers will receive our Drug Benefit Training kit. In addition, the SHIP Resource Center will be hosting onsite training sessions in select communities nationwide.

We are also sharing other best practices identified by our partners, to further assist them in managing this increased demand. For example, the SHIP in West Virginia developed a collaborative call center among the SHIP, AARP, and the Access to Benefits Coalition. It uses the state-wide SHIP toll-free number and is staffed by specially hired and trained staff. In North Carolina, the SHIP manages about 1000 volunteer counselors across the state at this point. Please share your best practices with us, and we will spread the word. In addition to education and enrollment help, we are also working with all of our partners across the country including other federal agencies, state and local governments, nursing homes and other health professionals to insure there is no lapse in prescription drug coverage for the full dually eligible beneficiaries.

People with Medicare and Medicaid have already been enrolled in a Medicare prescription drug plan. CMS has taken many steps to insure that there will be no lapse in drug coverage. For example, we have worked closely with states over the past year to obtain very high match rates between their enrollment information and Part D enrollment – match rates well over 99 percent. And if a dually eligible beneficiary goes to their local pharmacy without knowing anything about their plan, the pharmacist can use a new electronic system that is working now to quickly identify their assigned plan and help them get their drugs. CMS has also developed a process for a point-of-sale solution, if the beneficiary somehow has not been automatically enrolled in Part D. If they have evidence of Medicare and Medicaid eligibility, they can leave the pharmacy with their prescriptions.

As many of you know, there is not only comprehensive coverage available to all Medicaid beneficiaries, but also comprehensive coverage for millions more people with limited income and

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resources who have really been struggling until now. People who are eligible for the subsidy can sign up through the Social Security Administration. We are working closely with SSA and our partners to reach beneficiaries who may qualify for this extra help, and thousands more are enrolling every day. Please join us and the Social Security Administration in particular, to continue to expand the use of this valuable subsidy.

Let's finish where we began – this is a big task. My sense is that people with Medicare will want a number of encounters with information on the new benefit before they feel comfortable enough to make a confident decision. That is why we have provided so many different ways for people to get assistance – our 1-800-MEDICARE customer service line, available 24/7, our medicare.gov website, and thousands of partners and thousands of local events across the country. All offer both education and personalized assistance. As one part of this effort, we have targeted our messages to the friends and families of people with Medicare. We're advocating a national conversation about this new benefit. This conversation will take place in thousands of different locations and between many different combinations – mothers and daughters, between neighbors, sisters, and brothers. Just about everyone knows someone with Medicare, so just about everyone can take part. We hope many conversations take place during this holiday season – in living rooms and kitchen tables across the country.

Please help spread the conversation. We developed the “Friends and Family Took Kit,” which is on Medicare.gov, to give you some simple steps to help guide this conversation. The national conversation is off to a big start. Our website and our toll-free hotline activity are proof of that. Over the Thanksgiving holiday, more than 3.5 million pages were viewed on Medicare.gov. That's four times more than last Thanksgiving, and we've seen web traffic continue to increase since then. Also, since enrollment began on November 15, more than a million people a week have called 1-800-MEDICARE. You are the leaders in your community – and this national conversation works best locally, back home in your communities. We will work with you as true partners, and provide as much support as we can. And together, we will transform 21st century health care – improving health by helping Medicare beneficiaries get better coverage, better benefits, and peace of mind – today and for many years to come – for the millions of older Americans who are looking to us to help them get better health with long-term living.

Thank you very much.

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December 12, 2005

REMARKS BY:

ROBERT ESSNER

CHAIRMAN, PRESIDENT AND CEO, WYETH

“The Patient Is Waiting”

It's a great pleasure to speak with people who are on the front lines of aging about a subject that has very much been on my mind – although having celebrated my 58th birthday recently, I've come to understand that I'm on the front lines of aging myself.

What's been on my mind is a topic in which we all have a vested interest: Alzheimer's disease.

This is an interesting time to be thinking about Alzheimer's and questioning whether we're prepared for the coming epidemic. I say “epidemic” because that's what we're headed for. An epidemic of enormous proportion. I am sure everyone in this room understands that better than most others.

I'm fairly certain, though, that the population at large does not really see Alzheimer's disease as an epidemic. Not yet.

If you were to say the word “epidemic” today, I'd bet that most people would immediately think first about avian flu, the so-called “bird flu.”

That's understandable because avian flu is getting massive attention in the media, and people are genuinely and understandably frightened by the possibility of this disease sweeping the world.

The projected mortality and morbidity from such a pandemic are indeed frightening. The CDC, the WHO and other organizations around the world have tracked every death from avian flu in humans since the mid-1990s. Researchers are working to understand avian influenza in the most minute detail and are mapping, with ever more intricate simulations, how the disease might spread if the feared mutation into a disease transmittable between humans were to occur.

So far, WHO has documented 135 people who have contracted avian flu in various parts of the world, primarily in Asia; 69 of them have died from it. My company, Wyeth, is one of the few vaccine research and development organizations in the world today so I've had the chance to see firsthand

how we are confronting this potential pandemic on a global basis. In fact, the page 1 story in *The Wall Street Journal* this morning discussed the new avian flu vaccine for birds developed by Wyeth's veterinary division.

And although you can always argue that more could be done or that it could have been done sooner, the effort being made here in the United States and around the world is off to an impressive start. President Bush has clearly placed himself at the center of this endeavor; Health and Human Services Secretary Michael Leavitt has been designated to lead this task and is actively engaged. Public health officials and regulators are beginning to work in a coordinated fashion among themselves and with Congress and industry to ensure that we are preparing ourselves as quickly as possible to limit the spread of avian flu and to arm ourselves with a supply of drugs and new vaccines that can be decisive. And, of course, the media is doing its job with a nearly obsessive focus on bird flu that keeps the topic front and center.

A Disease of Epidemic Proportions

With all the intensity and excitement being generated about avian influenza, I sometimes think we lose sight of the fact that this disease — scary as it is — is only a potential threat that we may or may not actually have to deal with. Unfortunately, unlike avian flu, there is little uncertainty about Alzheimer's disease. We know that an epidemic is coming - in fact, it's already here. We can predict with chilling accuracy its incidence and prevalence. We know the horrifying and ultimately fatal course of this illness. We know the collateral damage it does to the families of those who suffer from it. And we can project with reasonable precision the enormous financial toll that caring for the patients who suffer from it will take on our country's health care budget and our economy.

Sheldon Goldberg, former President and CEO of the Alzheimer's Association, made the following prediction: "The U.S. health care system is about to implode, and Alzheimer's disease will be the detonator. ... You will not – you cannot – save Medicare and Medicaid unless you get this disease under control. The cost of long-term care will bankrupt families first. And then it will bankrupt Medicaid."

What Sheldon Goldberg was referring to is the coming collision between the enormous baby boom generation now entering its 60s and our national health care budget. You can see the train wreck coming: An estimated 4.5 million Americans have Alzheimer's disease — double the number since 1980. This year, 470,000 new patients in the U.S. have been confronted with the dehumanizing reality of Alzheimer's disease.

And that number will increase every year from now on.

In addition, more than 50 percent of individuals who are 85 years of age or older are afflicted with Alzheimer's disease. You've probably heard these statistics before. But you may not have heard that national direct and indirect costs of caring for individuals with Alzheimer's disease are at least \$100

billion per year, according to estimates used by the Alzheimer's Association and the National Institute on Aging.

And I imagine that Dr. Mark McClellan, who spoke with you earlier this afternoon, is well aware of the projection that annual Medicare costs for beneficiaries with Alzheimer's are expected to increase 75 percent over the next five years — from \$91 billion in 2005 to \$160 billion in 2010.

I think you get the picture.

What is so horrifying about Alzheimer's is not just that it kills but that it is debilitating and dehumanizing. Alzheimer's essentially eats away at the very essence of its victims: not just their physical and mental capabilities — but also their hearts and souls.

Wyeth's Scientists Eagerly Begin Research

Because Wyeth is involved in the fight against Alzheimer's, I have a kind of front row seat in our efforts against this disease. Wyeth's research efforts in Alzheimer's began in earnest in the year 2000, when a group of our scientists came to me with a proposal. They wanted to enter into a collaboration with another much smaller company to advance a new technology against Alzheimer's. The team told me that this was, in their opinion, the single best approach to creating a really effective treatment for this disease and that they thought it had the highest chance of success of anything in development. I, of course, had to ask a few questions.

First, why were they so enthusiastic and why did they think we had any chance of success in a disease that had proved so elusive? They explained that this technology was aimed at quickly ridding the brain of the beta amyloid plaque that was — and still is — thought to be an important causal factor in Alzheimer's and that the work done so far on this principle in animal studies had produced the most dramatic results ever seen in these types of tests. So I asked them how long it would take before we would have any real idea about whether or not this would be useful in people because we all know that animal work, particularly in diseases involving the brain, is not very predictive. They told me that they expected it would take about three more years of research effort before they would know whether the project could move into full-scale development. Then I asked them a critical question: How much would we have to spend over those three years to get even a preliminary appraisal of efficacy? After a little hemming and hawing, they told me they thought it could cost up to \$100 million to do those studies.

Then I asked the really hard question: If we invested that much money over the next three years, what was the probability that when we were done with that work the answer would be “yes” — that we would have sufficient evidence that the drug works and is safe enough to move into the large-scale studies necessary for approval. This brought a lot more hemming and hawing and a little shuffling about until someone said “maybe 30 percent probability of success” — to which I responded, “Really!” Then someone said, “Well, maybe it's more like 10 percent.” When I challenged that, the real answer

came out — which was that the odds of success were so low that no one could say what they were.

However, we made the decision to go ahead — our scientists were so passionate that if I had turned them down, I would have had a mutiny.

Wyeth created a partnership with the Irish company, Elan. It was an unprecedented effort in that, for the first time, we brought together scientists from Wyeth's three research divisions. We asked leaders from our central nervous system drug discovery and development units to work in day-to-day collaboration with some of our leading biotechnology specialists and experts from our vaccine research effort.

The problem-solving abilities of these scientists, together with those of our partner, have brought to this project the unusually broad array of scientific tools and creativity that have kept us going. More than five years have gone by since we made our decision, and about all we can say after five years of effort is that this program still has the tantalizing possibility of success. Our first drug candidate was stopped when we saw some early signs of a safety issue in a few patients. But we're back with two additional approaches, an antibody which is now in Phase 2 clinical studies in Alzheimer's patients and a vaccine approach, just now starting in clinical research.

And by the way, that \$100 million estimate has long ago been spent --and, in fact, our partnership has invested well over \$200 million, and, unfortunately, we're still closer to the beginning than the end. Either of these programs has the potential to be the kind of new tool we need to treat or even prevent Alzheimer's if we get really lucky. But risks are high, and, in the current environment, we are still probably at least five years away from introducing an approved therapy to patients. And I can tell with complete candor that if this were a program in virtually any other disease, it would have been terminated years ago.

The power of this disease and the challenge of conquering it drives us on. Wyeth and Elan obviously are not alone on this path in trying to find a solution for Alzheimer's; there are other companies also at work, as well as scientists in academia and research institutes who are making their own contributions.

Small Steps Create Reasons for Optimism

Although there are reasons for hope — our better understanding of the disease and its progression, better diagnostic tools and some modestly useful therapies available today — the reality is that our efforts against Alzheimer's are moving at a pace that is in no way commensurate with the problem we're trying to solve. Unlike my example of avian flu, there is no global focus. Scientific work and drug development go on but at a snail's pace. Public health agencies sometimes appear to be focused more on dealing with the seemingly inevitable devastation of the disease than in working toward its cure. And regulatory agencies like the FDA handle the review of Alzheimer's projects more like the cautious and arm's length way they review new anti-hypertensives rather than in the

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accelerated and collaborative way they handle drugs for HIV/AIDS or bird flu. On the regulatory front alone, worldwide cooperation between reviewers and researchers could significantly improve the probability that we do succeed and reduce development time lines by years.

There are always issues with moving more quickly: Speed places increased pressure on all involved. But given the mounting toll this disease is taking every year, we have no other choice. Our collective efforts against HIV/AIDS give us another instructive example of what can be done. In the war against AIDS, government, regulatory agencies, scientists in industry and academia, and patient groups worked hand in hand to develop new therapies and evaluate them as rapidly as possible. The results were remarkable. AIDS was first identified around 1980, and just six years later, there was a breakthrough medication that helped people manage the symptoms. Today, there are dozens of medications to treat this disease and many more on the way. For many patients with AIDS, these medications have transformed the disease from a death sentence to a chronic condition. The war has not been won with AIDS, but we have made significant progress.

Knowing all of this, how do we convince the world that Alzheimer's is the next pandemic? Public awareness of the disease is high — and so, too, are assumptions and misconceptions. Unlike avian flu, which has popped up in the public eye over a relatively short period of time, a disease like Alzheimer's has been known for generations. Too many people still believe that “it's a natural process” or “it's just a part of growing old” or “there's nothing much to be done.”

We've all known someone — a parent, an aunt, an uncle — who has fallen prey to this disease. A recent Gallup Poll found that nearly 50 percent of respondents worry about developing Alzheimer's. However, instead of spurring people into action, this knowledge seems to engender a sense of resignation, of inevitability.

On the other end of the age scale, my teenage son, Ben, isn't too worried about Alzheimer's but gets his thrills by watching action movies. We recently saw “Deep Impact,” a disaster film of epic proportions: a sevenmile-wide rock is hurtling through space, its course bound straight for earth. If you haven't seen this particular film, you've seen one like it.

Within days of the discovery of the asteroid, everyone on the planet knows it will be the end of life as we know it when the asteroid finally hits earth. The fact that it's not going to happen tomorrow doesn't make any difference — public concern demands a solution.

As always in these films, through a mixture of massive effort, new technology, individual heroism and many theater-shaking explosions, the earth is saved.

In much the same way, Alzheimer's should be our health care “asteroid.” We know it's an enormous threat — and we know it's coming. We know the fears we all share should Alzheimer's strike us or, worse yet, someone we love.

What we lack is a worldwide clamor for immediate action and a solution — we need to generate a sense of urgency because, even with the best of luck, the answer won't come overnight. We need

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to start now. Those of you in this room are serving on the front lines; we need your leadership, your voice, your passion to turn this around.

We have a saying in my industry that we use from time to time when the going gets tough, when we find ourselves caught up in the frustrations of a process that is, by its nature, slow and prone to failure. That saying is “The patient is waiting.” I know of no disease in our country where more patients are waiting with so much need and so little hope. And I came here this afternoon to tell you it does not have to be so.

Thank you.

White House Conference on Aging Policy Tracks

December 12, 2005

REMARKS BY:

**THE HONORABLE DIRK KEMPTHORNE
GOVERNOR OF IDAHO**

It is a pleasure to be here today. I want to thank Chairman Hardy and the White House Conference on Aging for inviting me to speak to you on the crucial topic of longterm care.

I would also like to thank Hal, Mary, Josefina and many of my friends who are here, as well as my fellow Idahoans...I am delighted to be with you.

I would also note that several of my fellow Commissioners from the National Quality Forum for Long-Term Care are here today, both as delegates and as committee members with the Conference. It has been an honor to serve with each of you and I look forward to our next meeting.

As appointed delegates to this Conference, each of you has been given the duty to make recommendations to the President that will ultimately set the course for public policy for tens of millions of aging Americans.

This is a great responsibility...because when you think about it... there isn't a single one of us who isn't aging. From the moment we receive that "rap on the rump," the clock starts ticking.

So this isn't an issue that affects a large number of Americans, it's an issue that affects every American.

Something more to consider: this Conference takes place once every 10 years. That means the next time we meet to talk about policy for aging Americans, the first wave of 77 million Baby Boomers will have turned 65 years old.

Chairman Hardy says the Boomers are on their way and the next time you convene, they will have arrived.

But will we be ready? Will we have charted a course forward that will allow us to meet the needs of the next great generation of American seniors?

The answer is that we must be ready. There is no more time to wait...we must take action now.

If you fast-forward 10, 20 or 30 years down the road, will we see a system that fosters dignity for elderly Americans as they grow frail and are limited by their aging bodies?

Father time takes his toll on everyone, without regard for a person's previous station... people of great achievement and influence...the system may not recognize who you used to be. When you're

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in a hospital, and the back of your gown is open, it's not going to matter that you were a CEO, the draft of cold air is still going to feel the same.

I know this from recent experience...a year and half ago I had to have back surgery, in fact, I had to have two back surgeries. Thank goodness I have a loving wife, in Patricia, because here I was the CEO of a sovereign State and I had to have my wife put my socks on. I had to have her assistance so that I could roll in bed and her assistance to get out of bed. It was pretty humbling.

And yet, I knew that I would recover...I had the finest in medical care and a loving family. I knew I would recover because I still had age on my side. I was not on a glide slope, knowing that that was as good as I could expect.

We must begin to prepare a system that will preserve the dignity of our seniors. The golden years of life ought to be polished with a reverence for a lifetime of accomplishment, not tarnished by a moment of limitation.

As a Governor, I can clearly see that the genesis for such a revision should start with the states. I see the impacts that long-term care services are having on state budgets, even today.

Over the past decade, Medicaid spending on long-term care services for the elderly and the disabled has nearly doubled, increasing from just under \$46 billion in 1994 to nearly \$90 billion in 2004.

Long-term care accounts for approximately one-third of all Medicaid spending nationally and is one of the fastest growing expenses in every state's budget.

The spiraling costs of long-term care threaten our ability to provide critical services to our citizens, including public safety and education. In fact, in 2003, total Medicaid spending surpassed elementary and secondary education spending for the first time and is now the largest single appropriation in overall state budgets.

Spiraling health care costs are placing grandparents and grandchildren on a collision course to compete for the same finite resources and it will lead to the difficult proposition of choosing between the care of our elderly or the education of our children.

This is not a situation that any grandparent wants.

That is a grim prognosis for a system that is designed to care for our most frail and vulnerable citizens, but it is the reality if we do not take action now to modernize long-term care in these United States.

Over the past several years, I have been working on exactly this issue. In 2003, as Chairman of the National Governors Association, I made long-term care my Chairman's Initiative for the year.

During that time, I traveled around the country meeting with academic and business experts on long-term care, as well as state and federal government officials who run these vital programs.

As a result of that effort, two nationally televised programs were aired on PBS and the NGA

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published a series of policy papers highlighting the best practices for longterm care at the state, federal and local levels.

Through that initiative, we began a national movement to help states prepare for the coming generation of Baby Boomers.

And I'll tell you something else I learned: during that period of time – every person I talked to, whether it was a college professor, a reporter or even a Governor – everyone has a personal story of a loved-one who is in need of long-term care.

As part of the 2004 NGA Summer Meeting in Seattle, I held a town hall meeting with caregivers and other Governors to talk about the implications of long-term care at the personal level and at the policy level.

We held this meeting as part of a PBS production called, “Thou Shalt Honor”, which aired this past summer.

As they went around the room, they asked some of the caregivers to talk about the personal issues they face in their individual situations. Then they would ask the Governors to respond to some larger policy questions.

What was interesting to me, and what was very telling about this issue, is that before any Governor talked about policy, they first told a very personal story about their relationship as a caregiver to someone in their life.

There were many times during the taping of that program that it became very emotional.

You see, long-term care is not simply a policy issue...it is a personal issue.

When I talk about caregivers, I am often reminded of my years as a college student at the University of Idaho, where I used to work nights as an orderly at Gritman Medical Center in Moscow, Idaho.

During my time at Gritman, I had a real education about what it means to be a caregiver...

I remember with one particular gentleman, time had created a very distinguished face, and it was creased with many wrinkles. One morning I was asked to give him a shave. I lathered him up and begun meticulously trying to get into every little crevice. He finally took the razor and within one minute he had finished shaving his face...with thirty cuts. He put the razor back in my hand... I looked at his face and then at the razor. Just then the supervisor walked in and looked at me.

I also will tell you about an elderly lady named Mrs. Kennedy. When I first met her as a patient, she was one of those who only laid facing the wall. She was despondent and she would not talk to me. When I tried to greet her in the mornings and get her to take a walk, she would simply moan and say “leave me alone.”

But, I persisted...and finally one morning, to everyone's surprise, her call button came on. I went to her room and she said, “Young man, get me those slippers because we are going to take that walk that you have been talking about.”

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I said, “Now that’s the spirit Mrs. Kennedy!”

So I helped her walk around the floor of the hospital. Two days later she was scheduled for surgery. And, I heard the discussion that took place, and I knew that she wasn’t ready. But, the next morning I helped prepare her and placed her on the gurney that would take her to the operating room.

As I looked down on her, I told her that I would be waiting for her that I would be right there when she got back. And she reached up and put her hand around my neck and pulled me closer and gave me a kiss on the cheek. And she said, “Sweetheart, you have been wonderful, but I am not coming back.”

I said, “Mrs. Kennedy what do you mean.”

And she said, “I don’t want to go on like this”...and she said “goodbye”.

I said, “Mrs. Kennedy, I will be waiting for you”.

Mrs. Kennedy died on the operating table...because she had lost the will to live. That precious, precious thing...the will to live.

I also know what it is like to be a son and a caregiver to elderly parents. My mother was an angel...I have known that all my life. But some seven years ago she was the victim of a stroke. She became a prisoner of her own body. I watched the women that had always lived with such great dignity, and always been there to help everyone else...I watched her become the one who needed the help...and there were gaps in that help.

My father was a champion. Being in his late eighties, he devoted the rest of his life to taking care of her, but we lost her about a year and half ago. It just confirmed to me that even angels could grow tired and pass on. My father, bless his heart, is still with us and is doing fine.

I believe we must take action to ensure that the system that is in place for America’s seniors to have both the health and dignity of the individual is always in place.

We owe it to them to make sure it’s the best it can be.

As the principal payers of long-term care services, state Medicaid programs are the natural laboratories for such significant change. But out-dated federal regulations often act as a roadblock to real reform.

If we are truly going to solve the problems of the current long-term care system, we must turn our focus away from an antiquated, regulation-based system and toward one that focuses on results.

That is why I recently proposed a series of common-sense reforms that will modernize Medicaid in the State of Idaho and significantly change the way we approach long-term care under this program.

We will focus on results instead of rules, outcomes instead of cumbersome regulations.

It is a vision of what Medicaid and long-term care should be...not just of what it’s allowed to be

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under the current bureaucratic framework.

We will direct services toward quality of care instead of using the “one-size-fits all” approach of offering the same services to everyone, regardless of need.

As you all know, Medicaid enrollment is based on a multitude of eligibility categories. I am proposing that we reduce that to three separate programs: low-income children and working age adults; individuals with disabilities or special health needs; and the elderly.

These programs will have different policy goals and objectives based on the needs of those in each respective program. For example, low-income children who are relatively healthy will have a program focused on primary care, prevention and wellness.

It is important to realize, even from a long-term care perspective, that individuals do not develop chronic illness only when they turn 60. The habits that lead to those conditions are often developed at a much younger age.

And we’re seeing this in America, today.

In fact, for the first time ever, since we’ve been able to track this data in the United States, Type 2 Diabetes...commonly referred to as “adult onset diabetes” ...is being diagnosed in children.

This is the beginning of an epidemic – some studies even suggest that if this trend of chronic illness among America’s youth continues, today’s generation of children will have a shorter life expectancy than their parents.

As a nation, we cannot allow this trend to continue.

We must be proactive in our efforts to reverse it, so that kids can be healthy and future generations of Americans – who will one-day be served by the programs we’re here to discuss today – will be as healthy as possible when they begin to use those services.

We must also be proactive in eliminating barriers that prevent people with disabilities from seeking employment. And we will significantly enhance an individual’s ability to choose and direct the services that are most appropriate for him or her under a model of self-determination.

The program for the elderly will focus on strengthening support services through family and informal caregivers and helping individuals stay in their homes and communities longer rather than being forced to rely on more expensive nursing home care.

Today we have a system that requires that, before we can help someone in their home, they must become so frail that they qualify for nursing home level care. Does this make sense to anyone? It is wrong and it should be changed.

We know that a spouse, a child or even a neighbor, is caring for many of those individuals who have not yet deteriorated to the point that they qualify for long-term care services under the Medicaid program. In many cases, the care they provide is keeping their loved one from needing the more intensive and expensive services offered by Medicaid.

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But we also know the health of the caregiver is often fragile, and that the stresses and physical exertion of providing care can sometimes lead to a health care crisis for that individual, as well.

So what's the result? Unfortunately, what is becoming an all too familiar story, is that the person on the brink of qualifying for Medicaid is often pushed over that line, and is now relying entirely on Medicaid for his or her care...and sometimes that means actually deteriorating to a point where they need to go into a nursing home.

Again, this doesn't make sense.

So, I am proposing to significantly increase respite care and training for those informal caregivers who are taking care of a loved one.

By proactively addressing the needs of the individual who requires care, as well as the caregiver – collectively – we will extend the period of time that individuals do not rely on Medicaid and thereby reduce the overall cost of the program. It makes sense!

Seniors want to remain in their own homes...sometimes they just need a little help to do it. And, we should provide that help.

We should also promote the use of non-Medicaid financing options for long-term care, like reverse mortgages and the Long-Term Care Insurance Partnership program – a program that allows individuals who purchase a qualifying long-term care insurance policy to rely on Medicaid only after their policy has been exhausted, and without having to spend down all of their assets to qualify.

Simply put, if an individual buys a long-term care insurance policy, and if they hit the benefit cap of the policy, they will not have to become impoverished to qualify for Medicaid.

Because they took the steps to be personally responsible, we'll take the steps to reward that behavior.

Doesn't it make sense to encourage individuals to purchase long-term care insurance, instead of waiting for a serious need to arise before trying to figure out how to pay for the appropriate care?

Through a combination of the Partnership program and tax incentives, I believe long-term care insurance could be an effective tool to divert people from state and federally financed Medicaid programs, and even improve the quality of care those individuals receive.

In Idaho, as in many states, we've taken the rights steps. Two years ago, I proposed and the legislature passed a 100 percent tax deduction for long-term care insurance premiums.

When you consider that many families are already taking advantage of comparable tax incentives, like Education Savings Accounts, it becomes clear that the means are there to help pay for long-term care insurance.

I would suggest that the last payment parents make to their children's Education Savings Account should be followed by the first payment to their own long-term care insurance policy.

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Parents invest so much in their child's education because they want them to succeed in life. They should now take the next step to make sure, in the event of an accident or illness, that they do not inadvertently saddle their children with the expenses and the responsibility of being their primary long-term care provider.

While I believe in families taking care of families, I also believe that planning for the inevitable is the right thing to do, so that our children won't be required to take on that responsibility any sooner than may be necessary.

At this point, I am going to mention a couple of heroes of mine. It is a couple, Vern and Shirley, and they are dear friends. They are in the situation where they are raising their grandchildren. The parents are out of the picture and will be forever. But, you know the rest of the story, they are also preparing the meals for their elderly parents.

This is a growing story that is happening more in more throughout the United States. And, we need to be aware and cognizant of this...the role of Grandparents and foster Grandparents and all that they are doing for the next generation.

I make this point as you are attending this wonderful White House Conference on Aging...Please keep in mind that we are all in this together.

It doesn't begin at 60...it does begin at birth.

And if we can't make efforts and we can't be holistic and think about the wellbeing of the young children and their health habits, more and more it will fall to the Grandparents who will have to care for those children. It must be a holistic approach.

In order to be aggressive in promoting these non-Medicaid financing options, the federal government must take the same steps as states and provide incentives for our citizens to purchase private long-term care insurance policies.

The federal tax code should include a deduction or credit for long-term care insurance, and all states should be allowed to participate in the Long-Term Care Partnership program. Currently, federal law prohibits all but four states from participating in this program. That should be changed.

With these recommendations, you can begin to see the steps that we need to take to implement a system that will provide the kind of long-term care that we would all want for our parents, our children, and ourselves.

It is our choice, how we will live. I believe that we will choose to live better. And I believe that if that is our choice, this is where we ought to begin. As you go throughout this conference, I hope that these principles will be prevalent on your minds.

States must have the flexibility to implement common sense reforms to simplify Medicaid eligibility, to promote home and community-based services and to eliminate arcane rules that

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require individuals to become frail before we provide comprehensive, supportive services and respite.

The Federal Government must follow the example of states to provide significant tax incentives that will encourage individuals to invest in non-government funded long-term care financing instruments...like a long-term care insurance policy.

And all of this must be done with an eye focused on the health, dignity and independence of our seniors, as well as future generations of Americans who will one day use these very same programs.

As a nation, we are living longer. It is now up to us to decide if we will live better.

White House Conference on Aging Policy Tracks

December 12, 2005

ADDRESS OF

HAL DAUB

**PRESIDENT AND CEO OF THE AMERICAN HEALTH CARE ASSOCIATION (AHCA)
AND NATIONAL CENTER FOR ASSISTED LIVING (NCAL)**

The Older Americans Act sets out several objectives including “An adequate income in retirement in accordance with the American standard of living.” This is a worthy goal, but, in the wise words of the writer Antoine de Saint-Exupery “a goal without a plan is just a wish.” Planning—by individuals and policymakers—is crucial to meet the challenges that our aging populations face in the 21st Century. The largest challenge is the demographic shift now underway as the baby boomers move into their disability-prone and retirement years. But that is hardly the only challenge. The changing face of private sector pensions requires additional planning so they can continue to play their important role in lifetime income. Medicare and Medicaid are taking an ever growing share of our Nation’s production. Rising health costs will also consume an increasing portion of retiree income to meet premiums, deductibles, and other out-of-pocket costs. And, with the aging population increasingly composed of the older old, we will rapidly see an explosive increase in the need for long-term care and other intensive services.

At the beginning of the twentieth century, most Americans did not really participate in the concept of retirement. Life expectancy was shorter both at birth and at older ages. Social Security and Medicare did not exist. Few private pension programs existed. Most people expected to continue working as long as they could – often until they died. Over the course of that century, and especially the latter half of that century, there were great changes. People lived longer and retired earlier. We had great advances in technology and productivity and a growing and more highly trained and educated workforce. Our prosperity and our demographics made possible both private and public institutions that were able to provide a significant degree of security in retirement. But, even in the advantageous circumstances of the last 50 years, we have not achieved the goal of an adequate income in retirement. Social Security, which is supposed to be the foundation for retirement security, represents almost the entire income—90 percent or more—for one out of every three beneficiaries. It is more

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than half of income for 2 out of every three beneficiaries.

If we are going to hold our own, let alone make progress, in our quest for retirement income and health security in this challenging 21st century, we are going to have to do a much better job of accumulating resources over our lifetime. Government programs like Social Security, Medicare, and Medicaid will still play an important role in retirement security, but it would be a great mistake to think that the relatively smaller workforce of the future can support the growth in those programs that would be needed to provide our aging society an adequate retirement. They don't do it now. They will be even less able to do it in the future. So what is the answer? We—as individuals and as a society—are going to have to do a better job of preparing for our future by planning over the lifespan to accumulate and manage the resources we will need.

The Social Security program, although it obviously needs immediate attention, has the right basic approach. Social Security accumulates over the long period of one's working lifetime. It's not “just there”, automatically, if one lives to be 62 or older. Workers pay into the program as soon as they start working. In part, of course, that provides valuable survivorship and disability protection. But most working men and women think about their Social Security taxes as contributing towards their future retirement. That same mindset needs to be nurtured for participation in pensions, individual savings, and long-term care insurance. We used to view life in 3 stages: a startup phase when you concentrate on raising a family, educating your children, buying a home; a mature phase when you begin socking away funds for retirement; and a retirement phase when you start drawing down those savings. That approach of postponing retirement accumulations to later in the career really doesn't work all that well now, and certainly is not an adequate plan for a future of longer lives, greater need for intensive services, and public programs that must be financed by a smaller working-age population. We've gone from a nation that had 5 workers for each Social Security beneficiary in 1960 to 3 workers per beneficiary now and continuing to drop to 2 workers per beneficiary by 2040.

So our theme for individuals and also for society has to be “sooner rather than later” or—realistically—“sooner rather than too late.” As a Nation, we certainly need to start soon to fix the programs that we can clearly see are in trouble. Social Security and Medicare and Medicaid are the obvious and most serious cases. These foundational programs, in their current form, are not sustainable. Medicare's Hospital Insurance program is already paying benefits that exceed its earmarked payroll taxes. Social Security will be in the same situation in little more than a decade. Together Medicare, Medicaid, and Social Security now consume about 8 percent of the Nation's total output. By mid-century, that will grow to about 18 percent. Only by acting soon can we fix these programs without drastic increases in taxes on a smaller workforce or drastic and sudden cuts in benefits. And we need a broad perspective that sees these programs and individual accumulations as an integrated package of retirement security. Changes in Medicare affect the adequacy of Social Security benefits. Typical out-of-pocket costs not covered by Medicare will increase to nearly 50% of

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the average Social Security benefit amount within the next 15 years. For many Medicaid recipients, their Social Security benefits represent an offset to what Medicaid will pay for long-term care. We need to encourage creative integration like the partnership programs for combining Medicaid and long-term care insurance. It makes no sense for Federal laws to prohibit such incentives as they now do in all but 4 States. In fixing Social Security, we should also find a way to assure that individuals will supplement that basic protection with their own individual accounts.

How do we actually bring about lifespan planning and preparing for retirement? Some voices will say that we are being too pessimistic. Somehow unexpected levels of productivity may offset the coming one-third reduction in the relative size of the working-age population. Maybe medical technologies and cures for Alzheimer's and osteoporosis, instead of continuing to drive up costs, will reverse course and make us all live healthier lives at lower cost. That is wishful thinking, or special interest promotion, but clearly a head-in-the-sand approach. Even if we can trim costs per day of long-term care and provide research incentives that could accelerate these hoped for cures, we are going to be spending a lot more on expensive treatments and care. The number of people over age 85 will double by 2020 and double again by mid-century. Providing the care these fragile populations will need is labor intensive whether you are talking about care in a skilled facility or care at home. With accelerating workforce shortages, global costs are going to be more expensive. So we can't waste time.

A couple of general approaches do make sense. We can shape government programs to provide incentives and support for lifetime planning and the accumulation of resources. And we can get serious about the need for financial planning.

We must incorporate financial management into the mandatory core curriculum of our education systems. No one should graduate from high school without having learned what individuals need to accumulate in the way of personal resources for retirement, how much difference it makes to begin that accumulation at the start of their working life, and how they can avoid being taken advantage of by practitioners of fraud and abuse. This type of financial education should be reinforced in adult education programs. Employer sponsored retirement plans provide a huge contribution to the retirement security of Americans. But the economic context for such plans is changing. Some large industries, facing increased global and domestic competition, have terminated their pensions in bankruptcy. Even for healthy companies, the changing nature of the workforce has brought about a move away from the traditional pension providing an annuity and towards plans involving less risk, more individual ownership, and usually payouts in the nature of lump-sums rather than annuities. This has some advantages for an increasingly mobile workforce, but it also raises the need to make sure the governmental policies affecting this sector are designed to encourage building an adequate retirement. For example, given the need for greater accumulation of resources, many older individuals want to continue working on a part time basis instead of taking an early retirement, but government rules now make such phased retirement difficult. That should change. The Pension

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Benefit Guarantee Corporation takes over terminated pension programs and assumes their liability for benefit payments. Unfortunately, current rules have loopholes allowing some plans to over promise in a risky way without paying premiums that cover the risk. That needs to be corrected so that workers can count on the protection offered by the PBGC, but the changes need to address the risky plans without discouraging the continuation or formation of responsible plans. The greater flexibility of many of today's plans place a greater burden on workers to understand and manage those plans. Employers can provide more guidance to their employees and structure default choices that favor increased participation and balanced investment strategies. Government policies should protect employers who take those actions. Lump-sum payouts also create challenges for assuring adequate lifetime income. Tax rules and other policies should encourage more annuitization.

More can be done to stimulate individual lifetime preparations for retirement security through private savings and participation in programs of insurance against the increasingly likely need for long-term care. Some incentives already exist but need to be made more widely known. For example, Health Savings Accounts are a hidden tool. Amounts in those pre-tax, tax-advantaged accounts that are not needed to cover current medical costs can be expended to pay the premium for long-term care insurance. Individual Retirement Accounts—IRAs—are a wonderful incentive for savings. But they work best when started early, and the rules should be reexamined to remove barriers to participation. Currently, for example, there are penalties if distributions do not begin at age 70½. With so many people living to their 80s, 90s, and beyond, we should be encouraging them to hang on to those savings so that they will be available when they need the additional income to cover more intensive services. We should also encourage it because we need increased savings to produce a more productive economy. We should repeal or raise the age fixed in law for forced withdrawals.

Lifetime planning and preparation is crucial to a successful retirement security policy, so incentives should be particularly strong at earlier ages. The rules for IRAs, 401(k)s, and other forms of tax advantaged savings should provide larger tax advantage for those who begin to participate early in their career. Similarly we should provide tax incentives for early participation in long term care insurance when the premium cost is much lower. The law could, in exchange for the more stimulative tax break, make coverage or content rules like a minimum payout of 36 months or more, home health and companion care, and assisted living as well as skilled nursing home care, and pay with only two ADLs.

As individuals, far too many of us are not adequately prepared for the financial and health-related needs we will face in old-age. As the boomer—this tsunami of age—wave approaches, we must seize this transformational time to develop government incentives and private initiatives to become less dependent on tax paid or subsidized benefits in retirement. Policymakers need to adjust the institutional arrangements that will help meet those needs: fix Social Security, programmatically

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deal with the costs of Medicare and Medicaid, improve the legal and tax framework for employer-sponsored retirement plans, and raise incentives for savings and for long-term-care insurance.

But these cardinal tasks will not be achieved unless we first of all foster the public and individual education and planning that will enable us to understand how great these challenges are and to accept the reality that an adequate future can only be assured if we, as individuals and a society, plan for our future and divert some of our resources from current consumption to savings for that future — sooner rather than later.

Remarks by David Eisner at the White House Conference on Aging, Policy Track Discussion on Civic and Social Engagement

DAVID EISNER, CEO OF THE CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

- AS PREPARED -

Thank you, Ms. Hunt, for that kind introduction.

I am grateful for the chance to address the delegates to this historic conference and I am honored to speak alongside so many important partners for my organization. In fact, as Administrator McClellan can attest, there are Senior Corps volunteers all over the country right now helping other seniors to navigate the new web-based tool for Medicare and to select their new prescription drug plan.

Believe it or not, I also appreciate the chance to speak right after Ken.

He is a hard act to follow, but by talking about aging in terms of opportunity, Ken sets the stage perfectly for a discussion about how the aging of the baby boom generation is an opportunity for our entire society.

Let me start with the story of Joe Guarino, a volunteer with one of our programs out in Hemet, California.

Joe and a group of volunteers started a citizen patrol a few years ago to help support and supplement the local police department. The benefits have been tangible – crime, graffiti, vandalism, all down. More to the point people in Hemet just feel safer.

But consider this: for all the benefits to the town of Hemet — there's also a benefit to Joe and the other volunteers.

Joe Guarino, after all, is not a baby boomer: he's 93 years old.

The fact that Joe's out directing traffic and riding in bike patrols when many people his age are in long-term care may have something to do with good genes, but if you ask Joe, he'll tell you it has even more to do with his volunteer work.

And it's not just Joe. More than 500,000 older Americans serve in our Senior Corps programs – helping disadvantaged children through Foster Grandparents, helping older Americans to live independently through Senior Companions, and serving a range of causes through RSVP.

And they'll all tell you that two really good things are happening everywhere they go: American communities are made stronger, more just, and more whole – and volunteers themselves are made

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happier, better connected and more fulfilled.

Research tells us that they're better off in other ways, as well: there are significant health benefits associated with the kind of meaningful activity and social connectedness that volunteering brings to older people. We're talking about lower incidents of depression and attempted suicides, fewer strokes and heart attacks, fewer cases of diabetes, less high blood pressure and so on.

All of which – and this needs to be really clear – dramatically increases the individual's quality of life, even as it dramatically reduces the costs and burdens to society: the cost and burden of care for that individual, and the cost and burden of whatever social problem that individual invested time and talent to solve.

And that's why engaging the baby boom generation presents such a remarkable opportunity.

This is a generation that will have more years on this earth to make a difference than any generation that has come before.

So, as baby boomers approach retirement age, reinvent themselves, or just reach out, they have tremendous potential to improve lives in communities around this country. And they can improve their own lives in the process.

So “civic and social engagement” is more than a nice thing to do; it's something that we, quite literally, cannot afford not to do.

And that's the real reason I'm speaking to you today. You, here in this room, have a rare opportunity to shape the national agenda, the strategy, for how America manages aging in the first years of this new millennium.

I believe it's time for that national strategy to include the imperative of engaging the baby boom generation.

So I hope you are all voting for resolutions 56 and 59 today. And, to help remember those numbers, think of it in boomer years: after all, the oldest members of that generation are 59 right now.

Let me spend a moment expanding on why America has so much to gain. You know the numbers – 77 million people – the most formidable generation in our history.

Well here's a number that may surprise you: 26 million.

That's the number of baby boomers who already volunteer – and it's been rising steadily in the past several years. Boomers, in fact already represent the highest rate of volunteering of any age cohort.

The leading edge members of this generation were in their formative years when President Kennedy called on all Americans to ask what they could do for their country. And they have retained that underlying commitment to social idealism.

Now think about what that might mean for the nation.

If we can realize even a fraction more of that potential for service, we will have millions of human solutions to our social challenges.

And, in fact, President Bush has challenged us all to be part of the solution: after 9/11, he urged every

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American to contribute 4,000 hours of service during his or her lifetime.

Again, in boomer years, that would add up to a total of more than three million decades of service.

The possibilities are nearly endless.

Think, for example, about New Orleans and the Gulf Coast.

Clearly, in addition to government and private investment, recovery is going to take the hard work of many Americans who will volunteer their time and talents.

In fact, we're looking to baby boomers to take the lead ...

Which is why, I'm proud to announce today that the Corporation for National and Community Service is awarding \$4 million in new challenge grants – that will add up to \$12 million with the match. These grants are going to six organizations providing relief in the hurricane-affected areas of the Gulf Coast – and they're doing it by engaging volunteers from the baby boom generation.

And, across the rest of the country, boomers could be having an extraordinary impact in their own communities – preparing pre-school children to learn; mentoring and tutoring children living in disadvantaged circumstances; strengthening communities' ability to respond to disasters; helping the frail elderly to stay independent; reforming our schools.

And, when you harness the kind of time, skill, creativity and pure volume of this generation against some of these social issues, the impact could be extraordinary.

So let's talk about the challenges for a few minutes, because recruiting baby boomers as volunteers simply isn't a status quo proposition.

Research shows that boomer volunteers demand more variety in their volunteering opportunities than other age groups. They want their service to be more meaningful, they want to see the results of that service more directly, they want to serve on a more flexible basis, and they really want to be explicitly recognized for their contributions.

They don't want a lot of red tape, bureaucracy or rules.

Oh, and by the way, they don't even like the word "volunteering." And they really don't like the word "senior."

That certainly gives us pause, since my agency sponsors the single largest group of volunteer programs for adults over 55 – and it's called "Senior Corps."

But, you know, that's the great thing about civic engagement – it can be flexible, and it can accommodate everyone. And, anyone can be motivated to care about life in their community – that concern is not restricted by race, gender, income, education, disability, or even age.

Martin Luther King said it best: "everyone can be great, because everyone can serve."

However, let me be really clear – getting boomers to serve is actually more about changing the way we do business – as non-profits, the private sector, and government – than it is about making convincing arguments to them.

Now, in this town, when you start talking about that kind of change, people roll their eyes. Every blue

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ribbon panel and commission talks about the need for reform. And it's very, very hard to do – even when our most vital national interests are at stake. But this is a conversation we need to have if we are going to build a new national policy for aging.

We need to talk, for example, about improving the quantity and quality of volunteer opportunities.

And, to make volunteer opportunities more appealing, meaningful and fulfilling, there's no shortcut to improving the actual management of volunteers. This an area where non-profits are significantly under-invested – both in staff-time and money. The same charity that manages its cash contributions with oversight of the board and the CEO will, way too often, assign a short term intern to oversee the volunteer contributions.

We have work to do on the public policy side as well, ensuring that we create the right climate, provide effective incentives and remove barriers.

The business sector has a long way to go in connecting their employees more fundamentally with the needs of their communities, and building the habit and practice of volunteering before people retire.

And, importantly, we need to undertake an even more fundamental change – a cultural change.

The fact is that all Americans, all our institutions – we need to change our perceptions of aging and our expectations for people over 55.

We have to learn to see older people as an asset, not a burden, and retirement as a time for personal renaissance and societal relevance.

Now, you might think that kind of cultural change is a tall order, but this is, in fact, something that's already happening, as Ken Dychtwald made clear.

The growing prevalence of images of active, engaged individuals in their 50s and 60s tells us something. And although this shift today might seem to be mostly about selling products to the boomers, it's not only about that.

Look next month, for example, at the socially engaged boomer celebrities who will be highlighted in a national campaign by The Harvard School of Public Health and Met Life Foundation.

Look at The Purpose Prize, which Civic Ventures is awarding along with \$100,000 each to 5 social entrepreneurs who found new ways after the age of fifty to change society for the better.

And I'm proud to say that the Corporation for National and Community Service has also launched a national campaign – this morning, in fact. This multi-year effort, called "Get Involved," is aimed at attracting baby boomers to volunteer service, providing new opportunities to serve – and at shifting public perceptions of the role baby boomers can play.

And I'm thrilled that dozens of national organizations – from AARP and NCOA to the Red Cross, Habitat for Humanity, Catholic Charities, and Big Brothers and Big Sisters – have signed onto this campaign, as have major companies like IBM, America Online, CVS and General Mills.

With that, here is the first public viewing of one of these new Public Service Announcements...

[60 second PSA]

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That website again is GetInvolved.gov.

And, I should note that the people you just saw are all real volunteers—two of them are actually here. Carter, Ken – would you please stand up?

Thank you for being such an inspiring part of this campaign.

We hope our campaign will be a small, early part of a broader, successful effort to change the way Americans think about aging and to build boomer-based leadership in service that lasts 40 to 50 years.

If we fail in that task, we not only miss an opportunity for tremendous societal benefits, we miss an opportunity to lighten the societal costs and burdens of the “age wave.”

And if we succeed, we will leave behind a powerful legacy for all generations to come.

I hope we will have a chance to work together on a strategy for achieving the cultural and structural changes we need to see in order to start building that legacy.

Thank you very much.

2005 WHCoA
The Past, Present
and Future of Work
(and Retirement)

Ken Dychtwald, Ph.D.

The Historical Role of Work

Self-Worth



Social Connections



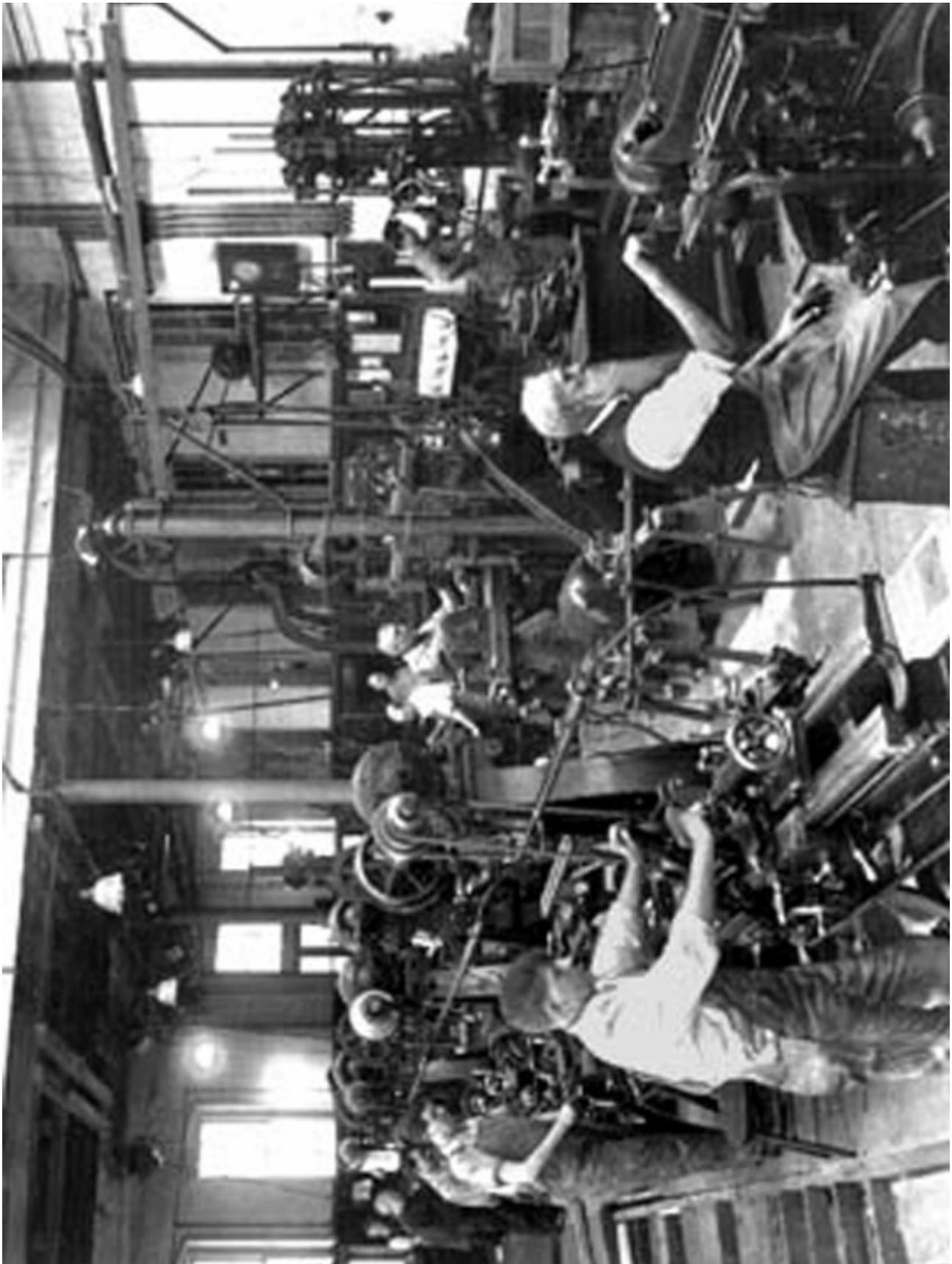
Earn a Livelihood



The Industrial Revolution

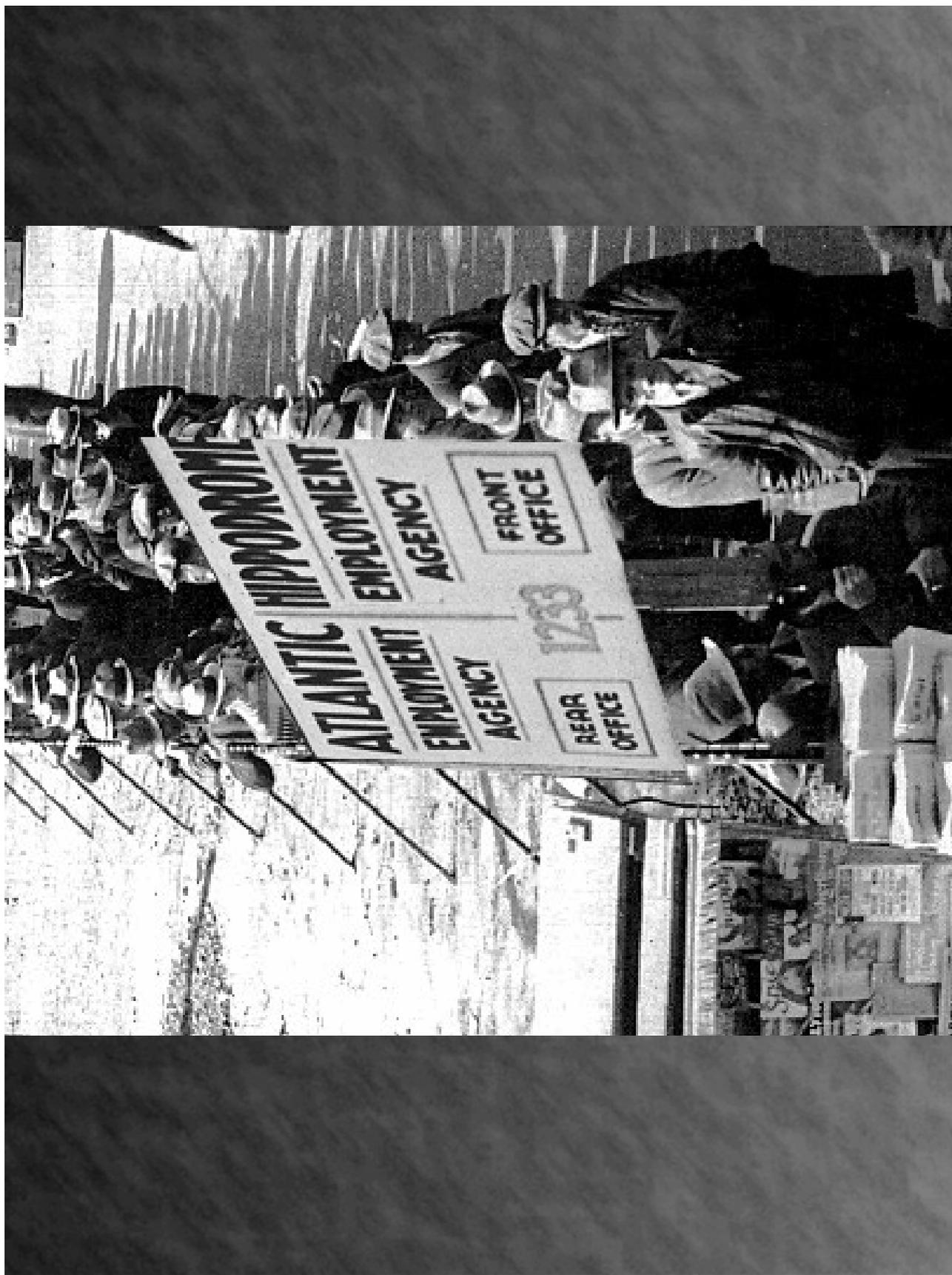
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The Evolution of Retirement

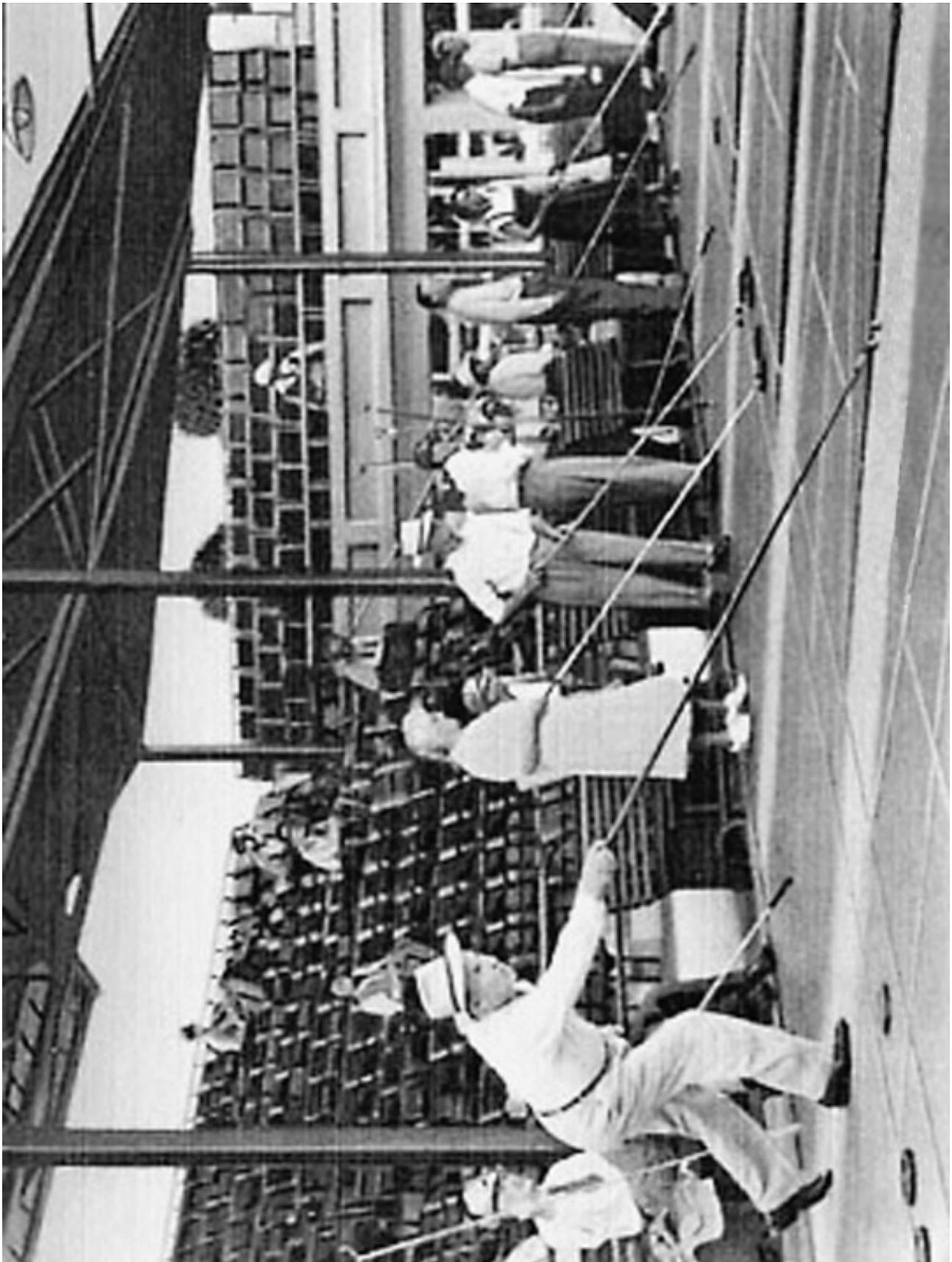
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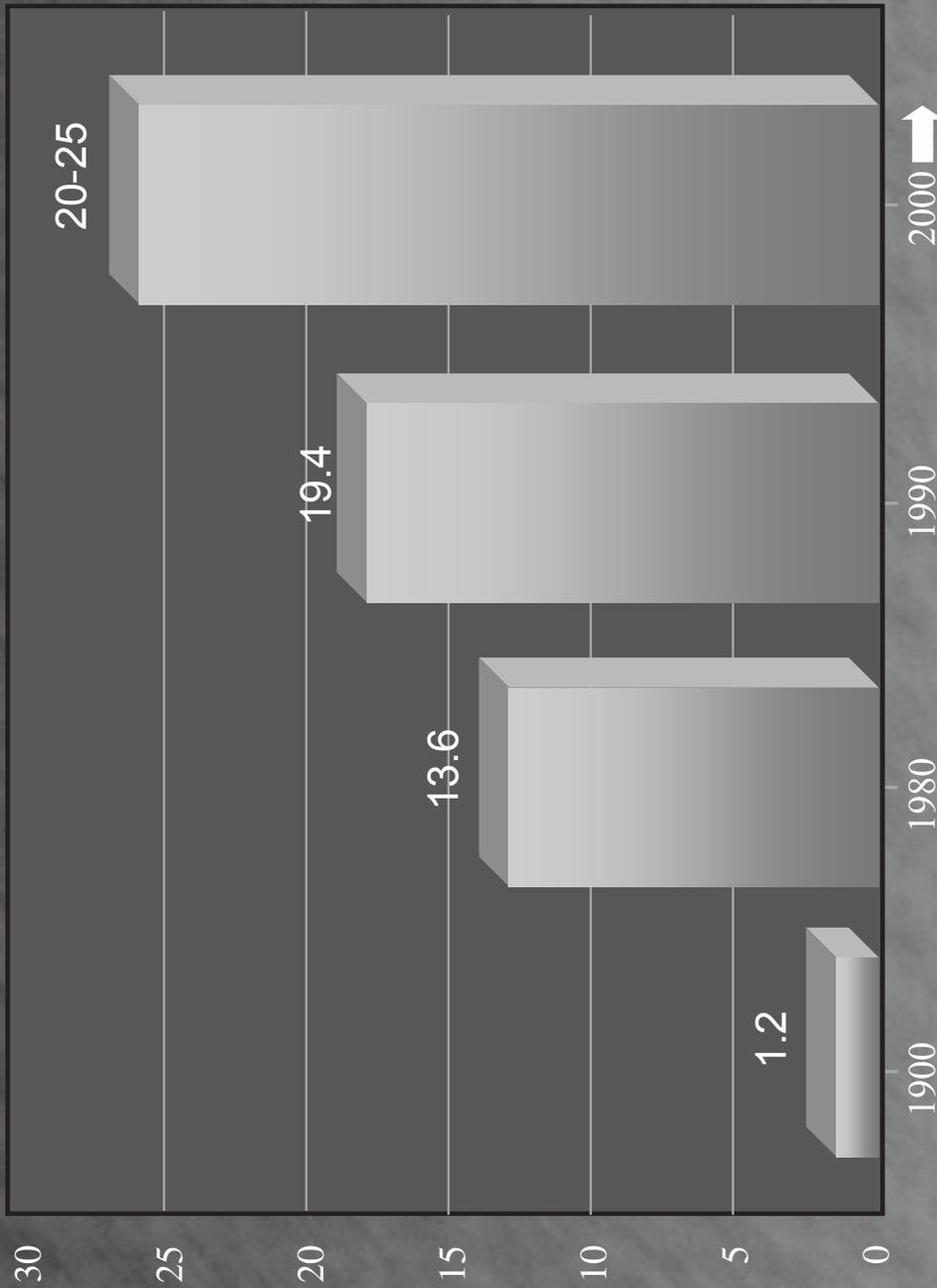


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Years Spent in Retirement



Webster's Definition of Retirement

- to disappear
- to withdraw



Source: Webster's New Twentieth Century Dictionary

Work/Retirement: At the Turning Point

1. The Longevity Revolution

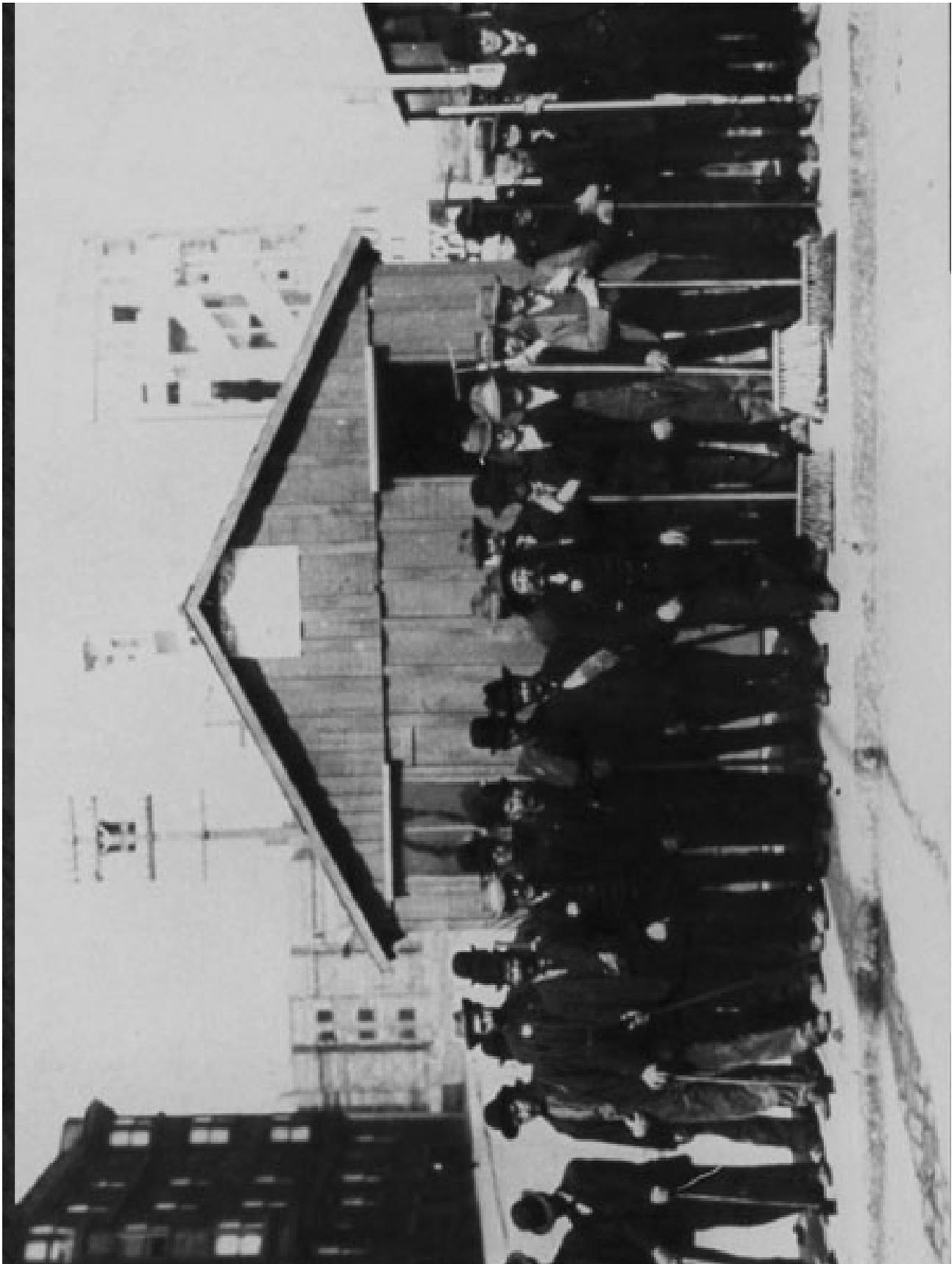
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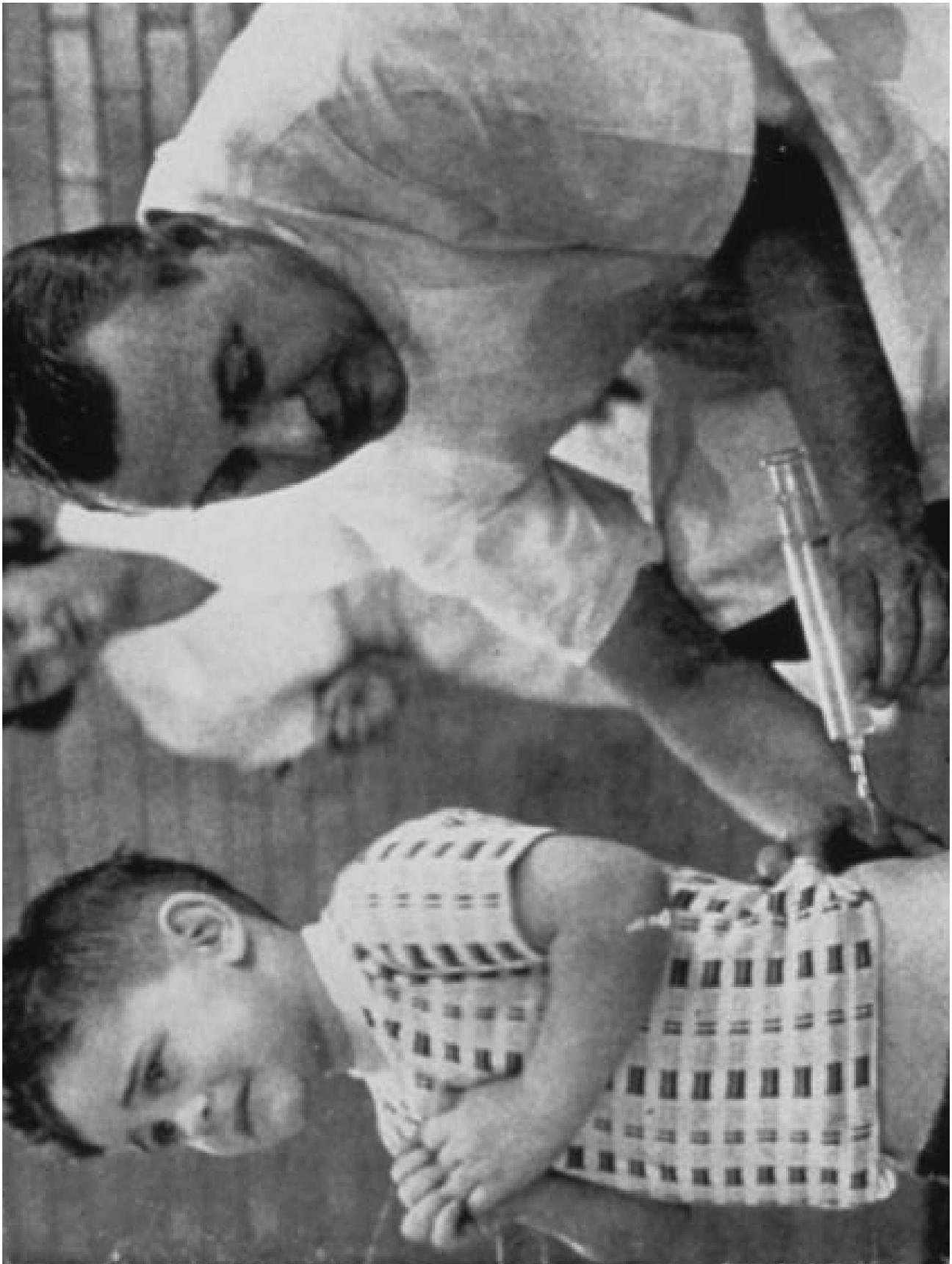
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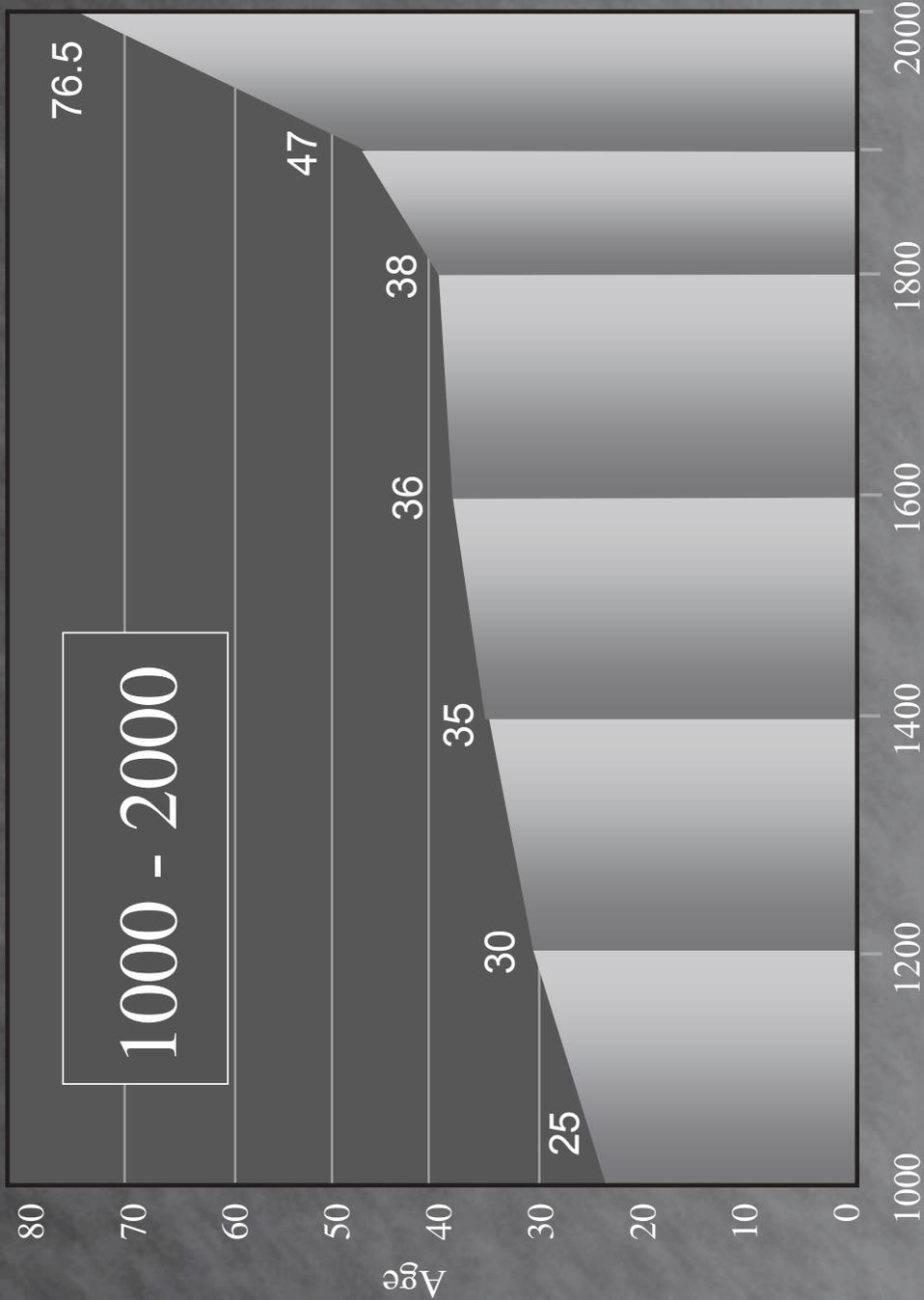


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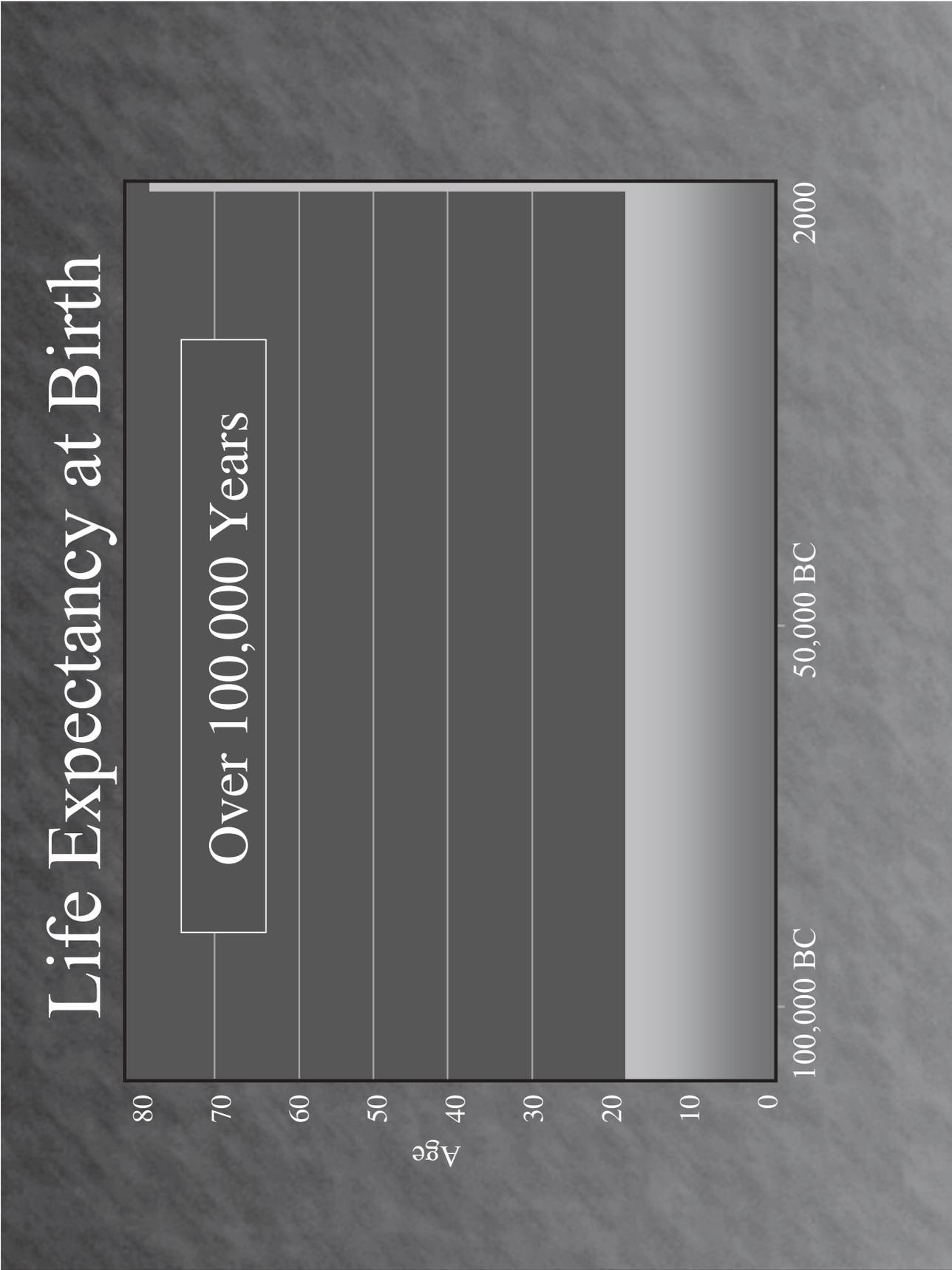
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Life Expectancy at Birth

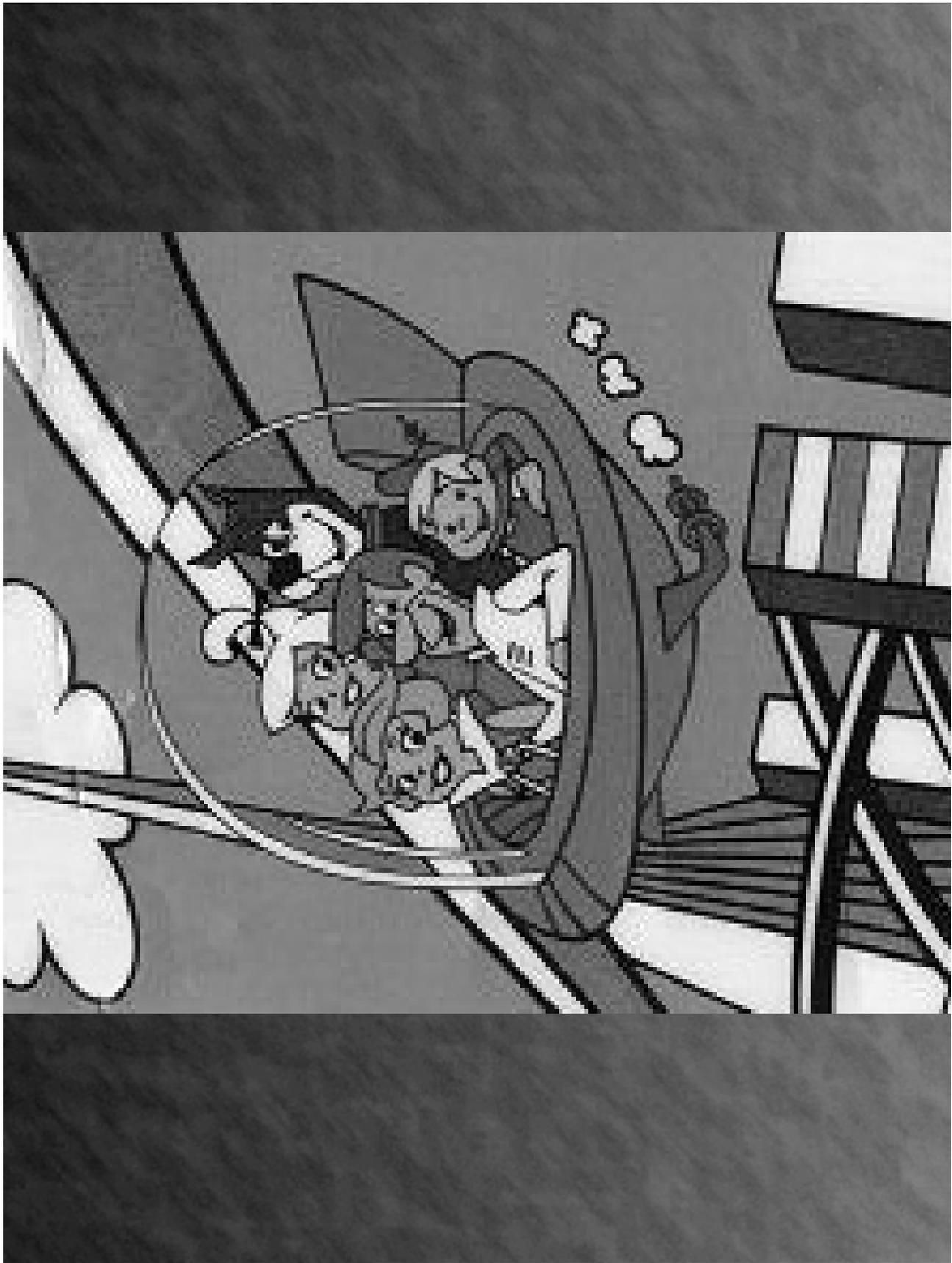


Source: Census Bureau, 2000

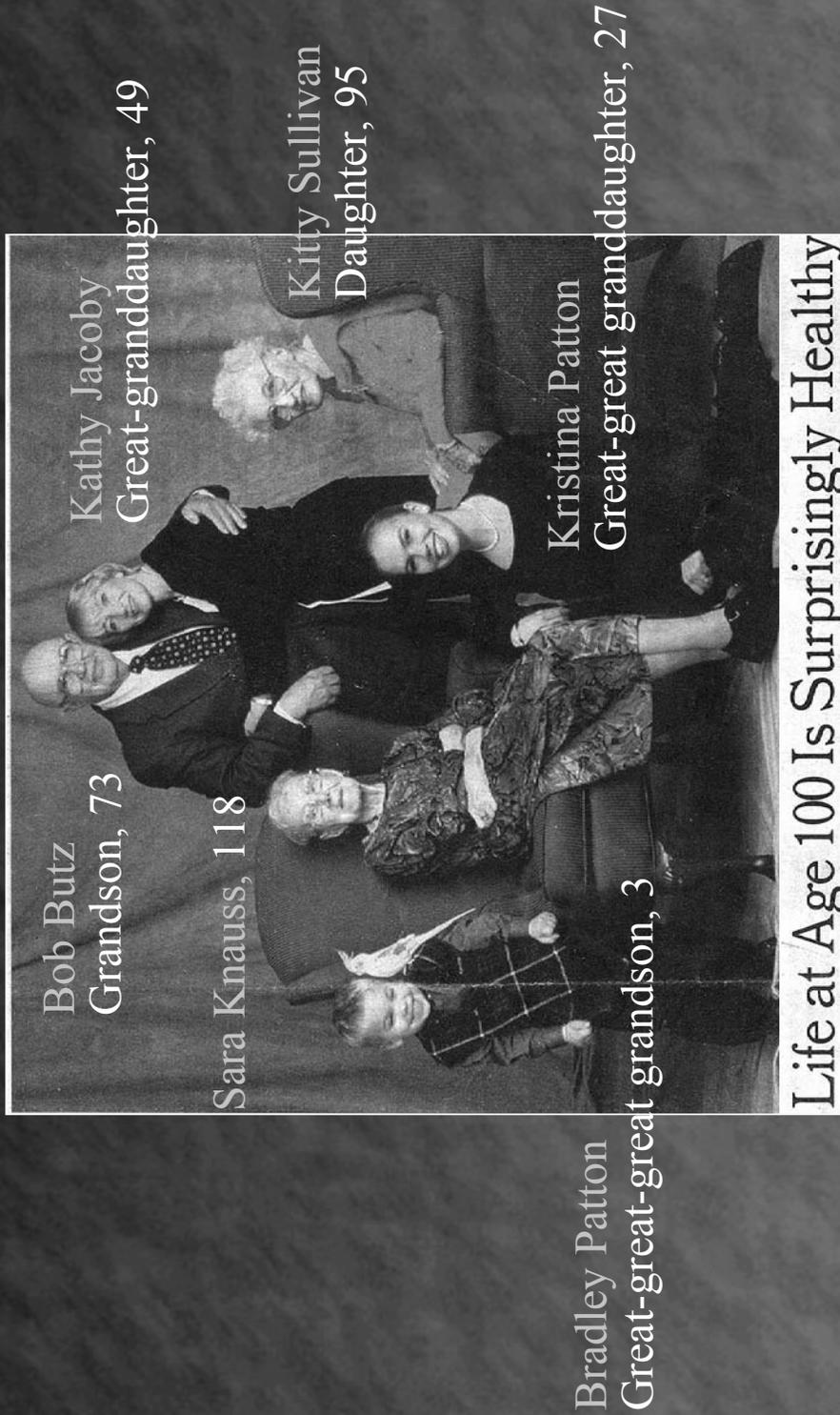


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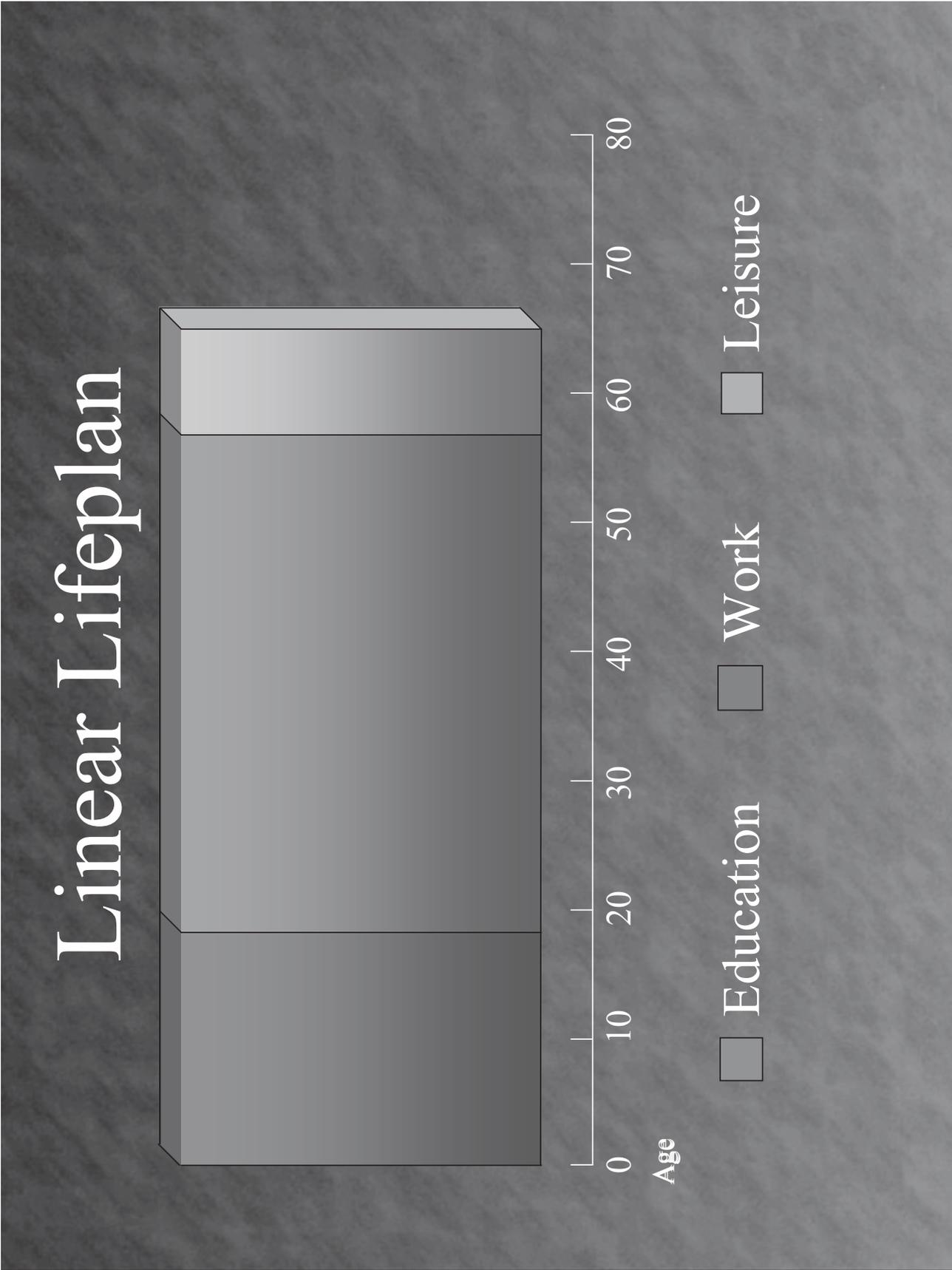


Six Generations



Source: New York Times, 2001

2. Desire for a New Work/Life Paradigm



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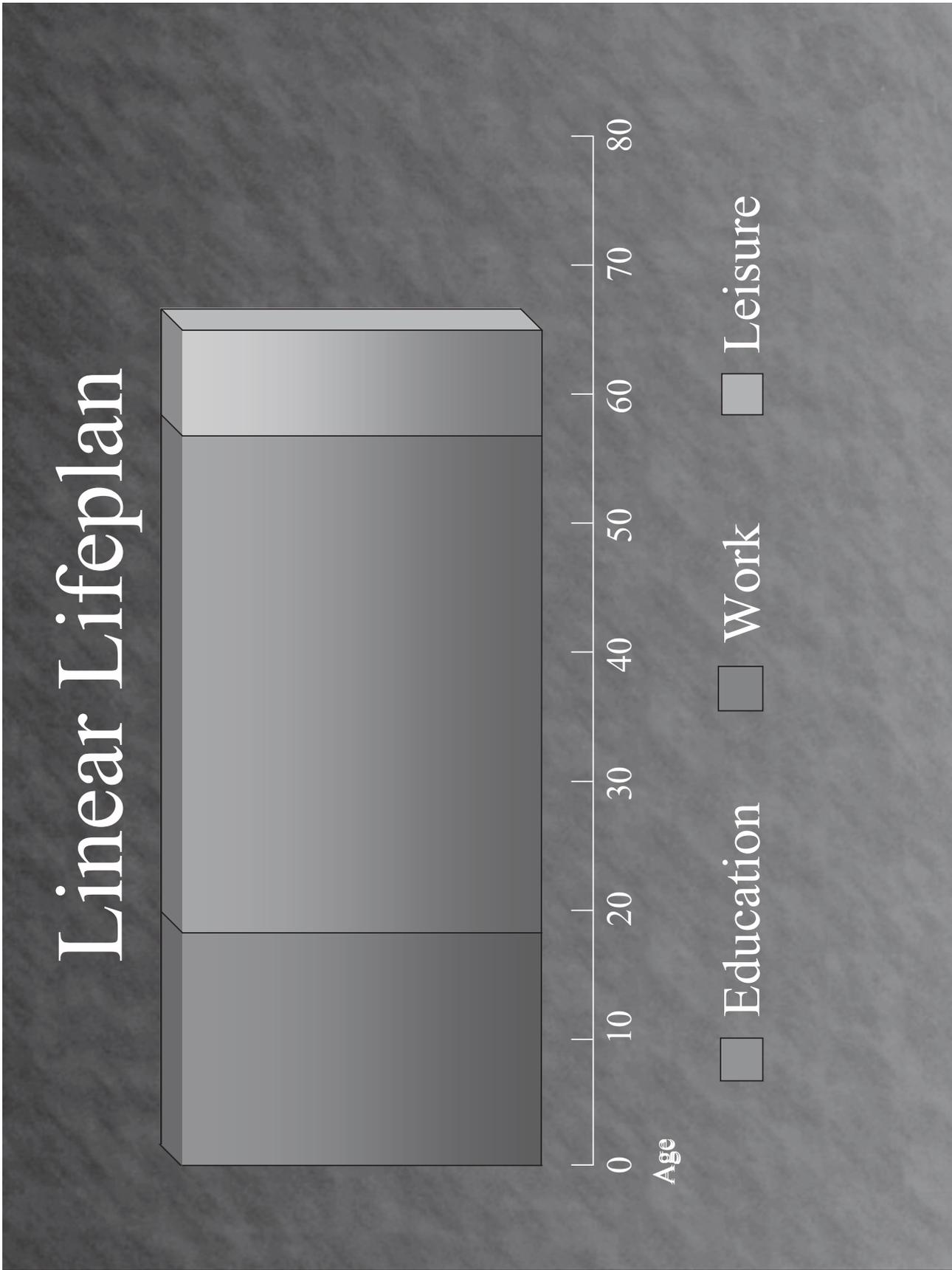
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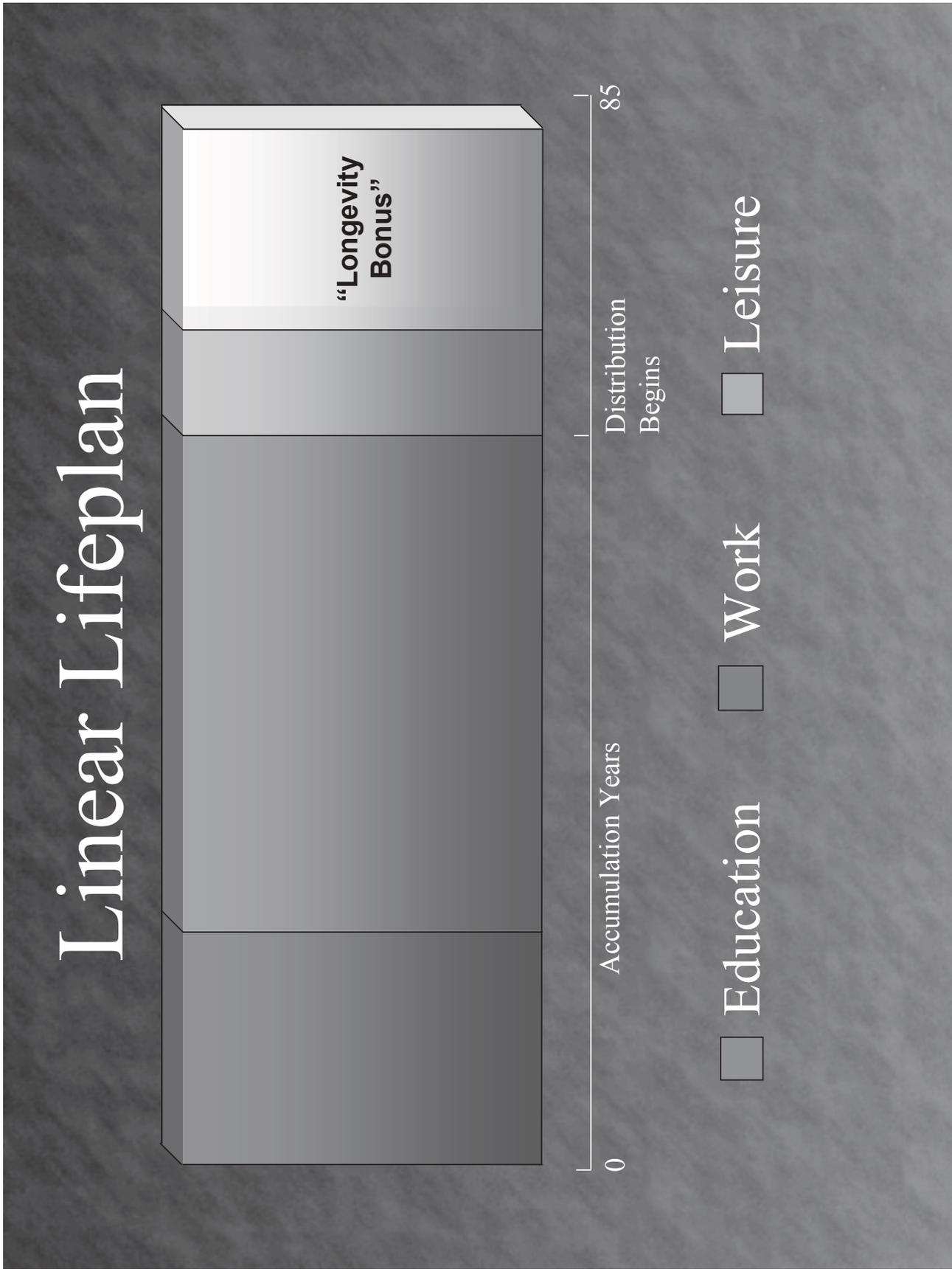


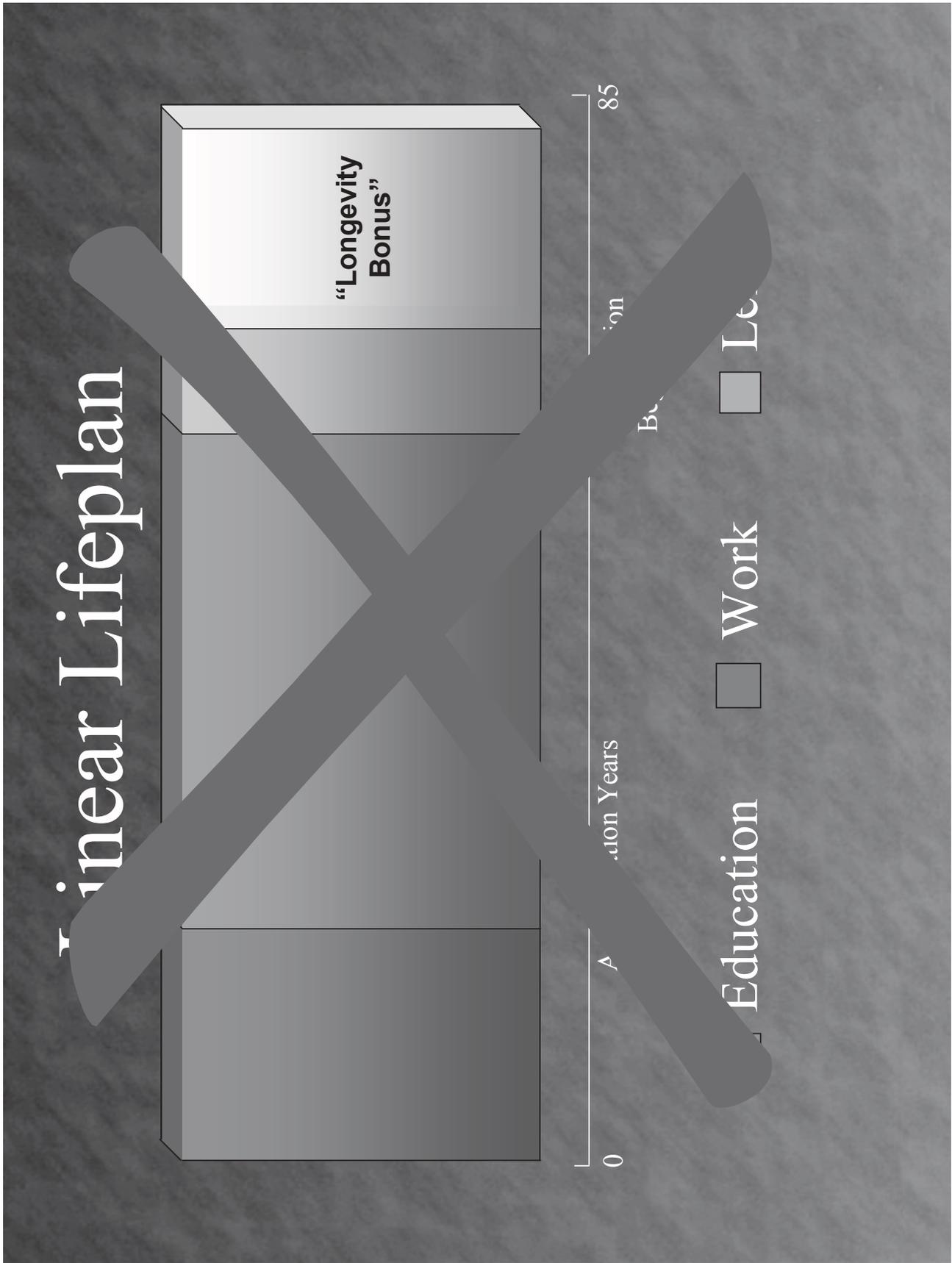
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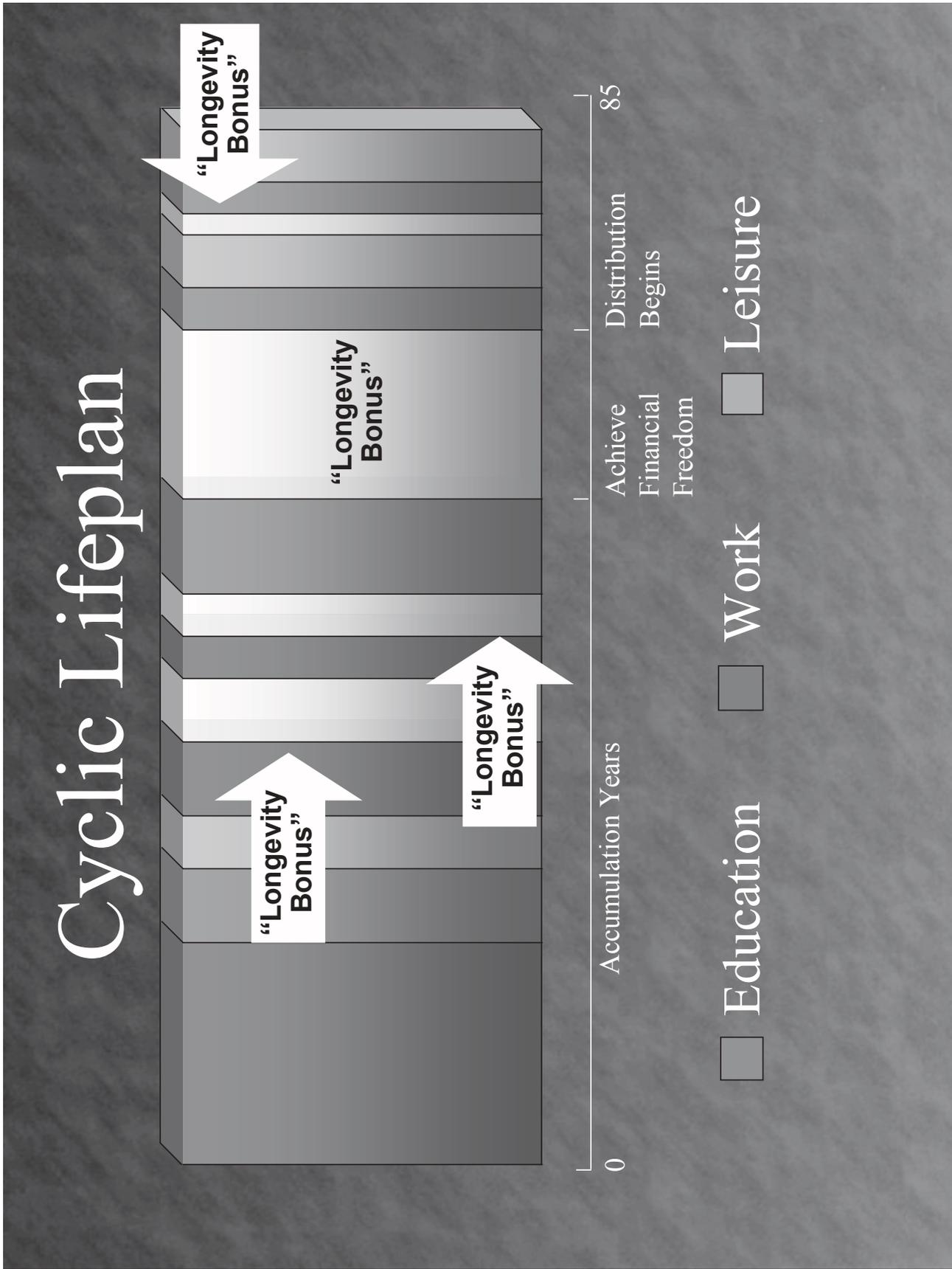
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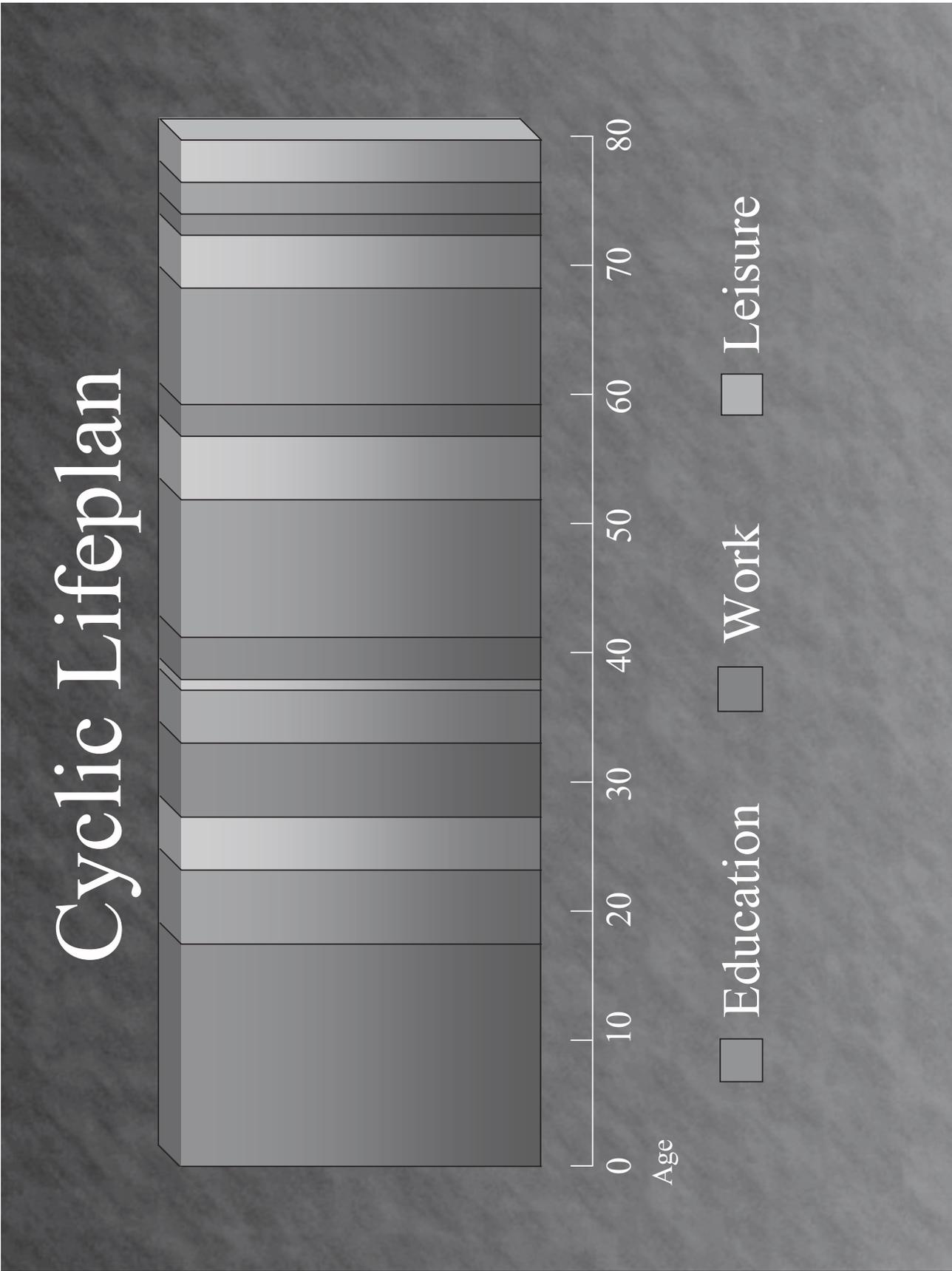






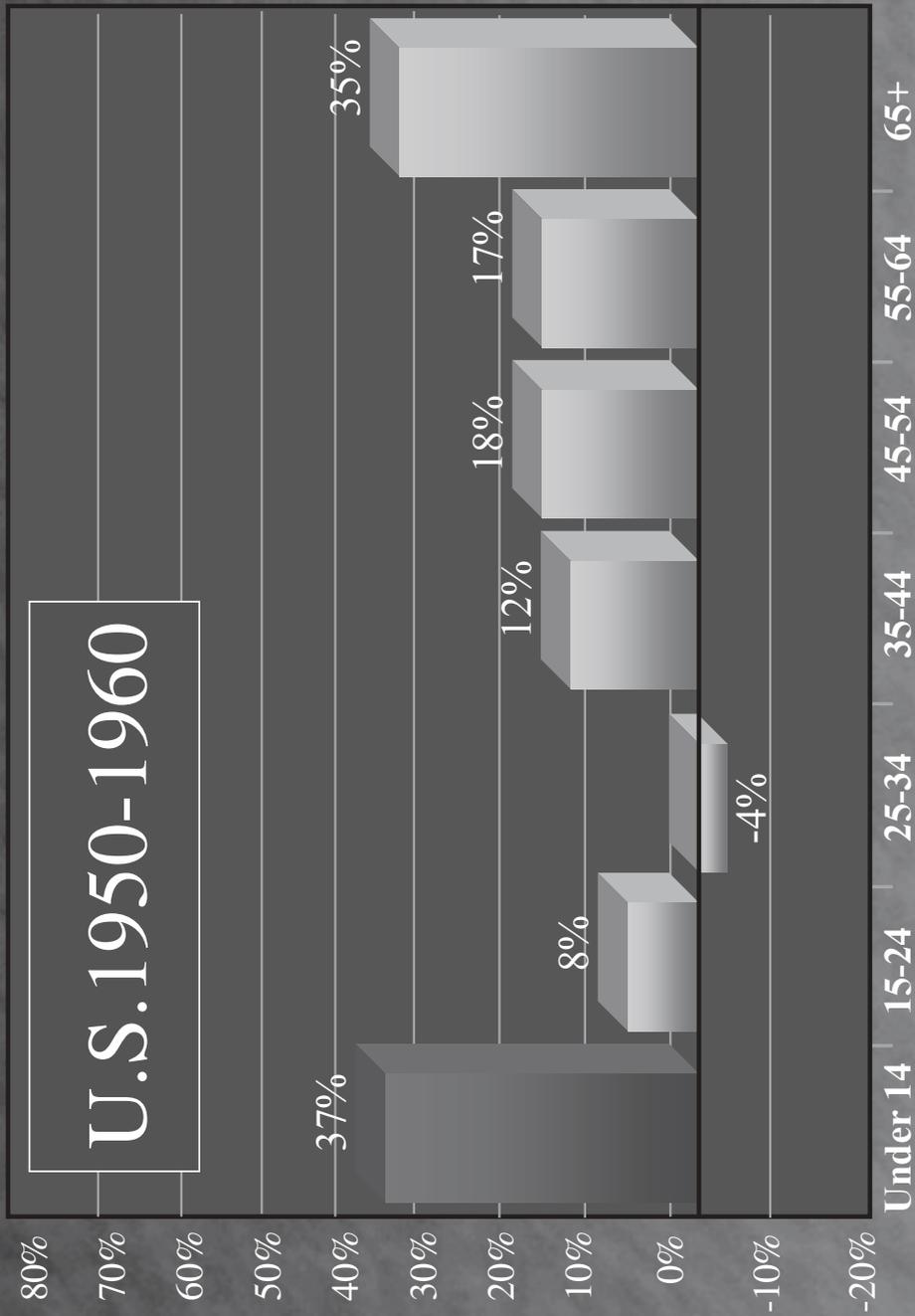






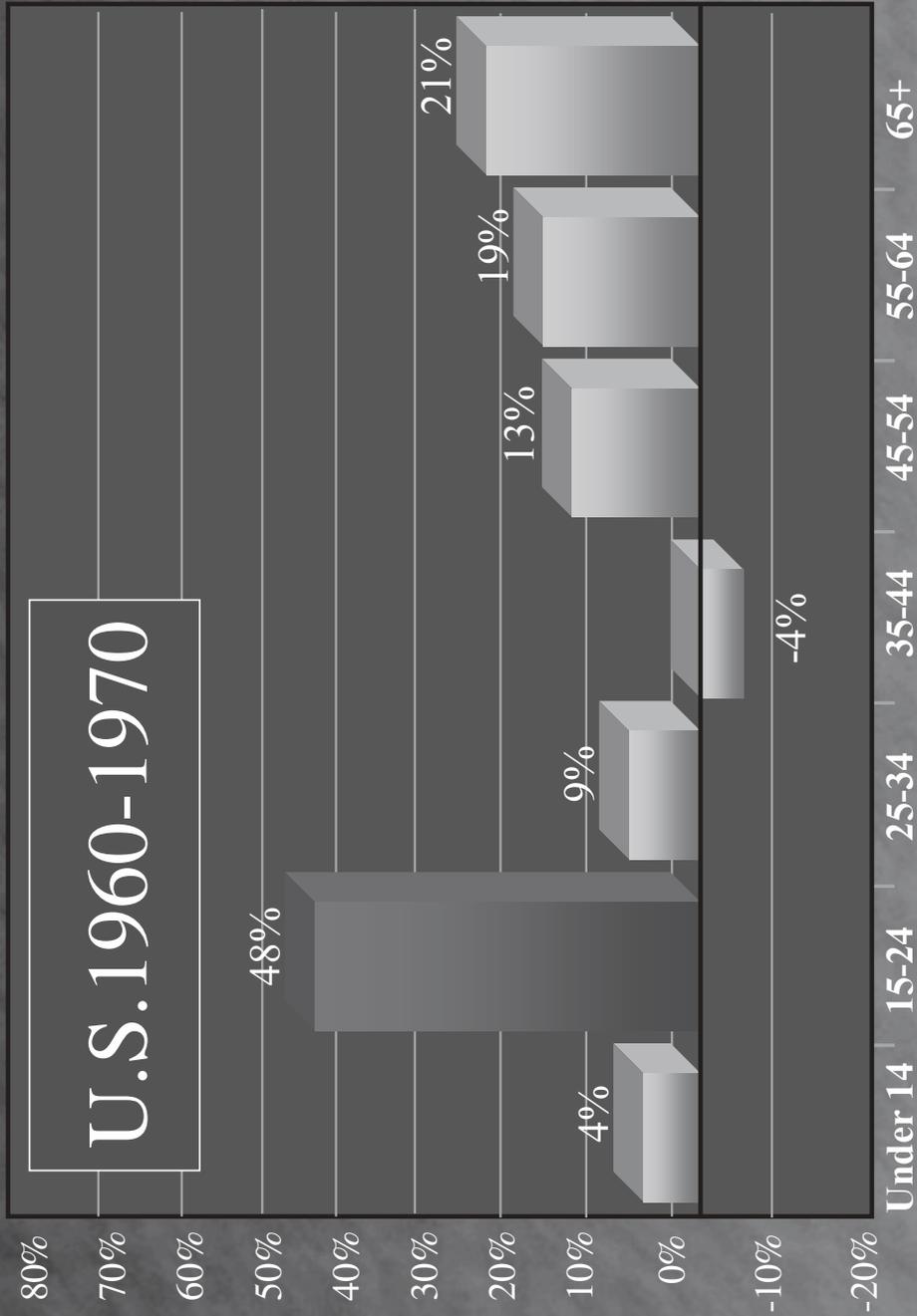
3. Unprecedented Demographic Shifts

Change in Population Growth



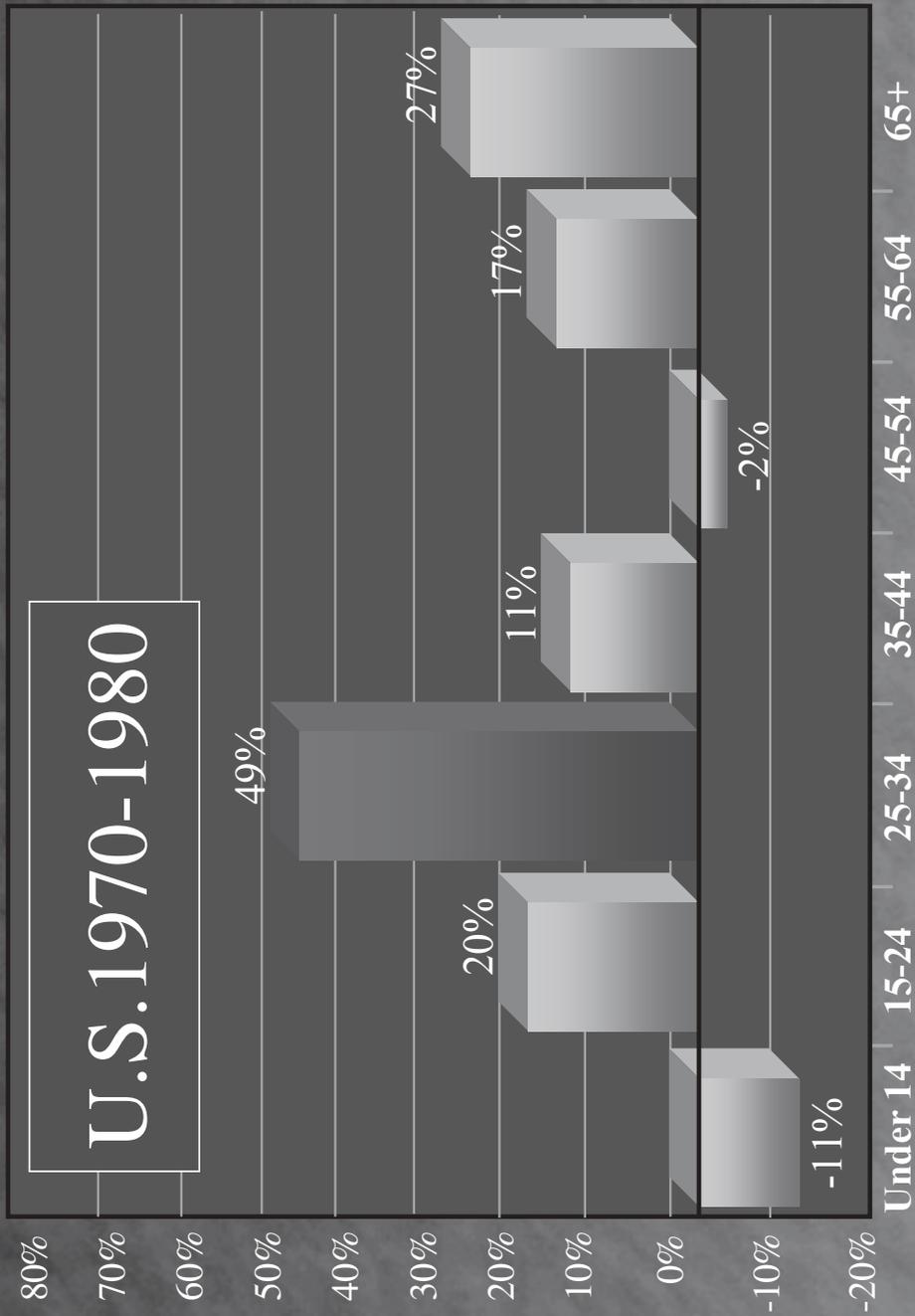
Source: U.S. Census, 2000

Change in Population Growth



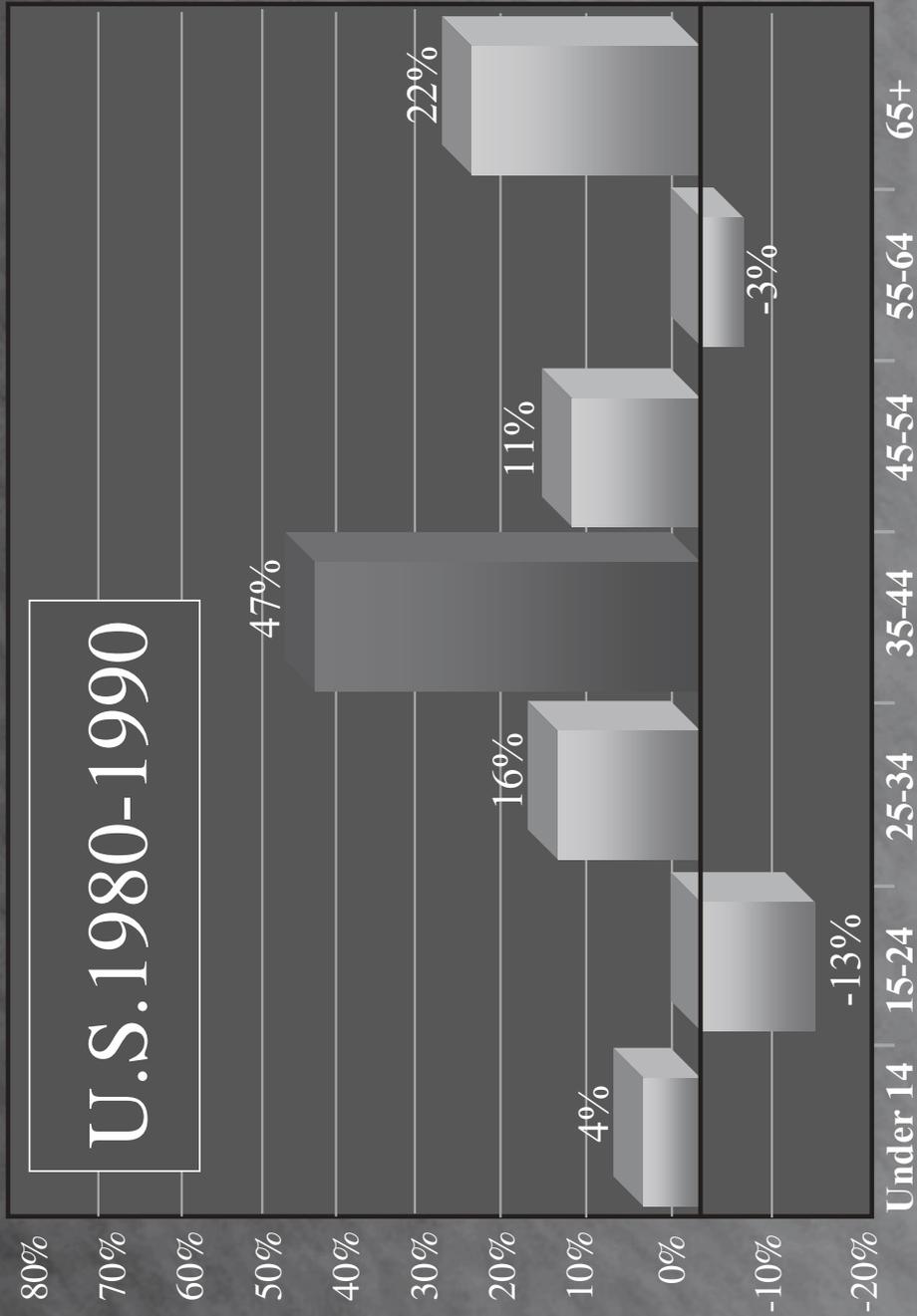
Source: U.S. Census, 2000

Change in Population Growth



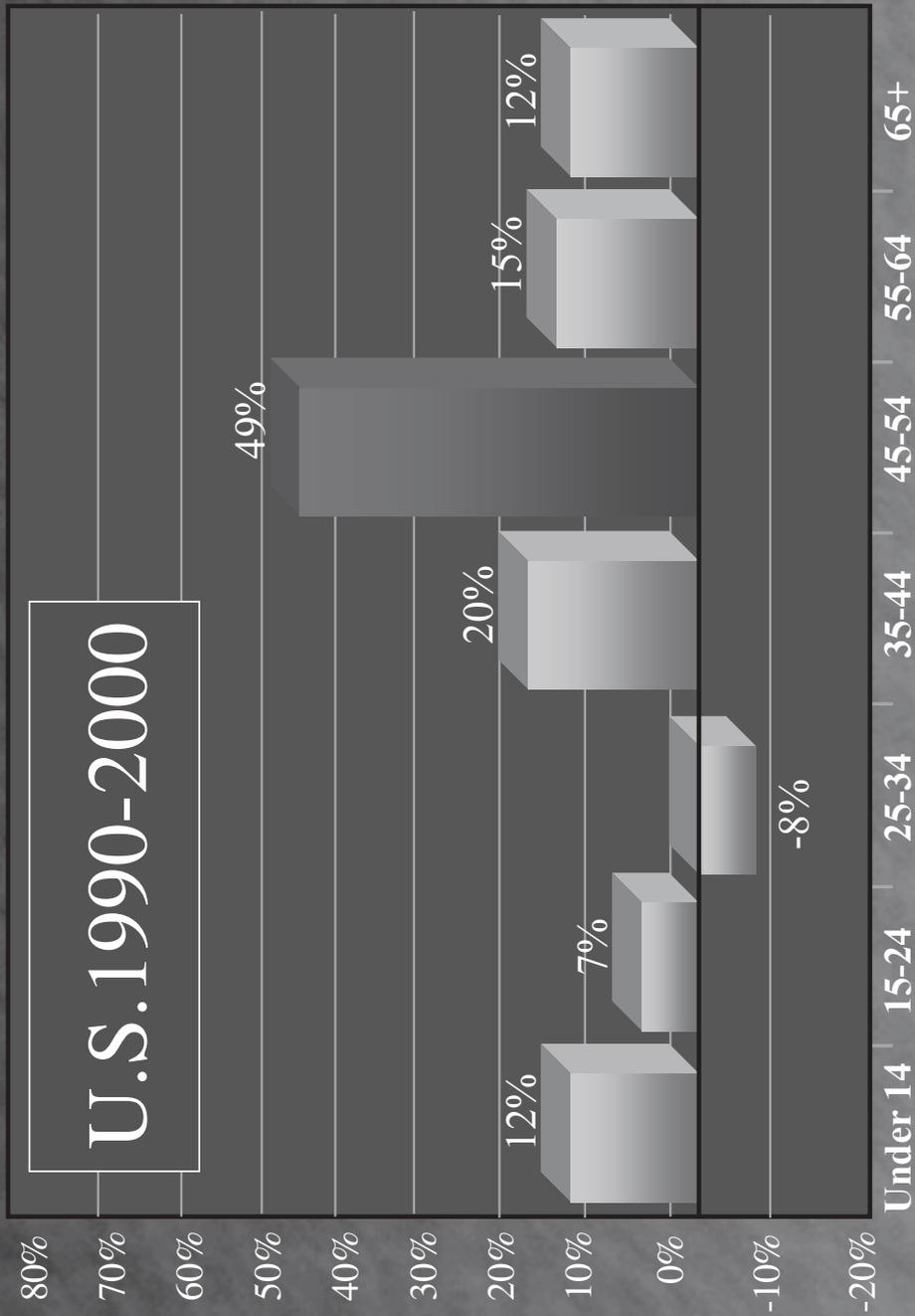
Source: U.S. Census, 2000

Change in Population Growth



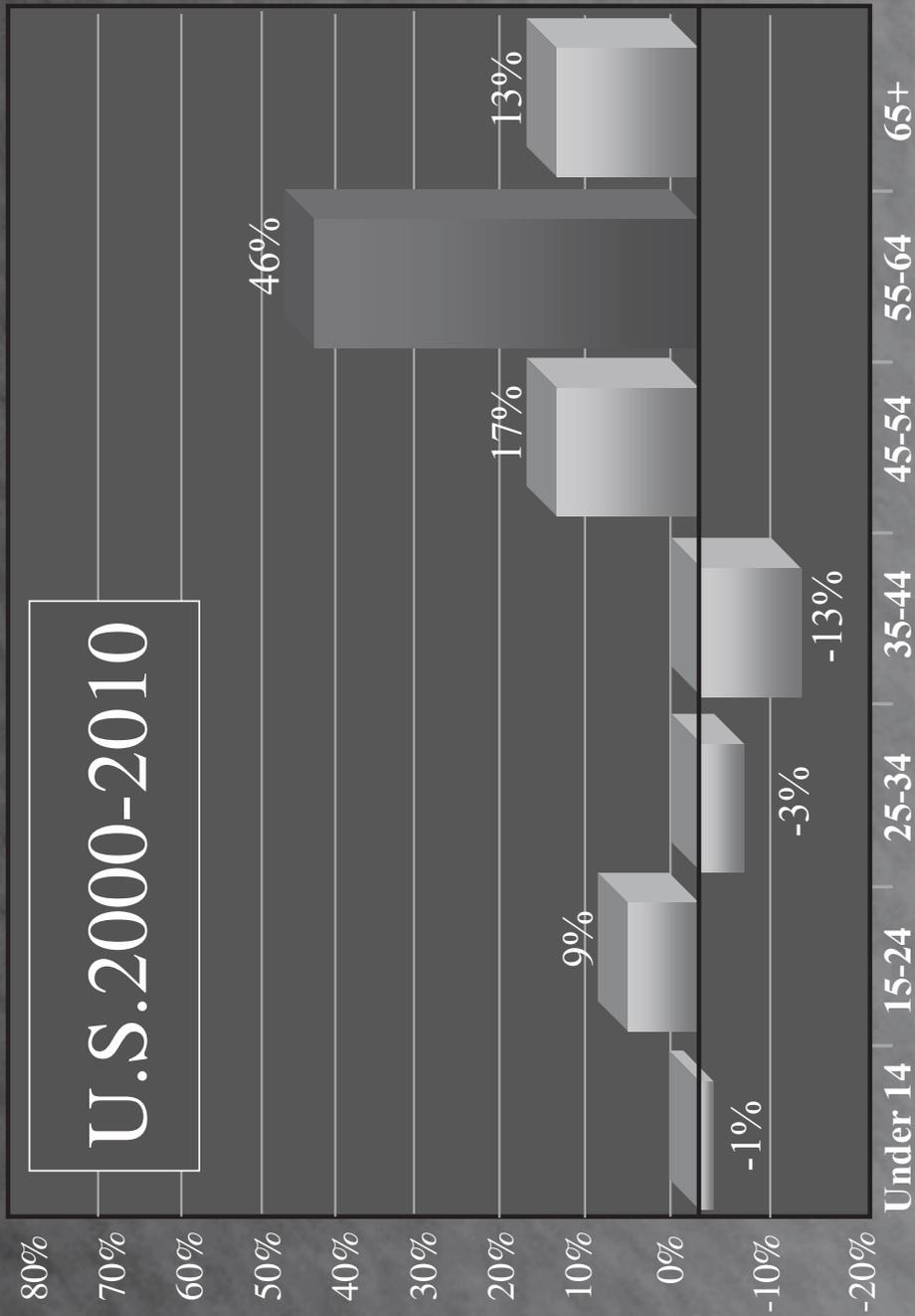
Source: U.S. Census, 2000

Change in Population Growth



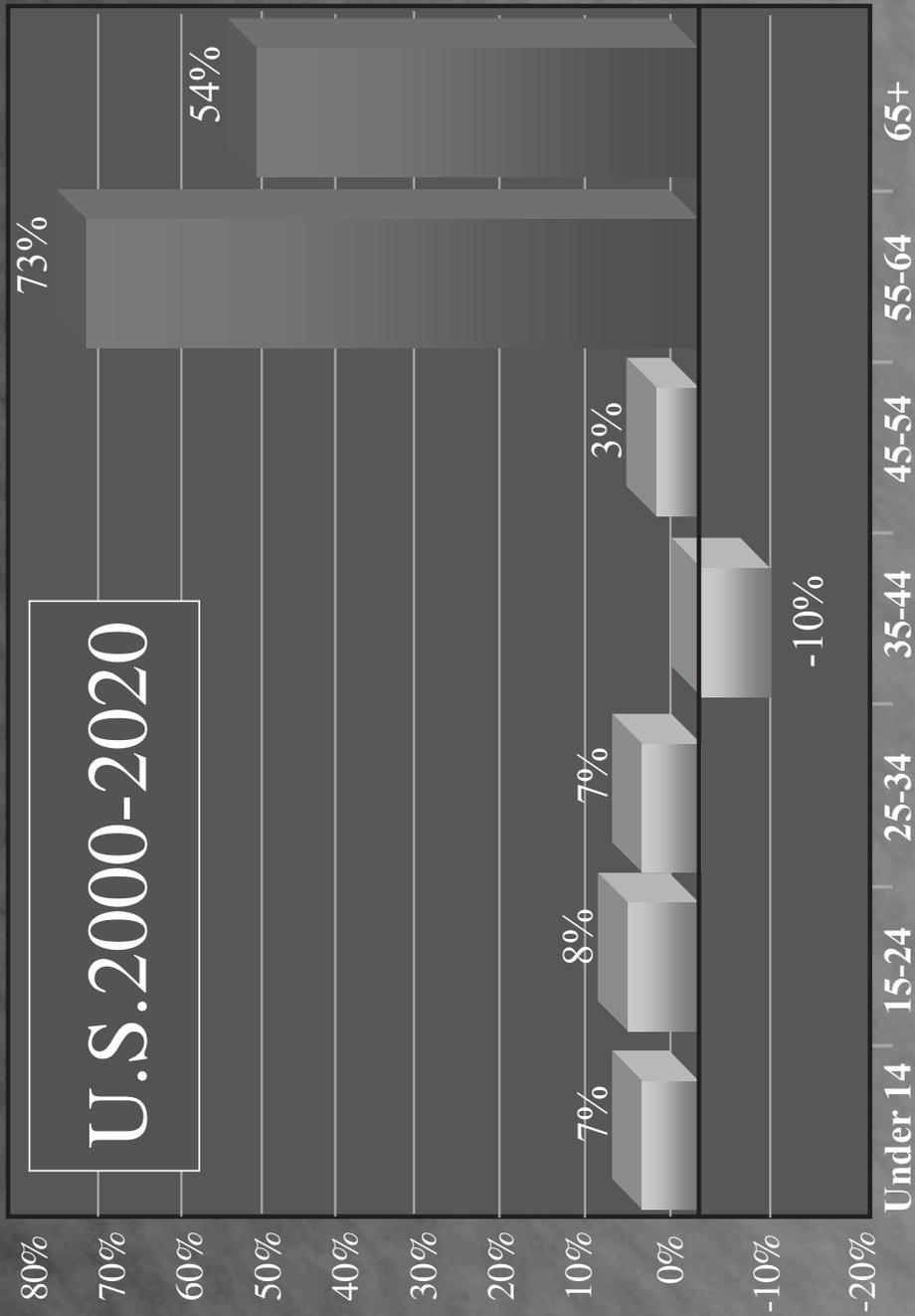
Source: U.S. Census, 2000

Change in Population Growth



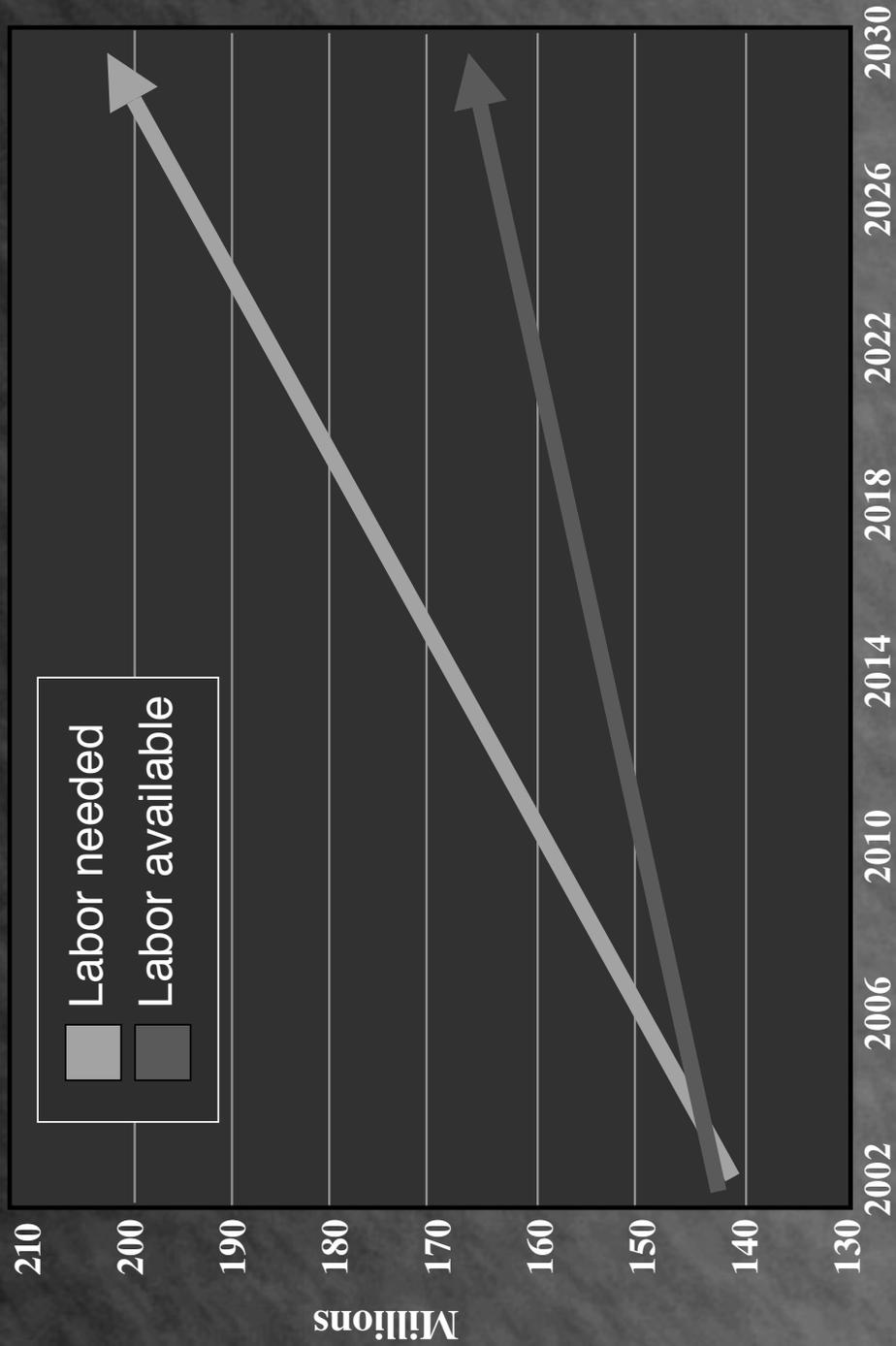
Source: U.S. Census, 2000

Change in Population Growth



Source: U.S. Census, 2000

Labor Force vs. Labor Force Demand



Source: Employment Policy Foundation analysis and projections of Census/BLS and BEA data, *American Workplace Report 2002*

BusinessWeek

SEPTEMBER 26, 1999

A PUBLICATION OF THE McGRAW-HILL COMPANIES

CBS & Viacom
The right strategy?

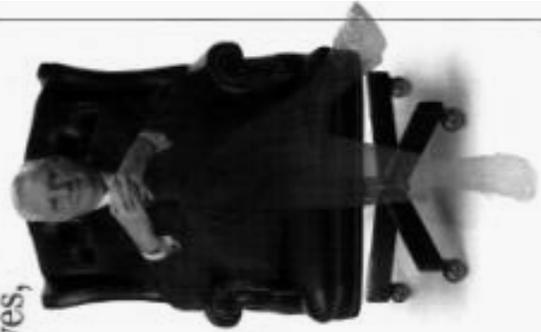
Finance
High-tech money laundering

Ellen Marram
Her new Web job

Politics
Wooing the working mom

BRAIN DRAIN

With older executives set to leave the workplace in droves, Corporate America is facing a dramatic talent shortage. Here's what smart companies are doing to keep their senior stars on the job.



4. Re-Inventing Retirement

The Four Faces of Retirement



AIG SunAmerica
Financial Network

Ageless Explorers – 27%

- Youthful, Empowered
And Optimistic
- Extremely Happy
- Love Retirement Freedom
- Seek Involvement,
Personal Growth,
Work and Reinvention



Comfortably Contents – 19%



- Living their “Golden Years”
- Content to Enjoy the Fruits of Their Labor
- Want to Relax and Play
- Seek Freedom from Work and Social Responsibilities

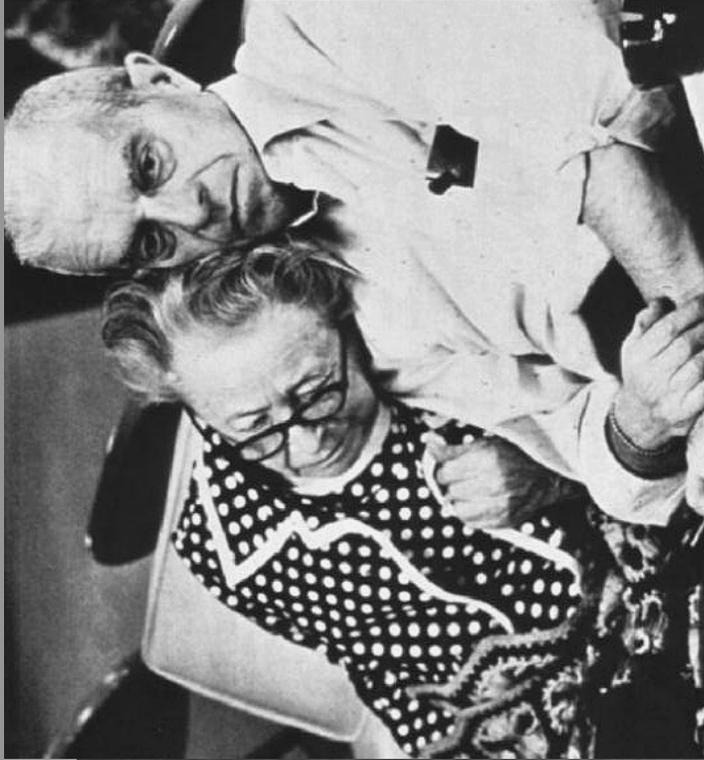
Live for Today's – 22%



- Are Fun and Adventurousome
- Have Pursued Active Lives and Personal Growth
- Are Financially Unprepared
- Are Anxious about Retirement and Have Many Regrets

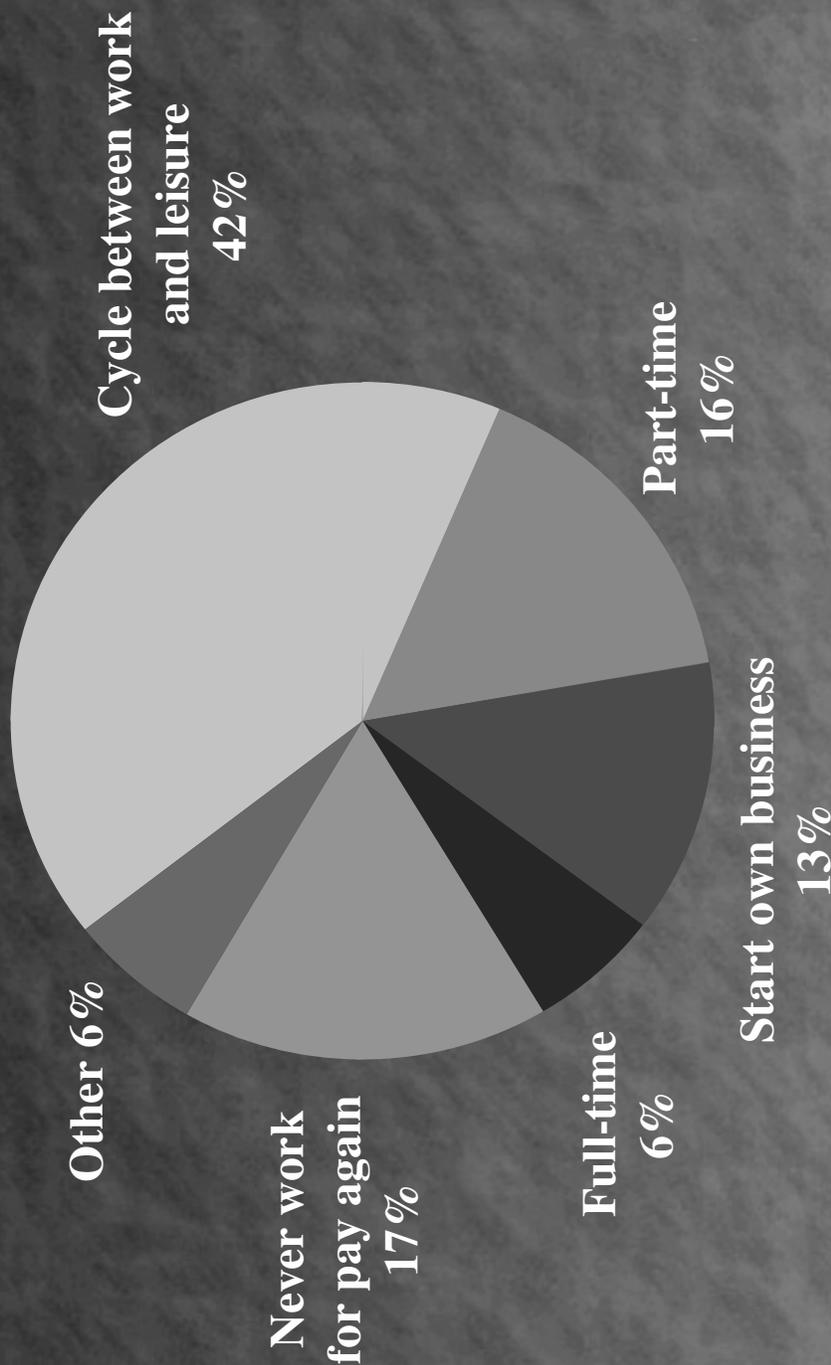
Sick and Tireds – 32%

- Inactive and Unfulfilled
- Worried about Everything
- The Least Happy
- Have Given up and have Little Interest in Anything



A “Cyclic Retirement” is the New Paradigm for Work in Later Life .

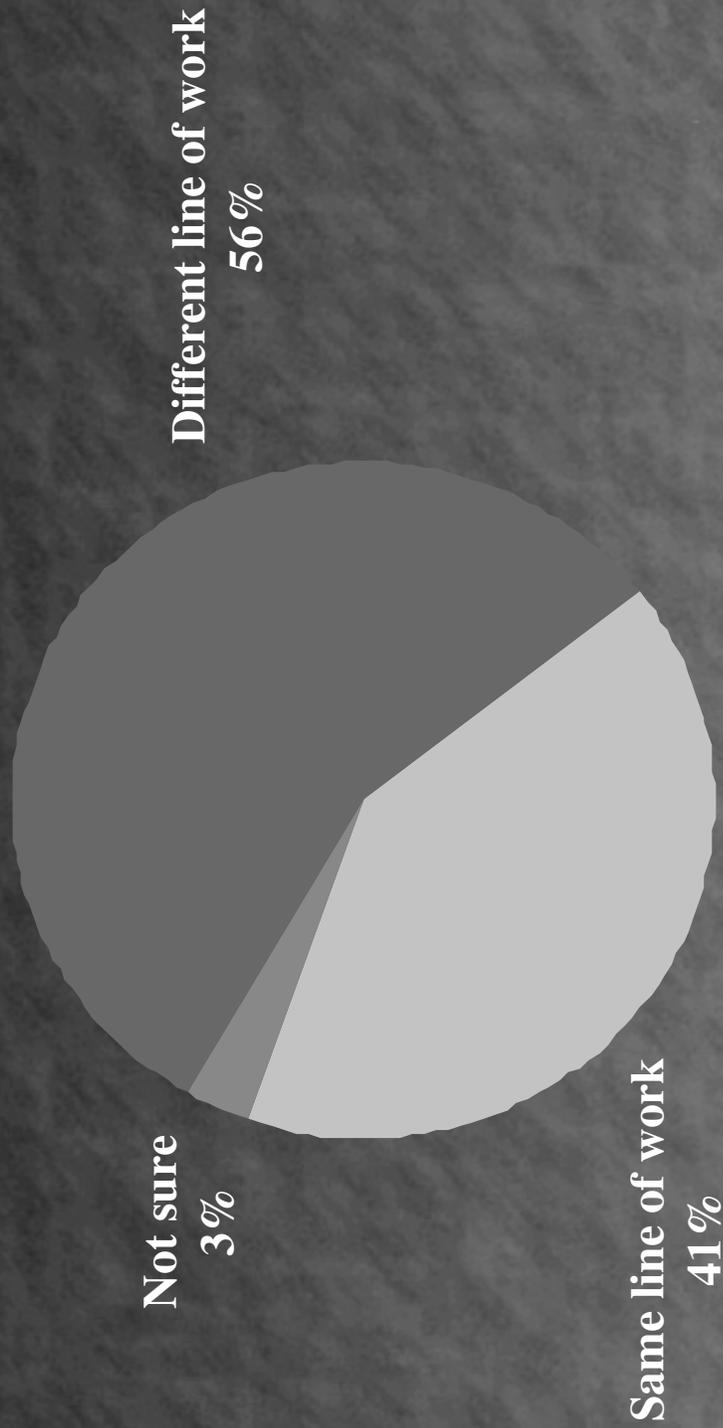
“Which represents the ideal plan for how you will live in the next stage of your life?”



New Retirement Survey

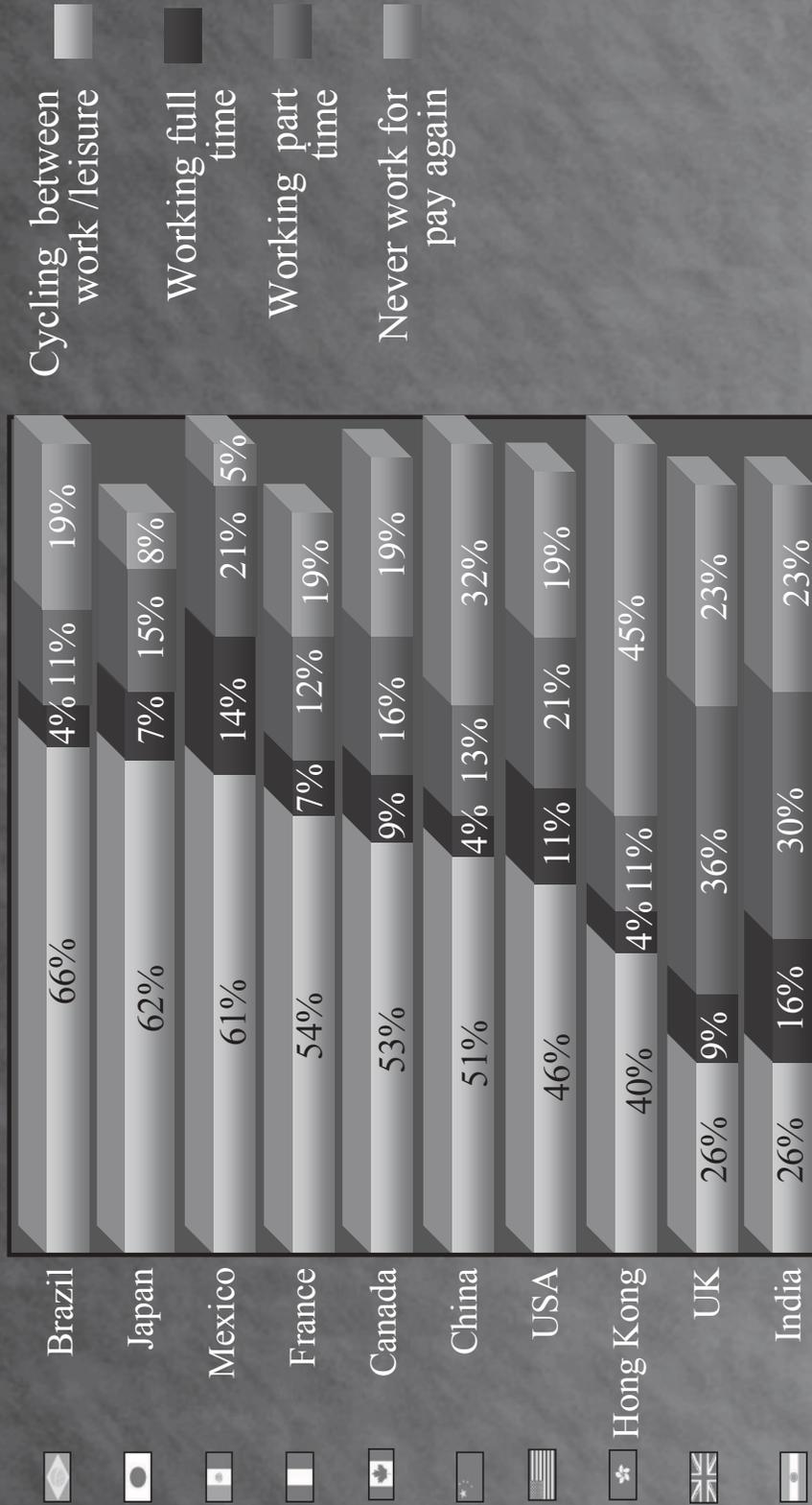
Most Boomers are Considering a Whole New Line of Work After Retirement

“Will you work in the same line of work or a different line of work?”



New Retirement Survey

How Would You Like to Balance Work, Leisure and Money in Retirement?



Source: HSBC Future of Retirement Survey

Webster's Definition of Retirement

- to disappear
- to withdraw



Source: Webster's New Twentieth Century Dictionary

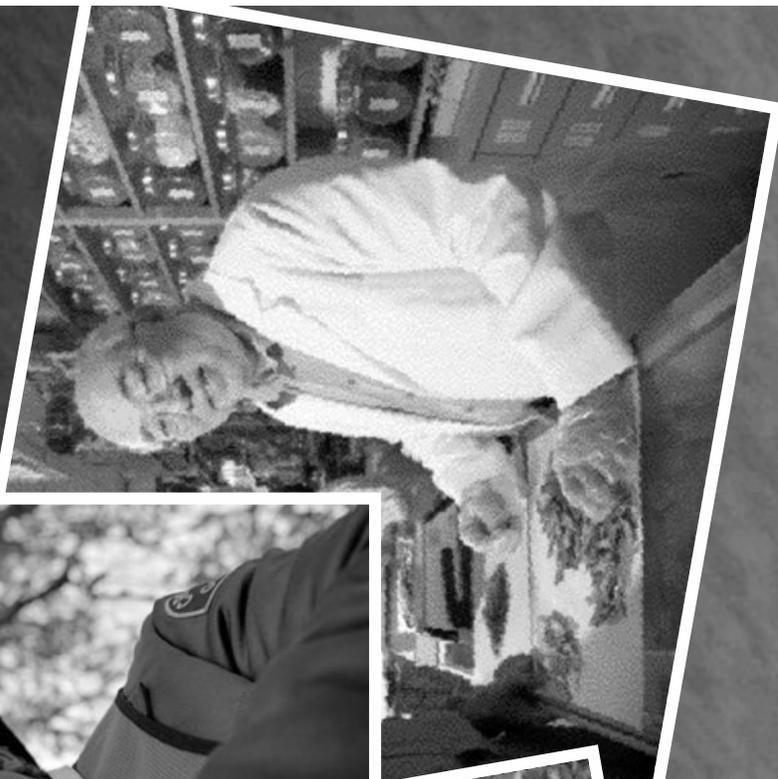
The New Definition of Retirement

- be connected
- to re-invent



The “New” Role of Work

Self-Worth



Social Connections



Earn a Livelihood





John Glenn
Returned to
space at 77

**Maya
Angelou**
One of the
world's most
renowned
poets at 78





**Warren
Buffett**
Investment
mastermind at
85

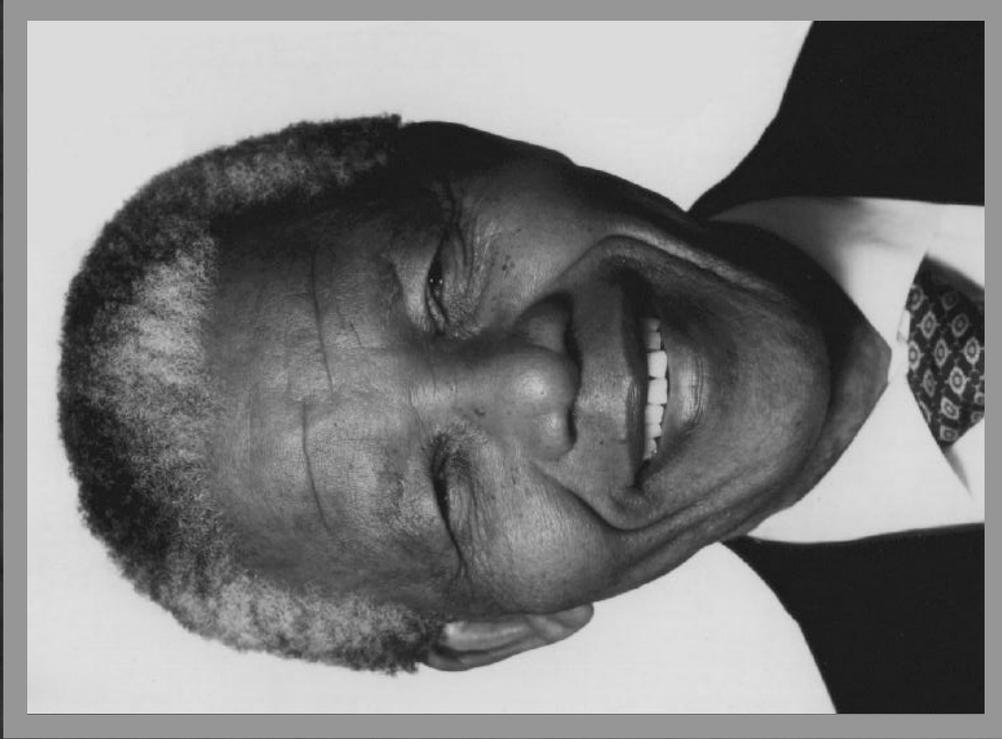
Sophia
Loren
Still beautiful
at 71





Joe Paterno
Still coaching
Penn State
football at 79

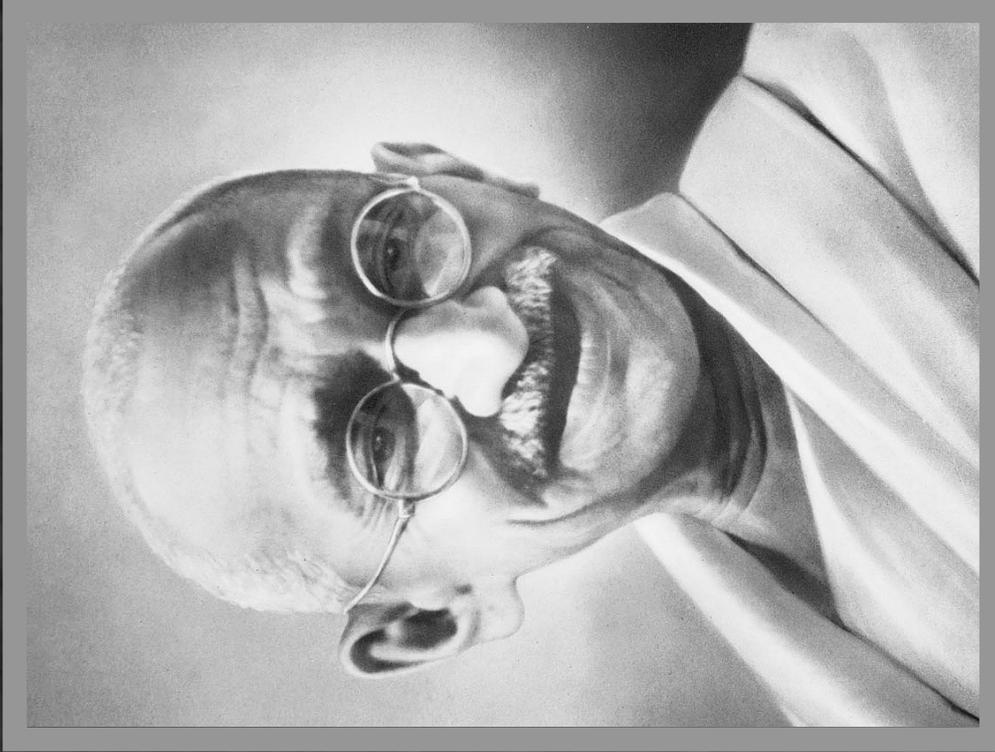
**Nelson
Mandela
Won the
Nobel Peace
Prize at 75**





Golda Meir
Prime minister
of Israel from
ages 70 to 76

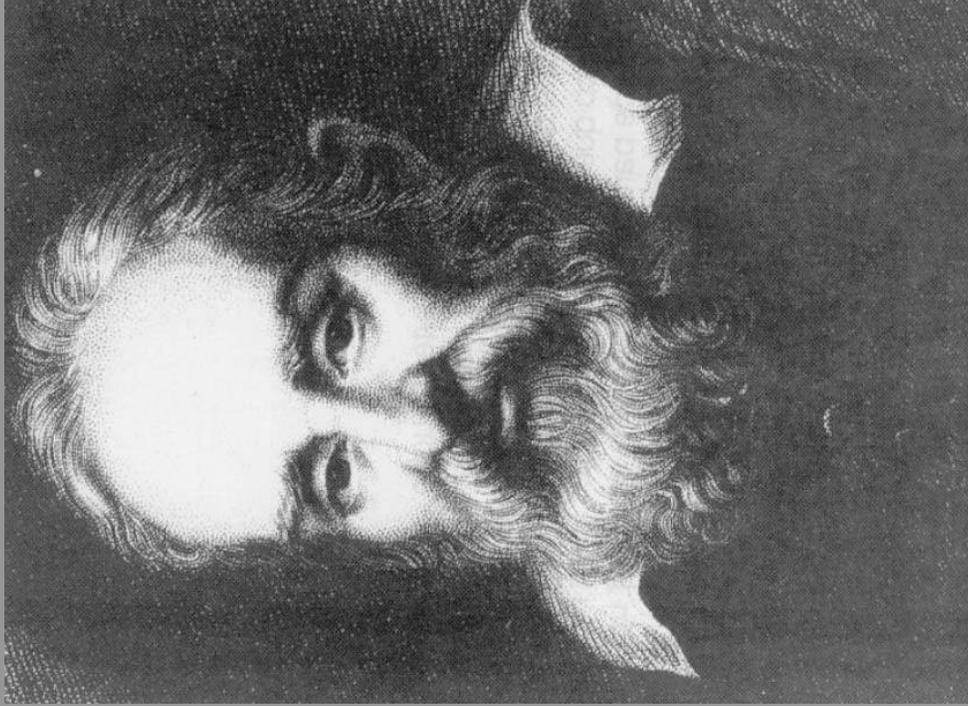
**Mahatma
Gandhi
Completed
successful
negotiations
for India's
independence
at 72**

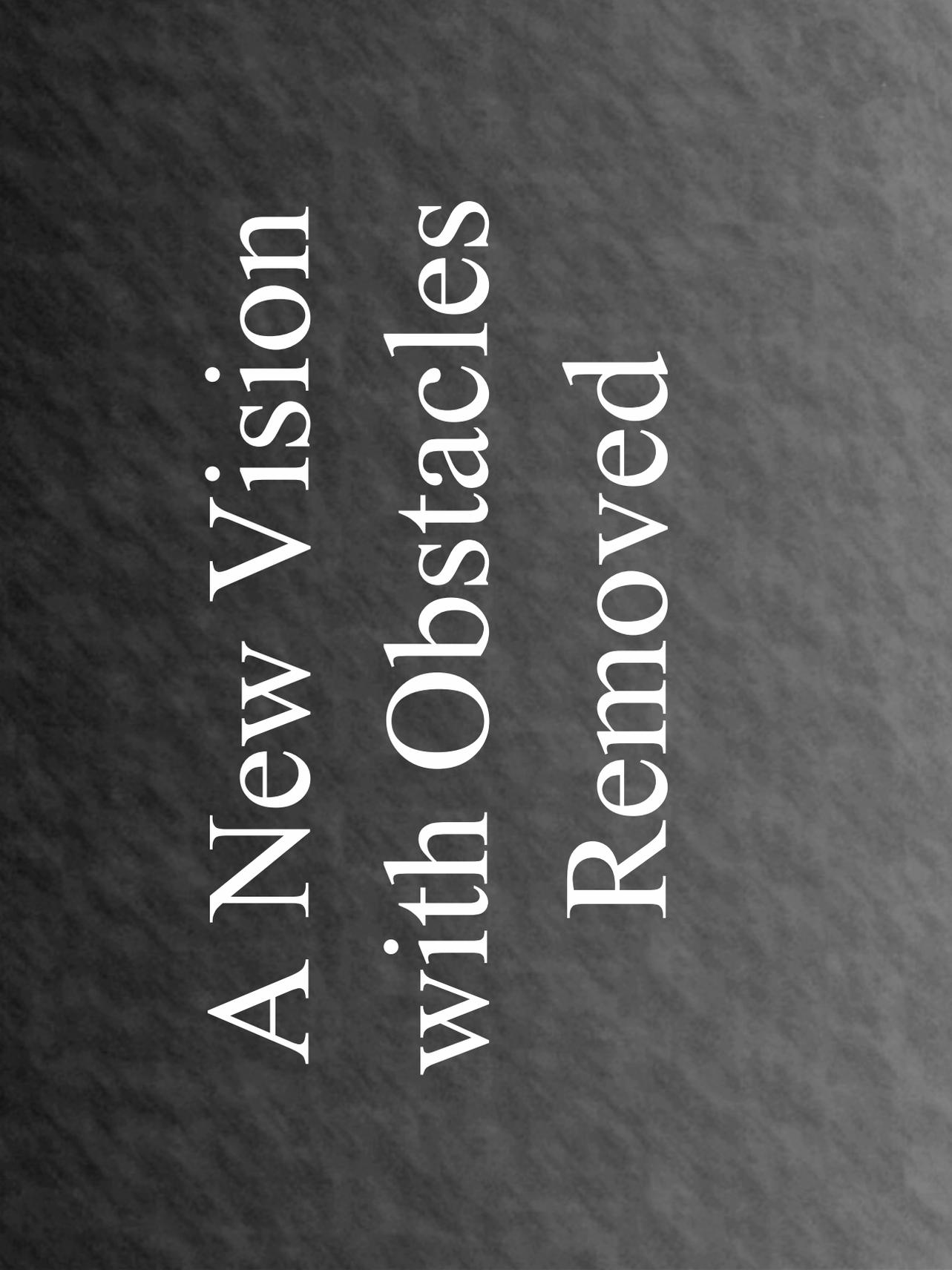


Noah
Webster
Published An
*American
Dictionary of
the English
Language* at 70



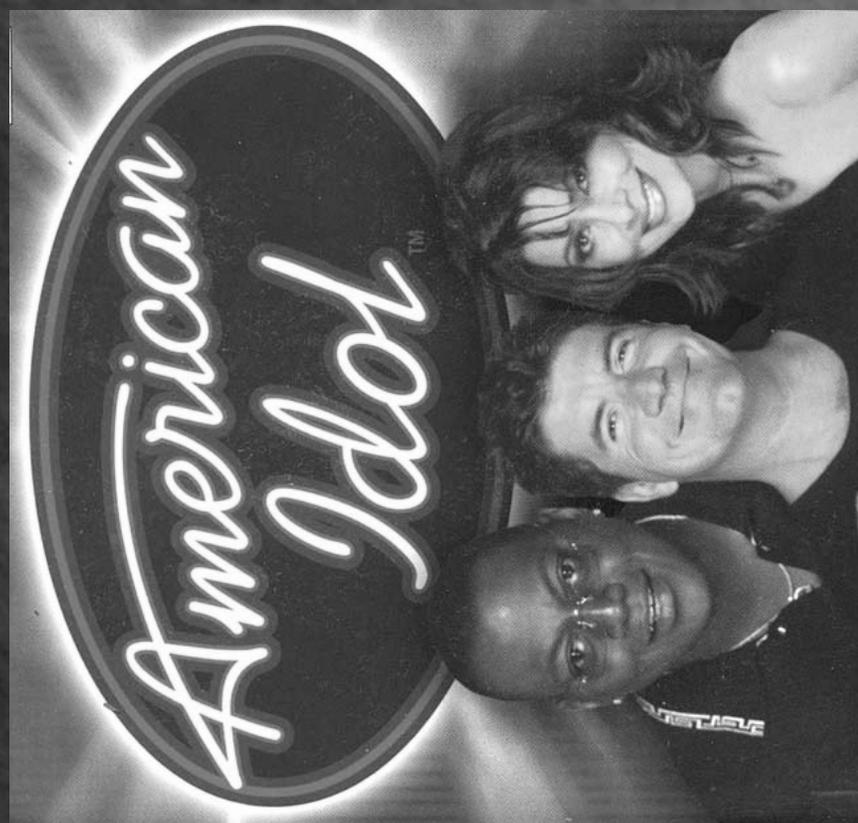
Galileo
Published
Dialogue
Concerning the
Two New
Sciences when
he was 74





A New Vision
with Obstacles
Removed

Eliminate Age Discrimination



Remove Disincentives to Continued Work



Mentoring, Flex-Retirement, Sabbaticals and other Innovations



Support Retraining and Career Reinventions



Support Assistive Technologies in the Workplace



Encourage Volunteer Contributions



Effectively Manage Age Diversity



Create a Society-Wide State of Aging Readiness



Prepare for the Coming *Age Wave*

2005 WHCoA

The Past, Present
and Future of Work
(and Retirement)

Ken Dychtwald, Ph.D.

White House Conference on Aging Policy Tracks

December 12, 2005

SPEECH BY

ABIGAIL TRAFFORD, AUTHOR OF MY TIME: MAKING THE MOST OF THE BONUS DECADES AFTER 50 AND HEALTH COLUMNIST OF THE WASHINGTON POST

The Community for Aging Well

My grandson is six years old. He lives in Staunton, Virginia, several hours away from Washington. I see him every month or so. Each time, he is changed significantly. And I think: now he's the one who is really aging fast! And wouldn't it be nice if every time he saw me, he'd throw his arms around me and say: *Oh my, Granny, how you've grown!* This is my message about aging: getting older is about growth and development. Our culture, so rooted in youth, is trapped in prejudice and ageist stereotypes. Yet with the graying of the population we are in the midst of a social revolution that is changing every aspect of our lives. We need a new language: Words such as "retirement" and "senior" don't describe aging today. We need a new infrastructure to educate, train, employ and nurture older men and women. We need a new culture that embraces living longer instead of denying it.

Longevity is not just about adding years to the end of life; it's about adding years of health and vitality before the end of life. Researchers at the MacArthur Foundation Aging Study estimate that we have gained on average ten biological years. This is huge. The AARP headline — 60 is the new 30 — is an obvious exaggeration, but the principle is correct: we are biologically "younger" than our grandparents were at the same age.

As a result, a new stage has emerged in the life cycle, a bonus period of vitality after mid-life but before traditional old age. I call this new stage — "my time" — because it is up to each of us to chart a new path. There is no road map. We are pioneers, the first generation to explore both the potential and the perils of living longer and healthier. My Time comes when the traditional adult tasks have been completed: the children are raised, the resume is fleshed out and then what? What do you do for the next 20, 30, 40, 50 years — a whole lifetime in generations past!

Men and women in the bonus years want to work and craft a legacy. Many want to give back — to their families, their friends, their communities. We often want to study and pursue creative works. We see ourselves as stewards of future generations. And we have a sense of urgency. After 50, there are frequent meetings with mortality. Chances are that we'll have these bonus decades, but we also know

they could end tomorrow. In fact over a long life span, many of us shift back and forth between being healthy and independent and being sick and needy.

All this presents a huge challenge to society. Those of you in the field of aging face a dual mission: to care for the sick and needy — of any age. There can be no slippage in fulfilling this social obligation to care for the frail. But there is also this new challenge: How to support and engage this unprecedented population of healthy older people.

Let's turn to the vision of what a community for aging well should look like. What are the essential elements?

Number One: Meaningful work and activity.

To age well, people need a purpose. In other words, jobs, jobs and more jobs! Surveys show that most boomers want to continue to work in their bonus years. As we've heard in previous speeches, many will have to work and earn money to support themselves. Others want to "give back" and do community service. And many want to work part-time. As Phyllis Moen of the University of Minnesota points out: what's so sacred about the 40-hour work week? Why not have 10-hour work units. Some can work two units a week, some ten units.

But where are the jobs? In the private and public sector? Age discrimination is prevalent in many companies. . . . Volunteer agencies are not prepared to use the talents of the boomer generation as it enters the bonus years. We are talking about a major restructuring of the workplace and the notion of work. Laws and regulations have to change to allow people to work after they officially retire.

Education has to open up to this generation — to train older men and women for new careers, to stimulate their minds and hearts. Why do we go to college only when we're 20 and not when we're 60? What would be the curriculum for a general degree in wisdom?

I was just talking to a man who is a lawyer and had served in Congress. He would like to teach high school students. But he would have to complete a several-year-long teacher training course geared to 20-year-olds. Why can't educational institutions design a credentialing program for people switching careers in their bonus decades to credit experience and expedite the training process?

Number Two: Social Support

To age well, we need an intimate circle of family and friends. The good news is that the family norm is now four generations: children, young parents, all of us in this new stage, and frail relatives. For the first time there are two robust generations to care for the two dependent generations. Care-giving crosses all generations. Older men and women are caring for and mentoring their grandchildren and children — emotionally and financially — just as they also depend on their adult children and grandchildren when they need care. Can we look at care-giving across the age spectrum and create programs and laws to support care giving in all generations? Respite care and tax breaks for grandparents raising grandchildren as well as grandchildren tending grandparents? Day care centers

for young and old?

Friendship is critical to health in these years. (Friends are people you can't imagine life without. They can be a spouse, a neighbor, a former schoolmate, a geriatric nurse.) How easy is it in your community to see old friends and make new ones? To take courses together at your local university? To go dancing and fall in love — again? To be cherished and cared for in time of need? To share stories, review the past and seek a spiritual anchor?

Whether we live in a nursing home or our own home, we need to create a web of kinship to sustain us.

Number Three: Resources

Where is the community center to provide information, guidance, support and connection? You notice I haven't used the word Senior Center. Centers all over the country are struggling with this word, Senior. As the boomer generation takes its place in the aging hierarchy, "senior" is associated with a stereotype of decline and dependency. In Arizona, people who "retire" there—another dicey word; people don't retire, they don't withdraw from life and disappear at this stage! Anyway, these new arrivals were refusing to go to senior centers because they didn't consider themselves senior. So the state has created a network of centers in public libraries called something like 'life option cyber cafes' in which older people can come in and get a cappuccino, hang out with peers and get all the services that a senior center would provide.

Every community needs a center to be the one-stop shopping place to coordinate services for older people and help them to find jobs, travel opportunities, home-health aids, exercise and nutrition classes, nursing care and the like.

Another obvious essential is an adequate health care system, which has been discussed by previous speakers. But what about mental health care? Communities need to pay attention to the mental health of older Americans. Depression is a major problem that is only recently getting attention from the medical establishment. (The highest suicide rates are among white men over 65.) The thinking was, you're old, you're depressed, of course you're depressed—you're old! That's AGEISM!

We encounter many losses in this stage—the deaths of loved ones, setbacks in health, reverses in the workplace. Grieving loss is normal. Depression is a disease that must be detected and treated.

Communities also need a strong public health system that can take care of the frail in emergencies. That is one of the many lessons of New Orleans.

Finally, every community needs a physical environment that promotes healthy aging. It's fine for the Surgeon General to recommend 30 minutes of daily exercise—but are the streets safe for walking? Are there sidewalks and walking paths and parks to encourage physical activity? In Washington, a favorite place for toddlers and young parents is Turtle Park with its special gym sets, sandboxes and neighborhood coziness. Well, where are the Turtle Parks for us? Better yet, where is our special gym set in Turtle Park so that we could all play together?

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Transportation is another essential. Many families struggle with the driving issue — Is it time to take away Granddad’s license because he can’t see well enough at night? But in many areas, people depend on cars to get around. If it’s not safe to drive at night, why not have a restricted license? Meanwhile, are the streets well-lighted, the signs easily visible? Could cars be redesigned to be more aging-friendly?

Public transportation barely exists in many communities. Taxis are expensive and often hard to get. Where are the shuttle services and volunteer drivers? Liability regulations need to be amended and new programs initiated to provide affordable transportation so that older people do not become isolated and home-bound.

Housing is about to change. How do older people want to live? Alone or with others? In their own house or across the country in a retirement community? With their own age cohort or in a mixed-generational setting? My sense is that we will find new housing arrangements, less segregated by age, with more people staying in or moving to cities (where there is more likely to be public transportation, jobs, educational and entertainment opportunities, medical facilities). Maybe the commune idea will come back with individuals and couples coming together to form their own household community with built-in, family-like supports.

If we create communities with these essentials, we will create a better America. I don’t call it — ‘aging in place’ because that sounds too static. I think of it as: ‘Aging Better Together.’

Closing WHCoA Dinner: The Booming Dynamics of Aging: From Awareness to Action

December 13, 2005

REMARKS BY

ROGER BARNETT

CHAIRMAN AND CEO, SHAKLEE CORPORATION

Thank you very much, Mary, for a very kind introduction, and also for being an inspiration for me to be here this evening. Greetings, everyone! I really would like to thank you.

It is a privilege for me to be here tonight. I want to thank and acknowledge the governor, senator, congressman, and I also want to thank and acknowledge the Honorable Dorcas Hardy for chairing this incredible event, and Bob Abrams for putting together a wonderful exhibit that I think was illustrative. Most importantly, I want to thank you, the delegates to the White House Conference on Aging. And the reason is because you all have dedicated your time and your effort to the most significant and important issue that will help to define this country over the next 50 years. That issue is how we choose to care for those who cared for us. I think it will define us from both a moral perspective and, equally important, it will define us from the perspective of whether or not we continue to be the economic super power that we are today, over the next 50 years.

I believe that the aging of our population in this country calls for celebration. I think there are many things to celebrate—increased longevity, a better and well-lived life, and the experience that comes with age. There are some people who look at the aging of our population purely from an economic standpoint and with alarm. But I want to share with you this evening something that I am passionate about, and a 50-year old model of success and hope for our aging society. Perhaps it is a small model from some perspectives; it involves 750,000 people over the last 50 years. But this model shows how people can be successful, engaged, financially independent, healthy, and active as they age over a long period of time.

Just to give you a little bit of personal background, I spent the last 20 years of my life following my passion of trying to combine economic incentives and harness them for the greater social good. In other words, I was trying to use economic tools to make the world a better place. And one of my inspirations is sitting here tonight, which is my mother, who spent 40 years of her career at the Legal Aid Society in New York working with homeless families and the lowest income families in the city of New York. And after 40 years, she said to the family, “I’m going to retire.” I think my mother is an example, not just for helping to instill in me a desire to help other people, but also a model of what

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happens as one ages over time.

After she told me that she was going to retire, I said, ‘Mom, after 40 years of helping all these people, congratulations, I think you deserve some time off.’ And she said, “That is not exactly the retirement that I had in mind.” She said, “I’m now going to move to Washington because I have accepted the position to be the head of the Legal Services Corporation of America so I can provide equal access to the justice system for all Americans. I have in some respects followed my mother’s footsteps. I actually graduated from law school twice. The first time I was inside my mother—she was six months pregnant with me—and the second time I did it myself. I would like to let you know it is a lot easier if you go to law school with someone else doing all the work for you.

Now, back to why I feel that aging is a cause for celebration. I want to share this story with you tonight. But, before I do that, here is a picture of the economic doomsayers who spread all the negativity about what happens with aging. These are the people who look at the statistics and report that the ratio of contributing workers to retired beneficiaries will drop almost in half over the next 50 years. They say that our retirement cost as a percentage of GDP will double, and therefore, our great country will no longer be economically competitive. And they say that aging is a drain on our economy and on our population. I want to show you this next slide because I think there is another way of looking at aging. And I think we should turn the logic on its head because I would like to propose to you that there is a model for not making the aging of our population a drain, but actually using it to develop a competitive advantage for the United States vis-_-vis all the economies in the rest of the world.

The 50-year experiment was started by a gentleman at the age of 61 years old named Dr. Forrest C. Shaklee. He came up with a concept of trying to provide an opportunity for anyone—regardless of race, education, or economic background—to provide a way to live a healthy life and be a contributor. Over the last year and a half, I have spent time with these people. The idea that Dr. Shaklee started when he was 61 years old in 1956, now involves 750,000 people. The average age of these 750,000 people is in excess of 60 years old. Their average hours worked is 20 hours per week. Their average household income is in excess of \$66,000. And their average health care cost is the lowest of any similar cohort in any other population in the world. In the last 30 days, I was in 17 states of this great country and traveled to four different countries. I spent time with some of these people and I want to share their stories with you.

This is Rocky Pratt and Mollie Pratt, and they live in Florida. You may have seen Mollie in the Shaklee exhibition area. Mollie is age 64, and Rocky is 65. Rocky was an airline pilot, and he has been using Shaklee products for 29 years. This is Margarita Gerritsen; age 66 and a remarkable woman. I was with her eight days ago. She came to this country not speaking a word of English and not having many skills or a formal education. Today, she makes close to \$400,000 a year. She is working with her other family members and she is actively engaged in life. She is someone who consults and teaches,

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and she is a model for other people. These are pictures of what I think is healthy aging.

This is Dean Smith from Illinois. He lives right outside of Chicago, and he is 79 years old. He recently won the gold medal at the worldwide rowing championships in the United Kingdom. Cy Perkins is 96 years old, lives in Oregon, and started selling Shaklee products when he was 64 years old. He is a sprightly man and he is charismatic.

He sat in the front row of a meeting in Portland, Oregon. He said, “My driver’s license expires in 2010 and I plan to work until then.” Cy has incredible vision, and the newspaper wrote a story about him.

This is Al and Carol Hegerman. After Al retired from the police force, he started engaging in this 50-year-old business model. Now at the age of 77, Al called me up the other day and said, “Roger, I’m so excited about what I want to do. I’m going to spend two weeks of the year living in San Diego and two weeks a year traveling around the country talking to people about this concept.” This past year, the Hegermans made \$1.2 million.

This is Naomi Cranney. Naomi turned 100 this year. She lives in the great state of Massachusetts. I flew out for her birthday in June, and Governor Romney declared it Naomi Cranney Day in the state of Massachusetts. This is a photograph taken of her this past year in Hawaii. This lady is 100 years old, and she flew all the way from Massachusetts to Hawaii. Why? Because she earned a free trip—thanks to her efforts in building her particular business. She makes \$338,000 a year on her own. We had a meeting in Hawaii, and Naomi’s room was in the far corner of the hotel. It took her at least 25 minutes to get down to the meeting area. I saw her there and I gave her a big hug and a kiss. And I said, ‘Naomi, bless you, thank you for coming.’ Naomi said, “Roger, you know, they told me I didn’t have to come, but if there was going to be something new announced I wanted to hear it first.” That is her attitude. Beyond these examples are hundreds of thousands of other people who are aging in a different capacity. They are aging healthfully. They are aging in an engaged way. They are not only funding for themselves, but they are contributing to the tax base of the country. I would like to suggest to you, that after 50 years, there is something here. And I just want to present it to you because I think somewhere in here are the seeds of a scalable model that can help turn the aging issue on its head.

This country was founded 230 years ago with three founding principles. It is right there in the Declaration of Independence—life, liberty, and the pursuit of happiness. And it didn’t say in the Declaration of Independence that it was only available to a certain group of people. It did not say that people who are older are not entitled to life, liberty, and the pursuit of happiness as well. I would like to say that, in order to be successful, you need to engage in all three elements. The success of the people that you have seen, whether they are 65 years old, 75, 85, or even a hundred—living this incredible life—is because all of those components are fulfilled.

I like to interpret life, liberty, and the pursuit of happiness in modern terms. Life today is no longer just about breathing oxygen and being alive. It is a certain quality of life. And my mission in life—and what I have dedicated the rest of my business career to doing—is to try to add 10 years of productive

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life to the general population. You can call it healthy aging, you can call it successful aging, you can call it whatever nomenclature that exists. But I have seen examples of the people who add 10 years, and that is my personal goal. Now, how do we accomplish that? Thankfully, there are tremendous advances in health care and medical science; all these are terrific to preserve longevity. We happen to focus on prevention. We think that prevention is important; to try to give people time now before they get sick. I bumped into three people who came up to me here. One is a woman whose husband has been taking our products for 40 years. Now, it is not just our supplements, it could be anyone's products. The concept is to help people add to their regimen and to care for themselves. Nutritional supplementation can help prevent so many issues, and we think that prevention is important.

Liberty. In today's world, you are not truly free unless you have economic freedom as well. I think we have a moral and social obligation to care for those who care for us. And we are going to have to get clever as a group to figure how to fund that care on a long-term basis so that we can continue to meet those obligations. And we think liberty and financial freedom is an important component to it. So, these folks that have the lowest health care costs as a percentage of their spending relative to any other cohort also have liberty and financial freedom that they generated. And it is not something that has any prerequisites, except wanting to have a better tomorrow than they have today. And, finally, we have the pursuit of happiness. And you can see here, if you take a look at these images—there is a woman on the left and a woman on the right—and they are basically the same person except one woman is living an isolated life, alone, somewhere else. The other woman is engaged and active. There was a study at the Yale School of Public Health which suggested that people who have positive feelings about their aging can live more than seven and a half years longer than a cohort who does not. Now, this is where we can have a competitive advantage. If you could package and bottle seven and a half years of incremental life to someone, it is priceless. How much is that worth to people? What we have—if you allow people as they age to have life, liberty and the pursuit of happiness and economic freedom—can turn from becoming what some economists consider a drain into a force of contribution to the economy. And that contribution in my opinion is what can be a worldwide competitive advantage. Why? Because people who are living in the preventive health mode tend to spend less on health care costs. Therefore, if they are engaged in life, they can also trade some of that engagement and longevity that they will gain for additional income.

I think there are many models for successful aging over time which are designed for the middle and upper class. But what I am talking about here is not that. One of my most exciting meetings here in the exhibition center was with people who are working with low income seniors. I think the challenge is how our country will address issues that provide this opportunity for life, liberty, and the pursuit of happiness for everyone. I quoted some large numbers to show what some of the people I met are earning. The point I was trying to make was that these earnings came from people who would be considered, when they started, low income people. Perhaps they were low income people without

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the ability to speak English, or low income people without the advantage of a formal education. Now I've been privileged myself to go to some very fine institutions but, when I got out of school, I was trained for nothing. I would suggest to you that partnering the opportunity for people to live their true potential is a way to celebrate what we are trying to do. And the question is, 'Can we do it?' I did not discover this business model; that is why I am passionate about sharing it with you. I want to share it with you because I hope some seed of it will inspire you, whether you are a public services corporation and you provide public benefit, or you are a CEO at the conference. I have met probably a hundred thousand people over the age of 60 who are among the most dynamic, engaged, and productive people I have ever met in my life. And if you want a testimonial how they can help you in your business and why you should try to retain them, please e-mail me, call me, or write to me. The question is, 'Can we do this?' It is not easy, but I think this model is scalable.

Now, take the example of Roger Bannister. Until 1954, no one broke the four-minute mile. Not one person. They said it is physically impossible to do. This one man, Roger Bannister, came along and refused to accept the impossible as impossible. And he went and did it. Now, many others have broken the four-minute mile barrier, including high school students. This picture of a jet is a physical manifestation of what happens when you break the sound barrier. And most people said it was impossible—the physics will not allow you to break the sound barrier. The plane that did it, by the way, is located here in a museum in Washington, D.C. It is a physical manifestation of how the impossible can become possible.

The Statue of Liberty has a plaque, and most people do not read all the words of this poem. It says, "Give me your tired, your poor, your huddled masses," and that is where most people stop. But I think the other part is critically important, "yearning to breathe free." And my belief is that there are a lot of people who are poor, who are tired; who are yearning to live a different kind of life. I think that there is an obligation on our part to try to provide an opportunity for them. And the proven success model over 50 years says that if you provide an opportunity for these people who yearn to breathe free, they will do so. They will take advantage of it and they will provide a tremendous contribution to our society.

I want to thank you because this experience has broadened my own horizons. I do believe the principle of life, liberty, and the pursuit of happiness is the central issue. This is my vision of what American competitiveness will look like 20, 30, 40, 50 years from now. I want to take this aging population, celebrate it, and turn it into a competitive advantage as we go forward in the market. I salute you for the work you are doing, and I thank you very much for the privilege of addressing you. God bless you.

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[START RECORDING]

MALE SPEAKER: Ladies and gentleman, please welcome the chair of the 2005 White House Conference on Aging Policy Committee, Dorcas R. Hardy.

DORCAS R. HARDY: Good morning. This is the final meeting of the 2005 White House Conference on Aging and will be an opportunity for the policy committee to report to you the fruits of your labors, the implementation strategies. I want you to know that we are very pleased with the strategies that you have suggested. Many are innovative, all are focused, and I believe that you should be commended for doing a great job. Thank you very much. [Applause]

I had a chance to attend several of the sessions and I was very much energized by your enthusiasm and by your passion for these issues. Before I begin formally with just a few short remarks, I would like to note the Yeoman's efforts of pulling together all this material last evening. You see why some people in the audience are still, well they are trying to speak now as opposed to earlier. I would especially like to thank the track coordinators and just highlight them for you, David Podoff, a Social Security Advisory Board member and also former Chief of Staff to Senator Moynahan, who did the planning along the lifespan; the work force area, Angela Arnett of the White House Conference on Aging staff; the community area, Peggy Ingram

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of Meals on Wheels Association of America and of the Borden Group; Health and long-term living, we had Winthrop Cashdollar of the America's Health Insurance Plans and Todd Smith of the American Health Care Association. In technology, we had David Brantley with Department of Commerce, and the cross cutting area we had Mary Guthrie from the Administration on Aging. They, plus the facilitators, the issue experts, and especially Mike McClendon, deputy assistant secretary of policy at the Department of Veteran's Affairs and his staff and he is also chair of the Advisory Committee. Thank you all very much! [Applause]

Let me describe quickly how our session will proceed this morning. I will introduce the policy committee members within their tracks, and they will in turn present the summary implementation strategies that have been developed within each track of the annotated agenda that was developed finally, or was finalized, by the policy committee on November 3rd. They will broadly present each of the resolutions and highlight those strategies, which receive the most support, and each track presentation will run 10-20 minutes, depending upon the track, the number of resolutions, and we are all trying very hard to adhere to the schedule. Time constraints are severe, and we have a great deal to get through and to share with you. So, before we begin the presentations, I want to make sure we all understand what

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will happen after today. All comments in your sessions will be pulled together so that we have an accurate record from the cards, the paper on the walls, the docs, the laptops of the recorders, and I believe that today's presentations will highlight examples of those implementation strategies that you offered, that were strongly supported, as well as where there has been common ground and consensus. Where there is no consensus, both or all sides of the strategies will be reflected by the policy committee as we develop the final report. Minority views will be included in that final report and the final report of the conference will reflect the full breath of the implementation strategies consistent with the session. I expect all the materials and presentations will be published on the Web very soon. Give us a few minutes to rest, and we will also want to contact all of you via E-mail shortly, I am not defining too short or too long, to ask you to fill out a short post-conference evaluation. At a policy committee meeting in mid-January, we will discuss the draft and final conference reports. A draft report will be sent to the governors for their comments about mid-March. The final report will go to the congress and the White House in early summer. That is six months by law, and shared with all the delegates. Once these Power Point presentations are posted on the White House Conference on Aging website, as well as all the conference speeches, some of which are already

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posted, I hope that each delegate and each delegation will use these results to further advance the mission and the goals of the White House Conference on Aging. You have worked hard, but your work really has just begun.

So, are we ready? I think we are ready. So we will proceed in the following order. You will note that some of the larger tracks have two speakers. We are going to start with the workplace of the future and that presentation will be made by Tom Gallagher, a businessman, a former CEO of a Fortune 500 company, a great contributor to the policy committee's bipartisan collaboration, and Tom is also a caregiver to both a parent and a grandchild. When you ask Tom about what information he wanted included in his bio, he says "married 38 years to the same woman, four children, five grandchildren, and that is what matters." Mr. Gallagher.
[Applause]

THOMAS E. GALLAGHER: Thanks, Dorcas. I want to start by saying this has been an extraordinary experience to be involved with this conference, and just to thank all of you again. I know that it takes a lot of effort to get here, to participate, you have worked very hard, and it's been just an amazing experience for me, and very humbling. As Dorcas said, I used to run a very large company. We had about 60,000 employees, and I thought I knew a lot about workplace issues, but I have to tell you that in working on this

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conference, I have learned an awful lot more, including things that I really never even thought about, and that is one of the purposes of this conference is to get us all to think about things that maybe we hadn't thought about, that hadn't occurred to us before.

The workplace of the future, which is the track I want to talk about at this point, presents enormous challenges and opportunities, and I think you can summarize it very simply. It is really a very simple question. How do we make sure that everyone who wants to work, regardless of age, has a chance to do so? And how do we make sure that those people have that opportunity, because we are going to need every one of them. Those of you who saw Ken Diqwall's [ph] presentation on Monday, and saw that wave coming across, saw that there is a trough behind it, that in fact because the baby boomer generation is such an enormous part of our workforce. As that generation continues forward in its lifespan, we are going to need a lot of them to remain engaged in all of the kinds of activities both for pay and in volunteer capacities that we have all talked about.

So, let me jump quickly to the resolutions. The two that we are going to talk about, give me the next slide. Resolutions No. 11 and No. 12, remove barriers to the retention and hiring of older workers including age discrimination, and promote incentives for older workers to

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continue working and improve employment training, [inaudible] every training program to better serve older workers. Next slide.

You know better than I, we had standing room only in those sessions, we had broad representation, and I must say I listened in both sessions as well as many others, and I have never been involved with a more articulate group of people, especially folks who are very well versed in the area of older workers. Next slide.

The morning and afternoon sessions agree that they wanted to present the strategies with respect to both of those resolutions and so that is the way we have reported them. As Dorcas said, these are just examples. We had many strategies that had very strong support, and what I am trying to do is highlight some of the ones that received the greatest support as well as a couple of examples of others that had strong support. Next slide.

Examples of the ones that got the strongest support, a number of them had to do with Title V of the Older Americans Act. That is the senior community service employment program. That is one that many of you know better than I. It provides part-time employment opportunities for low income individuals over the age of 55. Next slide.

Another one was focused on Title V, which was to eliminate the income eligibility requirement and encourage

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greater collaboration with the Work Force Investment Act program. A third one, again focusing Title V, these all had very strong support and in fact, I think it is fair to say that of that group, or that session, those were the strongest supported. It was to create a frontier section really to recognize the fact that our rural communities, and coming from Nevada, that is a particularly significant issue in my experience, to create greater flexibility for rural communities. Next slide.

Another of the strategies was to remove impediments to phased and flexible retirement options to encourage multiple work options for older workers and businesses, and some examples of that, I'm sorry next slide. I'm ahead of myself. There we go.

Examples of how to do that, and there were many others that will be included in our materials and ultimately in the report, but a couple of examples, permit pension payments to older workers who want to continue working, but want to cut back on their hours. As you know, that has been a problem in the way that our pension rules are designed. Similarly, take a look at ARISSA and ADEA and IRS provisions that discourage continued employment of older workers. Next slide.

Other examples of strategies that had strong support include providing greater access for educating and training

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older workers through education grants and tuition waivers, innovative financing mechanisms, and one example that somebody put forward was the notion of a training education 401K, a separate that you could in fact start saving to be able to fund your own retraining opportunity. Another was to create a task force within the Department of Labor that would focus on issues surrounding older workers. Next slide.

Finally, some other examples of strategies that had significant considerable support, and these are ones that I am particularly interested in, educate employers on the increasing value of older workers, particularly in light of baby boomer retirements. What I was saying a moment ago, we are going to need people to stay in the workforce, and one of the things we need to do is to find ways to encourage that, remove the disincentives, and in fact take advantage of the tremendous skills and the reservoir of talent that that generation represents. Secondly, encourage employers to provide employment benefits that assist in retention such as pre-retirement training and financial planning, health insurance, leisure and work options for re-career purposes, and finally flex time and job sharing options. So, those are examples, as I said that is not a complete list by any means. We had an enormous list of strategies, the group worked very hard, and I thank you again for the time and effort you put into it. So, thank you very much. [Applause]

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DORCAS R. HARDY: Our next track is our community, and before I introduce the two gentlemen, I do want to remind you these slides will go up on the web very soon. So, you don't all have to be taking absolute notes here. Our community is going to be presented by Clayton Fong and Bob Blancato. Clayton Fong is the executive director of the National Asian Pacific Center on Aging in Seattle. He has been cochairman of the social support subcommittee which has fed in and community has been part of that, which we all like to call the "kitchen sink," we've got everything in there including diversity issues as well as diverse issues around community civic engagement and marketplace. He is also a member of the policy committee executive committee and has served as chairman of the delegate selection committee.

Bob Blancato is president of Motts Blancato and Associates. As most of you know, he was the 1995 White House Committee on Aging executive director. He has provided invaluable advice and counsel to all of us, especially me, and he is a member of the executive committee and vice chair of the delegate selection committee, and he has traveled tirelessly to reach out to all of you predelegates as well as delegates. Before you were delegates, your groups around the country, and he has given support to the success of this conference. Mr. Fong and Mr. Blancato. [Applause]

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CLAYTON FONG: Thank you very much. We have 12 resolutions to cover, so we are going to get straight into it. I will say only though that we are just pleased and proud that this process was inclusive. It was thorough. You all did a great job, and these are going to reflect it. They are not everything. They can't be, but we are going to try to hit the high points. The first one is the resolution No. 17, the reauthorization of the Older Americans Act. I suspect half of all the delegates attended one session or another. There were an awful lot of folks that went to that one, and I think that was a good sign. Clearly, if there is something that we can do immediately, and based on following that resolution, that is to get to work on in the next six months to get that one passed, and passed quickly.

A couple of quick high points, top implementation strategies would be to increase the broad resources within that in terms of funding, in terms of resources for the simple reason of the growing demographics and the emerging community and how do we serve the baby boomers better. Secondly, a lot of discussion occurred around legislative advocacy, and how do we mobilize? Every one of us needs to get out there after this and go back home and make sure that we know that this is a priority, and so your job is to do that, and we talked a lot of about the advocacy, about bipartisanship, about how this is an Act that no one can

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disagree with, that it is absolutely essential to the underpinnings of the broad cross-section of serving elders around the country.

A couple of other things, looking at and create and Act to title under the Act that actually would allow for and provide for some preparation by the State Unison Agency, the Triple A's, the Tribes, and what have you to really focus on and meet the challenges of the emerging baby boom population and the growth in numbers. The Senior Community Service Employment Program, we talked about it already, but I will touch on a couple of other points, maintaining the dual structure, community service, and employment training and how critically those intertwine to best serve elders. So many elders, when they look at jobs at that phase are looking not only for employment options but the opportunity to make a difference, and this really does provide that. There was also discussion within that program to make sure the resources are there, to make sure that we reach and conserve a growing, but also a growingly diverse elder population, that is ethnically as well as geographically.

The Caregiver Support Title was discussed and we wanted to make sure, there is another resolution on that so I won't go into as much detail, but to talk about serving across all generations regardless of age, and you know, I'm not saying next slide am I? Oh, this guy is good. [Laughs]

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The Indian specific provisions of the Older Americans Act clearly need to be talked about, elevating the director of the American Indian office within Administration on Aging, establishing or reestablishing the occurrence of an Indian White House Conference on Aging. Maybe we all could take an idea on that one. In addition, we wanted to talk a little bit about other titles and areas, and certainly including Title VI and Title VII and the resources that are needed to really continue to serve a very tough population.

Last, but certainly not least, the bedrock in that Act is nutrition and meal services, and I think there was a lot of discussion around integration, which I think is key because it's not just about providing meals and providing meals hopefully three days a week or three times a day, seven days a week, but also to integrate in education and counseling and assessment, and that it is a really great opportunity to reach folks in their homes. That was obviously an important area. I know that is a long one. I don't think the rest of them will be quite as long, but that one really had a lot of folks there so we didn't want to short change it. To you, Bob.

BOB BLANCATO: Thank you, Clayton. [Applause] Good morning. Next slide please. The next slide is one of the blended resolutions that I think in many ways reflects an implementation strategy that involves local, state, and the

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national government to develop innovative housing designs to promote livable communities that enable aging in place. Two important terms that reflect looking to the future, livable communities and aging in place through changing zoning and building regulations, to include variety of choices, to encourage local building codes to require universal design, something that has been discussed quite a bit in this country, and next slide, changing of different zones and codes. Next one I think after that.

Again, another emphasis on universal design for new housing through interesting concept, education and training of builders, developers, designers, to make housing more senior friendly in the future and to provide tax incentives to achieve livable communities through housing. Clayton?

CLAYTON FONG: Thank you, Bob. Next one, encourage redesign of senior centers for broad appeal and community participation. Well, I wanted to hit on two or three important points that were the top go getters. Expanding the role of senior centers is really a focal point for reaching and serving seniors, and I think a lot of us can certainly relate to that in terms of an infrastructure and a backbone that really can get to seniors in their communities where they live, play, and pray. In addition, we wanted to talk about integrating senior centers with health care systems, service providers, community based organizations, businesses,

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public and private organizations, and also to make sure that we can serve culturally diverse and emerging communities, both ethnically as well as geographically. Thirdly, I think this is an interesting one, would be to create a separate title distinct within the Older Americans Act for the specific purpose of multipurpose senior centers as a fundamental building block to begin to serve seniors in an area. [Applause]

There shall be, and I think this is an important one, too, and that is that we should emphasize that seniors really are the place and focal point, and I know that sort of reiterates what we said, but it is the place and the focal point to getting to and reaching seniors and we thought it was important that we emphasize that role and THE is in capital letters. Back to you, Bob.

BOB BLANCATO: Next slide and I have to admit to being a little happy to be able to take this one. We are looking for a short-term and long-term commitment to elder justice in this country, and we will achieve it through this resolution and its implementation strategies including the passage of the bipartisan Elder Justice Act to finally build the capacity of adult protective services to do their job better by having specific funds and specific responsibilities to help in the fight against elder abuse, and this last one is a very interesting one to have an elder abuse awareness

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postage stamp. Knowing how successful those endeavors have been in other areas, it would do a fabulous job to raise awareness on this issue. Clayton. [Applause]

CLAYTON FONG: All right. We have got another important area, and that is transportation. Who doesn't relate to transportation? I think it got a lot of support. Two areas of transportation, both to deal with mobility and to help people continue to drive but the other side of the coin was once you couldn't, what other options would be available for you? Not in any specific order, requiring public transportation organizations and local governments to participate in disaster preparedness. I think that is a key one in light of what has happened with Katrina and a lot of the national disasters that we have seen. Additionally, we were talking about creating a line in the Older Americans Act that would really talk about and focus on support for transportation for elders across, and I think elders' ability to get services, transportation is critical to getting to getting services, without a doubt. The other area that I would like to talk about is senior friendly road and vehicle design. We have got to talk about folks being able to drive, and I suspect everyone in this room knows someone who has lost their driver's license. I know my parents did within the last three years, and it is a tough one, and so we wanted to talk about senior friendly road and vehicle design, but

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also about screening, rehab, and training to help people to continue to drive based on ability, not on age. Back to you, Bob. [Applause]

BOB BLANCATO: Next slide. Again, a blending of two resolutions but the fact that they both made it I think is indicative of how important housing will be to the future of aging in our country and especially to aging in place in our country. Increasing housing supply and options through combinations of governmental initiatives and tax credits, to encourage the private sector to provide senior housing in corporate campuses, and changing local laws that inhibit the growth of senior housing. Secondly, a federal housing trust fund of \$500 billion dollars and other mechanisms to meet planning and development needs for low income and disabled older adults to meet a critical shortage that we anticipate in the future, and to remove unduly burden some regulatory obstacles of building senior housing throughout communities. Next slide. Clayton, I'm sorry, it's yours.

CLAYTON FONG: All right. This is certainly an area that is indicative of how we are responsive to issues that hadn't really quite frankly come up in the past, and that is encourage the development of and coordination of federal, state, and local emergency response plans for seniors in the event of public health emergencies and disasters. No doubt one of the areas a lot of discussion was around tracking

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vulnerable individuals, and nothing could be more illustrative of that than what we saw a few months ago. But, I think what was really interesting in that area was the discussion of incorporating technology, whether it be GPS systems or other kinds of activities that would really assist both first responders as well as government agencies to really make sure that the most vulnerable citizens can be evacuated effectively and quickly. The other big area but I will summarize it, next slide would be clarifying the role and responsibility of the federal, state, and local governments, but also other agencies in terms of the need to make sure that the left hand knows what the right hand is doing, and that preparations have been done well.

The last area is to create a system for ensuring resources are expended on existing network, and I think that really just means in the senior area we haven't been focused on disaster preparedness, but there is a heck of a network, particularly in our aging network, and we have got to figure out how to leverage and utilize it to make sure that seniors are safe in the event of a disaster. Back to you, Bob.

BOB BLANCATO: Finally, the best resolution is many ways to carry over an extension of an important area in the 1995 White House Conference on Aging dealing with older adult caregivers raising their relatives' children. A series of important implementation strategies, getting to the basic

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rights and requirements of allowing relative caregivers to do simple things like sign affidavits to enroll children in school, to ensure that government programs including navigator programs offer an array of services to all relatives raising children. Thirdly, the outreach and education that is culturally and socioeconomic sensitive directed at caregivers, schools, and the public at large, which we all need, we must do, and provide adequate funding for grand families with focus on some very specific programs including the very exciting Legacy Program that has just got its initial funding this year and offers great hope for the future in this area, and reauthorization of the Indian Health Care Improvement Act is also critical to this implementation strategy. I, too, say thank you to all you delegates for the important contribution you made to this White House Conference on Aging. Thank you very much. [Applause]

DORCAS A. HARDY: Our next presentation focuses on planning along the life spans. Senator Larry Craig and the Honorable Barbara Kennelly. Senator Craig, who many of you met last evening, is past chairman of the Senate Aging Committee and now chairman of the Senate Veterans Affairs Committee. He has been chairman of the Economic Security Subcommittee which includes planning along the lifespan and the work place. He has actively participated in the policy committee business, despite a very heavy congressional

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schedule and we are most appreciative. Barbara Kennelly is the former congresswoman of the great state of Connecticut, and now is president of the National Committee to preserve and protect social security and Medicare. She has been very instrumental in achieving the bipartisan consensus building atmosphere of the policy committee, and it is a pleasure to have both of them present to us. [Applause]

SENATOR LARRY CRAIG (R-Idaho): Well, good morning everyone and Dorcas, thank you once again for your work. Barbara and I are extremely pleased to be with you this morning. While I chaired, Barbara and I worked as copartners in this committee to produce some of the resolutions and the proposals that came before you. I was extremely pleased that planning along the lifespan contains seven that we proposed are in your top ten, and we thank you very much for that. The last few days of course you have been working very hard to provide implementation of the strategies each one of these resolutions. This morning, Barbara and I will provide some highlights and summaries for you. We worked together before I came to the congress in '80. Barbara came in '82, that makes her a good number of years younger than I, and we will leave it at that. [Laughter] Planning along the lifespan, several strategies for increasing retirement savings were strongly supported including promotion of financial literacy as a core curriculum requirement, mandatory for high school

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diplomas as well as financial education across the lifespan. [Applause] Several strategies for increasing retirement savings were strongly supported included use the tax code to give further incentives to encourage retirement savings and purchase long-term care insurance, make permanent the capital gains tax rate on all distributions taxable at a rate of 15-percent. Several strategies for increasing retirement savings were strongly supported including, and I will turn to Barbara.

BARBARA KENNELLY: Thank you, Senator. I've been delighted to be on the policy committee, delighted to meet all of you. I have walked the halls the last several days and I am so delighted that you agree with me that the baby boomers should not be a source on consternation, but celebration. We are all living longer, healthier lives! [Applause] I started out my beginnings of my political life was being chairman of the Commission on Elderly in the city of Hartford 100 years ago when I was a very young woman, and I feel I have come totally full circle, and I can't thank the Senator more because he took part in this policy group and has been with us, and his staff has been wonderful.

Several strategies for increasing retirement savings were strongly supported, including encouraging new savings by enacting or expanding existing savings incentives, such as IRAs, 401Ks, 403Bs, and are the strength of the retirement

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picture for all Americans to include a 1,000 one time federally funded birth account unavailable to the beneficiary until reaching social security eligibility, making the saver credit refundable, repealing or raising the mandatory withdrawal age of 70, 70-1/2, and notarization and incentives independent on the credit. Several strategies were involved, and I was at most of those, I was at all of those sessions yesterday, and what we did, we had a strong objection to totally privatizing social security. [Applause] I counted the docs, I counted every doc and that is where we were, but we also want to maintain the entire system without privatization, retain the progressive defined benefit structure [applause]. Now I have to tell you some delegates support privatization on a voluntary basis, or with a limit on the proportion of the payroll tax to be put into private accounts. Some wanted to invest 2 percent of social security into private investment, in addition allow up to 13 percent of your own taxed income, but I think the general consensus was no privatization. [Applause]

SENATOR LARRY CRAIG (R-Idaho): Barbara, thank you. However [laughter], some delegates supported privatization on a voluntary basis or with a limit on the proportion of the payroll tax to be put into private accounts. Invest 2 percent [applause]—some proposed invest 2 percent of social security into private investment. In addition, allow up to

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13 percent of your own taxable income go into those kinds of investments. Several strategies supported raising the cap on earnings subject to social security tax or eliminating it altogether. [Applause] Support was expressed for expanding social security coverage to all workers. [Applause]

Delegates, Barbara and I were there in the early 80's when two Irishmen wrestled themselves to the ground on Capital Hill. One of their names was Ronald Reagan, and the other one was Tip O'Neil, and it was all over the issue of social security reform, and what certainly Barbara and I learned by that experience and the commission and the work product that came from it was that there are clearly times in this marvelous program which I call one of the most successful programs ever implemented by our government, in which reform is clearly necessary for the future years and for future payers. That time is near. I am proud of my president for being as bold as he has been in proposing an idea. Congress has four different ideas from this president. Delegates, listen up. Congress, Barbara, and I, and democrats and republicans alike will reform social security in the coming years, and it will be bipartisan [lengthy applause]. It will be bipartisan, and it will be strong, and it will be there as it has been in past generations for future generations to come. Thank you all so much for the work you have done in this area. Barbara. [Applause]

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BARBARA KENNELLY: Let me just add to that. I was there in '83, not only on the floor of the House, but I was in the ways and means committee, I took some of the toughest votes I ever, I don't know how I got reelected. Remember? We had to raise the age on social security. We had to tax it for the first time, but then there was a crisis. Right now, social security is the only federal program that still has a surplus, and I couldn't agree more with the Senator. I am not there anymore, but you know what was decided this year? Not to privatize. To reform, and we will do it, they will do it, and you know what? They are going to have to make some tough decisions, some very tough decisions, because we know how we are aging in America. But you know what? You reform it, you don't privatize it. [Applause]

SENATOR LARRY CRAIG: Thank you all! [Applause]

DORCAS R. HARDY: We're going to end on that note. I appreciate that. Okay. Maybe if I put my glasses on I can step in here. There are a couple of other pieces in the planning along the lifespan. One was about social security disability insurance. People worked hard to figure out what kind of incentives we need in that program to facilitate return to work, and to restructure perhaps as we go forward to really think about the future of the Disability Insurance Program, so there are some specific implementation strategies there as well, and they will be on the slides. We are now to

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health and long-term living. Dr. Alejandro Aparicio is our presenter and he is director of continuing education at the American Medical Association in Chicago. We call him "Doctor Al." He has been our policy committee doc. He is a geriatrician, he has a passion for health literacy and diversity issues, and he has been our leader on the health subcommittee. Dr. Al. [Applause]

ALEJANDRO APARICIO, M.D.: Good morning. Thank you, Madame [Inaudible]. It has been a real privilege to be part of this boss committee and this hard working group of people, and I have made some lifelong friends among them. I want to particularly thank the staff for putting this presentation together. It has been difficult. [Inaudible] and particularly proud of the fact that 22 of the 30 resolutions that were approved by this delegation had to do with health care. As someone that practiced medicine in Chicago for 20 years and advocated for my patients and their health care, it is gratifying to go back home and tell them that this conference agree with the importance of the topics. However, it has made my job a little bit difficult to try to report out on 22 resolutions in 15 minutes. So, we are going to go very fast. We are going to hit only the highlights. I was involved in several of the sessions yesterday and I can tell you the energy, the dedication, the hard work of the delegates was appreciated by all, and I want to give you my

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personal thanks for doing a great job in coming up with ideas for today and for the future. Next slide.

We are going to try to condense this into several general areas. I'm not going to go through each one of the resolutions individually. Coordinate long-term care policy, innovations in financings, and non-institutional options, care and services in rural America, health information and technology, disease prevention and management, Medicaid and Medicare, the geriatric health care work force, and strategies to reduce health care disparities. Next slide.

First, under long-term care, the coordinated care, innovations in finances, and institutional options, establish a national long-term care policy with key features that include comprehensive, educational program incentives to plan ahead, partnership involvement with the private sector and all stakeholders, comprehensive needs assessment, informational services that respect consumer choice, and extensive network of support for services for caregivers. Next slide.

Provide states, local communities, and maximum flexibility under Medicaid, especially providing non-institutional care services and coordinated with the private sector. [Applause] Provide a single point of entry for long-term care services. [Applause] Not highlighted, but there were several specific suggestions on how to go about

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achieving this goal. Provide taxing incentive for individuals and employers to encourage expansion of the private and group long-term care insurance markets, remove barriers to expansion of long-term care insurance partnership programs, and integrate financing and services of acute and long-term care to achieve savings. Next slide.

Under care and services in rural America, adopt and adapt successful models for rural America. For example, one of the suggestions was PACE as a program, regulatory and reimbursement flexibility for caring providers to be able to provide a fuller array of services, promote communication infrastructure and internal medicine, promote services and resources for long-term distance caregivers, and develop long distance mental health resources and techniques. Next slide.

Under disease prevention and management, have government and other stakeholders to corroborate, to implement and evaluate evidence based health promotions initiatives, establish a private public partnership to support a social marketing campaign for disease prevention and healthy lifestyles, provide reimbursement incentives for chronic care management, including medication and behavioral health, and demonstration projects to develop evidence based practices that could be implemented throughout the country. Next slide.

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Under health information and technology, a very exciting area that I think will help across all the other topics in this section, standardize the technology of health information records to facilitate interoperable electronic exchange of health, long-term care, disabilities, and wellness information, establish incentive for implementation of health information technology across all settings. Next slide. And, apply health information technology to disease prevention, chronic care management, and advanced erectus. Next slide.

Under Medicaid, create a seamless system, incorporating the full health and long-term care continuum including non-medical program services, eliminate in many cases institutional biases and eliminate the need for waivers. [Applause] Emphasize government and private sector working together to promote personal responsibility for health and long-term care. One example was, again, the partnership program that links acid protection to the level of private long-term care insurance benefits paid. Next slide.

Have reimbursement equal because of care, eliminate the caps, and eliminate the broad grants. [Applause] Mandate simplification of the eligibility process and enforce Albright 7. Fund impaired [inaudible] health. [Applause]

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And, full federal funding responsibility for dual eligibles.

Next slide.

Under Medicare, create Part E, a comprehensive lifetime long-term care benefit for all Americans of all ages. [Applause] Simplify Part D to one prescription drug program for everyone based on government negotiated practice. [Loud applause] Expand benefits, dental, [inaudible], mental health, substance abuse, and hearing loss. [Applause] Enhance emphasis on emergent preventive services. Next slide.

Geriatric work force, a subject dear and near to my heart. Reinstate and increase Title 7 funding to support geriatric education and career support programs. [Applause] Have states provide financial incentives and career ladders to support the recruitment, training, and retention of geriatric daycare workers. [Applause] Next slide.

Provide federal and state financial incentives to support advanced training, and cultural competence in geriatric medicine, mental health, social work, nursing, and dentistry. [Applause] Next slide.

The strategies to address health care disparities. Work with appropriate accrediting bodies to develop cultural competence curriculum for geriatric and other health care related training. Eliminate barriers to health care access

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arising in connection with, among others, gender, race, ethnicity, and GLBT. [Applause] Next slide.

Promote and support community based participatory research to identify best practices for older adults of various races, ethnicities and cultures. Next slide.

There are also many other, and because of the time issue we will not be able to go into all of them, but I was impressed by the innovative strategies that were to address health and nutrition, healthier lifestyles, care for veterans in all settings, responsiveness to mental illness and behavioral health, innovation in aging research, improve patient advocacy to assist in all care settings, patients surrounding end of life care, health care for Indian tribes, and health education and health literacy. Again, thank you very much for your enthusiasm and your hard work. It has been a pleasure to be with you. [Applause]

DORCAS R. HARDY: Thank you very much, Dr. Al. Our next presenter is on the topic of civic engagement. Mel Woods is president of Rubicon Public Affairs in Sacramento, California. He is a retired executive from Ely Lily, and current architect of our conference theme, the booming dynamics of aging, from awareness to action. An active member as well of the California delegation as well as a great policy committee member. Mr. Woods. [Applause]

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MELVIN WOODS: Thank you, Dorcas. Good morning. That was awful weak. Good morning. Thank you. And thank you for your votes on resolutions No. 56 and No. 59 in the civic engagement track. We had some really hard working people, and those of you who were in track 5 for civic engagement, please just raise your hands. Thank you very much. [Applause] What I would like to do before I launch into the implementation strategies is just take you a little bit back to yesterday, because I was impressed with yesterday and this is not going to take long. Yesterday's speakers gave us some real jewels to ponder. David Walker from the GAO mentioned a preference for "seasoned citizens" rather than retirees. Hal Dobbs said that it is really interesting that the longer you live, the longer you live. The translation here is longevity is here to stay. Ken Diqua [misspelled?] mentioned three assets that reinforce why people work. It's for one, self-worth; two, social connectiveness; and three, to earn a livelihood. Diqua said that boomers want to cycle between work and leisure, and boomers are looking for "a whole new chapter of life that transforms" remember this from yesterday "leisure to legacy." David Eisner, at the Corporation for National Service, clearly believes we need a national strategy on civic engagement and volunteerism, and didn't David Eisner cast the spirit of civic engagement when he quoted the Reverend Dr.

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Martin Luther King who said, "Everyone can be great because everybody can serve." What I find comforting from a policy perspective about the statements of these renowned speakers from yesterday's program is that for the two resolutions that we have voted on that made it into the 50, No. 56 and No. 59, that they truly fit into two overarching themes that truly impact our current seniors and the baby boomers. First thing, you probably figured it out, is social connectedness. Didn't we hear this loud and clear yesterday? Social connectedness will not go away folks, and just like social connectedness consumed you and me in our lives, social connectedness will grow with the baby boomers as well. The second theme is extended personal development, and of course there are exceptions to the rule, but most of us senior citizens, "seasoned citizens," probably have very few more mountains to climb, but there are still a lot of hills out there. As a matter of fact, with longevity as a bonus, we can almost count on enjoying several hills after the age of 60. Now our civic engagement track participants were very focused. They worked very diligently in coming up with some implementation strategies that are doable. We are going to go through them in just a moment. These are all the ones that receive consensus and the strongest support. All of the other strategies that we didn't highlight today in the upcoming slides are all going to be on the public record on

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the website as well. We are going to take a look at resolution No. 59 first, and I noticed that some of the other speakers got some nice crescendos. If you want to say "Amen," that is fine with me. We started with resolution No. 59, simultaneous with reauthorizing the national community service act. We also want to reauthorize the domestic volunteer service act with the following provisions. Double the total number of foster grandparents, senior companions, and RSVP volunteers to 1 million by 2010. [Applause] I understand that is a 100 percent increase over what is currently the case. I understand that we are about 500,000. Expand the RSVP program to every county in the nation, including travel organizations. [Applause] Simultaneous with reauthorizing the national community service act and reauthorize the domestic volunteer service act with the following provisions: Increase the income eligibility cap for foster grandparents in FC programs from 125 percent to 200-percent of national poverty level. Lower the eligibility age for foster grandparents in SC programs to 55 to 60, and recruit leading edge boomers. Another implementation strategy was to expand the Older Americans Act, and here we talked about integrating civic engagement into the Older Americans Act and the established aging network, as well as enable senior citizens to provide transition planning

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programs for baby boomers and pilot projects through Title IV grants. Next slide.

We also talked about incentives, a lot of support for funding the silver scholarships program. That is a 1,000 tax free transferable education award for older adults who serve 600 hours plus per year, and also provide tax credits for volunteer time and expenses. [Applause] The volunteers also mentioned some barriers that need to be removed, and there are two of them here. Eliminate volunteer driver liability to both encourage volunteer drivers and to help volunteers' access opportunities. [Applause] No amen's, but that is okay. Expand home based volunteer opportunities in addition to transportation assistance for disabled Americans. In the corporate business sector, provide subsidies, tax credits, and other incentives to encourage the business community to expand and reward volunteer opportunities to their employees and retirees. [Applause] This is kind of catchy. This has a little power to it. Our folks believe that there out to be a presidential commission. The president ought to establish a national commission to develop a blueprint for tapping boomers and older adults as social capital, and this commission ought to include broad representation from the public and the private sector. [Applause] Another is creating a fund for innovation. Establish a fund for innovation to foster the growth of promising practices and

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program models that promote volunteering by boomers and older adults to address critical human and community needs.

[Applause] This one I love, and this is the last slide.

Launch a national volunteering campaign program. Develop a national marketing and communication strategy to stimulate a new spirit of volunteerism, create a national online clearing house that matches volunteer skills and experiences with volunteer needs, and last establish a standard toll free number such as the No. 211 hotline, to link and match volunteers with local volunteer opportunities. This is the result of the work, and I hope that you are comfortable with it. [Applause] Just one comment. In my closing, it has just been a pleasure to serve on the White House policy committee on aging, all the folks on this dias [misspelled?] as well as the others who are not here are just fabulous people. They are very smart. They are very quick, and their heart is in the right place. So, I think that what we have given you is really something very substantive, and I know it is going to resonate with you. Thank you. [Applause]

DORCAS R. HARDY: I think we should say A-MEN! Tom Gallagher is going to present next on technology and the marketplace.

THOMAS E. GALLAGHER: Thanks, Dorcas. One of the big changes, of course, in this conference was the focus on technology and the addition of the exhibit hall and all of

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the various examples of technology, and that is one of the things that I think will make this conference particularly useful and memorable. I want to acknowledge and thank the cast folks for a terrific job. I would like to give them a round of applause. It was fantastic. [Applause] We all saw in that hall, there is an extraordinary number of technology examples that are already there and useful, but that exhibit is only the beginning, and it is very clear that technology is going to be an essential part of the solutions to many of the challenges we have talked about, and we have already seen examples in some of the other implementation strategies. Al stole a little of my thunder a moment ago when he talked about the use of technology in the health information area. That is an enormously promising area, and we will talk a little bit about some additional strategies, but it runs across the board. The notion of the number of people that are homebound and the opportunity to use technology to communicate with them, to make sure that they are getting up in the morning and taking their pills and getting their meals, those are just some very simple examples. We are just beginning to scratch the surface, but as said before, the notion that we are now looking at technology is a way to answer some of those problems, address some of the challenges, and frankly find more efficient ways to spend our

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health care dollars is a good example of the benefits of technology.

So, first slide. Resolution No. 61 was to promote the integration of health and aging services through access and quality of care for older Americans. A couple of the strategies that were particularly strongly supported was to update Medicare to provide a greater emphasis on establishing cost effective linkages to home and community based options through the aging network to promote chronic disease management and increase health promotion and disease prevention measures. Second, ensure access to health and aging services by all senior populations through the establishment of the new title under the OAA to create an aging and disability resource center as a single point of entry in each region across the nation charged to coordinate health and aging programs and ensure access to diverse populations. Next slide.

Include in OAA provisions to foster development of a virtual electronic database that is shared between providers; example: Medical, health, and social services, especially home and community based services. Another one, create a standard set of definitions and codes for a health care and wellness record to allow easier interfaces between multiple information systems and to establish reimbursement incentives

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for systems that incorporate these standardized definitions and codes. Next slide.

Continuing on that same theme, facilitate improved standardized information and the exchange in communication among providers using electronic systems, then identify, assess, and address the federal and individual state regulations that prevent information sharing between systems and amend HIPAA and the other restrictive regulations to allow meaningful communication between health providers and the aging network. [Applause] For those of you who heard Craig Barrett the other day talk about this issue, that is a classic example of the problem. As I mentioned earlier, the notion that we are in fact behind some of the other countries around the world in implementing the use of technology is in part a function of the fact that sometimes we tie our shoelaces together and then try to walk, and so this is an area that we really, I expect, will get some very strong focus as a result of this conference. Next slide.

The other resolution was to develop incentives to encourage the expansion of the use of technology in health information, and examples of that in terms of financial incentives, expanded Medicare and Medicaid coverage for Telehealth, that was a point that I think Craig and others made earlier that the notion that we encourage increased cost by forcing somebody to go to the doctor's office because we

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don't reimburse electronic communication between patient and doctors is somehow tying our shoelaces together. Similarly, reduced cost of malpractice insurance, again to reflect those people who are in fact using technology, that it has an impact on increasing the reliability of the services that are being provided, and we all know examples. There are so many ways in which we can use technology, even for example in the way in which prescriptions are dealt with. Reducing licensing fees, providing low interest loans, tax credits, sales tax exemptions for the systems, and private sector awards, these are all examples that came up of ways in which to help advance adoption of technology. Next slide.

Include incentives for the adoption of health information technologies in rural and medically under served areas. Again, I come from Nevada. We have an enormous breadth of the state where we have small communities and very few doctors, and one of the clear potentials for the use of technology is, as I said before, in the ability to communicate between doctors and patients across broad geographic areas. Increase accessibility and decrease the cost of technology by reviewing regulations. We talked about HIPAA but fraud prevention, any kickbacks, stark restrictions, so that we can in fact deplore the technology and finally improve reimbursement policies to encourage the

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investment in and use of health information technology. Next slide.

Fully fund the American health information community and the office of the national coordinator for health information technology. Establish a national commission for advancing health information technology in areas such as common standard data exchange, electronic health records, and interstate health care. You remember the notion that a doctor in California can't treat somebody in Nevada and vice versa? Competitiveness through innovation and finally incentives of the type we talked about before, especially at the provider and consumer end. Let me just wrap up on the technology point by saying that the legacy of this conference I believe is also the challenge going forward, and that is for us to in fact decide that we are going to use technology to address many of the issues of cost and efficiency of service that are out there.

Last point, and this is since the last time I am going to talk to you, I want to add my thanks again to these delegates, and particularly to the policy committee. I came late to the committee. I joined in March of this year, and it is has been a very interesting process. Others have said that this group is a very diverse group, just like all of you are, but it is also a group that have become friends, and it is an example, you know, Barbara and Senator Craig said a

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moment ago that it was a bipartisan effort. It really was. We wrestled hard. We had a lot of very interesting discussions from all different points of view, but the fact is that I am coming away from this with a lot of new friends, and they really are friends, because we had to face some very difficult issues, just as all of you try to do in the implementation sessions, and as we go forward from this conference, and stay involved, we had a press conference a few moments before we started and one of the reporters said what is going to be the legacy of this conference? What we said was that we think what is different is that because we all work together for a whole day on implementation strategies and worked hard, that people will leave here engaged in an effort to stay involved and to make sure that the good ideas that came out of this conference in fact get pushed forward and implemented, and so if there is one message that I want to leave you with, it is stay in the game. Don't go back home and say oh, that was a lot of fun. It was a lot of work, and let's have the benefit of that work in all of the states that we all came from as we go back and talk about what happened here and make sure that we don't let it end here. Thank you. [Applause]

DORCAS R. HARDY: Thank you. Our next presentation is cross-cutting issues, and Gail Hunt, CEO and President of the National Alliance for Caregiving, be our presenter. She

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has been cochairman of the Social Support Subcommittee, brought great intelligence and passion to this policy committee and great support and insight and good advice.

Gail. [Applause]

GAIL HUNT: Well good morning. Yes, I wanted to thank the members of the policy committee. It has been a great honor for me to be able to serve as part of the policy committee for the White House Conference, and really also I think to AOA for all the work that they have done. One of the things that I take away is I think it has been good to be able to bring family caregiving and the issues of long-term care more to the forefront than perhaps past White House conferences have focused on, and I think there is no question that those issues will continue as we have heard from everybody to matter a lot in the aging of America, since the majority of the care provided to older people is provided by family and friends. So, I am going to be talking about cross-cutting, which is like a hodge-podge of four different areas, and if I could have the first overhead. Next slide. Say the right words, obviously. Yeah, you got to be exact here, and this is dealing with resolution No. 72, which was to review the alignment of government programs, and there was a strong feeling, these are just some examples of some of the resolutions of the implementation strategies to charge the national academy of public administration to review alignment

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of programs for older Americans and provide recommendations to the domestic policy council. Next overhead.

Then, the other big meaty suggestion here was to incorporate key principles in administrative action and legislative proposals for government programs dealing with aging and these are just some of the examples of things that the delegates would like. Coordinated longitudinal services across the spectrum of medical and social services including, but not limited to, housing, transportation, caregiver support, family caregiver support, nutrition, and medical care, and integration of funding streams, I think we could all agree that we could get rid of some silos, pay for performance for continuity of care, consolidation of databases across government programs dealing with aging, and ongoing evaluation incorporating technological innovation. Next slide please.

This resolution dealt with improving state and local based integrated service delivery systems. The idea here was that the primary strongest suggestion was to integrate delivery systems to meet twenty-first century needs by creating a new title in the Older Americans Act called "Community Preparedness for an Aging Population." This would support Triple A's to assist cities, counties, tribal councils, as well as the private sector to really begin to address the needs of older adults in the areas of housing and

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transportation, health, human services, public safety, recreation, and work force development. It kind of runs across the whole board of every gamut of everything, and the goal overall was to ensure aging well in livable communities, something that we could I'm sure all agree on. [Applause] Next slide please.

To continue with this same theme, the idea here was to encourage design for an aging society that is the standard rather than the exception, including in housing design, accessibility, building codes, signage, and transportation, and then lastly, create 20 funded model integrated networks in various types of communities to serve as models for the rest of the country. Next slide please.

The next issue was a big one. I was in at least one of the two sessions on this, and that was to ensure basic accountability for follow-up to the White House Conference on Aging. It is the first time there has been an actual resolution that has come forth in any of the previous White House conferences to really say we don't want it just to stop here. We want it to continue. So, to ensure accountability [applause] for implementation of the 2005 White House Conference, there was a recommendation to secure congressional and other support including funding, for a bipartisan commission. Now that commission would be made up representative of all the primary stakeholders who were

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represented by the delegates here as well as congressional people as well as for example the private sector and the voluntary sector and the AAAs and all of the groups that were here, and the idea was this bipartisan commission would be responsible for continuing the momentum of the conference and ensuring implementation of the priority strategies that we have come up with. Next, we wanted to make records and documentation from the White House conference available and the White House should recognize the work of the White House Conference. [Loud applause] Right on! And, to conduct an evaluation of the White House Conference which we, as Dorcas mentioned this morning, are going to be doing. Next slide.

I thought this was particularly important and really was a wonderful idea, the delegates should continue the work of the White House Conference within their states by taking the final report when it comes and convening a meeting, either electronically or in person if it is possible, if you are in the small Rhode Island, maybe, by convening a meeting to disseminate the recommendations and talk about how they can implement the strategies and really get grass root support. Again, it is this idea of taking what we have done and not letting it just end there, but continuing on, and then lastly there was considering the concept of convening a Native American White House Conference, which was mentioned

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earlier in another resolution as well. [Applause] Next overhead, please. Next slide.

There we go, and last but not least, at least in my part, was the whole issue, the resolution that dealt with family caregiver support, and this resolution suggested that there be developing a national strategy for supporting informal caregivers, and sort of in summary what was developed as an implementation strategy was really that family caregivers need to be guaranteed fair working conditions, and these suggestions were examples of the kinds of things that would be components of that. For example, offering a range of financial and other incentives to encourage and support family caregiving such as tax credits for doing caregiving, affordable health care, particularly it was mentioned that you could have, if you quit your job you could participate in Medicare early. Affordable health care, that is another alternative, some kind of affordable health care program, public disability insurance, credit for social security for the quarters that you are taking off from work, which I think is a good idea, inflation protection for peak earnings and respite care, a big issue obviously for family caregivers. Next slide, please.

Double the \$162 million appropriations level for the national family caregiver support program, which I think would be a wonderful idea, of course, and include aging

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caregivers of adults with lifelong disabilities, a group that was sort of missed when they put the National Family Caregiver Support Program into effect, and expand the definition of family caregiver to include friends and neighbors. In addition, just sort of as an addition component to that, kinship care would include non-related caregivers in the Family and Medical Leave Act, the Older Americans Act, and other federal and state laws. [Applause] Then, obviously this has come up a number of times as well, permanently authorize the aging and disability resource centers through the Older Americans Act to be supportive resource centers for family caregivers, as well as for people with disabilities and older Americans. Well, that is sort of the summary of the major strongest supported issues that came across family caregiving, and I just wanted to emphasize again, this is really just the beginning, and that is really what I think is exciting, I think as Tom said, about this conference, is that we are not just going to go home and gosh we developed these resolutions with the where as's and the therefore's and define the problem, but we really started to define some solutions. That is what we have in these implementation strategies, and if nothing else, the final report really becomes a blueprint for advocacy organizations and for state and local and federal government to actually begin to work on, to implement some of these, so that is what

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I am encouraged about and I hope the rest of you are as well.
Thank you so much for being a wonderful delegate group.

[Applause]

DORCAS R. HARDY: Thank you, Gail. I would like you all to join me in recognizing the wonderful policy committee members. [Applause] Thank you all. I did neglect, and I apologize, to recognize also the good work of Greg O’Neal, who worked on the civic engagement track, as a track coordinator with the Gerontological Society of America. I apologize. [Applause] I would like to draw your attention before we adjourn here at the moment to all the corporate and the organizational sponsors that are in your program. We recognized them at the different events, but I just want you to know that without them, we could not have had this conference. They provided everything from support for your conference bags to all of our food to the exhibit hall area, and especially the CAST pavilion, the Department of Transportation exhibits, all the other exhibits, as well as the leadership of the American Association of Homes and Services for the Aged, the umbrella organization of CAST, and very especially Zeva guide, which has been the coordinator of the entire exhibit hall and did an outstanding job in a very short period of time, so we really do appreciate them.

[Applause]

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Now, I would like to go to the next slide, which is here. Next slide please. These are the Top 10 White House Conference of 2005 resolutions. We will be distributing this list and we will also be distributing, but we have a huge printing job, you'll get it before you leave, I just can't guarantee it's out there right now, the votes for each of the 73 resolutions, but these are the Top 10 and I wanted to make sure everybody understood and saw these first, and the numbers that go along with everything will be forthcoming shortly. We don't have a printing press here, and there are a lot of us. So, we think it is really exciting. We have gone over all of these in the policy committee presentations, and you will see the numbers shortly, and also have pieces of paper to take with you. We will convene again at lunch, 11:30 here, we need time to turnover this room, at which time we will have a celebratory healthy heart luncheon, and I would take the opportunity to check out and we really appreciate your participation, your enthusiasm, for our report this morning. More to come as we keep going on this process. [Applause]

[END RECORDING]

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THE
**BOOMING
DYNAMICS
OF AGING**

From Awareness to Action

**2005 White House Conference on Aging
Implementation Strategy Highlight Report**

12/14/2005

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Policy Track Presentation Outline

- Moderator: Dorcas R. Hardy, Chairman, WHCoA Policy Committee
- Workplace of the Future
Presenter: Tom Gallagher
- Our Community
Presenter: Clayton Fong and Bob Blancato
- Planning Along the Lifespan
Presenter: Senator Larry Craig and Barbara Kennelly
- Health and Long Term Living
Presenter: Dr. Alejandro Aparicio
- Civic and Social Engagement
Presenter: Mel Woods
- Technology and Innovation in the Marketplace
Presenter: Tom Gallagher
- Cross-Cutting Issues
Presenter: Gail Hunt

Workplace of the Future

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Workplace of the Future

Resolutions:

Remove barriers to the retention and hiring of older workers, including age discrimination

Promote incentives for older workers to continue working and improve employment training and retraining programs to better serve older workers

Workplace of the Future

- **Held two sessions that included both resolutions**
- **Each group had broad representation from the non-profit sector, various government institutions, and business and industry**
- **Both groups were very articulate and well-versed in the area of older workers and produced several innovative strategies**

Workplace of the Future

- **Morning and afternoon sessions concurred that they would like the implementation strategies to apply to both resolutions**

Workplace of the Future

- **Examples of implementation strategies that received the strongest support include:**
 - **Re-authorize Title V of the Older Americans Act, (the Senior Community Service Employment Program) which provides part-time employment opportunities for low-income individuals over the age of 55, to ensure the oldest, poorest and least skilled older workers do not fall through the cracks**

Workplace of the Future

- **Eliminate the income eligibility requirement in Title V and encourage greater collaboration with the Workforce Investment Act (WIA) programs that promote training, education, health and support for older workers, so as to provide more effective outcomes**

Workplace of the Future

- **Create a Frontier Section within Title V of the Older Americans Act to provide more flexibility for rural communities**
 - **Include distance learning options for education and training support, as well as work opportunities in rural communities**

Workplace of the Future

- **Remove impediments to phased and flexible retirement options to encourage multiple work options for older workers and businesses, for example:**
- **Permit pension payments to older workers who want to continue working, but wish to cut back on hours**
 - **Assess ERISA, ADEA and IRS provisions that discourage continued employment of older workers**

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Workplace of the Future

- **Other examples of strategies that had strong support, include:**
 - **Provide greater access for educating and training older workers via education grants, tuition waivers and innovative financing mechanisms, such as a training education 401K plan**
 - **Create a Task Force within the Department of Labor that would focus on issues surrounding older workers**

Workplace of the Future

- **Examples of strategies that had considerable support, include:**
 - **Educate employers on the increasing value of older workers, particularly in light of Baby Boomer retirements and the need for flexible work arrangements to retain such workers**
 - **Encourage employers to provide employment benefits that assist in retention, such as pre-retirement training and financial planning, healthcare insurance, leisure and work options to re-career, and flex-time and job sharing options**

Our Community

Our Community:

R. 17: Reauthorize the Older Americans Act

- **Provide a substantial increase in Older Americans Act funding**
- **Legislative advocacy: educate, advocate, obtain Results**
- **Create an new title within OAA to authorize SUAs, AAAs, and Title VI Native Americans to help communities prepare for the aging of the baby boomers.**

Our Community:

- R. 17: Reauthorize the Older Americans Act Continued**
- **Senior Community Service Employment Program—Maintain the dual structure of state, minority and national grantees; retain the vital, historic focus on community services to support local community organizations and the aging network; streamline program eligibility to promote increased participation to meet demographic changes and the growing ethnic and culturally diverse population to include tribal organizations.**

Our Community:

- R. 17: Reauthorize the Older Americans Act Continued**
- **Family care givers: Support family care giving across all generations regardless of age of care givers or persons needing service.**
 - **Support Indian-specific provisions in OAA**
 - **Elevate the Director of American Indian office within the AoA to the Deputy Secretary level**

Our Community:

- R. 17: Reauthorize the Older Americans Act Continued**
- **Re-establish the occurrence of the Indian White House Conference on Aging prior to the next WHCoA in recognition of the government-to-government relationship between the federal and tribal governments**

Our Community:

- R. 17: Reauthorize the Older Americans Act Continued**
- **Provide \$1M for elder abuse awareness grants under Title VII Part B for Indian Country**
 - **Provide \$1.3M for training and technical assistance for Title VI Directors instead of skimming it off the top of Title VI appropriations**

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Our Community:

R. 17: Reauthorize the Older Americans Act

- **Nutrition Services: Fully integrate nutrition services, such as congregate and home-delivered meals at 3 meals per day, 7 days per week, nutrition education, senior farmers' market nutrition program, screening, assessment, and counseling: through the employ of registered dietitians at the state, AAA, and local levels as well as services extended to caregivers where appropriate.**

Our Community:

- **Res. 14 & 18: Expand Opportunities for Developing Innovative Housing Designs that promote Livable Communities that Enable Aging in Place**
 - **Change zoning and building regulations to allow for good senior housing options including single family housing, congregate living options, shared housing, and public housing.**

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Our Community:

- **Res. 14 & 18: Expand Opportunities for Developing Innovative Housing Designs that promote Livable Communities that Enable Aging in Place**
 - Encourage local building codes to require universal design, including, but not limited to wide doorways, turning radiuses, lower light switches, barrier-free showers, grab bars, and good lighting

Res. 14 & 18: Expand Opportunities for Developing Innovative Housing Designs that promote Livable Communities that Enable Aging in Place

- **Change zoning and building regulations to allow for good senior housing options including single family housing, congregational living options, shared housing, and public housing.**
- **Encourage local building codes to require universal design, including, but not limited to wide doorways, turning radiuses, lower light switches, barrier-free showers, grab bars, and good lighting**

Res. 14 & 18: Expand Opportunities for Developing Innovative Housing Designs that promote Livable Communities that Enable Aging in Place
Continued

- **Encourage the incorporation of universal design into new housing for people of all ages and abilities through education and training of builders, developers, designers, local officials, and consumers, and through tax incentives such as tax credits and property tax abatement**

Res. 15: Encourage Redesign of Senior Centers for Broad Appeal and Community Participation

- **Support an expanded role for senior centers as focal points for community based services and civic engagement for senior centers as independent service.**

Res. 15: Encourage Redesign of Senior Centers for Broad Appeal and Community Participation Continued

- **Support policies and encourage efforts to create and expand opportunities and partnerships that integrate senior centers, health care systems, service providers, communities, business, public and private organizations to serve culturally diverse populations across all social and economic lines.**
- **Support efforts to modernize and upgrade facilities and programming that will attract and serve existing and new generations.**

**Res. 15: Encourage Redesign of Senior Centers for
Broad Appeal and Community Participation
(Continued)**

- **Create a separate and distinct title in OAA for multipurpose senior centers which are a system serving older adults, caregivers, and their families.**

Res. 15: Encourage Redesign of Senior Centers for Broad Appeal and Community Participation (Continued)

- **There shall be a federal requirement that all 50 states, territories and tribes establish statutes defining “multipurpose senior centers” as THE community based focal point for planning and coordination for the organization and provision for a broad spectrum of services suited to the diverse needs and interests of self determining older persons.**

Res. 19: Create a National Strategy for Promoting Elder Justice Through the Prevention and Prosecution of Elder Abuse

- **Enact and fully fund comprehensive elder justice legislation (The Elder Justice Act) to address elder abuse**
- **Build capacity of Adult Protective Services programs nationwide with specific funds & focus on elder financial abuse exploitation.**
- **Create an Elder Abuse Awareness postage stamp (similar to breast cancer stamp)**

**Res. 21 & 22: Ensure that Older Americans
Have Transportation Options to Retain Mobility
and Independence**

- **Require public transportation organizations and local governments to participate in disaster preparedness planning for evacuation of seniors without transportation—funding by the Department of Homeland Security.**

Res. 21 & 22: Ensure that Older Americans Have Transportation Options to Retain Mobility and Independence

***Continued**

- **Increase public and community transportation investment and include statutory language in the Older Americans Act that increases funding support to the Aging Network to promote senior mobility, expand cost-effective transportation options and facilitate coordination of human service transportation**
- **Better coordination among public and private transportation providers.*** Incomplete information was available when this slide was prepared. The correct information follows on next several slides.

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RESOLUTIONS

- **Support Older Drivers to Retain Mobility and Independence through Strategies to Continue Safe Driving**
- **Ensure that Older Americans have Transportation options to retain mobility and independence**

Examples of Transportation Implementation Strategies

- **Establish, fund and staff at the highest levels a Senior Mobility coordination function in the Office of the U.S. Secretary for Transportation to ensure that the mobility needs of seniors are taken into account in the development of all relevant transportation federal policies and programs**
- **Ensure availability of coordinated, interdisciplinary screening and assessment of functional abilities necessary for driving and for rehabilitation to help older drivers remain safe drivers.**

Transportation Imp. Strategies continued

- **Safer, easier to use, and “senior friendly” roadways, walkways and automobiles.**
- **Increase public and community transportation investment, and include statutory language in the Older Americans Act that increases funding support to the aging network to promote senior mobility, expand cost-effective transportation options and facilitate coordination of human service transportation**
- **Local and state governments need to work with insurance companies to develop (and fund) policies that cover volunteer drivers for door to door and door through door transportation services.**

**Res. 23 & 24:
Enhance the Availability and Affordability of
Housing for Older Americans**

- **Increase the housing supply and housing options for seniors through combinations of governmental initiatives and tax credits encouraging the private sector to provide housing in corporate campuses, as well as by encouraging the revamping of land use laws that inhibit the growth of senior housing.**

**Res. 23 & 24:
Enhance the Availability and Affordability of
Housing for Older Americans**

- **Establish federal housing trust fund of \$500 billion, and other mechanisms such as tax credits, to meet planning and development needs for low income and disabled older adults.**
- **Remove unduly burdensome regulatory obstacles to building senior housing in the community.**

**Res. 25:
Encourage the Development of a Coordinated
Federal, State, and Local Emergency Response
Plan for Seniors in the Event of Public Health
Emergencies and Disasters**

- **Develop a geographic information system (GIS) for tracking vulnerable individuals, combined with robust wireless communications networks, and global positioning system (GPS) tracking system (opt-in for individuals) for first responders and vulnerable individuals. This can leverage telemedicine technology.**

**Res. 25:
Encourage the Development of a Coordinated
Federal, State, and Local Emergency Response
Plan for Seniors in the Event of Public Health
Emergencies and Disasters Continued**

- **Clarify role and responsibility areas of federal, state and local governmental entities relative to evacuation procedures, funding to support evacuation, return, restoration, and service provision. Further clarify the relationship of Red Cross, and other relief agencies, with local entities. Develop and incorporate gatekeeper measures for seniors residing in shelters to minimize elder abuse, neglect and exploitation. These measures should be a part of operating guidelines for all shelters.**

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**Res. 25:
Encourage the Development of a Coordinated Federal,
State, and Local Emergency Response Plan for Seniors
in the Event of Public Health Emergencies and
Disasters (Continued)**

- **Create a system for ensuring resources are expended on existing service network.**

Resolution 26: Support Older Adult Caregivers Raising Their Relatives' Children

- **Encourage state school boards, Department of Education, Department of Health and Human Services to allow a relative caregiver without legal custody or guardianship to submit affidavit to enroll child in school and to consent to medical treatment on his or her behalf.**
- **Ensure that government programs, including navigator programs offer an array of services such as: legal, housing, health care, education, advocacy, counseling and respite care.**

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Resolution 26: Support Older Adult Caregivers Raising Their Relatives' Children

- Outreach and education that is culturally and socio-economically sensitive, directed at caregivers, schools and public at large
- Provide for adequate funding for grand families,
 - Title IVE foster care and for subsidized guardianship
 - NFCSP—Lower age limit, increase funding, and support national
 - Housing: HUD and NAHASDA and Legacy
 - Reauthorization of Indian Healthcare Improvement Act

Planning Along the Lifespan

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Planning Along the Lifespan

- **Several strategies for increasing retirement savings were strongly supported including:**
 - **Promotion of financial literacy as a core curriculum requirement mandatory for a high school diploma, as well as financial education across the lifespan**

Planning Along the Lifespan

Several strategies for increasing retirement savings were strongly supported including continued:

- **Use of the tax code to give further incentive to encourage retirement savings and the purchase of Long Term Care insurance**
- **Make permanent the capital gains tax rate on all distributions – taxable at a rate of 15%**

Planning Along the Lifespan

Several strategies for increasing retirement savings were strongly supported including Continued:

- **A \$1,000 one-time federally-funded birth account unavailable to the beneficiary until reaching Social Security eligibility, making the Saver Credit refundable, repealing or raising the mandatory withdrawal age of 70⁺, annuitization incentives, and dependent care credit expansion**

Planning Along the Lifespan

Several strategies for increased retirement savings were strongly supported including Continued:

- **Encourage new savings by enacting or expanding existing savings incentives such as IRAs, 401Ks, 403(b)'s, in order to strengthen the retirement picture for all Americans to include:**

Planning Along the Lifespan

- **Several strategies supported incentives, including changes to Social Security, to keep older Americans in the workforce**
- **Strong objection to totally privatizing social security was expressed in a number of strategies, e.g.:**
 - **“Maintain the entire system without privatization...”**
 - **“Retain the progressive defined benefit structure...”**

Planning Along the Lifespan

- **Some delegates supported privatization on a voluntary basis or with a limit on the proportion of the payroll tax to be put into private accounts:**
 - **“Invest 2% of Social Security into private investment...in addition allow up to 13% of your own taxed income...”**

Planning Along the Lifespan

- **Several strategies supported raising the cap on earnings subject to social security tax or eliminating it altogether.**
- **Support was expressed for expanding Social Security coverage to all workers.**

Planning Along the Lifespan

- **For the social security disability insurance program:**
 - **Create incentive and programs to facilitate Return to Work (RTW)**
 - **Extend Medicare and Medicaid coverage for period of time after RTW (helps employers & employee.**
- **Create incentives for employers and nonprofits to help beneficiaries RTW**
- **Enhance vocational rehabilitation services for beneficiaries**

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Planning Along the Lifespan

- **For the social security disability insurance program Continued:**
 - **Eliminate disincentives for RTW such as**
 - **Short trial work days**
 - **Part-time employment penalties**
 - **Definition of substantial gainful activity**
 - **Create expert resources to adjudicate difficult claims**

Planning Along the Lifespan

- **For the Social Security disability insurance program Continued:**
 - **Streamline the appeals process by using more presumptive awards**
 - **Create financial and medical protection during prolonged appeal process**

Planning Along the Lifespan

- **For the Social Security disability insurance program continued:**
 - **Better exchange of information among disability systems**
 - **Simplify application process**
 - **Create a system of reimbursement for healthcare providers to assist patients in application process**
 - **Eliminate waiting period by start cash on onset date**

Planning Along the Lifespan

- For the social security disability insurance program Continued:
 - Make Medicare available on onset date
 - Do not take attorney fee from back benefit.
- Award attorney fees from separate fund as in Equal Access to Justices Act.
- Provide medical (Social Security Medicare/Medicaid) or private insurance policy early in the claim (by 1st 30 days)
- Develop network of insurance companies (group purchase power)

Planning Along the Lifespan

- Strategies supported for modernizing Supplemental Security Income (SSI) included:
 - Adopt changes proposed in Flemming report that are not inconsistent with the other strategies shown below.
 - Increase benefit to 150% of Federal Poverty Level in 2008. In subsequent years increase monthly benefit 5% each year until it reaches 175% of federal poverty level.

Planning Along the Lifespan

- **Strategies supported for modernizing Supplemental Security Income (SSI) included Continued:**
 - **Increase the earned income exclusion to 25% of the federal poverty level. Liberalize the formulas related to income exclusion of \$65 per month in order to provide incentives for individuals to work and contribute to the program.**

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Planning Along the Lifespan

- **Strategies supported for modernizing Supplemental Security Income (SSI) included Continued**
 - **Simplify application process and appeals process with particular attention for those with limited English, low literacy rates, limited cognitive ability and/or emotional disabilities.**

Planning Along the Lifespan

- **Strategies supported for modernizing Supplemental Security Income (SSI) included Continued:**
 - **Simplify application process and appeals process with particular attention for those with limited English, low literacy rates, limited cognitive ability and/or emotional disabilities.**

Planning Along the Lifespan

- Simplify application process and appeals process with particular attention for those with limited English, low literacy rates, limited cognitive ability and/or emotional disabilities.
 - The Disability Determination Process should be simplified and accelerated to include greater consideration by physicians, geriatricians, therapy specialists (OT, PT, etc.) and the use of functional re-assessments.
 - Establish a quality control review process for denied disability claims.

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Planning Along the Lifespan

- Long term care strategies supported include:
 - Flexibility in the use of Medicaid Funds, especially for home and community based care.
 - Financial incentives to individuals & employers for Long Term Care insurance
 - Very strong endorsement of private sector options including partnership for LTC, tax incentives for planning and consumer education.

Planning Along the Lifespan

- Long term care strategies supported include:
 - Medicaid Reform and Single Point of Entry
 - Create Social Insurance program for Long Term Care
 - Expanded long-term care awareness campaign including counseling and insurance

Planning Along the Lifespan

- Prosecution of financial crimes:
 - Enactment of legislation and funding to create rapid response financial abuse specialist teams nationwide to increase prosecution of financial crimes

Health and Long Term Living

Health & Long-Term Living

- **Coordinated LTC Policy; Innovations in Financing; Non-Institutional Options**
- **Care and Services in Rural America**
- **Disease Prevention & Management**
- **Health Information & Technology**
- **Medicaid & Medicare**
- **Geriatric Care Workforce**
- **Strategies to Reduce Healthcare Disparities**

Long-Term Care: Coordinated Policy, Innovations in Financing, & Non- Institutional Options

- **Establish national LTC policy with key features**
 - **comprehensive educational program**
 - **incentives to plan ahead**
 - **partnership involvement with the private sector and all stakeholders**
 - **comprehensive needs assessment**
 - **information services that respect consumer choice**
 - **extensive network of support for services for caregivers.**

Long-Term Care: Coordinated Policy, Innovations in Financing, & Non- Institutional Options

- **Provide states - local communities maximum flexibility under Medicaid, especially in providing “non-institutional” care services. Coordinate with private sector**
- **Provide Single-point-of-entry into LTC**
- **Provide tax incentives for individuals and employers to encourage expansion of the private and group LTC insurance markets**
- **Remove barriers to expansion of LTC Insurance Partnership Program**
- **Integrate financing and services of acute and LTC to achieve savings**

Care and Services in Rural America

- **Adapt & adopt successful models for rural Americans (e.g. PACE).**
- **Regulatory & reimbursement flexibility for current providers to retool for fuller array of services.**
- **Promote communications infrastructure and telemedicine.**
- **Promote services & resources for long-distance caregivers.**
- **Develop long-distance mental health resources & techniques.**

Disease Prevention & Management

- **Have government and other stakeholders collaborate to implement and evaluate evidence-based health promotion initiatives.**
- **Establish a private/public partnership to support a social marketing campaign for disease prevention and healthy lifestyles.**
- **Provide reimbursement/incentives for chronic care management (including medications and behavioral health).**
- **Demonstrations to develop evidence-based practices.**

Health Information & Technology

- **Standardize the technology of health information records to facilitate interoperable electronic exchange of health, long-term care, disability, and wellness information.**
- **Establish incentives for implementation of health information technology across all settings.**

Health Information & Technology Continued

- **Apply health information technology to disease prevention, chronic care management, and advance directives.**

Medicaid

- **Create a seamless system incorporating the full health & LTC continuum, including non-medical program services**
 - **Eliminate Medicaid’s institutional biases/eliminate need for waivers**
- **Emphasize government & private sector working together to promote personal responsibility for health & LTC.**
 - **Such as the Partnership Program that links asset protection to the level of private LTC insurance benefits paid.**

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Medicaid

- **Have reimbursements equal the costs of care. No caps! No Block Grants!**
- **Mandate simplification of the eligibility process enforce OBRA '87**
- **Funding parity for mental health**
- **Full federal funding responsibility for dual eligibles**

Medicare

- **Enhanced emphasis on emerging preventative services.**
- **Expand benefits: dental, vision, mental health, substance abuse and hearing loss.**
- **Simplify Part D to one prescription drug program for everyone, based on government negotiated prices.**
- **Create a comprehensive, lifetime LTC benefit for all Americans of all ages (e.g. Part E).**

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Geriatric Workforce

- **Reinstate and increase Title VII funding to support geriatric education and career support programs.**
- **Have states provide financial incentives and career ladders to support the recruitment, training and retention of geriatric direct care workers.**

Geriatric Workforce Continued

- **Provide federal/state financial incentives to support advanced training and cultural competence in geriatric medicine, mental health, social work, nursing and dentistry.**

Strategies to Address Healthcare Disparities

- **Work with appropriate accrediting bodies to develop cultural competence curriculum for geriatric and other health-related training.**
- **Eliminate barriers to healthcare access arising in connection with:**
 - **Gender**
 - **Race**
 - **Ethnicity**
 - **GLBT**

Strategies to Address Healthcare Disparities Continued

- **Promote and support community-based participatory research to identify best practices for older adults of various races, ethnicities, and cultures.**

Develop Innovative Strategies

- Healthy Nutrition
- Healthier Lifestyles
- Care for Veterans in all Settings
- Responsiveness to Mental Illness
- Innovations in Aging Research
- Improved patient Advocacy to Assist in all Care Settings
- Issue Surrounding End of Life Care
- Healthcare for Indian Tribes
- Health Education and Health Literacy

Civic and Social Engagement

Policy Track Outline

Track 5: Civic Engagement and Social Engagement

Resolution 56: Develop a National Strategy for Promoting New and Meaningful Volunteer Activities and Civic Engagement Activities

Resolution 59: Reauthorize the National and Community Service Act to Expand Opportunities for Volunteer and Civic Engagement Activities

Track 5: Civic Engagement and Social Engagement

- **Simultaneous with reauthorizing the National and Community Service Act (NCSA), reauthorize the Domestic Volunteer Service Act (DVSA), with the following provisions:**
 - **Double** total number of Foster Grandparents (FG), Senior Companions (SC), and RSVP volunteers to 1 million by 2010.
 - **Expand** RSVP program to every county in the nation, including tribal organizations.

Track 5: Civic Engagement and Social Engagement

- **Simultaneous with reauthorizing the National and Community Service Act (NCSA), reauthorize the Domestic Volunteer Service Act (DVSA), with the following provisions Continued:**
 - **Increase** income eligibility cap for FG/SC programs from 125% to 200% of national poverty level.
 - **Lower** eligibility age for FG/SC programs to 55 (from 60) to recruit leading-edge boomers.

Track 5: Civic Engagement and Social Engagement

- **Expand Older Americans Act:**
 - Integrate Civic Engagement into the OAA and the established aging network.
 - Enable senior centers to provide transition planning programs for baby boomers, and pilot projects through Title IV grants.

Track 5: Civic Engagement and Social Engagement

- **Create Incentives:**
 - Fund the *Silver Scholarships* program, a \$1,000 tax-free transferable education award, for older adults who serve 600+ hours per year.
 - Provide tax credits for volunteer time and expenses.

Track 5: Civic Engagement and Social Engagement

- **Remove Barriers:**
 - Eliminate volunteer driver liability to both encourage volunteer drivers and to help volunteers access opportunities.
 - Expand home-based volunteer opportunities in addition to transportation assistance for disabled Americans.

Track 5: Civic Engagement and Social Engagement

- **Promote Corporate Citizenship:**
 - Provide subsidies, tax credits, and other incentives to encourage the business community to expand and reward volunteer opportunities for their employees and retirees.

Track 5: Civic Engagement and Social Engagement

- **Presidential Commission:**
 - President to establish a national commission to develop a blueprint for tapping boomers and older adults as social capital. Commission to include broad representation from private and public sector.

Track 5: Civic Engagement and Social Engagement

- **Fund for Innovation:**
 - Establish a fund for innovation to foster the growth of promising practices and program models that promote volunteering by boomers and older adults to address critical human and community needs.

Track 5: Civic Engagement and Social Engagement

- **Launch a National Volunteering Campaign:**
 - Develop a national marketing and communication strategy to stimulate a new spirit of volunteerism.
 - Create a national online clearinghouse that matches volunteer skills and experience with volunteer needs.
 - Establish a standard toll-free number, such as the “211” Hotline, to link/match volunteers with local volunteer opportunities.

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Technology and Innovation in the Marketplace

Promote the Integration of Health and Aging Services to Improve Access and Quality of Care for Older Americans (Resolution 61)

- Update Medicare to place greater emphasis on establishing cost-effective linkages to home and community based options through the Aging Network to promote chronic disease management, and increase health promotion and disease prevention measures.

Promote the Integration of Health and Aging Services to Improve Access and Quality of Care for Older Americans Continued (Resolution 61)

- Ensure access to health/aging services by all senior populations through the establishment of a new Title under the OAA to create Aging and Disability Resource Centers (ADRCs) as a single point of entry in each region across the nation charged to coordinate health and aging programs and ensuring access to diverse populations.

- Include in OAA provisions to foster development of a virtual electronic component data base that is shared between providers (i.e., medical, health, social services) – especially home and community based services.
- Create a standard set of definitions and codes for a healthcare and wellness record to allow easier interfaces between multiple information systems and establish reimbursement incentives for systems that incorporate these standardized definitions and codes.

- Facilitate improved standardized information and exchange/communication among providers—health records, billing, and other forms/ paperwork.
- Identify, assess, and address federal and individual state regulations that prevent sharing information between systems.
- Amend HIPAA and other restrictive regulations to allow meaningful communication between health providers and the aging network regarding client care.

Develop Incentives to Encourage the Expansion of Appropriate Use of Health Information Technology (Resolution 62)

- Advance the adoption of technology for enhancing the effectiveness and efficiency of the healthcare workforce through such financial incentives as:
 - Expanded Medicare/Medicaid coverage for telehealth
 - Reduced cost of malpractice insurance
 - Reduced licensing fees
 - Low interest loans
 - Tax credits
 - Sales tax exemptions
 - Private sector awards

- Include incentives for HIT adoption in rural and medically- underserved areas
- Increase accessibility to and decrease cost of health information technology by reviewing regulations such as HIPAA, fraud prevention, anti-kickback and Stark restrictions to facilitate deployment of such technology.
- Improve reimbursement policies to encourage investment in and use of Health Information Technology

- Fully fund American Health Information Community and the Office of the National Coordinator for Health Information Technology
- Establish a national commission for advancing health information technology in such areas as:
 - Common standard of data exchange
 - Electronic health records and standards
 - Interstate healthcare and reimbursement
 - Competitiveness through innovation (research and development)
 - Incentives for technology adoption and education (providers and consumers)

Cross-Cutting Issues

Cross-Cutting Issues

- Charge National Academy of Public Administration to review alignment of programs for older Americans and provide recommendations to the Domestic Policy Council

Cross-Cutting Issues

- **Incorporate key principles in administrative action and legislative proposals:**
 - **Coordinated longitudinal services across the spectrum of medical and social services including housing, transportation, caregiver support, nutrition and medical care**
 - **Integration of funding streams**
 - **Pay for performance for continuity of care**
 - **Consolidation of data bases**
 - **On-going evaluation incorporating technological innovation**

Crossing-Cutting Issues

- **Integrate delivery systems to meet 21st Century needs by creating a new title in the OAA “Community Preparedness for an Aging Population”. This would support AAA’s to assist cities, counties, tribal councils as well as the private sector to address the needs of older adults in the areas of housing and transportation, health, human services, public safety, recreation, and workforce development. The goal is to ensure “aging well in livable communities”**

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Crossing-Cutting Issues Continued

- **Encourage design for an aging society that is the standard rather than the exception including: housing design; accessibility; building codes; signage; transportation;**
- **Create 20 funded model integrated networks in various types of communities to serve as models for the country.**

Cross-Cutting Issues

- **Ensure accountability for implementation of the 2005 WHCoA recommendations by securing Congressional and other support, including funding, for a Bipartisan Commission.**
- **Make records and documentation from the WHCoA available and the White House should recognize the work of the WHCoA.**
- **Conduct an evaluation of the 2005 WHCoA by surveying delegates.**

Cross-Cutting Issues Continued

- **Delegates should continue the work of the 2005 WHCoA within their state by convening meetings to disseminate the recommendations, implement strategies and obtain grassroots support.**
- **Consider the concept of convening a Native American WHCoA.**

Cross-Cutting Issues

- **Develop a national strategy for supporting informal caregivers**
- **Offer a range of financial and other incentives to encourage caregiving such as: tax credits; affordable healthcare; public disability insurance; credit for time for social security; inflation protection for peak earnings; respite care**

Cross-Cutting Issues Continued

- **Double the \$162 million appropriations level for the National Family Caregiver Support Program and include aging caregivers of adults with lifelong disabilities and expand the definition of “caregiver” to include friends and neighbors.**
- **Permanently authorize the Aging and Disability Resource Centers through the OAA to be supportive resource centers for caregivers.**

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Top Ten 2005 WHCoA Resolutions (By Resolution Number)

- R 17 – Reauthorize OAA
- R 22 – Ensure Older Americans Have Transportation Options
- R 30 – Develop a Comprehensive LTC Strategy
- R-36 – Improve Recognition, Assessment, and Treatment of
MI/Depression Among Older Americans
- R-40 – Attain Adequate Numbers of Healthcare Personnel
- R-41 – Support Geriatric Education and Training
- R-42 – Promote Innovative Models of Non-institutional LTC
- R-50 – Strengthen/Improve the Medicaid Program
- R-51 – Strengthen/Improve the Medicare Program
- R-71 – Improve State/Local Based Service Delivery Systems

2005 National White House Aging Conference

Opening Prayer

DONE IN TEWA & TRANSLATED

December 14, 2005

**JOE GARCIA, GOVERNOR, SAN JUAN PUEBLO AND
PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS**

With all due respect. I am Sokuwa Owing Taa

I greet you this morning; I come before you with honor and respect

I have been asked by this honorable delegation to give an opening prayer

Today is a day to honor our elders, but as well to honor all people

In the midst of all that transpires today and things that have transpired in the past

We continue to strive for the well being of all people

Today especially and this past week we have sought to find ways to make things better for our aging through out our country

So important it is to understand that there are many ailments that don't have to be

We continue to struggle to make things better for all our people, the elders, ourselves, the young ones and even the unborn ones

We can provide much more to meet the needs of our people

But we must work together

Our elders have always told us, if you work together; put your minds, spirit, and energy for the betterment of those in need

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It will then be easier to accomplish

We have all these resources that we should work with

We continue to work separately, and that is not the way

We should take the messages given to us

You will see that the true heartfelt efforts will be heeded and supported

Remember that things that are hard to accomplish don't just happen because we wish them to be

We must work ever so diligently, patiently and with perseverance

To ensure that our efforts are successful

We ask the Great Spirit to help us, to be with us as we move toward a better future for all of us, the young ones and especially for the aging

We ask that those who are the decision makers be provided the blessing and the guidance to make the appropriate decisions on our behalf

We also ask that all of you have safe trips back home and spread the blessings with your family, friends, and community

Be happy, be strong, be blessed, and be respectful to all

This is what the creator has placed in my brain to relay to you

It is not normal to put these thoughts in English please forgive me for doing so

I respectfully remain, Sokuwa Owing Taa, Mark of the Misty Lake

Thank you

White House Conference on Aging

Closing Plenary Luncheon

December 14, 2005

ROBERT BUTLER, MD, PRESIDENT AND CEO OF THE INTERNATIONAL LONGEVITY CENTER

Thank you, Dorcas. And I'm wearing my red tie, signifying this healthy heart. Now I originally came to talk about some new information from the world of economics with respect to the remarkable interrelationships between health, longevity and wealth. We're also gathered together here at a very interesting time in which we see the reallocation of responsibilities among business, government, the civil society, and with greater and greater emphasis upon personal responsibility, both as individuals and as families. We're also gathered together at a moment in time when we have gained a remarkable increase in longevity, one of the great historic demographic shifts of all time, what we've called the revolution in longevity. We've gained an additional thirty years of life in the last century, with promises of more to come in the twenty-first. What used to be the distinct advantage of the few has become the destiny of the many.

Now we've long realized that as societies become wealthier, they're in a better position, obviously, to provide more benefits for their citizens, including health benefits. But it's interesting to realize that the reverse is also true. Various departments of economics and economists of varied persuasions, ideological and otherwise, from the University of Chicago, Harvard, Yale, Belfast, and our own International Longevity Center have shown that as societies become healthier and more longevitous, greater wealth is generated. For example, two countries that are in every way identical, but one has a five year advantage in longevity has a much faster growth in gross domestic product.

And if you think about it from a mechanism point of view, and you look at some of the very interesting work at the Rand Corporation, and follow the life course of a child, one who is healthy and vigorous and does not miss school, and through adulthood does not miss work, is able to be more and more productively and civically engaged throughout life and to actually save more and invest more. This further insures the lifelong productive and civic engagement. And we know of course that in Europe, Japan, the United States, the pressure is on for people to work longer, since people, after all, are living longer. And we also know from studies that we did at NIH back in the 1960's and 50's, and many others have found similar results, that if you have something to get up for in the morning, some goal, something important to do, people actually live longer and live better. This is a very happy convergence, something that's good both for society and for the individual. This certainly serves productivity, both individual and national. And of course we're now confronted with the possibilities of a worker shortage.

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Now there's a second connection between health and wealth to be mentioned, and much of the focus is upon the sense of providence, of thinking and planning ahead. I'm talking about what the Japanese call the silver industries. We call it the mature market, and in particular, the health industries, pharmaceutical, hospitality, travel, and the financial services industry. After all, living longer, both the individuals and societies, we have to plan more, we have to finance our longevity; we have to also be more attentive to maintenance of our own health and quality of life. And word "future" figures now in many programs, for example, the new Australia Future Fund, our own Social Security, 401k's, and all of our efforts to advance health promotion and better life styles.

So what else must we do to build upon this new knowledge about health and the future, all of which in my judgment speak to increasing both individual and collective productivity. One is the obvious need to redesign our health care system. Medicare, as wonderful as it is, is forty years old. It was established, as you know, based upon employer-based insurance, acute in focus, in terms of health care, largely oriented towards the concept of a man about forty years of age, and there were no geriatricians at the table. We need a very different type of health care system; moving along the continuum from health promotion to disease prevention, through acute care, through community-based care with greater emphasis upon community, long-term care, and certainly end of life care with the very important components of palliative and hospice medicine.

Second, we need to be much more attentive to a national campaign that will address our lifestyle. Last spring we had a paper in the *New England Journal of Medicine* concerning the rise of overweight and the sedentary life. We need to have a national walking campaign, and the need for us to have a prudent diet campaign, because otherwise we risk this extraordinary longevity which we've gained. And here the President's Council of Fitness and Sports, the American Heart Association, the Centers for Disease Control and Prevention, many private foundations, like the Robert Wood Johnson Foundation and others, can join together in a really serious, reinvigorated effort to advance our health and longevity, again contributing to both our individual capabilities of productivity and national productivity.

Third, we must create geriatrics in this country. How can we maintain vigorous and healthy older people if we do not have doctors that are well trained to understand the very special clinical differences? Just as we have pediatrics, we must have geriatrics. Older persons may have a heart attack, and yet only appear confused. They may have a thyroid condition that reveals itself just the opposite of what would be expected by the diagnosis of that thyroid disease. The hazards of heat and cold which we've seen that affect older people; the problems of adverse polypharmacy, and so forth.

These are just among the many issues that we need to make sure that our students understand. No one, but no one should graduate from medical school or any health services school, nursing, allied health, social work, without understanding the very special conditions of older people, and

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no one should graduate from a residency in medicine, for example, whether it's gynecology, urology, neurology, whatever, without understanding the very special conditions that affect older people.

Now when I had the very wonderful and special privilege of founding the National Institute on Aging, my legislative authority in the Research on Aging Act did not make it possible to train geriatricians. Compare that with the founding of the National Heart Institute in 1947. In the first twenty-two years existence of the institute it was able to train 16,000 cardiologists. The previous speaker certainly would appreciate the fact that this probably had at least something to do with the 60% reduction in deaths from heart disease and strokes since 1960. All because of having the opportunity to develop a field like cardiology. We need to have a private public initiative that really supports the development of geriatrics in the United States. It wouldn't take much. In our own experience, about ten teachers, ten key people to maintain first rate clinical services so students can learn, to have an academic research component which invigorates the curiosity of the student, can provide the kind of core group that you need within our one 144 medical schools. That's 1440 doctors out of 740,000 physicians in the United States.

Fourth is, we must invest in basic research on aging. And that means further support for the National Institute on Aging. What is it in our bodies that predisposes us to develop the age-related disease? Why does 80% of all cancer occur in people over fifty years of age? And Alzheimer's disease and dementia and frailty? Frailty and dementia are certainly the twin disasters of old age. And we must begin to invest more if we're going to maintain the productivity of our country. For years I have referred to Alzheimer's disease as the polio of geriatrics, and the nursing home is the iron lung of geriatrics. Fortunately we no longer hear the hum of iron lungs, and the fearful concerns of parents in the spring and summer because of the possibilities of polio. Doesn't this demonstrate very well the importance of research as the ultimate cost containment and the ultimate service to humanity?

Fifth, we need to have a national care giving initiative. There too, certainly the sapping of productivity, particularly in the lives of women, who provide so much of the care giving in our country. I personally believe that we should provide Social Security credits for the timeouts that women experience in childcare, in elder care, in disabled care.

Sixth, we have to recreate a different kind of educational system, one that's lifelong. Long ago we've talked about the three blocks – education, work, and retirement. We must interweave those activities of continuing education, continuing leisure and work, and an opportunity to constantly re-invent ourselves.

And seventh, we must transform the very culture and the personal experience of growing old in America. And I'm thinking particularly of the extent to which ageism occurs. At the International Longevity Center we have now issued and brought them here, report cards related to various domains in which ageism occurs in America today. It's one of the last vestiges of prejudice which we must overcome. Prejudice even in clinical trials, with respect to new medications, where there are no FDA

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requirements with respect to representation of older people. Where we have only one in ten nursing homes meeting federal standards. Where we have cash balance programs and pension systems which are adverse to older people. We will be issuing the full documentation of this early in March.

There are baby boomers here. I want you all to wake up and to realize that you're a generation at risk. And within seventeen days the oldest of you will hit 60. And you will reach your maximum size about 2025. But you know, society is not prepared for you and you're not prepared for longevity. Such precautions can't happen overnight. We can't just suddenly have well-trained doctors that understand the specific issues of aging. We can't just suddenly solve Alzheimer's disease and the other dementias. We can't just suddenly decide that you should begin to save and invest in order to have a financially secure old age. The maximum reach of the baby boomers is just twenty years from now.

So there needs to be a sense of urgency that we take away from this important White House conference on Aging. And yet the truth is that we haven't really put our energy to work on a national scale, and I'm hoping this White House Conference will help to mobilize us. Only 2% of foundation money goes to the field of aging, for example, pointed out by Corinne Reider, the President of the Hartford Foundation. A despite some efforts by the business community and by the civil society and by all of us as individuals, we still have not made a major effort to address this profound demographic event. We haven't as individuals taken full responsibility for our own health, and for maintaining our own financial security. The clincher, I think, about this wonderfully new and diverse economics work, is that it tells us that longevity and health are drivers of wealth. That we do not need to accept the Gloomy Gus' view that old age and longevity are burdens that are unsustainable. The facts are on our side.

Now I have to get very serious for a moment about an unfortunate event that's happened concurrent with this White House Conference on Aging, one that's ironic, even absurd. As you know, the conferees voted for resolutions 40 and 41, related both to the capacity or to the number and the training programs in geriatrics. In fact these two resolutions were among the top ten. But you may not know that this week our government dismantled Title 7 of the Public Service Act, which is the basis of training for geriatrics in the United States. And this very Monday evening, starting at six-o'clock, this very last Monday evening, the House Committee related to Health, Health Education, Labor and Pension, agreed to the zeroing out of this educational program in geriatrics. For those who may not be fully familiar, Title 7 provides support for fifty geriatric education centers in our country to a tune of \$19 million. It provides fellowships in dentistry and medicine, behavioral and mental health, at \$7 million. It provides academic career awards for teachers – for teachers. It's chicken and egg. If you do not have the teachers, you cannot have geriatrics. That's \$6 million. A total of \$31.5 million. This I would tell you, out of a federal budget of \$2.3 trillion, and a gross national economy of some \$12 billion – I seriously misspoke - \$12 trillion. So it's a modest amount of money,

\$31 million, and to see the end of the development of geriatrics is sad indeed. And the impact on young people who've been recruited to a difficult and challenging field who next September, if this dismantling

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holds up, will not have their paycheck, even though they competed successfully for these awards.

So what can we do? I would like each and every one of you who may know a member of Congress, whether on an appropriations committee or not, try to register your concern about the development of this important field. In Great Britain, every medical school has a department of geriatrics; it's the third largest specialty. And here we are in the United States having had great pioneers in developing this field, and to see it disappear - So that's one thing we can do.

Another, I think, is that a number of us have been talking about the need to establish a blue ribbon commission, perhaps very similar to the one that developed in the honor of and directed by Dr. Louis Sullivan, related to diversity and the problems of minorities in medicine; a very successful commission. But it would have to have very specific charges; an agenda that they would have to address. And this should, I think, be a private foundation supported in order for us to strongly mean what we say, that we really need to have partnerships between the public and private side.

The agenda: charge number one, how can we build geriatrics in the United States? Second, to reinstate the second year of the clinical geriatric fellowships programs that have been supported by the Veterans' Administration, and by and under Medicare. Because you can't create a teacher overnight, you really need to have that opportunity of five or more years to develop a teacher.

So you see why I say we have a generation at risk twenty years from now since we need five years even to develop the teachers in geriatrics. And it is ironic that Medicare itself, which has a graduate medical education fund, which has supported all sorts of specialties, other than the one-year fellowship, has never supported the development of geriatrics. Isn't that another irony; Medicare set up to service the old. We also must equalize the payment structure between private insurers and Medicare, because otherwise we run the risk of physicians, busy in their offices, caught up in their own private economics, not being able to deliver services to older people.

And the commission should address ageism and denial; the fearsome thought of growing old that I'm afraid underlies a lot of what happens here. And I think it should be given the charge, why not develop full-scale departments of geriatrics and gerontology in the United States?. I'm not just talking about medicine - nursing, social work, dentistry, paraprofessionals, allied health; in this aging revolution we need them all. We need to have departments, in part because of the political power that a department has within almost any institution of higher learning. And we need to have a counterpart of what happens in Great Britain. And I've learned from my dear friend Dr. Françoise Ferette, who's in this audience, and who's from France, that France is beginning to move rapidly in the development of geriatrics.

So - geriatricians certainly have heart, and they're very concerned about their patients who have hearts, and they realize that the number one reason for admission into hospitals is congestive heart failure, and that half of all deaths are related to heart disease. And I have on my red tie, and I applaud the efforts, all the efforts that have been expressed these several days to sustain healthy hearts,

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healthy minds, and healthy and productive aging. And I think we all want to work towards that end. But I must say, my heart is heavy with the thought after all these years in which I had hoped and worked to develop geriatrics, to see it dismantled at the very time we are having this important White House Conference on Aging. And so I need your heartfelt support, we all do, older people do, and all who would grow old do, in terms of having the kind of health and social care which can only come about with the advances of geriatrics and gerontology. So all the best and thank you very much.

Closing Plenary Luncheon

Wednesday, December 14, 2005

**REMARKS OF
THE HONORABLE DORCAS R. HARDY
CHAIRMAN, WHCoA POLICY COMMITTEE**

I would like to thank the Oneida Nation Color Guard for coming from Green Bay, Wisconsin to be here today, and Governor Garcia for leading us in the pledge of allegiance and providing us with a blessing as the 2005 White House Conference on Aging comes to a close.

I would like to recognize all the delegates from tribes and tribal organizations across the nation who have joined us for the 2005 WHCoA. Thank you for your continuing contributions to this country and to this Conference.

I would like to acknowledge the generous sponsor of today's lunch – Pfizer Pharmaceuticals — and in particular Karen Katen, Vice Chairman of Pfizer, Inc and President of Pfizer Human Health. Unfortunately, Karen has asked that I send her regrets that she could not be with us today and her warmest regards for a successful Conference.

Welcome to the closing event of the 2005 White House Conference on Aging - the Healthy Heart Luncheon! I see lots of red out there which reflects our collective support for the American Heart Association's Go Red for Women campaign. Thank you for supporting this important cause.

As many of you know, the American Heart Association has launched a national campaign to raise awareness about cardiovascular disease, which is the number one killer of U.S. women, claiming about 500,000 women's lives a year.

I hope you have received your pin that is at your place — generously donated by the American Heart Association — please wear it as a reminder of the urgent need to fight this life-threatening disease.

— And while this campaign is focused on women — we know that for all — men, women, young people, baby boomers and older persons — heart disease CAN BE PREVENTED by embarking on a healthy lifestyle — it is never too late to start.

It is now my personal privilege to introduce the man who knows a lot about prevention and the importance of leading a healthy lifestyle.

Dr. Robert H. Eckel began his tenure as President of the American Heart Association this past July.

Prior to this appointment, Bob served as an American Heart Association volunteer for more than 20 years.

He currently is a Professor at the University of Colorado School of Medicine where he holds an endowed Chair in Atherosclerosis. He also has a joint appointment in the Department of Food

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Science and Human Nutrition at Colorado State University and is renowned for his research into nutrition, health and obesity.

Bob and I share a passion for obesity prevention and a serious concern about the health and economic tolls it is taking on our nation. Obesity is a major risk factor for cardiovascular disease.

I am so pleased that Bob has agreed to join us today and to spend some time talking about the American Heart Association's work. Ladies and Gentlemen, Dr. Bob Eckel. {Eckel speaks and shows PSA}

Thank you Dr. Eckel.

(lunch is served)

Introductory Remarks for Robert N. Butler, MD

President and CEO of the International Longevity Center- USA

Dorcas Hardy:

This afternoon I am very pleased to introduce someone who really needs no introduction – Dr. Robert Butler, Professor of Geriatrics at Mount Sinai Medical Center, President and CEO of the International Longevity Center – USA.

In 1975, he became the founding director of the National Institute on Aging of the National Institutes of Health, and in 1982, he established the first department of geriatrics in a U.S. medical school.

Dr. Butler's extensive research on healthy aging has resulted in a different vision of aging – bringing our attention to ways in which we can live not only longer, but more productively and successfully.

As the Chair of the Advisory Committee for the 1995 White House Conference on Aging, Dr. Butler is a veteran of White House Conferences, more importantly, he is a friend – and he has a passion for aging issues and their solutions! Today he will speak to us about the importance of productive and successful aging.

Thank you, Dr. Butler, for your inspiring words. We recognize the leadership you have provided to our country over the past many decades and the unwavering commitment you continue to demonstrate to the future and betterment of aging throughout the world

I know I speak for everyone here today when I say you continue to have our deepest respect and admiration.

Now, I am delighted to introduce you to some exceptional folks who are gracing us with their gift of music as we near the conclusion of the Conference.

We are so pleased to have the Singing Seniors Chorale and their director and accompanist, Dr. Jeanne Kelly of the Levine School of Music with us this afternoon.

I know they have a busy schedule during the holiday season – and are appearing at the Kennedy

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Center tomorrow so this is a real treat for us. Ladies and Gentlemen, The Singing Seniors, and their director Jeanne Kelly.

CLOSING

Dorcas Hardy

{To the delegates:} Well, we made it!

And what an incredible four days it has been. It is a major milestone on a journey that for many of us started many months ago and, for some, even years.

I'd like to take this opportunity to once again thank the Policy Committee, Advisory Committee and the WHCoA staff who made this Conference possible.

I congratulate all the delegates for making it this far, and for the heartfelt efforts you have made over the past 3 days.

Personally, I have witnessed great enthusiasm, good humor, and endless energy throughout the Conference as the democratic process played out in rooms all over the hotel.

I have seen people eloquently and sometimes passionately share their thoughts and ideas.

I have seen diverse opinions expressed and consensus achieved.

The 50 resolutions that YOU voted on – and the corresponding implementation strategies — are representative of the everyday issues and challenges that impact each of us – or will - in our homes, our communities, our cities, states and across our country.

Those issues – whether it's the best way to care for a family member — to how we will spend and finance the next third of our lives – or deciding to start today to live a healthier life – these are issues that shape our values as individuals and as Americans. And they are all about the future.

It is important, however, that we remember and honor the past.

While we baby boomers may think we have cornered the market on what is “new and exciting,” these issues we have discussed this week have been with us since our country was much, much younger — and frankly, so were we.

We know we are not the first generation to grow old.

The issues that impact our aging have just become more evident and dramatic as our numbers swell, and we begin to enter another phase of our lives — which can be exciting and frightening all at the same time.

But we know we are not alone.

Those of you here today who are part of that “Greatest Generation” — which includes my mother and late father — have led us to where we are today with fortitude, personal sacrifice and an enduring sense of history. You still have much to teach us, and we are not too old to learn.

Several of us on the Policy Committee had a chance to be in San Antonio in late September for our

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final Solutions Forum which focused on civic engagement and disaster preparedness – timely issues in light of our recent natural disasters throughout the country and the world.

In keeping with our mandate to focus on the aging of today AND tomorrow, most of the excellent presentations in San Antonio were about baby boomers this and baby boomers that.

At some point (and I hope she will forgive me for borrowing her line) Texas Delegate Chris Kyker rose and spoke in eloquent detail — listing with pride the many contributions of the Greatest Generation — a generation to which she, and many of you here, belong.

She concluded by pointing out the Greatest Generation must truly be great — because its absolute greatest contribution is none other than the much celebrated 78 million baby boomers!! So for that, we thank you as well!

As I look out today, I see luminaries in the fields of aging and health and veterans of past WHCoA's. I see representatives of business and industry for whom this Conference has been a unique and enlightening experience.

I see members of faith-based organizations, non-profit, for profit organizations, representatives of technology organizations, members of federal, state, local and tribal governments, and I see great diversity. I see members of the media who are veteran “aging reporters” or ones who just dipping their toes into the pool called aging. I see young people who have their whole future ahead of them — and who, by the way folks, are taking notes.

But mostly, I see people who care deeply about the future of our country who came here this week from every corner of America to try to make a difference for future generations.

Please know that your work is not yet over.

When the fifth White House Conference in history ends in a few minutes, your job as delegates becomes even more important. You are the leaders of the grass roots of this Nation. You are the GRASSTOPS!!

When you go home, I ask that you continue to work to help make the resolutions and the action plans you developed reality.

Whether it's working with advocates to develop the foundation for a national long term care strategy, expanding the geriatric workforce, speaking to employers about retraining of workers, tossing that last pack of cigarettes or sugared donut in the trash, or signing up to volunteer in your community... these are real tangible outcomes of this Conference that will signal our ultimate success – as a group and as individuals.

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I want to take this opportunity to express our thanks to the following:

- 1) The volunteers – 200 plus strong who came from every corner of the country to help with this WHCoA
- 2) Susan Davis International – our logistics firm without whom this Conference would not have been possible
- 3) Last but not least, the staff of the WHCoA – Executive Director Scott Nystrom and all those who have come from Federal agencies and the private sector to make this journey with us.

Over the past few weeks, I have been asked many times about the significance of THIS White House Conference on Aging.

I have thought about that answer quite a bit over the past several days. The significance is you – the delegates.

Whether you were selected as a delegate by your Governor, your Member of Congress, the National Congress of American Indians or the Policy Committee, you have given of your time and energy to help our country prepare for the future at a time when your help is needed the most.

That is what America is all about. You have envisioned the future, and you have done so with courage, innovation and integrity.

I know that your families and communities and businesses are proud of the role you have played here this week and the importance you have placed on your responsibilities as delegates. We are proud of you, too.

If nothing else, I ask you to remember: We know there are Blue States and Red States in this Great Nation. But the issues of our future and the aging of America are Purple.

You are the Grasstops! Use your energy and passion to make a difference.

You have honored us with your presence. Let us go forth and continue to envision the future — for ourselves — for our families — and for our country. Thank you.

The 2005 White House Conference on Aging stands adjourned.



Media Report

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2005 WHITE HOUSE CONFERENCE ON AGING MEDIA COVERAGE

The WHCoA generated more than 300 news articles. Coverage came from national and regional newspapers, news magazines, trade publications, radio, television, Internet and other sources. The WHCoA approved 140 members of the press who applied for credentials at the conference including local, national and international media. National television and radio coverage occurred including C-SPAN which covered the opening plenary session along with Kaisernetwork.org who covered both the opening and closing plenary sessions, as well as the discussion of WHCoA Policy Tracks and the Conference Reports from the Policy Committee.

The Exhibit Hall and Technology Pavilion generated at least 30 print stories including The Washington Post, Associated Press (AP), San Jose Mercury News, The Washington Times, and Business Week. An AP story ran on more than 200 Web sites. Broadcast coverage included Fox News Channel, CNBC, Hearst Argyle News Service, PBS Nightly Business Report, and Channel 9 WUSA.

Media coverage continued to occur in the months following the WHCoA.