Population ageing: Implications for health & care services (& so for Physiotherapy?)

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CSP Founders’ Day Lecture. Birmingham, 19th October 2018
RCP founder: 1518. #rcp 500
This just out...
“Mansplain” verb. informal

Gerund or present participle. Mansplaining

(of a man) explain something to someone (typically a woman) in a manner regarded as patronising or condescending

“I’m listening to a guy explain Physiotherapy to a hall full of Physios”
“Fan”. noun

A person who has a strong interest in or admiration for a particular person or thing

Synonyms: Enthusiast, admirer, devotee, lover or addict
Let's hear it for allied health professionals

06 August 2013
25 comments

Authors

Reflecting on our recent paper on the NHS and social care workforce, modern health care is a team venture. It is impossible to deliver effective care without the crucial contribution of highly trained allied health professionals (or AHPs).

I look after older people with complex needs for a living. Alongside multiple co-morbidities, many have social vulnerability, functional impairment or communication difficulties which complicate

Allied health professionals are critical to new models of care

01 December 2015
34 comments

Authors

Allied health professionals (AHPs) make up 6 per cent of the NHS workforce – the third largest professional group – and still more work in social care, housing, local government, and the voluntary and private sectors. They are highly trained and professionally autonomous practitioners, yet too often their vital contribution is marginalised in a public discourse that tends to refer only to ‘doctors and nurses’. This needs to change.

Twelve diverse professions are listed under the AHP umbrella. I want to name them all:
Physiotherapists too modest re contribution to?

Skills & knowledge?
Clinical care?
Multidisciplinary teams?
Service & system leadership?
Research?
Education?
Innovation?
Advocacy & campaigns?
Advice, peer support, consultancy?

You bet!
Some of many physiotherapists I work with
Some of many examples re older people
To Cover:
How ageing changes need, priorities, approaches

I: Population Ageing
II: Why it’s not all bad news
III: The downside we shouldn’t deny or wish away
IV: Some broad implications for services
And so for Physiotherapy?

I’ll signpost some key resources as we go
What I won’t cover


*Issues generic & largely international.*

Detailed research evidence/case studies re Physios in services for older people

*The knowledge is in this hall and you’ll know more than I ever could*

I will give my contact details & do reply
Which older people?
I: POPULATION AGEING
Rectangularisation to Elongation of Survival Curve

Distribution of death England 1841 - 2006

1947 NHS Founded, 48% died before 65. In 2015 its c 12%
By 2030 men aged 65 will live on average to 88 and women to 91

Currently 83 and 86

UK Population Pyramid & Projection

Implications for pensions, retirement age, workforce, dependency ratio, unpaid carers, immigration policy
Crucial role of carers

Already around 6 million people UK are **carers**

By 2022, the supply of carers will be outstripped by demand

1.5 M are over 65 – many in poor health

0.5 M over 80

1 in 4 say own physical or mental health affected by caring role

< 5% get statutory support


Social care cuts means 400,000 fewer people in receipt of home care than in 2010 and crisis in care home places/social care workforce

Observer October 14th – situation worse*
State of Caring UK report 2018

“It is frequently forgotten or, perhaps worse, taken for granted that the majority of care provided doesn’t come from the NHS or from care homes. It comes in the form of unpaid care that relatives, friends and neighbours provide – estimated to be worth £132 billion a year.”

State of caring report (2018), Carers UK
The workforce challenge: Most pressing threat to sustaining health *and* social care? Questions for physiotherapy?

Facing the Facts, Shaping the Future
A draft health and care workforce strategy for England to 2027

For consultation

PUBLIC HEALTH

England

THERE FOR US
A better future for the NHS workforce
II: WHY AGEING’S NOT ALL BAD NEWS
Ageist/catastrophising language

“Grey tsunami”
“Ticking time bomb”
“Burden”
“The Elderly”

Polarised representations

Skydiving grannies vs Vulnerable Victims

Similar language creeps into healthcare

“Acopia” “Social Admission” “Bed Blocker” “Failed OT assessment” “no rehab potential”
The Geriatrics “Profanisaurus.”
Words and phrases we should ban?

David Oliver is a Consultant Geriatrician in Berkshire and a visiting Professor in Medicine of Older People at City University, London. He is President Elect of the British Geriatrics Society.

During the BGS Spring Meeting in Belfast, Prof Des O’Neill – probably the most cultured and

David Oliver: Minding our language around care for older people and why it matters
May 7, 2015

I love to plough through the newspapers, with radio or TV news on in the background. My enjoyment can be punctured by annoyances. Recurring candidates for this personal “room 101” are ageist language and attitudes. Comparing 2015 with my youth, I’ve seen a welcome sea change in the language deemed acceptable regarding race, sexuality, or disability—whether in the street or in the media. Yet ageist terminology remains far from taboo.

Older people are occasionally vilified, often mocked, and usually patronised. In media representations they are either invisible (“out of sight out of mind”) when it comes to, for instance, care home residents or the housebound; portrayed as vulnerable and victims; or “allowed in” if they are “spiritly” or “good for their age.” As for demeaning language? It’s often used.

Ageism and age discrimination in social care in the United Kingdom

A review from the literature

commissioned by the
Department of Health

carried out by the
Centre for Policy on Ageing
Ageing a success story for public policy, public health and medicine

Source: ONS, 2011

Mortality by major cause, in men and women (all ages), England and Wales, 1911-2010*
Disability-free life expectancy

Figure 4: The average number of years that people live free of disability at age 65 in England, 2005-07 to 2009-11

Source: Office for National Statistics (2014a,b)
OECD 2015 Self-reported health status

11. AGEING AND LONG-TERM CARE

Self-reported health and disability at age 65

11.6. Perceived health status in adults aged 65 years and over, 2013 (or nearest year)

% of population aged 65 years and over reporting to be in good or very good health

1. Results not directly comparable with other countries due to methodological differences (resulting in an upward bias).
Difficulties in ADLS by age

Figure 7: Number of difficulties with activities of daily living by age, England, 2012/13

Source: English Longitudinal Study of Ageing (2014)
Chart 50: Happiness in later life - age makes little difference

Source data: Cooper et al (2010)\textsuperscript{131}
Contribution of older people

Unpaid caring
Grandparenting
Ongoing employment
Spending
Volunteering & local community roles
Longer working lives in future? 2\textsuperscript{nd} careers?
Need to stop representing as burden/drain
“Asset based” approaches (what they can do) not just “deficits” (what they can’t)
Age UK/BGS work on falls/frailty confirm this from their point of view
III: THE DOWNSIDE WE SHOULDN’T DENY OR WISH AWAY
Chart 23: Physical inactivity

Source data: Health Survey for England\textsuperscript{59} Copyright © 2011, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

Figure 23: Levels of physical activity in men and women aged 55+ years, England, 2008
Chart 10: Mobility difficulties

Source data: HSE 2005. Copyright © 2011, Re-used with the permission of The Health and Social Care Information Centre.
Chart 24: Social isolation and loneliness

Figure 24: Percentage of people aged 50+ years not living with a partner/spouse, who replied ‘Often’ as opposed to ‘Sometimes’ or ‘Hardly ever’ when asked if they felt isolated or lonely, England, 2009

Source data: ELSA 2009
Chart 18: Social inequalities - shorter lives with more disability

Melzer D Age UK 2013

Source data: Health Statistics Quarterly 50, summer 2011, ONS48
Multimorbidity (Scottish School Primary Care Study. Lancet. Barnett et al 2013)
People with multiple LTCs are “core business”

It is estimated that people with long-term conditions, which cannot be cured but are managed with drugs or other treatments, account for:

- 50% of GP appointments
- 64% of outpatient appointments
- 70% of inpatient bed days
- 70% of the total health and care spend in England

Setting higher standards
Single disease models often unfit: polypharmacy follows
Guthrie et al BMJ 2013, Kendrick et al King’s Fund 2014

% of patients with this condition...

...who also have this condition (% = % of all patients with the condition)

<table>
<thead>
<tr>
<th>Condition</th>
<th>CHD (4.7%)</th>
<th>Hypertension (13.6%)</th>
<th>Heart failure (1.1%)</th>
<th>Stroke/TIA (2.2%)</th>
<th>Diabetes (4.3%)</th>
<th>COPD (3.2%)</th>
<th>Cancer (2.3%)</th>
<th>Painful condition (7.2%)</th>
<th>Depression (8.2%)</th>
<th>Schizophrenia/bipolar (0.7%)</th>
<th>Dementia (0.7%)</th>
<th>Any other (30.5%)</th>
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**Dementia Prevalence OECD 2015**

(n.b. 1 in 4 beds in Hospital, 3/4 in care homes)

11.10. Age-specific prevalence of dementia across all OECD countries, 2015

Source: OECD analysis of data from Prince et al. (2013) and the United Nations.

StatLink [Link](http://dx.doi.org/10.1787/888933281401)

11.11. Estimated number of people with dementia in all OECD countries, by age, 1995, 2015 and 2035

Source: OECD analysis of data from Prince et al. (2013) and the United Nations.

StatLink [Link](http://dx.doi.org/10.1787/888933281401)

Information on data for Israel: [Link](http://oe.cd/israel-disclaimer)
From Canadian Study on Frailty and Aging (Rockwood K et al)

Clinical Frailty Scale*

1. Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3. Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

5. Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, stand-by) with dressing.

7. Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally III – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

Distribution of electronic frailty index England >65s (n = 227,000)

Clegg et al 2016
Frailty Index (eFI): survival plots

(Clegg A et al Age ageing 2016)
### Electronic Frailty Index (England)

\( n = c 227,648 \) *(Clegg et al Age Ageing 2016)*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mild frailty (HR, 95% CI)</th>
<th>Moderate frailty (HR, 95% CI)</th>
<th>Severe frailty (HR, 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr care home admission</td>
<td>2.00 (1.68 to 2.39)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>5.94 (4.61 to 7.64)</td>
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<tr>
<td>3 yr care home admission</td>
<td>1.52 (1.37 to 1.69)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>3.42 (2.84 to 4.12)</td>
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<tr>
<td>5 yr care home admission</td>
<td>1.56 (1.43 to 1.70)</td>
<td>2.34 (2.10 to 2.61)</td>
<td>3.00 (2.42 to 3.70)</td>
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<tr>
<td>1 yr hospitalisation</td>
<td>1.85 (1.81 to 1.88)</td>
<td>2.96 (2.90 to 3.02)</td>
<td>4.62 (4.50 to 4.74)</td>
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<td>3 yr hospitalisation</td>
<td>1.71 (1.69 to 1.73)</td>
<td>2.54 (2.51 to 2.58)</td>
<td>3.64 (3.57 to 3.70)</td>
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<tr>
<td>5 yr hospitalisation</td>
<td>1.63 (1.61 to 1.64)</td>
<td>2.43 (2.40 to 2.46)</td>
<td>3.59 (3.54 to 3.65)</td>
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<tr>
<td>1 yr mortality</td>
<td>1.91 (1.78 to 2.04)</td>
<td>3.39 (3.15 to 3.65)</td>
<td>5.23 (4.73 to 5.79)</td>
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<tr>
<td>3 yr mortality</td>
<td>1.74 (1.68 to 1.81)</td>
<td>3.02 (2.90 to 3.14)</td>
<td>4.56 (4.29 to 4.84)</td>
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<td>5 yr mortality</td>
<td>1.66 (1.62 to 1.71)</td>
<td>2.73 (2.64 to 2.81)</td>
<td>3.88 (3.68 to 4.09)</td>
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How frailty presents

Figure 1: Vulnerability of frail elderly people to a sudden change in health status after a minor illness
How frailty presents
(Clegg et al Lancet Clinical Reviews 2012)

“Progressive dwindling” (Meyer and Bowman JRSM)
“Non-specific” e.g. not thriving, slowing up, Falls/Collapse
Immobility/worsening mobility
Delirium (“acute confusion”)
Incontinence (new or worsening)
Fluctuating disability
Increased susceptibility to medication side effects
  • e.g. Hypotension, Delirium
Falls – one example

People over 65 fall yearly on average
Over 80 – twice yearly
C 40% of ambulance call outs to over 65s
Top cause of ED attendance in over 80s
Biggest safety incident in NHS hospitals
Care Homes 3-4 falls per resident per annum
230,000 fragility fractures per annum in UK
80,000 Hip Fractures
Fear of falling, spiral of immobility
“Red flag” for underlying medical conditions including gait/balance/frailty

Opportunity to intervene, prevent further falls, reduce injuries, restore or maintain independence
Part of RCP falls and fractures audit prog (FFAP)
Image 1: Distribution of long-term conditions by age of A&E attendee 2012/13, Focus on A&E attendances, QualityWatch

Figure 4.3: Distribution of long-term conditions (LTCs) by age of A&E attendee, 2012/13

Source: Nuffield Trust and Health Foundation (2014)
Age of UK hospital inpatients

- 18-64: 25%
- 65-74: 22%
- 75-84: 32%
- 85+: 21%
Functional decline in acutely admitted older patients. *Mudge et al 2011*

![Bar chart showing functional decline in older patients](image)

**Figure 1.** Percentage of study participants (*n = 615*) requiring human assistance in each activity of daily living, at baseline, hospital admission, and hospital discharge.
Will prevention save the day?
Kingston et al Age Ageing 2018 Cognitive Function and Ageing Study

2015 -2035
Proportion with 4+ diseases will double to 17%  
2/3 with 4+ diseases will have dementia, depression, cognitive impairment).
Life expectancy gains M: 3.6 y F: 2.9 y  
With 4+ diseases (M: 2.4 y, 65.9%; women: 2.5 y, 85.2%)

“Need to focus on prevention and service provision for people with complex multimorbidity”
IV: SOME BROAD IMPLICATIONS FOR SERVICES
For all healthcare practitioners

Increasing/largest part of work – “core business”

Will be supporting older people with multimorbidity, frailty, age-related disability, cognitive impairment, carers

Skilled generalism

Working in multidisciplinary teams

Some role flexibility/cross-over

Growing focus on prevention and care coordination & out of hospital care

Integrated teams

Training, values, skills, expectations, prestige?
Older people, integration & care co-ordination

Older people
Especially with complex needs/frailty
Most likely to use multiple services
See multiple professionals
Suffer at hand offs between agencies
Get disjointed, poorly co-ordinated care
Rely on informal carer support
National Voices is calling for all people with long-term conditions, disabilities, health and care needs to have access to person-centred coordinated care.

The Narrative for Person Centred Coordinated Care

Person-centred coordinated care

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

- Care planning
- My goals/outcomes
- Information
- Communication
- Decision making
- Transitions
Emerging policy consensus

Geared to acute
Hospital-centric
Dr-dependent
Episodic
Disjointed
Reactive
System/disease
Patient passive
Self-care rare
Carers undervalued
Low-tech

Geared to LTCs
Community-centric
Team-based
Continuous
Co-ordinated
Preventive
Person-centred
Patient partner
Self-care supported
Supported as partners
High-tech
9 components of care: 10th = integration

Physiotherapy roles in each
Thankyou

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