Preventive cardiovascular care for older people: fundamental for healthy ageing?

Cardiovascular disease (CVD) is a major cause of mortality worldwide and accounts for over 50% of deaths in the European region [1]. Prevention is key to reducing its impact and in the UK this has been enacted by the introduction of the NHS Health Check [2] with the aim of detecting early disease and instigating optimal management to reduce cardiovascular risk factors. The programme specifically targets people aged 40–74 years without known CVD and offers lifestyle advice and appropriate medication, for example, prescription of a statin, in accordance with current guidelines.

Age is a non-modifiable risk factor for CVD but the effects of ageing can be lessened by preventing or delaying the onset of CVD. Over the last decade several randomised controlled trials have demonstrated significant benefits of prescribing both statins and hypertensive medication in older people [3, 4]. Notwithstanding current evidence for effectiveness, Sheppard et al. [5] recently reported a treatment-risk paradox for lipid-lowering drugs in a large study of routine data from primary care practices in the West Midlands; whereby the older patients were, the less likely they were to receive appropriate treatment. Poor preventive care in older people is not a new phenomenon: the ‘Rule of Halves’, an effect first reported 40 years ago in the USA by Wilber and Barrow [6], and replicated in the UK by Duggan et al. [7] in 2001, showed that half the patients studied were unknown hypertensives; half were known but not on treatment and half of those on treatment did not have adequate hypertension control.

The Equality Act 2010 enshrines nine protected characteristics including age [8]. The basic tenet of the Act is that a person should not be harassed, victimised or treated less favourably than others on the basis of any of the protected characteristics. This has implications for health and social care commissioners with responsibility for delivering CVD preventive care. Guidance for implementation of the Equality Act states that ‘the NHS will still be able to target screening programmes at certain age groups, provided that this is supported by statistical evidence that these groups are at high risk’ [9] but older people are likely to be at equal or greater risk of a cardiovascular event than their younger counterparts. The implementation of the NHS Health Checks with an upper age limit of 74 years is, therefore, an example of health policy that appears to reinforce age-based practice in the UK despite the commitment to root out ageism in services affirmed in the National Service Framework for Older People (2001) [10].

Ageist attitudes in healthcare are sometimes justified by the dilemma surrounding the allocation of scarce resources and the futility of preventing death as people approach the end of their functional lives [11]. In our view the challenge is not to postpone death but to decrease the morbidity associated with old age thereby improving quality of life for older people. Timely identification and treatment of hypertension, and early diagnosis of other CVD risk factors like Atrial Fibrillation could prevent cardiovascular events such as stroke, the debilitating effects of which can be catastrophic for previously independent older people. Moreover, encouraging and supporting lifestyle change can be beneficial for older people. Physical activity has been shown to reduce the decline in functional status in older adults and enables them to continue performing tasks of daily living; it has also been shown to delay decline in cognitive function and provide a medium for social interaction [12]. Further primary and secondary studies are needed to assess the relative benefits and disadvantages of preventive care for CVD as people age [13].

The UK population is changing; people are living longer and there are now 10 million people over the age of 65 (of whom 3 million are over 80 years of age); if population growth forecasts are correct, it is predicted that by 2050 one in four people in the UK will be over 65 [14]. This changing demographic means that we need to think differently about age. As a champion for older people, Age UK recognises the importance of this issue and has highlighted it in their strategy and annual policy report: Agenda for Later Life [15]. The proportion of people over 80 is one of the fastest increasing age groups in the UK and people are not only living longer but also becoming more active in retirement. Older people often have caring responsibilities for frail or disabled spouses or may be taking increasingly active roles in caring for grandchildren. Abolition of the default retirement age in October 2011 means that economic activity is being sustained and people are now able to remain in work for longer if they choose to do so. Furthermore, the post-World War II ‘baby-boomers’ have higher expectations of health and healthcare than previous generations; discrimination in healthcare is thus less likely to be tolerated by a new lobby of better connected, more educated and vocal older people.
There are therefore three challenges: first, there is a research challenge because evidence for age inequalities in the prevention and treatment of CVD exists but we do not understand fully the complex interplay of interpersonal, psychological and social factors that may contribute to physicians’ treatment decisions and patients’ choices. Nor do we fully understand the efficacy of preventive interventions, and their adverse effects, in older people as this population group is often under-represented in research studies. Secondly, there is the policy challenge for the newly configured public health services given that NHS Health Checks are at present restricted to those individuals between the ages of 40 and 74. Thirdly, there is a challenge for practice; for more education and training of health professionals and the development of a more sophisticated understanding of the ageing population. We urge the NHS to adapt quickly to the needs of an ageing population and put more resources into the prevention and management of long-term conditions.

Key points

• Eradication of ageism in health care.
• The compression of morbidity.
• Active promotion of health and preventive care for older people.

Conflicts of interest

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KATE MARY HILL1,*, ANA-CLAUDIA BARA2, SUSAN DAVIDSON3, ALLAN O. HOUSE2
1Leeds Institute of Health Sciences, University of Leeds, Charles Thackrah Building 101 Clarendon Road, Leeds LS2 9JF, UK Tel: 0113 343 0864. Email: k.m.hill@leeds.ac.uk
2Leeds Institute of Health Sciences, University of Leeds, Leeds, UK
3Age UK, London, UK
*To whom correspondence should be addressed

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