INTRODUCTION

Alternatives to hospital care for older people

In recent years, we have witnessed a marked reduction in the number of UK hospital beds. Britain now has about half the number of hospital beds per patient as France or Germany, and the lowest number of doctors per 1000 patients among the major industrial countries. At the same time, there has been an increase in the number of ill older people referred to hospitals. Expectations of patients and their families have risen. The system is often under strain, particularly during the winter months, when the increase in respiratory infections and other diseases means that many geriatric and general medical wards struggle to cope with large numbers of ill old people.

There are unfounded beliefs that many hospital admissions of older people are inappropriate or unnecessary, that many of these patients could be managed elsewhere and that some are purely ‘social problems’. The number and severity of hospital-acquired infections and the problem of accidental injuries to old people in hospital is of concern. Some old people are afraid of hospitals, fearing poor care or inevitable death. Others might prefer care in their own homes or in a local small hospital rather than a large distant one. There are good studies of the effectiveness of aspects of rehabilitation outside hospital.

One response to the concerns about there being so many older people referred to and admitted to hospital has been the concept of ‘intermediate care’. The hope has been that a range of non-hospital alternatives might be as effective as hospital care. They might also be cheaper. What is the evidence for these beliefs?

This supplement presents papers from a national, multi-disciplinary symposium which was held in Leeds in 1999. The purpose of the meeting was to present the facts about several alternatives to hospital care—community hospitals, outreach teams, hospital-at-home, nursing home care—as well as the assessment of older people in Accident and Emergency departments and the experience of initiatives in primary care. The developments in ‘intermediate care’ were carefully examined and questions of governance and autonomy were addressed.

The contributors were asked to clarify definitions, describe what was known about a specific model for care—the evidence of effectiveness, whether there are untoward aspects of care in that setting—and to identify gaps in our knowledge. They also posed questions for future research.

The care of older people has improved considerably in the past 50 years. Previously, care in understaffed old buildings was often poor. Many sick or disabled elders were not referred to specialists. As the number of geriatricians and old age psychiatrists increased and more beds for old people were opened in general hospitals, a greater proportion of older people received prompt, appropriate and high quality investigations and care. However, the hospital model is not perfect and a variety of approaches may be needed to match the diversity and meet the wishes of older patients and their families.

A change from the present system must be based on the principle that old patients should receive the best possible care. A range of options predicated on the needs of older people could be a positive development. Alternatively, some out-of-hospital alternatives could be undesirable, with the potential for missed diagnosis, fragmented and substandard care and low expectations. Moreover, such care may cost as much or more than hospital care. Before there is any remodelling of services for older people, there should be a careful assessment of the facts.

I believe that the papers in this Age and Ageing Supplement will help to inform thinking and debate on this topical issue. I hope that the careful considerations of the contributors are read carefully by policy-makers and that the challenge to do research into alternatives to hospital care for older people will be heeded.

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