Health Insurance for Preventive Services

Donald N. Logsdon, M.D.
Matthew A. Rosen, Ph.D.
Stanley G. Karson

Introduction

From the basic hospital expense benefit program that began in 1929 at Baylor University Hospital in Dallas, Texas, through the development of group insurance coverage for surgeon's fees in 1938 and medical expense benefits in 1943, to the introduction of major medical expense benefits in 1949, the prevailing concept of group health insurance has been to spread individual economic risks of injuries and illnesses through the insurance principle. Exceptions to the idea of spreading the economic risk of illness were the addition of dental expense benefit plans in 1959 covering all types of dental services on a group basis; the addition of vision care expense benefits in 1964, and the development of Health Maintenance Organization beginning in 1973.

Because preventive medical services including health examinations or periodic check-ups were unrelated to an illness, these services have generally been excluded from medical expense insurance coverage. A recent survey by ACLI's and HIAA's Center for Corporate Public Involvement has shown that 41 private insurance companies currently "offer" preventive benefits, and only 17 companies covered well baby care and physical examinations.

Private health insurance coverage though extensive seems to be undergoing some changes. About 84% of the U.S. population was insured for hospital expenses and 78% for surgical care in 1981 which has increased only slightly from 1976. There seems to be a trend toward more self-funded health plans among group health insurance customers. In 1981, it was estimated that approximately 30% of the group health insurance coverage was provided through Administrative Service (ASO) arrangements and Minimum Premium Plans (MPPs) compared to less than 5% of total insurance company group coverage that were using self-funded health plans prior to 1975.

Interestingly enough, a number of companies offering individual life insurance coverage have recognized the value of prevention. The State Mutual Life Assurance Co. of America offered a non-cigarette smoker life insurance policy in 1964 and demonstrated favorable mortality experience between 1973 and 1978 compared to the insurance issued to individuals who did not meet the non-smoker criterion. These actuarial studies, plus developments in the market place for life insurance products, have produced significantly reduced rates for non-smokers. Life insurers are also aware of the life-shortening effects of high blood pressure and of the benefits of long-term treatment in reducing the risk of premature death. As a result, applicants for life insurance who have elevated blood pressure may pay an extra charge. However, if the applicants succeed in controlling their blood pressure the premium is reduced, and patients with hypertension can obtain a rerating if the hypertension is brought under control.

The INSURE/Lifecycle Project

Theoretically, by improving health and decreasing illness and premature death, preventive services will not only result in healthier employees and dependents but will contain the cost of health care for group customers. In order to determine if this is so, the life and health insurance industry began the INSURE Project, Lifecycle study in 1980.

The project is completing the third year of a 3-year feasibility study to determine whether preventive services, including patient education, can be implemented in primary medical care, and to assess the short-term effects on practicing physicians and their patients. The cost of these services and the possible impact on cost containment are also being studied.

Donald N. Logsdon, M.D., assistant clinical professor, Department of Community Medicine, Mt. Sinai School of Medicine of City University of New York, is Director of the INSURE Project on Lifecycle Preventive Health Services. Matthew A. Rosen, Ph.D., adjunct assistant professor of Public Health, Division of Sociomedical Sciences, Columbia University, is Associate Director of the project. Mr. Stanley G. Karson is Executive Director of INSURE and Director of the ACLI and HIAA's Center for Corporate Public Involvement, 1850 K Street, N.W., Washington, D.C.
The concept of the Lifecycle study originated with a group of prominent medical educators and researchers assembled by the life and health industry in 1979. The study was recommended by the industry’s Advisory Council on Education for Health and announced by the Center for Corporate Public Involvement in 1980. INSURE, a non-profit, tax exempt 501(c)(3) organization operated solely for educational, scientific and charitable purposes, was established in 1980 to conduct the Lifecycle Study. The Board of INSURE consists of members from the Advisory Council and executives from supporting life and health insurance companies.

Funding for the INSURE Project began with contributions from 9 insurance companies and has now expanded to 28 companies for a total of $750,000 over 3 years. The Robert Wood Johnson Foundation and the John D. and Catherine T. MacArthur Foundation have made grants totalling $500,000 making the total project budget of $1.25 million for 3 years. The staff is based at Metropolitan Life Insurance Company in New York City.

The specific objectives of the Lifecycle study are as follows:

1. To define age-specific Lifecycle preventive health services, including patient education for all age groups and to implement these Lifecycle procedures at selected study sites by obtaining the participation of primary care physicians in group practice.

2. To develop medical protocols and educational materials for the participating physicians to use with their patients and to promote Lifecycle services among patients at these study sites.

3. To evaluate the short-term effects of the Lifecycle intervention on physicians and patients by using a quasi-experimental research design.

4. To determine the costs of Lifecycle preventive services in primary medical care.

The INSURE/Lifecycle Project has been implemented at three private, fee-for-service group practice sites: in Appleton, Wisconsin, in Danville, Pennsylvania and in Pensacola, Florida. Survey activities at control sites in Sheboygan, Wisconsin and Sayre, Pennsylvania have also been done. At the control sites, survey data on preventive services are collected but the Lifecycle protocols are not implemented. These control sites are necessary in order to make comparisons with the changes that are expected to result from the intervention at the study sites.

The Lifecycle model for preventive care focuses on preventive services for ten age groups from prenatal patients through geriatric care. The selection of services and the periodicity with which they are recommended are based on several recent major reports — the work of Breslow and Somers, the Institute of Medicine Ad Hoc Advisory Group, and the Canadian Task Force Report on Periodic Health Examinations. These studies led to the conclusion that for the "well", asymptomatic patient, health promotion and early detection of disease can best be accomplished through a more selective approach based on age and sex of the patient with emphasis on individualized patient education for risk factor reduction.

In 1977, the lifetime health monitoring program of Breslow and Somers provided visibility to the concept of including "cost-effective and health-effective preventive measures" in health care, based on goals and services for ten age groups. The consensus of the Institute of Medicine report further specified which health history, physical examination, clinical laboratory, and x-ray studies should be included for different age groups. The report of the Canadian Task Force in 1979 comprehensively evaluated screening and casefinding procedures for healthy persons.

The American College of Physicians reviewed the aforementioned reports and supported this approach to preventive health services. And in late March of 1983, the American Medical Association, Council on Scientific Affairs, published its first official recommendation on medical evaluations based on age and sex of the patient and encouraged patient education for prevention, particularly noting potential benefits for the doctor-patient relationship.

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The Lifecycle model consists of educating physicians at the selected study sites to use the Lifecycle protocols with their patients. Orientation sessions are conducted in advance of the study patient visits which are designed to familiarize physicians with the Lifecycle protocols, and to increase their awareness of their potential role in patient health behavior change. Educational materials for physicians and patients were developed in conjunction with Dartmouth Medical School, Department of Community and Family Medicine, and include reference manuals for physicians and patient guides for young children, adolescents and adults. Selected pamphlets on risk reduction were compiled and provided to the study physicians for distribution to patients.

Lifecycle Encounter Forms were developed to remind physicians of the protocols and to collect data on individual patients. A prevention prescription is part of the Encounter Form which is com-

3
lected by the physician for each patient. The prescription includes the specific “treatment” the physician is recommending for reduction of risk factors and the prescription is given to the patient by the physician at the time of the visit. Follow-up letters are sent to patients several weeks after the visit to remind them of the prescribed behavior change. Feedback sessions with the physicians are held to review the protocols and to report the progress of their patients regarding abnormalities detected and immediate behavior change reported by their patients.

At each of the group practice study sites, a payment schedule for Lifecycle examinations was negotiated with the group practice centers. This process involved defining the “covered” preventive services and agreeing to a schedule based on usual and customary fees. Physicians Current Procedural Terminology (CPT) codes were used to define the charges for services included in the Lifecycle protocols which would be paid in full. Fifteen minutes of patient education of risk reduction is specifically included as a “covered service” in addition to the recommended history, physical exam, laboratory and x-ray services. The group practice center is paid on a monthly basis by INSURE according to a cumulative bill after comparing services noted on the encounter form to Lifecycle age specific protocols. Exceptions are made to pay for services “not covered” (not in the protocols) only if the additional services resulted from a recommended procedure, i.e., ECG for a patient with chest pain, or chest x-ray for a smoking patient with a cough, and if so noted on the encounter forms by the physicians.

INSURE Project Study Design

The evaluation of the short-term effects of the Lifecycle model on physicians and patients was accomplished by means of a quasi-experimental design. The three study, or experimental sites, where the Lifecycle program is implemented are matched to similar group practice sites in the same region of the country. The controlled study is, of course, necessary in order to measure the independent effect of the LPHS program compared with secular or “normal” change.

The study design calls for inclusion of 750 patients of about 18 primary care physicians at each of the sites. Identical procedures for sample selection are used at the study and control sites. Approximately 18 physicians from the four primary care specialties (pediatrics, family practice, obstetrics/gynecology and general internal medicine) are identified. Using the group practice’s computerized billing roster as a sampling frame, 2,000 patients of these 18 physicians are randomly selected. The patient sample is stratified across the ten Lifecycle age groups: pregnant women; infants under 2 years of age; 2-5 years old; 6-11 years old; 12-17; 18-24; 25-39; 40-59; 60-74; 75 and older. Patients are over-sampled in order to end up with 750 patients at each of the six sites (or 75 in each of the 10 age groups) for a total of 2,250 study patients (750 x 3 study sites) and 2,250 control patients. The total number of patients in the study was approximately 4,500.

The design at the study sites included baseline telephone interviews with the study physicians concerning their attitudes toward prevention and patient education, their current practice patterns, especially with regard to the above, as well as their own health behavior. Patients are interviewed by means of mail questionnaires. A “walkthrough” of the clinic was conducted to observe current clinic procedures so that Lifecycle procedures and paper flow can fit as closely as possible with current practices. Focussed interviews or small group discussions were held with the doctors to gather qualitative information which was used in planning the physician education sessions. Following the physician education sessions, patients then came in for their Lifecycle examination with their physician which is paid for by INSURE. Telephone interviews with a 5 percent sample of non-respondents were conducted to assess response bias in the sample.

Follow-up meetings were held with the physicians to review cases as well as to report data on short-term (4 weeks post exam) behavioral change on a random sample of patients interviewed by telephone. Approximately 12 months following the baseline surveys, repeat surveys of doctors and patients were done to assess change in patients’ health related attitudes and behavior and in physicians’ practice pattern. At the control sites, only the survey activities were conducted with no education for the physicians or visits by the patients. A control site in Florida was not identified due to timing problems. An HMO in Seattle, Washington was substituted for purposes of obtaining descriptive information on preventive service in an HMO setting.

Initial Physician Data

The background characteristics of physicians at the three study sites — Appleton, Wis., Danville, Pa., and Pensacola, Fla. — show a high degree of similarity. Looked at as a whole, these 46 physicians have a mean age of 41 years and have been in practice for an average of 11.5 years. The doctors are almost all U.S. trained and are predominantly male. In terms of specialty distribution, roughly a fifth are family physicians, a third are pediatricians, about a third are internists, and OB/GYN are slightly more than a sixth. There are inter-site differences, with Appleton having a higher
The physicians’ responses to selected attitude items about prevention and patient education show that though physicians strongly endorse the principle of prevention — two-thirds strongly agree that physicians should devote more time to preventive services — they appear somewhat contradictory about prevention and patient education when it comes to doing it in their practice. It is of particular interest that a combined total of 74 percent of the physicians agree that therapeutic care provides more gratification than preventive care. The physicians believe prevention is important and that doctors should devote more time to it, yet they overwhelmingly agree that the lack of insurance reimbursement is a major obstacle. They report that they do patient education frequently yet they do not spend much time doing it, do not feel very effective, and appear to lack both factual and skills-oriented knowledge to do it.

The lack of financial incentives in the form of health insurance “coverage” and insufficient knowledge and skills seriously limit the physicians’ ability to provide more preventive services including patient education. These problems are addressed in the project by establishing a payment mechanism and through the INSURE/Lifecycle on-site education program for physicians. The degree to which the program is successful in modifying physicians’ practice patterns with regard to prevention may be largely due to the extent to which the Lifecycle program can correct these financial and educational barriers.

Initial Patient Data

Patients’ self-reported health attitudes and behavior vary across a wide range and are comparable to national norms. The purpose of the initial survey of patients was, among other things, to establish a baseline from which change can be computed after the Lifecycle intervention or program. In addition, initial data on patients from the Appleton site show not only variation, but their comparability to national data speak well for the integrity of this data set in general.

Very short-term follow-up data on a subsample of both Appleton and Danville patients suggest that, following their Lifecycle exams, patients will begin to change their health behavior based upon their doctor’s “prescription.” Thirty-two percent (n = 97) of patients interviewed by telephone report some behavioral change following their Lifecycle exam. For instance, nearly a quarter of patients counseled by their doctor to use seat belts report they are using them regularly. Two-thirds of patients counseled by their physician to cut down on their drinking report they have done so. While only 2 people counseled about cigarette smoking have stopped smoking, this success level (6.5%) is close to that reported by other investigators.

Subsample patients report an extremely high level of satisfaction with the Lifecycle examination. More than 90 percent say they are satisfied — with almost two-thirds reporting they are “very satisfied.” Patients find the exam to be thorough (85%) and especially like the sincere communication and concern shown by their doctor. More than half (55%) said their doctor seemed more interested in their lifestyle and health habits than he was in the past. The satisfaction data, although preliminary, suggest that the Lifecycle program may have some positive spillover effect on the doctor-patient relationship.

Thus, the initial data from patients and physicians show the Lifecycle model is not only feasible in primary medical care, but patients as well as physicians appear to be very positive about this program and are interested in participating. Follow-up data from physicians and patients is in the process of being collected. These data will allow for the measurement of short-term change resulting from the program.

Initial Cost Data

Preliminary information on 800 patients examined at the first study site in Wisconsin shows an average per capita cost of $59.00 for a Lifecycle examination. This figure is the result of a payment schedule based on usual and customary fees of the participating group practice physicians and includes a negotiated fee for physician’s time used in patient education, as well as, fees for history, physical exam, laboratory, and radiology services. The range of the charges by age of patients varies from $31.56 for 2-5 year-old children to $134.88 for adults 75 years old and older (see Table 1). These direct costs for the Lifecycle exam including lab and x-rays are less than expected probably because of the exclusion of unnecessary tests such as routine chest x-rays and electrocardiograms, and using a defined schedule for payment purposes.

As previously indicated, preventive care is not usually covered under insurance policies. Preventive check-ups have not been viewed as necessary services for accident and sickness. Even well-child visits are postponed by parents who must bear the total cost of these visits.

In order to develop some baseline data on costs and insurance coverage for prevention, patients in the LPHS study were asked a series of questions.
Table 1

Utilization Rate and Cost by Age Group
LPHS Study Site — Appleton, Wisconsin

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>UTILIZATION RATE (% OF ORIGINAL SAMPLE RECEIVING EXAMS)</th>
<th>AVERAGE COST PER PATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREGNANT</td>
<td>18.6%</td>
<td>$ 61.81</td>
</tr>
<tr>
<td>&lt; 2</td>
<td>62.5</td>
<td>35.85</td>
</tr>
<tr>
<td>2-5</td>
<td>63.1</td>
<td>31.56</td>
</tr>
<tr>
<td>6-11</td>
<td>53.5</td>
<td>32.82</td>
</tr>
<tr>
<td>12-17</td>
<td>59.2</td>
<td>35.85</td>
</tr>
<tr>
<td>18-24</td>
<td>27.3</td>
<td>59.79</td>
</tr>
<tr>
<td>25-39</td>
<td>45.0</td>
<td>60.63</td>
</tr>
<tr>
<td>40-59</td>
<td>36.4</td>
<td>86.36</td>
</tr>
<tr>
<td>60-74</td>
<td>42.7</td>
<td>115.72</td>
</tr>
<tr>
<td>≥ 75</td>
<td>27.7</td>
<td>134.88</td>
</tr>
</tbody>
</table>

| ALL AGES  | 43.9%                                                   | $ 59.05                  |

Dealing with their current insurance coverage as well as their interest in coverage for preventive services. These questionnaire items were developed in consultation with staff at the Health Insurance Association of America (HIAA) as well as experts at several of the large commercial insurance companies.

In terms of an insurance profile (Table 2), about 97 percent of patients in the sample are covered by some health insurance with almost 84 percent having group coverage. The data show that about four-fifths of respondents report they do not have coverage for preventive services.

More than one-half of respondents — 52.2 percent — report they are “very interested” in coverage for preventive services. When this figure is added to those who are “somewhat interested,” more than 83 percent of the respondents expressed interest in coverage for preventive services as part of their health insurance. These preliminary data suggest a strong demand for insurance coverage for preventive services.

Given the above response, how likely would patients be to get a covered check-up, if such services were covered? The data show that three-fourths of the respondents report they would be “very likely” to avail themselves of a covered check-up. It seems evident, therefore, that not only is there a demand for insurance coverage for preventive services, but a strong behavioral intention to utilize this coverage. The actual “utilization rate” (% of original sample of patients receiving a Lifecycle exam) in Appleton was 44%. This demonstrated that even with “first dollar coverage” for prevention, utilization is not excessive and varies by age groups.
 Ninety-seven percent (97%) of the Appleton patients involved in the study have health insurance coverage; 56.3% through private insurance companies, 32.5% through Blue Cross/Blue Shield, and 84% through group contracts. When questioned about preventive services, the following responses were obtained:

<table>
<thead>
<tr>
<th>Does your plan cover costs for:</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive checkups for adults</td>
<td>18.1</td>
</tr>
<tr>
<td>Preventive checkups for children</td>
<td>9.6</td>
</tr>
<tr>
<td>How interested are you in health insurance that covers preventive services for you and your family?</td>
<td>Very 52.2</td>
</tr>
<tr>
<td></td>
<td>Somewhat 31.0</td>
</tr>
<tr>
<td></td>
<td>Not 16.8</td>
</tr>
<tr>
<td></td>
<td>Interested</td>
</tr>
<tr>
<td>How likely is it that you would go for a checkup if you did not have to pay the full cost yourself?</td>
<td>Very likely 74.7</td>
</tr>
<tr>
<td></td>
<td>Somewhat 19.1</td>
</tr>
<tr>
<td></td>
<td>Likely 4.4</td>
</tr>
<tr>
<td></td>
<td>Unlikely 1.8</td>
</tr>
</tbody>
</table>

The data suggest that interest in coverage for preventive services extends beyond a free service as is the case in this special study. More than one-half of respondents are willing to pay $5 a month or $60 a year for coverage for prevention (Table 3). These data from the first site of the INSURE Project indicate that there is a demand or market for preventive services and that the average charges are very close to what patients are willing to pay, i.e., $59.00 per exam and $60 per year for extra premium. The patients in Appleton also rate coverage for preventive services more desirable than other health insurance benefits that are frequently covered in addition to basic hospital and medical expenses, i.e., dental coverage, prescription drugs, etc. (Table 3). Data are not yet available regarding cost containment. However, the project has begun to define the methodology and collect the necessary data by involving an employer, employees, providers and insurance carriers to study the impact of preventive services on health insurance claims experience. The issue of cost containment will also be addressed in more detail in the next phase of the project.

Since 1965 health care expenditures have grown at an average annual rate of 12.8% and in 1981 represented 9.8% of Gross National Product with an increase of 15.1% in overall health expenditures. All third party payers financed 68% of the total cost of personal health care in 1981 including 89% of hospital care, and 62% of physicians' services. For 1981 employers paid an estimated $59 billion on health insurance for employees which accounted for approximately 80% of private premium payments in 1977. Translated to the auto industry, the approximate annual cost of health benefits for the average auto worker is $2,000 which accounts for approximately 7% of total wages. The cost of health care in the price of an average U.S. car ranges from $150 to $300 (not $2,000 as often reported). In addition to health insurance there are other health related costs in employee benefits including life insurance, absenteeism, early pension, turnover, not to mention reduced productivity.

As health care costs continue to increase year after year, it seems clear that employers, employees, and health insurance carriers will become increasingly concerned with this issue of how to obtain appropriate health insurance coverage while controlling the cost of employee benefit plans. With the current “wellness at the worksite” programs in place, many large companies throughout the United States seem to be supporting the idea of preventive health care. These worksite programs do not deal with prevention for dependents of employees or involve the practicing physicians in the process. However, interest in prevention on the part of industry suggests that an insurance product...
TABLE 3

Most health insurance expects the patient to pay for preventive services. How likely would you be to choose health insurance which covers preventive services in full if you had to pay?

<table>
<thead>
<tr>
<th></th>
<th>Very Likely</th>
<th>Somewhat Likely</th>
<th>Somewhat Unlikely</th>
<th>Very Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5.00 per month extra premium</td>
<td>59.4</td>
<td>18.8</td>
<td>6.4</td>
<td>15.4</td>
</tr>
<tr>
<td>$10.00 per month extra premium</td>
<td>17.0</td>
<td>34.0</td>
<td>17.5</td>
<td>31.6</td>
</tr>
<tr>
<td>$15.00 per month extra premium</td>
<td>4.7</td>
<td>11.1</td>
<td>26.3</td>
<td>57.9</td>
</tr>
</tbody>
</table>

In addition to basic hospital and medical expenses, which of the following health insurance benefits do you rate as most desirable for you?

<table>
<thead>
<tr>
<th>Health Insurance Benefits</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage for preventive checkups for adults and children</td>
<td>35.5</td>
</tr>
<tr>
<td>Dental coverage</td>
<td>24.2</td>
</tr>
<tr>
<td>Prescription drug coverage</td>
<td>17.6</td>
</tr>
<tr>
<td>Maternity benefits</td>
<td>12.9</td>
</tr>
<tr>
<td>Eyeglasses coverage</td>
<td>9.8</td>
</tr>
</tbody>
</table>

100.0%

that provides selective coverage for preventive health care according to a payment schedule, and promises long-term health benefits while reducing the rise in costs, would be attractive to industry. The INSURE/Lifecycle Preventive Health Services study is designed to answer some of the persisting questions regarding the health and financial benefits of preventive services while demonstrating that it can be done.

REFERENCES


4. Ibid., pg.8.


Hypertension Survey Results

Recently released results of a 1982 survey conducted by the National Heart, Lung, and Blood Institute and the Food and Drug Administration portend a continued reduction in the deaths and disabilities from hypertension-related conditions. This survey showed that more Americans are aware of hypertension and its dangers, know that it can be treated effectively, and are getting their blood pressure checked than was shown in a survey conducted in 1973.

Results of the National Health and Nutrition Examination Surveys also show favorable trends. During the time period of 1971-72 to 1976-80, the percent of hypertensives aware of their condition increased from 51 percent to 73 percent. In addition, control rates more than doubled during this period, from 16.5 percent to 34.1 percent.

Researchers regard these findings as encouraging and as an indication that the decline in stroke and heart attack mortality is likely to continue. During the decade following 1972, stroke mortality dropped by more than 40 percent, and heart attack deaths decreased by nearly 30 percent. Officials of the National High Blood Pressure Education Program, the program that coordinates national efforts to control high blood pressure, point out that the increased number of hypertensives under effective treatment have contributed to these trends.

The National High Blood Pressure Education Program was created in 1972 to work with community groups, volunteer organizations, medical specialists, and industry to maintain a steady and coordinated effort to educate the public and professionals about high blood pressure and its increased risk of heart attack and stroke. Much of the Program’s success has been attributed to the many organizations and agencies at federal, state, and local levels that are actively participating in the mammoth effect to control high blood pressure.

Despite the recent progress, however, problems remain that require additional attention. Men lag behind women in controlling hypertension, and control rates for black men do not approach those of their white counterparts. Since the prevalence rate of hypertension is greater among the black population, detecting and treating high blood pressure among this group assume even more importance.

One key to continued success in the national effort is the participation of health professionals in a number of settings, particularly in getting and keeping hypertensives under control. Health professionals at all levels can encourage adherence to therapy. They can:

- Improve patient education and counseling. Encouraging the development of appropriate patient behavior for blood pressure control is a critical task for all health professionals. Patients may need help in making a decision or personal commitment to control the disease, in forming new habits for regularly taking medication, in making lifestyle changes, in monitoring progress toward their goal, and in resolving problems related to therapy.

- Become familiar with current treatment recommendations. The Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure offers guidelines for detection and confirmation of blood pressure elevations, referral, patient evaluation (including laboratory workup), and stepped-care drug therapy. It also addresses additional issues including managing mild high blood pressure, patient education for therapy maintenance, nondrug treatment, drugs for use in stepped-care therapy, managing the elderly and other special patient groups.

- Involve all types of health professionals. Successful control of high blood pressure requires patient access to a number of professionals participating in one or more steps within the control process. Yet barriers to interdisciplinary cooperation exist. Recent recommendations by
a multidisciplinary panel that examined profes-
sional roles urge that those barriers be overcome
in order to expand individual and community
high blood pressure control services.

This May, National High Blood Pressure Month, is
an appropriate time for us to examine our involve-
m ent in high blood pressure control and to determine
how we might expand such efforts. Our efforts to
encourage patient adherence can be multiplied by
working with other groups that may have ongoing
programs or resources to share. Some groups
interested in cooperative efforts may be the
American Red Cross, civic and fraternal organiza-
tions, community centers, fire and police departments,
health departments, hospitals and clinics, indus-
tries, newspapers, professional societies, senior
citizen and student groups, area health education
centers, and extension agencies.

The 1984 High Blood Pressure Month kit is
available to help health professionals work with
patients and the public. The kit includes a program
planning guide and educational materials that may
by used in publications or in other ways. Copies
of the Month kit and other information for profes-
sionals may be obtained from:

High Blood Pressure Month
High Blood Pressure Information Center
120/80 National Institutes of Health
Bethesda, MD 20205

Calendar of Events

May 27-30, 1984

The Thirty-Ninth Annual Meeting of the Canadian Life
Insurance Medical Officers Association.

Place: Valhalla Inn
Kitchener, Ontario, Canada

For information contact: Dr. R.D. Atkinson,
Mutual Life Insurance Company of Canada,
Waterloo, Ontario N2J 4C5
Canada
Phone: (519) 888-2249

May 31-June 1, 1984

The eleventh Mortality & Methodology Seminar will be
held immediately after the CLIMOA meeting.

Place: Valhalla Inn
Kitchener, Ontario, Canada

Fee: $100 per participant (Payable to ALIMDA)

Program Director: Robert G. Wood, M.D.

Registration should be submitted as soon as possible.
Registrants will be sent a package of material which
includes instructions for calculation of life tables, sam-
ple cases to be worked, reprints and a bibliograph. Ad-

This Seminar is sponsored by the Mortality and Morbid-
ity Committee of ALIMDA and participation is open to
all ALIMDA members. Seminar registration is limited
but will be opened to underwriters, actuaries and other
interested home office personnel if all places are not
taken by ALIMDA members.

For more information, contact: Dr. Robert G. Wood, P.O.
Box 2465, Houston, Texas 77001.
Phone: (713) 871-4958

June 27-29, 1984

International Symposium on Stress and Heart Disease
Place: Winnipeg, Canada

The scientific program will include invited speakers,
selected discussions and free communications in the
area of stress, hormones, hypertension, arrhythmias,
coronary spasms, sudden death, and cardiomyo-
pathies. For abstract forms and other information
please write to Dr. Robert E. Beamish, M.D., Experimental
Cardiology Section, Department of Physiology,
Faculty of Medicine, University of Manitoba, Winnipeg,
Canada R3E 0W3.

Dr. Norman W. McQuay, Medical Director, The
Dominion Life Assurance Company, Canada, ap-
proaching the completion of his career, has resigned
as a member of the Regional Editorial Board. We
wish him well, and offer our sincerest appreciation
for all of his efforts on behalf of the Journal of
Insurance Medicine.