

21st century health services for an ageing population: 10 challenges for general practice



INTRODUCTION

When Queen Elizabeth II was crowned in 1952, life expectancy was 66 years for males and 71 years for females. By 2001, these figures were 77 and 81 respectively. Average life expectancy at 70 is already 17 years for males and 19 years for females. Old age is often caricatured as a time of ill-health, loneliness, unhappiness, and dependence, but life satisfaction peaks in the 70s and most over-80s rate their health as being good or excellent and say they do not live with life-limiting long-term conditions (LTCs). Most over 65s are neither disabled nor dependent.¹

Despite this good news, ageing does pose significant challenges to health and social care systems, which need to change to meet radically different patterns of demand. I believe there are at least 10 key challenges for general practice in providing care for an ageing population. Several are well-illustrated by articles in this welcome themed issue of the *BJGP*.

MEETING THE EFFICIENCY CHALLENGE

In England, people over 65 years comprise 46% of spend in acute care, 37% in primary care, 60% in social care, 60% of admissions, and 70% of bed days in hospital. Many older patients have complex needs or use multiple services. There is major unwarranted variation between primary care trusts in rates of emergency hospital admission or bed utilisation in over 65s; and in a range of disease-specific processes and outcomes.² We need to focus more on older people with multiple morbidities, whose care should be more prominent in plans for service redesign.

IMPROVING QUALITY AND COMBATING DISCRIMINATION

Older patients often get a poor deal in the NHS and other systems relative to other age-groups.³ Common age-related conditions receive lower priority and older people receive generally lower quality of care than those in midlife with the same diseases. Frailer old people who present with so-called 'non-specific' or 'atypical' syndromes like immobility, falls, confusion, or failure to thrive are often written off as 'social' or 'acopia' instead of being accurately assessed and diagnosed; despite these presentations being entirely typical and the benefits of comprehensive geriatric assessment well-evidenced.⁴ Ageist attitudes or poor communication with older patients and their carers are common. All clinicians, including GPs, need to tackle these; whether through education, training, regulation, legislation, or re-balancing system or contract incentives.

A GREATER FOCUS ON PREVENTION

Most health and social care systems are seen as too reactive to crises or high levels of need, rather than preventing demand and preserving health.⁵ We need to 'invert the triangle', focusing more on prevention across the whole life course and the various stages of old age. Prevention can be 'primary', preventing the onset of LTCs, frailty, or disability (with some of the broader solutions lying in communities, housing, or technology rather than health services); 'secondary', helping those with these problems to remain well; and 'tertiary', ensuring that when people do suffer acute crises or complications they recover well. General practice is a key player in all three. Drewes *et al* illustrate these challenges, exploring GPs' views on prevention for more active older patients and those with frailty or disability for whom preventing functional decline and maintaining independence is the key goal.⁶

PROACTIVE CARE OF OLDER PEOPLE WITH MULTIPLE LTCs

There is a growing focus in health policy on risk stratification, proactive management, care planning, case-management, and telehealth and, for patients with LTCs, with 'anticipatory care', key to preventing deterioration, keeping patients well, independent and out of hospitals, or long-term care.⁷ In England, there is ongoing work

on developing whole year of care payments for patients with LTCs based on level of need rather than disease, with shared risk between primary and secondary care. However, some factors have been missing from many local LTC plans. First, most patients over 75 years have at least three LTCs, so that a 'single-disease' approach featuring the 'usual suspects' (for example, diabetes, respiratory, or cardiac disease) is not fit for purpose.^{8,9} LTC care needs to shift to older people with multiple comorbidities. Second, those 'usual suspects' tend to ignore common and costly conditions associated with ageing, such as dementia, incontinence, mobility problems, and bone fragility. Third, they rarely feature frailty syndrome or disability.

ADDRESSING THE UNTOLD STORIES OF FRAILTY AND AGE-RELATED DISABILITY

Most disabled people are over 65: 90% of those registered blind or partially sighted are over 65, and around 40% of over 65-year olds have significant hearing impairment. While only around 15% of over 65s in England and Wales are disabled, and only half of these are dependent on others for care, these older people account disproportionately for healthcare use and hospitalisation. Frailty syndrome can be characterised as 'poor functional reserve' or defined by weight loss, muscle weakness, slow walking speed, and fatigability. Although frailty only affects an estimated 6% of people over 65, it features highly in resource utilisation: as it underlies the so called 'geriatric syndromes' of falls, immobility, delirium, or incontinence which account for so much bed occupancy in acute hospitals, reliance on home care services, and often triggers the move to long-term care. There are overlaps between LTC management and the care of the oldest old, but they are not completely synonymous.

DEALING WITH DEMENTIA

There are already an estimated 800 000 people in Britain with dementia, projected to double over the next two decades. Dementia has been estimated to cost more to society than heart disease, stroke, and cancer combined.¹⁰ It complicates many other morbidities, so that one in four adult hospital beds is occupied by someone with dementia — with half never diagnosed before admission to hospital in crisis — and around two-thirds of long-term care residents have dementia or cognitive impairment. The

Dementia Strategy in England has prioritised earlier diagnosis and support, which has divided opinion among GPs about potential benefits and harms. Here Phillips *et al* present a fascinating exploration of barriers to dementia diagnosis among GPs;¹¹ next, perhaps, an exploration of interventions to overcome them?

CRISIS INTERVENTION AND RAPID RESPONSE

In addition to a greater focus on proactive care, there is also a need for rapid response to crises and supportive early interventions. Frail older patients are often unable to attend a surgery. They are also often seen in crisis by doctors from out-of-hours services who may be less familiar with their cases. Community nurses see many older people at home, but still value ready access to medical support. The role of the home visit for older patients may be important in service redesign. In this issue, Van Kempen *et al* spell out just how much older people and their families value and benefit from home visits.¹² With the changing nature of general practice, is it too late to turn back the clock? Very short consultations do not allow for the kind of comprehensive assessment and support that the patients described here rate so highly.

MEDICATION

The rising prevalence of LTCs with age inevitably means that long-term prescriptions and polypharmacy are highest in older people, as are potential drug-drug or drug-disease interaction, non-adherence, and iatrogenesis. Incentives such as the Quality and Outcomes Framework, which has done much to drive quality, have also probably led to over-prescribing in our oldest and frailest patients and done too little to drive medication cessation. Articles by Geerts *et al*¹³ and by McCann *et al*¹⁴ illustrate the challenges, describing interventions to improve prescription and monitoring of medications in 'at risk' groups, of older patients with chronic kidney disease and visual impairment respectively.

CARE IN NURSING HOMES

A relatively small proportion of our over 65s are in nursing and residential homes. But they are among the sickest and most complex patients, with multiple comorbidities, disability, a high prevalence of dementia, mobility, or continence problems, and often harmful polypharmacy.¹⁵ Residents too often end up being admitted to hospital as unplanned emergencies, sometimes avoidably and sometimes for end-of-life care. Older people in long-term care have much

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worse access to primary care and a range of community health services than those in other settings, and their care is too often reactive rather than proactive. We need concerted efforts to tackle this problem.¹⁶ McDermott *et al* describe GPs' views on their role in nursing homes and the wider factors that impact on their ability to avoid hospital admissions for residents.¹⁷

INTEGRATION, CONTINUITY, AND SYSTEM LEADERSHIP

Finally, in systems such as the NHS, where primary, secondary, social, mental health, and community health services usually have separate accountabilities, responsibilities, and information systems, patients may suffer care that lacks coordination and continuity. They often feel bewildered about 'who is who', find they have to repeat the same information to multiple professionals, and suffer errors and breakdowns of communication at the interfaces between agencies. Making care 'joined-up' has benefits for whole systems as well as for individuals, and it is crucial in considering older people that we think about every aspect of the care pathway, GPs need to be in the vanguard of driving this change as clinicians and as leaders as they have the best overview of the 'end to end' care pathway and the biggest stake in getting it right. This will require a major shift of focus from traditional ways of working both for GPs and their hospital colleagues, but population ageing is such a 'game changer' for services that we cannot continue as we are.

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Competing interests

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REFERENCES

1. Banks J, Lessof C, Nazroo J, *et al* (eds.). English Longitudinal Study of Ageing (ELSA). *Financial circumstances. Health and wellbeing of the older population in England. The 2008 English longitudinal study of ageing (Wave 4)*. London: Institute for Fiscal Studies, 2010.
2. Department of Health. *The NHS Atlas of Variation, 2011*. London: DoH, 2011.
3. Centre for Policy on Ageing. *Ageism and age discrimination in health and social care in the UK*. London: CPA, 2009.
4. Ellis G, Whitehead M, Robinson D, *et al*. Comprehensive geriatric assessment for older people admitted to hospital: a meta-analysis of randomised controlled trials. *BMJ* 2011; **343**: d6553.
5. Allen K, Glasby J. *The billion dollar question: embedding prevention in older peoples services – 10 high impact changes*. Birmingham: University of Birmingham Centre for Health Services Management, 2010.
6. Drewes YM, Koenen JM, de Ruijter W, *et al*. Perspectives of GPs on preventative care for older people: a focus group study. *Br J Gen Pract* 2012; in press.
7. Department of Health. *Long term conditions compendium of information*. 3rd edn. London: DoH, 2012.
8. The Kings Fund. *The management of people with long term conditions*. London: Kings Fund, 2010.
9. Barnett K, Mercer S, Norbury M, *et al*. Epidemiology of multimorbidity and implications for healthcare, research and medical education: A cross-sectional study. *Lancet* 2012. [Epub ahead of print] [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)60240-2/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60240-2/fulltext) [accessed 9 Jul 2012].
10. Alzheimer's Society. *Counting the cost of care for people with dementia in hospital wards*. London: Alzheimer's Society, 2009.
11. Phillips J, Pond CD, Paterson NE, *et al*. The difficulties in disclosing the diagnosis of dementia: a qualitative study in general practice. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X653598.
12. Van Kempen JAL, Robben SHM, Zuidema SU, *et al*. Home visits for frail older people: a qualitative study on the needs and preferences of frail older people and their informal caregivers. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X653606.
13. Geerts AFJ, Scherpbier-de Haan ND, de Koning FHP, *et al*. A pharmacy medication alert system based on renal function in older patients. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X653561.
14. McCann RM, Jackson A, Stevenson M, *et al*. Help needed in medication self-management for people with visual impairment: case-control study. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X653570.
15. British Geriatrics Society. *A quest for quality in nursing homes*. London: BGS, 2011.
16. British Geriatrics Society. *Failing the frail: a chaotic approach to commissioning healthcare services for care homes*. London: BGS, 2012.
17. McDermott C, Coppin R, Little P, Leydon G. Hospital admissions from nursing homes: a qualitative study of GP decision making. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X653589.