

Care for the elderly

The issues, the costs, and possible future strategies



This paper gives an overview of elderly care, discussing the current situation across developed health economies, explaining the urgent requirement for new strategies and to address the challenge that lies ahead. It discusses the need for a new kind of sector professional – from leaders to care workers – able to traverse the fast-changing landscape of elderly care while developing and embracing affordable yet sustainable strategies to meet the needs of this increasing segment of the global population.

DEFINITIONS

UK

PRIMARY CARE: Healthcare provided outside a hospital environment.

SECONDARY OR TERTIARY CARE: General or specialist hospital in or out-patient care, provided free at the point of use.

SOCIAL CARE: Care provided by a Local Government Authority on a means tested basis.

U.S.

PRIMARY OR OUTPATIENT CARE: Any care provided outside a hospital or nursing home.

INPATIENT CARE: Care provided in a hospital or nursing home.

There are different funding models for these types of care from country to country with Federal, State and Insurance sources used alone or in conjunction with individual funding.

For the purposes of this paper ‘the elderly’ are taken as those people over 65, as defined by the World Bank in their data collection.

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Background

One could be forgiven for thinking that healthcare provision in the developed world has never been so good. Advances in medical research and drug discovery, diagnostics, genomics and DNA sequencing, immunotherapeutic treatments, medical and health technology, and health promotion have all inevitably led to an improved life expectancy. Equally, because of such developments an increasingly discerning public in all developed countries has a greater expectation of what its health services should be doing to keep them healthy and cure them when things go wrong.

Dementia is currently costing the state £24 billion per annum.

New types of leaders, clinicians, researchers and carers will be required.

So far, so good, but the simple fact is that if you live longer you are more prone to develop one or more chronic diseases or mental health issues, or a mixture of both, so your extended final years may not be lived happily, peacefully or indeed knowingly. Cancer, chronic heart disease, obesity, diabetes and dementia all lie in wait, and many elderly people now battle with several of these conditions simultaneously, often partnered by osteo-arthritis and poor mobility. An uneasy statistic in the UK is that dementia is currently costing the state £24 billion per annum – more than cancer and coronary heart disease combined – and has become the number one cause of death in the elderly. Yet whilst one person in the UK develops dementia every three minutes, only a fifth of the research funding devoted to cancer goes to dementia. Dementia in 2015 cost the global health economy \$818 billion US. (All figures from Alzheimer's Research UK, 2017).

There is now ample evidence that increased longevity, leading to a much larger percentage of elderly people living with multiple chronic and long term conditions, will mean ever increasing financial and care demands on already over pressurised health systems globally. Whatever model of healthcare provision and funding is in place, unless funding priorities are changed the demands on the at home, care home, primary and secondary care sectors are fast becoming a major and possibly unaffordable burden on a state's overall financial system. New strategies rapidly need to be put in place for elderly care, covering funding (both for hospital, care home and at home residency), medical research, drug development, medical and nursing manpower, health technology, training and general management.

The needs of this sector of the population are enormous and steadily increasing, yet it has lacked either a coherent strategy or adequate funding in many countries. It is also an area where new types of leaders, clinicians, researchers and carers will be required, as countries move from a healthcare system optimised around treating individual conditions. The incoming leaders and professionals will help the ageing individual to keep as fit as possible, avoid hospitalisation and have a reasonable quality of life, whilst managing any long term or chronic conditions – with the concomitant increasingly large drugs bill – they might have.

The facts are unavoidable: more elderly people, living longer with more treatable or containable conditions, means yet more demand and associated cost – for the state, the insurer, the payor, the provider or the individual. This is exacerbated on the supply or provider side by ever

more available yet expensive drugs, (not necessarily regulated by physicians), greater availability and use of innovative high tech treatment and monitoring equipment, and ever increasing costs in state-of-the-art diagnostic and imaging equipment.

Another inevitable consequence of people living longer, especially in countries where birth rates are slowing, is that the number of workers contributing to GDP is increasingly outnumbered by those past working age who call for help from the public purse. Current healthcare systems are already feeling the strain everywhere, whatever their funding philosophy. If people really are going to benefit from their extra years on this planet, then drastic changes are required quickly, both in health education and also in establishing financial systems that will provide adequate affordable care, which should include end of life provision.

New strategies rapidly need to be put in place for elderly care, covering funding (both for hospital, care home and at home residency), medical research, drug development, medical and nursing manpower, health technology, training and general management.

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The Current Problem

In 1948 half the population in England died before they reached 65. That figure has now fallen almost as low as 10%. Over the last ten years the number of over 65s in the UK increased by more than 20% and those aged 85 or more increased by over 30%.

It is estimated that by 2030 the number of over 65s will increase by 75% across Europe – in England one in five people will be over 65. Projections from the Office for National Statistics show that in the UK the numbers of over 65s will effectively have doubled between 1966 and 2039, from 12% of the population to 23%, a rate of increase of 1.5% per decade. Already 40% of the NHS budget is spent on the elderly, and over 50% of local government social care funding is spent on people over 65.

Over 50% of general hospital beds in the UK are occupied by over 65s, very many of whom will have concomitant mental health problems. (The King's Fund 'Making our health and care systems fit for an ageing

population' 2014). The Alzheimer's Society has found that patients suffering dementia are likely to stay in hospital for seven days longer than others. 80% of those who remain in hospital for more than 14 days are over 65. Equally the majority of patients with dementia are very likely to have at least one other chronic disease. Nuffield Trust data indicates that an 85 year-old man will cost the NHS seven times more than a man in his mid to late 30s. As to the care actually provided to the frail, disabled or elderly, from whatever part of the Social Care system, more than 1.5 million care workers are involved (more than in the NHS) and it is estimated that upwards of six million unpaid carers supplement this care for friends or relatives at home.

1 in 5 people will be over 65 in England by 2030.

23% of the population in the UK will be over 65 by 2039 – an increase of 1.5% per decade from 12% in 1966.

40% of the NHS budget is already spent on the elderly.

50% of local government social care funding is spent on the over 65s.

50% of general hospital beds are occupied by over 65s in the UK.

80% of those who remain in hospital for more than 14 days are over 65.

Further to this, Age UK recently stated that over a million older people are living with unmet social care needs. Other recent scare stories in the UK national press have revealed that within the next eight years there will be a need for more than 70,000 extra care home places, yet because of reduced local authority funding and increased minimum wages many small care home providers have been forced to close, losing on average 2,000 places a year. So the need is increasing whilst the provision is reducing.

The UK is at last waking up to the enormity of this problem to the extent that Social

Care pushed Brexit and the economy down the agenda in the recent UK General election; not least because the 'austerity' agenda has seen social care funding fall in real terms, necessitating the elderly having to contribute more to their own care costs.

Even more worrying for other EU countries is the fact that the Office for National Statistics has shown that the UK is actually ageing more slowly than other countries in Europe and predictions show that the UK will be one of the least aged European countries by 2035.

In wider Europe, the EU average of over 65s is now 20%. Some examples are: Italy 23%, France 19%, Germany 21%, Spain 19%, Sweden 20% and the UK 18%. This compares to Canada at 17% and the USA at 15%. The average for the developing world, the Middle East and Africa is around 5%. In line with these figures the percentage of over 65s in 'high income' countries is 18% globally, but only 3% in 'low income' countries. (All preceding figures from World Bank Databank, 2016).

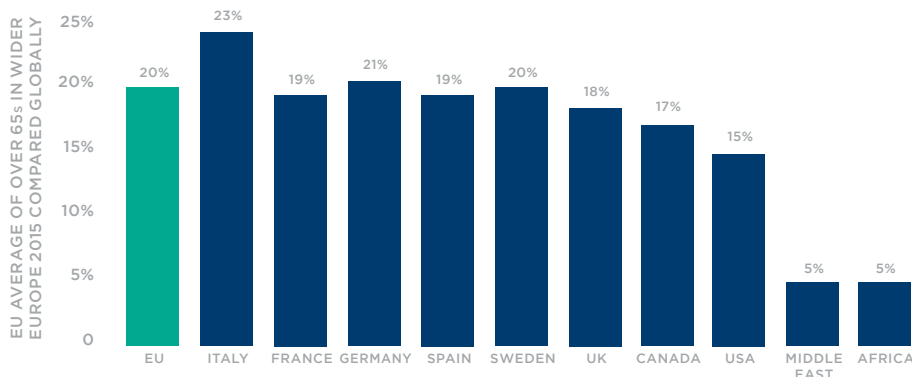
In our other specific countries of interest, the percentage of people aged 65 or over in the Netherlands is expected to increase from 19% now to 26% in 2035. Further, the proportion of adults over the age of 80 in the Netherlands is expected to increase from 3.9% of the total population in 2010 (Statistics Netherlands [CBS], 2012a) to 10.2% in 2050 (Statistics Netherlands [CBS], 2011).

According to the U.S. Census Bureau, by 2030, nearly 1 in 5 people (19%) in the U.S. will be age 65 or older, a dramatic increase from 12.4% in 2010 and 15% in 2016. In population numbers the total of over 65s is projected to more than double from 46 million today to 98 million by 2060, or 24 % of the total population. Again, Census Bureau statistics from 'An Aging World - 2015' show that in the USA the number of over 80s will increase from 3.8% of the population in 2015 to 8.2% by 2050.

In Australia 8% of the population were over 65 in 1964, 15% in 2014 and over 16% in 2016, with an age structure very similar to the USA. The over 65s are the fastest growing age group. (Australian Bureau of Statistics, Report 23 March 2016). Over the last 50 years numbers of over 85s have increased ninefold. Projections show that there will be almost ten million

people over 65 and two million over 85 in Australia by 2064. In a similar vein as seen in the UK, 40% of hospitalisations in Australia in 2013/14 were of people over 65, and 30% of deaths in older people were from CHD, cerebrovascular disease including stroke, dementia and Alzheimer's. (Australian Institute of Health and Welfare).

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Source:
World Bank Databank 2016

Chronic Diseases and Co-morbidity

There is an ever increasing range of complex co-morbidities in the over 65 age group in most developed countries and the majority of these conditions are long term.

Over 65% of GP's prescribing budgets and over 70% of total UK health and social care spend is on elderly people with long term conditions.

Chronic diseases and conditions – such as heart disease, stroke, cancer, diabetes, obesity, and arthritis – are among the most common, costly, and yet frequently preventable of all health problems. Despite major advances in treatment, these diseases are not reducing in incidence, and in the case of cancer for example an analysis of cancer trends by the Economist Intelligence Unit (EIU) estimated that there were 13 million new cancer cases in 2009. The cost associated with these new cancer cases was nearly \$300 billion US. Mainly as a result of ageing, the incidence of cancer will inevitably accelerate in the future and is expected to rise to 17 million by 2020, and 27 million by 2030. (Global Health and Aging, NIH/WHO paper, October 2011). Clearly as people are less likely to die early from certain diseases which are now better controlled, they are more likely to succumb to cancer in later stages of life.

In the UK the number of people with three or more long-term conditions was projected to rise from 1.9 million in 2008 to 2.9 million by 2018. The ageing population and increased

prevalence of multiple long-term conditions have a significant impact on the demands and costs of health and social care and could require £5 billion additional expenditure as early as 2018. (DH report – Long-term conditions compendium of Information: 3rd edition 2012). The care pathway from GP or primary care consultation to hospital admission to release back home, to the community or to a care home simply no longer caters for co-morbidity over the long term. Over 65% of GP's prescribing budgets and over 70% of total UK health and social care spend is on elderly people with long term conditions.

In the Netherlands, a 2008 General Practice study showed that more than 70% of the patients aged 55 years and older with one of 10 specified chronic diseases also had an additional chronic disease. (Multimorbidity and co-morbidity in the Dutch population – data from general practices. van Oostrom SH, Picavet HS, van Gelder BM, Lemmens LC, Hoeymans N, Verheij RA, Schellevis FG, Baan CA).

In the USA 86% of the nation's annual health care expenditure is for people with one or more chronic or mental health conditions. As of 2012, about half of all adults in the USA – 117 million people – had one or more chronic health conditions. One in four adults had two or more chronic health conditions, a figure that rises to three in four for the over 65s. Seven of the top 10 causes of death in 2014 were chronic diseases. Two of these chronic diseases – heart disease and cancer – accounted for nearly 46% of all deaths in the USA. (CDC Chronic Disease Overview Factsheet 28th June 2017).

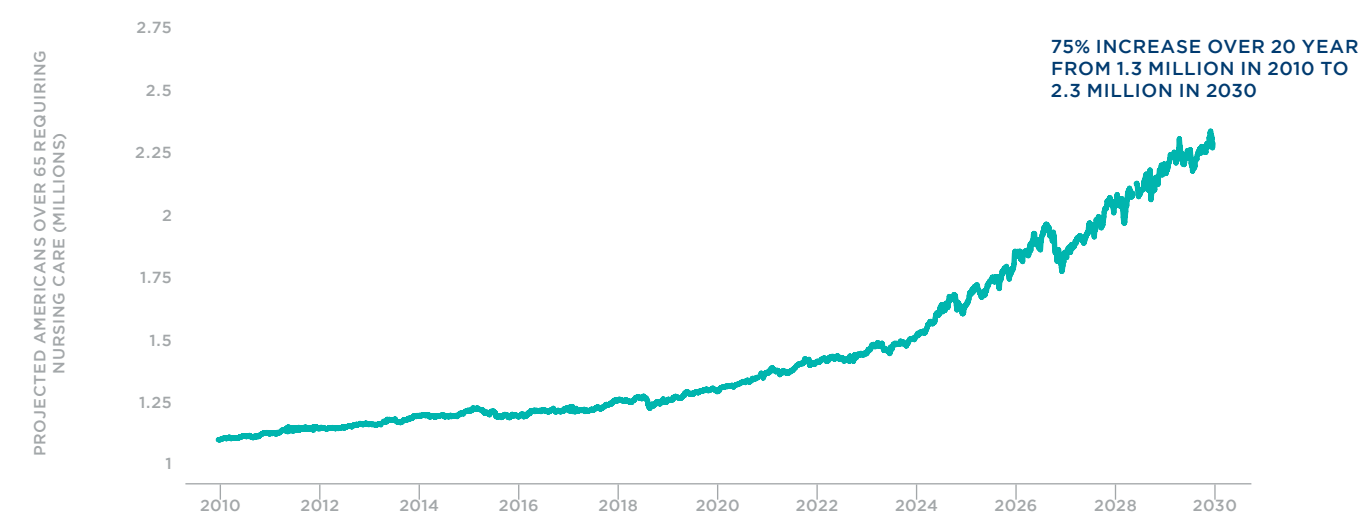
Obesity rates in the USA for older people have been steadily rising and by 2012 had reached 40% of 65-74 year olds. Demand for elderly care will also rise dramatically with projections showing that there will be a 75% increase in the number of Americans

aged 65 or older who will require nursing home care, equal to 2.3 million in 2030, from 1.3 million in 2010. There will also be a very steep rise in the number of Americans living with dementia and Alzheimer's disease, almost tripling from 5 million in 2013 to 14 million in 2050. As in other developed countries it is very likely that many of those suffering from dementia will also have a range of other morbidities. (US Population Reference Bureau, Fact Sheet: Aging in the United States 2016).

In Australia, self-reported data from the Australian Bureau of Statistics (ABS) National Health Survey shows that 1 in 4 (23%) Australians – 5.3 million people – had two or more chronic diseases in 2014-15. The rate of co-morbidity was higher for people aged 65 and over (60%) compared with people aged 0-44 (9.7%).

As demonstrated above, mental health issues form a key aspect of the burden of disease amongst the elderly globally and frequently accompany other morbidities. In recognition of this the UK NHS has recently pledged to provide a further 21,000 mental health posts by 2021, although the funding for this will inevitably be hard to find. Yet a July 2017 report in the Lancet indicates that a third of those suffering from dementia could have prevented that happening by factors within their own control.

Further, the WHO has estimated that over half of this overall enormous burden of disease in the elderly is actually avoidable, given better health education and an improved lifestyle.



End of Life Care

End of life palliative care, an area that historically has failed to generate much publicity or indeed funding outside charitable institutions, is suddenly becoming a major problem in developed countries.

Regardless of age the end of life period is very costly for most. It has been estimated that the proportion of health expenditure incurred by those in their last six months is around half of the total.

Indeed whether the funding comes from insurers, the state, charitable or religious sources, or the individual, a common problem is that there simply are not enough dedicated hospice places available. As the numbers of people living longer with terminal conditions increases, there is a resultant extra strain on hospitals and unnecessary in-patient care at end of life. Whilst it could perhaps be argued that by definition end of life palliative care will be very short term, it is surprising that virtually nothing is spent to help people leave this life with dignity and without pain, in comparison to the billions spent on bringing people into the world in the first place. When relatives and friends are already coping with the emotional problems around the imminent loss of a loved one, they do not want to be faced with difficult care and financial problems in parallel.

This problem does of course apply to people of all ages, and regardless of age the end of life period is very costly for most. It has been estimated that the proportion of health expenditure incurred by those in their last six months is around half of the total. The fact that people are dying later does not necessarily make this a bigger drain on resources but simply that the cost of dying

comes at an older age than previously. It still needs to be funded and provided for adequately.

As an example a 2nd August 2017 Sky News report has quoted Hospice UK as saying that whilst some 200,000 people every year are cared for in the country's 200 hospices, up to perhaps 120,000 terminally ill people cannot access palliative hospice care. It described how whilst hospices historically had generated two thirds of their income from donors, charitable trading outlets, investment income and bequests, one third had been made up by government funding through the NHS. Because of recent major reductions in NHS funding in real terms, this latter funding source has effectively been frozen over the last few years. The law of unintended consequences has then meant that of the half a million people who die in England and Wales every year, half of that number end up dying in expensive hospitals beds, when many have no clinical requirement to be there. They simply need somewhere where they can die with dignity and in minimum pain, ideally surrounded by friends and family – such as the home or a hospice.

The Rising Costs of Living Longer and Less Healthily

If healthcare – as in the UK – is provided free or is heavily subsidised then there will be excess demand and higher cost to the provider.

In many countries there are few incentives to prevent general practitioners from over prescribing or to make insurers constrain the costs of their providers. With the additional novel drugs and medical technology available, healthcare costs are destined to rise inexorably.

Comparative total healthcare expenditure as a percentage of GDP in 2016 for certain countries of interest was as follows:

incentive to keep premiums down in a competitive marketplace. As a result the USA is paying almost twice as much for a healthcare system that has less universal coverage than others.

The number of people globally aged 65 or older is projected to grow from an estimated 524 million in 2010 to nearly 1.5 billion in 2050, with most of the increase being in developing countries. (Global Health

and Torres Strait Islander people have a much lower life expectancy than non-indigenous Australians.

The majority of over 65's will be past working age, not contributing to GDP and accounting for a huge proportion of healthcare expenditure. Certain countries, including the UK, have increased retirement age as an improving measure, but this cannot be introduced with immediate effect for those nearing retirement age, so it will be some time before improvements in ratios of working to retired. However, if people can be kept healthier longer – with improved health education and improved health systems – they will also be able to work for longer with less time lost to sickness or chronic disease.

COMPARATIVE TOTAL HEALTHCARE EXPENDITURE AS A PERCENTAGE OF GDP IN 2016 FOR CERTAIN COUNTRIES OF INTEREST		
UK	9.7%	reducing
NETHERLANDS	10.5%	reducing
USA	17.2%	increasing
AUSTRALIA	9.6%	increasing
FRANCE	11%	reducing
GERMANY	11.3%	increasing
CANADA	10.3%	static

Figures taken from the latest OECD data sheet published on 30th June 2017.

Apart from the USA they show a marked similarity in percentage terms. In the USA healthcare is almost universally financed by insurance, with little

and Aging, NIH/WHO paper, October 2011). In many developed economies affluence dictates quality of long term care and life span. In Australia Aboriginal

EXPENDITURE AND FUNDING IN THE UK NHS AND SOCIAL CARE SECTORS

In the UK public spending on Social Care for adults has fallen below 1% of GDP with an ever widening gap between need and resource.

In the 2015/16 full year spend within the UK state sector on health, social care and sickness/disability benefits (the latter not included in the percentage figure above) amounted to over £220 billion, or 11.5% of GDP.

Almost £5 billion has been cut from adult social care budgets since 2010. Estimates show that over £3.5 billion extra resource is required by 2020, and has been promised by the Government. Continuing cuts to budgets mean that over 25% less people are now getting help from public funds. Local Authorities are beginning to be forced to limit care provision to the most vulnerable people, leaving others to seek assistance from unpaid carers. Reduced payments to Care Providers, minimum wage requirements and staff shortages have put many private sector companies under intense financial pressure unless they can increase the number of self-pay residents. Home care services are facing similar or worse pressures.

In the 2015/16 full year spend within the UK state sector on health, social care and sickness/disability benefits (the latter not included in the percentage figure above) amounted to over £220 billion, or 11.5% of GDP. This does not include self-pay or insurance expenditure on private healthcare and social care. Costs are spiralling but budgets are

shrinking. (Institute of Fiscal Studies Green Budget 2017). The inevitable result will be catastrophic if urgent measures are not taken.

Keeping the elderly relatively fit, living at home and out of hospital is severely threatened by budgetary pressures on GPs, Community Care nurses and intermediary care facilities. At the other end of the pathway, patients who do enter hospital are then unable to be discharged from hospital because of lack of social care funding or available facilities.

EXPENDITURE AND FUNDING IN THE NETHERLANDS

In comparison, in the Netherlands elderly people receive a relatively large amount of professional care.

Almost 18% of people 65 and older receive home care (Allen et al., 2011), which is the highest rate among all European countries (Bettio & Verashchagina, 2010). Six percent of people aged 65 and older receive residential care. Care is provided by non-profit organisations that are reimbursed by the government and new care entrepreneurs, who have stimulated innovation, quality, and diversity of care arrangements. Yet there are concerns services are only affordable for the wealthy.

All Dutch residents are required by law (Health Insurance Act) to have a private health insurance policy. In addition, a national insurance system for long-term care (e.g., nursing homes) is paid for through taxation. Total expenditures for health care and welfare (including child, youth, and senior care) were almost €90 billion in 2012 (US\$117 billion) or 14.9% of the gross national product (CBS, 2012). The cost of care for senior citizens comprises approximately 18% of total health care expenditure in the Netherlands (The National Institute for Public Health and the Environment [RIVM], 2012).

If the spiralling costs of healthcare in the Netherlands are not halted, then by 2040 a quarter of the Dutch population would need to be employed in the provision of either immediate or long term care and one quarter of the Dutch GDP would be absorbed by these healthcare costs, compared to 10.5% today. ('A vision for the Dutch health care system in 2040. Towards a sustainable, high-quality health care system'. WEF Healthcare Industry 2013). Whilst it seems this is very much a worst case assumption and begs the question of what will inevitably be put in place to avoid such a dire scenario, it does point to how seriously we should be addressing this overall issue.

Almost 18% of people 65 and older receive home care (Allen et al., 2011), which is the highest rate among all European countries.

Total expenditures for health care and welfare (including child, youth, and senior care) were almost €90 billion in 2012 (US\$117 billion) or 14.9% of the gross national product (CBS, 2012).

EXPENDITURE AND FUNDING IN THE USA

In the United States, chronic diseases, conditions and the health risk behaviors that cause them account for most health care costs.

- 86% of the nation's \$2.7 trillion annual health care expenditure is for people with one or more chronic and mental health conditions. (2010).
- 71% of the total health care spending in the United States is associated with care for those with more than one chronic condition. (2010).
- 35% of spending is for the 8.7% of the population who have five or more chronic conditions. (2010).

- It is estimated dementia and Alzheimer's cost the nation \$818 billion in 2015.
- Total annual cardiovascular disease costs to the nation averaged \$316.1 billion in 2012–2013 including lost productivity costs from premature death.
- Cancer care cost \$157 billion in 2010 dollars.
- Diabetes in 2012 cost \$245 billion.

(All 2010 percentage figures from Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. Multiple Chronic Conditions Chartbook. AHRQ Publications No, Q14-0038. Rockville, MD: Agency for Healthcare Research and Quality. April 2014).

The overall percentage of GDP spent on healthcare in the USA in 2016 was 17.1%, by far the largest of any developed country.

As shown, having multiple chronic conditions clearly is associated with substantial health care costs. Among Medicare fee-for-service individuals in the USA, people with multiple chronic conditions accounted for 93% of total Medicare spending. They also face major personal out-of-pocket costs, including higher costs for prescription drugs. (CDC Chronic Disease Overview Factsheet 28th June 2017).

Finally, as the proportion of the over 65s continue to increase in the USA, Social Security and Medicare expenditure alone will increase from a combined 8% of GDP now to 12% by 2050.

(US Population Reference Bureau, Fact Sheet: Aging in the United States 2016).

The overall percentage of GDP spent on healthcare in the USA in 2016 was 17.1%, by far the largest of any developed country. (OECD Data Sheet June 2017). Clearly this figure could change markedly in the future depending on the ongoing cost of the Affordable Care Act or whatever might replace it.

EXPENDITURE AND FUNDING IN AUSTRALIA

In Australia, inevitably care providers see the main challenge as the financial capacity of the country to fund the required and increasing demand, despite the mixed funding economy that spreads the risk to some extent.

Much comes down to a question of government funding which is currently inadequate and unsustainable. The Government has not yet recognised publicly that it will be unable to fund aged care at current levels into the future. It is putting as much of the expense on the individual as it can, whilst endeavouring to keep people out of hospital.

Figures for 2014/15 show that Government health expenditure grew by 1.3% to \$A108.2 billion. Non-government expenditure, was \$A53.4 billion, 33.1% of the total health spending of \$A161.6 billion. Total expenditure on health reached 10% of GDP for the first time. (AIHW 2016. Health expenditure Australia 2014-15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra)

Mental health, as in other countries of interest, is estimated by AIHW to be costing the country \$A8.5 billion per annum. As an indicator 50% of residents in Government funded aged care facilities are suffering from dementia.

The Australian Treasury Intergenerational Report 2010 Overview estimates that from 2010 to 2050 real health spending on the over 65s will increase seven times, and twelve times for the over 85s. Real health expenditure per person is now predicted to double over the next 40 years. The reason for this increase is estimated to be caused by an ageing population suffering from ever more chronic diseases, demanding higher and more costly standards of care. That said, overall GDP is expected to rise considerably in the same period.

Indeed these last indicators of snowballing healthcare expenditure can readily be transposed to the UK, the USA, the Netherlands or all developed economies.

Total expenditure on health reached 10% of GDP for the first time.

The Need for a New Strategy

It is crystal clear from the arguments developed in this paper thus far that to do nothing is not an option for any of the countries discussed.

It is equally clear that if early action is taken to address current underfunding, then all is not lost.

FUTURE STRATEGIES IN THE UK

The King's Fund 2014 report (Making our health and care systems fit for an ageing population – Oliver, Foot and Humphries) gives a very clear idea of the current status and its unaffordability, much stemming from a fragmented and disjointed system, with less than ideal co-operation between a wide range of people and organisations involved in the care of the elderly, who may not necessarily have the same motives or beliefs.

The future components of a new UK care system that would be affordable, workable and optimised for an ageing population could comprise inter alia:

- A public sector structure and funding framework which enables a simple patient pathway for integrated care across health and social care.
- More funding for Local Government social care services until NHS and Social Care budgets are unified. Thereafter funding would be centred on the patient journey from home, to community, to care home, or to hospital care, or eventually to hospice care.
- A unified structure embracing physical wellbeing, mental health, primary, community and secondary care.
- A major role for insurance and new financial products, allowing a mixed economy and a measure of choice in care.
- A major funding increase dedicated to extolling the benefits of healthy ageing and independence in later life, as well as urging people to make financial allowance for their old age earlier. A clear statement that many chronic diseases including dementia may be avoidable if the right lifestyle is followed.
- Increased use of modern web based technology to monitor, communicate, comfort and treat the elderly at home, or to trigger rapid intervention if required.
- Improved liaison and communication between all players along the care pathway, to minimise need for hospitalisation, to accelerate discharge as soon as safe, to improve rehabilitation and support after illness and to get individuals home as soon as possible.
- A major restructuring of the care home and hospice sector, incentivising the private sector and insurers, ensuring that there is sufficient provision for those with no alternative – especially if they have complex mental health needs.

FUTURE STRATEGIES IN THE NETHERLANDS

The very thorough report of the World Economic Forum (WEF) in conjunction with McKinsey & Company gave some stark warnings over the future direction and cost of the Dutch healthcare system but it also gave a series of pointers and recommendations which would lead to a high quality, affordable system in the longer term. ('A vision for the Dutch health care system in 2040. Towards a sustainable, high-quality health care system'. WEF Healthcare Industry 2013).

There was much agreement across both the supply and demand sides on where the problems lay and what strategies might be implemented to improve the situation. Amongst these were:

- Greater direct political leadership.
- Greater focus on education and prevention
 - increasing awareness amongst healthcare consumers.
- Rewarding providers for the value added rather than the volume of business.
- Reshaping the healthcare landscape.
- Revising financial models.

FUTURE STRATEGIES IN THE USA

Healthcare policy in the USA since the beginning of the Trump presidency is self-evidently in a state of flux, given the original intention to repeal most if not all of President Obama's Affordable Care Act, which has provided health care for many more US citizens.

More optimistically, the Chronic Care Act passed by the Senate Finance Committee in May 2017 will hopefully make a marked difference in the future as it aims to improve the Medicare program through a range of changes that target traditional fee-for-service, Medicare Advantage and Accountable Care organisations. It will:

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| <ul style="list-style-type: none">• Provide more care for the aged chronically ill in the home setting (vs. more expensive skilled nursing facilities).• Promote greater use of telemedicine.• Improve reimbursement for payers and providers covering seniors through | <ul style="list-style-type: none">• Medicare Advantage plans (health insurance plans), that consider their various conditions and co-morbidities.• Expand benefits for the chronically ill through Medicare managed care plans.• Give seniors with chronic | illnesses more options to participate in programs with unique benefits to them when they have chronic illnesses with anticipated downstream savings to the Medicare program. |
|--|--|--|

FUTURE STRATEGIES IN AUSTRALIA

In line with the recently delivered Federal Budget in Australia several changes are being made to health care for the aged which will allow people to remain in their own homes longer.

These will include Home Care Packages, offering assistance for elderly citizens who elect to stay in their own homes but who need some help. Such measures will now be directed more by the consumer rather than by the health authority.

By 2022, the Commonwealth Government’s vision is that Australia’s aged care system will:

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| <ul style="list-style-type: none">• Be sustainable and affordable, long into the future.• Offer greater choice and flexibility for consumers.• Support people to stay at home, and remain part of their communities, for as long as possible.• Encourage aged care businesses to invest and grow.• Provide diverse and rewarding career options. | <p>Other initiatives are:</p> <ul style="list-style-type: none">• Older people in residential care will have to contribute to the cost of that care on a means tested basis. Those who cannot contribute will have contributions made from the government.• Preventative medicine is being accentuated as a means of keeping individuals healthy longer. | <ul style="list-style-type: none">• Many health insurance schemes will now fund measures aimed at keeping older people in their own homes longer. These include gym memberships and alternate medicine therapies. |
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By 2050 the Commonwealth Government’s vision is that the health system: ‘will not simply deliver more of the same services to an older population. Instead, it will involve much more advanced technologies and types of care, catering to an older population with complex needs. This requires more than simply increasing the size of the health system.

A more responsive and co-ordinated system will be needed. One in which different professions collaborate effectively. One in which patients get the best possible care for the resources invested in the health system.’ (Australian Treasury IGR 2010 Overview)

Common Strategic Threads

A glance at the proposed concepts and initiatives emerging across our four countries in this study show some common themes:

- Keep people out of hospital and in their own home as long as possible.
- Governments cannot avoid regulating healthcare and the healthcare industry. New funding models, payment systems and instruments are required, especially insurance based, but it is very likely that all people will still have to make some contribution to their care in old age.
- Payment per service is outdated and the money should now better follow the patient through his or her integrated clinical pathway.
- People need to be educated from an early age that their health in old age to a marked degree depends on how they live their life on the way there. If they disregard that principle then they should not be surprised to have to pay the price in old age.
- Health promotion deserves more than adequate funding in order to focus on prevention, instilling a concept of healthy ageing in all people when they can still do something about it.
- Integrated care models are a must to treat a range of co-morbidities. Systems and structures need reshaping. Treating people in or near the home is essential.
- Greater use of innovative IT, Telemedicine and broader technology to enable the sick elderly to remain in their home as long as possible.
- Greater research funding is required devoted to the study of the elderly, their likely illnesses and the optimum means to cure or care for them.
- Dementia and mental illness more broadly will break the bank if ignored and if they do not then obesity and its related diseases will not be far behind.

Human Resource Implications

There is evidently a need for a whole new breed of people to develop and take these strategies forward across government, industry, academia, financial services, the healthcare professions and care managers, both on the commissioning and provider sides, and amongst health educationalists and those who will engage the public, nationally and internationally.

It will evidently not be straightforward to recruit outstanding leaders and senior managers from other sectors.

In many countries, a current shortage of nurses and care workers and of hotel and catering service staff already leads to sub optimal care standards for many older people. These workers form a key part of community support, hospitals and care homes and indeed are critical to helping the elderly to continue to live at home. In the case of the UK a large proportion of these workers are from the EU, and Brexit could have a major impact on this workforce. In turn a lack of trained care workers will inevitably lead to more family and friends becoming involved. Other methods of reducing the reliance on trained care workers include the whole area of computer assisted care, improved medical technology, better IT support at home, computerised aids to living, real time internet monitoring links to the GP or to hospitals, etc.

As to the leadership of this sector, in countries with a mixed health economy, clearly private sector skills will be very important, with a real need for leaders from outside the healthcare sector, with mature financial, marketing, accounting and customer service/service industry skills.

It is likely that leaders who come from the elderly care sector will be seen as less common. Indeed already in the UK many care home chains (often backed by venture capital and hedge funds) are run by financiers and senior managers with little or no experience of the sector – sometimes with unfortunate consequences. As mentioned earlier it is also becoming much less certain as to whether any substantial profit can be gained from these ventures under current local authority funding regimes.

Many of these people do not currently exist so will need to be recruited, trained, motivated and retained. It will evidently not be straightforward to recruit outstanding leaders and senior managers from other sectors and to persuade them to change direction and join a sector that is enormously challenged and where no job is a sinecure. Added to which the ever increasing but essential scrutiny of a sector where poor care quality can easily lead to death, gives another dimension to a leadership role that often is not well rewarded financially.

Conclusions

The time bomb is ticking and governments need to urgently address this area and make a serious readjustment to care systems and funding priorities.

The bare facts across all developed health economies, regardless of funding formulae or national wealth are:

- The percentage of the population over 65 is increasing at a very fast rate as living standards, medical advances and preventative strategies mean that people live longer. In many countries more people will be in retirement than are actually working and contributing to GDP.
- The over 65's are generally not economically productive and will be reliant on pensions, savings, insurance and/or government funding to cover their healthcare needs. This could however be balanced to some degree by delaying retirement age, especially if healthcare advances enable them to keep fit, active and capable of working.
- Those that live longer inevitably develop chronic conditions over time, often more than one, and also often have related mental health issues and wider disabilities.
- Health and social care support and interventions, whether at home, in hospital, in community care or care homes, are usually aimed at the individual condition rather than treating the co-morbidity of the whole person in an integrated way.
- Caring for more people with multiple conditions and more medication requirements over longer periods is becoming more expensive, due to costly drugs, technology and equipment and workforce costs. Yet since the Global Financial Crisis many developed countries have to maintain or improve on previous levels of public funding.
- More people must pay for their own care and more care is being provided by the family. End of life care is a particular problem area.
- On current projections, across a range of similar advanced health economies, adequate health and social care provision for the elderly will soon become unattainable, except for the very rich; unless a major reallocation of Government resources is made, with an inevitable impact on other areas of public spending.
- Many of the problems are caused by HR and workforce related issues, often caused in turn by poor levels of remuneration. Namely, the lack of trained health professionals in hospital and community settings, dedicated researchers in both clinical academic and drug discovery and experienced senior managers and leaders operating across funding, provision and delivery as well as in Government positions.

RECOMMENDATIONS

Drastic change at pace and scale is clearly now required, including but not limited to:

- Greatly improving health promotion and education to ensure individuals take more responsibility to alter their lifestyles to avoid preventable health issues. This could be made easier if it is stressed that in old age they may have to pay some or all of their own care costs.
- Increasing research funding with redirected research areas and aims, specifically looking at longevity, mental health, and establishing the determinants of healthy ageing.
- Establishing a more coherent and cohesive treatment of the elderly through integrated care models, with concomitant all-embracing funding whether for hospital treatment or social care, wherever provided.
- Initiating a major push to care for the elderly at home and in the community for as long as possible, even at end of life, assisted by the development of new technology to assist people to stay in their own homes.
- Recognising that there will inevitably be a greater role for the family to play in the future and that retirement age will inevitably be later for all than hitherto.
- Developing a range of funding models that might embrace: local or national government direct funding, insurance (either mandatory, employer or self-funded directly or through taxation), charitable funding or a mix of some or all of these. Governments will inevitably have to reprioritise budgets to ensure that there is adequate funding allocated to healthcare.
- Seizing the major opportunity that exists for financial services providers and insurers to support the changing consumption needs of the elderly through new and innovative financial products.
- Developing novel quality and efficiency measures and other economies to reduce the cost burden, to close the gap with available resources.
- Making the care of the elderly an exciting, rewarding and attractive area to work, with major recruitment drives, backed by improved training and education, of healthcare professionals, managers and leaders.

In sum, this is one of the most complex, pressing and difficult issues in healthcare faced by governments across the globe. As shown above the facts are very simple and unless some of the measures recommended are undertaken quickly and effectively, backed by adequate resources from whatever source, then old age will become for many something to dread rather than look forward to.

ABOUT ODGERS BERNDTSON

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FOR MORE INFORMATION



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Carmel Gibbons is a London based Partner and Head of the Healthcare practice. She is also a member of the Public Services and Not for Profit practice. Her work focuses mainly on senior appointments in the health and social care sectors. Carmel joined Odgers Berndtson in 2005. She was previously with Veredus Executive Resourcing, part of the Capita Group, where she was a Director and Head of the Health Practice. Prior to this, Carmel worked as a Consultant with PricewaterhouseCoopers Executive Search and Selection, where she managed a portfolio of assignments across the public sector including health, social care, education, local government and central government. Before joining PwC, Carmel completed the NHS Management Training Scheme and held a range of NHS managerial posts within the community, acute, mental health and policy settings.

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