

Centre for Policy on Ageing

Response to the GEO request for views on ways in which the use of age should be allowed to continue and exceptions to the ban on age discrimination in health and social care within the Equality Act 2010.

In 2009, the Centre for Policy on Ageing carried out a series of four reviews of age discrimination in health and social care to support the work of the Carruthers-Ormondroyd review. These reviews looked at ageism and age discrimination in primary and community care, secondary health care, mental health care and social care and followed on from an earlier review of the costs and benefits of legislation to outlaw age discrimination in health and social care services.

These reviews found that, while the organisation of social care remains problematic, for health care, other than mental health care and health screening programmes, explicitly age discriminatory policies had, for the most part been eliminated from the National Health Service.

There is, however, widespread statistical evidence that, even after issues such as frailty and co-morbidity have been taken into account, older people are more likely to suffer delays in diagnosis and referral and less likely to receive appropriate interventions and treatments or primary and secondary preventative measures than an equivalent younger person. In the absence of age discriminatory policies, this statistical imbalance can only have resulted from the cumulative effect of thousands of individual decisions on treatment by individual medical practitioners.

Secondary analysis of the NHS Inpatient survey reveals that while older people are less likely to complain about a hospital stay in terms of things such as hospital food or cleanliness, they are more likely to note that medical staff speak over them 'as though they were not there'.

All the evidence seems to point to the fact that, except for the case of mental health services and health screening programmes where explicitly age-based policies still exist, where age discrimination persists in health services it results from the, possibly hidden, ageist attitudes of individual medical practitioners which may, in turn, do no more than reflect ageist attitudes in society as a whole.

Except in the most extreme cases, it is unlikely that the legislation will be used to challenge individual medical judgments but the real strength of the legislation is that it will make medical staff think twice about whether they are being ageist which will itself do something to redress the observed statistical imbalances in treatment for older people.

The overall argument against exceptions.

As any legislative framework that may have an impact on professional practice gets closer to being finalised it is inevitable that pressure will come from some quarters to retain the status quo for particular existing working practices. Within the Equality Bill this would be achieved by means of exceptions.

Pressure for exceptions will only be necessary, and therefore will only come, in those areas where age discrimination is, or might be perceived to be, currently taking place.

The danger is therefore that an equality bill with exceptions may outlaw age discrimination 'except where it occurs'.

Individual professional judgement as an exception.

In its reviews of ageism and age discrimination in health and social care, carried out to support the Carruthers-Ormondroyd review in 2009, the Centre for Policy on Ageing found that, except for mental health and some screening programmes, the primary source of age discrimination in health

and social care is the cumulative effect of individual decisions rather than the result of written policies or organisational structures.

One of the most useful outcomes of the Equality Bill will be to make practitioners think twice about whether they are being age discriminatory and that will not be achieved if the bill provides an exception for individual professional judgements.

The reviews provide evidence that attitudes, behaviour and stereotypical assumptions on the part of professionals are key factors in the unfair differential treatment of older people in health and social care. There must therefore be, as a last resort, a process to challenge covert and subconscious, discriminatory professional judgement through the legal test of objective justification. Only in this way will the primary objective of changing attitudes be achieved.

Care and treatment should not be age blind but should be based on clinical and assessed need which may vary with age but should not be defined by age. The legal test of objective justification is an appropriate way of testing the rationale for any differentiation in treatment on the basis of age.

National public health programmes as an exception

Not being able to afford to treat everyone is not in itself sufficient reason for not treating older people and if it were the sole justification would be age discriminatory. Any decision about who should be monitored or treated in public health programmes should have a sound, evidence based, rationale taking into account, for example, the relative risks and likely benefits or adverse consequences of monitoring or treating particular age groups. Any such sound, evidence based rationale would have no difficulty in being objectively justified and would not be open to legal challenge. A decision process that cannot be objectively justified should not be being used as the basis for determining the age focus of a public health programme. There is therefore no good reason for public health programmes to be treated as an exception.

Age discrimination in mental health care

In its reviews CPA found ample anecdotal evidence and some statistical evidence of the occurrence of discrimination in the provision of mental health services for older people. Mental health services for older people are often separately organised with a cut-off around age 65. However, age discrimination does not occur because there is a separate service for older people but because that service is often perceived as being under-resourced relative to adult mental health service and lacks some of the services available to adults. In some areas patients are forced to transfer on reaching the cut-off age and 'graduates' transferring between the two services notice the difference. Overall in England, older people's mental health services have far fewer psychiatrists, psychologists, psychotherapists and social workers per case than adult mental health services.

A much more detailed breakdown of the evidence for and against the existence of ageism and age discrimination in health and social care services can be found at <http://www.cpa.org.uk/reviews>.

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