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Policy Brief on Health Promotion and Prevention of Disease

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Introduction

Health Promotion and Prevention of Disease

- Commitment 7 of the of the Madrid Action Plan on Ageing(MIPAA)
- Life-course approach
- Increase in health
  - effect on quality of life
  - reduced care needs in old age
  - reduced care cost

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Life Course approach

Life course in the context of health promotion is twofold:

- Prevention during working age
- Consideration of health and social needs of older persons

Risk factors in Disability-adjusted life year (DALY)

Risk factor	Total DALYs* (%)
1. High blood pressure	12.8
2. Tobacco	12.3
3. Alcohol	10.1
4. High blood cholesterol	8.7
5. Overweight	7.8
6. Low fruit and vegetable intake	4.4
7. Physical inactivity	3.5

Source: The World Health Report 2002– Reducing risks, promoting healthy life. Geneva, World Health Organization, 2002 (http://www.who.int/whr/2002/en/, accessed 5 August 2009)

The concept of prevention

- Result of preventive measures: reduction of costs
- Three types of preventive measures
- Primary prevention: all measures or treatment to prevent a certain disease to develop
- Secondary prevention: detect diseases at a very early stage
- Tertiary prevention: all measures to reduce of disease-related complication

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The prevention of disease throughout the life course

- Healthy diet
- Physical activity
- Smoking cessation
- Decrease in alcohol consumption
- Reduction of stress
- Access to preventive health care

Healthy Nutrition

- Healthy nutrition contributes to the reduction of chronic diseases, such coronary heart disease and cancer
- Measures: Awareness raising and healthy diet progrommes

"5 A DAY" scheme to increase healthy nutrition in the United Kingdom

"Cancer and coronary heart disease account for 60% of all early deaths."[2] To reduce these impacts, the UK Government has launched the "5 A DAY" scheme to promote healthy nutrition through eating at least five portions of fruit and vegetables per day. The scheme has proven to be an effective and cost efficient way to reduce early deaths from heart diseases and strokes. The "5 A DAY" campaign is funded by the government and includes advertisements, education on healthy nutrition and a website with practical hints about recipes, food storage as well as advantageous grocery shopping. Additionally, the "School Fruit and Vegetable Scheme" encourages children to reach the "5 A DAY" target. Children often do not eat fruit and vegetables sufficiently. At school, they are usually provided just one piece of fruit per day. The government is also concerned with the frequent substituting of fruit and vegetables with food supplements such as vitamin drinks. Supplements have shown to be less effective and therefore the "5 A DAY" campaign puts much effort into facilitating healthy decisions in grocery shopping. A "5 A DAY" logo may be found on food packages. It provides important information about ingredients and the food's value within the "5 A DAY" scheme, meaning it is indicated for how many of the five fruit portions the food serves.

To get people involved in the program, there exists the so called "5 A DAY" community, a communication platform where people can exchange experiences and good practices about "5 A DAY". For example, people give each other hints and encourage each other to buy seasonal fruit or frozen vegetables to save money or to include chopped vegetables also in meet sauces to make them more nutritious. Furthermore, on the webpage of the UK Department of Health includes detailed information about the program, its history, background and current state of research and progress.

Sources: United Kingdom, Department of Health (2009). "5 A DAY General Information". UK.
United Kingdom, Department of Health (2009). "5 A DAY" program webpage. UK.

Physical activity

- Sedentary lifestye contributes to more various chronic diseases such as cardiovascular diseases and conditions such as obesity
- Measures:
  - Awareness programmes about the impact of sedentary life styles
  - Encouragement to more physical activities

Smoking cessation

- Smoking contributes to ischemic heart disease, cerebrovascular accident (stroke), chronic obstructive pulmonary disease
- Measures:
  - Promotion of smoking cessation programmes
  - Enlargement of smoking prevention measures

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Decrease in alcohol consume

- Excessive alcohol consumption may lead to liver problems, mental health problems, foetal alcohol syndrome, cancer or cardiovascular disease
- Measures:
  - Monitoring consumption
  - Programmes to treat and prevent addiction

Addiction and Gender – Promoting a gender approach for alcohol therapy in Switzerland

Switzerland uses a holistic approach to prevent people from substance abuse and to help them quit consumption. Within the framework of alcohol abuse, prevention and rehabilitation, Switzerland has developed a special gender specific approach. Since women and men have different reasons and ways into addiction, therapy needs to take these differences into account. Only a therapy which individually adapts to a patient's experiences and needs may be efficient. Gender related differences in alcohol use involve also different role models. Women often tend to consume alcohol because of increasing stress due to multiple responsibilities such as the coordination of work and family, whereas men's reasons to abuse alcohol come rather from personal challenges mainly related to work and the pressure of being successful. Switzerland aims to build a system with specialists who are particularly qualified to understand these role models of their patients and to therefore create a trustful environment.

To push forward this gender approach, the platform "drugs and gender" coordinates rehabilitation and information service facilities. People may search for institutions which are the most suitable for their personal situation. Facilities are labelled to be specialized for men or women, or to be gender neutral and thus adapted for the concerns of women and men as well as the interaction between them. Institutions for women are, for example, mobile service institutions where women may receive information about drug consumption and additionally they may sleep and rest there in a place protected from men. An example for men is an intercultural care centre which helps teenage boys to stay in school and follow a regular lifestyle which should prevent them from abusive alcohol consumption.

Sources: Swiss Confederation Federal Office of Public Health (2006). Gendergerechte Präventions- und Suchtarbeit. Switzerland.
Drugs and Gender (2009). Intervention en matière de drogue en fonctions du genre. Switzerland.

Reduction of stress

- Stress is the major cause of many physical and mental diseases, such as burn-out and depression
- promotion of work-life balance as one solution
- Measures:
  - change public opinion about working behaviour
  - provide solid legal framework

The prevention of disease throughout the life course

- Integration of preventive health care into health care system:
  - Physical activity
  - Fall prevention
  - Nutrition and diet
  - Depression and/or substance abuse

Evidence-Based Disease and Disability Prevention Program (EBDP) in the United States

The EBDP aims to prevent illness, disability, and death associated with chronic disease. The programme consists of public/private collaborations of the Administration on Aging (AoA) with the Atlantic Philanthropies, Centers for Disease Control & Prevention, Agency for Healthcare Research & Quality, Health Resources & Services Administration, Substance Abuse & Mental Health Services and others. AoA requires each state to implement the Stanford University Chronic Disease Self-Management Program (CDSMP). In addition, each participating state is required to select and implement one or more evidence-based EBDP programs in the following subject areas:

- Physical Activity - Programs such as Enhance Wellness, Tai Chai or Healthy Moves, which emphasize low-impact aerobic activity, minimal strength training and stretching;
- Fall Prevention - Programs such as Matter of Balance and Stepping On, which emphasize strength training and behavioural modification to help prevent falls and the fear of falling;
- Nutrition and Diet – Programs such as Healthy Eating, which teach older adults the value of eating healthy foods, as well as maintaining an active lifestyle; and
- Depression and/or Substance Abuse – PEARLS or Healthy IDEAS, which involve the screening and referral of older adults who are currently experiencing or at risk of depression.

Before the implementation of those programs in the areas described above, each program has to be previewed by a random sample group, proved to be effective and discussed in peer-viewed programs.

These evidence-based programs have been proven to increase self-efficacy, decrease health service utilization, and enable participants to adopt healthy self-management behaviours.

Sources: United States of America, Department of Health & Human Services, Administration on Ageing (2009). "Evidence-Based Disease and Disability Prevention Program". USA.
United States of America, National Council on Ageing (2007). "EBDP National Resource Center". USA.
Merck Institute of Aging and Health and Centers for Disease Control & Prevention (2004). "The State of Health and Aging in America 2004". USA.

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Active ageing

Following WHO definition of active ageing:

"the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age"

Three key elements of active ageing

- Housing and environment
- Social integration
- Access to health care facilities

WHO: Age-friendly cities

The Age-Friendly City Project by the World Health Organization (WHO) is designed as an intersectoral approach towards the ongoing ageing process within many nations. It focuses on eight parts concerning the live in cities for older people: housing, social participation, respect and social inclusion, civic participation and employment, communication and information, and community support and health services. As a first step, a global guide was published by the WHO. That guide contains a checklist outlining the essential characteristics of an active ageing city.

The Metropolitan Municipality of Istanbul was among the first to implement the recommendations of the WHO. After having developed an action plan together with the WHO, governmental and non-governmental organizations, the municipality imposed these ideas and suggestions in close cooperation with civil society organizations. One improvement concerns the public transport system, as the older people can now use it at reduced prices, benefit from free rides on national holidays and special transportation is offered to disabled people. Significant additional changes have occurred in various areas such as the establishment of a commission for older people's services, construction of housing residences with regard to WHO recommendations, planning outdoor areas according to the needs of older people. Reports underline these findings: older persons enjoy increasingly the opportunity of social interactions and stay more active. Due to its positive experiences by receiving recommendations and advice from other cities all over the world, Istanbul got further involved in the project by hosting a meeting in 2008 to exchange good practices.

Source: World Health Organization, Age-Friendly Cities, http://www.who.int/ageing/age_friendly_cities/en/index.html, last accessed 29. October 2009

Housing and environment

- Focus on living circumstances
- Support of home modifications to promote freedom of movement
- Provision of home care

Village caregiver service in Hungary

In Hungary, a unique programme supports older persons living in rural and remote areas. Mostly on voluntary basis, the programme includes home based care to sick elderly as well as many other services such as running errands, cleaning or cooking.

Especially in remote areas, older persons very often face difficulties to receive services and care. The village caregiver service aims therefore at an improved accessibility to health care and other community services to avoid exclusion of older persons and the necessity for them to move to urban areas. It allows isolated elderly to rely on a trusted fellow villager to bring them a hot meal and ensure they are supported as long as they remain at home, which has a large impact on their quality of living.

Sources: Commission of the European Communities (2005). "Basic social services in rural settlements – Village and remote homestead community care-giving", Hungary.
Hungarian Ministry of Health (2009). "National public health programme summary". Hungary.
Republic of Hungary (2007). "National follow-up report of the Madrid International Plan of Action on Ageing (MIPAA) and the United Nations Economic Commission for Europe (UNECE) Regional Implementation Strategy (RIS)". Budapest.

Social integration

- Emphasis on family relationships
- Promotion of intergenerational, non-family relationships
- Launch of community activities for senior citizens

Home Sweet Mômes – Intergenerational leisure time in Belgium

It has been observed that quite often children and elderly are on the same wavelength. They seem to have similar interests in leisure enjoyment, and they seem to be in alike social situations – both not being economically active and both having either intellectual and/or physical limitations. Due to these similarities, social workers from "Home Sweet Mômes" organize meetings between elderly and children. On a regular basis, school children as well as even younger children from kindergarten visit the elderly in their homes to spend about two hours with them dedicated to culture, memory games, arts, games and creativity. Moreover, the meetings are accompanied by psychologists whenever necessary and in some activities like creating theatre pieces or visits to museums, also other family members are involved.

In this way, an intergenerational link is created which helps to integrate elderly and children better into the society. Through the frequent contact, both groups become familiar with the other's concerns which help to overcome boundaries between generations and encourage vivid conversation and intergenerational exchange.

Sources: Homes Sweet Momes (2009).

Access to health care facilities

- Easy access to health care facilities
- Development of market strategies for medical equipment and medication according to the needs

Support Programme for Dementia Patients who are living alone in Germany
Project time: 1/2007 – 12/2009
The number of elderly dementia patients living alone is rising. Despite their illness, their life expectancy is increasing and many patients wish to continue living at home in their habitual environment as long as possible. However, as the disease evolves, many everyday tasks become challenging and even dangerous.
A first phase of the German government's programme to support dement persons in their communities consisted of surveys done among Alzheimer patients. The undertaken surveys have shown that many of the patients wish for more understanding in their environment. Many people do not know how to deal with dementia patients with whom they may be confronted in their everyday lives. At the same time, patients may not feel supported which makes it difficult for them to continue to live alone.
To take these survey results into account and to improve the situation of single Alzheimer patients, the German government is now, as a second step, advancing prevention and education measures to better inform people about the disease. Especially policemen, fire fighters, bank, post and public transportation employees are in the focus as they often, even unaware, get in touch with dementia patients. Education programmes are offered to them and best practice manuals are distributed in various institutions to inform the community about dementia.
Sources: Deutsche Alzheimer Gesellschaft e.V. (German Alzheimer Association) (2009). Projekt "Allein lebende Demenzkranke - Schulung in der Kommune". Germany.
German Federal Ministry for Family, Senior Citizens, Women and Youth (2009).

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Recommendations

- Good health over the live course contributes to good health in old age
  - increases well-being of the individual
  - economic and societal impact
- Active ageing
  - decrease the need for care and assistance
  - thus the expenditure of health care costs

Health promotion and Prevention of Diseases : A Checklist		
Main Areas	**Areas of implementation**	**Key elements**
Prevention of diseases over the life course	Healthy diet	Awareness raising about nutrition
		Promotion of fruit and vegetables
	Physical activity	Awareness about affects of sedentary lifestyle
		Safe recreational areas for walking cycling, or swimming
		Promotion of physical activity for children
	Smoking cessation	Awareness raising about risks
		Smoking ban in public
	Decrease of alcohol consumption	Treatment of Addiction
		Control of Alcohol Consumption
	Reduction of stress	Legal frameworks for better work-life balance
		Counselling
	Access to preventative health facilities	Awareness raising
		Early treatment of diseases
Prevention of diseases in old age	Active ageing	Health
		Participation
		Social Inclusion
	Housing, Environment	Safe care at home and in care homes
		Prevention of elderly abuse, violence and crime
	Social integration	Family relationships
		Intergenerational, non-family relationships
		Community activities for senior citizens
	Access to health care facilities	Health prevention
		Treatment of chronic diseases
		Prevention and treatment of accidents and falls
		Dementia

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Further policy briefs

Thank you very much for listening…

- Further policy briefs are planned to the topics:
  - Institutional long-term care
  - Informal long-term care