kidney disease suggest that such studies should now be seriously considered.

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The case for the community geriatrician

Could bridge the gap between the community and hospital

Geriatric medicine has developed from being a specialty that concentrated mainly on caring for chronically sick patients in long stay wards to one that deals with one third of all adult medical admissions. Inpatient services are often backed up by day hospitals bridging the gap between hospital and the community.

Many changes are underway. Between 1978-9 and 1992-3 the average length of stay in wards for older people fell from 77·5 days to 27 days. At the same time the number of people aged 85 and over who live in residential and nursing homes doubled. The introduction of social security support in 1983 for people in these homes (both voluntary and private) was responsible for the shift of many older people out of hospitals and into care homes.

The implementation of *Caring For People* in April 1993 also dramatically changed the organisation of care for frail and disabled older people by shifting the budget for domiciliary and residential care from the Department of Social Security to local authorities.[1] Local authorities are now responsible for people seeking public support in private and voluntary homes, assessing individual need, designing care arrangements, and securing the delivery of care within available resources.

The success of community care depends on collaboration between health and social services to ensure that people with complex needs receive the right balance of health and social care. Sadly, the health needs of these patients are often forgotten in this complicated recipe. The Department of Health in its *Hospital Discharge Workbook* emphasises the importance of close multidisciplinary working when patients are transferred from hospital back to the community.[2]

General practitioners are responsible for the health care of the 95% of older people who live in the community and, as care shifts from the secondary to the primary sector, are being asked to manage an increasingly sick, old, and disabled population (traditionally the responsibility of consultant geriatricians). They have had to take on this extra work with no increase in resources and little support.

General practitioners also have to support and advise staff in care homes and carry out comprehensive checks on patients over 75 as part of their contract. Anecdotal evidence suggests that older people with reversible medical problems are experiencing delays in referral to specialist care and are not having their problems treated adequately. Evidence from the Department of Health on how *Caring for People* was implemented suggests that general practitioners and primary health care teams had a limited input into the assessment procedures in the five local authorities that were examined.[3]

Can the needs for care of vulnerable older people be better served? The British Geriatrics Society has recently offered a solution—the creation of a subspecialty of community geriatric medicine.[4] The consultant in this subspecialty could work mainly in the community but would have access to and responsibility for acute beds in district general hospitals as well as for rehabilitation and continuing care beds. Trusts would have to grant them equal status to their hospital colleagues if they were to set up an integrated service straddling both hospital and community. The society suggests that one of their key functions would be to liaise with primary health care teams; they would also provide a medical service to social services departments. All community geriatricians would have to be accredited in geriatric medicine.

Such an arrangement preserves the autonomy of general practitioners but enables consultants to take a lead in developing community care for older people. Rather than working in isolation, community geriatricians could form part of locality based teams. Community teams have been successfully developed for elderly patients with mental illness[5]; they should now be evaluated in older people with physical health problems. The creation of another subspecialty to bridge the gap between hospital and the community could break barriers not only between consultants and general practitioners but also between health and social services.

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