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Organ specialists coping with geriatric patients

# How to promote better care of elderly patients with multi-morbidity in Europe: A Swedish example

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ABSTRACT

How to improve the care of elderly patients with multi-morbidity, regardless of borders between medical specialities and professions, starting from the patients' point of view and ending with a powerful policy document with impact on the political system. A document written by the Swedish Association of Geriatric Medicine, the Swedish Association of General Practice and the Swedish Association of Internal Medicine.



## 1. Background

In Sweden – as in all European countries – the population is old and growing elderly. Of the 9.6 million inhabitants, 494,000 people (5.1%) are aged 80 and over, and 2,571,300 (26%) are aged 65 and over [1]. The largest increase is expected during the next decade, among the oldest persons. At the same time, the number of working-age people, those aged 20–64, will increase by just half that rate, meaning fewer people to provide for and take care of the elderly [1].

This is a challenge for society economically, with high costs for pensions and health care; politically, with the high proportion of elderly voters (in Sweden, 33%) [1]; and in matters of quality of care for the elderly, with a health care system more adapted to take care of patients with one or a few illnesses, rather than elderly patients with multi-morbidity, who instead receive fragmented care not adapted to their needs [2].

Due to these challenges, there is a growing political interest in better care for the elderly. Sometimes one hears different (more or less easy) political solutions as to how to solve the problems. These suggestions often arise out of politicians' personal experiences or as a result of information collected in a not-systematic way, with the risk of lack of consistency and inadequate coverage of the broad aspects of care of the elderly.

## 2. How did it all start?

One day, listening to a well-known Swedish politician (a doctor, too, by the way), I once again in her speech heard of some "easy solutions". After her talk I approached her and told her that I very much approved of her efforts to create a better care system for elderly residents. I said that I thought her suggestions sounded very good, but that I was afraid that they would not work when trying to realise them. Her response was: how can we as politicians know which changes to try to make in today's health care, when you doctors in the different specialities tells us different things? She had a very good point. First, I thought that doctors from different specialities were unlikely to succeed in developing a joint policy document, considering all the small battles and wars of the past decades over competence – who is going to do what and where – but after some thought I decided to give it a try. As president of the Swedish Association of Geriatric Medicine at that time, I contacted the presidents of the Swedish General Practitioners (GPs) and Internists. To my pleasure, both showed interest. The GPs were interested at once, and their president would participate herself in the work – the internists delegated the question to a board member who later left, but when a new president took over and he himself joined the work, the process was able to get under way. Two more members were recruited to the working group, the vice-president of the geriatricians association and the advisor of home care for the GPs, for a total of five persons.

During our work with the policy document, it was later showed, finding meeting times was actually harder than grappling with the contents of the document. We were very focused on the patients'

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perspective, and that helped us through most of our small disagreements. Of course, we had to negotiate and each of us gave in a little.

We started with a strong focus on the whole situation of life (getting well-cooked meals, be able to get out in the fresh air, feeling secure and living a life with dignity) – not the health care. Then we stressed the need for situation-oriented care with a holistic view – rather than a focus on different illnesses. To accomplish that aim, there is a need for many professions working in multi-professional teams, and of course, with gerontological and geriatric competence. In one point we had a structural focus, too: the need of special acute wards designed for elderly patients, with the competence of working with elderly people and in teams.

After four or five meetings, the document was completed [3] and after approval of our three medical associations, we were able to distribute the document to other medical associations and our National Medical Bulletin [4], politicians, senior citizens organisations and other professions involved in the care of the elderly. The interest from politicians was scarcely overwhelming at the beginning – but the senior citizens liked the proposals. We (mostly the president of the GPs and I) toured around the country giving presentations. Then, with our document as a base, several senior citizens organisations wrote their own joint document. This work resulted in another policy document (not translated into English) [5], in no way in conflict with our first document created by the doctors associations, but perhaps stressing more the need of multi-professional teams adapted to each patient's needs and geriatric competence. The senior citizens document strengthens the doctors document a put further pressure on the politicians to create a better care for the elderly with multi-morbidity. Below is the doctors' policy document written by the Swedish Association of General Practitioners (SAGP), Swedish Association of Geriatric Medicine (SAGM) and Swedish Association of Internal Medicine (SAIM). The document is slightly adapted to fit in the format of a scientific journal.

## 3. The policy document (translated from Swedish): better care for elderly patients with multi-morbidity[1]

Elderly patients with multi-morbidity are people who need care characterised by a holistic view, continuity and cooperation between different specialities and professions, and across organisational borders – care that would make life easier and more dignified for many patients and their relatives. It would also lead to reduced stress on the acute medical care system. This kind of care is already possible, but requires good geriatric expertise, a customised reimbursement system, improved information transfer and customised training.

### 3.1. Definition

Elderly patients with multi-morbidity are in this document defined as elderly people with complex needs of care, a care that demands tight cooperation between hospital care, primary care (family physicians and district nurses) and the care provided by the municipalities (home-help services).

### 3.2. Basic needs

First and foremost, elderly patients with multi-morbidity need living conditions and daily care, which reduce the risk of further deterioration and allow for a dignified life. Most important are a feeling of security in everyday life, the opportunity for social interaction, well-cooked and -served food and good personal hygiene, as well as access to suitable outdoor activities. In addition to these requests come the health care needs to be attended to.

### 3.3. Goals for health care

The goals for health care are as follows:

- every elderly person with multi-morbidity should have designated principal caregivers, both within the municipality's home care service and in the primary care system (home-help provider, district nurse and family physician);
- the elderly patient with multi-morbidity with greater needs should also have an appointed inpatient care provider with geriatric expertise, for inpatient care;
- For every elderly patient with multi-morbidity, a multidisciplinary and multi-professional team should be formed, based on the needs of the individual patient;
- responsible family physicians or geriatricians, or other specialists with appropriate geriatric expertise, should, in agreement with the primary care system, have prompt access to consultations with other medical specialties, this, not least, to reduce the need for the elderly person with multi-morbidity to come to the emergency or outpatient hospital departments;
- when in need of inpatient care, elderly patients with multi-morbidity shall have a special "fast track", that is, hospitalisation should be on a special ward through a direct contact between primary care and the geriatric department, and not through the emergency department;
- every elderly person with multi-morbidity shall – when needed – have access to situation-based[2] home care.

In Fig. 1 we have suggested an overall organisation map to meet the needs of elderly with multi-morbidity.

### 3.4. To achieve these goals, the following changes are needed

To achieve these goals, the following changes are needed:

- adaptation of the reimbursement systems, so that a situation-based approach is encouraged and enabled,
- establishment of systems that allow for safe and rapid transfer of information, and
- provision of resources for participation in continuing medical education customised for the needs of elderly patients with multi-morbidity and their care providers.

### 3.5. Background to today's health care of elderly with multi-morbidity

In most of the Swedish health care organisation, a disease- or diagnosis-oriented approach has developed over the years. This is an appropriate model for patients in need of occasional visits, but does not fit the needs of the elderly with multi-morbidity. They need a situation-based approach. For example, this is evident in situations when the goal of care is shifted from efforts to restore full health to efforts to achieve best possible well-being, and finally to achieve a good end of life. The point at which the transition between the different needs occurs for an individual person is difficult to predict and is influenced by many factors.

[1] For scientific and statistical purposes, the following specification has been used: persons aged 75 years and above, who have three or more diagnoses in three or more different diagnostic groups according to the classification system ICD 10, and who have been hospitalised three or more times during the past year.

[2] Situation-based care: care based on a holistic view of the person's accumulated situation of life (physical, psychological, social and functional) and in balance with accessible resources for care.