

## Opinion 1

# Principles to guide geriatric care services in Africa. A new era?

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### Abstract

*The emergence of geriatric services in Africa is inevitable. The new millennium offers an opportunity for health-care professionals, planners and politicians to collaborate in the development and provision of health-care services to older Africans. This piece discusses the options and principles which could be employed in such a collaboration. A case is made out for an evolution of African geriatric medicine away from western (structural) models towards an indigenous speciality model based on systems and processes.*

The past half century of continued high fertility and declining mortality in less developed regions has yielded a rate of population growth unsurpassed in the history of the world. Africa is the most under-developed region in the world, and is projected to have the largest increase in the number of elders in relation to its total population (Adamchak, 1989). Add to these two facts an almost complete lack of institutional preparedness throughout Africa to deal with current – never mind anticipated – challenges (Wilson & Nhwatiwa, 1992), and a sense prevails that the elderly of Africa are the most vulnerable in the world.

Special challenges face those who plan and deliver health-care services to elders in this context. Whether in the community or in a hospital setting, commonsense and experience dictate that one cannot impose a single established system of care, e.g. a British model of geriatric care, onto evolving African systems where people's needs and the priorities for resource allocation differ substantially. Yet there is no sense in re-inventing the wheel. What is required is that in each situation the best principles be selected from evolved systems and selectively applied to mould services appropriate to local circumstances.

I discuss some options and principles which could be employed in the evolving practice of Geriatric Medicine and health-care service delivery in Africa. I argue that this evolution could proceed as a speciality based on processes and systems, rather than along the classical bed-based (or structural) model.

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### Principles

#### *Focus on specific medical problems of ageing*

No matter where in the world, ageing will produce, to varying degrees, a mix of medical, mental, social and functional (physical) stresses. Medical stresses result from multiple pathologies, reduced organ function, polypharmacy, and the fact that older people present with common problems in an atypical way. Add to the above the loss of safety margins (i.e. a loss of homeostatic reserve or capacity) inherent in the ageing process, and more than a suspicion that intolerance is established in prevailing medical attitudes towards older persons; it is then reasonable to conclude that the most vulnerable are most at risk, not only in the community but in a hospital setting itself.

Of particular concern is a failure of medical personnel to accept, if indeed not to acknowledge, the significance of the diagnostic and management challenges posed by multiple pathology, when conventional medical teaching systematically emphasizes the unitary hypothesis – a single patient, a single diagnosis. In addition, an ingrained dependence on complex drug treatments results in often inevitable sequelae of polypharmacy. The effects of polypharmacy may be exacerbated by a reduced drug metabolism inherent in ageing and may result in unpredictable effects on physical and mental health which in turn adversely affect the maintenance of functional independence in older adults. Mental and psychological problems are common, resulting from bereavement, brain failure and depression, as are social problems, which are usually the consequence of segregation, isolation and financial hardship.

The problem compounds – and therein lies a recipe for decline. The pressures of life conspire with age to place an intolerable burden on an older individual.

Thus in developing models of geriatric care, special attention must be paid to the above factors, and a clinical emphasis placed on the early identification and correction of potentially reversible harmful phenomena.

#### *To demolish ageist stereotypes prevalent in medicine and planning*

Anecdotal experience shows that ageism exists in African medicine, reflecting western ageist stereotypes (Victor, 1991) to varying degrees and augmenting those that are locally bred. These stereotypes are widespread and they

prejudice the welfare of older people. What examples are there of these western stereotypes? Are they relevant, and if so, how can they be addressed?

**Stereotype 1: Normal ageing means poor health is the norm for older persons, whilst normal youth means the norm is vitality and good health**

This statement encapsulates the prevailing attitude of a cohort of women surveyed in the United Kingdom (Blaxter, 1983). A passive acceptance of inevitable decline and dependency with ageing emerges. It may not be established that such a stereotype is reflected in Africa, but a fair assumption at this stage is that if it does, it must be challenged. Multidisciplinary inputs from the medical and allied professions are targeted not only to enhance health but as a corollary to maintain self worth and social relevance. Thus a frail older person will achieve the maximum of his/her potential and remain as productive as possible. The inputs employed to achieve this are commonsense – which is achievable – and a logical use of professional multidisciplinary resources.

**Stereotype 2: To be old is to be frail, sick, dependent and vulnerable**

Again, this stereotype encapsulates a negative image of ageing (cf. Estes & Binney, 1988). It is through the education of medical and allied professionals and society in general that we will encourage changes in individual behaviour and outlook which result in improved health. Such positivity, which may be underpinned by community respect for African elders, is the key to reversing this negative perception.

**Stereotype 3: Resources, especially in developing countries, are too scant to apportion to the elderly in relation to other priorities such as maternal/child health**

This, or a similar argument, is frequently cited as a justification for the abdication by health ministries in hard-pressed and poor African countries from any provision of services for older persons. Yet with effective re-organization of existing resources, slim as they may be, a great improvement in quality of care may result. Such changes will accrue with a positive mindset, a modicum of management and motivation.

Health services which are excessively pre-occupied away from older persons do so at their future peril, for to ignore the prevailing demographic realities involves a risk of incurring future massive extra cost as well as unacceptable system failures. Cash-strapped societies cannot afford this.

**Stereotype 4: There is nothing really effective that can be done to improve the health of the elderly, so efforts are better targeted to more “deserving” and responsive sections of the population**

An opportunity now exists with various countries undertaking health sector reform to move away from this redundant state of mind, prevalent in many health ministries and, worse still, embodied by many medical professionals. Yet the implementation of efficient systems of medical care has already yielded improved quality in health care without additional resource implications. For example, Integrated Community Care Schemes in England is showing considerable promise in reducing the demand for in-patient beds whilst simultaneously gearing up community support (Wilson, 1995). Community health promotion and education are the by-product here, and there is no need for recourse to additional resources. An opportunity exists for similar locally appropriate schemes in Africa.

**Stereotype 5: Old people block hospital beds and interfere with the practice of interesting medicine**

“Bed blocking” is the bugbear of acute hospital in-patient services; older patients, whether in the first world or the developing world, are the pariah (cf. Wilson & Parsons, 1991). It is important to emphasize that a “bed blocker” is a victim of two service failures. First, there is a failure in the community to prevent, through a lack of appropriate support and services, an inappropriate admission. Second, there is a failure of the hospital medical teams to initiate effective discharge planning from the outset. What “bed blocking” is not is a patient's responsibility, yet medical personnel tend to stigmatize such persons and even subconsciously relegate them to a lesser level of care and attention. Thus medical care fails this category of patient.

Yet if multidisciplinary systems based on integrated care are properly set up in the community and in hospital, with proactive discharge and long-term planning, bed blocking, its attendant frustrations, and the misuse of precious and scant resources, can be a thing of the past.

**Stereotype 6: Old people need to be cared for (one-way care)**

This dated concept of elderly care, whilst well intentioned, has no place in modern geriatric medicine. This stereotype can be actively demolished by educating persons who are carers and the cared for, and by promoting autonomy through the involvement and integration of older persons in their own care programmes – as has been demonstrated in Zimbabwe (Mupedziswa, 1998). To be effective, it is necessary to take carefully balanced and well judged risks. Every older adult has the right to independence, even at some risk.

*Develop systems-based medical care*

It is tempting, particularly for physicians, to follow the western medical model of capital-intensive domains and structures to develop appropriate models of care for older people. This tempting pitfall should be avoided. Successful and skillful resolution of the problems of older persons may be achieved by concentrating on processes, through the development of care systems, rather than through the creation of physical structures.

Systems rely on people with a mix of skills to undertake processes of care. They require competencies such as teamwork, leadership (strategic and facilitative), and enhanced relationships between individuals and professions. Systems will spare capital, whilst structures will devour it; and systems will spare labour, whilst structures are labour-intensive. Systems do not depend on equipment, whereas structures demand equipment.

The medical and allied professions are efficiently utilized in well-evolved systems but tend to be reduplicated and segregated in structures; this is highly inefficient in terms of resources and most likely to be substantially more costly. Team development occurs naturally as a consequence of systems of care; at the same time, skills are mixed with an interchange of information between disciplines. But structures mitigate against team development (in fact they seem to promote internal competition at the expense of co-operation) and tend to separate skills and disciplines.

Thus care processes based on systems promote the breakdown of barriers between professional groups. These barriers are encouraged by structures. Potentially most harmfully, structures foster professional egos which foster health-care systems, which first address the needs of the medical professional rather than the patient. Those who devise and implement geriatric services need to consider these issues.

### Health care process

Existing resources applied to harnessing the talents and energies of multidisciplinary teams will be productive. These teams will identify patients where simple interventions will produce substantial enhancement of well-being. Each multidisciplinary team would incorporate appropriate specialist skills, most importantly rehabilitation and nursing.

As an example, the following could be developed in both a primary and a secondary care setting, working across the boundaries, to promote better health. A "movement team" would identify and address falls, strokes, syncope, Parkinson's disease and other movement problems. A "continence team" would attend to the generally neglected problems of bladder and bowel incontinence, which are often badly managed. A "sight team" would identify individuals with cataract and glaucoma for appropriate and cost-effective intervention. A "nutrition team" would improve the dentition and diet of those at risk. A recent community-based study in Zimbabwe identified movement, sight and nutrition as major factors where simple process-based interventions would yield substantial benefit (Allain, Wilson *et al.*, 1997). Yet there is no evidence to date that such simple interventions have been translated into health-service policy.

Underpinning the team approach could be a "generic" rehabilitation assistant. A generic worker is essentially a common-sense, lay individual, trained in the basics of mobilization and functional assessment, who could provide an effective and cheap means of enhancing the health of older people in their community. This concept of a generic worker has already been piloted in remote refugee camps with considerable success (cf. HelpAge Zimbabwe, 1991).

It is also important to incorporate and to encourage the participation of traditional healers, as part of the multidisciplinary process taking place in an appropriate cultural context.

A guiding principle should be to develop systems of care which keep an older person away, where appropriate, from hospital, by addressing health, functional and social concerns at home.

### Conclusion

There can be no doubt that with scant resources available in Africa, these resources should be allocated as a priority to the primary care setting. This action will provide the most cost-efficient use of resources. By selecting out and building on the principles outlined above, and by choosing to implement systems of care rather than to establish structures, medical care for older persons may be improved without incurring unacceptable extra cost or effort. What is of concern is the almost exclusive focus of health ministries away from older persons. This neglect has pitfalls. The neglect of realities relating to the impact of a rapidly expanding African ageing population will place unsupportable strain on existing, inade-

quate resources. To continue to allow such to occur by refusing to acknowledge the problem is wrong. Perhaps worse, this neglect is economically misconceived as it is based on flawed and short-term planning.

Older Africans should be seen as a resource that goes beyond child care or crop tending. They are a stockpile of unique cultural tradition and history, linked to ubuntu, and this stockpile is in danger of obliteration under the weight of exponential urban growth and the concomitant restructuring of pastoral, rural and urban socio-economic structures.

Health-service planners and the medical profession need to go a step further in the next millennium and to see older persons as a resource to work with. Appropriate care systems need to be encouraged whilst negative stereotypes are demolished.

A new era for geriatric medicine is about to emerge in Africa. By selecting the best principles from those which have been outlined above, and by choosing care systems rather than structures, the quality of life and health of older Africans can be greatly enhanced.

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### References

- Adamchak, D.J. 1989. Population aging in sub-Saharan Africa: the effects of development on the elderly. *Population and Environment*, 10(3): 162-176.
- Allain, T.J., Wilson A.O. *et al.* 1997. Morbidity and disability in elderly Zimbabweans. *Age and Ageing*, 26: 115-121.
- Blaxter, M. 1983. The cause of disease: women talking. *Social Science and Medicine*, 17: 56-69.
- Estes, C. & Binney, E.A. 1988. Toward a transformation of health and ageing policy. *International Journal of Health Services*, 18(1): 69-82.
- HelpAge Zimbabwe. 1991. Annual Report. Harare.
- Mupedziswa, R. 1998. Community living for destitute older Zimbabweans: institutional care with a human face. *Southern African Journal of Gerontology*, 7(1): 26-32.
- Victor, C.R. 1991. *Health and health care in later life*. Milton Keynes, UK: Open University Press.
- Wilson, A.O. 1995. Integrated community care: the Marlow experience. Paper read at the International Conference on Dynamic Ageing. Cape Town, October 4-6.
- Wilson, A.O. & Nhwatiwa, R. 1992. Does Zimbabwe need geriatric services? *Central African Journal Medicine*, 38(1): 14-17.
- Wilson, A.O. & Parsons, R. 1991. The forgotten: the Zimbabwean elderly in hospital. *Central African Journal Medicine*, 37(4): 110-14.