The geriatric imperative

A major challenge to health professionals

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In recent years I have noted, with increasing envy, the inherent strength as well as the impressive clinical and academic developments of geriatric medicine in the medical schools and hospitals of Europe, the UK and the USA. In this country, although congresses of the Medical Association of South Africa devoted full plenary sessions to the care of the aged as early as 1957 and 1961, the resulting changes in attitude, taken together with the profound societal, economic and other implications of the growth and ageing of the various population groups of South Africa, have produced only some material changes in the care of the elderly. A lot still remains to be achieved.

It is perhaps worth while to review the position of geriatric medicine in South Africa at present, in Johannesburg in particular, and to describe some of the problems as I see them. The full history of the early beginnings and the later developments of geriatrics in this country will form the basis of a separate future study and report.

Negative attitudes to old people and geriatrics

One of the major problems in the medical care of old people and the development of services has been the stigma and negative attitudes attached not only to the older person but to the professionals and setting providing this care. There is a tendency to categorise people into groups and ascribe to the whole group the characteristics of the majority. The fact is that the elderly are a group of *individuals*, whose only common feature is the length of time they have lived. They differ from each other in heredity, personality, education, intelligence, family life, previous occupations, financial and domestic circumstances, health, lifetime experiences and many other factors.

Proper geriatric medical education should teach a viewpoint and an attitude that is necessary for appropriate care of the aged, in addition to the pathophysiology of ageing and organ-systems specifics of case management.

Several important factors have contributed to the lack of attractiveness of geriatrics as a field of study or medical practice. These include: (*i*) absence of a well-defined career track or training posts in the academic hospitals; (*ii*) clinical geriatric practice is nearly indistinguishable from care in the old-age homes in Johannesburg; (*iii*) the challenge of diagnosis and the satisfaction of treatment of the aged are not visible; and (*iv*) there is no geriatric unit to act as a role model in the academic hospitals.

There is an urgent need to provide a broad range of career opportunities in the care of the elderly, not only on the medical side but for all health professionals in the academic hospitals of Johannesburg.

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The demographic imperative

In spite of the present youthful appearance of the black population of South Africa, it is estimated that the actual number of aged exceeds by far the aged in the white population. The numbers of blacks aged 65 years and over will increase from 779 400 in 1985 to 2 737 000 by the year 2020. The numbers of whites aged 65 years and over are expected to increase from 408 500 in 1985 to some 858 200 by 2020, while over the same period the coloured population is expected to increase from 103 500 to 346 200, and the Indian population from 24 800 to 81 000.

Thus the total number of people aged 65 years and over will increase from 1 316 200 in 1985 to some 4 022 400 by 2020 (President's Council Report PC 1/88),[1] which is only slightly less than the *total* white population in 1985. This rapid increase in the absolute numbers and relative proportions of people over the age of 65 years, and particularly those over the age of 75, in all population groups in South Africa must have fundamental social, economic, cultural and personal consequences.

The shift of the elderly, especially when ill, to the urban areas has placed additional pressure on the community, old-age homes and hospitals for the provision of medical, social and other services in Johannesburg and Pretoria. There is also an over-concentration of elderly whites in most larger coastal towns and cities.

The South African National Council for the Aged estimates that approximately 7% of people aged 65 - 74 years will need help with their personal care and activities of daily living. In the 75 - 84-year age group the proportion increases to 16%, and then to 39% in the group aged over 85 years, many of whom are frail and senile. Since these patients are often socially and economically deprived they are at high risk of premature and inappropriate institutionalisation.

Nowhere will the impact of an ageing population be greater than in the health care fields. The geriatric imperative will increasingly influence the provision of suitable accommodation, health services and the demand for increasing numbers of health care staff. It may even dominate medical and nursing care for years to come. When today's medical students reach the prime of their careers they may find themselves spending as much as 75% of their practice time with older patients. This will also hold true for dentists, nurses, pharmacists, hospital administrators and most other health professionals.

Administrative or policy-orientated assessment

The demand for medical and social facilities and services and the placement of the elderly ill and disabled are based on their diagnosis and the assessment of their needs. There are, however, two types of geriatric assessment and evaluation, administrative and clinical, which serve different purposes. The administrative or policy-orientated assessment, which measures diminution of the activities of daily living, ability for self-care and nursing requirements, has developed rapidly over the past few years. It is often done by a nursing sister or a social worker rather than a medical practitioner. This informa-

tion provides the basis for policy decisions by welfare organisations as well as the amount of financial subsidy provided by state health and welfare services for the provision and development of nursing facilities, services and accommodation.

The increased incidence of acute and chronic diseases and impairments associated with increasing age has resulted in a marked increase in the demand for placement in establishments providing nursing care. Pressure has also been placed on the old-age homes to provide increasing amounts of *skilled* nursing services. Considerable development has taken place in institutions serving the white sections of the population in and around Johannesburg, but there has been very little progress in the coloured and Indian sections. Similar facilities and services for elderly blacks have only recently been established, and still lag far behind their present needs.

In addition, over the past few years official policy and subsidy weighting has also resulted in a rapid increase in the numbers of elderly patients in old-age homes who are bedridden, incontinent and with long-term illnesses, requiring intensive skilled nursing care. Many old-age homes have become more like nursing homes than the sheltered housing originally intended. The medical supervision of these patients has remained virtually the same as before, however, resulting in a serious mismatch between nursing and medical services in many old-age homes in Johannesburg.

Clinical assessment

The clinical assessment of these same old people in the community and in old-age homes and hospitals, which is the cornerstone of modern medical care and is more important than any administrative or policy-orientated assessment, has remained virtually static in Johannesburg over a number of years.

There are, however, great possibilities for treatment in older patients, and although recovery may be slow, successful treatment and management is common. In fact, today more than ever before many more options are available for the successful treatment of conditions that occur in the elderly, such as parkinsonism, dementia and malignant disease. The proper application of these options depends on accurate clinical diagnosis and assessment of the problems. '*Diagnosis* [italics mine] in elderly people who are ill, is the fundamental problem in geriatric medicine' (Professor Sir Ferguson Anderson).[2]

Clinical assessment and evaluation provides information about acute and long-term illnesses, disability and above all prognosis. This enables the health worker to identify treatable conditions, whether acute or longstanding, and to plan further investigations, rehabilitation and follow-up.

Appropriate and effective clinical decision-making and follow-up are, nevertheless, based on comprehensive information obtained from various sources, including family members and other health professionals. Clinical assessment should therefore form only one component (although the most important by far) of comprehensive geriatric assessment. This assessment is best done in the setting of a geriatric assessment unit, inpatient and outpatient, closely linked with comprehensive facilities and services in the community. The health care received can then be matched with patients' needs.

Comprehensive geriatric assessment

In caring for frail elderly people, health professionals need to collect and use a vast array of clinically relevant information, including physical, mental, social, economic, functional and environmental data, and to develop a co-ordinated plan of intervention. This process has been termed comprehensive geriatric assessment and covers all the information used for administrative and clinical purposes.

Comprehensive geriatric assessment should be considered as a dynamic ongoing process of monitoring, with regular readjustment of the original assessment plan when necessary. This programme should also not be viewed as operating independently from the primary care-givers or the other elements of the health care system, but should allow for active ongoing consultation and communication.

Comprehensive geriatric assessment is conducted by a core team consisting of a physician, a nurse, a social worker, a physiotherapist and other health professionals with special expertise in caring for old people. It may be done in many different types of institutional or domiciliary settings, but is best done in a geriatric assessment unit within a teaching or a regional hospital.

The geriatric assessment unit

The geriatric assessment unit (for both inpatients and outpatients) has emerged as a new cost-effective approach to the care of the ill elderly person. This development has several benefits: (*i*) greater diagnostic accuracy; (*ii*) detection of new treatable conditions; (*iii*) improvement in patients' physical, mental and social function; (*iv*) an increase in the likelihood of successful rehabilitation and a decrease in the final disability; (*v*) appropriate community or nursing home placement; and (*vi*) above all, a decrease in the cost of hospitalisation and re-hospitalisation, with the optimal use of scarce resources, services and funding.

The geriatric assessment unit has become the norm within the mainstream of academic hospitals overseas.[3,4] There are now over 100 such units functioning in the USA and a similar number in the UK and Europe. These units are closely integrated with the functions and teaching of departments of internal medicine, family practice and psychiatry.

A geriatric assessment unit is yet to be established in Johannesburg.

Disease prevention and optimal health maintenance

Until recently medical research and literature on ageing has emphasised physical and mental decline, the loss of tissue, of neuro-transmitters and of reserve capacities of various organs, and the results of disease screening and treatment programmes. In addition, the 'medical and hospital model' predominates in the academic hospitals at present. In this the general physician is the central figure and the patient is referred to him because of an illness.

However, there is now a substantial body of knowledge supporting the view that the possible effects of the ageing process have been exaggerated. The considerable modifying effects of nutrition (quantity, under-nutrition without malnutrition, quality, vitamin and essential trace element content), exercise, personal habits and psychosocial factors have been underestimated.

For the present, therefore, the alternative theory is preferable — that ageing is but a normal stage of development, during which health and independence is the expected norm. Healthy old people can continue physically and intellectually productive and active lives into the 80s and even longer.

It should be the principal function of medicine to keep people well and free of disease, a state that can best be reached through proper lifestyle. Doctors should concern themselves more with the positive quality of life than with negative aspects such as disease. With proper measures one can foresee a continued decline in premature illness and the emergence of a pattern of natural death at the end of a healthy and active life.

Certification another step for geriatric medicine

Geriatric medicine has emerged as an academic discipline with a well-defined field of expertise. There has been increasing acceptance of the assertion that there is a clearly distinct area of geriatric medicine that could be identified by its special body of knowledge and approach to patient care. This body of knowledge includes complex medical problems of multiple chronic illnesses and concurrent acute problems occurring in greater frequency in advanced age. The geriatric approach also includes an understanding of a broad range of health care systems, including acute and long-term care, comprehensive assessment and the establishment of treatment goals with explicit consideration of questions of ethics, values and quality of life.

On 20 April 1988, the first examination for certification in geriatric medicine was held in the USA and Canada. Those who passed were awarded a certificate of recognition of added competence in geriatrics. Similar developments have already taken place in Belgium and are being considered in the UK as well as in South Africa.

A significant landmark in the USA has been that internal medicine and family practice have joined forces in the creation and administration of this examination, clearly reflecting the shared goals and standards of these two groups. Geriatrics is firmly rooted in primary medical care as well. In addition, the geriatrician should be expected to be a resource person and act as a consultant to other generalists and sub-specialists.

Geriatrics warrants a closer look by primary care, internal medicine and family health educators in South Africa and in Johannesburg in particular. The extension of aspects of geriatric practice into general internal medicine and family practice would help resolve existing problems in primary care and simultaneously help enlarge the pool of physicians knowledgeable in the appropriate care of the elderly. There is also a need for physicians training in internal medicine or family practice to obtain extra experience, training or even specialisation in geriatric medicine.

The academic model envisages a cadre of geriatricians in medical schools so that all physicians-in-training who care for old people will receive appropriate training. In the USA and the UK the number of graduates of specific training programmes in geriatric medicine falls far short of conservative estimates of the necessary number of geriatricians in even a purely academic model, let alone a community service role.[5,6]

In Johannesburg, although the curriculum in geriatrics for undergraduate students in medicine, dentistry, physiotherapy, occupational therapy and speech therapy has grown over the years, further developments are necessary.

In South Africa, and in Johannesburg in particular, there is an urgent need to establish an effective programme of recruitment and training of doctors in this field, to enlarge the pool of specialist physicians and medical practitioners knowledgeable about the appropriate care of the elderly. If the medical schools and the provincial hospital authorities are to meet the health manpower challenge resulting from the ageing populations, they must make informed decisions about the number and distribution of the trainees in geriatric medicine and nursing, as well as the content of their training programmes. Scant resources should be focused on centres of excellence to yield the highest quality of training for the next generation of academic leaders in geriatric medicine.

There is also an urgent need to look more critically at the present reluctance of young doctors to take up careers in geriatric medicine in Johannesburg. There is a need to establish a career structure in geriatrics, and to improve visible strategies and incentives for developing academic leaders. The use of some of the time spent by suitable candidates in a geriatric assessment unit in lieu of military training could be considered.

The new national health plan

On 14 August 1986, Dr W.A. van Niekerk, Minister of National Health and Population Development, announced a new National Health Plan.[1] The intention of the new dispensation is to provide a centralised, unified service within the tricameral parliamentary structure. Dr Van Niekerk stressed that 'the new dispensation makes it possible, for the first time, to provide a dynamic and comprehensive health service, reduces fragmentation and is expected to lead to considerable saving'.

In addition, Dr J.C. Bekker states: 'Another feature of the system is that it provides for devolution of government functions to the lowest possible level of government. The provincial authorities are authorised to exercise in their own right or on behalf of a state department or minister those functions entrusted to them. The object is to have certain functions performed at a level closer to the various communities. The state departments concerned will, as a result, no longer perform such functions, but will focus on overall planning, co-ordination and monitoring.'[7]

He adds: 'The fact that the new system paves the way for real devolution of functions is, with respect, a step in the right direction. However, in a relatively small country like ours, proliferation may result in unnecessary duplication, waste of funds and inefficiency. It is therefore trusted that the provisions for co-operation will be fully used.'[7]

The President's Council Report[1] (7.4, p. 151) also notes that: 'The apparent lack of co-ordination and overlapping in many fields in the care of the aged in both the public and the private sector is a general cause for concern. The desirability of more effective co-operation in all fields has been repeatedly emphasised.'

The Old Age Home Liaison Committees and the various Co-ordinating Committees for the Care of the Aged, which have been fully functioning for some years, are now in disarray because of the recent break in their channels of communication with the official authorities responsible for policy-making. The Co-ordinating Committees for the Care of the Aged based in Pretoria and Johannesburg have not met for some months, are without chairmen and are virtually dormant at present. There is urgent need to reconstitute these links of co-operation.

The Report[1] (7.9, p. 152) also recommends the establishment of a national committee for the care of the aged, as well as regional committees to function as part of the existing structure of the Welfare Council. The task of this committee should be more comprehensive than merely social welfare, and should include all facets concerning aged people, with emphasis on social welfare, housing, health and economic matters. This committee is also to promote co-ordination of planning and implementation at the national, regional and local levels.

The President's Council Report[1] also comes out strongly in favour of the establishment of an extensive central data bank, which should contain all possible information in respect of numbers, circumstances, distribution, health and needs of aged people, as well as particulars of care projects and programmes. Clearly there is now urgent need for official departments to address the present problems of large numbers of elderly patients in old-age homes who have acute and long-term illnesses and receive inadequate clinical assessment and diagnostics. In addition, there is an urgent need for the development of a fully co-ordinated hospital-based home care programme with a computerised central data bank of clinical and social information on all elderly hospital inpatients. Suitable access would be made available to health professionals working in old-age homes and in the community.

The establishment of a national committee for the care of the aged, as recommended in the President's Council Report,[1] has also become essential for the proper restoration of co-ordination of all services caring for the aged in Johannesburg.

Causes of concern in old-age homes

Some of the factors that brought about the rapid increase in the numbers of elderly patients in old-age homes who are bedridden, incontinent and have long-term illnesses requiring intensive, skilled nursing care have already been mentioned. Many old-age homes in Johannesburg have become more like nursing homes than the sheltered housing originally intended. The continuous heavy physical and psychological burdens being borne by the nursing staff, without the relief of looking after functionally and mentally able residents as well, must be an important reason for the difficulty of retaining skilled nursing staff in many institutions in Johannesburg.

In addition, the nursing staff of the old-age homes, as well as nurses in the community services, need almost daily to make important decisions concerning patient treatment and management, often with incomplete clinical information. Access to the clinical documentation held by the regional hospital and its diagnostic clinical and laboratory services is usually available on written request. This results in frequent unnecessary dispatch of ill patients to hospital, with a considerable increase in effort and cost. In addition to the transport cost borne by the old-age homes, a sum of R5 has to be paid for each visit to the hospital, as outpatient or inpatient, and for home visits by a district nurse. This applies to all patients, even pensioners, white as well as black. These additional costs add a considerable financial burden to the already rapidly increasing costs being borne by the old-age homes.

Rehabilitation is a process designed to improve a person's physical, mental, psychological, social and vocational potential. It clearly connotes the need for a multidisciplinary team and the need for close co-operation between various medical specialists and allied health workers and paramedical personnel. Above all, successful rehabilitation of an old person involves close co-operation between the regional hospital, the official and voluntary community services, and the individuals and their families. Effective comprehensive rehabilitation teams and programmes also need to be established in Johannesburg for all population groups.

In summary, the increasing interest in geriatric medicine stems from an appropriate recognition of the demographic demands. If this country is to meet the health manpower challenges of an ageing population, informed decisions about the number, distribution and training of future experts in geriatric medicine must be made *now*.

In addition there is an urgent need for the development of a fully co-ordinated comprehensive hospital-based home care programme with a computerised central data bank of clinical and social information on all elderly hospital inpatients and outpatients, with appropriate access by health professionals working in old-age homes and in the community

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