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Ageing, health, and social care: reframing the discussion

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The current age structure of the UK population is radically different from that at inception of the National Health Service (NHS) in 1948, and health inequalities are widening fastest in people aged 65 years.¹ On the one hand there are fit, highly advantaged people at advanced ages for whom functional limitations and disability are postponed (ie, compression of morbidity);² and on the other, there are those who age faster and die earlier, with a higher prevalence of chronic diseases, at least partly related to lifetimes of disadvantage and social environments that have not led to healthy ageing.³

What provisions are necessary, now and for future generations? The main political parties contesting the forthcoming UK general election endorse, albeit to varying degrees, the models of care espoused in the NHS's Five Year Forward View.⁴ Highly relevant to people aged 65 years is the focus on integrated primary and acute care, with the proposed model resembling the accountable care organisations emerging in the USA. Policy recommendations from the King's Fund and professional societies are broadly consistent with this ambition (although not necessarily the means), and include merging of access to health and social care, development of capacity in intermediate care (eg, step-up and step-down services as alternatives to hospital admission), and investment in health-care workers to provide high-quality, skilled care.^{5, 6} However, legislation from successive UK Governments since 1990 has not enhanced integration (either from individual or population perspectives), from the funding models to the introduction of the purchaser-provider split, private finance initiatives, and the 2012 Health and Social Care Act.⁷ This latest reorganisation was particularly disruptive and costly, and these changes affect the older population disproportionately. Policy development has been reactive or ideologically driven, rather than strategic and evidence-based. Even now, for the upcoming election, no political party is explicit about how locally devolved models of care, such as that envisaged in Manchester, UK, might weaken the ability to maintain an NHS or the implications for population health.

Persistent and widening health and socioeconomic inequalities in ageing call for reflection about the major influences that work against the rhetoric of integrated care.¹ Important

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amongst these influences are the continuing focus on single disease entities, highly specialised interventions, and the biomedical research that underpins them; societal emphasis on individual health and personalised responsibility for future health, rather than for whole population groups; and discourse about disability and end-of-life care, rather than extension of life at all costs. Culture, geography, and history all affect how each successive generation ages and is supported by society, which in turn affects how younger generations will support older ones, or not, as they age.⁸ Technological change will also inevitably have an effect on health, and the cohort effects therein mean that evidence based on current understanding is not necessarily stable across generations. The evidence base is even poorer for effects among other cultures in transition across the world, and among the many individuals who migrate between countries and health systems. Growing emphasis on personal rather than societal responsibility for health is leading to a preoccupation with monitoring, screening, and personal diagnostics. This change, and increasing private sector involvement in health, is leading the UK towards the US model, with the health market driving market health. This shift is likely to increase inequality further, with initiatives such as personal budgets easing the way for reduction in commitment to whole system care. New governments need independent analysis, perhaps statutorily empowered, which can create a better balance between innovation in medical advances and what is sustainable, affordable, and beneficial for current and future populations.⁹

Although single-disorder biomedical research has led to clear benefits for many individuals, this approach has led to increasing medicalisation of population groups. Definitions of disorders drift towards pre-disease constructs, for which the evidence base for treatment benefit and implications for society are less clear.^{10,11} As the population ages, the applicability of the single disorder–single pathway approach weakens. More people become regarded as having multiple diseases earlier, with attendant polypharmacy but with uncertainty about the cost–benefit ratio. Observational studies in large population groups describing the natural history of many technologically-based findings such as subsegmental pulmonary embolism,¹² leukoaraiosis,¹³ and β -amyloid positivity in the brain,¹⁴ are essential,

The next UK government should understand that health-care systems for ageing societies, whatever the component parts, must address the interplay between acute illness and functional decline in older people, rather than trying to define problems of ageing in discrete nosological categories. Incomplete recovery and enhanced survival, where death would have been the outcome in previous eras, result in new levels of disability. As individuals are shuttled between and within primary, intermediate, and secondary care, a major risk is the lack of overall understanding about the whole person in care, particularly regarding the accrual of cognitive and functional impairments along the way (eg, when these impairments might be modifiable, in whom, and by how much). An understanding of the point at which an individual fails to benefit from, and indeed might be harmed by, further intensive medical intervention is needed urgently, allowing for an appropriate compassionate supportive pathway, leading to palliative care.

Integration is at the heart of public health, and public health is at the heart of a socialised health-care system that is affordable, equitable, and effective. Public health should be able to

offer independent perspectives, representing all age groups now and in the future, trying to understand vested interests and informing balanced, evidence-based views. Achievement of this situation will require an honest dialogue about what, as a society, we want as we age, how medicalised we want the experience to be, and what we expect services to provide for us towards the end of life. What can we afford now, and at what cost to younger generations? Health manifestos offered for this election might be an opportunity to redress the balance, such that public health policies will lead this change from within the NHS, with social care aligned, to advocate for the health of whole populations now and in the future.

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