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AUTHOR Smith, Nancy H.; Howze, Elizabeth Harper
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ABSTRACT

Although there is a national emphasis on health promotion and preventive practices, questions remain regarding the equity of access to these services by low income and minority groups, and the implications of inequities for elder health. Data from a systematic survey of 500 public and private providers of health promotion services in northern Virginia were examined to see whether and to what extent services were targeted to specific user groups. Primary services were offered by 163 agencies in at least one of seven areas: alcohol/drug abuse, smoking, high blood pressure, fitness, weight control/nutrition, accident prevention, and health education. Health promotion was the primary goal in 29 of these agencies, mostly in the area of alcohol and drug abuse. Among public and private non-profit agencies, the concentration of services across risk categories was fairly even, with the exception of lower counts for smoking cessation, stress management, and mental health promotion. Among private for-profit agencies, services reported most frequently related to either weight control and nutrition or stress management. Services (N=40) which had specified target user groups were generally nutrition or physical fitness programs for the elderly or recreation programs for the handicapped. Only two services (alcohol abuse education for Hispanics and accident prevention for Indochinese) were targeted to minorities and none were targeted to low income persons. (NRB)

EQUITY IN ACCESS TO HEALTH PROMOTION AND RISK REDUCTION SERVICES: IMPLICATIONS FOR ELDER HEALTH

Nancy H. Smith
Elizabeth Harper Howze

Paper presented at the Annual Scientific Gerontological Society meeting, San Antonio, TX, November 16-20, 1984.

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IMPLICATIONS FOR ELDER HEALTH.

Nancy H. Smith, Elizabeth Harper Howze

Prepared for GSA Annual Meeting, 1984.

Good morning. Our contribution to the issue of equity this morning is on the topic of health promotion.

The struggle against the major disabling and killing diseases of today - heart disease, cancer and stroke - has led to a new national emphasis on health promotion and preventive practices. One consequence of this burgeoning public interest is a growth in the number and variety of risk reduction and health promotion programs in communities across the country. Yet, important questions remain regarding equity in access to these services by low income and minority groups, and the implications of inequities for elder health.

Our intention this morning is to raise these questions and to share the findings of a survey of health promotion services in Northern Virginia.

First, the questions. Is there equity in access to health promotion services? And what are the implications for elder health?

Let me begin with the easier of the two - the implications. From both the standpoint of risk of chronic disease and loss of independence, unequal access to health promotion and other preventive services carries potentially serious consequences for the health profile of our aged and the profile of residents in our nursing homes.

On the side of chronic disease, more and more evidence points to the correlation between chronic diseases and preventable risk factors. These include factors "under the control" of the individual (such as smoking and alcohol abuse) and others manageable through clinical intervention (such as high blood pressure). If one accepts this body of evidence, one implication of unequal access is clear - potential disparity in the risk of individuals, if not population sub-groups, to chronic, disabling diseases.

Racial comparisons of U.S. death rates only add to the seriousness of this scenario. Table 1 illustrates what has been called the "health gap" between white and black populations. In 1982, rates of leading causes of death among black men and women continued to be greater than for their white counterparts. Even more troublesome is the fact that, at least among males, the gap in death rates for heart disease widdened between 1978 and 1982, although gains were made in both groups.

Whether this trend is independent from or due, in part, to unequal access to preventive and curative health care, targeting health promotion services to at-risk persons can only add to efforts to bring rates down and more in line across racial groups.

And, the potential implications of inequities go beyond risk of chronic disease to issues of quality of life and continued independence in later years. Several studies have attempted to identify "risk factors" for nursing home admission - an important and costly measure of loss of independence.[1] Those risk factors cited most often are age, lack of social supports, and functional impairment. Again, if one accepts that preventive practices contribute to overall health and protect against early disability, then at least one of these variables - functional impairment - becomes a potentially preventable risk of premature institutionalization.

The key work here is early. The recent studies of Branch a Jette of personal health practices and mortality in Massachusetts throw the efficacy of health promotion services for persons over 65 into question.[2] While limited to mortality, study results do point to a potential irreversibility of poor health practices and, hence, the importance of adopting healthy lifestyles early on.

The "good news" side of our knowledge about chronic disease and institutional risk factors puts a fair amount of responsiblity on the emerging field of health promotion - a field yet in its infancy. Part of this responsiblity is to look critically at current services with the same eye to issues of service coverage, access and quality given to the medical care side of the health spectrum in the 1960's and 70's.

This leads me to the more difficult of the two questions raised earlier - <u>is</u> there equity in access to health promotion services?

TABLE 1

RACIAL COMPARISONS OF US DEATH RATES

(PER 100,000)

CAUSE OF DEATH	BLACK MEN	BLACK WOMEN	WHITE MEN	WHITE WOMEN
HEART DISEASE	327	201	277	134
(1978)	(322)	(204)	(294)	(137)
CANCER	229	129	160	107
(1978)	(222)	(130)	(133)	(108)
DIABETES	17.7	2.2	9.5	8.7
SUICIDE	11.4	2.4	19	5.7
HOMICIDE	71.9	13.7	10.9	3.2

SOURCE: DHHS, 1982

Questions of access have been addressed at length in regard to medical and social services, but little to no attention has been given to whether emerging health promotion services are adequately serving minority, low income and socially disadvantaged groups.....essentially, whether the public and private health promotion market has evolved as largely a white, middle class enterprise.

To try and answer this question, data from a systematic survey of 500 public and private providers of health promotion services in Northern Virginia were examined to see whether and to what extent services were targeted to specific user groups. This survey was part of a pilot project under CDC's Health Promotion and Risk Reduction Program to inventory and incorporate information on health promotion services into Northern Virginia's automated information and referral (I&R) database of over 2000 human service agencies.

Information on file is used to generate directories and special guides that are then used by local service providers, libraries and businesses to link individuals to appropriate community services. The purpose of the survey (conducted in 1982) was to expand the range of services in the database to include health promotion programs. As such, any conclusions about access are based on service descriptions rather than on any account of the types and numbers of persons actually served. The question of equity is therefore looked at from the vantage point of the user or, how services are "advertized".

Overall, the survey showed that a large number and wide range of health promotion services were provided by a range of public and private agencies in Northern Virginia. A total of 163 (33%) agencies maintained active, primary services in at least one the the seven categories questioned: alcohol/drug abuse, smoking, high blood pressure, fitness, weight control/nutrition, accident prevention, and health education (broadly defined). For 29 (18%) of these agencies, health promotion was also the primary agency mission. As shown in Table 2, the majority of these agencies were involved in the prevention of alcohol and drug abuse.

Looking at the types of services offered, Table 3 shows the concentration of services across risk categories. Among public and private, non-profit agencies, the concentration is largely even, with the exception of lower counts for smoking cessation, stress management and mental health promotion. Among private for-profit agencies, the types of services reported most frequently related either to weight control and nutrition or stress management.

TABLE 2

CHARACTERISTICS OF NORTHERN VIRGINIA HEALTH PROMOTION (HP) SERVICES - 1982/83

	TOTAL NUMBER	TYPES OF AGENCIES			
		Public	Private Non-Profit	Private For-Profit	Hospitals
Total # Agencies	163	64	68	19	12
# Agencies with Health Promotion as Primary Mission					
TOTAL	29(18%)	13(20%)	14(20%)	2(10%)	-
Alc/Drug Abuse	17	11	5	1	-
* HP/Hlth Ed.	5	1	4	-	-
Wght Ctr/Nutr.	5	-	4	1	-
High Bld Pressure	1	1	-	-	-
Accid Prev/CPR	1	-	1	-	-

* Includes services having a primary focus on health education and/or health screening for a range of risk factors.

TABLE 3

CHARACTERISTICS OF NORTHERN VIRGINIA HEALTH PROMOTION (HP) SERVICES - 1982/83

	TOTAL NUMBER	TYPES OF AGENCIES			
		Public	Private Non-Profit	Private For-Profit	Hospitals
Total # Agencies	163	64	68	19	12
* Services with Primary Focus in Health Promotion					
TOTAL	245	86	94	43	22
Alc/Drug Abuse	32(13%)	14(16%)	9(10%)	6(14%)	3(14)
Wght Ctr/Nutr.	43(17%)	11(13%)	19(20%)	10(23%)	3(14)
* HP/Hlth Ed.	36(15%)	10(12%)	14(15%)	5(12%)	7(32)
Fitness	32(13%)	12(14%)	15(16%)	3(7%)	2(9)
Smoking	8(3%)	1(1%)	4(4%)	2(5%)	1(4)
High Bld Pressure	24(10%)	7(8%)	14(15%)	1(2%)	2(9)
Stress Mngmt.	23(9%)	8(9%)	5(5%)	9(20%)	1(4)
Mental Hlth Promo.	16(6%)	7(8%)	4(4%)	5(12%)	-
Accid Prev/CPR	31(14%)	16(19%)	10(11%)	2(5%)	3(14)

* Includes services having a primary focus on health education and/or health screening for a range of risk factors.

So, that a range of health promotion services are available is all well and good. But what about the question of access? As shown in Table 4, 40 services (16%) had specified target user groups. The majority of these were either nutrition and physical fitness programs for the elderly or recreation programs for the handicapped. Only two services, education on alcohol abuse for Hispanics and accident prevention for Indochinese, were targeted to minorities. None of the services cited "low income" as an eligibility requirement or reported low income persons as a target user group.

This is not to say that minority and low income residents are not eligible for or included among users of health promotion services - only that a key "marketing" tool for these agencies, the region's I&R database, shows little in the way of specialized services. This suggests, at least in Northern Virginia, that health promotion services are largely generic in design.

One might rightfully argue that the absence of specialized services for minorities and low income is not altogether inappropriate - that the application of health promotion techniques transcends population sub-groups. But there are counter-arguments as well. First, the economic realities of health promotion and medical services makes targeting a likely if not forgone conclusion. Second, it can also be argued that what we have learned from studies of special needs groups under medical and social service models also applies to health promotion services.

A search of the literature did not reveal any evidence to suggest that cultural or economic factors play any less of a role in the use of health promotion than medical care services. In fact, the asymtomatic nature of "risk" in primary prevention may provide insufficient incentives for an individual to take advantage of services or to adopt healthier practices in the face of competing financial needs or cultural biases.

This asymptomatic quality only increases the importance of the "enabling" and "predisposing" sides of the health belief triangle. Without visible triggers of need (the third side), one's attitudes and system access factor heavily in any decision to seek services or modify life practices. It is therefore particularly important that health promotion programs be designed to be sensitive to the cultural environment in which they are being delivered.

TABLE 4

CHARACTERISTICS OF NORTHERN VIRGINIA HEALTH PROMOTION SERVICES - 1982/83

	TOTAL NUMBER	TYPES OF AGENCIES			
		Public	Private Non-Profit	Private For-Profit	Hospitals
Total # Agencies	163	64	68	19	12
# Services with Specified Target Population					
TOTAL	40(16%)	13	25	2	-
Elderly	6	5	1	-	-
Handicapped	12	4	8	-	-
Youth	7	1	6	-	-
Minorities	2	-	2	-	-
Employees	7	1	4	2	-
Low Income	-	-	-	-	-
Military	3	1	2	-	-
Women	3	1	2	-	-

* Includes services having a primary focus on health education and/or health screening for a range of risk factors.

There are no hard conclusions to be drawn here - only observations and an appeal.

Our observations are these.

- o That health promotion services and the "wellness" concept have evolved out of a largely middle-class health consciousness.
- o That recently, these services have been backed by increasing scientific evidence demonstrating the power of early intervention in reducing risk of disease and disability - winning them a place in the health care continuum.
- o That we are also becoming increasingly skilled in our ability to identify high risk persons and apply appropriate interventions.
- o But, that our promotion and intervention programs have remained largely generic in orientation and targeted to known risk factors and generic high risk groups without full attention to the special complex of cultural and economic factors operating to varying degrees <u>within</u> these high risk groups.

Our appeal is this.

As researchers, planners and practitioners, we cannot assume that health promotion programs and strategies are equally effective across population sub-groups. Neither can we assume that these programs are being effectively targeted to these groups. Rather, we have an obligation to, again, look critically at our service system and to engage in research to determine whether or not and <u>how</u> to ensure that minority and low income individuals are in fact enjoying equal access and using health promotion services.

Short of this, we may in the long term be also denying their equal access to prolonged, healthy and independent lives and negatively skewing the health profile of our elders and the profile of our nursing home residents.

CITATIONS

1. Jette, Alan M. and L. Branch. "Targeting Community Services to High Risk Elders: Toward Preventing Long-Term Care Insitutionalization. Aging and Prevention, The Haworth Press, Inc. 1983 pp 53-69.

2. Branch, Laurence and A. Jette, "Personal Health Practices and Mortality Among the Elderly", AJPH, (74)10, October, 1984.