

## **Health Inequalities - Access to Services**

### **Age Scotland**

Age Scotland is the leading charity for older people. We believe everyone can have a full, healthy and happy later life and we engage with Scotland's older people to inspire and support them to do so. We welcome the opportunity to give evidence to the Health and Sport Committee on access to healthcare services and health inequalities.

“Poor health, negative stereotypes and barriers to participation all currently marginalise older people, undermine their contribution to society and increase the costs of population ageing. Investing in health lessens the disease burden, helps prevent isolation and has broader benefits for society by maintaining the independence and productivity of older people.”

*World Health Organization*<sup>1</sup>

#### **1. Older people and health**

1.1. The burden of ill-health is carried by older people. 81.2% of all deaths in Scotland occur among people aged 65 and over, with a further 9.7% among people aged 55–64.<sup>2</sup> Half of Scotland's people aged 70 and over have a disability or long-term illness, as have a further third aged in their 60s, as opposed to 18% of the general population.<sup>3</sup> Older Scots have increased risks of the most common lethal conditions (cancer, heart disease and stroke), mobility problems and chronic pain. Almost all of those who experience some other debilitating conditions (diabetes, sensory impairments and cognitive difficulties, including dementia) are older. Alongside cognitive issues, mental health challenges such as anxiety and depression are more common among those with long-term conditions. And almost exclusively, it is older people who experience co-morbidities.

1.2. Long-term conditions and co-morbidities are both caused and exacerbated by poor general health. We have known for generations that diet and nutrition, exercise and physical activity, and exposure to health risks such as tobacco, alcohol and other toxic substances are key drivers of health.

1.3. However, they are also caused and exacerbated by physiological and social aspects of ageing. Unhealthy lifestyles produce more negative health outcomes in our later years, which is also when we are physiologically less able to cope with these (as explored in the medical disciplines of geriatrics

---

<sup>1</sup> Good Health Adds Life To Years, WHO (2012)

<sup>2</sup> Vital Events statistics (table 5.4), National Records of Scotland (2012)

<sup>3</sup> Scottish Household Survey 2012

and gerontology). Typically older people experience less mobility and stability, and are more likely to suffer problems with both continence and also memory and general intellect. Our immune system and bones are weaker and our vital organs are more susceptible to failure. However, maintaining good levels of health and fitness can delay or diminish many of these effects. Our sister charity Age UK has also published research which suggests that a positive attitude toward later life can also improve health, wellbeing and quality of life. Environmental factors, such as access to green spaces, may be relevant for both mental and physical wellbeing.

1.4. But despite the variety of health conditions linked to ageing, only some are specifically identified as such. The sole “tracer condition” adopted for standards of care for older people in NHS hospitals is hip fracture,<sup>4</sup> and the older people’s improvement programme for acute care focuses on delirium and frailty.

“Health in general tends to deteriorate as people get older. There may, however, be social inequalities in the trajectories of age-related health decline.”

*International Institute for Society and Health*<sup>5</sup>

## **2. Health inequalities**

2.1. The Scottish Government has adopted the social model of health and wellbeing (e.g.in Equally Well). They therefore recognise that factors such as low incomes, poor housing, lack of contact with others, limited involvement in civic and neighbourhood life and poor or unequal access to services can adversely affect not only quality of life but also overall health and wellbeing.

2.2. Some or all of these factors exist for many of Scotland’s older people; some may have existed in earlier life too, but others develop during later years, most commonly during difficult life transitions (e.g. retirement without replacing work with other stimulating activity; bereavement, especially the death of a carer, spouse or friends; children or extended families moving away for work). Without adequate and timely preventative services, these can tend to push older people toward unhealthy lifestyles (e.g. alcohol misuse) and poor mental health outcomes. Though it is not necessary to examine each of these factors in detail, some analysis may be useful.

---

<sup>4</sup> NB Healthcare Improvement Scotland is reviewing these standards during 2014, and Age Scotland is contributing to the project group.

<sup>5</sup> “Social inequalities in self-reported health in early old age: follow-up of prospective cohort study”, Chandola et al, British Medical Journal (May 2007)

2.3. Health inequalities make people's health poorer at an earlier age. The International Institute for Society and Health has estimated that a 70-year old who had a high-grade professional job will have the same level of physical health as a 62-year old who had a low-grade manual job. Those in the latter category also do not enjoy the same rate of improvement in mental health in later life as the former, leading to a widening gap.

2.4. Poverty drastically reduces life expectancy: in the 10% most deprived areas, men have an average life expectancy of 68.2 years and women 75.7; in the 10% least deprived areas, the respective figures are 81.4 and 84.6. There are even more stark differences in particular communities –in 2008, male life expectancy at birth in Calton in Glasgow was 54 years, compared with over 80 in places like Newton Mearns, Bearsden and Lenzie. So health inequalities reduce the length of later life and arguably deprive some people of it altogether.

2.5. One in six pensioners (160,000 in Scotland) live in poverty, defined as 60% of median income after housing costs. Pensioners are also the largest group on the brink of poverty, with more than 100,000 on the edge. These rates have not changed significantly in the past ten years. Low incomes in retirement are often linked to low pay during working lives or time out of employment (as carers, or experiencing unemployment or disability). Groups especially vulnerable include women and those living alone (given lower male life expectancy, these are often the same people).

2.6. Older people are not the group most directly affected by the recent welfare reforms. However, the State Pension age is increasing for women and will increase in future for both women and men, meaning both will be expected to work for longer or, if they cannot, will be part of the "working age" benefits regime for longer. Similarly, if and when Universal Credit is rolled out, this is calculated on the basis of household income. So if a household contains a couple, one of whom has attained State Pension age and the other has not, and if the latter is also a Universal Credit claimant, the former could be denied the Pension Credit to which they would previously have been entitled, and (if in social housing) both may be affected by the under-occupancy penalty for Housing Benefit.

2.7. Thirty years ago, the basic State Pension represented one quarter of average earnings; today it is one sixth. Additional benefits such as Pension Credit are designed to alleviate poverty, but there is a large and persistent problem of underclaiming this, because many pensioners are not aware they are entitled, are put off by the process or are reluctant to ask for help. Some free and universal benefits are extremely valuable in reducing pensioner poverty and improving quality of life, including eye tests, prescriptions, and television licences for the over-75s.

2.8. All pensioners are entitled to winter fuel payments and, when appropriate, cold weather payments. These are important, as is the Warm Home Discount negotiated with energy suppliers. However, more than half of all single pensioners are fuel poor, and pensioner households comprise more than half of all those who experience fuel poverty. Energy costs are now a significant cause of concern to more than half of pensioners. Cold temperatures –even for short periods –can have adverse consequences for health, increasing the likelihood and severity of flu, chest infections and other respiratory problems, but can also raise blood pressure, put people at greater risk of preventable deaths from heart attack and strokes.

2.9. Both the Scottish and UK Governments have schemes to improve home energy efficiency, but these have taken longer to implement than intended and their complexity can act as a disincentive for uptake. There have been notable underspends in the Scottish Government's home energy efficiency scheme recently. Consequently, it seems highly unlikely or impossible that the target of eliminating fuel poverty by 2016 will be met.

2.10. Many older people experience loneliness and isolation. Between 5 and 16 per cent of over-65s report feeling lonely and 12 per cent feel isolated. It has significant health effects, both physical (e.g. blood pressure) and psychological (e.g. depression), and also increases the risk of mortality. Its effects have been compared to a fifteen-a-day smoking habit. This is a developing area of research, but the most successful efforts in tackling this seem to rely on direct human contact and opportunities to connect within communities. This is an area where the third sector seems to have more success than public services.

2.11. The national concessionary fare scheme is a lifeline for many older people to use public transport, and there is evidence that such schemes encourage older people to be more mobile, to travel actively and walk, and therefore be fitter.<sup>6</sup> However, the lack of public transport options in remote rural areas mean many older people rely on community transport or taxis to get about. The latter are not a sustainable affordable option for most older people and the former are often not free for users –an issue on which Age Scotland has been campaigning recently.

2.12. Strategies to tackle health inequalities should therefore, in our view, address the particular context of health inequalities in later life, but often they do not. For example, Equally Well had only two recommendations for action

---

<sup>6</sup> "The impact of free older persons' bus pass on active travel and regular walking in England", S Coronini-Cronberg et al., American Journal of Public Health (2012)

specifically linked to older people –one relating to improving access to dental health for vulnerable groups, including older people; and the other recommending that the Scottish Government “should help people to maximise their income and encourage them to take up means tested benefits, starting with older people”.

2.13. There are some difficulties defining or identifying social inequality in older age. Data on poverty is often referenced by receipt of working age income-related benefits, but these are not available to those of State Pension Age or older. Income-related benefits such as Pension Credit are unreliable indicators of poverty because of underclaiming. However, these problems are not insurmountable.

2.14. Audit Scotland reported on health inequalities in 2012 and reported that it was unclear how NHS boards and local authorities understood and responded to health inequalities in their respective areas. It remains to be seen how the new Health and Social Care Partnerships will respond to the call for consistent and transparent application of Scottish Government funding to address health inequalities, for example through their strategic planning (formerly joint strategic commissioning), and how initiatives will relate to other public services (such as housing).

### **3. Access to healthcare services**

3.1. Age Scotland has not undertaken extensive research in this area, but we are aware of some issues which we are happy to draw to the Committee’s attention. Our partners, the Silver Line Scotland (formerly the Scottish Helpline for Older People), who receive calls from older people seeking information, advice and telephone befriending services, have heard instances of older people feeling mistreated by health services and wishing to pursue complaints about their treatment.

3.2. We have received complaints from older people who feel that doctors and hospital staff have not been aware of their needs or circumstances. There are examples of older people attending accident and emergency units during busy periods and not being informed of how long they might wait, or if they have the means to get home once they have been seen or discharged. We have received numerous reports of older patients being assumed to lack capacity to make decisions about their own treatment, or even to be informed. It is an important principle that a continuing power of attorney does not obviate the need to consult and inform patients themselves. Patient dignity is one of the NHS’s core values but it is not part of the standards of care for older people in hospitals and so does not form part of inspections, yet it contributes a great deal to patient experience. These issues should form part of the 2014 review of these standards by Healthcare Improvement Scotland.

3.3. Some symptoms of health problems may be confused with typical symptoms of ageing (e.g. excessive alcohol misuse increases the likelihood of loss of balance and falls, but these may be put down to ageing factors). Hidden harms are particularly challenging for older people because early detection of health problems (especially metabolic changes such as high blood pressure, blood sugar or cholesterol) significantly increases the likelihood of successful treatment and management.

3.4. Becoming older is one of the most common motives for moving house (into sheltered accommodation or housing supported by a care package, to be close to a relative or carer, or to a single storey property or one which has been adapted or is otherwise more manageable). An older person in this situation may have numerous co-morbidities which mean they require regular medical attention. Yet the house move may also necessitate registering with a new GP. GPs' surgeries routinely require two written forms of address identification when registering new patients. These may take some time to obtain, and the problem is even more acute where there is a continuing power of attorney, and the attorney or guardian receives the older person's mail. We know of instances where a lack of access to preventative care can contribute to a person falling into crisis.

3.5. GPs' surgeries now routinely employ computerised booking systems for appointments, often with patients directed towards computer terminals on their arrival rather than having face-to-face discussions with reception staff. Older people may be less comfortable with computer technology and so can be digitally excluded, and reluctant to ask for help for fear of seeming incompetent. The removal of the opportunity for a human conversation may also discourage older people from articulating their problems and concerns (which they may feel reluctant or unable to do without some kind of encouragement or support).

3.6. Many of these problems could be resolved by greater involvement of older people and their representatives in the design and delivery of services, and instilling an ethos of concern for older people and their potential specific needs among NHS staff at all levels.

**Age Scotland**  
**March 2014**