ROLE OF THE FAMILY PHYSICIAN IN DISEASE MANAGEMENT FOR ELDERLY PATIENTS

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ABSTRACT

Disease management as a new paradigm in health care delivery offers new challenges to the GP fraternity to stay relevant. There are two models of disease management. The primary care based disease management model is to be preferred over the carve-out model. The disease management paradigm for the elderly offers opportunities to provide better care for this group of people. The GP has much to offer in at least five areas of care for the elderly: reduction of risk factors to strokes and ischaemic heart disease; care of acute problems; management of the five giants of geriatrics; management of frailty and dependency; and detection of early cancer and management of the late stages. The GP's role is preventive, curative, palliative and supportive. He also has a role in caring for the carers. The response from the GP fraternity to the disease management paradigm needs to be both educational to enable and empower themselves; and political to win the support of the public, the profession, the policy makers and also the press.

INTRODUCTION

This paper examines the role of the GP fraternity in disease management and the responses needed from the stand point of a family physician.

THE CHALLENGE OF DISEASE MANAGEMENT

The care of patients by the GP has generally been episodic acute care and fragmented chronic care. This has been slowly changing as the values of a family doctor take root in the community in the wake of a family medicine vocational training programme which was introduced in 1988.

It is not unusual even in the present, for a patient to have several doctors: the GP for minor ailments and the specialist for hypertension, diabetes mellitus, and heart disease, and the polyclinic doctor to provide continuing care of the chronic medical problems. The GP commands a low fee and he or she has to resort to high volume of patients to earn the desired income. The specialist's fees are higher and less open to haggling.

The advent of more sophisticated patients, a larger number of GPs and the arrival of disease management as the next innovation in health delivery together with a growing elderly population presents a challenge that demands a rethink of the GP's role in order to stay relevant.

The GP needs to consider the change from an episodic and fragmented service provider to a disease management care provider. As the elderly will account for 27% of those 60 years and older in 2030, the GP will have increasing numbers of elderly patients seeking his care, provided of course, he stays relevant.

Models of disease management

Bodenheimer (Bodenheimer, 1999) commented on the possible models of disease management namely, a carve-out model or a primary care-based disease management model. Diabetes mellitus is a prototype condition for disease management.

Carve-out model. The proponents of carve-out disease management model would abandon a medical care system based on comprehensive health care organizations in favour of a fragmented collection of specialized facilities centred on diseases rather than people. The focus is on patients who are at high risk. The worry is that disease

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management this way could result in patients being shifted from programne to programme, with providers taking responsibility only for their particular "slice" (Nash, 1997).

Primary care-based disease management model. In such a model, the primary providers are in charge and they take care of not only the high risk patients but those with low risk as well. The focus is to teach patients to manage their own illness. Primary care teams are formed and supported by specialist staff to coach them how to make the best use of a 10-to-15 minute visit (Spalding, 1996; Von Korff et al, 1997).

Obviously we need to work towards the latter model. To achieve success, we need to set our vision to work towards:

- defining the GP's role in the paradigm of integrated care
- taking steps to adopt and adapt to this role

GENETIC ROLE OF THE GPS

The generic role of the GPs can be summed up by two pictures:

The prism of healthcare – to enhance and maintain health status, health promotion and disease prevention must form the base of our healthcare services, followed by primary care, secondary care and with the apex being contributed by tertiary care. The GP is therefore well placed for making a difference to the health of the elderly (Fig 1).

The spectrum of healthcare – for those who fall ill, the GP has a spectrum of care that he can provide: essential treatment and lifesaving care, palliative care, supporting carers and health education and prevention for future episodes (Fig 2).

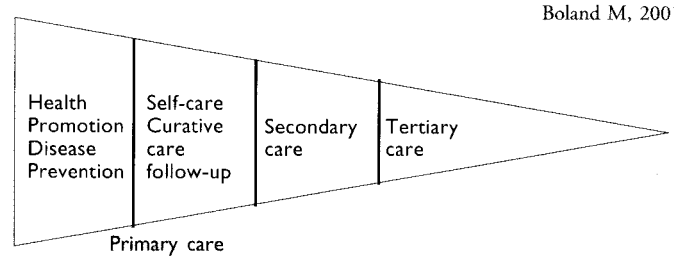

Fig 1. The prism of health care

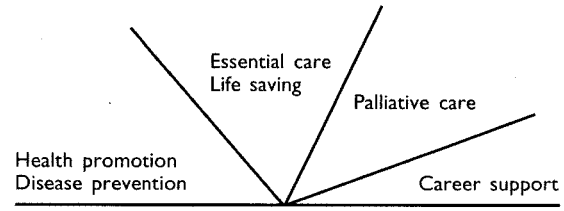

Fig 2. The spectrum of health care

PRIORITY CARE AREAS IN THE ELDERLY

The priority care areas of the elderly from the GP perspective are the following five:

(1) Reduction of risk factors for strokes, ischaemic heart disease and chronic obstructive airway disease – Contrary to common beliefs, there is much to be gained in reduction of risk factors, even in the elderly. Control of hypertension is important in preventing strokes; lipid levels and exercise in ischaemic heart disease; smoking in chronic obstructive airway disease; and diabetes mellitus in the reduction of multi-system complications.

(2) Treatment of acute infections and organ failures – these may present atypically, have only a small window of opportunity for intervention and restoration of the fragile health status.

(3) Management of the five giants of geriatrics – These are: instability, immobility, incontinence, iatrogenic effects of polypharmacy and intellectual failure.

Attention to these are important in preserving the fragile health status or quality of life. For example, attention to instability and immobility to reduce the risk of falls and fractures; drug use and side effects and risk of falls; intellectual failure and need for carer support in the face of deteriorating ability to provide self care.

(4) Management of frailty and dependency – the old-old (75 years and older) will be increasingly frail physically to need carer support to remain in the community. They would require particular care in helping them deal with infections and other acute insults.

(5) Management of cancer – these become more common in the elderly and early detection can reduce morbidity and mortality; for those who are beyond cure, attention to palliative care is important to ensure quality of life.

ROLE OF THE GP IN INTEGRATED CARE FOR THE ELDERLY

It can be seen that opportunities for the GP to work with the rest of the healthcare delivery system to ensure optimal care for a given level of resources are many.

SOME EXAMPLES

The acute unwell. We need to pay attention to the acute unwell to ensure that intervention is timely. The classical example is the patient with pneumonia. Appropriate and early use of antibiotics can reduce a downward spiral of poor health if not mortality.

The post-hospitalized patient. For the post-hospitalized patient, a system of step-down care with the GP playing a greater role once the acute hospital episode has been managed can be envisaged. An example of this is the stroke patient. The GP can certainly co-ordinate the rehabilitation of the stroke and work with the patient and carers to prevent a further stroke.

The low risk well elderly. We need also to pay attention to the low risk well elderly. Attention to these individuals may not be immediately cost effective yet the savings down the road will be hefty. An example of this is the control of hypertension.

More than one trial in the control of hypertension in the elderly demonstrated positive health outcomes in the reduction of stroke (SHEP, Eur-Sys, STONE).

The Systolic Hypertension in the Elderly Program (SHEP) illustrates the point. It was the first large-scale trial to document a benefit from treatment of Isolated Systolic Hypertension in the elderly. The 4,736 patients enrolled in this double-blind, randomized, placebo-controlled study were 60 years of age or older showed that the reduction of systolic pressure to less than 160 mm Hg in those with initial readings of more than 180 mm Hg and the reduction of the systolic pressure by 20 mm Hg in those with initial readings between 160 and 180 mm Hg resulted in an average systolic blood pressure of 155 mm Hg in patients taking placebo and 143 mm Hg in patients receiving medication (SHEP, 1991).

The overall results were very impressive. The number of strokes was reduced by 36% in the group receiving medication compared with the group receiving placebo. Analysis of secondary end points showed nonfatal myocardial infarctions plus death from cardiac causes to have been reduced by 27% and major cardiovascular events by 32%. The incidence of congestive heart failure was cut in half by treatment with medication (Pentz, 1999).

RESPONSE TO THE DISEASE MANAGEMENT CHALLENGE

Two responses are required of the GP fraternity in this context in delivery of care to the elderly:

- Enable and empower themselves in the knowledge, skills and attitude of disease management in the context of the elderly; this is the educational response;
- Win friends and influence people on what the GPs can do in the disease management era; this is the political response.

The political response is as important as the educational one. There is a need or the GP fraternity to convince the 4 Ps – public, the profession, the policy makers and the press.

The public needs to be convinced that their neighbourhood GP can now look after them for a large part of the care that they or their loved ones need. The dissemination of such information is much needed. The press can do this. Hence, it is also important to keep the press informed and convinced.

Within the profession, there is a need to convince each GP of the new focus as well as to enlist the support of the specialists to assist and include the GPs in the disease management programmes. In this way, the prism of GP care will be maintained.

The policy makers in the two clusters of health care would need to work with the GPs to develop a more integrated programme of care across the whole range of health care and population groups. There has been encouraging initiatives from the two clusters.

The GP fraternity need to work on these initiatives. GPs can be involved at the level of being in touch with the cluster initiatives, or at a higher level of shared care and stepped down care, or at yet a higher level of administration and liaison with the policy makers to implement the disease management concept that includes the GP fraternity.

CONCLUSIONS

The disease management paradigm is a challenge for the GP fraternity to continue to be relevant. There are opportunities for developing the primary care based disease management model in the care of the elderly. The response from the GP fraternity needs to be both educational and political. The fraternity needs to educate themselves and also to win friends and influence the public, the profession, the policy makers and the press of the new role that it can play.

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