

WHAT'S COMING NEXT IN SERVICES?

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INTRODUCTION

Futurology is generally a mug's game. Who predicted the revolution in the price of oil in 1970? — but it permanently transformed the world economy just 3 years later. Who predicted AIDS in 1980? — but it became a world epidemic well before the end of that decade. And who expected to see the Berlin wall coming down just a few years before its bricks became collectors' pieces? Who predicted Viagra 5 years ago?

I shall play safe. My theme is the growing salience of trends that have already begun. I draw from my experience of geriatric psychiatry, but the care of old people is like care of any other group, only more so, and all these matters are relevant to the care of people of all ages. I make no pretence to novel insight; most of my topics are already much discussed. But it may be helpful to bring them together here.

The themes that I identify may appear very disparate; in fact, they are largely inter-related. Some I do little more than list, as they either speak for themselves or are too complex to consider here in detail. My list follows no very logical sequence, and I shall try to avoid what is already well-accepted — such as the continuing transposition to 'the community' of much work, which was previously hospital-based, or the certain emergence of new drugs (although I do have a few words to say about the changing objectives of drug use).

TENSIONS BETWEEN GROWING CONSUMERISM AND RETRACTION OF PUBLIC PROVISION

'Consumerism' is gathering pace, and part of it is scrutiny of all forms of professional practice. The reliability of professionals is no longer taken for granted, and old attitudes of paternalism by professionals are now inappropriate. With growing expectations, successive generations of better educated 'service users' are turning from merely grateful acceptance of services, to a much more critical appraisal of them. People draw also on the hugely increased availability of information, which will be discussed below.

Alongside these changes is a shift in political ideology against the 'welfarism' that has largely formed a part of a public consensus in many countries. Pressures of demography, technology, expectations and cost, and particularly changing political ideologies, have brought about a retraction of public provision almost everywhere.

In a field such as psychogeriatrics, which is 'service intensive' and is used by old people, who everywhere are one of the largest groups of the poor and thus least able to buy alternative services, these developments are particularly telling. But in our field there is in addition the fact that long-stay care, or long-term intensive support at home, is so often at issue, and private payment for this is usually beyond the means even of the relatively well-off. Clinicians stand at the focal point at which tension is sharpest between consumer expectations and retraction of public provision.

RATIONING WITH SOCIALLY DIVISIVE CONSEQUENCES

In publicly provided health services, 'rationing' can be found almost everywhere, in covert or explicit form. We are likely to see much more explicit rationing, and with it, erosion of 'comprehensive' publicly provided care in countries where previously it was widely available. This has perhaps been most sharply visible in the new Eastern Europe. Even in rich 'Western' countries, much that is effective is no longer available to those who cannot buy it for themselves, or is rationed by waiting lists.

This applies alike to expensive treatments, high quality personal care for severe chronic illnesses, and to long-stay care; even the well-off will often find that paying the whole cost of good quality long-term care for heavy dependency is beyond their means, or is incompatible with their own natural expectations of conserving something to leave to their family or with expectations of their heirs of inheriting.

We seem to be nowhere near seeing an effective insurance system for long term-stay, the cost of this being potentially enormous — much higher than that of insuring against the need for major high-tech procedures. It may thus be that the well-off and the poor will together come to make common cause in favour of greater and better public provision of, or support for, such services; this may yet become one of the major political issues in 'rich' countries, because it touches the 'young', who have old relatives, as much as the old themselves.

DEMEDICALISATION AND SUBSTITUTION

These trends are growing everywhere. Partly they derive from a reaction against past medical paternalism and even arrogance, but probably the chief driving force is a more egalitarian view of the professions, and the fact that doctors are seen as expensive, and certainly are well paid in most countries.

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Without doubt much of what doctors have traditionally done can be as well done by less highly paid and less expensively trained staff — indeed sometimes better done, for that which for doctors may be seen as relatively unexciting routine work can give greater job satisfaction to some other workers, and work is generally better done when those who do it enjoy what they are doing. Thus, the scope of what is nowadays being done, and well done, by nurses and other health staff has grown hugely in recent years, and will probably grow even faster in the future.

MORE AND BETTER TRAINING FOR STAFF

This is a challenge, especially in the long-stay field where much or even most care is given by non-professionals. Vocational training for non-professionals is only just beginning, and it calls for a different approach from that which is appropriate to the education of professionals. The lay paid supporters of the disabled are now known as ‘carers’, a new word in this sense (the Oxford dictionary of ‘20th Century Words’ gives this as a coinage first seen in this sense in the 1970s). They provide indispensable paid care, and are already seeking and requiring training in huge numbers; they will no doubt come to aspire to near-professional status. ‘Dementia carers’ are already a defined subgroup, and many journals and meetings are devoted to ‘dementia care’.

Equally, training for professional staff in the care of the aged and the demented, and particularly ‘continuing professional development’, is already rightly in great demand, though the extent to which it consumes time and resources at the expense of care is not always recognised. The demand will grow as ‘revalidation’ becomes established.

RAPID ADVANCES IN NEUROSCIENCE — MOLECULAR BIOLOGY AND GENETICS

This is so huge a field that little can usefully be said here. Of ‘gene therapy’ the potential is still uncertain, but one instance from my field of the new importance of genetics, is the fact that giving genetic advice to individuals and families is already a routine item in the working week of the practical psychogeriatrician, and the demand for this — novel for those of us who began work in an earlier era — is likely to become a major activity, as new knowledge and new tests become available. The implications of the ability to predict, and the ethical and legal issues that flow from it, are already raising difficult questions.

THE ‘INFORMATION EXPLOSION’

This touches almost every aspect of our work, but perhaps least noted is its effect on our now much more sophisticated patients, who can be very searching in their questioning. This will become a major aspect of the dialogue with patients. ‘Complementary’ therapies are sure to feature more and more

in this dialogue. Potential patients will ask doctors for good evidence of their own past performance (much harder to measure in some branches of medicine than in others) and of ‘validated’ continued performance. The time is not far away when most consultations will be preceded, and followed, by a visit to the Internet — perhaps by both parties to the consultation.

Measurement of ‘outcomes’ of services and treatments are the subject of a torrent of writing and debate; we shall hear even more of it. Suffice it here to say that ‘outcomes’ in our field (as compared with some other fields, such as, say, surgery) can be hard to measure and easy to fake.

GROWING ETHICAL AND LEGAL DEBATE AND LEGISLATION

In my field, the law of ‘capacity’ is widely under review, and traditional statutory arrangements for the care of incapacitated people are stretched beyond their former scope by demography, and beyond their relevance to modern times by changing expectations. Topics such as advance directives and thorny questions of ‘physician-assisted death’ are under debate. Ethical questions include ‘rationing’, mentioned above, and in my context especially ‘ageist’ rationing (as I write Age Concern has published a report on evidence of ageist discrimination in our health service). One can safely predict a continued increase in the number of attempts to provide ‘evidence-based’ (another phrase of which even more will be heard, in diverse and often not clearly defined senses) disbursement of scarce resources.

IMPROVED TECHNOLOGIES FOR IMAGING AND OTHER INVESTIGATIVE AND THERAPEUTIC TECHNIQUES

For my generation, which grew up with ‘air studies’ of the brain (and for whom ‘fibre-optic’ technology was then unheard of) the huge increase and routinisation of such advances seems miraculous, and the future possibilities appear limitless. A recent issue of the British Medical Journal (13 November 1999) is devoted to ‘new technologies’; there (as one fingers one’s way between overprinted text and shrieking advertisements — another sign of a change of style) one can marvel as one reads of non-invasive ‘virtual colonoscopy’ replacing fibre-optic endoscopy, which itself in my time has replaced cruder techniques; or of ‘stem-cell technology’; and each item carries a pointer to relevant websites.

ELECTRONICS FOR RESTORING FUNCTION OR FOR ‘PROSTHETIC’ CARE

The scope for electronic ‘tools for living’ is practically unlimited and far transcends the applications that are already

in use. It ranges from electronic implants designed to alleviate or eliminate neurological disability, to electronic environments which act as replacements for human care. Its ultimate scope is no doubt still unimaginable.

NEW DRUGS

The fascination of the future is both in the certainty of powerful new drugs and drug delivery technologies, and in the issues that they may raise, such as the potentially ambiguous nature of their relationship to 'illness'.

Viagra is currently a much publicised case in point; another is 'age-related memory impairment'. Drawing the lines between treatments for 'disease', treatments for 'normal' changes, and treatments for 'aspiration' will become a drama in which patients, providers, citizens, insurers, governments and drug manufacturers will all be actors. Who will pay for drugs designed to make well people happier, or to perform better in examinations — or to be more attractive (at any age), or to retard or arrest aspects of ageing? Already there is

controversy on when impotence is to be recognised as a 'medical' matter, and when not. And when Viagra, or eventually an even more effective — and probably even more expensive — successor arrives, how many tablets should the state or insurers provide? One Viagra a week is our government's current rule for those deemed to be 'medically entitled'; they are the 'deserving impotent', like the 'deserving poor' of former times.

It is worth remembering that use of drugs for 'non-medical' purposes in no way takes them out of the medical domain, indeed it inevitably extends the latter, for the ingestion of novel chemical substances has medical implications, whatever its purpose.

CONCLUSION

The only conclusion must be that there is no conclusion to change — and that change will become even more rapid, and that it will surprise. But the 'jobbing peripatetic hands-on practitioner' is unlikely ever to be out of work.

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