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Thank you to the committee and chairman Scott for providing me with the opportunity to testify before you. My name is Dawn Carr. I am a professor of sociology and I direct the Claude Pepper Center, a translational policy center at Florida State University, which was named and funded in honor of one of the strongest advocates for aging policy in U.S. history– Senator Claude Pepper.

Since its inception in 1961, this committee has worked to evaluate critical problems and potential policy solutions to address the immediate needs of a rapidly growing population of older adults in the United States. As we navigate our later years, we are inevitably at higher risk of disability, loss of independence, social isolation, and poverty. In addition, middle-aged adults today face more significant health problems and disabilities than previous generations, and as they move into their later years over the next several decades, they are likely to face more complex health issues than previous generations of older adults.

However, in addition to ensuring that older adults and their families today have the supports they need to manage the challenges of daily living, we need to expand the scope of U.S. aging policy to ensure that future generations of older adults not only survive into old age, they thrive once they get there. Health problems in later life are strongly influenced by events, exposures, and behaviors that occur well before we reach our later years. Although the consequences of regular harmful exposures and habitual behaviors accumulate to erode health over time, there is growing evidence that if we intervene during critical inflection periods, we can modify health trajectories and bolster physiological resilience as we age.

Current clinical care is not designed with this approach, and with Medicare and Medicaid paying over $400 billion per year spent on long-term care alone, there are significant consequences if we maintain current practices. For example, genetic variations and lifestyle factors may place a thirty-year-old at higher risk of advanced heart disease three decades later, but if routine evaluation of blood-based markers shows “normal range” cholesterol, early interventions that could offer significant lifelong protection are unlikely to be discussed. Instead, treatment typically begins when a person is facing more advanced disease progression and irreversible damage has already occurred. Further, what is considered “normal function” is based on population averages, and in a

population facing earlier onset of disease and disability, averages are unlikely to provide meaningful benchmarks for long-term treatments that increase the likelihood of extended years of healthy aging. If our goal is to reduce disability and aging-related disease progression, we need to shift our focus from identifying problems based on deviations from the mean to leveraging a range of strategies that support maintenance of optimal health and function outcomes at all stages of life.

Identifying problems early and addressing health risks is not only important for the quality of life of individuals and their families, the benefits to society are also significant. If people reach later life with fewer years disabled, and several disability-free decades ahead of them, our families, communities, and businesses will benefit. We develop unique skills and abilities as we age that are largely under-utilized. Relative to younger people, older adults are better at processing complex emotions and dealing with interpersonal conflicts. Our goals shift and we prioritize relationships, legacy, and ways that we can make a difference, supporting the wellbeing of future generations. We are more willing to take risks and put our values on the line for the greater good. Multi-generational teams of workers are more effective and more productive than those that include only younger adults. Having a larger group of healthy older adults who have an active and meaningful role in society could help us solve some of the most pressing social problems of our time.

A New Framework for Aging Policy

To create a society enriched by a large group of healthy older people requires a new framework for aging policy, guided by several key principles:

1. An emphasis on health maintenance at every stage of life targeting risks related to aging-associated diseases and disabilities;
2. Acknowledgement of the developmental changes that occur as people move into and through later life, including the way older adults' unique strengths benefit society; and
3. An emphasis on the barriers to healthy aging that result in significant inequalities in health outcomes as people age.

Old age is often defined as age 65 or older, an age that is also often synonymous with retirement. Aside from 65 being the eligibility age for Medicare, this age is arbitrary and provides relatively little information about what people can do. Treating the period in which we are age 65 or older as a monolithic stage of life and age demographic does not make it possible to consider the stark differences in the needs of a typical 65-year-old and a typical 85-year-old, or the systematic differences in the health and function of older adults of the same chronological age.

Older adults who are navigating the period of old age when health problems interfere with daily function, a period sometimes referred to as the "Fourth Age," face significant challenges. Although many people living with certain disabilities lead high quality lives despite their health limitations, the significant losses that come with accelerated physiological aging often lead to poor quality of life, and loss of the ability to live

independently. The needs for of this group vary starkly with older people who are healthy and able to engage in a variety of activities and are seeking to engage actively in meaningful and purposeful social roles. This is the period sometimes referred to as the "Third Age."

Increasing the proportion of our lives spent as Third-agers and reducing the number of years in which people live in the Fourth Age could have a profound benefit for older people individually and for society. Third-agers have the ability to remain engaged in paid and unpaid (e.g., caregiving, volunteering) work. They help their families by providing care to children or adults who are sick, they have the time and wisdom to take on important leadership roles in their community, and they have a drive to leave a legacy, and mentor others. Although we have social programs designed to provide Third-agers with ways to stay busy, these opportunities often are not designed to leverage or support development of the unique capacities of healthy older people, and may even silo older people from younger people who can benefit from their abilities and wisdom. That is, Third-agers have a pool of talent that often goes unacknowledged and untapped.

Despite the potential of an expanded population of Third-agers, having access to a Third Age is not equally distributed. On the one hand, people who have spent their careers working in physically demanding jobs, have been exposed to dangerous materials on a regular basis, or who did not have access to high quality medical care across their adult lives, not only may stop working well before age 65 by necessity, they may not even survive that long. Alternatively, those who have had access to regular medical care across their adult lives and have had "good jobs" may be healthy enough to choose to use their time and abilities to engage in meaningful paid or unpaid roles even two decades beyond typical retirement ages.

Our current aging policy plays a critical role in addressing the needs of adults in the Fourth Age and should remain central priorities of this committee. Issues such as the enormous costs and challenges we face with long-term care as we prepare for a rapidly aging population, and new cohorts of middle-aged adults who, in the absence of major interventions, will continue to experience accelerated physiological aging, including early entry into the Fourth Age. Important Fourth Age policies also include those providing safety nets for poor and low-income older adults who rely on a fixed income because they are no longer able to work, and face increasingly complex health problems coupled with rising healthcare costs.

Expanding Aging Policy to Include Third Age Policy Priorities

To increase the chances that future generations of older adults can spend the majority of their later years in the Third Age will require an expansion of our current aging policy efforts. Aging policies that target the complex factors that shape our third-age life expectancy (i.e., the number of years we are in the Third Age) will ensure that future generations are both healthier and better positioned to utilize their health resources in ways that benefit our families, communities and society as a whole. These policies address issues such as occupational pathways that facilitate financial security in later life for all workers across the life course, access to high quality food, engagement in healthy

behaviors (e.g., exercise), and medical care that is informed by evidence-based research that promotes optimal health function at each life stage. These policies should also prioritize integration of older adults as valued members of our communities, their families, and as they choose, in paid and unpaid social roles.

Consequently, a healthy aging policy framework is one that emphasizes health maintenance at every stage of life, targeting those at highest risk for accelerated aging. I believe the following four key areas are the most pressing: 1) employment; 2) social engagement and social integration; 3) health literacy and lifestyle behavior supports; and 4) healthcare access and early treatment.

Employment and Financial Security

Working in later life is protective of health as people move into and through the Third Age. However, in many industries, older workers are less likely to be hired, and more likely to be excluded from opportunities for upward mobility and offered fewer opportunities for training/re-training. In addition, those in physically demanding or hazardous jobs are unlikely to be able to sustain their work into their 50s and 60s without significant health consequences, leading to early departure from work and retirement prior to full Social Security retirement age.

Hazardous work environments may be inevitable for a certain population of workers, but implementing occupational interventions where possible, and mid-life re-training for transitions to new career paths can increase the chance that workers remain healthy and fully employed until they reach full retirement ages. Part-time jobs are rarely institutionalized as a standard option in U.S. firms. However, making phased retirement or transitions to part-time work opportunities available to all older people would allow older workers to remain engaged in paid work longer. For example, schoolteachers might stay in the labor force longer if they are able to transition from running their own classrooms to splitting a classroom with another part-time teacher.

Social Engagement and Social Integration

Social isolation and loneliness accelerate physiological aging. Isolating older adults within communities is not only detrimental to the health and wellbeing of older people, it also prevents communities from benefiting from their skills and wisdom. There are very few programs designed to reach isolated older adults. Effective programs like meal delivery programs are low cost and have the added potential of improving access to high quality nutritious foods. Expanding these programs could have a significant impact on healthy aging trajectories.

In addition, increasing engagement of adults at all ages in their communities through activities like volunteering not only is health protective to volunteers, it facilitates social integration in the community and helps people of all generations work collectively to solve social problems. Developing a vibrant volunteer work force will require investment in new infrastructure within our communities, an investment that has been shown to provide exponential returns economically and support healthy aging outcomes. For instance, the Senior Corps volunteer programs have shown a conservatively estimated

return of between $3.50 and $5.08 for each dollar invested, reducing burden in the healthcare industry.

Health Literacy and Lifestyle Behavior Supports

Most adults in the United States do not have access to scientifically accurate information or resources they need to maintain lifestyles that greatly increase their chances of achieving a healthy old age and a long Third Age. Expanding the number of community health workers (CHWs) is one of the most effective tools for facilitating healthy behaviors across the life course, helping community members of all ages build trust with the healthcare system and navigate healthcare services to support healthy aging. Recent research suggests that there is a $2.47 return for every dollar invested in community health workers for the Medicaid program alone. For instance, CHWs increase engagement with behavioral health intervention programs which have profound benefits for mental and physical health and increasing health literacy and adherence to healthy lifestyle behaviors. Lack of access to high quality, nutrient dense foods is a persistent problem reinforced by ultra-processed unhealthy foods being subsidized so they are low cost. Making healthy foods financially accessible and disincentivizing consumption of ultra-processed foods is key to increasing healthy aging.

Healthcare Access and Early Treatment

Most adults do not see a doctor regularly to evaluate their health unless they are facing health problems. This is heavily influenced by clinical guidelines and insurance reimbursement. Scientific investments designed to identify disease progression in the earliest stages and effective interventions for halting disease progression is critically needed and can have a significant impact on healthcare costs even over a short period of time. We need to recalibrate health benchmarks so they reflect optimal health thresholds rather than population averages and identify critical biomarkers early enough that we can implement long-term treatment plans. For example, one in 10 adults over 65 has Alzheimer's Disease (AD), with the average person who gets AD living with it for 8 years. AD is among the most expensive aging-associated diseases, with AD treatment costs estimated at $321 Billion in 2022, with costs projected to increase. In addition, about half of all family caregivers care for an adult with dementia, collectively contributing close to 16 billion hours a year, worth about $270 billion, which doesn't count costs related to their foregone wages. However, growing evidence suggests that aggressively treating metabolic and lipoprotein health in middle aged adults will not only significantly reduce the number of adults who go on to get dementia, it will also reduce the number who go on to get diabetes, heart disease, and cancer, the most costly and consequential aging-associated health conditions.

Developing new metrics and strategies for treating early indicators of disease progression such as metabolic and lipoprotein health into the standards of clinical care is key to increasing our Third Age life expectancy. Although more frequent interactions with healthcare providers will be needed to monitor health, MDs are not needed for all stages of successful lifestyle interventions. Most lifestyle-related treatments can be monitored and carried out by nurse practitioners, physician assistants, and other healthcare providers, and with support from lower cost telemedicine monitoring technologies. The

benefits to this approach are not only related to long-term health outcomes, but a recent study showed that a metabolic and lipoprotein health intervention leveraging pharmaceutical interventions alone provided a five-year return on investment of nearly $10 for each dollar invested.

Next Steps

Reframing aging policy to promote healthy aging will require an expansion of our current aging-related policy goals. It will emphasize supporting healthy aging at every phase of the life course with a focus on expanding the Third Age and compressing the Fourth Age into fewer years. It means expanding healthy aging research, improving healthcare literacy and access, and incentivizing health behaviors and health interventions based on optimal health function goals. Finally, it also means thinking about viewing older people as a critical resource that improves our society, rather than as a barrier to societal progress. If future generations of older adults have access to a lengthy Third Age, and older adults can remain productively and socially engaged in meaningful ways into late life, old age could become a period of life we all look forward to, and our society as a whole will benefit.