Speculation on the future care of the elderly

ALTHOUGH we are always anxious to answer the questions we pose, there is virtue in the continued contemplation of complex issues if this encourages new ways of looking at problems. In considering the future care of the elderly there is no place for dogma, but a need for sensitivity and imagination. For example, it is probable that fewer old people wish to remain in their own homes than is generally supposed. The environment is becoming unsuitable for elderly people. Hypermarket shopping, the deterioration in public transport, and the increase of street crime produce feelings of insecurity in the elderly who live in blocks of flats or parts of otherwise unoccupied houses in large cities.

The static and compartmentalized organization of housing in Britain makes change difficult, whether one is an owner occupier, council tenant, or institutional inmate. Retirement communities in coastal resorts may be acceptable but the enforced concentration of elderly people in inner city areas is not. There are few incentives among the socially disadvantaged to maintain activity and independence. Pensions are inadequate and there is less than optimal deployment of social resources.

A campaign is needed to reverse the unfavourable stereotypes of ageing and resources must be shifted from institutions to ambulatory and domiciliary services. In addition, the role of the trades unions should be extended, and industry should be encouraged to regard the welfare of former employees as worthwhile, as happens in the Soviet Union. The work role of older people should be reviewed, and abrupt and arbitrary retirement reconsidered.

While there may be some decline in the numbers of those with cerebrovascular disease, there is likely to be an increase in the absolute numbers of elderly patients with dementia and osteoarthritis. Present trends in society seem certain to reduce the number of extended families, while the desire to complete childbearing at an early age, combined with longevity, will increase the number of three and four generation families. The trend towards easy divorce, remarriage, and serial cohabitation weakens family obligations to provide mutual support. Increased longevity into the ninth and tenth decades means that the next generation may be unable to assume responsibility for an older relative, and therefore the social services will become absorbed in the care of those lacking any family support, rather than in the support of families needing to be strengthened by professional help. Preparation for old age will need to start early in life. It is often not appreciated that long life has become the norm and not the achievement of a biological elite.

It is laudable that studies in geriatric medicine have advanced from observations made on artificial communities of the very old and very ill in hospital. As more becomes known about the borderline area between health and sickness the general practitioner is provided with details of the characteristics present to a greater or lesser extent in all other persons. For example, there is a long held belief that the elderly are underconsulters; yet in the contract of the general practitioner the workload of people over 65 years of age is considered onerous enough to warrant increased capitation fees. In this issue Ford and Taylor report on this aspect, based on their study in Aberdeenshire, and recommend that the focus of care should be on reported illness rather than on anticipatory assessment of basic needs, and that illness should be viewed from the perception of the patient rather than that of the doctor. This is an old-fashioned viewpoint, no longer tenable for diseases for which there is a continuum between apparent normality and gross disturbance, and for which differences of degree relate to variation in the rate of disease progression. Reliance on reported disability encourages cases to come to light only after social breakdown. Crisis intervention is then necessary, a situation which has made geriatric practice unpopular. However, Ford and Taylor do cause us to reconsider the approach of primary health care to the needs of elderly patients.

The judgement of clinical significance of a continuously variable process such as ageing needs to be much wider than that required to interpret information from discrete characteristics such as physical signs. Doctors should be encouraged to acquire the necessary skills and experience in general practice surroundings rather than in hospital. Only in general practice, for example, is it possible to conduct longitudinal studies into the relationship between sensory deprivation — whether from social isolation or from a lack of central registration of sensory input from the senses — and the onset of mental failure. Better intellectual tools are needed in order to think in terms of overlapping pathologies, for example, obesity, hypertension, hyperglycaemia, and ischaemic heart disease, rather than the mutually exclusive diseases categories which are the basis of specialist teaching. Overlap and multiple pathology are now the most common and important features of biopathology. It is on the basis of these considerations that general practice must formulate policies within the new population structure which is almost achieved in industrialized nations.

M. KEITH THOMPSON
General Practitioner, Croydon

Cervical screening

IS there anything left to write about cervical cytology? After the recent plethora of articles on the subject, both in the professional[1-5] and lay press, one might be forgiven for thinking the topic has been completely covered. Although over three million smears are taken each year, the number of deaths from cervical cancer in the UK still exceeds 2000 per year and the death rate in young women appears to be rising. An effective screening programme remains an ideal rather than a reality, and therefore present policies and resources need to be questioned.

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Over the years the Department of Health and Social Security Committee on Gynaecological Cytology has issued a series of guidelines on cervical screening. These have been notable for their complexity and have not provided a succinct, easy to implement programme. Not only are the instructions complex but the underlying concepts are inconsistant and lag behind recent research findings.

The most recent guidelines[6] aim to clarify the instructions, make better use of available resources and reduce the too frequent screening of younger women. However, they also suggest that all sexually active women should have regular five-