COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

CPME/AD/Brd/251002/34/EN/fr

At its Board meeting, Salzburg, October 25th, 2002, the CPME adopted the following policy : **"The future of healthcare for the elderly** (CPME 2002/128 Final EN/fr)

THE FUTURE OF HEALTHCARE FOR THE ELDERLY

Summary and CPME Policy

The Standing Committee of European Doctors (CPME) welcomes the Commission communication 'The future of health care and care for the Elderly: guaranteeing accessibility, quality and financial viability' (COM (2001) 723 final) as a valuable contribution to a very important issue of concern to all the countries of Europe.

This paper sets out the views of CPME and offers the following conclusions:

1. The numbers of elderly people in Europe, both in absolute terms and as a proportion of the total population, will continue to increase and a proper priority must be afforded to their heath and social care, in all its aspects

2. The elderly retain the same aims and aspirations as other groups to lead lives of independence with positive and satisfying roles within their families and communities. They have a right to expect health and social care according to their needs, in line with established ethical principles, free of discrimination on age or any other grounds and free from the fear of abuse and for this to be provided in their own homes and environment, with dignity, for as long as is safe and practical.

3. Health and social care for the elderly must be provided in the context of other continuing changes in society in line with the wishes of the individual but aimed at maintaining independent living, with community support when required, for as long as possible

4. Good social care remains one of the determinants of good health and good health care cannot be ideally provided in the presence of unsatisfactory social circumstances and good communication between all agencies involved in providing care

5. The special characteristics of disease and disability in the elderly require a continuing programme of medical education, both at undergraduate and postgraduate level for both specialists and general practitioners emphasising the complexity of problems faced by the elderly and focussed on appropriate screening, prevention, curative treatment and rehabilitation. A similar dedicated educational focus is required for all other health care professionals involved in the care of the elderly together with attention to the needs of lay carers for information and education.

6. The importance and frequency of dementia and other psychological disorders in the elderly requires special priority to be given to the organisation and delivery of psychogeriatric services.

7. The special characteristics of disease and disability in the elderly require a continuing programme of clinical and organisational research and evaluation

1.1. Following the previous contributions of CPME in this field the organisation acknowledges the duty of the medical profession to keep elderly people in good health, and to play a full part in ensuring a good quality of life, for as long as possible.

THE FUTURE OF HEALTHCARE FOR THE ELDERLY

1. Demography

1.2. Increasing life expectancy across the countries of Europe represents, at one level, a tribute both to developments in healthcare and to rising prosperity. However, it also presents one of the greatest challenges to the organisation and funding of both health care and social care systems in all countries.

1.3. The Standing Committee of European Doctors has previously considered the importance of managing the issue of the health related problems faced by the older members of society (CP 96/145 final) and the United Second World Assembly on Ageing, held in Madrid in April 2002, called for policies to address the problems of a rapidly ageing population and for an international plan of action on ageing.

1.4. The Commission communication 'The future of health care and care for the Elderly: guaranteeing accessibility, quality and financial viability' (COM (2001) 723 final) contains data illustrating the impact of the changing demography of the population pointing out that since 1970 life expectancy at birth has risen by 5.5 years for women and almost 5 years for men and is set to continue to rise. In 2000 life expectancy was 74.7 years for men born in that year and 81.1 years for women. It is suggested that in 2050 life expectancy will be 79.7 and 85.1 years respectively.

1.5. The inevitable result is that elderly people now comprise a higher proportion of the population, a trend which will continue to develop. The share of the total European population older than 65 years will increase from 16.1% in 2000, to 22% by 2025 and 27.5% by 2050. The proportion of the population over 80 years is set to rise from 3.6% in 2000 to 6% by 2025 and to 10% by 2050.

1.6. Whilst it is argued that the new generations of older people will remain fitter for longer this demographic change presents challenges which must be addressed as a matter of urgency.

1.7. Healthcare for the elderly requires attention to prevention, curative aspects, rehabilitation and palliative care in order to delay the onset of disease, maximise function and independence for as long as possible and to care for those with incurable or terminal diseases humanely and with dignity.

2. Ethical principals

2.1. The elderly, just as much as any other group in society, are entitled to healthcare of the highest possible standards and to receive care on the basis of clinical need free from discrimination on the grounds of the age of the individual, or indeed discrimination of any other sort, and to live with dignity regardless of the setting within which they live or are cared for.

2.2. An elderly person, as does any other member of society, has a fundamental right to expect the same high ethical standards from medical and other practitioners. Such rights will include:

- The right to take decisions on issues affecting their individual health and well-being for as long as they are competent
- The right to proper legal protection of their best interests when no longer competent
- The right to information sufficient and presented in such a way as to be able to inform their own decisions
- The right to receive healthcare according to their individual needs and not to be discriminated against on any ground, but particularly on the grounds of age alone

3. The elderly and family and societal developments

3.1. Recent trends in society have served to compound the problems both for older people in maintaining independence within their own homes and in providing health care and social care to the elderly. The industrialisation and urbanisation of society combined with the breakdown of traditional family structures and increasing mobility of the population, for employment and other reasons, often means that the frail elderly in particular, struggling to cope with increasing health problems disability and handicap, are left isolated and without the benefit of support which would have been provided by the traditional family unit in the past.

3.2. As an ideal the family remains the major social, economic and emotional resource supporting increasingly dependant older people. It has to be acknowledged that this ideal is increasingly frequently unattainable.

3.3. Of additional concern is the experience and fear of violence, such as mugging or burglary; a fear which may lead to the individual old person being restricted to their own home and afraid to leave. Such fear may be well justified but may sometimes be out of proportion to the reality of any risk of such violence. Either way it serves to increase the isolation and vulnerability of the individual.

4. The relationship between health and social care

4.1. Whilst self evidently the health related problems of old age, both physical and mental, require a properly resourced, integrated and effectively delivered system of healthcare, this can only ever represent one aspect of the overall requirements for care. Health care without proper attention to the social dimension must always be restricted in its expectations and will always be compromised in its achievements.

4.2. One of the key aims of health and social care for the elderly is to maintain people in their own homes, and in a familiar environment, for as long as it is possible, focusing on mobility and independence through appropriate support. Such a focus reflects and responds to the desire of most older people and almost certainly represents the most cost effective way of attending to and meeting their developing needs.

4.3. Proper attention to the housing needs of older people represents a significant step in maintaining each individual's health and independence for as long as possible and should help with the management of developing difficulties in the individual's known and familiar environment.

4.4. As health, independence and mobility deteriorate the availability of sheltered accommodation, with support provided appropriate to the individual's needs and degree of disability, becomes crucial and without this healthcare systems and clinicians alone will always struggle to cope adequately. An older person requiring long term care should be able to live with dignity.

4.5. In order to deliver effective healthcare and humane social care is essential that health and social services agencies and departments work in close and co-operative partnership.

4.6. In addition, health can never be completely separated from personal economic well being and the development and implementation of policies leading to improvements in this area should produce health benefits for the elderly as with all other population groups.

5. Communication between professionals and agencies

5.1. Within healthcare systems, proper communication and coordination between health care professionals and between primary and secondary care is essential. The full exchange of relevant information on referral or admission to hospital, prompt and comprehensive summaries of information on discharge and the involvement of primary care practitioners of all relevant disciplines and primary health care teams in proper discharge planning will all help the re- establishment of individuals into their own homes and families following discharge and should reduce the need for re-admission.

5.2. In addition if the difficulties faced by general practitioners, community nurses and other primary health care professionals in taking over the care of such recently discharged individuals can be minimised, time and energy is not wasted on grappling with inefficient systems and full attention can be given to the patients needs and their on going management.

5.3. Similarly, if the partnership between health and social care is to work properly it must be a partnership founded on good working relationships between individuals and organisations underpinned by clear agreement on responsibilities and policies and supported by adequate funding.

6. Health problems

6.1. Characteristics of the challenges posed in providing high quality healthcare to the elderly include:

- Co-morbidity - the prevalence of multiple pathologies in the same individual including physical, mental and social.

- The problem of iatrogenic disease, particularly that caused by the side-effects of drug treatment and particularly against the frequent background of multiple medication and multiple pathology.

- The problem of providing care for older people against a background of family breakdown and a highly mobile society, leading to the isolation of older people.

- The problem of managing disability in an unsuitable setting / environment.

6.2. The developing technologies continue to open up new possibilities in the prevention, early diagnosis and cure of many diseases. This is likely to accelerate over the coming decades, particularly against the background of developments in the gene technologies. Partly fuelled by the lay press the hopes and expectations of society in this respect continue to rise and will surely continue to do so.

6.3. It must be expected that these expectations will be reflected in the expectations of older people themselves, particularly as the current younger generations themselves grow into older age. The potential resource implications, and not only in terms of healthcare expenditure, are enormous and at some stage all societies are going to have to face the question of funding such expectations and developments and of managing the difficult questions of cost benefit in a way which maintains reasonable equity, fairness and transparency.

7. Morbidity

7.1. The common problems giving rise to very significant morbidity in older age include arthritis, chronic obstructive airways disease, hearing and visual problems, diabetes, ischaemic heart disease and stroke, dementia and depression.

7.2. Problems should not be automatically put down to ageing but should be investigated, explained and treated.

7.3. Early detection of disease or susceptibility to disease may lead to less morbidity.

7.4. Correct nutrition, fitness and attention to smoking and alcohol habits can reduce morbidity

7.5. In addition whilst 5% off people aged 65 years and over have dementia this figure increases to 20% of those over 80 years old. Further, numerous studies show that significant and often severe depression affecting the elderly is a common problem that often goes unrecognised and untreated. The case for a specific focus on the problems of dementia and other psychological problems of the elderly, especially against the background of long term care at home, is surely self evident.

8. Mortality

8.1. The principal causes of death in older people are from heart disease, cancer, cerebro-vascular diseases, infections and domestic accidents and their consequence.

8.2. The advances currently being made in reducing mortality need also to be match by reductions in morbidity and disability.

9. Elder abuse

9.1. Evidence is continuing to accumulate of the extent of the problem of abuse of older people, abuse that is sometimes physical, sometimes psychological and sometimes the results of financial deprivation partly arising from arrangements in different societies which may serve to discriminate against older people. Abuse and neglect of the elderly may be associated with mental illness, alcoholism or drug abuse in the elder person or in their carers. Financial or other family problems may also compromise the ability to provide adequate care.

9.2. Physicians are ideally situated to play a significant role in the detection, management and prevention of elder abuse and neglect, not only in the family, but also in institutional care.

10. Learning and teaching

10.1. As the absolute numbers of older people, and their proportion within the total population, continues to increase it will become increasingly important that those charged with their care, whether medical, nursing or social care, are adequately trained and prepared to manage the increasingly complex health and social problems faced by this group.

10.2. Whilst many of the specific pathologies faced by individual old people are similar or identical in nature to those faced by the younger generation, the issues of complexity, co-morbidity, the social context and the need to work in partnership with other agencies all point to the importance of giving this field specific attention during both undergraduate and postgraduate training, whether for potential specialists or general practitioners. In addition the specific pathologies of ageing, and in particular perhaps the specific problems posed by dementia, require special attention.

10.3. Further, developments in medical knowledge and treatment will give the elderly greater opportunity for receiving treatment and undergoing procedures outside the traditional hospital setting and close to or within their own homes. Against this background it is essentail that doctors have a thorough knowledge of the multiple pathologies often seen in elderly patients. This will inevitably increase the demands on general practitioners and the need for effective communication and cooperation with other specialists both within and outside the hospital setting.

10.4. Wide variation currently exists in the provision of undergraduate and postgraduate medical education in the EU/EEA. Some medical schools currently do not offer dedicated training in geriatrics and old age care in their curricula and steps should be taken to ensure the inclusion of geriatrics and old age care in all national and local curricula. This could be achieved involving professional organisations, national bodies, school boards, political groups and the general public.

10.5. Support for the development of models, pilots and educational resources will assist both the conceptualisation and implementation of curricula which will ensure appropriate adaptability and sensitivity to different teaching methodologies and cultures.

11. Research and evaluation

11.1. There is a priority need for continuing multi-disciplinary research into the problems of the elderly and their management. Such research should include, in addition to pure clinical research, research into the planning and organisation of healthcare delivery for the elderly.

11.2. Continued audit and evaluation of the standards of care received by the elderly and the delivery of that care should help ensure that clinicians continue to critically assess, adapt and develop their standards.

12. Conclusions

12.1. The numbers of elderly people in Europe, both in absolute terms and as a proportion of the total population, will continue to increase and a proper priority must be afforded to their heath and social care, in all its aspects

12.2. The elderly retain the same aims and aspirations as other groups to lead lives of independence with positive and satisfying roles within their families and communities. They have a right to expect health and social care according to their needs, in line with established ethical principles, free of discrimination on age or any other grounds and free from the fear of abuse and for this to be provided in their own homes and environment, with dignity, for as long as is safe and practical.

12.3. Health and social care for the elderly must be provided in the context of other continuing changes in society in line with the wishes of the individual but aimed at maintaining independent living, with community support when required, for as long as possible

12.4. Good social care remains one of the determinants of good health and good health care cannot be ideally provided in the presence of unsatisfactory social circumstances and good communication between all agencies involved in providing care

12.5. The special characteristics of disease and disability in the elderly require a continuing programme of medical education, both at undergraduate and postgraduate level for both specialists and general practitioners emphasising the complexity of problems faced by the elderly and focussed on appropriate screening, prevention, curative treatment and rehabilitation. A similar dedicated educational focus is required for all other health care professionals involved in the care of the elderly together with attention to the needs of lay carers for information and education.

12.6. The importance and frequency of all forms of dementia and other psychological disorders in the elderly requires special priority to be given to the organisation and delivery of psychogeriatric services.

12.7. The special characteristics of disease and disability in the elderly require a continuing programme of clinical and organisational research and evaluation

Following the previous contributions of CPME in this field the organisation acknowledges the duty of the medical profession to keep elderly people in good health, and to play a full part in ensuring a good quality of life, for as long as possible.