"Legislative and Administration Interests in Geriatric Health Promotion"

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The title of my talk, as listed on the program, is Administration and Legislative Interests in Geriatric Health Promotion. However, I believe it would be a bit presumptuous of me to speak about the Administration's interests or views, especially considering the individuals preceding me this morning. Also, I make no pretense of speaking for the Congress in any political sense. That said, it is my goal to present some thoughts about health promotion for elderly people and the forms of recent Congressional legislation in this area.

In many ways, there should be difference between a legislative interest in geriatric health promotion and that of the executive branch. In general, it is clear to all parties that health promotion is a worthy goal. While all segments of society are struggling to meet rising health care costs, it is equally clear that we may not want or be able to pay for preventable illnesses.

Divergences in viewpoints and thus "interests" become important when policy makers seek to turn the concept into reality. Actually, it would be more accurate to say "seek to *help*" since we should not by any means fall into the trap of thinking the federal government—whether legislative or executive—is the only actor in the process.

From the federal perspective, making expanded health promotion a reality involves a long (some would say cumbersome; others would describe it as necessarily cautious) sequence of events. It includes exploration of specific goals, information gathering about means of reaching those goals, technical analyses about programs and methods that might accomplish health promotion, decisions about how much and what types of health promotion programs are to be supported or otherwise encouraged, compromises on who will pay for programs, enactment of any needed statutes, actual implementation, and then evaluation of the success of the programs in bring about desired changes.

Congress has an interest in every one of those steps, but it has more capability and more of a mandate in some than in others. Clearly, the Congress has a large role in play in setting goals, since this is the first crucial step in lawmaking and goals must flow in large part from the needs of the elderly population. Identifying and reacting to this population-based

need is one of Congress' traditional roles. This must be supplemented by "technical" information (for example, on disease and demographic patterns and on behavioral characteristics) that in significant part can only be derived by application of the expertise and far larger resources of the executive agencies.

Similarly, Congress often must rely on executive expertise and research concerning the technical means to achieve the goals. This reliance is not as heavy as it once was; Congress has improved it informational resources over the years and now can turn to the General Accounting Office, the Congressional Research Service, the Office of Technology Assessment, and in certain cases, the Congressional Budget Office. But the fact remains that the resources of all the technical support offices of the Congress are extremely small compared to those of the executive branch.

Congress, of course, also has access to expertise in academia and the private sector. Here again, Congress has enhanced it capacity recently with respect to Medicare and Medicaid related issues by creating research and policy advisory bodies such as the Prospective Payment Assessment and Physician Payment Review Commissions. But still it is the executive branch that generates or supports much work in those sectors. The specific, relevant point here is that in an emerging, increasingly visible and important area such as geriatric health promotion, the ability of Congress to make informed choices depends to some degree on the quality and form of the information generated by the executive branch. The novelty is the continuing tendency of the Congress to increase its own research and external advisory capacities.

In shaping the debate about how much and what types of health promotion programs are to be supported or otherwise encourages, I believe that Congress and the Administration both have large roles to play. Congress plays its part through hearings, investigations by staff or by support agencies, interaction with constituents, and commissions.

Congress, of course, then must make it own decisions concerning enactment of authorizing statutes and of appropriations bills. This is one of the primary roles that Congress plays in health promotion. It is certainly not the only one—the oversight process can be significant— but it is one that distinguishes a legislative interest.

In the remainder of my presentation, I would like to accomplish three purposes. First, I would like to examine the context in which the Congress considers geriatric health promotion. I would then like to describe some of the efforts that have pursued by Congress to enact legislation in this area. And I would like to conclude by discussing some of the issues that the legislative branch must address in deciding which activities to support and at what level.

The ways in which the Congress seeks to further health promotion are in large part determined by broader concerns of the institution itself. At least two such concerns affect health promotion for older Americans. The first is the tendency to make incremental changes in existing programs rather than to enact a comprehensive strategy to achieve a particular goal.

In part, this tendency may be borne out of an appreciation for the complexities of implementing broad new programs as was done twenty years ago. However, the overriding cause of Congress' reliance on incremental strateiges may be fiscal reality. As I will explore further in a moment, concern over the federal budget during the past few years has made it more difficult to garner the political support within Congress to establish large, new programs. Indeed, the bipartisan efforts of the legislative and executive branch to provide protection for the elderly against catastrophic health expenses are one of the most successful attempts at "comprehensiveness" considered by Congress in recent years. And they are really an expansion of optional coverage under the Medicare program.

As we shall see, most Congressional efforts for geriatric health promotion in recent years have taken the form of incremental changes in four existing federal programs: Medicare, Medicaid, social services under Title XX block grants (all of which are authorized under the Social Security Act), and grants authorized by the Older Americans Act.

Proposals for changes in Medicare and Medicaid almost all seek to expand reimbursable health services for beneficiaries. By focusing its attention on insurance coverage, Congress emphasizes the importance of payment for services in the promotion of geriatric health. However, changes in Medicare and Medicaid can have influences far beyond the marginal increases in coverage for these programs' beneficiaries. As the largest single payer of health services, the policies adopted by the federal government will receive serious consideration by other insurers. This phenomonen has occurred since Part A of Medicare adopted a prospective payment system for hospital charges.

In the area of health promotion, the influence of the federal government as a major payer extends even farther. Proposals to expand Medicare and Medicaid coverage represent an explicit recognition by the federal government of the importance of health promotion and disease prevention. Coverage may educate the public about those activities that can improve or maintain health, and it may encourage behavior to bring it about. For example, proposals to pay for disease screening or immunizations under Medicare could thrust the federal government into a leadership role in encouraging all consumers to seek such care or health professionals to provide it.

I have already alluded to the second characteristic of Congress that shapes recent proposals for geriatric health promotion—the major role of the budget process in determining the Congressional agenda. The necessity for fiscal responsibility has set the terms of debate for recent proposals in geriatric health promotion. Much legislative support for disease prevention and health promotion lies in the hope that paying for prevention now will avoid more expensive treatment costs in the future. Hence, in carrying out its legislative duties, the Congress has an obligation (much like that of the executive branch) to consider both potential benefits and potential costs.

A great many health promotion activities are "worthwhile," and a fair number are "compelling" in their perceived value. Recent proposals to provide Medicare coverage for routine mammography are one example

of this debate. As the Office of Technology Assessment recently found, mammography coverage is unlikely to reduce Medicare costs in either the short or long run. However, it has tremendous potential in detecting early cancers and prolonging life. Other work conducted by our office on the regular use of outpatient pharmaceuticals suggests that Medicare coverage of "medically critical" drugs may reduce hospital costs and actually save money for Medicare. The Congress will ultimately weigh all this information in deciding whether to support these activities and at what level.

Even if one argues that a proposal is "cost-saving," the meaning of this statement can be ambiguous. The real question should be "cost saving for whom?" The costs of health promotion can be borne by an individual beneficiary, by a particular program by the federal government, or by society as a whole. A given proposal may reduce the costs of one program while increasing those in another. The net effect of the federal budget could be either positive or negative. Given the distribution of jurisdictional authority within the Congress, the ways in which these costs fall may have much to do with the success of a given proposal.

The budget process itself has numerous complicated steps. In general, the Congress passes an annual budget resolution in the spring or summer that sets broad spending limits. Appropriations bills provide funds for specific, authorized programs. Reconciliation bills allow changes in the authorizing legislation of entitlement programs to bring their spending in line with the budget resolution. As is probably well-known by this group and the American public as a whole, in recent years the last two steps of this process have been carried out well beyond the start of the fiscal year.

Attempts to contain or decrease the budget deficit have enhanced potential changes in entitlement programs like Medicare and Medicaid that have the potential to realize large budget savings. One would not expect appropriations or reconciliation bills to be vehicles for *expanding* eligibility or benefits of these two programs since Congress requires all components of this particular legislation to be germane to its original purpose. However, because the annual budget resolution passed early in the legislative year provides instructions for budget savings in entitlement programs like Medicare and Medicaid, any proposals to alter these programs become germane to a reconciliation bill even if the changes do not bring about budget savings (Fuchs and Hoadley, 1987). Recent expansions of Medicare to cover immunizations for pneumococcal pneumonia and Hepatitis B made use of this process.

I would now like to talk a bit more systematically about recent and current legislative proposals for geriatric health promotion. I have alluded to a number of changes in Part B of the Medicare program to pay for clinical preventive services such as immunizations and disease screening. In addition to the coverage of routine pneumococcal and Hepatitis vaccines, Congress recently agreed to establish a demonstration project to provide influenza immunications to Medicare beneficiaries.

In the 99th Congress, proposals were put forth to alter Medicare in other ways as well. One bill (S. 358) would have raised the deductible to receive

Part B benefits from $75 to $100, but would allow the cost of disease screening, immunizations and hypertension drugs to count towards that deductible. A companion bill (S. 357) would have lowered the Part B premium by $1 per month for non-smokers. The House considered a proposal (H.R. 1402) that would allow Medicare beneficiaries to purchase a supplemental insurance option to cover the cost of an annual preventive health physician visit. A similar proposal discussed on the Hill recently would provide a well-patient physician visit for new Medicare beneficiaries. In 1984 and 1986, Congress authorized a total of seven demonstration programs to provide community-based disease screening and referral services. Two of these projects have been funded and are currently in operation.

Medicare related proposals for health promotion in the current Congress fall into two categories. The first is the further expansion of coverage under Part B. There are currently five bills that would extend Medicare payment to routine, annual mammography. Two of these bills would also authorize Medicare to pay for annual Pap smears.

The second category consists of provisions in the catastrophic health insurance bill currently under consideration. The Senate version of this legislation (currently under discussion in conference committee) would allow enrollees to count the cost of several preventive services toward the annual deductible necessary to receive catastrophic benefits. These services are screening for glaucoma, cholesterol, cervical cancer by Pap smear, breast cancer by mammography, tuberculosis, colorectal cancer by occult blood in the stool, and immunizations against tetanus, influenza and bacterial pneumonias.

Both House and Senate versions of the catastrophic bill also provide for prescription drug coverage. Although the two versions of the bill vary somewhat, they nonetheless represent a legislative commitment to assist the elderly and disabled in gaining access to needed prescription drugs. In many cases, these drugs may dramatically improve the quality of an older person's life. Many control chronic conditions such as hypertension and prevent more serious manifestations of illness that might require hospitalization. It is interesting and important that this legislative commitment is made without clear-cut evidence that it will save money.

The prescription drug provisions of the catastrophic bills also express concern that pharmaceuticals be used wisely and appropriately. As the Office of Technology Assessment (OTA) recently pointed out, geriatric polypharmacy is now commonplace, with over a third of community dwelling and over half of institutionalized elderly using four or more drugs (U.S. Congress, 1987c). One researcher has estimated that adverse drug reactions play at least a contributory role in 12 to 17 percent of all hospitalizations among the elderly (Lamy, 1984). One version of the bill would assign the Secretary of Health and Human Services the responsibility for developing programs to ensure that drug therapy promotes rather than threatens geriatric health.

Among those proposals for geriatric health promotion not aimed at Medicare are changes in the Older Americans Act of 1965. In a set of

amendments to this act passed last fall (P.L. 100-175), Congress authorized the Administration on Aging to provide grants to states totalling $5 million a year to establish periodic health services within community senior centers. In addition to disease screening, the centers could offer exercise programs, home injury control, nutritional counseling, mental health services and education on Medicare benefits. The amendments also authorized demonstration grants to institutions of higher education for the design of prototype health education and promotion programs. States would be able to draw upon these prototypes in implementing their own preventive services. It is important to remember that each of these activities require that Congress yet appropriate the funds necessary to implement them.

Congress has also recently expressed interest in Alzheimer's disease and related dementias. It has provided funding for basic and health services research and has utilized nationwide expertise to provide the Secretary with particular external advice on this topic. Legislative interest and activity in the growing area of geriatric mental health will likely grow over the next several years.

Block grants to states are another way in which Congress has sought to further health promotion. In 1981, Congress combined eight categorial grant programs together in a Preventive Health Block Grant for public health and health promotion activities. States were given broad discretion in how they decided to spend these funds. This Preventive Health Block Grant is currently awaiting reauthorization. Another block grant uses funds authorized by Title XX of the Social Security Act to provide social services. While some portion of all these grants probably support geriatric health promotion activities, states vary greatly in how they spend their funds. One analysis indicates that 34 states use Title XX funds for health education (U.S. Congress, 1987b). On the other hand, despite its rather specific title, the Preventive Health Block Grants allow states to invest in measures as diverse as rodent control and fluoridation, emergency medical services and home health care in addition to health education.

Legislative activities in geriatric health promotion extend to the Congressional support agencies as well. At OTA, we have tried to help the Congress sort out the merits of activities in this area. In past years, we have examined the cost-effectiveness of pneumococcal and influenza vaccines. We recently completed an examination of health promotion options in large studies of *Technology and Aging* and Alzheimer's disease (U.S. Congress, 1985 and 1987b). Just this past fall, we analyzed the costs and effectiveness of mammography under Medicare (U.S. Congress, 1987d). Over the next year, at the request of the House Ways and Means Committee and the Senate Labor and Human Resources Committee, we will study the costs and effectiveness of up to five additional clinical preventive services that might be considered in the future for coverage under Medicare.

Having talked a bit about the legislative environment in which proposals for geriatric health promotion are considered and having outlined recent Congressional activities, I would like to close by focusing on some of the methodological issues that arise in evaluating various proposals. OTA is

grappling with each of these issues now as it analyzes potential costs and effectiveness. The Congress deals with them as it considers particular pieces of legislation. And you will face them in your deliberations over the next two days.

One of the first problems encountered in evaluating geriatric health promotion is the uncertain efficacy of many proposals. The various authors of the background papers prepared for your use have performed a valuable function in uncovering and synthesizing a diverse academic and clinical literature. In many cases, however, there is a pronounced lack of data about how well specific services work for the elderly (Stults, 1984).

This uncertainty has several sources. For some services, there have not been well-designed, randomized clinical trials. Glaucoma is one example where the efficacy of preventive treatment has not been well documented and clinical trials are badly needed (Eddy, Sanders and Eddy, 1983). In evaluating other services, researchers have excluded the elderly from those clinical trials that do exist (Stults, 1984). Traditionally, they have feared that the multiple morbidities of many elderly would preclude efficient statistical analysis of the activity under scrutiny. The Food and Drug Administration is currently reevaluating its own guidelines in order to expand elderly participation in its clinical trials. Finally, in some cases researchers may have erroneously assumed that treatment does not result in health benefits for individuals beyond a certain age. Smoking cessation falls into this category.

Many times those data that do exist on the efficacy of health promotion activities come from a single demonstration project. In trying to generalize from a particular project to an entire population, one must bear in mind those characteristics of the demonstration that might have contributed to the project's outcome. Such factors might not be reproducible in a program aimed at an entire population.

Efficacy can also depend heavily on the outcome one decides to measure. Traditionally, one examines changes in mortality or morbidity. For some services, however, this approach may not sufficiently measure the impact of the intervention. For example, one would usually measure the effect of screening for hypertension or cholesterol in terms of expected life-years saved or expected reductions in disability. However, the contact with a health professional afforded to the screening patient may have important secondary health benefits. Such contact may educate a patient about additional ways to maintain health or it may improve mental well-being by relieving anxiety about the patients' health. Hence, traditional measures of mortality and morbidity might undervalue the efficacy these health promotion activities.

Measuring the costs of geriatric health promotion also presents some complexities. Since I have already discussed these ideas in describing the Congressional environment for health promotion activities, I will not dwell on them here. I would, however, like to bear in mind that cost-effectiveness is a relative term. One activity can only be cost-effective in relation to an alternative. In a legislative environment that relies on incremental

changes in existing statutes, the cost-effectiveness of a health promotional proposal will likely be its cost per unit of efficacy achieved compared to not making an changes at all.

As I also mentioned earlier, cost-savings depend on the perspective from which one measures them. The Congress or one of its committees may be interested in potential cost-savings for an individual program such as Medicare or a select population such as the elderly or disabled. But such savings to a given program or group may actually be borne by other parts of the federal budget, other groups of people, or society as a whole.

Finally, there are methodological problems inherent in implementing geriatric health promotion activities. The reliance on marginal changes in existing programs may reveal a tendency towards services that fit easily into the established major payer structure, at least for federally implemented programs. Hence, the easiest programs for Congress to consider are those that expand reimbursable clinical services under Medicare or Medicaid. Public education and some counseling services, on the other hand, have little preexisting structure for implementation and are more difficult to execute.

Other disease prevention activities may not be viable under Medicare and Medicaid because of the nature of the disease itself. Osteoporosis screening is one example. While no one would debate the fact that osteoporosis is an important problem among older Americans, particularly women, or that the resulting fractures are seriously disabling, it is not clear that Medicare interventions will effectively forestall or avoid these undesirable outcomes. Rather, interventions need to begin at a younger age. For women, most calcium depletion occurs after menopause but before they become eligible for Medicare. Screening women at age 65 might alert them to their elevated risk of fracture, but it would not result in a substantial increase in bone density.

Another implementation issue important for geriatric health promotion is the uncertain definition of some services and their potential for abuse. This problem may be especially relevant to expansions of Medicare or Medicaid coverage. Earlier I mentioned proposals that would allow Medicare beneficiaries to receive a well-patient physician visit on an annual basis or when they enter the program. The legislation authorizing this coverage does not indicate exactly what activities would be (or should be) performed during such a visit. The cost of the proposal is dependent on its actual content. In the absence of a better definition or some alternative control, the services provided could use significantly fewer resources than are reflected in the government's reimbursement. Indeed, physicians could provide only a minimal or inadequate examination of their patients, or patients could seek redundant care from providers. While there may be potential health benefits and cost-savings of such visits , legislators will want to design such services to minimize unintended outcomes.

I do not pretend to have described in this paper all of the complexities in evaluating geriatric health promotion as public policy. Rather, I have tried to outline some of the major issues and constraints Congress must

address in considering proposals in this area. My purpose has been somewhat selfish. As I suggested early on, the Congress' ability to promote the health of elderly Americans depends in part on the expertise of the executive branch. Your efforts here in the next few days will greatly aid the legislative branch in its work. I wish you luck in your deliberations and look forward to your conclusions.

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PLENARY SESSION—"Setting the Pace in Geriatric Health Promotion"

"Healthy Older People"

Presented by Susan Maloney
Office of Disease Prevention and Health Promotion
Monday morning, March 21, 1988

As this workshop progresses, I am sure we will be hearing in great detail what is needed to spur the development of health promotion for older people. We'll hear calls for training health and aging professionals to care for today's elders—and to provide the opportunity of better health for tomorrow's; calls for sustained and consistent leadership for building and supporting the networks which provide services for older people; and calls to educate older Americans about how to stay healthy.

In my time with you today, I would like to spend a few minutes looking back to where we were in 1984 when the Federal initiatives in health promotion and aging got underway and examine what impact we've had to date. Specifically, I will be speaking from the perspective which has been gained from the first national health promotion program aimed at older Americans—Healthy Older People. In many ways, Healthy Older People serves as a demonstration of the potential there is out there for promoting the health and well-being of our older citizens—and there are many lessons to be learned.

Let me say at the outset, you would not believe the skeptical reactions I received from colleagues when I began talking about planning a national public education program for older people. Today, the skeptics are becoming believers. Although we continue to debate how best to change behavior, and to refine what we know regarding the potential impact of behavior change in this age group, or any for that matter, health promotion for the aging is moving into the mainstream.

In my view, that was certainly not the case a mere four years ago. In 1984, there was no consensus regarding what topics to address, no widely held view on what to say, and perhaps most basic, no sense that older people were indeed interested and willing to change behavior in order to improve health. Even had all this been agreed upon, there was no system, no network, no way to get the message out—much less provide the opportunity for personal support and encouragement which we know is necessary to change and sustain health habits. It goes without saying that there was no clear or consistent leadership in this area and no system of technical support to bring about such change.

So today, in assessing Healthy Older People, I ask what progress has been made along these lines and what have we learned about what to do next?

As I said before, the Healthy Older People program is a national public education program sponsored by the Office of Disease Prevention and Health Promotion (ODPHP). These programs, of which the Public Health Service has several, are often difficult to describe. While it is relatively easy to describe the materials which are developed and the special activities which are generated, it is difficult to convey how public education programs serve as a catalyst for action at the state and community—the level of real impact.

The primary goal of our program was to inform and educate older Americans about health practices which can reduce their risk of disabling illness and increase their prospects for more productive and active lives. We tackled this challenge in several ways—by producing a wide variety of informative materials for older people; by working very hard to establish and nurture a dissemination system to get the educational messages out; and by fostering the development of local programs serving older people.

First let me tell you what we learned about the importance of clarifying the health information we wanted to deliver and how that information was received. Too often we point to the piles of materials in our offices and to the press coverage of health-related topics, and conclude that there is plenty of information available and people just won't pay attention. I contend that it is not only important, but very difficult to develop understandable, accurate information that people actually can act on.

Before we developed the Healthy Older People materials, we conducted careful reviews of the scientific literature to ascertain in which areas behavior change can be most beneficial to health status in this age group. In fact, many of the areas selected are featured at this workshop: eating right, exercising, stopping smoking, preventing injuries, and using medicines and preventive services wisely. Next, we conducted focus groups with older people to determine how their beliefs and feelings coincided with the science base. We were then able to use public relations and advertising professionals to develop, test and refine the information.

The messages which were developed were clear, taught the skills needed to act, and conveyed a positive upbeat tone to underscore the general theme that health promotion is appropriate no matter what your age. The importance of this was highlighted in the evaluation conducted of the program. The materials were consistently described as "the information people are looking for" and as "taking complicated (nutrition) information and making it easy to use."

The messages were translated into a variety of broadcast and print materials including television and radio public service announcements, posters, and brief consumer fact sheets. Press kits and TV and radio segments were produced for news and talk shows and a variety of supporting materials were prepared for state and local groups on how to use the various media materials.

A validation of the need for and interest in clear health messages is the extent to which these materials were picked up. I must note that participation in the Healthy Older People program was completely voluntary--no State had to get involved. Even more telling is that no money was available from us to conduct programs or even to print materials. We were only able to provide samples of print materials and groups had to find sponsors.

Even with that, the results were excellent. Looking first at the TV public service announcements for which the best data are available, every state distributed the spots with 60% arranging personal delivery to TV stations. The service which tracks airplay of commercials reports that between September 1985 and September 1987 the Healthy Older People spots were aired 4713 times on local stations and all three networks. We saw it on five different Cosby shows alone.

The total advertising value of the spots, according to Broadcast Advertisers Reports, Inc., was $3,221,693. That is what it would have cost us to air these spots if we had to buy time from television stations. At this time, ODPHP's total expenditure for the program has been about $900,000—less than a fifth of comparable campaigns for high blood pressure or cancer prevention.

Though we do not have access to such precise numbers for other Healthy Older People materials, we do have some success stories. The so-named skill sheets proved to be a popular and versatile item. These two-pagers were available as camera-ready slicks and were used in nearly all the States. Not only were they reproduced and handed out to older people at senior centers, libraries, and drug stores, and in retirement seminars and housing units, but Blue Cross of New Hampshire sent them to each of their customers over 65. Hospitals and social service agencies gave them to their clients, and states and "house organs" used the information in their newsletters. As much as we talk "high tech" for information, we are still very reliant on the written word and we seek simple and concise direction for health maintenance.

One frequently reported use of the Healthy Older People materials which I had not expected was how often these items were used for professional training. We must keep in mind that, although we may have this information down pat, most professionals whose primary responsibility is for providing health or social services cannot keep current on the latest health promotion findings even if they recognize the benefits to their older client.

The skill sheets were also described as having a cross-disciplinary focus. We heard: "Both the health types and the aging types liked the sheets. For the first time, they both got behind the same product."

Bringing together the health and aging fields under the common banner of health promotion for this segment of the population was perhaps our greatest challenge and one of the most rewarding aspects of working on Healthy Older People. The quality of the materials helped—but ahead of that I'd place the opportunity to work jointly toward a common goal. This is how a public education campaign is able to foster the support network needed to provide programs and services.

You have already heard about the Federal call for the establishment of coalitions on health and aging. Speaking from the perspective of Healthy Older People, we have learned a great deal about how the coalitions were formed and what they are doing.

Early in the program we contacted each Governor's designee and worked our way through the bureaucracy to identify those who would be our own program contacts. These people were most often staff of either the health or aging department although sometimes the Governor asked both agencies to be involved or sometimes one agency decided to enlist the support of the other. We encouraged collaboration at regional training workshops, and via a toll free hotline, in a bi-monthly newsletter about the program, and through technical notes for professionals on various program development topics.

Eighty five percent of the states in which we conducted evaluation formed coalitions—many adopting the name of the program. Today, for example, we have Healthy Older Virginians and Michiganders and Iowans. The makeup of the coalitions varies. In three states, membership is limited to staff from state agencies. In just over half, the coalitions include state and local agencies and service providers such as hospital associations, university geriatric centers, the American Red Cross and AARP. Eleven states formed even broader coalitions which include private sector representatives. Among the six states which chose not to establish coalitions, two—Connecticut and Rhode Island—said their small size already facilitated close coordination. Eight of the state coalitions went on to foster the development of local coalitions.

The coalitions identified health and aging resources within the state and, most important, established viable, programmatic linkages which they expect to continue even when Healthy Older People is no lonqer around. Most coalition leaders reported that this was one of the first times there was effective collaboration between the health and aging sectors in their state. In some states this collaboration has led to an increasing interest in health promotion among older adults. I am just beginning to get calls from some of the state contacts asking for help in thinking through how to approach upcoming meetings within their departments about integrating health promotion more widely in existing programs. This represents a distinct shift from an initial focus on simply conducting an information program.

In addition to what we were able to do to support the formation of coalitions, we also tried to encourage the development of programs—and always to stress the need for local, accessible activities to encourage maintenance of healthy behaviors. Program development was enhanced by collaborative activities with national membership and voluntary organizations—organizations with ready access to our audience: older people. Two activities stand out—a series of training conferences on community health promotion programs sponsored by AARP and two teleconferences for health and aging professionals done in conjunction with the American Hospital Association.

It is in the area of program development that Healthy Older People exceeded my expectations. In all the states evaluated—41 of 50—program development of some type occurred. It appears that tens of thousands of older persons were reached in this way. Of the forty-one states queried, 15 reported doing needs assessments and compiling resource inventories; 38 described special events to educate consumers such as fairs, workshops, or "nutrition days"; several have developed their own video-taped programs which are shown on cable stations and in sites such as senior centers and community colleges; 31 states conducted provider education principally through statewide workshops and in an ongoing fashion through newsletters; and 35 of the 41 reported providing some type of wellness services to seniors.

How the different Healthy Older People topics were integrated into community programs is also worth noting. The greatest amount of program activity reported by our evaluation team must be categorized as wellness or health promotion for older people. Thirty-seven of the 41 states reported the adoption of this multiple risk factor focus for programs. Contacts liked the economy of scale in linking the topics, both in terms of limited staff and resources, and in terms of limited opportunities to provide activities for older persons. After wellness, the most frequently addressed single topic was exercise and fitness with walking events being the most popular. Special activities on the safe use of medicines and preventive health services were reported by twelve states, and nutrition by ten.

One factor which influenced selection of topics was familiarity with an issue. For example, the public health agencies found it easy to use their public health nurses to conduct risk assessments and health screening. The aging agencies, on the other hand, said they were intimidated with the medical topics, but felt they had a lot to offer in nutrition. The topics which could be made fun—or social—held great appeal. They also stood a better chance if they addressed a serious health risk or led to an easy intervention.

Given that last caveat, it should be noted only one state, Rhode Island, focused on smoking cessation. Since some of the definitive research on the benefits of quitting at a late age have only recently been published, I guess this is not surprising, but clearly more could be done in this area.

In assessing a national public education campaign in which participation is voluntary and schedules and activities are conducted as deemed best by a very decentralized network, it is difficult to tease out the impact of that program from concurrent events. For the 41 states evaluated, we developed a rating scale to determine how Healthy Older People fit in with other activities and priorities. Four categories were developed. In seven states, there had been no pre-existing activity in health promotion for the aging. Healthy Older People was cited as a direct impetus for program development. In eight states there was pre-existing activity, but Healthy Older People caused a reexamination and modification of strategies to reflect the national program. In 16 states, the existing priorities were maintained and resources, materials, and ideas were incorporated from our program. In ten states, Healthy Older People activities were conducted in

parallel, but not really related, to other health promotion activities. As of last August, there was no state in which Healthy Older People had no apparent impact. Indeed this spring we see the launching of two more major state initiatives—in Pennsylvania and Indiana.

The biggest lesson we've learned, I would say, is that Healthy Older People demonstrates the ability of the Federal government to establish a national agenda through a modest, but ambitious, program of this type. I would add that the success of this program in doing just that is that we had the right combination of the right people at the right time—not only the audience we wanted to reach: our aging population—but the talent and commitment of health and aging professionals who have recognized the need for and value of health promotion for this special population. As a result, we see a firm beginning of an interdisciplinary network of health and aging agencies and organizations committed to this initiative. And I think you will agree with me that we are further along in clarifying what information older people need in order to change health behavior.

Nevertheless some things are left undone—or I guess we would not be here today. Among them are professional training, national media attention, technical support for community programs, policy directions, and research and demonstrations to assess the impact of activities on health and functional status. The workgroups will help expand that list.

So we have a good beginning. We have captured the attention of professionals and have whetted the interest of older people in health promotion. But we know from experience that the substantial health benefits of behavior change do not come quickly or easily. Healthy habits and actions must be reinforced through repeated refrains from doctors, social workers and the local TV anchor person. We need to encourage fitness and good nutrition at the most personal level—in local parks and supermarkets, restaurants and neighborhoods.

I want to thank Surgeon General Koop for his leadership in convening this meeting because it is through opportunities such as this that we can help move health promotion for older adults up on the national agenda. And with your work here today and tomorrow—and your work back home—we eventually will see older people becoming healthier people.

Information about the Healthy Older People program is available from the ODPHP National Health Information Center, PO Box 1133, Washington, DC 20013, 800/336-4797, 301/565-4176 in Maryland.

"Project Age Well"

Presented by Anthony Vuturo, MD
School of Medicine, University of Arizona
Monday morning, March 21, 1988

Good morning, ladies and gentlemen. It is a pleasure to join you this morning in Washington and participate in the Surgeon General's Workshop on Health Promotion and Aging.

My task this morning is to give you an overview of Project Age Well. Age Well is a comprehensive project of the College of Medicine at the University of Arizona. This program is a coordinated approach to preventive geriatric care. It attempts to compress morbidity, reduce health care costs, and enhance the quality of life in older Americans.

In 1981 the Department of Family and Community Medicine began to develop primary health care efforts at apartment complexes devoted to the elderly. Eventually clinics were established at four city sponsored apartment complexes ranging in size from 75 to 450 apartments.

As with any good university enterprise, we initially focused on the three-pronged thrust of academia—teaching, service and research. Medical students and nursing students had the opportunity to enhance their educational experiences; service was provided both to the community and to the senior population; and new research projects were initiated, particularly in expanding our understanding of osteoporosis.

In the early 1980's the major driving mechanism for the service component of the University was our desire to add geriatric health care services to University Famli-Care, the health maintenance organization established by the Department of Family and Community Medicine.

We soon recognized that the traditional medical models were not capable of providing the scope of services required. We also believed that many of the health problems we were seeing in our elderly were preventable and could be anticipated. If targeted health issues could be promoted, we believed our clientele could anticipate a higher state of wellness in the aging process. This should reduce the potential financial risk to future HMO involvement.

In 1983 we took our modest proposal to New York and presented our ideas to the Brookdale Foundation. With the support and endorsement of the foundation and its board, as well as a commitment from the City of Tucson and the encouragement of the Area Council on Aging, we proceeded to enhance our commitment to the approximately 1,000 senior citizens with the initiation of a new activity called Age Well.

Our initial objectives were to provide and expand health maintenance and to promote wellness. We wanted to support those individuals who needed various types of rehabilitation. We recognized that we needed to define new professional roles and still be identified with the College of Medicine. It was important for us to create settings not just for the education of medical students and residents, but also for the training of nurses, pharmacists, nutritionists and exercise physiologists. We made a commitment from the outset to make our model widely available and to disseminate our activities.

We focused initially on prevention. In 1984 we felt most comfortable with a model that emphasized hypertension, cancer prevention, osteoporosis, depression, and control of iatrogenic diseases, and we wanted to introduce health promotion to counteract the belief that illness is inevitable.

By 1987 we had undergone significant changes in our focus areas. Rather than hypertension, it became apparent to us that it was possible to focus on the full spectrum of cardiovascular diseases. Our program of mental wellness grew beyond a focus on depression and now deals with bereavement, anxiety, loss, loneliness and stress. Clearly the leading iatrogenic problem was related to medications. Visiting people for about 4 years in their apartment complexes, seeing their furnishings, their kitchens, the way they kept house, and assessing the types of morbidity that we were beginning to see over time, we developed a vigorous campaign for safety promotion and accident prevention.

The intervention strategies that we identified include enhanced nutrition, education, a program in exercise, a strategy in community-based and peer-based health education, group and individual counseling methodologies focusing on medication and diet, health maintenance screening and stress management.

From the birth of Age Well in 1982 to the present, we have seen on our campus a major expansion of interest in the field of gerontology. We have campus committees on gerontology and interdisciplinary groups functioning in numerous areas, one of which is a long-term care gerontology center. The traditional departments within the College of Medicine have supported the expansion of our concerns for the elderly by creating a Division of Restorative Medicine which combines the disciplines of podiatry,medicine, ophthalmology, orthopedics, rheumatology, and an active outreach program which evolved out of Family Medicine.

Project Age Well is conducted at two types of sites. The first, as I have mentioned, are apartment complexes which have anywhere from 75 to 400 apartment units. Apartments may have single people or married couples. (As a matter of fact, we have seen romances blossom and marriages occur during our short involvement with Project Age Well). In addition to the residential sites, we also conduct our formal activity in two community centers, one located close to the central library and the second located within a major school district in metropolitan Tucson.

Promoting health in the elderly cannot be done in a vacuum. Project Age Well began a detailed and time-consuming process of networking with

many groups and interested parties around our community. Our initial objectives were to pass on some of the things that we were learning, as well as pick up new ideas and new thoughts in promoting a more fit lifestyle in our older population. We linked with the Pima Council on Aging, and with private local foundations dedicated to wellness. The Tucson Parks and Recreation Department linked with us, particularly in the area of physical fitness through walking, aerobics and stretching. We collaborated with the Wellness Council of Tucson, which had been established to promote worksite wellness. Numerous organizations, not all of which had exclusively elderly constituencies, became advocates and promoters of our activities.

Cable television adapted a new program called "The Prime of Life," which began to telecast many of our activities to the entire community. The Interfaith Coalition on Aging became involved with Age Well. Pastoral counseling students received instruction and the staff began to work with ministers and rabbis within the interfaith Coalition. Before we knew it, the process of health promotion was beginning to expand beyond the boundaries of the retirement communities into the churches throughout the community.

During the mid-1980's the notion of worksite wellness grew. Members of the Age Well team served on the Board of Directors of the Wellness Council of Tucson (WELCOT). At the moment, there are over 100 industries with 50,000 employees involved in health promotion, doing many of the things that we are involved with in Project Age Well. What had initially started off as a geriatric-focused health promotion and prevention project began to move in multiple directions. The Arizona Association of Community Health Centers, which is a statewide health promotion coalition, sought our assistance. The Arizona Area Health Education Centers began to provide the Age Well model with selected components throughout the state under the AHEC umbrella. The Hispanic Council on Aging in our city and state began to see unique applications crossing cultural dimensions. Through the Brookdale Foundation our network spread as far as New York City, where we shared information, videotapes, and assessment instruments with the commissioner of the Department of Aging in New York.

By word of mouth and through our presentations at various meetings, the word spread and crossed national borders. Visitors from the Government of Japan have come on at least two occasions to see the project firsthand. Three months ago we were guests of the government of China in Beijing, exchanging information and seeing which of their traditional health practices could be incorporated into our community-based and residential-based complexes to promote Age Well.

Now the Age Well and health promotion network is huge, reaching rural and urban communities and using all methods of communication, including television, newspapers, newsletters, fairs, walks, church and synagogue participation, school districts, peer awareness and national and international linkages.

What has evolved has been a unique mixture of professionals providing their various talents and skills in an interdisciplinary fashion to the needs of older people. At the present time we have nutritionists, pharmacists, nurse practitioners, exercise physiologists, pastoral counselors, social workers, anthropologists, and physicians involved in the team approach to Age Well.

One striking effect of the program is the interdisciplinary educational opportunities that have been created. We find students collaborating not only in health promotion and care, but also in research and scholarly inquiry. Students involved with Age Well are from many disciplines, including anthropology, medicine, nursing, nutrition, pharmacy, rehabilitation counseling and social work. The by-product of the educational experience is that we believe we are helping train the next generation of citizens to address the issues and questions of our aging population in thoughtful and informed ways.

Within Project Age Well we focus on primary, secondary and tertiary prevention, along with health promotion and functional assessments. You are quite familiar with primary prevention, including influenza, pneumococcal and tetanus vaccines, smoking cessation and diet modification. In secondary prevention, our emphasis is on early detection and treatment. This includes hypertension; cancer of the breast, colon and cervix; sensory deficits, particularly in vision and hearing; mental health, focusing on dementia, alcoholism and total mental wellness; social support; drug therapy; and numerous miscellaneous prevention activities directed at urinary incontinence, hyperthyroidism, podiatric problems, and osteoporosis. To date, our focus in the area of tertiary prevention has been in the areas of rehabilitation and physical medicine.

Our attention in health promotion has been on accident prevention. We have provided assistance and advice in the design of many of the apartments, with particular concern to the floor coverings, lighting, and bathroom engineering. In physical fitness and nutrition, our emphasis has been on walking, stretching, and endurance. Our nutritional promotion program includes some of our most popular activities. We have explored the introduction and use of microwaves, the packaging of food products for the elderly, and food wastage by older people.

Functional assessments include psychological, cognitive, perceptual and personality support. Within our assessment of the social support structure of our elderly clientele we have been able to enhance our understanding of their places of interest, policies that impede and promote, and economic situations affected by fixed incomes and discretionary spending.

At the University one of our major responsibilities to society is the acquisition of new knowledge through observation, evaluation, basic science inquiry, applied and operational research. It is only through the process of scholarly inquiry that we are able to continue to upgrade our educational methodology and add to those truths passed on to each new generation of men and women.

Our research projects at the moment include investigations into osteoporosis screening, zinc supplementation and its effect on alcohol, exercise

and treatment of hypertension in the elderly, the effect of exercise on the immune system, the role of sunscreen and its use on serum vitamin D levels, protein-calorie malnutrition in the elderly, the effects of endurance training, fee-for-service models and health promotion models, and the acoustic properties of emotional speech in aging.

Also, we study attitudes toward life in the aging, beliefs in health use, post-hospital intervention strategies, reminiscence as a therapeutic tool, peer counseling, spirituality and well-being in the aging, life care at home, cancer prevention in the elderly through the development of quantitative risk assessments, Telehealth and electronic communications, drug-food interactions and case management of the frail elderly.

Despite the diversity of research projects, we believe we have just begun to scratch the surface.

In many respects, health promotion cannot be separated from health education. The roots of health promotion lie in effective and interdisciplinary health education. The ability to communicate by whatever means necessary those concepts, programs, and activities that promote better ways of doing things, has been at the heart of our ongoing educational "classes." Our classes occur in the morning, afternoon and evening, in social settings, and at meal times.

Permit me to share with you some of the titles of the topics that we cover:

Feelings—Let Them Go
Calcium and Osteoporosis
Making the Most of a Visit to Your Doctor
Immunizations and the Elderly
Cough and Cold
Vitamins
Coping With Depression
Nutrition and the Elderly
Medical Self-Care—How To Be Your Own Doctor—Sometimes
Are You Healthy?
What Will Your Medical Exam Tell You?
Stress and Your Well-Being
An Old Dog Can Learn New Tricks
Community Resources: Do You Know What Is Available To Protect and Promote Your Health?
Medications: How They Help and How They Harm
Accident Prevention: In Your Home and in Your Environment
Nutrition: You Are What You Eat
Thoughts and Feelings About Cancer
Stress and Cancer
Eating To Avoid Cancer,

Additional topics include Coping With Death and Loss
Do You Play the Blues?
Learning To Manage Your Stress
If I'm Depressed
Who Can Help? Community Resources for Depression

Antidepressant Medicines and Their Effects
Hypertension (medications, nutrition, stress, exercise)
Osteoporosis (medications, nutrition, exercise)
Bone Scane Information
Leisure Resources
Medicare
Positive Sleep Habits (techniques, medications)
Personal Safety (safety outside the home, first aid)
Arthritis (exercise, nutrition, medications)
Gastrointestinal Problems (nutrition, medications)
Constipation and Diarrhea (diet, medications)
Medications and Aging
Using the Health Care System
Health Care Maintenance
Problem Solving.

Finally, we offer:

Diabetes (medications, nutrition, exercise)
Food Safety
The Grieving Process
Chronic Pain
Medications for Pain
Biophysical Feedback
Stress Reduction Techniques Which Also Can Relieve Pain
Physical Therapy
An Overview of CPR
Normal Sexual Function and Aging
Medications That Affect Sexual Activity
AIDS
Meeting Your Sexual Needs
Marital Therapy
Depression and Anger.

One of the fascinating observations that we have made is that health education is not a one-way street. We have been singularly impressed by how peers become involved in explaining, clarifying, and restating in different words the themes of the topics. We believe that health promotion through peer education, example, and guidance is a tool that should not be overlooked nor underestimated. It doesn't take a doctorate to be an effective communicator and instructor.

We have been with the group long enough to develop close friendships with the people we serve, but it is still possible to step back and from a more academic perspective try to put in perspective what we have learned. There is no question that it is better to prevent and promote wellness than to commit energy and resources to 20-30 years of ongoing care. It appears to us that the physician model of illness intervention through diagnosis and treatment is inadequate for the broadly defined health needs of our older people. We have learned and have been taught that very many older people are not necessarily disease-oriented. Many of their problems and

concerns are preventable. Older people are concerned with coping and with loneliness.

We have found that many people are on too many medications. Given our understanding of the importance of diet, it could be said that their diet is inadequate. Inadequacy is emphasized not only in terms of insufficient calories, vitamins, minerals, etc., but due to the beliefs, customs and the energy related to preparing meals, shopping for food, spoilage of food.

We have learned that the existing sources of public transportation are often inadequate. They don't meet the needs of many older people and can't accommodate chronic conditions that they have, the speed at which they move and the ability and time required for them to enter and exit the vehicles.

We have been surprised to find out that in our population there is more interest in cancer prevention than in the prevention of heart disease. Priority is given to dealing with existing infirmities, taking priority over screening for potential problems. We have found that people can develop a commitment to exercise, and many of our clients have been in programs for more than 3 years. We have observed that those people who bring to the community marginally social capabilities find a way of life in health promotion. We have noticed significant changes in the attitude of professionals, in the way they perceive the aging process, and also in our young people, as we incorporate young schoolchildren into some of our programs.

In summary, while we may have been a bit ambitious in our goals, and while we certainly have been expansive in our approach, it is not because the need has not been there. We have learned over time that the needs of our senior citizens are complex. We are as concerned with the demographic changes and trends that we see as you are. We believe that our understanding of the boundaries of health promotion and prevention are limited only by our imagination and by the time and energy we are able to wish to devote to the needs of this special population group.

We have learned that it is impossible to plan programs unless one has lived, worked and experienced the issues first-hand over a period of time. We have experienced the fact that there is no formal constituency for health promotion. The informal constituency is not limited to the aged but cuts across age boundaries and working class. We have learned that while there is no quick fix to the problems of health care for the aged, there are numerous strategies that improve the quality of their lives.

I would like to thank my senior colleague, Dr. Evan Kligman, who has orchestrated, implemented, negotiated and developed much of what I have told you, to the Brookdale Foundation for their generous support, not only financially but through their insistence that we share our information as widely as possible, even though the last word is not in on many of the strategies and directions we have taken, and finally to the Pima Council on Aging under the direction of Mrs. Marian Lupu, who has played such an instrumental role on networking the activities and actions of Project Age Well.

Finally, I would like to thank the Surgeon General, Dr. C. Everett Koop, for his keynote address and his kind invitation, particularly to a group based

so far from Washington, to discuss the key directions and dimensions of Project Age Well with you.

"International Geriatric Health Promotion Study/Activities"

Presented by David Macfayden, MD
former Manager, WHO Global Programme for Health for the Elderly
Monday morning, March 21, 1988

I have been asked to speak on the theme "International Activities in Geriatric Health Promotion." Geriatrics is a word coined 80 years ago by the New York physician, Ignatz Leo Nascher. Dr. Nascher used the term to cover the same field in old age that is covered by the term pediatrics in childhood. This idea crystallized from his international perspective. On a European trip he observed low mortality in Viennese elderly people whose physicians dealt with them as individuals with needs particularly to their age group, just as pediatricians dealt with children. Thus, a new word, a new discipline and a new philosophy of aging emerged when a first generation American compared health approaches in New York and Vienna. Eighty years on, international comparisons on aging offer the same opportunity for generating creative ideas. As an international physician, I passionately believe that searching for cross-national experiences of healthy aging will benefit all. Indeed cross-national research is indispensable if we are to understand how to remain healthy as we age.

Let me first give you the context in which activities in health promotion have gained prominence in the World Health Organization. In doing so, I should like to emphasize that the recent international movement towards health promotion paralleled moves at the national level, not least of which was that imparted by the 1979 Surgeon General's Report "Healthy People" and the national goals and objectives emanating from that publication.

When the World Health Organization's constitution was ratified few realized that is definition of health would be seized upon by the world's elder citizens. It is now the aspiration of many in this room to transit through their 60s, 70s and even 80s "not merely in the absence of disease, but in a state of complete physical, mental and social well-being." And, on the Organization's 40th anniversary, on April 7, 1988, this aspiration is clearly articulated in the World Health Day theme "Health for all: all for health."

A more recent international anniversary is commemorated in the ten year old Unicef/WHO Declaration of Alma-Ata, which established the philosophy of primary health care. The keystone of this philosophy is that prevention and promotion should be the central focus on health care.

Just as the 1979 United States report was translated into some 223 health objectives, so the WHO policy statements of Alma-Ata were collectively refined by the countries of Europe into 30 time-specific targets. Broadly, the European goals were:

- to add years, by preventing premature death;
- to add health to life, by minimizing disability and preventable disease; and
- to add life to years, to attain the highest attainable level of health for elderly people.

The involvement of European governments in settling collective health targets gave a high political profile to health promotion, witnessed by the Ottawa Charter on Health Promotion and the Second International Conference in Health Promotion taking place next month in Adelaide, Australia.

As stated earlier, what happened internationally was a reflection of what was happening within nations. Advocates for health promotion in older persons spoke with two tongues within nations. There was the voice of rhetoric and the voice of reason. Thus, when the World Health Organization's expert committee on health of the elderly came to consider preventive actions, they were cautious about the rhetoric but nevertheless accorded prevention high priority, based on rational examination of available evidence. Here are some of the conclusions:

There have been great enthusiasm of late for the concept of promoting wellness among the elderly. Recommendations for diet and exercise claim great benefits in terms of improved function and enhanced well-being. Unfortunately, there is very little evidence to support this enthusiasm.

One potential problem lies in confusing risk factors with modes of intervention: they are not synonymous. In some cases, the risk factor may be associated with permanent changes in the organ at risk. For example, diastolic hypertension is a well known risk factor for heart disease and stroke, but its effects may be due to changes in the vessel wall already in place. Lowering the blood pressure may thus have less effect than measures which lower the risk of thrombosis.

Recent data from Sweden describe impressive improvements in the physiological performance of 70 year olds separated by only five years. Although these reports suggest that such improvements are the result of alterable conditions on lifestyle, we have not yet demonstrated which ones produce the desired ends nor how susceptible to direct influence they are.

A number of areas of potential preventive action for the elderly have been identified. Some involve primary preventive strategies, others screening. The former include immunization for influenza and pneumococcal pneumonia, and smoking cessation. Elderly cigarette smokers can markedly reduce their risks of lung cancer and heart disease by stopping smoking even into their 70s.

Screening tests are appropriate if they have a reasonable chance of uncovering medically and economically treatable conditions. Thus vision screening for cataracts can be very helpful. So too can audiometry uncover remediable conditions. Certain laboratory tests such as thyroid screening can uncover treatable pathology. Other candidates for secondary preventive efforts are screening for breasts, cervix and colorectal cancer, oral examination, detection of alcohol abuse, attention to nutritional status, evaluation of blood cholesterol levels, and accident prevention. These areas