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.

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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.

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-

yearly cervical smear tests and that a smear should be taken when a women first presents for contraception and early in every pregnancy. If implemented, these suggestions would increase the number of smears taken in younger women. With our present knowledge of the aetiology of cervical cancer it would seem more sensible to recommend that the first smear be taken within the first two years of women becoming sexually active and then at regular intervals. The suggested intervals at present are based on cost rather than effectiveness.[1] All screening is a balance between cost and effectiveness and the priority must be to ensure that women have their first smear test. However it is strange that a screening interval of five years continues to be advocated, when more and more professionals advise three years.

Are the right women being tested? Most deaths due to cervical cancer occur in older women but in younger women there is a small but worrying increase in deaths and a larger increase in the rate of positive smear tests and carcinoma *in situ*. In younger women cervical screening may be holding in check a much larger increase in the incidence of invasive cancer;[7] an increase probably associated with changing patterns of sexual activity, and with earlier and long-term use of the oral contraceptive pill. As older women who have never had a smear test are most at risk it is sensible to increase the uptake rate in this age group, but at the same time younger sexually active women should continue to be tested.

Are enough smears being taken? The answer must be no, even though three million smear tests per annum are performed. Primary care has failed to respond to the challenge of cervical screening, perhaps through lack of conviction, lack of assistance with organization, and possibly through lack of money — item of service fees are not the sole stimulus to activity by general practitioners. This is shown by the fact that most smears are taken from young women and attract no fee and by the fact that some practices[2] have more than fulfilled the aspirations of the proposals while others have shown no interest.

The Department of Health and Social Security could do more. The recall system (albeit inadequate) which was available, instead of being improved, has been disbanded. Family Practitioner Committees have now been given the responsibility of organizing the recall system, but a recent survey showed that few have responded.[8]

Computerization of the registers of Family Practitioner Committees would enable general practitioners to receive data regularly and a proper call and recall system could be instigated.[5] However the government would need to make money available for this. Self audit of cervical screening by general practitioners could thus become an expected and regular activity. The people least to blame for the present situation are the clients. Some women have formed pressure groups to try and improve the service. Blaming women who fail to respond to an invitation to have a smear test is inappropriate. Better attempts need to be made to explain the reasons why they should avail themselves of the offer, to allay their fears and to organize the services in such a way that they can be easily used.

What of funding? In spite of the assurances of the government to the contrary, laboratory facilities are being stretched beyond capacity and cannot cope with any increase in demand. Oxfordshire, together with several other health authorities, has recently put a temporary embargo on all new routine smear tests except in special cases. This is to allow the laboratory to catch up with the backlog. Figures show that even if unnecessary smear tests were stopped — for example, yearly smear tests of asymptomatic young women — laboratory services still could not cope without further resources. If there is to be a serious attempt to adequately screen all women at risk more resources will be needed even if the number of unnecessary smear tests is reduced.

Are the systems for follow-up of women with positive smear test results adequate? From the recent tragic events in Oxford, obviously not. However even prior to this the Nottingham study[9] found satisfactory follow-up for only 59 per cent of women who had been found to have positive smear test results. No system can be completely fail-safe, but there are ways in which communications could be improved. Routinely informing women of the result of their smear test with advice as to when the next test is due, would be an improvement on the common policy of saying to patients 'no news is good news'.

Cervical screening suffers from the problems common to any screening programme. Each problem needs to be clearly defined and steps taken towards solving it. The problem cannot be solved by anyone else; if the guidelines of the Department of Health and Social Security are improved, they will have to be implemented by the primary care team.[10] Even the old and probably inadequate guidelines are insufficiently acted upon. People must continue to talk and write about cervical screening until an effective national programme is implemented. The programme will only be implemented if it is clear, credible and simple.

A start can be made in general practice. The responsibility for organizing the system within each practice should rest with one person, who need not be a qualified doctor. Nurses, receptionists and other members of the practice team, can collaborate in the identification of those women who need a smear test and in the taking of smears. The cervical smear status of all new patients should be ascertained. It may be necessary to organize cervical smear clinics to clear the backlog of women needing smear tests. Labelling records can act as a reminder to perform a smear test on non-attenders when they next attend the practice. Women themselves can be issued with a card detailing their last smear test result and when their next smear test if due. It should no longer be necessary to convince colleagues of the necessity and efficacy of cervical screening. An absolute committment by all those involved, the Government, the Department of Health and Social Security, Family Practitioner Committees and doctors, is essential. This must include adequate funding for appropriate resources and facilities.

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References

1. Chamberlain J. Failures of the cervical cytology screening programme. *Br Med J* 1984; **289:** 853-854.
2. Standing P, Mercer S. Quinquennial cervical smears: every woman's right and every general practitioner's responsibility. *Br Med J* 1984; **289:** 883-886.
3. Paterson MEL, Peel KR, Joslin CAF. Cervical smear histories of 500 women with invasive cervical cancer in Yorkshire. *Br Med J* 1984; **289:** 896.
4. Ellman R, Chamberlain J. Improving the effectiveness of cervical cancer screening. *J R Coll Gen Pract* 1984; **34:** 537-542.
5. ICRF Coordinating Committee on Cervical Screening. Organization of a programme for cervical cancer screening. *Br Med J* 1984; **289:** 894-895.
6. Department of Health and Social Security Health Services Development. *Screening for cervical cancer.* London: DHSS, 1984, FPN 368 HC (FP) (84) 3.
7. Cook GA, Draper GJ. Trends in cervical cancer and carcinoma in situ in Great Britain. *Br J Cancer* 1984; **50:** 367-375.
8. Commentary from Westminster. Screening for cancer of the cervix. *Lancet* 1984; **2:** 1483.
9. Elwood JM, Cotton RE, Johnson J, *et al.* Are patients with abnormal cervical smears adequately managed? *Br Med J* 1984; **289:** 891-894.
10. Magregor E. *Br Med J* 1984; **289:** 1453.