stimuli in health[53] and disease.[54] Meanwhile, we should aim at providing patients with as clear an understanding of their disease as possible and using the drugs available with circumspection, remembering that treatment is likely to be lifelong. Decisions should be made with, rather than for, the patient, making it possible to share disappointment at failure and pleasure when treatment is effective.

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1 Raynaud M. *On local asphyxic and symmetrical gangrene of the extremities and new researches in the nature and treatment of local asphyxia of the extremities. Selected monographs, Vol 121.* London: Sydenham Society, 1888. (Translated by T Barlow).
2 Lewis T. Experiments relating to the peripheral mechanisms involved in spasmodic arrest of the circulation in the fingers. A variety of Raynaud's disease. *Heart* 1929;**15**:7-101.
3 Black CM. Connective tissue disorders: scleroderma. *Br J Hosp Med* 1979;**22**:28-37.
4 Tan EM, Chem EKC, Sullivan KF, Rubin RL. Antinuclear antibodies (ANAs): diagnostically specific immune matters and clues towards the understanding of specific autoimmunity. *Clin Immunol Immunopathol* 1988;**47**:121-41.
5 Freedman RR, Sabharwal SC, Desair N, Wenig P, Mayes M. Increased alpha-adrenergic responsiveness in idiopathic Raynaud's disease. *Arthritis Rheum* 1989;**32**:61-5.
6 Keenan EJ, Porter JM. Alpha-two adrenergic receptors in platelets from patients with Raynaud's syndrome. *Surgery* 1983;**94**:204-9.
7 Kahalch MB, Osborn I, Le Roy EC. Elevated levels of circulatory platelet aggregates and beta-thromboglobulin in scleroderma. *Ann Intern Med* 1982;**96**:610-3.
8 Goyle KB, Dormandy JA. Abnormal blood viscosity in Raynaud's phenomenon. *Lancet* 1976;i:1317-8.
9 McGrath MA, Peek R, Penny R. Blood hyperviscosity with reduced skin blood flow in scleroderma. *Ann Rheum Dis* 1977;**36**:569-74.
10 Blunt RJ, George AS, Hurlow RA, Strachan CJL, Stuart J. Hyperviscosity and thrombotic changes in idiopathic and secondary Raynaud's Syndrome. *Br J Haematol* 1980;**45**:657-1.
11 Dodds AJ, O'Reily MJG, Yates CJP, Cotton LT, Flute PT, Dormandy JA. Haemorrheological response to plasma exchange in Raynaud's syndrome. *Br Med J* 1979;ii:1186-7.
12 Cunliffe WJ, Menon IS. Blood fibrinolytic activity in diseases of small blood vessels and the effect of low molecular weight dextran. *Br J Dermatol* 1969;**81**:220-5.
13 Browse NL, Gray L, Jarret PE, Morland M. Blood and vein-wall fibrinolytic activity in health and vascular disease. *Br Med J* 1977;i:478-81.
14 Halpern A, Kutum PH, Sheftel HE, *et al*. Raynaud's phenomenon and serotonin. *Angiology* 1960;**11**:151-67.
15 Terregino CA, Seibold JR. Influence of the menstrual cycle on Raynaud's phenomenon and cold tolerance in normal women. *Angiology* 1985;**36**:88-95.
16 Heslop J, Coggon D, Acheson ED. The prevalence of intermittent digital ischaemia (Raynaud's phenomenon) in general practice. *J R Coll Gen Pract* 1983;**33**:85-9.
17 Bennett R, Blueston R, Holt PJL, Bywaters EGL. Survival in scleroderma. *Ann Rheum Dis* 1971;**30**:581-8.
18 Freedman RR, Ianni P. Role of cold and emotional stress in Raynaud's disease and scleroderma. *Br Med J* 1983;**287**:1499-502.
19 Jobe JB, Sampson JB, Roberts DE, *et al*. Induced vasodilation as treatment for Raynaud's disease. *Ann Intern Med* 1982;**87**:706-9.
20 Jobe JB, Batham WP, Roberts DE, *et al*. Induced vasodilation as a home treatment for Raynaud's disease. *J Rheumatol* 1985;**12**:953-6.
21 Goodfield MJD, Rowell NR. Hand warming as a treatment for Raynaud's phenomenon in systemic sclerosis. *Br J Dermatol* 1988;**119**:643-6.
22 Smith CD, McKentry R. Controlled trial of nifedipine in the treatment of Raynaud's phenomenon. *Lancet* 1982;ii:1299-301.
23 Thomas RHM, Rademaker M, Grimes SM, *et al*. Nifedipine in the treatment of Raynaud's phenomenon in patients with systemic sclerosis. *Br J Dermatol* 1987;**117**:237-41.
24 Rademaker M, Cooke ED, Almond NE, *et al*. Comparison of intravenous infusions of iloprost and oral nifedipine in treatment of Raynaud's phenomenon in patients with systemic sclerosis: a double blind randomised study. *Br Med J* 1989;**298**:561-4.
25 Grigg MJ, Nicolaides AN, Papadakis K, Wolfe JHN. The efficacy of thymoxamine in primary Raynaud's phenomenon. *European Journal of Vascular Surgery* 1989;**3**:309-13.
26 Jarrett PEM, Morland M, Browse NL. Treatment of Raynaud's phenomenon by fibrinolytic enhancement. *Br Med J* 1978;ii:523-5.
27 Martin MFR, Dowd PM, Ring EFR, *et al*. Prostaglandin E_1 infusion for vascular insufficiency in progressive systemic sclerosis. *Ann Rheum Dis* 1981;**40**:350-4.
28 Kyle V, Parr G, Salisbury R, *et al*. Prostaglandin E_1, vasospastic disease and thermography. *Ann Rheum Dis* 1985;**44**:73-8.
29 Dowd PM, Martin MFR, Cooke ED, *et al*. Treatment of Raynaud's phenomenon by intravenous infusion of prostacyclin (PGI_2). *Br J Dermatol* 1982;**106**:81-9.
30 Belch JJF, Newman P, Drury SK, *et al*. Intermittent epoprostenol (prostacyclin) infusion in patients with Raynaud's syndrome. *Lancet* 1983;i:313-5.
31 Rademaker M, Thomas RHM, Provost G, *et al*. Prolonged increase in digital blood flow following iloprost infusion in patients with systemic sclerosis. *Postgrad Med J* 1987;**63**:617-20.
32 McHugh NJ, Csuka M, Watson H, *et al*. Infusion of iloprost, a prostacyclin analogue, for treatment of Raynaud's phenomenon in systemic sclerosis. *Ann Rheum Dis* 1988;**47**:43-7.
33 Aldoori R, Campbell WB, Dieppe PA. Nifedipine in the treatment of Raynaud's syndrome. *Cardiovasc Res* 1986;**20**:466-70.
34 Sorkin EM, Clissold SP, Brogden RN. Nifedipine: a review of its pharmacodynamic and pharmaceutic properties and its therapeutic efficacy in ischaemic heart disease, hypertension and related cardiovascular disorders. *Drugs* 1985;**30**:182-274.
35 Coulton DM. Eye pain with nifedipine and disturbance of taste with captopril: a mutually controlled study showing a method of post marketing surveillance. *Br Med J* 1988;**296**:1086-8.
36 Birmingham AT, Szolcsanyid J. Competitive blockage of adrenergic receptors and histamine receptors by thymoxamine. *J Pharm Pharmacol* 1965;**17**:449-58.
37 Myers KA, Hobbs JT, Irvine WT. Haemodynamic action of thymoxamine in occlusive peripheral arterial disease. *Cardiovasc Res* 1968;**2**:360-6.
38 Aylward M, Bater PA, Davies DE, Dewland PM, Lewis PA, Maddock J. Long term monitoring of effects of thymoxamine hydrochloride tablets in the management of patients with Raynaud's disease. *Curr Med Res Opin* 1982;**8**:158-70.
39 Yardumian DA, Isenberg DA, Rustin M, *et al*. Successful treatment of Raynaud's syndrome with iloprost, a chemically stable prostacyclin analogue. *Br J Rheumatol* 1988;**27**:220-6.
40 Belch JJF, Madlok R, Shaw B, Leiberman P, Forbes CD, Turrock RD. Double blind trial of CL115,347, a transdermally absorbed E2 analogue, in treatment of Raynaud's phenomenon. *Lancet* 1985;i:1180-3.
41 Cooke ED, Bowcock SA, Watkins GJ, *et al*. CL 115347. An analogue of prostaglandin E2. Peripheral circulatory effects of single ascending doses administered transdermally in normal subjects and patients with Raynaud's phenomenon. *Angiology* 1985;**36**:867-71.
42 Dunger DB, Dillon MJ, Daman-Willems C, Cooke ED, Bowcock SA. Treatment of childhood Raynaud's disease by transdermal prostglandin E2 analogue. *Lancet* 1985;ii:50.
43 Rustin MHA, Almond NE, Beacham JA, *et al*. The effect of captopril on cutaneous blood flow in patients with primary Raynaud's phenomenon. *Br J Dermatol* 1987;**117**:751-8.
44 Roald OK, Seems E. Treatment of Raynaud's phenomenon with ketanserin in patients with connective tissue disorders. *Br Med J* 1984;**289**:577-9.
45 Seibold JR, Terresino CA. Selective antagonism of S_2-serotonergic receptors relieves but does not prevent cold induced vasoconstriction in primary Raynaud's phenomenon. *J Rheumatol* 1986;**13**:337-40.
46 Nakir AM, Schapira D, Scharf Y. Double-blind randomised trial for nitroderm TSS in the treatment of Raynaud's phenomenon. *Isr J Med Sci* 1986;**22**:139-42.
47 Anonymous. NSAID's. A gimmick or a godsend? [Editorial] *Lancet* 1989;ii:779.
48 Rice R. Fish oils—their significance to human health. *J R Soc Med* 1988;**81**:499-501.
49 Fisher S, Weber PC. Thromboxane A_3 (TXA_3) is formed in human platelets after dietary eicosopentanoic acid (20:5W_3). *Biochem Biophys Res Commun* 1983;**116**:1091-9.
50 Fisher S, Weber PC. Prostaglandin I_3 is formed in vivo in man after dietary eicosopentanoic acid. *Nature* 1984;**307**:165-8.
51 Di Giacomo RA, Kremer JM, Shah DM. Fish-oil dietary supplementation in patients with Raynaud's phenomenon: a double-blind, controlled, prospective trial. *Am J Med* 1989;**86**:158-64.
52 Singer HA, Peach MJ. Endothertian-dependent relaxation of rabbit aorta. I. Relaxation stimulated by arachidonic acid. *J Pharmacol Exp Ther* 1983;**226**:790-801.
53 Flavahan NA, Vanhoutte PM. Thermosensitivity of cutaneous and deep veins. *Phlebology* 1988;**3**(suppl 1):41-5.
54 Cooke ED, Ward C. Vicious circles in reflex sympathetic dystrophy; a hypothesis. *J R Soc Med* (in press).

Care for the infirm elderly

A widening gap between the poor and the better off

The 1990s seem likely to be a worrying decade for the elderly in Britain—all of whom are uneasily aware that at some time they may need residential care. The publication of the white paper *Caring for People* on 14 November 1989[1] put an end to the speculation about whether and how the government would respond to the Griffiths report on community care.[2] It also completed another part of the jigsaw of radical reorganisation of health and social services provision that began with *Promoting Better Health*[3] and *Working for Patients*.[4] The latest white paper has provoked less controversy than its predecessors, but it falls short of the Griffiths report's recommendations, and it spells out new arrangements for financing and providing services for elderly people that require close analysis.

The white paper cites the 100-fold increase in public subsidy of residential and nursing home care over the past 10 years as evidence of the government's investment in community care. But it also acknowledges the criticism by the Audit Commission[5] and Griffiths that existing social security policies have created "perverse incentives" towards institutional care. In the new proposals a unified budget covering the costs of "social care" will be introduced and managed by local authorities. It will be available for either domiciliary or residential care according to individual need. People in residential care will be entitled to claim income support or housing benefit on a means tested basis, as they would in their own homes, but they will be required to pay most of that income to the local authority that is funding their care. Social services departments will be given the responsibility for assessing the social care needs of dependent people and for planning and purchasing packages of care. They will be expected to collaborate closely with health and other agencies, to set up a system of quality control, and to reduce the part they play as direct providers. The government expects local authorities to make "maximum use" of independent sector

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homes and will discourage (through financial penalties) the continued use of part III accommodation.

The creation of a climate for innovation and growth in domiciliary care will be welcomed, though it is disappointing that the community care budget will not be "ring fenced," as Griffiths recommended. Nor will the new provisions include the long stay hospital sector (even for the elderly)—which would have increased flexibility and helped to avoid the new gulf between hospital and social care which the simplistic distinction in the white paper may encourage.[6] The greatest anxiety, however, must be over the level of funding—particularly in the transitional stage—which Griffiths argued so cogently would be the key to the success of the whole scheme.

Laing and Buisson have recently shown just how far costs in private residential and nursing home care have outstripped even the massive growth in public subsidy over the past few years. Two fifths of elderly residents finance their own care completely, but the remaining three fifths are funded by social security, health, or local authorities.[7] Only 3% of private homes currently charge fees that are at or below the income support level; the average fees for shared (that is, the cheapest) rooms are £30-40 per week above this level. This financial gap bars entry to Department of Social Security clients unless their families can find the money to top up the payments. With these gaps increasing there will inevitably be underfunding as social security money is diverted to the community care budget. Savings from the purchase of (possibly) cheaper domiciliary care packages will be offset by the higher costs of placing people in residential or nursing home care.

The reality may well be that local authorities will have to choose between more care for fewer people or less care for more. Hence the effect of the white paper may be to widen the distinction between the poor and the better off in old age. The elderly poor, who make up half the population in residential care, will have little choice between different homes: they will have to go into those homes with which the local authority can afford contracts. Few will have the option of a single room. Those at the other end of the social scale will have much wider choice in both domiciliary and residential care. Owner occupiers with limited income whose "social care" will be means tested will have a reasonable choice within the residential sector once they have sold their homes, but they seem likely to have cash flow problems with expensive domiciliary packages. As Laing and Buisson comment, many elderly people may be "asset rich," but they are often "income poor."[7]

The crucial question for many elderly people is: What happens when the money runs out? *Caring for People* addresses this issue in part. Residents of residential and nursing homes who are already receiving income support will continue to do so when the new funding structure comes into existence on 1 April 1991. Other residents, who are currently financing their own care but who eventually spend down their capital to income support limits will also be entitled to public support, though they may have to move to cheaper homes. New residents entering residential care after April 1991 should not, in principle, run out of money because local authorities will have accepted financial responsibility for them. Nevertheless, they may find that if they or their families cannot top up their social security entitlements they will be forced into the poorest and cheapest accommodation.

Radical changes in financing residential care are likely to have a major impact on the way the care is organised and marketed. Reduced public subsidies may see the closure of some homes, economies made in staffing costs and amenities, and the growing dominance of commercial providers (such as brewers, hotel chains, and the leisure industry), which benefit from economies of scale. Local authority provision is likely to decline, and the cottage industry of family run homes will give way to more profit orientated care supplied by major corporations. While the physical facilities in homes may improve as a result of these changes, there may be as little sympathy for the elderly person running out of resources as there is for the hotel guest who cannot pay the bill. The new provisions for inspecting and monitoring residential care will be vital in protecting the interests of vulnerable elderly people who buy, or have bought for them, a package of services in the market place.

Mr Clarke will enjoy a wider measure of professional support for this white paper than has been his experience at the Department of Health, though there will again be anxiety at the flaws and oversimplification inherent in the broad sweeps of his brush. He must be given credit for placing the central responsibility on social services departments, but they will be taking on a very tall order with little time to deliver. Successful implementation will require exceptional good will and detailed collaboration over workload and budgets locally. If this is to succeed adequate funding will be absolutely crucial, particularly in the period of transition.

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1 Secretaries of State for Health, Social Security, Wales and Scotland. *Caring for people*. London: HMSO, 1989. (Cmnd 849.)
2 Griffiths R. *Community care: agenda for action*. London: HMSO, 1988.
3 Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland. *Promoting better health*. London: HMSO, 1987. (Cmnd 249.)
4 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989. (Cmnd 555.)
5 Audit Commission. *Making a reality of community care*. London: HMSO, 1986.
6 Ruddle S, Higgins J. *Caring for people: the government's proposals for community care. A commentary*. Southampton: Institute for Health Policy Studies, University of Southampton, 1989.
7 Laing WA, Buisson AJ. *Care of elderly people: market survey 1988/89*. London: Laing and Buisson, 1989.

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