Chapter 3

Health and Quality of Life in the 21st Century

The first decade of the twenty-first century can serve as a reminder of how much the world has changed and will continue to change. We have recently witnessed a very damaging terrorist attack on a major American city and subsequent attacks elsewhere in the world. There is now an ever present concern that a manmade biological weapon will someday be used. Additionally, pandemics such as HIV/AIDS and emerging possibilities such as Avian Flu remain center stage in public health agencies worldwide. With recent natural disasters, such as Hurricane Katrina and the Indian Ocean Tsunami, we are well reminded how woefully under-prepared we are for disruptions in our daily lives.

Indeed, Alvin Toffler, perhaps the best known futurist in the world and author of *Future Shock; The Third Wave;* and *Powershift,* said that the winds of change have reached hurricane proportions. He suggested that change comes in major waves that affect all aspects of life. In his view, there have been three waves of change. The first occurred approximately 10,000 years ago, when small tribes of people wandered from place to place in search of food and water. Because of the development of agriculture, most of these tribes were able to give up their migratory form of life and instead stay in one place and farm the land. The spread of farming changed almost everything—the economy, political system, social structure, and even religion—for most groups of people. Some presumably thought this change would be the end of the world, and they were partially correct: it was the end of the world as they had known it.

Toffler suggests that the second wave occurred when the emphasis changed from agriculture to industry. This wave, known as the Industrial Revolution, also was accompanied by widespread and profound change. Factories were built and cities grew up around them, creating many new problems. Life became standardized, specialized, and centralized. Small families became the rule. There were new forms of communication, transportation, education, defense, entertainment, and religion. Again, people’s lifestyles were altered irrevocably.
Toffler contends, and most futurists agree, that the world is currently in the midst of a third wave of change—a transformation from an industrial-based society to a technocratic society. The new era, often called the Information Age, was initiated by the development of computers, and computerization continues to be a dominant feature.

There are now computers in virtually every organization in America, as well as in a large percentage of homes. Most business transactions involve a computer at one or more stages. Increasingly, shopping is done at home, work assignments are done at home, college degrees are earned at home, and even worship services are participated in at home via computer technology. The globalization of the economy is facilitated by computer networks that connect businesses in different parts of the world.

Some Information Age technological developments include an increasingly robust information highway that provides access to a diverse array of on-line databases; standard digital formats that allow for the distribution of movies, music, and books to media such as CDs and DVDs and to hand-held devices; Wi-Fi wireless technology and interactive video conferencing that facilitate intra-organizational communications; and advances in robotics and nanotechnology that continue to revolutionize manufacturing and other fields.

CURRENT DEVELOPMENTS IN HEALTH CARE

On the world health scene, AIDS continues to be a costly disease, while diseases such as smallpox and polio largely have been eradicated. The mid-1990s saw death rates from heart disease and automobile accidents continue to decline in the U.S. Tobacco use has also gone down in the U.S. but continues to rise in developing countries. Food supplies are better labeled to promote healthier choices, based on calorie content, fat content, sodium content, and nutrient enrichment, yet being overweight is still a major causative factor of chronic disease and disability in the developed world.

The 1988 Institute of Medicine study on the future of public health contributed to a number of changes in health care. The study identified three core functions of public health: assessment, policy development, and assurance. The needs assessment function involves determining what the major health-related problems are, the policy development function involves planning how to respond to these problems, and the assurance function involves monitoring public health efforts to ensure that results are consistent with the goals set during the planning stage. Needless to say, the study focused on the relationship between health care providers and local and state public health agencies and was written from a “managed care” perspective.

In 2004 the Institute of Medicine held its first annual summit, A Focus on Communities, aimed at moving the nation closer to a vision of a twenty-first cen-
tury health care system. The reports from this and subsequent summits synthesize many strategies and action plans proposed to improve health care.

Health care is in such rapid flux it is hard to even describe it. Diagnostic work formerly done on an inpatient basis is now being done in community clinics or even in the home. More treatments are also provided in the home, and hospital stays have been dramatically shortened. Computers have made laser surgery, magnetic resonance imaging, ultrasound diagnosis, and a whole host of other medical interventions possible. Long-term care of the growing segment of aged and infirmed people is a major concern of the “sandwich generation,” who attempt to cope with the care of both their children and their parents while working. The gap between the health status of the rich and the poor is greater than in the past and is getting larger, and the size of both groups is getting larger as the middle class continues to shrink. (Increasingly, a college degree is what separates those in the high-income bracket from those in the low-income bracket.)

Hospitals are getting bigger and nicer, a smaller percentage of people are going to them, and lengths of stay are generally shorter. However, inner-city emergency rooms are more crowded and understaffed. HMOs and PPOs have become commonplace, routinely providing office visits and prevention services at a relatively low cost for insured members, but unemployment and other factors have resulted in an increase in the number of people without insurance. Meanwhile, the entire nation is attempting to reduce health care expenditures and poverty programs, and real fears exist that a generation of children will be severely adversely affected by the reductions.

What does this mean for this new century? Specifically, what health issues must be addressed by those living and working in the first decades of the new millennium?

**ACTION-BASED CONCEPT**

Managers need to think in terms of trends, recent changes, current shifts, and emerging issues, and read materials on trend analysis.

**EMERGING ISSUES**

The conditions that provide the context for a quality lifestyle must receive increasing attention. The public health issues of the disposal of toxic waste, the pollution of our great bodies of water, the destruction of the world’s tropical
forests, the supply of potable water to large population centers, the distribution of food to developing nations and to the poor in economically advanced nations, and the provision of affordable and accessible care for a rapidly aging population will become increasingly important. Redistribution of the health care dollar must continue to be discussed as a priority issue, because most health care expenditures are currently being used to prolong the life of terminally ill patients and relatively little is being spent on prevention. As noted earlier, the rich are getting richer and the poor are getting poorer, and history shows that the rich will dominate policy decisions. The expenditure of dollars to keep terminally ill people alive longer is understandably not viewed as a priority by the poor. Wealth usually carries with it power and influence, so it is reasonable to ask what educated, wealthy, influential policy makers want or need.

A FOURTH WAVE OF CHANGE: THE GROWING EMPHASIS ON QUALITY OF LIFE

Using Toffler’s notion of waves of change, might we not ask whether a fourth wave of change is already in evidence? We believe, in fact, that the recent emphasis on the quality of life as opposed to the mere length of life may grow to have the kind of impact that would qualify it as a bona fide wave of change.

Quality of life advocates look at the consequences of an action and weigh the pluses and minuses. If the “plus” consequences predominate, the action is seen as good. Of course, a social perspective is also possible. For example, one can ask the question “Will the action result in the greatest good for the greatest number of people?”

Quality of life ethicists have developed criteria to evaluate individual behavior. According to Winifred Pinch, “These criteria range from quite minimal qualities, such as ability to maintain basic physiological functioning, . . . to the complex ability of self-actualization as described in Maslow’s Theory of Human Development.” Possible criteria within this scope include “intellectual level, optimal personality development, social usefulness or dire need of health care.”

The World Health Organization’s definition of health, dating back to 1947, is still just as salient today: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity.”

Many different individual actions and social policies can be evaluated by considering their consequences for individuals’ quality of life, and thus their health. Indeed, with regard to any action or policy, it is possible to ask the following questions:

- Will it increase the ability of individuals to achieve self-actualization?
- Will it increase the intellectual level, personality development, and social effectiveness of individuals?
• Will it improve human relationships?
• Will it increase the ability of individuals to express concerned caring and actions supportive of others?
• Will it increase individuals’ social worth and thereby increase their personal well-being and happiness?
• Will it increase the quality of life in society and the world as a whole?

Although these questions may not seem immediately relevant to health education and health promotion, it is important to remember that health promotion seeks to improve the conditions of living and to enhance not only physical, but also mental, emotional, and spiritual well-being. Moreover, social health has become a priority, especially given the Healthy People 2010 agenda set by the federal government.

Preventing or treating chronic diseases such as AIDS, coronary artery disease, diabetes, and cancer usually contributes significantly to the quality of life of the individuals treated and the community. Similarly, promoting prenatal, infant, and child health has major quality of life ramifications for children, their parents, and society.

Even though the genetic potential for human life is estimated to be as high as 120 years, many people are not interested in efforts to extend life indefinitely. The right to die with dignity when a decent quality of life is no longer possible is more widely accepted than ever before. Paradoxically, society continues to spend most of its health care dollars on the terminally ill. This raises the question, does spending most of our health care dollars on the terminally ill do more for the quality of life of society as a whole than would spending them on prevention programs? This question will permeate many discussions throughout the twenty-first century.

CURRENT QUALITY OF LIFE INDEXES

Hopefully, many health educators realize that improving quality of life is a fundamental goal of the Healthy People 2010 national health objectives or that quality of life is currently being measured as part of the Behavioral Risk Factor Surveillance System. According to the Center for Disease Control and Prevention (CDC) in Atlanta, GA:

Quality of life, not just physical functioning, should guide the design, organization and integration of services. Although quality of life is a subjective concept, valid measures exist for assessing many of its components, including physical, cognitive, psychological and social functioning. By broadening our attention to embrace all these determinants of individual well being, we are more likely to develop service delivery systems that prevent needless impairment and disability.6
In fact, the mission of the CDC is “To promote health and quality of life by preventing and controlling disease, injury, and disability.”

Health promotion personnel should be encouraged by some recent results. Health status is better. People are living longer and enjoying a better quality of life. Yet the studies say that quality of life is still threatened, albeit by factors other than physical ailments. Nearly one-third of Americans say they suffer from some mental health problem every month. Mental health problems can be just as prevalent and disabling as physical conditions. In fact, in the rapidly developing research in the neurosciences, it is being found that the distinction between mental and physical processes is pretty nebulous.

Stress, depression, anxiety, and other emotional problems are cited frequently, with a wide variety of causative factors. The prevalence of mental health problems has led health promotion experts to explore an ecological model of quality of life (see Table 3–1).

**ACTION-BASED CONCEPT**

Managers must attend to quality, promoting it and insisting on it, for nothing can replace the impact that quality has on all an agency does.

**AN AGENDA FOR THE FUTURE**

As a relatively new profession, health education has not adequately encouraged or funded research. Its neglect of research is ending, however, and the development of a research agenda is becoming a higher priority. The merging of an increased emphasis on prevention programming and quality of life issues suggests that the following areas will grow in importance.

Violence—including child abuse, spouse abuse, rape or other sex abuse, gang conflict, and homicide—is becoming a topic of primary concern. Can the quality of life be very high if people are afraid they will be assaulted? Does not the fear of violence cause stress? Community organization and education theories and experiences can be applied to violence-related problems, yet very little is really known about them outside of sociological studies or pop culture perceptions.

What settings are most effective for health education interventions to combat violence? What methods are appropriate for which populations? People are no longer willing to tolerate violence because of its impact on the quality of life, and health educators must respond to their demand for an end to the prevalence of fear.
Table 3–1 Selected Elements from an Ecological Model of Quality of Life

<table>
<thead>
<tr>
<th>Level</th>
<th>Physical Environment</th>
<th>Social Environment</th>
<th>Health and Social Environment</th>
<th>Medical Condition</th>
<th>Functional Status</th>
<th>Lifestyle/Behavior</th>
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<td>Societal</td>
<td>Climate</td>
<td>Peace</td>
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<td>Mortality</td>
<td>Active life expectancy</td>
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<td>International</td>
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<td>Large Community</td>
<td>Transportation</td>
<td>Education</td>
<td>Ambulance service</td>
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<td>Hospital beds</td>
<td>Citizen participation</td>
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<td>Region</td>
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<td>Small Group/</td>
<td>Walk trails</td>
<td>Values</td>
<td>Medical care resources</td>
<td>Disease clusters</td>
<td>Family dysfunction</td>
<td>Group behavior</td>
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<td>Community</td>
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<td>Social support</td>
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<td>Individual</td>
<td>Privacy</td>
<td>Leisure time</td>
<td>Medical care access</td>
<td>Symptoms</td>
<td>Disability</td>
<td>Physical activity</td>
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<td>Personal space</td>
<td>Spirituality</td>
<td>access</td>
<td>Illness</td>
<td>Emotional</td>
<td>Safety</td>
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<td>Body</td>
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<td>Self-care</td>
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<td>function</td>
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Source: Reprinted from Workshop on Quality of Life/Health Status Surveillance for States and Communities, Report of a Meeting on December 2–4, 1991, Stone Mountain, GA, Centers for Disease Control and Prevention, Atlanta, GA, 1993
Group-specific interventions to improve quality of life must be studied carefully because not certain interventions work better in some populations than others. For example, how should interventions in a Hispanic-American, largely Catholic, somewhat patriarchal society to prevent cancer or HIV/AIDS differ from interventions in an African-American, largely Protestant, somewhat matriarchal society? The profession knows that age-specific interventions are generally appropriate and that gender-specific interventions are often necessary, not to mention socioeconomic class–specific interventions. A poor, rural mother of six will usually require a different strategy than an upper-income lawyer mother of two, even if the health problem being addressed is the same.

The research base is so small that many of these issues have not been investigated on a group level, let alone on an individual level. For example, there are several methods for helping people to stop smoking, but not enough research exists to allow any one of them to be prescribed with confidence.

Quality of life advocates want effective, efficient interventions at low cost, and the past “one size fits all” answers of the profession will no longer satisfy an empowered minority.

One important quality of life issue is drug abuse. Increasingly, people are demanding drug abuse prevention help for their kids, their spouses, their fellow employees, and neighborhood drug users. Amazing progress has been made in reducing tobacco use through the Smoke Free 2000 programs. The success of these programs has caused many people to demand similar programs for alcohol abuse and illegal drug use. Yet no proven strategy to eliminate alcohol and drug abuse exists, and people are running out of patience with the health profession because of its seeming inability to solve the problem of abuse.

Quality of life issues are bringing churches to the forefront again. Yet only a few health educators are focusing on spiritual health and how to promote other aspects of health in churches. The resurgence of parochial schools, religious family life centers, and church membership provides an opportunity for spiritually-based health education.

The family structure in the U.S. is changing significantly. For one thing, divorce and single-parent families are far more prevalent than they used to be. Unfortunately, health education hasn’t done enough for parents who are trying to cope with the real-world problems they and their children face.

Transferability needs more research devoted to it as well, because of the importance of spending every health care dollar wisely. Are there group intervention strategies that impact more than one health risk factor? Are there common methods of increasing resistance to drug use and resistance to risky sexual activity? Where is the largest return on investment, especially with high-risk populations?

Finally, how can the media best be used for health promotion? After all, society depends on the media for news, education, and entertainment. The media is admittedly made up of private, profit-making organizations and so resists control,
but many believe that a combination of regulations and incentives can make the media, especially television, an effective health promotion tool. No one disputes that the media affects the quality of life for better and for worse, but the question remains as to how its positive impact can be maximized.

CONCLUSION

The decades ahead are likely to bring a whole new set of problems requiring innovative solutions. Toffler cautions,

\[\text{Society needs people who take care of the elderly and who know how to be compassionate and honest. Society needs people who work in hospitals. Society needs all kinds of skill that are not just cognitive; they're emotional, they're affectional. You can't run the society on data and computers alone.}\]

Sadly, in some respects health education and health promotion programs are still using nineteenth-century strategies and twentieth-century thinking. Socioeconomic and educational levels are changing, and many social groups are being empowered. Society is demanding better service, and health educators must provide it if the golden age of health education is to continue. Practitioners and administrators must keep in mind that they are in the life-saving business and that people can be profoundly affected by their efforts. Health, in the final analysis, is a means to an end—a self-actualized, socially responsible, and personally satisfying life.

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IN-BASKET ASSIGNMENTS

TO: Health Education and Health Promotion Specialists
FROM: The Executive Director
RE: Long-Range Plan

I want to create a long-range plan (perhaps with a ten-year time frame) and would like you to do some background work for me. What do you think the critical health issues that could be influenced by health education and health promotion will be in ten years? What critical health issues will be the most controversial? What issues will impact the most people?

Please prepare a summary and come see me to discuss it.

* * * *
TO: Health Education and Health Promotion Specialists
FROM: The Director
RE: Quality Emphasis

We are reading more and more about quality—quality of life, quality of work, quality of products, quality of programs. I have heard of quality improvement teams in industry.

Why do you think there is so much emphasis on quality?

Increasing quality will obviously drive up price. Is it worth it? What are the payoffs of increasing quality? What are the tradeoffs?

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**MANAGEMENT CASE STUDY**

**Setting**

The National Tuberculosis Association was a nationally prominent voluntary health agency with state and local chapters. It was one of the oldest of such agencies and one of the best. It emphasized research on treatment and prevention, education of patients and health care personnel, and service to all involved in the battle against TB. Its efforts, when combined with the efforts of government agencies, were spectacularly successful. Tuberculosis was largely eradicated, at least in the United States.

**Problem**

Financial contributions decreased, as did the number of volunteers willing to work. The organization had an escalating organizational maintenance problem. The National Tuberculosis Association could not readily help others when the organization itself was not healthy.

**Alternatives Considered**

1. Allow the organization to die in dignity, because its purpose had been accomplished.
2. Change the focus of the agency to another disease, permitting the organization to survive.
Actions Taken

The organization changed its name to the American Lung Association and expanded its scope to include other respiratory diseases, such as lung cancer and emphysema.

OUTCOME

The expanded scope and name change resulted in a major infusion of new dollars, volunteers, energy, and ideas, and the organization has had a major impact on both lung cancer and emphysema.

DISCUSSION QUESTIONS

1. Are there other organizations that “worked themselves out of a job” and either expanded their focus or closed down?
2. What were the results?
3. What factors could have led the National Tuberculosis Association to close down?
4. Are there some health organizations that should close or be closed?
5. What characteristics do they possess that might support a decision to close?
6. What problems of the 1980s and 1990s are close enough to being solved that the agencies devoted to solving them should consider reorienting themselves or closing down?
7. What new problems are emerging that might call for a national voluntary agency?
8. What organizations are especially concerned with the quality of life?

NOTES

2. Institute of Medicine, Crossing the Quality Chasm: A Focus on Communities (Washington, DC: National Academy Press, 2005).
4. Pinch, “Quality of Life”: 41.