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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Falling rate of provision of residential care for the elderly

SIR,—Emily Grundy and Professor Tom Arie (13 March, p 799) rightly call attention to the increasing difficulty of providing adequate care for the elderly. The level of funding of the NHS in England and Wales was inadequate even in 1976, their base year. Although the service has been better treated than some others, resources since then have been insufficient even to keep up with the inevitably increasing needs of the old. Personal social services have been treated worse than the NHS, and that makes pressure on the hospital and community health services even more serious. Polly Toynbee in the *Guardian*[1] describes how disruptive of family life failure to relieve families of excessive burdens can be. The third arm, provision of sheltered or specially adapted housing, has been treated even worse, and development of this component of services for the elderly could become most important of all in the future. It is surprising that the relation of housing and its management was not discussed along with residential care. Derek Fox brings out this need in Hobman's book *The Impact of Ageing*.[2] Ms Grundy and Professor Arie make the valid point that geriatric and psychogeriatric services cannot respond to demands that should be met by the other services. It is sheer hypocrisy for ministers to advocate greater reliance on community care if the funds needed for its support are then reduced.

There is, however, a major uncertainty about the authors' projections. They have simply applied the age-specific rates of residential provision in 1976 to the population of future years. We do not know either that the age-specific incidence of dementia quoted from the study of Kay *et al*[3] 20 years ago still applies or that the needs of the population of 1976 are matched in the same but larger age groups of 1982, still less that they will be the same in the year 2000. This is a major defect in the information required for planning both health and social services.

My own superficial observation of the patients in the infirmary wards and the inmates of the house blocks in public assistance institutions over 40 years ago compared with patients in geriatric units and residents in old peoples' homes in more recent years is that they were more often in bed, were at least as enfeebled, but, although they were on average at least 10 years younger, they were far less likely ever to go home. That would be consistent with a finding that although we will inevitably have many more people aged over 85 in the future a smaller proportion of them will need to be in residential care. I do not assert that that will be so, still less that the number requiring such accommodation will not rise, but only that we should try to find out from a longitudinal study what really happens. Fries and Crapo in their book *Vitality and Ageing*[4] maintain that the human life span is not changing, but the stage of terminal decrepitude is coming later and lasting a shorter time. One small longitudinal study by Hagnell *et al*[5] in Sweden found that the risk of contracting a "severe age psychosis" for the first time was less in the period 1957 to 1972 than it had been in the period 1947 to 1957. This was a prospective longitudinal study carried out by experienced psychiatrists and suggests that a real change was occurring in Sweden—and may be continuing.

If a change of this kind is not happening the NHS, the personal social services, and the housing service will be in desperate straits by the end of this decade even if more money has become available. Unquestionably new capital investment is needed, but should it go mainly into geriatric facilities, residential homes, or suitable housing, and what staff do we most need to train—and employ?

GEORGE GODBER
Cambridge CB1 4NZ

[1] Toynbee P. *Guardian* 1982;Mar 19:12 (col 1-8).
[2] Fox D. In: Hobman D, ed. *The impact of ageing: strategies for care*. London: Croom Helm, 1981.
[3] Kay DWK, Bergmann K, Foster EM, *et al*. *Compr Psychiatry* 1970;**11**:26-35.
[4] Fries JF, Crapo LM. *Vitality and ageing*. San Francisco: Freeman, 1981.
[5] Hagnell O, Lanke J, Rorsman B, Ojes L. *Neuropsychobiology* 1981;**7**:201-11.

SIR,—Emily Grundy and Professor Tom Arie (13 March, p 799) are quite right to be concerned about the declining number of places in residential homes for the elderly.