

Making health care responsive to the needs of older people

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Abstract

This commentary highlights the importance of health system responsiveness to older people living with complex health needs. Age-related changes and associated morbidity can present barriers to identifying an individual's health needs, expectations, values and preferences, and so sufficient time, skill and resource is required to inform the development of a tailored plan for each individual. A focus on responsiveness moves thinking beyond the responsibilities of the individual clinician in the single encounter, and allows us to identify elements of the wider system that may constrain how well the clinician is able to respond. Setting the goal of responsive health care requires us to assess the suitability of wider health system features and processes for meeting the diverse needs of individual people throughout their journey, and the extent to which the system can adapt dynamically as needs change. Standardised approaches to care prescribed across organisations (such as time-based targets or routinised approaches to inpatient nursing care) are likely to result in low responsiveness as individual complexity grows, disadvantaging patients with needs that do not fit the prescribed approach. Responsiveness is high when individual practitioners and clinical teams have the resources, decentralised authority, flexibility and autonomy to provide the care required. Building a more responsive health system requires a greater understanding of how these conditions can be achieved.

Key Words (3-5)

Older people, health system responsiveness, healthcare improvement, shared decision making, patient involvement.

Key Points (3-5)

Responsiveness is a highly relevant characteristic of health systems for older people, especially for older people living with complexity associated with multimorbidity and other health needs.

Responsiveness is high when health care providers have sufficient skills, autonomy, flexibility and resources to dynamically identify and adapt to the needs and expectations of individual people.

Responsiveness is low when standardised approaches to care are prescribed across an organisation.

Low responsiveness disadvantages older people with complex needs and marginalises certain needs.

Using the notion of responsiveness as a conceptual frame in health care for older people draws attention to the differentiated needs and expectations of individuals, while enabling us to consider the barriers and levers for change in a complex adaptive system.

Making health care responsive to the needs of older people

The evidence base for good health care for older people is growing, but we understand less about the contexts in which delivery of such care is possible [1]. There is now a wide appreciation that clinicians should share decisions about treatment and care with patients [2], but patient involvement of this kind is not an end goal in and of itself. Working with older people to identify needs, expectations, values and preferences precedes the development of any plan that, in practice, is negotiated within the limits of what is possible within that health system. A larger question, however, is whether and the extent to which *the health system has the capacity to dynamically respond to individual needs and expectations*. We argue that closer attention to responsiveness as a health system characteristic can inform the promotion of system conditions more conducive to the delivery of good health care to older people.

The goals of a health system are better health, fairness of financial contributions and responsiveness to the legitimate expectations of individuals as to how they should be treated, physically and psychologically [3]. Mirzoev and Kane have characterised responsive health systems as those which *“anticipate and adapt to changing needs, harness opportunities to promote access to effective interventions and improve quality of health services, ultimately leading to better health outcomes”* [4](p. 2). While widely studied as a concept in wider political science and, to a lesser extent, in relation to public sector management, responsiveness of health systems has received less attention [4, 5]. This is in spite of its particular relevance to health care, as the threat that illness and healthcare can bring to dignity, identity and ability to control events is of greater significance than most other life experiences [3]. Responsiveness is the health system characteristic with the potential to anticipate and address these threats for individual people.

This potential is being recognised in health policy, albeit slowly and inconsistently. For instance, the recently published long term plan for the National Health Service (NHS) in England highlighted three major goals, one of which was that the NHS would increasingly be more differentiated in its “support offer” to individuals [6]. This commitment was in response to a recognition that “one-size-fits-all” services have disadvantaged people with highest need, contributing to inequalities in access and outcome [6](p.12). The practical steps set out in the NHS plan to achieve more personalised care include expanding choice of elective care provider, more personalised medical therapies such as cancer immunotherapy, and supporting and training healthcare staff to work in partnership with patients, to ensure individual values and preferences are honoured in decisions about health [6].

A commitment to more differentiated support is timely, perhaps even overdue, in the face of ageing populations and the complex health challenges that old age can bring. Conditions that are

associated with old age can be manifestly complex. Disease types, constellations, progression and symptom profile vary between individuals over time, and also in the way that these elements interact with people's personal characteristics including age-related biological changes, with social needs, socio-economic status, social networks and available resources playing a big role. The crux of responsive health systems is that health care providers must have the capacity – the skills, autonomy, flexibility and resources – to meet the patient as a genuine partner, and identify and meet each person's needs and expectations, in the context of their personal goals and preferences [4]. These interactions are not just about the single clinic visit, but apply more widely to interactions and encounters with the system over time and across an individual's care journey, accommodating changes in needs that can be frequent and unpredictable. A dynamic receptivity (or not) to people's concerns manifests itself in the individual's experiences within and beyond each interaction, and so being able to access people's experiences longitudinally, and as close to real time as possible, is at the core of assessing responsiveness [4].

These experiences explicitly reflect the interaction, but are also shaped by people's expectations and by the wider health system response to these (Figure 1). Accessing older people's experiences, and indeed eliciting their expectations of health system encounters, can be far from straightforward. Expectations may be difficult to put into words, or latent, manifesting only when not met [4]. Cognitive impairment, communication difficulties, perceived power imbalances between care provider and patient, fears of legitimacy of health need and reluctance to ask for help, are all patient-based characteristics which, when coupled with the remarkably low expectations of health care that old age can bring for some [7-9], can be problematic for individual practitioners to then respond in a personalised way [8, 10]. Relationships within families and wider communities will also play a part in shaping expectations [4]. These very real difficulties for health service providers, while certainly not the case for all older people, raise important questions. If expectations are low and are likely to lead to poorer health outcomes, what is the responsibility of health providers to re-shape these expectations in order to improve care, and downstream, outcomes? If expectations cannot be accessed, how can health providers ensure that individual needs are not marginalised and resources not then just concentrated on service users whose expectations can be accessed? Inequities and unfairness would result. And any such added layers of complexity probably mean that more skill, time and resources will be required to unpack expectations and needs, in order that a tailored response can be formulated.

The influence of the wider historical, social, cultural and political context, including attitudes to old age, definitions of health and legitimate health care need, inequalities in access and the role of a society in funding the care required all have significant implications for older people, shaping their

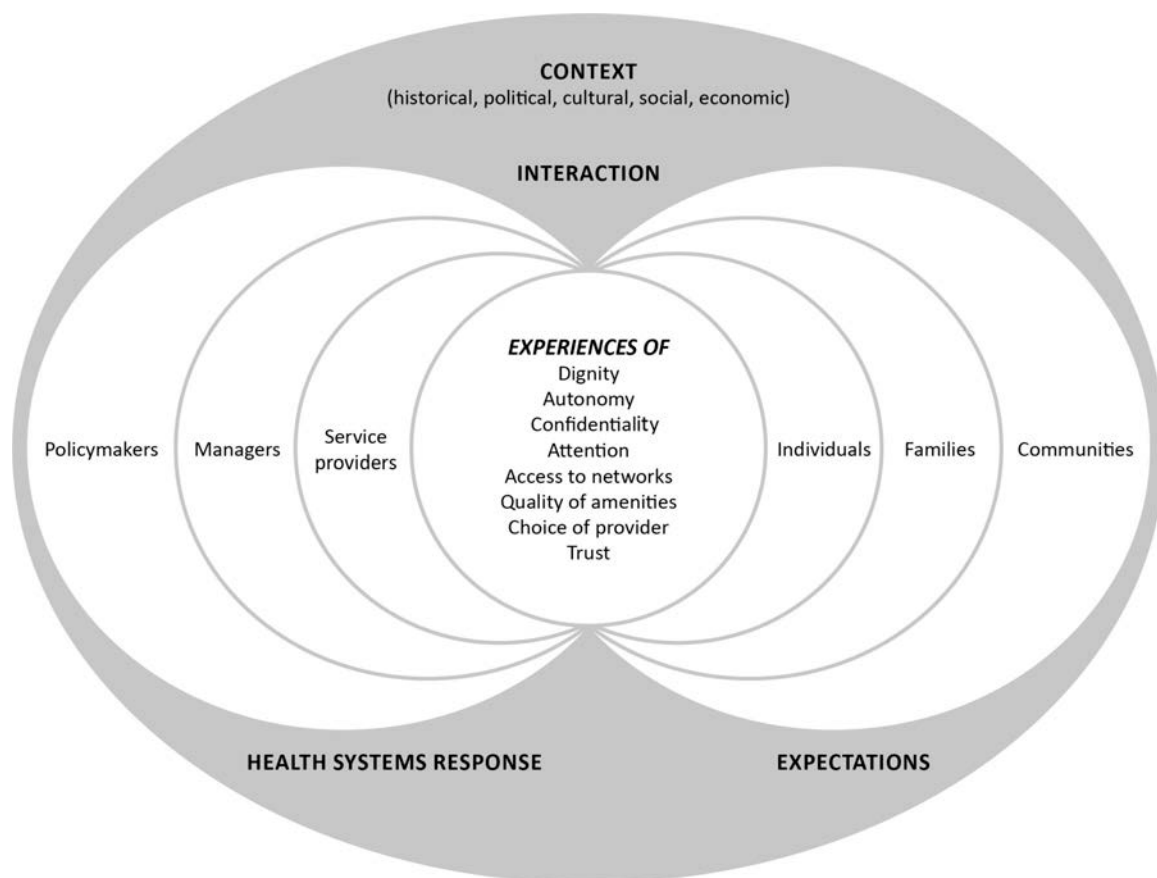


Figure 1: Conceptual framework for health systems responsiveness (Reproduced from Mirzoev & Kane 2017). Creative Commons Attribution (CC BY 4.0) license

own expectations and decisions about whether to access care, but also determining the services available to them and presented to them as options. The wider health system response to expectations also shapes older people’s experiences. Relationships between a variety of actors in the system (including service providers (clinicians and others), managers and policymakers), and the nature of various institutional and organisational arrangements and processes all shape availability, accessibility and quality of health services [4].

For instance, older people admitted to hospital are differentiated in their needs for health care, the way that these needs manifest and through their individual values and preferences. The higher the complexity of need, the higher the heterogeneity between individuals and thus the greater the need for a high level of responsiveness. Research findings in English NHS settings suggest that the responsiveness of ward-based nursing care to older people’s needs can be very low, leading to marginalisation of needs and expectations that are not anticipated in the standardised approaches

to care that take precedence [11, 12]. Routinised and task-based approaches to the management of care predominate with care organised to meet organisational targets of efficiency and predictability rather than actual patient needs [11, 12]. This situation is exacerbated as nursing vacancies rise and nursing work intensifies through shorter admissions [8, 13]. Much of the routinisation of care emanates from a top-down style of management and these standardised forms of care serve an organisational function of more predictable and malleable work, creating opportunities to rationalise and standardise [14]. Nursing staff can feel they have very little, if any, discretion to fully respond to individual need, although this varies between teams and organisations, suggesting that a higher level of responsiveness is possible [13]. A reluctance or inability of many older patients to ask for the help they need compound the difficulties in achieving responsiveness, and serves to render invisible the unmet need.

As this example illustrates, strongly hierarchical relationships between policymakers, managers and service providers are more likely to result in low responsiveness because decisions about the organisation and delivery of services are made at a distance from the individual patient. Where service providers can access a direct appreciation of the needs and expectations of individuals, and have the autonomy and resources to provide the care required, responsiveness can be high. So our example from hospital nursing above implies that improvements in responsiveness in these contexts, for instance, require the decentralisation of organisational arrangements, thereby enabling higher discretion and independent action on the part of frontline practitioners, and care governance and organisation that is congruent with heterogeneity of individual needs, values and preferences. These changes would require the disruption of widespread and deeply embedded ways of working, and so service improvements along these lines would need to directly address how this disruption could be achieved, while weighing up the positive and negative consequences. In essence, decades of shifting toward more centralised, standardised models of care would need to be arrested.

Responsiveness is a highly relevant health goal for a system that wants to be flexible and tailor care to older people, especially those living with complexity associated with multimorbidity and other health needs. While there may be practical difficulties in accessing older people's local and nuanced experiences of interactions, there is value in pursuing assessments of the impact on responsiveness for this group in the context of wider system changes. Using the notion of responsiveness as a conceptual frame for considering care for older people draws attention to the differentiated needs and expectations of service users, while enabling us to consider the barriers and levers for change in a complex adaptive system [15]. These lines of enquiry are likely to reveal the scale of the transformative effort required across the health system to consistently deliver responsive health

care for older people, while at the same time pinpointing the specific institutional structures and processes that are amenable to modification in pursuit of this important goal.

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