USSR Letter

Care of the elderly

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The Soviet Government's preoccupation with very low birth rates in European areas of the Soviet Union has tended to obscure a striking demographic shift which is occurring at the other end of the age scale. That the Soviet population has been "aging" rapidly in recent decades may be inferred from the number of people receiving an old age pension; the latest statistical yearbook records an increase from 16.0 million to 33.1 million between the years 1966 and 1980. Over this period pensioners as a group increased sharply from 6.8% to 12.4% of the total population.

These bare statistics prompt the question: what responses have been devised by the health service in the face of a clearly formidable challenge? A partial answer was provided recently by *Meditinskaya Gazeta* in an article whose critical analysis appears so authoritative and well-documented that it suggests concern on the part of the Communist Party, the self-proclaimed guiding force of Soviet society.¹

Detering the patient

Approaching his subject by way of anecdotal description—a standard route in much Soviet journalism—the author first writes about a lively old man who lives in the neighbourhood. This informant, by name Afanasi Kuzmich, provides an incisive report of his experiences at the local polyclinic.

"You see, I complain to the doctor about my heart and she interrupts me with 'But how old are you?' Politely but pointedly. Then I hear her say, 'But what do you expect, dear man? I am not going to give you my heart.'"

The nurse who administers his treatment, although also polite, murmurs:

"Oh, if I had a pension like yours, granddad, I would enjoy myself and not go visiting doctors."

So, not at all surprisingly, Afanasi visits the polyclinic only rarely.

The author does not contend that the attitudes illustrated above are deeply embedded in the country's sociocultural history and can thus be expected to have a large-scale deterrent effect. Nevertheless, such a conclusion might well be suggested by data that he cites for frequency of contact with the health service: "Only 29.4% of sick persons aged 60 and over seek medical assistance at least once in the year—the remainder do so less frequently."

A degree of blame for this situation is apportioned to medical institutes, where two major omissions are pinpointed in training programmes. Firstly, students are not given appreciative

preparation for a work setting in which "a good half of their future patients will be old people who, of course, cannot be given a new heart but who have an urgent need for the sympathy and warmth of another's heart."

The second criticism relates to inappropriate methods of treatment used by ordinary polyclinic doctors. Frequently they display an ignorance of how drugs interact in the organism of an old person. Moreover, again according to "specialists" whom the author had interviewed, they often place excessive reliance on drugs in managing patients and are prone to prescribe large doses. Incidentally, confirmation of that point was contained in letters from complainants, one of whom wrote: "If you go to a young doctor, be prepared to carry away a heap of prescriptions in your pocket. If you see another doctor a month later, again you'll get a lot of drugs—but they will have different names. . . ."

A basic contradiction

Here it is relevant to recall that the doctors in question are sector *terapevty* (general physicians), who share responsibility for providing a first-line service with other basic specialists, such as sector paediatricians. At present geriatrics is beginning to emerge as a new specialty at polyclinic level and, ironically, this development appears likely to complicate the problem of improving medical care for the elderly. The article notes: "It is not accidental that, in those polyclinics where geriatric rooms have been opened, the doctors working in them spend more time on treating patients than acting as consultants. Elderly patients in such cases no longer go to the sector doctor but prefer the geriatrician. When he treats them he takes account of their age and makes suggestions about nutrition, rest, and how to lead an active life; in a word, he gives advice on everyday problems."

The preference of patients, referred to above, constitutes empirical evidence of the theoretical contradiction which lies at the root of outpatient care in the Soviet Union. This contradiction resides in the fact that demarcation of areas for specialist practice, and the related disaggregation of patients by reference to age, sex, or presenting symptom, has the inevitable consequence of reducing the sector *terapevt*'s opportunities and incentives to adopt the holistic approach of family doctoring.

At present, admittedly, the issue of irreconcilable tendencies hardly arises in connection with geriatrics, since this specialty has reached only a nascent stage. It does not appear on the official list of specialties, and the number of geriatric rooms in the whole Soviet Union stands at a mere 140. Work in geriatrics has little attraction because it is demanding—"one has to display special patience during consultations and speak loudly in order to be heard"—and because remuneration is less and leave shorter than for sector *terapevty*. In any case, the number of qualified applicants for the new posts must be fairly small since the country has only one professorial department of geriatrics, which is located at the Institute for Advanced Medical Training in Kiev.

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A Cinderella service

Commenting on the slow progress being made in geriatrics, the article isolates as the main underlying cause "a certain psychological barrier that hinders appreciation of the vital importance of training doctors in geriatrics and of seeking organisational solutions for improving sociomedical care for people of 'the third age.'" In April 1977 the USSR Ministry of Health issued an order that envisaged the establishment, on an experimental basis, of geriatric medical and social centres. But four years later no decision had been reached as to what specific range of functions should be performed by these units. That responsibility for this protracted lead time rests primarily with the Health Ministry seems probable, but the article states that many health service administrators and chief specialists at republican and regional levels have a lazily dismissive attitude to the requirements of geriatrics.

Against a background of various competing requirements, the author suggests, provision for the elderly is regarded as something that can wait its turn for attention. This perception, however, fails to take account of the quantifiable realities: about 30% of hospital beds are occupied by those aged 60 and over, and this category also accounts for roughly half of all house calls by polyclinic staff and brigades of the emergency care service.

That improvements in care at polyclinic level may turn out to be cost-effective is strongly suggested by the findings of a study that examined the reasons for "03" calls for emergency care. The researchers reported that 20% of calls proved to be unjustified and that half of them were made by patients who could have been treated by the polyclinic doctor, "had he been more attentive towards old people." In the time they spent on such cases the brigades could have attended to others whose need was more urgent.

Improvements in outpatient care could also result in more rational use of that most costly resource—the hospital bed. At present some hospital administrators attempt to avoid blocking beds with chronic cases by adopting a policy of restricted admission for pensioners. In a letter to *Meditsinskaya Gazeta* a member of an emergency care brigade pointed out that not only his colleagues and polyclinic doctors knew of this discrimination

but that pensioners themselves sensed it. Confirming this point, the author goes on to record the resentment conveyed in many letters whose dominant theme was: "When we worked we were needed. But what about now?" On a lighter note, he recounts how the sister of his informant Kuzmich was admitted to hospital thanks to an adroit ruse: the sector *terapevt* telephoned in advance and, when giving the patient's age, knocked off some ten years.

Examining options

It appears that the USSR Health Ministry has yet to formulate any clear policy guidelines in respect of hospital provision for the elderly, and the article touches briefly on various possible developments. One is the long-stay unit; but the desirability of such a hospital is questioned on the ground that it is liable to become a sad refuge for old people who are dying. Another is the hospital catering for the chronically sick, in which pensioners would be treated alongside younger patients. That option receives no adverse comment. More likely to be adopted, though, is a strategy that "specialists consider suitable"—namely, the establishment of geriatric departments within general hospitals. It is interesting that these imprecisely identified "specialists" are also reported as examining the concept of the day hospital.

The Soviet Union may be considered fortunate in that the "aging" of its population has occurred later than in many other developed societies. The advantage for Soviet health care planners obviously lies in the opportunity to examine accounts of policies adopted elsewhere and, by learning from others' mistakes, to avoid pitfalls in the way ahead. Whether in practice they will devote close attention to cross-national studies must depend on various factors, including the priority-rating assigned to the task of developing a geriatric service. To judge from the evidence cited above, the Health Ministry is not currently engaged in vigorous pursuit of that objective.

Reference

- 1 Borich I. Dedushka zabolet. *Meditsinskaya Gazeta* 1981;78:2.

A young woman is visiting the Middle East for an archaeological dig for the second year running. Last year she was given a prophylactic dose of gammaglobulin for hepatitis—should this preventive treatment be repeated?

Viral hepatitis is a common hazard for expatriates visiting the Middle East, particularly if they are living "rough" as might be expected on an archaeological dig. Gammaglobulin can provide some measure of protection against virus hepatitis A for three to six months.¹ As the protection period is short the preventive treatment with gammaglobulin should be repeated before she returns to the Middle East.—D R W HADDOCK, senior lecturer in tropical medicine, Liverpool.

¹ World Health Organisation. *Vaccination certificate requirements for international travel and health advice to travellers*. Geneva: WHO, 1982:49.

A patient regularly suffers from "harvest mite" spots when fruit picking in the summer. This year the patient developed the first spots in April, and these continued whenever she went gardening until October. What might be the reason for this, and what treatment is advised?

In Europe the common harvest mite is *Trombicula autumnalis*, which is generally active from May to October when the larvae are feeding on low vegetation. To complete their life cycle they need to feed on animal protein, which is why they attach themselves to a passing animal host. In the case of man they tend to move to where the horny layer is thin and to moist areas such as the thighs, groins,

waist, and ankles.¹ The mite attacks the host's skin by producing a liquid by the action of injected saliva on the superficial keratin. Having completed its meal, which takes up to five days, the mite then drops off to complete the life cycle in the soil. The attack by the mite produces a trivial, usually unnoticed, reaction. Occasionally a much more severe erythematous, irritating response may occur. In the case of pyemotes, the grain mite, there is evidence of a type I allergic reaction, and in one patient a positive patch test suggested a type IV (delayed) sensitivity.² Such an allergy might account for why only a few of the individuals exposed to mites develop severe reactions.

Insect repellents such as dimethylphthalate that have a toxic effect on the mite are effective, but application must be repeated frequently. Benzyl benzoate has a prolonged effect, and there is one report of soldiers finding that clear nail varnish gives immediate relief when applied to the site of the bite. Lorexane (gamma benzene hexachloride) is effective as an insecticide.³ It is also safe when used in a 1% concentration. The duration of exposure is less important than the concentration, as shown by studies of blood and tissue concentrations in chronically exposed workers. In young children there is a particular risk of seizures after excessive exposure. Blood dyscrasias, haemolytic anaemia, depressed liver function, and cardiac arrhythmia have been reported.—P K BUXTON, consultant dermatologist, Edinburgh.

¹ Rook A, Wilkinson DS, Ebling FJG. *Textbook of dermatology*. 3rd ed. St Louis: Mosby, 1979:945-6.

² Hewitt M, Barrow GI, Miller DC, Turk SM. A case of Pyemotes dermatitis. *Br J Dermatol* 1976;94:423-30.

³ Solomon LM, Fahrner L, West DP. Gamma benzene hexachloride toxicity. *Arch Dermatol* 1977;113:353-6.