

Falkingham concludes that these results show the importance of economic activity in the determination of dependency and in so doing they point to the inadequacy of much of the debate on retirement provision. The 1983 Green Paper on the reform of the State Earnings Related Pension Scheme (SERPS) used the argument that future higher dependency levels would be too great for the economy to bear without a reduction in the cost of state pension provision. In failing to acknowledge the importance of economic activity on dependency, policy options other than the reduction in the cost of pensions, such as the scope for increasing employment levels, increasing female labour market participation and encouraging 'guestworkers' into the economy were not considered. The author concludes her paper with a brief discussion of some of these alternatives, acknowledging that there are ethical and practical considerations to be taken into account.

Comment

This paper offers an interesting analysis of the time trend in Great Britain's dependency ratio between 1951 and 1981. By looking at how changing levels of economic activity have affected it over time, a possible weakness in the argument that there should be a reduction in the cost of state benefit provision, to reduce the burden on the economy of an ageing population, is highlighted. Research such as this shows that, if the worry over dependency levels is well founded, policies designed to increase the level of economic activity also need to be considered.

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Primary Health Care

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C. Muller, M. C. Fahs and M. Schechter. Primary medical care for elderly patients, part I: service mix as seen by an expert panel. *Journal of Community Health*, 14, 2 (1989), 79-87.

M. C. Fahs, C. Muller, M. Schechter. Primary medical care for elderly patients, part II: results of a survey of office based clinicians. *Journal of Community Health*, 14, 2 (1989), 89-99.

In preparation for a United States national conference on paying physicians for geriatric care held in May 1986, a two-part study of geriatric non-hospital care was carried out. The aim of this research

was to gain more insight into the special needs of the elderly and their connection with the United States health care payment system. The results of both studies are published as two papers.

In the first study a telephone interview was conducted with six geriatricians in different parts of the country. Four themes of geriatric care were explored during these interviews: the ability to distinguish long-term health decline from reversible aspects of a patient's condition, environmental (physical and social) influences on health, prevention and the difficulties in the functional assessment of this client group. The interviewers also asked questions on the extent to which the physical, cognitive and emotional characteristics of elderly people affected the care they should receive, in terms of the time taken in consultation and the interpretation of the presenting symptoms. The geriatricians were also asked about the special responsibility physicians had when dealing with the elderly and the limitations the Medicare payment structure imposed on care given. The results of this research are not presented in a rigorous manner and are only discussed by way of background to the second study, which is detailed in the second paper.

The second survey was designed to look at the fit between the special needs of community-dwelling elderly people and the services and payments approved of by Medicare and available from primary-care physicians. To do this a sample of primary-care physicians were questioned about the services they provided for elderly patients, the time it took them to perform various tasks, the services they would like to see added – or believed to be restricted – by features of the payment mechanism, and the merits of alternative reimbursement systems suggested to them. The findings are presented and compared with the views of the geriatricians obtained in the first survey. The sample was selected on a geographic and specialty basis. In terms of the latter, those eligible for inclusion were general and family practitioners and internists in office-based settings serving the elderly. The response rate obtained was not given, but a total of 60 physicians were interviewed.

The physicians were first asked about the care they gave to the elderly. It was found that the majority of the sample had made adjustments to their practice to meet the needs of the elderly, such as being willing to make house calls and visit nursing homes. Most said that obtaining a history from the patient took longer with elderly people. The average amount of time spent on an initial consultation was reported to be 38 minutes, although one in nine said they spent less than 20 minutes with their patient. Only one in five spent at least an hour with the person, which was the amount of time recommended by the geriatricians.

In terms of the effects of payment coverage on practice patterns, between 30 and 57% of the physicians were aware of a negative effect different payment limitations had on their own practice. More than half (57%) of them believed that Medicare's benefit structure limited their diagnostic and treatment options and made the patient less willing to visit or revisit. Deductibles and co-insurance were said to constrain decisions less frequently. Thirty per cent said there are procedures they performed which were not covered at all by Medicare. Some of those things thought to be important by geriatricians, but difficult to cover under the benefit structure, such as mental state evaluations, environmental appraisals and functional assessments, were not mentioned as being performed at all by most of the respondents. A large proportion of respondents (43%) said that there were non-physician services needed by them to carry out a plan of care that were not covered. Respondents mentioned either home care or social service provision in this category.

The opinions of the physicians were sought on the subject of alternative payment mechanisms. The largest majority for any proposal was registered in favour of payments to be made for preventive and health maintenance services. Most respondents supported increasing the relative payments for office visits compared with surgery. A majority also approved of making payments proportional to the time spent 'with or for' the patient and increasing the payment for house calls. The use of capitation payments for all the elderly was favoured by only 30%.

In their discussion of the results, Fahs *et al.* conclude that this exploratory survey suggests that there is a real gap between the geriatricians' view of ideal care for the elderly and the care they actually receive. This discrepancy could be due to several factors, such as the limited expectations physicians may have as to what can be done for this group. It is likely though that a major obstacle to appropriate care for the elderly is the failure of the Medicare payment system to reflect the special needs of this group, as to the types of service and amount of physicians' and other professionals' time required in their management.

Comment

These papers offer an initial investigation into the probability that elderly persons will not receive health care appropriate to their needs in the US. Also that this is a consequence of the inadequacies of the Medicare reimbursement mechanism. Both of these conclusions are interesting if not very surprising. There are problems with this type of

research though, both methodologically and in the interpretation of any findings obtained. The main problem being that it is the reported and not the actual care that is recorded. Also the physicians were given a convenient rationale, in terms of the inadequacies of the reimbursement mechanism, for the pattern of care they delivered. It would have been interesting to have compared their responses to the same questions about the care they delivered to other patients' groups. Nevertheless, the results reported here are of interest to those concerned with the medical care of elderly people in the United States.

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