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At the International Longevity Centre

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Promoting Age Equality in the Delivery of Health Care

Introduction

In 2001, the United Kingdom launched the National Service Framework for Older People, calling for the 'rooting out of age discrimination' in all aspects of health care financing, planning and service delivery.[1] This policy initiative came as a result of mounting evidence that older people often waited longer, were offered fewer treatment options and received suboptimal care compared to younger patients.[2] On the grounds that they were 'too old', individuals were often denied access to surgical procedures, excluded from clinical trials, not offered effective but high-cost chemotherapy and radiotherapy for cancer, and delayed admission to intensive care units.

Most of the above evidence comes from the UK. However, research across Europe suggests that most health care systems are ill-equipped to address the needs of the ageing populations they are meant to serve. Modern health care systems were founded on the principles of acute care and are dominated by a focus on growing specialization, efficiency, and expediency. Yet older patients presenting with chronic illness and comorbidities require continuity of care that bridges across traditional medical boundaries and care settings.

That ageism is an integral feature of our societies is accepted. How ageism manifests itself in the way we deliver care is poorly understood. Age barriers are often implicit rather than explicit. 'Rooting out age discrimination' implies much more than simply removing age criteria from clinical protocols and guidelines. Instead, the values and principles that govern health care need to shift if health care systems are to foster healthy ageing.

This issue brief explores the challenges we face in *promoting age equality*[3] in health care delivery. It is based on a study of age discrimination and measures to achieve age equality in eight European countries. Examples are drawn, where appropriate, from these national contexts.[4]

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Promoting Age Equality in the Delivery of Health Care

By Dr Suzanne Wait

Does Age Discrimination Exist in Health Care?

Age discrimination may be described as an 'action which adversely affects older persons because of their chronological age alone."[1] *Direct discrimination* is, for example, when a 70-year-old woman is denied treatment in the stroke unit when this care is offered to a younger patient in the same clinical situation. Reforms aimed at shortening hospital stays are an example of *indirect discrimination*, as they may inadvertently disadvantage older patients who may require longer recovery time due to comorbidities or discharge to intermediate care or rehabilitation facilities that are not readily available.[5]

In reality, most discrimination is indirect or hidden. Age limits are rarely explicitly stated in clinical protocols or practice standards. Instead, clinical practice is guided by inherited beliefs and practices, such as generalized assumptions about older people's ability to benefit from treatment.

Promoting Age Equality

Offering each patient appropriate treatment means not making assumptions about his or her ability to benefit on the basis of age alone and adapting treatment to individual needs—for example by adjusting treatment dosages if needed.

> *'Any discussion of equality must have a dual emphasis. It must reveal and challenge the prejudicial nature of assumptions that old people have failing health and capability. But at the same time those who do face ill health must be treated fairly and equitably.'*[6]

Understanding where ageism has infiltrated our health care systems requires taking an age lens to health care policies, planning, and practice, notably:

- Rethinking how our health policies are developed—do they take into account the needs of an ageing population?
- Reexamining how care is organized and delivered—is it designed to offer people throughout their life course the most appropriate, highest-quality care possible?
- Scrutinising the way care is provided to older patients—do differences exist in the care being offered to older patients as compared to younger patients? If differences do exist, are they justified?

The task at hand is vast and one may wonder where to begin. The remaining sections of this document thus focus on selected areas where we believe the most significant changes are needed in order to advance the above goals.

Changing Perceptions

Dispelling the myth of the expensive older patient

It is commonly assumed that the ageing of the population is one of the main causes of exploding health care costs. Equally, it's assumed that older patients use up more health care resources than younger people. In actual fact, both of these assumptions are false. Macroeconomic studies have suggested that the ageing of the population plays a very limited role in explaining the rise of health care expenditure. Factors such as the uptake of expensive new technologies may be much more significant.[7]

On the aggregate, it is true that the older segment of the population consumes a high share of resources simply because of the higher probability of disease and death with advancing age. But this does not hold true at the individual patient level: For the same condition, older patients tend to use *less* health care than younger patients.

The highest costs occur in the 12 to 18 months prior to an individual's death, and this is true at any age. What is expensive is the *cost of dying*, not the *cost of ageing*.

Do older people really cost the system more?

Dixon et al. in the UK conducted a retrospective cohort study of over 250,000 in-hospital deaths to determine age-specific costs of treatment in the last three years before death. They found that the median number of days spent in hospital before death did not increase with age. The authors conclude 'the older sector of the population accounts for a higher proportion of acute healthcare resources because they are nearing the end of their lives, not because care is individually more expensive.'[8]

Brockmann investigated the hospital costs at different age groups and found that average hospital costs systematically decrease with age in Germany. The author suggests that these lower costs are evidence of age-rationing, as less intensive treatments were used on older patients as compared to younger patients with the same illness.[9]

Seshamani and Gray found that health care costs amongst people aged 65 and older in England increased less than those of middle-age groups over the period 1985–87 to 1996–99. A parallel shift in social care costs, however, occurred over the same period.[10]

Recognising age as a contributor to health inequalities

Inequalities in access, quality, or outcomes of care may occur because of many factors, of which socioeconomic status, gender, race, ethnicity, and educational level are the most recognised. Yet age rarely enters into the debate on health inequalities. Age may be compounded with other forms of inequality, resulting in *'the double whammy of discrimination'*. A notable example is the fact that older women receive much less aggressive treatment for cardiovascular disease compared with younger men.[11]

Better Planning of Service Provision

The need for adequate training

All physicians, regardless of their area of specialty, need to receive dedicated training to be able to provide appropriate care for older patients. There is also a growing need for geriatricians. Yet geriatric training remains patchy across medical curricula, and provision of geriatric care is still insufficient in many countries.

Who will treat our ageing populations?
Some country examples:

- **Poland** has seen a marked decrease in the number of geriatricians over the past decade.
- **Spain:**
  - Geriatricians represented 2 percent of hospital physicians in 2002.
  - Only 43 of the 5000 postgraduate training posts available for physicians were allocated to geriatrics medicine.[12]
  - Hospitals only have 10 percent of the hospital beds needed to meet older people's needs.
  - In general hospitals, the deficit in geriatric specialists is around 55 percent.[13]
- **Germany:** Significant geographic inequities exist, with nearly 50 percent of all newly established geriatric day clinics are located in the North-Rhine Westphalia region alone.[14]
- **France:** One of the outcomes of the tremendous death toll due to the 2003 summer heat wave has been to ensure adequate provision of geriatrics beds, services, and training in hospitals.

Better planning for long-term care

Provision of long-term care also remains grossly insufficient in most European countries. It has been estimated that long-term care expenditure in the UK would need to rise by about 315 percent in real terms between 2000 and 2051 to meet current demographic pressures.[15] In Spain, public services would need to be increased fourfold to provide adequate coverage for the population. Currently the majority of long-term care provision is provided by the private sector and receives no state support.[16]

With a dearth of available services, older people with severe chronic illness or disability risk falling through the net: They are viewed as 'too sick' to be placed in nursing homes or are considered 'social cases' that are 'too long-term' for the acute hospital sector.[17]

Providing for mental health

Alzheimer's disease is the most significant public health problem facing us in years to come. Yet there is alarming evidence that our health care systems, clinical skills, social services, and societies are ill-equipped to address the scale of this problem.[16] The number of people with cognitive impairment is expected to rise by over 60 percent over the next 30 years. Of people in

nursing care, 32 percent are there because of dementia.[18] A Polish survey estimated that only 10 percent of practicing GPs are able to recognize the symptoms of dementia.[19] A similar audit of mental health services for older people in England and Wales found that two-fifths of GPs were reluctant to diagnose dementia early. Most of them did not use protocols for diagnosis, and less than half of them felt they had sufficient training.[20]

Mental health in older people remains poorly understood in general. Many clinicians view depression, for example, as a natural component of ageing and may not treat it as a result.[21] Clinical staff may have a tendency to relabel all mental health problems as dementia as soon as patients hit the age of 65. The segregation of mental health services into adult and geriatric mental health services may have the perverse effect of exacerbating this problem, as the cutoff age (usually 60 or 65) may not reflect the epidemiology of conditions being treated. Illustrating this point is the fact that one person out of 20 has dementia after the age of 60, but this rate is one in five after the age of 80.

Improving the Equity of Financing

The right to publicly funded health care is recognized in all 25 EU member states. Social care, however, is usually means-tested, which effectively leaves a large proportion of the population bearing the full costs of care. Provision of social care is increasingly decentralized, so that the quality and coverage of local services is highly variable. A growing burden for informal care falls upon families, often at great expense. *Without modifications to the financing of health and social care, existing financial barriers to care are likely to increase, particularly for the older population.*

Who pays for Alzheimer's care?

In France, a strategic plan for the management of Alzheimer's disease ('Plan Alzheimer') was introduced in 2004, making all drugs for Alzheimer's disease fully covered by Social Security. These drugs typically cost between €50–100 per month. By contrast, home care may cost up to €1524 for eight hours of care per day or €4573 per month for 24-hour care. These costs are not covered by Social Security and thus remain the full financial responsibility of patients and their families. Moreover, an Alzheimer's patient living at home but treated in hospital will only pay 5 percent of hospital costs, whereas in a long-term care facility, he is responsible for 60 percent of costs.[22]

Modifying Practice: Providing Patient-Centred Care

The past decade has seen a number of policy documents advocating patient-centred care, tailoring care to individual needs, and moving away from generalised assumptions based on age. But how is this applied in practice? The following table offers some possible guidance:

Guiding principles for providing patient-centred care to older patients[23]

- Physiological age, not chronological age, should be the first criterion upon which treatment regimens are based.
- Do not make assumptions about treatment effectiveness by age in the absence of solid evidence.
- Do not dismiss an unusual symptom as a natural manifestation of ageing.
- Evaluate the general health status of a patient and adapt the therapeutic regimen if necessary.
- Develop workable models that may facilitate engagement of the patient and his/her carers.
- Ensure that follow-up care is provided in accordance with the patient's social and family situation, so as to allow for optimal outcomes from care for each patient.

Building the Evidence Base

Older people have traditionally been excluded from clinical trials. As a result, the evidence base upon which one may decide how different treatments may work in older age groups is weak. Where evidence does exist, it is often limited and dated, thus discouraging changes in practice. This vicious circle of *'evidence breeds practice'* may only be broken by taking a critical look at the data on treatment benefits by age group and other factors. Based on these data, a decision about which patient characteristics are the best predictors of response to treatment can be made. Needless to say, in our high-pressure, underresourced and often understaffed health care environments, this is nothing short of a formidable challenge.

Clinical practice led by inadequate evidence: the case of cancer care

There is a widely held misconception that cancers in older patients are slow-progressing, which in actual fact is applicable to breast and prostate cancer but not to other forms of cancer. Cancer diagnosis is often made late in older patients, as comorbidity may mask the usual symptoms of cancer both for the patient and for the treating physician. Clinicians may also assume that older patients cannot benefit from treatment on the basis of their age alone. Whatever the reason, the outcome is the same: Older patients are denied effective treatment, thus compromising their prognosis and outcomes.[24] To cite just two recent examples from the literature:

- In a study of lung cancer patients, rates of full histological staging, which is necessary to ascertain prognosis, of chemotherapy and radiotherapy, were lowest in older patients.[25]
- Only 49 percent of women with breast cancer over the age of 70 were offered adequate adjuvant treatment, as compared to 83 percent of women aged 50 to 69 years with similar prognosis.[26]

Promoting Age Equality: Advancing Policy

The need to adapt our health care systems to meet the needs of our ageing societies is slowly being recognised in EU and national policy documents. But to address a problem, one must quantify it. Yet there is very little published evidence across Europe under the label of 'ageism', 'age barriers', or 'age discrimination'. *It is important to recognize that many factors: staff attitudes, resource constraints, current standards of practice, patient and carer preferences—all interplay to determine what kind of care is given to older patients.*

Promoting age equality requires much more than wagging an accusing finger at those guilty of age discrimination. It requires a shift in values in all involved in clinical encounters—doctors, nurses, managers, patients and carers alike—and changes in practice supported by reliable and timely evidence.

Promoting Age Equality: Calls to Action

At the level of health policymaking

- Recognise age as a factor contributing to health inequalities in the access, quality, and outcomes of care.
- Scrutinise health and social care policies to ensure that they do not indirectly discriminate against older people.
- Develop policies that allow to integrate health and social care planning and delivery. Watch that policies do not break down due to difficulties in implementation on the ground.

In the training of future clinical staff

- Ensure that all clinicians receive better training to accommodate factors such as comorbidity and chronicity of conditions in their treatment of older patients.
- Encourage the development of geriatrics as a speciality.

In health care planning and service provision

- Critically assess the appropriateness of specialist services for older people and the impact on the quality of care received.
- Insert greater flexibility into service provision, not assuming that all older people want the same thing.

At the level of clinical practice

- Guarantee all patients, regardless of age, access to the most appropriate, high-quality treatment.
- Provide timely information to all users about diagnosis, therapeutic choices, and results in an appropriate and sensitive manner. Do not limit this information on account of a person's age, socioeconomic condition, culture, sex, or educational level.
- Encourage more exchange with older patients and their carers about their expectations and aspirations for services. Involve them in decision making.
- Encourage the practice of evidence-based medicine throughout all aspects of care.

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Afterword

By Michael K. Gusmano, Ph.D.

The term "ageism" was first used in 1969 by Dr. Robert N. Butler, co-chair of the Alliance for Health & the Future. He defined it as a process of systematic stereotyping and discrimination against people because they are old. Dr. Wait's review of age discrimination in health care suggests that, more than 30 years later, ageism is still with us. Confronting ageism is a significant challenge because, as Wait explains, it often involves indirect and, in some cases, institutionalized forms of discrimination. As a result, eliminating ageism in health care requires "much more than simply removing

age criteria from clinical protocols and guidelines." Instead, we must engage in a more comprehensive review of the degree to which existing health care policies and practices lead to age-based inequities.

Stereotypes about older persons are still an important source of the problem. False assumptions about the benefits of treatment for older persons lead physicians to deny potentially beneficial care to older patients. False assumptions about the consumption of medical care by older persons leads policymakers to ration care inappropriately on the basis of age. The consequences of such decisions are widespread. Limiting the availability of health, social, and long-term care on the basis of misconceptions is not only unfair to older persons, it increases the burden faced by friends and family members who care for them. More often than not, the burden of informal caregiving falls disproportionately on women. Furthermore, as the population of Europe grows older, the vibrancy of its economy may depend, in part, on the degree to which older persons remain healthy, active, and productive members of the society.

A greater investment in geriatric training would help to improve the understanding of older patients among medical professionals, but an investment in geriatric medicine is only one aspect of what is required. The Alliance for Health & the Future hopes to confront "myths" about ageing and longevity though a research and education campaign targeted at policymakers and the general public. Dr. Wait's succinct review of age discrimination in health care and "call for action" are important parts of this effort.

Michael K. Gusmano, Ph.D., is senior research analyst at the ILC-USA, assistant professor of health policy and management at Columbia University, and co-director of research at the Alliance for Health & the Future.

Notes

1. National Service Framework for Older People. Department of Health. March 2001. Weblink: http://www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf

2. Ellis J. Bad old days. *Nursing Standard* 2002; 16(25):23–4.

3. Whilst younger age groups may also be faced with particular barriers in their access to care, this paper focuses on those barriers faced by the older citizens in our societies.

4. The full report, *Promoting age equality in health care: a study of 8 European countries*, is available on the Alliance for Health and the Future website, www.healthandfuture.org.

5. Examples of possible age discrimination in the British National Health Service are described in further detail in Roberts E, Age discrimination in health care, in *Age discrimination in public policy: a review of evidence*, Help the Aged, 2002; Billings JR, Staff perceptions of ageist practice in the clinical setting: practice development project, commissioned by the East Kent Coastal PCT, working paper, July 2003; Office of Public Management, Getting our fair share of life: a review of age related equalities in Haringey. Final report, Sept 2002, weblink: www.opm.co.uk. Less evidence is published from other European countries; however, anecdotal evidence and comments obtained in expert interviews suggest that the UK examples are also observed in many other European health care settings.

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11. For further information on this topic, refer to 'A Healthy Heart for European Women', available on www.ilcuk.org.uk or www.ehnheart.org.

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13. Information obtained from Informe sobre recursos hospitalarios especializados para personas mayors, 2003. Cited by Esther Martinez in *Health Policy Monitor*, www.health-policy-monitor.org/, Feb 2003, and Confederación Española de Organización de Mayores (CEOMA). Weblink: www.coema.org (accessed 12 Sept 04).

14. Meyer M. EUROFAMCARE. Services for supporting family carers of elderly people in Europe: characteristics, coverage and usage. National background report for Germany. July 2004. Weblink: http://www.uke.uni-hamburg.de/extern/eurofamcare/presentations.html#anknbr.

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16. Huber M. Long-term care for older people in 19 OECD countries (presentation). Paris, Oct. 2004. Martinez Esther. 2003. Ageing society, health and dependence. *Health Policy Monitor*, www.health-policy-monitor.org/, Feb 2003.

17. Holmerova I. 2004. EUROFAMCARE. Services for supporting family carers of elderly people in Europe: characteristics, coverage and usage. National background report for the Czech Republic. Aug 2004. Weblink: http://www.uke.uni-hamburg.de/extern/eurofamcare/presentations.html#anknbr.

18. Bowman C. Continuing Care Conference, International Longevity Centre-UK, Feb 2004.

19. Derejczyk J. Analysis of health care needs of older people and the Polish health care service (personal communication, 2004).

20. Audit Commission. Forget Me Not. Developing Mental Health Services for older people in England, 2002.

21. There have been several policy documents advancing the general cause of mental health in Europe over the past few years, however few have focused their attention on older people. The Mental Health Declaration for Europe, issued in January 2005, has as one of its actions to 'offer targeted support and interventions sensitive to the life stages of people at risk, particularly the parenting and education of children and young people and the care of older people.' (WHO 2005, weblink: http://www.euro.who.int/document/mnh/edoc06.pdf).

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The Alliance for Health & the Future was organized in 2003 to combine research, education, and policy efforts to promote good health and productivity throughout the life course. Operating as a division of the International Longevity Center-USA, the Alliance secretariat is in Paris with additional offices in London and New York. The aim of the Alliance is to advance knowledge and provide training, skills, and systems to help individuals and society realize a healthy future.

Alliance publications are available online at www.healthandfuture.org.

The International Longevity Center–USA (ILC–USA) is a not-for-profit, nonpartisan research, education, and policy organization whose mission is to help individuals and societies address longevity and population aging in positive and productive ways, and highlight older people's productivity and contributions to their families and society as a whole.

The organization is part of a multinational research and education consortium, which includes centers in the United States, Japan, Great Britain, France, the Dominican Republic, India, South Africa, and Argentina. These centers work both autonomously and collaboratively to study how greater life expectancy and increased proportions of older people impact nations around the world.

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