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Research paper

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 feels 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.

1. 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

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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 HbA1 C in diabetes), can lead to "bad quality" for the patient (in this case, if pursuing low HbA1 C 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?

2. 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.

2.1. 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.

2.2. 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.

3. 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