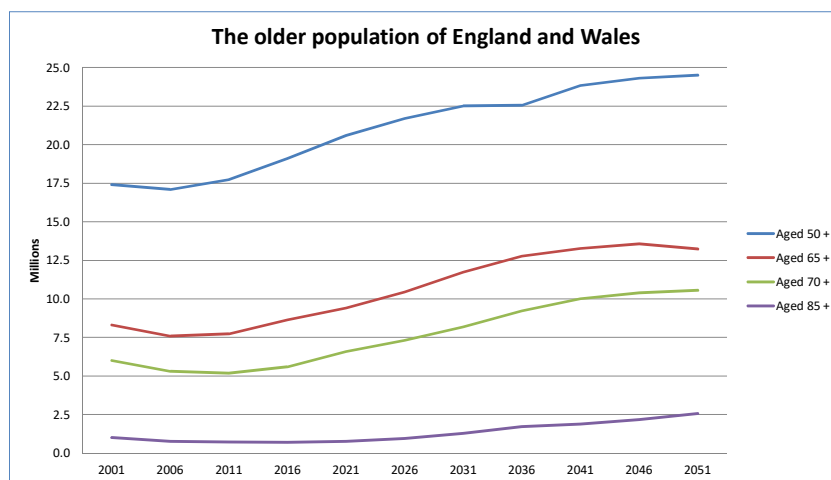


Age Differentiated Services – Age Appropriate or Age Discriminatory?

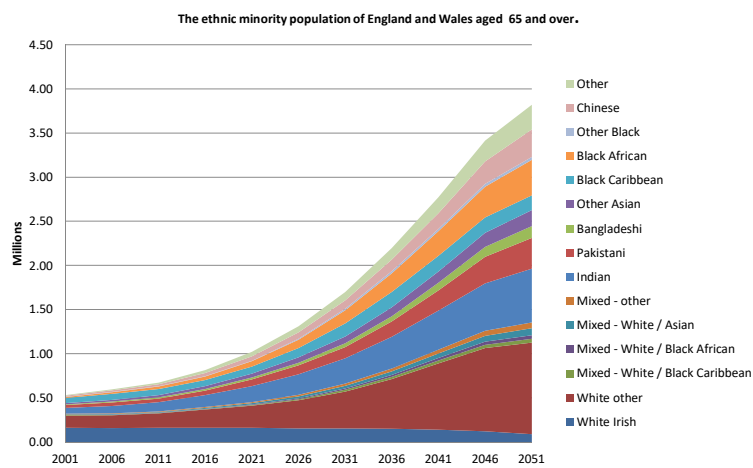
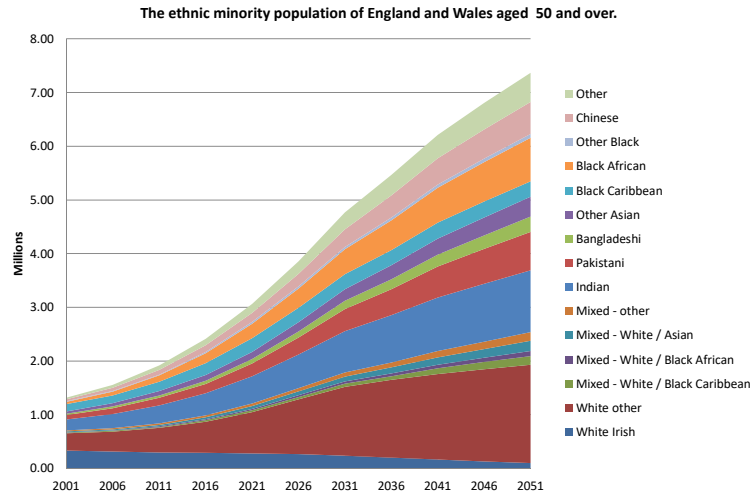
BGS Policy Committee

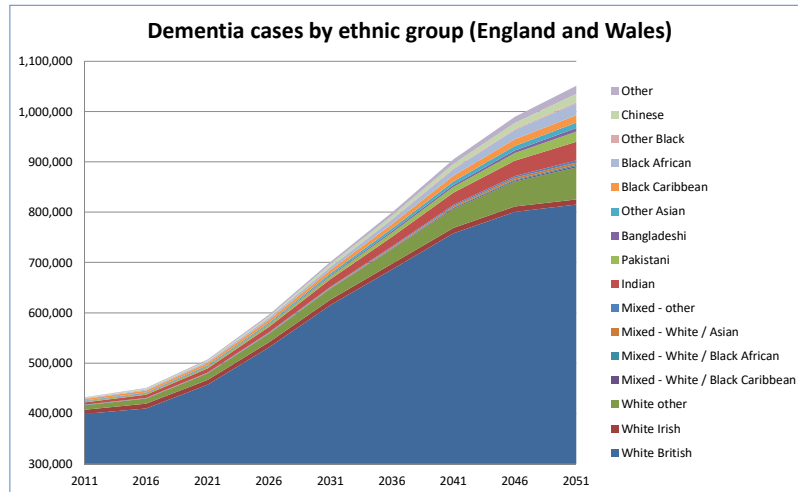
Nat Lievesley
Centre for Policy on Ageing
18th November 2010

Centre for Policy on Ageing
C|P|A
New attitudes to old age



Source: Centre for Policy on Ageing, 2010





Note: The left axis starts at 300,000 to visibly display the ethnic minority groups and therefore does not show the majority 'White British' group proportionately.

CPA reviews of age discrimination

In the lead up to the introduction of the Equality Act, as part of the Carruthers-Ormondroyd review of how local authorities and the NHS can 'tackle' age discrimination the Department of Health commissioned the Centre for Policy on Ageing to carry out four literature based reviews of age discrimination

- Primary and community health care
- Secondary health care
- Mental health care
- Social care

“Whenever a clinical stone is turned over, ageism is revealed”

(John Young, Editorial, British Medical Journal, September 2006)

Ageism, Age Discrimination and Age Differentiated Behaviour

- *Ageism* – an attitude of mind, that leads to...
- *Age Discrimination* – actions and outcomes that can be observed
- *Direct Age Discrimination* – unjustifiably different treatment of individuals with the same needs on the basis of age
- *Indirect Age Discrimination* – equal treatment of individuals of different ages with different needs so that those with greater need are disadvantaged
- *Age Differentiated Behaviour* – appropriate and thoughtful action based on a recognition of age differences

Equality Act

- Age discrimination allowed by the act
 - Proportionate means of achieving a legitimate aim (objective justification)
 - Exceptions (written into the bill to allow discrimination which would be difficult to justify objectively)
 - Possibly to have no 'exceptions' to age discrimination in health and social care – all age discrimination would have to be objectively justified
- Timetable for implementation of Health and Social Care provisions
 - 2012 – earliest date for ban on age discrimination in services and public functions
 - Later for Health and Social Care?

Age Discrimination

- Institutional – written into policy
- Individual – resulting from ageist attitudes
- Overt – open, explicit and visible
- Covert – hidden conventions, subconscious attitudes

Age Discrimination in Health and Social Care

- Actions following the National Service Framework (Older People) 2001 have meant that most **overt, institutional, direct** age discrimination has been eliminated from the NHS. The exceptions are...
 - Screening programmes
 - Mental Health Care
 - NICE use of the QALY in assessing overall relative cost effectiveness of treatments that are only or mainly for older people
- Social Care – services and funding streams are organised by age and there is clear evidence of direct explicit age discrimination

Some key findings from the reviews – Primary Care – Access to care

- Access to GP services
 - Access from home
 - Over 65s visit GP 7 times per year (4 for younger adults)
 - Transport problems
 - Mobility problems
 - Lack of Saturday surgeries
 - Home visits
 - Percentage of home visit consultations has fallen from 22% in 1971 to 4% in 2006
 - *"if you are over 70 years old and ill or in pain and have to walk to the surgery more chance of a home visit from a doctor would be nice"* – Bristol Older People's Forum, 2007
 - Out of hours services
 - Creates barriers to access for older people who prefer face to face contact and fear travelling at night to a treatment centre
 - Access from a care home
 - There is evidence that the 400,000 older people living in care homes have difficulty accessing the services of a GP and other primary care services
 - Care Quality Commission carrying out a major review of healthcare standards in care homes

Some key findings from the reviews

– Primary Care – Quality of care

A 2008 study from the English Longitudinal Study on Ageing, compared self reported care received in comparison with 32 quality of care indicators for adults aged 50 or over in England (Steel et al, 2008)

Health Condition	% of QoC indicators received	Health Condition	% of QoC indicators received
Ischaemic heart disease	83%	Patient centred care	58%
Hearing problems	79%	Poor vision	58%
Pain management	78%	Osteoporosis	53%
Diabetes	74%	Urinary incontinence	51%
Smoking cessation	74%	Falls management	44%
Hypertension	72%	Osteoarthritis	29%
Stroke	65%	General medical	74%
Depression	64%	Geriatric	57%

Included in the GP pay for performance contract (75%), excluded (58%)

Some key findings from the reviews

– Primary Care – Referral to specialist care

- Large unexplained variations in referral rates between GPs
- Evidence that age of the patient is a factor in referral patterns for Parkinson's Disease, Diabetes, chronic kidney disease, cholesterol testing, angiography and revascularisation
- Possible conflict between the need for early referral and what some GPs see as a gate-keeping role to secondary care

Some key findings from the reviews

– Primary Care – Prevention

- There is evidence of gender and age inequality in the prescribing of preventative cardiovascular therapies to older people in primary care
- GPs appear reluctant to follow guidelines for cholesterol measurement and lipid lowering agents in people over 75
- Few GPs assess the risk of falling among their older patients or even know how to do such an assessment
- Smoking, alcohol and safe drinking are rarely tackled in health promotion for older people
- GPs are less likely to discuss life style changes like weight reduction with older people than younger people

Some key findings from the reviews

– Primary Care – Other services

- Dental care
 - Access to NHS dental services is problematic for older people particularly for the 20% who are functionally dependent
 - Barriers older people face include mobility problems, illness, inconvenience, the scarcity of NHS dentists, the cost or fear of cost
- Vision
 - There are variations in waiting times for cataract operations for younger and older people which indicates the possibility of age discrimination. In some areas people aged 65 and over wait more than twice as long for cataract operations than those aged under 65.
- Podiatry
 - Foot care services are under resourced and in many areas have been reduced, which affects older people disproportionately
 - Foot problems are given low priority in the NHS and chiropody services are not subject to any government targets for improvement
 - Fifty-eight per cent of older people needing foot care services used private services, while 35% used the NHS

Some key findings from the reviews

– Secondary Care – Hospital care

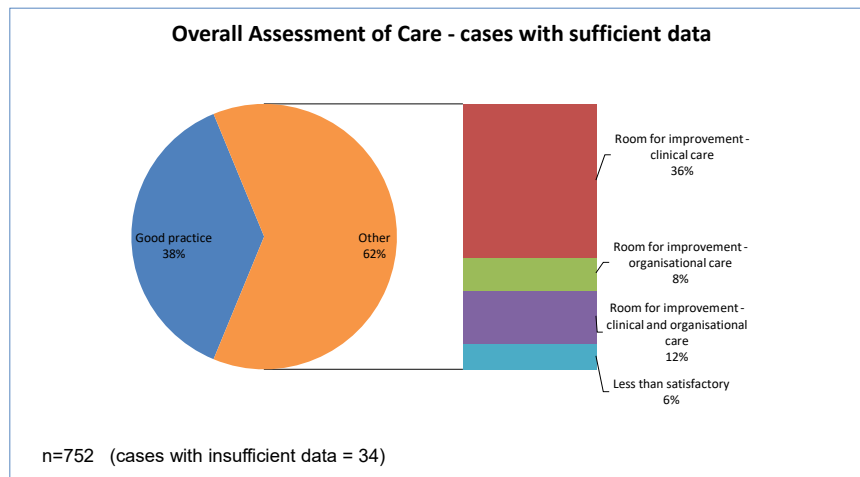
- The older patient's experience –
(based on secondary analysis of 2004 inpatient survey)
 - Older people are less likely to be critical of any hospital experience
 - Older people are more likely to feel talked over 'as if they weren't there' by medical staff
(Doctors are worse offenders than nurses)
 - Older people are more likely to be placed in a mixed sex environment

Some key findings from the reviews

– Secondary Care – Surgical intervention

- older patients are less likely than younger patients to be referred for surgical interventions for cancer, heart disease and stroke. This may, at least in part, be a function of perceptions of how the older patient will cope with a surgical procedure.
- Major elective [*non urgent*] cardiac, vascular, oncological and orthopaedic surgery can be performed on patients over 75 years old with good outcomes and adverse event rates similar to younger patients. For carotid endarterectomy "...the contribution of age to operative mortality is less than that of gender – the risks for older people over 75 are lower than those for women as a group." (Preston et al, *Geriatric surgery is about disease not age*, 2008)
- Older patients could sustain higher levels of surgical intervention than is currently the case but, for this to be successful, **the physiological changes and special needs of older patients must be recognised.**

NCEPOD survey of all patients, aged 80 and over, who died within 30 days of elective or emergency surgery. 1st April – 30th June 2008.



An Age Old Problem, NCEPOD, November 2010

Some key findings from the reviews

– Secondary Care – A&E and Intensive care

- **Accident and Emergency / Trauma care**
 - Evidence of age discrimination in accident and emergency care is mixed. Older people wait longer in A & E but are more likely to be admitted to hospital. Older trauma victims are less likely to be taken from A & E to intensive care, be managed in a resuscitation room or transferred to a regional neurosurgical care centre.
- **Intensive Care**
 - There is a recognised shortage of intensive care beds in the UK for patients of all ages but the proportion of patients on a general ward who should have been in intensive care increases with the age of the patient. An older trauma victim is much less likely than a younger patient to be transferred to intensive care.

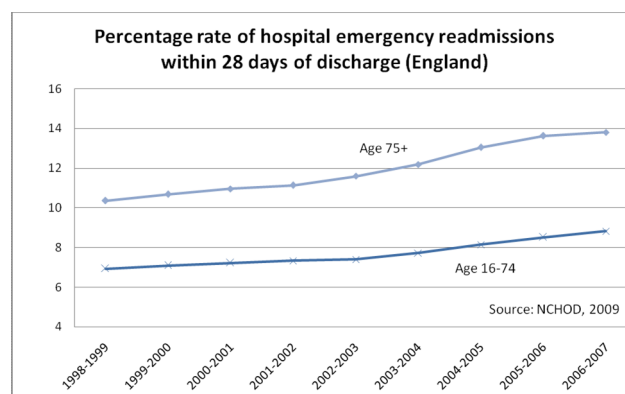
Some key findings from the reviews

— Secondary Care – End-of-life care and Resuscitation

- End-of-life Care
 - Older patients do not receive equivalent levels of end-of-life care to those received by younger patients. In part this is explained by the better end-of-life care received by cancer patients who are, on average, younger, but age appears to be an independent factor both in place of death and access to specialist care.
- Resuscitation
 - Suspicion of ageism in the application of 'Do Not Resuscitate' order is widespread but, although there is firm evidence that guidelines on consultation are not being adhered to, there is no firm evidence of age discrimination in their application.

Some key findings from the reviews

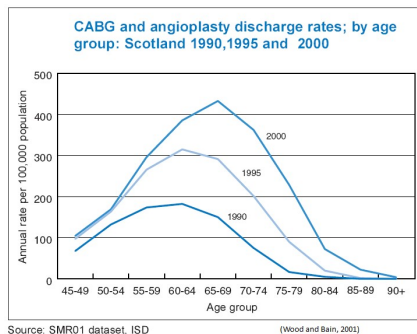
— Secondary Care – Emergency readmission



The high, and increasing, rates of hospital readmission within 28 days of hospital discharge, for older patients, is a clear indication of problems with the hospital care or discharge procedures for this group. This would appear to be a case of indirect discrimination, where universally applied policies are particularly disadvantageous to older people.

Some key findings from the reviews

— Secondary Care – Heart disease, Cancer and Stroke



- There is clear and widespread evidence of age discrimination in the hospital based investigation and treatment of **heart disease** and in the instigation of secondary prevention regimes following treatment.
- There is clear, multiple and widespread evidence of a reduction in the investigation and treatment of **cancers** with the increasing age of the patient. The link with age appears to be clear even when other factors such as comorbidity and tumour subsite are taken into account.
- There is clear evidence of age discrimination in the treatment of **Transient Ischaemic Attack and Stroke**. Older patients are less likely than younger patients to be referred to a specialist stroke unit, or to receive appropriate investigation and treatment. They are also less likely than younger patients to be prescribed secondary prevention measures.

Some key findings from the reviews

– Mental Health Care

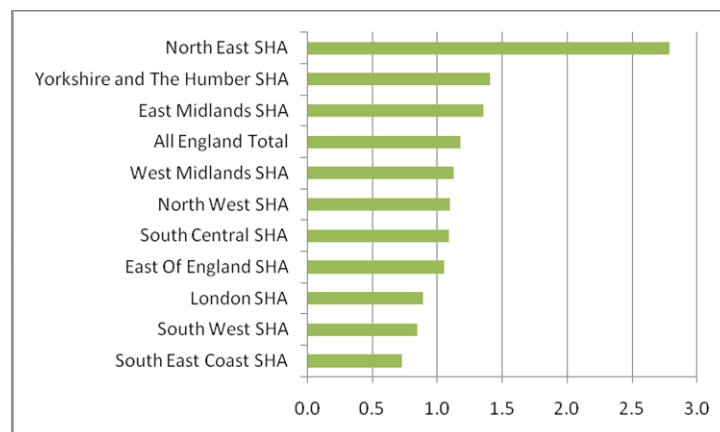
- Wealth of anecdotes and cases to demonstrate age discrimination in Mental Health services
- Shortage of quality numeric information to back it up
- Comparison of adult and older people's services is difficult because the case-mix is so different
- PSSRU estimate that to bring mental health services for over 55s up to the level of the best (35-54 age group) would cost £2 billion per year

Some key findings from the reviews – Mental Health Care

“The thing was I went to this service for several years, on and off, and then to my horror I discovered that at 65, they no longer take people because ‘it’s not for pensioners’.”

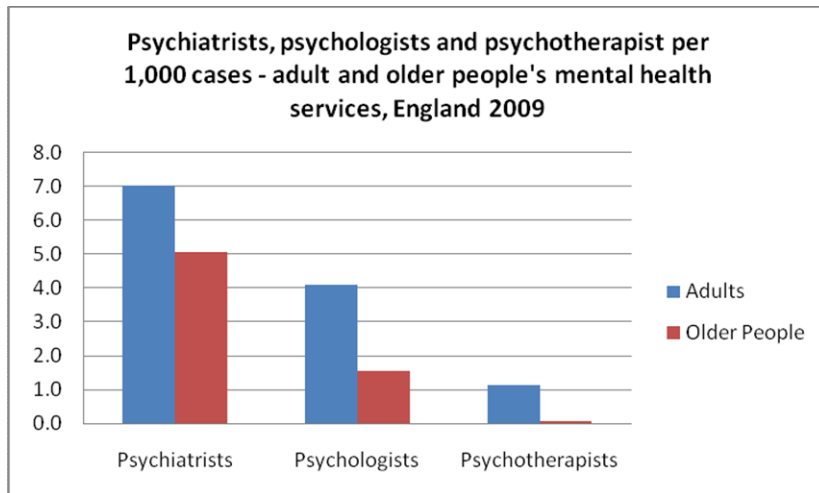
Some key findings from the reviews – Mental Health Care

Ratio of staff per case in older adult mental health services to that in adult mental health services



Source: Department of Health, CSIP – Combined Mapping Framework, 2009

Some key findings from the reviews – Mental Health Care



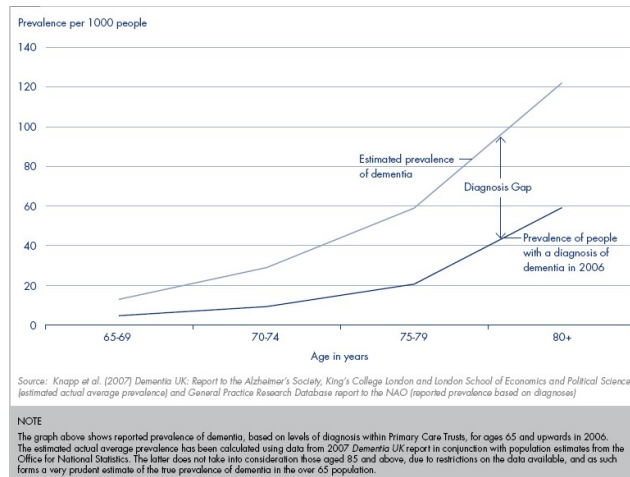
Source: Department of Health, CSIP – Combined Mapping Framework, 2009

Some key findings from the reviews – Mental Health Care

- There is continued existence of explicit institutional 'direct' age discrimination through the age split into adult and older age services with 'graduates' those with continuing mental health conditions who cross the threshold finding services provided by the older people's service are less good
- Under recognition and late diagnosis of both Depression and Dementia in GP services. Depression seen as just part of ageing. Value of early recognition of dementia questioned
- Under use by older people of mental health services.
- Widespread variation in the way mental health services for older people are organised results in a postcode lottery
- Possible double discrimination resulting from combination of ageism and the stigma of mental illness

Some key findings from the reviews – Mental Health Care

More than half of people with dementia are not diagnosed



National Audit Office (2007) - Improving services and support for people with dementia

Some key findings from the reviews – Social Care

- There is explicit direct age discrimination in social care provision, in both service organisation and funding streams, resulting from the division of social care services into adult and older people's services with poorer services and reduced funding for older people.
- Low level support has become equated with less effective or worthwhile support but for older people it can be particularly important in maintaining independence and control.
- Services are generally restricted to a small number of people needing intensive care and rationed through the use of tight eligibility criteria. There are perceptions that older are disadvantaged by this approach.

Some key findings from the reviews

– Social Care

- The boundaries between health and social care, and the division of means tested and non means tested services can lead to disjointed care and allegations of unfairness for older people.
- Discrimination is evident in social care for older people based on ageist assumptions about how older people should live their lives. There is a low level of expectation from both older people and service providers, of what constitutes a life worth living for older people.
- The differential funding of packages for older adults and younger adults with disabilities is explicit

Some key findings from the reviews

– Social Care

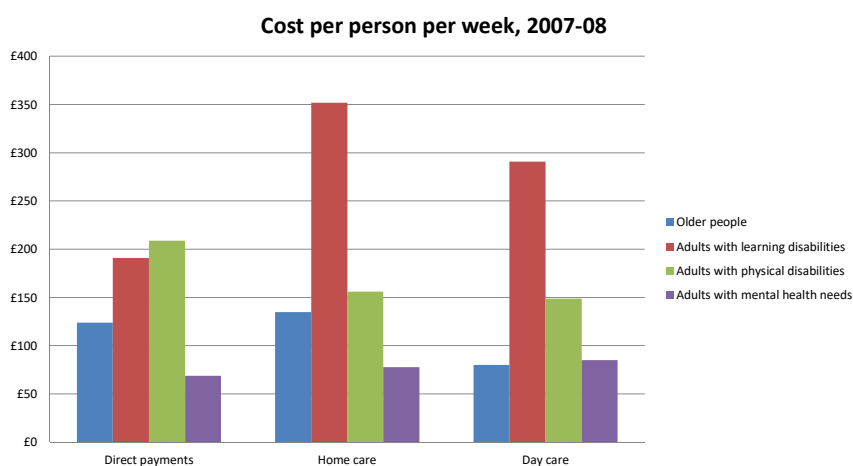
- Transition between services is triggered by age rather than need giving access to different levels of funding stream and grants
- Benefits
 - Attendance Allowance (AA) and Disability Living Allowance (DLA) are age based with DLA allowing additional money for a 'mobility' component which is not available to older people with disability. DLA is not available to people who become impaired after 65.
 - People over 65 are not eligible to apply for support from Independent Living Funds, but once they are in receipt of funds they may continue to receive them after 65.

Older people with learning disabilities

Peter lives in a group home with three younger men but when he reached the age of 65 he was 'retired' from the day centre he had been attending for many years. The minibus still collects the other men each morning but Peter finds this very distressing.

Foundation for People with Learning Disabilities, *Today and Tomorrow: the report of the Growing Older with Learning Disabilities Programme (GOLD)*, 2002

Some key findings from the reviews – Social Care



Source: Personal social services expenditure and unit costs England, 2007-08, NHS Information Centre 2009

Key issues

- Attitudes

- There is some evidence of ageist attitudes held by health practitioners and that doctors may be more ageist than other NHS staff but it may be that doctors are the ones most aware of the complexities in the treatment of older people. Ageist attitudes among medical staff may do no more than reflect ageist attitudes in society at large.
- The key to eliminating age discrimination in the National Health Service is seen by many to be the raising of awareness of ageist attitudes through education and training both during the pre-qualification period and in post.

'The training and education of healthcare professionals needs to change to reflect the fact that their day-to-day role will increasingly centre on the care of older people with long-term conditions rather than younger patients with curable single conditions.'

(Oliver, *How do you stand working with these old people*, 2007)

- With older people forming an increasing proportion of patients, the physiological changes associated with ageing should receive increased emphasis in mainstream pre-clinical education and training for all medical staff.

Are medical professionals' attitudes just reflective of society as a whole?

Are Geriatricians any different from other medical professionals in this respect?

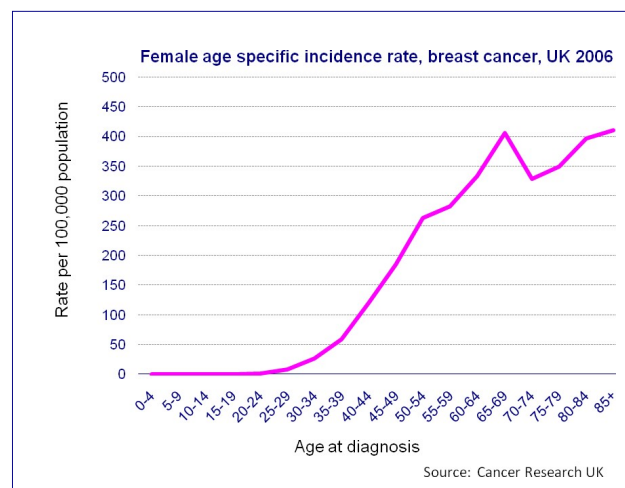
A 2006 group study, presenting the same cases to GPs, cardiologists and elder care specialists found

- Care of the elderly specialists are much less likely than cardiologists to refer an older patient for an angiogram or revascularisation
- Care of the elderly specialists are less likely than GPs to refer a patient to a cardiologist

[Bowling A, Harries C, Forrest D and Harvey N (2006) Variations in cardiac interventions: doctors' practices and views, *Family Practice* 23 (4) : 427-436]

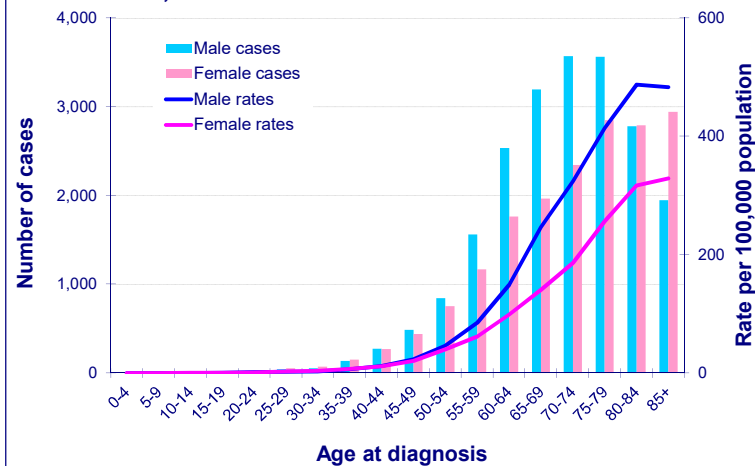
Key issues

- Screening
 - Currently upper age limits of 69 for breast and bowel cancer screening, 64 for cervical cancer screening by routine invitation
 - No national screening programme for prostate cancer
 - Vascular screening programme upper age limit 74 although most strokes occur in people aged 75+



Incidence rate of a condition is not the only factor indicative of the efficacy of a screening programme. Other factors include the risk of false positives and the availability of suitable treatment. The incidence rate above, however, would argue against the upper age cut-off for breast cancer screening.

Numbers of new cases and age-specific incidence rates, by sex, bowel cancer, UK 2007



Source: Cancer Research UK

Bowel cancer screening by flexible sigmoidoscopy and polyp removal – announced by David Cameron on Andrew Marr programme – 3rd October 2010. Trialled on age 55-64 and likely to be rolled out for that age group although presence of adenomas / polyps increases from age 50 but remains roughly the same for age 60+ and 70+.

Key issues – NICE and use of the QALY

- There is a strong suspicion that, no matter how it is packaged, the use of Quality Adjusted Life Years to assess the relative cost effectiveness of treatments and procedures will discriminate against those procedures and treatments, for example for Alzheimer's Disease, Osteoarthritis, Osteoporosis or Age-related Macular Degeneration, that are mainly beneficial to older people with few remaining years.
- It is however argued that, on the contrary, treatments provided on a pay-as-you-go basis, without large up-front costs, have the same marginal cost / benefit trade-offs at any age.

Key issues – Clinical trials

- It has been common for drug trials to exclude people 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.
- The continued under-representation of older people in clinical trials, while improving, is a clear form of age discrimination outside the NHS which has a knock-on effect on available treatments for the older patient inside the NHS.
- Changes to the regulatory frameworks controlling pharmaceutical and medical device licensing might bring pressure for further improvement

Age Differentiated Services

- Have developed organically over time in response to need
- Are **not** inherently age discriminatory
- **Are** discriminatory if older people's services are under-resourced in comparison to adult services and in relation to need
- To eliminate age differentiated services in response to age discrimination legislation would
 - 'throw out the baby with the bathwater'
 - Be a means of hiding but not eliminating age discrimination

[The four CPA reviews of Age Discrimination in Primary and Community Health Care, Secondary Health Care, Mental Health Care and Social Care are available on the Centre for Policy on Ageing website.]

<http://www.cpa.org.uk/reviews>



Questions for the future

- Organisational Structures

- What should be done about the continued explicit direct age discrimination in mental health services and social care?
- Is a separate older age specialism justified in mental health and social care?
- Does the compartmentalisation of the NHS detract from the treatment of older people?
- How can primary care and care homes improve referral to mental health and other specialist services?

Questions for the future

- Age discrimination or age differentiation

- Are the age cut-offs in screening programmes justified?
- Should conditions such as depression and osteoarthritis be seen as just a part of ageing or actively diagnosed and treated?
- Should professionals have different expectations of how people live when designing services for older people?
- Should older people, as a group, pay for their own social care or is that a form of age discrimination?

Questions for the future

- Fair processes for service delivery

- Are commissioners' ageist attitudes affecting the provision of services for older people?
- Are the Charges for Residential Accommodation Guide (CRAG), Fair Access to Care (FAC) and the use of Quality Adjusted Life Years (QALYs) fair processes for determining services and treatment for older people?
- What can be done to alleviate the postcode lotteries in service provision for older people?
- Will the personalisation agenda, direct payments and individual budgets make a difference?

Questions for the future

- Cultures and attitudes

- Are ageist attitudes of health and social care professionals typical of society as a whole or are doctors particularly ageist?
- Are older people listened to and taken seriously? How can expectations be improved?
- Why do older people not want to use mental health services?
- Why do health and social care professionals not want to work with older people?
- How can education and training be improved?
- Will the advent of the baby boomers to older age make a difference?