

# **Ageing and Health in Europe**

## **Challenges, opportunities and the role of Specialist Health Care for Older People**

A position paper for the  
UNECE Ministerial Conference on Ageing (Berlin 2002)  
“Age Integration, the Changing Life Course, and Intergenerational Solidarity”

from the  
**European Union Geriatric Medicine Society**  
and the  
**Section of Geriatric Medicine of the European Union of Medical Specialists**

"The state of health in the European Union is better than ever before. This is due to spectacular progress made over the second half of this century in terms of medical research, health services provision and living conditions. However, **older people require more, and substantially different, health and care services than younger people.** The central challenge of the policy makers is to ensure that future health care policies will provide an adequate and cost effective response to the changes brought about by demographic trends."

*Towards a society for all ages*

The collective ageing of our populations is one of the most significant triumphs of the 20<sup>th</sup> century. Older Europeans make, and have made, enormous contributions to our society. Existing European Union policy is dedicated to maintaining social inclusion of older people. Optimising health status and preventing disability are key elements of maintaining this social inclusion. The primary policy on ageing in Europe, *Towards a Europe of All Ages*, emphasizes three main themes for health and older people - prevention, equity of access and an adequate supply of quality care for older people.

The fulfilment of all three of these aims requires access to a community of knowledge which recognizes the opportunities and challenges of later life and which is able to incorporate a gerontological knowledge base into a systematic approach which recognizes the complexities of disease presentation and management. Geriatric medicine has developed in response to these specialized needs and has shown itself capable of providing responses to these challenges which are not only effective in terms of quality of life but also cost-effective and judicious in their use of personnel and resources.

Among the key elements of this approach are:

1. a philosophy of assessment and care which is multidisciplinary and holistic,
2. a recognition of subtle and atypical presentations of illness in later life,
3. capabilities in recognizing and dealing with multiple illnesses
4. careful attention to syndromes such as falls, fits, faints, dementia and incontinence which standard medical care ignores or compounds
5. training across a spectrum of care, including care in the community, acute geriatric medicine, rehabilitation and palliative care

Just as paediatric medicine developed at the end of the nineteenth century as a result of the failure of the generic medical system to cater for the needs of children, geriatric medicine has arisen as a result of the failure of the generic medical system to cater for the needs of older people. These failures range from the pioneering studies of the under-recognition of illness among older people <sup>1</sup> to the undertreatment (even when diagnosed) of depression in later life <sup>2</sup>, the increase with death and institutionalization arising out of generic care after fractured hip <sup>3</sup> and failure of medical care to meet the complexities of care of older people <sup>4</sup>.

Multiple studies have demonstrated the worth and cost-effectiveness of the geriatric medicine approach to acute care, ambulatory care, care in the community, rehabilitation and in extended care. This focus on effectiveness as well as that of adding life to years may be a critical success factor in meeting the challenge of maximizing health and social gain for older people while contending with constraints on health service financing. For example, if the model of acute geriatric medicine for acute medical emergencies results in less disability, less institutionalization and shorter lengths of stay than the traditional model, both older people and the health system gain from switching to the geriatric medicine model.

The European Union Geriatric Medicine Society, on behalf of the 10,000 specialists in geriatric medicine in the EU, was founded to further best practice in healthcare for older people. Its mission aims are:

- To develop geriatric medicine in the member states of the European Union as an independent specialty caring for all older people with age-related disease
- To support that these services become available to all citizens of the European Union
- Promote education and continuing professional development, and in particular an annual scientific meeting
- In conjunction with the Section of Geriatric Medicine of the EUMS, to promote geriatric medicine to the European Commission and Parliament
- Promote evidence-based guidelines for the most efficacious preventive and treatment strategies for older people in the European Union
- Liaise with other European bodies promoting the specialty in Europe, such as the Section of Geriatric Medicine of the EUMS, the clinical section of the International Association of Gerontology (European Region) and the European Academy of Medicine and Ageing

This report is prepared in conjunction with the the Section of Geriatric Medicine of the European Union of Medical Specialists (UEMS): the statutory purpose of this organization is the harmonization and improvement of the quality of medical specialist practice in the European Union (EU).

We present this report jointly in the spirit of contributing positively to the response of the Regional Ministerial Conference on Ageing to the International Plan of Action on Ageing, which resulted from the Second World Assembly on Ageing in Madrid, April 2002.

We provide the following examples illustrate some of the developments in which geriatric medicine has spearheaded developments which are sensitive to the needs of older people.

**Example 1: Acute Geriatric Medicine**

A large proportion of patients attending general hospitals as medical emergencies is elderly. Their needs are more complex than those of younger people - only one in six of those over 75 has a single pathology - the other 84% have multiple illnesses and/or rehabilitation needs<sup>5</sup>. Older people are also most likely to suffer from further iatrogenic illness including delirium, pressure sores and adverse drug reactions if not treated appropriately. Several studies have now demonstrated favourable outcomes without increased spending if acute medical care for these patients is provided using the geriatric medicine model<sup>6-8</sup>.

**Example 2: Specialist care in the community**

There is clear evidence of effectiveness for a mixed specialist geriatric medicine and primary care approach in both preventive and therapeutic care of older people<sup>9</sup>. One of the foremost commentators on the provision of care in the community has emphasized that intensive care in the community of high-need older people is best managed through ensuring strong links with geriatric medicine<sup>10</sup>. This contention is supported by recent positive outcomes of geriatric medicine allied to home care<sup>11</sup>.

**Example 3: Stroke Care**

Five out of six of those suffering from stroke are aged over 60 and this devastating illness is often complicated in later life by other pathologies and loss of function. Organized stroke care represents a practical and realistic way to save lives, reduce disability, lessen institutionalization and reduce length of acute hospital stay. The input of geriatric medicine to the Stroke Unit care has helped to shape an effective methodology of lessening the burden of this age-related disease<sup>12</sup>.

**Example 4: Falls**

Falls are one of the commonest reasons for older people to attend accident and emergency departments with trauma. Geriatricians have been to the forefront in developing effective prevention and treatment programmes. One prevention programme using exercise showed a 10% reduction in falls<sup>13</sup> while a radically new approach to falls almost eliminated admission to the general hospital with falls and succeeded in more than halving the number of falls over the subsequent year<sup>14</sup>.

**Example 5: Delirium**

Delirium, or acute confusion, is a frequent consequence of illness in later life. An important programme based on key principles of geriatric medicine has shown a reduction of in-hospital delirium from 15% to 9%, with concomitant savings in personal suffering and resource utilization<sup>15</sup>.

**Example 6: Dementia**

Not only have geriatricians been active in developing assessment and care packages for this devastating and common age-related illness but they have also been instrumental in developing important preventive research. One such approach (directed by a French geriatrician) has shown that the yearly incidence of dementia can be more than halving by controlling systolic hypertension<sup>16</sup>.

**Example 7: Hip fracture**

Hip fractures are increasing at an almost exponential rate and represent a very important cause of death and institutionalization, particularly as they are most common in the most frail elderly. Modern geriatric medicine has developed systems of joint care between geriatric medicine and orthopaedic surgery which hold great promise of reducing disability and institutionalization<sup>17,18</sup>.

**Example 8: Nursing home care**

Geriatricians have developed the tools for caring for the most vulnerable section of our older population, those in nursing home care. Not only have geriatricians highlighted these care needs<sup>19,20</sup>, but many European geriatricians are working on the development and implementation of assessment instruments to improve the quality of care in nursing home care<sup>21</sup>.

**Example 9: Urinary incontinence**

Urinary incontinence affects 10% of older Europeans but many suffer unnecessarily from this unpleasant syndrome. One of the core competencies of geriatric medicine is the assessment and management of urinary incontinence and there is clear evidence of the effectiveness of this approach<sup>22</sup>.

**Example 10: Elder abuse**

Elder abuse was first described in the scientific literature by a geriatrician<sup>23</sup> and many geriatricians are involved with the development of assessment and management protocols<sup>24,25</sup> of a problem which affects 3 to 5% of older Europeans.

**Example 11: Ethics**

The ageing of our populations has thrown up ethical challenges, ranging from those of ageism and lack of access to needs-based care to dilemmas in trying to decide how best to guide people and clinicians to decide when interventions represent ordinary or extraordinary care. Geriatricians have been to the fore in developing this important area, one which requires significant investment in original research<sup>26-28</sup>. Again it is important that those who are providing the specialized services develop ethical guidelines in conjunction with older people.

### **The role of geriatric medicine in education and research**

A strong and thriving specialist sector is a prerequisite to ensuring that doctors at all levels of the health services have access to appropriate training at undergraduate and postgraduate levels in the skills needed to deal sensitively and appropriately with the needs of older people. It is essential that this training occurs in the setting of service delivery rather than by didactic lectures alone. It is well recognized that ageist attitudes are ameliorated among medical students who are exposed to geriatric medicine in their undergraduate training. Family doctors can also benefit from this exposure and in a small number of European countries it is now recommended that trainees in family practice and internal medicine should spend some of their training period in geriatric medicine.

### **Development in geriatric medicine: a lot done, much to do**

Some European countries have already adopted a proactive approach to the development of geriatric medicine, with national policies stipulating departments of geriatric medicine in all general hospitals, academic department of geriatric medicine in teaching hospitals and gerontological training for specialist nurse and therapists. Some have developed postgraduate diplomas in geriatric medicine to cater for the needs of family doctors for whom older people represent one of their important service groups.

Many developments have taken place in the individual countries and at a European level. Minimum standards for specialist training in geriatric medicine have been agreed by the UEMS for the EU, covering the wide spectrum of skills and experiences need<sup>29</sup>. The EUGMS has developed an academic programme to further postgraduate education for geriatricians in Europe, while the Clinical Section of the International Association of Gerontology provides a multi-disciplinary forum. Geriatricians have co-operated with other gerontologists to develop a EU Masters in Gerontology in Public Health<sup>30</sup>.

However, much remains to be done. Geriatric medicine is not represented in three countries of the EU, many medical faculties have no academic departments of geriatric medicine and it is likely that the majority of medical students in the EU do not have formal exposure to geriatric medicine in the course of their training<sup>31</sup>.

## **Recommendations**

1. The EU should recognize that the care and welfare of older Europeans will be best advanced by ensuring that geriatric medicine is promoted as an important component of integrated health and social care for older people.
2. Each general hospital in the EU should encompass a department of geriatric medicine with adequate complement of appropriately trained geriatricians and support staff
3. Each medical school in Europe should have an academic department of geriatric medicine to provide leadership in undergraduate and postgraduate training and research.
4. Training in geriatric medicine should be a compulsory part of the undergraduate curriculum for medical students as well as for the vast majority of medical specializations in primary and secondary care who come into contact with older people in their everyday practice

This document was prepared on behalf of the EUGMS and the Section of Geriatric Medicine, UEMS by

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