To: 5.1.2e , 5.1.2e . (5.1.2e)[5.1.2e @minvws.nl]; 5.1.2e @radboudumc.nl[5.1.2e @radboudumc.nl]; 5.1.2e . (5.1.2e)[5.1.2e @minvws.nl]
Cc: 5.1.2e @radboudumc.nl[5.1.2e @radboudumc.nl]; 5.1.2e . (5.1.2e)[5.1.2e @minvws.nl]
From: 5.1.2e 5.1.2e 5.1.2e 5.1.2e 5.1.2e)
Sent: Tue 12/8/2020 3:29:45 PM
Subject: RE: hogere overlijdingskans 80+ in Nederland
Received: Tue 12/8/2020 3:29:45 PM

Wat is het causale verband?
Mijn indruk is dat in NL het beleid is dat er veel kritischer wordt gekeken naar het nut van behandelen op de IC. Veel scherper wordt gekeken of er behandeld gaat worden en ook hoelang een behandeling wordt doorgezet. Dat is de gemeenschappelijke oorzaak van zowel een kleiner aantal IC-bedden als een groter aantal overlijdens.

Van: 5.1.2e , 5.1.2e . (5.1.2e) < 5.1.2e @minvws.nl>
Verzonden: dinsdag 8 december 2020 11:28
Aan: 5.1.2e @radboudumc.nl; 5.1.2e , 5.1.2e . (5.1.2e) < 5.1.2e @minvws.nl>; 5.1.2e 5.1.2e 5.1.2e 5.1.2e 5.1.2e) < 5.1.2e @minvws.nl>
CC: 5.1.2e @radboudumc.nl; 5.1.2e , 5.1.2e . (5.1.2e) < 5.1.2e @minvws.nl>
Onderwerp: FW: hogere overlijdingskans 80+ in Nederland

Hoi 5.1.2e e.a.,

Ik ben niet overtuigd van de conclusie die er getrokken wordt, dat uit het feit dat er op de Duitse IC's er relatief meer 80+-ers liggen (tov andere leeftijdsgroepen) dan in Nederland en in Nederland 80+-ers mogelijk uitgesloten *kunnen* worden van behandeling op de IC, verklaart waarom er relatief meer 80+-ers zijn overleden in Nederland dan in Duitsland.

1. Allereerst is het aandeel 80+-ers van de totale bevolking in Duitsland en Portugal een stuk hoger dan in Nederland en Verenigd Koninkrijk (zie onderstaande tabel): logisch dus dat er in Duitsland relatief meer 80+-er op de IC liggen dan in Nederland.
2. Verder zou er voor de andere leeftijdsgroepen moeten worden gekeken of ook daar relatief minder patiënten zijn overleden: volgens mij scoort Duitsland overall veel lager qua Covid-19 slachtoffers. In dat geval is het maar de vraag in hoeverre het beeld bij de groep van 80+ afwijkt van die van bijv. 65-80 jaar.
3. En als voor de 80+-ers er een ander patroon is te zien dan voor andere leeftijdsgroepen, weet ik niet of de triage voor IC-bedden daar een oorzaak van is. Ik denk eerder dat er in een verpleeghuis een afweging wordt gemaakt om de zorg van heel kwetsbaar ouderen niet over te dragen aan een ziekenhuis, juist met het oog op de kwaliteit van het (nog resterende) leven; dat geldt in ieder geval voor veel non-Covidpatiënten aan het einde van het leven.
4. Daarbij komt dat in Duitsland veel kwetsbare ouderen vaak al min of meer op het ziekenhuisterrein wonen en de dagelijkse verpleegzorg onder de ziekenhuiszorg valt (zie KvZ-notitie uit 2015). Het is dan ook een veel minder grote stap om, als er voldoende capaciteit is, in het ziekenhuis resp. IC opgenomen te worden. Hoe dat voor Portugal zit, weet ik niet.

	Aandeel 80+-ers van de totale bevolking
Portugal	**6,4%**
Germany	**6,3%**
France	6,0%
Belgium	5,6%
Switzerland	5,2%
Sweden	5,1%
United Kingdom	**5,0%**
Netherlands	**4,6%**

Los hiervan blijft het een hele interessante vraag waarom in Duitsland het totaal aantal Covid-19 slachtoffers per 100.000 inwoners zo veel lager ligt dan in Nederland: 22 op 100.000 versus. 56 op 100.000 inwoners, terwijl Duitsland binnen Europa voorop loopt

qua vergrijzing.

Vriendelijke groeten van 5.1.2e

Van: 5.1.2e 5.1.2e 5.1.2e 5.1.2e 5.1.2e) < 5.1.2e @minvws.nl>
Verzonden: maandag 7 december 2020 13:54
Aan: 5.1.2e @radboudumc.nl; 5.1.2e , 5.1.2e . (5.1.2e) < 5.1.2e @minvws.nl>; 5.1.2e , 5.1.2e . (5.1.2e) < 5.1.2e @minvws.nl>
CC: 5.1.2e @radboudumc.nl; 5.1.2e , 5.1.2e . (5.1.2e) < 5.1.2e @minvws.nl>
Onderwerp: RE: hogere overlijdingskans 80+ in Nederland

Dank voor doorsturen, heel interessant. Ik haak 5.1.2e ook aan.
Zonder aan deze cijfers iets af te doen, is er ook iets bekend over de kwaliteit van leven na behandeling van 80+ers voor Covid? Zijn daar grote internationale verschillen?

5.1.2e

Van: 5.1.2e @radboudumc.nl < 5.1.2e @radboudumc.nl>
Verzonden: maandag 7 december 2020 11:10
Aan: 5.1.2e 5.1.2e 5.1.2e 5.1.2e 5.1.2e) < 5.1.2e @minvws.nl>; 5.1.2e , 5.1.2e . (5.1.2e) < 5.1.2e @minvws.nl>; 5.1.2e , 5.1.2e . (5.1.2e) < 5.1.2e @minvws.nl>
CC: 5.1.2e @radboudumc.nl
Onderwerp: hogere overlijdingskans 80+ in Nederland

Zie onder een analyse (horen ook grafieken bij) waar wordt gesteld dat de kans op overlijden van 80+ veel hoger is in landen met minder ICU bedden, waaronder dus Nederland door (impliciete) rationering.

Special report: How rationing care in the pandemic is killing the elderly

Rachel Lewis NOVEMBER 26, 2020

People over the age of 80 are up to three times more likely to die of a COVID-19 infection in countries using rigid rationing guidelines that can exclude the elderly from intensive care – and sometimes even from hospital. HBI's extensive analysis of death, hospital and ICU data reveals that Sweden has lost eight times more, England seven and the Netherlands six of its elderly population compared to Germany. In a special report, we explore how rationing killed the elderly.

An imminent threat of resources scarcity hit the European healthcare sector in mid-March when doctors in Lombardy had to decide who lived and who died. Wheezing patients had to be treated on the floors of Madrid's hospitals and care homes across Europe were forced to accept COVID-19 patients to clear hospital beds. Triage guidelines started to circulate – officially or not – typically setting a ceiling of care dependent on age and co-morbidities.

The impact on deaths is clear: countries with widespread evidence of rationing medical care have seen far higher fatality rates among the elderly. Germany, Portugal, and Switzerland have the lowest fatality rates of countries studied, with 13% of people aged 80+ who have a confirmed COVID-19 infection dying. That person would be three times more likely to die in England and twice as likely in Sweden, the Netherlands, and Belgium.

Throughout the first wave, rationing came at all stages of the patient pathway. In the UK, an unofficial points-based system counted age and chronic morbidities to decide a ceiling of care. A patient scoring eight or above was excluded from ICU: anybody over the age of 80 was automatically given nine points. The guidelines

recommended domiciliary care and face-mask oxygen for the frailest and most vulnerable, thus de-medicalising COVID-19 therapy. It is not clear how many elderly got such treatment at home when ambulances refused to transport them to the hospital.

Attempts to push treatment into the community were made elsewhere. In Sweden, up to 12 August, just 17% of people who lived in social housing and died of COVID-19 had received inpatient care and in Belgium two-thirds of its deaths were care home residents. "Until the end of March, it didn't even occur to us to send people to the hospital," said Geert Uytterschaut, a director of VLOZO, which represents the elderly care sector in Flemish Belgium.

Germany consistently gave older people access to medical treatment for COVID-19. Nearly a quarter of all mechanically ventilated patients from one study were over the age of 80 in Germany, and a third were between the ages of 70-79. Another cohort saw identical intubation proportions, but also saw that the over-80s made up 34% of hospital admissions and 28% of ICU admissions.

This is in stark contrast to Lombardy at its peak, where the over-80s accounted for just 1% of ICU admissions and intubations, and England where, in May, it was 2.6%, increasing to 5.5% in September.

In contrast to the UK's guidelines, Germany's ethics guidelines (from its Interdisciplinary Association of Intensive Care Medicine) say that only when ventilators run out should decisions be made based on perceived chances of successful ventilation. "This is not about life expectancy in the medium or long term but about as many people as possible surviving," its president Uwe Janssens told DW. "And by that, we mean everyone: disabled people, old people, young people, those with dementia — all those who have a real chance of surviving."

Its constitution says that human lives must not be measured against other lives, meaning that age, chronic illness or disability should not be factors for discrimination. For instance, all the over-80s not intubated in one German cohort had specific do-not-intubate (DNI) orders: there was no blanket ban.

Gender, ethnicity, and co-morbidities are widely cited as prominent risk factors by academics across Europe but age is always singled out. "Older age stands out as the strongest risk factor for all outcomes especially for death as absolute is risk was small for those younger than 50," said research on 20k COVID-19 patients in Portugal. "Increasing age after 60 years was the greatest determinant for all outcomes. Being aged 80-89 years was the strongest determinant of hospital admission, 70-79 years for ICU and over 90 years for death."

Outcomes for older people with mechanical ventilation are actually virtually identical in England and Germany. Around 3 in 10 of the over 80s survive, 4 in 10 of the 70-79s, and slightly more than half of 60-69s, suggests research from 10,000 publicly insured patients in Germany and a weekly report by ICNARC (The Intensive Care National Audit & Research Centre) for England, Wales and Northern Ireland.

Germany does have the luxury of about six times as many ICU beds as the UK and seven times that of Sweden. In at least one German state, politicians suggest that rationing should be seen as a planning failure, rather than a clinical support tool. "Our primary goal is to save the hospitals from having to make a decision about admission between two patients due to a lack of capacity," said Saarland premier Tobias Hans in November, when briefing on staff shortages.

But academics in Germany point out that putting the elderly in hospitals has another benefit: isolating any confirmed infections to avoid outbreaks in long-term and elderly care facilities. Indeed, as an academic in Portugal points out, age being the biggest risk indicator has "implications in terms of risk-stratified public health measures that should prioritise protecting older people although preventive behaviour is needed in all ages."

Excess deaths through the first wave show just how much older people, in this case, people over the age of 65, died at higher excess rates than younger cohorts. This captures deaths from COVID-19 that didn't have a positive diagnosis, as testing regimes differ across time and geographies, but also captures the extra deaths from non-COVID causes.

Particularly in the UK, rationing has infiltrated the public conscience. The government slogan 'Stay Home. Protect the NHS. Save Lives' has partly caused a 50% drop in heart attack A&E attendances, according to charity the British Heart Foundation, and rising cancer waiting lists. While some screening and primary care activity has dipped in most countries, systems with rationing will likely see far higher non-COVID related deaths going forward.

We would welcome your thoughts on this story. Email your views to Rachel Lewis or call 0207 183 3779.

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