

INTEGRATED CARE FOR OLDER PEOPLE

Realigning primary health care to respond
to population ageing



TECHNICAL
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**ON PRIMARY
HEALTH CARE**

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Key messages

- The primary health care approach has a key role in meeting the holistic needs of older adults.
- The responses to the health needs of older people include supportive policies, plans and regulatory frameworks.
- In addition, to face the increasing demands for health care by the growing number of older adults, a fragmented care system has to be replaced by person-centred integrated care that has primary care as a central element; this includes:
 - Undertaking a comprehensive assessment that can assess the health and social needs of older people; and
 - empowering and engaging individuals, families and communities in the management of their health systems, in decisions about their health care, and in their ability to take care of their own health and the health of those they care for.
- Actions towards delivery of integrated care for older people can take place at all levels of health care.
- Information and communication technologies will help in training health care workers to provide personalized care to allow older people to do what matters most to them in the latter part of their life.

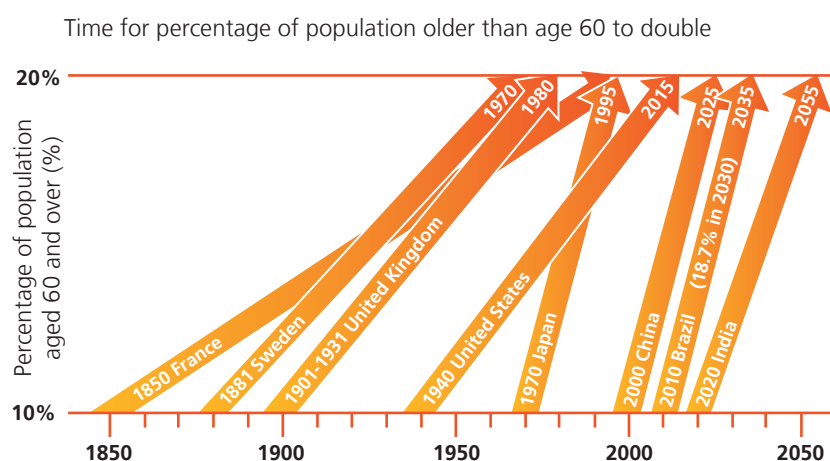
The policy context

Rapid demographic changes

At a time of unpredictable public health challenges, one thing is certain – the world's population is rapidly ageing. From 2015 to 2050, the proportion of the world's population aged 60 years or more will nearly double (from 12% to 22%) (1), with profound consequences for health care systems.

As depicted in Fig.1, the rate at which the proportion of the population aged 60 years or more is increasing much more quickly than in the past (1). For example, the proportion of the French population that was older than 60 years rose from 10% to 20% over a period of almost 150 years, whereas countries such as China and India will have only slightly more than 20 years to adjust to similar changes in the age structure of their populations. A child born in Brazil or Myanmar in 2015 can expect to live 20 years longer than one born just 50 years ago (1).

Fig. 1. Pace of demographic transition



Source: (1).

Diverse health care needs

As people age, their *intrinsic capacity* (i.e. the sum of their physical and mental capacities) tends to decline while their health issues become more chronic and complex. Multimorbidity (i.e. the presence of multiple chronic conditions at the same time) is increasingly prevalent with age. Older people can develop geriatric syndromes such as frailty, urinary incontinence and propensity to falls, which do not fit into discrete disease categories.

Challenges and complexities of providing health care to older populations

Around the world, health systems are struggling to respond to the wide diversity of physical and mental capacities of older people, and to promote positive trajectories of healthy ageing from early life onwards. An older person's capacities can change rapidly – over the course of hours in some cases. Care systems struggle to be nimble enough to respond quickly to changes in a person's needs.

Numerous health care workers (HCWs) may be involved with one person's care, especially in countries with extensive availability of medical specialists. In addition, the social care sector is often involved when older people experience significant declines in their capacities and need help with activities of daily living. Health and social care services for older people are typically provided in more diverse settings and with greater frequency than is typical for younger populations. In addition, families and other unpaid carers often play substantial caregiving roles (2).





Health care mismatch

Many health care systems around the world were designed for a relatively young population. They tend to emphasize curative care for a different set of health needs than those faced by populations today. In the past, services were often structured around diagnosing and curing acute health issues, using a biomedical “find it and fix it” approach. This worked well when communicable diseases were the most prevalent health care issue.

Today, population demographics have shifted, yet there is little clinical focus on problems that matter to older people such as chronic pain, and management of ongoing difficulties with hearing, seeing, walking or performing daily activities. Also, there is often a lack of protocols for preventing and managing geriatric issues such as frailty and urinary incontinence. Early markers of declines in intrinsic capacity, such as decreases in gait speed or muscle strength, are often not identified, treated or monitored, although these actions are crucial if declines in capacity are to be reversed or delayed.

Another challenge is that older people's health issues are often managed in disconnected and fragmented ways, and there is little coordination between care providers, among different settings and over time. Nevertheless, the involvement of numerous health professionals and the use of multiple clinical interventions necessitate a high degree of coordination, both between health professionals, and within treatment levels and settings.

The physical infrastructure of many health care settings is not well matched to older people's needs. Examples of infrastructure issues include a lack of accessible toilets, long waiting lines, physical barriers to access, and communication barriers resulting from a lack of accessible information for people with hearing loss and visual impairment. The shortage of affordable transportation to clinics is another major barrier to accessing health care, especially for older people who live in rural areas, because services are often concentrated in large cities far from older people's homes and communities (3).

Finally, health care and social care are typically fragmented from one another. Deeply rooted differences in the way that these services are financed, governed and organized creates complications for older people who use both types of services. Separate budgets and competing incentives for the various organizations are not conducive to care coordination. Differences in education and professional culture, and unfamiliarity with other professionals' ways of working, are additional barriers.

Poorly prepared health care workers

As with health care systems, health care workers (HCWs) are often unprepared to effectively manage the health care needs of older adults. Most current training approaches were developed in the 20th century, when acute, communicable conditions were the world's most prevalent health problems (4). As a result, HCWs are often trained to respond to pressing health concerns, rather than to proactively anticipate and counteract changes in function, and they are rarely prepared to work with older people to ensure that those people can increase control over their own health (4–6). Furthermore, although most patients treated within health systems are older people, training curricula frequently overlook gerontological and geriatric knowledge and training, and may lack guidance on the management of common problems such as multimorbidity and frailty (7, 8).

Meaningful reform will require the concerted and sustained efforts of academic leaders and health professional groups; so far, this has not happened to a large degree.

Responses

Integrated care for older people

Evidence suggests that integrated care for older people is the best approach for implementing the complex spectrum of interventions that are needed if older people are to experience the best possible outcomes (9–12).

Integrated care for older people refers to services that span the care continuum, are integrated within and among the different levels and sites of care within the health care and long-term care systems (including within the home), and are integrated according to people's needs throughout the life course. Integration does not mean that structures must merge; rather, it implies that a wide array of service providers must work together in a coordinated way. Most successful programmes have taken a bottom-up approach to change, which has been supported by higher level policy, and by mechanisms for shared financing and accountability within teams (13, 14).

This type of care is person-centred, which means that it is grounded in the perspective that older people are more than vessels of their disorders or health conditions. Instead, they are viewed as individuals with unique experiences, needs and preferences. It also views older people in the context of their daily lives, as part of a family and a community.

To illustrate the elements of this type of care, in a 2015 report, the World Health Organization (WHO) proposed actions at three levels (1):

- **Focus on the older person's needs and goals.** All elements of an integrated care approach for older people revolve around each older person's unique needs and goals.
- **Integrated clinical care.** Integration at the level of clinical care is especially important for older populations. This includes a comprehensive assessment, a common goal and a care plan that is shared across all providers.
- **Health system alignment.** Aligned health systems can make it easier to integrate care for older people. WHO has identified key building blocks of health systems: service delivery; human resources for health; health infrastructure, products, vaccines and technologies; information and data, leadership and governance; and financing (15).

What primary care providers can do

Front-line health workers who deliver care to older people can take several steps to provide more integrated services. For example, they can:

- use case management strategies, including comprehensive assessments, care plans and proactive follow-up;
- implement evidence-based clinical interventions tailored to level of intrinsic capacity; and
- work collaboratively with other providers.

These approaches are discussed in the following pages.



Case management strategies

Case management entails assessing individual needs and developing a comprehensive care plan, then organizing services so that they work collectively towards the goal of maintaining intrinsic capacity (16).

Conduct comprehensive assessments

Comprehensive assessments are an essential aspect of case management. They take stock of the intrinsic capacity of the older person and its trajectory, specific conditions, behaviours and risks that may influence this capacity in the future and the environmental context. As such, comprehensive assessments provide the information needed to prioritize and tailor interventions.

Set care goals together with the older person

It is crucial that the older person is involved with decision-making and goal setting from the outset, and that goals are established in accordance with the older person's unique needs and preferences.

Develop and use integrated care plans

Integrated care plans are developed based on the outcomes of comprehensive assessments. The care plan is centred around the older person's goals, how those goals will be addressed, the roles that different sectors of the health and social system will play, and a plan for follow-up and re-assessment. Once the care plan is developed, it serves as a roadmap for unified action and is a way of measuring progress against the older person's individual goals and preferences.

Provide systematic self-management support

Provision of systematic self-management support involves providing older people with the information, skills and tools that they need to manage their health conditions, prevent complications, maximize their intrinsic capacity and maintain their quality of life (17, 18). This does not imply that older people will be expected to "go it alone", or that unreasonable or excessive demands will be placed on them. It does, however, recognize their autonomy and ability to direct their own care, in consultation and partnership with health care providers, their families and other carers.

Provide regular and sustained follow-up

Proactive and planned follow-up is part of most case management approaches. It promotes early detection of complications or changes in functional status, thus preventing unnecessary emergencies and related waste of health care. It also provides a forum to monitor progress in relation to the care plan and to provide additional support as needed.



Implement evidence-based clinical interventions tailored to levels of intrinsic capacity

Within any population of older people, many will experience periods of high and stable capacity, declining capacity and significant loss of capacity. Each of these three periods requires different responses from health care providers, as discussed below.

High and stable levels of capacity

For older people with high and stable levels of capacity, the goal is to build and maintain these levels for as long as possible. The emphasis should be on disease and risk prevention; promoting capacity-enhancing behaviours; ensuring that acute problems are adequately addressed; and detecting and managing chronic, noncommunicable diseases at an early stage.

Declining capacity

For older people experiencing declining capacity, the goal is to delay, slow or even partly reverse this trajectory through targeted interventions early in the process (19–20). Healthy behaviours remain crucial, but the focus broadens from risk factor reduction, to encompass actions that can directly help to maintain capacity or reverse loss of intrinsic capacity. For example, aerobic exercise is important for cardiovascular disease prevention (21), but exercise that can help build muscle mass, strength and balance becomes increasingly important as a person's capacity declines (22–27). Nutritional advice also changes as people lose capacity, with the focus shifting to nutrient density, particularly that of protein intake, vitamin D and other micronutrients, although calorie intake is also an important target (28). At this time, there is increased focus on the chronic care of multiple conditions, to mitigate their impact on capacity.

Significant loss of capacity

For older people experiencing significant loss of capacity, the twin goals are to continue to optimize clinical trajectories and to compensate for these losses through the provision of social care services. Clinical interventions should continue to focus on recovering and maintaining capacity, including ongoing disease management, rehabilitation, palliative interventions and end-of-life care. Rehabilitation services can help to prevent permanent functional disability and care dependency, and can reduce avoidable hospital admissions and delayed discharges (29).

Work collaboratively with other providers

Integrated care for older people requires health care providers to collaborate with one another, and with social care providers. This is a different way of working for many providers. Differences in education and professional culture, and unfamiliarity with other professionals' ways of working must be overcome.





How primary care services can be organized and delivered

The starting point for aligning services to support integrated care for older people should be ensuring that better care is provided, rather than adopting a fixed organizational model with a pre-determined design.

Regardless of the organizational structure, important aspects of service delivery for older people are active case finding, and community- and home-based care, all anchored by a strong and high-performing primary health care (PHC). Self-management support provides older people with the information, skills and tools that they need to manage their health conditions, prevent complications, maximize their intrinsic capacity and maintain their quality of life. Community engagement leverages existing resources and helps to provide support for older people and their families. Useful approaches to organizing primary care are outlined below.

Use multidisciplinary teams

Multidisciplinary teams share responsibility and accountability for clinical processes and care outcomes, for individuals and in defined populations. To succeed, teams need to meet regularly, share information, explicitly define clinical roles, and perform complementary and coordinated functions for people and populations (30).

Share information across providers, settings and time

Rapid advances in information and communication technologies (ICTs) offer much promise for sharing relevant clinical information across providers, settings and time (31). Electronic health records can organize information about individuals and entire clinical populations of older people to help identify needs, plan care over time, monitor responses to treatment and assess health outcomes.

Implement active case finding

Community outreach and active case finding can reach older people who do not self-present to health centres. Moving beyond clinic walls into communities facilitates the identification, monitoring and support of older people in need of health services.

Prioritize community- and home-based care

Locating health services close to where people live is especially important for older people. Distances to health centres that might be reasonable for the general population can be insurmountable for older people with significant impairments; hence, accessible and affordable public transportation to health care facilities should be available (32). In cases where specialist health services entail long travel distances, age-friendly and affordable transportation services can be offered. Home visits delivered by health care providers in the context of community-based programmes can have positive effects for older people (33–34).

For those with significant care needs, hospital-at-home services can provide treatment at home for people who would otherwise be admitted to an acute hospital. These services involve a team of health and long-term care professionals. Outcomes are higher client and carer satisfaction, reduced deaths and reduced readmission rates with this model compared with a “traditional” hospital (35, 36). Most rehabilitation services can be provided outside hospital settings, in communities or at home (28).

Engage communities

Community engagement leverages untapped resources and helps to ensure healthy and facilitative environments for older people. The community includes families and households, employers, religious organizations, the physical and social environment, and community organizations of different types (e.g. older people’s associations, social services and educational services).

How can health systems support integrated care?

The primary role for policy makers and health system leaders is to support the integration activities of front-line providers at the level of clinical care, as summarized in Box 1. Organizational and structural integration are not necessary to achieve this aim.

Box 1. National-level support for integrated care for older people

- ✓ Adopt an integrated care approach to older people within the country's national health policy.
- ✓ Adapt and implement clinical guidelines for providing integrated care for older people.
- ✓ Evaluate the country's capacity to deliver integrated care, identify gaps, develop a plan and monitor progress.
- ✓ Make needed changes within local health systems (e.g. essential medicines, health information system and infrastructure).
- ✓ Train health workers about the integrated care approach and interventions to prevent declines in capacity and functioning.
- ✓ Develop support mechanisms within communities for self-management, caregiver support, and transportation of older people to clinics and hospitals when needed.

As a first step, senior leaders must recognize the importance of addressing this agenda and make it a health system priority. One entry point is to evaluate the country's capacity to deliver integrated care, identify gaps, elaborate a plan to guide the necessary changes in local health systems and monitor progress.

Policies, plans and regulatory frameworks can be updated to support integration at care levels (e.g. PHC, nursing homes and hospital-based services), and also between health and social care systems. Joint budgeting, monitoring and accountability systems can be used to solidify integration. Strong political support from senior leadership can spur this type of action.

Other essential action points are presented below.

Develop the workforce

Health care and social care workers need the right competencies, and need to be organized and deployed in ways that make the best use of their potential contributions. Core competencies for all health professionals include basic gerontological and geriatric skills. Both health and social care workers need general competencies related to integrated care, such as working as part of a multidisciplinary team and proactively supporting older people to optimize their health and capacity. More doctors and nurses with expertise in geriatrics are also needed, to provide support to primary care HCWs and to treat complex cases. In addition, new workforce cadres (e.g. care coordinators or community health workers) can be considered, alongside options for extending the permissible scope of practice for some professions.

Developing the workforce in these ways will require a well-functioning governance infrastructure. Essential aspects of governance are workforce assessment, policy development, planning and monitoring. Strengthening governance capacities and coordination mechanisms to address major workforce challenges associated with population ageing will be important in many settings.



Invest in information and communication technologies

Information and communication technologies (ICT) can help to transform health systems to deliver integrated care for older people, particularly in middle- and high-income settings. Advances in ICT are being used globally to improve access, quality and safety of health care, and cost-effectiveness of health services delivery (30). In many ways, ICT has become fundamental to effective multidisciplinary team care. Automated reminders, prompts and warnings on clinical health records systems can help providers to deliver evidence-based care. Patient portals and other ehealth infrastructure can enable older people to participate more fully in their treatment and care; these tools can also link older people with their health care team, and with community and social services.

ICT also can be used to monitor, evaluate and plan care at the policy level, to improve the care of older people. For this to be realized, common indicators must be broadly agreed on and consistently used. Indicators for underlying causes and domains of intrinsic capacity (e.g. undernutrition, mobility impairment, cognitive impairment and sensory impairments) must be defined, operationalized and consistently measured.

Implement shared financing and accountability

Several financing mechanisms can be considered to stimulate integrated care for older people. Within a wide range of financing schemes, pooled budgets or bundled payments (or both) can be used to enable providers and organizations to work together in a more integrated way. Other financing mechanisms include contractual incentives to encourage new ways of working or to reward positive outcomes, and stimulus or seed funding to support the development of local initiatives.

Regardless of the financing scheme, providers must be compensated and provided with incentives to undertake key functions associated with integrated care. They must, for example, be remunerated for the time and resources spent conducting comprehensive assessments and developing care plans, as well as for the time spent on consultation and collaboration within the multidisciplinary team. Providers should also be eligible for compensation related to the services that they provide in older people's homes or communities.





Conclusion

Integrated care for older people produces a better return on investment than more familiar ways of working. It also enables older people to participate and contribute as productive members of society (1).

Integration at the level of clinical care is especially important for older populations. This generally includes a comprehensive assessment, a common goal and a care plan that is shared across all providers. Ongoing case management, led by a designated care coordinator, helps to ensure that integration continues over time (2). Key health system levers are:

- supportive policies, plans and regulatory frameworks;
- workforce development;
- investment in ICTs; and
- use of pooled budgets, bundled payments and contractual incentives to support integrated ways of working.

PHC is key to achieving such integrated care for older individuals. From a service delivery perspective, primary care as a subset of PHC provides first contact, comprehensive care that meets the essential health needs of older people. In addition, PHC is important in the coordination of care across different levels of the health system, as well as intersectoral collaboration (including the role of social care).

Action towards the delivery of integrated care for older people can take place at all levels of health care: from front-line providers through to senior leaders. This action could make a substantial contribution towards achieving the Sustainable Development Goals (SDGs), by fostering inclusive economic growth, achieving universal health coverage for current and future populations, and ensuring that older people have the opportunity to contribute to, and are not left behind by, development.

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