

Future care for older people in general practice: paradigm shifts are needed

THE DEMOGRAPHY OF AGEING

The population is growing worldwide. The World Health Organization (WHO) estimates that the global population will approach 10 billion by the year 2050.¹ In addition, the population is ageing rapidly in all continents. In 2050 almost 35% of the European population will be >60 years of age, as compared with 25% at present.² This will have marked impact on the population composition of most European countries; at the end of this century 40% of the so-called 'dependant population', which is the joint proportion of those aged <18 years and >60 years, will consist of older people and 60% of <18-year-olds, as compared with 15% of >60-year-olds and 85% of <18-year-olds at present.¹ This will have large economic, societal, and healthcare consequences, as it brings up the fundamental question: who will take care of whom in future? Finally, ageing is affected by societal inequity: in the UK there is an almost 10-year difference in life expectancy between the most and the least deprived.³ This is even more striking for disability-free life expectancy, where this difference is almost 17 years.

HEALTH PERSPECTIVE OF OLDER PEOPLE

Health at older age is very heterogeneous; individual factors such as genetics, biology, lifestyle, and disease, as well as the environment people live in, determine the physical and mental condition of the ageing individual. From a medical perspective the prevalence of disease among older people varies widely across age groups. Across Europe multimorbidity, defined as the presence of at least two major chronic conditions, increases from 6–16% at 55 years to 13–20% at 65 years, and >20% at 75 years of age.⁴ The standardised prevalence of Alzheimer's disease among ≥60-year-olds reaches up to almost 6% for Central and Eastern Europe, and 7% for Western Europe.⁵ Multimorbidity is not random. Analysis of Scottish population data demonstrated a significant clustering of multimorbidity around major diseases such as diabetes, coronary heart disease, and cancer, especially with pain and depression.⁶ At 65 years there was a 19% difference in comorbidity between the least and the most deprived population groups. Generally speaking, multimorbidity

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started 10–15 years earlier among the most deprived.

The impact of ageing and disease on daily functioning is complex and the relationship is far from linear. Functional decline is very heterogeneous among ageing people. Important in functional capacity is the ability to perform vital activities of daily living (ADL), such as eating, bathing, dressing, getting in and out of bed, and using the toilet. Marked differences are reported in functional decline among European older people, varying from 3% (Switzerland) to 20% (Poland) of the 65–75-year-old cohort reporting one ADL limitation, and 12% (the Netherlands) to 35% (Portugal) of the ≥75-year-old cohort.⁴ Health at older age is obviously not randomly distributed, and from a health perspective there is no 'typical' older person.

SOCIETAL PERSPECTIVE OF AGEING

A popular saying is everyone wants to grow old, nobody wants to be old. Although the past increase in life expectancy in Western countries resulted in an extra day a week during 25 years of one's life, this has not yet changed the societal perspective on ageing. Traditionally we consider ageing as an inevitable biological process of physical and psychological decline, and older people are seen as a homogeneous group.

The scientific recognition of the heterogeneity of ageing started in 1987 with the landmark paper of Rowe and Kahn.⁷ They demonstrated that, up until then, research on ageing had emphasised average age-related losses, had exaggerated the effects of the ageing process itself, and had underestimated the modifying effects of lifestyle and psychosocial factors.

They suggested criteria for 'successful ageing': not only the absence of disease and disability, but also maintaining physical and mental functioning and active engagement with life.⁷ Research on successful ageing shows that there are a growing number of older people who function at high level. In a systematic review of 28 studies, 36% of included older people were identified as successful agers (SD 19%).⁸

The WHO introduced the concept of 'healthy ageing' as the process of developing and maintaining the functional ability that enables wellbeing at older age, or 'being able to do the things we value as long as possible'.³ For promotion of healthy ageing several changes in society are needed. One of them is a change in the way we think about ageing and older people. Ageing is not just losing youth; it is also a new phase in life, with new challenges and opportunities.

CHALLENGES FOR HEALTH CARE

Actions needed to support healthy ageing are dependent upon the physical, mental, and social status of the individual. Initially the focus should be on building and maintaining capacity, by reducing risk factors, early detection of disease, and enforcing healthy lifestyle. In case of declining capacity, healthcare efforts should focus on slowing down this decline, by treating underlying causes, and maintaining physical strength and cognitive functioning. In the final stage of irreversible loss of capacity, health care should focus on compensating for functional decline, by ensuring rapid-access healthcare facilities.

The key challenge for health care in its support for healthy ageing lies in the necessary alignment of the system to the needs of the older individual. This requires that healthcare professionals put older people at the centre of health care, and shift from the present focus on managing diseases to optimising people's lives while respecting their autonomy and maximising their functional capacity. The health workforce needs to be prepared for the required actions, that is, dealing with diversity and reducing inequity among older people, enabling choice, and making sure that ageing takes place in the optimal environment.

FUTURE CARE FOR OLDER PEOPLE IN GENERAL PRACTICE: PARADIGM SHIFTS REQUIRED

The cornerstones of general practice,

“... we have to actively engage older people in the management of their own health ...”

that is, care provision from a personal and longitudinal relationship through an integrated approach, provide excellent opportunities to realise care for older people. However, a number of paradigm shifts are needed.

First of all we have to change focus; not on the disease, but on the autonomy! Older people want to be able to do the things they consider important as long as possible. Add life to years, not years to life. Treating chronic disease may be important, but only to prevent limitations. This approach fits in the new concept of health as a dynamic state, in which the emphasis is on the ability to adapt and self-manage, while facing the physical, social, and emotional challenges of life.⁹

Second, care for older people should be proactive instead of reactive, with focus on older people at high risk of losing intrinsic capacity. A minority of older people are frail due to multimorbidity, high psychosocial burden, or physical limitations. Frailty increases the risk of health deterioration, functional decline, and loss of quality of life. Timely identification of frail older people, followed by geriatric assessment, and advanced care planning can help to slow down deterioration and to limit unplanned admissions.

We have to move from protocolised to personalised older-persons care. Although scientific evidence is essential, interventions should be valued in the personal context of the older individual. Evidence from clinical trials reflects effectiveness in the average patient population. The biology of ageing is so heterogeneous that there is no ‘mean’ older individual, and — more than in other patient groups — treatment decisions need to be personalised.

This does not only involve the person’s physical and mental health status. Treatment decisions also need to be tailored to the individual demands, carefully weighing potential benefit and harm against the individual prognosis, preferences, and life expectancy. We have to actively engage older people in the management of their own health. Shared decision making should become mandatory, especially in cases of high-impact decisions such as invasive surgery, chemotherapy, and end-of-life care.¹⁰

Finally, future care for older people is multidisciplinary and requires collaboration between medical, nursing, and community health professionals. Collaboration should be structurally embedded in local care networks, linking primary care, hospital, and long-term care, optimally using all available expertise.

CONCLUSION

Ageing is a personal and unique journey, and the older population is heterogeneous, with different patterns of ageing. GPs can promote and facilitate healthy ageing, by providing personalised, integrated care within a personal relationship, but we have to adapt our way of working to the needs of the ageing individual.

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REFERENCES

1. United Nations Department of Economic and Social Affairs Population Division. *The 2017 revision of the world population prospects*. UN, 2017. <https://esa.un.org/unpd/wpp/> [accessed 22 Sep 2017].
2. United Nations Department of Economic and Social Affairs. *World population ageing*. New York, NY: UN, 2015. http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Highlights.pdf [accessed 22 Sep 2017].
3. World Health Organization. *World report on ageing and health*. Geneva: WHO, 2015. <http://www.who.int/ageing/publications/world-report-2015/en/> [accessed 22 Sep 2017].
4. Survey of Health, Ageing and Retirement in Europe (SHARE) Munich Center for the Economics of Aging. Wave 4, release 1.1.1. www.share-project.org/homeo/wave4.html [accessed 22 Sep 2017].
5. Alzheimer’s Disease International. *World Alzheimer report 2015: the global impact of dementia*. London: ADI, 2015. <https://www.alz.co.uk/research/world-report-2015> [accessed 22 Sep 2017].
6. Barnett K, Mercer SW, Norbury M, *et al*. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet* 2012; DOI: 10.1016/S0140-6736(12)60240-2.
7. Rowe JW, Kahn RL. Human aging: usual and successful. *Science* 1987; **237**(4811): 143–149.
8. Depp CA, Jeste DV. Definitions and predictors of successful aging: a comprehensive review of larger quantitative studies. *Am J Geriatr Psychiatry* 2006; **14**(1): 6–20.
9. Huber M, Knottnerus JA, Green L, *et al*. How should we define health? *BMJ* 2011; **343**: d4163.
10. Butterworth JE, Campbell JL. Older patients and their GPs: shared decision making in enhancing trust. *Br J Gen Pract* 2014; DOI: <https://doi.org/10.3399/bjgp14X682297>.