Authors' reply

EDITOR,—Our study did not look at whether things had improved but at whether inequalities had narrowed or widened. From a clinical point of view, protection from infection depends on an interplay between an individual's immunisation status and herd immunity, which for children may vary between the home, school, and neighbourhood. Not until coverage is over 90% in all potential "herds" do variations in coverage stop being important. At lower levels the odds of being immunised are a good proxy measure for the chances of being infected. High coverage may overcome the consequences of inequalities to everyone's benefit, but the underlying inequalities remain. Statistically, there are three ways of comparing the ends of the social distribution.

The absolute health gain is the percentage difference between the highest and the lowest groups. We do not discount this method: one of us used it to monitor equity in a related study.[1] It implies, however, that a difference between areas with coverage of 50% and 60% is equvalent to a difference between areas with coverage of 85% and 95%. Although the excess numbers of the deprived population at risk are the same in both cases, initially there are 1·25 times as many at risk in the deprived area as in the affluent area, whereas subsequently there are three times as many. It is debatable whether the health gain has been distributed fairly.

The relative health gain is the ratio between the coverage rates. The disadvantage of using this is the problem of "polarity." If we use the rate of immunisation rather than the rate of non-immunisation as the measure of health then the above example suggests a narrowing of differences and not a widening as we have argued, nor an equivalence as Chris Foy and Raj Bhopal argue.

The odds ratio is not affected by polarity, and the values in the above example (1·5 and 3·4) show that protection has improved relatively more in the affluent group than in the deprived group.

Strictly, none of these methods are entirely appropriate for monitoring inequalities as they take no account of the distribution of health between the two extremes. Unfortunately the only method we know that does this adequately, the concentration index,[2] also suffers from the problem of polarity.

To be fair to Foy and Bhopal, we too had difficulty in deciding on the most appropriate way of comparing inequalities in health over time, which is why we hedged our bets in the paper.

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Successful childhood immunisations may endanger adults

EDITOR,—The task of improving uptake of immunisation within a district rests with the district immunisation coordinator, who is often a consultant in communicable disease control or a community paediatrician. Richard Reading and colleagues' conclusion that district-wide interventions do not necessarily reduce social inequalities in uptake is something that district immunisation coordinators need to be aware of.[1] The authors do not, however, mention a serious consequence of the situation they describe. The potentially preventable morbidity suffered by unimmunised children is now more serious than it was a decade ago. The success of the measles immunisation programme means that much less measles virus is circulating in the community than previously. The probability of a young unimmunised child acquiring the infection in any one year is low and steadily falling. This means that people may first come in contact with measles virus as adults, when morbidity is higher than it is in children.

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1 Reading R, Clover A, Openshaw S, Jarvis S. Do interventions that improve immunisation uptake also reduce social inequalities in uptake? *BMJ* 1994;308:1142-4. (30 April.)

Community geriatricians

Evidence of usefulness is lacking

EDITOR,—The creation of posts in community geriatric medicine serves the needs of the health service and health professions rather than elderly patients. Jackie Morris and the British Geriatrics Society have welcomed the development of this subspeciality.[1,2] But the roles and responsibilities of community geriatrics and the training and facilities required are identical with those of geriatric medicine.

It would be more logical to ensure that tasks requiring liaison with local authorities, community services, and primary care were taken seriously and done properly by all consultants concerned with providing health services for elderly people. The results of this work not being done by hospital geriatric medicine teams are likely to be increased lengths of stay, poorer quality care for the patients managed in hospital, and poorer communication. Dilution of responsibility and confusion of roles are familiar problems in primary care, and community geriatric medicine will simply add to them. The line taken by the British Geriatrics Society raises two questions. Do consultants in geriatric medicine wish to avoid these tasks? If so, why don't they wish to do the job for which they have been trained?

There is no evidence to support the value of community geriatric medicine; a randomised controlled trial has shown an increased death rate in patients managed by a community geriatric medicine team.[3] The main benefits of geriatric medicine occur when the teams are involved early in the acute and rehabilitation phases in hospital; work after the acute phase may not be as useful[4] and may divert attention from the most important aspects of geriatric medicine. There is extensive evidence of the value of comprehensive services for elderly people provided in the context of hospital services.[5] We should be striving to achieve the benefits shown in randomised controlled trials rather than attempting to launch a new, untested form of intervention on the elderly population.

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Are not a good idea

EDITOR,—In the editorial presenting the case for the community geriatrician Jackie Morris misrepresents the positions of the British Geriatrics Society, which has never supported the creation of such a subspecialty.[1] Indeed, the society states clearly in its discussion document that it "does not endorse this type of appointment" and rejects the use of the term community geriatrician.[2] It considers that all consultant physicians in geriatric medicine should work mainly in hospital and be integral members of hospital departments rather than locality teams.

It should be possible to extend outreach services from a secondary care base into the community to meet the needs outlined by Morris. The society envisages that one or more consultants in a hospital department of geriatric medicine would take a lead role in developing local community initiatives; the title of consultant community physician may be appropriate for such consultants to emphasise their responsibility in this area rather than simply to recognise their involvement. Ideally all or at least most consultants trained in geriatric medicine should provide care for elderly people beyond the hospital setting. Training requirements need to reflect this aspect of consultant work.

General practitioners, who face an increasing demand for care from greater numbers of more independent older people, and social services departments, which are taking on the new responsibility for assessing complex health needs, are likely to welcome the skill of specialists in geriatric medicine. But the boundary between primary and secondary care needs careful consideration before community initiatives are launched. Additionally, the role of the consultant outside the hospital must complement the work of the primary care team rather than duplicate it.

The efficient delivery of care for older people can occur only through effective cooperation between the hospital and community sectors. Increasing the involvement of consultant physicians in geriatric medicine in community care by providing outreach services from hospital would go a long way in helping to achieve this, without the need for the creation of a subspecialty.

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Existing general practitioner based system is adequate

EDITOR,—Jackie Morris acknowledges that general practitioners are responsible for the health care of 95% of older people.[1] Regrettably, and with insufficient evidence, Morris then casts doubt on the quality of that care by proposing the creation of the post of community geriatrician. This suggestion could undermine the harmonious relationship that exists between most general practitioners and their colleagues in geriatric medicine; it strikes at the heart of the referral system.

The continuing care of older people in their own

homes is a prime responsibility and a core function of general practitioners and other members of the primary care team, for which they possess the appropriate knowledge and skills. What is the evidence that this system is not working well? Why does it need to be replaced by an alternative in which the planning of care for elderly people in the community becomes a consultant's responsibility?

As the reorganisation of the NHS proceeds, issues of responsibility at the interface between generalist and specialist are assuming prominence in every specialty. The division of responsibility embodied in the referral process has served the health service well and should not be discarded lightly. It allows the patient access, when appropriate, to two opinions—that of the general practitioner, who has special knowledge of the patient and the context of his or her problem, and that of the consultant, for a condition that may need specialist skill. In times of limited resources only those with a clear need for specialist care should be referred for it. Any erosion of the referral process will undermine the skills of both specialists and generalists and thereby the effectiveness of their complementary combination.

General practitioners broadly support the tendency for more specialist care to be delivered in community settings. We contend, however, that the referral process must remain intact if both generalists and specialists are to be maximally effective. General practitioners must retain the responsibility for referring patients for specialist care regardless of the setting in which that care is to be delivered. There are no grounds for making the care of elderly people in the community an exception and for general practitioners not to take the lead when older people are being assessed for long term care.

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Elderly people need "high tech" services too

EDITOR,—Jackie Morris is rightly concerned that the health needs of vulnerable elderly patients may be overlooked by local authority assessment for community care.[1] We disagree, however, with the assertion that the creation of community geriatricians would solve the problem.

Successful rehabilitation and placement of elderly patients depend on the patients' acute medical problems being assessed and treated, early and appropriately, by physicians with a special interest in elderly people. The reduction in mean length of hospital stay (to about 15 days in our unit) has not been achieved just by shifting people into local authority, private, and voluntary homes. It has been achieved by multidisciplinary teams, including geriatricians, ensuring that their elderly patients have full and timely access to all the "high tech" services of the acute hospital, linked to a holistic, rehabilitative approach.[2-4] To this end the role of the geriatrician has always entailed close liaison with community services, carers, and primary health care teams. This sometimes necessitates community assessment and treatment, but not as a substitute for acute hospital admission.

By supporting the creation of community geriatricians Morris encourages the view that the medical problems of elderly people can be dealt with by "low tech" services and suggests that existing geriatricians do not work in the community. Morris's views may be welcomed by some managers and purchasers, and even by some colleagues in other specialties, but we do not believe that this approach will deliver the best health care to elderly people. Recent press reports suggest that the public may no longer accept that elderly people should receive only low tech services.

Improved liaison between community services and acute hospital services is essential but is not going to be served by pushing geriatricians out into the community.

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Clinical medical officers could provide service

EDITOR,—Jackie Morris proposes that the gap between community and hospital services for elderly people should be bridged by a new subspecialty of community geriatric medicine.[1] Since the formation of trusts and the implementation of community care, consultants in medicine of old age have been more involved in hospital work. The role of community geriatrician as specified by Morris seems the same as the role of a consultant geriatrician used to be when the specialty of geriatric medicine came into force. The role has changed along with the attitudes of physicians, who prefer not to be called geriatricians; as a result of amalgamation of this specialty with general medicine, the sharing of the medical intake and out of hours duty rota makes it difficult to continue to fulfil the traditional role of providing care in the community. My concern is that the same would happen with community geriatricians in the future.

Morris is unaware that the gap between community and hospital services is filled in certain districts by clinical medical officers or senior clinical medical officers. Their involvement in acute care, rehabilitation, and continuing care varies across districts. The number of doctors is small but requires a review, as happened with the child health service.[2] The joint working party on non-child health community services is working on producing guidelines.[3] Clinical medical officers and senior clinical medical officers have provided these services for years, and their experience should be recognised. Appointment as a community geriatrician should be an option for senior clinical medical officers with higher qualifications. If an employer considered that a senior medical officer had the relevant skill to undertake consultant work it could seek dispensation from the requirement to advertise. Senior clinical medical officers should be given other options, such as training or being allowed to retain their posts. Similarly, clinical medical officers should be offered appropriate options. It is of paramount importance that senior registrars training for this subspecialty should have acquired experience in community geriatric medicine before being accredited; in this the Royal College of Physicians should work closely with the Faculty of Community Health.

It is time for us to create such posts to make community care successful. Those who are involved in this aspect of care must continue to influence purchasers. Funding jointly by health and social services would be appropriate for these posts.

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More geriatricians are needed

EDITOR,—Jackie Morris reminds us of the challenge to primary care of both the increasing numbers of frail elderly people in the community and the complexity of the problems they present.[1] The issue of community geriatricians is, unfortunately, also complex. One of the main driving forces behind the interest in community geriatricians has been purchasers frightened by the apparently irresistible rise in emergency admissions to hospital—about 10% last year. They have raised the question whether the appointment of community geriatricians could reverse this trend. I believe that there are several problems.

Firstly, we have no idea why emergency admissions are rising, although there are plenty of theories.

Secondly, no studies have been carried out in Britain to look at the effectiveness of a community geriatrician compared with that of a properly staffed service for elderly people based in a district general hospital where all the consultants have both a hospital view and a community view of their patients' needs.

Thirdly, there is concern that community geriatricians might be used to restrict acute hospital care for frail elderly people—for example, those already in institutional care.

Fourthly, community appointments that might seem to have a primary care role in some areas have not found favour with the Royal College of General Practitioners. When I surveyed 30 local general practitioners recently 27 were opposed to consultants having continuing responsibility for patients in institutional care.

Fifthly, while a community geriatrician would certainly need to have accredited training in geriatric medicine, no specific training schemes exist that address the other training needs of such a consultant—for example, time in general practice and in public health medicine.

Lastly, at present there is concern about the calibre and training of people who might apply for such a post. A recent advertisement for a community geriatrician in south east Thames region failed to result in an appointment, which led to considerable changes in the job description.

Urgent research certainly needs to be done into the reasons for the rise in emergency admissions to hospital, but the real way forward for purchasers is to ensure that in each locality enough consultant time is available for older patients to ensure a seamless service in both the hospital and the community sectors. Far too many districts still fail to have the minimum standard of one whole time equivalent consultant in elderly medicine for 4000 of the population over 75.

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Drink-driving

EDITOR,—I echo Andrew Guppy's call for a more scientifically based campaign to prevent drink-driving.[1] To call for a change in legislation merely on the basis of a discussion of measured blood alcohol concentrations, however, is to oversimplify the matter. The case-control studies quoted may