Editorial: Canadian Association on Gerontology Policy Statement on Health Promotion for Individual Seniors

Statement of the Problem: Health promotion, currently defined as "the process of enabling individuals and communities to increase control over and improve their health" (Ottawa Charter, Epp,1986; W.H.O., 1984, p. 3) presents particular challenges for those involved in health policy, planning, and delivery of services for seniors. One challenge relates to the fact that over 80 per cent of seniors have chronic medical conditions (National Advisory Council on Aging, 1989). Functional disabilities and illnesses in old age are often managed as acute medical problems, not as persistent life challenges which call for continuous attention to promoting health and preventing disease. Consequently, older persons easily become "patients" dependent upon professional management of care, a relationship which contributes to low self-esteem and lack of confidence, further reinforced by ageism and asymmetrical power relations between seniors and their professional caregivers (McWilliam, Belle Brown, Carmichael, & Lehman, 1994).

Scope: Although up to 8 per cent of seniors receive help with at least one activity, including a variety of instrumental activities of daily living (National Advisory Council on Aging, 1993), only 20 per cent of seniors report major limitations to their activities and 64 per cent rate their health as "good" to "excellent" for their age (National Advisory Council on Aging, 1993). The vast majority of seniors with chronic illness have the psychological determination (National Advisory Council on Aging, 1990), the mental capacity (Baltes, Kliegl, & Dittman-Kohli, 1988), and the motivation (Benson et al., 1989; Hall et al., 1992; Higgins, 1989) needed to engage in proactive health promotion.

Analysis of the Evidence: Health promotion for individual seniors has been found to improve health outcomes (Kaplan, Greenfield, & Ware, 1989), perceived control and autonomy (Berkowitz, Waxman, & Yaffe, 1988), self-concept, and in turn, self-care (Braden, 1990; Smits & Kee, 1992) and quality of life (Smits & Kee, 1992). Personal control has been associated with intellectual, emotional, behavioural, and physiological vigour (Spinhoven, Ter juile, Linssen, & Gazendam, 1989). These findings suggest that models of care aimed at individualized health promotion and

disease prevention constitute an important component of health services for seniors. Indeed, a wide variety of health promotion interventions have yielded significant improvements in mortality rates, functional independence, measures of well-being, quality of life, self-efficacy and health care practices (Leigh et al., 1992; Fries, Bloch, Harrington, Richardson, & Beck, 1993; Elder, Williams, & Drew, 1995; Ruffing-Rahal, 1994; Cox & Parsons, 1996; McWilliam et al., 1999; Schweitzer et al., 1994; Hall et al., 1992; Hamdorf, Withers, Penhall, & Haslam, 1992).

Recommendations: The Canadian Association on Gerontology rejects the societal myth that proactively promoting the health of older individuals does not have an impact in old age and believes that health promotion is a justifiable priority even for those who are already frail and chronically ill.

The Canadian Association on Gerontology encourages effort to place a stronger emphasis both on individualized health promotion and preventive care than currently exists for seniors, and on the integration of health promotion with traditional illness-oriented care.

The Canadian Association on Gerontology supports the public funding of health promotion and preventive care for seniors.

The Canadian Association on Gerontology recommends that academic institutions provide more extensive education in individualized health promotion and its clinical applications in all health science and social service fields.

Note

The Canadian Association on Gerontology also recognizes health policy through community efforts using the Population Health model.

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