Assess first, admit second

‘Population ageing is unprecedented, without parallel in the history of humanity. Increases in the proportions of older persons (those aged 60 years or over) are being accompanied by declines in the proportions of the young. By 2050, the number of older persons in the world will exceed the number of young for the first time in history, with the fastest growth being in those aged over 80 years. By 1998 this reversal in relative proportions of young and old had already taken place in the more developed regions. This is due to the demographic transition from high to low levels of fertility and mortality.’ These sentences are quoted from the opening paragraphs of a United Nations report [1] and graphically describe the broad context for health and social policy for older people.

Demographic change has been accompanied by increased urbanisation and a reduction in the numbers of older people living in the same household as their children. Increasingly older people are living on their own; this trend is worldwide but most pronounced in northern Europe [1]. One feature of the health and social care systems in the more developed countries has been the growth in residential and nursing homes to accommodate frail older people.

In England about half a million older people reside in care homes; 341,000 are in residential homes and 176,000 in nursing homes and dually registered accommodation. For the year ending March 2002 nearly 50,000 people entered permanent residential care and 35,000 entered permanent nursing home care. A further 106,000 entered care homes on a temporary basis [2]. Whilst the number of care home places has declined slightly due to economic and regulatory pressure, demand for places continues as evidenced by the numbers of hospital inpatients waiting for care home places [3].

The study by Challis and colleagues in this issue of Age and Ageing researches the value of specialist assessment of those on the threshold of admission to a care home and refers to previous work that provided evidence of the value of specialist assessment from as far back as 1978. Assessment should identify remediable disorders and define treatment which might delay or even avoid the need for admission to a care home, or equip care home staff to plan appropriate care for new entrants. The translation of this evidence base into practice underpinned by relevant legislation and funding has not occurred in the United Kingdom with regard to placements in care homes even though large numbers of people are affected with considerable funding implications [4].

Australia provides an example of a process governing admission to care homes with a national assessment programme in which multidisciplinary Aged Care Assessment Teams (ACATs) determine eligibility for admission across the entire continent. This and other measures to assist older people are backed by a Minister for Aged Care heading the Office for Older Australians. Government maintained web sites provide information about services for users and professional staff. The teams are usually based at a hospital, geriatric centre or community centre, but can visit people in their own homes. The teams can include medical staff, nurses, social workers, occupational therapists and physiotherapists. Geriatric assessment teams underwent trial in 1984, by 1991–1992 ACATs were approving over half of admissions to nursing homes. In 1994–1996 156,000 assessments were carried out equating to a rate of 110 assessments per 1,000 persons aged 70 and over in Australia. The number of assessments rises with age. Eight per cent were aged 65–69, 34% were aged 70–79 and 58% were aged 80 and over. The assessment links with the person’s regular medical attendant, and in addition to the assessments by staff mentioned earlier includes carer support, advice on equipment, respite care, and measures to maintain independence [5].

In the United States the American Geriatrics Society began campaigning in 1990 for the establishment of Medicare reimbursement for geriatric assessment [6]. The Society strongly supported the efforts, started in 2001, of US Senators to introduce the Geriatric Care Act which would provide funding through Medicare for geriatric assessment of senior citizens and a consequent increase in staff including geriatricians. Those efforts proved unsuccessful and a fresh attempt supported by additional sponsors is being made in 2003 [7].

In England people who fund their own care can choose to enter a care home. Those who are publicly funded must be assessed by a social worker and receive a nursing assessment to ascertain the level of National Health Service contribution towards nursing costs. No system exists to provide an automatic geriatric assessment to explore means of reducing dependency and to exclude remediable medical problems although information about health status is obtained from general practitioners or hospital staff. Hospital inpatients already under the care of geriatricians should have benefited from a comprehensive assessment. However, those from other clinical services may not have received such an assessment although many would regard it as good practice for a geriatrician to see such individuals before a decision is made. The continuing fragmented and inconsistent approach to long-term care is described in the Health Services Ombudsman’s Report 2003 [8].
The developed world is facing a problem: too many older people and too few younger people to look after them. A powerful case exists to ensure that remediable conditions are not missed and that where possible levels of dependency are reduced, to ensure improvements to the quality of individuals’ lives and the most efficient use of one of the most expensive types of health and social intervention: long-term care.

Challis and colleagues provide welcome additional detailed and comprehensive evidence coupled with an economic analysis, based on a randomised controlled trial.

Skilled assessment of those at the threshold of entry to a nursing home does provide benefits that can be realised through the use of about 1 hour of specialist staff time per case. The authors’ contribution should be required reading for geriatricians and policy makers as they collaborate to meet the challenges of an ageing population and the problem of providing the personnel to deliver care.

**References**


**Anaesthesia and the older surgical patient: something old, something new, something borrowed…**

In the past eighteen months there have been a number of editorials in major anaesthetic journals on the anaesthetic management of the older patient [1, 2]. In December 2001, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) issued guidelines to members on the perioperative care of the elderly. In particular, the AAGBI called for the appointment of a lead clinician in each anaesthetic department with an interest in the care of the elderly [3]. What has increased the profile of the older patient in the field of anaesthesia and intensive care?

Changing demographics with consequent expansion of resource utilisation is the most powerful explanation. As the elderly have surgery four times more often than the rest of the population, in the near future the majority of patients presenting for surgery and anaesthesia will be aged older than 65 years, with a substantial proportion older than 85 years.

To date, anaesthetic management of the elderly patient has not attracted significant clinical or research interest. Comparison may be made to developments in the field of paediatric anaesthesia, which lead to a greater appreciation of the difficulties associated with patients at the extremes of age, but arguably to a decline in skills among anaesthetists in general.

It will not be possible to ring-fence anaesthesia for the older patient. Firstly, by the year 2040 there are expected to be 4.4 million people over 80 years [4]. The elderly patient is found in almost every surgical specialty, with the obvious exceptions of obstetrics and paediatrics! Confining the older patient to the specialty of anaesthesia for the elderly may mean a diminution of skills among anaesthetists of all grades. Continued exposure to the needs of the elderly is vital to our safe practice. Anaesthetists play an integral part