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# Health Policy Development: Health Promotion and Illness Prevention Among Older Adults in Illinois

## **Cover Page Footnote**

Funding for this paper came from the Retirement Research Foundation, Baxter Foundation, and the League of Women Voters of Illinois Education Fund.

# Health Policy Development: Health Promotion and Illness Prevention Among Older Adults in Illinois\*

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## ABSTRACT

*This paper offers recommendations for health promotion and illness prevention for older adults in Illinois and offers a structure for policy development. It is based on the premise that policy development should consider the experiences of older adults, family members, and health care providers delivering direct services. Personal experiences and expert analyses were examined in the context of strategies to promote health. This example of policy development is discussed in terms of its application to alternative methods of social and health change and identifies roles for the sociological practitioner.*

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## Introduction

The means by which public health policy for older adults is formulated is often marked by a lack of understanding as to the needs of older adults as well as to the concerns of policymakers and the service delivery system. Meaningful health policy must be an integration of the concerns of older adults, service providers, and policymakers. This paper focuses on policy development for health promotion and illness prevention for the aged based on input from older adults and service providers, and offers a structure for an alternative method of social and health change.

Implementation of this program began with public hearings which gathered testimony on personal experiences from older adults, family caregivers, and other community groups concerned with health care for older adults. This testimony offered themes, or content areas, for briefing papers. Health promotion/disease prevention for older adults was one of the themes identified. Once identified, a health promotion briefing paper was written incorporating:

- 1) testimony offered through public hearings; 2) a review of national and statewide documents pertaining to illness prevention for older adults; and 3) a statewide survey of actual services available pertaining to health promotion and disease prevention. A briefing paper which offered recommendations for policy development was circulated to health care providers, advocates, and other community leaders, who evaluated and suggested revisions of the recommendations. What follows is a list of goals for health care policy and strategies to meet these goals.

This paper provides an overview of issues associated with health promotion and disease prevention for older adults and a summary of the status of prevention in one state—Illinois. Although the recommendations offered are specific to Illinois, both the procedure and many of the recommendations are applicable to other states. The paper concludes with recommendations for promoting prevention efforts and a discussion of the role of the sociological practitioner in the process of health care policy development. Our goals are to offer and examine recommendations which may help these efforts, thereby resulting in better comprehensive health care policy for older adults within the state; this study may serve as a model for other states as well.

## Background

The health and well-being of older adults is not just the result of health care and medical interventions; it is also a consequence of day-to-day efforts in health promotion and disease prevention. It is now widely recognized that

prevention in older adults can be both efficacious and effective in preventing or delaying the onset of many chronic diseases and can contribute significantly to reducing disability associated with chronic illnesses. "From a public health perspective, preventive activities stand out as an important tool. If it is possible to prevent the development of debilitating chronic disease, to delay its onset, or to reduce the disability associated with it, then such activities could go far toward meeting at least some of the challenges associated with an aging population" (Kaplan and Haan, 1989:28).

Advancing age in the United States is associated with the onset and progression of chronic illness and disability. Prevention plays a major role in the treatment of many of these diseases and chronic conditions. For example:

- 80 to 90 percent of all reported deaths from influenza occur among persons aged 65 and older. Only 20 to 30 percent of older adults receive flu shots each year (Buchner, et al., 1989).
- Nearly 26,000 persons aged 65 and older died in 1987 as a result of unintentional injuries (NCHS, 1989).
- Estimates of the percent of elderly aged 65 and older with drinking problems are 10 percent or greater, with 8 percent of these being classified as problem drinkers (Atkinson, 1984). Alcohol use has been associated with cognitive deterioration and a number of chronic illnesses, including liver disease, cardiovascular disease, hypertension, and stroke. Nationally, alcohol dependent individuals account for about 20 percent of nursing home residents (Atkinson, 1984).
- According to the National Council on Patient Information and Education, at least 60,000 [older] Americans lost their lives needlessly in 1986 alone as a result of not taking prescription medication properly.
- Diet is a major factor in late onset diabetes and plays a role in some forms of cancer, stroke, and osteoporosis, as well as other diseases (Woolf, et al., 1990a).
- The U.S. Surgeon-General has said that as much as half of all U.S. mortality may be the result of lifestyle and behavioral factors (Surgeon General's Workshop, 1988).

Given the impact of lifestyle on chronic illness and disability in older adults, it seems difficult to understand why more attention has not been directed to prevention in this group.

### Cost Benefits

It has been argued that prevention programs for older adults are an inappropriate use of health care resources, in that any program designed to prevent

illness and reduce mortality and disability will show diminishing returns with advancing age and frailty of the target group. Others claim that it is more appropriate to devote these resources to infant and child programs than to older adults, and that medical care limits should be set for an aging population (Callahan, 1987).

Cost effectiveness and cost benefits of prevention services for older adults need to be considered in more than dollars saved and years of life extended or even the percentage of individuals who have prevented specific illnesses. The full impact of health promotion and prevention for older adults must include indications of the degree of disability prevented, improved quality of life, and the length of delay in which costly health care services such as institutionalization have been diverted. In addition, the costs and consequences of inappropriate health practices should be examined in the context of the family and the total community. For example, the older problem drinker on the road is as potentially threatening as younger motorists who are intoxicated.

Cost benefits have been documented for prevention programs such as immunizations for older adults in the community as well as in nursing homes (Sims, 1989). Other prevention strategies, such as walking exercise programs, have low associated costs with significant health gains. Maximizing individual and self-help initiatives whenever possible and designing programs that utilize existing resources are keys to cost effective preventive services.

### Targeting

It is often difficult to identify those older adults in the community who would be the most appropriate group for whom to target health promotion. With an estimated elderly population (aged 65 years and older) in Illinois close to 1.5 million, health promotion/illness prevention cannot be all things to all people. However, contact with the most frail of the older population most frequently occurs in the health care system (i.e., during hospitalizations, within the community care program, and during physician's office visits). It seems logical and cost effective, given that a system already exists which identifies these individuals, that prevention efforts should utilize this method of contact with the elderly.

Another method of targeting prevention efforts for older adults is to consider resource deficiencies for specific groups such as rural elderly and ethnic groups. "Older rural people, by almost all economic, health, and social indicators, are poorer, less healthy, live in poorer stock [housing], have

fewer options in personal transportation and less availability of transit services, and have significantly more limited access to health professionals as well as community based long-term care programs and services than do their suburban and urban counterparts" (Howard and Bane, 4 March 1991:14). This, then, would seem to be an appropriate population to target.

Prevention efforts should also be targeted to older persons who are relatively healthy and would take full advantage of health promotion initiatives. Prevention efforts have been criticized for their focus on the majority population of elderly and on messages and interventions geared toward the advantaged socioeconomic groups. Although there is a need to continue efforts for the majority of older adults, it is critical to target culturally sensitive prevention efforts at minorities, because of their large percentage of "at risk" older adults. The key to successful targeting is that the prevention strategies and programs recognize the limitations and possible accomplishments of the intended audience.

### Prevention Responsibility

As critical as health promotion and illness prevention are to the health and well being of older adults, in most cases the individual has the right and responsibility to decide whether to engage or not to engage in these activities. Immunizations for older adults, for example, are not required by law in Illinois. Informed consent is required and patients are given information on the benefits and consequences of immunizations. However, when the decision of the individual to forego appropriate health practices impinges on the rights and safety of others in the community, the rights of the community must take precedence. Thus, immunizations may be required for persons entering a nursing home or other community facilities in which the health of others may be affected. Still, the primary responsibility for health promotion and illness prevention lies with the individuals themselves.

Health professionals are also responsible for health promotion and disease prevention. Persons aged 65 to 74 consult with a doctor an average of 8.2 times each year while those aged 75 and older see or talk to doctors an average of 9.9 times per year (NCHS, 1986). The National Health Interview Survey reported that 87 percent of persons aged 65 years and older had access to health care in the past year (NCHS, 1986). This suggests that the clinic setting would be an ideal location for dissemination of illness prevention information and health education. Despite the potential impact of the clinic setting, however, prevention plays an insignificant role in the education of most physicians. In a survey of 90 medical schools,

Moser, et al. (1985) found that students receive an average of only 18 hours of instruction in hypertension management over the entire course of their education, even though it is the most common chronic disease in America. It would seem, then, that the role of the health care system in health promotion and illness prevention should be increased.

The government must also play a role in providing opportunities for the individual to take full advantage of resources to promote health and prevent disease. The sociological practitioner can provide a basis for understanding health care decisions and the impact of these decisions on society as a whole. The role of health education is to provide information about the risks and benefits of a healthy lifestyle. Based on this information, it is up to the individual to decide whether or not to adopt these activities. It is, however, the right of older adults to have access to health promotion services. The division of responsibility is best summarized by Green and Kreuter (1990:329): "The practicalities of health promotion planning require that the optimum mix of responsibility to be assumed by those involved—individuals, families, professionals, private or governmental organizations, local or national agencies—must be worked out on a case-by-case basis. It is essential that those directly affected have a voice in negotiating this division of responsibility."

### **Basis for Recommendations**

The following summary of the status of illness prevention and health promotion for older adults is based on three sources of information: testimony offered during the ElderHealth public hearings sponsored by the Illinois League of Women Voters; a review of national and statewide documents pertaining to illness prevention for older adults; and a statewide survey of health promotion and disease prevention services available in the state. The statewide survey was distributed to a representative sample of local health departments and to all Area Agencies on Aging. This summary is followed by a statement of concerns and problems regarding illness prevention for older adults in Illinois and a list of recommendations to address these problems.

#### **ElderHealth Public Hearings**

Six public hearings were held in rural, urban, and suburban areas across the state as part of the ElderHealth project. The purpose of the public hearings



was to provide a public forum in which those most directly involved with health care issues for older adults could express their concerns and comments on the health needs of the aged. Older adults, representatives of agencies concerned with the health and well-being of older adults, government officials, and concerned individuals were invited to provide written and/or oral testimony during these hearings. A summary of prevention issues raised during the hearings follows.

Unlike other health issues discussed during the public hearings, relatively little direct testimony was offered concerning the need for assistance in matters of prevention services and health promotion. The reason for this is that prevention is traditionally viewed very differently by health professionals and the public. Physicians are likely to hold a biomedical view of prevention and offer technological interventions, such as inoculations and medical screening, while public health professionals are likely to view prevention in terms of environmental risks and behavioral risk factors. The older adult may not even tend to view health promotion and disease prevention services as part of health care services. While most individuals understand the relationship between health risk behaviors and chronic illness, they may not request assistance to change inappropriate health practices. Other individuals typically see treatment rather than prevention for behavioral risk factors as the appropriate response from the health care system. For example, testimony was provided concerning the need for treatment of older adults with alcohol related problems. However, there was no testimony offered concerning how to prevent alcohol abuse prior to it becoming a health problem. A written synopsis from the hearings recognized only the need for alcohol and drug treatment.

The abuse of alcohol and other drugs only exacerbates an older adult's medical problems and ensuing costs. By offering senior outreach services which can help them obtain needed chemical dependency treatment, there are health and life quality gains which can be made by the individual, as well as a financial gain by those who must pay the medical costs created by alcoholism and drug dependence. Unfortunately, sometimes professionals are unaware of the problems of substance abuse of older Americans.

There were a few individuals providing testimony at the public hearing who did recognize the utility and the need for preventive services. For example, written testimony from the Older Women's League stated that:

Some [insurance] policies still do not cover preventive tests such as a yearly PAP test. If health insurance companies want to reduce costs by preventing illness, they need to invest in wellness and preventive coverage. Statistics show that women access health care more often than men, and many problems women encounter, such as osteoporosis, are related to aging. Research has shown some of the effects of these problems can be decreased with proper early detection and treatment, but most insurance will not pay for a physician's most important diagnostic tool—a complete physical.

Testimony also referred to the difficulties minority elderly have in accessing services, specifically those services provided under the Older Americans Act. Communication and geographical barriers were cited as the most evident. Difficulties in communication between the provider and the minority client in marketing services and in explaining health promotion avenues, as well as between the client and the provider due to cultural and emotional differences, were reasons for these access problems.

Concern over prescription regimens was also mentioned. Elders are often not compliant for a host of rational reasons, including: hearing difficulties when instructed on medication use; vision difficulties when reading printed instructions; and the lack of standardization of medication color and shape.

Recommendations concerning prevention for older adults were occasionally offered, including developing a program of regular physical activity and good nutrition; avoiding risk behaviors (e.g., overeating, smoking); maintaining an active mind; and maintaining and developing a spiritual awareness.

### Prevention Literature

Probably one of the best known documents pertaining to health objectives for older adults is *Healthy People 2000: National Health Promotion Disease Prevention Objectives* (Healthy People 2000, 1991). In this work, national goals have been offered concerning the health and functional status of older adults in the U.S. which include a number of prevention objectives. The U.S. Preventive Services Task Force (USPSTF 1989) has provided a summary of prevention strategies specifically for older adults (Woolf, et. al. 1990a, 1990b). The recommendations of the USPSTF were intended only for clinical settings, however, and do not apply to preventive interventions in other community settings. Another resource which served as a basis for the recommendations that follow was the Institute of Medicine (IOM) report on health promotion and disease prevention in later

life (1990). Information derived from these national resource documents (USPSTF report, IOM report, Healthy People 2000) were then examined in the context of health care and health promotion strategies offered by the Illinois health care system as presented in *The Road to Better Health for All of Illinois* (Roadmap Implementation Task Force, 1990).

Recommendations from other sources were reviewed for specific health practices and disease prevention methods for older adults. These included: nutrition policies and implementation strategies (Marion and Gilbride, 1990), designing medication instructions to promote proper medication management (Morrow, et al., 1988), and the *Surgeon General's Workshop Proceedings on Health Promotion and Aging* (1988) pertaining to alcohol, physical fitness and exercise, injury prevention, medications, nutrition, preventive health services, and smoking cessation. Enhancement of the health status of the older citizens of Illinois through prevention is also a major concern of the public health system. Recommendations from the Roadmap Implementation Task Force (1990) were considered.

### Illinois Prevention Survey

The list of preventive health services investigated in the following pages is not exhaustive, but it does delineate major service areas of concern that are reflected in the survey results (discussed below), literature, and/or taken from the testimony.

These areas of service have been divided into four categories: 1) modification of behavioral risk factors; 2) screening tests; 3) counseling and health education; and 4) immunizations.

A survey was distributed to the thirteen Illinois Area Agencies on Aging (AAoA) and to two health departments in each of the eight regions defined by the Illinois Department of Public Health (IDPH). The survey's purpose was to locate agencies that provide preventive health services, to enumerate the specific services provided or funded, and to list barriers associated with care delivery. Because of time constraints, a comprehensive study of the services provided was not an option; but with the plethora of information already written, facts gathered during the survey process, and working knowledge of the public health industry, a general idea of existing services, barriers or lack of services, and general practice in delivery of services can be offered. The services listed do not include the private physician population, although the paper alludes to problems associated with care offered at that level.

## Modification of Behavioral Risk Factors

These risk factors include tobacco use, alcohol consumption, drug use, lack of physical activity, and inadequate nutrition. Available services for reducing tobacco use are basic smoking cessation classes. These are offered sporadically through a variety of different agencies: AAOA, local health departments (LHDS), American Association of Retired Persons (AARP), local hospitals, and continuing education programs (CEPs), in addition to other community organizations. One difficulty in determining the effectiveness of these classes is that most programs are not tailored for the older individual. Even when funding is designated specifically for the senior population, the provider is rarely trained to tailor the program to this group. Also, the necessary follow-up by personal physicians is not usually available to seniors (or any audience) because many physicians do not include a discussion of lifestyle changes in their normal appointments. Physicians rarely counsel older patients to quit smoking. CEPs offer classes for a minimal fee and offer discounts for the senior population; but again, classes are not tailored for older adults. Fees charged, minimal continued follow-up service, and lack of continued physician emphasis on modification of health habits not only limit the clientele that use these programs, but deter permanent change. Additionally, in marketing this type of service, LHDS and other agencies often focus on pregnant women who smoke. Although this is a necessary target, it may keep the older population from using this service. New formats specifically for the older population have been developed, but have yet to be implemented in the community on a regular basis.

Alcohol consumption and drug use are sometimes dealt with at the community level, but usually only on a referral basis. Referral is given only when behavior has reached a point that requires a program for treatment or even institutionalization. Most agencies and even private physicians offer a referral system; however, the system is not standardized. The Illinois Department of Alcohol and Substance Abuse refers agencies and individuals to programs for treatment and further prevention.

Although physical activities may not be the focus of many health related agencies, the AARP offers many programs, specifically designed for the elderly, on diet and exercise through local community units or chapters. Existing formal and informal exercise groups (e.g., mall walking exercise groups) are relatively scarce and not well-known in the communities in which they are found. Private membership to facilities is another option, but it can be costly and not realistic for the older individual when they are designed and marketed for younger, unimpaired individuals. The exception occurs when a physical fitness or rehabilitation program is prescribed by a

physician and coordinated with a local hospital, but this is generally only initiated as a result of serious illness. Television also offers low cost opportunities in some areas: some exercise programs are specifically designed for the older or homebound adult, but these require motivation on the part of the individual and need to be incorporated into other areas of a healthy lifestyle.

Inadequate nutrition is often a problem for the older adult, especially those living alone or on limited incomes. The survey revealed an abundance of available services: the Community Care Program offers assistance in nutritional meal preparation; AAOAs coordinate congregate meals, home delivered meals, and nutritional education; LHDS offer education on eating habits and weight loss practices; and local churches and lodges offer congregate meals and meals on wheels.

### Screening Tests

Screening tests include both physical testing, such as height, weight, blood pressure, vision, hearing, and clinical breast exams as well as lab and procedural testing, which include cholesterol, mammogram (now covered under Medicaid), fecal occult blood, tuberculin skin test, colorectal, diabetes, Papanicolaou smear, osteoporosis, and digital rectal exams. The most commonly offered screening tests are those that are physical in nature. This is mainly due to cost and the fact that providers need not be licensed. Testing most commonly offered are cholesterol and Pap smears, both of which are given through LHDS. AAOAs offer minimal screening, which may include diabetes and cholesterol testing, and some offer wellness programs which include most physical testing.

### Counseling and Health Education

Counseling and health education encompass a wide variety of subjects. Of major concern for older adults are counseling on medication use and misuse, basic health education and promotion (e.g., self breast examination), and injury prevention (e.g., home safety, home safety assessment, safety belt usage, and use of smoke detectors).

Medication misuse is a result of many factors, including an inability to pay for needed prescriptions. The coordinator for Health Advocacy Services (HAS) of the AARP indicated that many inappropriate uses of medication are a result of economics. And all too often elderly swap medications they are no longer using, or take only half of the prescribed dosage to extend and minimize usage. The Pharmaceutical Assistance Program (PAP) helps eliminate misuse of necessary medications by assisting with

payments for cardiovascular heart medicines, arthritis medicines, and insulin. The PAP, however, is only offered to Circuit Breaker claimants. Other medical programs exist but are not statewide and are not normally covered by financial assistance programs. Many gaps therefore, appear in this area.

Basic health education is offered by many agencies: AARP has health promotion information available through health fairs or by contacting their local offices. LHDs have health education units offering health seminars on particular topics to the community. Some LHDs also offer adult health clinics that incorporate education on lifestyle and self breast examinations, and provide relevant literature. The benefits of health promotion literature, however, presuppose the ability to read and comprehend.

Risk reduction of unintentional injury by education on injury prevention (e.g., home safety education, home safety assessment, safety belt usage, and use of smoke detectors) is offered by the Community Care Program through the Illinois Department on Aging (IDA), since these programs are designed for home and general safety education. (Actual classes are provided by the Case Coordination Units, which are community based agencies). Local AAOAs offer home safety education and driver education, as well as other educational seminars.

### **Immunizations**

Three types of immunizations to which every senior should have ready access are tetanus-diphtheria booster (Td) influenza vaccine, and the pneumococcal vaccine. AARP offers free immunizations when funds are available, and LHDs offer some free immunizations, specifically tetanus-diphtheria and influenza. However, these are not used to their full extent by seniors because they may either be unaware of the services or they may lack access to them. Lack of perceived utility of these immunizations may also be a problem, which results in less than full compliance. AAOAs offer funding for immunizations in some areas of Illinois, while Medicare covers pneumococcal but not tetanus-diphtheria and influenza.

### **Concerns and Problem Areas**

The following summary is a synthesis of the ElderHealth hearings, the literature reviewed, and the survey discussed above. While a considerable number of services are offered to the older adult, there remain a significant proportion and number of older adults who are engaging in health risk

behaviors and inappropriate health practices. Without additional efforts in primary prevention, we can expect to see these numbers increase considerably in the future. Hickman (1990) argued that community level health promotion program interventions must incorporate sociological concepts when adapting primary prevention interventions to the community. The AAOAs commented that numerous services are available, but that there are many obstacles in receiving them. Those obstacles most prevalent are lack of finances, transportation, or actual knowledge that services exist. Also, no standardization of services exists between agencies and/or areas. The AAOAs as a provider and funder of services have difficulty in gaining enough human resources, especially in rural areas. LHDs also have inadequate funds and tend to prioritize programs for the younger age groups.

Illinois currently has no method of determining the extent and focus of prevention efforts from region to region throughout the state or the success of these programs in targeting and treating older adults. Surveillance of behavioral risk factors in older adults in Illinois is minimal. IDPH is currently accumulating information on the reported health practices of adults residing in the community via the Behavioral Risk Factor Survey. While the Behavioral Risk Factor Survey can provide information about which older adults are at risk due to health risk behaviors, it will not tell us why the problem exists. It is unlikely that the survey can be used to evaluate the success of a specific program or to inform us as to the type and level of preventive services available in a specific area.

The LHD and AAOA believe that services are available, but a percentage of individuals do not have access to them or lack services in appropriate areas at the time of need. Many of the gaps in services could conceptually be covered by a mix of LHDs and township or other municipal programs. However, the current level of service is varied and responsiveness is different for each area and type of government. Lack of LHDs in some counties also complicates service provision. There is evidence that low participation of minorities may more likely reflect cultural and ethnic, rather than racial differences. For example, although safe and effective vaccines to prevent pneumonia and influenza are available, minorities and other identifiable at risk older adults (e.g., those living alone) are underutilizing these immunizations. Although there are multiple reasons for older minority underutilization of health care services, utilization is often limited by inadequate marketing. Providers often target these populations, as mandated by the Older Americans Act, but have had limited success. Many cultures and handicaps need to be addressed when considering marketing strategies and health education to senior populations. Greater participation

in health promotion program activities by divergent ethnic groups is more than a matter of cultural sensitivity. The considerable sociological research on understanding ethnic norms, values, and belief systems can be employed to overcome low rates of participation by these ethnic groups (American Association of Retired Persons, 1990).

Access to transportation presents difficulties for frail older adults due to design barriers. Although "medicars" and other sources of transportation are available, the number and service areas of these vehicles are limited. Transportation problems due to difficulties in "getting through" on the telephone to arrange for transportation was also expressed as a concern in the public hearings.

Prevention services are more limited in rural areas. LHDs in rural areas were much more likely to mention limited prevention resources than LHDs in urban areas. Rural areas have hardships in delivering services because of low population in large geographical areas, and loss of physician population, as well as hospital closures. Rural areas lack the resources more readily available in a metropolitan area because they are affected by economics and population and thus have spatial inequalities (Luloff, 1990). Rural communities would like to open congregate meals and nutrition sites and also offer home delivered meals, but the human resources are not available. In this type of setting, health must be seen as a social rather than a medical problem.

Rural areas also have minimal transportation services available. The provision of preventive services, however, is directly linked to accessible transportation. The importance of access to adequate transportation was examined by the National Association for Counties, which concluded: "Even the best designed elderly housing, health care or supportive services would prove ineffective without the means to make them accessible." (Markwood, 4 March 1991:10).

Larger metropolitan areas have a greater foundation for community-based services which are provided by Community Care Programs (CCP). CCPs offer in-home and community-based services to eligible seniors to prevent or delay premature institutionalization. Although these types of services are also offered in rural areas, the services vary greatly and are not available everywhere nor in sufficient quantities.

Many older adults do see a physician on a regular basis, but relatively few receive health promotion counseling and education from their personal physician (Woolf, et al., 1990a). Findings from the National Health Interview Survey (NCHS, 1986) report that 87 percent of those aged 65 years and older have a particular clinic, health center, doctor's office, or other place where they usually go when they are sick or need advice about



their health. Physicians, however, are less likely to provide health education counseling to their older patients. This is due, in part, to a lack of confidence in addressing such issues with older adults.

## **Recommendations**

Rather than merely repeating prevention recommendations from existing resources, our intention was to offer suggestions which consider recommendations from the three sources of information reviewed (public hearings, prevention literature, and the statewide survey of health promotion and diseases prevention) and apply them to specific needs and resources within the state. The decision to recommend a specific service or activity also had to meet all of the following four criteria:

1. *It should be demonstrated that the health risk behaviors impact on the health and well-being of the older adult and the public.*
2. *The incidence and prevalence of the behavior should suggest that a significant proportion of the older community is at risk.*
3. *There should be evidence that it is possible to change the level of risk in the older population and that changing the risk factor has meaningful positive health consequences to the individual and the community.*
4. *The recommendation should be cost beneficial.*

In addition to these criteria, recommendations should be evaluated in terms of whether they improve quality of life, as well as prevent or delay the disability associated with chronic illnesses. The success of a program should not be measured by the proportion of older individuals who have specific diagnoses, but rather by the degree to which these individuals can *maintain independence in performing daily activities*. Estimations of costs for the goals and recommendations offered below are not provided because many of the costs can be absorbed through reassignment of already existing resources. Minimal cost was the intention when developing these goals. Those with potentially higher cost were included due to their importance.

**GOAL 1: A coordinated cohesive delivery system of a standardized array of health promotion and illness preventive services should be available.**

**RECOMMENDATION A:** All state programs dealing with health promotion and disease prevention should be the responsibility of one overseeing agency (Illinois Department of Public Health).

**RECOMMENDATION B:** All senior centers should have a minimum standardized prevention program which includes modification of behavioral risk factors, screening tests, counseling and health education, and immunizations. Senior centers need structure, programs, and a measure of professionalism by staff members.

**GOAL 2: Senior understanding and physician, pharmacist, and other health professionals support, and emphasis on preventive services and health education activities should be increased.**

**RECOMMENDATION A:** All health professionals should improve interaction with older adults to encourage healthy lifestyles and preventive services and offer appropriate referrals for these services.

**RECOMMENDATION B:** Medications must be evaluated carefully to prevent misuse, abuse, or complications.

**RECOMMENDATION C:** Seniors must be educated as to the importance of health behavior change, health risks, and prevention strategies at their stage in life.

**RECOMMENDATION D:** When educating and distributing literature, those who have hearing or vision difficulties and those who are non-English speaking or illiterate, should be appropriately targeted.

**GOAL 3: A system to monitor the extent of prevention activities for older adults offered through various programs and the success of these programs should be developed.**

**RECOMMENDATION A:** A data base of behavioral risk factor patterns and health risk should be established for all of Illinois using the IDPH Behavioral Risk Factor Survey, demographics, and morbidity information.

**RECOMMENDATION B:** Patterns of health promotion and illness prevention service use must be determined.

**RECOMMENDATION C:** Programs should be modified according to data base and current service use assessment.

**GOAL 4: Immunizations (pneumococcal, influenza, and Td) need to be available and appropriately given to all seniors.**

**RECOMMENDATION A:** Medicare should be expanded to include TD and influenza vaccine reimbursement.

**RECOMMENDATION B:** Immunizations should be offered automatically upon hospital discharge of elderly patients.

**RECOMMENDATION C:** Local public health programs should be encouraged to extend the free immunizations which are offered to children to the senior population.

**RECOMMENDATION D:** Home health agencies should provide immunizations for all patients or clients.

**RECOMMENDATION E:** Immunizations of all nursing home residents should be encouraged.

**GOAL 5: Remove transportation as a barrier to preventive services.**

**RECOMMENDATION A:** All preventive programs should consider access to transportation as part of their program.

**GOAL 6: Reduce the number of unintentional injuries in the senior population.**

**RECOMMENDATION A:** Safety at home should be improved.

**RECOMMENDATION B:** Automobile safety should be improved. Physicians should be encouraged to report older patients whose medical status may impair driving ability. Safety belt public service education should be tailored to older adults.

**GOAL 7: Special programs for high risk and minority senior populations should be available.**

**RECOMMENDATION A:** Existing case management systems (e.g., hospital discharge planners, community care case managers) should be encouraged to assist seniors unable to obtain services or unable to change lifestyle on their own.

**RECOMMENDATION B:** Improved usage of preventive health services by minority older adults should be encouraged.

**GOAL 8: Insure that recommendations in this paper are implemented.**

**RECOMMENDATION A:** A state agency should be assigned the responsibility to review and insure proper implementation of the previously mentioned recommendations.

## Conclusions

This briefing paper is an example of public health policy as it developed from the older individual and the community to those who implement specific policy recommendations. Although it is based on the Illinois experience, the means by which recommendations were generated and evaluated may serve as a guide for other communities to enact public policy.

Public hearings are frequently used as a means to generate an understanding of the concerns individuals and community agencies have pertaining to health service delivery. Although public health policy is guided by the medical profession and national health standards (Healthy People 2000, 1991), it also must acknowledge the social context of health care and service delivery. Hickman (1990) noted that setting health in a social rather than a medical context requires input from individuals, families, organizations, and health care service agencies within the community. Public hearings provide a method for these community groups to provide input. Community input through public hearings was useful for generating issues or themes which served as a foundation for identifying the needs of the community. However, public hearings alone are not sufficient for appropriate health care policy development. Once recommendations are developed, agencies and health care providers should assess the practicality of the product.

At least three areas in which sociological practitioners can contribute to this process of health care policy development have been identified. First, by translating and analyzing the health concerns expressed by the community, the sociological practitioner can provide insight into the health care needs of the community. Identification of needed health promotion and education services for older persons is an ongoing process in which health priorities will change as new cohorts enter the aged population. Second, development of public health care policy from community input to legislative action and implementation can be examined and enhanced by sociological concepts. The practitioner will prove invaluable by offering insights into the consequences of health policy recommendations prior to implementation. Finally, sociological practitioners play a valuable role in educating all those involved with promoting the health of older adults. Older individuals need to be informed through health education programs stressing the importance of illness prevention and health promotion activities. The practitioner also plays a pivotal role in developing programs to educate health professionals on the utility of health education and health promotion for older adults.

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