Geriatrics' turning point

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Van den Heede et al. report the results of the analysis of hospital discharge and population data in Belgium to estimate the required hospital capacity by 2025 for the older population. The study was funded by the Belgian Healthcare Knowledge Centre, a federal institution financed by the National Institute for Health and Disability Insurance, the Federal Public Service of Health, Food and Food Chain Safety Environment, as well as by the Federal Public Service of Social Security [1]. Data were retrieved by population surveys and the National Hospital Discharge Dataset and the analysis was conducted for all inpatient stays from 2003 to 2014. Although all existing data in the database were analysed, the present publication concerns exclusively the older population—all patients hospitalized in acute geriatric or psychogeriatric settings or else aged 75 years and older. Accordingly, parameters taken into account were population changes, trends in hospital admission rates and length of stay. Very interestingly, the authors calculated a “base” forecast and an “alternative” scenario, based on the two possible conditions of “normal” and “accelerated” aging of the population in the upcoming years.

The authors present an expected increase of inpatient stays by 23% from 2014 to 2025, which will be compensated through a decreased length of stay by 18%. In case of accelerated aging, inpatient days will increase by over 50%, with almost a 22% increase in inpatient days and a 21% in hospital beds. In this latter case, not much will be compensated in terms of net hospital costs by reducing the length of hospitalization [1].

These projections pose several points of reflection. First of all, we may remember that until Marjorie Warren overtook in 1926 the West Middlesex County Hospital, multi-morbid patients with disability were not managed from a medical point of view and were instead “kept” in institutions, being commonly called “inmates”; the recognition of the positive effects of treating chronic disease in older patients and possible implementation of a “progressive care” system for older patients (left panel, [2]), was described in which the acute medical intervention in the hospital is only one step of a longitudinal treatment process including home and post-discharge settings [2].

Panel A

Panel B

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In 2012, the official journal of the Royal College of Physicians of London, *Clinical Science*, dedicated its cover to the threat of “hospitals on the edge” and called for actions and for setting higher standards (right panel [3]). After, respectively, 57 and 7 years, not only not much has been done in this sense, but the forecast of a silver-tsunami-driven massive increase in hospitalizations still induces the authors to ask policy makers for substantial investments in good alternatives [1].

These alternatives, as mentioned above, are focus of geriatric medicine and research since several decades, much longer before that healthcare systems would face the two unique challenges in human history of global aging and global obesity; however, no discipline like ageing medicine is hit by the “know–do gap” [4]. While the discussion of the reasons for this gap goes beyond the scope of the present editorial, let’s briefly and pragmatically go through its possible practical solutions. Demographic, scientific, clinical and didactic paradigm shifts, with none of the levels being more or less relevant than the others, are:

- From the demographic point of view, the life expectancy is continuously increasing since 1840 and is projected to increase until 2040 [5], which means that the focus of healthcare actions has to change from survival to quality of life and wellbeing or, visionarily expressed, from lifespan to healthspan [6].
- From a clinical point of view, the prevention of geriatric cascades (from light fever to delirium, for instance, or from confusion to pulmonary embolism, or from dehydration to perthrocane fracture) as a sole focus of geriatric expertise might be in part shifted to the use of resilience factors and resources of the older person to manage geriatric syndromes.
- From a research perspective, it is mandatory to put in action all possible efforts to bridge the gap between geroscience and geriatrics, in a way that biogerontology concretely feeds geriatric interventions and vice versa; also, it is mandatory to define critical terms such as multimorbidity, morbidity clusters, polypharmacy, frailty to perform valid studies; finally, include real-world patients representative of the general population in real-life studies.
- From a didactic point of view, medical students need to be educated and prepared geriatricians need to be trained so that they can adequately recognize and promptly manage the person with a given medical problem and not the medical problem itself; this can only occur by shifting the didactic approach from input (centered on the educator) to outcome (centered on the trainee).

Strikingly, geriatrics is the only discipline which by definition [7] performs since decades [8, 9] that kind of

medicine now on the brightest spot worldwide: personalized medicine, i.e., the one focusing on several dimensions of the patient, not only on the physical one. It is therefore urgent time that the cornerstone of geriatrics, the comprehensive geriatric assessment (CGA), as well as those derived tools representing its development (like multidimensional prognostic indexes), escape the “know–do gap” and become the systematically utilized methods in medicine to improve patients trajectories [10]. This way shared clinical decisions can be taken with the aim of real goal-oriented, patient-centered, value-based tailored interventions. The use of CGA and CGA-based instruments in authentic comanagement with other medical disciplines and diverse healthcare professionals warrants the gradual but determined shift from disease to functioning, from ICD to ICF, from cut-offs and DRGs to intrinsic capacity. It is very unlikely that a further decrease in hospital length alone, or in the even more unlikely scenario of not yet defined alternative structures, will compensate for the consequences of accelerated aging, multimorbidity and disability. Multidimensional, individualized interventions along with geriatric education and training as well as realistic research to create evidence are the best available methods to be implemented right away. The first baby boomers of several upcoming millions are already 70 years old.

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Compliance with ethical standards

Conflict of interest The author declares that she has no conflict of interest

Ethical approval This study does not contain any studies with human participants performed by any of the authors.

Informed consent For this type of study formal consent is not required.

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