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Linking up with the over 75s

THE 1990 general practitioner contract[1] has substantially increased the workload of most general practitioners. One aspect of this increased workload is the requirement to carry out a full scale surveillance programme for patients aged 75 years and over, which constitutes part of the new terms of service. The thinking behind this requirement is not at all clear. Presumably it reflects a belief that whatever elderly people themselves may think, prevention of this kind is right and proper. At present there is little evidence that elderly people will welcome this new and unsolicited annual intrusion of their privacy. Furthermore, the evidence concerning the benefits of such a programme is equivocal[2-4] and many would argue that the in depth surveillance programme required by the contract should be carried out only on a smaller group of elderly people identified to be 'at risk' by an initial screening exercise such as that described by Barber and colleagues.[5,6] Finally, whatever the potential benefits, it is highly arguable whether there is any justification in a democratic society for the imposition on the medical profession by the government of the precise means of achieving such objectives, however desirable they may be.

Whatever the scientific or moral arguments, the new contract with its statutory requirement to link general practitioners at least once annually with their elderly patients appears to be quite clear in its intention to ensure that the surveillance is carried out in a systematic and structured way, rather than simply encouraging an informal annual visit. It specifies eight parameters: a home visit at least annually to see the home environment and to find out whether carers and relatives are available, a social assessment (lifestyle, relationships), a mobility assessment (walking, sitting, use of aids), a mental assessment, an assessment of senses (hearing and vision), an assessment of continence, a general functional assessment and a review of medication. All of these are highly appropriate and recognize the broad spectrum of potential need in this age group,[2] though a requirement to review which services elderly people are actually receiving is inexplicably missing. There is, however, a difference between specifying these assessments and ensuring that they really happen. If the surveillance programme is to be anything more than a mere rubber-stamping exercise, there should be a clear undertaking to commit the additional resources which will undoubtedly be required.

The first and most critical resource is manpower. The exact workload required by the surveillance programme has yet to be determined, though a number of studies examining this in an experimental setting have suggested that it may be considerable.[7,8] On average around 7% of the population is aged 75 years or more[9] (at least 100 patients per general practitioner), and the figure is expected to increase for at least the next 40 years, largely because of the growth of those over the age of 85 years. Even allowing for list inflation and patients refusing assessment, around three quarters of elderly patients are likely to accept the offer of a home visit each year.[10] Judging from previous experience, the full assessment will take 60–90 minutes to perform,[11] far too long to be incorporated into a routine domiciliary visit. Indeed, this is equivalent to three to four normal house calls[12] and does not take into account the time taken to set up the appointment. The extra additional workload for each general practitioner could thus amount to the equivalent of eight to 10 visits per week. While some doctors may have sufficient flexibility in their existing schedules to incorporate this new requirement, most will not. The contract seems to recognize this difficulty by specifying that the service may be provided by the general practitioner

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personally or a practice team member. However, it is unlikely that any other member of the existing primary health care team will have the time to take on this work. Practice nurses will be busy not only with the routine work of dressings, injections and venepuncture but also with the health promotion sessions and registration checks required under the terms of the new contract. District nurses are fully occupied dealing with the minority of elderly patients requiring regular nursing care, while most health visitors can only just manage to fulfil their requirements for visiting children without having to take on a new caseload from the other end of the age spectrum. Thus, it seems possible that the job will either not get done at all or will be carried out in a piecemeal and inconsistent fashion.

Given the constraints on general practitioners and their existing staff, provision should be made for additional manpower to ensure that the surveillance programme is carried out properly. Previous studies have shown that non-professional staff can successfully perform the assessments after appropriate training and that such 'link workers' could probably be recruited from the same pool as home helps and nursing auxiliaries, attracting a similar salary.[10,13] Working full time, each link worker should be able to complete at least two new home assessments each day, making a total caseload for annual surveillance of around 300–500 patients. This would be sufficient to satisfy the requirements of a group practice with a total list size of 10 000–12 000 patients. Link workers could be allocated to smaller practices on a sessional basis with appropriate provision for reimbursement. As family practitioner committees face cash limited budgets and increasing pressure to limit the allocation of ancillary staff to practices, the prospect of employing a new team member may not at first sight seem very attractive. Nonetheless, they should consider it seriously, for by so doing they will not only help general practitioners to satisfy the terms of the new contract, but will also have a golden opportunity to provide health authorities and social services departments with the information on needs in the community which family practitioner committees are required by government to collect.[14,15] This policy is being pursued by at least one family practitioner committee, which as part of a larger elderly people's integrated care scheme involving a social services department, a district health authority and the Helen Hamlyn Foundation, is facilitating the establishment of an agency to employ link workers on behalf of general practitioners (North Kensington Elderly People's Integrated Care Scheme: a service overview. Royal Borough of Kensington and Chelsea, 1990). Other family practitioner committees seem likely to follow suit.

In addition to manpower, materials will also have to be provided. At the very least, these should include the necessary data recording forms, but ideally checklists and standardized structured interview schedules should be supplied. At present there are no accepted standards and these will have to be selected, piloted and evaluated in a number of settings before being made more generally available through appropriate bodies. There should also be provision of training in how to carry out the screening programme, including call/recall systems and the appropriate use of the instruments and record forms.

The only way to resolve the uncertainties about the value of the requirement to carry out annual assessment of elderly people will be to ensure that there is a comprehensive evaluation programme based in a variety of settings. This too will require substantial resources and those responsible for advising government about the future development of general practice should ensure that these are provided. In the meantime, there can be little doubt that unless personnel, materials and training are made generally available to primary health care teams, the scheme risks not only imposing a large and unjustified burden on general practice but also failing to benefit the very people for whom it has been designed.

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Academic departments of general practice at the crossroads?

At a time when academic departments of general practice are entering a new era of importance in education and success in research, there is growing concern about the survival and development of the discipline. The problems centre around a haphazard career structure and inadequate financial resources for the expansion or indeed the continued existence of the departments within medical schools. In 1986 the Mackenzie report,[1] prepared by three senior academic general practitioners, summarized the state of the discipline and emphasized some of its inherent problems. Many of these problems are unique to this discipline, as emphasized by both the Academic Medicine Group[2] and the government.[3]