The organisation of hospitals and the remuneration systems are not adapted to frail old patients giving them bad quality of care and the staff feelings of guilt and frustration

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Abstract

Background: In the coming half-century the population of old people will increase, especially in the oldest age groups. Therefore, the prevalence of multiple chronic conditions, and consequently, the need of health care including care in hospital, is rising.

Materials and methods: This article includes results from three mainly qualitative articles (interviews with frail old people, physicians, and an observational study in acute medical wards) and a cross-sectional survey of newly discharged elderly patients.

Results: Health care does not take a holistic approach to patients with more complex diseases, such as frail old people. The remuneration system rewards high production of care in terms of numbers of investigations and operations, turnover of hospital beds, and easy accessibility to care. Frail old people do not feel welcome in hospital, with their complex diseases and a need of more time to recover. The staff providing care feel frustrated, and often guilty when taking care of old people.

Discussion and conclusion: To improve quality of care of frail elderly a model is suggested with the following main components: more hospital wards which can address the patients' whole situation medically, functionally, and psychologically, i.e. comprehensive geriatric assessment (CGA). Better identification of frail elderly people is necessary, together with a change in remuneration system, with a focus on the patients' functional status and quality of life. More training in geriatrics is required for staff to feel confident when treating frail old people.

Background

The population in most parts of the world is growing older, especially in the oldest age groups (1). This development leads to more people with multiple chronic conditions and frailty (2, 3).

The multiple chronic conditions, frailty, and all medical prescriptions caused by these conditions often lead to hospitalisation (4, 5). As a consequence, frail old people are common in hospital—and they are also costly. In Sweden, for the patient group defined as 75 years or older, with >2 different diagnoses and >2 in-hospital stays during the last year, the costs comprise 19% of all national in-patient costs (6).

Frail old people need care that considers all diagnoses and medications together, in order to improve their quality of life and diminish the adverse effects of frailty. Adverse effects of frailty are often described as institutionalisation, loss of independence, and mortality.

Comprehensive geriatric assessment (CGA) has shown to be an effective tool for approaching this kind of care (7, 8). CGA is characterised by a multidimensional, multidisciplinary assessment to evaluate an older person's functional, physical, cognitive, and socio-environmental circumstances (9). As the definition implies, this means a holistic view and working in a multidimensional team. This is not the most common way of working in hospital today—not even when working with old people. On the contrary, there has been a trend towards more and more super-specialised care (10), a development driven by the increasing amount of knowledge and research and the status accorded to highly specialised practitioners by physicians and laypeople. Therefore, instead of addressing multimorbidity, the focus lies on one or a few illnesses at a time, and this focus is related to the present physician's specialty, not to the patient's symptoms and conditions as a whole (11).

One of the cornerstones needed to perform a CGA is geriatric competence. This is needed to detect, diagnose, and treat geriatric syndromes (12), but generally the educational level in geriatrics is low among non-geriatric specialists, despite the demographic shift to more and more old people (13).

To increase health care efficiency, several governments have changed remuneration systems dating from the 20th century, where fixed budget frames were common, to more market-oriented competitive system (14, 15). These competitive systems emphasise cost reduction and high health care production volume, using indicators such as numbers of patients seen in ambulatory services, length of in-care time, measures of accessibility, and number of treatments (15)—and to ensure quality, also registers of quality of care.

These registers are generally coupled to only one or a few illnesses, such as registers of diabetes, hip fractures, or myocardial infarctions, each having different recommendations—for instance, for pharmacotherapy, for the conditions focused on in the register—but not necessarily compatible with recommendations for other illnesses in the same person with multimorbidity. This means that producing “good quality” on the basis of follow-up in a register (such as low HbA1C in diabetes), can lead to “bad quality” for the patient (in this case, if pursuing low HbA1C increases the risk of hypoglycaemia, and consequently, frail old people are more susceptible to falls and fractures). Therefore, in general, it can be difficult to follow up quality of care of old people through registers of quality of care.

In 1969 Dr. Robert Neil Butler defined “ageism” as a prejudicial attitude towards older people (16). In many parts of the world old people are seen as feeble in mind and body, and as an economic burden to society (17). Unfortunately, this sentiment is shared by many health care professionals (18).

Taking into account all these difficult preconditions for good care of frail old people in hospital, how does it feel to be one of these patients? And how does it feel to be a health care provider taking care of them?

Material and methods

The material in this article has been collected through four substudies. The participants were frail old people in hospital or newly discharged, and health care professionals charged with their care. Altogether the material consisted of 25 one-to-one tape-recorded interviews, 18

health care staff member, 5 focus group interviews of physicians, and 26 days (between two and five hours per day) of observations in acute medical hospital wards. In three of the studies the method was mainly qualitative (19-21), and in one (22), quantitative. The methods of analysis in the qualitative studies were content analysis (23) and grounded theory (24, 25). The quantitative study was analysed with standard descriptive statistics.

Setting

The health care system in Sweden is mainly funded by income taxes (26). Sweden has 60 hospitals serving 9 million people, providing specialist care, with emergency services available 24 hours a day. Most hospitals serve a population between 50 000 and 200 000 inhabitants. The studies referred to in this article were conducted in five teaching and non-teaching hospitals in three different counties in the southeast of Sweden.

Integration of results

To interpret the results from a more general perspective, the results from the four substudies were reanalysed and recategorised. The integration meant searching for variation and similarities in the whole material. The integrated results gave new, possible explanations describing the situation for frail old people in hospital and for the feelings of the health care staff working with them. This led to a suggestion for a model to explain current state of affairs and a suggestion for a model to improve the care for frail old people in hospital, while at the same time improving the work environment for the health care staff.

Results

The interviews with the old people newly discharged from hospital showed how frail they were. Thirty-five per cent of patients were in such a poor condition that they could not participate in medical decision making (22). Furthermore, the studies showed expressions of ageism; communication with the elderly patients was truncated and often difficult to understand; frail old patients were described as “problem patients” in acute hospital wards,

because they produce unfavourable statistics and are difficult to treat. As one senior consultant said: “We have got enough trouble with the patients that are really sick!”

Old people tend to occupy beds for a long time—they are looked upon as “bed-blockers”, especially if there is a shortage of beds. The staff, especially the physicians, wants to avoid them in the emergency departments, and decisions about discharge are taken “over the head” of the patients.

As for the decision about discharge, the staff expressed it in a manner suggesting that someone else, and not themselves, had taken the decision. For instance, the senior consultant spoke to an 89-year-old woman suffering from anaemia and heart failure: “One could think that it would be good if you went home today, think about it!”—and then there was no further communication about the discharge decision.

The health care staff expressed that they have little knowledge of all the medications that these patients often have. They are also aware that older patients are in need of more time for communication and a more holistic perspective than they can give. As the staff feels forced to dismiss them hastily, they often feel uncomfortable while doing so.

A special problem was language, as many physicians are not from Sweden (19, 22). Several patients described bad experiences in emergency wards, with long waiting times and elderly patients receiving a low priority (19). Sometimes the patients felt unwelcome, as if they were a burden to the health care system, and also that they were not listened to or given the chance to explain their symptoms. A 90-year old woman in a medical ward related: “They just want to get rid of me. That is how it is.”

This was particularly a problem when the symptoms did not “belong” to the ward to which the patient was admitted, such as urinary incontinence in an internal medical ward.

In focus group interviews with physicians there were both expressions of lack of interest and knowledge about “frail old people”, and also frustration and feelings of guilt about taking care of these patients. The physicians reported lack of a holistic view, lack of geriatric competence, lack of beds, and above all, the remuneration system, as responsible for the bad quality of care

of old people. The physicians felt haunted by the remuneration system that forced them to meet health care production targets, including fast discharges. They were appreciated by the health care administrators when they could avoid having patients who would result in poor quality metrics.

It can be an orthopaedic, surgical, or internal medical condition, but nobody wants the patient, as our remuneration system is built on the basis that the more of these patients you can avoid, the better financial results for your department. Now I will be even harder; so, it is important to effectively try to avoid these patients that will not give you any money, i.e., be tough at the emergency ward and your boss will reward you. It is not a good system we have created, not making the frail elderly feel welcome. I think that many of these patients feel unwelcome, because they are regarded by us physicians as just a cost. You are educated as a physician to take care of people, but you end up with the “knife in your back”—it is not good. (Senior consultant)

Even in this quotation there is an expression of frustration and bad conscience.

In summary the care of old people in acute care was fragmented, undignified and the patients were not welcome as they did not fit in the hospital care-system

Discussion

The main results of the study are unfortunately not unique. The results of the study is in line with the work of Winn Tadd who found that acute care is not the right place for older people and there is a failure to acknowledge that the largest group of users of hospitals are the very old, the frail and the dependent (27).

There is an observable demographic shift toward an increasing elderly population.

Convincing evidence exists that old frail people are better cared for when given holistic care based on CGA -in terms of being more likely to return home and to be discharged with better functional status compared to those who receive usual medical care (12, 28-31). It is therefore surprising that there has not been a more substantial shift from “usual care” to “care based on CGA”. also It has also been shown that costs for care based on CGA are tenable, although evidence here is sparse (12).

There can be for several explanations for the current situation. It is likely that the status-driven super-specialisation of health care and the phenomenon of ageism are very important components. To have a holistic view of a patients' total situation medically is both time-consuming and difficult because the frail old patients of today survive many more diseases and difficult conditions than those of 20 years ago, thanks to improved treatment results. At the same time it is important to remember that this need for a shift in focus of much health care is the result of many years of successful health care in the developed countries (32).

Just reading the medical record is a challenge intellectually and in terms of time expended. It is also an activity not easy to measure and follow up. On top of that, performing CGA, which requires a social, psychological, and functional perspective, needs the competence of a multiprofessional team and regular team meetings, also time-consuming and burdensome to organise, apart from being difficult to measure and remunerate.

This brings the discussion back to money. As long ago as in 1986 James Buchanan was given the Nobel Prize for his theories about "politics without romance", or "money rules" (33). To address the problem of a care system not attuned to age, it is inevitable that the remuneration system for care of frail old people has to change. When it comes to this group of patients, other indicators such as preservation of function, continuity of care, and quality of life are more appropriate. The use of these parameters in follow up is in itself time consuming, and thereby expensive, however necessary (34). Also, there is no consensus on an easy way to differentiate between robust old people and frail old people, and accordingly, who should be followed up in terms of quality of life and ADL activities, and who could be followed up in the more usual fashion?

A transition to a more age-attuned health care system is difficult also because a change in the ruling systems of power in health care will be necessary. The generalist specialities such as GPs and geriatricians must become more (or equally) appreciated than the super specialist. There must be much more education in geriatrics, which means pushing back education in other areas if not prolonging medical education.

Methodology: The results of this article are built on studies all performed in Sweden, which could diminish transferability. The results would probably not fit remuneration systems where patients pay by themselves or through private insurance schemes, however in most Western European countries, this is not the case.

Suggestions to improve care for frail old people

Based on the problems described above, there will have to be changes in the health care system. Methods will have to be devised to identify frail, elderly patients in need of care based on CGA. Such identification could be possible in several ways more fully described by Clegg and colleagues (34) but until now no valid and easy instrument has been identified, apart from the suggestion that certain diagnoses should automatically lead to screening for frailty, such as dementia and hip fracture. It should also be possible for patients to seek CGA-based health care at their own (or by their relatives) initiative, to be assessed more deeply by geriatricians or health care staff with special geriatric skills. Regardless of the method, the activity of trying to identify frail elderly patients will increase the alertness around patients in need of a more holistic (or CGA-based) healthcare.

When such patients are identified, it is essential to have a remuneration system with incentives for continuity of care and which measures health outcomes other than those used for usual care, e g quality of life and independence. Last but not least, geriatric skills need to be increased.

The figure below suggests a model for steps to improve the care of frail elderly patients.

Figure 1. A model to improve health care of frail elderly people.

The evidence for the superior outcomes of CGA-based care is convincing (12) – but many studies are quite old (30, 31). Is there a need of even more and more recent evidence, or should this change of health care come from a more political viewpoint and from the retiree organisations? The only way out of today’s inappropriate care for so many old people would probably be not to take *one* first step – but several steps in parallel, which makes it a big challenge for future health care.

References

1. EU. "Population projections" - Statistics Explained (2012/12/1) < available at: http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Population_projections 2012.
2. Marengoni A, Angleman S, Melis R, Mangialasche F, Karp A, Garmen A, et al. Aging with multimorbidity: A systematic review of the literature. *Ageing Research Reviews*. 2011;10(4):430-9.
3. Hubbard RE, Theou O. Frailty: enhancing the known knowns. *Age and Ageing*. 2012 September 1, 2012;41(5):574-5.
4. Passarelli MCG, Jacob-Filho W, Figueras A. Adverse Drug Reactions in an Elderly Hospitalised Population: Inappropriate Prescription is a Leading Cause. *Drugs & Aging*. 2005;22(9):767-77.
5. Florian Schneider, Vladimir Kaplan, Roksana Rodak, Edouard Battegay, Holzer B. Prevalence of multimorbidity in medical inpatients. Validation of estimates based on administrative data *Swiss Med Wkl*. 2012:142.
6. Ekerstad N, Edberg A, Carlsson P. Characteristics of multiple-diseased elderly in Swedish hospital care and clinical guidelines: Do they make evidence-based priority setting a “mission impossible””? . *International Journal of Ageing and Later Life*. 2008;3(2):71–95.
7. Sergi G, De Rui M, Sarti S, Manzato E. Polypharmacy in the Elderly: Can Comprehensive Geriatric Assessment Reduce Inappropriate Medication Use? *Drugs & Aging*. 2011;28(7):509-19.
8. Lampela P, Hartikainen S, Lavikainen P, Sulkava R, Huupponen R. Effects of Medication Assessment as Part of a Comprehensive Geriatric Assessment on Drug Use over a 1-Year Period: A Population-Based Intervention Study. *Drugs & Aging*. 2010;27(6):507-21.
9. Wieland D, Hirth V. Comprehensive Geriatric Assessment. *Cancer Control*. 2003;10(6):454-62.

10. Ďuriš I, Kiňová S, Murín J. The concept of general internal medicine of the Slovak Society of Internal Medicine. *European Journal of Internal Medicine*. 2000;11(3):174-6.
11. Edwards N. WHO: A report on the priorities for strengthening the hospital and health care delivery system in the WHO European region. available at http://www.euro.who.int/_data/assets/pdf_file/0007/167569/Improving-hospitals-report-FINAL.pdf. 2012.
12. Ellis G, Whitehead MA, O'Neill D, Langhorne P, D R. Comprehensive geriatric assessment for older adults admitted to hospital (Review). *The Cochrane Library*. 2011 (7).
13. Bragg EJ, Warshaw GA. ACGME Requirements for Geriatrics Medicine Curricula in Medical Specialties: Progress Made and Progress Needed. *Academic Medicine*. 2005;80(3):279-85.
14. Coulter A, Ham C. The global challenge of healthcare rationing. Buckingham: Open. University Press. 2000.
15. Harrison MI, Calltorp J. The reorientation of market-oriented reforms in Swedish health-care. *Health Policy*. 2000;50(3):219-40.
16. Wilkinson J, Ferraro K. Thirty Years of Ageism Research. In Nelson T (ed). *Ageism: Stereotyping and Prejudice Against Older Persons*. Massachusetts Institute of Technology, 2002. 2004.
17. Lovell M. Caring for the elderly: Changing perceptions and attitudes. *Journal of Vascular Nursing*. 2006;24(1):22-6.
18. Rees J, King L, Schmitz K. Nurses' Perceptions of Ethical Issues in the Care of Older People. *Nursing Ethics*. 2009 July 1, 2009;16(4):436-52.
19. Ekdahl AW, Andersson L, Friedrichsen M. "They do what they think is the best for me." Frail elderly patients' preferences for participation in their care during hospitalization. *Patient Education and Counseling*. 2010;80(2):233-40.

20. Ekdahl AW, Hellström I, Andersson L, Friedrichsen M. Too complex and time-consuming to fit in! Physicians' experiences of elderly patients and their participation in medical decision making: a grounded theory study. *BMJ Open*. 2012 January 1, 2012;2(3).
21. Ekdahl AW, Linderholm M, Hellström I, Andersson L, Friedrichsen M. 'Are decisions about discharge of elderly hospital patients mainly about freeing blocked beds?' A qualitative observational study. *BMJ Open*. 2012 January 1, 2012;2(6).
22. Ekdahl A, Andersson L, Wirehn A-B, Friedrichsen M. Are elderly people with co-morbidities involved adequately in medical decision making when hospitalised? A cross-sectional survey. *BMC Geriatrics*. 2011;11(1):46. PubMed PMID: doi:10.1186/1471-2318-11-46.
23. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*. 2004;24(2):105-12.
24. Webb C, Kevern J. Focus groups as a research method: a critique of some aspects of their use in nursing research. *Journal of Advanced Nursing*. 2001;33(6):798-805.
25. Charmaz K. *Constructing Grounded Theory - A practical guide Through Qualitative Analysis*. London: SAGE; 2006.
26. The Swedish Government: Health Care in Sweden. Available at: <http://www.sweden.se/eng/Home/Society/Health-care/Facts/Health-care-in-Sweden/> 2013 [2013/01/05].
27. Win Tadd, Alex Hillman, Sian Calnan, Mike Calnan, Tony Bayer, Read S. "Right place - wrong person: dignity in the acute care of older people". *Quality in Ageing and Older Adults*, . 2011; 12 (1):.33 - 43.
28. Baztán JJ, Suárez-García FM, López-Arrieta J, Rodríguez-Mañas L, F. R-A. Effectiveness of acute geriatric units on functional decline, living at home, and case fatality among older patients admitted to hospital for acute medical disorders: meta-analysis. *BMJ*. 2009;338:b50

29. Counsell SR, Callahan CM, Clark DO, Tu W, Buttar AB, Stump TE, et al. Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial. JAMA. 2007 December 12, 2007;298(22):2623-33.
30. Rubenstein LZ, Siu AL, Wieland D. Comprehensive geriatric assessment: toward understanding its efficacy. Aging (Milano). 1989;1(2):87 - 98.
31. Stuck AE, Siu AL, Wieland GD, Rubenstein LZ, Adams J. Comprehensive geriatric assessment: a meta-analysis of controlled trials. The Lancet. 1993;342(8878):1032-6.
32. Lloyd-Sherlock P, McKee M, Ebrahim S, Gorman M, Greengross S, Prince M, et al. Population ageing and health. The Lancet. 2012;379(9823):1295-6.
33. Buchanan J. Public choice: Politics without romance. available at: <http://www.montana.edu/econ/hfretwell/332/buchananpublicchoice.pdf>. 2003.
34. Clegg A, Young J, Iliffe S, Rikkert MO, Rockwood K. Frailty in elderly people. The Lancet. 2013 //;381(9868):752-62.