EUGMS PRESIDENT-ELECT PROFESSOR FINBARR MARTIN OUTLINES HOW THE PROVISION OF HEALTHCARE FOR OLDER PEOPLE COULD BE APPROACHED, INCLUDING ADDRESSING HEALTH INEQUALITIES AND PRIVATISATION

The new reality

The World Health Organization (WHO) predicts that the number of people aged 85 years and older in Europe will rise from 14 million to 19 million by 2020 and to 40 million by 2050. While this population ageing can be seen as a success in terms of public health policies and for socioeconomic development, the WHO also warns that that success will not come without challenges.

Over the last 50 years, geriatric medicine has evolved as a specialty to meet the challenges of the increased complexities of healthcare in later life. Blending the principles of gerontology (the science of ageing), internal medicine, rehabilitation and palliative care, geriatric medicine is now recognised as an effective instrument to deliver high-quality, humane, interdisciplinary, appropriate and cost-effective care to older people, proportionately the most significant group of healthcare users in all European populations.

Pan European Networks asked the president-elect of the European Union Geriatric Medicine Society (EUGMS), Professor Finbarr Martin, about some of the ways in which the provision of healthcare for older people needs to be approached.

When it comes to the provision of healthcare for older people, what are the biggest challenges posed by the ageing demographic?

The challenge for health services is essentially that they need to re-orientate their understanding of what healthcare is, and how they arrange themselves to meet the needs of the different populations that we have in Europe. As such, the problem is not the demographic; it is the speed and time it takes for the health services to adapt to reality.

Finbarr Martin

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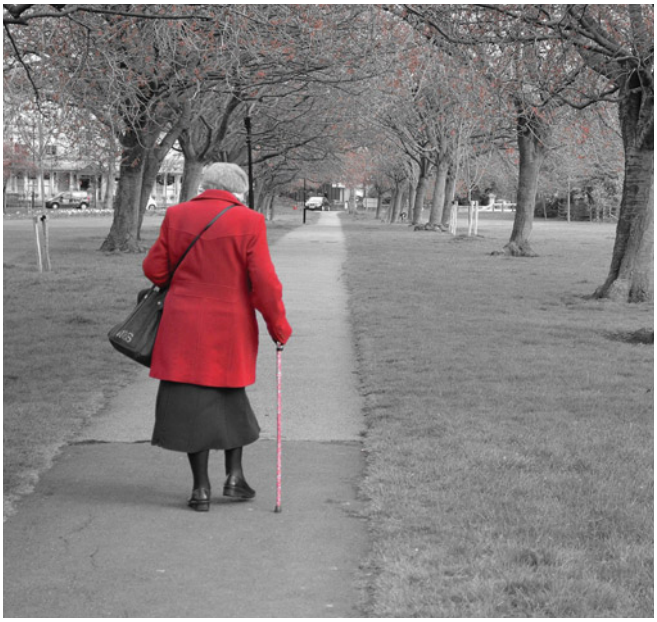
Is that a policy problem?

The proposition from politicians is that if we develop more comprehensive health and social care provision in the community, then significantly fewer older people would need to go into hospital. This is a speculative proposition with limited evidence. Certainly, there is some evidence that it is possible to reduce the number of hospital admissions in various ways, and as geriatricians we are keen to achieve that, but developing the skilled workforce and the right models of care takes time. Additionally, an overemphasis on this could have a very negative influence on the mindset of the modern hospital.

We need to accept that the majority of the acutely ill people in hospital are going to be older people because most people are dying old now, and they tend to have therefore accumulated more long-term conditions, with dementia being perhaps the most important. As a result, the nature of the task at hand is somewhat different than it would have been 20 or 30 years ago – perhaps not fundamentally different, but it is a matter of proportion.

As such, hospitals need to make sure that they are able to meet the needs of ill older people – and not only older people, but younger people who present similar challenges of multimorbidity, sometimes related to drug and alcohol problems, for instance.

Policy therefore can be seen to be an issue in that the efforts to improve prevention and to provide alternative and community-based responses to illness and frailty could divert attention from the equally essential task of age-attuning hospitals. This view, that a realignment of health services is necessary, is also promoted by the WHO, and the UK government (like many others) signed up to a series of statements which included realigning healthcare systems for the ageing population at the World Health Assembly last year.



The evidence shows that many people with poor hearing will simply respond by getting depressed and isolated

It is not only about policy, however; it is also true that we healthcare professionals have also been too slow to adapt our current systems to the new reality. For example, research has shown that some 70% of people aged over 70 who are admitted to hospital for routine operations on their vascular system have some degree of cognitive impairment. What that means is that this is a group of people going into a surgical department for a planned procedure carried out by vascular surgeons who have been highly trained to deal with the blood vessels of those patients, but not to deal with the very high risk of delirium or post-operative complications associated with this cognitive impairment and other aspects of frailty.

Historically, there has been a clear-cut organisational division between surgery and medicine which is increasingly redundant. For example, in most areas, the complications that people experience after operations are now due to medical problems; the surgeons successfully do their jobs, and very few people die due to complications with anaesthetics, but there are departments and teams of doctors and nurses dealing with an outdated paradigm, and that is for us as professionals to address. This is already happening, but once you follow the logic of that it is clear that the nature of some elements of the education and training that is provided for healthcare practitioners requires modification.

Given these points, the answer to your question is that the problem is not the demographic, but the fact that we haven't reoriented to the reality of our patients.

The risk of being 'poor' increases after retirement age in western Europe (especially in the UK). What added societal challenges does this pose, and how can they be addressed alongside the healthcare system challenges (given that the two areas are inextricably linked)?

I agree, and this is related to the wider issue of health inequalities, which get greater as you get older. So, whilst both healthy life expectancy (the time before people develop a disability) and total life expectancy (the time that people have before they die) have increased significantly in the last few decades, the figures also show increasing socioeconomic inequality over the same period. In the UK, for example (although this is perhaps true more generally across Europe), the proportion of the added years which are spent healthy is greater for those with better socioeconomic circumstances.

On average, UK pensioner households are much better off than in previous generations: the so-called 'baby boomers', generally speaking, aren't going to be poor (though there is an increasing sense that their children will be). Within this ageing generation, inequality persists and contributes to differences in happiness as well as health in older age. There are, of course, many countries in Europe where there is increasing poverty in old age, but it is quite patchy, and in most countries the socioeconomic spectrum is significant.

The way in which we can begin to respond to the lack of either social or financial resources for a lot of people is essentially to increase the provisions which are not personally owned. This could include, for example: leisure centres that are older person-friendly and have cheap and accessible activities; transport systems such as single-deck buses that visit back streets or rural areas which typically lack public transport links; and the availability of healthy foods in quantities that people want and that don't financially compromise them. This can often be done through social enterprises and other forms of local distribution. Where that has happened, it has proved very popular.

What we need to look at is all the things that make a difference to people's sense of involvement in society, their ability to participate in what is out there in terms of social and leisure facilities, transport, the cinema, and so on, as well as their access to food. We have to look at that from the point of view of people who haven't got much in the way of personal resources – not only in terms of financial resources but also in reference to people who lack the confidence to solve some of their problems. Indeed, much of this relates to other issues, such as intergenerational solidarity and social cohesion, and there are big opportunities for tackling issues of poor access in these ways.

Certainly, and that perhaps also highlights just how important it is to acknowledge the fact that mental health is tied in very closely to physical health and, indeed, that things like loneliness – which can lead to more physical and psychological illnesses – are also significant issues for older people.

Yes, that is true. If you think of poor health outcomes as being the loss of the function to be able to do what it is that you want to do, as well as dying, then the things that are predictive of that in middle age and coming into old age are vision and hearing problems, low mood, cognitive

problems, malnutrition, and poor mobility, and there is a twin approach to the extent to which those things impact functional ability.

On the one hand, we need to identify earlier those people who are beginning to lose some of those intrinsic capacities and begin to address them; and, secondly, we have got to look at how these things actually result in people being isolated and disabled, and tackle those societal issues, too. For example, are older people able to access free health checks and free vision checks, and so on? But we need to do a lot more work on identifying early hearing impairment and making it easier for people to have hearing aids that work and making sure that they are able to replace the batteries easily when they need to, as the evidence shows that many people with poor hearing will simply respond by getting depressed and isolated. Simplifying free access can be tackled by using more outlets, including private high street providers.

This is perhaps a good example of the extent to which health inequalities should or can impact the way services are offered. That is, at the moment, our services are not necessarily set up in a way that makes it easier for people who are not accessing them to do so – even though health professionals and even more social care professionals fully understand health and social care inequalities.

We need to acknowledge that the way health systems interact with people will have to begin to accommodate the large numbers of resource-poor people, and resource-poor is not just poor in financial terms, it is also poor advocacy; they may have nobody to advocate for them and may lack initiative or confidence. We therefore need to think more about how we are going to do that, and again this has to take into account the fact that these problems occur five-to-ten years earlier in poor people than in rich people.

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Do you feel that more needs to be done to better understand – and perhaps address – public expectations of healthcare systems?

In general, it is probably still true that the people with the greatest need make the least demand. However, that is becoming less so, and the reports from general practice certainly suggest that a lot of people whose problems essentially can't be solved by primary care are continuing to approach it (and sometimes emergency units, too). Thus, there probably is an element to which some people who have intractable difficulties in their lives haven't yet found a way of responding to them apart from going to healthcare services which haven't got a solution, and that is an issue.

In general terms, telling people not to go somewhere where the light is on doesn't work; you have to get a light on somewhere else. Perhaps the solution for that can be found by identifying the nature of why people are perhaps becoming more demanding and trying to see whether alternative responses or outlets can be developed within society.

There is still an appreciable number of people who don't get what they could out of the health service, and so we have to be clearer about

what's preventing them from doing that. We need to ask whether the way we have set ourselves up is making it difficult for them. Or is it their low expectations of their own health? It is a complicated message, because while we don't want people wasting the health service's time, there are those who will persuade themselves that they are the ones who should be staying away when, in fact, they are probably the ones who need help.

Does the privatisation of national health services hold answers to some of the challenges facing geriatric medicine?

I don't think so. Privatisation can take elements from what we deliver when they are easier to predict in terms of volume, delivery and cost (such as, for example, community outpatient physiotherapy). The problem, however, is that this could result in a health system that is essentially doing all the hard bits, which financially doesn't make a lot of sense. That is not to say, of course, that the private sector hasn't shown how some things could be done better, not least because the health service generally can be complicated and cumbersome.

Given that a one-size-fits-all approach to these issues is impossible, how could a more holistic approach be achieved in the European region?

EUGMS's mission is to promote geriatric medicine in Europe, and that includes promoting it where it doesn't yet exist. Indeed, one of the things we have done is collaborate across Europe, looking at the requirements of expertise for doctors to work in care homes. That is something which varies widely. In some places, specialised training is required by regulation; in others, any doctor can work in this setting. If you then look at the nature of the medical work in care homes, particularly care homes with nursing, it is actually really quite difficult medicine, and GPs generally don't like doing it.

Having demonstrated that there is enormous variety, we are now looking at the competencies and to produce a statement of what we think these are for regarding medical work in care homes. That, we hope, will help individual countries to decide how best to get the right workforce, which may be a partnership between general practitioners and geriatricians.

If we begin to articulate what the competencies are, then it becomes possible to look for alliances. For example, at the European level, the AGE platform holds that some specialist knowledge and skills are necessary to work in this sector, but if we said it can only be done by geriatricians, this would be resisted.

We have also collaborated through the Union of European Medical Specialists (a non-governmental organisation representing national associations of medical specialists in the European Union and in associated countries). Working with this body, EUGMS members have articulated what an undergraduate curriculum should look like in order to train the future medical workforce for a changing population. We are also in the process of doing the same for postgraduate training.

Furthermore, through the European Institute for Collaboration on Ageing (EICA), we have now started another stream of work to start collaborating with other medical specialists to develop training programmes that will help those other medical areas work more effectively with older people.

At the European level we are working with the European Medicines Agency (EMA), which, at the moment, hasn't adequately reflected in its requirements the fact that many drugs used for older people haven't been researched sufficiently within this population. Through working with the EMA we hope to improve the requirements of the incorporation of older people in research and guidance about medicines that are used predominantly on older people. That is, again, something that will impact the practice of many different types of doctors who have older patients, and we feel that our job, in a sense, is to try and spearhead that.

We also believe that geriatric medicine as a specialty should be established in all European countries, and it currently isn't. Last year we held our congress in Portugal, and we chose this location because many internal medicine specialists and general medicine specialists are beginning, in a sense by default, to work with older people because there are very few geriatricians there. We wanted to increase the profile and esteem of medically working with older people. We therefore held our congress there in the knowledge that most of the Portuguese people who came would not be geriatricians, but we wanted to let them know that specialist knowledge is out there and that while they may not be geriatricians by title, if they are working with older people, they can benefit from that.

Of course, we also try to form alliances where small groups of geriatricians exist in some countries to try and help them formulate arguments for an expansion of their specialty, but the specialty cannot exist as a silo: it must collaborate with other professionals, public and patient organisations, and regulators because the realignment of healthcare for an ageing population is everybody's business.

Professor Finbarr C Martin MD MSc FRCP
President-elect
European Union Geriatric Medicine Society (EUGMS)

http://www.eugms.org/home.html

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