Why not better care for the elderly?

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THERE have been three outstanding biological changes during the middle of this century: the earlier maturation of the young, a decline in the birth rate and an increase in the proportion of older people in the population. The twenty-first century will be the century of ageing.

So different are the institutionalized elderly from the 94 per cent living in the community that there can be little doubt that geriatric medicine should be taught, for the most part, by general practitioners; and if, as seems likely, doctor/patient contacts with the very old double by 1993, the organization of general practice itself must change radically. Four avenues need urgent study.

Education. Despite great advances in geriatric medicine, geriatrics is not acknowledged as an important academic discipline. Higher qualifications in subjects such as paediatrics and maternity have conferred prestige upon them, and attracted doctors into fields with special opportunities. Why not, then, a Diploma in Geriatric Medicine?

Integration of primary care teams. The team developed from geriatric practice. If a general practitioner is not committed to geriatrics is he or she a good team leader? How common are common recording systems, joint visiting and joint planning? Why not have joint training to produce a more collegiate type of team?

Record-keeping. Being obliged to keep records does not influence their quality. Most records, even now, are unstructured and jammed into envelopes conceived during the Lloyd George premiership. Because old people are lucky if they can recall their past history, and are referred to or between institutions with the patchiest of proper data, an efficient record system is more than usually important in caring for the elderly.

Practice organization. There has been comparatively little thought given to improving the delivery of care to older people. The decline in home visiting, and the rather superficial five-minute encounter as the standard NHS consultation, are a disservice to the elderly with complex medical and social problems. As misfits in the established scheme, they can be unpopular. They are also poor reporters of illness and, forming the bulk of those treated on repeat prescribing lists, they can remain unseen for prolonged periods.

Finance

It is largely fiscal policy which determines what doctors do, and how they do it. The present pay structure, with reimbursement of ancillary staff, can emphasize preventive care; and fees for items of service are actively sought after. Yet the elderly attract no item of service payment or inducement. Instead, there is an across-the-board higher capitation fee, paid in the expectation of increased work-load. Some observers remain unconvinced that these fees are justified by actual performance. In my own practice I can demonstrate that those aged between 65 and 74 make no greater demand on my services than younger patients.

Why not item of service payments for the elderly?

In my view, there should be two new item of service payments. There should be an incentive to reconstruct the patient's record on reaching the age of 70. A structured and selective record of information about active and inactive problems, the patient's level of function and social and housing situations would be more useful than the present accumulation of irrelevant details, stretching back for seven decades.

The second payment should be for a full physical examination, including some routine testing, without which the patient profile would be incomplete. There is no suggestion of identifying diseases or screening, simply of bringing together the doctor and patient for the purpose of recognition.

The completed record would be a valuable document for patients sent to hospital in emergency. Why not let it become a co-operation card like that used in maternity care? Why not pay more for these services to doctors who have taken a Diploma in Geriatric Medicine? Could not the College and the British Geriatric Society collaborate once more as the examining body? Then the care of the elderly might have prestige; the skills of doctors would certainly develop. Why not?