Enteral Feeding Tubes in End-Stage Dementia Patients: To Insert or not to Insert? Administrative and Financial Aspects

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In this issue of IMAJ, Leibovitz et al. [1] present yet another problem with the long-term use of nasogastric feeding tubes in the frail elderly. But a more fundamental question arises: do the present Ministry of Health guidelines for tube use in such patients make any sense at all? In the Israeli context, for historical reasons beyond the scope of this paper, the two forms of enteral feeding are perched on opposite sides of a Great Divide that separates the jurisdiction of the Ministry of Health from that of the four health management organizations. In order to fully understand the present situation in Israel, one needs to be clear as to the definitions of patients deemed either as "nursing" (*siyudi* in Hebrew) or "complex nursing" (*siyudi murcav*) [2].

As defined by the Health Ministry, "nursing" patients must meet the following requirements:

"A person with poor health and functional status as a result of chronic disease or a physical or mental deficit, and who suffers from ongoing medical problems requiring professional follow-up and that cause any of the following:

- bedfast or confined to a wheelchair
- single or double incontinence
- serious gait disorder resulting from various diseases."

In 2003, there were approximately 19,000 beds licensed for the care of such patients in Israel [3–5]. Like the Canadian and British systems, Israel's National Health Insurance Law covers payment for acute and rehabilitation care for all ages. However, should a patient require long-term institutional care, the Israeli system of subsidies (*codim* in Hebrew) is more analogous to the American Medicaid system. Here, the patient/family (in Israel including both spouse and children) must "spend down" in order to become eligible for such support [3,4]. Unlike the situation that pertains to "complex nursing" care, coverage of the "nursing" patients is *not* included in the Ministry of Health's approved basket of services and can cost the family up to 9,000 shekels per month (US$ 2,045; US$ 1 = 4.4 NIS).

Although patients belonging to either long-term category may be considered for enteral feeding, only percutaneous enterogastric tube use is allowed for "nursing" patients. Should a nasogastric tube be utilized (even if the patient exhibits no other change in medical status), the patient jumps to the higher category of "complex nursing." These patients, for whom there are approximately 1,000 beds, must meet the criteria for "nursing patients" plus any one of the following:

- pressure sore, stage II – IV
- use of an NG tube for long-term feeding
- disseminated carcinoma requiring enteral and parenteral palliative care using opiates
- continuous intravenous therapy
- on dialysis.

The situation in Israel

There are many problems, both clinical and administrative/financial, with the present situation. To begin with the clinical, many would challenge the ethics of such an intervention (either NG or PEG) in the care of an end-stage dementia patient, where enteral feeding is usually deemed futile [6]. Space does not allow us to go into the reasons for the very high rate of tube use in Israel compared to other western countries [7]. However, when such therapy is used, most authorities hold that for the patient there is no significant *medical* advantage of either technique, with each offering a similar risk-benefit equation. That being said, most clinicians would still favor PEG for aesthetic reasons and because it does not impede the patients' ability to talk or swallow. The question then arises why these feeding methods should be used to distinguish between different *levels* of care (i.e., "nursing" vs. "complex nursing"), especially since both techniques require similar amounts of nursing care. In a recent survey in which 10 senior geriatric nurses and 10 senior geriatricians in Israel were asked to grade the "heaviness" of various aspects of nursing care, almost all gave both NG and PEG an identical score of 4/4, judging the burden of care of both techniques to be identical [8].

From the administrative point of view, the present situation in many ways exacerbates the ongoing struggle between the HMOs and the Health Ministry. For example, given that a "nursing" patient is transferred to the "complex nursing" category simply by the act of having an NG tube inserted (or reverts to "nursing" status when it is removed), there exist perverse incen-

NG = nasogastric
PEG = percutaneous entergastric
HMO = health management organization

tives for the HMOs to encourage the practice of extricating the NG and/or replacing it with a PEG. In this case, the responsibility for payment for the patient's care shifts from the HMOs to the patient and the Health Ministry. In the opposite direction, it is to the advantage of the limited Ministry of Health subsidies budget to favor NG over PEG feeding.

To further complicate matters, as alluded to above, there are also significant financial implications for the patient/family depending on which choice is taken. This is so because the care of a chronic patient with an NG is included in the basket of services of the NHI law, while that for such a patient with a PEG is not. And if the situation described above were not chaotic enough, there is a financial incentive to a long-term department that is licensed for "nursing" patients to favor PEG use over NG and for the "complex nursing" department to encourage just the opposite in order not to lose their patients.

The situation can become even more absurd. For example, when Health Ministry officials come on a regulatory visit to a "nursing" unit where one of the patients has an NG tube, sometimes the ward staff actually pull out the NG tube (temporarily!) so that the Ministry supervisors will not demand that the patient be transferred to a "complex nursing" ward. In these cases, immediately after the Ministry team leaves, the NG is reinserted so that the patient can continue to "illegally" stay in the "nursing" department.

As such, each of the three interested parties – the Ministry, the HMOs, and the treating department (either "nursing" or "complex nursing") – all have differing and often conflicting goals, none of which puts the clinical needs of the patient first. To the best of my knowledge, there is no other country or health jurisdiction in the world that utilizes such a system of classification for long-term patients. And while the Israeli system is not the only one in which financial incentives can influence the placement of the feeding tubes, it is, unfortunately (given the necessity to spend down to become eligible for a "code" subsidy), the American system to which we are closest [9,10].

To make matters worse, the above-described clinical and administrative chaos constitutes only one of many problems due to the lack of full implementation of the NHI law [3,4,11]. As will be recalled, according to the 1995 NHI law, in order to regulate the above anomaly and for other related reasons, the financing of and care for the "nursing" patient were meant to be transferred from the jurisdiction of the Ministry of Health to that of the HMOs by 1998. In this way, the HMOs, which are already responsible for the major part of the spectrum of elder care (acute and rehabilitative), would be offered a powerful incentive to invest in health promotion/prevention, rehabilitation and comprehensive geriatric assessment; all this in order to minimize the number of elderly patients who would require long-term institutionalization at any level of care. To date, the law has not been fully implemented, despite many high level calls to do so, the most recent of which includes a report from the prestigious Dead Sea Conference held in 2002.

Quo vadis?

The present illogical situation provides multiple perverse incentives for both the HMOs and the Ministry of Health (as well as the Treasury) to ignore the real clinical needs of chronically ill elderly patients when classifying the level of nursing care required. Patients and their families, *if* they can understand the rules, realize the absurdity and unfairness of the present situation and understandably balk at following them. It also encourages "illegal" behavior by many long-term institutions and leads to a waste of time and energy on the part of the regulating staff of the Ministry in an attempt to enforce ludicrous and illogical regulations

Of interest is the fact that published specific recommendations on how to deal with this unfortunate situation were offered by a very sensible set of guidelines published by the Israel Medical Association [13]. They can be briefly summarized as follows:

- Provide clear, ethically sensitive guidelines for the use of enteral feeding technologies for the end-stage dementia patient. Given the universally dismal clinical prognosis of such patients, a palliative as opposed to an active approach is usually indicated. Tube feeding is not always indicated in such patients.
- Where enteral feeding is ulilized, allow only the *clinical* considerations to determine which technique is preferred. In most cases, given the similar risk-benefit equation and increased comfort and aesthetics of PEG over NG, the former technique would normally be chosen.
- Neither PEG nor NG should artificially be placed on either side of the "nursing" and "complex nursing" definitions, nor should the choice of feeding method be used (alone) to determine patient status.
- A redrawing of the definitions of the levels of long-term institutional care should be considered and investigated in the direction of the work initiated by Dwolatzky [8]. In designing these scales, the use of NG and PEG would be given equal weight.
- The NHI law should be *fully* implemented, as originally planned, to include long-term institutional care within the basket of services [10–12]. This step will, among other things, reduce the perverse incentives relating to the use and abuse of enteral feeding and increase the quality of clinical care for Israel's frail and terminally ill elderly.

Israel's frail, demented elderly, especially those in long-term care, deserve a better deal. They are already sick and have lost not only their homes but their independence as well. It is tragic that in a matter as basic as feeding, so many suffer from an administrative quagmire that honors no one and provides so little comfort – to both patients are their families.

NIH = National Health Insurance

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