Age Discrimination in Health and Social Care

and the cost of its removal.

Nat Lievesley,
Centre for Policy on Ageing,
September 2008

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Context

- National Service Framework for Older People (NSF-OP) (2001)
  - '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.'
- European Commission Draft Directive (July 2008) – COM(2008) 426
  - 'Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation '
  - 'Discrimination based on ... age ... is prohibited by both the public and private sector in: social protection, including social security and health care; ...'
- Equality Bill (2008-09 parliamentary session – Queen's speech 3rd December 2008)

The Equality Bill

- "... will ... make it unlawful to discriminate against adults aged 18 and over because of their age when providing goods, facilities and services and carrying out public functions..."
- the specifics of the new law will be set out in secondary legislation made under the Equality Bill
- The legislation will not prevent the differential provision of products or services for people of different ages where this is justified.
- "Recent research suggests that implementation challenges will be greatest in the Health and Social Care sectors, so we anticipate that this sector will require the longest transition period"

(*The Equality Bill – Government Response to the Consultation*, Cm 7454, July 2008)

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Ageism vs Age Discrimination

- 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.
- '…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)
- '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)
- 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)

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Ageism

- Ageism may also be used to refer to **any decision making on the basis of age**. In health service decision making:
  - *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.
  - *Productivity ageism* – gives priority to young adults because they are socially and economically more productive. Health gains at different ages are weighted accordingly.
  - *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.

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

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Age Discrimination

- Age discrimination is an unjustifiable difference in treatment based solely on age.
- In definitions of discrimination within legislation, a number of countries distinguish *direct* and *indirect* discrimination
  - *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.
  - *Indirect discrimination* occurs when a seemingly neutral provision, measure or practice has harmful repercussions on a person.

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Measuring Age Discrimination

- Measures of age discrimination have to accommodate variations in need as well as variations in outcomes.
  - '…Variations in need mean that the same allocation of resources does not facilitate the same opportunity to achieve a valuable goal.' (Burchardt, 2006)
- DH benchmarking tool to assess whether PCTs / SHAs are being age discriminatory in the application of health procedures
  - Number of procedures carried out on a particular age group is divided by population of that age to find the 'rate' for that procedure
  - An appropriate, non-discriminatory, rate is not known so the procedure rate for older people is divided by procedure rate for younger people to get the ratio of the rates
  - The ratio of the rates is then used to compare the relative tendency to discriminate in different PCTs and SHAs
  - The method is also used to compare the treatment of people in advanced old age with those in earlier old age

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Age discrimination and age-based rationing in healthcare

- Given that budgets are not unlimited, overt and covert health care rationing has always been a feature of the National Health Service.
- Age based rationing may take place at a
  - Strategic level,
  - Programmatic level
  - Clinical level.
- Justifications include 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 I and Fraser N (2000) Age-based rationing in the allocation of health care, *Journal of Aging and Health* 12 (4) : 511-537

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Strategic level – Institutional Ageism?

- Cost Effectiveness Analysis (CEA) using QALYs (Quality Adjusted Life Years), the process through which the National Institute for Health and Clinical Excellence (NICE) assesses the relative cost effectiveness of treatments, may be inherently age discriminatory
- "Whilst macro level use of CEA greatly reduces the scope for age discrimination it does not entirely remove it. The benefits to older people will still be lower and so treatments that mostly impact on an older population will still be affected by a generally lower ability to produce QALYs."

  Cost-effectiveness analysis and ageism: a review of the theoretical literature, Edlin R, Round J, McCabe C, Sculpher K and Cookson R, June 2008

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Age discrimination at the clinical level – likely to be covert

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

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Age discrimination at the clinical level – pervasive

- Stroke
  (Bhalla et al, 2004; Rudd et al, 2007)
- Ischaemic heart disease
  (Bond et al, 2003)
- Cardiology
  (Bowling,1999)
- Colorectal cancer
  (Austin & Russell, 2003)
- Blunt trauma
  (Grant et al, 2000)
- Renal failure
  (McKee et al , 2005)
- HIV
  (Emlet, 2006)
- Drug trials
  (Godlovitch, 2003)
- Screening programs eg breast cancer
  (Dey & Fraser, 2000)

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Older people and the cost of healthcare

- 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)
- 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)
- A number of studies postulate that **proximity to death** (at any age) 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)
- 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)

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The cost of eliminating age discrimination in health care

— a zero-sum game or pressure for extra resources?

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Countries that have implemented age discrimination legislation

- **Australia**
  - Age Discrimination Act 2004 (23rd June 2004)
- **Belgium**
  - Anti Discrimination Acts 2003 (25th Feb 2003)
  - Anti Discrimination Acts 2007 (10th May 2007)
- **Canada (Ontario)**
  - Ontario Human Rights Code 1990
    [38-39% of Canada's total population live in Ontario]
- **Ireland**
  - Equal Status Act 2000 – 25th October 2000
  - Equality Act 2004 - 19th July 2004
- **USA**
  - Age Discrimination Act (ADA) 1975

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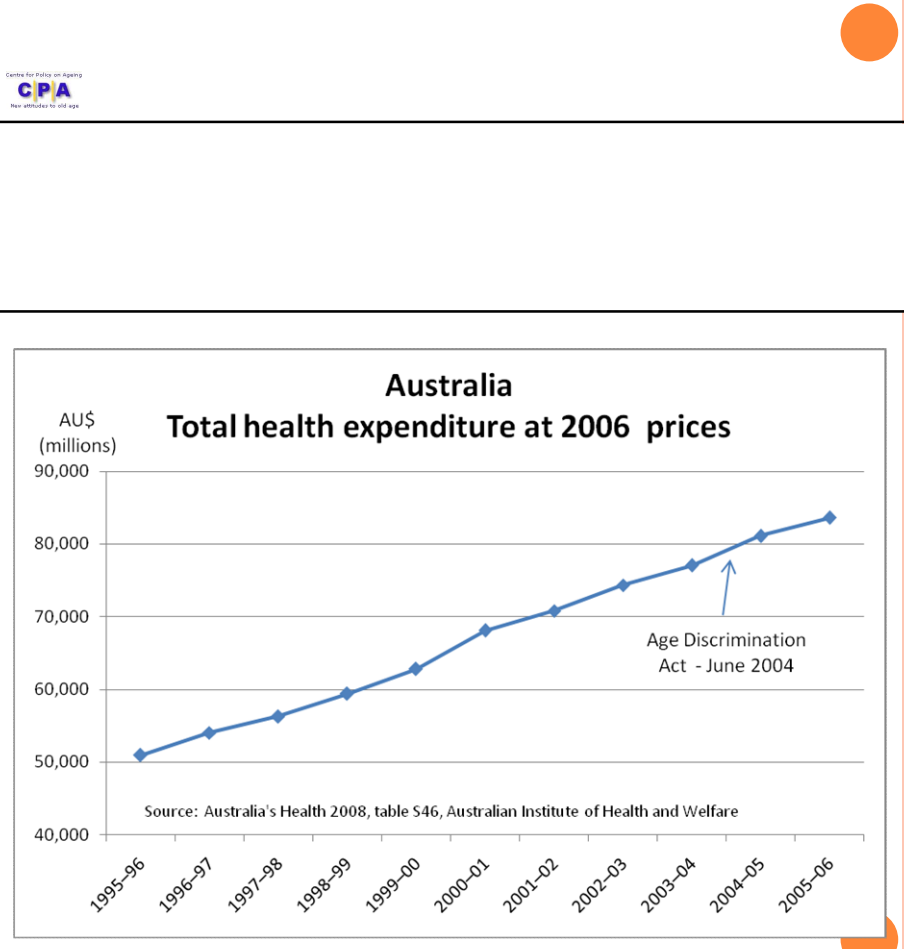
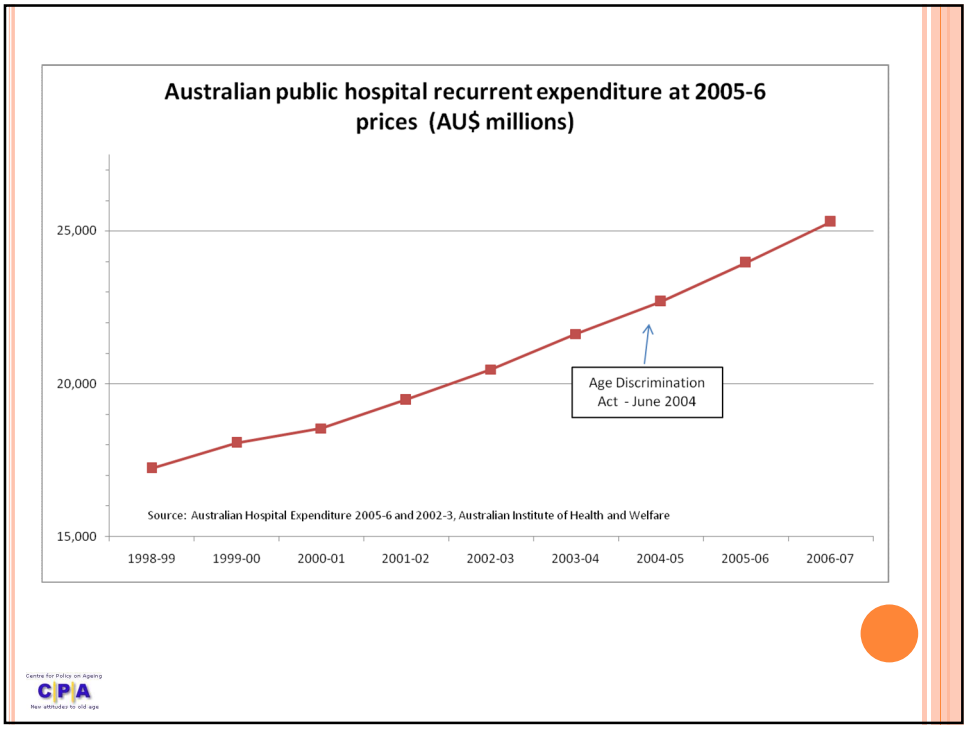
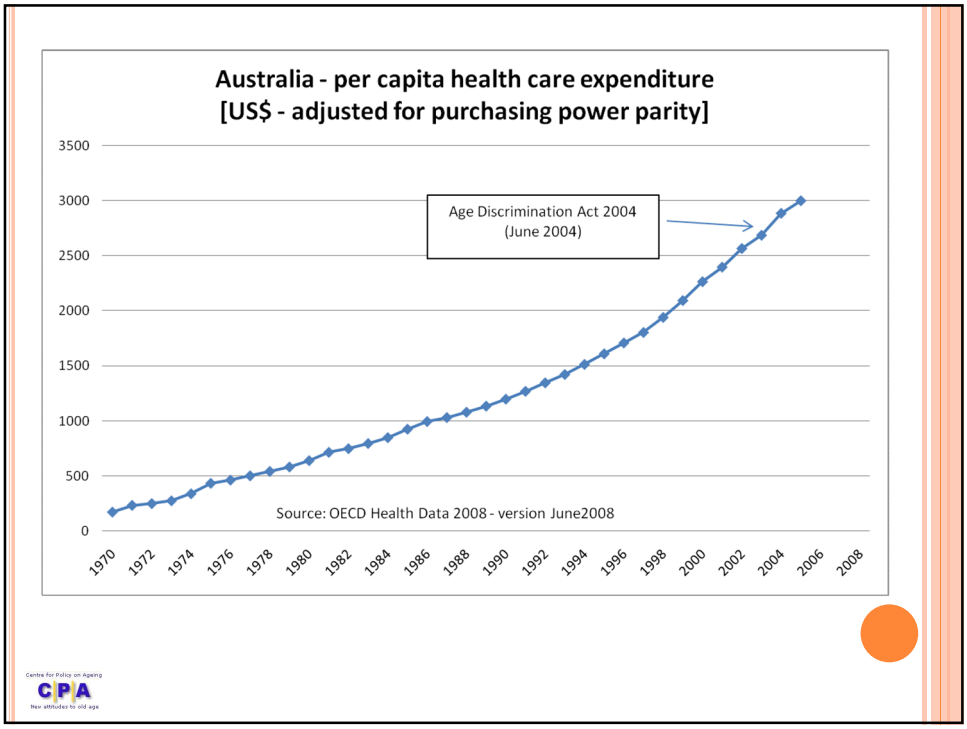
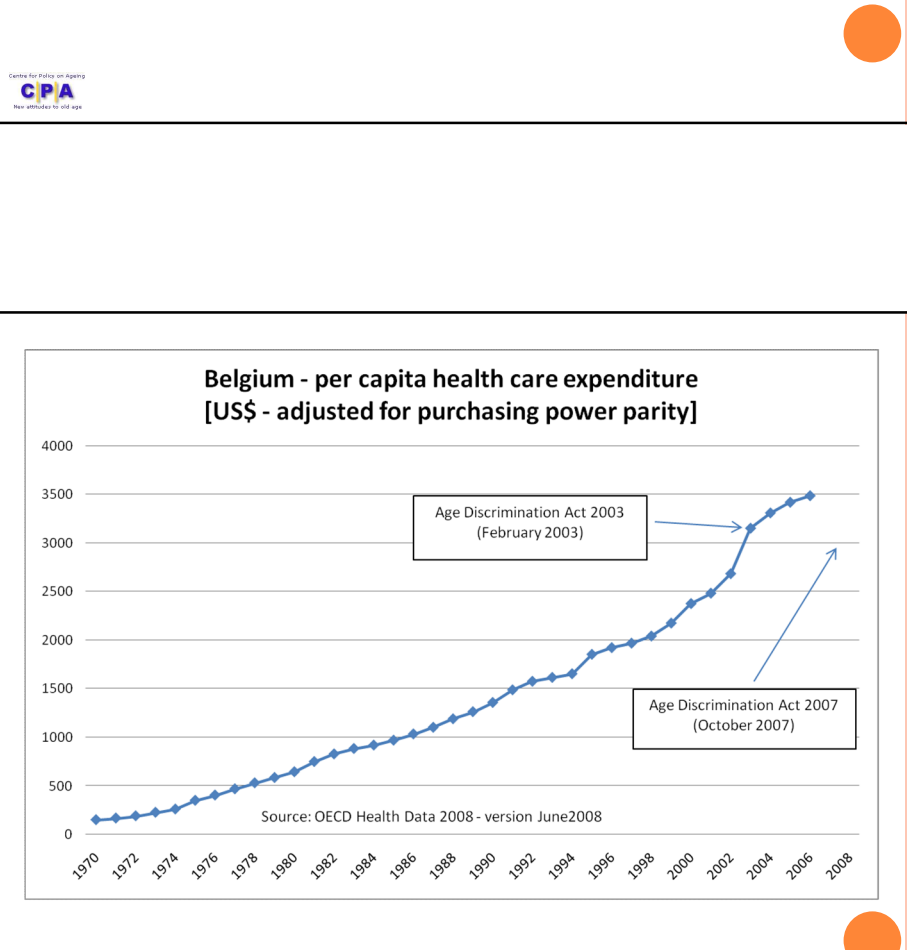
Australia


Australia
Total health expenditure at 2006 prices
AU$ (millions)
90,000
80,000
70,000
60,000
50,000
40,000
Age Discrimination Act - June 2004
Source: Australia's Health 2008, table S46, Australian Institute of Health and Welfare
1995–96
1996–97
1997–98
1998–99
1999–00
2000–01
2001–02
2002–03
2003–04
2004–05
2005–06


Australian public hospital recurrent expenditure at 2005-6 prices (AU$ millions)
25,000
20,000
15,000
Age Discrimination Act - June 2004
Source: Australian Hospital Expenditure 2005-6 and 2002-3, Australian Institute of Health and Welfare
1998-99
1999-00
2000-01
2001-02
2002-03
2003-04
2004-05
2005-06
2006-07


Australia - per capita health care expenditure [US$ - adjusted for purchasing power parity]
3500
3000
2500
2000
1500
1000
500
0
Age Discrimination Act 2004 (June 2004)
Source: OECD Health Data 2008 - version June2008
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004
2006
2008

Belgium


Belgium - per capita health care expenditure
[US$ - adjusted for purchasing power parity]
4000
3500
3000
2500
2000
1500
1000
500
0
Age Discrimination Act 2003
(February 2003)
Age Discrimination Act 2007
(October 2007)
Source: OECD Health Data 2008 - version June2008
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004
2006
2008

Canada

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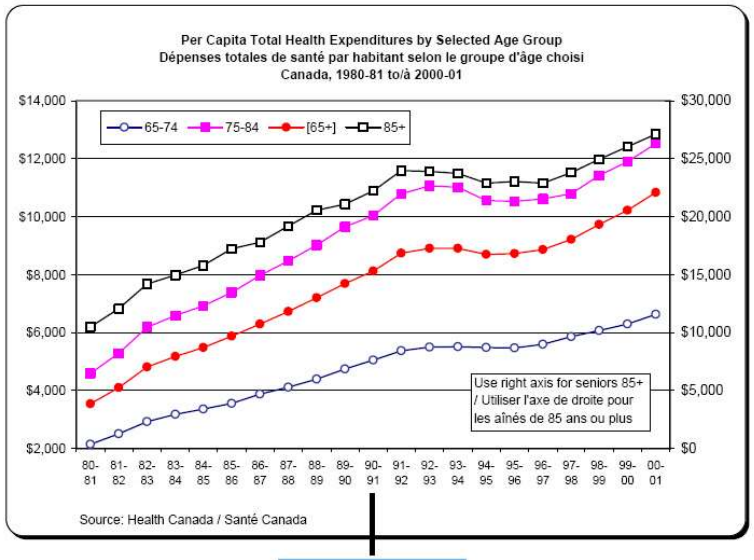
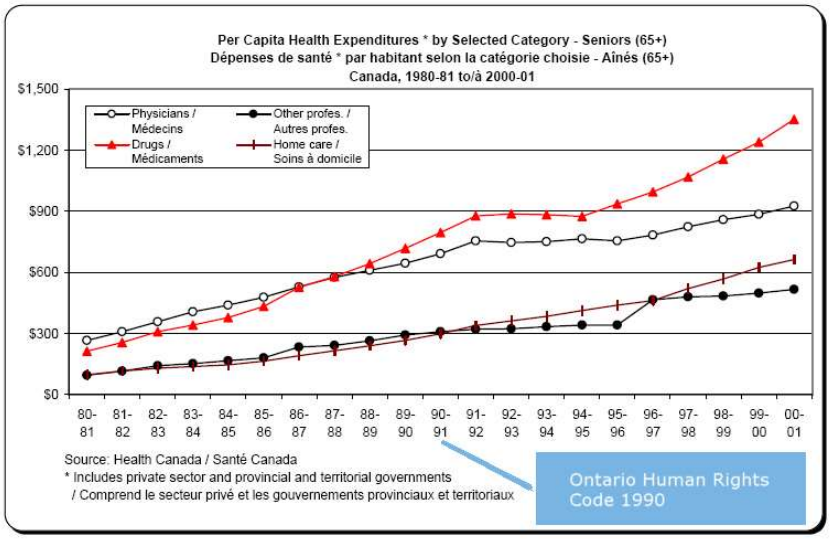


Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-2001 - Statistical Annex

Ontario Human Rights Code 1990

Dépenses de santé au Canada selon l'âge et le sexe, 1980-1981 à 2000-2001 - Annexe statistique



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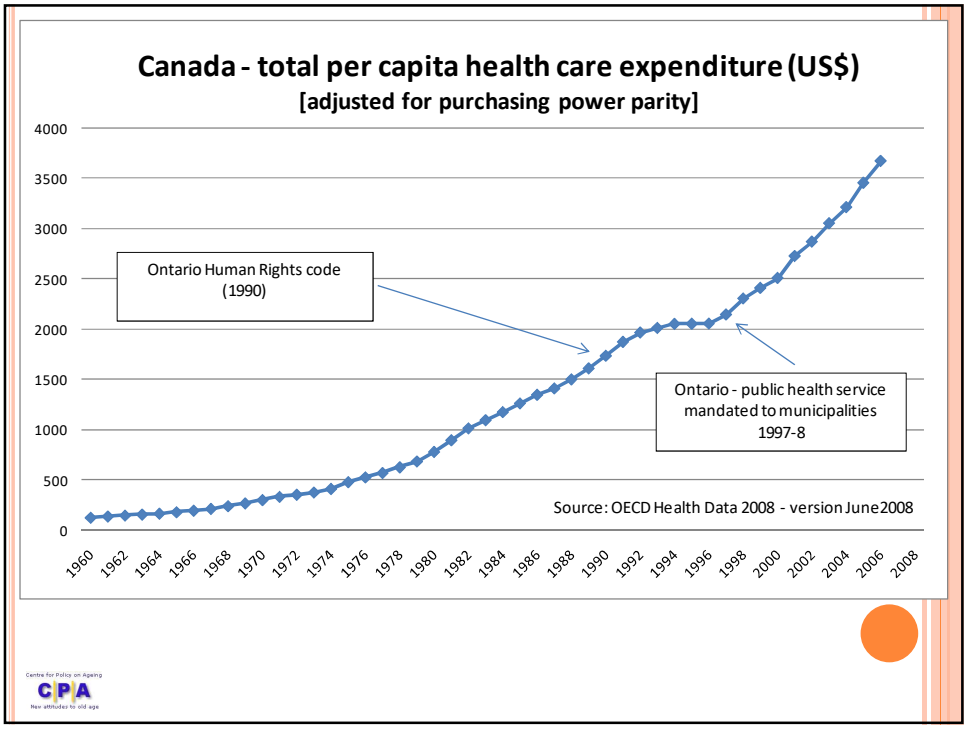
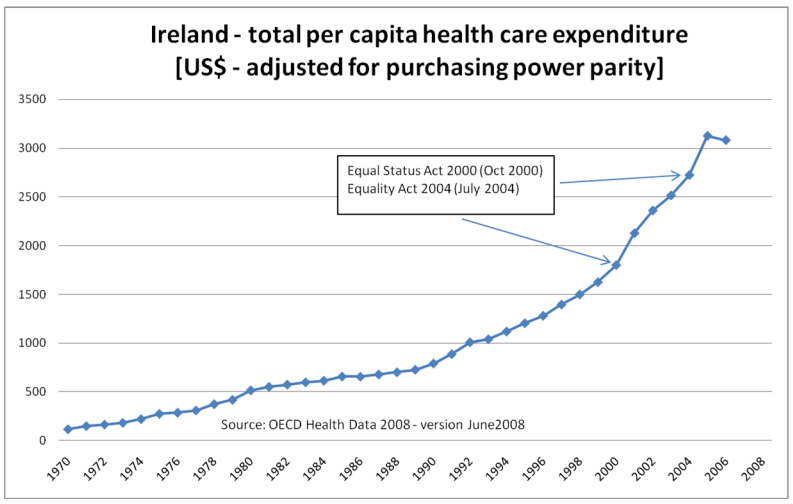
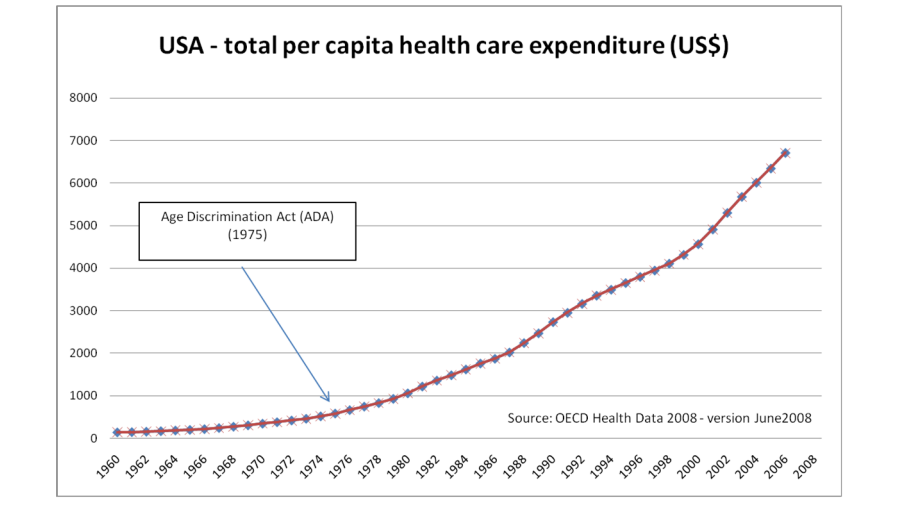
Dépenses de santé au Canada selon l'âge et le sexe, 1980-1981 à 2000-2001 - Annexe statistique



Ireland


Ireland - total per capita health care expenditure
[US$ - adjusted for purchasing power parity]
3500
3000
2500
2000
1500
1000
500
0
Equal Status Act 2000 (Oct 2000)
Equality Act 2004 (July 2004)
Source: OECD Health Data 2008 - version June2008
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004
2006
2008

USA


USA - total per capita health care expenditure (US$)
8000
7000
6000
5000
4000
3000
2000
1000
0
Age Discrimination Act (ADA) (1975)
Source: OECD Health Data 2008 - version June2008
1960
1962
1964
1966
1968
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004
2006
2008

Age Discrimination in Social Care

- '… 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.' (*Age of Equality? – outlawing age discrimination beyond the workplace*, Age Concern England,2007
- "...at an individual level, after controlling for needs and outcomes, the support (ie. cost-weighted service utilisation) received by older people is significantly less than the support received by younger people..."
- "...[for] a levelling up policy, the analysis suggests the need to increase support to older service users of around £60 per week on an average spend of around £240 per week, that is a 25% increase"

(Forder J, *The Cost of Addressing Age Discrimination in Social Care*, Personal Social Services Research Unit, April 2008)

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Age Discrimination in Mental Health Services

- "... use of mental health services is lower among older people, after adjusting for need and other factors. The age-cost association appears more marked for 'common mental disorders' such as depression and anxiety than for psychosis, although the physical health needs of people with schizophrenia, especially as they age, complicate the picture. Equalising expenditure across age bands while controlling for need would cost in around £2.0 billion."

(*Age Discrimination in Mental Health Services*, PSSRU, May 2008)

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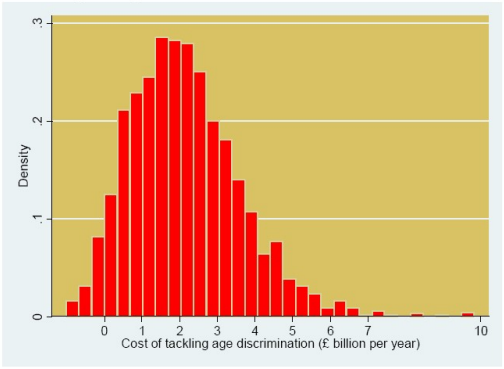
Histogram of expected cost of tackling age discrimination in mental health services (annual)



The central estimate is some £2.0 billion at 2006/7 prices (90% confidence intervals £0.4 billion to £4.0 billion). This is subject to a range of caveats relating to the use of PMS data. It is based on the assumption that to eliminate age discrimination, expenditure per person would be equalised across age bands (controlling for need) and that this would be achieved by levelling up expenditure for those aged 55 and over to the levels of those aged 35 to 54.

(*Age Discrimination in Mental Health Services*, PSSRU, May 2008)

The Benefits

- ... 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, How bias starts at 65, *Community Care*, 30 August 2007)

Postscript

- the launch of the Equality Bill is an important step on the road towards ending age discrimination in health and social care
- it is not the end of the road but provides a valuable tool in the work to come
- economic costs and benefits are just one view of age discrimination
- we have an ethical and moral duty to ensure that older people are treated with equity, dignity and respect in the future provision of health, mental health and social care services.

Nat Lievesley, Centre for Policy on Ageing, September 2008