Doctors will become more involved as more trafficked persons are identified. Practitioners should draw on existing guidance for similarly vulnerable populations, including migrants, refugees, and victims of sexual abuse and other forms of violence, while also recognising the unique characteristics of human trafficking. Representatives from the Department of Health, NHS, and primary care trusts should work with the Home Office, UK Human Trafficking Centre, and state and non-governmental support services to ensure that the role of the health sector is clearly defined and providers are adequately trained and resourced to care for victims.


Age based discrimination in health and social care services
Will be against the law if the 2009 equality bill is enacted

The 2009 Equality Bill will, if enacted, make age based discrimination in the provision of health care and social care illegal for the first time in the United Kingdom. In a speech in 2008, the then health secretary, Alan Johnson, said, “Old age is the new middle age. Health and social care services need to adapt to the changing needs of today’s older people. . . to promote health in old age and help older people to maintain independence and quality of life.” People over 65 already account for more than 60% of hospital bed days and most expenditure on health and social care. In 2007 there were 8.2 million people aged over 65 in England and Wales, but this is projected to increase to 11.6 million by 2026—an increase of 46%—with similar projected rises in the prevalence of disability and dependency. Core users of health care will continue to be older people, many of whom will be frail, have long term conditions, and rely on support from social services or informal carers. A demographic shift in the ratio of working people and multiple competing demands on health services and local government make this a challenging situation.

Health services are not uniformly “age proof and fit for purpose.” Structured, or incentivised to meet the needs of older people—especially those with complex needs—who may be a “disadvantaged majority” and potential victims of age based discrimination. Many sources provide evidence of this. Surveys of professionals, managers, and service users repeatedly show that these people see health services as inherently ageist.

Common conditions of old age are often less well recognised, managed, and resourced than those affecting younger people. Conditions affecting all ages are often comparatively less well managed in older people. Older people presenting “non-specifically” with falls, poor mobility, impaired cognition, or loss of function are often labelled as “social admissions” or as having “acopia” instead of receiving a detailed assessment, diagnosis, and plan to treat the medical problems that usually underlie such presentations. Targets, performance incentives, commissioning priorities, resources, and research funding are often skewed towards conditions of childhood and midlife.

The attitudes, priorities, education, and training of staff often fail to reflect the needs of older patients. Reports of undignified care, poor communication, and patronising attitudes are still all too common.

Organisational and cultural change is an iterative process requiring many approaches, but legislation is an important lever in tackling these problems. Although the NHS constitution sets out “respect and dignity,” “compassion,” and “everyone counts” among its principles, no current UK law protects people from age based discrimination by healthcare or social care services. The 2009 Equality Bill aims to rectify this by extending the duty for public sector equality to age, alongside the other “protected characteristics” of disability, sex reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation and banning such discrimination. The legislation will apply throughout the UK and could be used by individual older people, or more probably campaign groups and charities, to challenge apparent discrimination.

The secretary of state has commissioned a review, which reports in October, into when and how the NHS and social care system should implement the provisions in the bill in relation to age equality. At a national level, the review is supported by an advisory group representing key national stakeholders. It has issued a “call for evidence” from stakeholders for examples of age based
Does improving quality of care save money?

Not necessarily, as higher quality is mainly driven by professional reasons

As the NHS enters a period of little or no real growth in funding but incessant demand and cost pressures, the idea that improving the quality of services, treatment, and care could actually save money is an attractive proposition. But although there is plenty of evidence that poor quality health care and adverse events are costly both for the NHS in financial terms and for patients in terms of health consequences, there is a dearth of evidence that improving quality leads to lower costs.

In a wide ranging literature review for the Health Foundation, John Øvretveit unearthed just eight reasonably robust and well researched examples—mainly from the US—where service or clinical change has led to identifiable savings. These include annual savings of $0.7 million from reducing deep surgical wound infection rates and $0.3 million from earlier patient discharge and reductions in delays in dealing with pathology specimens.

The poor standard of much of the evidence on quality improvement and cost will be disappointing news for those at the Department of Health pushing to extract a silver lining from the approaching financial cloud. But as Øvretveit also points out, there are numerous reports of the avoidable costs of error, adverse events, and poor quality. For example, the Department of Health has estimated that the cost of discrimination or differentiation, justifiable or beneficial exceptions, and the potential effect of changing the law. It is also undertaking work in the south west of England with the NHS, local authorities, the voluntary sector, and patient representatives on the practical implementation of the bill.10

Key review principles are that “unjustifiable age discrimination and unfair treatment have no place in a fair society which values all its members”; that “meeting individuals’ needs should be based on their individual circumstances and not arbitrary assumptions about their age”; and that “services should be differentiated by age only when justifiable or beneficial.” (So that “differentiation” is not always “discrimination.”)

In law, to prove the existence of age based discrimination, no material difference should exist between the circumstances relating to each case (for example, in diagnosis, prognosis, or individual ability to benefit from treatment) with the test resting on relative differences in treatment between groups or individual patients and not against absolute standards such as those set out in clinical guidelines. The bill allows for justifiable exemptions where differentiation is a “proportionate means” of achieving “legitimate aims.” Emergency plans to ration hospital beds or intensive care beds by age in a flu epidemic provide a topical scenario, which could hypothetically be subjected to these tests if challenged in law.

When can age based differentiation be justified? Some services, investigations, or treatments may legitimately use age based cut offs on the basis of patient need or evidence of benefit. The National Institute for Health and Clinical Excellence (NICE) walks a tightrope when it determines cost-benefit using quality adjusted life years, which could be seen to discriminate against people with a shorter life expectancy and those with disability. However, NICE guidelines have sometimes advocated treating older people preferentially on cost-benefit grounds and have provided key guidelines to drive quality in several common conditions of old age. Some people argue that the current amount spent on older people is effectively “super serving them,” and that on the basis of the “fair innings” argument for life prolonging treatments, we are morally obliged to discriminate in favour of younger people.12

The current consultation and scrutiny process is a unique opportunity to contribute to the debate on whether age discrimination or differentiation can be justified in the context of our ageing population and the intrinsic NHS commitment that “everyone counts.” Older people—especially those who are frail, chronically ill, or cognitively impaired—have tended not to have the same powerful self advocacy as other vulnerable groups. If enacted, the Equality Bill will change this and will be a key bulwark against discrimination.

4 Centre for Policy on Ageing. A literature review of the likely costs and benefits of legislation to prevent age discrimination in health, social care and mental health services and definitions of age discrimination that might be operationalised for measurement. www.cpa.org.uk/information/readings/age_discrimination.pdf.