

Who will care for our elderly people?

A conference on the topic 'Who will care for our elderly people?' was held at the Royal College of Physicians on 16 March 1992. It began with a consideration of the challenge in terms of numbers and problems.

Dr Emily Grundy (London) presented the demographic picture. Apart from the expected increase in numbers of the very old over the next decade, the UK is also encountering a downturn in the numbers of school-leavers traditionally recruited into the caring professions. But Dr Grundy also pointed to some positive features about the immediate future, notably the increasing number of children in the families of older people which has been occurring since its nadir in the late 1970s. In addition, the demographic data suggest that some of the other negative features—the effects of family migration, the return of women to work in middle life, and the impact of divorce and remarriage—which had been expected to reduce the amount of informal care available to elderly people, do not appear to be having a significant effect. Dr Grundy commented that new and even more severe problems are likely to appear in the second decade of the 21st century as a second large cohort of people reaches old age. Although the immediate future offers us something of a demographic breathing space, this is merely a prelude to a more severe challenge. It is to be hoped that social policy will prepare us better for this 'second front' than it did for the first.

Needs

Professor Shah Ebrahim (London) emphasised the impossibility of making any firm predictions about the future pattern of disease and disability in later life. Longevity is increasing but we do not know to what extent this is due to greater fitness of older people, and how much to the prolongation of life of the disabled. Although there are falling incidence rates or rising treatment rates for some disabling conditions, self-report data in the General Household Survey imply that increasing numbers of people in later age groups are dissatisfied with their state of health. This may well represent rising expectations of well being in later life and not necessarily a true decline in fitness. The impact of Social Security regulations on the desirability

or otherwise of being 'ill' or 'disabled' also has to be considered in interpreting data from self-report. There are powerful cohort effects which may have an impact on specific sources of disability. Stroke mortality and, probably, incidence have been falling for some years, and the incidence of coronary heart disease has recently started to decline in the UK, as it has been doing in the USA for more than a decade. We do not know what is happening with other important sources of disability, notably dementia, arthritis and osteoporosis. Professor Ebrahim also pointed out that simple measures of prevalence or incidence cannot be directly translated into need for services because these are determined by such factors as knowledge and demand by the public, the gatekeeper function of general practitioners, and limitations in service provision. Nonetheless, if one simply projects into the future current patterns of disability and service provision, the present ageing of the population could lead to large increases in public expenditure. The increase in projected expenditure on institutional care is particularly alarming, given the supposed universal commitment to care in the community.

Developments

In reviewing the potential for community as opposed to institutional care, **Dr David Challis** (Canterbury) drew attention to the proven benefits of the case management principle in deploying community care. While earlier studies have demonstrated the ability of case management to prevent admission to residential care, the Darlington Project, by transcending the barrier between hospital geriatric service and community social services, has shown that patients who would otherwise have remained in long-stay hospital care can be cared for at home. The overall cost of care is probably not very different in the two settings, but patients and families seem to prefer domiciliary care. The project does, however, represent a significant transfer of costs from the hospital to the local authority budget. How well such a transfer of funds could be brought about in the future is an open question. Although average costs are similar in the two settings, the variance in costs in the community is greater. This raises some ethical problems since, as a later commentator pointed out, the costs of care plotted against degree of disability show a steeper rise with domiciliary care than with institutional care, so that there is a cross-over point. Although at present service planning is based on the idea that patients and clients should have whatever pattern of care they choose, it is doubtful whether this will prove ethically acceptable because a client who opts for the more expensive option may be depriving another of any care at all.

Dr R. H. McNeilly (Tunbridge Wells) presented an informative review of the health insurance company, Private Patients Plan and their recent developments in

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the field of insuring for long-term care (in the community or institution) and in developing high-quality nursing homes. He emphasised the feasibility and importance of setting standards, particularly the value of agreed and written protocols for nurses to follow in the event of intercurrent illness or disability in the residents of the nursing homes. It emerged clearly from the subsequent discussion that good-quality care is more expensive than is reflected in current levels of Social Security support for nursing-home care, or in the NHS costing of its long-stay hospital beds. These figures are disturbing, since it seems that present government policy can only be sustained by providing care at an unacceptably low level.

Professor Michael Horan (Manchester) considered the extent to which 'high technology' care applied also to older people. Although age is frequently used as a basis for selecting people for expensive interventions, this has no scientific or ethical basis. It is not age but physiology that determines outcome, and in clinical practice insufficient care is taken over selecting people for interventions. The more that is known about the physiology of an individual patient, the less important age becomes as a predictor of outcome. Unfortunately, for many interventions clinicians are working from an inadequate information base, because the necessary research has not yet been done. In the subsequent discussion it was pointed out that high technology is changing and becoming physiologically less challenging. The newer and less invasive procedures, such as angioplasty and 'keyhole' surgery, may be more applicable to frail patients than the earlier and more invasive ones. The Royal College has recently pronounced that there is no clinical justification for withholding cardiological investigation and intervention from patients on the ground of age alone. This principle now needs to be extended to all specialties and made explicit throughout the health services. There is a danger that the new financial arrangements in the National Health Service could increase overt or covert age discrimination.

Training

The training programmes of general practitioners, nurses, hospital doctors and social workers were reviewed by **Dr E. C. Gambrill** (GP, London), **Mrs M. Watkins** (nurse, Plymouth), **Dr B. L. Pentecost** (hospitals, RCP) and **Dr S. Biggs** (social work, London). Social workers are greatly concerned about their future role when the Community Care Act is implemented in 1993. Training has therefore to focus on flexibility and concentrate on the embodiment of the principles rather than the details of assessment. The philosophy of training has shifted from a preoccupation with qualifications to a concern for ultimate professional competence. (One commentator noted the analogous distinction that has been drawn in medicine

between learning how to pass medical examinations and learning how to be a doctor—a distinction that underlies the London Royal College of Physicians' objection to an exit examination in higher medical training.)

For the nursing profession, too, flexibility is seen as a major theme in training programmes. The needs of the public as well as the service context in which those needs are being met are changing, and nurses are also exploring a range of new roles for their profession. After the basic training, schools of nursing are setting up a wide variety of training modules from which individual nurses can put together their own portfolio of training best suited to equip them for the career they wish to follow. This contrasts with the rigidity of medical training in both general practice and hospital medicine. In general practice only about 40% of vocational trainees spend any time in geriatric departments. While this is partly due to lack of adequate opportunity, there seems little doubt that recruits to general practice are not usually very enthusiastic about the care of elderly people. Only a fairly small proportion of general practitioners take the Diploma of Geriatric Medicine (DGM) but, as a commentator pointed out, this might be through lack of appropriate guidance. One published review of diplomas by a trainer in general practice said there was little point in taking the DGM 'as it carried no financial advantage'. This hardly reflects the best traditions of professional dedication to the welfare of patients. Dr Gambrill suggested that an additional problem is a lack of Senior House Officer posts in geriatric departments suitable for vocational training. More posts are needed as well as more interaction between geriatricians and general practitioner trainers to ensure suitable experience for future primary care physicians.

The training of hospital physicians is also inadequate with regard to specific training in care of elderly people. While most doctors training to be specialist geriatricians also now become accredited in general medicine, only a small proportion of those training in other medical specialties gain geriatric experience. It is even claimed that the Royal Colleges approve general and higher medical training in general medicine in centres where the local arrangements for clinical care preclude doctors other than those in geriatric departments from seeing patients aged over 75. However, Dr Pentecost, the JHMT coordinator at the RCP, considered it unacceptable that junior doctors should have experience in care of elderly people imposed on them if this involved rotation into unattractive posts in departments of geriatric medicine. This stance received less than unanimous approval from the audience, and several people pointed out that general professional training is of its very nature an imposition. If the way it is being administered by the Royal Colleges does not adequately prepare doctors for the needs of the public, training should perhaps become the responsibility of some other body.

Policy versus needs

Dr Eric Midwinter, until recently Director of the Centre for Policy on Ageing, brought the day to its climax with a witty and perceptive presentation of the views of older people. All too often the services provided for them do more to salve the social conscience of the providers than to meet the needs of the recipients. In part this is due to the voice of older people not being heard, but it is also due to the fact that older people do not raise their voices enough. In future the focus needs to be on the rights of older people as citizens, not on their rights when (and only when) they become social casualties. Dr Midwinter prophesied a change when new cohorts of people with greater social awareness become old. He painted an amusing picture of future street riots in which old age pensioners overturn meals-on-wheels vans in protest against late or irregular delivery; the rioters, however, would be unlikely to set fire to the vans since the vegetables they contained would probably already be over-cooked.

The message

The final discussion drew together some of the themes of the day. While the 'demographic breathing space' could give us time to think and plan more rationally, it might also be a time in which worsening deficiencies of provision could pass unnoticed.

Training in the care of elderly people for the medical profession seems less adapted to current needs and less able to adapt to future needs of the public than that for the social work and nursing professions.

The lack of sophistication of the elderly public allows them to be 'fobbed off' with less than optimum care. In the United States conscious efforts are made to educate older people to be more perceptive and more demanding about the care they receive from health and social service professionals.

In the last analysis, the public will get the services it demands. Politicians need to be reminded that people aged over 65 constitute 20% of the electorate.

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General medicine and ophthalmology: common interests

A conference entitled 'General Medicine and Ophthalmology' was held at the Royal College of Physicians on 1 June, 1992.

Eye diseases are frequently a manifestation of systemic conditions; it is therefore in the patient's best interest for ophthalmologists and physicians to co-operate in their management. Without such co-operation there is the risk that patients fall between stools and neither condition is adequately treated. Medical specialties in which eye conditions are particularly prominent include dermatology, endocrinology, neurology, rheumatology, and cardiovascular diseases.

The advantages of joint clinics in medicine and ophthalmology were demonstrated by Professors Alex Crombie and Pat Kendall-Taylor for Graves' disease, by Mr Philip Murray and Dr David Young for uveitis, and by Professor Eva Kohner for diabetes. These included more expert assessments of patients leading to quicker and more complete diagnoses, earlier recognition of complications, and access to a wider range of investigations and treatments, opportunities for collaborative research, improved education for patients and doctors, increased patient convenience, and a stimulus for better control of factors which can worsen the disease.

Thyroid-associated eye disease

Professor A L Crombie (Newcastle upon Tyne) pointed out that visual loss in thyroid-associated eye disease (TAED) is often missed. Its causes include corneal ulceration, papilloedema, optic atrophy, macular oedema, choroidal folds, and most commonly acquired hypermetropia which only needs refraction correction. The 'differential intraocular pressure', which is defined as the difference in intraocular pressure with the eye in the axial position and looking as far up as possible, may be an important clinical indicator of the severity of thyroid eye disease. The physician's specific contribution is the treatment of the dysthyroid state

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