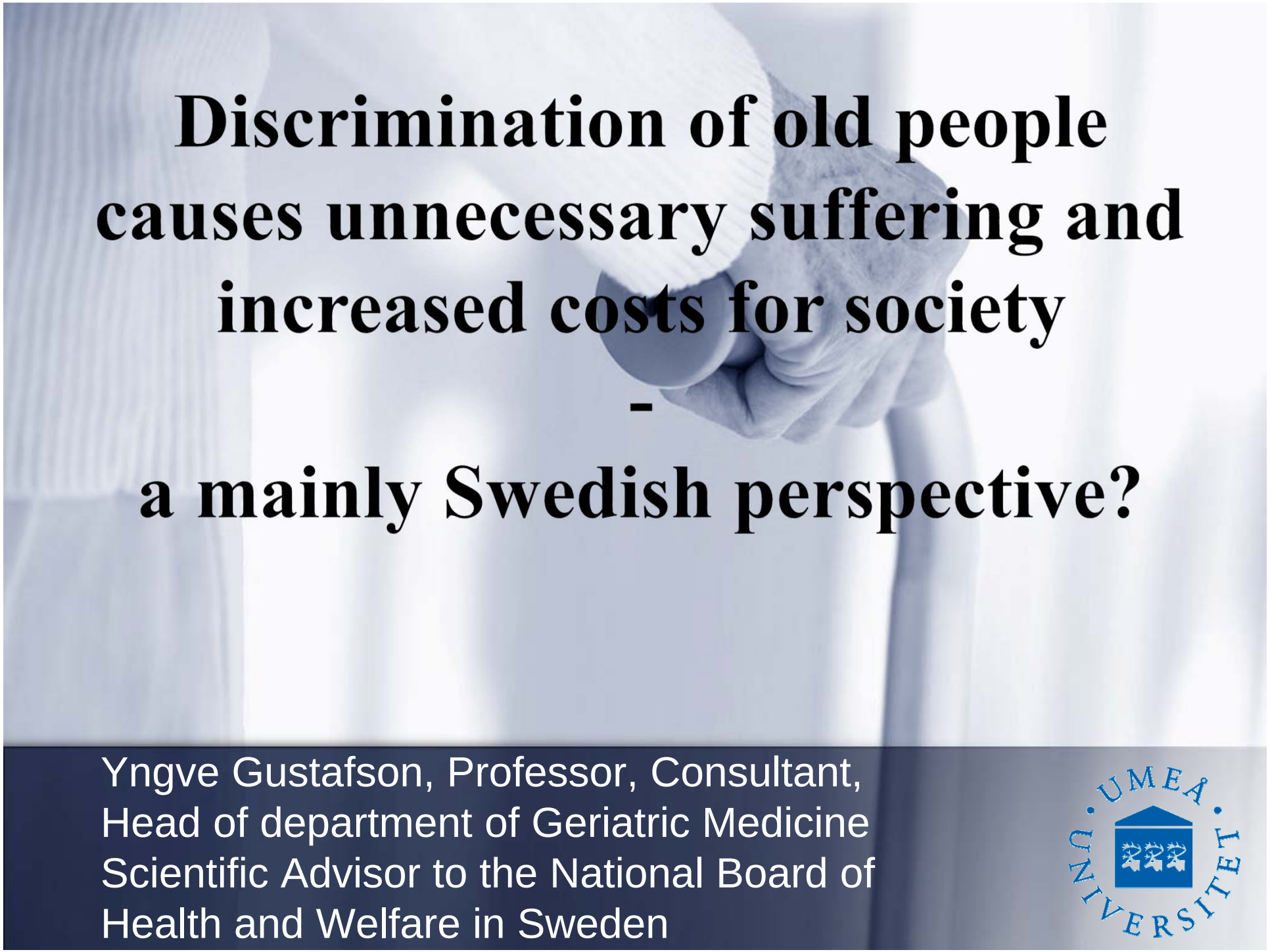

Discrimination of old people causes unnecessary suffering and increased costs for society

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a mainly Swedish perspective?

Yngve Gustafson, Professor, Consultant,
Head of department of Geriatric Medicine
Scientific Advisor to the National Board of Health and Welfare in Sweden

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- Auctions to sell poor and disabled persons and orphans to those who demanded less economic compensation was forbidden by law in 1918 in Sweden

- People who moved in to an old peoples home lost their rights to vote -1945

- Auctions for eldercare and healthcare was reintroduced in the 90:ties

- Those most disabled can not utilize their rights in the system

Discrimination of the poor and disabeled reintroduced

- The legislation for animals guarantees horses better care than old people in Sweden.
- Horses should not be out of food more than 9 hours during the night and they should play outside with other horses several hours each day.
- The mean time without any food in residential care facilities during the night was 14,5 hours and less than half of the residents had been outside the last month.

The legislation does not protect old people from neglect

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- Quality registers were implemented to control the quality of care of old people
- The measurements lacked scientific evidence and took time from the care
- What was measured was improved but other areas deteriorated
- Those improper drugs that were registered were replaced with even more dangerous drugs

Quality registers makes the care worse

- The Swedish legislation discriminates old people

- One law for those up to 65 another law after 65

  Before 65: LSS (Lagen om Stöd och Service) which guarantees certain rights

  After 65: SOL (Socialtjänstlagen) – no care is guaranteed

- One legislation for certain psychiatric disorders (LPT) with protection of the persons rights while that law is not applicable to people with dementia who lack protection in the legislation

- Normal ageing results in reduced reserve capacity – which means that acute diseases are more rapidly life-threatening and thus old people need av quicker assessment and treatment
- In Sweden the government pays bonus to the municipalities if old people are not send to the emergency room partly due to that the emergency rooms have poor quality of care of old people with acute diseases.
- Why not adjust the care in the emergency room to meet the needs of frail old people???

Discrimination of old people

- Old people with many diseases and drugs are regarded as ”Black Petter” who no one wants to take care of – acute hospital care is not adjusted to take care of such patients.

- The reimbursement system discriminates such patients

Discrimination of old people

- Healthcare guarantee (the longest time you have to waif for treatment) is unfavourable for old people. Younger and healthier people are more profitable for the care-providers. Return-visits to follow up effects and sideeffects of drugs are not profitable in the system.

- Drug-side effects is the most common cause of visits to the emergency room for old people and if drug treatment is not followed-up it will cause more harm than good to the old person.

Discrimination of old people

- Economy and not the needs decides what support an old person receives
- Assistance assessors lack medical education – and know too little about the consequences and needs of people with dementia and other psychiatric disorders
- Symptoms of dementia are misjudged as normal ageing and the person is not offered adequate assessment and treatment

Discrimination of old people

- Only treatment of symptoms and not the underlying causes is common and dangerous in old people and especially in those with dementia disorders
- Only treatment of symptoms results in under treatment of underlying serious diseases
- Symptom treatment causes unnecessary drug side-effects

Treatment of symptoms is dangerous for old people

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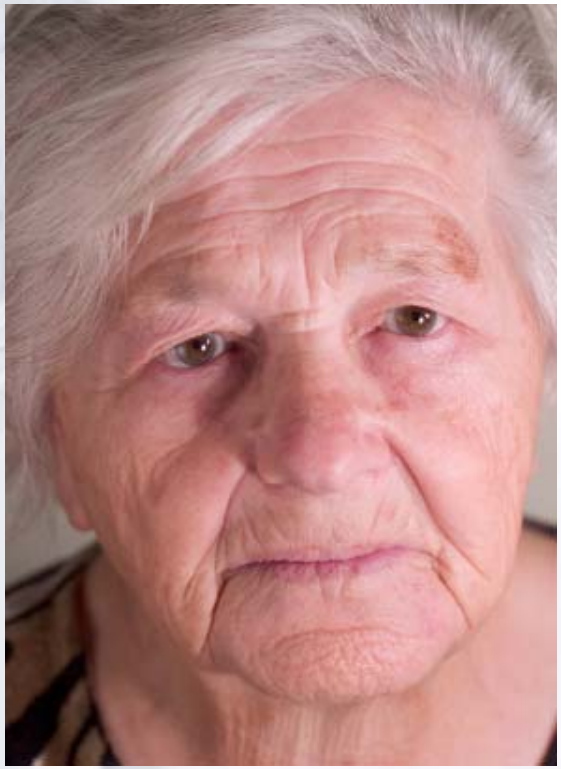
- Palliative care – treatment of symptoms instead of assessment, treatment and rehabilitation
- Palliative care – instead of seeing the individuals resources and to work with a rehabilitative focus
- Palliative care is supported with economic bonus to the municipalities when the person is dead if the person is registered in the Palliative register
- Palliative care is started already in the early phase of dementia and shortens life with several years

A dead old person is economically profitable

- Only 8 of the 21 county councils in Sweden have units for old age psychiatry
- Depression causes more suffering than any other disease
- Half of all people with dementia disorders suffer from depression
- Almost no resources for treatment and care or for research in the field of old age psychiatry



Mental Health in old age – most neglected

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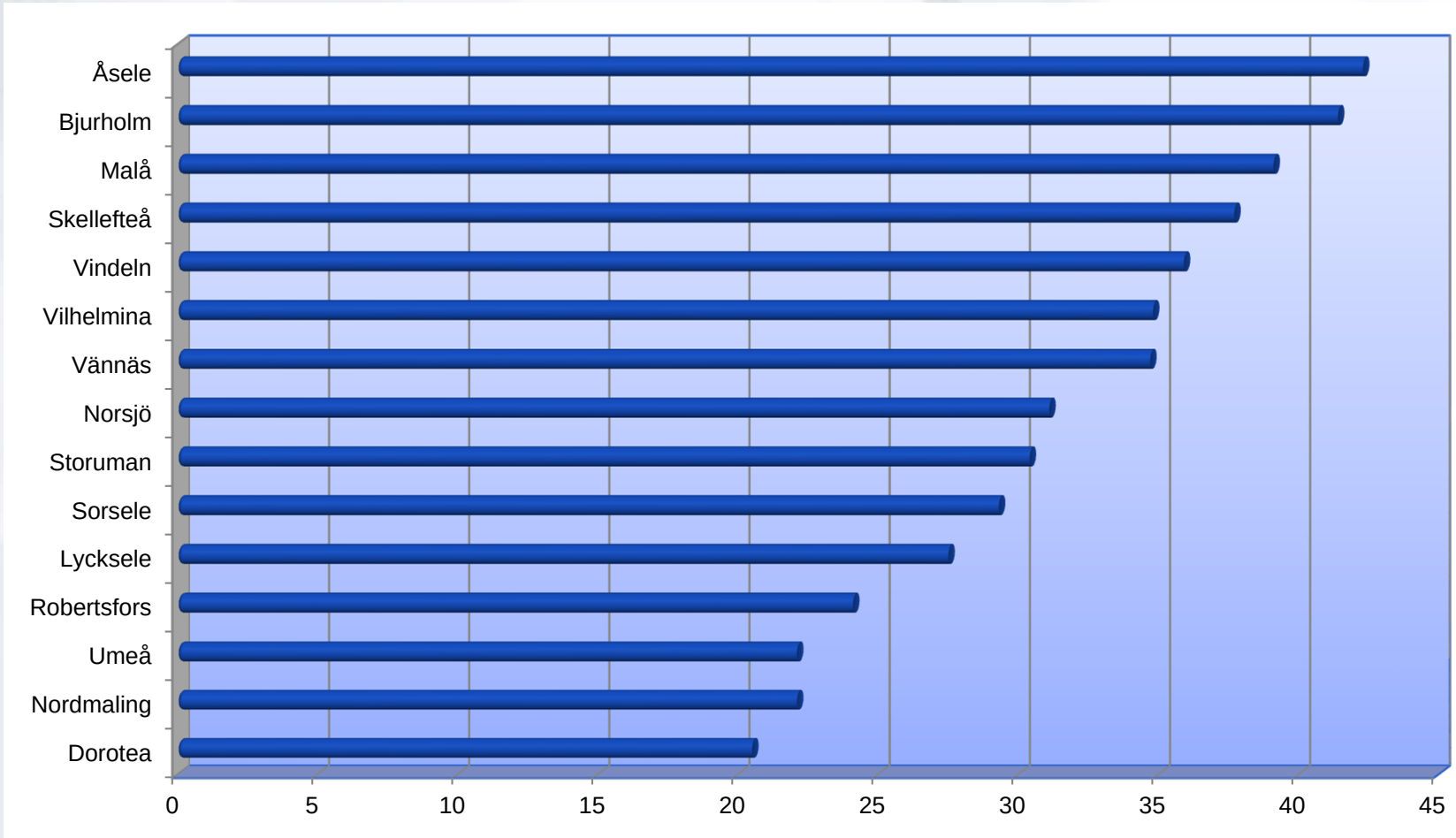
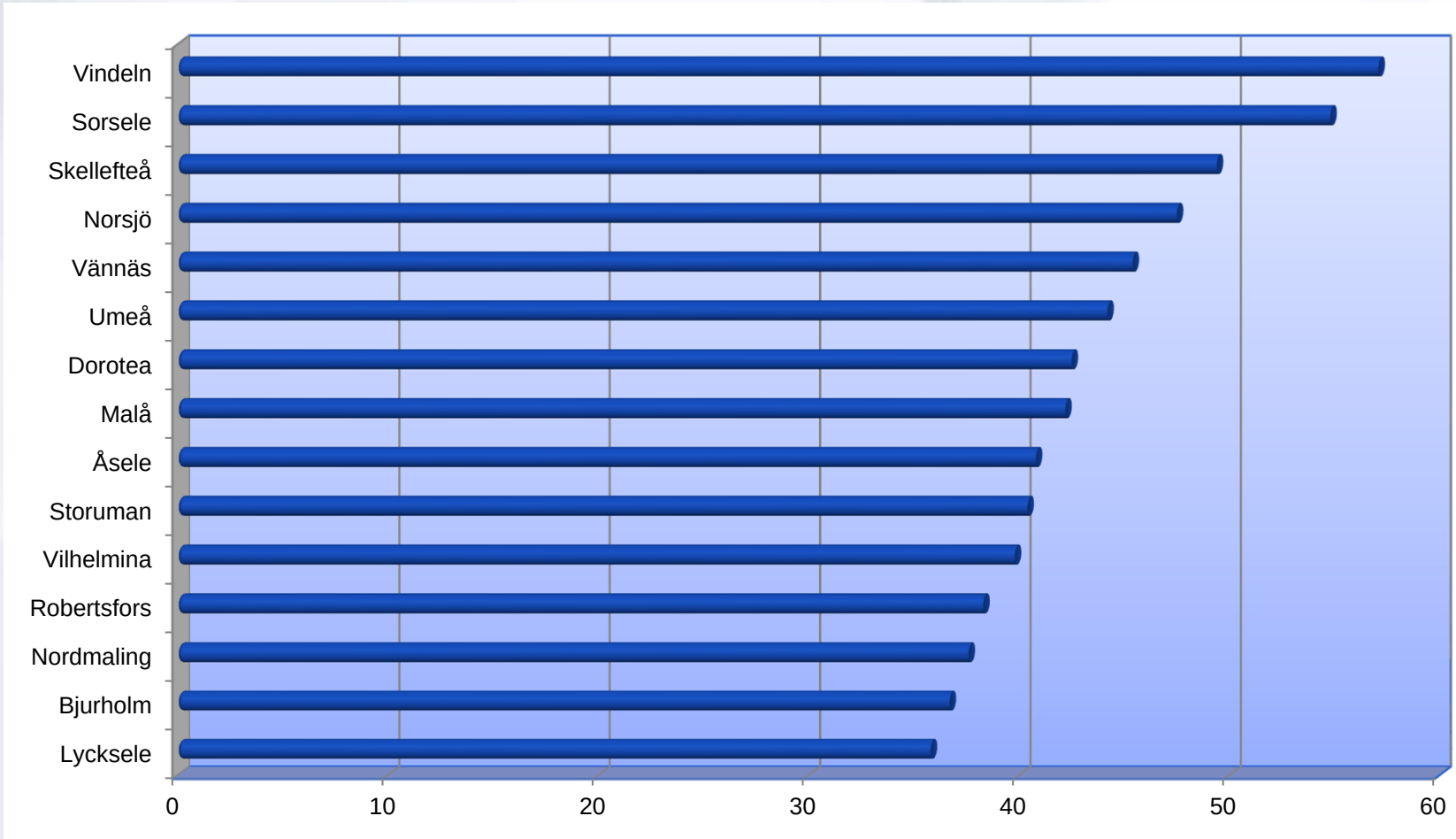
- Education in gerontology and geriatrics is neglected in all parts of the education system in Sweden, especially in the education of physicians

- Despite that the majority of patients in most medical specialities are old - almost no specialist training (except geriatrics) includes gerontology and geriatrics

Old people are discriminated in education



Proportion experiencing negative attitudes torwards old people in health care



Proportion of old people experiencing negative attitudes torwards old people among politicians

- Diskrimination and experienced negative attitudes towards old people results in reduced trust in healthcare and eldercare
- Low trust results in increased costs for society
- Low trust in health care is associaten with poor mental health among old people
- Poor mental health in old age has increased by 68 % during 20 years in Sweden. The SWEOLD investigation 1992-2012.

Low trust causes increased suffering and costs

- Knowledge in gerontology is a prerequisite for assessing and treating old people
- Normal ageing changes all body functions
- Gerontology a discriminated subject in education

Geriatric medicine

- Different etiology of diseses
- Changing pathophysiology
- Changing symptoms of diseses
- Changing prerequisites for assessment and diagnosis of diseses
- Changing prerequisites for treatment and rehabilitation of diseses and injuries
- Changing prerequisites for prevention of diseses and injuries

Knowledge in geriatrics a prerequisite for assessing and treating old people

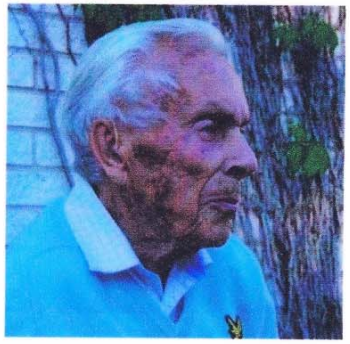
In Sweden by 2050

- 80+ will double
- 90+ will triple
- 100+ have doubled in ten years

Changing demografi

- In ten years 90+ with hipfractures has increased by 150%
- People with dementia will more than double
- We live longer with good health but the years with disability also increses

Changing demografi



85 PLUS
UMEÅ

The GERDA project started as the Umeå 85+ study

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- In the GERDA/85+ study – only 50% of those with depression were detected
- More than half of those treated with antidepressants were still depressed
- One third was depressed and depression had more impact on wellbeing than any other disease
- More women than men were depressed

Depression in old age – underdiagnosed and poorly treated

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- Five years later – 86% of those depressed were still depressed
- People with depression had a doubled mortality rate
- Twenty-six percent of those without depression at baseline had developed depression 5 years later
- Depression more letal than cancer and heart diseses in old age
- Depression among old people is increasing (both the incidence and the prevalence)

Depression in old age – chronic and with doubled mortality

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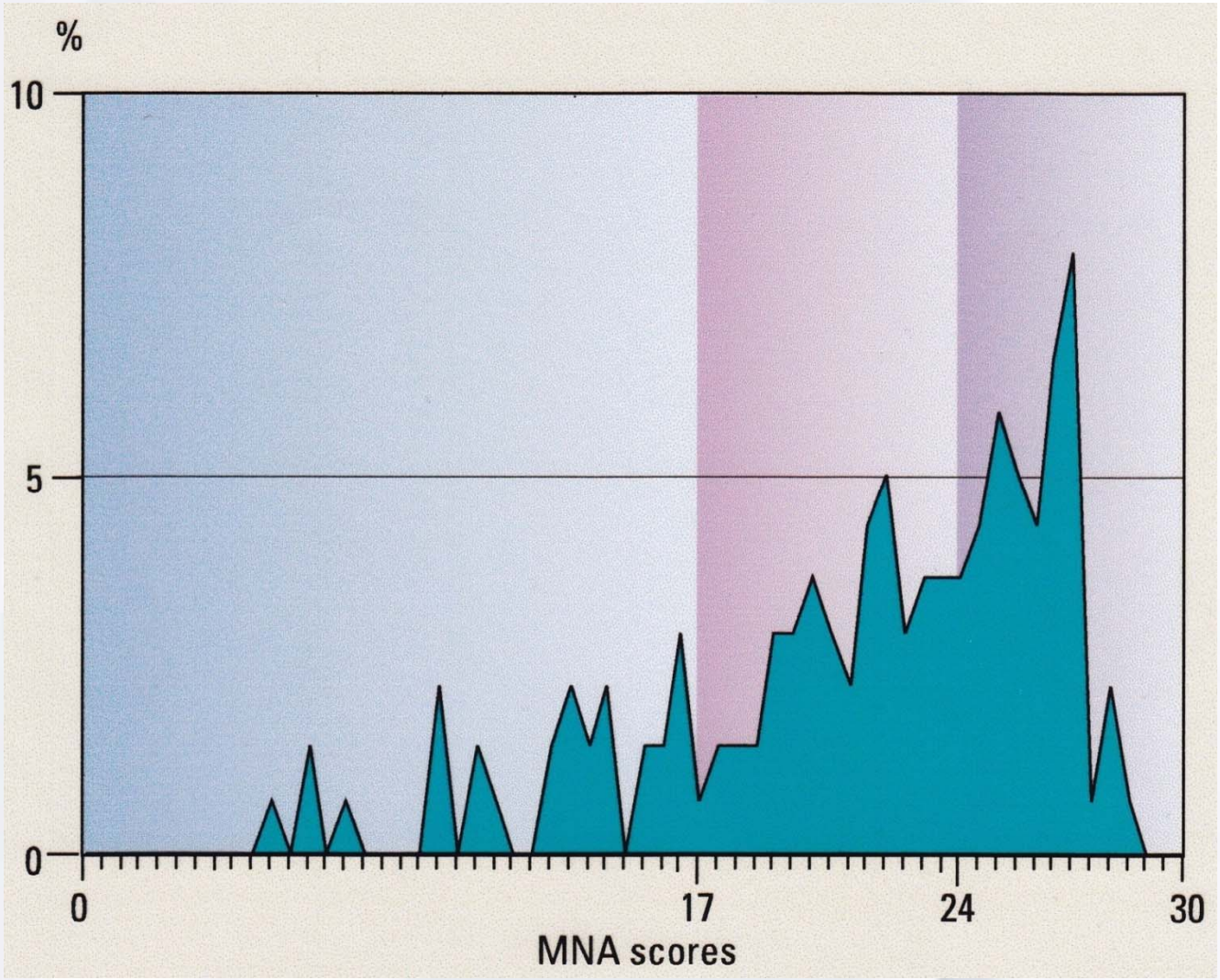
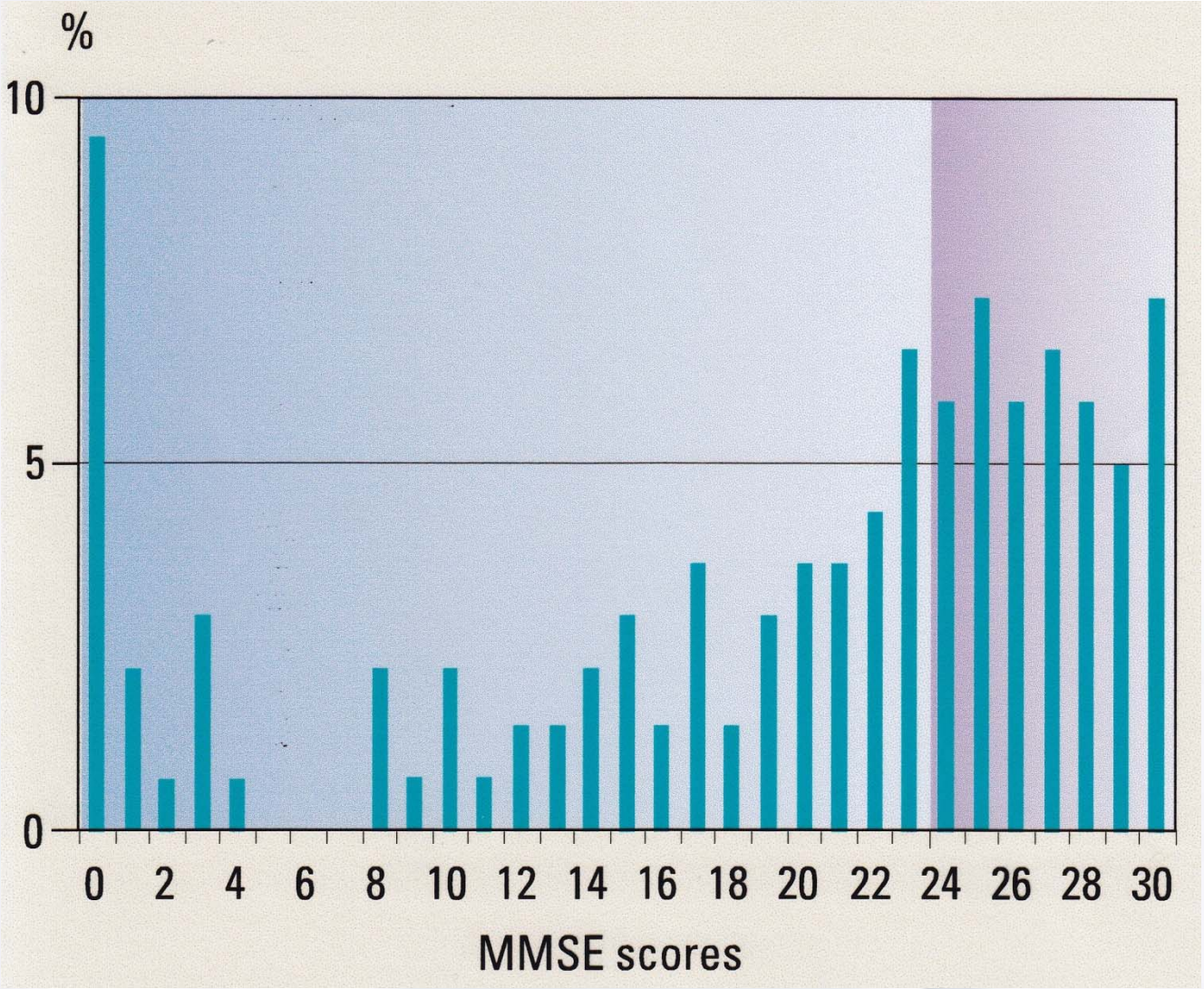


Malnutrition – a common and serious threat against a good ageing



The incidence and prevalence of dementia increases in northern Sweden

Treatment of symptoms in old people is dangerous

- Delays and prevents detection of treatable diseses
- Is a threat to the life of the patient and results in prolonged hospital stay and increased costs

Underlying causes of symptoms must be detected

Neuroleptics to people with psychiatric symptoms (BPSD) wereresulted in increased mortality by delaying diagnosis and treatment of serious underlying diseses that caused the psychiatric symptoms

Rochon et al Arch Intern Med 2008.

Neuroleptics increases mortality because of serious sideeffects in people with dementia

Ballard et al Lancet Neurology 2009.

Neuroleptics increases the risk of death

The most common cause of admission to hospital for old people:

<u>DRUG-SIDE EFFECTS!</u>

- Wrong doses
- Drugs unsuitable to old people
- Dangerous combinations of drugs

- Cost of drugs 30 billion SKr
- Costs for side-effects 15 billon SKr

Old people suffer from drug-side effects

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- If drugs are tested in old people they are only tested in healthy old people with one single disese

- The drug industry:

  ”it is unethical to test drugs in old people – they suffer so many drug side-effects”

Drugs used in old people are seldom tested in old people

- Admissions to hospital due to drug-side-effects has doubled in 30 years.
- Number of drugs old people receive has doubled in 30 years
- The proportion of patients who are followed-up by the doctor who initiated the treatment has been reduced dramatically

Drug-side- effects have increased

- Comprehensive geriatric assessment
  - Assess and treat underlying causes of symptoms
- Adjust doses to the individual
- Prioritize the most important treatements
- Always follow-up and evaluate effects and side-effects of all treatment

Prerequisites for adequate drug treatment of old people

ABSURD GENDER DIFFERENCES:

- Men are assessed – women get treatment of their symptoms
- **The Umeå 85+/GERDA project:**
- Women get significantly more drugs for depression, insomnia, anxiety, laxatives, analgesics and diuretics
- Men receives more expensive drugs
- Women get more symptomatic treatment for symptoms from the stomac-region without assessment

Old women are doubly discriminated

ABSURD GENDER DIFFERENCES:

- Women with dementia less often got ”dementa-drugs” especially when they were expensive
- A larger proportion of old women get symptomatic treatment for their angina
- Three times more men are operated and get new coronary arteries (CABG)
- Five times more 85 year olds were operated with CABG 2005-2007 compared to 2000-2002

Old women are doubly discriminated

The scientific evidence why Comprehensive Geriatric Assessment - Prevention Rehabilitation and Management (CGA-PRM) is effective

- One year mortality was reduced by 23%
- A 68% lower proportion were living in residental care facilities one year later

(A meta-analysis by Stuck et al, Lancet 1993)

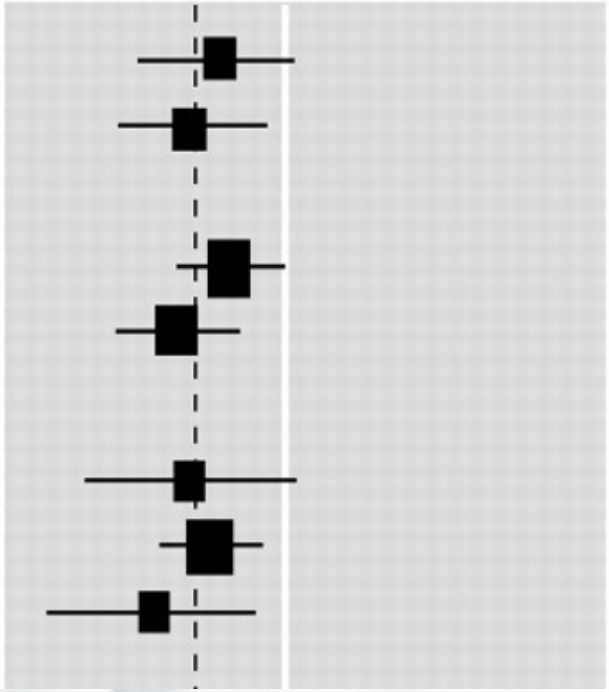
Proportion of patients either dead or living in an institution one year after stroke *(BMJ, 1997)*

Patient subgroups

Sex:
- Male
- Female

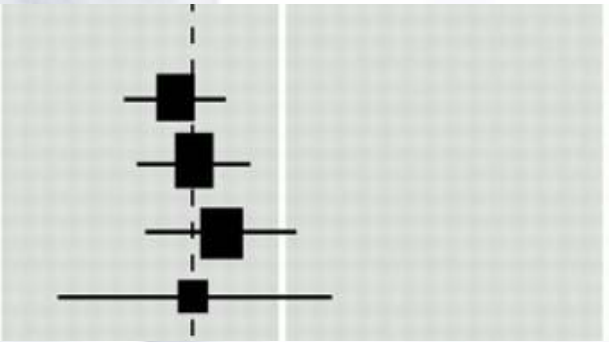
Age:
- ⩽75 years
- >75 years

Stroke severity:
- Mild
- Moderate
- Severe



Proportion of patients either dead or living in an institution one year after stroke *(BMJ, 1997)*

Departmental setting:
- Geriatric medicine
- General medicine
- Neurology
- Rehabilitation medicine



CGA-PRM compared to general internal medicine at Umeå University hospital, Sweden

(Asplund et al, J Am Geriatr Soc, 2000)

- Shorter length of hospital stay (- 20%)
- Reduction of persons needing institutional care at discharge and three months later (- 50%)

CGA-PRM compared to general interna medicine at Trondheim University hospital, Norway.

(Saltvedt et al, J Am Geriatr Soc, 2002)

- Three months mortality 12% versus 27% (p=0.004)
- Reduced number needing institutional care after three months (p=0.005)

Introducing CGA-PRM to a general Internal Medicine Department at Sundsvall County Hospital, Sweden
(Lundström et al, J Am Geriatr Soc, 2005)

- One week intensive course in CGA-PRM and a follow-up seminar once a month
- Lenth of hospital stay (- 30%, $p<0.001$)
- Reduced prevalence of delirium (- 50%, $p<0.001$)
- Reduced in-hospital mortality (2 versus 9, $p=0.03$)

A meta-analysis of CGA-PRM (Ellis G, et al, BMJ 2011)

- 22 RCT-s from 6 countries including over 10 000 patients
- Returning home (OR 1.16; p=003)
- Still living at home one year later (OR 1.25; p<0.001)
- Reduced risk to die or deteriorate: (OR: 0.76; p=0.001)

- Fewer suffered delirium
- Fifty per cent reduction of duration of delirium
- Fewer in-hospital falls (- 60%)
- Less malnutrition, decubitus ulcers and infections
- Ten days shorter hospitalisation
- Odds ratio of being an independents walker one year later 3.0

CGA-PRM for old people with hip-fractures (*Lundstrom M, Ageing Clin Exp Res 2007, Stenvall M, J Rehab Med 2007, Stenvall M, Osteoporosis Int 2007*

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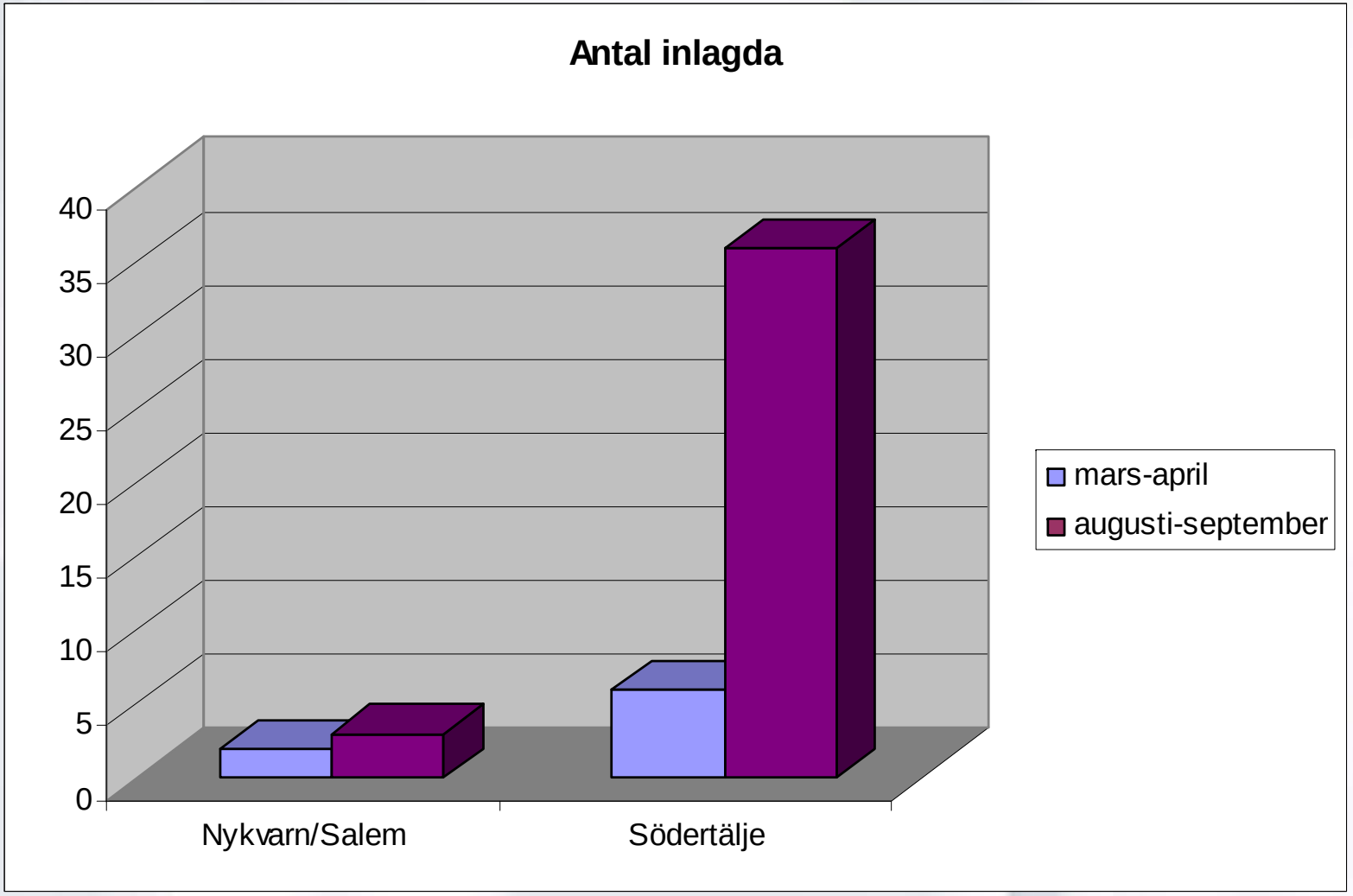
- Reduction of falls (- 51%)
- Reduction of hip-fractures (- 77%)

CGA-PRM in residential care facilities in prevention of falls and fractures *(Jensen J et al, Ann Int Med, 2002)*



Proportion of old people admitted to hospital from residential care facilities when GP:s took over the responsibility from geriatricians

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1. Improved knowledge in gerontology and geriatric medicine in all professions who work in the care of old people

2. The health-care system has to be adjusted to meet the needs of the old person with multiple diseses. A health-care system according to physicians sub-specialities is a threat to a cost-effective health-care system.

3. Team-work is a prerequisite for assessment, care and rehabilitation of old people. All professions in the team have to aquire and develop competence in gerontology and geriatric medicine

Ten prerequisites for high quality and cost-effective care of old people

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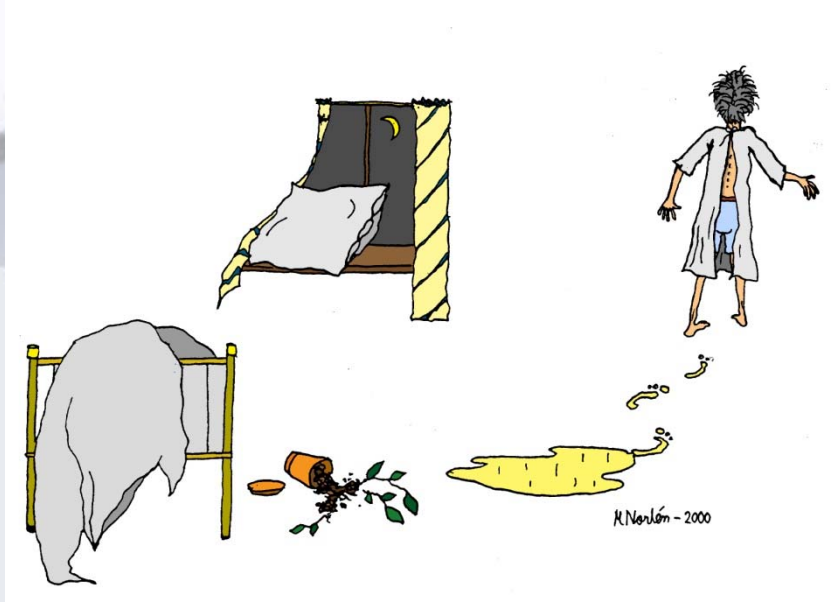
4. Symptoms in old people have to be assessed to the same extent as in younger people. Improper symptom treatment causes a large proportion of drug-side effects, unnecessary suffering and increased costs



5. Since no drugs are evaluated in frail old people – all drug-treatments have to be regarded as an experiment. All drug treatments demands a proper assessment and always an evaluation of effects and side-effects in old people. Physicians should be allowed to prescribe drugs to old people without a proper education in geriatric medicine including geriatric pharmacology

6. Ethical consideration are necessary before assessment and treatment of sick old people. All patients should receive optimal treatment but not always maximal treatment. Mild and moderate dementia is not a reason to deny a person assessment, treatment and rehabilitation.

7. Different caring levels/organisations have to co-operate with the best of old people as their main goal.

   Close co-operation is a prerequisite for cost-effectiveness.

   Old peoples needs should never be allowed to be used in the struggle of savings between different organisations (In Sweden between the county councils and the municipalities)

8. All types of medical treatment, such as drug-treatment and rehabilitation methods have to be evaluated scientifically in old people.This should also include people with dementia.

9. Prevention has to be prioritized but the major challanges are quite different in old people. Falls, osteoporosis, loneliness, depression, dementia, drug-side effects, urinary tract infections, malnutrition, inactivity are examples of major heath problems in old age that should be the focus of prevention.

10. Our future depends on research in gerontology and geriatric medicine. One third of acute hospital cost is the result of lack of knowledge, low competence and negative attitudes towards frail old people.

- The more we learn the less we know that we know
- We start to realize that we know very little about the management of old people – at least we should avoid causing them unnecessary harm because of our lack of knowledge
- We have a lot to learn those who think they know how to treat old people
- Gerontology and geriatrics have to be the most prioritized research area for the future!!!!

Discrimination of old people causes unnecessary suffering and increased costs for society

Thank You for Your attention!