

Geriatric Medicine: Isn't there a Better Alternative?

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I Philp

The greatest achievement of the 20th Century has been the conquest of disease, so that the vast majority of humankind in the developed world can expect to live into old age. The epidemic at the Millennium is not AIDS or mad cow disease (which affect tiny and ultramicroscopic proportions of the population) but the diseases of old age. Our very success in the prevention and treatment of diseases in younger age groups carries the seeds of our undoing in our approaches to the health care of old people. We suffer from the "American madness", a denial of our mortality. We consume more health care resources in our last year of life than in the whole of the rest of our life in an increasingly desperate battle against frailty and bodily decline. As a result, we are bankrupting our health care systems, and are denying ourselves the health care we want and need in old age.

What do we want from health care services in old age? Surveys with frail old people, their health care professionals and the managers and purchasers of services show remarkably uniform opinions^(1,2). Our top priorities are to maintain or improve quality of life, reduce disability and promote independence and autonomy. For old people, not being a burden on their families is of equal importance. Of least importance to all groups is to reduce the risk of death. Yet our health care systems are geared to achieving the opposite ends. We fail to provide the rehabilitation, long-term care and family support services which enhance quality of life, reduce disability and over-reliance on family carers, but we feed our high-tech hospitals with old people so that they can receive expensive, life-saving treatments.

In my hospital in Sheffield, seven out of ten medical inpatients are not only old, but also frail, defined as having one or more of the syndromes of old age: instability (prone to falls), immobility, incontinence of urine or faeces, or intellectual impairment (delirium or dementia). Typically, they suffer from three or more long-standing diseases such as arthritis, heart failure, diabetes and chronic bronchitis. They receive a complex regime of drugs from which they suffer some side-effects. Their income and housing quality is worse than that of the general population and their main source of help at home will come from a member of their family (usually their spouse, daughter or daughter-in-law). In hospital they receive the best that modern health care can deliver; blood tests to monitor every bodily function,

advanced imaging with scanners of many kinds, life-support systems with intravenous drugs and fluids, resuscitation and ventilation if required. But when diagnosis and treatment are over (for the time being at least) they will receive inadequate rehabilitation because of lack of rehabilitation specialists, and the over-riding demands of the next batch of mainly elderly emergency patients. Discharge is likely to be delayed whilst under-resourced community services are mobilised, or inappropriate, with transfer to a nursing home, creating unnecessary institutionalisation and loss of independence.

Where have we gone wrong?

The visibility and glamour of high-tech hospital care encourages popular support, resisting politicians' attempts to control health care expenditure, and forcing withdrawal of funding for less glamorous rehabilitation and long-term care services.

The nursing home industry offers a siren call to a health service in crisis. It can provide a safe refuge for the long-term care of frail older people, and a means of early discharge from hospital. But nursing homes have no incentive to rehabilitate patients. In fact, they have a perverse incentive to discourage rehabilitation in order to keep their patients longer, and turn patients with rehabilitation needs into patients with long-term care needs. Where nursing homes are funded according to the level of dependency of their patients, as they are in the United States, there is an added perverse incentive to increase patients dependency to increase payment to the Home.

Is there a better alternative to current trends in the health care of old people?

To look forward, we need to look back to health care for old people in the UK in the 1960's and 70's. At that time, the UK had experienced most of its demographic transformation to an ageing society, an accident of history, which combined with political foresight, produced pioneering approaches to the development of health services for old people. The principles of geriatric medicine were established. These were the rapid and appropriate response to need, limiting iatrogenesis by the avoidance of hospital admission and unnecessary treatment where possible, the development of multi-disciplinary teamworking, support to family carers, co-operation with social services, and the maintenance of old people in their

Centre for Ageing and
Rehabilitation Studies
Northern General Hospital
Herries Road
Sheffield S5 7AU
UK

I Philp, MD, FRCP
Medical Director of the School
of Health and Related Research

own homes for as long as possible. Although standards varied, a good local geriatric service provided specialist domiciliary assessment, multi-disciplinary day hospital care, and in-patient assessment, rehabilitation respite and long-term care. Because the system was comprehensive, it was possible to strike the right balance between the different components of care. The main priority was given to the prevention of disability through effective intervention and rehabilitation.

This system of care was affordable, because services operated from the redundant old fever hospitals and poor-law infirmaries, and were staffed in the main by the least well paid members of medical, nursing and therapy professions. This system of health care for old people scores highly on the six important dimensions of quality in health care; efficiency, effectiveness, relevance, access, equity and comprehensiveness.

Unfortunately, in the 1980's in the UK, politicians lost their senses, fragmenting the health care system with terrible consequences for its most significant patient group, old people, throwing added burden on family carers and driving up the costs of health care.

The UK experience of the 1970's shows that in spite of demographic trends, it is possible to deliver effective and affordable care for old people, but only with political and professional leadership which strikes a courageous course against powerful vested interests in the health professions and the health care industries.

The geriatric medical services of the UK in the 1970's inspired the development of similar models of care in Canada, Australia and New Zealand and could serve as a model for Singapore. However, circumstances in both the UK and Singapore are very different from each other and from the UK of the 1970's.

Looking to the future development of geriatric medicine, I advocate five principles:

1. integration of specialist knowledge and skills in health care for old people within all components of the system;
2. education of health professionals in multi-disciplinary and multi-agency work;
3. routine, comprehensive assessment of need;
4. prioritisation of service response according to patient (and carer) priorities;
5. measurement of success through the routine use of appropriate outcome measure for individual patient care, service performance and public health targets.

The most positive aspect of recent changes to geriatric medical services in the UK has been the integration of specialists in geriatric medicine with general physicians. This has extended the influence of geriatricians within hospital medicine. Although some geriatricians have been swamped by the demands of emergency medicine, others have been able to promote multi-disciplinary working and a holistic approach to patient care with benefits for patients from all age groups. However, to succeed within an integrated service, geriatricians need real power and influence and the full support of hospital

administration.

Collaboration extends to working with surgeons, particularly in the care of patients with fractured hips. With geriatricians extending their reach in hospitals, it may be necessary to develop a sub-speciality of community geriatric medicine to reverse the decline in the priority given to slow-stream rehabilitation and long-term care. However, efforts to develop community geriatric medicine in the UK have been met with limited success.

Education of health professionals in multi-disciplinary and multi-agency work is essential to make a fragmented health care system work. We are beginning to see the emergence of new university-based undergraduate and postgraduate modularised courses for health professionals and administrators to dip in and out of, as their educational needs dictate⁽³⁾. Erosion of barriers, misconceptions and prejudices amongst professionals and between professionals and administrators, can be overcome through joint approaches to education, which would include specific education on team working.

The development of appropriate patient information systems is necessary to ensure comprehensive geriatric assessment, prioritisation of service response according to need and to measure the outcomes of care.

Under the guidance of the European Office of the World Health Organisation, the essential elements for comprehensive assessment of need of older people were agreed at a Consensus Conference of European experts in health care for old people⁽⁴⁾. These were: perceived health and well-being, loneliness, housing adequacy, economic sufficiency, social functioning (shopping, meal preparation, housekeeping, use of the telephone, handling medicine and money), disability (dressing, feeding, toileting, continence, bathing, mobility within and outside the home), hearing, chewing, swallowing, communication and carers' needs.

To encourage routine comprehensive assessment, I was asked by the World Health Organisation to develop a standardised questionnaire, called EASY (Elderly Assessment System) covering these domains⁽⁵⁾. The questionnaire has been tested in a number of centres in Europe for its acceptability to patients and practitioners, reliability, and validity. EASY not only helps practitioners obtain a broad picture of the needs and circumstances of their patients, but also helps to prioritise service response according to patients (and carers) priorities, as it includes a section for individual needs assessment. The practitioner asks the patient (or carer) "if one thing could be done to make things better for you, what would it be?". The practitioner and patient (or carer) then agree on a realistic goal and a time-scale for its achievement. At follow-up, the outcome is recorded as well as the patient (or carer's) satisfaction with care. Use of EASY helps to monitor the outcomes of care for the individual patient. It can also be used to generate data for measuring service and population outcomes. The European Office of the World Health Organisation, through its quality improvement

programme, has established a database for the analysis of data from EASY to set targets for improving the health of the population.

The five approaches which I have advocated for improving the quality of health care for old people are appropriate not only for old people, but also for patients of all age groups who suffer chronic diseases. As we all have a high chance of developing chronic and disabling disease at some stage in our lives, we, as the consumers of the future, as well as the providers of today, need to re-focus our priorities if we are to deliver high quality health care for the epidemic of the next millennium, the diseases of old age.

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The Secretariat
UICC Workshop on NPC
c/o Singapore Cancer Society
15 Enggor Street
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Tel (65) 221 9577 Fax (65) 222 7424 Email fightcncr@pacific.net.sg