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Chronic disease management: mistaken approach in the elderly

ABSTRACT

Lifestyle changes, including unhealthy eating habits and high rates of physical inactivity and stress, along with an increase in life expectancy have been accompanied by increasing rates of chronic non-communicable diseases. Chronic diseases are the main causes of death and disability in Brazil. Chronic disease management is one of the most important challenges facing health managers who are constantly seeking interventions and strategies to reduce costs and hospital admissions and to prevent other conditions. However, most existing models of health care have focused exclusively on disease, but it is a mistaken approach. An integrated approach is required to effectively meet patient needs. The purpose of this article was to further discuss policies and strategies for the development of new models of care for the elderly with an emphasis on prevention and resolution actions.

DESCRIPTORS: Aged. Chronic Disease. Long-Term Care. Patient Care. Health Services for the Aged. Health Promotion.

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INTRODUCTION

As society grows steadily older, the health problems of the elderly defy existing models of care. Technological advances and health science offer those who have access to such modern tools the chance to enjoy better quality of life in a longer old age. Preventative strategies throughout the course of life have become more important in resolving today's challenges and, increasingly, those of tomorrow.¹³

Some efforts, albeit timid, have been made in Brazil. The Ministério da Saúde has included health for the elderly as a priority item in its agenda and issued a new National Health Policy for the Elderly, in which contemporary concepts were introduced. This policy is based on the functional capacity paradigm, approached in a multi-dimensional manner. Its practical effects have still not been felt, as the weight of traditional care is still very much preponderant.

In accordance with the perspective of preserving health and providing more years of healthy life, the Agência Nacional de Saúde Suplementar (ANS – National Agency of Supplementary Health), through Normative Resolution nº 265, incentivises the use of health plans, through the possibility of discounts to the monthly payments.^b This is new to Brazil: suggesting that health insurance providers offer financial benefits to clients who participate in programmes for preventing and detecting illness – without doubt a timely initiative. The ANS proposal is aimed at all age groups, but has a particular impact on the elderly, as it stimulates active ageing.

The logic of the health system is guided by the treatment of illness, not its prevention. Inverting this model is imperative to assuring better quality of life for the elderly and wellbeing in the population as a whole.^{14,16}

The objective of this article is to contribute to the discussion of policies and strategies which will allow the introduction of models of health care for the elderly with an emphasis on projects for prevention and resolution, as these campaigns are still in their infancy. There are many badly conceived and, consequently, unsuccessful initiatives, which reinforces the abandonment of preventative activities. In order for such programmes to be successful, it is imperative that we identify the errors committed.¹² Among the proceedings which have low impact, the management of chronic illness stands out. Although presented as

an innovative solution, it can be construed as failing the elderly population.

EMPHASIS OF CHRONIC DISEASE MANAGEMENT BY THE PRIVATE SECTOR

Based on a study carried out by the ANS, information on how providers operate preventative and promotional health programmes and campaigns for the early detection of diseases common in later life was collected. A spreadsheet containing projects registered with the ANS was analysed.^c

The spreadsheet is extensive, composed of 511 columns representing providers. The lines are variables of the programmes and incorporate adult and elderly health. Upon analysing programmes specifically for the elderly, the variables informed the topics of the campaigns – e.g.: programme for high blood pressure (yes; no), healthy eating programmes and stop smoking programmes among others. The title alone does not guarantee being able to evaluate the approach and efficacy of the programme. In spite of the information lacking in detail, it was possible to identify threads for this discussion.

In campaigns specifically aimed at the elderly, the following variables were observed, which are the areas of campaigns carried out by the health providers: alcoholism, healthy eating, colon and rectal cancer, lung cancer, other types of cancer, palliative care, diabetes mellitus, Chronic obstructive pulmonary disease (COPD), sexually transmitted diseases (STD), cardiovascular disease, occupational diseases, systemic arterial hypertension, vaccinations, lack of physical activity, cardiac failure, respiratory failure/pulmonary rehabilitation, osteoporosis, oral health, overweight/obesity, smoking and others. There were other conditions that were listed as a priority on the ANS spreadsheet. The majority of the proposals by the providers were for programmes which focussed on the disease, and many were programmes for clients with diabetes or high blood pressure. In fact, these are prevalent diseases in this age group. However, in the elderly the focus should not exclusively be on the disease. The elderly do now have one, single condition. In addition to the multiplicity of pathologies, it is also necessary to consider the strong influences of social determiners in illnesses which affect this age group. In contrast to what was observed, the focus on combatting the diseases (various types of cancer, diabetes, COPD, cardiovascular disease,

^a Ministério da Saúde (BR). Portaria nº 2.528, de 19 de outubro de 2006. Aprova a Política Nacional de Saúde da Pessoa Idosa. *Diário Oficial Uniao*, 20 out. 2006 [cited 2012 Sep 5]. Available from: <http://portal.saude.gov.br/portal/arquivos/pdf/2528%20aprova%20a%20politica%20nacional%20de%20saude%20da%20pessoa%20idosa.pdf>

^b Ministério da Saúde (BR), Agência Nacional de Saúde Suplementar. Resolução Normativa - RN nº 265, de 19 de agosto de 2011 [cited 2011 Oct 3]. Available from: http://www.ans.gov.br/texto_lei.php?id=1796

^c Veras R. Relatório analisando as vantagens e desvantagens para as operadoras de planos privados de assistência à saúde ofertarem programas de atenção à saúde, especialmente formulados para idosos. Rio de Janeiro; 2012. Contrato OPAS/ANS BR/CNT/1100826.001, produto 03, 2012.

osteoporosis among others), the same emphasis should be placed on the risk factors which lead to these illnesses.

There are five main risk categories for extensively studied diseases: alcoholism, smoking, stress, physical inactivity and unsuitable nutrition. These are factors which cut years from life and, more importantly, reduce the quality of those years lived. Greater longevity is a fact of life these days. With concern focussed on these five categories we could not only increase the number of years lived but, above all, provide conditions to enjoy society's greatest achievement: living 20 or 30 years more than previous generations – and with quality.

The large number of campaigns aimed primarily at a set of diseases prevalent among the elderly shows that the majority of the programmes carried out by the providers are about “managing chronic illness”. Their effectiveness is limited in this age group. This logic of care is effective in younger age groups, who tend to have only one chronic illness. Among the elderly, multiple conditions are common. Once they set in, they are with the individual until death. Care, therefore, should be aimed at stabilising these conditions, avoiding them getting worse in the pursuit of quality of life.¹

The effort of some providers who have already identified the need for promotional and preventative campaigns should be looked on favourably. Some of these campaigns are adequately run, with advantages for both the clients and the company. However, a significant number are only serve publicity and have shown no practical results. What is worse: they waste money and serve as an alleged demonstration of the poor effectiveness of preventative programmes and monitoring campaigns, which is not true. These programmes need to be developed in a professional, qualified manner as, like anything else in life, poorly carried out campaigns only lead to waste of money, disrepute and inefficiency.

IMPLEMENTING PREVENTATIVE MODELS

There is a large gap between the desire to implement new health campaigns and their actual use. There is also a lack of theoretical knowledge and information about suitable and effective preventative models. In spite of preventative concepts being well-structured and accepted by providers and health care professionals, their implementation is fairly precarious, especially in the elderly age group which involves complicated theoretical factors. The preventative model was conceived of in a less aged world than we live in today. The emphasis, therefore, was on younger populations.

Articles on the topic show that managing chronic illness is mainly aimed at reducing costs and minimising hospital stays, and is focussed on ill individuals with developed chronic illness.^{3-6,21}

We are assuming that there is a consensus in the application of preventative strategies and in integrated health care. There is a discourse among health professionals which is favourable to the method, possibly due to the fact that being against prevention is to be retrograde – and, therefore, difficult to do. However, in practice, in spite of the hegemonic discourse in favour of prevention, the emphasis is on traditional care and services.^{2,d}

The excuse on the part of the providers for such a dichotomy is attributed to the difficulty in measuring the efficiency, from a financial point of view, of such programmes. Since the 1986 Ottawa Charter,^e there has been concern with demonstrating the effectiveness of the preventative model and with characterising effective practice which leads to changes in health determiners.

OPERATIONAL DIFFICULTIES IN CHANGING THE MODEL

Accumulated knowledge and new research should stimulate the health sector to design and/or widen more contemporary models, which offer better outcomes and more suitable costs.^{18,19}

The majority of the providers know that the number of elderly who have multiple, coexistent problems, which frequently lead to appointments with various specialists as a result of the fragmentation of the health system, is significant. In addition to raising the cost of care, this does not necessarily represent positive cost-effectiveness, as it may result in important iatrogeneses, with unwanted consequences.

The presence of comorbidities associated with the losses concomitant with ageing should not be seen as a condition of ageing badly. It is the administration of such losses (avoiding, postponing or compensating for limitations), through correctly managing a contemporary care model, allies with available competencies and resources, which can guarantee the elderly and their families the conditions to experience this stage of life as an achievement.^{8,16}

The ageing process, even without chronic illness, involves some functional loss consistent with physiology, expressed through reduction in vigour, strength, alertness or systemic reaction rate. Elderly populations have high prevalence of chronic illness which

^d Azevedo ERFC. Os desafios das operadoras de planos de saúde de autogestão em um cenário de envelhecimento populacional e cronificação de doenças [monografia de especialização]. Rio de Janeiro: Universidade Anhanguera para o Desenvolvimento do Pantanal; 2010 [cited 2011 Oct 15]. Available from: http://www.santosediniz.com.br/wp-content/uploads/2011/09/os_desafios-das-operadoras_de_planos_de_saude_de_autogestao.pdf

^e Carta de Ottawa: Promoção da Saúde nos Países Industrializados. In: Primeira Conferência Internacional sobre Promoção da Saúde; 1986; Ottawa, Canadá. [cited 2012 Sep 5]. Available from: http://www.saudepublica.web.pt/05promocaosaude/Dec_Ottawa.htm

accompany functional loss in organs and tissues over the years – less than 10% of people aged 65 and over have no type of chronic health condition and more than 10% report at least five concurrent chronic conditions. The high prevalence of chronic illness exacerbates the loss of functional capacity of subjects who are ageing.¹⁵

One of the “bottlenecks” of the care model consists in the inadequate identification and precarious uptake of this clientele. The low effectiveness of outpatients services, the lack of monitoring of the more prevalent diseases and their risk factors and the scarcity of services which provide home visits means that primary care occurs, in many cases, when the disease is at an advanced stage. This increases costs and diminishes the chances of a favourable prognosis.⁹ Moreover, the traditional medical approach, focussing on the main complaint, and the medical habit of bringing all the symptoms together in one diagnosis may be suitable, with some limitations, in caring for young adults, but certainly does not apply to the elderly.

With the rapid and intense ageing of the Brazilian population a new health paradigm is being outlined: in an ageing population, a strategic indicator of health is not the presence or absence of chronic illness but the degree of the individuals’ functional capability and the ability to lead an independent and autonomous life.^f

The majority of chronic illnesses which affect the elderly have age itself as their principal risk factor. Ageing without any chronic illness is the exception rather than the rule. The focus of any contemporary health policy should be on promoting healthy ageing, maintaining or even progressively improving the functional capacity of the elderly, preventing illness, recovering health of those who fall sick (and/or stabilising the disease) and the rehabilitation of those with restricted functional capacity.¹⁷

Those elderly who become fragile tend to increase with the extension of lifespan. Policy could be proposed which focus on maintaining functional capacity, on preventative programmes, on investment into methodologies for early detection, on monitoring health problems, on the personalised medical system (the good old family doctor), among other measures. All of this to the detriment of the focus on several diseases and to the abandonment of the rest, as has occurred with the management of chronic illness in the elderly.^{7,20}

A prime example of such attempts in action in the health market can be seen in the United Kingdom. Clients of one of the largest health insurance providers, PruHealth,^g received financial benefits for exchanging their car for walking, using a pedometer with a cardiac

monitor. They also obtained discounts when buying fruit and vegetables in supermarkets associated with the health provider and received incentives for using gyms. All of these positive factors lead to reductions in the cost of their health insurance policy.

The English experience has not yet arrived in Brazil and it is not known whether it would have a positive effect and be accepted by society. Either way, the message it gives deserves to be reflected on: health insurance plans operate in a kind of mutualism, in which the less healthy consume more medical services and inflate the values paid by those who still have functional capacity and are in good shape. For many years, we have had difficulty in accepting financial stimuli to care for our health.

The application of epidemiological input and the emphasis on prevention mean that this new approach favours reductions in care costs at the same time as improving quality of life on giving priority to knowledge technology rather than the technology of machines and images. This implies reorganising the current model of health care.

The message is simple: business has to adapt new technologies to modern gerontology. It is unthinkable to maintain the logic of disease.

REWARDS AND PREVENTATIVE CAMPAIGNS

ANS’ understanding of the need to launch induction mechanisms for consumers too is important. Their take up is fundamental to the success of preventative campaigns.^h Thus, the consumer benefits twice, avoiding illness and obtaining discounts and rewards. The relation between provider and more elderly client has always been one of distrust. The providers have never been enthusiastic in providing services to the elderly. Their policy was always to try and reduce the weight of this segment on their bottom line. The elderly clients, for their part, constantly complained of the difficulty of receiving care and the rejection of many of the requested tests, which made it difficult to use their health plans, which they considered to be very expensive. For the providers, the value paid by this age group is reduced and does not adequately cover the risks of a population with a high probability of falling ill and impacting on their costs.

This is a unique situation. There is no other commercial relationship in which provider and client are in such an antagonistic position and do everything possible to rid themselves of each other. If it were possible, insurance providers would not accept these clients; the elderly

^f Gordilho A, Sérgio J, Silvestre J, Ramos LR, Freire MPA, Espíndola N, et al. Desafios a serem enfrentados no terceiro milênio pelo setor saúde na atenção integral ao idoso. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2000.

^g Information concerning PruHealth can be accessed on: <<http://www.ifaonline.co.uk/tag/pruhealth>>

^h Oliveira M. Políticas para o envelhecimento ativo. *Jornal O Globo*, 2011 maio 20; Seção Opinião, p.7.

dream of a plan which would cover all their needs. In this belligerent and hostile climate, it has traditionally been difficult to suggest and implement preventative campaigns, as the client is very distrustful.

MANAGING CHRONIC ILLNESS

The management of chronic disease, characterized by the prospective approach and focused on the disease, includes the provision of health care in all its stages in the search for a more cost-effective relation. A programme for managing chronic illness has the objective of: identifying sick individuals with high risk care; prevent worsening of the condition and complications; increase the patients' involvement in caring for themselves and construct a database of these patients.¹ Considering the systemic complexity and multifactorial nature of chronic degenerative diseases and comorbidities, defining the scope of program activities and training a multidisciplinary team are imperative to the success of the program.

The programmes for managing illness in the elderly have low cost-benefit ratios, as properly treating the disease leads to a reduction in the morbidity rate of the disease. However, as they are patients with multiple chronic illnesses and which make use of different medical specialities, focussing on one disease is not the most appropriate measure. The best option is to structure models which function in an integrated way and manage to encompass the whole range of care. If not, the problem is difficult to resolve, as the other illnesses and the fragility remain. Moreover, resources will be used inappropriately.⁴

For Porter,¹⁰ it is fundamental that managers in the health sector stay focussed on creating value and not just on cutting costs. According to this author, there is a crisis in the current model, adopted in various countries, according to which one has to lose for another to gain. In a recent analysis of the current system all over the world, Porter¹¹ concluded that the greatest problem is the focus on treating illness to the detriment of prevention, which leads to a win-lose relationship in which someone always has to foot the bill. Porter & Teisberg²¹ presented a new Health Care Cycle, in which health precedes care and affirm that underlying it is the need to measure and minimise the risk of illness, offer comprehensive disease management and make preventative services available to everyone, including the healthy ones. They add that health cannot develop merely from care, but from preparation by the service (which increases the efficiency of the value chain), intervention, recuperation, monitoring/managing the clinical condition, promoting access, measuring results and, finally, disseminating information. The argument is based on the proven fact that, for every dollar invested in the prevention and management of chronic disease, the return is US\$ 2.9, i.e., almost 3 to 1 benefit.

All over the world, there are disagreements about the ideal percentage of investment in promoting health compared with the amount dedicated to care. In spite of this being a complex sum which depends on the model in force, we can conclude that it is more and more necessary to invest resources in preventing people falling ill. Prevention is not a cost, but an investment with guaranteed profit.

The concepts reported here are backed by scientific studies and, from the point of view of quality of life, are the most appropriate instrument to apply. Therefore, we can present several questions that are not often touched on. Managing illness is effective in populations with only one complaint to be treated, i.e., not elderly adults. For those with just one chronic illness, establishing programmes to avoid the illness becoming worse if the most suitable and correct policy. Our criticism is when this proposal is extended to all age groups, particularly the elderly, who are patients with multiple chronic illnesses.

For this age group, actions need to take place in an integrated manner. We are not talking about managing a chronic illness but rather about monitoring the patient's health profile. Often, treatment for one problem can only take place with the reduction or suspension of other actions which are being developed. This is why geriatric/gerontology health teams have a different profile to that of teams caring for other age groups. As the slogan "chronic disease management" is enshrined and accepted by all, we need to add this clear warning: the same actions performed for young adults cannot be applied to the elderly.

FINAL CONSIDERATIONS

The main concern presented here has to do with understating the heterogeneity which characterises the elderly population, in the high cost of health procedures aimed at them, in the diversity of the costs for subgroups of this population and in the insufficient quantity of specialists in geriatrics. However, its value is in perceiving that without a preventative, integrated approach which links epidemiological reflection with systematic planning of health campaigns, there is no way out of the sector's financial and restructuring crisis.

These reflections aim to encourage discussion on the need for new strategies. Caring for the elderly and their chronic illnesses should have an innovative and creative focus, with an integrative approach, including prevention, risk factors and treatment. These individuals are those which most suffer the effects of their fragility and, therefore, those who most deserve quality services and who most need an efficient health sector.

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