

They've had a Good Innings!

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We all fear the prospect of becoming ill and dependent in old age and it is reassuring to feel that we can count on the National Health Service. But as more and more doctors speak out about gaps in NHS cover, can we be sure it will be there when we need it? Not only are there good reasons for worrying about the ability of the NHS to cope, there is now strong evidence of deliberate discrimination against the elderly. At the very time we need care most, it may be withheld because a doctor takes the view that we have 'had a good innings'.

Worse still, the NHS fails to provide health care for some elderly people even when the improvement in health status would be the same or greater than for younger people. Some coronary care units have upper age limits, even though there is no evidence that older people who have suffered acute heart attacks benefit less than younger people from specialist cardiological care. These examples of discrimination occur, argues Professor Grimley Evans of Oxford's Radcliffe Infirmary, because of 'poor science and woolly ethics'.¹

A study of the NHS in Northern Ireland found that some doctors' judgements about which patients should be given priority for heart surgery were influenced by age, as well as other characteristics such as smoking and 'body mass'. In plain English, people who were fat, old or smoked were given lower priority.²

A Scottish study found that older patients who had been admitted to hospital because of a heart attack benefited from less extensive investigation (angiography) and fewer treatments, including coronary artery bypass grafts (CABGs or 'cabbages' in medical slang) than younger patients. Angiography involves taking x-rays of arteries after the injection of a dye. It was provided for 38% of the under 50s; 27% of the 50-59 year olds; 14% of the 60-69 year olds; but only 3% of those aged 70 plus.

There was a similar failure to carry out coronary artery bypass grafts. They were provided for 10% of the under 50s; 11% of the 50-59 years olds; but only 6% of the 60-69 year olds; and a mere 1% of those aged 70 or more.³ Yet, studies of patients in their 80s have found that, if operated on when the disease is still under control, they can tolerate surgery and enjoy a quality and quantity of life similar to that of others in their age group.⁴

Many elderly people are conscious that advancing age has led the NHS to treat them differently. In April 1999 a Gallup survey commissioned by Age Concern asked a random sample of adults aged over 50: 'Do you feel the NHS has ever dealt with you differently since you have been 50 or older?' 10 per cent of all respondents said 'yes'; 8 per cent of those aged 50-64 said 'yes'; and 13 per cent of those aged 65 and over answered 'yes'.

If anything, they underestimated the extent of the discrimination. Breast cancer screening is offered every three years to women aged 50-64. Despite the fact that the risk increases with age, women over 65 must request a mammogram and when they do so there is evidence that obstacles are sometimes put in their way. Several studies have found that screening 65-69 year olds produces the same 20-30% reduction in mortality as in 50-64 year olds.⁵ A study of women in the Netherlands found that regular mammographic screening of women over age 65 (and at least up to age 75) could reduce breast cancer deaths by about 45%.⁶

Moreover, a major US study, the Breast Cancer Detection Demonstration Project, found that 5-year survival for women aged 60 or more was not very different from that for younger age groups. Death from breast cancer after 5 years occurred in 7.4% of those aged under 50; in 8.5% of those aged 50-59; and in 9.7% of women aged 60 or more.⁷

A study based on 3.7 million people in Yorkshire found that people over 75 suspected of having cancer were less extensively investigated and when diagnosed, received less treatment than younger patients. These reductions were not explained by the frailty of patients nor by the presence of other complicating illnesses.

Among the women suspected of having breast cancer, 97% of those under 65 had the diagnosis confirmed by histology (the optimal laboratory test). Among those aged 75 plus it was 63%. Not only were elderly people subject to less thorough *diagnosis*, the optimal *treatment* was often not provided. One per cent of those aged under 65 did not receive the optimal treatment for their clinical condition (in the words of the study, 'no definitive treatment' was provided). However, 4% of those aged 65-74 failed to receive the optimal treatment; and 11% of those aged 75 plus. Lung cancer sufferers had a similar experience. Of those aged under 65, 80% had their diagnosis confirmed by histology; compared with 70% for the 65-74 year olds; and 44% for those aged 75 plus. And 'no definitive treatment' was provided for 32% of the under 65s, 48% of the 65-74 year olds and 76% of those aged 75 plus.⁸

The simplest explanation is that some doctors take the view that the elderly have had a 'good innings' and prefer to spend their limited budgets on younger people. This view is reinforced by the tendency to treat individuals as if the average characteristics of their group – the old – applied to every individual. It is accepted by medical ethicists that some treatments can do more harm than good and it

is true that the pain and suffering entailed by some medical interventions may outweigh any potential gain. Moreover, at some point death is inevitable and it may be futile to delay it by a few days or weeks. In addition, elderly patients are more likely to have additional complicating illnesses – perhaps both a heart condition and renal failure – and in such circumstances it may be that interventions like renal dialysis and cancer or cardiac surgery will be less effective. But no such conclusion can be drawn in every case. Medical codes of ethics expect decisions to be based on an individual assessment of each patient and the physical condition of people of the same chronological age varies substantially. Medical decisions should, therefore, be based on the individual's unique biological age, not mere chronological age.

Rigid categorisation is not the only problem, however. The underlying cause of age discrimination is that decades of rationing health care have undermined the professional ideal of the doctor as the patient's champion. If there are too few doctors to go round, even the most dedicated will find themselves routinely concocting excuses for not providing clinically necessary treatments.

Two figures reveal the huge disparity between the UK and similar European nations. OECD figures for 1996 show that the UK had 1.7 practising physicians per 1,000 population. Germany had 3.4 per 1,000, France 2.9 and Poland 2.4. The only countries with a lower proportion among the 20 leading nations who supplied information to the OECD were Korea (1.2), Mexico (1.2) and Turkey (1.1).⁹ However well motivated individual doctors might be, if they are in short supply, the inevitable result is the dilution of care.

Total spending on health care is also low by international standards. In 1997 total expenditure on health care in the UK was 6.9 per cent of GDP. The German figure was 10.7 per cent and the French, 9.6 per cent. Of the 29 advanced countries studied by the OECD, only Hungary, Ireland, Korea, Mexico, Poland and Turkey spent less. To match German levels would require an increase of nearly £30 billion per year over and above the £44 billion spent in 1997.

As we get older we tend to need more medical attention and the chief defence of the NHS is that it will provide care for everyone in their time of need. The unfortunate reality is that is *less* likely to be there just when we need it most.

Notes

- 1 Grimley Evans, J., 'This patient or that patient' in Smith, R. (Ed) *Rationing in Action*, London: *BMJ*, 1993, p. 120. See also Grimley Evans, J., 'Rationing health care by age: the case against', *BMJ* 1997;314:822 (15 March).
- 2 Kee, F., et al., 'Urgency and priority for cardiac surgery: a clinical judgement analysis,' *BMJ* 1998;316:925-929 (21 March).
- 3 MacLeod, M.C.M., et al., 'Geographic, demographic, and socioeconomic variations in the investigation and management of coronary heart disease in Scotland,' *Heart* 1999;81:252-56.
- 4 Bufalari, A., et al., 'Surgical care in octogenarians', *British Journal of Surgery*, 1996, vol. 83, pp. 1783-87.
- 5 Sutton, G., 'Will you still need me, will you still screen me, when I'm past 64?' *BMJ* 1997;315:1032-33 (25 October).
- 6 van Dijck, J.A., et al., 'Mammographic screening after the age of 65 years: evidence for a reduction in breast cancer mortality,' *International Journal of Cancer* 1996; 66:727-731.
- 7 Morrison, A.S., et al., 'Breast cancer incidence and mortality in the Breast Cancer Detection Demonstration Project,' *Journal of the National Cancer Institute*, vol. 80, no. 19, 7 December 1998, pp. 1540-47.
- 8 Turner, N.J., 'Cancer in old age – is it inadequately investigated and treated?' *BMJ* 1999; 319:309-312 (31 July).
- 9 *OECD Health Data 99 (CD)*.