MANAGING AN AGEING POPULATION: LESSONS THE UK COULD LEARN FROM CUBA

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Abstract

Both the UK and Cuba face an ageing population, which presents major challenges for their health and social care sectors. Although the UK is considerably more developed than Cuba, its disorganised and inadequate community services for older people, combined with a less preventative approach to the health of its older population have increased pressure on care homes and hospitals alike. In contrast, Cuba’s cheaper, preventative and holistic elderly care programme integrates health and social care to sufficiently serve its older population. This article demonstrates the flaws in the UK elderly care system and highlights the successes of the Cuban system, before formulating three suggested areas of research for potential implementation in the UK based on Cuban principles. These are: 1) associating care homes with medical professionals, 2) overhauling the NHS health check system and 3) providing each local authority with a

1 Having read a degree in Biomedical Sciences at the University of Durham, Caroline Jarman is now in her fourth year of studying Medicine at King’s College London. She came to understand some of the health and social care challenges in managing and caring for an ageing population whilst undertaking a clinical placement in Care of the Elderly and whilst working as a care worker at a care home in Hertfordshire. As a result, Caroline researched other approaches for how best to care for an ageing population, and she found the Cuban system to be extremely successful. Having written her article, Caroline had planned to travel to Cuba over the summer of 2020. Unfortunately, these plans were impeded by the COVID-19 pandemic. She hopes to travel there when possible in the future.
wider variety of facilities for the older person. Modelling Cuba’s elderly care system with these suggestions may improve the management of an ageing population in the UK by increasing disease prevention and care planning. This should improve the overall health of the UK’s older population whilst saving the health service both money and time.

**Key words:** UK, Cuba, elderly, ageing, care, health

**Introduction**

The UK and Cuba both face an ageing population and associated challenges. By 2030, older people, defined as those aged over 65 years, are set to comprise 21.7% of Cuba’s population (United Nations 2019), and 21.8% of the UK’s population (Age UK 2019a). Despite their societal and cultural differences, both aim to care for older people in the community for as long as possible and maintain their health to minimise hospital admissions (Reed 2008; Age UK 2019b). However, attempts to achieve these goals have had varying success. The UK’s inadequate community services have contributed to overstretching care homes and hospitals, whilst Cuba’s widespread, government-run elderly care programme has more levels to its system and employs a disease-preventing approach. This article will highlight the flaws of the elderly care system in the UK and discuss the successes of the Cuban system before proposing suggested areas of research for implementation into the UK elderly care system based on Cuban principles.

**The Flaws of the UK Elderly Care System**

The UK offers a relatively narrow range of community services for the older population who live at home. As there is no centrally run programme coordinating the delivery of these facilities, their availability varies dramatically between health authorities, creating a postcode lottery. The provision of services for local communities is organised by Clinical Commissioning Groups (CCGs) formed of groups of GPs (NHS England 2020a). As CCGs are totally separate from one another, the commissioning of services is not coordinated across the UK, so care options for elderly people vary greatly with location. For example, “meals on wheels”, an initiative whereby people pay a small fee for meal deliveries, has reduced its service by 24% since 2014 as a result of a 47% spending cut (Mortimer and Green 2015; National Association of Care Catering 2018). It is now offered by just 42% of CCGs (National Association of Care Catering 2018). The CCGs also vary in size dramatically, so residents of larger CCGs often encounter access issues. This is especially problematic for the 24.3% of over 65s who live in rural areas, where transport
links are notoriously poor (Age UK 2018). Even with adequate transport links, many locally run facilities are extremely individualised and thus highly labour-intensive, with comparatively high running costs and low population coverage. Age UK’s befriending service, which tackles loneliness by assigning companions to older people, requires a high staff-to-citizen ratio and therefore benefits relatively few (Age UK and NHS England 2015). Again, this is only available in certain areas and increasingly relies on volunteers (Age UK and NHS England 2015). The lack of coordination between CCGs, combined with access issues and the inability of facilities to cater for large populations, leaves the needs of many unmet, as shown in Figure 1 (Socialcare.co.uk 2016; The Kings Fund 2016a).

![Fig. 1 The breakdown of the management of care needs for the over 65s in the UK](image-url)
Day centres represent the only facility to offer an intermediate level of support, by providing basic, day-time care to those who require some assistance, but not full-time care (Age UK 2020). This facility is very efficient as it caters for a large population with relatively few staff whilst tackling issues such as nutrition and loneliness (Age UK 2011). The cost per person per day is substantially lower compared to other settings, and users have been found to remain independent for longer (Age UK 2011). This achieves long-term savings and helps relieve pressure on care homes and carers (Age UK 2011). However, funding cuts of 55% have seen numbers of these facilities decrease by 41% between 2010 and 2018 (Roberton 2018; Green 2018). This is reportedly because centres received fewer referrals and were accessed by fewer people (Mortimer and Green 2015). The decreased demand is possibly linked to financial constraints, which prevent centres from offering desirable services, or may simply be because day centres are viewed as a less attractive option by many in the UK (Comas-Herrera 2015).

Care homes also cater for older people with effective staff-to-resident ratios. The UK has two types of care home: residential homes provide accommodation and personal care; nursing homes have qualified nurses on site for those who require the most support (NHS 2020a). However, both are under pressure: 36% staff stated that financial pressures resulted in nursing homes accepting residents with complex care needs that do not fit within their official category of registration (Royal College Nursing 2010). Moreover, achieving adequate staffing levels is difficult – the NHS has a severe shortage of nurses, with 40,000 nursing vacancies in England alone (Royal College Nursing 2020). The pressure on nursing homes, combined with a lack of intermediate community care services, has impacted residential homes. Consequently, residential homes house large, heterogeneous populations of residents, many of whom either 1) require levels of care above that which can be reasonably provided and would be more suited to nursing homes, or 2) are too self-sufficient to live in a residential home and could exercise more independence.

Despite the care needs of residents becoming increasingly complex, residential homes do not have onsite medical staff or medically trained carers (NICE 2015). Considering residential homes house some of the most vulnerable older people in society, this is perhaps surprising. Additionally, GP appointments must often be made in the same way as they would be for anyone else, subjecting residents to the same lengthy wait times, despite their need to access medical care more regularly than most. Some GP practices prioritise care of the older person by forming strong links with local residential homes, but doing so is an individual choice which, once again, results in a postcode lottery.

Indeed, emergency hospital admissions from care homes increased by 62% from 2010/11 to 2016/17, highlighting the demand for onsite medical professionals, or more appropriately trained carers (Age UK 2019b). In support of this, The Kings
Fund (2010) found that training care staff to detect problems early and manage conditions better may help avoid hospital admissions and relieve pressure on the NHS. Despite the difficulties residents face to access medical care, the demand for places is predicted to rise by up to 150% in the next 50 years (ILCUK 2017). This is concerning as the market is becoming increasingly precarious – local authorities try to reduce spending by decreasing care home budgets, enabling private companies to play an increasingly large role (Age UK 2019b). Currently over 97% of care

![Weekly Residential Care Costs](image)

**Fig. 2** Average weekly residential care costs in the UK by region.

is provided by private organisations, whose high prices, shown in Figure 2 (Age UK 2017), make care homes inaccessible for many, especially as funding is only available if strict criteria are met (Age UK 2019b).

The Care Act states that local authorities have a duty to ensure that the care market is sustainable and offers choice between local authority and private services. However, this duty is not being fulfilled (Age UK 2019b). Their inadequate role in UK society places pressure on 1) older people, families and unpaid carers and 2) hospitals (Mortimer and Green 2015). Over the last decade, all older age groups have seen increases in delayed discharges due to waits for social care and residential places and in hospital admissions for conditions like UTIs, that should not usually require admission (Age UK 2019b). This demonstrates that elderly care is failing across all sectors and is not purely due to excess pressure on care homes. A lack of robust preventative measures may also drive this. Although the UK does offer some preventative care, namely a free NHS health check every five years from the age of 40 (NHS 2019); and several screening programmes for the “at-risk” (NHS 2018), it is down to older people to self-refer after age 74 if they would like to continue being screened. Self-referral relies on the oldest people in society presenting to the appropriate facility at the appropriate time, and requires a certain level of independence and self-sufficiency. This is not possible for everybody, especially when this sector is disproportionately affected by sensory impairments and comorbidities (NICE 2015). These problems are compounded by the limited information about the available services, a large proportion of which is distributed online, and is thus not very user-friendly for many older people. Hence, care is fragmented, as shown by a survey conducted by NICE (2015) which found that people with multiple long-term conditions want joined-up, coordinated services. This reflects the disorganised nature of care, and highlights access issues, whilst demonstrating the dissatisfaction of older people with the management of their health.

**The Successes of the Cuban Elderly Care System**

If employed in the UK, Cuba’s initiatives may address some of the problems the UK faces with its elderly care system. Cuba’s Program for Comprehensive Care for the Elderly is a centrally run programme which actively engages with older people to coordinate care and ensure widespread availability of relevant facilities. In 1980, in anticipation of a sharp increase in over-60s, the government doubled the number of geriatric consultants, increased all elderly care facilities and established national economic support systems for this (Bertera 2003). The programme has a preventative approach whereby a specialist Multidisciplinary Gerontological Care Team (MGCT), formed of a family doctor, nurse, social
worker and psychologist, regularly review all older people within a community and refer those with declining health to a geriatrician (Bertera 2003). There are 444 MGCTs, one for each “health area”, helping to avoid a postcode lottery (Perez 2015). Additionally, the programme addresses mental health by assisting Cuban retirees to organise their free time and maintain productivity (Bertera 2003; Perez 2015). Hence, access to care is widespread as the Cuban government has a larger role in organising and performing the systematic surveillance and referral of older people to services than the UK government.

The Cuban elderly care system has more tiers than the UK system, enabling it to aptly support a heterogeneously ageing population. Grandparents Circles cater to the more able by providing 30–60-minute exercise classes or cultural and social activities to those older people with similar functionality (Hernandez 2018). They were begun in the 1980s when it was realised many older people sought emotional and social support from their family doctor, rather than healthcare (Perez 2015). Prior to beginning classes, an MGCT assesses the older person’s health and recommends the type and frequency of exercise that would benefit them. Qualified physical education staff lead each class and ensure an appropriate level of exercise for the participants (Hernandez 2018). The 5,214 circles around Cuba serve 138,411 participants, most of whom live at home (Bertera 2003). Hence, this service is widely available, uses an effective citizen-to-staff ratio and helps older people to maintain more independence than a facility such as a day centre. A free, population-wide yet personalised facility such as this also enables widespread health surveillance and promotion, and tackles loneliness. The UK lacks similar services.

Cuba also offers an intermediate between total independence and residential care – Grandparents’ houses represent another tier to elderly care in the community that the UK does not have. Akin to a day centre, but more like a second home, these adapted houses offer more comprehensive care to those who can perform non-instrumental activities of daily living, such as washing, dressing and continence, but not instrumental activities of daily living, which include shopping and cooking (Perez 2015). Hence, this facility targets people who are at risk of falls, loneliness or depression and supports those who may be left alone during the day but who can return home at 6pm (Bertera 2003; Perez 2015). The recreational, physical and social activities offered by the houses improve mental and physical health, and tackle nutrition with provided meals (Perez 2015). MGCTs run the houses and are permanently on site, so they can survey the health of these more vulnerable older people (Bertera 2003; Perez 2015). A facility such as this helps people maintain independence for longer and means that fewer people with high levels of functionality use care facilities that are designed for people with greater care needs. Moreover, the direct access that attendees
have to specialised medical teams is a preventative approach which eases pressure on other medical facilities.

As other facilities support those with fewer care needs, Cuba’s 146 care homes are reserved for people who require more advanced, permanent care and who cannot remain within the community (Destremau 2018). This avoids having a variety of dependent and independent residents, as occurs in the UK, and makes meeting the needs of all easier. Like many of Cuba’s other elderly care facilities, all care homes have permanently resident medical professionals who can provide onsite medical care. Consequently, they get to know residents well and can monitor their health (Perez 2015). A more specialised, medically oriented care facility such as this may be beneficial in the UK. Despite their successes, care homes represent the weakness in Cuba’s elderly care system – although heavily subsidised (Perez 2015), access is very difficult as citizens must qualify for places, and the homes themselves are rundown and short of care workers (Destremau 2018). Thus, care homes offer poorer standards of care than many other Cuban facilities.

These Cuban facilities each target a different level of health and independence, collectively providing widespread population coverage. Their central organisation avoids a postcode lottery and enables facilities to adequately serve citizens, unlike in the UK. These services also enable the continuous follow-up of all older people within each community, providing a preventative approach to healthcare. In turn, hospitals do not seem to be facing the same crisis as those in the UK. Although data on elderly admissions to Cuban hospitals is scarce, the percentage of all outpatient and emergency admissions decreased with the turn of the century as comprehensive, preventative care was implemented (Keck and Reed 2012). This suggests a successful disease-prevention programme decreases the burden on hospitals, something that could benefit the UK. All of this is achieved on a smaller budget – in 2014, the total expenditure on health per capita was Intl $3,377 in the UK (WHO 2020a), and Intl $2,475 in Cuba (WHO, 2020b).

However, there are several barriers to implementing Cuban ways in the UK. First, Cuba has a far greater emphasis on primary care. Hence, combining health and social care to achieve a preventative approach is far easier. Cuba has more doctors per person – in 2018, it had 8.4 physicians per 1,000 people and the UK had just 2.8 (Data Worldbank 2020). As over 97% of all Cuban physicians specialise in family medicine, the proportion of GPs is far higher in Cuba than in the UK – Cuba has 33,000 GPs (WHO 2018), only slightly fewer than the 33,872 that the UK had in 2017 (RCGP 2018). Secondly, Cuban elderly care services rely heavily on volunteers. Volunteering is one of the ideological pillars of society that is considered an obligation in Cuba and counts towards allocations for commodities such as housing and cars (Bertera 2003). However, volunteering
holds less importance in the UK, and many facilities that rely on it, such as Age UK’s befriending service, are failing (Age UK and NHS England 2015). Thirdly, Cuba is socialist so almost all facilities are government owned and operated – privatisation is not an issue, unlike in the UK (Keck and Reed 2012). Finally, elderly care is regarded differently in Cuba and in the UK. Care of the older person is a duty in Cuban society, and it forms an integral part of the healthcare system (Bertera 2003). The Cuban family set-up enables this – houses are multigenerational, with half of over 60s living with their descendants (Destremau 2018). Although tradition, socialisation and economic relationships generally burden females with the elderly care duties, this is not viewed as particularly problematic (Perez 2015). Indeed, the predominant role of the family in elderly care likely explains the success of Grandparents’ houses, as attendees can be cared for by their children when houses close (Destremau 2018). The personal responsibility that families feel for caring for their elderly relatives eases pressure on the government to provide as many services as are required in the UK. Hence, only 10% older people live in government-run facilities in Cuba, and care homes are in far less demand than in the UK because placing a relative in one is generally perceived as abandonment (Destremau 2018). However, in the UK, caring for parents is often viewed as a burden; multigenerational households are rarer (ONS 2020a) and a greater proportion of women work (ONS 2020b), leaving fewer people available to care for their parents. It is hugely problematic that the declining provision of local authority care services is shifting pressure onto families and unpaid carers in the UK, yet this does not seem to be viewed as an issue in Cuba.

Proposed Changes to the UK Elderly Care System Based on Cuban Principles

Despite their differences, the UK could investigate adopting the principles behind some of Cuba’s initiatives to improve the state of its elderly care system. Therefore, having highlighted the flaws of the UK’s elderly care system, and the successes of the Cuban system, this article proposes three suggestions based on Cuban principles to be researched for implementation in the UK.

Residential Homes must have Strong, Sustainable Associations with Medical Professionals

If the UK is to care for their most vulnerable older population more effectively, they must model Cuba by being proactive in helping GPs prioritise the needs of care home residents and in enabling residents to have easy and prompt access to treatment. Although care homes represent the weak link in Cuba’s care of the
elderly system due to poor access and a deficit of care workers, they have permanently resident medical professionals who provide onsite medical care to ease pressure on other primary care services. However, this is unrealistic in the UK due to a severe shortage of doctors, and especially of GPs, where 15% of posts remain vacant (NHS Support Federation 2020).

Until 2016, care home residents were visited routinely, once or twice weekly by their GP (Thegoodcaregroup.com 2020). However, GPs voted to remove these NHS-funded care home visits, arguing that they took up a disproportionate amount of time and calling for care homes to provide medical care, or for the NHS to create proper visit schemes (Thegoodcaregroup.com 2020; Albert 2020). This was condemned by Age UK, who argued that people in care homes are just as entitled to NHS treatment as anyone else, and opposed by the British Geriatrics Society (BGS) who argued this duty of care should not be removed without first putting in place alternative arrangements (Thegoodcaregroup.com 2020; Albert 2020).

A new contract in December 2019 tried to reintroduce the link between GPs and care homes by making “enhanced health in care homes” one of its five main aims (NHS England and NHS Improvement 2019). This contract states that GP practices should form an association with local care homes and deliver a weekly, in-person, “home round”. This must be conducted by a GP or community geriatrician at least fortnightly (NHS England and NHS Improvement 2019). They must also help develop personalised care plans for all residents and coordinate pharmacy teams to undertake structured medication reviews (Bowmer 2020).

However, this contract has also been rejected by GPs, not because they are opposed to prioritising vulnerable elderly patients but rather due to the suggested methods for trying to achieve this (Bostock and Bowmer 2020). Amongst the main reasons for rejecting the new contract is that this new role will be unfunded (Haynes 2020). If this strategy is to be successful and sustainable, it must not overburden GPs and it must be appropriately funded. GPs are businesses which cannot increase their workload without financial reward (NHS England 2020b). Practices are paid per capita and also for hitting targets detailed in the Quality and Outcomes Framework (QOF), so there must be more of a financial focus (NHS England 2020b). Of the 24 QOFs for the year 2020/2021, only one exclusively relates to care of the older person: the “Dementia” QOF (NHS Digital 2020). Hence, creating a QOF specifically for visiting care home residents and planning their care may address GPs’ concerns about the lack of funding, and help to prioritise this vulnerable group by creating a financial incentive to do so.

Another reason for rejecting the new contract was that this additional workload falls unequally on GPs compared with other members of the primary care team (Haynes 2020). There is no explanation as to why it must be a GP or
community geriatrician who must visit at least fortnightly, rather than other medical professionals. A recent study showed that emergency hospital admissions are higher in residential homes than nursing homes, despite nursing home residents being sicker than those in residential care (Wolters et al. 2019). This may highlight the instrumental role of the nurse in providing medical care to nursing home residents, and calls into question why nurses cannot play a larger role in visiting residents in residential homes and help decrease reliance on emergency services. This aspect of the contract must be validated with research to prove that having such heavy GP involvement is strictly necessary. Moreover, the workload could be reduced further if more research is carried out into telemedicine, a suggestion proposed by NICE in 2018. This would eliminate travel time and may make it easier for practices to hit targets.

Creating sustainable links between GP surgeries and residential homes by setting QOFs and researching 1) the role of telemedicine and 2) the most appropriate health care professionals to carry out the visits may help lay the foundations for a sustainable link between GPs and residential homes, and for better integration of health and social care, as occurs in Cuba.

Overhaul the NHS Health Check System

Although the “one-size-fits-all” NHS health check is being made more personalised by considering factors such as age, location and genetics (Gault 2019), it must provide greater population coverage and better integrate health and social care to enable long-term planning for older people. This can be done in three main ways.

Research and Redefine the Population Eligible for the NHS Health Check

The NHS health check was born from a desire to reduce and manage vascular risk; hence it identifies cardiovascular risk but does not reduce the risk of other age-related diseases (PHE 2013). In fact, a Cochrane review found that general health checks did not reduce morbidity or mortality for cardiovascular causes or cancer at all (Krogsbøll et al. 2012) and Public Health England admits the NHS Health Check programme is being implemented in the absence of direct randomised controlled trial evidence (PHE 2013). To implement high-quality preventative care more research is needed to identify which investigations are and are not effective in preventing disease. In particular, there must be more research into the use of the NHS health check in the over 74s. No explanation can be found as to why over 74s are excluded from routine invitations but are still eligible for the health check on request. The fact that people can still self-refer after 74 may suggest the health check has some benefit in this age group, but there is no
evidence to support this. If the health check is proven to be of benefit for those over the age of 74, the self-referral system must be removed, and people should continue being invited for the NHS health check until the age at which is it proven to be of no benefit. As previously described, the ability to self-refer relies on many factors, so expecting the oldest people in society to do this is unrealistic and unfair, especially if they may benefit from it.

**Research Offering a Comprehensive Health Check for the Older Person**  
If the UK is to practise the same high level of preventative care as Cuba, it seems logical that some form of surveillance should occur in the oldest and most vulnerable age group, which carries the highest burden of disease. Furthermore, if primary care teams are to regularly survey care home residents, then older people, especially those with community care packages, should be prioritised in the same way.

Depending on whether the NHS health check is found to be valid for use in the over-74s, surveillance for age-related morbidities could either be encompassed in a version of the NHS health check that has been adapted for the older person, or it could be offered as separate, stand-alone screening. Both methods should encompass identification of those at risk of frailty and subsequent personalised care planning to prevent their deterioration. Currently, the BGS recommends primary care professionals assess frailty during routine encounters and refer those with frailty to a geriatrics team to perform a Comprehensive Geriatric Assessment (CGA) (Turner and Clegg 2014). This is a multidimensional holistic assessment for older people that is currently used in UK hospitals to identify medical, psychosocial and functional limitations and subsequently develop a plan to address areas of concern (BGS 2019; UpToDate 2018). It has been proven to reduce hospital admissions and readmissions in those recently discharged, as well as to reverse frailty, although its use has not yet been validated in the community (BGS 2019). However, this strategy relies on older people presenting to the GP to be screened, and there is no standard frailty screening tool in widespread use in primary care, although the “Electronic Frailty Index” is recommended and supported by NICE (NHS England 2020c). Hence, frailty assessments vary in delivery and application (Davies et al., 2018).

In fact, the BGS did not recommend population-wide frailty screening in 2014 due to the cost of this venture and the low chance of it resulting in better outcomes or saving money (Turner and Clegg 2014). However, this approach has been recommended in international guidance and since then, there have been calls to intensity efforts to screen for frailty among older adults (Walston et al. 2018). Moreover, there has been subsequent development of frailty screening tools and the BGS itself has created a shortened version of the CGA, the “Primary Care Settings Toolkit”, to identify frail individuals most at risk of requiring
secondary care admission (BGS 2020). Although this still needs to be supported by evidence for specific use in primary care, a 2006 systemic review explored the impact of CGA interventions on emergency department use and found that only interventions in primary care and care homes reduced emergency department use – secondary care use of the interventions had little effect (Davies et al. 2018). Hence, it would appear that screening for frailty in primary care does reduce hospital admissions, and is even advantageous over hospital interventions. In support of this, a UK study by Challis et al. (2004) compared the effectiveness of a one-time, holistic assessment against “standard primary care” and found the one-time assessment resulted in greater individual functioning, reduced stress for carers, statistically significant lower A&E visits and reduced nursing home admissions at no net cost difference (NICE 2015).

There is also a lack of clear guidelines on how frequently to screen for frailty. Only screening older patients at routine encounters creates heterogeneity as older people who visit their GP frequently may be screened more regularly than those who visit less. Hence, encompassing care planning, medication reviews and a frailty assessment such as the Primary Care Settings Toolkit into one holistic health check designed specifically for the older person may help create a “best practice” for deciding who to offer the full CGA to. Adapting the NHS health check in this way could help identify those who will benefit most from the CGA, provide some level of uniformity in the screening process and serve as the only facility to directly screen the mental health of older people whilst avoiding a blanket CGA of all older people (BGS 2019). Indeed, a pilot in North Yorkshire was found to be effective in identifying the changing needs of over-74s, as well as being appreciated by participants, who enjoyed discussing their health needs (Nursing Times 2002). A strategy such as this would mimic the proactive nature of the Cuban system by ensuring GPs are responsible for seeking out individuals at risk of frailty and would remove the onus from the older person to present to their GP in the pre-frailty stages. Hence, an assessment similar to that conducted by the MGCT in Cuba may address several of the UK’s problems. However, clearly, for this to be implemented, a great deal of further research is needed to validate this approach and create guidelines on recommending an effective frailty screening tool, the frequency of screening and the management of patients identified as at-risk.

**Offer the NHS Health Check at All GP Surgeries** Attendance must be increased to make the NHS health check a more effective intervention and enable it to better contribute towards preventative care. Hence, it should be offered by all GP surgeries. Although the NHS health check is offered by all local authorities, it is not
currently offered by all surgeries within these areas but can instead be found at pharmacies, leisure centres and mobile units (NHS 2019). Access varies with location – those registered at a surgery that offers it receive an automatic invitation to visit their surgery; those registered at a surgery that does not offer it receive an appointment letter explaining where to go to access it (NHS 2020b). However, this system is prone to error. A study by Harte et al. (2017) found that only 33.8% of those eligible attended their health check in 2013–18, largely due to a lack of awareness about it, suggesting that a significant proportion of people do not receive invitations (Harte et al. 2017). Doubts regarding pharmacies as an appropriate setting for the health check was also found to contribute to non-attendance (Harte et al. 2017). Hence, ensuring this assessment is available at all GP surgeries as well as at other sites may increase attendance by addressing the fact that many people do not want to have the health check in alternative locations. As the check includes basic investigations that are already performed in GP surgeries as part of routine practice, it should be straightforward for all surgeries to offer it. Furthermore, many older people live closer to their GP surgery than to the alternative location that they must travel to. In rural areas, these alternative locations may be especially far flung, making access difficult. In fact, a study by the National Institute for Health Research found that most people who had a health check did not respond to an invitation letter but were offered one whilst attending their surgery for another reason. They concluded that opportunistic health checks may more effectively increase uptake than changing the invitation system (National Institute for Health Research 2020). Hence, surgeries that do not offer the NHS health check will be unable to increase attendance in this way. Ensuring all GP surgeries offer the NHS health check will reduce confusion about where to access this service, and may be more user friendly for older people, who will only have to travel to their registered GP practice, which is likely to be accessible to them.

CCGs must Provide their Local Areas with a Wider Variety of Facilities

Each CCG should provide several tiers of facilities that cater for a heterogenous population of older people, from the most to the least able. Making suggestions about reorganising community services is particularly difficult as CCGs have limited funding and direct competition with private companies. Moreover, there is very little existing research into why services like day centres are failing in the UK, and which services older people consider to be desirable. Without sufficient data it is difficult to make any suggestions on how to improve and expand community facilities. However, the community-based services for older people are inadequate, and this must change. The decline of day centres may be due to their
unpopularity, and so investing resources into reviving this type of facility may be futile (Comas-Herrera 2015). Despite this, older people should be able to come together for meals or activities if they wish. Perhaps expanding the facilities of care homes to encompass other services, rather than investing in many small, local facilities is a solution. Popular activities that were offered by day centres, such as entertainment, exercise classes and lunch clubs, could be run from existing care homes. As these classes are likely to be busier due to the guaranteed group of attending residents, they may be more appealing for older people in the community and securing funding may be easier. This strategy will reduce social isolation amongst community members and residents alike and is likely to be a good business decision for both CCGs and care homes. Not only will adapting homes be easier and more cost-effective for CCGs than creating new community facilities; it will benefit care homes as visitors from the community are more likely to choose that home to move into if they need to go into care in the future. Moving into a care home can be a stressful time for new residents and their families, but a familiar environment, where they know the staff and where the staff know them, makes this transition easier. This is especially helpful for those with dementia, where new environments and unfamiliar people can be particularly unsettling (Alzheimer’s Society 2017). Facilities such as these should be sign-posted to older people at their NHS health check, where visits to these facilities should be properly planned as part of social prescribing. This will help raise awareness and maximise use.

This strategy would appear to be supported by Alzheimer’s Society, which recommends inviting members of the local community into care homes (Alzheimer’s Society 2018). However, they suggest no clear method as to how to do this aside from advertising services with posters (Alzheimer’s Society 2018). Investing in care homes to enable the expansion of services to the local community provides a means by which to achieve this recommendation. A limited selection of homes does offer similar facilities, but those that do are not widely available throughout CCGs. If this technique is to make a real difference, the service must be regulated to reduce the postcode lottery and enable it to benefit more people. Furthermore, care homes must be adequately staffed and funded to be able to offer desirable services and to cope with influxes of members of the local community. Hence, funding must be channelled into services that are sustainable and which benefit the most people. Investing resources into reviving failing facilities is wasteful. This aims to mimic the services offered by Grandparents’ houses by adding another tier to elderly care that is not currently widely available in the UK. It targets older people of intermediate independence who do not need full-time care but who would benefit from company and proximity to care workers who can help them if necessary. Moreover, like the
Grandparents’ houses, this would provide a ‘relief’ option for carers, either informal or employed, who can ensure their loved one will be looked after for the day, whilst having some respite.

Discussion

Creating sustainable links between medical professionals and care homes and overhauling the NHS health check aim to mimic the regular community surveillance of older people that is so successful in Cuba as part of their Program for Comprehensive Care for the Elderly. Although this programme is achieved via home visits to older people in the local community, this is less feasible in the UK due to time constraints and understaffing. Therefore, community surveillance via health checks and care home visits provides a more realistic, alternative approach for preventative health care that may provide a similarly high level of population coverage to that in Cuba. Regulating the delivery of care across CCGs mimics the central organisation of this programme. It is noteworthy that CCGs must differ in some respects to adequately cater for their unique, resident populations – what is appropriate in one area of the UK may not be appropriate in another area. However, elderly care services should be regulated to at least allow older people throughout the UK to have equal opportunities to access high-quality health and social care. Some areas may need to provide considerably more services for the older population than others, but no areas should be without these services at all.

Providing a wider variety of community facilities by running services from care homes leaves no equivalent community service to that of Grandparents Circles – there are limited opportunities for older people in the community to attend exercise classes, or take part in cultural and social activities in the UK. Therefore, the more able population has fewer facilities that cater for them. However, these may not be in as high demand in the UK as they are in Cuba, partly due to unpopularity. There is little data on whether the Cubans themselves enjoy these services, but societal differences between the UK and Cuba mean that taking group exercise forms part of the ideology in Cuba, whereas it is more a matter of personal choice in the UK. Hence, facilities which offer this may be less used. However, the MGCT assessment prior to commencing activities at Grandparents Circles can be replicated by ensuring older people are signposted to any available and appropriate services on contact with primary and secondary care.

More research is needed to validate these suggestions before their implementation – there must be a greater understanding of 1) the types of services that older people value, 2) interventions that do and do not reduce hospital admissions, and 3) the evidence behind existing policy. Clearly, effective promotion
would also be necessary to implement these suggestions – huge cultural changes would be required, both at the level of the government who must create policy to ensure uniform and fair access to improved health and social care services for the older person; and at a social level, where older people must understand the benefit of engaging with the services offered to them.

Although these three suggestions may appear to be labour intensive, and some may argue they may stretch the health service further, or that they cannot be resourced adequately, this article proposes that a great deal of healthcare professionals’ time and money will be saved by reducing 1) the number of hospital admissions and 2) the length of hospital stays. These plans will reduce the number of hospital admissions that were rising due to lack of preventative measures and help avoid admissions for conditions which should have been managed in the community. The length of hospital stays may be reduced by avoiding delayed discharges. The hospital admission itself is often the trigger that identifies that the older

Fig. 3  Delayed transfers of care from hospitals, 2010 to 2016 (number of delayed days by reason for delay)
person’s current living arrangement is unsafe or inadequate for them. It is then impossible for the medical team to discharge the patient to an environment which they have discovered to be unsafe for that patient. Therefore, the older patient may be forced to stay in hospital for several weeks whilst medically fit for discharge, until social services make new, more suitable community care arrangements for them, as shown in Figure 3 (The Kings Fund 2016b). If this process can occur before the person’s ill health flags up the need for social care input, their admission may be totally avoided, or at the very least, significantly shorter, as they can be discharged when deemed medically fit. Aside from saving money and time, implementing these changes could increase the physical and mental health of the older population by recognising and preventing deterioration early, and before it significantly impacts the health of that person. These suggestions may also satisfy the wishes of the UK health secretary, who states “personalised, preventative healthcare is a mission critical to the future-fit healthcare service” in the UK (Gault 2019).

Conclusion

In conclusion, both Cuba and the UK face an ageing population and associated challenges. The provision of elderly care in the UK is disorganised, which has created a postcode lottery and resulted in poor access. This is pressurising care homes, driving inappropriate hospital admissions and delaying discharges. In contrast, Cuba has a more organised, preventative approach that incorporates more tiers to its system and consequently integrates medical and social care more successfully. This more adequately meets the needs of their ageing population. Although these ideas are easier to carry out in a socialist country such as Cuba, the key principles behind the Cuban initiatives should be investigated for adoption in the UK to improve elderly care. The UK could create a more uniformly organised programme coordinating the fair and equal delivery of services across CCGs to meet the needs of more people. Modelling Cuba by expanding community-based facilities, associating GPs with care homes and overhauling the NHS health check system may help improve accessibility and employ a more preventative approach to care of older people. This should improve the overall health of the older population and reduce hospital admissions, in turn helping to relieve pressure on care homes and hospitals alike.

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