

BEHAVIOR MATTERS

15 Years of Health Behavior Advocacy

JESSIE GRUMAN, PH.D.

BEHAVIOR MATTERS: 15 Years of Health Behavior Advocacy
Copyright © 2008 by Jessie Gruman, Ph.D.
All rights reserved.

No part of this book may be used or reproduced in any matter whatsoever without written permission from the publisher except in the case of brief quotations embodied in critical articles or reviews. For more information address: Health Behavior Media, Center for the Advancement of Health, 2000 Florida Avenue, NW, Suite 210, Washington, DC 20009.

Published by Health Behavior Media

Health Behavior Media books are published by
the Center for the Advancement of Health.

Library of Congress Cataloging-In-Publication Data

ISBN: 978-0-9815794-0-5

Visit CFAH's website at www.cfah.org.

First U.S. Edition 2008

CHAPTER 3

Is Health Promotion for Older Adults Just Nice or Really Necessary?

At the Center for the Advancement of Health we believe that evidence should inform the values. Evidence tells us that individual and societal actions that value ounces of prevention over pounds of cure will help us eat, breathe, laugh, play and live as well as we can for as long as we can. Evidence also tells us that health will improve not just because of the latest medical or technological fix but also because we create healthier environments for ourselves.

Nice, But Not Necessary

When we talk about the needs of older people, we do so with the understanding that in the last century, through improved nutrition, medical care and social policy, Americans experienced a 56 percent increase in life expectancy—from 49 years to 77 year—and earned the means to enjoy it. Overall, older Americans have the lowest poverty rate of any age group, but they also spend far more of the nation’s health care dollars per capita than any other age group. Almost 30 percent of Medicare expenditures are spent on those who are in the last year of their lives.

One “moral values” question that we at the Center have been asking is: How is it possible to shift the allocation of resources so that effective health promotion efforts can, to the extent possible, reduce unnecessary pain and suffering and thus decrease the demand for acute and post-acute medical intervention?

At a time when both the Medicare and Medicaid programs confront chronic and growing funding problems, there’s a need to reallocate resources and set priorities. Simply spending more isn’t an option. Spending more wisely is a requirement.

4. This essay was adapted from a keynote address at the Gerontological Society of America Annual Meeting in Washington, D.C., in November 2004.

How to do so will be powerfully influenced by the Three A's.

- *Ageism* is the prejudice that leads to underestimating the capacities of older people, which results in assigning low priority in research funding and program implementation that could contribute to healthy aging.
- *Affordability* is the concern that promoting and maintaining health—even if that just means increasing simple physical activity, changing eating habits and implementing safety precautions—costs more than might be expected and even more for older people with fixed incomes and a range of abilities.
- *Accommodation* is the notion that health and social policies and community programs should be structured to take into account the unique requirements of older people.

America treats health promotion for older adults as a bonus: nice but not necessary. For many this emphasis of “nice as opposed to necessary” is unacceptable. If things can be done that have a good chance of slowing decline, reducing disability and improving quality of life, we should do them. If we are willing to pay for pharmaceutical, surgical and medical treatments to accomplish these goals, shouldn't we also be willing to pay for social programs and policies?

Many of us who work to ensure that an adequately funded and widely used set of health promotion approaches and programs are a necessary dimension of services for elders have spent significant time making this same argument for the population in general. How many times have we trotted out the statistics of the long-term effects on kids of smoking, lack of physical activity and poor diet? This has been a long, tough battle. With the widespread recognition of the obesity epidemic, we are only now beginning to position ourselves for progress. However, health promotion directed to older adults is not gaining a lot of traction, even as baby boomers are starting to deal with their aging parents' medical, money and mobility concerns.

Society takes responsibility for acute care for those over 65, but does not for younger people. Thus, older people are in a special programmatic category. That changes the political debate. Advocating health promotion for seniors means competing for dollars that others would like spent on an expanded Medicare treatment menu, but also raises the possibility of trimming the amount of treatment needed.

Ageism

Why are the prospects for health promotion for older Americans so dim on the policy radar screen? Ageism may be the most pernicious of the three A's and, as the following examples indicate, may be manifested across a range of people with a stake in the health of older adults.

Physicians, nurses, other health care professionals and sometimes even older people themselves ask: “Why bother? Older people have been eating, drinking and amusing themselves for a lifetime and are not likely to change now.”

Politicians believe that we're spending a lot of money on older people through Medicare and in finding cures for the diseases that afflict older people, and lesser amounts on other people, largely because of the power of the senior lobby. Less than 10 percent of the NIH budget is spent on anything related to behavior and

less than 5 percent of the National Institute on Aging budget is directed toward health promotion intervention research. Institutional body language is eloquent. The Administration on Aging has been chronically underfunded relative to its mandate, and members of Congress consistently decline to invest in CDC health promotion activities for older adults.

For health promotion researchers, there are few incentives to investigate the effects of behavior change interventions on older people. Besides the scarcity of research support, older people are not easy subjects to manage over time: They get sick with diseases unrelated to the intervention, have multiple chronic conditions and tend to die.

Although it may not be ageism, people who are not yet 65 but who have parents and other loved ones are forced to invest their attention where the need is most urgent. Anyone who has ever tried to get a parent to exercise or eat better knows that it is not a simple or comfortable undertaking. So we focus on the acute, the

KEEPING FIT FOR A LIFETIME

Kraft, one of the giants in the food business, recently announced that it would begin highlighting nutrition benefits on the labels of many of the hundreds of its products. Some restaurant chains are putting calorie values on their menus, so maybe instead of those little hearts next to the chef salad and skinless chicken entrees, we will soon see an icon of a truck scale.

The surgeon general, the NIH director, the CDC director and the commissioner of the Food and Drug Administration (FDA) have toured the nation with an anti-obesity message, but their service in an administration dedicated to deregulation constrains their message.

Of course one's weight results largely from the many choices an individual makes. The orange or the soda? The bus or the bike? But these choices are powerfully influenced by the availability of options and incentives.

For example, the president's own state of Texas restricted sodas and snack foods in school vending machines, and the FDA has ordered food manufacturers to put information about trans fatty acids on their labels—indications that we may finally have reached a tipping point, so to speak, in the war against fat.

Largely successful against smoking, public health advocates are now on the verge of getting people, if not moving, then at least thinking about losing weight. Some of the same legal strategies from the tobacco wars may apply in this fight, but only to a point. A person can always stop smoking. Unless you are a monk or a cover girl, you cannot stop eating. You can go cold turkey from cigarettes, but if you're overweight all you can do is eat cold turkey.

The government can direct research money to not only the biology of obesity but also to the psychology of it. After all, if you give a man an Oreo, you feed him for a day. If you teach him how to eat broccoli, you keep him fit for a lifetime.

urgent, the life threatening and the medical solutions that require our attention now instead of facilitating the daily practices that make a difference over time.

Older adults are sometimes caught between the desire to live active, engaged lives and their own limits. Suggest to an older adult that a little more physical activity might help him lose some weight, and he may well tell you, “I can’t exercise with my arthritic knee.” We all feel the impulse to take a pill to fix a problem and don’t have the patience to wait for exercising to pay off. Perhaps this is not ageism, but simply lowered expectations about how our abilities change over time.

While there is evidence that many older people are willing to participate in organized activities to increase healthy behaviors *and* there is evidence that they can gain substantial benefit from them, many choose not to do so.

Ageism mutes the potential of health promotion: Ageism contributes to a limited supply of health promotion information and programs, sparks little demand for them by users and their advocates—their kids, spouses and health care providers—and provides few incentives for this to change.

This is a recipe for health promotion for older adults remaining a nice but not necessary health investment.

Affordability

The confidence of many in this country in our abilities to pull up our socks and take responsibility for our health has led to peremptory statements about how easy it is to become healthier. These sentiments have been repeatedly echoed in articles in the business and popular press.

One article recently offered this list of “simple” how-to suggestions:

- Join a gym or get a personal trainer.
- Buy top-of-the-line workout shoes once a year.
- Buy home exercise equipment.
- Do yoga, Pilates, meditation or massage therapy.
- Quit smoking.
- Change your food-buying habits.

This sounds good, but at what price?

- A gym membership can cost between \$600 and \$1,200 a year and personal trainers ask \$40 an hour.
- Good shoes can cost \$100 a year.
- A home treadmill can cost between \$700 and \$1,700.
- People who already engage in alternative forms of medicine spend an average of \$300 a year on yoga, massage, Pilates and related therapies.
- Smoking cessation may require patches, gum, SmokEnders sessions or \$150-an-hour hypnosis.
- Changing food-buying habits makes sense but often means paying a premium for healthier foods.

All six of these preventive health suggestions are great if you have several thousand dollars at your disposal and the time, will and physical and mental agility to do Pilates.

Are simple health promotion activities nice for older adults? Of course. But if these activities are *necessary*, a good chunk of the older population (as well as the rest of the population) is going to need help to get access to fresh vegetables and safe venues for physical activity.

Accommodation

These suggested health promotion activities are also emblematic of the third “A,” which is accommodation. This is the notion that there are many relatively simple “fixes” to existing practices and policies that would transform them into useful, health promoting—or, at least, not health-*limiting*—approaches. The list above simply assumes that these ostensibly simple steps to good health are applicable to everyone. Indeed, older adults are most often the recipients of health messages targeted to the population at large. These messages are not tailored to the needs and interests of this population and so are often ignored.

The economic barriers to changing health behavior are formidable, and so are the frustrations and annoyances faced by older people who just want to get around as they used to, if only a bit slower and more safely. For example, if you do have good shoes and good knees, what use are they to your health if your neighborhood is poorly lit and has a high crime rate as well as broken sidewalks that invite you to fall?

Even modest changes in public and private policy could make a huge difference in reducing the barriers to healthy aging. A lot of older people take their meals at senior centers or have them delivered, but the food available for this purpose is often high in sodium and fat. Yet there is little will in Congress or the agencies to address this concern. It is optional, nice but not necessary. No death certificate ever listed Velveeta cheese as the cause of death.

The bias toward a medical approach to aging has eclipsed population- and community-based behavioral and public health approaches to helping people live as long and as well as they can. I believe I have made the case that health promotion is doomed to remain as “nice but not necessary.” No one would ever say these things aren’t important or that it is not important to delay decline for as long as possible. However when the rubber hits the road, health promotion will be given a little support, but not enough to institutionalize it and thus significantly contribute to the social norm of adults remaining active and engaged in our society for as long as they can.

Nice AND Necessary

I am tired of making this argument against “nice but not necessary” because it sounds like whining, is a dispiriting analysis and doesn’t accomplish anything or help us figure out what to do next. Instead, let me make a few observations and see if I can move us out of this funk:

We have a positive context.

The Bush administration *has* taken a fairly aggressive stance toward personal responsibility for health. On one hand, that signals a retreat from paternalistic, government approaches to health protection. On the other hand, there may be opportunities to advance a tighter, evidence-based agenda for helping older adults stay healthy.

None of the Medicare reform or health care reform proposals currently under consideration seeks to *lessen* the responsibilities of individuals for their health or health care.

Framing carefully chosen policies and practices that promote the health and independence of older adults as key to increasing personal responsibility may have promise. Success depends on the wise choice of a few options, clear evidence of value in terms of both outcomes and cost, and ensuring that those who are unable to fulfill those responsibilities because of age, illness, disability or lack of resources have the support to do so. It also depends on our recognition that the public health terminology—the coded shorthand that researchers and public health advocates use to communicate—has no currency when making the case to these elected officials and bureaucrats.

The marketplace is not oblivious to the aging of financially well-off baby boomers.

If baby boomers want low-riding jeans with Velcro closures instead of zippers and buttons, they are going to get them. Some gyms will blast Diana Ross and the Rolling Stones while boomers work out. Cars will be modified to meet seniors' changing physical and cognitive needs, hardware stores will specialize in high-tech design for safe bathrooms and assisted living centers will offer macrobiotic and vegan choices. Boomers have money and are going to spend it on the stuff they like. Many avenues of health promotion will become more available to more people and will become cheaper and ubiquitous because of the numbers of adults willing to pay for these goods and services.

The question that must be answered over the next five years is: “Where will the market fall short?” Just as the pharmaceutical industry is reluctant to invest in research on drugs to cure rare diseases, some effective health promotion strategies for older adults will not attract commercial interest. We used to think that chronic disease self-management was one of these areas, but an entirely new industry has developed that says it is taking it on. It remains to be seen whether this industry will survive and thrive.

Regardless of what happens, I think it is worthwhile for health promotion advocates to anticipate the future and invest our considerable talents in conducting research and developing programs that are clearly focused on fulfilling needs that the marketplace will ignore.

The Great Depression and World War II continue to influence people over 75.

For most members of this population: doctors are kings, modern medicine is a miracle worth any price and old age looks like a disease that should be cured. Their baby boomer kids do not share these attitudes. Modern medicine has always been

a fact of life for them, and they know all too well that physicians are human and lack magic powers.

I think the baby boom generation is going to have a very different notion about health promotion and its place in the hierarchy of responsibilities of the public sector, the private sector and individuals. Were I to guess, I would say that this bodes well for advocates of the “necessary, not just nice” approach to health promotion for older adults.

Overall, I now find myself more optimistic about the future of health promotion than I had been. I believe that in this time of “values-based” rhetoric, health promotion for older adults is an investment that is difficult to deny, regardless of political persuasion. No one opposes removing the barriers to older adults remaining vital and engaged, living as well and for as long and they can.

But it is the responsibility we advocates of the “not just nice but really necessary” school to recognize that this is not an invitation to “whatever it takes” approaches. Rather it is a time for researchers, practitioners and advocates to analyze current constraints and to anticipate the effects of the aging baby boomers on the marketplace and on the profile of health promotion. It is also necessary to develop consensus on a lean, focused, elegant agenda that has the likelihood of making headway, given what we imagine the future looks like.

Until now, standard practice in gerontology has consisted of curiosity-driven explorations and relatively strategy-free interventions. This will not move the needle on health promotion in this environment. The predictable future demands a new approach and offers new opportunities. Health promotion attracts idealists; I know because I am one.

I wish I could foretell a different, more expansive, enthusiastic future for health promotion but I think that the sage poet of the baby boom generation, Mick Jagger, nails what I believe should be the new theme song for advocates of health promotion for older adults: “You can’t always get what you want... but if you try sometimes, you just might find you get what you need.”