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Governance and Geriatrics

Can hospitals deal with an aging population and a rising prevalence of Alzheimer's disease? The new governance structure, Hospital 2007*, strives to meet this pressing challenge. It will undoubtedly produce other care sections, more gerontology networks, provide better support for the local hospital and regulations for general and regional hospitals. However, beyond the structural level, these governance processes are complex and are torn between unity and diversity. Talk of transdisciplinary care must no longer be empty rhetoric between those who are responsible for service provision clusters and representatives for caregivers and administrators. This applies particularly to those on hospital executive boards, who are a new decision- making force.

A Demographic Overview

People over 75 years of age represent nearly half of all general hospital admittances and the majority of unscheduled early re-hospitalisations. The PAQUID-Bordeaux study** projects that this age segment will increase from 7.7% of the population in 2003 to 9.6% in 2010 and 18.1% in 2050. In conjunction, the prevalence of dementia (be it Alzheimer's or similar conditions) will increase from 6.5% between 75 and 79 years old, to 15.1% between 80 and 84, and to 27.9% between 85 and 89. For its part, life expectancy is still on average 3 years for 90 year-olds. These figures are higher for rural areas, which is a particular cause for concern because in these outlying areas, health services are already offered at a lower level, with fewer general practitioners, fewer nurses, etc.

The main epidemiological conclusion made from both the PAQUID study coordinator and a parliamentary report is that the State is failing to institute measures aimed at prevention, early diagnosis and subsequent care of dementia. There are cases of loss of opportunity for the patient and his or her family, disorganised recourse to the healthcare system and a lack of adequate study regarding those not seeking treatment. There are also increasingly high numbers of household accidents and maltreatment cases. With the current numbers of vulnerable groups set to increase, the number of accidents (household, automobile and other) is also expected to rise, despite national campaigns set on prevention.

Hospital Care and Geriatrics

The level of geriatric care in hospitals is insufficient: Few hospitals offer a complete range of short-term stay care (including Alz heimer's and daytime admittance beds), followup and rehabilitation care, longterm care, mobile units attached to the emergency ward, out-of-hospital gerontology networks with the hospitals' participation, among other necessary services.

Hospital missions are increasingly technical in nature, with a gradual divestment from their social role. Senior citizens take up a great deal of resources but count for few points under the new rating system. This situation has already been studied in two regions and used as a test of new measures for resource distribution for the follow-up and rehabilitation care sectors. However our aim is to partner with the administrative, medical and caregiving stakeholders of the hospital sector to envision a new governance structure centred on gerontology.

Transdisciplinarity, Intercultural Approaches and Geriatrics

Within hospitals, there are three sub-groups: doctors, caregivers and administrators. Older patients who are hospitalised are cared for in a general hospital setting half the time, and much more often in a local hospital setting. It is not standard practice for executive boards to include a geriatric specialist among their 6 or 8 members, however the board must periodically define the institution's policy on geriatrics. Therefore, hospital specialists in geriatrics wield little influence over decisions, even if they lead their departments. Whether they strive to create geriatric day beds (or increase their numbers), encourage investment of more resources into another typical aspect of geriatric hospital care or to create specialised assessment consultations in liaison with networks within or beyond the hospital setting, often, geriatric specialists are facing an uphill battle.

The commonality between all the hospital-based gerontology public health necessities is their real financial impact. This impact is minimal in comparison with that of an emergency room restructuring or a capacity increase for an intensive care unit or an operating theatre, but as the medical and administrative community sees the field of geriatrics as being subordinate and a secondary priority, its value is often underrated and misunderstood. What is then to be done in the case of those over 75, and even more urgently the "very old" in Anglo-Saxon parlance, those over 80, when they are no longer "capable" of leaving hospital for socio-medical reasons?

The Pau Experiment

Let's study the real world case of the Pau Hospital, where despite having 40 short-term stay geriatric beds (over 2000 admittances a year) and 4 geriatric day hospitalisation beds, current needs for emergency and specialised services continue to outstrip geriatric care offerings. The coefficients of occupancy and length of stay are both incompressible.

After 2 years of planning (2002- 2004), an official working plan was signed at the Regional Hospitalisation Agency (ARH) in 2005. The objective was to replace 10 beds in a closing department with a short stay geriatric hospitalisation unit as of 2006. Length of stay would be considerably shorter (4 days); services offered would be coordinated with other hospital departments (i.e. geriatric day beds, emergencies) and coordination with structures outside of the hospital (i.e. social and socio-medical services, developing local level gerontology networks) would be optimised.

Over 800 admittances were received over the first full year of operation (2007). All of these admittances were processed from emergency cases, thus alleviating the pressure on the latter service. The unit has also implemented collaborative measures with other hospital departments and organisations outside the hospital setting (follow-up services, home care). In fact, in cases in which a stay in this unit was initially meant to be brief but was underestimated, a transfer to another branch of geriatric care can ensue. In most cases, this short hospital stay allows for the main clinical diagnosis to take place without affecting the functional autonomy or worsening the level of dependency of these patients.

Nonetheless, the Achilles heel of the structure established in Pau and in all other institutions of this type is a significant re-admittance rate (33% at approximately 6 months). This leads one to question, why there is a quasi-absence of home-based healthcare specific to geriatrics in France, and more generally why the need for care before and after hospitalisation is not being addressed?

This accomplishment shows that when doctors, even those in less common fields such as geriatrics, strive to communicate with administrators and caregivers, they can convey their messages and trigger change that benefits all.

Gerontology Networks

Additionally, a Béarn-based gerontology network centred on palliative care has existed in one county since 1996, and in six counties since 2004. Its survival depends on financing allocated by authorities according to decisions made by State service providers. In 2005, the region's social services promoted a network that complemented their programmes, though they did not finance it. While it gathers together many health institutions, currently this network only exists at the institutional level.

To be truly effective, it should enable real collaboration between general practitioners, independent nurses and hospitals as well create an easily accessible structure for all geriatric care providers.

Such networks act before and after hospitalisation:
•To assess of the senior citizen;
• To coordinate caregivers in order to avoid certain hospitalisations (for example, admittance to retirement homes);
• To foresee problems (admittance without being processed by emergency services), and
• To take steps to avoid unnecessary re-hospitalisation.

Gerontology networks are a highly desirable complement to short stay geriatric hospitalisation and are an important part of a good public health governance plan.

This example of the pairing of short stay geriatric units with gerontology networks illustrates:
• An alternative to standard hospitalisation;
• An attempt at finding answers to issues related to demographic aging for hospitals;
• A decompartmentalisation of hospital caregivers in relation to each other and to outside agencies, and finally
• A genuine attempt to adopt a interdisciplinary approach.

This melding of expertise is indubitably at the core of Hospital 2007 and cannot be ignored in the fields of gerontology and geriatrics in particular. Following the new hospital governance is clearly also a question of learning how to think and act with complexity in mind. It all flows from keeping track of the fundamental regulations, which oversee its vital equilibriums.

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