United Kingdom have made much progress in the general direction which they map out. In some areas we are world leaders. But there can be no room for complacency when the Acheson report,[8] the Black report[9] and the Harding-Frost report[10] still await decisive action. Let us hope that the Bordeaux conference is not ignored here, like its predecessor at Alma-Ata, and that there follows an open discussion of national policies for health and for primary health care. General practice could only benefit from this reappraisal.

Financial stringency is a good reason to take stock of plans and priorities for future development; not to inhibit all progress. Did not food shortage in the second World War produce a food policy which resulted in better nutrition? For policies to be effective, they must involve not just the DHSS and the health professions, but the community at all levels—from the Cabinet to the patients in the waiting room.

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## References

1. World Health Organization (1978). Primary health care. Report of a conference. Alma-Ata USSR. 6–12 Sept 1978. WHO/UNESCO. Geneva. Health for all series No 1.
2. World Health Organization. *Health for all* series, Nos 2–8. Geneva: WHO, 1979–82.
3. Kaprio L. *Primary health care in Europe.* EURO reports and studies No 14. Copenhagen: WHO Regional Office for Europe, 1979.
4. Kaprio L. *The work of WHO in the European Region.* Report of the Regional Director. Copenhagen: WHO Regional Office for Europe, 1983.
5. Vuori H. Primary health care in industrialized countries. *J Coll Gen Pract* 1982; **32:** 729-735.
6. Horder J. Alma-Ata Declaration. *Br Med J* 1983; **286:** 191-194.
7. World Health Organization. *Primary health care—from theory to action.* Symposium. EURO reports and studies No 69. Copenhagen: WHO Regional Office for Europe, 1983.
8. London Health Planning Consortium. *Primary health care in Inner London.* Report of a study group (chairman, Professor E. D. Acheson). London: Department of Health and Social Security 1981.
9. Townsend P, Davidson N. *Inequalities in health.* The Black Report. Harmondsworth, Middlesex: Penguin books, 1982. (Originally published by the DHSS London in 1980.)
10. Joint Working Group. *The primary health care team.* (Harding-Frost report). London: DHSS, 1981.

# Care of the elderly

IN this issue of the *Journal* three papers—from Northern Ireland,[1] Wales[2] and Scotland[3]—look at different aspects of the health and care of elderly people in the community.

The study from Northern Ireland[1] reports the response to a questionnaire which was sent to all general practitioners, health visitors and district nurses in Northern Ireland. There was a response rate of 60 per cent. The answers revealed a high level of practice attachment among health visitors and district nurses and yet this has not resulted in effective teamwork in the care of the elderly. Although many of the practices had age-sex registers, only a minority of practices systematically reviewed their elderly patients. Several practices had attempted the task but activity had not been sustained. Satisfaction with the standard of care provided by the practice was claimed by half the general practitioners—a greater proportion than that of the health visitors and district nurses, and particularly surprising when almost all studies made over the two decades since Williamson and colleagues[4] have found a high incidence of unmet health needs in old people at home. In the main, the general practitioners were convinced of the benefits of having a district nurse attached to their practice, but a third of them were doubtful about the value of attachment of health visitors. There is much that needs to be done to prove to doctors that the health visitor has an important role in the promotion of health. All three professional groups saw the lack of resources as the major obstacle to proper care of the elderly. More institutional places and more practical help, for example, in the form of bathing attendants and home helps, were advocated. In addition to the inadequacy of resources, many of the respondents had doubts about their own effectiveness and efficiency.

The report from South Wales,[2] in line with other surveys and contrary to popular myth, indicates that families do support and care for their elderly relatives. Indeed, the vast majority of elderly and disabled people in the community are looked after by their families and the contribution of the statutory services, though important, is relatively small. Individual carers of the disabled—usually the spouse or a daughter—often shoulder their burden completely alone. They may become ill themselves and be isolated from the surrounding community. This paper draws attention to this neglected group of people and, like the Northern Ireland paper, recommends practical help for these carers.

Taylor and Ford, in their paper from Aberdeen,[3] do give some hope to general practitioners who may be feeling overwhelmed by the size of the problem of elderly patients. Their analyses of groups of elderly people who have been traditionally regarded as being at high risk have produced useful information: while recognizing that many old people at home do have health problems, these authors have identified as particularly at risk those people who have recently moved house, those recently discharged from hospital, the divorced or separated, and those aged 80 years and over. These groups should be identifiable in all practices, and will reduce the percentage of the practice population requiring assessment from approximately 15 per cent to 5 per

cent. It is an edifying thought that one of the ways of lessening risk in old age is to avoid marriage.

Traditional methods of providing care for old people in the community have been demonstrated to be inadequate. A team approach in primary care has not yet fulfilled its potential, and improvements in the future may lie in providing support for the supporters and concentrating on those who are most in need of attention.

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### References


1. Woods JO, Patten MP, Reilly PM. Primary care teams and the elderly in Northern Ireland. *J R Coll Gen Pract* 1983; **33**: 693-697.
2. Jones DA, Victor CR, Vetter NJ. Carers of the elderly in the community. *J R Coll Gen Pract* 1983; **33**: 707-710.
3. Taylor RC, Ford EG. The elderly at risk: a critical examination of commonly identified risk groups. *J R Coll Gen Pract* 1983; **33**: 699-705.
4. Williamson J, Stokoe IH, Gray S *et al.* Old people at home: their unreported need. *Lancet* 1964; **1**: 1117-1120.


## Thiazides diuretics and bone mineralization

The thiazide diuretics are known to cause calcium retention. In order to study the effect of thiazides on bone mineralization, the mineral content of bone at five sites (the distal radius, the distal ulna, the proximal radius, the proximal ulna, and the os calcis) was measured in 1,368 men with a mean age of 68 years, including 323 who were taking thiazides for hypertension. The results were adjusted for age and body mass index.

Thiazide users had significantly more bone mineral content at all five sites than did non-users. Untreated hypertensive patients and persons without hypertension and comparable bone mineral content, indicating that the higher mineral content found among thiazide users is related to the drug and not to the underlying hypertension. These findings suggest the possibility of a preventive or therapeutic role for thiazides in osteoporosis.

Source: Wasnich RD, Benfante RJ, Katsuhiko Y *et al.* Thiazide effect on the mineral content of bone. *N Engl J Med* 1983; **309**: 344-347.

## Deaths by cause

The total number of deaths registered in 1982 was 581,861 compared with 577,890 in 1981, an increase of 0.7 per cent. This increase was accounted for by a rise in the numbers of deaths registered in the first half of the year, there being decreases in the September and December quarters. As in the previous two years, there was no influenza epidemic and the annual death rate at 11.7 per 1,000 population compared with 11.6 for 1981.

The main causes of death by age group have remained nearly the same as in 1981, the exception being age 5–14 years, where deaths assigned to diseases of the nervous system and sense organs have displaced congenital anomalies as the third highest group. This reflects a decrease in the latter rather than any increase in the former.

Source: Office of Population Censuses & Surveys. *OPCS Monitor* 1983; DH2 83/4: 1.

## Coxsackie-B-virus specific IgM and diabetes mellitus

Coxsackie B1-6 virus IgM responses were detected by an enzyme-linked immunosorbent assay in 11 of 28 (39 per cent) children aged 3-14 years in whom insulin-dependent (juvenile onset; type I) diabetes mellitus (IDDM) developed in 1982. Five patients had a homotypic response to Coxsackie B4 and one had a homotypic response to B5. A serum sample had been obtained from each patient 2 to 16 weeks after onset of IDDM symptoms. Islet-cell cytoplasmic antibodies were detected in 15 of 18 sera tested, but only six of these sera were positive for Coxsackie-B-virus-specific IgM which suggests that Coxsackie-B-virus and islet-cell antibodies are not cross-reactive. Coxsackie-B-virus-specific IgM responses were present in only 16 of 290 (5.5 per cent) age-matched non-diabetic London children whose sera were also collected during 1982. Sera from children with virologically confirmed Coxsackie B-virus infections showed that development of homotypic or heterotypic Coxsackie B1-6 responses was age-related. Twenty-nine of 36 (81 per cent) children aged 6 months to 4 years had a homotypic response, whereas 44 of 57 (77 per cent) persons aged 15 years had heterotypic responses. Mothers of two children with Coxsackie-B-virus-induced neonatal myocarditis had Coxsackie-B-virus-specific IgM responses directed against serotypes 3 and 4, whereas their infants had a response to Coxsackie B2 virus alone.

Source: King M L *et al.* Coxsackie-B-virus-specific IgM responses in children with insulin-dependent (juvenile-onset; type 1) diabetes mellitus. *Lancet* 1983; **1**: 1397-1399.