HEALTH PROMOTION

Achieving High-Level Wellness in the Later Years

Third Edition

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PREFACE

Health promotion initiatives for older adults in the 1980s were mixed more with words of "hope" than action. There is hope, however, that the disinterest and misguided presumptions behind health promotion efforts for older adults will erode in the 1990s. Much of this hope is based on the Healthy People 2000: National Health Promotion and Disease Prevention Objectives (U.S. Department of Health and Human Services, 1990) report. This report contains a number of challenging health objectives that may entice the active involvement of allied health profession efforts to initiate health promotion programs for older adults. The theme of the Healthy People 2000 report for older adults is independence and vitality in later life. Underlying this theme is the concept that health promotion goes beyond disease prevention by regarding health as more than simply the absence of disease.

Health promotion draws from the concepts of holistic health, wellness, self-care, and health prevention. Essentially, health promotion may be defined as the science and art of helping people alter their lifestyles to move toward optimal health. This continuum definition of health promotion is illustrated in Figure 1.

The left end of Figure 1's continuum represents premature death or a state of extreme illness. The right end represents optimal health or well-being. The midpoint is a neutral point or a state of no discernible illness or well-being. Medicine has traditionally focused on the left side of the continuum by working with patients who have symptoms of disease or disabilities. Once an individual reaches the midpoint or neutral point of wellness, traditional medicine has few tools to assist this individual in reaching optimal well-being.

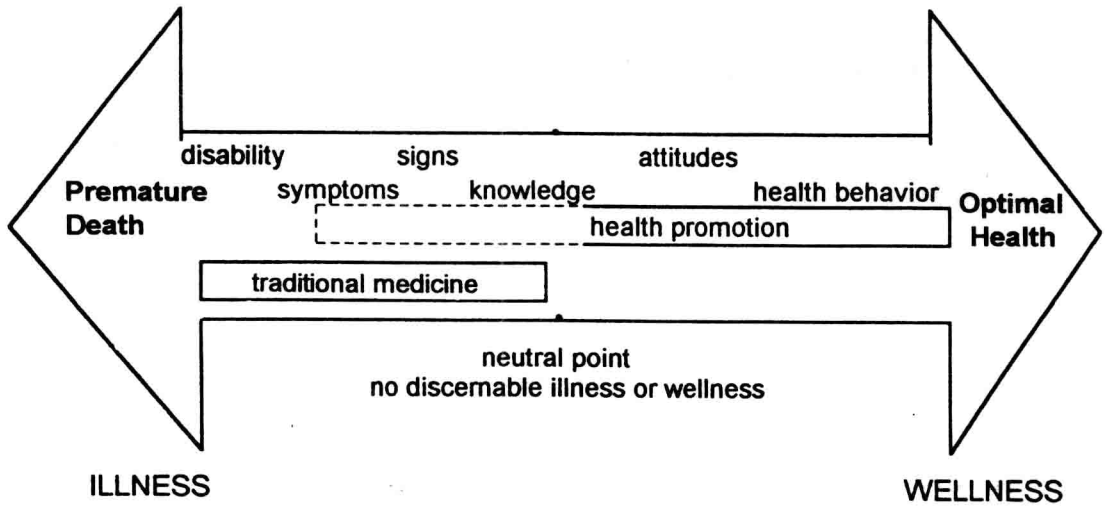

Figure 1. Health continuum.

Health promotion has traditionally focused on the right side of the Figure 1 continuum by working with people who may be described as overtly healthy. The tools of health promotion are the changing of knowledge, beliefs, attitudes, and lifestyle practices and behaviors that reduce health risks and promote optimal health, that is, physical, emo-tional, spiritual, intellectual, and social health.

Recently, health promotion efforts have been directed toward the left side of the continuum as well, by focusing on the rehabilitation of sick patients. For example, exercise programs have been used with cardiac, stroke, or musculoskeleton problems; and nutrition programs have focused on diabetes, osteoporosis, obesity and biochem-ical dysfunction. However, the point is that regardless of a client's or patient's health condition, the goal of health promotion is to help people move toward a state of optimal health. This book examines this dual role of health promotion (i.e., working on the right and left side of Figure 1) as it applies to the elderly.

Yet, Figure 1 would suggest that health promotion generally is an integrated, techno-logical field. To the contrary, health promotion is in its infancy. The practitioners of health promotion include physicians, nurses, recreation therapists, exercise scientists, nutritionists, social workers, physical therapists, and health educators. Each of these professions has experienced some success in health promotion by applying the know-ledge of their exclusive disciplines. Unfortunately, most professionals who practice some dimension of health promotion do not understand the interdisciplinary nature of the field.

If we permit this exclusiveness to continue, the issues of professional turf and how to separate wellness from medicine will impede the future development of health promo-tion programs for the elderly. For example, certification in exercise science leads to more fragmentation in the field and more battles over turf. Payment for services on a fee-for-services basis will encourage further licensing and fuel inflation. The point is that a full range of service providers, both licensed and unlicensed, need to participate in the structuring of health promotion programs for the elderly. Thus the health promotion skills and knowledge evident in this book should be taught and incorporated into existing professional categories in a broadened aging network.

TABLE OF CONTENTS

CHAPTER 1

HEALTH PROMOTION FOR THE ELDERLY: NEED FOR A NEW PERSPECTIVE

Health promotion programs for the elderly cannot be separated from the larger issues of health care, of America's policy choices in regard to aging, or the social, economic, and political environments that govern policy choices. The dominant view among yesterday's and today's policy makers is that health services, especially high-cost, medically based technology, can solve the "aging" problem. Although the attention devoted to the biological and biomedical aspects of aging is important, this exclusive emphasis has diverted attention from the significant influence of multiple social, behavioral, and environmental factors on aging.

Health promotion signifies a shift from a biomedical definition and model of health and disease toward a view that encompasses the social and physical environment, as well as individual lifestyle and behavior. The authors address this paradigm shift from a medical model to a broader health model and its impact on health promotion programs for the elderly. Specifically, we will focus on: (1) older adults and the health care crises, (2) cost-extrapolation projections for future Medicare and nursing home health care, (3) movement toward a new health paradigm, (4) the new rhetoric that surrounds health promotion programs for older adults, and (5) the theory underlying health promotion programs for containing health care costs.

THE HEALTH CARE CRISIS

Estes, Gerard, Zones and Swan (1984) describe the 1980s as an "era of crisis"; e.g., fiscal crisis, energy crisis, productivity crisis, education crisis, health care crisis. Crises provide an important impetus for future policy action and, often, broad discretion by government. Actions by government that may be ordinarily opposed are often readily accepted by the public in response to a crisis. Berger and Luckmann (1966) have called such crises "the social construction of reality." In reference to the health care crisis, Estes et al. (1984) add

> A reality once perceived, comes to exist because others believe and act as if it is real. Policy actions and social consequences flow from such definitions and perceptions, although they may represent only partial realities. Thus we have crises of health care and crises of aging. (p. 94)

The health care crisis, and the role of the elderly in this crisis, has been a source of stormy debate in the 1980s. Paradoxically, the aspect of America's special circum-

stances that seems to require explanation is less the fact of the cost explosion associated with an aging society than the indignant reaction to this crisis.

Health Costs

In 1965, Americans spent approximately $39 billion for medical needs of all kinds. This expenditure amounted to 5.9% of the gross national product (GNP). By 1979 total health care expenditure increased to $212 billion which was slightly less than 9% of the GNP. Health costs in 1984 reached $387 billion (10.8% of GNP) and rose to $425 billion in 1986. Today, health care expenditures are topping the $500 billion mark (11% of GNP). Under our present trend, the annual health care bill will hit a trillion dollars in the early 1990s (15% of GNP) and continue to double every six to seven years thereafter.

A key impact of rising health care costs has been the dramatic increase in health benefit premiums. Health insurance premiums soared in 1989 (22% increase) and are projected to soar even more in 1990. Some firms expect premium increases of 40 to 50%. Factoring in dental plans and Health Maintenance Organizations (HMOs), total health benefit costs increased nearly 17% from $2,354 in 1988 to $2,748 in 1989. Health analysts project that health benefits will surpass $3,200 per employee in 1990--a 23% increase (Thompson, 1989). Califano (1986) described how this soaring cost in health care bills and insurance premiums impacts our economy:

> We pay more for health care than for chrome or upholstered bucket seats when we buy a car. In 1984 the auto industry had to sell at least 500,000 cars and trucks just to pay its health care bills. For each $500 day a patient spends in the hospital, some $30 of the bill goes to pay health benefits for hospital employees. Three cents of the cost of each fast-food hamburger we buy goes to the health industry. A new automobile tire costing $57 includes $2 for health care; a $200 airline ticket, $4. Health benefits for active and retired employees account for $60 of the cost of every metric ton of aluminum ALCOA produces.
>
> Health costs are a large part of the reason why America still can't compete with foreign steel. The United States spent $1,580 per person on health care in 1984—far more than the next highest outlay, West Germany's $900 per person, three times more than Japan's $500, and four times Great Britain's $400. Yet, in each of those nations, health care is sophisticated and modern. Life expectancy is just as high as in the United States and infant mortality is lower. (p. 59)

Medicare and Medicaid

In the 1960s, Congress recognized that America's elderly faced a significant gap between the medical care they needed and what they could afford. Medicare and Medicaid were enacted to close the gap. The rationale behind the Medicare and

Medicaid program was for the government to protect the economic standing of the elderly during their declining years. But like the elderly they protect, Medicare and Medicaid have become less "healthy" with age.

Both Medicare and Medicaid paved the way to a healthier nation and an increased quality of life for older adults. But in 1988 Medicare spending increased 7.7% ($179.9 billion). Hospital spending rose 1.9% and physician spending increased by 18.9%. Medicare was responsible for 27% of hospital bills and 22% of physician bills. Growth in the elderly population and the continued expansion of health services will almost triple the number of hospital days for patients over 65 by the year 2000. The share of hospital beds for the elderly will increase from 30% to 58%. It should not be surprising that the Medicare trustees estimate that the program's health insurance will be bankrupt in the 1990s unless significant changes are forthcoming.

The Medicaid system is also falling on hard times. Medicaid was primarily designed for poor people who qualify under the Aid to Families with Dependent Children (AFDC) and Supplementary Security Income (SSI). AFDC children and parents represent 70% of Medicaid recipients, but they receive less than 30% of the program's funds. The aged, blind, and disabled make up the remaining 30% of recipients and consume over 70% of all Medicaid spending. Medicaid's share of our overall health care expense ranged between 10 and 11% in the 1980s. Americans spend in excess of $42 billion annually in nursing home care, with the government assuming approximately 48% of this tab (mostly through Medicaid).

COST-EXTRAPOLATION AND FUTURE HEALTH CARE COSTS

Escalating health care costs are of immense concern to local, state and national governments. Inflation of hospital and health care provider costs, the emergence of new diseases such as AIDS, and the development of new therapeutic modalities and medical technology are principal factors behind escalating health care costs. In this chapter, however, our focus is on another factor that has and will continue to have a dramatic impact on health care costs in the coming decades: aging of the aged. The "aging of the aged" refers to those individuals aged 85 years and above. This "old-old" segment of society is the fastest-growing age group in the United States.

Chronic Conditions in Old Age

Older adults are afflicted less by acute conditions than young adults. But they are afflicted much more often by chronic conditions, such as heart disease and arthritis. More than 80% of the elderly suffer from at least one chronic condition, and almost 50% report two or more such conditions. Approximately 24% of older people living in the community have severe chronic conditions that prevent them from carrying on one or more major daily life activities (Public Health Service, 1989). The prevalence of chronic conditions and subsequent daily activity limitations increase with age (Table 1-1). People age 85 and older represent only 7% of people age 65 and older but "constitute

19 to 37% of people dependent in home management activities, 18 to 26% of people dependent in personal care activities, 27% percent of people dependent in mobility activities, and 16% of people who were incontinent daily" (Public Health Service, 1989, p. 7-7). These dreary statistics portray a very clear picture of the impact of poor health in the later years.

Projecting Future Health Costs for Medicare and Nursing Homes

Schneider and Guralnik (1990) used the current U.S. Census Bureau projections for the growth of the "old-old" age group to project future costs for Medicare and nursing homes. These projections were based on low-mortality, middle-mortality, and high-mortality assumptions that affect the growth of older age groups (Figure 1-1).

Figure 1-2 provides an overview of the impact of an aging America on Medicare costs. We caution that interpretations from Figure 1-2 should be guarded. Projecting future health care costs from Census Bureau data has many limitations (projected number of individuals age 65 and older, estimates of morbidity at specific ages, estimated health care costs at different ages for specific conditions). Nevertheless, policy makers use projections from Census Bureau data to formulate plans and justify programs. Average annual Medicare costs in 1987 were $2,017 for individuals aged 65 to 74 and $3,215 for those aged 85 years and above. These costs, using the middle-mortality assumption, will nearly double (using 1987 dollars) by the year 2020. By the year 2040, the level of Medicare spending for the age 65 and older population may range from $147 billion (low-mortality assumption) to $212 billion (high-mortality assumption). This three-fold increase in Medicare costs is based on 1987 dollars.[1]

Schneider and Guralnik's (1990) projection for nursing home care costs is even more alarming (Figure 1-3). In 1985 dollars, the cost of nursing home care could rise to between $84 billion (low-mortality assumption) and $139 billion (high-mortality assumption) by the year 2040. The reader should note that approximately 40 percent of current nursing home costs are reimbursed by the federal government through Medicaid. It is quite conceivable that government expenditure for nursing home cost may reach $56 billion (40% of 139 billion).

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[1]In 2031 the first baby boomer will turn 85 years old. By 2040, the average age of the baby boomer will be 85 years old.

Table 1-1. Functional limitations of the elderly residing in communities (not in nursing homes or institutions), United States, 1984 (in thousands, except percent). Covers persons 65 years old and over who were living in communities outside of nursing homes or other institutions (civilian noninstitutional population).

Functional Limitation	Persons 65 years and over	65-74 years old			75-84 years old			85 years and over	Living	
	Total	Male	Female	Total	Male	Female	Total		Alone	others
Total, 65 years and over	26,433	16,288	7,075	9,213	8,429	3,128	5,121	1,897	8,397	18,036
Percent with difficulty in										
Walking	18.7	14.2	12.9	15.1	22.9	18.3	25.7	39.9	20.4	17.9
Getting outside	9.6	5.6	4.5	6.5	12.3	7.5	15.3	31.3	9.7	9.5
Bathing or showering	9.8	6.4	5.7	6.9	12.3	9.2	14.2	27.9	9.9	9.7
Transferring	8.0	6.1	4.8	7.0	9.2	6.0	11.2	19.3	8.8	7.6
Dressing	6.2	4.3	4.4	4.2	7.6	7.3	7.7	16.6	5.0	6.8
Using toilet	4.3	2.6	2.4	2.7	5.4	3.6	6.5	14.1	3.4	4.7
Eating	1.8	1.2	1.5	.9	2.5	2.5	2.4	4.4	1.2	2.1
Preparing meals	7.1	4.0	3.0	4.8	8.8	6.0	10.5	26.1	6.0	7.6
Shopping for personal items	11.3	6.4	4.6	7.8	15.0	9.6	18.4	37.0	11.9	11.0
Managing money	5.1	2.2	2.8	1.8	6.3	5.4	6.8	24.0	4.0	5.5
Using the telephone	4.8	2.7	3.5	2.0	6.0	7.9	4.8	17.5	2.6	5.8
Doing heavy housework	23.8	18.6	11.2	24.3	28.7	15.9	36.4	47.8	28.0	21.9
Doing light housework	7.1	4.3	3.5	5.0	8.9	6.2	10.5	23.6	6.6	7.4
Percent not performing activity										
Preparing meals	5.2	4.6	9.8	.5	5.5	12.0	1.6	8.9	1.1	7.1
Shopping for personal items	2.0	1.1	1.9	.5	2.5	2.9	2.3	7.5	2.2	1.9
Managing money	1.9	1.3	1.6	1.1	2.2	2.1	2.2	5.9	.8	2.4
Using the telephone	.8	.5	.8	.3	.9	1.4	.6	2.1	.8	.7
Doing heavy housework	9.7	8.1	12.7	4.6	11.5	16.3	8.6	15.9	7.1	11.0
Doing light housework	3.5	2.8	6.1	.3	4.0	7.8	1.7	7.1	.7	4.8

Source: Judah Matras, *Dependency, Obligations, and Entitlements: A New Sociology of Aging, the Life Course, and the Elderly*, 1990, p. 291. Reprinted by permission of Prentice-Hall, Englewood Cliffs, NJ.

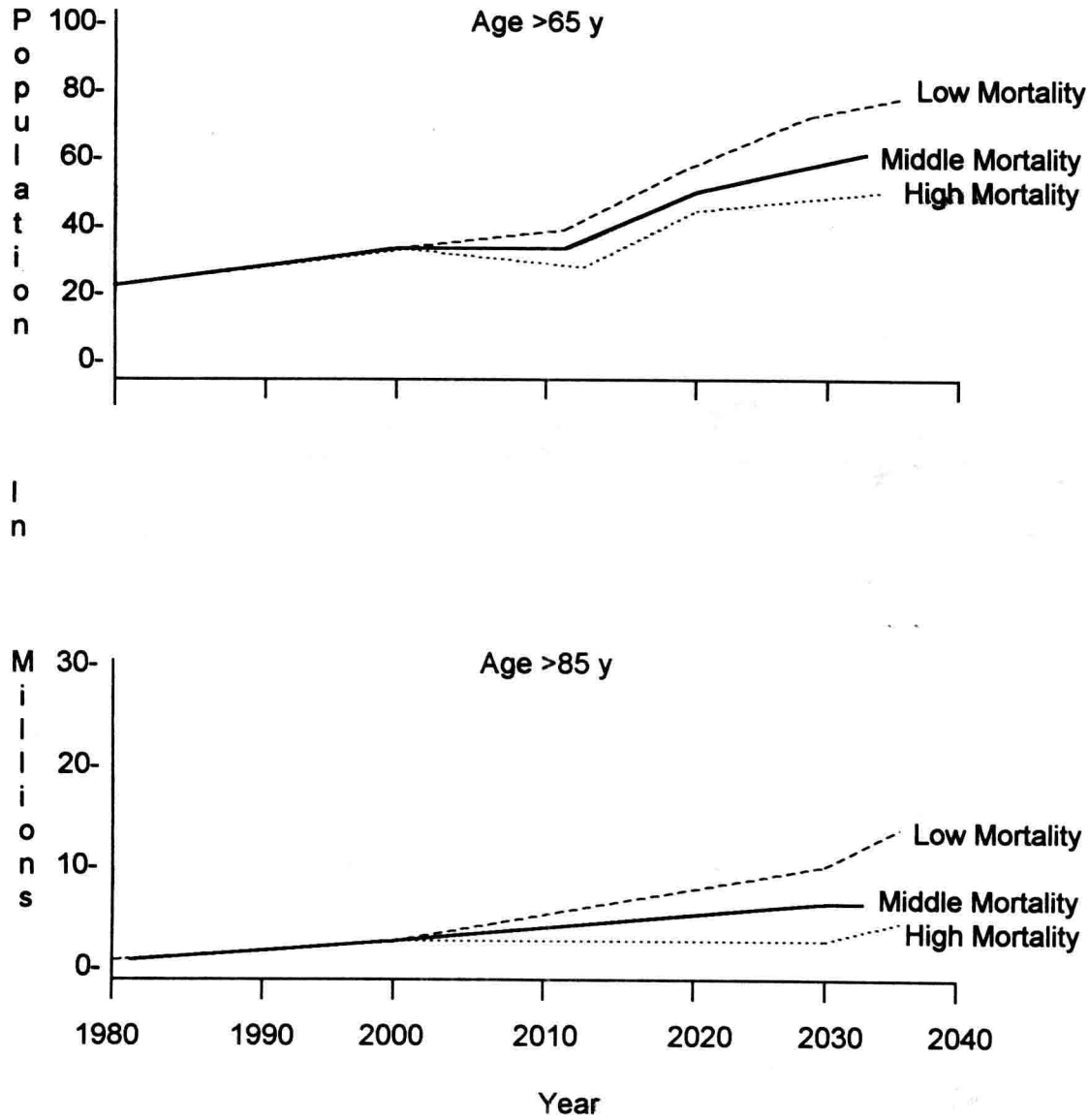

Figure 1-1. Projected growth of the population aged 85 years and above. Projections are based on low- (Series 9), middle- (Series 14), and high- (Series 19) mortality assumptions from the U.S. Bureau of Census.
From *Dependency, Obligations, Entitlements* by Matras, Judah, c 1990. Reprinted by permission of Prentice-Hall, Inc., Upper Saddle River, NJ.

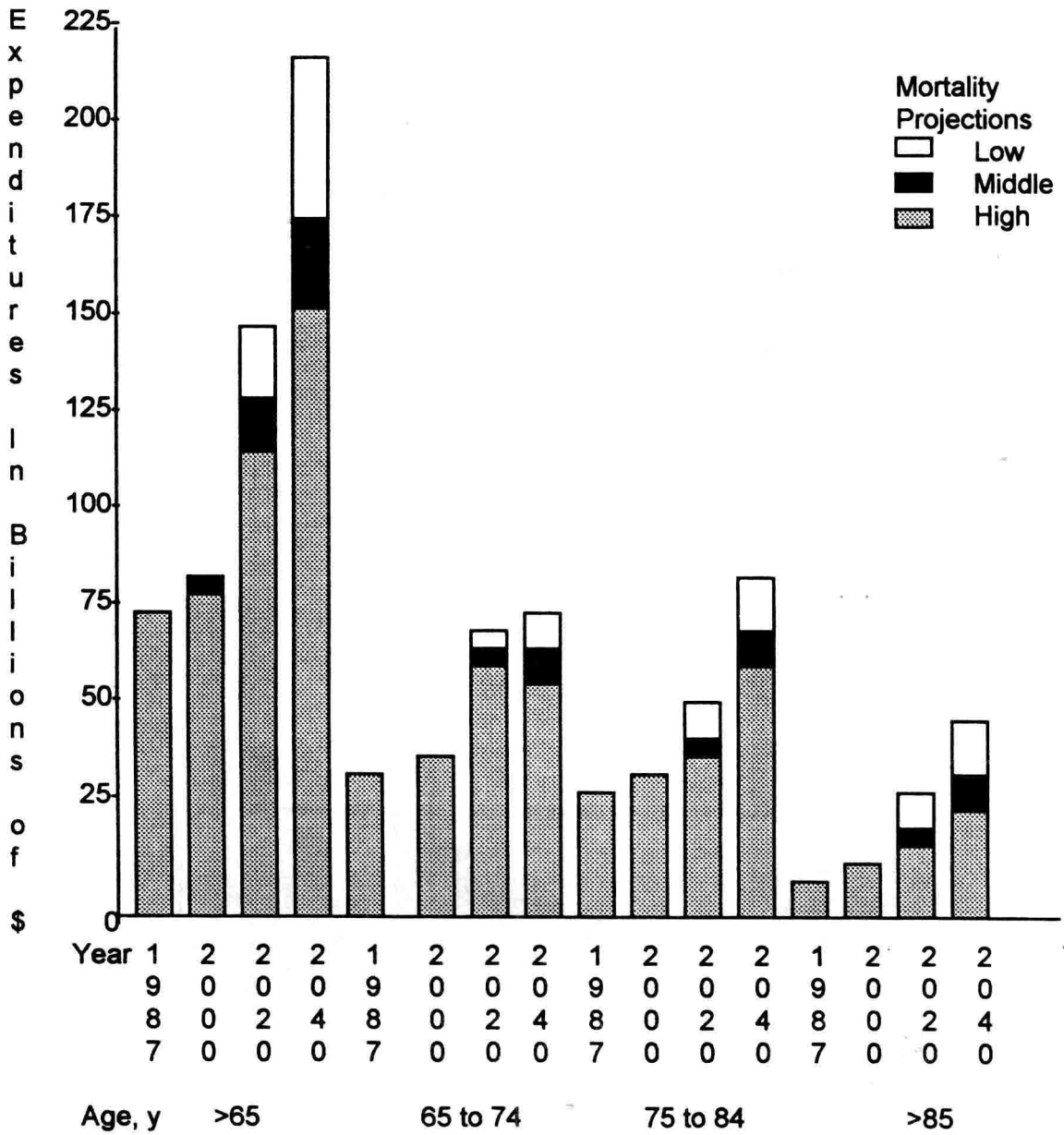

Figure 1-2. Actual (1987) and projected Medicare expenses in 1987 dollars by age group. Average Medicare expenses per person were obtained from data from the Health Care Financing Administration. Cost projections are based on low- (Series 9), middle- (Series 14), and high- (Series 19) mortality assumptions from the U.S. Bureau of Census. Source: E. L. Schneider and J. M. Guralnik. The Aging of America: Impact on Health Care Costs, *JAMA*, (263), May 2, 1990, p. 2337. Copyright 1990, American Medical Association.

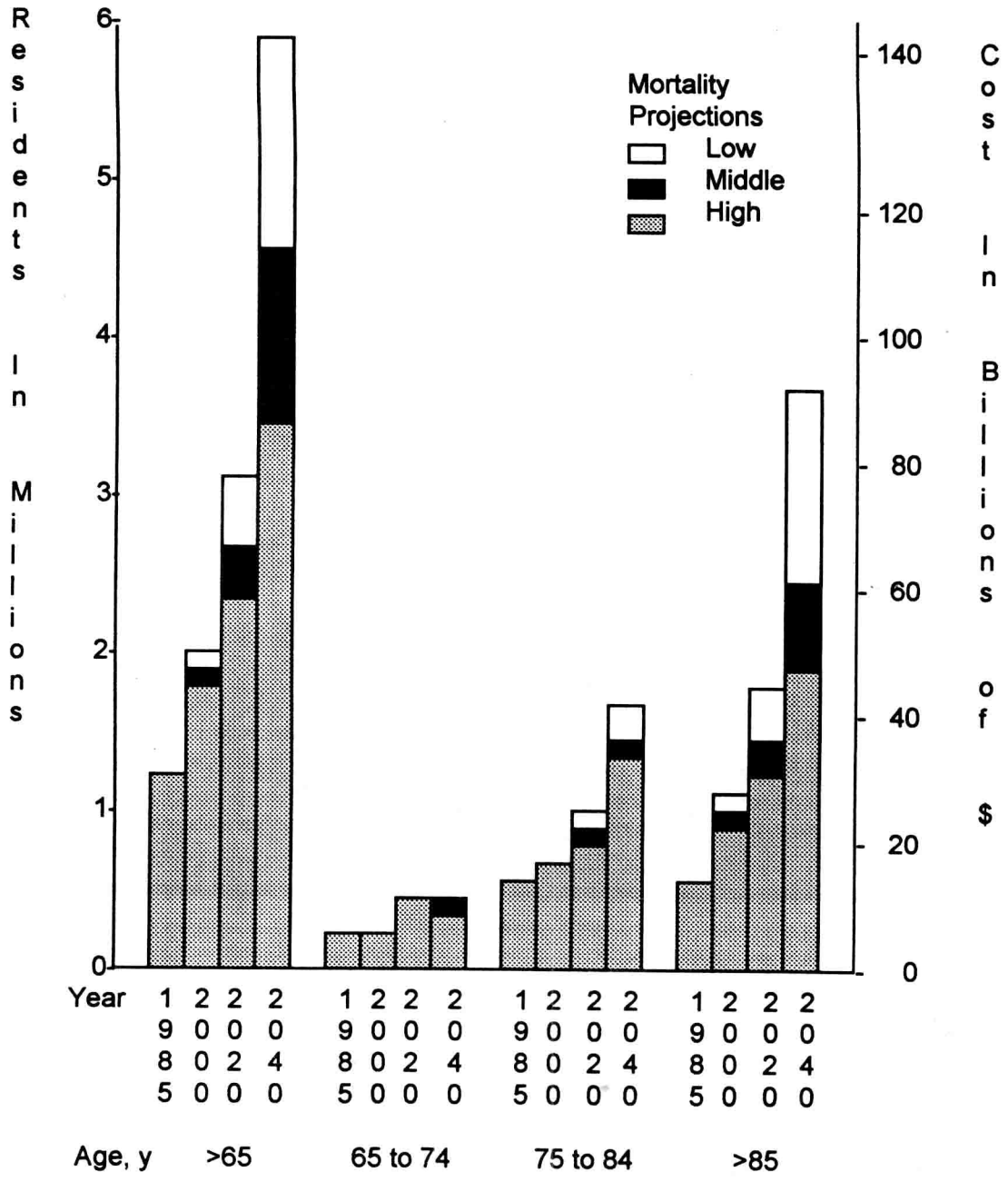

Figure 1-3. Actual (1985) and projected numbers of U.S. nursing home residents and costs in 1985 dollars by age group. The numbers of nursing home residents in 1985 are from the National Nursing Home Survey, and the costs per resident are from the Health Care Financing Administration. Projected numbers of residents and costs are based on low- (Series 9), middle- (Series 14), and high- (Series 19) mortality assumptions from the U.S. Bureau of the Census and 1985 costs.

Source: Data from E. L. Schneider and J. M. Guralnik, "The Aging of America: Impact on Health Care Costs" in *JAMA* (263), May 2, 1990.