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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1 Colver AF. Evaluation of the health surveillance of preschool children. Newcastle upon Tyne: University of Newcastle upon Tune, 1992. (MD thesis.)
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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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1 Morris J. The case for the community geriatrician. *BMJ* 1994;308:1184. (7 May.)
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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