

Promoting the health of older Australians: program options, priorities and research

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Abstract

Relatively little emphasis has been placed on identifying health promotion research and program priorities for the older age group. A one-day conference culminating in an interactive session was organised to engage health service professionals in a process to identify such priorities in Western Australia. Physical activity, social isolation, mental health and medications were deemed issues warranting more attention by both health promotion research and health promotion intervention programs. Additional consultation with representatives of the target population is recommended to further refine the priorities.

Background to the project

Intervention programs and health promotion research have traditionally focussed on children and youth and to some extent on young adults. It is only in recent years that Australia and other high-income countries have given attention to setting priorities for health promotion programs and health promotion research with respect to seniors.

As part of the process in Western Australia, a daylong conference was held for health professionals working with seniors and/or interested in their health. This involved a review of health issues for seniors and the presentation of case studies covering services and risk factors, culminating in an interactive process to identify priorities for both more health promotion programs and health promotion research in relation to seniors. This paper summarises the process that was undertaken and discusses the results in relation to the national health priorities.

The ageing population and the need for health promotion

The increasing size of the ageing population raises social and public health concerns. Today about 10% of the world's population is 60 years of age or older, which is expected to increase to 20% by 2050 (Health Department of Western Australia 2001). In Australia the 2001 census recorded the proportion of people aged 65 years and over as 12.6% (2.4 million). This group is estimated to comprise 25% of the population within 50 years (AIHW 2002a).

Age is generally associated with declining health status, with older Australians contributing more to health costs per capita than other groups. Seniors accounted for 35% of the total health expenditure and 48% of patient days in hospital in 2000-2001 (AIHW 2002a). There is a growing literature on the predicted economic impacts of this group and their demands for housing and health care (e.g. Dychtwald 1999). In contrast, there is evidence that older persons, who are permitted to play a role, feel needed and continue to be active, will retain their health and capability far longer than those who are deprived of these possibilities and feel content or obliged to withdraw (Fletcher, Breeze and Walters 1999; Maddox 1987). Nevertheless, many societies, including Australia, may be ill prepared to handle the conditions associated with a rapidly aging population (Foran and Poldy 2002; Mitka 2002).

Many of the health problems and disabilities that occur in old age often develop from earlier behaviours and experiences. After peaking in early adulthood, functional capacity typically declines, due largely to such factors as physical inactivity, inappropriate alcohol and drug use, tobacco use, and inappropriate nutrition (Kalache and Keller 1999). This provides a strong rationale for health promotion to focus on people when they are young. Nevertheless, there is a growing body of evidence that promoting health amongst older age groups can also significantly influence health gain and compress morbidity and mortality (Fletcher, Breeze and Walters 1999). Health promotion aimed at increasing the health status of seniors in Australia should therefore be given increasing importance.

Increased interest in the health of seniors at an international level is evidenced by the publication of reports by the World Health Organisation and a range of countries, including the United States, the United Kingdom and Australia (AIHW 2002a; National Institute on Ageing 2001; Victor and Howse 2000; WHO 2002a; WHO 2002b). In Australia at the State level, reports are appearing acknowledging an increase in health promotion intervention programs aimed at seniors (Giles-Corti et al. 2003; HDWA 2001; Queensland Health 2002). However, relatively little work has been carried out in Australia to identify priorities for health promotion programs and research in relation to older people.

The identification of priorities needs to involve several complementary processes. These include a review of statistical data to identify morbidity incidence and prevalence rates, mortality rates, trends, and Disability Adjusted Life Years (DALYs) associated with particular conditions. As well as statistical data, the priority setting process needs to involve consultations with the various key stakeholders such as seniors (the target group) as well as health providers (Green and Kreuter 1999). It could also include consultations with future seniors – e.g. the baby boomer generation. Such consultation is essential if we are serious about practising what is a central premise of health promotion, viz ‘consumer participation’ – active involvement of both the health service providers and the target groups in identifying needs and developing interventions.

Health promotion can be regarded as a combination of educational, organisational, economic and political actions *designed with consumer participation*, to enable individuals, groups and whole communities to increase control over, and to improve their health, through attitudinal, behavioural, policy, social and environmental changes (Howat et al. 2003). While we acknowledge the importance of consultation with the primary target group, i.e. seniors themselves, there is also value in consulting the secondary target groups, i.e. their carers and service providers. Seniors have opinions about what their personal needs are, and those they perceive of their peers, as well as the type of interventions they are receptive to (Iredell et al. 1998). Health service providers, program planners and researchers however, are usually better informed in general about the scope and nature of health issues, and about options for intervention programs and research. It is logical then that they are consulted as part of the priority setting process. Accordingly, during the conference we held an interactive session that provided opportunity for engagement with health service providers in identifying priorities.

Identification of priorities

Following an assessment of data on the health status of seniors, a review of literature pertaining to health promotion priorities in Australia and overseas was undertaken (e.g. AIHW 2002a; Victor and Howse, 2000; WHO 2002a; WHO 2002b). These activities guided the content and structure of a one-day conference held in Perth in 2002, which was one of the first attempts to involve health professionals in Australia in the identification of priorities for both health promotion programs and health promotion research for seniors (Boldy et al. 2002).

Conference Papers

Two keynote papers provided a broad perspective on the health issues relevant to seniors. Professor Christina Victor provided a review of health promotion research relevant to seniors in the United Kingdom and issues that were considered as part of setting a UK research agenda (Victor 2002). She pointed out that there are comparatively few intervention programs in Britain aimed specifically and exclusively at older people. Several attempts have been made in recent years to acknowledge the importance of promoting health and active life in old age.

The most recent strategic development in this area is the National Service Framework (NSF) for Older People, which consists of eight standards. The eighth standard, which focuses on health promotion, highlights three major areas: 1) to ensure older people have access to mainstream health promotion programs; 2) to ensure there are health promotion activities of specific benefit to older people such as increasing physical activity or improving nutrition; and 3) to ensure initiatives involve a multi-sectoral approach to promoting health, independence and wellbeing in old age (Victor 2002).

The second keynote address reviewed health priorities for older people established by the Department of Health of Western Australia (Jackson 2002). It was acknowledged that the Department's health promotion interventions recognised that many chronic disabling conditions are preventable; that seniors can benefit from a healthy lifestyle; and that as well as individual behaviour change, social organisation and environmental changes need to be considered (Jackson 2002).

The other nine 'case study' papers covered a range of health issues relevant to health promotion of older people broadly grouped into health services and risk factors. Topics covered under health services included: falls prevention, health promotion by general practitioners, a home independence program, self-management of chronic disease and age friendly hospitals. The risk factors category included: physical activity, pedestrian injury, loneliness and nutrition.

Interactive Session

A total of 77 conference delegates engaged in a 90-minute interactive activity in groups averaging 11 participants. In identifying where they believed there was a need for either more health promotion research or more health promotion programs for seniors in Australia, the participants had the benefit of the 11 conference presentations to focus their thinking. In addition, the interactive session was structured to enable discussion about the various relevant health problems and health risk factors, in order to provide additional clarification. A Nominal Group Process (NGP) was used to minimise the possible dominating influence of a few vocal participants (Boldy et al. 2002). This process is one of the best ways to equalise the relative influence of each participant on the rating of priorities.

Each group member received a work sheet, which contained a list of health problems and risk factors (= health issues). They were instructed to circle a number opposite each health issue "...that best describes what you feel about the need for more health promotion programs for seniors in Western Australia – i.e. where you believe there is insufficient health promotion for the health issue at present." Ratings were possible on a five-point scale. They were invited to add other health issues to the list and similarly rate them.

The individual ratings were followed by the NGP that led to group ratings of each health issue, where participants could allocate up to six votes to particular health issues, however they liked. Thus, the maximum score overall was 77 x 6 = 462. The process was repeated for identifying the need for more health promotion research for seniors. The data from both the individual and group ratings were collated and analysed.

The list that participants rated in the nominal groups included 19 health issues. These represented those identified from the literature as the likely priority areas for seniors' health promotion, together with those added by participants, namely continence and dementia (mental health being seen as too broad). It is possible that the issues on the original list received more attention in the individual ratings due to a prompting effect. However, this was addressed by the NGP, which allowed group discussion and clarification of the various health issues, followed by additional (group) ratings. It is the group ratings that are considered the most relevant, and these are presented in Table 1, for both programs and research, ranked by the mean percentage accorded to both.

Table 1: Priorities for health promotion programs and research for seniors

Health Issue	Programs (n=412)		Research (n=406)		
	Rank	Votes	%	Votes	%
1. Social isolation		68	17	83	20
2. Physical activity		87	21	34	8
3. Mental health		59	14	62	15
4. Medications		42	10	40	10
5. Falls injuries		19	5	20	5
6. Diabetes		30	7	5	2
7. Nutrition		29	7		<1
8. Sexuality/relationships			<1	27	7
9. Dementia		7	2	22	5
10. Attitudes about ageing			<1	18	4
11. Arthritis		12	3	4	1
12. Continence			<1	11	3
13. Osteoporosis		6	1	8	2
14. Stroke		5	1		<1
Others: (<1% for both programs and research)					
Asthma; Traffic injuries; Indigenous health; Stress; Cancers					

The total number of votes allocated by participants for 'programs' was 412, and 406 for 'research'. The votes for each health issue are also shown as a percentage. The totals for the percentage columns add up to less than 100% because several of the low priority health issues have been excluded from the list and some of the votes were not allocated.

Priorities for health promotion programs and research

The group ratings for more programs shown in Table 1 represent the distribution of the 412 votes (50 unallocated) of the 77 participants allocated to all health issues. The top four health issues, or priorities for more health promotion programs, each with 10% or more of the votes, are in order: *physical activity, social isolation, mental health and medications.*

Similarly, the group ratings for more research, based on 406 allocated votes, indicate that the top health issues, or priorities for more health promotion research, are in order: *social isolation, mental health, medications and physical activity.* It is significant to note that these are the same four issues/priorities, if in a slightly different order, as identified for programs.

Discussion

The interactive session focussed on identifying where there was a need for more health promotion programs and more health promotion research for seniors. Participants were expected to take into consideration that significant attention was already being given to some of the health issues with respect to health promotion programs as well as research.

One of the conference presentations included details about programs that the Health Department of Western Australia was currently conducting – namely falls prevention, nutrition and cancer screening (Health Department of Western Australia 2001; Jackson 2002). Other papers outlined programs for seniors in other parts of the world, especially in the United Kingdom, with emphasis on research priorities (Victor 2002). Interestingly, the participants did identify priorities that were consistent with such data, in particular physical activity, social isolation, mental health and medications.

In considering physical activity, participants gave a somewhat higher rating to the need for programs rather than research (Table 1). This implies that there is a reasonably adequate research literature about the benefits of physical activity and the type of interventions suitable for older people. On the other hand it acknowledges that more actual interventions are required to raise their level of physical activity. A similar comment applies to diabetes and nutrition, which of course are related areas. Topics for which somewhat higher ratings were given for research rather than programs include sexuality/relationships, dementia, attitudes about ageing and continence. This reflects recognition that more research about these issues is required to identify efficacious health promotion strategies before actual interventions can be justified.

In contrast, participants gave more similar ratings as regards programs and research for social isolation, mental health and medications. The high ratings for these three issues are not surprising. Many of the conference participants would be well aware of the substantial evidence and media publicity about their impact on health status of older people (AIHW 2002a; Jackson 2002; Victor & Howse 2000; WHO 2002b). In the discussions that took place as part of the interactive session, participants acknowledged not only was there a need for more intervention programs per se, but more research was also required to identify efficacious health promotion strategies (Boldy et al, 2002).

It is interesting to note that falls injuries received similar moderate to low scores for research and programs. This is probably due to the perception that substantial research has already been conducted and that numerous intervention programs are occurring.

The six health priority areas identified for Australia in 1999 account for 70% of the total burden of disease and injury (Mathers et al. 1999). They are cardiovascular disease, cancers, mental health, injury, diabetes mellitus, and asthma. The 10 major risk factors associated with these six health priority areas are tobacco, physical inactivity, hypertension, alcohol harm, overweight/obesity, diet, high blood cholesterol, illicit drugs, occupation and unsafe sex (Mathers et al. 1999). As would be expected, a number of these health priorities and associated risk factors for the whole population are the same as those identified by the conference participants as priorities for seniors.

A recent report that presented a review of health promotion program and health promotion research priorities for funding provided by the Western Australian Health Promotion Foundation in WA is also consistent with the conference outcomes with respect to priorities for seniors. Maintaining and increasing physical activity and reducing social isolation were given special emphasis for health promotion interventions (Giles-Corti et al. 2003). While the report placed greatest emphasis for both health promotion research and interventions on children and youth, many of the recommendations for the population as a whole included the health issues identified by the conference participants.

Limitations

It is acknowledged that the interactive process has limitations and that the priorities identified are not necessarily a definitive list. Nevertheless, the information compiled complements data already assembled in official reports based mainly on statistical data, (e.g. AIHW 2002a; Giles-Corti et al. 2003; Health Department of Western Australia 2001) and could in turn be strengthened through additional priority setting processes such as individual interviews and focus groups with seniors themselves.

Conclusions

The interactive process provided opportunity for health service providers to indicate their views as to priority areas for both more health promotion programs as well as more health promotion research. Their selections were generally consistent with data contained in recent Australian and overseas reports (e.g. AIHW 2002a; Corti et al. 2003; HDWA 2001; Victor and Howse, 2000; WHO 2002a; WHO 2002b).

The priority setting process should involve data gained from several processes to provide triangulation. In particular, specific consultation with members of the target group (i.e. seniors) is recommended to complement the data presented above. Focus groups, nominal groups and in-depth interviews are possible options. It might be expected that such an expanded consultation process will confirm that key priorities should be attached to the areas of physical activity, social isolation, mental health and medications.

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