EDITORIALS

Care in the community

'Most people who need long-term care can and should be looked after in the community, this is what most of them want for themselves and what those responsible for their care believe to be the best.'

Welsh Office, 1981

BY 1986 the numbers of elderly people in the 75–85 years age group will have increased by 80 per cent compared with 1980, and the increase in the over-85 years age group will be about 40 per cent. For various groups—the aged, the mentally ill, and the mentally and physically handicapped—'care in the community' has become the catch phrase. Many individuals in these groups who would previously have been in a hospital or institution have been discharged into the community. Since 96 per cent of elderly people already live at home, the remaining 4 per cent is likely to involve those with serious handicap. Doubts have been raised as to whether the reasoning has always been altruistic or whether this can be seen as yet another way of solving problems of accommodation and of taking responsibility and financial liability away from the National Health Service hospital budgets. Certainly there is evidence that, when all the costs, both obvious and hidden, are taken in consideration, care in the community is no longer a cheaper alternative.

Increasingly, patients are remaining in the community, both through failure to be admitted to institutions and through being discharged from them. It is timely therefore to enquire into the problems that arise and the solutions that are being adopted. The coastal areas so popular with retired people have already had considerable experience of the sorts of problems that are increasingly likely to appear in other parts of the country.

It is indeed unfortunate that this explosion in the elderly population is taking place in a period of restricted resources and financial restraint. At such a time, there is a need to review the automatic provision of benefits to all those over retirement age and to consider, perhaps, concentrating resources on the older and more needy. Certainly, it is those aged over 75 years and more particularly those over 85 years who pose the major medical and sociological problems.

What, then, are the solutions? Care has to be centred around the family doctor and the primary care team. The latter needs to be strengthened in the areas where a strong pattern has not developed, with attachments to practices rather than by geographical areas, making feedback easier. In courses for district nurses there should be more emphasis on the principles of geriatric nursing, with input by general practitioners and nurses working in the field. Since the Court Report,[1] health visitors have seen their role much more in the care of the young than the elderly. There is a need for a new type of health visitor, with two main roles: a 'search and find' role to identify (aided by the practice age–sex register) individuals who may be at risk and a role of continuing support for those identified as being in need but not requiring the services of the district nurse. It has been shown that, to be effective, there has to be a close link with the general practitioner service. Alert and experienced receptionists can often recognize developing problems, either from a telephone call or when the patient attends the surgery.

Social services departments have a major complementary role to play in the support of individual clients and in the provision of services, such as home helps, meals-on-wheels, day care, night sitters, which make it possible for the elderly to live independently or in the care of the family. Properly briefed home helps are invaluable for alerting members of the primary care team to developing problems. A major requirement of these support services is that they can be made available immediately, and for seven days a week if necessary. Arrangements for dealing with emergencies must be widely known.

Dementia in the elderly often poses the most difficult problem. It has been calculated that 10 per cent of those aged over 70 years show some degree of dementia, half of these patients being severely demented. Mobile patients with dementia can be exhausting and disruptive both to their family and, if admitted, to hospital staff. The Hospital Advisory Service highlighted the growing concern about 'the rising tide' of mental disorders in the elderly; one leading article said that 'the tide threatens to overwhelm the health and social services (where it has not already done so)'.[2] As part of their plan to reduce overcrowding and improve conditions, psychiatric hospitals are increasingly reluctant to admit patients with senile dementia. Appointments of psychogeriatricians have been helpful, but there is often a shortage of resources. The use of psychiatric nurses for the confused elderly can provide support for families, by advice, organization of day care and short-term custodial care. It is essential, however, for these services to become

closely allied to the primary health care team and not be seen as outreaches of the hospital empire.

Although the great majority of the elderly live on their own or with their family, a proportion needs some form of sheltered accommodation. Local councils are building more sheltered accommodation units with warden control; private housing associations are building similar complexes, while voluntary societies such as the Abbeyfield provide accommodation with a degree of communal living. Old people's homes run by the local Health Authority (Part III accommodation) have long provided a haven for the elderly, and continue to do so. In the present financial climate it is unlikely that sufficient new homes will be developed in time to cope with the projected explosion in the elderly population, and nor it is likely that more long-stay geriatric hospital beds will be available. The geriatric service, which was originally developed to care for the neglected long-stay patient, now sees itself as an acute rehabilitation service with the immediate aim of discharging patients back into the community. However, a domestic situation which was acceptable before admission may no longer be acceptable after discharge. As one solution to this problem, hospital doctors, geriatricians, general practitioners and social workers are arranging admission to private nursing homes and rest homes. In some areas there may be hundreds of beds available within a small district. Practices may have patients in a number of nursing homes; each home may have a large number of visiting doctors. The development of management policies is difficult: since the hospitals are discharging patients to these nursing homes and the Department of Health and Social Security is willing to pay the full fees incurred, it is appropriate that attention should be focussed on this sector.

Care of the elderly in the community is likely to be one of the major challenges for primary care in the future; in many areas it is becoming a fact without adequate consultation or transfer of resources. Even the Oxford Region, which recently published its 10-year plan for community care, appears to have been guilty of failure to consult local practitioners. Close cooperation between the College (covering the educational aspect) and the general Medical Services Committee (overseeing the organizational side) is urgently needed for these solutions.

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Night calls—an emotional issue

PROGRESS in the debate about deputizing services and the organization of out-of-hours care generally will only be made if we give due consideration to the emotional aspects of night calls. The quantitative analysis of night calls is relatively easy, and is invaluable when comparing different practices and places. It is the qualitative aspects of night calls which attract the most interest and criticism. Lockstone's criteria of urgency,[1] which are biased towards biophysical medicine, reflect the perceptions of most doctors. Nevertheless, the anxiety of the mother about her child who is coughing may be real although inappropriate. Asking the doctor to call during the night is an exceptional event for the individual patient and not undertaken lightly. It is not true that night calls are generally a manifestation of emotional disturbance[2] but they do provide an opportunity for psychotherapeutic intervention.

Home confinements are now rare. Similarly, most deaths now take place in hospitals. The night call remains as one of the few opportunities for a general practitioner to intervene at a time of crisis in a patient's life. It is accepted that follow-up by a doctor the next day is seldom necessary; nevertheless, some night calls and particularly those with an overt psychological factor mark a significant change in the relationship between doctor and patient. Previous psychological and social barriers become irrelevant in the immediacy of a consultation at 02.00 hours.

It is generally agreed that the doctor on night duty should be a qualified general practitioner. What is implied in the recent discussions about deputizing services is that the public would prefer the duty doctor to be their own general practitioner or a colleague of his. One rational argument in support of this policy has been that it is only the patient's own general practitioner who will have access to medical records, and yet it is not known whether doctors with access to medical records do actually make use of them. The real point is surely that at a time of crisis the patient wants to see a familiar face. This desire for familiarity is not only understandable but it also has therapeutic effects. The possibility exists for both the patient and the doctor to benefit from a satisfactory night call, which can only happen if the duty doctor is in the same practice as the patient's own doctor.

It is necessary to look also at how general practitioners themselves respond to night calls. For experienced general practitioners the dominant emotions may