Preventive home visits to elderly people

Their effectiveness cannot be judged by randomised controlled trials

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In preventive health services the old axiom that lack of evidence is not evidence of lack is important. No one should be surprised that the meta-analysis undertaken by Elkan et al (p 719), the systematic reviews by Stuck et al and van Haastregt et al, and the randomised controlled trials undertaken by these and other researchers produce apparently conflicting results.[1–3] Most importantly, the lack of a clear justification for preventive home visits to older people, in terms of the outcomes of mortality, institutionalisation, and particular measures of function, should not be used as an excuse for discontinuing the service.

Some of the limitations of meta-analyses and systematic reviews were identified in the correspondence that followed the publication of van Haastregt's review.[3] The reliance of these approaches on randomised controlled trials recognises that such trials are the most rigorous form of assessing the effectiveness of medical interventions but fails to recognise that they may not be adequate or appropriate for evaluating services such as home visiting. These services comprise a complex mix of uncontrollable independent variables embedded in what is more a social process than a treatment programme. Studying home visiting as an intervention in randomised controlled trials is analogous to studying drug treatment without specifying the drug or its dosage. To dismiss the effectiveness of health visiting on the basis of currently available studies of home visiting is like dismissing the effectiveness of aspirin as a remedy for headache on the basis of a study in which the dose was 10 mg and the headache was caused by a brain tumour.

Evaluating the effectiveness of health visiting—and especially decisions on whether, how, and to whom the service should be provided—requires a much better understanding of health visiting than we have now. Such questions cannot be answered by randomised controlled trials. McNaughton's useful review of qualitative research on home visiting shows that the success of specific interventions in a visit, such as providing health information, depends on the achievements in earlier stages of the visit, including building a relationship with the client (a complex multistage process) and getting to know them (much more complex than the use of specific assessment tools).[4] Factors that affect the achievement of these preintervention stages include the client's previous experience of home visits; past experiences of health care; other interpersonal relationships; and the perceived need for a home visit (the voluntary nature of the health visiting service creates challenges that are very different from those of the demand led services of doctors); the views of the client's family; and the source of the referral for home visiting. It is unlikely that such factors could be controlled in such a way as to meet the requirements of randomised controlled trials. The royal commission on long term care said, "Further longitudinal research is necessary to track the processes and outcomes of preventive interventions and to assess their impact both on quality of life and long term costs."[5] Unfortunately such research is expensive and not encouraged by present funding arrangements.

The selection of outcome indicators is also important and reflects the orientation and goals of the discipline within which the study is being undertaken. Different disciplines value primary, secondary, and tertiary prevention differently. The medical model focuses on disease, values secondary prevention, and seeks the reduction of mortality and morbidity as outcomes. Health visitors use other models that value primary prevention and focus on goals such as empowerment, autonomy, independent decision making, improved self esteem and self confidence—outcomes that are far more difficult to measure than mortality and morbidity. Has any research sought to identify which outcomes older people themselves would select as indicators of effective services?

The royal commission on long term care pointed out that preventive strategies for older people are supported by two arguments. Firstly, by delaying the onset of disability and dependency, preventive strategies prevent, or at least postpone, the need for more intensive and therefore more costly forms of care. Secondly, they improve the wellbeing and quality of life of older people. The commission noted that although there was more evidence to support the second argument than the first, both arguments were valid. The report from the Continuing Care Conference claimed, on the basis of analyses by the Department of Health, that if morbidity rates could be reduced by a modest 1% a year, then the costs of publicly provided formal care would be reduced by 30% (£6.3bn a year) by 2030.[6] The real issue, however, may have nothing to do with research at all. A recent review of health visiting services in Wales found that home visits by health visitors to older people had almost disappeared—not as a result of any demonstration of their effectiveness or otherwise, nor even as a result of a deliberate policy decision, but simply by default, because older people were not seen as a priority.[7]

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BMJ 2001;323:708