

Perspective Article

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Longterm Care Needs and Their Impact on Healthcare Budgets The Role of Nurses in a Sustainable Care Model

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Introduction

Population ageing is associated with a higher prevalence of chronic conditions which already accounts for most healthcare spending in many countries. Rising demand for long term care has led to frequent “social hospitalization” in which older patients are admitted not for acute medical need but for lack of community based alternatives driving up hospitalizations emergency department visits and reimbursement pressure on public and private healthcare funds.

This perspective article discusses four directions for building a more sustainable model of care shifting resources from acute hospital care toward home and community based services treating investment in prevention as a mechanism that avoids higher future costs rather than as a discretionary expense and using artificial intelligence based cost effectiveness analysis to guide resource allocation toward the most efficient long-term care models and not the last pillar role of a nurse.

It advocates that nurses are the professionals best positioned to operationalize these directions through patient education care coordination chronic disease management and team based models of care and situates this role within a broader global shift toward predictive personalized longitudinal technology enabled and patient led health systems.

The article expresses a personal approach based on the author’s working experience as a former deputy general director of Romania’s National Health Insurance House with practical and policy implications including predictable financing for home care outcome based evaluation of prevention programs and formal recognition of the nurse’s care coordination role through job descriptions reimbursement pathways and continuing education.

Population ageing is no longer a projection it is a present clinical and financial reality. Advanced age comes almost invariably bundled with multiple chronic conditions and treating them already consumes the overwhelming share of health spending in most European countries [1].

As the population ages, healthcare demand among older adults grows accordingly producing what is frequently described as “social hospitalization” the admission of an older patient not for an acute medical emergency but because no adequate alternative exists in the community. When the family has moved away and homecare services are missing or insufficient the hospital becomes the only option even though it is the most expensive and often the least appropriate setting

for the patient’s actual condition. The cost of this pattern is not confined to a single hospital’s budget it propagates through the wider system in the form of longer waiting lists beds occupied unnecessarily and staff stretched across tasks that strictly speaking are not acute medical care.

The direct consequence is a steadily growing demand for reimbursement from public and private health funds at a time when resources are not growing at the same pace as needs. The number of admissions and emergency department visits keeps rising and costs follow the same trajectory particularly in countries with older populations where sustainable financing and efficient resource allocation have become urgent priorities.

This article outlines directions to reduce the excessive growth of hospitalization costs while maintaining and improving the health of older people and examines the central role nurses should play.

Discussion

1st Topic: Shifting Acute Care to Home and Community Care

A first direction is the gradual movement of resources from acute hospital based care toward homebased and community care. This does not mean discharging patients prematurely but building a genuine network of services outside the hospital, mobile teams, remote monitoring and properly coordinated home care services able to meet a patient’s needs at the point where a medical need becomes in practice a need for support with daily living.

This direction is supported by comparative economic evidence. OECD analysis indicates that homebased care is generally less costly than facility based care for people with low to moderate needs and estimates that a 10 increase in the ratio of spending on long term care at home relative to spending on care in facilities is associated with a 4.9 decrease in overall long term care spending [2].

The same analysis notes that a lack of adapted housing and of affordable home and community services currently limits the extent to which older people can age in the community underlining that this shift requires investment in infrastructure not only a change in clinical practice [3].

2nd Topic: Prevention as an Investment not an Expense

A second direction concerns how prevention is financed and evaluated. As long as prevention is treated as a discretionary budget line readily cut whenever financial pressure rises its results will remain limited.

Preventing the progression of chronic disease, through therapeutic education active monitoring and early intervention, reduces the incidence of costly complications from acute exacerbations to repeat hospitalizations.

OECD estimates suggest that a 10% increase in spending on prevention is associated with a 0.9% decrease in the share of the population with chronic conditions after five years evidence consistent with treating prevention as a mechanism that avoids larger future expenditure rather than as an added cost [4].

3rd Topic: AI Supported Cost Effectiveness Analysis

A third more technical direction is the use of cost effectiveness analysis built on artificial intelligence tools to continuously evaluate and update long term care models. Such tools do not replace clinical or administrative judgement but they give decisionmakers a more precise view of where resources produce the greatest benefit relative to their cost.

In a resource constrained system the capacity to direct funding to where it has the greatest impact is a basic condition for financial sustainability not merely a technical refinement.

4th Topic: Nurses as Pillar of a Patient Centered Model

Achieving these three previous directions in practice depends substantially on the healthcare workforce and nurses are positioned in the best place.

Nurses provide patient education coordinate transitions between hospital home and community services manage chronic disease over the long term and promote team based models of care. Their role as care coordinator increasingly described in the nursing literature is supported by outcome data a systematic review and meta analysis of nurse coordinated interventions for frail older adults discharged from hospital found a significant reduction in one month readmissions and a systematic review of nurse led education for adults with heart failure reported associated reductions in hospitalization readmission and cost alongside improved quality of life [5-6].

Investment in nurses acting as care managers is on this evidence not simply a workforce policy but a direct lever on the costs discussed above.

Toward a Global Model of Preventive Health

This shift aligns with a broader transformation discussed in international health policy forums which proposes moving from a reactive model, treating disease once it appears, toward a proactive one built on five characteristics predictive identifying risk before it escalates personalized tailored to individual biology and behavior longitudinal providing continuous rather than episodic support technology enabled using digital tools and artificial intelligence to extend access and patient led empowering individuals through access to their own health data []. A model of this kind cannot function without a profession able to sustain it daily close to the patient nurses by the nature of their training and practice occupy that position.

Implications for Practice and Policy

Translating these directions into practice requires concrete decisions. Funding for homecare services needs to become as predictable as hospital funding or any shift “toward the community” will remain largely theoretical.

Prevention programs should be evaluated by their measurable effect on hospitalization rates and long-term complications not by the number of campaigns delivered. Realizing a sustainable community

centered model of long-term care depends on recognizing training and supporting nurses as its central pillar.

The introduction of AI based analytical tools should be accompanied by training for the professionals who will use them so that resource allocation decisions remain anchored in clinical judgement rather than in algorithmic output alone.

Finally, for nurses to take on the coordination role described above this competency needs formal recognition, through job descriptions reimbursement pathways and continuing education programs, rather than remaining as is often currently the case an informal extension of their existing workload.

Reflections

Population ageing will continue to place pressure on health budgets regardless of the political or economic direction taken by individual states What remains within reach is the choice of response continuing to absorb costs through a hospital centered model that is increasingly difficult to sustain financially or deliberately building a system centered on community care prevention and the efficient allocation of resources.

The evidence reviewed here suggests that the second path depends in large part on recognizing training and supporting nurses as the central pillar of this transition.

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