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EDITORIALS

Effectiveness of preventive care programmes in the elderly

Preventive care in the elderly has been the subject of debate for at least 40 years with, in my experience, many doctors being unconvinced of the value of preventive care programmes in older people. At the same time it must be said that the findings, even in controlled trials, have been conflicting, which is scarcely likely to convince the sceptics. Such confusing results are probably due to the heterogeneous nature of these studies with a diversity of age cohorts, objectives and duration of studies, forms of intervention, indicators of outcome, etc. As a result the sceptics remain unconvinced. However, anyone who has run a well-organised preventive care clinic for older people will recognise how much better it is to see an older patient, whose problems are well documented, in such a clinic when time is not at a premium since these problems (medical and paramedical) are often complex. In a surgery, on the other hand, the doctor has to investigate the nature of the patient's problems *de novo* before undertaking a physical examination at a time when he or she may well be under pressure. Thus, the risk of missing problems is inevitably increased.

In 1990, under the new general practitioner (GP) contract, a set of measures was introduced to improve preventive care in older patients [1] which, although well intentioned, was perhaps an object lesson in how not to launch a programme of this type. With so many doctors unconvinced of the value of this approach, it was vital to try to convince them that this system was at least worth trying, bearing in mind that repeated attention has been drawn to the problem of unmet need in the elderly [2–5]. Six of the eight randomised controlled trials done in this field used time spent in institutional care as an indicator of outcome and all showed a reduction in this time among study patients compared with controls. In addition, the difference was statistically significant in four of the six studies [6]. This alone should make preventive care programmes appealing to patients and governments alike. Institutional care of the elderly is one of the most expensive areas of patient care.

In implementing this programme the government made no attempt to define clear objectives for the programme or train the GPs in the planning, organisation and administration of the programme. The shortcomings of conventional care were not defined and the doctors were not made aware of the conditions most likely to be overlooked by conventional care. In addition, family doctors were required to offer this assessment annually, which was quite unnecessary in many cases. Finally, no audit was built in.

GPs were simply required to offer check-ups when the patient reached 75 years of age. It was not a recipe for success and there is evidence that the standard of the work done varied widely from practice to practice [7]. In addition, by contaminating the field, it made the running of a randomised controlled trial in the UK impossible. Yet the elderly are the group with the highest level of disease, disability, social and economic problems likely to affect health and the quality of life in the community. They are also the fastest growing age sector in the population and these two factors together suggest major problems ahead if this situation is not addressed.

To understand the requirements of older people we need to define clearly the nature of their problems. Without doubt the central problem is the pervasively negative attitude of society in general, but also of many care workers, relatives and patients, to the health prospects of the elderly. This is due, mainly, to limited student and vocational training of nurses and doctors (especially the latter) in preventive care for older people and inadequate health education of the elderly and their relatives. As a result, patients and carers tend to treat any symptoms, e.g. poor sight or hearing, as simply the price of ageing. The result is under-reporting of illness by both and under-recognition and late diagnosis by doctors. All of this causes patients unnecessary suffering, especially with conditions such as sensory impairment, depression and alcoholism.

In addition, there is a tendency for care workers, especially doctors, to see their task as concerned almost exclusively with health and disease. By contrast, older people are more worried about disability, dependence and displacement from society, especially in advanced old age, as they become less mobile and more isolated.

Lack of integration of health and social services is another problem in this field, i.e. the services tend, sometimes at least, to operate independently in parallel rather than in a co-ordinated fashion.

With conventional care it is all too easy to underestimate the stress on the carer of a highly disabled patient and to miss the point of breakdown where stress and frustration in the carer may lead to battering. This problem has been made worse now that home visiting by the primary care team has been discontinued, except for emergencies, in many practices. Older patients suffering severe or progressive forms of disablement often need to be seen in their homes every 3–4 months by a member of the primary care team to assess the often changing day-to-day problems of the patient and his carer.

Family doctors are, at present, not always aware of the conditions most likely to be overlooked by conventional care—depression, dementia, urinary tract disorders, disorders of the feet, sensory impairment, anaemia, Type 2 diabetes, alcoholism and battering [2, 8]—on which preventive care in this field needs to be particularly focused.

Perhaps the worst problem of all for older people is living in an ageist society where so many people take a pessimistic view of the health prospects of the elderly. Doctors are as guilty as any in this respect and this leads many of them to view preventive care in old age as a field to be avoided. They point out that there is no unequivocal evidence that it improves health, which is correct, but health is hard to define and measure. At the same time, arguments about maintaining function and independence while reducing time spent in institutional care cut little ice.

Yet at the age of 75 years most people have an average of 3–4 diseases or disabilities and the life expectation at this stage is on average about 9.6 years for men and 11.7 years for women [9]. It is hard to believe, with so much pathology on which to work over a period of roughly a decade, that care workers using a carefully designed programme cannot improve the lot of older patients. Indeed we simply must find a way of handling their problems better.

The research continues and in this issue Walker and Jamrozik report a study [10] showing that their screening programme was not effective in reducing emergency admissions to hospital in the elderly. This confirms the findings of a study in Australia producing the same outcome and the results are disappointing. Nonetheless this is a valuable study which adds to the sum of our knowledge in this field, although the time spent in institutional care is likely to prove an even better indicator of outcome and value.

Based on my own experience of running a preventive care clinic for the elderly over 12 years, I believe this system is immeasurably better than conventional care because it identifies problems earlier and offers more time per patient than in a busy surgery. However, it must be acknowledged that the value of this approach has not been established beyond doubt by research studies and this can only be achieved by a randomised controlled trial (RCT), which meets the following requirements:

- it must be powerful enough to command respect;
- it must be done outside the UK because of the contamination caused by the provisions of the programme for preventive care of the elderly introduced in 1990;
- doctors involved must be open minded, familiar with the evaluative research findings in this field and aware of the special problems resulting from current care of the elderly;
- it is essential that doctors be given training for preventive care of older people including clear definition of objectives, instruction in how to plan, organise and run a clinic, and familiarisation with the conditions most likely to be overlooked by conventional care. One is bound to wonder about the results in any evaluative study done in this field in which the doctors doing the evaluation have ageist views and no special training for the work whether they are specialists or GPs;
- the programme must include an intelligence system using questionnaires to identify problems earlier and must be very carefully designed;
- a carefully designed record system which gives a clear profile of the problems involved is also vital thus facilitating management and identifying the patients at greatest risk;
- a need for good co-ordination of health and social services is essential;
- a strong emphasis on thorough health education of patients is perhaps the most important element of all.

To summarise, conventional care of older people is simply not doing its job in identifying the needs of the elderly. We must therefore devise a national programme which addresses the problems listed above and evaluate it carefully. Training in the planning, organisation and management of this programme is vital and must be undertaken at both student and postgraduate level for all care workers. Continuing audit of the programme after its introduction will also be important. The role of academic departments of geriatrics and primary care in this work will be vital.

In the meantime I would like to see more primary care teams experimenting with care programmes designed to meet the problems, listed above, of older people. Running a preventive care clinic for the elderly gave me more pleasure than any other work I had done in general practice, once it was properly organised. The diversity of the health problems and therapy involved made the work a real challenge. Also, my experience is that old people are the most grateful of patients, especially when they feel that they are the object of special interest. It is, after all, a new experience for them.

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