Addressing the Healthcare Needs of an Ageing Population: The Need for an Integrated Solution

Ashby S[1] and Beech R[2]

[1] *Lecturer Keele University School of Nursing and Midwifery*

[2] *Reader in Research Development Keele University School of Nursing and Midwifery*

[*] **Corresponding author:** S Ashby Lecturer, Keele University School of Nursing and Midwifery, Clinical Education Centre, University Hospitals of North Midlands NHS Trust, Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, ST4 6QG, Tel: +44 (0) 1782 679550, Fax: +44 (0) 1782 679576; E-mail: s.m.ashby@keele.ac.uk and R Beech, Reader in Research Development Keele University School of Nursing and Midwifery, Clinical Education Centre, University Hospitals of North Midlands NHS Trust, Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, ST4 6QG, Tel: +44 (0) 1782 679687, Fax: +44 (0) 1782 679576; E-mail: r.beech@keele.ac.uk

Abstract

All stakeholders involved in healthcare are well aware of the ticking time bomb of our ageing world with demand exceeding supply even within the most affluent of countries. The Director-General of the World Health Organisation (WHO) has recently drawn global attention to the fact that even in low income countries people are living longer; however pointedly adds that longevity is not enough. To benefit society as a whole there needs to be a refocus on how later years in life are significant to the older person; with attention to dignity and good health.[1]

A recent survey in the United Kingdom (UK) has identified that approximately 752,000 people over the age of sixty five have made a decision between keeping warm or spending their money on food.[2] The inability to meet basic need is often missed until a crisis event draws attention to circumstance; even then there is a possibility that this is overlooked. Consider the high risk of falls in this population, with falls and falls related injuries being a major issue for healthcare providers across the world and often the indicator of an underlying medical condition in older people.[3] There is limited use of falls prevention strategies that can address individual factors such as low income, environmental hazards and social isolation.[4] In 2007 O'Shea warned that if predisposing factors were left unaddressed a crisis was waiting to happen in systems already stretched beyond capacity; it seems that we are still acknowledging and still calling for action.[5]

The alignment of resources to support the fundamental care needs of older people also requires attention. Recent high profile reports in the UK have identified that basic needs have not been met.[6,7] Fragmented care has been acknowledged as a significant contributor to poor care; for example the development of malnourished patients in hospitals.[8] Advocates for older people in America have also drawn attention to how fundamental care in long term care settings such as relieving pressure areas and supporting nutrition are being replaced by more costly care to heal pressure sores and treat dehydration; shifting from prevention to consequential treatment.[9]

Older people have a real fear of decline in functional capacity and becoming dependant on social care; which is recognised as factors which compromise mental health and well-being.[10,11] They also have the added complexity of multi-morbidity.[12] The impact of living with multiple long term conditions (LTCs) and the additional challenge of the

natural process of ageing has the potential for sign-posting to either condition focused specialists or geriatricians depending on: how a person presents, the healthcare system and the pathways of care that are available at that time.[13] Older people may find their care follows an age related pathway or a specialist pathway; drawing attention to the role of the geriatrician and the holistic perspective of treatment and subsequent care management as opposed to the condition specific knowledge of specialists. If an older person's priority of need is deemed condition specific this may lead to the management by a specialist. This focus may be to the detriment of supporting underlying age related processes to the frustration of geriatricians who focus on supporting older people in maintaining mental and physical capacity. On the other hand it could be defended that the specialist knowledge optimises the older person's outcome; giving access to a knowledgeable condition focused team.

Integrated care has been evidenced as the best approach to improve outcomes and avoid 'fragmented and episodic care'; underpinned by the ideology of placing the person at the centre of their care.[14-16] Dr Martin McShane the lead for LTCs in the UK also gave a call to action recognising the fragmentation of services for people who have multiple LTCs.[17] Providing a focus on seamless care the terms 'informational', 'managerial' and 'relational' continuity were introduced, recognising the need to allow people to hold their own health information, wrapping services around the person and forming trusting relationships to achieve person-centred care.[17]

However this vision of integrated care and more person centred care is challenging. Safe and effective complex care requires coordination of multiple health professionals over time; supporting interacting treatments across differing settings at different stages.[16,18] This coordination often breaks down resulting in a 'burden' for older people and their families to repeatedly provide important health related information; leading to a loss of confidence and connectivity with professionals. Attempts to promote equity of access to treatment, and a recognition of the older persons' prioritisation of need, uniqueness and place in society, can also lead to care pathways being introduced that move away from segregation of older people and reduce age specific dedicated areas of care. However age related needs cannot be ousted. There is a danger that attempts to avoid ageism may disperse the resources required to support older people; ironically within systems striving to support this exact need. For example, the higher concentration of therapists required to support conditions relating to the ageing process (more traditionally allocated to wards medically supervised by geriatricians) may now be stretched across a variety of areas supported by specialists e.g. respiratory physicians. McShane also draws attention to the generalist/specialist divide between general practitioners (GPs) in the community and hospital specialists; making a stand that patients belong to all.[17]

So the question arises in relation to how integrated and person-centred care can be achieved for older people at the same time; whilst also achieving timely access to specialist care. First of all a change in mind-set on what older people can do rather than what they cannot may assist professionals in preserving functional ability and well-being; with improved training in supporting people who are frail and empowering all people to take control of their own health. A letting go of the shackles of chronological age and recognising that ageing is not dependant on number of years lived but how the years have been lived is needed. The WHO calls for a refocus of clinical gaze from disease to intrinsic capacity.[16] From the perspective of supporting older people this does have significant implications for healthcare. In the UK the healthcare system gears funding towards acute care and there is a need to address the balance to shift funds and

appropriately resource services which enable older people to achieve independence, health and well-being. Acknowledging that integration reaches far beyond the point of location; a move towards this could be the basing of specialists within the community readdressing funds which follow the patient.[17] There needs to be a willingness of generalists and specialists to work together across community and hospital based care and a supportive strategic framework which embraces age friendly communities.[19]

Secondly investment in prevention and timely intervention is required globally acknowledging the differing systems that are in place. The WHO advocates a three pronged approach: 'case management, self-management and ageing in place'.[16] This has similarity with the Kaiser Permante triangle relating to supporting people with LTCs which is illustrated with the tip of the triangle recognising high complexity case management, a middle ground of high risk care management and an acknowledgement to 70 to 80% of self-care support management with an emphasis on supporting care closer to home and delaying or preventing long term care.[20] Integration requires a shared responsibility; supporting people across whole systems of care, breaking down hierarchical and physical structures that have traditionally separated joined up thinking and subsequent care.[21]

Lastly all professionals now have the challenge of identifying evidence to support the management of multi-morbidity; a realignment of support focussing on symptom management as a common thread may draw together professionals to share expertise. For example cardiologists and respiratory physicians may hold joint clinics to effectively determine an accurate diagnosis and management of chronic breathlessness. Impress explore the symptom-based approach of chronic breathlessness 'to take everyone out of the box' with the aim of maximising health with co-ordinated interventions; encouraging integrated innovative approaches.[22]

As the WHO calls for the provision of more person-centred and integrated care for older people surely it is now time to act; by the very nature of longevity time is of the essence and no one is so powerful that they can stop the march of time. Despite the challenges, a footprint of effective integrated care for older people across the world has already started to take place.[16,23] This should be celebrated and embraced; after all integrated older person-centred care potentially improves the path of care for all.

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