TALKING POINT

A new approach to the elderly

J M KELLETT

Between 1976 and 1996 the population over the age of 65 in the United Kingdom will increase by 0·4% but the population over 80 will increase by 28%. The effect on general practice will be to increase the number of home visits as people over the age of 75 require twice as many home visits as those aged 65 to 74. The effects of chronic physical illness, however, tail into insignificance when compared with the burden of patients with dementia. Blessed and Wilson have shown that not only are more patients with dementia being admitted but there are twice as many remaining in hospital at the end of two years compared with those admitted in 1948.[1]

The arrangements for the residential care of the demented elderly remain chaotic: hospitals, the only free resource, cater for only a small minority. Local authority part III homes are hit by staffing cuts and are already coping with patients for whom they were not originally designed, while private homes, though available, are often not used by relatives for fear of the financial commitment. Sheltered housing, a concept which at one time seemed almost the ideal for the mildly demented, has ceased to be suitable when full time supervision by wardens has been reduced to part time supervision. The position in the community is no better. Support services for the elderly at home are being squeezed by the financial pressures on the local authorities, and tolerance of eccentric behaviour in the community is falling. Neighbours ring the caring relatives whenever the afflicted patient is seen to emerge from his house. The outcome is angry, guilty relatives, who may ultimately reject the old and eccentric family member. The problems facing the relatives include the strain of accepting continuous responsibility and making up for deficiencies in domiciliary services—for example, providing meals at weekends, checking that medication is taken, providing support when the home help does not come, and so on.

The residential facilities that are provided are often poorly adapted to their purpose. Part III homes are designed for those who are capable of mixing sociably with their peers, dressing, and maintaining personal hygiene, the latter two functions being lost early in dementia. Hospital care imposes on patients with dementia the whole circus troupe of the Health Service. Care is provided by expensively trained nursing staff and supervision by doctors and administrators. This is no more appropriate to patients with dementia than it would be to orphans and may lead to the mistaken philosophy that the purpose of care is to maintain health and prolong life.

When scandals occur the instinct of the politician is to pour in money. If there appear to be insufficient hospital beds for the elderly the policy would be to build more, and in present circumstances that would be at the cost of the already strained acute services. This is a policy of despair not only because the demand is inexhaustible (easily filling the 356 000 NHS beds in England) but because hospitals are not the proper place for patients who are confused or suffering from dementia.

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Criteria and categorisation

The solution need not be expensive but would make certain that patients with dementia and their relatives would not have to sacrifice their future to survive in the present. The first step would be to draw up criteria to diagnose irreversible dementia. A committee made up of a doctor, social worker, and representative of the Department of Health and Social Security would then place the patient in one of three categories: (*a*) capable of an independent existence; (*b*) capable of living in the community provided help was given for meals and bathing; (*c*) requiring continuous supervision.

The latter two categories would qualify for a special grant to bring total income up to a level that would pay either for a private home—for example, £100 per week (category (*c*))—or for meals on wheels and other domiciliary services—for example, £30 per week (category (*b*)). The grant would be given independent of means but would be taxable, thus ensuring that capital was retained for the next generation though income from that capital would contribute to care.

The patients or their relatives would be expected to pay for all services that were required, including home help, luncheon club, day centres, meals on wheels, etc. This would have several important economic consequences. Local authorities with an unusually large number of elderly, such as those on the south coast, would be freed from their unfair burden while the domiciliary services would be tailored to meet the demand without placing a heavy burden on ratepayers. Carers would realise the economic costs and so use the services more appropriately. If residential care was required, either to provide a temporary break or for permanent care, the allowance would provide the finance. Hospital units would close their long stay facilities and local authority homes would either become self financing or could change their function to care for those whose physical frailty required institutional care. The bulk of institutional care would be provided by privately licensed homes, the licence being granted on the basis of regular inspection. Fees would be controlled so that increases would match increases in the grant, thereby protecting the elderly from having to leave a home through lack of funds. Funding would need to be sufficient to enable the homes to run at a profit and to compete for clients, thus ensuring for patients good quality of care and prompt transfer from hospital. Doctors and nurses, freed from the difficulties of providing long term care, could then concentrate on establishing the causes of dementia and treating patients whose behavioural disturbances would respond to treatment.

Such a concept may seem Panglossian and uneconomic. Some at least of the economy would depend on private homes being run more efficiently than State facilities, a not unreasonable assumption, given that cost for an inpatient bed in a long stay mental hospital is now £200 a week and in a part III home is £170 per week, whereas some private homes may offer the same quality of care for £100 per week. There would be a transfer of financial responsibility from local authority to central government and this would ease the burden on the rates and fit in with the present Government's policy. Many of the services that are

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now paid for by other funds would be paid for by relatives though the actual costs of these services would remain much the same. The only difference between this system and the existing one is that areas where resources are particularly slim could be quickly brought up to meet local needs and the State's resources would be distributed more evenly.

By transferring the cost of caring for patients with dementia to the Exchequer the real costs to our society would become apparent and the paltry sums now spent on research in this area would be evident. Thus an opportunity would be offered for enabling many elderly people to live their lives in reasonable comfort and with self respect.

Objections

There would inevitably be objections to the scheme. Firstly, the assessment committee might be pressed to classify people as demented unnecessarily, thus increasing State expenditure; secondly, the funds, when given, might be misused by the caring relative; and, thirdly, private homes might exploit their clients. These are real objections and adequate safeguards would have to be built into the scheme. The use of standard assessment procedures, such as the Clifton assessment schedule[2] and the presence of a centrally appointed assessor—perhaps a representative from the DHSS—on the committee, should ensure a reasonably consistent application of criteria for dementia. Comparison between different areas should quickly show up those committees which were out of line. The demented old person is vulnerable to exploitation and an adequate system of inspection and control (similar to that used by the court of protection) must be included in the scheme. There is no reason, however, to assume that caring relatives are less likely to take account of their elderly kinsfolk's needs than an impersonal State authority. The value of private homes would also be assessed by the family, who would be free to transfer their demented relative as they thought appropriate. Good homes should, therefore, be profitable and poor ones empty.

Finally, the benefits would not be restricted to the elderly and their carers. Many of the "young elderly" (65 to 75) are preoccupied by the fear of becoming a burden to their young relatives. Nowhere is this fear greater than in the prospect of senility. The knowledge that proper provision was available for those who became demented would lessen their anxieties and enable them to enjoy an active retirement.

References

1 Blessed G, Wilson ID. A contemporary natural history of mental disorder in old age. *Br J Psychiatry* 1982;**141**:59-67.

2 Pattie AE, Gilleard CJ. A brief psychiatric assessment schedule validation against psychiatric diagnosis and discharge from hospital. *Br J Psychiatry* 1975;**127**:489-93.

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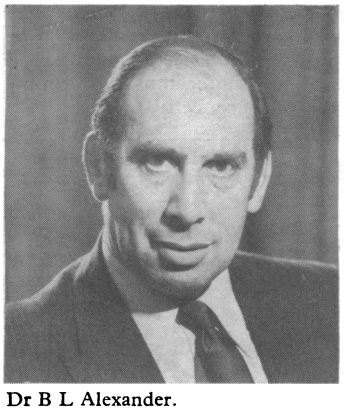
Superannuation Committee

General practice trainees and assistants

At its meeting last month the Superannuation Committee reappointed Dr B L Alexander as chairman for the 1982-3 session. The committee had studied the report of the debate in



Dr B L Alexander.

the House of Commons on 22 October on index linked pensions and was pleased that the Government did not intend to interfere with the index linking of public sector pensions at present.

The BMA had asked the Department of Health and Social Security to accord general practitioner trainees injury benefits similar to those which applied to junior hospital doctors. The committee was disappointed with the following reply from the superannuation branch and will raise the matter again: "There is no general principle that National Health Service staff who are 'in training' should have a higher deemed pay for injury benefit purposes, and the fact that a general practitioner trainee and a junior hospital doctor are both in training for a career does not therefore apply. The special concession given to junior hospital doctors was not based on a factor or prospects which all training grades can look to but on one which is unique in public service—the existence of a choice straightaway after full qualification between on the one hand entry into general practice in which peak earnings are thereafter quickly attainable and on the other hand entry into hospital service in which peak earnings are attainable only after very many years."

More success had been achieved with the request for improved employment terms for members of the Women Doctors' Retainer Scheme who opt for assistantships in general practice. Until now women doctors with less than five years' service who opted for assistantships and who incurred a disqualifying break were forced to take a refund of contributions. They may now apply for approval and, as such, their contributions will be preserved in the scheme until they resume superannuable National Health Service employment.

University cuts: NAHA's dismay

The National Association of Health Authorities is dismayed at the Government's decision not to allocate extra resources to medical schools to cover the reduction in their grant from the University Grants Committee.[1] This is contrary to the recommendations made by the House of Commons Social Services Committee that an extra £5m in 1982-3 and a further £5m in 1983-4 should be allocated to medical schools as protection for clinical medicine.

The assocation, however, has welcomed the Government's decision not to investigate the present arrangements for funding medical academic posts. At present if a doctor spends seven tenths of his time teaching in the medical school and the rest of his time in clinical work for associated hospitals the health authority does not pay the university for his time. Similarly, a hospital funded post may mean a considerable amount of teaching for the university. Neither the health authority nor the university loses out—the "knock for knock" system.

In a press statement the NAHA's director, Mr Maurice Naylor, said that "although the Government says that so far there has been no serious consequences to NHS patients as a result of the UGC cuts there could be serious long term consequences to the NHS if the quality of medical education declines. Medical research could be the first to suffer." The association is monitoring the effect of the UGC cuts on the NHS and is undertaking a second survey of health authorities to find out the extent of the problem. The results of an earlier survey showed that many health authorities felt under pressure to take over the funding of former university funded posts with a Health Service commitment.

1 Department of Health and Social Security. *Government response to the first report from the social services committee, 1981-2 session.* Cmnd 8744. London: HMSO, 1982.