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EDITORIAL

INTEGRATED CARE AND GERIATRICS: A CALL TO RENOVATION FROM THE COVID-19 PANDEMIC

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In recent decades, we have witnessed the progressive aging of the world population. According to the latest global demographic estimates by the Population Division of the Department of Economic and Social Affairs of the United Nations, people aged 65 years or older represented 9% of the entire population in 2019 (1). It is well-established that the risk of severe health-related events increases with age. Thus it is not surprising that the COVID-19 pandemic has shown once more how the older adults and the frailest subjects are particularly exposed to adverse outcomes (2). The often neglected problems of geriatrics are today evident (at least, for those who want to see them), and indicate the need to reshape our healthcare systems according to characteristics of the older population.

Besides soliciting the adoption of preventive measures to limit the spread of the SARS-CoV-2 virus (e.g., social distancing, personal protection equipment, PPE), the pandemic has mainly been counteracted by strengthening the centrality of the hospital setting through the reinforcement of intensive care units and emergency departments. The priority has been to isolate COVID patients (and/or suspect cases) as soon as possible, hospitalize them, and offer prompt respiratory support when symptoms appear and start to dramatically worsen (3). Such an approach might appear reasonable in a period of emergency. However, it becomes less logical if considering the widespread unpreparedness in front of this catastrophic event. In particular, everything may appear frustrating thinking that 1) previous pandemics (e.g., SARS) have taught nothing (but luckily exceptions do exist! (4, 5)), and 2) many countries have been found not adequately organized even after months from the first cases. In this context, the evident fragmentation of our healthcare systems, unadapted primarily to the needs of older and frail persons, represents a critical point to discuss, with a view to implementing the management of possible future waves of COVID-19.

A paradigmatic example comes from long-term care facilities (LTCFs). This setting of geriatric care has been traditionally marginalized within healthcare networks. LTCFs have constantly been living in the ambiguity that their residential nature does not fit with the relevant clinical burden of care of their frail and complex residents. Not surprisingly, during the pandemic, the undefined/neglected role of nursing homes has been translated into a high tool of fatalities among their residents. A similar situation has been observed for primary and community healthcare services, which have suffered in terms of death of many professionals found themselves unprepared on the frontline, and have experienced a decrease in home care, outpatient care, and caregivers' support.

These problems are mainly related to the hospital-centered approach of our healthcare systems, a perspective that implicitly tends to reduce resources to other settings of care that are equally important for the proper functioning of the healthcare network. In the aging population, prevention of hospitalization is crucial, but the current primary healthcare services are often unable to ensure safety and continuity of care for older persons. Moreover, geriatricians still have limited visibility in the system, playing a marginal role in the planning and organization of care. Paradoxically, during the current pandemic, while geriatricians have often been employed at the frontline against COVID-19 given their background as internists, concepts of major importance for geriatric medicine (e.g., biological age, multidimensionality, frailty, functional ability, continuity of care) have frequently been put aside on the pretext of the emergency. In this context, the poor diffusion of geriatric knowledge concurs with feeding rampant ageism, affecting capacities of all those settings that are traditionally devoted to the care of older persons. In fact, in daily clinical practice, older persons are frequently discriminated against due to their chronological age, which has been used as the main criterion for the allocation of care resources.

In its immense tragedy, the COVID-19 pandemic may become an opportunity to prove the weaknesses of the healthcare system and may indicate which parts are at the most urgent need of reorganization (6–9). It is evident that a restructuring according to more modern models of care based on integration of healthcare services, multidimensional assessment, and person-centered approach is needed, especially for the most vulnerable individuals. There is a pressing need to strengthen primary care to prevent, slow, or even reverse declines in intrinsic capacity (10). Such adaptation of the system to the new needs is clearly explained by the World Health Organization in its guidelines to Integrated Care for Older PEople (ICOPE). Important elements for delivering ICOPE and guaranteeing continuity of care include the comprehensive assessment of the older person, personalized

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interventions, self-management support, community engagement and caregivers' support… (10), all aspects that have traditionally been promoted by geriatricians and presented as the only way of dealing with the complexities of the frail older person. In this general reorganization of the system towards models that are more careful at the basic principles of geriatric medicine (11), it might be important to foresee a more formal engagement of geriatricians in institutional decisions. Given its transversal nature, geriatric medicine should be reinforced across all the healthcare settings, both inside the hospital setting (for example, through the generation of more frequent collaborations/exchanges with other specialties) and the territory (for example, creating links with primary care). Under this perspective, geriatricians may assume a relevant responsibility, playing the critical role in connecting the two souls of the healthcare system, the hospital one and the other based on the community.

Hopefully, public health authorities will become better aware of the urgent need to guide our society towards a cultural renovation that starts from the reorganization of the healthcare system. A more modern system, together with the promotion of ad hoc training for healthcare professionals and the educative role of mass communications, may result decisive in giving value to geriatric medicine and fighting the diffusion of age stigma.

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