TALKING POINT

Could the consultative document have its priorities wrong?

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We have tried to evaluate critically the national guidelines and targets for services for the elderly, concentrating particularly on the following services: home nursing, home helps, meals on wheels, local authority residential places, day centres, and hospital geriatric beds. We have excluded community hospital beds and chiropody even though an expansion rate was given for each of these services. We did not include the community hospital services because at present this is experimental. Chiropody, however, was excluded because no formal guideline for the service was produced.

Methodology

We decided to express all expansion rates (national targets) in actual units of service—that is, number of home nurses, meals, etc—rather than in a percentage of current expenditure. This was done by applying the DHSS's estimated cost per unit¹ (where applicable) to the estimated yearly increase in current expenditure to produce a unit measurement. Since the yearly increase in current expenditure is constant for all services the assumption was made that the corresponding yearly unit value would also be constant. We have not allowed for any compound effect in our calculations because we feel that the effect would be negligible unless the annual percentage growth rate in current expenditure was inflation-proofed—a highly unlikely situation.

Unit costs are those costs which would purchase one unit of a particular service—for example, one home nurse, one home help, etc—and were calculated so as to reflect, wherever possible, all salaries and operational and administrative costs. The unit costs relating to health services supplied by a health authority are departmental estimates, whereas those unit costs applicable to local authority supplied services are by courtesy of the Social Services Department of Dorset County Council.

In calculating the period until parity between the required number of units (as suggested by the guidelines) and the actual number of units one fundamental and basic assumption has been made. This is that the expansion rates, as expressed in current expenditure terms or in number of units as suggested by the document, will be sustained up to and beyond 1985.

Data

We have used, wherever possible, the figures contained in the document. Thus any limitations that may apply to the document's figures would correspondingly apply to our own.

The yearly total population for England was based on the figure quoted in the document² and a simple extrapolation technique was applied to these estimates to reflect the

indicated growth rate of 1% between 1973 and 1985. The population estimates for the elderly (taken to include all persons aged 65 and over), on the other hand, are based on 1974 mid-year estimates and were supplied by courtesy of the Office of Population Censuses and Surveys.

Evaluation

Only by examining the magnitude of the "shortfall" that exists between currently supplied services and those that should be supplied (according to the document) and commenting on the implications of the differences will it be possible to determine the usefulness of the document in terms of providing an overall format for the development of the nation's health.

HOME NURSING

The figure shows that parity will be achieved by the 1980s. Thereafter growth in the home nursing sector will be "surplus." At first sight this appears encouraging, but it assumes that the function of the home nurse will remain the same. Recent trends, however, show that this may not necessarily be the case.³ For example, with the development of attachments to the primary health care team the home nurse is dealing more and more with patients which her traditional colleague would regard as outside her responsibility. This is also happening due to the evolution of the specialist community nurse—that is, for the mentally ill, mentally handicapped, psychogeriatrics, etc. Because there are insufficient nurses to provide a comprehensive service (whether this be desirable or not) one of the functions that the specialist community nurse has developed is that of advising and supporting the members of the primary health care teams, hence bringing the home nurse into contact with a whole new range of problems, so altering her traditional nursing patterns.

HOME HELP AND MEALS SERVICE

The figure also shows that the growth rate and targets suggested by the priorities document will not solve, in the short term, the problem of deficiencies for these services, since the period required to reach parity is approximately 65 and 45 years respectively. Interestingly, it is the predicted fall in the elderly population that is the prime factor in eventually reaching the target (see table).

LOCAL AUTHORITY RESIDENTIAL PLACES

At the given growth rate of 2000 places per year, the figure illustrates that parity will be

Population projections, 1974-based, England*

	Males 65 and over	Females 65 and over	Persons 65 and over
1976	2 581 700	4 059 400	6 641 100
1977	2 614 400	4 096 600	6 711 000
1978	2 648 400	4 137 600	6 786 000
1979	2 680 000	4 176 900	6 856 900
1980	2 707 000	4 212 600	6 919 600
1981	2 710 500	4 219 400	6 929 900
1986	2 730 600	4 251 700	6 982 300
1991	2 785 400	4 290 900	7 076 300
1996	2 757 100	4 215 300	6 972 400
2001	2 701 800	4 076 800	6 778 600
2006	2 694 600	3 991 600	6 686 200
2011	2 817 300	4 070 600	6 887 900

*Source: Office of Population Censuses and Surveys, July 1976.

achieved in about 25 years. Here again it is the predicted fall in the elderly population which brings the target date forward, in this case by approximately 10 years. A growth rate of 4000 places per year would be required to achieve the target by 1986.

Evidence from social service planners, however, does not support the assumption that the purposes and general philosophy regarding local authority residential establishments remain the same. It has been suggested that the established role of the old person's home should change, emphasising a much more rehabilitative and re-enabling function; the home element of care being provided within a housing context, be it sheltered or warden-serviced accommodation.

DAY CENTRES

There is a long timespan (45 years) before the target is achieved (see figure). To bring this date forward so that parity is reached at the same time as that of residential homes or, alternatively, geriatric beds, the rate would have to be increased from 300 places per year to 600 or 1000 places per year, respectively.

Approximate date at which national guidelines for specified services will be achieved, given the suggested growth rates.

HOSPITAL GERIATRIC BEDS

A growth rate of 1150 hospital geriatric beds a year enables parity to be obtained by 1987 (see figure). The main caveat, however, is the question, "What is a geriatric case?" This raises the question—not pertinent to our discussion here—whether geriatrics is a true speciality.

Discussion

In a document which recognises that one of its functions is "to provide the detailed information that will enable the right choices to be made and effective planning to be achieved,"² some of the basic detailed information must be questioned. An important aspect of this information is that of targets and growth rates. Targets or norms are well known to be difficult to assess as is the balance between such targets. It is beyond the scope of this paper to consider the assessment of need but we emphasise that the targets given in chapter 5 of the priorities document must be looked at with caution. The home helps, meals, and day centre provision will require 40 to 65 years before the targets are achieved at the given growth rates. If such a timespan is not acceptable then the growth rate and targets given, or both, must be challenged.

If, for the sake of argument, we accept the targets given then one should examine the balance of care that will result from the policy for the care of the elderly advocated in the document. Our data show that the health service component at least has a realistic look (home nursing and hospital geriatric beds), whereas the social service component of care (home helps, meals, residential and day places) does not. Planning for the elderly must adopt a holistic approach, but the priorities policy for the elderly provides an unbalanced picture for the next 65 years. This, in effect, will do nothing to ease the present problem and may even exacerbate it.

The difficulties may be compounded particularly in areas where recruitment to such services is insufficient. Certainly, this has been the experience within the Dorset area, mainly because the hotel industry attracts potential NHS labour. Furthermore, in an area with a skewed age distribution the pool of employees is smaller than the national average, while the needs of the community are probably greater than elsewhere.

Perhaps we are expecting too much from the document. Indeed, it states that, "it is on the balance of priority *between* these policies rather than the policies themselves,"² that the DHSS is primarily inviting views. Taking that criticism into account there is the question of the balance of priority, for example, between services for the elderly and primary care. Development of primary health care services which is envisaged is understandable and also aids the stated objective of helping the elderly "to remain in the community for as long as possible,"² so in these terms the balance between policies is acceptable. Nevertheless, the slower growth rate of primary social care services indicates an imbalance between policies.

The consultative document recognises that there would be co-ordinated planning across administrative boundaries, and joint care planning teams (JCPTs) are singled out as a focus for this. If this is the case (and departmental guidance confirms it⁴) then one of the prime functions of the JCPT, or subgroups,

should be producing balance of care models for their areas and districts. Identifying deficits of balance as well as particular sectors of provision are also important functions for consideration. One of the difficulties in restoring balance is that the methods of funding the matching local and health authorities are so different. Joint financing goes a little way to overcoming this problem, though initial reaction from local authorities to such financing is certainly cautious for the moment. Nevertheless, if JCPTs concern themselves with balance of care then they would be more able to issue useful guidance as to the most appropriate areas for joint financing.

Conclusion

This paper is not a comprehensive review of the services used mainly by the elderly. There are many other issues which could be raised, such as the function of the health visitor, the place of the community hospitals, and the contribution of housing and voluntary bodies. All too often the private sector is omitted, but it is fulfilling a need that, within the present economic constraints (leaving political issues aside), the NHS cannot meet.

Rather than preparing a review we have tried to look at the DHSS package for the elderly. For strategic and operational planning this package gives so little. So, at best the problems experienced by geriatricians, social workers, nurses, and general practitioners are unlikely to get worse, but nor are they likely to get better.

It is pointless developing primary care within the NHS if social service care is not complementary. The all too familiar situation of patients having to be admitted to, or unable to be discharged from, hospital facilities because of social reasons will be perpetuated if we adopt the model outlined by the DHSS.

References

- ¹ DHSS Circular HC(76)29.
- ² *Priorities for Health and Personal Social Services*, a consultative document, DHSS. London, HMSO, 1976.
- ³ *On the State of the Public Health for the Year 1974*, DHSS. London, HMSO, 1976.
- ⁴ DHSS Circular HC(76)18.

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Dutch doctors visit Worcester

At the end of September, 21 members of the North Friesland Division of the Royal Netherlands Medical Association visited Worcester as guests of the Worcester and Bromsgrove Division of the BMA. The visit was a return match, for eighteen months ago 17 divisional members had travelled to the Netherlands. The four-day programme included medical and social events, the first evening ending with a civic reception at the Guildhall in Worcester.

One whole day was spent in clinical visits and discussions. Each guest accompanied his host as he carried out his clinical work in general practice, hospital, or industrial medicine. Health care in the Netherlands and Great Britain was compared at a symposium, at which the area medical officer, Dr H P Ferrer, commented that NHS reorganisation had not yet achieved the greater efficiency and development that many members of the profession had hoped for. Dr J F Murray compared working conditions in similar district hospitals in England and Holland and Dr Robin Steel gave his impressions of general

practice in the Netherlands. The Dutch doctors visited Worcester Health Centre, a partially completed psychiatric and psychogeriatric hospital in Worcester, a mental hospital in Powick, and the Institute of Mental Subnormality in Kidderminster.

On the last day the visitors toured the Malverns, the Severn Valley, and Stratford and in the evening they were welcomed in Dutch by the chairman of the AHA, Mr A E Meredith, at a joint divisional/AHA reception at Hartlebury Castle. The Secretary of the BMA, Dr Elston Grey-Turner, was present and he hoped that the successful visit would be a model for other exchanges between BMA divisions and their counterparts in the EEC. The success of the visit was due to the hard work of the Worcester organising subcommittee—fortunately its secretary, Dr F J Borchardt, speaks Dutch—and the secretary of the Worcester and Bromsgrove Division, Dr H M White, hopes that the friendships will be renewed at the Joint Clinical Meeting of the BMA and the RNMA in September 1977.

Left to right: Dr David Hill (chairman, Worcester and Bromsgrove Division, BMA), Dr (Mrs) Mary White, Dr E Grey-Turner (BMA Secretary), Sir Michael Higgs (chairman, Hereford and Worcester County Council), Mr A E Meredith (chairman, Hereford and Worcester AHA), Dr Eenkema von Dijk (Holland), Dr Macpherson Knowles (Worcester Health Centre), Dr J Dambrink (Holland), Dr I McKim Thompson (Midlands Area Secretary, BMA), and Dr H M White (honorary secretary, Worcester and Bromsgrove Division, BMA). (Photo: Bromsgrove Messenger.)