Needs of Older People in the Community

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The Hong Kong population is ageing rapidly. According to the HK Census data, there are about 900,000 people aged 65 and over (or 13% of the population) in 2007, which is double that for the past two decades. The number is projected to rise to 2.1 million (or 25% of the population) by 2030. Yet our society is ill-prepared for how the elderly should be cared for in the community, in terms of knowledge of diagnoses and management of geriatric syndromes and availability of complementary multidisciplinary team support in primary care. In general, patients are managed as adults or children, ignoring the growing number of elderly people within the adult group who require different management approaches that deal with multi-morbidity, physical and cognitive functional decline, poor mental health, and increasing frailty. These are intertwined with social needs as dependency increases. A ‘typical’ patient would be an 80 year old woman with hypertension, diabetes, renal impairment, osteoporosis, declining visual acuity from age-related macular degeneration, anaemia, sarcopenia, incontinence, frequent falls, depression, taking 15 prescribed drugs, and partly dependent on a carer.

In primary care, management is often focused on individual diseases, according to evidence-based guidelines. Yet this approach ignores the fact that evidence is derived from a different population with single disease only, and not to the ‘typical’ elderly patient described above. A comprehensive assessment of the patient covering functional, psychological, nutritional, and social domains is seldom carried out as a result of lack of time or expertise, and it is not surprising that patients’ needs are not met. It has been pointed out that there are potential pitfalls of disease-specific guidelines for patients with multiple conditions, and that following guidelines for an elderly patient with chronic obstructive pulmonary disease, hypertension, diabetes, osteoporosis and osteoarthritis can result in a regime that is so complicated that it becomes unrealistic. Evidence from randomised controlled trials that systematically exclude frail elderly people applied indiscriminately becomes evidence-biased medicine. Guidelines based on such evidence are widely promulgated, but are only appropriate mainly for those up till 75-80 with single disease, while there are increasing numbers of people aged above 80 with multi-morbidity and increasing complexity in management. The prevalence of the most frequent chronic diseases occurring without any co-morbidity varies from 5% for hypertension, to 1% or less with diabetes and hip fracture. Subjects with co-morbidity and disability were excluded in many randomised controlled trials of congestive heart failure. In hypertension trials for example, the Hypertension in the Very Elderly Trial (HYVET) used a target BP of 150/80. The intervention group had reduced all cause mortality, mortality from cardiovascular causes and from stroke, and fatal and non fatal stroke. Yet in a typical outpatient population with the same age group, the percentage with dementia, stroke, diabetes, heart failure, myocardial infarction, and impaired renal function is significantly higher than the active treatment group in the HYVET. Furthermore, using the same target blood pressure as for HYVET, 64% of patients had poor blood pressure control as a result of adverse drug reactions, showing the difficulty in achieving a modest target blood pressure of 150/80 in those aged 80 years and over, with 4% requiring withdrawal due to postural hypotension, suggesting that implementation of HYVET recommendations in clinical practice may be difficult. It can be seen that guidelines for the majority of such patients should be derived from clinical trials carried out in a typical outpatient population with common patterns of co-morbidity.

A comprehensive geriatric assessment will identify problems in domains other than diseases, and enable formulation of management plans in addition to the prescribing of drugs. It is possible that management may not involve prescription of drugs at all, in managing functional or cognitive decline, or under nutrition.

Preventive care other than screening for chronic diseases and vaccinations is also important. Prevention of frailty and measures for maintenance of function may be provided in day care facilities, and delay the need for long term institutional care. Preventive measures could be incorporated in primary care settings that complement doctor consultations, which are limited by time constraints. These include nurse-led clinics, prescribed aerobic, resistance and balance training exercises, as well as activities to stimulate cognitive function. The role of traditional Chinese Medicine (TCM) would also have a place in primary care, since the emphasis of TCM is to maintain and promote health, rather than to provide cure for diseases. Traditional services do not include provisions for preventive measures of a maintenance nature, while desired outcomes tend to be measured in terms of admission to hospitals, rather than maintenance of old function, avoidance of long term institutional care or quality of life of the older person.

It is important to appreciate needs of the elderly from their perspective. The most frequently expressed opinion from a focus group study was that existing government medical services were inadequate. The
waiting time was too long, being one to two years for some specialties. There were concerns regarding the affordability of fees for drugs, there being a prescription charge of HKD 10 for each item. This was of particular concern for those who need long term medication for chronic conditions. However this is waived if the patient is receiving comprehensive social security allowance. Some suggested that a discount scheme should be offered to elders admitted to hospitals and emergency service. Staying in hospital for a fortnight would cost over one thousand HKD for example. They also requested better medications to be prescribed by doctors. Public hospital doctors were viewed as unwilling to prescribe better medications to the patients because of cost constraints. They tended to prescribe medications that were cheaper but had side effects and then prescribe another drug to deal with the side effect. The cheaper medications were usually viewed as ineffective. In general there were comments about the attitude of medical staff not being friendly or helpful. The staff may shout at them or were rude towards them, not really caring about the patients and ignoring their needs. They commented that staff should learn how to be polite and respect elders. The common opinion on elderly homes was that government subvented old age homes had much better quality than the private ones in terms of hygiene and cleanliness, and that there was insufficient number of RCHEs of good quality. The latter often had long waiting lists, while good quality homes were more expensive and largely unaffordable for many people. There was a consensus that the government should impose more supervision on private homes, as well as provide training for workers in these homes to improve quality of care.

In response to needs identified in surveys and focus group studies, a demonstration model of community care was initiated (Jockey Club Cadenza Hub: JCCH), as part of the Hong Kong Jockey Club Cadenza Project, an initiative to promote an elder-friendly Hong Kong [www.cadenza.org.hk]. The objectives are to support frail elderly people with multiple morbidities in the physical and psychological domain in the community using a case management approach; to support informal care givers; to carry out health promotion and health maintenance (optimising function for those with chronic conditions); to provide services designed from the user’s perspective taking into account gaps in current services. It represents an innovative model of service delivery, integrating health, social, primary and secondary care of older people. The service is comprehensive and multidisciplinary in nature, the target population being the soon-to-be old and seniors in the community. The programme consists of three categories: health promotion and health maintenance programmes for the soon-to-be old and independent elderly; optimal lifestyle and disease control programmes for those with chronic conditions; and prevention of decline and regaining physical and or mental function in a day care setting.

A key feature of this experimental centre is the integration of social and health needs, to reflect that these are not separated from an individual’s perspective. An important characteristic is that people would be attracted to come to the centre on a regular basis, as the environment is designed with the atmosphere of a club. At the same time activities relating to health are incorporated, but not dominant. Intergenerational mixing is encouraged. Other features that distinguish the centre from current existing services include walk-in–needs determined by professional staff; needs either met by the centre or directed to relevant care providers; various flexible programmes and products based on local evaluation of effectiveness for health and psychological benefits e.g. group programmes for chronic diseases; locally designed hip protector to fit HK Chinese elderly; emphasis on raising health literacy and empowerment; involves multiple partners and is multi-disciplinary; being a seamless one stop service. It is also run on a self-sustaining basis in the nature of a social enterprise to meet current service gaps in the government or private sectors. Such a centre may also be used as a basis for future development of the step care approach for combating depression, a major cause of global disease burden. Since inception, the users profile and requests for types of services provide a good reflection of the needs in the community. At any one time a large proportion of users of the Day care section consist of older people with dementia. Users found the concept of case management reassuring, as the nurse is seen as a liaison between all the different types of medical services in both public and private sectors, being able to spend time assessing patient needs and caring problems, checking medications, detecting health problems early and liaising with primary care doctors. In one case this type of community support resulted in the return of an elderly patient with stroke from long term residential care back home after case conference with various family members. Lifestyle modification programmes with an emphasis on behaviour change were also popular, suggesting that this model may complement pharmacological treatment by doctors for many lifestyle-related diseases. Group exercise programmes to prevent falls were devised as a combination of social as well as health promoting activities in a social setting with regular sessions over a 36 week period, unlike the traditional physiotherapy sessions lasting for a shorter duration and without the social component. It was designed as such to ensure good compliance with the exercises. Comments on factors that motivated elderly people to participate include noted beneficial effects on their activities of daily living with increased capacity to carry out housework and improved walking stability; regular and long term scheduling; manageable level of difficulty; comfortable and friendly environment with a group of peers.

To meet the needs of the elderly in our community, models of primary care need to be developed to complement existing medical model that is reliant on doctor consultation and drug prescription, and both the public and private sectors will have a role in meeting these needs.

References