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Inquiry into the long-term strategies for Ageing

Prof BK Nair
John Hunter Hospital and The University of Newcastle
Newcastle, NSW 2305
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I sincerely thank the House of Representatives Standing Committee on Ageing for inviting me to address you. I believe this is a vital area needing immediate and evidence-based decisions to plan for the ageing population of our country. I applaud the initiative.

I consider myself to be a clinician, teacher, academic and researcher in that order. I have a busy clinical practice and I am in touch with older patients, their families, careers and health professionals all the time. My submission today will be from these perspectives.

Educational and Workforce Issues

Geriatric Medicine is a young specialty and was first established in the UK in the 1940s. It is still in an infantile stage in many of our hospitals and teaching facilities, even though the core business of these facilities are care of the older patients.

Older patients have multiple disabilities and geriatricians are well trained to care for these people, particularly their social, physical, and psychological as well as medical needs. There is an urgent need for us to train adequate numbers of geriatricians to meet these needs. Unfortunately, as the population is ageing, the gap between the availability and need is widening. There should be a national resolve to solve this crisis.

It is widely acknowledged that there is a shortage of geriatricians in our country on all counts. The general physicians are a dying breed too. Most of the specialists are single organ specialists: patients with single organ disease get excellent care, while older patients with multiple problems are often under-diagnosed and under-treated. The medical work force should match the medical needs of the community. I believe this is the case with other health care professionals involved in geriatrics too.

Most of the medical needs of older people should be met with a holistic and generalist approach, not a subspecialist approach.

Even though the number of older people with chronic multiple medical problems is on the rise and most of medicine is about chronic care, our medical and health professional education is still about acute care and still concentrated on hospital-based care. We have

approximately 55 000 hospital beds and 141 000 residential care beds. While the care for the hospital-based patients is of high quality, nursing home care is not co-ordinated and is often reactive rather than pro-active. We often have difficulty in finding general practitioners to accept patients into nursing homes.

Residential care homes are also good venues for teaching health care professionals. This will improve the quality of care of the patients and quality of the education for the health professional students. The attitude of students to older patients is likely to change too.

The majority of older people are in the community and placing students in the community will give them the correct perspective. There is some evidence that if students are exposed to well, older subjects early in their career, their attitude to older patients will be positive and they are less likely to develop ageist attitudes.

Some of the initiatives in the USA are interesting and worth pursuing. There is a move to rotate all specialist trainees through geriatric medicine units. This is vital when we already know that the majority of patients under the subspecialists are very old.

While the 20th century had been labeled as evidence-based and individualistic, the 21st century will be based on systems of care because of the changing demographics of our patients.

One of the major requirements for the holistic care is for the health professionals to work together, rather than to work along side each other. The latter is the norm now. If students in health professions are trained together in their undergraduate courses, they are more likely to work together on graduation leading to better patient outcome and satisfaction.

We do not have a national curriculum in geriatric medicine and only a very small amount of contents and time are devoted to ageing. This is not a true reflection of the real life situation in the community.

In conclusion, we need a uniformly strong and adequate national curriculum for health professional education both in quality and quantity, to meet the demands of our ageing population.

Clinical Issues

The core business of health is care of the older patients. Twelve percent of the population account for almost 35% of hospital admissions and 50% of bed days. Older people account for up to 25% of general practice visits. However there is no co-coordinated approach to their care. There should be a national organising and review committee to coordinate this, since there are many players in the field.

Often an older patient is seen by different systems and health professionals for the same problem in different locations. Good example is a patient with falls seen in a surgery, emergency room, geriatric outpatient clinic, day hospital and then wait for the Aged Care Assessment Team to do a home visit and then wait for several weeks for a home care assessment for personal care. The very group of patients who are less able to advocate for and organise their care needs are left to wait for unduly long times. A single patient should have a single assessment.

Management of older people in the Emergency Department (ED) should be multidisciplinary and comprehensive. Twenty percent of attendees in the ED are above the age of 80 years. Moreover, ED is the entry point for inpatient care for these patients and these facilities should be made use-friendly.

Discharge planning should start at the time of admission. Management of acute confusional state (40% prevalence) is suboptimal, in spite of this condition causing high morbidity and mortality. Older people should be better "case managed" in hospital in purpose-built wards. Post-acute care and follow-up is also vital. Many of these patients will need a very long time to recover from the physical deconditioning and cognitive impairment, after hospitalisation.

Evidence based practice is applying external clinical evidence for the care of individual patient. While it is easy to get evidence in younger patients with single clinical issue, this is nearly impossible in an older patient with multiple problems. Older patients are not included in research studies because often they meet the exclusion rather than the inclusion criteria.

Even when evidence is available it is difficult to apply. A good example is the treatment of high blood pressure, a condition seen in 70% of people above the age of 70. The best treatment for this is a group of drugs called Thiazides in small doses. Unfortunately, they are not easily available on the PBS. Instead more expensive and less effective drugs are prescribed which may cause side effects.

More and more data are available on the issue of vitamin D deficiency in Australia. Even though we have abundant sun light, one has to go out in the sun on a regular basis to get this and many of the elderly are unable to do this. Vitamin D is very cheap, costing less then $8 per month, which will prevent costly falls and fractures in this population. Again vitamin D is not easily available on the PBS.

The National Health and Medical Research Council (NHMRC) recommends routine vaccination against Influenza, Pneumonia and Tetanus for all people above the age of 65. Our own research had found the immunisation rates are sub-optimal. If the rates were low in any other sub-group of patients there would be a national campaign.

Older people deserve the best care based on the best evidence. It is our duty to provide this, since apart from the moral duties, it is their taxes that built our hospitals and universities.

Research

Even though the research in aged care fields are of high quality, relatively little money is allocated for ageing research. A consortium of researchers and research units in Australia was commissioned by the NHMRC to do Scoping study on Ageing Research and the recommendations were to have an ageing stream in the Council and to encourage multiprofessional research. If the recommendations are accepted it will go a long way in filling the gap.

Conclusion

In conclusion, the aged care will have to change. To do this we must a have a proactive, evidence-driven, multidisciplinary approach focused on the needs of older people. We must strive to make it on par with the quality of care we deliver to the other sections of the society. The underlying principle should be "to add life to years and not years to life".

Enclosed: (PowerPoint slides of the talk).