




Implementing care for healthy ageing

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ABSTRACT

The WHO concept of Healthy Ageing (ie, the process of developing and maintaining the functional ability that enables well-being in older age) has initiated a global discussion about the need for shifting paradigms to reorient health and social services towards person-centred and coordinated models of care. In particular, the integration of health and social care services is critical to provide the basis for comprehensive information sharing and service delivery to support the evolution of the older person over time. The capability to monitor and respond to an older person's changing health and social care needs will enable prompt and personalised health and social care plans to be implemented.

The implementation of an integrated care approach involves all the settings where persons age, but also requires a concerted action among micro (clinical), meso (service delivery) and macro (system) level. The community is of particular relevance given the primary objective of "ageing in place". However, from the perspective of the continuum of care and services acting synergistically, all health and social care settings (including long-term care facilities and hospitals) need to evolve and embrace an integrated way of operating to support functional ability in older people, while maximising resource and information sharing efficiencies.

In this paper, we explain that government actions to promote well-being in older age should be built on a seamless continuum of care starting from the assessment of the older person's intrinsic capacity and functional ability with the final aim of providing care aligned with the individual's needs and priorities.

Current models of care for older people have repeatedly been criticised for not being adequately responsive to their diverse needs, priorities and environments.¹ The disease-oriented approach, typical of traditional healthcare, often obscures aspects of the health status relevant to the individual and his/her family. In particular, many older persons, especially the most vulnerable ones, often experience inequalities in access to care, consequently remaining with major unmet health needs. In fact, the inadequacy of the traditional care systems on a background of the clinical complexity frequently generates malpractice, determining

Summary box

- ▶ Health and social services should be reoriented towards person-centred and coordinated models of care.
- ▶ Effective integration of health and social care services is critical to promote healthy ageing.
- ▶ The continuum of care and integration of services are two primary goals for transforming and adapting the current disease-oriented healthcare systems to the needs of all the older persons.
- ▶ The WHO Integrated Care for Older People approach is designed to promote integrated and coordinated provision of the broad spectrum of services.
- ▶ The integration of care services generates a virtuous approach allowing a more appropriate allocation of resources to the ageing population.

misdiagnosis, mistreatment and/or ageist attitudes.^{2,3} Furthermore, the usual medical practice is habitually designed to be reactive to diseases and not sufficiently proactive on the longitudinal trajectories of the individual's capacities and characteristics. It is also noteworthy how the ageing process per se contributes to increasing interindividual variability and weakening the categorical definitions of traditional nosological diseases.^{4,5}

In this context, the *World Report on Ageing and Health* first introduced the concept of intrinsic capacity (ie, the composite of physical and mental capacity of the person) and functional ability (ie, the health-related attributes that enable people to be and to do what they have reason to value).⁴ The WHO concept of Healthy Ageing (ie, the process of developing and maintaining the functional ability that enables well-being in older age) has initiated a global discussion about the need for shifting paradigms to reorient health and social services towards person-centred and coordinated models of care.⁶ For example, the recent *Decade of Healthy Ageing: Baseline Report* emphasises the importance of implementing a high-impact, research-validated, transformative process shared by all



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the critical stakeholders to the care systems to optimise the older person's functional ability.⁷

The evolution of a system to promote healthy ageing cannot occur without effective integration of health and social services within long-term care (LTC).⁸ LTC has been defined as activities 'to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms, and human dignity'.⁴ Notably, the definition implies that healthy ageing is possible even when experiencing a significant loss of intrinsic capacity, consistent with the broad concept of health regardless of the presence of diseases, infirmity or underlying health conditions.⁹ We argue that, in line with the definition of healthy ageing, government actions to promote the well-being of its older people should be built on a seamless continuum of care that is person-centred. Therefore, it is essential to start assessing the older person's intrinsic capacity and functional ability and providing care, including LTC services, as per the individual's needs.

Efforts at micro, meso and system level are needed to improve the integration of services and support healthy ageing. The three levels are equally critical for the successful reorientation of the approach to the older person and embracing a more holistic, interdisciplinary, and coordinated model of care.

The recent *Integrated Care for Older People (ICOPE)* guidelines and guidance go indeed in such direction, addressing the issue of clinical-level^{10 11} and service/system-level¹² integration. They are focused on halting/reversing the declining trajectory of intrinsic capacity through a range of tailored, multimodal interventions, social care and supports. For this reason, the recommendations are designed to prioritise implementation of integrated care at the community and primary care level, which underlines:

1. The preventive nature of the ICOPE approach.
2. The community at the centre of the network of care services.
3. The importance of shifting care activities from the hospital towards where persons reside and age at home and in the community.
4. The individual's priority of ageing in his/her place.

As the individual's intrinsic capacity gradually deteriorates, the implementation of integrated care and services (eg, assistive care, palliation, rehabilitation, carers support) to manage the environmental barriers to optimal functional ability becomes crucial to guarantee the person's function and well-being. In other words, older people with significant loss of intrinsic capacity (ie, the most vulnerable ones) require not only healthcare, but also a strong social care and support to compensate for loss and sustain a healthy and dignified life. In this context, integrated LTC becomes an essential part of the model for promoting healthy ageing. The ICOPE and LTC paradigms complement each other in coordinating and providing holistic/comprehensive care at different

stages of the individual's life experience. Whereas the fundamental principles and objectives remain the same (as detailed in the *World Report of Ageing and Health*⁴ and the *Decade of Healthy Ageing: Baseline Report*⁷), the tools and services may necessarily vary at different time points according to the actual status of the person.

Only through effective integration of health and social care services will it be possible to promote healthy ageing. In this way, the necessary capacity to monitor (ie, early recognition, screening, targeted assessment, diagnostic procedures) the dynamic changes of the individual's health can be achieved, enabling predisposing to prompt and personalised health and social care plans. At the same time, an integrated approach within and between health and social care systems will deliver goal-oriented care plans through coordinated interdisciplinary actions, avoid redundancies in the system and better address the complex needs of the older person.

In this context, it is essential to consider that person-centred care is different from the so-called 'precision medicine' and the derived concept of 'precision public health'.¹³ Precision medicine and precision public health are designed to apply biological and medical models in treating biologically and/or genetically defined individuals/populations. Differently, the person-centred care defined by the WHO promotes the holistic care of the person, taking into account his/her health and social needs as well as his/her preferences and goals. The central importance that precision medicine and precision public health give to genomics in the personalisation interventions is a cause of concerns because (1) the field of research is still premature for clinical/public health implementation, (2) it introduces potentially major ethical issues, and (3) it obscures the potential more relevant role that socioeconomic and environmental factors play for health and well-being. Whereas the genetic profile is recognised as the biological substratum of the individual's intrinsic capacity, the WHO puts particular emphasis on the modification of the environment for the benefit of the individual and the population, in combination with prevention of declines in intrinsic capacity (see, for example, the current WHO action on universal health coverage¹⁴).

INTEGRATION OF CARE AT THE INDIVIDUAL LEVEL

The trajectories of the person's intrinsic capacity and functional ability determine the prompt provision of services and support (eg, promotion of intrinsic capacity, prevention of declines in intrinsic capacity, acute care, rehabilitation, assistive care). This approach is applicable for every individual, irrespective of their level of intrinsic capacity and functional ability. Indeed, the trajectories of health parameters (already used in other medical fields, eg, growth charts in paediatrics¹⁵) can better reflect the dynamics of the individual's composite reserves, signposting when specific interventions or supports are

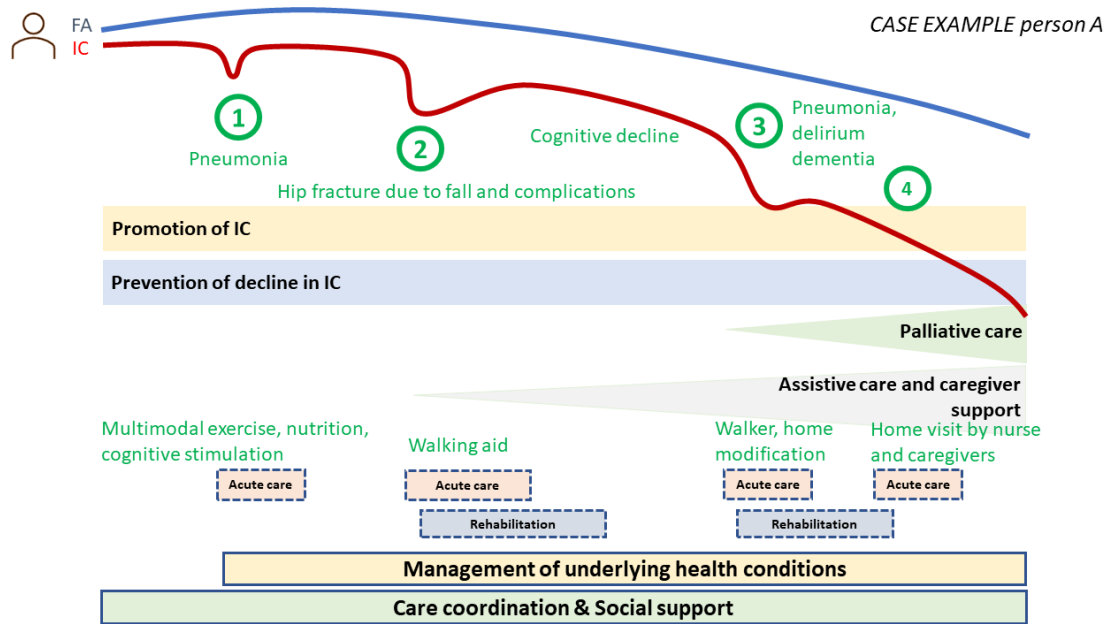


Figure 1 Case example of person A, showing the integration of care services over life course depending on clinical events. FA, functional ability; IC, intrinsic capacity.

needed. This proactive/preventive approach also predisposes to an improved allocation of care resources.¹⁶

In the case example (figure 1), the trajectories of intrinsic capacity and functional ability of an older person and services to be provided are described. Whereas the functional ability tends to remain relatively stable over time, intrinsic capacity may fluctuate and decline more rapidly with biological ageing.⁷ The promotion of intrinsic capacity and prevention of its decline should be considered as two constant components of the approach, informing health and social care over time. The focus on intrinsic capacity implies that capacities and reserves become central to the activation of care services, which will then consider diseases and their management as a component of the personalised care plan.

Every acute condition (eg, a pneumonia, a hip fracture) may threaten the capacity to restore the pre-event intrinsic capacity. The declining intrinsic capacity may require the episodic and/or long-term provision of services to compensate acute losses or more chronic impairments, such as the provision of assistive products or assistance for daily activities. However, at the individual level, the trajectories of functional ability and intrinsic capacity can potentially cross each other. For example, adverse life events (eg, loss of spouse/partner, medical emergency, loss of job, imprisonment, social restrictions due to pandemic) may determine a sudden loss of functional ability by reducing the support that the individual may have received from the environment or other persons in the accomplishment of daily activities (figure 2).

As evident from figure 1, the trajectories are developed not only in clinical settings, but rather where the person ages. They follow the person over time and as their life context changes. A comprehensive and interdisciplinary

approach is fundamental, given the heterogeneity of needs and evolving priorities. The integration of health and social care services provides the basis for sharing multidimensional and comprehensive information describing the evolution of the older person. Clinical and social information can support the identification of realistic objectives and goals for the person's care plan, followed by the design of interventions to positively influence the future trajectories of his/her intrinsic capacity and functional ability. Sharing the person's clinical and social information as well as his/her values and preferences becomes critical to monitor and adapt care plans according to the emerging and changing conditions. Meanwhile, an older person's decisional autonomy about his/her care needs and priorities (eg, therapeutic objectives, palliative care) might be limited. This implies the importance of developing a model of care considering the need to anticipate directives and actions, including the more active involvement of family and carers.

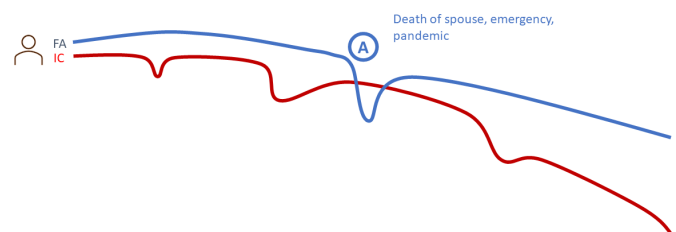


Figure 2 Potential overlapping/crossing of the functional ability (FA) and intrinsic capacity (IC) trajectories at the individual level. The graphical expression is dependent on the standardisation of the IC and FA units.

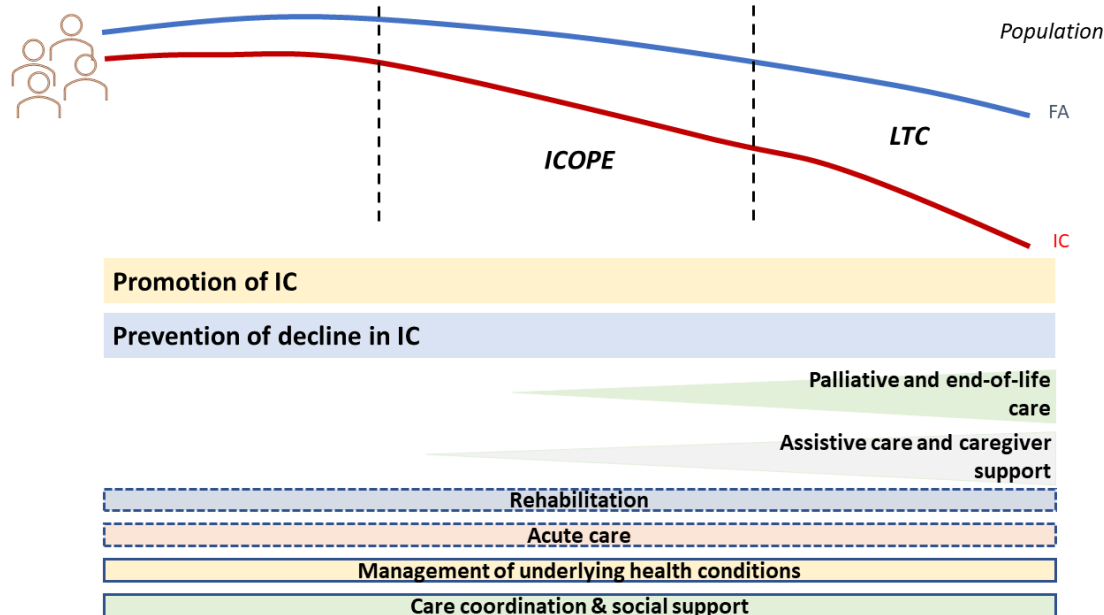


Figure 3 Integration of care services over life course at the population level. FA, functional ability; IC, intrinsic capacity; ICOPE, Integrated Care for Older People; LTC, long-term care.

INTEGRATION OF CARE AT THE POPULATION LEVEL

At the population level (figure 3), the allocation and provision of care resources are determined by the proportion of older people who experience a decline of intrinsic capacity. Whereas the current ICOPE interventions are mainly focused on the population experiencing a declining intrinsic capacity (thus providing recommendations for halting/reversing the process in the intrinsic capacity domains), the provision of specific services (eg, palliative care, assistive care, carers' support) becomes essential to compensate the significant loss of intrinsic capacity (ie, when the individual has lost his/her capacity to cope with stressors). This means that, in the presence of a significant loss of intrinsic capacity, the adoption of services specifically focused on functional ability, and acting on optimising the physical and social environment becomes increasingly important. Through investments in the health and social care systems, education, environment and social protection, the older population will obtain major benefits in terms of health, knowledge, social relationships, safety, security and personal dignity. Such beneficial effects will then translate in major returns for the society as workforce participation, further investments, innovation, social and cultural contributions, and social cohesion.⁴

The transition of services towards LTC is gradual. It does not consider fixed thresholds because the activation of services depends on the characteristics of the population and the country's organisation of the health and social care system.

The implementation of an integrated care approach involves all the settings where persons age. Indeed, the community is of particular relevance given the primary objective of "ageing in place". Therefore, the need to integrate care services for community-dwelling older

persons represents a priority. Additionally, in the perspective of the continuum of care and services acting synergistically, every knot of the health and social care settings (including LTC facilities and hospitals) needs to evolve and embrace a novel way for functioning at micro, meso and macro levels.^{10 17}

Within and between each of these levels, there is a need to reorient activities to optimise integration of care planning, practice and policy. The reshaping of these will then be determined by the evolving observations and needs that stem from more holistic approaches.

Care systems should, therefore, shift from conventional models having services working in siloes towards ones where the person's needs are addressed through an approach that provides these services seamlessly across settings and among multidisciplinary health and care workers. This will also enable better monitoring of his/her biological, clinical and social changes. The facilitated flow of information and provision of an integrated care plan will allow better consideration of personal history; consider his/her contemporary needs, preferences, and priorities; design personalised care plans; and implement proper follow-up evaluations. The gathering of the clinical and social information will also allow describing the evolving health and social care needs of the population. The model will thus generate the opportunity to monitor the effects of public health and social interventions by evaluating those aspects that are the most essential for the person's health. In other words, understanding the factors that drive health and social disparities (eg, age, gender, place of living, religion) in communities is essential to develop equitable, sustained, and integrated services and promote concrete transformation in the social, economic, and political context. Policies to reduce health and social disparities (eg, universal health coverage,

engagement and empowerment of older people, families and communities) are critical to promote integrated care for older people. In this scenario, it is also possible that data describing the population's behaviours could inform policymakers and governments on how to design and tailor interventions for specific areas and subgroups. For example, it has been described that data collected via daily life technologies (eg, actimeters in smartphones) may describe certain behaviours (eg, sedentariness) in specific regions, thus allowing to better calibrate the allocation of resources for the population (eg, development of green public areas).¹⁸

The integration of care services also requires a different way of interaction among health and care workers. The comprehensive and interdisciplinary approach to care finds its rationale on the fact that the traditional unidimensional approach based on diseases is not sufficient anymore to capture the complex and dynamic profiles of the older person. All the health and care workers involved in the care for the older person (eg, community healthcare workers, social care workers, nurses, physicians, physiotherapists, occupational therapists, nutritionists, dentists, formal and informal caregivers) should be adequately trained to develop the necessary knowledge and skills to deal with such complexity within an interdisciplinary team approach. It is thus vital to involve all the stakeholders, especially those acting at the community level. In addition, the community itself should be empowered to adopt preventive strategies for the promotion of healthy ageing. It will also be critical to recognise the critical role played by informal caregivers (ie, family, friends, volunteers), especially in the provision of LTC, by training and supporting them. Furthermore, countries should set up actions to tailor care according to population needs and progress towards universal health coverage, defining a minimal set of services that are safe, effective, and timely provided without financial hardship for older people and their families.

CONCLUSIONS

We conclude that the implementation of integrated care services to promote healthy ageing requires the coordination of multiple actions at three levels. The process requires recommendations facilitating the system evolution towards the approach that is person-centred, proactive, holistic, based on interdisciplinarity and present where the person ages. The WHO has been developing guidance on ICOPE and LTC to facilitate the evolution towards the continuum of care and promotion of healthy ageing.

The continuum of care and integration of services are the primary goals for transforming the current disease-oriented healthcare systems and adapting them to the needs of all the older persons. The person-centred care by a coordinated interdisciplinary team, driven by the five key domains of intrinsic capacity (ie, locomotion, cognition, sensory, psychological, vitality) and the regular

assessment of physical and social environment and optimisation of functional ability, remains critical. Services to support the biological, clinical and social heterogeneity of the ageing population require adaptations in the means and objectives. In this context, it is important to stress the following points:

- ▶ At the individual level:
 1. Integrated care remains the overarching framework, applicable to every older person and setting.
 2. LTC is an essential component of integrated care, providing adaptations consistent with the dynamics of the individual's intrinsic capacity and functional ability over the life course.
 3. The WHO ICOPE approach is designed to promote integrated and coordinated provision of the broad spectrum of services (from preventive to palliative care), according to the individual's needs and preferences.
 4. The transition into LTC is gradual under the umbrella of integrated care. It depends on the person's status and criteria of programmes or interventions run by countries and institutions. Furthermore, LTC might also be episodic since driven by the need rather than the stage of life.
- ▶ At the population level:
 1. The integration of care services generates a virtuous approach to the ageing population allowing a better allocation of resources and reduction of redundancies or overlaps in service provision.
 2. An integrated care approach is more responsive and proactive to the needs of the population, evolving its services according to the changing in demands and priorities.
 3. Integrated care means considering all the settings of health and social care at the same level, facilitating data/information sharing and communication. It is here implied intrasystem and intersystem integration. In addition, it implies the possibility of exiting from hospital-centred models in favour of the provision of care where the person lives and ages "ageing in place".

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