Critical Age Theory: Institutional Abuse of Older People in Health Care

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ABSTRACT

Theories of elder abuse focus on the characteristics of the victim, the perpetrator, and the context of abuse. Although all three factors play a role, we are biased to notice individual misbehavior as the primary and sole cause of abuse. We see individuals as responsible for abuse. By examining abuses across a spectrum of healthcare services, abuse is more likely to be due to the institutional culture that includes the use of medications, Assisted Living, Skilled Nursing Facilities/nursing homes, hospices, hospitals, and Medicare Advantage programs. This study highlights multiple and consistent institutional abuses that result in harm and death of older adults on a consistent basis. The results show that when profit is increased, standards of care are diminished, and abuse ensues. Assigning responsibility to the management of healthcare becomes a priority in reducing this level of abuse. However, there are biases that stop us from assigning blame to institutions. Individual healthcare workers adhere to work protocol and rationalize the negative outcomes as inevitable or due to the vulnerability and frailness of older people. This culture is socialized for new employees that develop a culture of diminishing the needs of the individual patient in favor of the priorities dictated by the management protocol. In addition, the public is focused on assigning blame to individuals. Once an individual is assigned blame then they do not look beyond that to understand the context of abuse. A context that is generated by healthcare facilities maximizing profit and denigrating patient care. Regulatory agencies such as the U.S. DHHS, CDC, State Public Health Agencies, State/City Elder Abuse units, and Ombudsmen Programs all collude, for multiple reasons, in diminishing institutional responsibility.

Keywords: Conformity, elder abuse, iatrogenic, medical profiteering.

I. INTRODUCTION

Elder abuse—the harming of older adults—has many definitions that includes, domestic violence, family violence, intimate partner violence, institutional abuse, granny bashing, elder mistreatment, elder abuse, and neglect. Such diversity in terms results in ‘definitional chaos’ [1]. The problem emerges when we try to specify a generic understanding of abuse. For example, the World Health Organization defines elder abuse as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.” [2]. The ambivalence lies in how to define operational terms such as relationship, trust, harm, and distress. These might seem intuitive adjectives, but they are difficult psychometric constructs.

Within this chaos of scientific definitions lies semantic variances in how to define the act of abuse outside of the clinical settings. Variances exist between the legal and clinical (shouting might be considered abuse in a legal setting but difficult to define in a clinical setting when nursing staff shout at hard-of-hearing residents); individual and community (a couple might have a contentious relationship privately that would be judged abusive in public); cultural and moral (some cultures allow family members to dictate the management of parent’s private affairs without consent of their parents); historical and present (a perpetrator might have been abused by the victim earlier in their relationship); young and old definition of abuse (while smacking children is legal in most countries, it is considered abusive when performed on older adults.) The context of abuse emerges as a pivotal factor in elder abuse and forms the basis for Critical Age Theory. “Critical” refers to abuse that is part of the institutional culture, “age” is that we see such abuse more prevalent for those over 65 years of age, and “theory” refers to the predictive ability of this approach, where abuse is anticipated.

There is also the sociological problem in defining the amount of abuse that triggers the definition-variances in how the perpetrator is identified, how they are reported to the authorities, how the claim is investigated, and the consequences of being found guilty for both the victim and the perpetrator. All of these uncertainties become academic once the law is involved since the sole purpose of the law then is to identify the perpetrator and bring about “justice.” Once
there is evidence of trauma and hurt, the legal system employs confirmatory bias to channel all efforts to identify the perpetrator that caused the harm. This confirmatory bias forms the only methodology in prosecuting elderly abuse, a bias established to prove that the perpetrator is guilty or otherwise. However, this confirmatory bias methodology is not valid for scientific studies. In addition, justice is hard to establish as abused older adults never reclaim what they have lost. In addition, Critical Age Theory argues that institutional abuse is hidden from, colluded with, and ignored by authorities.

Elder abuse has no universal age cut-off for defining who is considered an “elder.” In some cases, elder abuse is studied among victims who are 55 years and older [3]-[5]. Some researchers and practitioners use 60 years and older [6], [7], while most others use 65 years.

One outcome that elder abuse victim share is the many long-term negative consequences-both health and economic-as a result of the abuse. These also include a higher rate of mortality. However, these outcomes are always mediated by other factors such as gender, age, ethnicity, income, smoking, alcohol, depression, and poorer social network [8], [9]. Under certain conditions abused older adults have a higher rate of morbidities and mortality [10], [11], and more likely to experience disability [12], hospitalization [13], and nursing home placement [14]. Because victims never reclaim what they have lost, justice in elder abuse is punitive rather than restorative. Again, the legal system is a poor system to prevent abuse and is deficient in promoting scientific knowledge. As Critical Age Theory will show, the legal system can be malleable and manipulated to hide abuse despite the fact that older people are constantly being harmed in their thousands every day.

Within academia, abuse is studied not to bring about retribution, but to try and prevent it by understanding its precursors and antecedents and to understand the mechanism of affect—the emotional context of the abuse. But since elder abuse is on the increase, it seems that we have not yet understood enough of its precursors and antecedents to contribute to the prevention and flatten the curve. A theory of abuse must help in identifying paths for mitigating this projected increase in abuse. Critical Age Theory has the potential to drastically reduce the abuse of older adults today.

II. THEORIES

A recent review identified thirteen theories of elder abuse [15], although “…it is unlikely that any single theoretical perspective could explain all forms and situations [of abuse]” [16]. As with any social interaction, there are many variables, and some variables might be more prominent than others in some situations. Traditional types of elder abuse include physical, sexual, psychological, and financial abuse, neglect, abandonment, and self-neglect [17]. However, abuse is usually studied under three prisms, based on the victim, perpetrator, and context. One of the oversights from these approaches-one that Critical Age Theory promotes-is that of institutional abuse which will be the focus of this study.

III. VICTIM

The main theory of abuse that focuses on the victim relates to their frailty and isolation as an antecedent of abuse. Because frail older adults require regular assistance-because of physical or mental limitations-they are more likely to be exposed to interactions that might turn out to be abusive. Older adults who are frail are two and a half times more likely to be abused [18]. In addition, a systematic review of six studies reported that in the past year between 11% and 19% of older people with dementia or depression experienced physical and psychological abuse respectively [19]. Similarly, those patients that were referred to geriatric psychiatry services-and therefore have psychiatric issues-were ten times more likely to experience abuse if they were living with a non-spouse, compared to living with their spouse or in a supervised setting [20]. While being widowed, divorced, or separated resulted in being five times more likelihood of being abused than married patients [20]. Since the *modus operandi* of abusers (including child abuse) involve isolating the victim, the more isolated, frail, and dependent the older adult becomes, the easier it is for the abuse to be carried out. This Opportunistic Theory [21]-can also be viewed as Convenience Theory, and Routine Activity Theory [22]-suggests that it is more an issue of the context rather than the perpetrator, however, in some cases the perpetrator manages to isolate the victim and therefore they manipulate the context. The perpetrator is the cause of the victim’s isolation.

The victims themselves might behave in ways that increase their likelihood of being abused. For example, in the Opportunistic Theory, it could be that not only the perpetrator isolates the victim, but that the older adult tend to isolate themselves. This Disengagement Theory [23] suggest that as people get older they tend to cut off engaging in civic activities. Disengagement is made worse by substance abuse [24] which may also cause provocative or difficult behavior [25] resulting in 70% of self-neglect cases. Substance abuse also contributes to abuse by others by reducing the ability to function. There are consequences of certain characteristics of the victim that attract abuse.

Even with this introduction, starting with the study of abuse from a victim’s perceptive it quickly emerges that the victim’s perspective is not isolated from the perpetrators or the context. All these factors inter-relate. The context is primarily centered on the victim, but many factors impinge upon the context.

IV. PERPETRATOR

Although most frail older adults receiving care at home are cared for appropriately when the burden of their care falls to others who are either incapable, unable, or unwilling to perform these services the outcome is likely to result in either abuse or neglect [26]. Since only some caregivers become abusive, the easiest explanation is that the abuser has a psychiatric problem for abusing their older adult charge. This Psychopathology of the Caregiver Theory [27], [28] argues that caregivers lack the ability to make appropriate judgments. It is also likely that the added strain placed on the caregiver unbalances their judgment. In the Role
Accumulation Theory [29] family members that might be unwilling to take over the added task of looking after a frail family member might become overwhelmed with the additional responsibilities. These theories suggest that under certain circumstances, the caregiver becomes overwhelmed and the stress spills into acts of abuse. This is similar to Situational Theory [30] where the caregiver gets overburdened by the situation that they find themselves in. If all caregivers become abusive under situational stressful conditions, then this becomes context-bound rather than perpetrator-bound, but the distinction is not clear-cut. Some caregivers are predisposed to abuse and the added strain and perhaps the increasing frailty of the older adult brings about the opportunity for abuse.

It could also be that the perpetrator has learned to behave in an abusive way from their upbringing. The most important theory in the literature is Social Learning Theory [31] also known as intergenerational transmission of violence, transgenerational theory, and the cycle of violence. Given its prominence in the literature, it is surprising to find that Social Learning Theory is rarely applied in elder abuse because of the legal emphasis on elder abuse. Because most elder abuse cases must be brought to the court, by suggesting that the perpetrator could have possibly learned this behavior from the victim at previous times in their association, diminishes a legal case. Acknowledging that little research is done outside of the legal system-it is important to realize that Adult Protective Services is a legal entity-research in the social psychology of learned behavior is sparse. However, Social Learning Theory [32] strongly predicts that abuse is a method of coping with stress that is learned from previous generations. Especially under Stress Theory where perpetrators who suffer from mental or physical deficiencies do not have sufficient coping strategies with mounting stress and they end up expressing this stress through violence [33].

All of these theories suggest that the perpetrator is less accountable for the abuse as their behavior might have been learned while interacting with the victim at early periods in life. One evidence that social learning theory might be more significant than it is given credit for is the method used to “other” the potential victim. Research shows that the perpetrator using a method to diminish the (older) victim is to treat them as children and possibly indicates how the perpetrator themselves were treated. In this context, the caregiver diminishes the victim by interacting with the older adult as if they are a child. This Infantilization Theory [34] involves a person of authority using baby talk, patronizing type of speech, using overly familiar forms of address, such as pet names, and publicly disclosing the client’s personal and medical information in front of the older person, ignoring the person, and using inappropriate-age activities [35], [36]. By diminishing the other person to an infant status, a diminished status, it becomes that much easier to then behave in a dominant and abusive way with them.

Theories that focus on the perpetrator provide a dual version of responsibility. One where the perpetrator has some psychiatric or psychological deficits and an alternative version where the perpetrator has learned this abusive behavior from earlier interactions either with the victim or with other older adults.

V. CONTEXT

Most theories focus on the context of the caregiving situation. Critical Age Theory—where institutions promote elder abuse falls within this broad category of theories. A potentially abusive perpetrator or a frail and potentially vulnerable older adult might never be in a context where the perpetrator has an opportunity to abuse the older adult.

One of the oldest theories of abuse emerges from Feminist Theory which suggests that in general, older women are disproportionately affected by disability, poverty, and violence including elder abuse. Despite great variation and lack of robust data, in a systematic global review of self-reported elder abuse by community-dwelling older women about 1 in 6 women experiences abuse across the world [37]. Feminist Theory also includes Domestic Violence Theory which reflects domestic violence that continues into older age [38]. This dynamic is part of a larger cultural expectation about the role of women and later, about the role of older adults. Such expectations in explaining elder abuse are covered by Symbolic Interactionism Theory which suggests that our cultural expectations-stereotypes, prejudices, and roles-determine how we interact in a social environment and that these expectations undervalue older adults, especially older women. Culture influences the perpetrator’s relationship with an adult as the age and as their individual roles change. These are part of the larger macro-perspective theories of elder abuse. These theories are not specifically designed to explain elder abuse but they contribute a broad view of how elder abuse can be culturally sanctioned. Such theories include Political-Economy Theory [39], Ecological Theory [40], as well as the Social Exchange Theory [41]. All these theories suggest that the mutual dependence between older adults and their caregivers opens up the likelihood of abuse when expectations are not reached especially once older adults retire and start relying on others. Stratification Theory suggests that there is a disparity in terms of the social class strata that caregivers and their care recipients occupy. Caregivers' low education and low job satisfaction contribute to a coping strategy that results in abuse [42]. These broad theories argue that older adults are marginalized in society with the consequence that there is a higher tolerance for abuse. Not only is elder abuse less recognized by the public and law enforcement as a serious crime but there is less motivation to intervene [43]. In contrast, social support and social cohesion are associated with a lower incidence of elder abuse [44]. Trust within the community lessens the risk of abuse.

All of these factors/precursors compound and influence each other but they leave one aspect that occupies a more macro view of abuse. One macro perspective is the institutional aspect—how institutions are designed in a way that generates abusive outcomes. Critical Age Theory refers to how institutions cause abuse to older adults sometimes regardless of individual staff.

In one of the first rigorous estimates of elder abuse in the institutions based on self-reports by older residents and staff [45] found that a third of residents reported that they were the victim of abuse, while more than half of the staff (64%) admitted to conducting elder abuse over the past year. These estimates are on the low-end but consistent with the anecdotal evidence and the belief that abuse in residential facilities for
older people is widespread [46], [47]. The prevalence of elder abuse in institutional care settings ranges from 31% in Israel for overall abuse [48] to 86.9% for neglect in the USA [49] and 53.7% for psychological abuse and neglect in Germany [50] to 78.8% for overall abuse [51].

VI. CRITICAL AGE THEORY

Critical Age Theory is distinct from abuse that happens “at” an institution but instead focuses on abuse that is “determined” by an institution. For example, if under normal conditions three nurse aides care for a ward of 20 older patients with few negative health outcomes then by reducing the number of nurse aides to one we can predict that the level and quality of care will decline leading to diminished health and in some cases death of residents. This is institutional abuse. The argument is whether the abuse was intended or an unintended side effect of cutting staff. In legal circles intent matters, but in health, it does not. Whether you are aware or not that smoking causes lung cancer, the probability of lung cancer will increase with smoking. Similarly, Critical Age Theory predicts that any reasonable person will see that reducing staff will have predictable negative consequences on patients. Culpability can be defined under three stages of men rea starting with being negligent or careless, then being reckless and having knowledge of consequences, and at the end having purpose or intent.

The reason behind reducing staff is to increase profits. Some owners of older adult facilities argue that their ambition to generate profit justifies the negative outcomes. Long-term care facilities have specific laws protecting residents and their “right to be free” from abuse, neglect, or exploitation [52] but there is a much larger picture. Because institutional abuse is the result of the ambition for higher profits, established practices to reduce costs is reckless and directly provoke conditions that promote abuse.

One of the best lessons to help us see the difference between individual intent and institutional bias is a widely shared study conducted by the Institutes of Medicine in 2003. The report Unequal Treatment looked at racism in the healthcare setting [53]. The report found many examples of the mistreatment of racial minorities. This did not mean that doctors and nurses in the U.S. are racist. What it means is that there exists an unrecognized bias against members of a social group that affects communication and ultimately the care offered to those individuals. This subtle bias creates large discrepancies. What the report highlighted is that such implicit bias can operate without a person’s intent or awareness. Critical Age Theory similarly implies that there is an implicit acceptance of protocols such as reducing staff, hiring lower qualified and cheaper staff, accepting more frail and vulnerable patients, increasing the volume of patients, and reducing services and visits, all of which ultimately promote abuse.

Individuals working in the healthcare industry are mostly motivated by altruism. Their career path is designed to better the world by providing care to the most vulnerable and sick. In contrast, the sole motivation for the healthcare industry they operate under is to generate profit. Older adults are the primary consumers of health care and the most lucrative consumers, as a result, evidence of institutional abuse is overwhelming among this population. Prosecuting abuse when there is little evidence other than obvious outcome (e.g., bedsores, death) proves complicated and time-consuming for district attorneys with limited time and shrinking resources as there are so many layers it is difficult to identify the responsible party. It is abuse undertaken in unison by the many layers that make-up an institution.

Most of these institutional abuses are a direct result of following procedures to increase revenue and/or reduce costs. This objective became immortalized in a 1970 essay for The New York Times entitled "A Friedman Doctrine: The Social Responsibility of Business is to Increase Its Profits." After the COVID-19 pandemic in mid-2021, when visitation was reinstated in nursing homes, 87 percent of families reported that their loved one showed a decline in physical appearance, including significant weight loss, the rigidity of limbs from lack of activity, and pressure sores. In addition, families reported that their loved one had significant cognitive decline, suicidal thoughts, and seemed drugged and/or non-responsive. Most families (69%) stated that the facility had insufficient staff to care for residents, noting that residents were dirty, ungroomed, and lacking basic care and hygiene. While some families (40%) noted that their loved ones were missing dentures, glasses, and clothes [54]. What happened was abuse at a scale that is difficult to comprehend because we personalize our narrative and overlook institutional abuse.

Similarly, institutional abuse hides under the cloak of their business model. But it is the business model that dictates the quality of health care provided, when abuse occurs, we hold individuals accountable not the business model. We are inclined to see the individual as responsible and to deny the importance of the work environment and the work culture that they are functioning within. The following examination presents an array of institutional environments that are culpable in abusing older adults, from Medications, Assisted Living, Nursing Homes, Hospice, and finally Medicare Advantage.

VII. MEDICATIONS

Health care is provided across a broad array of services. Most of the health care costs are on hospital care (31%), followed by physician and clinical services (20%), while prescription drugs consume 10% of the costs. Residential care, personal care services, nursing care facilities, and Continuing Care Retirement Communities each share 5% of costs. Prescription drugs are number three on the cost of health care. In 2019, the pharmaceutical industry spent $83 billion dollars on research and development, with some 59 new drugs introduced in 2018 [55]. The United States spends more on prescription drugs per person than most other countries. We pay more for less and only Japan and Mexico had higher relative prices [56].

From 1994 to 2014 the proportion of older adults taking five or more drugs tripled from 14% to 42% [57]. With half the older population already taking more than 5 drugs daily the risk of adverse drug reactions increases by a third (35%) [58]. Polypharmacy--taking multiple medications--contributes to the development of frailty [59], and increases medical errors [60]. These negative outcomes are on top of the existing conditions that they are taking the medications for

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which by themselves could be dangerous.

Older adults are the primary users of pharmacology and they are also more likely than younger people to react adversely to drugs [62], and they are also more likely to be admitted to hospitals or die because of adverse reactions. One in ten hospital readmissions is due to adverse drug reactions among community-dwelling older adults [61]. Polypharmacy, inappropriate prescribing, and lack of monitoring of medications further predispose older adults to adverse drug reactions. Around a third (30%) of hospital admissions of older adults are drug-related, with more than 11% attributed to medication non-adherence and 10–17% related to adverse drug reactions. Older adults discharged from the hospital, on a regime of more than five drugs, are more likely to be re-hospitalized during the first 6 months. Older adults are nearly seven times more likely than younger persons to be hospitalized after an emergency visit, caused mainly by blood thinners, diabetes medications, seizure medications, and opioid analogies [63]. Each year in the United States approximately 1.3 million emergency department visits and 350,000 hospitalizations result in $3.5 billion in excess medical costs [64]. Adverse drug events occur in 15 percent or more of older patients presenting to offices, hospitals, and extended care facilities. These events are potentially preventable half of the time and include hospitalization include falls, orthostatic hypotension, heart failure, and delirium [65]. We know many probable causes of older medication abuse, and sadly, little is done to mitigate them. Institutional abuse of medications is through over-marketing of medications, prescribing medications that are inappropriate, dangerous, expensive, and confusing to vulnerable older adults that we know, have difficulty following the necessary medication regime. Profit seems to drive this growth rather than efficacy or quality of life.

The continuing and growing demand for medications reflects the growth of older adults with chronic diseases. The growth is also reflected in the pharmaceutical market, growth that is built on demand primarily by older adults. The market has been growing at an annual rate of 5.8% since 2017 when it posted a revenue of $1.1 trillion and reached $1.5 trillion in 2021 [66]. On an investment of $83 billion, the margin for profit is spectacular. Drugs related to age-related and chronic diseases are seeing the largest growth such as cholesterol-lowering drugs that had nearly quadrupled, use of antidepressant, antihypertensive and antidiabetic drugs nearly doubled in industrialized countries [67]. Big pharma is getting bigger and problems with medications among older adults are mirroring this growth.

Every few years the American Geriatrics Society releases an updated and expanded BEERS Criteria, that lists inappropriate medications for older adults from reviewing over 6,700 clinical studies. The latest available in 2019 named a total of 8,094 potentially inappropriate medications that harm older adults, 581 more than what they found in 2015 [68]. That is 8,094 potentially inappropriate medications that are still being prescribed today for older adults.

This is further complicated since nearly half of prescription users also take at least one over-the-counter medication and a third of older adults additional use herbal or dietary supplements (e.g., ginseng, gingko biloba extract, and glucosamine). All of these may interact with prescription drugs and lead to adverse events.

We do not know all of the ill effects of medications on older adults, especially among older women, because these drugs are rarely if ever, tested among older adults, especially among women. In 2021 a new drug Aduhelm (aducanumab its clinical trial name) was approved for Alzheimer’s disease by the U.S. Food and Drug Administration (FDA) despite all members of the FDA’s Advisory Committee rejecting the drug. This is difficult to understand both clinically and statistically how we got to a situation where the government approves a drug that is both minimal useful and extraordinarily dangerous, and if economically successful will bankrupt Medicare [69]. A quick review of the researchers involved in the FDA’s decision shows conflicts of interest [70]. Predictions indicate that by prescribing Aduhelm, Medicare will be paying nearly $29 billion in just one year matching three-quarters of Medicare’s total spending for all Part B drugs [71]. There is no explanation other than to generate profit.

Providing medication without the appropriate supervision results in negative outcomes. Culpability is known, but the zeal for profit goes beyond providing dangerous, ineffective drugs to people with dementia, it also extends to giving medications to people who are not yet sick. Preventive pharmacy is a euphemism that makes all of us potential customers by addressing problems that might never emerge. Although this might make the perfect marketing strategy it is however a dangerous health strategy. Pharmacological industries are culpable in the abuse as the outcomes of prescribing multiple medications to a vulnerable population are known and predictable. A problem that will continue to surge as consumption of medicine increases.

VIII. ASSISTED LIVING-AL

In 2016, there were 65,600 long-term care service providers serving over 8.3 million people in the U.S. There were 4,600 adult day services centers, 12,200 home health agencies, 4,300 hospices, 15,600 nursing homes, 28,900 assisted living (AL) and similar residential care communities [72]. That same year there were an estimated 286,300 participants in adult day services centers, 1,347,600 nursing home residents, and 811,500 residents living in residential care communities [72]. Older people are large consumers of care.

AL is the first stage in Long-Term Care, traditionally a step away from a Skilled Nursing Facility/Nursing Home. At the most basic level, AL refers to housing where people pay a monthly fee for a room in a building where they can also receive help with their daily activities—such as bathing, cooking, eating, and toileting—from paid caregivers. Usually, residents’ needs arise because of age-related neurogenerative diseases such as dementia, Parkinson’s, or stroke, and with an increasing aging and frail population, AL is catering more and more to people with such degenerative diseases. Although ALs are caring for more compromised clients, their capacity to deal with this added responsibility remains poor, and oversight remains superficial, despite their successful growth. California has almost six times more AL units than nursing homes. Although most are small, most residents (70%) reside in large units with over 50 beds. As chimeras,
there is no national definition of AL and therefore their definition and oversight vary across states.

More than 810,000 people reside in AL facilities, costing an average of $4,300 per month. About 2% of older Americans live in ALs. Most are women (71%) in their eighties (average age 84), that have memory impairment (71%), and just under half have moderate to severe memory loss (42%) [73]. The average length of a stay in an assisted living facility is 22 months before moving to nursing homes or other types of senior care, or death. Most ALs are for-profit, ranging from 65-96%, particularly among small facilities [73].

The 2013 documentary “Life and Death in Assisted Living” [74], followed by the investigation, “Elderly, At Risk, and Haphazardly Protected” [75], examined cases of death among patients with dementia that were attributed to the lack of care. These focus on the Emeritus Corporation the country’s largest for-profit AL company, with annual revenue of $1.6 billion. A more recent review [76] reexamined these abuses and still found dangerously abusive low staffing levels with obvious culpability. Top executives testified that “They were constantly being told to cut labor expenses” [76]. Because of the tremendous pressure to fill up beds to capacity, managers had to admit residents with complex health conditions that the facility could not provide care for. Together with minimal staffing, they had grossly insufficient dementia care training. Inevitably negative outcomes ensued that were covered up, ordering staff not to talk about the issues or they will be fired. Any regulatory encroachment into this powerful industry’s path to profit is instead met with calls for less regulation and minimal public disclosure [75].

Abuse at AL is primarily caused by a lack of staff, lack of training, and improper supervision of protocols. Staffing is the foundation of care and legal requirements are insufficient to reduce abuse. If a facility has a waiver for half-capacity bedridden residents, it is physically impossible for the legally required number of staff to turn the residents the requisite number of times during the night. The law as is written allows abuse with impunity. Although similar practices of reducing staff also exist in nursing homes and hospitals, ALs have an additional and unique component, that relates to the low quality of food. Since, unlike Nursing Homes, most small AL facilities have no dietitian in charge of nutrition, resulting in variable quality, quantity, and consistency of nutrition that contributes to malnutrition. With a daily cost of food between $3.82 and $6.62 in ALs, feeding residents within these meager allowances has one consequence, residents become malnourished [77]. No studies could be found looking at malnutrition in ALs.

In search for profits, some AL facilities also abuse their workers. Especially small AL facilities with six or fewer beds that hire live-in caregivers who are paid a flat rate without accounting for hours worked and therefore without any minimum wage or overtime, sometimes paying the caregivers $3 per hour [78]. By classifying caregivers as independent contractors, managers escape labor standards and wage compliance [78]. In California alone, caregivers have filed 526 wage theft claims since 2011 that amounted to $2.5 million in stolen wages. Because of weak regulation and inconsistent training standards abuse of patients as well as workers will surge “…it’s almost impossible for this not to occur.” [74]. A dearth of research in this area ensures that we have little evidence. A Canadian study found that a third of AL residents (39%) ended up in hospital every year. Three times higher than nursing home residents who have more severely ill patients. Hospital admission was predicted by smaller facilities with no hired nurses on site [79]. A fifth of these hospitalizations could have been prevented and likely reflects on the poor quality of care [80]. Abuse will become more prevalent in ALs as residents become increasingly older and frailer and caregivers will become fewer, lack adequate training, and remain underpaid.

IX. SKILLED NURSING FACILITIES-SNFs

Nursing homes—technically known as Skilled Nursing Facilities-SNFs—will care for more than a third of older adults in their lifetime. In the U.S., some 15,500 SNFs provide care to more than 1.35 million people every year [81]. Being admitted into a SNF increases your chances of elder abuse. A 2014 report from the Department of Health and Human Services Inspector General found that a third of Medicare beneficiaries were harmed within a matter of weeks after they entered the SNF [82]. More than half (64%) of SNF staff admitted to some form of elder abuse in the past year, ranging from psychological abuse (33.4%), physical (14.1%), financial (13.8%), neglect (11.6%), and sexual abuse (1.9%) [45]. Frequent news articles reporting deaths and serious injuries to residents from poor care [83], [84] make good headlines but they do not change policy.

But sometimes the abuse does not even make it into the news. There is a form of institutional abuse that is completely ignored by authorities in the U.S. In an average week, SNFs administer antipsychotic drugs to “chemically-restrain” over 179,000 patients who have dementia and for which the drugs are not approved and without free and informed consent, violating human rights laws [85]. This form of abuse-unapproved antipsychotic medications-apart from the inhumanity of the practice, increases the risk of blood clots, stroke, and hip fracture [86], and even death [87]. This widespread and systematic abuse and neglect of residents requires immediate government intervention that is not forthcoming [88]. Critical Age Theory exposes the complicity of regulatory agencies when the abuse is carried out in the name of business. For-profit SNFs are more likely to chemically-restrain patients as a result of lower staffing and more quality deficiencies [89]. A 2021 study similarly noted that in the past two decades there has been an increase in Private Equity (PE) investment in healthcare, resulting in an increase in mortality of Medicare patients by 10% [90].

In the US, half of all SNFs (56%) are owned by chains or conglomerates. In 2015 the five largest for-profit nursing home chains in the US controlled more than 10% of all SNF beds. Apart from Life Care Centers of America, which is privately owned, all the other top SNF chains have complex ownership structures with multiple owners, holding companies, and subsidiary companies. While these companies made between $1.3-$5.6 billion in profit (2015-
All five chains were settling charges of fraudulent practices brought on by the US Department of Justice and none make annual reports available, so they are opaque in ownership as they are in business practice [90]. All five chains are registered in the tax haven of Delaware. Chains have an opaque structure for a reason. One company owned by the chain might own the land, another company owned by the chain owns the building and manages the upkeep, while another company also owned by the chain runs the management of the SNF. Then each SNF worker is either on contract as an independent contractor or an employee with “restrictive covenants” that limit their capacity to complain.

These chains generate profit by reducing patient care costs and by making the SNF management company pay excessive “insider transactions” and “disguised dividends”-paying for services outside of the SNF but within the chain. In one example, in 2015 Brius Homes an SNF facility owned by Shlomo Rechnitz and his relatives purchased $67 million in goods and services from more than 65 companies controlled by them [91]. While one of Shlomo Rechnitz’s SNFs paid him $3.5 million for financial advice [91]. These insider transactions that include monitoring fees, interest, and lease payments leave little money for patient needs. On top of this, chains ensure that they get as much money out of the patient as possible by creating “launch customers” where each patient that needs additional services (e.g., X-ray, podiatry, skin care) is referred to an outside company owned by the same chain—a practice known as “clustering.” A patient in an SNF becomes a customer for the other goods and services that are provided by the same chain. This practice multiplies the individual SNF customer into multiple customers. Since these non-patient costs are purchased from other facilities owned by the same owners it takes money away from patient care while generating profits for the owners [90]. Less than half (49%) of Medicaid money that goes to an SNF is used on direct services [92].

As a result, SNFs show that they are losing money-by paying large overheads that generate profits for the owners-while lobbying for more state and federal monies. But there is an added bonus for SNFs’ opaque funding structure, they become impervious to legal suits. There is no legal basis for suing the owners as the SNF facilities are run by a separate private management company and each employee or private contractor signs protocols of care that exonerate management. The only person responsible is the worker. Such opaque ownership allows the SNF to generate profit by cutting patient care and committing abuse with impunity.

Neglect and abuse are related to inadequate nurse staffing levels which occur in 75% of U.S. SNFs. This happens more often in for-profit facilities and chains that knowingly balance high profits with low staffing, wages, and benefits [89]. Since government regulatory agencies decline to prosecute SNFs, abuse of older adults will continue because they have managed to secure impunity. Government and regulatory agencies are as culpable to elder abuse as the SNFs themselves.

In 2021 during the COVID-19 pandemic, after more than 183,000 people died in nursing homes-due, in part, to nursing home negligence-a Department of Health and Human Services Office of Inspector General report [93] found that States were culpable in not acting upon nursing home abuse. Although the rate of complaints per 1,000 residents increased from 45 in 2015 to 52 in 2018, 21 States failed to meet federal regulations in investigating these complaints in all 3 years from 2016 through 2018 (before the COVID-19 pandemic). Focusing on one of the largest states, complaints against California nursing homes are similarly exploding, with 10,021 complaints against nursing homes in 2017-18, up 54% from just four years ago. For the more recent data 2020-2021 first quarter there were 3,267 cases in three months [95]. While California’s backlog of complaints continues to grow, peaking at 15,889 cases in 2018, it bears to highlight that these complaints are not trivial as half of all complaints were judged to be either immediate jeopardy or high priority [93]. Between 2006 and 2015, SNF deficiencies increased by 35 percent resulting in serious injury, harm, impairment, or death to residents while, strangely, citations decreased [92]. Meanwhile, nursing home payments to their owners-insider transactions and disguised dividends—grew by 66 percent exceeding $1 billion annually. This system continues to operate because SNF chains have engineered the Medicare and Medicaid payment system to work for their profits rather than for the benefit of patients. As profits go up SNFs cut costs by reducing staff, causing abuse and neglect, and increasing infringements while government agencies look the other way by not issuing citations. A perfect system to generate profit at the cost of care and conducted with the full knowledge and blessing of government agencies.

In an attempt to bring some ostensible semblance of order, in 2009 the Center for Medicare and Medicaid Service (CMS) developed a rating system for nursing homes, a star system much like for hotels. But this oversight was quickly manipulated by the owners of SNFs. A 2021 New York Times article titled “Maggots, Rape and Yet Five Stars: How U.S. Ratings of Nursing Homes Mislead the Public” [95] reports how CMS allows the SNF industry to manipulate the rating system. This false criterion was exposed during the Covid-19 pandemic of 2020-2021 when residents at five-star facilities were just as likely to die as those at one-star SNFs [95]. Much of the data submitted by nursing homes to the federal government is wrong, erring on the positive. Nine out of every ten nursing homes have some deficiencies, with the average being 6-7 deficiencies per inspection [96]. Facilities have a “yo-yo” or “in and out” compliance history suggesting that they rarely address underlying systemic problems that give rise to repeated cycles of serious deficiencies, which pose risks to older residents’ health and safety [97]. CMS reported that the pandemic killed 132,481 residents and 1,931 staff in SNFs [98]. Despite this, in California for example citations and fines declined in 2019-2020 by more than a third, reversing a trend of increasing citations and fines [99]. In most cases, these infringements are created as a result of the SNF cutting corners to make higher profits. One example is rehospitalization-going from hospital to SNF and then back to the hospital, known as “bounce-backs” [100]. The other rehospitalization is from SNFs to hospitals and then back to SNFs known as “churning” [101]. In California, 2.6% of Emergency Department (ED) discharged patients were rehospitalized within 7 days, and they were more likely if they were very old, those on Medicare, and end-stage renal disease [100]. Bounce-Backs, also referred to as “complicated transitions,” refer to rehospitalizations due to...
the inability of the hospital to discharge the patient appropriately, especially from ED, especially when Medicaid will pay for the rehospitalization [102]. While Churning is done so that patients that leave an SNF as Medicaid patients come back from hospitals as Medicare patients paying higher reimbursement rates to the SNF. Re-hospitalization has been shown to be frequent, costly, and often preventable. One study found that in 2004, one-fifth of all Medicare beneficiaries were re-hospitalized within 30 days, costing Medicare $17.4 billion [103]. Roughly 40% of Medicare beneficiaries are discharged to a post-acute setting, either stand-alone or within SNF. Not only is this expensive, but it is also detrimental to patients. “Churning” and “bounce-back” are associated not only with more medical errors but the experience of being moved from one institution to another causes delirium and functional decline [104].

SNF residents often develop infections from hospitals that result in becoming more functionally and cognitively diminished on their return to SNF [105]. Sadly, these abuses are predictable on the basis of economic rather than health factors, since higher rates of infections after re-hospitalization came from SNFs that were for-profit, had less generous Medicaid payment rates, and offered “bed-hold policies”–where SNFs are paid to reserve the bed of a hospitalized resident since some residents were refusing to go to the hospital so as not to lose their bed [106]. Economic factors that generate profit for the SNF determine the rate of abuse of older patients.

Such abuses are multiplied when there is a natural disaster or a pandemic as the 2019 Federal HHS Office of Inspector General report found. What is not surprising is that this report was ignored by the California Department of Health California [107]. SNFs not only cause a lot of harm and abuse to older residents, but they intentionally have no protocol to deal with cyclical disasters that are predicted to cause an increase in harm to older adults. Not preparing for an emergency when patients are hopeless, pushes the culpability scale from reckless to the intent of future abuse.

X. HOSPITALS

At the pinnacle of the medical care complex lies the most technologically advanced and most complex community of medical intervention: the hospital. It was therefore a bombshell when half a century ago, in 1974, Ivan Illich wrote “Medical Nemesis: The Expropriation of Health” followed in 1999, by the Institute of Medicine’s famous report “To Err Is Human.” Both these seminal publications established the concept of iatrogenic disease–illnesses and death directly caused by medical intervention primarily in hospitals. In 2013, in one of the first U.S. national studies that enumerated deaths solely from medical intervention, between 210,000 and 440,000 patients each year die due to preventable harm caused while in hospital [108]. The operative term here is “preventable.” Hospitals are predictably killing and maiming their older patients.

Although such hospital-induced iatrogenic disease among older people can be due to a variety of causes–including frailty, complications, poly-pharmacology, multiple chronic diseases, multiple physicians, and medical or surgical procedures-hospital-protocols that should address these causes are ignored [109].

An early study from 1989 observed that nearly one-third of patients aged 75 years and over develop at least one new disability in Activities of Daily Living-ADL after an acute illness and admission to a veteran’s hospital [110]. A more recent follow-up study similarly reported attrition in all functional scores for mobility, transfer, toileting, incontinence, feeding, and grooming among older patients at the prestigious Stanford University hospital [111]. It seems that there is no escape from such dangers in hospitals. A current multidisciplinary, multi-professional working group reported that between 30-60% of older patients lose some independence in basic ADLs during a stay in the hospital [112]. In general, a third of older patients came off worse from being admitted to a hospital.

Studies that assign blame to the frailty of patients–calling them “complicated patients”–have a point, but they deflect from acknowledging that we know what the risk factors are for these frail older adults before hospitalization. But hospitals still fail to address these needs in their protocols. This recklessness is a dereliction of duty. To bring about effective change since we cannot change the frailty of older adults–we need to focus on the institutions responsible for not preventing functional decline due to a lack of geriatric knowledge, inadequate evaluation, and management of functional status. One in ten older patients develop a disability (12%) most of which (82%) could have been prevented, especially those related to excessive bed rest (27%), lack of physical therapist intervention (55%), overuse of diapers (49%), and transurethral urinary catheterization [113]. These are all preventable with the proper care that older adults require. Any geriatrician knows this. These statistics exposed the significance of medical errors as the third-leading cause of death in the U.S. behind heart disease and cancer, an appalling honor that remains to this day [114].

Direct hospital abuse extends to defrauding Medicare, Medicaid, and insurance companies. These types of fraud involve “phantom billings” for goods or services that were not provided, “upcoding” medical conditions to higher severity so that hospitals can charge more, paying “Kickbacks” in exchange for referring patients, “padding” billing for unnecessary tests or procedures, charging personal expenses to Medicaid, “denial of services” where Managed Care Organizations (MCOs) refuse to provide services that the insurance already paid for, “cherry picking” recruiting healthy patients, and “double dipping” billing for services already performed and paid for [115]. All of these practices reflect a “culture” of fraud and abuse rather than sporadic individual episodes.

XI. HOSPICE

At the most vulnerable stage in life, when a patient is dying, hospice is designed to provide comprehensive care that includes both palliative care to alleviate pain (not to cure), and also bereavement counseling with family therapy. In the U.S., hospice is an option under Medicare-Part A–for those individuals, whose physician determines that they have less than six months to live. However, services offered by hospice tend to be variable.

In 2018, the average length of stay was higher among
Medicare decedents in assisted living facilities (155 days) or a nursing facility (106 days) rather than at home (93 days) [116]. Each patient costs Medicare $12,200 every year and this is increasing by over 7% annually. Patients with dementia continued to lead Medicare hospice spending consuming a quarter of total costs, followed by patients with circulatory/heart (20%), cancer (18%), and other diseases (13%) [116]. Patients with dementia, circulatory/heart, and respiratory illnesses saw the fastest increase in costs [116]. Because patients follow a “U” curve in costs-high costs at the start and at the end of life—there is an economic incentive for hospices to “live discharge” patients before they become costly at the end of life. Not surprisingly, charitable hospice programs had a lower rate of live discharges compared to for-profit hospices (15% versus 22%) [117]. Despite charitable hospices being the genesis of the US hospice movement, hospices have transitioned into an industry dominated by for-profit providers. New hospices from 2010 through 2018 were exclusively for-profit. As a result, for-profit hospices in 2018 made up more than two-thirds (70%) of all hospices compared to less than a third in 2000 [117]. This does not bode well for the quality of care at the end of life.

The U.S. Government Accountability Office (GAO)—that oversees government spending—found that for-profit hospices were likely to have the lowest scores on some quality measures [118]. These included more than half of patients quitting from hospice prior to death that suggests dissatisfaction with care. The GAO also found that for-profit providers were more likely not to have hospice nurses, physicians, or nurse practitioners visit the patient within the last 3 days of their life—a critical time in offering quality care at the end of one’s life. For-profit end-of-life care was absent at the end of life [118].

The new business model lobbies [119], bribes [120] and lies [121] to make a profit from older people at the final stage of life. A hospice stands to gain if it can oversubscribe services, double dipping using nursing homes and assisted living services in lieu of providing any services itself, reducing staffing, using fewer clinicians and more homemakers, withholding services when most needed at the end of life, and using live discharges. The ideal economic candidate is a patient with long-term chronic disease, primarily needing assistance with daily living activities (such as patients with dementia) rather than medical (such as end-stage renal disease), requiring less clinical care, and living in an assisted living facility. As such, there are some chronic diseases that are more amenable to this business model. For example, the longest stay in hospice is by patients with dementia (average stay of 105 days), followed by stroke (82 days), heart disease (80 days), respiratory (72 days), and other diseases (64 days) [116]. Dementia is a special case as patients at the end of their lives are already being cared-for either at home or in AL/SNF that are already covered by either Medicare or Medicaid. In contrast, cancer and chronic kidney disease had the lowest stays (46 and 38 days, respectively) [116]. This business model has been obvious for years “...a hospice stands to gain financially if it provides minimal services to a beneficiary over a long period of time.” [122]. Double dipping is something that has been known for decades by the Department of Health and Human Services as early as 1997 when they reported that “... the nature of services provided by the hospice staff, while appropriate and efficacious appeared to differ little from services a nursing home would have provided if the patient was not enrolled in hospice.” [123]. For-profit hospices have significantly fewer registered nurses, medical social workers, and clinicians [124]. By employing less qualified staff, hospices are willingly lowering care for their patients. Lower care translates to intentional abuse as the outcomes are predictable.

The practice of live discharge is particularly offensive as it is carried out, in most cases, to reduce the economic burden of the hospice especially if they have overextended their services and are not making a profit. However, this practice is dangerous and abusive. A quarter (24%) of those live-discharged from hospice were hospitalized within 30 days [117]. We also see a lot of “bounce-back” and “churning” as 8% had a pattern of hospice discharge, hospitalization, and hospice readmission. A revolving door that hospice was supposed to have shut. These latter cases account for $126 million in Medicare reimbursement annually [117].

The sliding level of quality and quantity of care is reflected in the increasing number of complaints. Between 2005 and 2015, a total of 12,931 complaints were received about hospice care. Although complaints only concerned 12% of all hospices, complaining about end-of-life services must be traumatic in context of overwhelming distress. Quality of care was the primary concern (45%), followed by patients’ rights (20%), and administrative/personnel concerns (14%). For-profit agencies were more likely to receive complaints (33% more) or notes of deficiency (52% more) than not-for-profit [125]. Also, it is getting worse, as 2020 saw the largest single-year total of criminal cases for submitting false claims and some of these included hospices [126]. Hope Hospice—with total annual revenue of $11 million for 2017-paid $3.2 million to settle claims for knowingly submitting false claims to Medicare, Medicaid, and TRICARE for care provided to non-terminally ill beneficiaries who did not qualify for those services [127]. That same year Metropolitan Jewish Health System Hospice and Palliative Care a New York nonprofit hospice-with a total revenue of $86 million [128]-paid $5.2 million (6% of revenue) to settle allegations that it improperly billed Medicare and Medicaid for services provided to hospice patients who did not qualify for those services [129]. Such punitive measures are not an existential threat but the cost of doing business, the outcome is however strategic abuse of older adults.

What Critical Age Theory teaches us about hospice is that eventually all health care will follow the path of least resistance and morph into agencies of profit that sideline caring for the most vulnerable people, older people dying. The ultimate expression of this zeal for profit can be seen with the emergence of Medicare Advantage (MA). Critical Age Theory predicts that MA will become the main provider of care not just for older adults, as it is currently established, but for all Americans.

XII. MEDICARE ADVANTAGE-MA

Medicare Advantage (MA), based on the original Plan C of Medicare, was conceived as a way of reducing costs by combining different services together. However private firms...
have learned how to game the system and increase their Medicare payments by manipulating the severity of an illness. The severity of an illness is determined by a “risk score” that is reliant on diagnoses. Organizations get paid more for a patient with a higher risk score. Billions of tax dollars are wasted every year through the manipulation of this risk score [130]. From 2007 to 2017, the average risk score has increased by approximately 1.5 percent per year largely as a result of successful efforts by insurance plans to identify additional diagnoses—also known as “coding intensity” —and not because of changes in enrollee’s true diminishing health [131]. Over the next decade, this manipulation of adding more diagnostic codes to a patient’s medical record will increase Medicare expenditures by 10 percent or by $200 billion [131]. In contrast, MA plans provide less expensive care, providing more primary rather than specialist care, and outpatient rather than inpatient surgery [132]. They manage to reduce costs by providing fewer and cheaper services, 15% fewer colon cancer screening tests, 24% fewer diagnostic tests, and 38% fewer flu shots. Although MA has a higher revenue of about 30% per patient their spending is 25% lower than traditional Medicare [132]. By restricting services provided to sicker individuals—patients are discharged home from the hospital rather than to post-acute care—MA controls who gets services and what services are offered, while getting paid more regardless of whether the patient receives the services or not. And the regulatory agencies that are meant to oversee them are colluding with this practice.

The Center for Public Integrity reports that government audits continue finding billing errors in 30 percent or more of the patient files reviewed. In February 2012, CMS officials forgave the overpayments to Medicare health plans made from 2008 through 2010. More than $32 billion of “improper” payments to MA plans were absorbed, which then went straight into the pockets of the investors [133]. Congress has turned into a cheerleader for the program. Our tax money is promoting the continuation of these deceitful practices and our regulatory agencies have become complicit [130]. The Center for Public Integrity reports [130] that institutions knowingly create conditions that create the environment for abuse. Critical Age Theory brings about the condition of abuse. Critical Age Theory “the harm of older adults” is part of the institution of health care in the U.S. even when health care is delivered appropriately. How we find ourselves in this situation is easy to see if we follow the money.

The traditional care industry had a clear distinction between public and private funding, but this is now no longer the case. After the Second World War, each country’s healthcare system crystalized [136], and Critical Age Theory predicts a convergence to a for-profit business model that sidelines care in favor of profit. Increasingly, the public and private sectors are working conjointly to fund and deliver health services [137]. But in the U.S., the insurance industry was allowed to take over health care. For example, although the U.S.A and Canada had similar healthcare systems, after the 1960s, Canada’s provinces implemented single-payer programs that displaced private insurers, whereas the U.S. added new public coverage for seniors (Medicare) and for the poor (Medicaid) while leaving private insurers in place. In 1970, health spending as a share of gross domestic product (GDP) was virtually identical in the two nations: 6.2% in the U.S. and 6.4% in Canada, but by 2017, U.S. costs rose to 17.9% of GDP exceeded those in Canada at 11.3%, and all other industrialized countries. Many features of Canada’s approach-for example, tighter control of drug prices, physicians’ fees, hospital budgets, and investments in high-tech facilities-underlie the price disparities. Excess administrative costs incurred by U.S. hospitals, clinics and SNFs by their owners, inflate the costs [137].

Many corruption and abuse scandals involve cooperation among numerous upstanding community members. Healthcare workers are mostly altruistic individuals. Institutional abuse, caused by a culture of how services are conducted, is rationalized as part of doing business and not seen as either fraudulent or abusive by individuals. Rationalizations are mental strategies that allow healthcare workers to justify their behavior and reduce their concerns in a process of diffusion of responsibility. This diffusion of responsibility will exacerbate this lack of concern once artificial intelligence becomes more deeply embedded in the healthcare setting [138]. Diffusion of responsibility shields the role of the healthcare facility and its management.

Individually, by diminishing any regrets or negative feelings that emanate from their participation in unethical acts they make the business model take responsibility for any negative outcomes, exonerating themselves. With older adults, there is the admission that older people are frail and vulnerable to medical errors anyway. These attitudes are transmitted to new employees through socialization. The culture of doing business is transmitted to newcomers who are induced to acquiesce to, and participate in, ongoing unethical acts. This culture establishes enduring normalized behaviors within organizations that causes damage and harm to older adults and becomes “institutionalized in seemingly innocuous processes” [139].

On the other side of the arena is the public. We ignore institutional abuses because we are sensitized to see harm by individuals and not institutions. In elder abuse, we personalize the interaction. However, in most cases, “the institutional makeup—what we euphemistically refer to as their business model or business culture-determines how individual workers behave within an agency” [140]. Since the business model dictates workers’ hours, duties, and responsibilities, it is logical to examine the business model applied. However, when abuse happens, we do not venture beyond assigning responsibility to the individual that had contact with the victim, we hide the institutional context that brought about the condition of abuse. Critical Age Theory aims to re-address this perceptual bias but providing evidence that institutions knowingly create conditions that create abuse. Regardless of the workers, abuse is predicted by a work culture. Older adults are more prone and vulnerable to these eroded oversight practices. Regulatory agencies such as the U.S. DHHS, CDC, State Public Health Agencies, State/City Elder Abuse units, and Ombudsmen Programs all
collude in diminishing institutional responsibility. Critical Age Theory aims to readress this asymmetry of responsibility.

CONFICT OF INTEREST

Author declares that he does not have any conflict of interest. This paper is based on a book by the same author “Critical Age Theory: Institutional proffiteering from the last stages of aging.”

REFERENCES


