Discrimination of old people causes unnecessary suffering and increased costs for society - a mainly Swedish perspective?

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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.
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.
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.
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 quicker assessment and treatment.

In Sweden the government pays bonus to the municipalities if old people are not sent 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???
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.
Healthcare guarantee (the longest time you have to wait 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 side effects 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.
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.
Treatment of symptoms is dangerous for 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.
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
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.
Proportion experiencing negative attitudes towards old people in health care
Proportion of old people experiencing negative attitudes towards 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 associated 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.
Knowledge in gerontology is a prerequisite for assessing and treating old people

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

Geriatric medicine

- Different etiology of diseases
- Changing pathophysiology
- Changing symptoms of diseases
- Changing prerequisites for assessment and diagnosis of diseases
- Changing prerequisites for treatment and rehabilitation of diseases and injuries
- Changing prerequisites for prevention of diseases 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
In ten years 90+ with hip fractures has increased by 150% 

People with dementia will more than double 

We live longer with good health but the years with disability also increase
The GERDA project started as the Umeå 85+ study
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
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 lethal than cancer and heart diseases in old age

Depression among old people is increasing (both the incidence and the prevalence)
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 diseases
- Is a threat to the life of the patient and results in prolonged hospital stay and increased costs
Neuroleptics to people with psychiatric symptoms (BPSD) resulted in increased mortality by delaying diagnosis and treatment of serious underlying diseases that caused the psychiatric symptoms


Neuroleptics increases mortality because of serious side effects in people with dementia


Neuroleptics increases the risk of death
The most common cause of admission to hospital for old people:

**DRUG-SIDE EFFECTS!**

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

- Cost of drugs 30 billion SKr
- Costs for side-effects 15 billion SKr
Drugs used in old people are seldom tested in old people.

- If drugs are tested in old people, they are only tested in healthy old people with one single disease.
- The drug industry: “It is unethical to test drugs in old people – they suffer so many drug side-effects.”
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.
Prerequisites for adequate drug treatment of old people

- Comprehensive geriatric assessment
- Assess and treat underlying causes of symptoms
- Adjust doses to the individual
- Prioritize the most important treatments
- Always follow-up and evaluate effects and side-effects of all treatment
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 receive more expensive drugs
- Women get more symptomatic treatment for symptoms from the stomach-region without assessment
ABSURD GENDER DIFFERENCES:

- Women with dementia less often got ”dementia-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 residential 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

- 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
- Length 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)

- 22 RCT-s from 6 countries including over 10 000 patients
- Returning home (OR 1.16; p=0.003)
- 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

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

1. Improved knowledge in gerontology and geriatric medicine in all professions who work in the care of old people
Ten prerequisites for high quality and cost-effective care of old people

2. The health-care system has to be adjusted to meet the needs of the old person with multiple diseases. 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 acquire and develop competence in gerontology and geriatric medicine.
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 demand 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 considerations 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 challenges are quite different in old people. Falls, osteoporosis, loneliness, depression, dementia, drug-side effects, urinary tract infections, malnutrition, inactivity are examples of major health 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!