Why should policy makers be interested in the demography of ageing?

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In a series of three essays, I will examine why policy makers should be interested in some key demographic trends within ageing and the challenges that these will create for the delivery of future health and long term care in the UK. I also examine possible policy responses and how other considerations influence whether these can realistically be put into practice.

Increasing life expectancy and health care funding

The UK population is ageing. By 2032 the number of people over 65 is projected to rise to around a quarter of the population (Dunnell, 2008). Historically, the dramatic decline in the fertility ratio has been the main driver of population ageing in the UK and the rest of the developed world. More recently, a reduction in mortality and increased life expectancy has also contributed to population ageing (Dunnell, 2008). In recent decades, improvement in mortality rates for older adults, rather than infants, has contributed most to improved life expectancies (Christensen et al., 2009). It is still debated whether life expectancy will continue to rise (Oeppen and Vaupel, 2002) or is approaching its natural limit due to the rise in lifestyle diseases like obesity (Olshansky et al., 2005). One certain consequence of increasing life expectancy will be an increase in absolute numbers of older adults and older patients.

Although there is a prevailing sentiment from economists that an ageing population will result in spiralling costs of health care (Beck, 2009), globally, it is unclear if there is a link between life expectancy and health care expenditure (HCE) (Han et al., 2013) (Barros, 1998; Lubitz et al., 2003). In the UK, it is known that HCE per capita is three times higher for over 65s compared to the 5-64 group (Seshamani and Gray, 2002). The rise in the prevalence of chronic disease (Lafortune and Balestat, 2007) is thought responsible as treating these consume greater resources (Gonzalez-Gonzalez et al., 2011). However, chronic conditions affect people at all ages (Hoffman et al., 1996) and in the UK, the proportion of national HCE for over 65s actually fell between 1986 and 1999 (Seshamani and Gray, 2002).
In the UK, NHS England appears to be taking a high risk view of population ageing with a projected deficit in NHS funding of £30 billion by 2020 thought due to funding shortages and an ageing population (Iacobucci, 2014). UK political parties have differing ideologies of how this projected deficit should be met, and more generally how state transfer systems, such as health, should be funded. Historically, Labour governments have supported publicly funded health care and have increased NHS funding through taxation (Appleby et al., 2009). Conservative policy has focused on improved efficiency through the introduction of market-oriented reform and decentralisation of health strategy and funding. Other parties have suggested more radical reform of UK health care and the introduction of insurance based schemes (Mason, 2014). However, there is little evidence internationally that market based or decentralised care health improves efficiencies and decreases HCE (Lorenzoni et al., 2014; Mosca, 2007). With the rapidity of UK population ageing with the over 65 group set to double in 40 years (Martin, 2011), a bipartisan agreed strategy on a long term NHS funding solution is needed soon.

Is age-based health care rationing a solution to increasing life expectancy?

One theoretical response to potential pressures of an ageing population on the health system is age-based health care rationing (Fleck, 2010). Williams defines this as the use of age as a ‘criterion for choosing which people who could benefit from health care’ and believes it can be an appropriate response to the finite nature of medical resources (p. 820)(Williams and Evans, 1997). There is evidence that age-based health care rationing already occurs, particularly in more interventional fields like cardiology (Bowling, 1999, Fairhead and Rothwell, 2006). Fleck suggests that the policy could be made more acceptable to the public by ensuring the savings from age-based rationing are used to fund more cost effective interventions for elderly people (Fleck, 2010). Unsurprisingly, age-based health rationing is ethically contentious. Giordano argues that the myth that an ageing society is bankrupting health care is being used to justify an inherently unjust policy (Giordano, 2005). He argues that disability and disease, not age, are the big consumers of health resources (Giordano, 2005) and age is only one factor in the risk-benefit analysis of any proposed medical treatment (Williams and Evans, 1997).

The rise of the ‘oldest old’ and the frail

A consequence of increasing life expectancy is a rise in the ‘oldest old’ (over age 85). It is the fastest growing demographic group in the UK and by 2032, the oldest old is expected to double to over 3 million people (Dunnell, 2008). This presents significant challenges to health care policy makers, not least due to the issue of frailty. Frailty is a poorly understood syndrome resulting in decreased resilience to stressors with age (Morley et al., 2002). It is associated with disability, death, co-morbidity, falls and more complex needs (Fried et al., 2004) and any increase in frail patients would present real challenges to health care (Bergman et al., 2002). Potential policy response to the projected increase in the frail population could centre on strategy. The National Service Framework for Older People has helped in some areas such as falls (Cryer and Patel, 2001), but no national frailty strategy exists. This may reflect scientific uncertainties about the frailty syndrome (Cryer and Patel, 2001) and research is needed to understand how many older adults avoid frailty (Ahmed et al., 2007). Policy could also support promising interventions such as tele-care (Barlow et al., 2007), respite for carers (Mason et al., 2007), new models of care in primary care (Coleman et al., 1999) and rehabilitation to preserve function (Gill et al., 2002). Education, workplace planning and improved integration of health and social care may also be needed to address the complexity of care needs in frail patients (NHS England, 2014). Obstacles to implementation include
lack of funding, poor scientific understanding of frailty (Baltes, 1998), lack of validated care measures (Boyd et al., 2005) and the relative invisibility of the frail population.

In the next essay, I will examine key projections for morbidity trends and the difficulties that these present for health care planners.

References


