

Prevention in the Elderly: Health Promotion and Disease

Abstract

Despite the fact that prevention is regarded as a major concern for general practice, there is a dearth of evidence regarding interventions provided by general practitioners to people of middle age and older age. This is despite the fact that clinical preventive strategies aimed at these groups have key indicators and recommendations for monitoring their use, and both the World Health Organization and the European Commission recognize the significance of interventions for healthy and active aging. The two keynote speeches that were given at the 2015 European General Practice Research Network (EGPRN) autumn meeting in Edirne, Turkey, from October 17 to 20, are the basis for this paper. General practitioners should develop and implement prevention services and programs to encourage healthy and active aging, according to the EU2020 strategy. Interventions for multimorbid patients should be their primary focus, whether that is by increasing vaccination uptake or falling and frailty prevention, or by increasing prescribing and plan adherence.

Keywords: Prevention • Elderly • Health and active ageing • Research in general practice

Introduction

The two keynote speeches that were given at the EGPRN autumn meeting in Edirne, Turkey, from October 17 to 20, 2015, serve as the basis for this paper. It aims to provide a summary of these two presentations, comment on them, and draw some general practice-relevant recommendations [1]. The goal of one presentation (CL) was to discuss the difficulties and priorities for elderly prevention in the general practice setting and to draw attention to the primary determinants of active and healthy aging (AHA).

In healthcare systems all over the world, prevention is regarded as a magic bullet, and many stakeholders have a significant role to play in health promotion and prevention for the elderly. The living conditions of this group ought to be as supportive as is humanly possible for them to maintain their health. As a result, national governments and healthcare policies, as well as scientific organizations that provide clinical practice guidance, continue to place a strong emphasis on "prevention." Active aging, according to the World Health Organization, is "the process of optimizing opportunities for health, participation, and security to enhance quality of life as people age," enabling them to "realize their potential for physical, social, and mental wellbeing throughout the life course." In a similar vein, at the end of 2011, the European Commission established the European Innovation Partnership on Active and Healthy Ageing in order to make it abundantly clear that the Commission is interested in enhancing cross-sectional and inter-disciplinary approaches to the problem of demographic aging and the associated costs and burden [2]. Health promotion and disease prevention are a major emerging theme in geriatric medicine and health care as a whole. Despite the fact that efforts have typically focused on younger people, there is increasing evidence that this strategy is suitable for people over 65 and can be implemented. One way to deal with a problem that is becoming more and more of a feature of our time is through health promotion and disease prevention [3]. The number of elderly people suffering from multiple chronic illnesses or functional impairments. This strategy has the potential to reduce the incidence and prevalence of both chronic and acute disease among the general population and the elderly, although it will not

Dr. Tabish Malayeri*

Department of Medicinal and Organic
Chemistry University of Medical Sciences,
Iran

*Author for correspondence:
malayeri.t@gmail.com

Received: 02-Feb-2023, Manuscript
No. jmoc-23-89042; **Editor assigned:**
06-Feb-2022, PreQC No. jmoc-23-
89042; **Reviewed:** 13-Feb-2023, QC
No. jmoc-23-89042; **Revised:** 23-Feb-
2023, Manuscript No. jmoc-23-89042
(R); **Published:** 28-Feb-2023; DOI:
10.37532/jmoc.2023.6(1).13-15

replace medical care for the treatment of acute diseases or acute flare-ups of chronic illnesses. Naturally, there is also a continuing need for research to improve the diagnosis, treatment, and prevention of chronic and acute diseases as well as long-term medical care for many diseases [4].

Vaccination

There are many reasons why the elderly are at risk for infectious diseases, but the most common reason is that they have multiple chronic conditions and weaker immune systems, which is made worse by their unwillingness to receive booster injections for several diseases. This shows how difficult it is to get more people to get vaccinated and more research in general practice is needed to improve health outcomes by preventing diseases, saving money on healthcare, and protecting the community. It pertains to the fourth and third EC2020 domains, respectively [5]. Although multidisciplinary and integrated care appear to be the key to promoting healthy aging in some European settings, both concepts have not yet been discussed or incorporated into national health systems.

Critical issues and risk

Five issues are of current concern in the health promotion and disease prevention approach to health care:

1. The inconclusiveness of the scientific and clinical evidence of the efficacy of many promotion and prevention activities
2. The need for additional knowledge concerning factors that facilitate behaviour modification among persons of all ages
3. The shortage of health care personnel trained in this approach
4. The potential impact that accelerating growth in the number and utilization of health maintenance organizations and other systems with prepaid capitation fees will have on this approach to health care
5. The effect that prospective payment systems, as exemplified by diagnosis-related groups for the elderly under Medicare, will have on the services received

Many of the current trends in health promotion and disease prevention lack a solid scientific foundation. There is only a scant amount of evidence that, once established, certain behaviors and interventions can either prevent disease or reduce the impact of illness and disability on the elderly. For instance, it is unknown whether exercise lowers the risk of coronary heart disease and stroke in older people and women. In a similar vein, it is still unclear whether being obese now or having a history of obesity is a risk factor for coronary heart disease [6]. Additionally, the relative risks and benefits of various levels of physical activity for seniors, particularly those with chronic diseases, have not yet been established. Nevertheless, numerous activities and behavioral shifts have been widely promoted as health-promoting and disease-preventing strategies for avoiding heart disease and cancer. Although the scientific and clinical evidence on which much of the popularized advice to the public and to individuals is based is frequently inconclusive or conflicting, private sector initiatives in the areas of physical fitness, nutrition, and diet counseling have been largely responsible for this [7].

The recent dramatic increase in the number and use of prepaid health plans by the general public and the elderly, as well as the provision of coverage and reimbursement for Medicare enrollees and providers of care in health plans that are paid prospectively according to a fixed rate capitation formula, are two developments that may have an impact on the rate at which the health promotion and disease prevention approach gains widespread acceptance [8]. In exchange for a fixed monthly or annual fee, HMOs—one type of capitated plan offer—a comprehensive array of medical or health care services within a single organization [9]. As their name suggests, health maintenance organizations (HMOs) may be expected to encourage their members to keep their health and avoid disease through the particular variety of services they provide and the gatekeeping tasks they carry out to reduce utilization of more costly forms of healthcare. It would be crucial to have information regarding the extent to which these functions are carried out. Between June 1983 and June 1985, enrollment in HMOs increased by 20% annually, reaching an estimated 19 million

people, or 8% of the US population, as of June 1985. HMOs were encouraged to enroll Medicare beneficiaries on a capitation basis by regulations issued by the Health Care Financing Administration in 1985 [10].

Conclusion

Section 8 of the Health Research Extension Act of 1985 mandated a personnel study for elderly health needs. "Conduct a study on the adequacy and availability of personnel to meet the current and projected health needs of elderly Americans through the year 2020," was the directive given to the secretary of the United States Department of Health and Human Services. The study was carried out by the National Institute on Aging in collaboration with the Health Resources and Services Administration. The director of the National Institute on Aging served as the chair of a committee that included representatives from a number of different federal agencies. The recommendations in the secretary's report, which was presented to Congress in the fall of 1987, concern the number of primary care physicians, dentists, and other health care professionals required to provide adequate care for the elderly; the funding of geriatric and training activities, as well as the education and training requirements of other doctors, dentists, and health care personnel in order to provide care that is tailored to the particular requirements of the elderly. Although it recognizes health promotion and disease prevention as a special issue, the study does not specifically focus on it, despite the fact that it addresses the manpower and training requirements for many different kinds of health personnel who provide care to the elderly. In addition, the Department's Public Health Service's Office of Disease Prevention and Health Promotion does not routinely collect data on the number of health professionals providing elderly health promotion and disease prevention services or on their training in this area. The panel thinks this kind of information is important

for figuring out if elderly health promotion and disease prevention training programs and additional trained staff are needed.

Evidence-based interventions for frailty, medication use, personalized health management, fall prevention, and vaccination uptake should be the primary focus of elderly prevention. The content and method of these interventions require additional discussion.

Acknowledgement

None

Conflict of Interest

None

References

1. Jacobs B, Bigdeli M, Annear PL *et al.* Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries. *Health Policy Plan.* 27: 288-300 (2012).
2. Carrillo JE, Carrillo VA, Perez HR *et al.* Defining and targeting health care access barriers. *J Health Care Poor Underserved.* 22: 562-75 (2011).
3. Jones G, Steketee RW, Black RE *et al.* How many child deaths can we prevent this year? *Lancet.* 362: 65-71 (2003).
4. Kumanyika S, Jeffery RW, Morabia A *et al.* Obesity prevention: the case for action. *Int J Obes (Lond.)* 26: 425-36 (2002).
5. Vineis P, Wild CP. Global cancer patterns: causes and prevention. *Lancet.* 383: 549-57 (2014).
6. Goodman GE. Prevention of lung cancer. *Crit Rev Oncol Hematol.* 33: 187-97 (2000).
7. Risser NL. Prevention of lung cancer: the key is to stop smoking. *Semin Oncol Nurs.* 12: 260-9 (1996).
8. Koh HK. An analysis of the successful 1992 Massachusetts tobacco tax initiative. *Tobacco Control.* 5: 220-5 (1996).
9. Zhang J, Ou JX, Bai CX *et al.* Tobacco smoking in China: prevalence, disease burden, challenges and future strategies. *Respirology.* 16: 1165-72 (2011).
10. Chiqui JF. Obesity Prevention Policies in U.S. States and Localities: Lessons from the Field. *Current Obesity Reports.* 2: 200-210 (2013).