Palliative Care Frameworks And Social Inclusion Policies For Older Adults

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Introduction

Palliative care is support for people who have a life-limiting illness. Therefore, it is also called supportive care (Can Mollaoğlu et al., 2019). A limiting illness is a disease that cannot be cured and is the main cause of death for people having such a disease. Examples include advanced cancer, dementia, and motor neuron disease. Therefore, palliative care is primarily aimed at providing a good quality of life to people, which involves the management of physical symptoms, providing psychological, emotional, and spiritual support, supporting family and friends, and providing social care. People with life-limiting diseases choose to receive palliative care, but it does not mean that they will die soon. Instead, some people have had palliative care for many years alongside other treatments, medicines, and therapies.

However, palliative care is not provided to people who are approaching their end of life, and for those patients, personalized care is called “end-of-life care”. Approaching the end of life means that the patient is likely to die within a year, and such patients often have advanced incurable conditions, general frailty, co-existing conditions, and life-threatening acute conditions. This makes person-centred palliative care and end-of-life care very important to ensure the social and emotional strength of the patients and provide them with the necessary support to have decision-making ability and die with dignity. In this regard, many palliative care frameworks have been designed to assist patients in dealing with their life-limiting illnesses.

The following report analyses all such historical and current palliative care frameworks to investigate how they have been improved with time. Also, different social inclusion policies for older adults have been discussed to determine their effectiveness in achieving the intended purpose.

Historical And Current Palliative Care Frameworks

According to Luckett et al. (2014), it is the basic human right of people to receive appropriate care at the end of life; however, with the increasing number of diseases every year, it has become highly important to decide who should be provided palliative care. Furthermore, it is not even feasible to provide specialized palliative care to everyone because some patients with complex palliative care deserve more. This further highlights the importance of advanced palliative care frameworks that integrate palliative care services according to needs and preferences in the healthcare sector.

In the following sections, some attributes of the most widely used frameworks, i.e., home-based models, acute care models, residential aged care models, and models used for palliative care during transitions, are discussed, while certain elements that make these models effective are also highlighted.

Home-Based Models

Home-based models are most commonly used for palliative care to support family caregivers and social health professionals. These models have been widely considered effective because they support coordination and communication and provide a channel for skill improvement for both informal caregivers and palliative care teams, which include practitioners as well. They also outline the goals of advanced care management (Luckett et al., 2014).

Acute Care Models

The acute care models consist of specialist consultative services (SCS) or in-patient palliative beds. Many studies according to Luckett et al. (2014) have demonstrated the positive impact of acute care models on the overall well-being of patients. These SCS models focus on discussing the prognosis, goals of care, and diagnostic interventions, pursuing documentation of advance directives, family and patient support, discharge planning, and symptom management. According to Hanks et al. (2002) and Morrison (2008), when these services are provided by the hospital palliative care teams, a significant improvement in quality of life and symptom control is observed, while in some cases, patient satisfaction is also enhanced, which consequently reduce the total cost of the hospital.

However, as noted by Luckett et al. (2014), only the larger hospitals, “not-for-profit” hospitals, academic medical centres, and “Veterans Affairs hospitals” offer such specialized palliative care. Therefore, the healthcare sector, in general, lacks the necessary facilities to meet the increasing need for palliative care. Furthermore, in some cases, the emergency departments perform this job and are often highlighted as an effective platform for end-of-life care. These emergency presentations have resulted from inadequate care, inappropriate symptom control in the community, and poor financial condition of the community, where people prefer to receive necessary medication from emergency departments as compared to other services. However, in such departments, health professionals have to face many challenges in effective decision-making when they do not have any previous medical history of the patients. Thus, the “coordinated models” of care can significantly decrease the use of unwanted emergency departments in intensive care (Richardson, 2012).

Residential Aged Care Models

Residential aged care has proved very challenging in enhancing the quality of “end-to-life” care. Older people, especially, are more likely to have weak symptom control, sub-optimal communication,

unwanted hospitalizations, and insufficient care management and are less likely to have SCS services. This requires an effective multi-component palliative care model that can be efficiently used to identify the residents who will receive specialized palliative care, make palliative care leadership teams, educate the care staff, provide technical assistance, and target efficient symptom control strategies.

Care Required During Transitions

Certain challenges care models frequently face whenever the care settings are changed because, during such transitions, patients are highly likely to fall through the cracks while their quick response is also required. In such circumstances, an efficient management plan and support of caregivers are essential because patients and caregivers both lack knowledge of the different services that they can access and use while navigating the transition. Otherwise, health professionals may lack the necessary knowledge and use treatment strategies focused solely on prolonging life at the expense of the quality of life, especially in the case of dementia.

Shared Element Of Effective Frameworks

All palliative care frameworks have some integrated dynamic elements to improve communication and collaboration between service providers, enable access to required services, and enhance palliative care skills for informal carers and non-specialists. All these factors together increase the capacity to effectively respond to the patients' changing preferences and needs. Some of these elements include case management, shared care, integrated care, volunteers, and cost-effectiveness. Case management is an important feature in all successful models that are aimed at analyzing the palliative needs of the patients and then meeting them efficiently to improve their quality of life. There, it not only includes healthcare services but also involves social services and personal care.

Shared care is also an important element for effective palliative care delivery, which several different models have utilized (Trivedi et al., 2012). One of the most prominent characteristics of shared care is that it enables a recognized lead clinician to work with healthcare staff from completely other fields. Integration is the coordination among different services intended to meet the needs of individual patients. It has reported many positive effects of integrated care not only for the patients and their families but also for the overall efficiency of the organization and the satisfaction level of the healthcare staff.

Volunteer models have frequently been used in different palliative care settings, but as noted by Claxton-Oldfield & Claxton-Oldfield (2012), no substantial evidence of their evaluation is available. Lastly, the cost-effectiveness of such services has been established by many studies where they found no significant cost difference between palliative care services and usual care (Finlay et al., 2002).

From the above discussion, it can be assessed that several frameworks of palliative care have been adopted based on the care settings and particular needs of the patients, and they all have their effectiveness. There are also some common elements shared by all these frameworks to ensure that the quality of life of patients with life-limiting diseases is improved. In the following section, different policies that are utilized to increase the social inclusion of older adults are discussed, and their effectiveness in achieving this purpose is examined, and recommendations are made accordingly.

Policies To Improve Social Inclusion For Older Adults

People with older age have more chances of being excluded from society. For instance, Sacker et al. (2017) have highlighted several factors such as low participation in social activities, no future aspirations, bad family relationships, and poor financial health as the conditions that lead to the social inclusion of common members of society and for older adults with some chronic disease, these factors have far greater consequences. In response, governments implement different strategies and policies to reduce this increased exclusion of older people and make them an active part of society. Therefore, as noted by Sacker et al. (2017), there are many such policies devised by European countries to cope with such issues and provide older adults with an environment in which they can engage themselves in the process of active ageing and realize their potential for social, physical and mental well-being.

Thus, these policies are oriented toward providing older adults with a platform to participate in several social activities based on their needs and preferences while also assisting them in their time of need. However, as argued by Sacker et al. (2017), although these policies are aimed at increasing the quality of life of older adults and improving their social inclusion, the exact understanding of different pathways and mechanisms through which these objectives will be achieved is still missing. Moreover, as noted by Walker (2017), there is a demographic revolution taking place in society, with older adults having a greater proportion of the overall population of the society every year. This population increase is the result of declining fertility and rising longevity. In 2014, the average age of mothers was observed to increase to 30.2 years while the fertility rate decreased to 1.83 children per woman.

However, not only the fertility rate has led to the increased population of older adults, but their life extension due to better health facilities has also contributed to this increase. There are some other factors in this equation, such as net migration. Therefore, the United Nations has called the UK an “ageing society” since 1930, when people above 65 years of age accounted for 7% of the total population. It is also estimated that this population comprises 20% of the total population of the UK (WALKER, 2017). With such an increased population of older adults in the country, the possibilities of their social exclusion also increase. And when such a huge proportion of society is disconnected, it has a lot more diverse consequences for almost all the sectors of the country. Therefore, it is essential to not only provide them with a platform to become an active member of society but also to

understand the whole ageing process and avoid any such circumstances for them in the later stages of people.

In policy terms, it is meant to measure the various risk factors of the ageing process and then take necessary actions to reduce the severity of the chronic conditions and improve the lifestyles of people in the later stages of life. For instance, this can include increasing the taxes on harmful substances such as alcohol and tobacco and some new taxes on saturated fat, etc., which often impact the health of people in older age. In this regard, as noted by WALKER (2017), the modest levy on the sugar content of soft drinks was highlighted by the government authorities in 2018, which aimed to reduce obesity among adults. Similarly, levy on other health hazardous products such as smoking and alcohol can prevent cancers in the later stages of life and thus improve the health conditions of older adults in society.

Furthermore, the government can shift its direction from older people's policies to ageing policies to ensure the increasing inclusion of aged people in society. Also, it should improve the planning of neighbourhoods for people of all ages to increase the inclusion of people in their local localities. Similarly, policymakers can launch different programs to promote the development of financial products among older people. According to CPA (2021), there have been several reports issued by government departments on the issue of the social exclusion of adults, but no significant results have been produced yet. Therefore, considering the adverse impacts of an ageing society and their exclusion, more rigorous actions need to be taken.

Conclusion

Palliative care is the support provided to patients to make their remaining lives valuable and meaningful. Different frameworks have been developed to meet the particular needs of patients in different care settings. However, among all these frameworks, it is a shared factor that the primary goal of palliative care is not only to diagnose the diseases but also to meet all mental, psychological, and physical needs of the patients. Moreover, from the administrative point of view, the government needs to understand the ageing process thoroughly and include different strategies in the policies that not only address the aged population but also address the ageing process.

References

Can Mollaoğlu, M., Günay, D., & Mollaoğlu, M. (2019). Palliative Care Services from Past to Present. *Palliative Care*. https://doi.org/10.5772/intechopen.88990

Claxton-Oldfield, S., & Claxton-Oldfield, J. (2012). Should I Stay or Should I Go? *American Journal of Hospice and Palliative Medicine®*, *29*(7), 525–530. https://doi.org/10.1177/1049909111432622

CPA. (2021). *Centre for Policy on Ageing – Policies on Ageing* –. Cpa.org.uk.

https://www.cpa.org.uk/cpa/policies_on_ageing.html

Finlay, I. G., Higginson, I. J., Goodwin, D. M., Cook, A. M., Edwards, A. G. K., Hood, K., Douglas, H.-R. ., & Normand, C. E. (2002). Palliative care in hospital, hospice, at home: results from a systematic review. *Annals of Oncology*, *13*, 257–264. https://doi.org/10.1093/annonc/mdf668

Hanks, G. W., Robbins, M., Sharp, D., Forbes, K., Done, K., Peters, T. J., Morgan, H., Sykes, J., Baxter, K., Corfe, F., & Bidgood, C. (2002). The impact study: a randomised controlled trial to evaluate a hospital palliative care team. *British Journal of Cancer*, *87*(7), 733–739. https://doi.org/10.1038/sj.bjc.6600522

Luckett, T., Phillips, J., Agar, M., Virdun, C., Green, A., & Davidson, P. M. (2014). Elements of effective palliative care models: a rapid review. *BMC Health Services Research*, *14*(1). https://doi.org/10.1186/1472-6963-14-136

Morrison, R. S. (2008). Cost Savings Associated With US Hospital Palliative Care Consultation Programs. *Archives of Internal Medicine*, *168*(16), 1783. https://doi.org/10.1001/archinte.168.16.1783

Richardson, D. B. (2012). Emergency department targets: a watershed for outcomes research? *Medical Journal of Australia*, *196*(2), 126–127. https://doi.org/10.5694/mja12.10003

Sacker, A., Ross, A., MacLeod, C. A., Netuveli, G., & Windle, G. (2017). Health and social exclusion in older age: evidence from Understanding Society, the UK household longitudinal study. *Journal of Epidemiology and Community Health*, *71*(7), 681–690. https://doi.org/10.1136/jech-2016-208037

Trivedi, D., Goodman, C., Gage, H., Baron, N., Scheibl, F., Iliffe, S., Manthorpe, J., Bunn, F., & Drennan, V. (2012). The effectiveness of inter-professional working for older people living in the community: a systematic review. *Health & Social Care in the Community*, *21*(2), 113–128. https://doi.org/10.1111/j.1365-2524.2012.01067.x

WALKER, A. (2017). Why the UK Needs a Social Policy on Ageing. *Journal of Social Policy*, *47*(2), 253–273. https://doi.org/10.1017/s0047279417000320