Palliative care for older people

Do older people have equitable access to specialist palliative care? A number of studies addressing this question have been published in recent years; however, all have methodological flaws limiting the generalisation of their findings. Therefore, the systematic review by Burt and Raine [1] on the effect of age on referral to and use of specialist palliative care services in adult cancer patients is particularly welcome. They find some evidence that older cancer patients are less likely to be referred to or use specialist palliative care services, but emphasise the failure of all studies to consider variations in the need for such services. Consideration of need is crucial when evaluating equity of access to health services. The authors conclude that ‘Sensitive and flexible prospective methods should be developed to examine the extent to which the use of specialist palliative care is fair’. This is true. However, is it the most urgent question to be asked now regarding palliative care for older people?

The need for comprehensive and high-quality palliative care provision for all patients regardless of age, diagnosis and geography is now a given [2, 3]. There is also the widespread recognition that the palliative care needs of the elderly require specific attention [4–10]. Unusually in the field of palliative care, central funding in support of service development has become available in recent years [11–14]. Such monies have financed more equitable spread of services across networks and specific initiatives in end of life care. Such initiatives, including the Gold Standards Framework, Liverpool Care Pathway for the Dying and the Preferred Place of Care Document, aim to improve provision of general palliative care for all and to prompt referral to specialist palliative care services as necessary [15].

These end-of-life initiatives are based on existing specialist palliative care expertise. However, new knowledge and models are required to shape services to meet the needs of older people at the end of their lives [5–8]. Work is in progress to explore the values, attitudes and needs of the older population in relation to dying, death and bereavement [see for example 6, 16, 17]. Policy groups have been established to evaluate the evidence base for palliative care service provision, needs and service models for specific conditions prevalent in the elderly, such as dementia [5]. Any model of palliative care provision for the elderly must also address cross-cutting factors relevant to the older population in general, for example increasing frailty, comorbidities, increased psychosocial vulnerability and altered physiology [5–7]. Most people say that they want to die at home but few do. Service-based research is under way to explore the reasons why this is the case and to develop or redesign services to facilitate home deaths for those who choose this [18].

There can be no doubt that new models are needed for end-of-life care. Nationally, there are 2,674 specialist palliative care (hospice) inpatient beds [19] and a shortfall of specialist palliative care professionals. Such specialist resources are unlikely to expand significantly. Therefore, we do need to establish and monitor how best to use these services. Meanwhile, there is a pressing need to improve palliative and terminal care for patients in their current locations and to promote patient choice regarding place of care and death. Specifically, palliative care for patients in hospitals and care homes needs to be improved, and the number of people enabled to die at home needs to be increased [3, 8, 18]. For this to happen, a system-based approach is required, with collaboration among patients, carers and providers and commissioners of services at all levels. The context includes societal attitudes and practices, in relation to advance care planning, willingness to provide care for family and friends to enable them to remain at home, the legality or otherwise of assisted dying and how much we are prepared to pay personally and as a society for health and social care. The framework incorporates the network of health and social professionals and informal carers, with consideration of who is best placed to meet needs without unnecessary duplication or gaps [5, 6]. Necessary processes include advance care planning regarding individual preferences for place and goals of care; the development of competencies in palliative care for different professionals, with appropriate training in symptom management, psychosocial care and...
carer support; care pathways and referral criteria for specialist services. Practicalities include the timely availability of palliative care medications in all settings and at all times, particularly controlled drugs.

It is very encouraging that palliative care is now being addressed in national policy documents, particularly the national service frameworks [4, 20] and command papers [3, 11, 13, 14]. A growing research base and more widespread debate specifically addressing the palliative care needs of the older population and their carers mean that our collective task is now much clearer. Most of us will die when we are old. Being ‘old’ comes at different times to different people, and services should be developed around need rather than chronological age, diagnosis or other variables. Palliative care services must be able to encompass the needs of a spectrum of patients from the independent to those with multiple comorbidities, increasing frailty and protracted dying, and psychosocial vulnerability including degrees of mental incapacity and social isolation. As models of care develop, they need to be evaluated and experiences and examples of good practice shared. Recent financial investments are unlikely to be continued, and the emphasis will be on reconfiguring existing resources [20]. Public and professional expectations will need to be managed in the light of this.

For most of us, dying well will be dependent on the availability, effectiveness and flexibility to individual need, of general social and health care, with support from, and for, those close to us. Some of us will also need to access specialist services. Developing the right care models is crucial, and then equity of access to end-of-life care can be evaluated more meaningfully.

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