

Ageism and age discrimination in primary and community health care in the United Kingdom

A review from the literature

commissioned by the
Department of Health

carried out by the
Centre for Policy on Ageing



‘Ageing, in all its complexity, is a central issue in human health and disease, and cannot be addressed as an afterthought.’ (Lamb 2002)

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This review is one of four reviews of ageism and age discrimination in health and social care available from <http://www.cpa.org.uk/reviews>

1. Introduction

1.1. Purpose of the review

The Department of Health (DH) commissioned the Centre for Policy on Ageing (CPA) to identify possible evidence of age discrimination in policy and practice in primary health care in the UK through a review from the literature. The remit for the review of primary care services was to signpost areas where negative discrimination may be occurring for service commissioners and providers to use as a starting point in reviewing and revising their practice.

Evidence from the review of primary care will support DH's activities to root out age discrimination in the context of the European Commission Draft Directive (July 2008) – COM (2008) 426 and the introduction in the UK Parliament of the Equality Bill (April 2009) and related secondary legislation that will set out details of the new age discrimination ban in the provision of goods and services. It informed the national review on age discrimination led from the South West region by Sir Ian Carruthers, Chief Executive of the South West Strategic Health Authority, and Jan Ormondroyd, Chief Executive of Bristol City Council. The national review produced a report in October 2009 with recommendations on the timing of implementation of the ban and on those areas of age-based differentiation that should be maintained under the new law (Carruthers and Ormondroyd 2009).

The DH commissioned CPA to undertake separate reviews from the literature to provide evidence of ageism and age discrimination in social care, secondary health care and mental health services. The four reviews are rapid semi systematic literature reviews and not systematic reviews. Each review was conducted over a period of ten weeks. While it is acknowledged that age discrimination can apply to all ages, this report on primary care, and the CPA reviews mentioned above, focus primarily on the experiences of older people. Issues around multiple discrimination, gender and minority ethnic groups are not singled out for special attention but are discussed within individual studies.

Mental health services, including dementia care, are specifically outside the remit of this review of primary care. It should be noted that mental health services, organised as separate services for younger and older people, can be viewed as an example of systemic age discrimination as '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 2007, policy document). This is supported by a finding from an audit of mental health services in which older people reported a noticeable difference in their experience of accessing appropriate services as they reached and passed the age of 65 (Healthcare Commission et al 2006, study).

This review of primary health care does not provide an economic or cost-benefit analysis of the removal of age discrimination in primary health services but does provide a starting point for such an analysis. Also it does not provide a critical and evaluative study of the nature and cause of discrimination in the health services set within a wider societal and cultural context, although reference is made to the presence and impact of health care professionals' ageist attitudes.

The studies considered in this review of primary care are from within the UK, except where findings have wider applicability, for example in the case of under representation of older people in drug trials. Reviews from the literature have their limitations. In order to fulfil the DH's remit, because of the paucity of systematic research on age related inequalities in primary care, it was necessary to scrutinise literature focusing on treatments for individual conditions, services and practices – following a citation trail – in an effort to unearth evidence of possible discrimination from patterns of differential access, referral and treatment (see methodology in appendix 1). It is not always possible to establish the reasons for differentiation where it occurs, although discrimination based on age may be a factor. We have been constrained by the studies addressing issues around age discrimination that have been carried out to date, the ability to search and find evidence in such a disparate and extensive literature within the given time frame and obviously the varied approach of each study. Although search processes have been rigorous, inevitably some relevant literature may have been overlooked.

To make it easier to assess the nature and weight of the evidence presented in this report we have, split the sources of the evidence into a small number of simple categories. Category labels have been added to the reference citations in the body of the text to provide an at-a-glance first indication of the weight of the evidence.

Large survey	Sample survey of 800+ from a large population
Survey	Sample survey of 120-800 from a large population or 50%+ from a small population. We will use the generic term <i>survey</i> to include retrospective case audits.
Small survey	Sample survey of less than 120 from a large population or less than 50% of a small population
Group study	Focus group, panel or equivalent study
Study	Individual research project, observational study or analysis not carried out as a group study or survey
Opinion	Opinion of a respected authority, editorial etc.
Systematic review	Systematic review, with or without meta analysis

Review	Literature and other reviews not structured as a 'systematic review'
Policy document	Government or professional overview
Campaign document	Document to promote a particular point of view
Guide	Guide, information pack or toolkit

1.2. Government policies to support older people

This review of primary care is part of a continuing process of developmental work comprising government research, strategies and initiatives that are designed to improve outcomes for older people and act as levers for tackling inequalities in services. Activities include the National Service Framework for Older People (NSFOP) (DH 2001); the cross government strategies on ageing - Opportunity Age (2005) and Building a Society for All Ages (2009); the Dignity in Care campaign (2006); the End of Life Care strategy (2008); and the National Dementia Strategy (2009). The Prevention Package (PP) for Older People, launched as part of Building a Society for All Ages, prioritises better preventive care for older people and a renewed focus within the NHS at local level to work in partnership with social care, local authorities and older people. It encompasses a new focus on innovative healthcare, such as telecare; better services for falls, fractures and osteoporosis; a review of foot care services; and an ongoing commitment to reduce waiting times for hearing tests and the fitting of aids. Existing preventive measures cover flu vaccination, cancer screening, abdominal aortic aneurysm (AAA) screening, eye checks and vascular checks. A refresh of Intermediate care guidance is also included in the strategy.

Interim reports evaluating the Partnerships for Older People projects (POPPs) have provided some evidence that care initiatives that focus on early interventions can have a positive impact on people's health. The underlying aim of the 29 pilot sites is to create a sustainable shift in resources and culture away from the focus on institutional and hospital-based crisis care toward earlier and better targeted interventions for older people within community settings. 'In the longer term, the findings from the NE will contribute to the evidence on effectiveness of initiatives aimed at promoting independence, prevention and early intervention as highlighted in the *White Paper Our Health, Our Care, Our Say: A new direction for community services* and more recently in *Putting People First - Transforming Adult Social Care*' (Windle et al 2008, study).

1.3. Primary health care

Primary health care has a broad reach and the majority of the population are treated within a primary care setting. The principles of accessible, comprehensive, continuous, and coordinated personal care in the context of family and community are central to primary care.

'Primary care is first-contact, continuous, comprehensive and co-ordinated care provided to populations undifferentiated by gender, disease, or organ disease' (Starfield 1994, review).

The Department of Health (DH) describes primary care as health services that play a central role in the local community and are 'provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners, together with district nurses and health visitors' (www.dh.gov.uk).

Within this review, the General Practice, with an independent status, and certain community health services, run by PCTs and outreach services from hospitals are considered. Some of these services are proportionately more important for older people than younger people. The general practitioner (GP) is generally the first point of contact for people, providing immediate health care, and also acts as a gateway to further services including making referrals to secondary care. There is increasing integration and overlap between providers of health services arising from the need to address the management of long term conditions within the primary care setting and to provide holistic care. Sixty per cent of GP consultations relate to chronic diseases, such as arthritis, asthma, diabetes, heart disease or depression (APHO 2008) and the *National Service Framework for Older People* outlined key roles for GPs in the management of stroke, dementia and falls. Community nurses and matrons, specialist nurses (to manage continence, palliative care, heart failure, diabetes) and other allied health professionals work in parallel with the GP to deliver personal health care and meet the needs of people with multiple problems.

Primary care also encompasses the provision of preventative care services, which include screening and immunisation, health promotion, oral health care and foot care.

1.4. Ageing population and health

Both men and women are living longer into older age. In 2003 those aged 50-59 represented 37.8% and those aged 85 and over represented 5.5% of the 50 and over population. Projections indicate these proportions will be respectively 28.6 and 7.9% by 2031. Projections for 2031 indicate a more rapid ageing of the population over the next 30 years. People aged 85 and over will then comprise 3.8% of the UK population. Older women outnumber older men, as death rates are higher among men than among women, although the improvement in death rates among older men has led to a

narrowing of the gap. The greater number of women than men is most pronounced among the very old, as women tend to live longer than men, with life expectancy at birth in the UK being 75.9 years for men and 80.5 years for women in 2002. However, women are also more likely to have more years in poor health (www.statistics.gov.uk). Nearly half of those aged over 65 report their health as 'not good' and a similar proportion say they have a limiting long-standing illness (Nat Cent Social Research 2007 [HSE 2005]).

The main causes of mortality in those aged 65 and over are cancer (29% in men, 21% in women), heart disease (21% in men, 15% in women), stroke (9% in men, 13% in women), other circulatory disease (9% in men, 10% in women), respiratory disease (16% in both men and women) and digestive disease (4% in men, 5% in women). For all these causes of death mortality rises steeply with age and at each age death rate is higher for men than for women, except for stroke and digestive disease. These figures are not comprehensive as many people with health conditions do not contact health services. In addition, most health service contacts are with primary care where data collected is limited. Many of the common diseases, to which older people are more susceptible, such as arthritis, hypertension, diabetes and Parkinson's disease are mostly treated in primary care. Nearly 47% of women and 32% of men aged 65 and over reported that they had arthritis while 13% of men and 10% of women reported having diabetes (data from APHO 2008).

The term 'older people' covers a hugely diverse population from the young old to very old. The National Service Framework for Older People identifies three groups of older people that may require different types of health care:

- **Entering old age** This is a socially-constructed definition of old age, which, according to different interpretations, includes people as young as 50, or from the official retirement ages of 60 for women and 65 for men. These people are active and independent and many remain so into late old age.
- **Transitional phase** This group of older people are in transition between healthy, active life and frailty. This transition often occurs in the seventh or eighth decades but can occur at any stage of older age.
- **Frail older people** These people are vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both. Frailty is often experienced only in late old age. (DH 2001, policy document)

1.5. Ageism and age discrimination in health care

In 1969, Robert Butler introduced the term 'ageism' defined as 'a process of systematic stereotyping, prejudicial attitudes and direct or indirect discrimination against people because they are old' (Butler 1969).

'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, in 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. Such beliefs are socially created and reinforced, embedded as they are in functions, institutions, rules and everyday social life (Hewstone 1989, in McGlone and Fitzgerald 2005).

'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 et al 2006). Ray et al identify three different types of discrimination:

- under representative – passive/indirect discrimination by omission
- positive/protective – special treatment to benefit group
- negative/overtly harmful – direct discrimination.

Direct age discrimination occurs when a person is treated less favourably because of their age; indirect discrimination occurs when 'care is offered in such a way that older people are disadvantaged because they are disproportionately affected' (Roberts and Robinson 2000).

Adams et al (2006) describe indirect discrimination occurring when 'practitioners' or 'organisations' ageist attitudes and assumptions inform decision-making and service provision, as when older people are seen as having lower priority than younger people and are therefore less likely to receive the care they need. This form of ageism is subtle and often covert or invisible, making it difficult to challenge.'

Some age related practices are based on evidence of actual age related changes that may require differential treatment.

'Ageist behaviour grows out of stereotypes, prejudices and stigmatization. Age-differentiated behaviours are, however, an appropriate function of the age of the target person, based on an understanding of development and thoughtful recognition of age differences' (Hagestad and Uhlenberg 2005).

1.6. Equality Bill

The Equality Bill creates a single public sector equality duty, covering eight protected characteristics: age, disability, gender reassignment, pregnancy or maternity, race, religion or belief, sex, and sexual orientation. It establishes that discrimination is about relative rather than absolute standards.

'Discrimination law is about a person's treatment relative to that of a comparator (except pregnancy and maternity) including a hypothetical comparator (except equal pay), not about absolute standards.' Direct discrimination is treating someone *less favourably because of a protected characteristic*. This does not have to be the victim's own characteristic: association and perception are also covered. Indirect discrimination is applying to someone a provision, criterion or practice which puts them, and persons with whom they share a protected characteristic, *at a particular disadvantage*. When assessing evidence of discrimination it is important to be clear that disadvantageous discrimination that would otherwise be indirect discrimination (for any protected characteristic), and less favourable treatment that would otherwise be direct discrimination (for age only) is not discrimination if the person applying it can show it to be a proportionate means of achieving a legitimate aim (also referred to as 'objective justification').

1.7. Identifying age discrimination

Age discrimination is challenging to identify in practice as it takes many forms and may occur at the individual, clinical level and at a structural level. Age discrimination may be found in policies; custom and practice; access to specific services; attitudes; privacy and dignity; the environment; information; and staffing. The subtle manifestations of age discrimination can make it hard to pin down. Older people 'may have no way of knowing whether their experiences might have been different if they were younger, or whether the services are simply not good enough for anyone of any age' (Levenson 2003).

Age barriers are often implicit rather than explicit so that simply removing age criteria from clinical protocols and guidelines will not necessarily eliminate ageist practices. Implicit discrimination at the individual, clinical level is harder to assess.

Precisely because clinical judgment is meant to involve 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)

There has been relatively little formal research on ageism and age discrimination in health care. *Adding Life to Years: Report of the Expert Group on Healthcare of Older People* (NHS Scotland 2001, study) provides an overview and description of the major health problems of older people in Scotland including a section on ageism and health inequalities between older and younger people. The Expert Group commissioned a review of the published literature expressly to feed into *Adding Life to Years [The Health and Wellbeing of Older People in Scotland* (Wood and Bain 2001, review)] around not for resuscitation orders, exclusion of older people from clinical trials, exclusion from breast screening, management in A&E units, cancer care and cardiology. It concludes that the research considered does not appear to support allegations of widespread discrimination, although it does provide evidence of episodes of poor care for older people. However this conclusion may be suspect due to the paucity of systematic research as 'absence of evidence is not evidence of absence' (NHS Scotland 2001, study).

While there are reports documenting older people's experiences of care, there is still 'little evidence on the scale of age discrimination or exactly how it affects access to services in general' (DH 2002, study). Ann Bowling (2007, opinion) discussing ageism in medicine agrees that 'there is insufficient research into the full extent of age-related inequities in primary care'.

The Department of Health has developed benchmarking tools to measure and monitor age discrimination in social care, acute hospital and primary care (DH 2002, guide). In relation to primary care these include for example comparisons of procedure rates between different age groups, selected prescribing rates, dentist registration ratios and immunisation. Benchmark comparisons can be made with neighbouring PCTs, regional sectors and within the country as a whole. The limitations are that health needs differ between areas and optimal procedure rates for different age groups are not known. The data are helpful in raising questions about equity but are inconclusive in themselves. Equality Impact Assessment of policies and functions include consideration of age, as well as other factors such as race, disability, which will help to identify and root out unjustifiable age discrimination.

Summary

The aim of the review is to signpost areas where discrimination may be occurring in primary care services leading to unfair treatment. Age discrimination is interpreted as an unjustifiable difference in treatment based solely on age. Direct age discrimination occurs if people with comparable needs are treated differently on the basis of age alone; indirect discrimination occurs when a service or practice has no explicit age bias, but still has a disproportionate impact on people in a particular age group. It is challenging to identify age discrimination in primary care as there is little formal research on the extent of age-related inequities and benchmarking tools cannot provide conclusive evidence of age discrimination. This does not mean there is an absence of discrimination in primary care.

2. Ageist attitudes

Levy (2001) argued that 'every person who has internalised the age stereotypes of their culture is likely to engage in implicit ageism, and it is for this reason that much ageism is hidden' (referenced in Adams et al 2006, study). According to Berkman et al (1994, study) 'health care professionals are particularly susceptible to ageist stereotyping and negative attitudes toward the elderly because they lack training in caring for older people'.

Ageist beliefs and attitudes of health practitioners can influence the decisions regarding which services and treatments are to be offered to older people. Dr Karen Kee, commenting on findings from new research on stroke care for older people laid the blame for unequal access on 'negative views, attitudes and behaviours of healthcare professionals towards older patients' (BBC News 16 April 2009). She concluded that 'A change in the attitude of healthcare professionals is needed to root out ageism.'

GPs ageist attitudes are identified as a barrier to implementing evidence-based guidelines in the treatment of hypertension in older people (Cranney et al 2001, group study). In an interview study of GPs in Merseyside, many said they were more likely to treat hypertension in the young because they have more active and stressful lifestyles, although they recognised that these assumptions were not always justified.

'Although we know what the benefits are, whether it's an innate conservatism or what, I don't know, but something does seem to hold us back a little bit.'

A minority of GPs interviewed felt that older patients had reached their life expectancy and so pursuing treatment was unnecessary. Also treating people with dementia was not worthwhile because of their poor quality of life.

Ninety 90 GPs and consultants took part in a study of hypothetical cases of 72 patients aged 45 to 92 presenting with symptoms of a heart problem. Age was a factor influencing their decision and nearly half of the doctors treated the over-65s differently.

'If they are in their 90s with chest pain and angina I might be less likely to refer'

'Age. I would be less likely to prescribe for an older patient'

'Age does come into it so the the oldest old are excluded. We would manage these ourselves.'

'Age has a definite influence. I'd be more likely to refer a 65 than a 95 year old because they probably wouldn't survive surgery at that age.'

'They wouldn't want an angiogram if they were over 70.' (Bowling et al 2006, group study)

Billings (2003, group study) undertook a focus group study of 'staff perceptions of ageist practice in the clinical setting' covering both acute and community sectors. There was a consensus that older people were more likely to experience insensitive treatment such as excluding them from conversations, shouting at them and being patronising. 'The general issue of communicating inappropriately to them was a common experience across all groups.' Assumptions were also made about the needs and capabilities of older people that were perceived as 'small but significant examples of ageist practice'.

Research has shown that clinical professionals devalue the care specialties that are related to ageing, including social workers, physicians, psychologists, and nurses. Many professionals avoid clinical work with older adults because of fiscal disincentives and a lack of clarity that often exists about the professional's role with older adults (Rosowsky 2005, review).

A descriptive survey design was conducted, within a regional Cancer Centre, to evaluate oncology healthcare professionals' attitudes towards elderly people. Regardless of gender, profession and clinical experience persistently negative attitudes were displayed towards elderly people. No statistically significant difference was detected between gender, profession, clinical experience or specialist education (Kearney et al 2000, survey).

Among a survey of 870 family and hospital doctors, almost 60 per cent said the NHS could not provide full healthcare to everyone and that some individuals should pay for services. One in three felt care should be limited on age grounds and that elderly patients should not be given free treatment if it were unlikely to do them good for long (Telegraph, January 2008).

A significant number of medical practitioners specialising in the care of older people believe ageism exists and age discrimination operates within the NHS. A survey of members of the British Geriatrics Society (Help the Aged 2009, small survey) concluded that:

- 47% think the NHS is institutionally ageist
- 55% said they would be worried about how the NHS will treat them in old age
- 66% agreed that in their experience older people are less likely to have their symptoms fully investigated
- 72% said older people were less likely to be considered and referred on for essential treatments

Summary

There is evidence some health care professionals hold negative views about older people influencing their behaviour towards them. GPs ageist attitudes can be a barrier to implementing evidence-based guidelines in treating older people and they may make assumptions about the needs and capabilities of older people. Older people are likely to experience insensitive treatment such as being excluded from conversations or 'talked over' as though they do not exist. Medical practitioners specialising in the care of older people believe ageism exists and age discrimination operates covertly within the health service and there is no evidence that GPs are not implicitly affected by wider cultural attitudes to ageing.

3. The National Service Framework for Older People (NSFOP)

The National Service Framework (NSF) for Older People (DH 2001, policy document) is the key policy framework for ageing and older people's health care and set the standard that the treatment of older people should be based entirely on clinical need and not on age. The NSF acknowledged the existence of age discrimination within the NHS. 'Services sometimes fail to meet older people's needs – sometimes by discriminating against them, by failing to treat them with dignity and respect, by allowing organisational structures to become a barrier to proper assessment of need and access to care, and because best evidence-based practice is not in place across important clinical areas.'

Standard One in the NSF 'Rooting out age discrimination' seeks to prevent age discrimination and inequity in the treatment of older people within the NHS:

- Aim: To ensure that older people are never unfairly discriminated against in accessing NHS or social care services as a result of their age.

- Standard: 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.

The NSF identified age discrimination locally in two key different forms:

- low overall rates of provision of those interventions which are relatively more important for older people – for example, hip and knee replacement, cataract surgery, occupational therapy, chiropody, community equipment, assistive technology, hearing aids or NHS dentistry.
- low relative rates of access of older people to specialist services compared with younger people or refusal of particular treatments or care – for example, revascularisation or expensive drugs

An audit of age related policies undertaken by the DH (2002, study) concluded that only a very small number of policies are explicitly age discriminatory. It identified a number of age-related national policies that have been considered to be based on good clinical evidence, but needed review at national level. However, the ‘main problem is likely to be around implicit or unintentional discrimination’, i.e. in the attitudes, custom and practice in the NHS. Concerns related to primary care include:

- Access to services in the community
- Identification and treatment for depression
- Overprescribing
- Access to alcohol dependency/addiction services
- Levels of home care available
- Rates of GP referral

(DH 2002)

The report, *Living Well in Later Life: a review of progress against the National Service Framework for Older People* (Healthcare Commission et al 2006, study), concluded that explicit age discrimination has declined since the NSF was published. However, there was still evidence of age discrimination and ageist attitudes among health care professionals which had a negative impact on older people’s lives. It suggests that ‘progress needed to improve services used by older people can only come about through support from central government’, particularly through helping to shape a more

positive culture on attitudes to ageing and giving a higher priority to services for older people in the community.

Suzanne Wait (2005, review) discussing age equality in the delivery of health care suggests how ageism manifests itself in the delivery of 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.'

Summary

Standard One of the NSF for older people establishes that NHS services are to be provided, regardless of age, on the basis of clinical need alone. Few policies are explicitly age discriminatory – the main problem is around implicit or unintentional discrimination. Ageist practices in health care reflect a wider cultural attitude to ageing that needs to be combated by education, training and central government policies.

4. Access to GP services

This section looks at whether older people are disproportionately disadvantaged as a group by the way GP services are provided. Access to healthcare can be viewed in several ways. It refers to the potential for healthcare use and the act of using or receiving healthcare. Barriers to care delivery include availability, accessibility, affordability, acceptability and accommodation (Guagliardo 2004, review). There is no consensus as to what constitutes 'appropriate' access and what indicates a high degree of access. In general terms, good access exists when patients can get 'the right service at the right time in the right place' (Chapman et al 2004, systematic review).

Older people may be disadvantaged by their inability to access services or the services do not take into account their specific needs indicating indirect discrimination.

4.1. Physical access

People aged 65 and over visit their GP on average seven times a year. This compares with an average of four visits a year by younger adults.

The transport implications of services and the costs that the individual has to meet are significant factors in access. *The Independent Inquiry into Inequalities in Health* report (Acheson 1998, study) found that lack of access to transport is experienced disproportionately by older people, limiting their access to goods, services, opportunities and social contacts. A review of transport services in

Living Well in Later Life identified a lack of reliable and accessible transport in all areas visited (Healthcare Commission et al 2006, study).

Older people with severely reduced mobility and those caring for them, are not able to get to a surgery, however near and convenient, without help. A group study (Age Concern 2006) revealed that for those without personal transport, a visit to the doctor's surgery and back, stopping off at a pharmacy to pick up prescribed medicines, can take a whole day. It can then take another day if people are required to visit the hospital for blood tests, x-rays, etc.

'There are a range of [health] centres and so on. But if you don't have transport to them and there's not a decent bus service it's actually physically very difficult for people to get together.' (Older person quoted in Murtagh et al 2003, study)

Manthorpe et al (2008, study) examine the particular perspectives of older people living in rural communities and note that changes in primary care, such as centralised out-of-hours services, affect both urban and rural dwellers in the same way. Similarly difficulties in accessing primary care services through lack of transport are not unique to those living in the country. In some cases developments had enhanced primary care services in rural areas thereby making access easier and reducing the need to travel to a regional hospital for services. Some newer proposed services might be harder to deliver in rural areas. 'Less easy to organise are the kinds of outreach services that bring the professional expertise to the person, ranging from telemedicine to "hospital at home".' The heterogeneity of rural areas leads the authors to caution against using 'rural' as an overarching category when analysing health service provision for older people, with the exception of transport concerns.

4.2. Making appointments

Some surveys of older people's experiences suggest that only a small number of older people have problems making an appointment to see a GP (Age Concern 2008, survey; West Suffolk Older People's Voice et al 2008, group study). The type of problems older people experience in making an appointment by telephone include *'it's frustrating as you have to ring at 8.30 am'* and with automated systems *'I don't like using numbers [as options] as I can't see very well'* and confusion over options to select (West Suffolk Older People's Voice et al 2008, group study). Bristol Older People's Forum Family Doctor Survey 2007 (633 completed survey forms returned) found gaining access to the GP was a significant problem citing *'allowing sick older people to stand in a queue outside your premises at 8am in the morning in all weathers in order to get an appointment'*; *'asking*

sick older people to sit in a crowded and uncomfortable waiting room for many hours for an appointment which may only take a few minutes'; and *'operating appointments systems that are so difficult for people to access that some sick older people give up trying*'; *'told to try next day unless it is urgent. What is urgent?'* (BOPF 2007, survey).

Opening hours during the week do not appear to be an issue but a strong preference is expressed for Saturday morning surgery appointments *'we all feel a bit funny with no surgery from Friday until Monday'* and *'there should be a Saturday surgery for emergencies'* (West Suffolk Older People's Voice et al 2008, group study); *'Saturday surgeries to be brought back'*; *'a weekend surgery'* (BOPF 2007, survey).

The GP Patient Survey 2006/2007 (DH 2007) around issues of access found that levels of dissatisfaction for older people increased around not being able to book a GP appointment in advance and for the GP surgery not being open on Saturday.

4.3. Time with the GP

Older people may need more time than younger people in a consultation to describe presenting problems and discuss treatments for multiple conditions, and because of the complexity sometimes more time to assimilate information *'it takes me longer to understand the treatments'* (West Suffolk Older People's Voice et al 2008, group study). Older people reported in *Primary Concerns* (Age Concern 2008, group study) that time given during an appointment to discuss their needs were satisfactory. A similar positive response was given by West Suffolk Older People's Voice (2005), who were asked questions to assess their perceptions and experiences of age discrimination within their local health/social and voluntary services. Individual comments on GP services suggest that on occasions insufficient time is given to discuss their conditions *'they don't go into it enough with older people'*, *'they haven't got time to listen to deaf old blokes'*, and *'they are too busy to listen to you'*. Some panel members felt their opinions were disregarded while discussing treatments. Another complaint was that as you get older *'People decide for you'* and don't allow people to take control, *'they think they know best'*. A fairly large proportion of panel members had been told by GPs that their symptoms were *'just your age'*.

A conclusion of the researchers is that *'although older peoples' perception is that they have not been discriminated against ... their comments indicate that there is discrimination, but they are not aware of it'*, ie behaviours that older people accept as the norm in reality are ageist practices (West Suffolk Older People's Voice et al 2005, group study).

4.4. Out of hours services

Since 2000, people calling their general practice in the evening or at weekends are redirected to the out of hours service which may offer telephone advice, a home visit or a visit to a treatment centre. Older people appear reluctant to make use of out of hours services particularly those based around less personal models of care and are critical of the trend away from out of hours care being delivered by a familiar GP. Barriers include fear of travelling at night, reluctance to make excessive demands on health services through out of hours and using telephone advice services (Foster et al 2001, group study).

A study by Richards et al (2007, study) 'Exploring users' experiences of accessing out-of-hours primary medical care services' found 'A common perception was that home visits were discouraged by the out of hours service.' Foster et al (2001, group study) suggest that home visits are particularly appreciated by older people and that the new model of out of hours care may not suit them. Older people may therefore under-use the service, despite their higher morbidity and likelihood of living alone. Some older people experienced real difficulty in knowing which agency to contact initially – out of hours or the emergency services (West Suffolk Older People's Voice et al 2008, group study). Others expressed concern of using out of hours *'if you are ill in the evening or weekend, God Help You!'* (West Suffolk Older People's Voice et al 2008, group study); *'I would like our own doctors to revert to 24-hour care, and not to use the services of outside doctors who have no knowledge of us';* *'Sort the confusing complexity of access to out of hours medical or nursing help. As older folk we need to deal with a human being, not an automated telephone or an NHS "message taker"'* (BOPF 2007, survey).

4.5. Older people living in care homes

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. The Care Quality Commission, the new healthcare regulator, announced on 1 April 2009 that it is to launch a major review on healthcare standards in care homes. The review will look at standards across both the public and private sector after reports that residents do not get sufficient access to dentists, GPs, nurses and dementia specialists. Currently, 14% of care homes do not meet national standards covering access, but the regulator will also be looking at quality of care and the choice that patients are being offered. The regulator stated care homes should be ensuring these 'vulnerable people' are given exactly the same service as those in the rest of the community (BBC News, 1 April 2009).

The British Geriatrics Society 's (BGS, policy document) submission to the UK Parliament, Joint Committee on Human Rights drew attention to potential shortcomings in care home residents accessing primary care services. The population of care homes has become increasingly frail and dependant over the last 20 years. Only 40% of the GPs will have received any postgraduate training in the care of frail older persons with multiple pathologies. This can result in older frail persons in care homes receiving sub-standard treatment. Some GPs and District Nurses regard their responsibilities in care homes as additional to their normal workload and an area for which they have not received any specialist training. Many older persons in care homes who would benefit from multi-disciplinary rehabilitation and medical treatment for their chronic diseases cannot access it (BGS 2007, policy document).

Glendinning et al (2002, survey) note there is little systematic information about access to medical care for nursing and residential home patients. They conducted a survey to investigate patterns of access within a nationally effective sample of 765 homes drawn from 72 English primary care groups/trusts (PCG/Ts). 'Extensive variations in homes' policies and local GP services raise serious questions about patient choice, levels of GP services and, above all, equity between residents within homes, between homes and between those in homes and in the community'. They recommend PCTs responsibilities for developing systems of clinical governance should extend to cover the range of services provided by GPs to care homes; and PCTs should review ad hoc arrangements for paying GPs for services to care homes. Some GPs are being paid to provide basic services that are part of the GMS contract with costs being passed to residents. The management of frail elderly people in nursing homes has been regarded by some GPs as beyond the scope of the general medical services contract and as a non-core activity.

The English Community Care Association (ECCA) produced two reports on access to primary care and retainer fees. *Can We Afford the Doctor?* and *PostCode Tariff* (Patterson 2008; ECCA Press Release January 2009) found that many care homes have to pay a GP retainer just to secure NHS medical care for residents in the home and there were wide variations in fees. *PostCode Tariff* provides examples of initiatives to improve access to health care in care homes - Salford PCT has commissioned a new practice for all residents of nursing and residential homes in Salford. It will provide enhanced services in the areas of medicine management, end of life care, active case management and dementia care. Lambeth PCT has developed a service level agreement for GP practices to work with care homes with nursing.

The demarcation between nursing (health) and personal (social) care in care homes may lead to the redefinition of the needs of older people suffering from a combination of chronic conditions from health care to social care 'relocating the source and solution of their pain and suffering away from disease and illness. Social care puts a barrier between people who suffer the greatest and most complicated burden of illness and the specialist healthcare professionals that they need' (Heath 2002, review).

Most older people living in care are unable to initiate a referral for a medical review although they often have complex medical problems. They depend on care staff to act on their behalf and determine whether a presenting problem should be 'assessed, diagnosed and managed' (McMurdo and Witham 2007, review). 'Both health and palliative care are often poorly organised in these settings and are associated with out of hours' crises and resultant high anxiety and unpredictability for staff and residents. The lack of clarity around clinical leadership for care homes may result in GPs only visiting when called' (Morris et al 2007, opinion).

There are pockets of good practice but there are difficulties securing basic medical support for care home residents. 'Focused investigations on the health needs and health service response to care home residents could reasonably be anticipated to report serious failures or at the least uncover "unmet need" that would initiate new commissioning criteria and consequent innovation in provision' (Bowman 2007, opinion).

4.6. Policies to improve access

Improving access to primary care is a key National Health Service priority. Chapman et al (2004, systematic review) in a review of provision to improve access to primary care note that while 'Innovative ways of delivering primary care have been introduced to facilitate and broaden access, ... little is known about the ways in which these interventions improve access and which methods are most effective in reaching different groups.' They single out older people as benefiting particularly from Personal Medical Services (PMS); pilots of PMS 'made small but significant improvements in the quality of mental health care and the care of older people (where these were the focus of the pilot)'.

It is important for the needs of different populations to be recognised in developing policies to improve access to health services. Walk in Centres may increase access for younger adults but for example the availability of home visits from health practitioners is of particular importance to older people. The percentage of consultations undertaken as home visits fell from 22 per cent in 1971 to

4 per cent in 2006 (Age Concern 2008, survey). 'Although Department of Health policy has emphasised the importance of "care closer to home", less attention has been paid in policy to the requirement for care in the home for those who need it' (Age Concern 2008, survey). Older people have specifically expressed desire for more home visits '*a willingness to make a home visit without having to be quite firm that you require one*'; '*very poor response to home visits – more needed*'; '*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*' (BOPF 2007, survey).

In a survey (Age Concern 2008, survey) older people expressed support of polyclinics, in principle, but were sceptical that all appointments would be scheduled on the same day to avoid making several trips. They also expressed reservations about continuity of care and developing relationships with specific GPs, which is especially important to them in view of their sometimes complex conditions. Older people favoured primary care services in one site to include physiotherapy, podiatry, dietician, exercise activities, eye and hearing services dental services and GPs (BOPF 2007, survey; West Suffolk Older People's Voice et al 2008, group study). Reforms of health services delivery have not explicitly recognised the fact that older people are the main users of services and 'there is a significant risk that changes will be made which will not tackle the problems that some older people face in accessing health services in their local areas' (HtA 2008, policy document).

Choice is a key goal in the White Paper, *Our Health, Our Care, Our Say* (DH 2006, policy document). Assumptions have been made that older people do not want the responsibility of making personal healthcare choices and there is a paucity of literature examining whether current choice mechanisms (including Choose and Book) are either appropriate or desired by older patients. A study by Weir and colleagues based in a GP practice revealed that choice was very relevant to older patients (75+) but perceived barriers included lack of information to make an informed choice and the lack of time to make a decision limited to the length of the consultation. Older people require additional support to make choices which is beyond the means of the GP because of workload pressures and no remunerative incentives for the additional workload involved (Weir et al 2007, study).

Summary

Good access could be said to exist when patients can get 'the right service at the right time in the right place'. Older people have particular problems accessing GP services for physical reasons, ie lack of mobility and suitable transport. They prefer continuity of care with someone who is familiar with their medical history and home visits when they are particularly unwell. Out of hours services can

create barriers to access for older people who prefer face to face contact and fear travelling at night to treatment centres. There is strong evidence of unmet need and difficulties accessing GP and primary care services for care home residents.

5. Evidence of ageism and age discrimination in GP practice

GPs perform a wide range of tasks to include acute curative care, care management for people with chronic disease and preventative activities. They also coordinate care for patients among different service providers and for different patient concerns, responding to the fact that many patients have multiple problems.

Evidence of direct and indirect age discrimination in the provision of services is not clear-cut and different patterns of treatment for patients of different ages do not necessarily imply discrimination on the basis of age. Absence of data on age related differences in treatments and services does not mean an absence of discrimination.

Living Well in Later Life (Healthcare Commission et al 2006, study) noted that 'Assessing whether services are provided fairly between age groups is not straightforward, not least because many organisations cannot provide detailed data on who uses their services. In addition, for many health procedures used chiefly by older people, the comparison with younger age groups is unlikely to be helpful.' In general the prevalence of most health problems increases with increasing age hence older people may be expected to receive more care (Wood and Bain 2001, large survey).

This section considers treatment of conditions, unmet need in the older population and quality of care to determine whether there is any evidence of discrimination based on age. The topics are divided into treatments and quality of care; referrals; preventive strategies and screening; and meeting the needs of older people who are frail and with several concurrent medical conditions. Indirect discrimination may be occurring when services that are proportionately more important to older people are shown to be inadequately resourced and provided with poor levels of care measured against accepted quality indicators.

5.1. Treatment and quality of care

The 2003 general medical services contract signalled the government's determination to invest in evidence based interventions in primary care and to encourage further expansion of chronic disease management into general practice. A recent investigation found GPs are 'hugely' under-represented on academic papers suggesting that the primary care perspective may not be adequately reflected within the evidence base. A snapshot showed fewer than a fifth of academic papers in major medical

journals included any primary care input. Only 14% of research and review papers published in the *British Medical Journal* in November 2009 were by primary care researchers, none of those in *The Lancet* and 16% in *Journal of the American Medical Association*. It suggested that the UK was 'very poor' at conducting primary care research and that this had a direct effect on the quality of care GPs offered (*Pulse* 9 December 2009).

5.1.1. Overview

In his article, "Acopia" and "social admission" are not diagnoses: why older people deserve better', Dr David Oliver states the acute, the rare, the high tech and the curative are prioritised over the reality of modern medical practice treating the majority with illnesses which are long-term and common and treatments which are low-tech and palliative or disease-modifying. He gives as examples poor recognition, diagnosis and delivery of evidence based treatments for common conditions of ageing such as osteoporosis, falls, incontinence or delirium (Oliver 2008, review).

Nicholas Steel et al (2008, large survey) carried out a study to assess the receipt of effective healthcare interventions by adults aged over 50 with serious health conditions living in private households in England. Information on quality of care was collected from 8688 participants in the 2004-5 wave of the English longitudinal study of ageing, of whom 4417 reported diagnoses of one or more of 13 conditions. Thirty two quality indicators were included for: cerebrovascular disease (stroke), depression, diabetes mellitus, falls, hearing problems, hypertension, ischaemic heart disease, osteoarthritis, osteoporosis, pain management, smoking cessation, urinary incontinence, and problems with vision (cataract). The quality indicators were classified into one of three domains of care: screening and prevention, diagnosis, and treatment and follow-up. Each of the 13 conditions was classified into one of two clinical categories, general medical or geriatric care.

The study found that the care people received varied substantially by condition. 'The percentage of indicated care received by eligible participants was highest for ischaemic heart disease (83%), followed by hearing problems (79%), pain management (78%), diabetes (74%), smoking cessation (74%), hypertension (72%), stroke (65%), depression (64%), patient centred care (58%), poor vision (58%), osteoporosis (53%), urinary incontinence (51%), falls management (44%), osteoarthritis (29%), and overall (62%). Substantially more indicated care was received for general medical (74%), than for geriatric conditions (57%), and for conditions included in the general practice pay for performance contract (75%), than excluded from it (58%).'

The authors conclude 'Shortfalls in receipt of basic recommended care by adults aged 50 or more with common health conditions in England were most noticeable in areas associated with disability and frailty, but few areas were exempt. Efforts to improve care have substantial scope to achieve better health outcomes and particularly need to include chronic conditions that affect quality of life of older people.'

Fahey et al (2003, study) undertook a study to assess the quality of care given to older people in Bristol and compare the care given to 172 residents in nursing homes with 526 people living in their own homes. They found that overall standard of care was inadequate when judged against the quality indicators, irrespective of where patients lived. The overall prescribing of beneficial drugs for some conditions was deficient, for example only 38% of patients were prescribed beta blockers after myocardial infarction. Nursing home residents received poorer quality care in terms of underuse of beneficial drugs, overuse of inappropriate drugs (such as neuroleptics), and poor monitoring of chronic disease such as diabetes.

A national survey of 1600 health service managers 'rated older people and those with mental health needs as the most neglected groups in the service and those which had benefitted least from NHS reforms' (Roberts and Seymour 2002, survey). Another survey of British Geriatrics Society (BGS) members commissioned by Help the Aged (2009, survey) found 47% of geriatricians think the NHS's systematic failure to provide older people with an acceptable standard of care is a form of discrimination that amounts to institutional ageism. The BGS members comprise consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, nurses, allied health professionals, scientists engaged in the research of age-related disease and others with a particular interest and expertise in the care of the frail older person and in promoting better health in old age. The two surveys reflect the opinions of experts from a wide range of settings in health care.

The studies above indicate that measured against independently verified quality indicators the healthcare interventions for older people in many cases can fall below recommended levels of care and the greatest scope for improvement is in chronic conditions that affect the quality of life of older people. 'Arguably barriers to implementing evidence based practice for geriatric conditions are greater, despite the national service framework for older people, than for the high mortality conditions that are the focus of much medical practice, and the clinical skills required for these conditions may be less well taught to doctors' (Steel et al 2008, large survey).

5.1.2. Cancer

GPs play a significant role in the diagnosis of cancer and post diagnosis management of cancer. It is widely recognised that late presentation and delayed diagnosis are major contributors to poorer survival rates in the UK compared to other European countries. The combination of patient and primary care delays are responsible for at least two thirds of total diagnostic delays (Neal et al 2008, study). A National Awareness and Early Diagnosis Initiative (NAEDI) was established by the Cancer Reform Strategy (DH 2007) to address the problem. The national target is a reduction in death rates from cancer by 20% by 2010 in people under 75 (from the 1995-97 baseline). People over 75 are excluded from the targets. Primary Care Audit templates to measure the incidence or extent of delays in primary care amongst patients subsequently diagnosed with cancer may highlight variances by age.

A comparison of cancer death rates in the UK with Europe and America found that over the past decade the numbers of people dying from cancer in the under 75s has dropped in the UK but little progress has been made in the over 75s and the gap in death rates is getting wider. 'Cancer is largely a disease of older people, with about half of all cancers diagnosed in those aged 70 or older. Most 75 year olds could be expected to live for at least another ten years and we would expect them to benefit from improvements in treatment', Dr Tony Moran, lead researcher from The North West Cancer Intelligence Service (NWCIS) (NWCIS Press Release, 25 June 2009).

In older people 'the diagnosis work-up is often less extensive compared to their younger counterparts, so that there is a higher proportion of unstaged disease in the elderly'. Reasons given include 'lack of knowledge of the normal process of ageing and of life-expectancy, stereotyped opinions, and therapeutic nihilism' which contribute to 'referral filters, of which the exact magnitude and underlying mechanisms still have to be unraveled' (Wymenga et al 2001, review).

A study of the relevant literature by Turner et al (1999, review) 'Cancer in old age – is it inadequately investigated and treated?' revealed that 'Although more than a third of cancers are diagnosed in people over 75, this group is less extensively investigated and receives less treatment than younger patients; reduced levels of intervention are not wholly explained by appropriate adjustment for comorbidity or frailty'. They conclude that 'Ageism in healthcare staff, lack of awareness of life expectancy and treatments available, and beliefs and fears about cancer and its treatment in elderly patients and their relatives may be factors in this disparity.'

5.1.3. Cardiovascular disease

There is evidence that older people with cardiovascular disease are relatively undertreated and undertested compared to younger people. Harries et al (2007, group study) compared angina treatment in general practice, cardiology and gerontology to determine which doctors are influenced by a patient's age. They found 46% of GPs and care of the elderly doctors, and 48% of cardiologists treated patients aged 65+ differently to those under 65, independent of comorbidity. This effect was evident on several decisions: elderly patients were less likely to be prescribed a statin, given a cholesterol test, referred to a cardiologist, given an exercise tolerance test, angiography and revascularisation; instead they were more likely to have their current prescriptions changed and to be given a follow-up appointment. Age, independent of comorbidity, presentation and patients' wishes, directly influenced decision-making about angina investigation and treatment by half of the doctors in the primary and secondary care samples. Doctors explicitly reasoned about the direct influence of age and age-associated influences.

Adams et al (2006, study) investigated the influence of patient's age on primary care clinical decision-making about coronary heart disease (CHD). A review of the literature showed that while GPs were more likely to diagnose older people with CHD than younger people with identical chest pain symptoms, 'the higher probability diagnosis did not give older patients more access to appropriate care interventions'. Older people, compared with younger people, were more likely to receive both delayed and fewer diagnostic interventions; fewer prevention drugs; fewer prescriptions for drugs that are known to be effective cardiac treatments; and have more limited access to specialist care facilities.

Their analysis of GP decision making does not establish that there was substantial ageism in the doctors' decisions, but rather suggest that diagnostic processes pay insufficient attention to the significance of older patients' age and its association with the likelihood of co-morbidity and atypical disease presentations. The doctors also demonstrated more limited use of 'knowledge structures' when diagnosing older than midlife patients (Adams et al 2006, study).

Research commissioned by the House of Commons Health Committee inquiry into health inequalities found that, in 2005, patients aged 75 years and over with coronary heart disease were less likely to be prescribed a beta blocker, aspirin or an ace inhibitor than younger patients.

<i>Age</i>	<i>Beta blockers</i>	<i>Aspirin</i>	<i>Ace inhibitors</i>
45-54	58% (n=208)	90% (n=208)	67% (n=92)
55-64	48% (n=630)	90% (n=630)	66% (n=221)
65-74	48% (n=986)	90% (n=986)	68% (n=368)
75+	39% (n=1231)	85% (n=1231)	61% (n=479)

(Parliament. House of Commons Health Committee 2008, study)

5.1.4. Heart failure

Heart failure affects around 900,000 people in the UK and is particularly common among older people, with prevalence expected to increase over the next 20 years, partly as a result of an ageing population. Current treatments for heart failure can relieve symptoms and slow the progression of the condition. In its review of progress for the management of heart failure, the Healthcare Commission (2007, study) found that services remain underdeveloped. In particular, little progress had been made on the identification of people with heart failure in primary care - the national recorded prevalence (1.8%) was lower than expected (2.3%) based on estimates, and there was considerable variation by PCT (0.19% to more than 5%). The establishment of registers to identify and monitor the care heart failure patients receive is poor compared to other coronary heart disease patients. This could mean that there is a largely unseen demand for investigations, clinical assessment and care.

GPs experienced specific problems diagnosing and treating older people with heart failure according to Fuat et al (2003, group study). There is uncertainty about clinical practice, including lack of confidence in establishing an accurate diagnosis and worries about using angiotensin converting enzyme inhibitors, blockers, and spironolactone in patients who are often elderly and frail, with comorbidity and polypharmacy. There is also a lack of awareness of relevant research evidence in what was perceived to be a complex and rapidly changing therapeutic field. Doubts about the applicability of research findings in primary care, and fear of information overload also emerged. Fuat et al conclude that simply establishing national guidelines is unlikely to have an impact on clinical outcomes. Young (2006, opinion) commenting on the research suggests 'From an older person's perspective this apparently benign form of age discrimination is just as damaging as blatant ageism because older patients are still denied potentially beneficial treatments openly available to younger people.'

5.1.5. Osteoporosis

The annual number of osteoporotic fractures is predicted to increase considerably with the continued ageing of the population in future decades. In the UK around 230,000 people every year suffer a fracture because of osteoporosis, many of whom are elderly and very vulnerable. As a public health concern osteoporosis continues to be under recognised, undertreated and largely preventable. 'Although therapy that can reduce the risk of osteoporotic fractures is available, osteoporosis often remains undiagnosed until a fracture occurs. In addition, patients with osteoporosis-related fractures often are not evaluated or treated for osteoporosis and sustain additional fractures' (Mauck and Clarke 2006, review).

An audit of 1600 women with a fracture attending a specialist clinic showed that 31% had suffered a previous break but only 28% had been on recommended bone-protective drugs. Only 45.1% of women aged 75 years and over with a previous history of fracture were receiving bone protective therapy. The results of the audit demonstrate low rates of treatment in postmenopausal women with a history of low trauma fracture (Premaor 2009, survey).

There is some concern about the effectiveness of NICE guidelines on osteoporosis. The National Osteoporosis Guideline Group, a group of UK osteoporosis specialists, has published national guidelines for the diagnosis and management of osteoporosis to provide evidence based recommendations on issues not dealt with by current guidance from NICE. These take into account advances in the management of osteoporosis over the past few years, including new techniques for measuring bone mineral density, better methods for assessing the risk of fracture, and new treatments that reduce the risk of osteoporotic fractures. 'All we have at the moment is very restricted, out of date guidance on the secondary prevention of fractures in postmenopausal women. This leaves out the primary prevention of fractures, men, steroid induced osteoporosis, and the newer treatments', Juliet Compston, professor of bone medicine at the University of Cambridge School of Clinical Medicine and Addenbrooke's Hospital (Mayor 2008).

5.1.6. Continence

Incontinence is a distressing problem that afflicts a large number of older people. Urinary incontinence is particularly prevalent in women and older people. In the UK, over a one year period, over a third of people aged 40 and over have symptoms of urinary incontinence, urgency, frequency, nocturia or bladder storage problems. Incontinence has been linked in various studies to depression and even suicide (APHO 2008).

The National Audit of Continence Care for Older People (65+) in England, Wales and Northern Ireland (Wagg et al 2005, large survey) showed variations in service provision, a widespread failure to establish the cause of incontinence, with inadequate use of routine assessments, such as bladder diaries and the measurement of residual bladder volumes. The audit report concluded that an emphasis on containment (through pads and catheters), rather than treatment of incontinence, was expensive, and suggested a missed opportunity to assess, treat and reduce the numbers of incontinent people. Whilst basic provision of care appeared to be in place, the audit identified deficiencies in the organisation of services, and in the assessment and management of urinary incontinence in the elderly. 'There is an urgent need to re-establish the fundamentals of continence care into the practice of medical and nursing staff and action needs to be taken with regard to the establishment of truly integrated, quality services in this neglected area of practice' (Wagg et al 2008, study).

Stoddart et al (2001, study) undertook a study to investigate unmet need in relation to the prevalence and impact on everyday life of urinary incontinence in men and women over the age of 65 years. They took a stratified random sample of 2000 community-living older people (equal numbers of men and women, aged 65 to 74 years and over 75 years) in 11 general practices in a British city. The response rate was 79%. The overall prevalence of incontinence in the previous month was 31% for women and 23% for men. Only 40% of men and 45% of women with incontinence had accessed health services. The authors conclude 'There is the opportunity to improve the lives of many older people with urinary incontinence, by a combination of increased public, patient, and professional awareness that should lead to earlier presentation and initiation of effective care.' These findings are supported by the Steel et al (2008, large survey) study reported above.

HSE 2000 Health of older people survey reported that people in care homes were more likely to have bladder problems than those in private homes - 30% of men and 28% of women in care homes aged 65 and over complained of bladder problems compared to 15% of both sexes living at home (Hirani and Malbut 2002, survey). De Laine et al (2003, study) look at continence care in relation to the NSF eliminating discrimination and promoting person centred care. Practice examples 'appear to reflect an attitude that incontinence is an acceptable and expected consequence of ageing'. They go on to say that 'rather than perpetuating the idea that nothing can be done, healthcare professionals should actively encourage recognition of continence difficulties'. NHS Trusts have varied policies on providing continence services to care homes and 'differences in provision could mean that clients do

not receive a standardised assessment and that their treatment and management is subsequently poor.'

5.1.7. Parkinson's disease (PD)

Parkinson's disease is a progressive neurological condition affecting movements. The average age of onset is around 60 years and the risk of getting PD increases with age (up to around 2% of the population aged 80 and over). There is evidence of both under treatment and over-treatment of Parkinson's disease in the community. The relationship between the patient's age and the GPs decision whether to treat or refer provides a strong indication of age discrimination among GPs.

A survey undertaken by the Parkinson's Disease Society (PDS) in 2001, conducted among approximately 400 randomly selected GPs throughout Great Britain, showed that GPs were less likely to prescribe older people newer, more expensive medicines such as dopamine-agonist drugs which produce fewer side effects (Turner 2006, review). Key points from the survey regarding treatment are:

- A quarter of GPs always initiate drug treatment in all new patients
- 57 per cent of GPs said age is a contributing factor in the decision to treat
- 47 per cent always treat patients aged over 71
- 90 per cent sometimes or always treat patients aged 61–70
- 38 per cent never treat patients aged under 50, while only 5 per cent never treat patients aged 71–80 (quoted in Thomas and MacMahon 2002, study)

People with Parkinson's in England are more likely to have their medication review conducted by a GP rather than a specialist, despite their lack of specialist knowledge (MacMahon et al 2006, review). Also see section 5 on GP referrals.

The over use of neuroleptics in nursing homes means that the likely prevalence of drug-induced parkinsonism is high (McGrath and Jackson 1996 quoted by Thomas and MacMahon 2002, study). Nearly half of those now living in residential care feel that staff do not fully understand Parkinson's and how it affects them (PDS 2008).

5.1.8. Diabetes

The majority of people with diabetes are aged > or =65. The greatest increases in numbers of total cases of diabetes is occurring among older people. This is because of the ageing of the overall population as well as a greater absolute increase in the prevalence of diabetes among older people

than among young people. Few recent studies have examined the relationship between age and the quality of care received for diabetes. Gray et al (2006, survey) undertook a survey to determine the quality of diabetes management in primary care in 36 practices in South West London with 635 adult patients over 18 years (16.6% -18-44 yrs; 15.2% - 45-54 yrs; 24.7% - 55-64 yrs; 26.6% - 65-74 yrs; 16.9% - 75+ yrs). They found large variations in diabetes management between general practitioner practices with poorer recording of care in younger patients (18-44). Younger patients had a worse cholesterol and glycaemia profile, although hypertension was more common in older patients. 'These differences may reflect tighter management policies for older patients within practices and better treatment compliance amongst this patient group'. They also found that patients aged 75+ years did not appear to receive poorer quality care when compared to younger patients.

Studies of diabetes in older age do draw attention to its underappreciated complications that include cognitive disorders and physical disability, falls and fractures. 'Such outcomes, as well as having a direct impact on quality of life, loss of independence, and demands on caregivers, may ultimately be as great a concern to older people with diabetes as the more traditionally recognised vascular complications. The specifics of how to manage elderly patients with diabetes, prioritise their problems, and implement effective interventions for functional outcomes are not clear.' Guidelines for the quality of care in diabetes are based primarily on research conducted among middle aged populations, and their appropriateness in the face of complex complications related to ageing is less clear (Gregg et al 2002). A large community based study by Sinclair et al (2008, study) to examine the nature of functional impairment in older people with diabetes concluded that they would benefit from comprehensive geriatric assessment and tailored diabetes management.

DiabetesE is an online self assessment tool designed to promote continuous improvement in the quality of diabetes services in line with the Diabetes National Service Framework (NSF). The fourth national report analysing the findings from DiabetesE stated that 'the module that seeks to encourage the improvement of diabetes services for elderly people that are housebound or in institutional care remains the lowest scoring one for the fourth year. This position suggests that more concerted effort and action is needed at local and national levels if this element of the NSF, and the inequalities agenda, is to be realised within the timescale of the NSF.' (Innove 2009, report).

Residents of care homes with diabetes are likely not to be receiving adequate treatment for their condition. In a study conducted by Benbow et al (1997, survey) of 1611 residents in 44 homes, 159 (9.9%) had diabetes. Fifteen (14%) diabetic residents received diabetic care solely from the GP and

27 (25%) received care from a hospital clinic. Seventy (64%) patients had no record of anyone being medically responsible for diabetes review and management the previous year. Diabetic residents with mental illness were significantly less likely to be receiving formal diabetic care than other residents. Many residents had no medical team responsible for their diabetic care and had not been assessed for the presence or risk of diabetic complications.

Summary

Evidence shows shortfalls in receipt of basic recommended care by adults aged 50 or more with common health conditions and poor recognition, diagnosis and delivery of evidence based treatments for common conditions of ageing, such as osteoporosis, falls, incontinence. Failure to provide older people with acceptable standards of care amounts to institutional ageism. Older people with cancer and cardiovascular disease are relatively undertreated and under tested compared with younger people. Lack of knowledge of the ageing process and life expectancy amongst health care practitioners may lead them to misjudge older people's quality of life in a negative way.

6. GP referrals

GPs have a central position in the health care system. The GP is generally the first professional confronted with a patient's problems and the first to decide which kind of services are required. Other care professionals, such as medical specialists, are accessible only after referral by a GP. In this way GPs control the use of specialist, hospital or other expensive services thereby acting as a mechanism for rationing services. Studies suggest there is a large variation in the referral rates of GPs to specialist services amongst all age groups. Patient characteristics explain <40% of the observed variation; practice and GP characteristics <10%. The availability of specialist care does affect referral rates, but its influence on the observed variation of referral rates is not known. Variation in referral rates amongst GPs remains largely unexplained (O'Donnell 2000, review).

A King's Fund survey of health managers on age discrimination found the role of GPs as gatekeepers was rarely referred to. The authors concluded that this 'may be because practice-level data, e.g. referral patterns by age, tends not to be systematically monitored by PCT managers, or, indeed, by anyone' (Roberts and Seymour 2002, survey).

Studies by Adams et al (2006, study) and Harries et al (2007, group study) draw attention to the low referral rates of older people for cholesterol testing, angiography and revascularization. A related study on variations in cardiac interventions by Bowling et al (2006, group study) showed that not all

patients who were eligible for specific investigations or treatments received them. Almost a fifth of doctors interviewed (total 76) were influenced by the patient's socio-demographic characteristics. They note that 'failure to take equity of patient access into account when analysing intervention and referral rates leads to false conclusions and wrong policy decisions.'

Parkinson's disease, one of the commonest neurological conditions to affect older people, is difficult to diagnose and diagnostic errors are common. It is best practice to refer patients with a suspected diagnosis of PD for specialist assessment by an experienced clinician, ideally before treatment is started (BGS online). The Parkinson's Disease Society survey of GPs in 2001 showed that age of the patient appeared to be central in decision making, with 94% of GPs referring all patients aged 50 and under for specialist advice compared with 58% who said they always referred patients aged 71 and older to specialist care; 11 per cent never refer patients aged over 81. Forty four per cent of GPs said age is a contributing factor in the decision to refer indicating that ageism could be common in primary care for people with Parkinson's disease (Thomas and MacMahon 2002, study). Another PDS survey in 2005 highlighted that a third of GPs were not referring patients to secondary care, despite admitting a lack of specialist knowledge in Parkinson's disease. A report by the Royal College of Physicians revealed a 47% error rate for GPs diagnosing PD (Turner 2006, review). In 2007 the PDS undertook a large scale survey of people with Parkinson's and their carers with 13,000 responses (PDS 2008, large survey). It showed widespread failings in service provision with 46% of patients never referred to physiotherapy, 63% not receiving speech and language therapy and 66% not being referred to an occupational therapist. One in five people with Parkinson's diagnosed in the last year was diagnosed by their GP and not by a specialist; over half of those diagnosed in the last year and referred by their GP to a neurologist waited more than six weeks for the appointment.

Early referral to nephrologists is critical because mortality rates for late-referred patients entering End Stage Renal Disease (ESRD) programmes are very high. Examining patient characteristics associated with late referral of patients with chronic kidney disease to nephrologists, Navaneethan et al (2008, systematic review) found old age was consistently associated with late referral in several studies. One study showed that even age > 55 years is associated with late referral and several others showed age > 75 years as a major predictor of late referral. The renal registry report for the United Kingdom for 2002 indicates the acceptance rate for dialysis for patients over 65 is approaching 300 patients per 1 000 000 population, compared with 72 per 1 000 000 population in those aged 18-64 years. 'It is now clear that age alone should be no contraindication to dialysis and that good outcomes can be achieved. It is the responsibility of nephrologists to communicate this so

that renal services are not rationed on the basis of age at point of referral' (Sims et al 2003, study). This view is supported by a study on 'the quality of life by age with renal replacement therapy' by McKee et al (2005, study).

A 2000 study of seven Leicestershire general practices found that older patients were less likely to be referred to a specialist hospital diabetes clinic and more likely to receive a diabetes review in general practice, which might be an indication of covert age discrimination. The main predictors of attending for review in general practice were older age, less co-morbidity, and being white (Goyder, McNally and Botha 2000, survey).

In relation to rehabilitation referrals Seymour (1998, study) finds a disregard for older people means that they are less likely to be given access to rehabilitation services, either because of explicit policies that ration services or because the service they are presented with in the community lacks professionals with the appropriate skills.

Summary

Variation rates in referral rates among GPs remain largely unexplained. There is evidence of low referral rates for older people in particular areas such as cholesterol testing, angiography and revascularisation; younger adults with Parkinson's disease are more likely to be referred for specialist treatment than older adults; old age has been consistently associated with late referral of patient with chronic kidney disease to nephrologists; older patients may be less likely to be referred to a specialist diabetes clinic.

7. Preventative strategies

In recent years, concerns about equity of access to treatments, including preventative interventions, have focused on ageism. A key issue is that women and older people remain underrepresented in published trial literature relative to their disease prevalence (Rehwagen 2005). It is common for drug trials to exclude older people, usually over 65 or 70. As a result 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, despite the lack of systematic collection of age-relevant data (Godlovitch 2003). For example, statin drug trials have suffered from age and gender bias, having been mainly conducted in middle-aged male populations (Bandyopadhyay et al 2001).

7.1 Vascular disease

Stroke affects approximately 120,000 people per year in the UK with another 30-40,000 having transient ischaemic attacks (TIA). The average age of stroke patients is 75 years. Stroke accounts for

10% of deaths in England (50,000 per year) and although good data are lacking, there are probably 900,000 people living with the consequences of stroke. One in four people can expect to have a stroke if they live to 85 years. Stroke is in most cases a preventable disease, through aggressive management of hypertension, hyperlipidaemia, atrial fibrillation and other vascular risk factors (BGS 2007, policy document).

Many patients who may benefit from anticoagulation still do not receive it, whereas others at lower risk of stroke do, while the likelihood of receiving it decreases sharply with age after 75 years. The lower likelihood of women receiving anticoagulant is of particular concern (De Wilde et al 2006, study).

The national service framework for cardiovascular disease aims to reduce the number of people dying from coronary heart disease (CHD) by 40% by the year 2010 with advice that standards set out in this framework apply to all people, irrespective of age:

- General practitioners and primary care teams should identify all people with established cardiovascular disease and offer them comprehensive advice and appropriate treatment to reduce their risks.
- General practitioners and primary care teams should identify all people at significant risk of cardiovascular disease but who have not developed symptoms and offer them appropriate advice and treatment to reduce their risks.

Older people are at particularly high risk of recurrent and fatal CHD. There is robust evidence to support the use of statins in older people, including those over 75 (Turnbull 2001, study; Hippisley-Cox et al 2005, study; Roberts et al 2007, review; Strandberg 2008, opinion). Several studies examine age inequality in the prescribing of preventative cardiovascular therapies to older people in primary care.

Reid et al (2002, study) investigated possible inequities in the use of statins for 760 people with coronary heart disease. Only 19.9% of subjects with coronary heart disease were receiving lipid lowering drugs (151 of 760; 95% confidence interval (CI) 17.0% to 22.7%). The likelihood of receiving statins was greatly reduced for older age groups: compared with those aged less than 65 years, the odds of receiving statin treatment were 0.53 (95% CI 0.35 to 0.80) for subjects aged 65–74 years, and 0.11 (95% CI 0.06 to 0.21) for subjects aged 75 years and over.

There is an 'ageism' bias in the treatment of hypercholesterolaemia (Jacobson 2006, review). Because older people have a higher attributable risk of coronary heart disease as a result of

hypercholesterolaemia, more coronary deaths and overall events can be prevented via treatment in this age group compared with younger persons with hypercholesterolaemia. The efficacy, safety and tolerability of HMG-CoA reductase inhibitors (statins) have been confirmed in randomised, controlled, multicentre trials involving large numbers of patients aged > or =65 years. These favourable clinical findings should help clinicians counter highly prevalent 'ageism' bias in statin prescribing, whereby elderly patients, particularly those at highest cardiovascular risk, are often denied the benefits of statins without any meaningful foundation. Marshall (2000, opinion) supports this view on the basis that 'statins reduce the risk of ischemic heart disease by 30% and are recommended for patients at >30% annual risk of the disease. We know that everyone over 75 in the UK has this annual risk of the disease; therefore everyone over 75 should take statins'.

Hippisley-Cox et al (2005, study) compared uptake of coronary prevention in patients aged 75 years and over with younger patients. Improvements were demonstrated in the recording of coronary risk factors and of disease control measures. However, compared with patients aged <75 years, older patients were significantly less likely to have a serum cholesterol level recorded at baseline; to be on lipid lowering drugs; to be on beta blockers post myocardial infarction and to have well controlled blood pressure. These differences persisted at follow-up.

Ramsay et al (2005, survey) in a study of secondary prevention of coronary heart disease in older British men found that prevalence of use of all drugs increased in 2003 and was markedly higher in patients with a history of myocardial infarction than angina. However, older age was related to lower prevalence of drug use, particularly statins. Marked age inequalities in statin use were present both in 1998-2000 and 2003.

Mangin et al (2007, study) suggest that general practitioners may not be comfortable about applying the national service framework for heart disease in elderly people and are reluctant to follow guidelines for cholesterol measurement and lipid lowering agents in people over 75. They argue that single disease models should not be applied to preventive treatments in elderly people as 'By using preventive treatments to reduce the risk of a particular cause of death in elderly people are we simply changing the cause of death rather than prolonging life?' They conclude 'We need a way to assess prevention and treatment of risk factors in the elderly that takes a wider perspective when balancing potential harms against putative benefits.'

A study by De Wilde et al (2003, study) of trends in the use of lipid lowering drugs in the UK, concluded that although prescribing has increased, many patients who may benefit from lipid lowering drugs either do not receive it or are undertreated, possibly because of lack of awareness of

the relative potency of the different statins. Patients with angina and the elderly are less likely to receive treatment that may prevent a coronary event

An age and gender bias exists in the prescription of important secondary preventive therapies in primary care that may lead to increased mortality from ischaemic heart disease in these groups (Williams et al 2003, study; Usher et al 2004, study).

7.2. Falls prevention

Falls, falls-related injuries and fear of falling are important health issues for older people. Falls represent the most frequent and serious type of accident in the over-65s and are a serious cause of morbidity and mortality. Thirty per cent of community dwelling people over 65 and 50% of those over 80 years will fall in 12 months with 60% of those who fall once, falling again within the same year. A proportion of these will fracture. Half of those who suffer a hip fracture never regain their former level of function (Parliament. House of Commons Health Committee 2008, study). Deaths from accidental falls rise steeply with age and over 2200 people aged over 65 in England were recorded as having died as a result of falls in 2005. Sixty per cent of those admitted to hospital because of a fall are aged 65 or over and 40% are aged 80 or over (APHO 2008). There is now a clear understanding of the factors contributing to risk of falling in older adults and preventing falls depends on identifying those most at risk. Despite this few general practitioners will have assessed the risk of falling among their older patients or even know how to do it (Järvinen et al 2008, study).

Falls prevention is also linked to diagnosis and treatment of sensory impairments in older people. Older people with sight problems are not only more likely to fall, but are at a greater risk of multiple falls, compared to their fully sighted peers. Thirty-six per cent of participants in an identification project mentioned they had fallen, or tripped, as a result of their sight loss reported by Campbell (2005, study), *Deteriorating Vision, Falls and Older People: The Links*. Some participants in the study commented that 'when visiting their GP after a fall, they had been told to expect to fall as they get older and were told that nothing can be done to help'. (See section 12 on vision in this report.)

The second national clinical audit to investigate the organisation of services for patients who have fallen and fractured bones (hip, wrist, arm, pelvis or spine) shows that commissioning of falls services is very variable, rarely providing a co-ordinated falls and fracture strategy (Martin et al 2009, large survey). 'This audit demonstrates that the services provided for older people at risk of falls and fractures fall short of the services that the evidence supports, that national guidelines

dictate, and that older people deserve' Dr Jonathan Trembl, Associate Director of the National Falls and Bone Health Audit Programme.

The situation does not appear to have improved since the previous audit in 2006. The results of the first national audit suggest that most areas have the infrastructure with potential to identify need and for provision of specialist falls assessment and treatment. Despite this, the amount of clinical activity is surprisingly low, there are notable gaps in provision, and arrangements in hospitals for case finding and secondary prevention are inadequate (Husk et al 2006, review).

7.3. Health promotion

Guidelines for health promotion of older people are covered in the NSF for Older People, Standard Eight: 'The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils'. It states that older people should have access on the basis of need, not age, to health promotion activities announced in the Mental Health NSF, Coronary Heart Disease NSF and the NHS Cancer Plan as well as health promotion activities of specific benefit to older people, tailored where necessary to reflect cultural diversity. Breast cancer screening, smoking cessation and hypertension management have the best evidence for effectiveness in older people.

Health promotion and active ageing are key to reducing health inequalities and improving the gap between life expectancy (and quality of life) in the next ten years (Bowers et al 2003, study).

Promoting health in the 'younger' population will have a knock on effect in later years. Behavioural risk factors such as smoking, diet and physical activity have an impact on diseases of later life, such as cancers, heart disease and respiratory illness. Evidence suggests that adopting a healthy life style in later years can produce greater wellbeing and slow down decline (Lauder 1993, review; Killoran et al 1997, study). Older people can benefit from key lifestyle changes such as smoking cessation, improved nutrition and diet, physical exercise and reducing alcohol consumption.

Studies show that smoking and alcohol and safe drinking are rarely tackled in health promotion for older people (Chiva and Stears 2001, review).

The percentage drinking heavily (for men >21 units/wk for women >14) decreases with age but the percentage drinking frequently increases with age. In contrast to the number of units drunk per week, the percentage drinking on five or more days is higher in older people than in younger people. As with units consumed, the percentage of men drinking frequently is higher than for women. It can

be seen that an average of 23% of the over 65 age group drink on at least five days per week compared to 18% of all adults aged 16 and over (data from APHO 2008).

Drink-related hospital admissions for the over 65s are increasing. In 2002/03 admissions for over 65s were just over 197,000 but by 2006/07 were 323,595 and amounted to 40% of the total 800,000 admissions (BBC News, 5 March 2009). However, GPs are more likely to ask about alcohol consumption and smoking, and more likely to give advice to 55 year olds than to otherwise identical 75 year olds (Arber et al 2004). The current national alcohol strategy does not mention drinking in later life (Parliament. House of Commons Health Committee 2008).

Smoking greatly increases the risk of numerous diseases including heart disease, stroke, and several types of cancer and older smokers still stand to gain extensive health benefits by quitting. There is evidence that age is strongly related to chances of success in stopping smoking with people over 65 years having a high probability of success, while those aged 25-64 have a medium probability of success (West et al 2009, study). A small study of 20 current and former smokers aged over 65 years found knowledge of local cessation services was generally poor and many had received little help and support from health professionals when attempting to stop smoking (Kerr et al 2006, group study).

Adapted exercise even for very frail older people can help strength and balance and reduce the risk of falling. After the age of 40 muscle mass is lost at a rate of 1-2% per year, however a three month exercise programme can rejuvenate muscle mass by a 15 year equivalent, so community based training programmes for healthy older people can have profound effects in reversing muscle wasting. The House of Lords Science and Technology Committee suggested that local authorities should improve facilities for exercise and make them suitable for older people to use. The Social Exclusion Unit found that lack of physical activity contributed to several aspects of social exclusion. Lack of physical activity can be due to poor transport network, limited mobility and lack of local services (APHO 2008). Seventy per cent, 82% and 92% of 65-74 year olds, 75-84 year olds and 85+ year olds respectively have very low levels of physical activity. The number of people walking for 30 minutes continuously at least once in the last four weeks remains fairly steady at around 70% up to the age of 65 but thereafter decreases with age so that only 32% of those aged 85 and over walk even this much (APHO 2008). Many generally available facilities, e.g., leisure/exercise, exclude older people by not accounting for their needs as the special needs of younger people are accounted for. Older people are not considered in many lifestyle initiatives by local authorities, including nutrition, exercise and leisure programmes (Murtagh 2003, study).

Research on stroke care for older people confirmed that older patients do not receive same levels of lifestyle advice with a third of younger patients counselled about weight reduction compared with just over one in 10 older patients (BBC News 16 April 2009). GPs being interviewed about hypertensive treatment for older people said they would not discuss lifestyle changes with them as only young hypertensive patients were considered likely to modify their lifestyles (Cranney et al 2001, study).

Information on sexual health and health related behaviour in older people is limited. Studies have shown that older people seeking advice on sexual problems are most likely to see their GP, but that many do not seek help because they believe that it is due to normal ageing or because of embarrassment. However health professionals may not be aware of older people's sexual health needs, or may be reluctant to discuss a topic which they did not feel to be legitimate (Gott et al 2004, group study). The majority of older people surveyed reported receiving very little information on sexually transmitted disease and HIV (APHO 2008).

7.4. Screening

Upper age limits for screening programmes appear to be an explicit example of discrimination on the basis of age.

The new UK vascular screening programme for 40-74 year olds was launched in April 2009. The upper age limit has been capped at 74, which excludes a large number of people who may benefit as vascular problems intensify with age. 'Most strokes occur in people over 75. To prevent stroke, it is important to ensure that hypertension is controlled in this age group' (Xavier 2009).

Women from 50-70 are routinely invited to breast screening; once women reach the upper age limit for routine invitations for breast screening, they are encouraged to make their own appointment. In December 2007, the Department of Health's Cancer Reform Strategy announced that from 2012 the NHS Breast Screening Programme would be extended to cover women between the ages of 47 and 73. To date there is no clear evidence on the extent to which it is beneficial to extend the age range for breast screening as no trial has looked at the added value of one extra screen within an existing screening programme. Research reported by White (1999, study) showed that breast and cervical cancer screening offer the most benefit and that extending breast cancer screening to the age of 74 would be more effective than cervical screening at any age. It also indicated that cervical screening policy should be extended to the age of 69 because more lives are lost to cervical cancer among women in their 70s than among women under 30 years. Bennett et al (2009) investigated

breast screening performance measures in the English screening units that began inviting women aged 65–70 between 1 April 2001 and 1 April 2004 and results for women aged 65–70 were compared to women aged 50–64 and 60–64. Uptake rates are high in older women, and many more older women attend screening following an invitation than had previously self-referred. The cancer detection rate is higher in the older age group - for women previously screened within five years the invasive cancer detection rate was 17% higher in the 65–70 age group than in the 60–64 age group. In screening for cancers – breast, cervical, bowel - significant age-related disparities appear to exist for both evidence-based and non-evidence-based cancer-screening interventions (Jerant et al 2004, large survey).

The UK's national bowel screening programme has an age span of 60-69 although there are plans to extend this to 75 at the end of 2010; people outside the upper age limit have to be highly proactive and request a screening kit by telephone. There is no clear evidential base for the upper age limit in the bowel screening programme (Quarini and Gosney 2009, review).

Prostate cancer is a significant health problem mostly affecting older men and is the second leading cause of cancer-related mortality after lung cancer. Although the disease can be cured if discovered early, it is a slow-growing malignancy that leads to death if left untreated. Differential diagnosis often is complicated by co-morbid conditions that are part of the normal ageing process. Screening initiatives remain controversial, partly because of the risks of over diagnosis and potential treatment side effects of impotence and incontinence (McDougall et al 2000, study; Donovan et al 2005, opinion; Lee and Patel 2002, opinion; Martin 2007, study). The UK National Screening Committee (NSC) has not recommended population screening for prostate cancer as at present the available evidence of benefits does not outweigh the potential harm arising from screening (Burford et al 2009, review).

Osteoporosis is common among older adults and results in costly osteoporotic fractures. It is a disease in which screening of asymptomatic individuals may be beneficial because it has a long preclinical course before the onset of fracture and because of the availability of both a reliable test to establish the diagnosis and treatments that have been shown to reduce the risk of fractures. General consensus exists regarding the recommendation that osteoporosis screening with Bone Mineral Density measurements should be individualized, but how this individualized approach to screening should be achieved remains controversial. 'Disagreement among the published guidelines reflects, at least in part, variances in expert opinion and gaps in the available evidence to support these recommendations. Most guidelines recommend using risk factor assessment to help select

patients for bone density testing, but because of inadequate data, no consensus exists about which risk factors are most important to consider' (Mauck and Clarke 2006, review). Several groups have suggested guidelines for BMD testing in postmenopausal women, the population group for which the most evidence is available. The UK NSC has concluded that to date there is insufficient evidence to support screening for osteoporosis. This policy is due to be reviewed again in 2009/10 following review of NICE guidelines.

Summary

There is evidence of gender and age inequality in the prescribing of preventative cardiovascular therapies to older people in primary care and some 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 know how to do such an assessment. GPs are less likely to discuss life style changes like weight reduction, smoking, alcohol and safe drinking with older people than younger people. One of the most explicit forms of age discrimination in healthcare in the NHS is the age limits applied to screening programs by invitation. While some have a sound evidence base and for others there is no available evidence, some are clearly discriminatory and are not justifiable by disease prevalence or any other clinical indicator.

8. Fail older people and multimorbidity

Due to technological progress and improvements in medical care and health policy the average age of patients in primary care is continuously growing. An increasing proportion of mostly elderly primary care patients present with multiple coexisting medical conditions.

'To date, the number and diversity of articles on multimorbidity are both insufficient to provide scientific background for strong evidence-based care of patients affected by multiple concurrent chronic conditions. Research is needed to increase knowledge and understanding of this important clinical topic.' (Fortin et al 2005, systematic review).

Frailty in older people can be defined through traits such as unidentified weight loss, weakness and slow walking; or through a multiple of vulnerabilities and instabilities in a process of deficit accumulation (Flicker 2008, review). The DH defines frailty as 'living with disability through multiple long-term conditions although the consequences are a tendency towards exacerbations of these long term conditions' (DH 2009, policy document).

Older people with multiple chronic illnesses and concomitant functional disability may be prone to medical neglect. Common syndromes such as falling, immobility, confusion and incontinence can be wrongly attributed to the ageing process, denying the person a correct diagnosis and treatment, which is a form of age discrimination.

Older patients with chronic illness and multimorbidity require continuity of care that cross traditional medical boundaries and care settings (Wait 2005, study). 'When such patients are seen by several specialists, each of which has expertise in a single condition, the sum of the advice can be both conflicting and excessively burdensome to the patient' (Heath et al 2009, study). However, the most underdeveloped aspects of clinical care for older people are multidisciplinary working and the limited knowledge and skill base in general practice (Iliffe et al 1998, study). 'There is a need to examine the health care of patients with multimorbidity, as they often receive fragmented specialist care which does not meet their needs, or indeed support their professional carers, especially in primary care' (Smith and O'Dowd 2007, review). Research highlights difficulties accessing care and problems with healthcare providers, particularly specialists (Noel et al 2005, study; Bayliss et al 2003, group study).

There is limited information on 'best' processes of care for persons with multimorbidities. In a study by Bayliss et al (2008, group study) of how older patients with multimorbidities would prefer to be treated, participants expressed a desire for convenient access to providers (telephone, internet or in person), clear communication of individualised care plans, support from a single coordinator of care who could help prioritise their competing demands and continuity of relationships.

There is evidence that 'older patients do benefit from medical interventions, coupled with the judicious use of therapies to increase functional status and introduction of community support' (Flicker 2008, review) even though frail older people continue to remain under-represented in clinical trials (Habicht et al 2008, study). Results of the Hypertension in the Very Elderly Trial (HYVET) demonstrates that treating high blood pressure in those aged 80 and over can be beneficial (Birmingham 2008, study).

Summary

Older people who are frail and have multiple chronic illnesses require special care to meet their specific care needs. The knowledge base for treating people with multimorbidities is limited leading to fragmented specialist care and possibly neglect of medical conditions perceived as part of the ageing process but that can be treated.

9. Prescribing rates and polypharmacy

The Health Survey for England 1998 found that about two in five men (39%) and half of all women (49%) were taking prescribed medicines. From age 45, use of prescribed medicines rose steeply with age. From age 75, 81% of men and 86% of women received prescribed medication, with more than two in five of those on medication taking four or more medicines. The evidence base for prescribing to frail and older people is small and disproportionate to the level of prescribing. Only 3% of randomised, controlled trials and 1% of meta-analyses are published about people over 65 years of age (Le Couter et al 2004, review).

Inappropriate prescribing encompasses acts of commission i.e. giving drugs that are contraindicated or unsuitable, and acts of omission i.e. failure to prescribe drugs. The lack of evidence of efficacy, coupled with perhaps a natural reluctance to prescribe potentially toxic medication, may lead to under prescribing (Crome and Natarajan 2004, study). While the evidence base is increasing 'even when the evidence base does not extend to a particular age group, effective treatments should not be withheld purely on the basis of age, just as treatments would not be denied to specific ethnic groups who are under-represented in clinical studies' Milton et al (2008, systematic review).

Inappropriate medication use is a major patient safety concern for the older population.

Polypharmacy and use of inappropriate drugs in this group increase the risk of adverse drug reactions (ADRs) (Crome and Pollock 2004, review; Mukhopadhyay et al 2007, review). O'Mahony and Gallagher (2008, review), reviewing the causes of inappropriate prescribing, suggest that it could be minimised by regular scrutiny of medicines of older patients and the introduction of a screening tool that will enable the review to be undertaken in a systematic and orderly way.

Routledge et al (2003, study) argue that the occasional unavoidable occurrence of adverse drug reactions in the elderly should be set against the knowledge that dose-related failure of existing therapy to manage the condition adequately may be one of the most important reasons for admission of older people to hospital. Thus, age is not a reason for withholding effective therapies since, although the risk of death due to several common diseases (e.g. coronary heart disease, stroke, and cancer) is greater with increasing age, the proportional reduction in mortality is often as great or greater in older rather than in younger people.

Ward et al (2004, study) undertook a study of GP practice prescribing rates for five major coronary heart disease (CHD) drug groups. They concluded 'Differences have been found between PCTs and between CHD drugs, although the main point is that GP prescribing rates seem to be inequitable on

the basis of patient age (patients aged over 75 years) and ethnicity, levels of deprivation and SMRs for CHD. Indeed, the NSF for CHD recognised that "many people with CHD are not receiving treatments of proven effectiveness" and there are "unjustifiable variations in the quality and access to some CHD services". This study adds weight to these assertions and may form the baseline for further studies to assess the effectiveness of the NSF for CHD in reducing the inequities in prescribing rates.'

In another study Ward et al (2005, study) looked at actual and expected prescribing rates for statins, beta blockers, and ACE inhibitors for each GP practice, ie the interface between who could benefit (eg, older populations, South Asian populations, deprived populations, populations with a high prevalence of CHD and/or high mortality rates from CHD) and who actually receives the drugs. 'Whilst the clinical and epidemiological data on statins, beta-blockers, and ACE inhibitors has allowed for the development of evidence-based guidelines and evidence-based prescribing, this paper suggests that in practice, actual prescribing rates may not be related to healthcare need.' This study advances the suggestion of inequities in prescribing rates for coronary heart disease (CHD) drugs.

The Commission for Social Care Inspection investigation of medicine management in care homes (CSCI 2006, large survey) found that nearly half of care homes are failing to meet national minimum standards for how they give persons their medication, prescribed by their doctors, to treat their medical conditions. This can result in older people being given the wrong medication, someone else's medication, medication in the wrong doses or no medication at all. Those living in nursing homes appear to receive poorer care than those living at home in terms of underuse of beneficial drugs, poor monitoring of chronic disease, and overuse of inappropriate or unnecessary drugs.

Summary

The exclusion of older people from drug trials that study efficacy and safety can lead to treatments being withheld purely on the basis of age even though the use of effective therapies for older people can lead to a proportional reduction in mortality as great as or greater than that for younger people. Standards of medicine management in care homes are poor leading to residents being denied prescribed medicine or medicines being improperly administered and monitored.

10. Rehabilitation services

Stroke, cardio-respiratory diseases and fractured neck of femur become more common as people age leading to chronic disease and disability. Older people are likely to require more time than

younger patients to make a full recovery or regain some functional ability through a process of multidisciplinary assessment and appropriate rehabilitation services.

Two studies show that health professionals appear to have knowledge of the benefits of cardiac rehabilitation for older people, but that the scarcity of resources prevented them from offering more accessible and appropriate services. The implication is that older people face specific barriers to rehabilitation because of their age despite evidence that 'older people acquire similar benefits to those of younger people after cardiac rehabilitation' (Clark et al 2002, study).

A case study by Tod et al (2002, study) explored what barriers exist for patients in accessing cardiac rehabilitation services within the South Yorkshire Coalfield locality. A comprehensive and individualised cardiac rehabilitation programme by suitably trained staff has been shown to reduce mortality by as much as 20% to 25% over 3 years. The study revealed a limited service capacity creating a fundamental barrier to the many people accessing cardiac rehabilitation after a heart attack. Older people were among the groups who fared worse in terms of access to services, along with women and those in traditional working class coalfields communities. Older people also experienced specific barriers in accessing cardiac rehabilitation. Staff and patient participants thought existing services inappropriate for older people, often because of the hospital base. Frailty because of age or comorbidity may exacerbate problems with travel, transport and distance to services in this case the distance between the ex-mining villages and the hospital where cardiac rehabilitation services were based. Older participants also emphasized the importance of routine in their lives and the security this offered. If cardiac rehabilitation attendance disrupted their routine, they would not attend.

I refused help from the hospital...I said, 'Well, what's the times?' He said, 'Mornings.' I said, 'That's out. (Patient)

'Limited capacity and inflexibility prevented staff offering an appropriate range of services to ensure access' (Tod et al 2002, study).

The study by Clark et al (2002) investigated the role of age in affecting access to cardiac rehabilitation in Scotland. A national survey of rehabilitation centre coordinators found that although all respondents thought that there should not be an age limit for entry to cardiac rehabilitation programs, 77% believed that rationing by age still occurred. Criteria influencing selection for rehabilitation were all more common during old age, i.e. the presence of other medical ailments, lower initial exercise tolerance and poor access to private or public transport. Older

patients were seen as requiring more staff time, the provision of transport, and dedicated programme choices and locations. The participants in both focus groups agreed that cardiac rehabilitation was often inadequately funded and that older patients suffered most from the resource constraints.'

Morris et al (2007, opinion), in response to an article by McMurdo and Witham (2007, review) discussing the health and welfare of older people in care homes state 'Many older people are moved into care homes without a comprehensive geriatric assessment or opportunity for rehabilitation. ... Failure to identify and treat reversible conditions may lead to a loss of dignity, progressive functional decline, urinary and faecal incontinence, sepsis, pain, malnutrition.'

A large proportion of people with Parkinson's, a disease mostly occurring in older age, have never been assessed or had treatment from therapists even though therapies are increasingly part of a holistic approach to managing the condition: 46% have never had physiotherapy; 63% have never had speech and language therapy; and 66% have never had occupational therapy. In addition, over a quarter of people with Parkinson's in the UK have never talked to a Parkinson's Disease Nurse Specialist (PDS 2008).

Stroke is a major cause of disability. A significant number of survivors experience disabilities of varying degree and require ongoing care and rehabilitation. Mold et al (2003, review) reviewed the qualitative literature to explore social factors of patients' uptake and professionals' delivery of stroke services, 'A key concern has been to investigate attitudes towards the older stroke survivor and whether age dictates willingness to provide medical and rehabilitation services.' There was some evidence of negative attitudes among professionals which hindered access to preventative health initiatives and healthcare information restricting the options available to older stroke survivors. In turn, older people themselves might view stroke as a consequence of old age and be less inclined to seek services.

Older adults in long-term care can benefit from exercise and activity. In a study of care homes many respondents (managers, owners) were willing, in theory, to refer residents to physiotherapy, yet physiotherapy was seldom regarded as having an integral role within homes (Chesson and Duthie 2000, survey).

Summary

Older people may face specific barriers to rehabilitation services because of their age and a high proportion of service providers believed that rationing by age has occurred restricting access to

cardiac rehabilitation programmes. A large proportion of people with Parkinson's disease, a disease primarily of older age, have not been offered physiotherapy, speech and language therapy, and occupational therapy. Older people can be moved into care homes from hospital without a comprehensive assessment and opportunity for rehabilitation.

11. Palliative care

A considerable body of evidence shows that older people suffer unnecessarily owing to widespread underassessment and under treatment of their problems and lack of access to palliative care. As a group older people have many unmet needs in palliative care (Davies and Higginson 2004a,b, studies). There are concerns about ageism and attitudes to older people in pain management; especially problematic is the pain experienced by older people in nursing homes; and pain in the person with dementia (Lavelle 2003, study).

Age discrimination is evident in access to palliative care. People under 65 with terminal conditions have disproportionate access to palliative care. This is partly explained by the higher allocation of resources to patients with cancer, rather than other terminal illnesses which are the main cause of death in older people. However, even within specialist palliative care for people with cancer, younger people receive proportionately more care than older people from every type of service (DH 2008, policy document; National Council for Hospice and Specialist Palliative Care Services 2004, review; Fallon and Dunlop 2002, study; Addington-Hall and Altmann 2000, study).

The prevalence of symptoms in people with a non-cancer diagnosis has many similarities to that for people with cancer. But only 1% of those with a non-cancer diagnosis have access to specialist community teams in the last year of life compared with 40% of those with cancer. (National Council for Hospice and Specialist Palliative Care Services 2004)

A comprehensive needs assessment for palliative care education within nursing homes revealed inequalities across the network with regard to educational provision and uptake of palliative care services (Mathews and Finch 2006, study). In residential care homes palliative care is often poorly organised and is associated with crises and unpredictability for staff and residents (McMurdo and Witham 2007, review).

The issue of pain management in primary care is a concern of older people highlighted by panel members discussing experiences of general practices *'my pain is not an area where we seem to progress, I have tried to discuss this on numerous occasions'; 'I would like the opportunity of discussing my pain relief'* (West Suffolk Older People's Voice et al 2008, group study). Many stoically

accepted pain even though it could be treated. 'Pain in older people is highly prevalent and widely accepted as something to be expected and regarded as "normal" in later life. Hence, suffering associated with persistent pain in older people often occurs without the appropriate assessment and treatment' (Kumar and Allcock 2008, group study).

Summary

People under 65 have disproportionate access to palliative care and older people have unmet needs in palliative care and pain management. There is evidence palliative care in nursing homes for older people is poorly organised. Older people can experience persistent pain without appropriate assessment and treatment.

12. Dental care

Oral health care is as important for older people as any other age group and an integral part of any general health checks (Help the Aged 2008, policy document). Older people are retaining natural teeth for longer and these teeth will require regular maintenance to provide good oral health. The results of the last three Adult Dental Surveys indicated that the percentage of people in each age with no teeth is reducing each decade. In the 65 and over age group the percentage has decreased from 79% in 1978 to 46% in 1998 (APHO 2008). Oral health problems have a profound impact on quality of life and overall health for older people. There is evidence that older people are particularly vulnerable to nutritional and diet imbalances if their oral condition deteriorates. Poor oral health is also linked to infections, including aspiration pneumonia, to which older people are particularly susceptible; periodontal disease and diabetes; and cardiovascular disease and stroke. There is a concern that oral health care for older people has not been given sufficient priority in service commissioning (Gerodontology Association 2005, review; Help the Aged 2006, study; BDA 2003 and 2009, policy documents).

It is well documented that access to NHS dental services can be problematic for older people (Help the Aged 2008, policy document; BDA 2003 and 2009, policy documents). The barriers older people face preventing them from receiving adequate dental care include mobility problems, illness, inconvenience, the scarcity of NHS dentists and the cost, or fear of the cost, of treatment (Age Concern 2008, survey; Gerodontology Association 2005, review). Those living in rural areas experience particular difficulties with limited access to preventative dental healthcare and treatment and 'There is a clear disadvantage to those who cannot afford to pay for treatment' (Healthcare Commission 2006, study). Analysis of national data indicates that 'the level of contact between older people and dental services is relatively low, and definitely lower than for adults in

general' (Gerodontology Association 2005, review). The data also shows compared with other treatment types, preventative treatment is rarely undertaken for older people even though it is likely to be appropriate for almost every older person with their own teeth.

A study by Bristol South and West Primary Care Trust (2006, large survey) on 'Commissioning better dental services for older people' found high levels of unmet need in the older population. Existing dental services had developed over time without strategic direction. The majority of older people live independently in the community throughout the PCTs, including rural areas, with problems of access. Twenty per cent of the older population are functionally dependent; amongst this group there is a low uptake of dental services.

Redditch and Bromsgrove PCT undertook a health equity audit into age discrimination looking at access to NHS dentistry (Redditch and Bromsgrove PCT 2005, study). The audit found there is evidence to support the view that there is poorer access to NHS dentistry for older people than younger people and thought it likely to be due to a combination of factors, which may include age discrimination. Under some circumstances, NHS dentists may view older people's treatment as less economically attractive compared with younger counterparts. Equally treatment of older people can be more time consuming due to co-existing morbidity, disability and limitation of mobility. The dentists may therefore be more inclined to recruit and retain younger people on their lists than the older age groups. The audit concludes that interpretation of the information is difficult. 'In all likelihood, the findings represent a dearth of NHS dental provision for all the population. Within this, older people may be worse off and this could be due to patients demanding less, or dentists discriminating against older people.'

Frail older people unable to go to a dentist surgery and people living in care homes with dementia or other debilitating health conditions are particularly vulnerable. The DH commissioned strategic review of oral health care for older people found that only 4% of all claims for older people involved domiciliary care in the last year [2004]. The situation is getting worse as the rate is 44% lower than it was 5 years ago (Gerodontology Association 2005, review). The Community Dental Services (CDS) only manage to treat a very small percentage of the total older population and there is considerable geographic variation in the provision of this service.

The oral health of older people living in care homes can deteriorate rapidly. Studies over the past 25 years have shown that dental neglect occurs at a significant level in long term care settings, with many older people experiencing debilitating dental diseases and infections. This is due in part to lack of assessment, professional dental visits and education on part of care staff (Paterson 2000, study).

In a key policy paper the BDA (2003, policy document) said that the configuration of dental services should take greater account of the needs of older people; this may include the use of mobile services to ensure people can access dentistry. The BDA also called for residential care homes to take a more proactive approach to ensuring their residents have good dental health with homes compelled to comply with a set of basic local standards, for instance scheduled visits by a dental professional.

Summary

The level of contact between older people and dental services is relatively low, and definitely lower than for adults in general. Barriers older people face include mobility problems, illness, inconvenience, the scarcity of NHS dentists, the cost or fear of cost. There is evidence to support the view that there is poorer access to NHS dentistry for older people than younger people, factors for this may include age discrimination. Dental neglect occurs at a significant level in long term care settings, due in part to lack of assessment and professional dental visits.

13. Eye care services

Prevalence of sight loss increases significantly with age. Nearly all (98%) of visually impaired adults are aged over 65 years. Only an eye examination can separate a serious visual impairment from 'normal' ageing changes. Age related eye conditions include cataracts, the leading cause of blindness in older people, uncorrected refractive errors, glaucoma, macular degeneration, and diabetic retinopathy. The majority of older people with sight problems have some useful vision and with appropriate low-vision support can be helped to use their remaining vision. 'The effects of such problems can be lessened considerably by better health care and appropriate and timely intervention and support' (Smith 2006, study). Smith states that 'age discrimination is a factor in both identification of visual impairment in older people and provision of services and support to meet the needs of older people with sight problems. Because impaired vision is seen as an acceptable consequence of ageing – an 'acceptable' condition rather than a severe disability – the potential for older people to experience prejudice and unfair treatment is high'.

Studies carried out in the 1990s identified a major problem of preventable or treatable visual problems in the older population in the UK (Campbell 2005). An example is Reidy et al's 1998 study of 1547 people in north London, which estimated that 88% of older people over 65 with visual impairment due to cataract are not in contact with any eye services and 75% of people over 65 with glaucoma are not in contact with an eye specialist (Gray et al 1999).

Evans and Rowlands (2004, review) undertook an extensive review of the literature to determine the prevalence of correctable visual impairment (VI) in older people in the UK and to find out why so many older people have correctable but untreated visual impairment. Studies suggest that visual impairment affects about 10% of people aged 65–75, and 20% of those aged 75 or older. There is a strong relationship between impaired vision in older people and both reduced quality of life and increased risk of accidents, particularly falls. The literature on the prevalence of undetected reduced vision in older people reveals that between 20 and 50% of older people have undetected reduced vision. The majority of these people have correctable visual problems (refractive errors or cataract). Reasons for this include people assuming nothing can be done; being told nothing can be done; and long waiting lists for assessments. Primary care optometric services are widely available in the community yet this review clearly shows that many older people have undetected poor vision. ‘The notion that older people with poor vision will all regularly attend optometrists for refractive corrections and the detection of ocular pathology is clearly little more than just an ideal. Even the cases where pathology is diagnosed and they are seen by an ophthalmologist often fail to receive appropriate low vision services.’

Macular degeneration (MD) is a chronic, progressive eye condition that mainly affects people over the age of 50 years. It is a major cause of blindness among those of European descent over the age of 60 years. It is estimated that, in the UK, between 182,000 and 300,000 people are blind or partially sighted because of MD (Fletcher et al 2001, review). For the majority there is no treatment and, where treatment is available, it does not cure the condition but instead slows or halts its progress for an indeterminate period. Evidence from a survey of 2000 randomly selected members of the Macular Disease Society (MDS) indicates that ‘many people with macular disease have unsatisfactory experiences with health professionals around the time of diagnosis and subsequently. The data point to shortcomings in the provision of information and in the affective quality of interactions with ophthalmologists and other health professionals’ (Mitchell et al 2002, survey).

Immediate referral and fast tracking of people with symptoms of exudative (wet) age related macular degeneration to specialist retinal centres provides access to a range of treatments that can help to minimise damage to the macula (Chopdar 2003, study). Evidence collected by the Macular Disease Society shows that ‘7,500 people who develop wet AMD every year are being lost in the system. ... [and] over the last 12 months 30% of people throughout the UK who could have benefited from PDT (photodynamic therapy) have not been treated’ (MDS 2005, large survey). The MDS also reports that only half of patients reach the appropriate clinician within the three-month window of

opportunity (before irreversible eye damage and blindness sets in), partly because of delays in the referral process and long waiting times for appointments; many GPs and support staff in surgeries and eye clinics are not aware of the need for speed for treating suspected wet AMD (MDS 2005, large survey).

Summary

The majority of older people with sight problems have some useful vision and with appropriate low-vision support can be helped to use their remaining vision. Between 20% and 50% of older people have undetected reduced vision, most of which can be corrected. Low vision services are fragmented and there is a wide disparity in the quantity and quality of services between different parts of the UK. Age discrimination can be a factor in both identification of visual impairment in older people and provision of services and support to meet the needs of older people with sight problems. Older people with macular degeneration have reported negative experiences in the provision of information and quality of interactions with ophthalmologists and health professionals. Many people with wet AMD reach treatment centres too late to prevent irreversible eye damage and blindness.

14. Foot care services

Chiroprody services are important for the well being and continued mobility of older people and levels of available services affect older people disproportionately. Many older persons in the UK cannot get help with podiatry from the NHS, as eligibility criteria have been tightened, leaving them in pain, housebound and at increased risk of falls and in extreme cases unable to mobilise. 'PCTs with financial deficits have made cuts to foot care services by raising eligibility criteria to exclude people who were previously offered a service' (Age Concern 2008, survey). In a review of progress against the NSF for older people, 'podiatry services appeared under resourced in all the areas inspected' (Healthcare Commission 2006, study). Older people reported how they had to use private services or wait very long times for NHS treatments. In the same review, people reported frequent delays in providing low cost services such as toe nail clipping.

In a report on access to primary care services, Age Concern noted that there were very significant geographical variations in access to NHS services and consequent use of private services. 'Only 22% of older people who needed foot care in the South West region had used an NHS service compared to 59% in the Northern region.' This is confirmed in the APHO report on older people's health (2008)

'There is wide variation between regions in the care episode rate which is highest in London and West Midlands and lowest in East of England and South East regions.'

The majority of the need for footcare is not being met by the NHS. Fifty-eight per cent of older people needing foot care services used private services, while 35% used the NHS. One per cent uses services provided by voluntary/charity sector and 6% had no service at all (Age Concern 2008, survey). In a study of the treatment of people with diabetes in care homes, Benbow et al (1997, study) found out of 159 people with diabetes, within the previous four months 97 (89%) had seen a chiropodist (non-state registered in a quarter of cases), though payment for this was made by 68 (62%).

Waiting times for chiropody services are not subject to any government targets for improvement and data is not maintained centrally. The NHS appears to give low priority to foot problems although health economic assessment suggests that the cost effectiveness of chiropody surpasses other interventions. Bryan et al (1991, study) applied a QALY measurement to chiropody - a 'low-tech' life-quality enhancing area of health care. Information on changes in quality of life following chiropody interventions was obtained from both practitioners and patients and the authors found the apparently low benefit, but low cost service of chiropody to be a potentially cost-effective use of NHS resources.

It is not clear whether delivery of service is targeted to those in greatest need. A study by Harvey et al (1997, study) suggests that rationing of chiropody occurs through inability to access services out of the home and 'this mismatch between the capacity to benefit from care and the pattern of provision of that care affects a number of common but low status health problems'.

Summary

Foot care services appear to be 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. Rationing of chiropody can occur through inability to access services out of the home

15. Hearing services

The majority of people with hearing loss are in the older age group. There is no formal examination procedure required in order to register as deaf or hard of hearing. Being deaf is defined as: those

who (even with a hearing aid) have little or no useful hearing, and the definition of being hard of hearing is: those who (with or without a hearing aid) have some useful hearing and whose normal method of communication is by speech, listening and lip reading.

Hearing problems can compromise safety because of difficulty hearing fire alarms, traffic and pedestrian crossings etc. Other practical problems include hearing doorbells, telephones and other devices and difficulty with communication can lead to social isolation. Up to six million people in the UK would benefit from a hearing aid, but only two million have one, according to the Audit Commission. It includes nearly 20% of people aged between 51 and 60; 36% of people between 61 and 70; 80% of 71 to 80-year-olds and 92 per cent of those aged over 81 (Parliament. House of Commons Health Committee 2007, study).

Waiting times for hearing aids continue to be a major problem. Although there is no national data on waiting times to obtain hearing aids, the charity RNID has evidence that – despite improvements in some parts of the country – in other areas people are still waiting between one and two years between GP referral and having their first hearing aids fitted (Parliament. House of Commons Health Committee 2007, study). The report by the Health Committee, *Audiology Services*, said audiology services had not been seen as a priority in the NHS modernisation programme and at a local level some primary care trusts failed to give audiology services the priority they deserved. Audiology is excluded from the general 18 week waiting time target.

A separate survey by the British Society of Audiologists in 2007 (www.bshaa.com) reported long delays for patients seeking to swap old-fashioned analogue hearing aids for modern digital ones recommended by the NHS. In total, 59 hospitals had waiting times longer than a year for patients in need of a digital upgrade.

Summary

Many older people would benefit from hearing aids but do not have them. Waiting times from referral to having aids fitted can be up to two years. At a local level some primary care trusts fail to resource audiology services and they are excluded from targets for waiting times

16. GP Performance Contract

The Quality and Outcomes Framework (QOF) provides performance indicators and incentives for primary care organisations in the NHS in England. The QOF of the 2004 UK General Medical Services (GMS) contract links up to 20% of practice income to performance measured against 146 quality

indicators. The intention is to drive up standards of care using evidence-based interventions but there is some concern that the GP performance contract could skew preventive care/treatment in favour of certain areas excluding areas that may also be of considerable concern to older people. Coronary heart disease, hypertension and diabetes are the most heavily weighted domains of care. 'Will such heavy reliance on the explicit use of incentives make GPs less willing to respond in the best interests of patients when not directly rewarded?' (Smith and York 2004, study).

For example, there are few performance targets to incentivise more joined-up and proactive care for frail older people. "Urinary incontinence affects 25% of women over 65; 50% of people over 80 fall at least once a year, and women have a 50% lifetime risk of osteoporotic fracture; over 1 million people in the UK currently have dementia—yet none of these appear. Clearly such prevalent and debilitating conditions are of major importance, but as they primarily affect older people they haven't been at the forefront of thinking' (Oliver 2008, review).

In Steel et al's (2008, large survey) review of quality of care for older people, quality for geriatric conditions specifically was relatively poor. They suggest that inclusion of geriatric conditions in future payment for performance schemes could improve quality. This is linked to making information on performance available for a wider range of conditions which can be seen as an essential component of quality improvement. In a separate study, Steel et al (2007, study) report that care has not changed for conditions which were not included in the QOF. There is very little research evidence in this area, but it is a significant issue for GPs. 'Has the QOF turned GPs from health professionals interested in the patients in front of them to mere box tickers? Or will it increasingly do so in future? This is perhaps the most fundamental and insidious threat that the QOF presents' (Roland 2007, review).

A cross sectional study carried out with 310 general practices in Scotland investigated the effect of QOF on the management of patients with coronary heart disease in primary care (McGovern et al 2008, study). The subjects were patients with CHD as identified by their GP. Main outcome measures were the recording of CHD-related health indicators and prescribing of medicines at pre- and post-contract time points (covariates: gender, age, co-morbidity, deprivation and practice size. Post contract, the 'oldest patients (75+) were less likely than the youngest patients (under 65) to have a referral for an exercise test and/or specialist assessment after a new diagnosis of angina, receive smoking cessation advice, have a record of beta-blocker or ACE inhibitor therapy and have a record of blood pressure or cholesterol measurement'. The study also found a substantial increase in the

use of exception reporting and suggested further investigation is required to ascertain reasons for this.

There is considerable unmet need among the older population that is ignored by the QOF. Bayley (2005, review) argues that until the identification and appropriate management of older people prone to falling, and those at high risk of osteoporotic fractures, are targeted as a domain within QOF, there will not be system wide improvements in the standards of management within primary care. Bayley asks 'If GPs were able to identify the expected numbers of recurrent fallers that we know are out there, would the currently resourced level of integrated falls services cope? Are there enough properly trained professionals to deliver the complex evidence-based interventions that reduce falls? If not, is there any hope in the present financial climate that we could expect sufficiently increased service provision?'

In assessing the benefits and shortcomings of the QOF, Roland (2007, review) raises issues that may impact on older age groups such as the mechanism of 'exception reporting' whereby GPs can say that an indicator does not apply to a particular patient where evidenced based guidelines are not applicable; GPs may concentrate on patients who are easier to treat; and the holistic and caring aspects of the GP's roles may be undermined. Sigfrid et al (2006, review) examining the QOF and data on diabetes management conclude that 'high levels of exception reporting may be disguising unmet need, particularly in practices with deprived populations.

Also crucial for older people presented with an array of possible treatments is 'enabling people to engage in meaningful decisions about their care, an area where the performance of GPs is lower than GPs in other countries' (Roland 2007, review). This is supported by research which found that two quality aspects of care not incentivised – doctor-patient communication and continuity of care – declined after the QOF was introduced 'This could be an unintended and perverse effect of the scheme and is a concern since continuity is an aspect of family practice that patients value'. (Campbell et al 2009, study). One possible explanation is that practices focused on meeting rapid-access targets in which access to any doctor in the practice within 48 hours was linked to incentives but access to a particular physician was not.

The potential for benefit for medical interventions increases with age but so do the risks of harm. The clinical activities that are measured and rewarded by the QOF are mostly evidence based; however the majority of trials focus on younger patients excluding older patients (Heath et al 2007, study). The difficulty is that the evidence base about risk and benefit in the older population is still limited (Bowling 2007, opinion).

Summary

GP performance contract could skew preventive care/treatment in favour of certain areas excluding areas that may also be of considerable concern to older people. There are few performance targets to incentivise more joined-up and proactive care for frail older people. 'Exception reporting' may impact on older people where evidenced based guidelines are not applicable. Two quality aspects of care not incentivised – doctor-patient communication and continuity of care – declined after the QOF was introduced.

17. NICE guidelines and the use of QALYs

The National Institute for Health and Clinical Excellence (NICE) is responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health in public health, clinical practice and health technologies. NICE uses Quality Adjusted Life Years (QALYs) to assess the relative cost effectiveness of health outcomes as a mechanism for distributing scarce resources. The QALY combines life expectancy after treatment with measures of the expected quality of that life. QALYs are used to determine not only which rival treatments to give a particular patient or group of patients, but also 'whether or not to offer any treatment at all to some patients, or whether to offer a particular treatment to some patients even when no alternatives are preferred' (Harris 2005).

In primary care the QALY has been used to assess the cost-effectiveness of treatments ranging from acupuncture and arthritis management to screening programmes for cancer, age related macular degeneration and vascular disease. The age discriminatory implications of the use of the QALY is examined in more detail in CPA's companion review 'Ageism and age discrimination in secondary health care'.

Some argue that the QALY is inherently age discriminatory while others do not – opinion remains divided as indicated below. NICE believes that their guidance overall is not discriminatory towards older people and suggest that local implementation of guidance may require closer examination.

'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 in Taylor 2007, study).

'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. ...

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, study).

'Some of the criticisms raised (particularly by John Harris) relate not to whether or not older people "produce" fewer QALYs but instead to the ethical relevance of any difference in outcome. This stance argues that patients have an inviolable right to health care that is not diminished by the size of the likely health benefit. If this basis is correct, then CEA [Cost-effectiveness Analysis] (whether using QALYs, life years gained, or any other measure) is a source of indirect age discrimination' (Edlin et al 2008, review).

'...provided costs and the health gains are the same, the incremental cost per QALY will be no different for a three year old than for an 83 year old. The QALY is not therefore inherently ageist...'
'...the elderly might in theory be disadvantaged in the evaluation of an exceptionally expensive procedure, device, or drug (given as a single dose or a short course) whose health gain persists over a long period. A child aged three years would then be likely to enjoy more than 70 years of benefit compared to the additional five years that an 80 year old could expect. We cannot, though, think of a single example...' (Rawlins and Dillon 2005, opinion).

Christopher Newdick, in his book 'Who should we treat?', questions the effectiveness of the QALY as a reliable unit of measurement as it has inherent assumptions that older people are less healthy than younger people and suffer from several health problems that will inevitably mean that successful treatment of one aspect will be less effective in terms of overall health benefit. 'Particularly in relation to elderly patients a more sensitive measure of the benefits of care must be found.'

'Many elderly patients will derive terrific benefit from medical treatment and lead full and independent lives thereafter. Thus, a fit elderly person with a life expectancy of 10 years might score (say) $10 \times 0.8 = 8$ QALYs. Compare this to a younger person with a serious illness and a life expectancy of 30 years, for whom medical intervention will have a limited value. Such a patient might score $30 \times 0.5 = 15$ QALYs. Too narrow an application of a theory which automatically favoured the maximisation of QALYs would increase the level of disability in society and inflate the costs of health care' (Newdick 2005, study).

Frail, older people with co morbidities may be particularly disadvantaged. The Royal College of Physicians of Edinburgh's written evidence to the Joint Committee on Human Rights (Parliament. Joint Committee of Human Rights 2007) states the use of the QALY by NICE has an inbuilt discriminatory impact and can result in the denial of beneficial treatment for frail, older people 'Benefit should be measured in terms of improvement in function, symptoms, health and quality of life and not by measures of duration of survival alone, which implicitly disadvantage older populations.'

This view is supported by the Royal College of Nursing (Parliament. Joint Committee of Human Rights 2007) which considers the use of QALYs puts older people with chronic illness at risk as the measures focus on physical rather than psychological or social disability. 'Age is a very poor and blunt way to inform decisions about resources. At best it is based on statistical averages and at worst it is based on discrimination.'

NICE decisions are based on the 'best available' evidence but 'the best available evidence is not always very good and is rarely (if ever) complete. It may be of poor quality, lack critical elements or both' (Parliament. Joint Committee of Human Rights 2007).

The QALY divides expert opinion. A recent review of NICE's appraisal procedures found there was a need for further research into the way QALY's were calculated. 'NICE should sponsor or participate in research to determine whether the instruments used to calculate QALYs and capture health benefits are entirely appropriate to NICE's needs and they are applied properly and consistently'. The same review however also stated '...the approach adopted by NICE is fundamentally sound. Indeed I would go further and describe the ICER/QALY approach as quite simply the best tool available to do the job which NICE has been set' (Kennedy 2009, review).

Summary

Opinion is divided over whether the QALY is inherently age discriminatory. The use of QALYs may result in the denial of beneficial treatment for frail, older people. Older populations could be indirectly disadvantaged in NICE's decision-making due to a poor evidence base for the treatment of older people with multiple conditions. NICE believes their guidance overall is supportive of older people and promotes cost effective beneficial treatments.

18. Focus of the NHS

The population has aged since the establishment of the NHS over 50 years ago where the key focus was on the treatment and care of younger people who had one thing wrong at a time. Older people,

many with multiple conditions that can be effectively managed, now constitute the main users of the NHS. There is evidence throughout this review of primary care that the NHS has not changed its focus sufficiently to meet their needs, a structural ageism identified in *Adding Life to Years* 'The failure of NHS Scotland to adapt to the changing needs of a changing population could also be seen as structural ageism' (Scottish Executive 2001, study). It suggests that NHS services as currently organised are unable to meet the needs of increasing numbers of older patients especially those with chronic, multiple and recurrent medical problems. A view supported by Rockwood 'If we design a system for patients with one thing wrong, but patients with several things turn up, the problem lies not with the users but with the system' (quoted in Oliver 2008). A GP reported in *Adding Life to Years* states: 'In my experience the elderly are not denied access to specific acute care services when compared with younger patients. However there is a significant under-investment in services specifically for the elderly, when compared with acute disease-based services.'

'Were we to engage in blue-sky thinking, we would certainly not design from scratch systems of which mitigate against high quality care for the largest group of service users' (Oliver 2008, opinion).

'Preferential treatment for younger people may have made sense in 1948, when 40% of people died before they reached 65 years of age, compared with the current 7%. It is less defensible now, given the improvement in longevity, the effectiveness of medical interventions for older people which is apparent in clinical practice, and the compression of morbidity into the last years, or even months, of long and active lives' (Bowling 2007, opinion).

The culture and training of health staff focuses predominantly on intervention and cure, with less attention to long term holistic care. Research confirms that multidisciplinary teams led by geriatricians achieve better outcomes for people with multiple pathologies and functional problems. 'Comprehensive geriatric assessment, augmented by expertise in history taking, appropriate investigation and holistic assessment, sets the standard for elderly care. In the UK in 2006, 25% of trusts lacked a multidisciplinary falls service (a hallmark of integrated elderly care), despite the fact that falls affect 30% of over-60-year-olds and 40% of over-70-year-olds every year, and are a major cause of morbidity and mortality' (Editorial, *The Lancet* 2008).

Summary

Older people, many with multiple conditions that can be effectively managed, now constitute the main users of the NHS. Structural ageism in NHS channels service delivery, training and performance management that focuses on treatment and rehabilitation of younger people with acute conditions

rather than long term holistic care. Multidisciplinary teams can achieve better outcomes for people with multiple pathologies and functional problems

19. Conclusion

The aim of this review from the literature is to signpost areas where discrimination may be occurring in primary care. Age discrimination is an unjustifiable difference in treatment based solely on age. It can be direct or indirect in form. Direct age discrimination occurs if people with comparable needs are treated differently on the basis of age alone. Indirect discrimination occurs when a service or practice has no explicit age bias, but still has a disproportionate impact on people in a particular age group, with the result that the needs of that group are not fully met. Discrimination in health care may occur in policies and practices; systems and structures; resources and staffing; health promotion and ageing well.

It is not an easy task to ascertain the extent of discrimination occurring in primary care. The Scottish Executive identified the lack of formal research on age discrimination in health care generally. Most health service contacts are with primary care, and, while data are routinely collected in thousands of separate general practices throughout the UK, its fragmented nature makes it difficult to assess and compare access and quality of care for different age groups. If data from individual practices were aggregated, it potentially could be a resource for audit and determining quality around investigations, diagnoses, referrals, treatment and outcomes, nationally and locally (Gnani and Majeed 2006, study).

The King's Fund (www.kingsfund.co.uk) announced in April 2009 an 18-month inquiry into the quality of care and services provided by GPs and other health professionals working in general practice in England. The inquiry will examine a number of key areas, including patients' access to care, the quality of diagnosis and referral, and how patients with long-term conditions are cared for. The outcome is to be a set of measures that can be used to compare and assess the quality of patient care in different practices. As older people are high users of services in primary care, this focused research should help to provide an evidence base on the extent of age related inequities and root out covert discrimination.

Studies of older people's experiences of health services provide valuable circumstantial evidence of discrimination and ageist practices. However sometimes patients themselves do not recognise covert ageist behaviours 'too often age discrimination is not experienced as what it really is by the

older person on the receiving end – they simply accept that their treatment is the normal order of things’ (BOPF 2007, group study).

19.1. Evidence of discrimination in policies and practice

The audit by the Healthcare Commission et al (2006, study) found that explicit age discrimination has declined since the National Service Framework for Older People was introduced in 2001. One of the most explicit forms of age discrimination in healthcare in the NHS is the age limits applied to screening programs by invitation.

There is evidence that older people are subject to covert, indirect discrimination. Stereotyping people on the basis of chronological age which can lead to older people being excluded from treatments that are shown to be beneficial is a form of indirect discrimination. ‘The notion of age based rationing of treatment has become unsustainable and unethical as robust evidence has accumulated that shows comparable outcomes for treatment of older and younger people’ (Young 2006, opinion).

Evidence of covert discrimination is shown in limited preventative care for older people; reluctance to refer older people to specialist services; poor quality of care for conditions associated with ageing, which includes under treatment for conditions.

Covert discrimination is demonstrated in shortfalls in receipt of basic recommended care by adults aged 50 or more with common health conditions: cerebrovascular disease (stroke), depression, diabetes mellitus, falls, hearing problems, hypertension, ischaemic heart disease, osteoarthritis, osteoporosis, pain management, smoking cessation, urinary incontinence, and problems with vision (cataract). People with ‘geriatric’ conditions received less indicated care than those with general medical conditions.

Older people with cardiovascular disease are relatively undertreated and under tested compared with younger people. There is evidence of gender and age inequality in the prescribing of preventative cardiovascular therapies to older people in primary care and there are

There is evidence that people over 75 could be dying prematurely from cancer.

Older age is a factor in deciding to refer for specialist treatment with low referral rates for older people for cholesterol testing, angiography and revascularisation; Parkinson’s disease; chronic kidney disease; and cancer.

The exclusion of older people from drug trials that study efficacy and safety can lead to treatments being withheld purely on the basis of age even though the use of effective therapies for older people can lead to a proportional reduction in mortality as great as or greater than that for younger people. Standards of medicine management in care homes are poor leading to residents being denied prescribed medicine or medicines being improperly administered and monitored.

19.3. Evidence of discrimination in systems and structures

Older people, many with multiple conditions that can be effectively managed, now constitute the main users of the NHS, but there remains a general absence of a multidisciplinary approach to care of older people with complex needs. The current structure of the NHS, with its focus on 'specialisms', creates barriers to treating people with multiple conditions cutting across medical boundaries and care settings. There is evidence that multidisciplinary teams achieve better outcomes for people with multiple pathologies and functional problems.

The lack of education and training around the care of older people in primary care may lead to people with multiple chronic illnesses and functional disability not being properly diagnosed and treated as their condition is put down to 'ageing'. This lack of knowledge of the ageing process and life expectancy amongst health care practitioners can lead them to misjudge older people's quality of life in a negative way and deny them beneficial treatments as a result.

Older people are moved into care homes without a comprehensive assessment and opportunity for rehabilitation, compared to younger people requiring support. 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. Many care homes residents who would benefit from multidisciplinary rehabilitation and medical treatment for their chronic diseases cannot access them.

Older people have particular problems accessing services for physical reasons, i.e. lack of mobility and suitable transport. Older people favour coordinated access to services featuring key services in one site to include GP, podiatry, physiotherapy, dietician, dental services, exercise facilities. Out of hours services create barriers to access for older people who prefer face to face contact and fear travelling at night to treatment centres.

There is some evidence that the GP performance contract could skew preventive care/treatment in favour of certain areas excluding areas that may also be of considerable importance to older people. There are few performance targets to incentivise more joined-up and proactive care for frail older people.

Opinion is divided over whether the Quality Adjusted Life Year (QALY) is inherently age discriminatory and can result in the denial of beneficial treatment for frail, older people. The evidence base about risk and benefit in the frail, older population is still limited. However, NICE believes their guidance overall is supportive of older people but it may not be implemented consistently locally.

19.4. Evidence of discrimination in resources

Older people are a numerically important group and one which requires particular services but the evidence suggests there is under-investment in services that are proportionately more important for older people than younger adults. Discrimination is implicit in a general lack of priority for services that benefit older people, such as chiropody, integrated falls services, continence services and audiology services. Older people have difficulty accessing rehabilitation services and dental services; older people have hearing and vision conditions that are not identified but could be treated; and there can be long waiting times to access aids which would significantly improve quality of life. Palliative care and pain management are identified as being poorly provided for older people within the community and there is evidence of unmet need.

19.5. Evidence of discrimination in health promotion and ageing well

There is evidence that some health care professionals hold negative views about older people influencing their behaviour towards them and potentially failing to take problems that are treatable seriously. Some practitioners may have low expectations of what services and interventions can achieve for older people and make assumptions about their needs and capabilities. GPs ageist attitudes can be a barrier to implementing evidence-based guidelines in treating older people.

Older people are more likely than younger adults to experience insensitive treatment such as being excluded from conversations or 'talked over' as though they do not exist. Older people can receive poor quality of care that suggests implicit ageism by placing less value on their experiences and quality of life. Practitioners may also underestimate older people's capacity for a good life.

GPs are less likely to discuss life style changes like weight reduction with older people than younger people and smoking, alcohol and safe drinking are less likely to be addressed in health promotion for older people. Information on sexual health and health related behaviour in older people is limited.

19.6. Future research

GPs

It is clear from this review that evidence of discrimination in primary care is not straightforward. Different patterns of treatment for patients of different ages or even the same age do not necessarily imply discrimination on the basis of age. However it is widely acknowledged that there is considerable variation in the quality of GP services; there is little objective evidence of the effectiveness of GP referrals to specialists; and there are large variations in overall prescribing rates between GP practices. Until some of these variations are unpicked, possibly utilising new sources of data from GP's electronic records, it is difficult to determine the extent of age discrimination in the provision of services.

How do GPs perceive their roles and responsibilities in terms of managing chronic conditions that affect the quality of life of older people as this area is not clearly defined and information on 'best' processes of care for people with multiple conditions is limited?

Does the GP performance contract skew preventive care/treatment in favour of certain areas with a focus on individuals with single chronic conditions and exclude areas that may be of considerable concern to older people?

ATTITUDES/PRACTICE

Covert discrimination that is difficult to challenge arises from attitudes, custom and practice that practitioners may not recognise as being ageist. Further research could help to bring out instances of this covert discrimination.

ACCESSING SERVICES

Innovative ways of delivering primary care have been introduced to facilitate and broaden access but more research is required to provide evidence about the ways in which these interventions improve access and which methods are most effective in reaching different groups, including users experiences of out of hours services arrangements.

CARE HOME RESIDENTS

Research is required into the discrimination faced by older people living in care homes who have difficulty accessing the services of a GP and other primary care services, and frail older people with multiple conditions that are untreated. Barriers to accessing specialist healthcare professionals may

be erected by the redefinition of health care needs as social care/personal care needs when an older person moves into care.

20. References

- Acheson D (chairman) (1998) *Independent Inquiry into Inequalities in Health: report*, London: The Stationery Office
- Adams A, Buckingham C D, Arber S, McKinlay J B, Marceau L and Link C (2006) The influence of patient's age on clinical decision-making about coronary heart disease in the USA and the UK, *Ageing and Society* 26 (2) : 303-322
- Addington-Hall J and Altmann D (2000) Which terminally ill cancer patients in the United Kingdom receive care from community specialist palliative care nurses?, *Journal of Advanced Nursing* 32 (4) : 799-807
- Age Concern England (2006) *What older people want from community health and social care services*, London: London: Age Concern England
- Age Concern England. Policy Unit (2008) *Primary concerns: older people's access to primary care*, London: Age Concern England
- Anderson D; 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*, <http://www.rcpsych.ac.uk/docs/The%20Human%20Rights%20of%20Older%20Persons%20in%20Healthcare.doc>
- Arber S, McKinlay J, Adams A, Marceau L, Link C and O'Donnell A (2006) Patient characteristics and inequalities in doctors' diagnostic and management strategies relating to CHD: a video-simulation experiment, *Social Science & Medicine* 62 (1) : 103-116
- Association of Public Health Observatories (APHO) and West Midlands Public Health Observatory (2008) *Indications of public health in the English regions. 9: Older people*, http://www.wmpho.org.uk/resources/APHO_OP.pdf
- Bandyopadhyay S, Bayer A J and O'Mahony M S (2001) Age and gender bias in statin trials, *Quarterly Journal of Medicine* 94 (3) : 127-132
- Bayliss E A, Edwards A E, Steiner J F and Main D S (2008) Processes of care desired by elderly patients with multimorbidities, *Family Practice* 25 (4) : 287-293
- Bayliss E A, Steiner J F, Fernald D H, Crane L A and Main D S (2003) Descriptions of barriers to self-care by persons with comorbid chronic disease, *Annals of Family Medicine* 1 (1) : 15-21
- Bayly J (2005) Falls, fractures and strokes: how is primary care managing under the new GP

contract?, http://www.bgsnet.org.uk/May06NL/13_falls.htm *BGS Newsletter* (March 2005)

BBC News (2009) *Gap in care 'has to be bridged'*, <http://news.bbc.co.uk/1/hi/health/7974994.stm> (1 April 2009)

BBC News (2009) *NHS treating more older drinkers*, <http://news.bbc.co.uk/1/hi/health/7922002.stm> (5 March 2009)

BBC News (2009) *Stroke care 'failing the elderly'*, <http://news.bbc.co.uk/1/hi/health/8000642.stm> (16 April 2009)

BBC News (2002) *Cancer care 'ageist'*, <http://news.bbc.co.uk/1/hi/health/1883505.stm> (220 March 2002)

Benbow S J, Walsh A and Gill G V (1997) Diabetes in institutionalised elderly people: a forgotten population?, *British Medical Journal* 314 (7698, 28 June 1997) : 1868-1869

Bennett R L, Blanks R G and Moss S M (2009) Evaluation of extension of breast screening to women aged 65–70 in England using screening performance measures, *British Journal of Cancer* 100 (7) : 1043-1047

Berkman B, Rohan B and Sampson S (1994) Myths and biases related to cancer in the elderly, *Cancer* 74 (7, Suppl) : 2004-2008

Billings J (2006) Staff perceptions of ageist practice in the clinical setting: practice development project, *Quality in Ageing* 7 (2) : 33-45

Billings J; University of Kent. Centre for Health Services Studies (2003) *Staff perceptions of ageist practice in the clinical setting: practice development project*, http://www.kent.ac.uk/CHSS/docs/staff_perception_of_ageist_practice.pdf

Birmingham K (2008) Discriminating between the old, *Nursing Older People* 20 (4) : 3

Blagojevic M, Jinks C and Jordan K P (2008) The influence of consulting primary care on knee pain in older people: a prospective cohort study, *Annals of the Rheumatic Diseases* 67 : 1702-1709

Bonastre J, Le Pen C, Anderson P, Ganz A, Berto P and Berdeaux G (2002) The epidemiology, economics and quality of life burden of age-related macular degeneration in France, Germany, Italy and the United Kingdom, *European Journal of Health Economics* 3 (2) : 94-102

Bowers H, Secker J, Llanes M and Webb D; Health Development Agency; Older People's Programme. National Evaluation Team (2003) *The gap years: rediscovering mid-life as the route to healthy active ageing - a report of a national evaluation of eight pilots focusing on improving health for people in*

mid-life (50 to 65 years), <http://www.hda-online.org.uk/documents/gap-years.pdf>

Bowling A (2007) Honour your father and mother: ageism in medicine, *British Journal of General Practice* 57 (538) : 347-348

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

Bowman C E (2007) Important campaigns poorly served by misconceived editorial: Health and welfare of older people in care homes, <http://www.bmj.com/cgi/eletters/334/7600/913#165075>
British Medical Journal (rapid responses) (8 May 2007)

Bristol Older People's Forum (2007) *Family doctor survey 2007* (BOPF Opinion research survey, no 7), Bristol: Bristol Older People's Forum

Bristol South and West Primary Care Trust (2006) *Commissioning better dental services for older people*, Bristol: Bristol South and West Primary Care Trust

British Dental Association (2009) *The British Dental Association oral health inequalities policy*, http://www.bda.org/Images/oral_health_inequalities_policy.pdf

British Dental Association (2003) *Oral healthcare for older people 2020 vision*. (A BDA Key issue policy paper), London: British Dental Association

British Geriatrics Society (2007) *The human rights of older persons in healthcare call for evidence: submission by the BGS to the UK Parliament, Joint Committee on Human Rights* (British Geriatrics Society Position Paper), http://www.bgs.org.uk/Publications/Position%20Papers/psn_human_rights.htm (February 2007)

British Geriatrics Society (2007) *Stroke: Best Practice Guide 6.3*, http://www.bgs.org.uk/Publications/Compendium/compend_6.3.htm

Bryan S, Parkin D, Donaldson C (1991) Chiropody and the QALY: a case study in assigning categories of disability and distress to patients, *Health Policy* 18 (2) : 169-185

Burford D C, Kirby M and Austoker J; NHS Screening Programmes (2009) *Prostate Cancer Risk Management Programme; information for primary care: PSA testing in asymptomatic men. 2nd ed*, <http://www.cancerscreening.nhs.uk/prostate/prostate-booklet-text.pdf>

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

Bytheway B (1995) *Ageism*. (Rethinking ageing series), Buckingham: Open University Press

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

Campbell S M, Reeves D, Kontopantelis E, Sibbald B and Roland M (2009) Effects of pay for performance on the quality of primary care in England, *New England Journal of Medicine* 361 (4) : 368-378

Campbell S; Visibility (2005) *Deteriorating vision, falls and older people: the links*, Glasgow: Visibility

Carey I M, De Wilde S, Harris T, Victor C, Richards N, Hilton S R and Cook D G (2008) What factors predict potentially inappropriate primary care prescribing in older people? Analysis of UK primary care patient record database, *Drugs and Aging* 25 (8) : 693-706

Carruthers I and Ormondroyd J; Department of Health (2009) *Achieving age equality in health and social care: a report to the Secretary of State for Health ... October 2009*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107278

Carruthers I and Ormondroyd J; Department of Health, National Development Team for Inclusion, Social Care Institute for Excellence, University of West of England. Faculty of Health and Social Care, Centre for Policy on Ageing and University of Leeds (2009) *Achieving age equality in health and social care: annex to a report to the Secretary of State for Health ... October 2009: working papers ...*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107278

Centre for Policy on Ageing (2009) *Ageism and age discrimination in mental health care in the United Kingdom: a review from the literature; commissioned by the Department of Health*, London: Centre for Policy on Ageing

Centre for Policy on Ageing (2009) *Ageism and age discrimination in secondary health care in the United Kingdom: a review from the literature; commissioned by the Department of Health*, London: Centre for Policy on Ageing

Centre for Policy on Ageing (2009) *Ageism and age discrimination in social care in the United Kingdom: a review from the literature; commissioned by the Department of Health*, London: Centre for Policy on Ageing

Centre for Policy on Ageing (2008) *Research on eliminating age discrimination in health, social care and mental health services*. (CPA briefings), London: Centre for Policy on Ageing

Chapman J L, Zechel A, Carter Y H and Abbott S (2004) Systematic review of recent innovations in service provision to improve access to primary care, *British Journal of General Practice* 54 (502) : 374-381

Chesson R and Duthie J (2000) Staff attitudes to physiotherapy and activities in private nursing homes, *Elderly Care* 12 (1) : 11-13

Chiva A and Stears D (2001) *Promoting the health of older people - the next step in health generation*, Buckingham: Open University Press

Chopdar A, Chakravarthy U and Verma D (2003) Age related macular degeneration, *British Medical Journal* 326 (7387, 1 March 2003) : 485-488

Citizens Advice Bureau (2009) *Submission to the Department of Health: National review of age discrimination in health and social care. (Evidence)*, London: Citizens Advice Bureau

Clark A M, Sharp C and Macintyre P D (2002) Role of age in moderating access to cardiac rehabilitation in Scotland, *Ageing and Society* 22 (4) : 501-515

Clark J (2001) Preventive home visits to elderly people: their effectiveness cannot be judged by randomised controlled trials, *British Medical Journal* 323 (7315, 29 September 2001) : 708

Clark J, Buttigeig M, Bodycombe-James M, Eaton N, Kelly A, Merrell J, Palmer-Thomas J, Parke S and Symonds A; University of Wales Swansea. School of Health Science (2000) *A review of health visiting and school nursing services in Wales*, Swansea: University of Wales Swansea, School of Health Science

Commission for Social Care Inspection (2006) *Handled with care? Managing medication for residents of care homes and children's homes - a follow up study*, London: Commission for Social Care Inspection

Cranney M, Warren E, Barton S, Gardner K and Walley T (2001) Why do GPs not implement evidence-based guidelines? A descriptive study, *Family Practice* 18 (4) : 359-363

Crome P and Natarajan I (2004) The National Service Framework for older people - England's approach to ending age discrimination in services and therapeutics, *Drugs and Aging* 21 (8) : 499-510

Crome P and Pollock K (2004) Age-discrimination in prescribing: accounting for concordance, *Reviews in Clinical Gerontology* 14 (1) : 1-4

Davies E and Higginson I J (2004a) *Better palliative care for older people*, Copenhagen: World Health Organization Regional Office for Europe

Davies E and Higginson I J (2004b) *Palliative care: the solid facts*, Copenhagen: World Health Organization Regional Office for Europe

De Laine C, Scammell J and Heaslip V (2003) Continuing professional development: older people.

Continence care and policy initiatives... [This CPD was previously published in Nursing Standard vol 17, no 7, 2002], *Primary Health Care* 13 (1) : 43-51

De Wilde S, Carey I M, Bremner S A, Richards N, Hilton S R and Cook D G (2003) Evolution of statin prescribing 1994-2001: a case of agism but not of sexism?, *Heart (British Cardiac Society)* 89 (4) : 417-421

De Wilde S, Carey I M, Emmas C, Richards N and Cook D G (2006) Trends in the prevalence of diagnosed atrial fibrillation, its treatment with anticoagulation and predictors of such treatment in UK primary care, *Heart (British Cardiac Society)* 92 (8) : 1064-1070

Denneboom W, Dautzenberg M G, Grol R and De Smet P A G N (2007) Treatment reviews of older people on polypharmacy in primary care: cluster controlled trial comparing two approaches, *British Journal of General Practice* 57 (542) : 723-731

Department of Health (2008) *End of life care strategy: promoting high quality care for all adults at the end of life: equality impact assessment*,
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277

Department of Health (2007) *Cancer reform strategy*, London: Department of Health

Department of Health (2002) *National service framework for older people: interim report on age discrimination*, London: Department of Health

Department of Health and NHS Executive (2001) *National service framework for older people*. (Health service circular HSC 2001/7; Local authority circular LAC (2001)12), London: Department of Health

Department of Health; Royal College of General Practitioners; Royal Pharmaceutical Society and NHS Primary Care Contracting (2009) *Guidance and competences for the provision of services using practitioners with special interests (PwSIs): older people*,
http://www.pcc.nhs.uk/uploads/pwsis/March%202009/updated_older_people.pdf

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

Dockter L and Keene S (2009) Ageism in chemotherapy, *The Internet Journal of World Health and Societal Politics* 6 (1)

Dolan T A, McNaughton C A, Davidson S N and Mitchell G S (1992) Patient age and general dentists' treatment decisions, *Special Care in Dentistry* 12 (1) : 15-20

Donnelly L (2008) Don't treat the old and unhealthy, say doctors, *Daily Telegraph* (27 January 2008)

Donovan J L, Martin R M, Neal D E and Hamdy F C (2005) Prostate cancer: screening approaches, *British Journal of Hospital Medicine* 66 (11) : 623-626

Eastleigh Southern Parishes Older People's Forum (2008) *Pills & perils: repeat prescribing for older patients*, <http://www.hsrpp.org.uk/2009/PillsAndPerils.pdf>

Edlin R, Round J, McCabe C, Sculpher M, Claxton K and Cookson R; University of Leeds. Faculty of Medicine and Health. Leeds Institute of Health Sciences (2008) *Cost-effectiveness analysis and ageism: a review of the theoretical literature; prepared for the Department of Health*, http://www.leeds.ac.uk/lihs/auhe/papers/cea_ageism.pdf

Elkan R, Kendrick D, Dewey M, Hewitt M, Robinson J, Blair M, Williams D and Brummell K (2001) Effectiveness of home based support for older people: systematic review and meta-analysis, *British Medical Journal* 323 (7315, 29 September 2001) : 719-725

Evans B J W and Rowlands G (2004) Correctable visual impairment in older people: a major unmet need, *Ophthalmic and Physiological Optics* 24 (3) : 161-180

Fahey T, Montgomery A A, Barnes J and Protheroe J (2003) Quality of care for elderly residents in nursing homes and elderly people living at home: controlled observational study, *British Medical Journal* 326 (7389, 15 March 2003) : 580-583

Fallon M and Dunlop R (2002) Palliative care - or is it?, *Palliative Medicine* 16 (1) : 1-3

Fee L, Cronin A, Simmons R and Choudry S; Health Education Authority (1999) *Assessing older people's health and social needs: qualitative research investigating health beliefs and social factors relevant to older people's health*, London: Health Education Authority

Fletcher A, Donoghue M and Owen C (2001) *Low vision services for people with age-related macular degeneration in the UK: a review of services needed and provision*, Denbigh: Macular Disease Society

Flicker L (2008) Should geriatric medicine remain a specialty? Yes., *British Medical Journal* 337 (7661, 12 July 2008) : 78-79

Fortin M, Lapointe L, Hudon C and Vanasse A (2005) Multimorbidity is common to family practice: is it commonly researched?, *Canadian Family Physician* 51 (2) : 245-245

Foster J, Dale J and Jessopp L (2001) A qualitative study of older people's views of out-of-hours services, *British Journal of General Practice* 51 (470) : 719-723

Francis R (1994) Established osteoporosis - the case for treatment, *Geriatric Medicine* 24 (4) : 37-38

Fuat A, Pali A, Hungin S and Murphy J J (2003) Barriers to accurate diagnosis and effective management of heart failure in primary care: qualitative study, *British Medical Journal* 326 (7382, 25 January 2003) : 196-200

Gerodontology Association (2005) Meeting the challenges of oral health for older people: a strategic review; commissioned and funded by the Department of Health, *Gerodontology* 22 (Suppl 1) : 1-48

Glendinning C, Jacobs S, Alborz A and Hahn M (2002) A survey of access to medical services in nursing and residential homes in England, *British Journal of General Practice* 52 : 545-548

Gnani S and Majeed A; Imperial College London, Department of Primary Care and Social Medicine (2006) *A user's guide to data collected in primary care in England*, Cambridge: Eastern Region Public Health Observatory

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

Gott M, Hinchliff S and Galena E (2004) General practitioner attitudes to discussing sexual health issues with older people, *Social Science & Medicine* 58 (11) : 2093-2103

Goyder E C, McNally P G and Botha J L (2000) Inequalities in access to diabetes care: evidence from a historical cohort study, *Quality in Health Care* 9 (2) : 85-90

Granville G (2001) The National Service Framework for Older People - "the promotion of health and active life in older age", *Generations Review* 11 (3) : 6-8

Gray C S, Crabtree H L, O'Connell J E and Allen E D (1999) Waiting in the dark: cataract surgery in older people, *British Medical Journal* 318 (7195, 22 May 1999) : 1367-1368

Gray J, Millett C, O'Sullivan C, Omar R Z and Majeed A (2006) Association of age, sex and deprivation with quality indicators for diabetes: population-based cross sectional survey in primary care, *Journal of the Royal Society of Medicine* 99 (11) : 576-581

Gregg E W, Engelgau M M and Narayan V (2002) Complications of diabetes in elderly people, *British Medical Journal* 325 (7370, 26 October 2002) : 916-917

Guagliardo M F (2004) Spatial accessibility of primary care: concepts, methods and challenges, <http://www.ij-healthgeographics.com/content/3/1/3> *International Journal of Health Geographics* 3 (3)

Habicht D W, Witham M D and McMurdo M E (2008) The under-representation of older people in clinical trials: barriers and potential solutions, *Journal of Nutrition, Health and Aging* 12 (3) : 194-196

Harries C, Forres D, Harvey N, McClelland A and Bowling A (2007) Which doctors are influenced by a patient's age? A multi-method study of angina treatment in general practice, cardiology and gerontology, *Quality and Safety in Health Care* 16 (1) : 23-27

Harris J (2005a) It's not NICE to discriminate, *Journal of Medical Ethics* 31 (7) : 373-375

Harris J (2005b) Nice and not so nice, *Journal of Medical Ethics* 31 (12) : 685-688

Harrop A, Jopling K and contributors; Age Concern and Help the Aged (2009) *One voice: shaping our ageing society*, London: Age Concern and Help the Aged

Harvey I, Frankel S and Marks R (1997) Foot morbidity and exposure to chiropody - population based study, *British Medical Journal* 315 (7115, 25 October 1997) : 1054-1055

Health Service Journal (2008) Sixty not out: managers' survey, *Health Service Journal* 118 (10 January 2008) : 28-30

Healthcare Commission (2007) *Pushing the boundaries: improving services for people with heart failure*, London: Healthcare Commission

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

Heath I (2002) Long term care for older people: increasing pressure for change, *British Medical Journal* 324 (7353, 29 June 2002) : 1534-1535

Heath I, Hippisley-Cox J and Smeeth L (2007) Measuring quality through performance: measuring performance and missing the point?, *British Medical Journal* 335 (7629, 24 November 2007) : 1075-1076

Heath I, Rubinstein A, Stange K C and van Driel M L (2009) Quality in primary health care: a multidimensional approach to complexity, *British Medical Journal* 338 (7700, 18 April 2009) : 911-913

Help the Aged (2009) *Specialist doctors label the NHS institutionally ageist and demand a law to bring it to an end*. (Press release, 27 January 2009),
<http://press.helptheaged.org.uk/press/Releases/items/Specialist+doctors+label+the+NHS+institutionally+ageist+and+demand+a+law+to+bring+it+to+an+end.htm>

Help the Aged (2008) *Extracting the evidence: the oral health and dental care needs of older people: policy statement*, <http://policy.helptheaged.org.uk/NR/rdoonlyres/BFD24136-8841-49B5-BE23->

[4093E08882BD/0/extracting_evidence_090208.pdf](http://www.medicalnewstoday.com/articles/77840.php).

Help the Aged (2007) Access to GPs in care homes still non-existent for many,
<http://www.medicalnewstoday.com/articles/77840.php> *Medical News Today* (26 July 2007)

Help the Aged (2006) *Improvements in NHS dental services deemed vital for older people*, London:
Help the Aged

Hewstone M (1989) *Causal attribution: from cognitive processes to collective beliefs*, Oxford: Basil
Blackwell

Hippisley-Cox J, Pringle M, Cater R, Coupland C and Meal A (2005) Coronary heart disease prevention
and age inequalities: the first year of the National Service Framework for CHD., *British Journal of
General Practice* 55 (514) : 369-375

Hirani V and Malbut K; National Centre for Social Research. Joint Health Surveys Unit, Royal Free and
University College Medical School. Department of Epidemiology and Public Health, Department of
Health and Office for National Statistics (2002) *Health survey for England 2000: The health of older
people: Disability among older people*, London: TSO

Husk J, Potter J and Lowe D; Royal College of Physicians. Clinical Effectiveness and Evaluation Unit
(2006) *National audit of the organisation of services for falls and bone health for older people;
commissioned by the Healthcare Commission*,
<http://www.rcplondon.ac.uk/college/ceeu/fbhop/nationalauditreportfinal30jan2006.pdf>

Iliffe S (2004) The development of a short instrument to identify common unmet needs in older
people in general practice, *British Journal of General Practice* 54 (509) : 914-918

Iliffe S, Patterson L and Gould M M (1998) *Health care for older people - practitioner perspectives in
a changing society*, London: BMJ Books

InnovE (2009) *Continuous quality improvement in diabetes services: findings from DiabetesE: fourth
national report*, <http://www.innove.co.uk/>

Jacobson T A (2006) Overcoming 'ageism' bias in the treatment of hypercholesterolaemia : a review
of safety issues with statins in the elderly, *Drug Safety* 29 (5) : 421-448

Järvinen T L N, Sievänen H, Khan K M, Heinonen A and Kannus P (2008) Shifting the focus in fracture
prevention from osteoporosis to falls, *British Medical Journal* 336 (7636, 19 January 2008) : 124-126

Jerant A F, Franks P, Jackson J E and Doescher M P (2004) Age-related disparities in cancer screening:
analysis of 2001 Behavioral Risk Factor Surveillance System data, *Annals of Family Medicine* 2 (5) :
481-487

Kearney N, Miller M, Paul J and Smith K (2000) Oncology healthcare professionals' attitudes toward elderly people, *Annals of Oncology* 11 (5) : 599-602

Kennedy I; National Institute for Health and Clinical Excellence (2009) *Appraising the value of innovation and other benefits: a short study for NICE*,
<http://www.nice.org.uk/media/98F/5C/KennedyStudyFinalReport.pdf>

Kerr S, Watson H, Tolson D, Lough M and Brown M (2006) Smoking after the age of 65 years: a qualitative exploration of older current and former smokers' views on smoking, stopping smoking, and smoking cessation resources and services, *Health and Social Care in the Community* 14 (6) : 572-582

Killoran A, Howse K and Dalley G (eds) (1997) *Promoting the health of older people: a compendium*, London: Centre for Policy on Ageing; Health Education Authority

Kumar A and Allcock N; Help the Aged; University of Nottingham and British Pain Society (2008) *Pain in older people: reflections and experiences from older person's perspective*, London: Help the Aged

Lamb A (2002) Medicine and ageing: an agenda for progress, *Clinical Medicine* 2 (3) : 259-262

Lancet (2008) Who cares for the elderly? Editorial, *The Lancet* 371 (9617, 22 March 2008) : 959

Lauder W (1993) Health promotion in the elderly, *British Journal of Nursing* 2 (8) : 401-404

Lavelle K, Moran A, Howell A, Bundred N, Campbell M and Todd C (2007) Older women with operable breast cancer are less likely to have surgery, *British Journal of Surgery* 94 (10) : 1209-1215

Lavelle K, Todd C, Moran A, Howell A, Bundred N and Campbell M (2007) Non-standard management of breast cancer increases with age in the UK: a population based cohort of women >65 years, *British Journal of Cancer* 96 (8, 23 April 2007) : 1197-1203

Lavelle M (2003) Pain management and the older person: older people feel pain too - conference report, *Quality in Ageing* 4 (1) : 32-36

Le Couteur D G, Hilmer S N, Glasgow N, Naganathan V and Cumming R G (2004) Prescribing in older people, *Australian Family Physician* 33 (10) : 777-782

Le Grand J (2002) Further tales from the British National Health Service, *Health Affairs* 21 (3) : 116-128

Lee F and Patel H (2002) Prostate cancer: management and controversies, *Hospital Medicine* 63 (8) : 465-470

Lee P Y, Alexander K P, Hammill B G, Pasquali S K and Peterson E D (2001) Representation of elderly persons and women in published randomized trials of acute coronary syndromes, *JAMA, the Journal of the American Medical Association* 286 (6) : 708-719

Levenson R (2003) Institutional ageism, *Community Care* (1481, 17 July 2003) : 42-43

Levy B R (2001) Eradication of ageism requires addressing the enemy within, *The Gerontologist* 41 (3) : 578-579

MacMahon D (2001) Evidence of ageism in Parkinson's disease management by GPs, <http://www.bmj.com/cgi/eletters/322/7287/668> *British Medical Journal (rapid responses)* (17 March 2001)

MacMahon D, Grosset D, Macphee M and Turner K (2006) Parkinson's disease: ageism in prescribing, *Geriatric Medicine* 36 (5 (Suppl)) : 23-26

Macnicol J (2006) *Age discrimination: an historical and contemporary analysis*, Cambridge: Cambridge University Press

Macular Disease Society (2005) *Playing games with patients' sight: patients with wet related age-related macular degeneration (AMD) reach treatment centres too late: a briefing and call to action*, www.rnib.org.uk/xpedio/groups/public/documents/publicwebsite/public_mdsweb.doc

Mangin D, Sweeney K and Heath I (2007) Preventive health care in elderly people needs rethinking, *British Medical Journal* 335 (7614, 11 August) : 285-287

Manthorpe J, Iliffe S, Clough R, Cornes M, Bright L, Moriarty J and Older People Researching Social Issues (OPRSI) (2008) Elderly people's perspectives on health and well-being in rural communities in England: findings from the evaluation of the National Service Framework for Older People, *Health and Social Care in the Community* 16 (5) : 460-468

Marshall T (2000) Ageism occurs in prevention of heart disease too, *British Medical Journal* 320 (7241, 15 April 2000) : 1077

Martin F C, Trembl J, Husk J, Grant R and Spencer-Williams M; Royal College of Physicians. Clinical Effectiveness and Evaluation Unit (2009) *National audit of the organisation of services for falls and bone health of older people 2009; commissioned by Healthcare Quality Improvement Partnership*, <http://www.rcplondon.ac.uk/clinical-standards/ceeu/Current-work/Falls/Documents/National-Falls-and-Bone-Health-Public-Audit-Report-March-2009.pdf>

Martin R M (2007) Commentary: Prostate cancer is omnipresent, but should we screen for it?, *International Journal of Epidemiology* 36 (2) : 278-280

Mathews K and Finch J (2006) Provision of palliative care education in nursing homes, *Nursing Times* 102 (5, 31 January 2006) : 36-40

Mauck K F and Clarke B L (2006) Diagnosis, screening, prevention, and treatment of osteoporosis, *Mayo Clinic Proceedings* 81 (5) : 662-672

Mayor S (2008) Osteoporosis experts launch guidance to fill gaps left by NICE, *BMJ* 337 : a2204

McDougall G J, Weber B A, Dziuk T W and Heneghan R (2000) The controversy of prostate screening, *Geriatric Nursing* 21 (5) : 245-248

McGarry J (2008) Exploring relationships between older people and nurses at home, *Nursing Times* 104 (28, 15 July 2008) : 32-33

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

McGovern MP, Boroujerdi MA, Taylor MW, Williams DJ, Hannaford PC, Lefevre KE and Simpson CR (2008) The effect of the UK incentive-based contract on the management of patients with coronary heart disease in primary care, *Family Practice* 25 (1) : 33-39

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

McMurdo M E T and Witham M D (2007) Health and welfare of older people in care homes, *British Medical Journal* 334 (7600, 5 May 2007) : 913-914

Milton J C, Hill-Smith I and Jackson S H D (2008) Prescribing for older people, *British Medical Journal* 336 (7644, 15 March 2008) : 606-609

Mitchell J, Bradley P, Anderson S J, Ffytche T and Bradley C (2002) Perceived quality of health care in macular disease: a survey of members of the Macular Disease Society, *British Journal of Ophthalmology* 86 : 777-781

Mold F, McKeivitt C and Wolfe C (2003) A review and commentary of the social factors which influence stroke care - issues of inequality in qualitative literature, *Health and Social Care in the Community* 11 (5) : 405-414

Morris J, Barrett J, Tadd W, Chambers N, Hurst P, Wardle J, Wagg A, Gladman J and Holmes P (2007) Better-targeted health care will ensure care home residents human rights and dignity,

<http://www.bmj.com/cgi/eletters/334/7600/913#165182> *British Medical Journal (rapid responses)* (9 May 2007)

Mukhopadhyay I, Lally F and Crome P (2007) Appropriate prescribing in older people, *Reviews in Clinical Gerontology* 17 (2) : 139-151

Murtagh M J, Cresswell T and Bailey K; Northern and Yorkshire Public Health Observatory (2003) *Ageing and inequalities: tackling inequalities in older people's health in the North East of England*, https://www.nepho.org.uk/view_file.php?c=360

National Centre for Social Research. Joint Health Surveys Unit, Department of Health. Information Centre, and Royal Free and University College Medical School. Department of Epidemiology and Public Health (2007) *Health survey for England 2005: The health of older people*, <http://www.ic.nhs.uk/default.asp?sID=1174999361712>

National Collaborating Centre for Mental Health, National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (2007) *Dementia: a NICE-SCIE guideline on supporting people with dementia and their carers in health and social care*. (National clinical practice guideline no 42), Leicester: The British Psychological Society and Gaskell

National Council for Hospice and Specialist Palliative Care Services (2004) *The House of Commons Health Committee Inquiry into Palliative care: submission of evidence*, http://www.ncpc.org.uk/download/publications/archive/The_House_of_Commons_Inquiry.pdf

Navaneethan S, Aloudat S and Singh S (2008) A systematic review of patient and health system characteristics associated with late referral in chronic kidney disease, *BMC Nephrology* 9 (3)

Newdick C (2005) *Who should we treat? : rights, rationing, and resources in the NHS; 2nd ed*, Oxford: Oxford University Press

NHS Scotland. Expert Group on Healthcare of Older People (2001) *Adding life to years: report of the Expert Group on Healthcare of Older People*, Edinburgh: Scottish Executive

NICE (National Institute for Health and Clinical Excellence) (2008) *Social value judgements: principles for the development of NICE guidance. 2nd ed*, London: National Institute for Health and Clinical Excellence

Noble C (2001) Access is denied, *Nursing Standard* 15 (47) : 16-17

Noel P H, Frueh B C, Larme A C and Pugh J A (2005) Collaborative care needs and preferences of primary care patients with multimorbidity, *Health Expectations* 8 (1) : 54-63

O'Dea G, Kerrison S and Pollock A M (2000) Access to health care in nursing homes: a survey in one

English health authority, *Health and Social Care in the Community* 8 (3) : 180-185

O'Donnell C A (2000) Variation in GP referral rates: what can we learn from the literature? , *Family Practice* 17 (6) : 462-471

Oliver D (2008) 'Acopia' and 'social admission' are not diagnoses: why older people deserve better, *Journal of the Royal Society of Medicine* 101 (4) : 168-174

O'Mahony D and Gallagher P F (2008) Inappropriate prescribing in the older population: need for new criteria, *Age and Ageing* 37 (2) : 138-141

Parkinson's Disease Society (2008) *Life with Parkinson's today: room for improvement: results of the UK's largest every survey of people with Parkinson's and carers*, London: Parkinson's Disease Society

Parliament. House of Commons. Health Committee (2008) *Dental services: fifth report, Health Committee, session 2007/08* (HC 289, session 2007/08), <http://www.parliament.the-stationery-office.com/pa/cm200708/cmselect/cmhealth/289/28902.htm>

Parliament. House of Commons Health Committee (2008) *Health inequalities. Vol 1: Written evidence*. (HC 422-I, session 2007/08), <http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/422/422ii.pdf>

Parliament. House of Commons Health Committee (2008) *Health inequalities. Vol 2: Written evidence*. (HC 422-II, session 2007/08), <http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/422/422ii.pdf>

Parliament. House of Commons. Health Committee. (2007) *Audiology services: fifth report of session 2006-07; report, together with formal minutes, oral and written evidence*. (HC 392 2006/07), 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 1: Report and formal minutes*. (HL 156-I 2006/07; HC 278-I 2006/07), 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*. (HL 156-II 2006/07; HC 278-II 2006/07), London: TSO

Paterson H (2000) Oral health in long-term care settings, *Nursing Older People* 12 (7) : 14-17

Patterson M; English Community Care Association (2008) *Can we afford the doctor? GP retainers and*

care homes, London: English Community Care Association

Patterson M; English Community Care Association (2008) *PostCode Tariff: PCTs and GP retainers in care homes*, London: English Community Care Association

Peat G, McCarney R and Croft P (2001) Knee pain and osteoarthritis in older adults: a review of community burden and current use of primary health care, *Annals of the Rheumatic Diseases* 60 (2) : 91-97

Premaor M O, Pilbrow L, Tonkin C, Adams M, Parker R A and Compston J (2009) Low rates of treatment in postmenopausal women with a history of low trauma fractures: results of audit in a Fracture Liaison Service, <http://qjmed.oxfordjournals.org/cgi/content/abstract/hcp154v1> *QJM*

Pritchard K I (2007) Have we been guilty of ageism in the primary treatment of breast cancer?, *British Journal of Cancer* 96 (7) : 1011-1012

Quarini C and Gosney M (2009) Review of the evidence for a colorectal cancer screening programme in elderly people, *Age and Ageing* 38 (5) : 503-508

Raleigh V S, Scobie S, Cook A, Jones S, Irons R and Halt K; Commission for Health Improvement (2004) *Unpacking the patients' perspective - variations in NHS patient experience in England*, London: Commission for Health Improvement

Ramsay S E, Morris R W, Papacosta O, Lennon L T, Thomas M C and Whincup P H (2005) Secondary prevention of coronary heart disease in older British men: extent of inequalities before and after implementation of the National Service Framework, *Journal of Public Health* 27 (4) : 338-344

Rawlins M and Dillon A (2005) NICE discrimination, *Journal of Medical Ethics* 31 (12) : 683-684

Rawlins M D and Culyer A J (2004) National Institute for Clinical Excellence and its value judgments, *British Medical Journal* 329 (7459, 24 July 2004) : 224-227

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 into age discrimination - access to NHS dentistry*,
http://www.worcestershirehealth.nhs.uk/RBPCT_Library/board_meetings/June_05/For_info/ENC%2017%20age%20discrim%20-%20dentistry.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) : 849-865

Reed J, Stanley D and Clarke C (2004) *Health, well-being and older people*, Bristol: Policy Press

Rehwagen C (2005) Older people are wrongly excluded from drug trials, *British Medical Journal* 331 (7529, 10 December 2005) : 1360-c

Reid F D A, Cook D G and Whincup P H (2002) Use of statins in the secondary prevention of coronary heart disease: is treatment equitable?, *Heart* 88 (1) : 15-19

Reidy A, Minassian D C, Vafidis G, Joseph J, Farrow S, Wu J, Desai P and Connolly A (1998) Prevalence of serious eye disease and visual impairment in a north London population: population based, cross-sectional study, *British Medical Journal* 316 (7145, 30 May 1998) : 1643-1646

Reidy A, Minassian DC, Vafidis G, Joseph J, Farrow S, Wu J, Desai P and Connolly A (1998) Prevalence of serious eye disease and visual impairment in a north London population: population based, cross sectional study, *British Medical Journal* 316 (7145, 30 May 1998) : 1643-1646

Rhind G and Macphee G (2006) Ageism in medicine: a problem for all, *British Journal of Hospital Medicine* 67 (12) : 624-625

Richards S H, Pound P, Dickens A, Greco M and Campbell J L (2007) Exploring users' experiences of accessing out-of-hours primary medical care services, *Quality and Safety in Health Care* 16 (6) : 469-477

Roberts C G P, Guallar E and Rodriguez A (2007) Efficacy and safety of statin monotherapy in older adults: a meta-analysis, *Journals of Gerontology Series A: Biological Sciences and Medical Sciences* 62A (8) : 879-887

Roberts E and Robinson J; King's Fund (2000) *Age discrimination in health and social care*. (Briefing note) , London: King's Fund

Roberts E and Seymour L (2002) *Old habits die hard: tackling age discrimination in health and social care : summary report findings*, London: King's Fund

Rochon P A, Bronskill S E and Gurwitz J H (2002) Health care for older people: Scottish report has international relevance, *British Medical Journal* 324 (7348, 25 May 2002) : 1231-1232

Rockwood K (2005) What would make a definition of frailty successful?, *Age and Ageing* 34 (5) : 432-434

Roland M (2007) The Quality and Outcomes Framework: too early for a final verdict, *British Journal of General Practice* 57 (540) : 525-527

Rosowsky E (2005) Ageism and professional training in aging: who will be there to help?, *Generations (American Society on Aging)* 29 (3) : 55-58

Routledge P A, O'Mahony M S and Woodhouse K W (2004) Adverse drug reactions in elderly patients, *British Journal of Clinical Pharmacology* 57 (2) : 121-126

Seymour J (1998) The unsound barrier, *Nursing Times* 94 (20 May 1998) : 56-58

Sigfrid L A, Turner C, Crook D and Ray S (2006) Using the UK primary care Quality and Outcomes Framework to audit health care equity: preliminary data on diabetes management, *Journal of Public Health* 28 (3) : 221-225

Sims R J A, Cassidy M J D and Masud T (2003) The increasing number of older patients with renal disease, *British Medical Journal* 327 (7413, 30 August 2003) : 463-465

Smith C (2006) Making the link: ageing and sight loss, *Journal of Integrated Care* 14 (3) : 32-38

Smith P C and York N (2004) Quality incentives: the case Of UK general practitioners , *Health Affairs* 23 (3) : 112-118

Smith S M and O'Dowd T (2007) Chronic diseases: what happens when they come in multiples?, *British Journal of General Practice* 57 (537) : 268-270

Speight P M, Palmer S, Moles D R, Downer M C, Smith D H, Henriksson and Augustovski F (2006) The cost-effectiveness of screening for oral cancer in primary care: executive summary, *Health Technology Assessment* 10 (14)

Starfield B (1998) *Primary care: balancing health needs, services, and technology. Rev ed*, New York: Oxford University Press

Starfield B (1994) Is primary care essential?, *The Lancet* 344 (8930) : 1129-1133

Steel N, Bachmann M, Maisey S, Shekelle P, Breeze E and Marmot M (2008) Self reported receipt of care consistent with 32 quality indicators: national population survey of adults aged 50 or more in England, *British Medical Journal* 337 (14 August 2008) : a957

Steel N, Maisey S, Clark A, Fleetcroft R and Howe A (2007) Quality of clinical primary care and targeted incentive payments: an observational study, *British Journal of General Practice* 57 (539) : 449-454

Stoddart H, Donovan J, Whitley E, Sharp D and Harvey I (2001) Urinary incontinence in older people in the community: a neglected problem?, *British Journal of General Practice* 51 (468) : 548-552

- Strandberg T E, Pitkala K H and Tilvis R S (2008) Statin treatment is associated with clearly reduced mortality risk of cardiovascular patients aged 75 years and older: letter to the editor, *Journals of Gerontology Series A: Biological Sciences and Medical Sciences* 63A (2) : 213-214
- Summerton N (2000) General practitioners and cancer, *British Medical Journal* 320 (7242, 22 April 2000) : 1090-1091
- Taylor J G (2007) NICE, Alzheimer's and the QALY, *Clinical Ethics* 2 (1) : 50-54
- Thomas S and MacMahon D (2002) Managing Parkinson's disease in long-term care (*Continuing professional development: Parkinson's disease*), *Nursing Older People* 14 (9) : 23-31
- Thomson S and Crome P (2002) Appropriate prescribing in older people, *Reviews in Clinical Gerontology* 12 (3) : 213-220
- Tinker A (1997) *Older people in modern society*. 4th ed. (Longman social policy in modern Britain series), Harlow: Longman
- Tod A M, Lacey E A and McNeill F (2002) 'I'm still waiting...': barriers to accessing cardiac rehabilitation services, *Journal of Advanced Nursing* 40 (4) : 421-432
- Turnbull P J (2001) Failure to measure serum cholesterol in elderly people - ageism or science?, *Ageing & Health (Institute of Ageing and Health, West Midlands)* (7) : 49-53
- Turner K (2006) Counteracting ageism in Parkinson's disease: a challenge for nurse specialists, *British Journal of Neuroscience Nursing* 2 (7) : 327-331
- Turner N J, Haward R A and Mulley G P (1999) Cancer in old age - is it inadequately investigated and treated?, *British Medical Journal* 319 (7205, 31 July) : 309-312
- Usher C, Bennett K and Feely J (2004) Evidence for a gender and age inequality in the prescribing of preventative cardiovascular therapies to the elderly in primary care, *Age and Ageing* 33 (5) : 500-502
- van der Hooft C S, Jong G W, Dieleman J P, Verhamme K M, van der Cammen T J, Stricker B H and Sturkenboom M C (2005) Inappropriate drug prescribing in older adults: the updated 2002 Beers criteria - a population-based cohort study, *British Journal of Clinical Pharmacology* 60 (2) : 137-144
- Wagg A, Mian S, Lowe D and Potter J; Royal College of Physicians. Clinical Effectiveness and Evaluation Unit and Royal College of Physicians, Healthcare for Older People Programme (2005) *Report of the national audit of continence care for older people (65 years and above) in England, Wales and Northern Ireland; prepared on behalf of the Continence Working Party*, London: Royal College of Physicians

Wagg A, Potter J, Peel P, Irwin P, Lowe D and Pearson M (2008) National audit of continence care for older people: management of urinary incontinence, *Age and Ageing* 37 (1) : 39-44

Wait S; International Longevity Centre. Alliance for Health and the Future (2005) *Promoting age equality in health care: a report for the Alliance for Health and the Future*, http://www.eldis.org/UserFiles/File/GHF/Age_Equality.doc

Ward P R, Noyce P R and St Leger A S (2005) Differential associations between actual and expected GP practice prescribing rates for statins, ACE inhibitors, and beta-blockers: a cross-sectional study in England, *Therapeutics and Clinical Risk Management* 1 (1) : 61-68

Ward P R, Noyce P R and St Leger A S (2004) Are GP practice prescribing rates for coronary heart disease drugs equitable? A cross sectional analysis in four primary care trusts in England, *Journal of Epidemiology and Community Health* 58 : 89-96

Weir N A, Kotecha M A and Goel K L (2007) Expanding choice options for older patients in relation to practice-based commissioning: a qualitative study of older patients in a small GP surgery, *Quality in Primary Care* 15 (6) : 331-337

West R, Fidler J and Vangeli E (2009) *Smoking and smoking cessation in England: findings from the Smoking Toolkit Study*, London: Tobacco Research Group, Cancer Research UK, Health Behaviour Centre, University College London

West Suffolk Older People's Voice, Age Concern Suffolk, Suffolk Primary Care Trust and Suffolk County Council (2008) *Primary care access and responsiveness: older people's experiences of their general practice*, <http://www.onesuffolk.co.uk/AgeConcern/Aboutus/WestSuffolkOlderPeoplesPanel.htm>

West Suffolk Older People's Voice, Age Concern Suffolk, Suffolk West Primary Care Trust and Suffolk County Council (2005) *Age discrimination - affecting older people*, <http://www.onesuffolk.co.uk/AgeConcern/Aboutus/WestSuffolkOlderPeoplesPanel.htm>

White C (1999) Upper age limit should be raised for cancer screening, *British Medical Journal* 318 (7187, 27 March 1999) : 831

Williams D, Bennett K and Feely J (2003) Evidence for an age and gender bias in the secondary prevention of ischaemic heart disease in primary care, *British Journal of Clinical Pharmacology* 55 (6) : 604-608

Wilson A and Parker H (2003) Intermediate care and general practitioners: an uncertain relationship: guest editorial, *Health & Social Care in the Community* 11(2) : 81-84

Windle K, Wagland R, Lord K, Dickinson A, Knapp M, D'Amico F, Forder J, Henderson C, Gerald Wistow G, Beech R and Roe B; University of Hertfordshire; Personal Social Services Research Unit - PSSRU; University of Keele; John Moores University; University College London and Edge Hill University (2008) *National evaluation of Partnerships for Older People Projects: [second] interim report of progress*, http://networks.csip.org.uk/library/Evaluation_of_POPP_interim_report.pdf

Wood R and Bain M; NHS Scotland. Information and Statistics Division (2001) *The health and well-being of older people in Scotland: insights from national data*, Edinburgh: NHS Scotland

Wymenga A N M, Slaets J P J and Sleijfer D T (2001) Treatment of cancer in old age, shortcomings and challenges, *The Netherlands Journal of Medicine* 59 : 259-266

Xavier G (2009) The new health checks must not be allowed to increase inequalities, <http://www.nursingtimes.net/nursing-practice-clinical-research/practice-comment-archive/the-new-health-checks-must-not-be-allowed-to-increase-inequalities/5000508.article> *Nursing Times* (14 April 2009)

Young J (2006) Ageism in services for transient ischaemic attack and stroke, *British Medical Journal* 333 (7567, 9 September 2006) : 508-509