Ageing Britain — challenges and opportunities for general practice

THERE is a greater number of older people in the population than ever before; this is expected to increase so that by the year 2040 one-quarter of the total population will be over 65 years of age and the number of black and minority ethnic older people will have increased tenfold. The challenges and opportunities these facts present to general practice are considerable and there is already evidence that in many ways general practice is failing to meet them. Indeed, the misleading description of the 'demographic time bomb' may itself have scared primary care practitioners away from thinking constructively about ageing well and dealing with the problems that will occur in most people's lives.

The issues thrown up by the demographic changes and their implications for the future have been examined in a nationwide public consultation exercise, organised by Age Concern England and entitled the 'Debate of the Age'. The discussions were informed by the published reports of specialist study groups[1] and one of the papers was concerned with the future of health and care. A number of issues of importance to primary care were identified[2] but, in addition to these, there are others that need attention.

Discrimination

Discrimination against older people is both widespread and widely tolerated in the National Health Service (NHS),[3] exemplified by a number of reports relating to topics such as the investigation and treatment of heart failure,[4] coronary care,[5] cancer care,[6] and renal disease.[7] A wider spectrum was shown in an NOP survey[8] that sampled the views of general practitioners (GPs) and found that 77% of interviewed GPs claimed that age rationing occurs despite government assurances that treatment is based on clinical need alone. Sixteen per cent said that older people have to wait longer for NHS treatment than other people and 33% said that older people do not enjoy the same quality of care in hospital that others do. While 95% of GPs support the principles laid down in the General Medical Council's code of Good Medical Practice,[9] 42% said that priority is not given on the basis of clinical need. No wonder that nearly half the GPs interviewed had concerns over the way the NHS would deal with them when they became old. Discussions within groups of older people indicate that this is an area of considerable concern to them as well. They are proportionately more likely to favour rationing on grounds of age than other age groups but that may only reflect a degree of selflessness. What is clear is that there is a need for far greater clarity and transparency about the factors which are taken into consideration in health care rationing, and by whom those decisions are taken.

The majority of general practitioners said they did not discriminate on the grounds of age; however, 15% did so either because the patient had already had a 'good innings' or because they believed that limited resources should be prioritised to younger people. At the recent British Medical Association annual conference a number of GPs spoke in favour of the proposition that younger people should come before the elderly. 'If we accept that rationing exists, age has to be entered in, not as the main factor but as one of the factors,' said one speaker.[10] This statement is based, we believe, upon the mistaken concept that a lifetime is lived in separate units of steadily diminishing importance and that beyond a certain point all the value has been used up. Once a 'good innings' has been achieved then value is exhausted. This immediately begs the question: what constitutes 'value'? Less abstractly, it is also contradicted by historical fact as well as the experience of most GPs. Nelson Mandela would have used up the greater part of his value while still a prisoner on Robben Island. Winston Churchill was well into his seventh decade of life before he became Prime Minister. Most GPs can recall numbers of people for whom they have had to battle in order to obtain care and who have then fulfilled a full range of their aspirations and hopes.

Discrimination manifests itself most dramatically in the decisions not to resuscitate, and more commonly in the upper age limits placed on a range of treatments and surgical procedures. However, it manifests itself most subtly in the lack of respect, removal of personal autonomy and depersonalisation commonly handed out to the elderly, especially when handicapped or vulnerable in some way.

Ageism should be as unacceptable as sexism and racism and the ingrained attitudes giving rise to this behaviour require much attention by receptionists, nurses and doctors in primary care. This is primarily an educational task but requires clarification within NHS thinking about the value to society of all age groups. That does not necessarily mean treating older people in exactly the same way as younger people, or even — arguably — providing all the most aggressive therapies for them. It does, however, mean equal respect and equal consideration — being, in other words, considered of equal value.

Elder abuse

Elder abuse is a topic to which some attention is paid today; however, while child abuse routinely hits the headlines, elder abuse seldom receives the mindfulness that it is due. There is not now, and may never be, a reliable measure of the incidence and prevalence of elder abuse, either in the community or within institutions. This is partly because of the difficulty in definition — elder abuse comes in many forms, including physical and psychological abuse and financial exploitation — and partly because of the difficulties in collecting accurate data. It is even difficult to be certain that the more handicapped are most at risk or that those in institutions are more at risk than those looked after within the family.[11] Clough[12] suggested that abuse within institutions was more likely when nursing and hygiene standards were poor. The use of the nose when visiting institutions can be a very valuable guide to this. Elder abuse is not uncommon and, while depression or behavioural changes in older people are more likely to be owing to other causes when they exist in an unexplained setting, abuse should at least be on the list of differential diagnoses.[11] The over-prescription of drugs, especially tranquillisers, to control behaviour causes great offence to relatives and friends visiting the older person in a home. 'The picture of older people sitting in a drug-induced stupor in front of a non-stop television set, in a nursing home, arouses universal dismay'.[2] Early signs of physical abuse, such as recurring or unexplained injury, require a high index of suspicion. Vigilance is needed within the whole primary care team if the security of this vulnerable group is to be effected.

Carers

The importance of carers is acknowledged and the primary care team has a very important role in supporting them. The provision of respite care is generally inadequate and often only available when care is on the verge of breaking down altogether. This is a highly unsatisfactory situation that causes great anxiety to both patient and carer, once it has arisen. Pressure for more and better services in this area is required.

Palliative care

End-of-life issues include the right to dignity and the requirement to take into consideration the dying person's wishes. Autonomy is particularly important towards the end of life and all general practices should have clear policies about how they handle such issues as, for example, refusal to accept treatment and advance directives (known sometimes as 'living wills'). Both of these matters require that information is available and readily understandable to enable older people to make necessary choices.

Accessibility

Another major issue troubling the older person relates to the accessibility of services. Most practice premises are reasonably accessible to older people and, with most, there is good light, adequate space, easily accessible toilets, and an absence of stairs. Not all premises have such standards and those that do not require attention. What should be remembered is that one-quarter of people over 60 have some sort of mobility impairment and currently one-half do not have access to cars. During the next few years, car availability is likely to increase but it does mean that already substantial numbers of older people have difficulty in attending practices, even for such matters as picking up a repeat prescription. At the same time the number of people substantially over 80 years of age will increase and that may outweigh any gain that an increase in car access provides. House calls may yet re-emerge as an important feature of care in the community, and indeed perhaps they should. Increased access for older people to the new information technology will impact upon the way health care is delivered. It is simply not true that older people are 'technophobes'. A recent survey[13] has shown that 25% of those older than 50 now use a computer, spending more time on this than watching TV. Already, shopping on the Internet for groceries has ceased to be a rare phenomenon. Many pharmacies deliver repeat prescriptions to people in their homes. Information about aspects of health care is now so widely available upon the Internet that it is bound to affect the pattern of demand. This does mean that primary care teams will have to give serious thought to how they are going to meet the needs of better informed older people and not base systems on middle-aged, mobile populations.

Homes

In too many cases, the medical care of older people in nursing and residential homes is barely adequate. Managers of such homes speak of the difficulty in obtaining good medical supervision on a continuing basis as well as emergency care when needed. Relatives have problems in getting to talk to the doctor responsible and in obtaining information. Too often, the vulnerable are spoken to in a patronising way, denied choice, and inadequately informed. Medical care is occasionally perfunctory and shared between varieties of individuals. Individual doctors and nurses often do not get to know their patients well and record systems do not facilitate continuity of care; for example, nursing records kept within the home while general practice records are kept at the surgery with records relating to social care kept in another place.

Palliative care has made considerable strides over the past two decades but, although the majority of older people wish to die at home, the vast majority eventually die in hospital, which comes a poor third to home or the hospice in most surveys. Better training is needed for members of the primary care teams as well as more resources devoted to domiciliary care.

The role of primary care

However, Primary Care Groups (PCGs) and Primary Health Care Teams (PHCTs) have not yet got up to speed in most of these areas. They must recognise older people and the needs of carers; they must recognise isolation among the elderly and be aware that there are many ways of dealing with it, whether it is organised by local social services or managed by PCGs or PHCTs themselves. The new agenda for PCGs and PHCTs requires issues for older people to be at the very top and a recognition that older people lack 'asking power' to underpin their decision-making.

What should be clear to the caring professions is that if the care of an older person is not of the quality and responsiveness that a doctor or nurse would want for their own relatives then it should not suffice for the parents of others. Primary care has a duty to see that a dependent older person has just the same access to high quality care as does a younger and independent patient.

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Is it time to review the idea of compliance with guidelines?

GUIDELINES were intended to be aids to decision-making by patients and practitioners;[1] however, we do not use them in this way. Instead, they are used to modify the clinical behaviour of practitioners and reduce inappropriate variations in care. It follows that the measure of success of a guideline has not been whether it has assisted in decision-making, but whether patients and practitioners have complied with it. Yet the distribution of guidelines to practitioners usually has virtually no impact on performance. Therefore guideline developers, like the quality assurance enthusiasts who came before them, have launched a quest for effective methods of achieving compliance. Such methods are generally referred to as 'implementation strategies'.

Some implementation strategies appear to be more effective than others. In summarising the findings of 18 systematic reviews, Bero and colleagues were able to identify several strategies that generally had some effect (educational outreach visits, reminders, multifaceted interventions, and interactive educational meetings).[2] A number of other strategies were of variable effectiveness (audit with feedback, local opinion leaders, local consensus procedures, patient-mediated interventions) and some that have little or no effect (educational materials, didactic educational meetings). However, no strategy is invariably effective. Practitioners and their patients appear to be remarkably resistant to the efforts of implementers. In consequence, researchers have begun to investigate the reasons why practitioners are so non-compliant. The NHS Centre for Reviews and Dissemination summarised the findings of reviews of implementation studies and concluded that most strategies can be effective under some circumstances, but none is effective under all circumstances.[3] Several theoretical models were suggested, and implementers were advised to undertake a preliminary analysis of the prevailing circumstances and barriers to change. Other problems may be simpler to resolve, such as the size of the guideline (short ones are preferred[4]) or the format of the system for grading the recommendations.[5] Interest has also turned to health care organisations — how do they support or hinder the ability of practitioners to act on guidelines?

A paper by Frijling and colleagues[6] in this issue points to another factor that is likely to be important. They investigated the care given by Dutch general practitioners to people with hypertension and found — as we should by now have learnt to expect — wide gaps between guidelines and clinical practice. General practitioners clearly found it difficult to achieve the recommended target levels of blood pressure control. I am familiar with this problem in my own practice. Is the blood pressure consistently raised, or is it just high today? Is it reasonable to give this outwardly healthy person yet more medication despite the risk of side-effects? Why should they respond to my advice about weight loss when they have ignored it for years? How can I check compliance without causing offence? To comply with the guideline, the practitioner must address these issues efficiently and in a manner acceptable to the patient. It is quite a challenge. To act on the guideline the practitioner needs special skills in the consultation and adequate time to apply those skills.

Is it now time to abandon the concept of compliance with guidelines, and view the problem from a different perspective? The development of guidelines that are of genuine help to both patient and practitioner would be a good start. Such guidelines would be easy for both to understand. They would present clear information about the management options available and the likely consequences of each. They would be available in a variety of forms to suit the needs of the patient. There would be fewer guidelines for the same topic. As far as hypertension is concerned, the guideline should enable the patient to decide what level of cardiovascular risk to accept and how to reach that target.[7] In monitoring the effect of the guideline, the extent to which they have assisted decision-making will be examined. If they have been of assistance then the consequences for outcomes should be determined. Eventually we might have guidelines that do assist decisions and therefore influence outcomes.

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