Screening elderly people: a review of the literature in the light of the new general practitioner contract

ELIZABETH R PERKINS

SUMMARY. There is a considerable volume of literature on the needs of elderly people, derived from both the medical and social sciences. This article reviews material relevant to preventive care and the best ways of arranging it, with particular reference to the developments as a result of the new general practitioner contract. It is argued that although the new contract disregards much of the medical research, there are still some benefits to be gained by applying research findings within the new framework, as well as by reviewing its operation in the light of research and experience currently available.

The extent and nature of need among elderly people

OVER recent years there has been increasing concern about our ageing population, and about appropriate responses from the caring professions to the needs of elderly people. The early studies in Scotland, responding to geriatricians' concerns for better relationships with the community services, revealed that statutory services were only seeing the tip of the iceberg and that a wide range of illness and disability was present, unknown to general practitioners.[1-3] The echoes of these early studies still resonate, with many professionals worried that somewhere in the community are untold numbers of elderly people in distress whose needs are going unreported. The prospect of trying to find resources to deal with these people is not appealing, and can hinder preventive programmes in their infancy. The new general practitioner contract[4] has obliged general practitioners to offer all their patients over 75 years of age a health check and a home visit, without apparently making any extra financial provision for dealing with problems so identified.

Ironically, later research in general practice has been studying the shape of the iceberg, and finding it to be less extensive than was feared originally. First, it seems that most elderly people who do not visit their general practitioners refrain from doing so because they are healthy enough not to feel they need their services. This finding has resulted from several studies of non-consulters,[5-9] and has emerged also from accounts received from those practices which set up their own home visiting programmes before the new contract.[10] Patients suffering from a combination of unrecognized senile dementia, malnutrition, advanced disability and poor housing conditions are rare. The stereotype has lingered partly because cases still occasionally arise and gain wide publicity with concomitant blame on professionals, and partly because the caring professions, dealing with sick, disabled and distressed patients, may lose a sense of perspective regarding the vast numbers of healthy elderly people in the community who do not need their services.

There is also a failure to appreciate the historical setting of the early Scottish research. This had surveyed people who had grown up in a country where medical care cost money, and where poverty dictated that one called the doctor only in dire need. The advent of the National Health Service for those aged in their seventies in the late 1950s and early 1960s would have had limited impact on the stoical habits of a lifetime. The assumption that individuals reaching 75 years old in the 1980s or 1990s would have similar attitudes to earlier generations is unsupported: these are people with much experience of the NHS, and there is no reason to suppose that their ability to decide sensibly when they need help will change at the age of 75 years. It is interesting that the only study found of under-reported illness which also covers other age groups suggests that middle aged women rather than elderly people are the group at greatest risk of self-neglect; elderly people are similar to other groups in the proportion of complaints they take to the doctor.[11]

This does not mean, however, that there is not a role for medical and social services to undertake health checks and home visits for elderly people, since some needs are going unmet. There are specific kinds of complaints which elderly people tend not to report to their doctor when consulting for other reasons; Ebrahim and colleagues have shown that problems were greater among those already receiving care from a doctor or district nurse than in those who were not receiving professional attention.[6] These problems seem to be those concerned with continence, eyesight, hearing, teeth, feet and mobility, dementia and depression.[12-14] Most of these are not readily seen as diseases; all may be perceived incorrectly as an inevitable and unavoidable consequence of old age. If elderly patients believe that nothing can be done about their complaints, it is entirely rational for them to decide not to bother the doctor but instead learn to live with the problems and restrict their lives accordingly. This can be tragically unnecessary.

It is from this understanding that the consensus in the literature has emerged in favour of the functional assessment of elderly people,[15] rather than a more medically oriented attempt to identify specific diseases in their early stages. The emphasis is on problems in everyday living such as mobility, sight and hearing. Such an assessment can also be extended to cover problems which are of social rather than medical origins, where help may be needed to maintain elderly people in their own home if this is what they want. As with some of the medical problems, elderly people may believe that no help is available, and thus do not ask for fear of refusal. Sometimes, unfortunately, they may be right. Professionals are working with limited resources, and there may be a shortage of community care assistants, chiropodists, occupational therapists to assess for aids and adaptations, and local authority funding to make adaptations when assessments have finally been made. Professionals can be tempted to ration referrals: it may not be surprising therefore if elderly people do the same with their own problems.

Variation and variability in elderly people

A number of studies stress the variations within the elderly population, between social classes, between men and women, and between age groups. Most recent work differentiates between the 'young old' and the 'old old', and follows Williams and colleagues in setting the dividing line at 75 years old.[16] A full exploration of the fact that most elderly people are women, particularly in the over 75 years age groups, has yet to be developed, though some moves are being made in that direction.[17-19] More recently, research on the ethnic dimension shows

E R Perkins, MA, PhD, elderly monitoring project coordinator, Community Unit, Nottingham Health Authority.
Submitted: 7 January 1991; accepted: 20 February 1991.

the same pattern of variation in ethnic groups that may be in danger of being stereotyped.[20,21] Social class is also relevant. Taylor and Ford,[22] using the concept of resources available to meet stresses, found that the distribution of the resources they identified, such as financial resources, social support, health and physical functioning, and psychological functioning, were distributed differently among different age, sex and class groups. Their work is an important corrective to untested assumptions, both about the homogeneity of the age group and of the definition of vulnerable groups. They suggest, for example, that older middle class women may constitute 'an important and barely recognized low resource and potential risk group', lacking social support as they enter old age and losing their health advantage when over 70 years of age.

Taylor and Ford's work illustrates the complexity of the issues involved, and the danger in defining at risk groups for one purpose and extending the thinking elsewhere. There is normally considerable concern about risks to old people living alone, yet Taylor and Ford raise doubts about the concept of at risk groups, pointing out that there are more cases to be found outside these groups than within them.[23] A study of carers funded by the Department of Health and Social Security,[24] showed a concentration of services for those apparently at risk, such as those living alone, while neglecting the needs of elderly people who were living with relatives who often had far more serious problems. This study recommended that home helps, for example, should be concentrated on those living with relatives, not those living alone.

Laslett,[25] starting from an academic base in historical demography, argues against the use of age markers to define groups, seeing them as simple but misleading. He values Neugarten's[26] distinction between the 'young old' and the 'old old', but has developed these into concepts of the third age as a time of personal achievement and fulfilment, and the fourth age as a time of final dependence, decrepitude and death. The first and second ages are, respectively, that of dependence, immaturity, socialization and education, and that of independence and responsibility, earning and saving. Laslett sees the transition from one age to another as ill-defined, with early retirement a growing trend, and the difficulty of predicting with any certainty the course of an individual's health, despite the increasing general expectation of life. Age markers, in his view, can encourage people to limit their own horizons unnecessarily and professionals can reinforce or even trigger this process.

Laslett's views complement Finch's findings in a qualitative study of elderly people aged 70 years or over, which looked at their perceptions of health.[27] Her respondents saw the only real difference in normal health as they got older as a 'gradual physical slowing down and a dulling of other senses'. When illness occurred and activities were seriously curtailed, people were likely to feel old. If they recovered from the illness physically and mentally, they reverted to the previous state, possibly with a few activities modified or given up; the alternative was that they decided that they were truly old, a concept which seems to have more in common with Laslett's fourth age than with his third, and which is, as he suggested, not directly related to chronological age.

The idea that one may move in and out of old age has also been suggested by Williams.[28] He proposed a diagrammatic representation of the ageing process in a set of three concentric rings. The outer ring represents sociability, the middle ring consists of domestic tasks, and the inner ring of personal care. Older people's social decline can be represented as a movement from the outer to the inner ring, which can itself become impossible to maintain unaided. Individuals can move inwards with startling speed under the impact of a crisis, such as illness or the loss of a partner; they can, however, also move out again, though they may need encouragement to do so.

All these different studies confirm the immense variety of life in older age and the invalidity of simple assumptions about elderly people, even elderly people over a certain age. Many also underline, in different ways, the vulnerability of elderly people's self-concepts as competent citizens with something to contribute and the ability to manage their own lives. To the obvious risks of illness and bereavement must also be added the pressure from other people to settle down peacefully in the modern equivalent of the chimney corner and let others make decisions for them. Younger relatives are one source of this kind of pressure. Harrison[18] quotes a woman aged 75 years catching the last train home after an evening with friends 'All the way home I thought my kids would kill me if they knew I was out at this time'. Professionals are another; there is an instructive anecdote about an elderly man being asked as part of health check whether he needed meals on wheels. 'Need them? I deliver them'. If routine health checks and home visits are not handled well, they could become another source of unhelpful labels. Those who undertake these visits would do well to try and leave their stereotypes at the door, and approach each new person as an individual.

This may be difficult when time is short. Dant and colleagues describe an approach to interviewing elderly people at risk based on getting to know about their past life before trying to solve their present problems.[29] While this was acknowledged to be time consuming, care coordinators in the Gloucester project found it particularly rewarding when dealing with patients whose needs were hard to meet, including 'difficult' patients apt to refuse help after agreeing to it, those with family problems, and those with senile dementia. As the coordinators got to know patients as individuals, they found it easy to see what kind of solutions had a good chance of working and what would be likely to prove too difficult for the elderly to work with or to accept. While this approach in full is both too intrusive and too time consuming for it to be appropriate to the health checks demanded by the new contract, the spirit behind it is not. If, as Freer suggests,[30] 'it may be that what doctors do is less important than how they do it' a study of this approach could be of considerable value to those who have the task of following up problems identified in the course of routine checks.

Studies of the organization of screening programmes

Most of the practice-based literature written before the new general practitioner contract has endeavoured either to survey the likely extent and nature of need among elderly patients, or to devise strategies to detect it by professional assessment in particular practices. There has been little work aimed at reducing the extent of unmet need by information campaigns in the media which set out to inform the public about certain conditions which can be cured or alleviated, and what services are available to help. Welfare rights campaigns, for example, suggest that if attempts are made to inform people about allowances and benefits, there may be an increase in claims.

The studies on organization, however, have been thorough; Professor Barber's work in Glasgow has estimated staffing costs for providing a programme to screen patients aged over 75 years old.[31] Barber and Wallis suggest that to cover a practice population of 4000 patients, 18 hours per week of health visitor time would be required during the first year of the screening programme and 11 hours per week for subsequent years. This cost is clearly considerable. Barley, writing in the *British Medical Journal*,[32] estimated that the resources involved in staffing this kind of screening programme throughout the country would involve between 3000 and 6000 extra health visitors or their equivalent, requiring a diversion of trained staff from existing

work or a considerable expansion in training programmes to fill the gap. This would be a difficult proposition at present when demographic changes mean we face a decrease in the number of teenagers, the usual recruiting base for nurses.[33] It is worth noting that Barber's recommended programme, with costings, was a selective scheme. He sent out a pre-screening letter with nine simple questions concerned with difficulties in everyday living and the presence of unreported problems, and patients were visited only if they showed evidence of difficulties or problems, or if they failed to return the questionnaire. This resulted in 80% of the practice's patients over 75 years of age requiring a visit.[34] Further work on this questionnaire by other researchers suggests that if the aim is to identify medical rather than social problems, the number of questions can be reduced to four, and the visiting rate reduced to 37% of the practice population over 75 years old.[35]

An alternative approach to controlling the workload has been pioneered by Freer,[36] and is based on earlier research which showed that most elderly patients (between 66% and 93%) saw their doctor at least once a year[6] and that those who did not consult, rarely had problems. Freer established that a version of Barber's pre-screening questionnaire could be used by general practitioners as part of their consultation with patients in normal surgery hours, thus identifying problems which patients had not raised themselves, and making it possible for them to be followed up in the future.

Both these approaches build on past research findings, and allow for patient initiative in identifying their own needs. The terms of the new contract, while they have the merit of simplicity, cut across this thread of research and apparently ignore it, by stating that all patients over 75 years of age should be offered a health check and a home visit. Unless and until a review of the results of the provisions of the new contract is undertaken (and there has been no government provision for such a review) this line of research has come to an end. Despite its emphasis on practicability, the research cannot currently be used to inform practice.

Patient self-assessment

The foregoing analysis suggests that there is little room for manoeuvre to apply most existing research on anticipatory care in general practice in the current climate. With the exception of the emphasis on functional assessment in the new contract, earlier medical research seems to have been ignored, including the difficulties of evaluating programmes of this type.[37] There is still scope for exploring the practical implications of orienting health checks for the over 75 year olds towards problems of everyday living instead of disease detection. Anecdotal evidence suggests that there is an emphasis on clinical testing within the frequently very limited time a nurse spends with the patient. There is a sense that the new world in the NHS has little connection with the research and development undertaken in the old. Fortunately, this is not so with regard to work undertaken outside the specific context of general practice.

There is, for example, a body of research on the validity of patients' own assessment of their health which is relevant both to any debate about the value of systematic screening programmes for elderly people and to issues about how those which are recommended under the new contract should be conducted. Early cross-cultural research in the 1960s[38] showed results congruent with the early medical screening studies in Scotland in the 1950s and 1960s. British elderly people were more stoical, having more problems at any given level of self-rated health than either Danish or American elderly people. More recent studies, however, suggest that this British stoicism is changing. Taylor and Ford found that their respondents' self-ratings of health reflected their reporting of problems.[22] The older elderly, women and people in social classes 3m, 4 and 5 were more likely to report problems to their doctors and report their health in self-ratings as poor or fair than the younger elderly, men and people in social classes 1, 2 and 3N. The Nottingham health profile studies[39] showed that 'perceived health status accorded well with objective health status' in four groups of elderly people pre-defined by their health status: men involved in a physical exercise group, those with no diagnosed illness who had not consulted their general practitioner for the last two months, attenders at a social services lunch club with a range of physical, social and emotional disabilities, and a group with diagnosed chronic illness which would be likely to produce symptoms and impair well-being.

If elderly people can, on the whole, be relied upon to assess their health correctly, the task of providing preventive care may be much simplified. It need not focus on identifying illness or disability disregarded by or unknown to the patient; it can instead concentrate on making it easy for elderly people to raise health problems with a professional. Professionals will need to show that the practice is interested in those problems of everyday living which older patients have been found to be less likely to mention to a doctor on their own account. They will also need to establish the right climate for conversation since people do not bring up problems they are uncertain about with professionals who appear rushed or uncaring.[40] Professionals may also need to convince patients that something can be done about their difficulties, if indeed this is the case, since solutions to some problems are hard to find because of a shortage of resources.

If health checks for over 75 year olds are approached in this spirit, the practice nurses who seem to be doing most of them will need the skills to encourage elderly people to state their own needs, and to listen while this takes place, rather than act as a facility for preliminary diagnosis. The resultant list of problems may or may not be shorter, but it will have the merit of including those problems perceived by the elderly as important, rather than 'problems' identified by professional health workers which actually cause them comparatively little bother.

Beyond the new contract

The new contract has meant that many practices are struggling to implement the many changes with little time to prepare for them. This may mean a diversion of time and resources from one activity to another, a potentially serious effect. It may also be that not all the effects of the new contract will be beneficial to patients; it is worth bearing in mind the possibility that harm could be done in the course of health checks. One obvious potential side effect of any screening programme, however loosely defined, is the arousal of anxiety where little or none existed before.[41] Another is well expressed in a review by the Bristol University network for developmental initiatives in the community, which openly rejects screening programmes saying that 'such a narrowing of perspective [to focus on problems] does little to help older people reach a level of optimum coping within the limitations of their life histories and environment'.[42] They suggest instead an imaginative scheme for 'grey cooperatives' where younger and fitter retired people seek out elderly people at risk, accepting referrals from health and social services staff as well as those identified by the lay network, and work with clients to solve problems chosen by the clients themselves. This work would be on the basis of a contract with the client, and would not be allowed to become social visiting. When the problems were solved, or the client lost interest, the worker would stop visiting.

As with the Gloucester project, these recommendations may seem distant from the reality of health checks under the new

contract. However, it is possible to consider the principles behind the recommendations and to explore ways of incorporating them into current work. Practices' response to the contract provisions in the short term must inevitably be to get something started, however imperfectly. In the medium and long term, however, there are options to review their working, both locally and nationally, in the light of a wide range of previous research as well as considering the results from their own experience. Maximizing the benefits to the patients using the existing provisions, and reducing the risks to a minimum, involves general practitioners and practice nurses thinking broadly about ideals as well as practicalities. The research has highlighted that elderly people cannot be regarded as an homogenous group; they are individuals with differing perceived problems which may change over time. Professionals must acknowledge each elderly person's needs. A re-examination of the new arrangements on a national scale should certainly frame its questions in the light of the reviewed literature.

References

1. Anderson WF, Cowan NR. A consultative health centre for older people: the Rutherglen experiment. *Lancet* 1955; **2:** 239-240.
2. Williamson J, Stokoe IH, Gray S, *et al.* Old people at home: their unreported needs. *Lancet* 1964; **1:** 1117-1120.
3. Anderson F. The evolution of services in the United Kingdom. In: Kinnaird J, Brotherston J, Williamson J (eds). *The provision of care for the elderly.* Edinburgh: Churchill Livingstone, 1981.
4. Department of Health and the Welsh Office. *General practice in the National Health Service. A new contract.* London: HMSO, 1989.
5. Williams EI. Characteristics of patients aged over 75 not seen during one year in general practice. *BMJ* 1984; **288:** 119-121.
6. Ebrahim S, Hedley R, Sheldon M. Low levels of ill health among elderly non-consulters in general practice. *BMJ* 1984; **289:** 1273-1275.
7. Goldman L. Characteristics of patients aged over 75 not seen during one year in general practice. *BMJ* 1984; **288:** 645.
8. Williams ES, Barley NH. Old people not known to the general practitioner: low risk group. *BMJ* 1985; **291:** 251-255.
9. Dr. Stringfellow's team. Prevention for patients over 75: is it worth the bother? *BMJ* 1986; **292:** 1243-1244.
10. Perkins ER. *The fruits of local experience: preventive care of the elderly in general practice.* Nottingham: Nottingham Health Promotion Unit 1990.
11. Ford G, Taylor R. The elderly as underconsulters: a critical reappraisal. *J R Coll Gen Pract* 1985; **35:** 288-290.
12. Williamson J. Prevention screening and casefinding: an overview. In: Taylor RC, Buckley E (eds). *Preventive care of the elderly. Occasional paper 35.* London: Royal College of General Practitioners, 1987.
13. Jones RVH. The use of an occupational therapist in a screening programme. In: Taylor RC, Buckley E (eds). *Preventive care of the elderly. Occasional paper 35.* London: Royal College of General Practitioners, 1987.
14. Killingback P and Sanderson C. Use of a postal questionnaire in screening for common problems. In: Taylor RC, Buckley E (eds). *Preventive care of the elderly. Occasional paper 35.* London: Royal College of General Practitioners, 1987.
15. Taylor RC, Buckley E (eds). *Preventive care of the elderly. Occasional paper 35.* London: Royal College of General Practitioners, 1987.
16. Williams EI, Bennett FM, Nixon JV, *et al.* Sociomedical study of patients over 75 in general practice. *BMJ* 1972; **2:** 445-448.
17. McDonald B, Rich C. *Look me in the eye: old women, ageing and ageism.* London: Women's Press, 1983.
18. Harrison J. Women and ageing: experience and implications. *Ageing Society* 1983; **3:** 209-235.
19. Crawley C. Feminism and the older woman — an area of neglect. *Action Baseline* 1988; **39:** 7-12.
20. Barker J. *Black and Asian old people in Britain.* Mitcham: Age Concern, 1984.
21. Glendenning F, Pearson M. *The Black and ethnic minority elders in Britain: health needs and access to services. Working paper on the health of older people No. 6.* Keele: University of Keele, 1988.
22. Taylor R, Ford G. Inequalities in old age: an examination of age, sex and class differences in a sample of community elderly. *Ageing Society* 1983; **3:** 183-208.
23. Taylor R, Ford G. Functional geriatric screening: a critical review of current developments. In: Taylor RC, Buckley E (eds). *Preventive care of the elderly. Occasional paper 35.* London: Royal College of General Practitioners, 1987.
24. Levin E, Sinclair I, Gosbach P. *The supporters of confused elderly persons at home.* London: National Institute for Social Work Research Unit, 1984.
25. Laslett P. *A fresh map of life: the emergence of the third age.* London: Weidenfeld and Nicholson, 1989.
26. Neugarten B. Age groups in American society and the rise of the young old. *Ann Am Acad Political Soc Sci* 1974; **415:** 187-198.
27. Finch H. *Health and older people.* London: Health Education Council, 1986.
28. Williams EI. A model to describe performance levels in elderly people. *J R Coll Gen Pract* 1986; **36:** 422-423.
29. Dant T, Carley M, Gearing B, *et al. Identifying, assessing and monitoring the needs of elderly people at home. Care of the elderly at home. Project paper 2.* Milton Keynes: Open University and Policy Studies Institute, 1987.
30. Freer CB. Detecting hidden needs in the elderly: screening or casefinding. In: Taylor RC, Buckley E (eds). *Preventive care of the elderly. Occasional paper 35.* London: Royal College of General Practitioners, 1987.
31. Barber JH, Wallis JB. The effects of a system of geriatric screening and assessment on general practice workload. *Health Bulletin* 1982; **40:** 125-132.
32. Barley S. An uncompromising report on health visiting for the elderly. *BMJ* 1987; **194;** 595-596.
33. United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *Project 2000 report.* London: UKCC, 1986.
34. Barber JH, Wallis JB, McKeating E. A postal screening questionaire in preventive geriatric care. *J R Coll Gen Pract* 1980; **30:** 49-51.
35. Taylor R, Ford G, Barber H. *The elderly at risk.* London: Age Concern Research Unit, 1983.
36. Freer CB. Consultation-based screening of the elderly in general practice: a pilot study. *J R Coll Gen Pract* 1987; **37:** 455-456.
37. Williams EI. *Caring for elderly people in the community.* 2nd edition. London: Chapman and Hall, 1989.
38. Shanas E, Townsend P, Wedderburn D, *et al. Old people in three industrial societies.* London: Routledge and Kegan Paul, 1968.
39. Hunt SM, McKenna J, McEwen J, *et al.* A quantitative approach to perceived health status: a validation study. *J Epidemiol Comm Health* 1980; **34:** 4: 281-286.
40. Egan G. *The skilled helper.* Belmont, California: Brooks/Cole, 1986.
41. Fowler G. Screening. In: Gray M, Fowler GH (eds). *Preventive medicine in general practice.* Oxford University Press, 1983.
42. Network for Developmental Initiatives in the Community. *Senior citizens life programme proposals document.* Bristol: Bristol University, 1987.

Address for correspondence

Dr E Perkins, 1 Park View, Nottingham NG3 5FD.