Centre for Policy on Ageing

CPA

New attitudes to old age..

A literature review of the likely costs and benefits of legislation to prohibit age discrimination in health, social care and mental health services and definitions of age discrimination that might be operationalised for measurement.

Carried out by the Centre for Policy on Ageing on behalf of the Department of Health.

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Summary

This review distinguishes Ageism, an attitude of mind, from Age Discrimination, an unjustifiable difference in treatment based solely on age. Age discrimination is inherently measurable and this review looks for ways in which age discrimination has been or might be measured.

Older people are disproportionately high users of health care facilities but closer examination reveals that proximity to death rather than age may be the predominating factor in health care costs.

Examples of age discrimination are widespread in health, mental health and social care services, most overtly in health screening programmes, drug trials and mental health services.

QALYs (Quality Adjusted Life Years) the process through which the National Institute for Health and Clinical Excellence assesses the cost effectiveness of treatments, may be inherently age discriminatory.

Legislation to outlaw age discrimination in goods and services, including health services has been enacted in a number of countries including, Ireland, Australia, Canada (Ontario) and Belgium. In the USA, which has had legislation in place since the 1970s, the restricted nature of the legislation is considered to have rendered it ineffective.

Although this review provides a useful analysis, from literature written internationally, of age discrimination in health, social care and mental health services and the costs of providing these services for an ageing population, no studies were found which directly address the key focus of the review namely a post hoc analysis of the costs and benefits to social care, health and mental health services of introducing legislation prohibiting age discrimination.

Two possible courses for future action are therefore recommended:

1) an international comparative study of costs (and benefits) for those countries that have introduced age discrimination legislation in services and
2) a bottom-up calculation, within the UK, of the costs of removing discrimination from those health, social care and mental health services that currently discriminate by age.

A literature review of the likely costs and benefits of legislation to prohibit age discrimination in health, social care and mental health services and definitions of age discrimination that might be operationalised for measurement.

Contents

1 Brief

1.1 The brief was for a rapid (4 weeks) literature review with the key focus on costs (and if possible benefits) of removing age discrimination in social care and mental health services with particular emphasis on international literature. A supplementary study examined definitions of age discrimination that might be operationalised for measurement.

2 Background and context

2.1 The European Union Council Directive establishing a general framework for equal treatment in employment and occupation (Council Directive 2000/78/EC) required all member states to introduce legislation to prohibit unjustified forms of age discrimination in employment by December 2006. The Employment Equality (Age) Regulations 2006, which came into effect on 1st October 2006, has made unjustified age discrimination in employment illegal in the United Kingdom.

2.2 A partial regulatory impact assessment (RIA) was carried out in advance of the introduction of the legislation. (Employment Relations Directorate - Department of Trade and Industry - DTI, 2005)

2.3 Pressure has been mounting to extend the prohibition of age discrimination to other areas, including the provision of goods and services which, in turn, includes the provision of health, social care and mental health services.

2.4 European organisations representing older people, among them, from the UK, Age Concern and Help the Aged, have met with European parliamentarians to present a draft directive. Article 5 encapsulates the view that 'health care should be provided on the basis of need of an individual rather than rationed using age as a criterion for allocation'. (Age Concern England et al, 2006)

2.5 In June 2007 the United Kingdom government published a green paper 'A framework for fairness' consulting on proposals for a Single Equality Bill for Great Britain. In its response, Age Concern indicated 'In relation to health care, eliminating age discrimination would allow older people to have access to services on the basis of clinical need alone. Age based differences would only be permitted if they could be objectively justified.' (Age Concern, 2007)

2.6 In the Regulatory Impact Assessment to accompany the green paper, the Department for Communities and Local Government, estimated the costs that the removal of age discrimination from goods and services might have on health and social care providers. They anticipated 'Minimal additional costs in most areas, where commitments to eliminate discriminatory policies and practices are already in place (eg mental health services) but potentially significant costs in respect of social care which have not yet been quantified'. Overall benefits were estimated to be between 12 and 39.5 million pounds per annum. (Department for Communities and Local Government, 2007)

3 Methods and summary results

3.1 The methods used to locate relevant material were

- Searching relevant international electronic databases
- Google based internet searches
- Browsing and searching of key websites
- Scanning references in already located material
- Contact with key academics, researchers and policy makers, likely to be aware of material in this area.

3.2 Searches were made of 21 online databases: Ageinfo, Ageline, Applied Social Sciences Index and Abstracts (ASSIA), BBC News Archive, BLEPS Catalogue, Combined Academic and National Research Library Catalogue (COPAC), Cumulative Index to Nursing and Allied Health (CINAHL), Database on Anti-discrimination and Equality Law (DADEL), Dissertation Abstracts, EconLit, ERIC, Gerolit, International Bibliography of the Social Sciences (IBSS), ISI Web of Knowledge, Medline, National Database of Ageing Research (NDAR), NHS Economic Evaluations Database (NHS EED / DARE), SCIRUS, Social Care Online, Social Policy and Practice, SourceOECD, and Zetoc.

3.3 These searches were supplemented by general web searches using Google and Google Scholar and searching and browsing of key web sites including Age Concern, AGE the European Older People's Platform, agediscrimination.info, the European Commission, Care Services Improvement Partnership, Institute for Public Policy Research, Kings Fund, the sites of individual national anti-discrimination bodies including The Equality Authority (Ireland) and the Human Rights and Equal Opportunities Commission (Australia) as well as individual specialist academic units including the National Institute of Economic and Social Research, Sheffield Health Economics Group and University of York Centre for Reviews and Dissemination.

3.4 Contact was also made with a number of key academics, researchers and policy makers.

3.5 Particular emphasis was placed on those countries deemed to have already implemented age discrimination legislation in goods and services. These included Australia, Belgium, Canada, Ireland and the USA.

3.6 A major problem in the searching process was the 'noise' generated by the large number of articles and reports on age discrimination legislation in the field of employment, the contents of which were not relevant to this study.

3.7 Over 600 relevant documents were located of which 100+ of the more important are listed in the references and key bibliography and around 400 selected items in the full bibliography that accompanies this review. However, no studies were found which directly address the key focus of the initial review namely a post hoc analysis of the costs and benefits to social

care, health and mental health services of introducing legislation prohibiting age discrimination.

4 Ageism and Age Discrimination

4.1 Ageism

4.1.1 Ageism is primarily an attitude of mind which may lead to age discrimination. Age discrimination, on the other hand, is a behavioural process with outcomes that may be measured, assessed and compared.

4.1.2 '…ageism is used to describe stereotypes and prejudices held about older people on the grounds of their age. Age discrimination is used to describe behaviour where older people are treated unequally (directly or indirectly) on grounds of their age.' (Ray, Sharp and Abrams, 2006)

4.1.3 The first recorded use of the term *ageism* was in an article in 1969 by Robert Butler. (Butler, 1969)

4.1.4 'Ageism is a set of beliefs … relating to the ageing process. Ageism generates and reinforces a fear and denigration of the ageing process, and stereotyping presumptions regarding competence and the need for protection. In particular, ageism legitimates the use of chronological age to mark out classes of people who are systematically denied resources and opportunities that others enjoy, and who suffer the consequences of such denigration, ranging from well-meaning patronage to unambiguous vilification'. (Bytheway , 1995 - referencing Bytheway and Johnson, 1990)

4.1.5 Some writers consider age discrimination to be a facet of ageism itself. (Ray, Sharp and Abrams, 2006) Ageism may be seen as having an *affective* component (feelings), a *cognitive* component (beliefs and stereotypes) and a *behavioural* component (discrimination). (Nelson, 2002; Palmore, Branch and Harris, 2005) Ageism may be positive or negative. (Reed et al, 2006)

4.1.6 Ageism is broader than age discrimination. It refers to deeply rooted negative beliefs about older people and the ageing process, which may then give rise to age discrimination. (McGlone and Fitzgerald, 2005)

4.1.7 Ageism may also be used to refer to any decision making on the basis of age. Tsuchya, examining public attitudes to discrimination on the basis of age in health service decision making, identifies

4.1.7.1 *Health maximisation (utilitarian) ageism* – in which health units, eg quality adjusted life years (QALYs), are given equal value. Other things being equal, younger people, with greater life expectancy, will benefit from decisions made on this basis.

4.1.7.2 *Productivity ageism* – gives priority to young adults because they are socially and economically more productive. Health gains at different ages are weighted accordingly.

4.1.7.3 *Fair innings ageism* – in which an individual's expected remaining healthy life years are compared with an average and given a higher relative weighting if they fall below. Other things being equal, younger people will again benefit from decisions made on this basis.

4.1.8 The general public seem willing to accept health decisions based on age but there is conflicting evidence about which forms of ageism are acceptable. (Tsuchiya, Dolan and Shaw, 2003; National Institute for Clinical Excellence. Citizens Council, 2004)

4.1.9 Ageism, as an attitude of mind, can be measured using psychometric tests, most notably the Aging Semantic Differential (Rosencranz and McNevin, 1969) and the Fraboni Scale of Ageism (Fraboni, Saltstone and Hughes, 1990). Measures of this type generally find that ageism gets less as people get older and that men are more ageist than women. (Rupp, Vodanovich and Credé, 2005)

4.2 Age Discrimination

4.2.1 Age discrimination is an unjustifiable difference in treatment based solely on age. The meaning of 'age' is generally understood although, within legislation, different age ranges may apply in different jurisdictions.

4.2.2 In definitions of discrimination within legislation, a number of countries distinguish *direct* and *indirect* discrimination

4.2.2.1 *Direct age discrimination* occurs when a direct difference in treatment based on age cannot be justified. A direct difference in treatment is a situation in which a person is, was or could be treated in a less favourable manner than another person in a comparable situation based on his/her age.

4.2.2.2 *Indirect discrimination* occurs when a seemingly neutral provision, measure or practice has harmful repercussions on a person.
(Belgium - Discrimination Act of February 25, 2003; Ireland - Equal Status Act 2000-2004)

4.2.3 The 2001 National Service Framework for Older People declared that NHS services will be provided 'regardless of age, on the basis of clinical need alone'. (Department of Health, 2001)
The provision of service purely on the basis of need reflects the health equity concepts of horizontal equity (the equal treatment of equals) and vertical equity (the unequal, but fair, treatment of unequals) (Mooney and Jan, 1997)

5 Measuring Age Discrimination

5.1 Measures of age discrimination have to accommodate variations in need as well as variations in outcomes. 'The most intuitive idea of equality is probably equality of outcome… Despite its convenience and popularity, equality of outcome in its crudest form is not well supported philosophically. …Variations in need mean that the same allocation of resources does not facilitate the same opportunity to achieve a valuable goal.' (Burchardt, 2006)

5.2 Measuring age discrimination by comparing health outcomes at different ages is confounded by a number of factors including '…period effects (what happened during a particular year or decade), cohort effects (the experience of that group born during a particular year or group of years), the process of ageing itself and the social as well as physiological aspects of growing older. Moreover there has been an upward trend in the reporting of sickness…' (Carr-Hill and Chalmers-Dixon, 2005)

5.3 Despite widespread searching of international sources, the only operational implementations of measures of age discrimination located came from within the United Kingdom.

5.4 The UK Department of Health has developed benchmarking tools to measure and monitor age discrimination in areas such as social care, acute hospital and primary care. ' The benchmarking tool contains data on the number of procedures by age, and on the population of the same age. This enables the generation of age-specific rates of service provision. If there were a simple, generally agreed, appropriate rate for each procedure at each age then it would be sufficient to examine procedure rates for older people, and consider whether they met the agreed appropriate rate. In practice, there is no such agreed rate. … The Tool works by comparing across PCTs and SHAs the ratio of the procedure rates for older adults to the procedure rate for younger adults (the ratio of the rates – the rate for older adults divided by the rate for younger adults). The Tool also looks at the ratio of the rate for people in advanced old age to the rate for people in earlier old age.' (Department of Health, 2002)

5.5 UK NHS Health Equity Audits are designed to address health inequalities including age discrimination. Health Equity Audit: a guide for the NHS (Department of Health, 2003), indicates that a HEA programme should address the dimensions of health inequalities, … aiming to narrow the gap in health outcomes between age groups particularly by … prolonging active healthy lifestyles in the over 50s. The guide proposed using data to compare service provision with need, access, use and outcome measures. A basket of Public Health Observatory local indicators is available on the London Health Observatory web site. (www.lho.org.uk)

5.6 Health Equity Audits of age discrimination can also use the DH benchmarking tool described above, for example in Redditch. 'The benchmarking tool produces age specific rates of access to a given intervention. On their own, these do not indicate whether discrimination is taking place – we do not know the "right" access rate for any given intervention and any given age group, and neither can routine data take account of need, or prevalence of disease. Indeed, deprivation and standardization for deprivation are often using as a proxy for need. In this instance, the rates are not standardized for deprivation, but comparator groups are given, in this case ONS cluster groups (prospering small towns). However, by comparing the ratio of the rate of a given intervention in one age group, against the rate in a different age group, we can gain some insight as to whether one group is unfairly advantaged over another. The implicit assumption is that the ratios should be broadly similar between PCTs of similar composition. Data is compared against our ONS cluster for PCT based indicators, and against other shire counties for community services. Results are given as quartiles. It should be noted that lack of age discrimination implied by a ratio of 1 or more between older and younger age groups do not mean that need is being met. Similar low access rates across age bands implies unmet need for all ages, and discrimination

between our PCT and another PCT which commissions or provides more of a service.' (Redditch and Bromsgrove PCT, 2005)

5.7 A wide ranging teaching guide to the measurement of health inequalities is provided by *The Public Health Observatory Handbook of Health Inequalities Measurement* (Carr-Hill and Chalmers-Dixon, 2005)

5.8 General health equality measures, for example Lorenz curves the Gini coefficient, the Slope Index of Inequality (SII) and the concentration index (Braveman, 2006; Low and Low, 2004; Macinto and Starfield, 2002) might be adaptable to measure age based inequalities but we have not found any examples of their use in this way.

6 Legislation, outside the UK, on age discrimination in areas other than employment

'It is probably fair to say that in most cases, concern about age discrimination in the field of goods and services arose following on from debate about age discrimination in the field of employment.' (Age Concern et al, 2004)

'Discrimination on grounds of age is regulated, to a greater or lesser extent, in most countries (with the exception of Denmark, Malta, the Netherlands, Sweden and the UK). Every country permits age differences in treatment in relation to access to pensions…'

'... Bulgaria, Ireland, Luxembourg, Romania and Slovenia have adopted comprehensive measures in this context and Austria, Belgium, Cyprus, Estonia, Finland, Germany, Hungary, Lithuania, Portugal and Spain also provide a significant degree of protection.' (McColgan, Niessen and Palmer, 2006)

Two reports, 'Addressing Age Barriers' (Age Concern England et al, 2004) and 'Comparative Analyses on National Measures to Combat Discrimination Outside Employment and Occupation' (McColgan, Niessen and Palmer, 2006) provide a cross-country analysis of age discrimination legislation outside employment and occupation.
Two web sites **http://ec.europa.eu/employment_social/fundamental_rights/legis/lgms_en.htm** and **http://www.agediscrimination.info/** provide a country by country breakdown of age discrimination legislation.

Except where indicated, the following brief notes, by country, of age discrimination legislation in services, particularly health, mental health and social care services, are drawn from these four sources. A systematic country-by-country comparison of European or worldwide legislation was beyond the scope of this review.

6.1 Australia

6.1.1 The Australian Age Discrimination Act came into force on the 23rd June 2004. The Australian Government says Australia is the first country to propose and pass stand-alone age discrimination legislation that will cover, among other things, access to goods and services and education, as well as employment. It also claims that the present legislative provisions governing age discrimination are broader than those enshrined in the USA, New Zealand, Canada and Ireland.

6.2 **Belgium**

6.2.1 An Act was passed on February 25, 2003 combatting discrimination and amending a previous Act of February 15, 1993 relating to the foundation of a centre for equal opportunities and opposition to racism.

6.2.2 Belgian law also includes a prohibition on age discrimination contained in the so-called Anti-Discrimination Act of 10 May 2007. This act transposes EU Directive 2000/78 (Framework Directive).

6.2.3 According to the Act of 25 February 2003, direct age discrimination occurs when a direct difference in treatment based on age cannot be justified. A direct difference in treatment is a situation in which a person is, was or could be treated in a less favourable manner than another person in a comparable situation based on his/her age.

6.2.4 Direct age discrimination is only justified in the following cases:

- The Anti-Discrimination Act specifies that with regard to employment issues, a different treatment based on age is justified if a characteristic constitutes an essential and determining professional requirement, due to the nature of the professional activity or the context in which it is performed, provided that the objective is legitimate and the requirement is proportionate to that objective.
- Furthermore, with regard to employment issues and supplementary social security schemes, direct differences of treatment on grounds of age shall not constitute discrimination if they are objectively and reasonably justified by a legitimate aim, including legitimate objectives of employment policy, labour market or all other comparable legitimate objectives, and if the means used to achieve that aim are appropriate and necessary.

6.2.5 With regard to supplementary social security schemes, various differences in treatment based on age are excluded from the definition of discrimination (such as the fixing of different ages for admission and entitlement and so on).

- Affirmative action based on age is allowed and can justify direct and indirect differences based on age.
- Finally, direct and indirect differences based on age can not be considered to be a discrimination if the difference in treatment is imposed by law.

6.2.6 Indirect age discrimination occurs where an apparently neutral provision, criterion or practice has harmful effects on a younger or older person compared to another person, unless the provision, criterion or practice can be objectively justified by a legitimate aim and the means to achieve that aim are appropriate and necessary.

6.2.7 Harassment is considered as a form of discrimination. An instruction to discriminate is also deemed to be discrimination itself.

6.2.8 Age discrimination law applies to all persons, in both the public and private sectors, including public bodies, in relation to:

- the supply of goods and services which are available to the public;
- social protection including social security and health care;

- social benefits;
- supplementary social security schemes;
- employment issues;
- being named in an official document or report;
- the membership or involvement in an employer's or employee's organisation or any organisation of which the members practice a certain profession, including the benefits these organisations offer;
- the access to and the participation in or any other exercise of an economic, social, cultural or political activity accessible to the public.

6.3 **Bulgaria**

6.3.1 Law on protection against discrimination - January 1, 2004

Article 4

(1) Any direct or indirect discrimination on the grounds of sex, race, nationality, ethnic origin, citizenship, origin, religion or belief, education, opinions, political belonging, personal or public status, disability, age, sexual orientation, marital status, property status, or on any other grounds, established by the law, or by international treaties to which the Republic of Bulgaria is a party, is forbidden.

Article 37

A refusal to provide goods and services, as well as providing goods and services of a lower quality or under less favourable conditions on the grounds referred to in Article 4, paragraph 1 shall be forbidden.

6.4 **Canada**

6.4.1 Note: As a federal jurisdiction, Canada's ten provinces and three territories do not have identical age discrimination laws. The following information applies solely to **Ontario**, Canada's largest province.

6.4.2 The Canadian Charter of Rights and Freedoms ("Charter") applies to certain federally regulated employers in Ontario. The Charter contains an "equality" clause at section 15(1) prohibiting discrimination based on age:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

6.4.3 In addition to the Charter's application, every employer in Ontario is subject to the provincial Human Rights Code ("Code")[1] which enumerates age as a protected ground. Sections 1, 2(1), 3, 5(1) and 6 of the Code guarantee every person the right to equal treatment with respect to services, goods and facilities, the occupancy of accommodation, the right to contract, employment and membership in any trade union without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.

6.4.4 Age discrimination in Ontario is treated as a human rights matter, governed by the *Ontario Human Rights Code 1990* (the "*Code*"). The *Code* currently prohibits age discrimination against those over 18 years of age (with some caveats)

Anti-discrimination in healthcare services is covered by the Code.

6.4.5 Ontario has recently amended its definition of age, effective December 12, 2006. The previous definition was:
"age" means an age that is eighteen years or more, except in subsection 5 where "age" means an age that is eighteen years or more and less than sixty-five years
The revised definition of age is: "age" means an age that is 18 years or more

The definition of age has, therefore, been expanded to prohibit discrimination against employees over the age of sixty-five. This has the effect of ending mandatory retirement in Ontario.

"In both **Belgium** and **Ontario**, it is fair to say that age discrimination in goods and services formed part of a broader anti-discrimination drive, contained within a human rights context. Indeed, in Ontario, the provisions dealing with age discrimination (both for employment and goods and services) are found in the body of the Ontario Human Rights Code." (Age Concern England et al, 2004)

6.5 Finland

6.5.1 Age discrimination provisions are mainly included in the Finnish Constitution (731/1999, as amended), the Employment Contracts Act (55/2001, as amended) and the Non-Discrimination Act (21/2004, as amended). The provisions of the Non-Discrimination Directive 2000/43/EC and the Non-Discrimination in Employment Directive 2000/78/EC have been implemented in Finland by passing the Non-Discrimination Act on 1 February 2004.

6.5.2 The Finnish Constitution contains a general principle of equality which forbids every form of discrimination.

6.5.3 The Finnish Penal Code (39/1889, as amended) covers discrimination in the provision of public services and in the discharge of public duties, where the penalty is a fine or imprisonment for up to six (6) months.

6.5.4 Discrimination Act 2004

Nobody may be discriminated against on the basis of age, ethnic or national origin, nationality, language, religion, belief, opinion, health, disability, sexual orientation or other personal characteristics.

Excludes: different treatment based on age when it has a justified purpose that is objectively and appropriately founded and derives from employment policy, labour market or vocational training or some other comparable justified objective, or when the different treatment arises from age limits adopted in qualification for retirement or invalidity benefits within the social security system.

(* This law does not apply to health services etc except for discrimination by ethnic origin)

6.6 Ireland

6.6.1 *The Equal Status Acts 2000 to 2004 prohibit discrimination on nine grounds including*
The age ground: This only applies to people over 18 except for the provision of car insurance to licensed drivers under that age

Good and Services: People cannot discriminate (subject to certain exemptions):
• When they are providing goods and services to the public (or a section of the public);
• Whether these are **free** or where the goods and services are sold, hired or rented or exchanged;
• **Access** to and the **use** of services is covered.
Services provided by the State (health boards, local authorities etc.) are covered (subject to exemptions). The main exemption is that anything required by Statute, or EU law is exempted. This exemption would not cover circumstances where there is an element of choice or discretion as to how the services are provided.
Exemption on the ground of age: The Acts allow people to be treated differently on the age ground in relation to: ***Adoption/Fostering*** Where age requirements are applied for a person to be an adoptive or foster parent where this is reasonable having regard to the needs of the child.
Other exemptions - a) The different treatment of a person does not constitute discrimination where the person is treated solely in the exercise of a clinical judgment in connection with a diagnosis of illness or his/her medical treatment.
Source: The Equality Authority (Ireland): The Equality Status Acts 2000 and 2004

6.7 Latvia

6.7.1 Article 91 of *the Satversme of the Republic of Latvia establishes that all human beings in Latvia shall be equal before the law and the courts. Human rights shall be realized without discrimination of any kind.*
Differentiated attitude to a person or group of persons on any kind of distinction, such as race, color, sex, age, language, religion, political or other opinion, national or social origin, property, birth or other status if there is no legitimate aim and objective reason necessary in a democratic society, is considered as discrimination. (Source: Latvian National Human Rights Office)

6.7.2 The main problem with Latvian anti-discrimination legislation is the patchy nature of the regulation, from which most other problems arise. Some fields are left uncovered, notably, access to goods and services available to the public, and even within the fields covered, some of the grounds remain ambiguous; the basic definitions exist only in the Labour Law and Law on Social Security, and only the Labour Law provides for the shift of burden of proof.
(Source: Executive Summary Latvian country report on measures to combat discrimination by Gita Feldhune)

6.8 Mexico

6.8.1 Age discrimination cannot be legally justified in Mexico.

6.8.2 On April 2001 Article 1 of the Mexican Federal Constitution was amended and its third paragraph recognises the individual guarantee against discrimination. This article declares that in Mexico rights shall not be limited based on discrimination because of ethnic origin or nationality, gender, age, different abilities, social condition, health, religion, opinions, preferences, civil status or for any other cause which is against human dignity and has as its purpose the annulment or diminishment of rights and freedoms of the individual.

The above mentioned amendment incorporates the Federal Law to Prevent and Eliminate

Discrimination, which, in Article 4, defines discrimination as any distinction, exclusion or restriction, based on ethnic or national origin, sex, age, disability, social or economic conditions, health conditions, pregnancy, language, religion, opinions, sexual preferences, civil status or any other reason whose purpose is to impede or annul the recognition or the exercise of rights and real equity for persons' opportunities. This law establishes the powers and duties of the State in promoting the eradication of discrimination in Mexico. Its general scope includes private and public discrimination.

The Federal Labor Law prohibits discrimination in the workplace. For the same work performed under the same efficiency conditions, the same remuneration shall be granted, without distinction among employees.

Law for the Rights of Older Adults (LROA). This establishes principles and guidelines for the Health, Education, Work, and other Federal Ministries, in order to protect senior citizen's rights.

National System for the Social Assistance Law; and the General Law for the Social Development. These laws include senior citizens as important targets for social assistance.

Mexico City's Criminal Code establishes in its article 206 a punishment from one to three years of prison and a fine of from 50 to 200 days to any person who discriminates against another for reasons of age, sex, pregnancy, civil status, race, ethnic origins, language, religion, ideology, sexual preferences, skin color, nationality, origin, social position, job or profession, economic position, physical characteristics, disability, health status and to anyone who provokes or incites

6.8.3 The LROA defines senior citizens as people above 60 years old. This law sets out the principles and rights for senior citizens such as: strengthening their independence and personal development; participation in public life; fair and proportional treatment regarding access to and satisfaction of needs for welfare; and the prohibition against distinctions based on sex, economic situation, ethnicity, belief, religion or any other characteristic.

6.9 **Netherlands**

6.9.1 The constitution of The Netherlands (article 1) contains a general prohibition on discrimination. This article forms the basis of all Equal treatment legislation in The Netherlands.

6.10 **Norway**

6.10.1 Under Norwegian legislation there are two Acts that solely regulate discrimination: The Gender Act and the Discrimination Act. In addition to this legislation, there are discrimination regulations in the Employment Act, chapter 13, and also in the Criminal Code.

6.11 **Spain**

6.11.1 Under Spanish law, there is a general principle of equality, which forbids all forms of discrimination. According to Article 14 of the Spanish Constitution, Spaniards are equal before the Law and may not be subjected to any discrimination by reason of birth, race, sex, religion, opinion or any other personal or social circumstances.

6.12 **USA**

6.12.1 The United States of America introduced the Age Discrimination Act (ADA) in 1975. Despite its long history, the Age Discrimination Act is reputed to have had only a very limited effect.

6.12.2 'The Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) enforces Federal laws that prohibit discrimination by health care and human service providers that receive funds from the HHS. One such law is the Age Discrimination Act of 1975 ("ADA").'

'…The ADA prohibits discrimination on the basis of age in programmes or activities receiving Federal financial assistance. …The ADA can be said to have a limited effect in that (like other U.S. civil rights statutes) it applies only to programmes or activities in which there is an intermediary (recipient) standing between the Federal financial assistance and the ultimate beneficiary of that assistance. ….The ADA, therefore, does not apply to programmes of direct assistance (such as the Social Security programme) in which Federal funds flow directly and unconditionally from the Federal government to the individual beneficiary of those funds.' (Age Concern England et al, 2004)

7 Impact Assessments of anti-discrimination legislation

7.1 A report "Comparative Analysis of Existing Impact Assessments of Anti-Discrimination Legislation" prepared for the European Commission, in December 2006, by Human European Consultancy and Migration Policy group, looked at 22 assessments of anti-discrimination legislation outside the field of employment and occupation. (Masselot et al, 2006)

7.2 Few of the evaluations were of legislation prohibiting age discrimination as such and those that were, did not have an analysis of the costs and benefits.

7.3 The only cost-benefit impact assessment specifically of age discrimination legislation was in the field of employment and was the partial regulatory impact assessment (RIA) carried out by the United Kingdom Department of Trade and Industry in advance of the introduction of the Employment Equality (Age) Regulations 2006. (Employment Relations Directorate - Department of Trade and Industry - DTI, 2005)

7.4 Disability is often associated with older age and measures against discrimination on the grounds of disability may disproportionately benefit older people. A number of cost-benefit analyses are available for disability-discrimination legislation but to include these would cloud the issue around age discrimination.

8 Ageing, proximity to death and the cost of health care

8.1 Older people are disproportionately greater users of health services. Although people aged 65 and over constitute around 16 per cent of the general [UK] population, they occupy two-thirds of acute hospital beds and account for 25–30 per cent of NHS expenditure on drugs and 45 per cent of all items prescribed. (Robinson, 2002)

8.2 Despite this, at the macro-economic level, the vast majority of studies find that age structure has a small or non significant impact on health care expenditures, whereas GDP has a

sizeable and highly significant impact. At the individual level, micro-economic studies find as well that the influence of age on health care expenditure is significantly reduced when proximity to death is taken into account (Dormont, Grignon and Huber, 2006)

8.3 A number of studies postulate that proximity to death is a better predictor of health care costs than age and that, when proximity to death has been accounted for, age may disappear as a significant predictor of costs. (Zweifel et al, 1999) A 2000 study of GP care costs found that those who died were significantly more costly to care for than those who survived, and that, for those who died, costs were related to proximity to death but not to age. (O'Neill et al, 2000)

8.4 A 2006 study using a two-equation exact aggregation demand model using Australian Medicare payments data over an eight-year period (1994-2001) suggested that 'once proximity to death is accounted for, population ageing has either a negligible or even negative effect on health care demand' (Johnson, 2006)

8.5 Only in the case of Long term Care does age remain a cost factor after proximity to death has been removed (Werblow, Felder and Zweifel , 2007)

8.6 Proximity to death may be a useful modeling tool which can not, in itself, be discriminatory since, for any individual, it is not known until after the event. Physicians accurately estimate the remaining survival time of terminally ill patients only 20% of the time. (Christakis and Lamont, 2001) Although proximity to death will be correlated with age, the temptation to use age as a proxy has to be avoided.

8.7 'The problem lies not so much in an ageing population as in the changing pattern of illness and disease, with a shift in mortality from sudden and acute infections to mortality as a termination of longer term morbidity' (Dey and Fraser, 2000)

8.8 'Epidemiological studies have shown….that there might be a compression of morbidity, whereby additional years of life are lived in health rather than illness, making a 65-year old 10 years from now healthier on average than a 65-year old now. Economically this translates to a concentration of health care expenditures in the last years of life' (Seshamani, 2004)

9 Age, health care costs and advancing technology

9.1 'The aging of the population is only one driver of health care expenditures, and the effects of the relatively slow pace of demographic change may be overwhelmed by other factors like the introduction of new technologies and treatments' (Payne et al, 2007 quoting Cutler and McClellan, 2001)

9.2 'When a technology is initially developed, it may be used mostly among younger people, because of lack of sufficient knowledge of the effects on older patients, and lack of technical

expertise to prevent mistakes from which older people may be less likely to recover. Over time….the rate of technology use may rise at a faster rate in the older age groups than the younger age groups, leading to a disproportionate rise in expenditures. One study in Sweden found that utilization rates for coronary artery bypass grafting (CABG) were constant from 1987 to 1994 for ages 60 and younger, but increased nearly five-fold for the age group 80-84.' (Seshamani, 2004)

10 The cost of prohibiting age discrimination - a zero-sum game or extra pressure for increased resources?

10.1 It could be argued that removing age discrimination will, in itself, have no overall effect on total health and social service costs because the total budget available for health care and social care is determined by external factors and removing age discrimination only affects how the available total budget is distributed.

10.2 'It is not inevitable that the elimination of age-related rationing would necessarily push up the costs of care. Rationing (or priority ratings) would merely be based on other criteria, transferring restrictions onto other groups of people, for example, those considered to be in less acute need. However, ever-increasing public demands for more and better health care for everyone are likely to intensify the political pressures that will lead to higher expenditure on care services. This alarms politicians and civil servants keen to ensure that public expenditure keeps within reasonable bounds, and managers who have long relied on age-related rationing in order to balance the books.' (Robinson, 2002)

10.3 A 2002 study by Seshamani and Gray, comparing the period 1985-87 with 1996-99 found that, although for the period 1996-99 per capita health costs in England and Wales for those aged 85+ were still more than five times greater than for those aged 16-44, between the two periods per capita health costs for the 16-44 age group rose by over 40% while falling by 7% for those age 85+.

10.4 An international comparison of England and Wales, Japan, Canada and Australia for the two periods noted that, for those aged 65+, per capita health care costs in England and Wales rose by 8% while those for Japan, Canada and Australia rose by 12%, 20% and 56% respectively. (Seshamani and Gray, 2002)
Although the reasons will be various and complex it is worth noting that, from 1990, Japan introduced the 'Gold Plan' and 'New Gold Plan', a 'ten year strategy to promote health and welfare services for the elderly' and, in 1990, Canada's largest state Ontario introduced its Human Rights Code which outlaws age discrimination in health services and in 1997/8 it mandated public health services to municipal governments. Although Australia introduced a Disability Discrimination Act in 1992/3, the Australian Age Discrimination Act did not come into effect until much later in 2004.

10.5 A longitudinal study of hospital expenditure in Oxfordshire over a 29 year period (1970-99) reported that while comparing an 80 year old person with a 65 year old person, expenditure

in the last year of life was 30% higher for women and 37% higher for men, when the same comparison is made of 95 year-olds and 80 year-olds there is a 20% fall for both men and women. (Seshamani, 2004) This may reflect the increased frailty of the oldest old and therefore shorter hospital stays under equal treatment, or a discriminatory bias which, if removed, would be reflected in increased costs.

11 Age discrimination and age-based rationing in healthcare

11.1 Given that budgets are not unlimited, overt and covert health care rationing has always been a feature of the National Health Service. The 2001 National Service Framework for Older People affirmed that 'NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.' Legislation to outlaw age discrimination in services would mean that health care rationing decisions based on age could be challenged in the courts.

11.2 Age based rationing may take place at a Strategic, Programmatic or Clinical level. (Dey and Fraser, 2000) A variety of justifications are made including the 'fair innings' argument. 'A more subtle version of the fair innings argument justifies age-based rationing in terms of redistribution of health care, not from the old as a social group to the young, but within an individuals life span from one's old age to one's youth' (Dey and Fraser, 2000 referencing Daniels, 1983)

11.3 'Precisely because clinical judgment is meant to involve a holistic assessment of individual needs, it is no easy matter to assess the way age is used at the clinical level. If clinical decisions involve age-based rationing they are likely to be covert. Nevertheless research suggests that covert discrimination by age is a pervasive feature of clinical practice. …Those concerned to reduce rationing by age cannot take refuge in decision making at the clinical level , where discrimination seems rife but hard to challenge' (Dey and Fraser, 2000)

11.4 'In one study, GPs claimed to be aware of upper age limits restricting access to heart by-pass operations (34 per cent), knee replacements (12 per cent) and kidney dialysis (35 per cent). Other studies have shown that 20 per cent of cardiac care units operate upper age limits and 40 per cent had an explicit age-related policy for thrombolysis. Upper age limits have been fairly common in cardiac rehabilitation programmes and in high or intensive care units following surgery.' (Robinson, 2002)

11.5 Stroke care varies considerably across European centres, with older people more likely to gain access to organised stroke care in many centres but less likely to receive diagnostic investigations, therapy input and outpatient review. (Bhalla et al, 2004)

11.6 There is clear evidence of an age effect on the delivery of stroke care in England, Wales, and Northern Ireland, with older patients being less likely to receive care in line with current clinical guidelines. (Rudd et al, 2007)

11.7 In the management of ischaemic heart disease 'It appears that age per se causes older cardiac hospital patients to be treated differently'. (Bond et al, 2003)

11.8 In cardiology, 'rates of use of potentially life saving and life promoting interventions and investigations decline as the patient gets older. Higher rates of cardiological intervention occur among younger people, despite the high incidence of the condition among older individuals.' (Bowling, 1999)

11.9 It is still not possible to be sure whether there is ageism in the management of older patients with colorectal cancer. However, the rate of histological verification fell markedly with increasing age, making it questionable whether decisions to treat were based on best clinical practice at the time. (Austin and Russell, 2003)

11.10 A 2000 study of the management of elderly blunt trauma victims in Scotland found that significantly more of the elderly died than would be predicted. Age appeared to be an independent factor in the process of trauma care in Scottish hospitals. (Grant, Henry and McNaughton, 2000)

11.11 A 2005 study of the significance of age for the quality of life (QoL) of older and younger people with end-stage renal failure (ESRF) and in receipt of renal replacement therapy (RRT) suggested that using older age as a criterion for refusing full access to healthcare resources in ESRF is a simplistic and potentially erroneous strategy. (McKee et al, 2005)

11.12 A 2006 study of Older adults living with HIV infection, found 'the majority (68%) of the respondents experienced both ageism and HIV-associated stigma. The experiences were often separate, although some interrelated stigma did occur. (Emlet, 2006)

11.13 It is common for drug trials to exclude older people, usually over 65 or 70. Many of the drugs which are successfully tested are then registered and become available for use. Healthcare professionals either do not prescribe the medications to those in the excluded age groups because of the lack of age-relevant data, or they prescribe off-label. (Godlovitch, 2003)

11.14 The most overt form of age-based rationing and discrimination in health care lies in the implementation of screening programmes. For example, breast cancer screening, by invitation, is restricted to 50-70 year old women although older women may attend. 'Age may be a good predictor of risk, though in breast cancer it is only so at the lower age rather than the upper age threshold.' (Dey and Fraser, 2000)

11.15 Perceived or self-reported discrimination is linked to diminished well-being, the primary driver of perceived age discrimination being age--not cohort or historical period. Perceived age discrimination is high in the 20s, drops in the 30s and peaks in the 50s. (Gee, Pavalko and Long, 2007)

11.16 In an attempt to standardize and rationalize health care rationing, the National Institute for Health and Clinical Excellence (NICE) uses Quality Adjusted Life Years (QALYs) to assess the relative cost effectiveness of treatments. Some argue that the QALY is inherently age discriminatory.
'…if the effects of treatment are expected to last for life, patients with a short life expectancy cannot expect to come out as favourably as those with long to live.' (Taylor, 2007)

'It is the fact that younger people usually (though not always), have more life expectancy to gain from treatment that makes the QALY "inherently ageist".' (Harris, 2005 quoted in Taylor, 2007)

11.17 'The influence of age on QALY league table estimates is normally quite small because the estimates derive from averaging results from patients of different ages.
Where a treatment is predominantly for older patients, the estimate would be affected by the lower life expectancy of the elderly…' (Dey and Fraser, 2000)

11.18 'NICE openly works to a utilitarian model, but this is not to say it endorses discrimination. The discretion applied after the application of the QALY and the other stages of appraisal are intended to account for this. … NICE is applying utilitarian principles and then adapting them to conform to the egalitarian restrictions placed upon them by the NHS. … adaptation and even weighting of the QALY, can never fully reflect the principles supported by the NHS due to the differing ethical basis, and as such NICE should be cautious in applying the results of such a model in situations such as the current Alzheimer's controversy.' (Taylor, 2007)

12 Specialist health services for older people

12.1 Specialist health services for older people raise issues of positive and negative ageism which may be inherently discriminatory.

12.2 'The criteria that define old age cannot serve as a shorthand descriptor of needs. Older people vary considerably in their physical, psychological, economic and social states, and this variation makes it difficult to identify what knowledge and skills a specialist practitioner needs. … There is then a paradox in identifying older people as a distinct group who would benefit from specialist services, because this approach tend to reinforce social stereotypes and assumptions about the characteristics of older people. This paradox is evident in British government policy about health-care provision for older people, as exemplified in the NSF-OP …' (Reed et al, 2006)

13 Age discrimination in Social Services

13.1 In the Regulatory Impact Assessment to accompany the green paper 'A framework for fairness', the Department for Communities and Local Government , estimating the costs that the removal of Age discrimination from goods and services might have on health / social care providers, anticipated '… potentially significant costs in respect of social care which have not yet been quantified'. (Department for Communities and Local Government, 2007)

13.2 '… age discrimination remains part of the fabric of a social care system in which services for older people and younger adults have been managed separately, with very different standards and expectations.
Older people have to make do with poorer services and a system that neglects their social needs and wellbeing. Community services such as shopping, cleaning and social activities may be all that is needed, but funding for this support has been systematically eroded.' (Age Concern England, 2007d)

13.3 Research, funded by Help the Aged, is currently being undertaken by the University of Leicester, Department of Health Sciences to examine 'Age discrimination in social care assessment and provision' in two local authorities to establish whether older people are less favourably treated with respect to both the allocation of funding and the implementation of assessment, care planning and service provision. The research is due to report in May 2008.

14 Age discrimination in mental health services

14.1 The assertion in the regulatory impact assessment accompanying the green paper 'A Framework for Fairness' that removing age discrimination would involve 'Minimal additional costs in most areas, where commitments to eliminate discriminatory policies and practices are already in place (eg mental health services) …' (Department for Communities and Local Government, 2007) presupposes that mental health services for older people are currently adequate and without discrimination. This view is challenged by a number of organisations including the Royal College of Psychiatrists, Age Concern England and the Mental Health Foundation.

14.2 According to the Royal College of Psychiatrists '… with mental health care … older people do not have access to the range of services available to younger adults despite having the same, and often greater, need.' (Royal College of Psychiatrists Faculty of Old Age Psychiatry, 2007)

14.3 A 2006 joint report from the Healthcare Commission, Audit Commission and Commission for Social Care Inspection found that older people reported a noticeable difference in their experience of accessing mental health services as they reached and passed the age of 65, that out of hours services for psychiatric advice and crisis management are much less developed than for working age adults and older people with dementia experience unacceptably long waits for specialist care. (Healthcare Commission, Audit Commission and Commission for Social Care Inspection, 2006)

14.4 Direct age based discrimination continues to be entrenched in mental health services where age-based rules are organised separately for working age adults and older people. (Lee and Crown, 2007)

14.5 According to Age Concern England, by 2021, not meeting the mental health needs of older people could be costing the UK economy £245bn per year in lost consumers, £230bn in lost workers, £15bn from the absence of lost carers, £5bn from lost volunteers and £4bn from lost grandparents. (Lishman, 2007)

14.6 Perceived discrimination can itself have a detrimental effect on the mental health of older people (Vogt Yuan, 2007) contributing to a negative spiral.

14.7 Age Concern England have developed estimates of the costs associated with the removal of age discrimination from mental health services.

14.7.1 "The {UK} government is currently {May 2007} piloting talking therapies but is restricting them to people of 'working age', despite older people's ability to benefit from them.

Involving older people in the national roll-out of a new service would by 2010/2011 add around **£100 million** to the projected cost of the project."

14.7.2 "For severe and enduring mental illness, if older people's access to services were equalized with that of younger adults, the total cost would be around **£800 million**." (Age Concern England, 2007d)

15 Conclusions and recommendations

15.1 A large number of studies are available comparing anti-discrimination legislation in goods and services, legislation impact assessments, the contribution of older people to overall health care costs and rationing and discrimination in health care, social care and mental health services. Many are listed in the bibliographies accompanying this report.

15.2 No study has been found, in any country, providing a post hoc analysis of the costs and benefits of introducing legislation to remove age discrimination from health, social care and mental health services.

15.3 Age discrimination is recognised as an unjustifiable difference in treatment based solely on age. It is measurable by observing outcomes for particular age groups other than those to be expected had no discrimination taken place, after taking into account variations in need.

15.4 The only fully developed measure of age discrimination found was the UK Department of Health's own benchmarking tool.

15.5 Recommendations for further action:

- An international macro level comparative study of the changes over time in the age group specific per capita costs of health care, social care and mental health services in countries where anti age discrimination legislation has been introduced and to identify any changes in underlying trends resulting from the introduction of the legislation.
- A bottom up study, within the UK, to identify individual health, social care and mental health services that discriminate on the basis of age, to provide individual estimates of the likely effect on costs of removing that discrimination and to estimate the cumulative effect of these measures.

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References and key bibliography

Age Concern England (2007a) *Age Concern's response to A framework for fairness: proposals for a Single Equality Bill for Great Britain*, London: Age Concern England

Age Concern England (2007b) Age Concern's response to A framework for fairness: proposals for a Single Equality Bill for Great Britain: *summary*, London: Age Concern England

Age Concern England (2007c) *Age Concern's response to the Joint Committee on Human Rights' inquiry into the human rights of older persons in healthcare - summary*, London: Age Concern England

Age Concern England (2007d) *Age of equality? - outlawing age discrimination beyond the workplace*, London: Age Concern England

Age Concern England (2004) *Championing age equality - older people, the law and the Commission for Equality and Human Rights*, London: Age Concern England

Age Concern England (1998) *Age discrimination: make it a thing of the past*, London: Age Concern England

Age Concern England, AGE (European Older People's Platform) and other European Age Sector non-Governmental Organisations (2006) *Towards European legislation on age discrimination in goods, facilities and services: explanatory memorandum: proposal for a draft directive on age discrimination in goods, facilities and services, European Parliamentary meeting, October 4 2006*, London: Age Concern England

Age Concern England, DaneAge Association, LBL (Dutch expertise centre on age and society) and Kuratorium Deutsche Altershilfe (2004) *Addressing age barriers: an international comparison of legislation against age discrimination in the field of goods, facilities and services*, London: Age Concern England

Akid M (2002) The age of contempt, *Nursing Times* 98 (10, 7 March 2002) : 12-13

Aksoy S (2000) Can the "quality of life" be used as a criterion in health care services?, *Bulletin of Medical Ethics* (162, October 2000) : 19-22

Ament A and Baltussen R (1997) The interpretation of results of economic evaluation: explicating the value of health, *Health Economics* 6 (6) : 625-635

Anderson J M, Kennell D L and Sheils J F (1983) Estimated effects of 1983 changes in employer health plan/Medicare payment provisions on employer costs and employment of older workers, Washington, DC: National Commission for Employment Policy *Research Report Series* (RR-83-15)

Arber S (1996) Is living longer cause for celebration?, *Health Service Journal* 106 (5512, 18 July 1996) : 28-31

Asthana S, Gibson A, Moon G, Dicker J and Brigham P (2004) The pursuit of equity in NHS resource allocation: should morbidity replace utilisation as the basis for setting health care capitations?, *Social Science & Medicine* 58 (3) : 539-551

Austin D and Russell E M (2003) Is there ageism in oncology?, *Scottish Medical Journal* 48 (1) : 17-20

Avorn J (1984) Benefit and cost analysis in geriatric care - turning age discrimination into health policies, *The New England Journal of Medicine* 310 (20, 17 May 1984) : 1294-1301

Bagust A, Hopkinson P K, Maslove L and Currie C J (2002) The projected health care burden of Type 2 diabetes in the UK from 2000 to 2060, *Diabetic Medicine* 19 (s4) : 1-5

Bains M and Oxley H (2004) *Ageing-related spending projections on health and long-term care; Chapter 7 IN Towards high-performing health systems: policy studies; OECD Directorate for Employment, Labour and Social Affairs* , Paris: Organisation for Economic Co-operation and Development

Baker P M (1983) Ageism, sex, and age: a factorial survey approach, *Canadian Journal on Aging* 2 (4) : 177-184

Balducci L (2000) Geriatric oncology: challenges for the new century, *European Journal of Cancer* 36 (14) : 1741-1754

Baltussen R, Leidl R and Ament A (1996) The impact of age on cost-effectiveness ratios and its control in decision making, *Health Economics* 5 (3) : 227-239

Barros P P (1998) The black box of health care expenditure growth determinants, *Health Economics* 7 (6) : 533-544

Barry M, Tilson L and Ryan M (2004) Pricing and reimbursement of drugs in Ireland, *European Journal of Health Economics* 5 (2) : 190-194

Bayer A and Tadd W (2000) Unjustified exclusion of elderly people from, studies submitted to research ethics committee for approval: descriptive study, *British Medical Journal* 321 (7267, 21 October 2000) : 992-993

Bell M, Chopin I and Palmer F (2007) *Developing anti-discrimination law in Europe: the 25 EU Member States compared; prepared ... for the European Network of Independent Experts in the non-discrimination field ... [and] European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities Unit G2*, Luxembourg: Office for Official Publications of the European Communities

Binstock R H and Post S G (eds) (1991) *Too old for health care? controversies in medicine, law, economics, and ethics*, Baltimore, MD: Johns Hopkins University Press

Blomqvist A (2002) QALYs, standard gambles, and the expected budget constraint, *Journal of Health Economics* 21 (2) : 181-195

Bond M, Bowling A, McKee D, Kennelly M, Banning A, Dudley N, Elder A and Martin A (2003) Does ageism affect the management of ischaemic heart disease?, *Journal of Health Services Research and Policy* 8 (1) : 40-47

Bosanquet N (2001) A 'fair innings' for efficiency in health services?, *Journal of Medical Ethics* 27 (4) : 228-233

Bosanquet N and Sikora K (2004) The economics of cancer care in the UK, *The Lancet Oncology* 5 (9) : 568-574

Bowling A (1999) Ageism in cardiology, *British Medical Journal* 319 (7221, 20 November 1999) : 1353-1355

Braveman P (2006) Health disparities and health equity: concepts and measurement, *Annual Review of Public Health [US]* 127 : 167-194

Breda J and Schoenmaekers D (2006) Age - a dubious criterion in legislation, *Ageing and Society* 26 (4) : 529-548

Breyer F and Felder S (2006) Life expectancy and health care expenditures: a new calculation for Germany using the costs of dying, *Health Policy* 75 (2) : 78-86

Breyer F and Schultheiss C (2002) "Primary" rationing of health services in ageing societies - a normative analysis, *International Journal of Health Care Finance and Economics* 2 (4) : 247-264

Breyer F and Ulrich V (2000) Gesundheitsausgaben, Alter und medizinischer Fortschritt = [Ageing, medical progress and health care expenditures], *Jahrbucher fur Nationalokonomie und Statistik* 220 (1) : 1-17

Brockmann H (2002) Why is less money spent on health care for the elderly than for the rest of the population? Health care rationing in German hospitals, *Social Science and Medicine* 55 (4) : 593-608

Brooks R, Regan S and Robinson P (2002) *A new contract for retirement - modelling policy options to 2050*, London: Institute for Public Policy Research

Bryan S, Roberts T, Heginbotham C and McCallum A (2002) QALY-maximisation and public preferences: results from a general population survey, *Health Economics* 11 (8) : 679-693

Burchardt T; ESRC Centre for Analysis of Social Exclusion. Suntory-Toyota International Centres for Economics and Related Disciplines. London School of Economics and Political Science (2006) *Foundations for measuring equality: a discussion paper for the Equalities Review (CASEpaper 111)*, London: STICERD

Butler R N (1969) Age-ism: another form of bigotry, *The Gerontologist* 9 (4, part I) : 243-246

Bytheway B (1995) *Ageism*, Buckingham: Open University : 142 pp (Rethinking ageing series)

Bytheway B and Johnson J (1990) On defining ageism, *Critical Social Policy* 10 (2) : 27-39

Callahan D (1989) Rationing health care: will it be necessary? Can it be done without age or disability discrimination?, *Issues in Law and Medicine* 5 (3) : 353-366

Care Services Improvement Partnership (CSIP) (2005) *Everybody's business: integrated mental health services for older adults: a service development guide*, http://www.olderpeoplesmentalhealth.csip.org.uk/everybodys-business/download-documents.html

Care Services Improvement Partnership (CSIP) and National Older People's Mental Health Programme (2007) *Age equality: what does it mean for older people's mental health services? Guidance note [on]: Everybody's business: integrated mental health services for older adults: a service development guide*, London: Care Services Improvement Partnership

Carr-Hill R, Chalmers-Dixon P and Lin J; University of York. Centre for Health Economics and South East Public Health Observatory (2005) *The public health observatory handbook of health inequalities measurement; edited by Jennifer Lin*, http://www.sepho.org.uk/extras/rch_handbook.aspx

Charny M C, Lewis P A and Farrow S C (1989) Choosing who shall not be treated in the NHS, *Social Science and Medicine* 28 (12) : 1331-1338

Christakis N A and Lamont E B (2000) Extent and determinants of error in doctors' prognosis in terminally ill patients: prospective cohort study, *British Medical Journal* 320 (7233, 19 February 2000) : 469-473

Comas-Herrera A, Wittenberg R, Costa-Font J, Gori C, Maio A Di, Patxot C, Pickard L, Pozzi A and Rothgang H (2006) Future long-term care expenditure in Germany, Spain, Italy and the United Kingdom, *Ageing and Society* 26 (2) : 285-302

Coulter A and Ham C (eds) (2000) *The global challenge of healthcare rationing*, Buckingham: Open University Press

Denton F T, Gafni A and Spencer B G (2002) Exploring the effects of population change on the costs of physician services, *Journal of Health Economics* 21 (5) : 731-803

Department for Communities and Local Government (2007) *Equality impact assessment: Discrimination Law Review:*, London: Department for Communities and Local Government

Department for Communities and Local Government (2007) *Proposals to simplify and modernise discrimination law: initial regulatory impact assessment*, London: Department for Communities and Local Government

Department of Health (2003) *Health equity audit: a guide for the NHS*, http://site320.theclubuk.com/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084138

Department of Health NSF OP Implementation Team (2007) *Standard One, [National Service Framework for Older People] - Rooting out age discrimination; last modified date: 15 August 2007*, London: NSF OP Implementation Team,

Department of Health. NSF OP Implementation Team (2002) *Age discrimination benchmarking tools and user guides [for]: acute hospital procedures; social care; local information input; and primary care*, http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Olderpeoplesservices/DH_4071271

Department of Health. NSF OP Implementation Team (2001) *National Service Framework for Older People ... : NSF Standard One: Rooting out age discrimination: audit of policies for age-related criteria: a guide*, http://www.dh.gov.uk/en/Policyandguidance/SocialCare/Deliveringadultsocialcare/Olderpeople/DH_4001924

Department of Trade and Industry. Employment Relations Directorate (2005) *Partial Regulatory Impact Assessment (RIA) : Age discrimination - summary: [Coming of age consultation]*, London: Department of Trade and Industry

Department of Trade and Industry. Employment Relations Directorate (2003) *Partial Regulatory Impact Assessment (RIA) for age discrimination legislation*, London: Department of Trade and Industry

Dey I and Fraser N (2000) Age-based rationing in the allocation of health care, *Journal of Aging and Health* 12 (4) : 511-537

Dormont B and Huber H (2006) Causes of health expenditure growth: the predominance of changes in medical practices over population ageing = Causes de la croissance des dépenses de santé : la prédominance des changements des pratiques médicales sur le vieillissement; Troisième Conférence de l'Institut d'Economie Publique., *Annales d'Économie et de Statistique* 83-84 : 187-217

Dormont B, Grignon M and Huber H (2006) Health expenditure growth: reassessing the threat of ageing, *Health Economics* 15 (9) : 947-963

Eisen R and Sloan F A (1996) *Long-term care: economic issues and policy solutions (Developments in health economics and public policy, vol 5)*, Dordrecht: Kluwer

Elder A T (2005) Which benchmarks for age discrimination in acute coronary syndromes?, *Age and Ageing* 34 (1) : 4-5

Emlet C A (2006) "You're awfully old to have this disease": experiences of stigma and ageism in adults 50 years and older living with HIV/AIDS, *The Gerontologist* 46 (6) : 781-790

Esslinger A S, Franke S and Heppner H J (2007) Altersabhängige Priorisierung von Gesundheitsleistungen - Perspektiven für das deutsche Gesundheitswesen = [Age-dependent prioritisation of health-care spending - perspectives for the German health-care system], *Gesundheitswesen* 69 (1) : 11-17

Feder G, Hull S, Middleton Hugh and Shaw I (2005) NICE guidelines for the management of depression, *British Medical Journal* 330 (7486, 5 February 2005) : 267-268

Fraboni M, Saltstone R and Hughes S (1990) Fraboni Scale of Ageism (FSA): an attempt at a more precise measure of ageism, *Canadian Journal on Aging* 9 (1) : 56-66

Freund D and Smeeding T M (2002) *The future costs of health care on ageing societies: is the glass half full or half empty? Prepared for the seminar, Ageing Societies: Responding to the Policy Challenges, Monday, April 8, 2002, University of New South Wales, Sydney, Australia*, http://www.sprc.unsw.edu.au/seminars/Tim%20Smeeding%20paper.pdf

Gandjour A, Greb J, Bomsdorf E and Lauterbach K W (2005) Impact of demographic changes on healthcare expenditures and funding in the EU, *Applied Health Economics and Health Policy* 4 (1) : 1-4

Getzen T E (2001) Aging and health care expenditures: a comment on Zweifel, Felder and Meiers, *Health Economics* 10 (2) : 175-177

Getzen T E (1992) Population aging and the growth of health expenditures, *The Journals of Gerontology* 47 (3) : S98-104

Godlovitch G (2003) Age discrimination in trials and treatment: old dogs and new tricks, *Monash Bioethics Review* 22 (3) : 66-77

Grant P T, Henry J M and McNaughton G W (2000) The management of elderly blunt trauma victims in Scotland: evidence of ageism?, *Injury* 31 (7) : 519-528

Gray A and Seshamani M (2004) Ageing and health-care expenditure: the red herring argument revisited, *Health Economics* 13 (4) : 303-314

Gunderson A, Tomkowiak J, Menachemi N and Brooks R (2005) Rural physicians' attitudes toward the elderly: evidence of ageism?, *Quality Management in Health Care* 14 (3) : 167-176

Hanratty B (et al) (2007) Inequality in the face of death? Public expenditure on health care for different socioeconomic groups in the last year of life, *Journal of Health Services Research and Policy* 12 : 90-84

Heale J D, Abernathy T J and Kittle D (2000) Using healthy life years (HeaLYs) to assess programming needs in a public health unit, *Canadian Journal of Public Health* 91 (2) : 148-152

Healthcare Commission, Audit Commission and Commission for Social Care Inspection (2006) *Living well in later life: a review of progress against the National Service Framework for Older People*, London: Healthcare Commission

Hornstein Z, Encel S, Gunderson M and Neumark D (2001) *Outlawing age discrimination - foreign lessons, UK choices*, Bristol: The Policy Press, on behalf of the Joseph Rowntree Foundation

Jacobzone S E, Cambois E C and Robine J M (2000) Is the health of older persons in OECD countries improving fast enough to compensate for population ageing?, *OECD Economic Studies* 30 (1) : 149-190

Jacobzone S E, Cambois E C and Robine J M (1998) *The health of older persons in OECD countries: is it improving fast enough to compensate for population ageing? (OECD labour market and social policy occasional paper, no 37)*, Paris: Organisation for Economic Co-operation and Development

Johnson D and Yong J (2006) Costly ageing or costly deaths? Understanding health care expenditure using Australian Medicare payments data, *Australian Economic Papers* 45 (1) : 57-74

Journal of Health Services Research and Policy (1997) Equity and equality: ageism in evidence-based medicine, *Journal of Health Services Research and Policy* 2 (2) : 129-131

Levenson R (2003a) *Auditing age discrimination: a practical approach to promoting age equality in health and social care*, London: King's Fund

Lishman G (2007) How bias starts at 65, *Community Care* (1688, 30 August 2007) : 30-31

Long M J and Marshall B S (2000) The relationship of impending death and age category to treatment intensity in the elderly, *Journal of Evaluation in Clinical Practice* 6 (1) : 63-70

Low A and Low A (2004) Measuring the gap: quantifying and comparing local health inequalities, *Journal of Public Health* 26 (4) : 388-395

Macinko J A and Starfield B (2002) Annotated bibliography on equity in health, 1980-2001, *International Journal for Equity in Health* 1 (1) : 1-20

Masselot A, Larizza M, Landman T, Wallace C and Niessen J (2006) *Comparative analysis of existing impact assessments of anti-discrimination legislation: mapping study on existing national legislative measures - and their impact in - tackling discrimination outside the field of employment and occupation on the grounds of sex, religion or belief, disability, age and sexual orientation, VT/2005/062*, Utrecht: Human European Consultancy; Brussels: Migration Policy Group

Mayhew I (2000) *Health and elderly care expenditure in an ageing world (IIASA research report, RR 21)*, Laxenburg, Austria: International Institute for Applied Systems Analysis

McColgan A, Niessen J and Palmer F (2006) *Comparative analyses on national measures to combat discrimination outside employment and occupation: mapping study on existing national legislative measures - and their impact in - tackling discrimination outside the field of employment and occupation on the grounds of sex, religion or belief, disability, age and sexual orientation, VT/2005/062*, Utrecht: Human European Consultancy; Brussels: Migration Policy Group

McGlone E and Fitzgerald F; National Council on Ageing and Older People, Ireland (2005) *Perceptions of ageism in health and social services in Ireland: report based on research undertaken by Eileen McGlone and Fiona Fitzgerald, QE5*, Dublin: National Council on Ageing and Older People

McGrail K, Green B, Barer M L, Evans R G, Hertzman C and Normand C (2000) Age, costs of acute and long-term care and proximity to death: evidence for 1987-88 and 1994-95 in British Columbia, *Age and Ageing* 29 (3) : 249-254

McKee K J, Parker S G, Elvish J, Clubb V J, El Nahas M, Kendray D and Creamer N (2005) The quality of life of older and younger people who receive renal replacement therapy, *Ageing and Society* 25 (6) : 903-923

Menec V, Lix C, Steinbach O, Ekuma M, Sirski M, Dahl M and Soodeen R-A (2004) *Patterns of health care use and costs at the end of life*, Winnipeg: Manitoba Centre for Health Policy, Faculty of Medicine, University of Manitoba

Ministry of Justice, Department for Education and Skills, Department of Trade and Industry, Department for Work and Pensions and Department for Communities and Local Government (2007) Discrimination Law Review: a framework for fairness: proposals for a Single Equality Bill for Great Britain: *overall summary of: consultation document, initial regulatory impact assessment, equality impact assessment*, London: Department for Communities and Local Government

Mooney G and Jan S (1997) Vertical equity: weighting outcomes or establishing procedures?, *Health Policy* 39 (1) : 79-87

Moor N (2000) Why are older people left out? Is ageism built into services for older people with mental health problems?, *Nursing Times* 96 (47, 23 November) : 27-28

National Institute for Clinical Excellence. Citizens Council (2004) *NICE Citizens Council report on age*, www.nice.org.uk (21 January 2004)

Nelson T D (ed) (2002) *Ageism, Stereotyping and Prejudice against Older Persons*, Cambridge, Massachusetts: MIT Press

Norton E C and Stearns S C (2004) Time to include time to death? The future of health care expenditure predictions, *Health Economics* 13 (4) : 315-327

O'Connell J M (1996) The relationship between health expenditures and the age structure of the population in OECD countries, *Health Economics* 5 (6) : 573-578

O'Neill C, Groom L, Avery A J, Boot D and Thornhill K (2000) Age and proximity to death as predictors of GP care costs: results from a study of nursing home patients, *Health Economics* 9 (8) : 733-738

Palmore E (2001) The Ageism Survey: first findings, *The Gerontologist* 41 (3) : 572-575

Palmore E B (2004) Ageism in Canada and the United States: research note, *Journal of Cross-Cultural Gerontology* 19 (1) : 41-46

Palmore E B, Branch L and Harris D K (eds) (2005) *Encyclopedia of ageism*, Binghamton, NY: Haworth Press

Parliament. Joint Committee on Human Rights (2007) *The human rights of older people in healthcare: eighteenth report of session 2006-07, House of Lords, House of Commons, Joint Committee on Human Rights - Vol 1: Report and formal minutes*, London: TSO

Parliament. Joint Committee on Human Rights (2007) *The human rights of older people in healthcare: eighteenth report of session 2006-07, House of Lords, House of Commons, Joint Committee on Human Rights - Vol 2: Oral and written evidence*, London: TSO

Parry E and Tyson S (2007) *The impact of age discrimination legislation on the higher education sector: a literature review*, Cranfield, Bedford: Human Resource Research Centre, Cranfield University

Payne G, Laporte A, Deber R and Coyte P C (2007) Counting backward to health care's future: using time-to-death modeling to identify changes in end-of-life morbidity and the impact of aging on health care expenditures, *Milbank Quarterly* 85 (2) : 213-257

Ray S, Sharp E and Abrams D; Age Concern England and University of Kent. Centre for the Study of Group Processes (2006) *Ageism: a benchmark of public attitudes in Britain*, London: Age Concern

England; Canterbury: Centre for the Study of Group Processes,

Redditch and Bromsgrove PCT (2005) *Health equity audit - age discrimination and SHA return: PCT Board meeting 26 April 2005: report from Caron Grainger, Director of Public Health to Board, Redditch and Bromsgrove PCT (Agenda item 21, enclosure 17)*, http://www.worcestershirehealth.nhs.uk/RBPCT_Library/board_meetings/Apr_05/ENC%2017%20Age%20discrimination.doc

Reed J, Cook M, Cook G, Inglis P and Clarke C (2006) Specialist services for older people - issues of negative and positive ageism, *Ageing and Society* 26 (6, November) : 849-865

Robinson J (2002) *Age equality in health and social care; presented to the IPPR seminar, 28 January 2002, at the King's Fund; the fourth in a series of six seminars on the IPPR project Age as an Equality Issue, funded by the Nuffield Foundation*, London: Institute for Public Policy Research

Rosencranz H A and McNevin T E (1969) A factor analysis of attitudes towards the aged: [the Aging Semantic Differential], *The Gerontologist* 9 (1) : 55-59

Royal College of Psychiatrists. Faculty of Old Age Psychiatry (2007) *The human rights of older persons in healthcare: response [to the Joint Committee on Human Rights' inquiry] from the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists*, London: Royal College of Psychiatry

Rudd A G, Hoffman A, Down C, Pearson M and Lowe D (2007) Access to stroke care in England, Wales and Northern Ireland: the effect of age, gender and weekend admission, *Age and Ageing* 36 (3) : 247-255

Rupp D E, Vodanovich S J and Credé M (2005) The multidimensional nature of ageism: construct validity and group differences, *Journal of Social Psychology* 145 (3) : 335-362

Salas C and Raftery J P (2001) Econometric issues in testing the age neutrality of health care expenditure, *Health Economics* 10 (7) : 669-671

Seshamani M (2004) *The impact of ageing on health care expenditures: impending crisis, or misguided concerns?*, London: Office of Health Economics

Seshamani M and Gray A (2004a) A longitudinal study of the effects of age and time to death on hospital costs, *Journal of Health Economics* 23 (2) : 217-235

Seshamani M and Gray A (2002) The impact of ageing on expenditures in the National Health Service, *Age and Ageing* 31 (4) : 287-294

Syrett K (2007) *Law, legitimacy and the rationing of health care: a contextual and comparative perspective (Cambridge law, medicine and ethics, 6)*, Cambridge: Cambridge University Press

Taylor J G (2007) NICE, Alzheimer's and the QALY, *Clinical Ethics* 2 (1) : 50-54

Tsuchiya A (2001) *The value of health at different ages (Centre for Health Economics Discussion paper 184)*, York: Centre for Health Economics, University of York

Tsuchiya A, Dolan P and Shaw R (2003) Measuring people's preferences regarding ageism in health: some methodological issues and some fresh evidence, *Social Science and Medicine* 57 (4) : 687-696

UK Inquiry into Mental Health and Well-being in Later Life (2007) *Improving services and support for older people with mental health problems: the second report from the UK Inquiry into Mental Health and Well-being in Later Life; written by Michele Lee, Project Manager, on behalf of the Inquiry Board*, London: Age Concern England; Mental Health Foundation

UK Inquiry into Mental Health and Well-being in Later Life (2006) *Promoting mental health and well-being in later life: a first report from the UK Inquiry into Mental Health and Well-being in Later Life*, London: Age Concern England; Mental Health Foundation

Werblow A, Felder S and Zweifel P (2007) Population ageing and health care expenditure: a school of 'red herrings'?, *Health Economics* 16 (10) : 1109-1126

Yuan A S V (2007) Perceived age discrimination and mental health, *Social Forces* 86 (1) : 291-312

Zweifel P, Felder S and Meiers M (1999) Ageing of population and health care expenditure: a red herring?, *Health Economics* 8 (6) : 485-496