Making Our Health and Care Systems Fit for an Ageing Population: Considerations for Canada

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ABSTRACT

A report from the United Kingdom on making health and care systems fit for an ageing population proposes a range of interventions to make care better for older adults, especially those who are frail. Here, we discuss the proposed shift for the acute care hospital to other models of care. The key for these models of care requires a fundamental shift to care that addresses the full range of an individual's needs, rather than being based around single diseases. How this might apply in the Canadian context is considered. We emphasize strategies to keep people out of hospital but still receive needed care, make acute hospital care less hazardous, and improve the interface between acute and long-term care.

Key words: frail older adults, acute care, hospitals, intermediate care, long-term care

INTRODUCTION

Geriatricians in Canada have long looked to our colleagues in the United Kingdom for inspiration and guidance. A recent report by David Oliver, Catherine Foot, and Richard Humphries on behalf of the King's Fund raises many issues regarding current problems with the care for older adults in existing health-care systems and also suggests ways forward.[1] Given our long association and shared history (the debt that we owe includes many of our pioneering clinicians), there is reason to read *Making Our Health and Care Systems Fit for an Ageing Population with Care*.

Here we hope not to summarize a lengthy and comprehensive review of many aspects of the health-care system, which are either problematic or promising in the care of frail older adults, but rather to highlight a few key issues which may help guide our thinking about the future of Geriatric Medicine in Canada.

One key shift in mindset argued for by Oliver and colleagues is an increased focus on community-based and intermediate care as alternatives to acute-care hospitalization. Hospital-centred care has such a strong culture that sometimes avoiding it can be more effective than trying to reform it.

COMMUNITY-BASED CARE

The framework of "discharge to assess" versus "decide to admit" presents a useful alternative to our current "admit by default" acute care-centered paradigm. In a "discharge to assess" model, acute health needs are the focus of acute care encounters. Patients are then discharged home, as soon as their condition has stabilized, for rapid follow-up of ongoing care and support needs by community-based clinicians. Alternatively, clinicians can actively decide to admit patients who require admission for specific medical therapies, rather than having admission be the default path of least resistance. Much stands to be gained from designing our systems of care to focus on care in the community and in the least acute setting possible, rather than subjecting older adults to the harms that are well-known in acute care and that typically have defied reform.

Solid systems of care in communities can also potentially streamline assessment processes and avoid duplication of efforts. Some jurisdictions in the UK have even recognized that the assessment and therapy needs of older people living in their own homes do not take weekends off, leading to implementation of "seven day" care at home.

There are different styles of geriatric practice. In Canada, it would seem that we have an opportunity to chart a new course. We can "skate to where the puck is going" (as Wayne Gretzky famously said) and get out in front of the move to community-based care.

INTERMEDIATE CARE: LESS IS MORE

Our patients still will have complex care needs. In consequence, the important role remains for clinical specialists working in tandem with primary care systems and clinicians and (in an ideal world) an organized form of so-called "intermediate care". Such facilities aim to offer an environment

in which rehabilitation and recuperation can be the primary focus, rather than settling onto the treadmill of yet more investigations which may add less benefit to frail patients then do solid clinical acumen, and a focus on improving function and meeting goals that are truly patient centered. It also means making routine care less hazardous—for example, by avoiding the twin evils of over sedation and inadequate pain treatment—and promoting early mobilization, proper nutrition, interprofessional collaborative practice, and early involvement of patients and families in setting goals of care.

When it was introduced, intermediate care was quite controversial, as it appeared to harken back to the regrettable era in which geriatric medicine was viewed as an undertaking of care for second-rate patients in second-rate facilities by second-rate doctors.[2] In a sharply worded 2001 *BMJ* commentary, Raymond Tallis and Grimley Evans argued that in the operationalization of the UK National Service Framework for Older People, the good intentions of clinical experts were sidetracked by the political agenda to "keep old people out of hospital" by reducing their "inappropriate" use of hospital beds, an agenda largely driven by cost savings but which had undertones of value judgments on the patient population, as well.[3] In any event, renewed focus on good intentions and the evidence base (of reducing harmful interventions and environments which thrive in acute care hospitals) allows the benefits of intermediate care, with its focus on sensible medical care, rehabilitation, and re-enablement, to be realized.

The idea of "intermediate care" might sound pejorative still, but it should be recognized that it can be either a "step up" (from care at home) or a "step down" (from acute care hospital). Here, less is more: ideally, intermediate care is provided close enough to acute care that clinicians have an easy commute, but far enough away to allow them to avoid the temptation to over-investigate and treat what need not be investigated or treated. For many frail older people, the trap of access to invasive investigations that are too easy and too often-used, again by default, is a deep one. Still, in an era in which patients labelled as "subacute" can be very ill,[4] and those labelled as "social admissions" have a high risk of death,[5] we need to be alert that words matter, especially when they are meant to designate whole areas of activity; they're not called "brands" for no reason.

ALTERNATIVES TO ACUTE-CARE HOSPITALS

In recent years there has been an increasing focus on efforts to keep frail older adults out of Emergency Departments. While these efforts may be well intentioned, Emergency Health Systems, including paramedics, ambulance services, and Emergency Departments, remain an important point of access to care when need is greatest.[6] In consequence, we should seek not to turn people away who need help, but rather to create better pathways of care once they have reached out for assistance.

For example, once a 911 call is made, if paramedics are trained and equipped to provide assessment and care on-site, a transfer to hospital may be avoided. Even so, this can only work sustainably if care in the home does not end when the ambulance pulls away from the curb. Clinical care programs focusing on rapid follow-up of older patients discharged from Emergency Departments (e.g., home visits by specialized clinicians trained in the principles of home-based Comprehensive Geriatric Assessment [CGA]) show great promise in Canadian settings and should be a focus for implementation and, importantly, evaluation and research.[7]

Our current models of care for frail older adults have been heavily hospital-based. Given that hospitals can do more harm than good for frail older adults, this is not unproblematic. Alternatives include:

1. Keeping them out of hospital in the first place (geriatricians will have a pivotal role here, with familiar principles of CGA and optimizing function, to which we would add a key role for advance care planning);
2. Making care less hazardous in the hospital (here we see a great role for intermediate care and attention to cultures of care which minimize iatrogenic and environmental harms); and
3. Attention to the interface between acute and Long-Term Care—this will have both clinical and administrative aspects—with an emphasis on home supports that are flexible enough to meet the needs of users.

EARLY PRIORITIES AND QUICK WINS

The King's Fund report challenges us to "identify early priorities for change and quick wins". We also need to focus on what our brand will be, if we are to prosper, and not just compete, as Canadian health care comes to grips with population ageing.[8] What would be our quick win in a Canadian context? Community-based care, while perhaps not entirely quick, could be that win.

CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

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