How can the mental health needs of the elderly be managed in a context of ageing population and financial constraint?

A comparison between Wales and France

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Methodology

This report is the result of a two months project conducted by a French Director of Health and Social Services Trainee from the French Public Health School (EHESP, Ecole des Hautes Etudes en Santé Publique). The goal of this study was to draw a comparison between French and Welsh policies about the mental health of the Elderly. As a future Director of nursing home, with a background in Law School and a Master degree in health’s legislations, this field of research was particularly relevant for the author who had the opportunity to get accustomed to different approaches and mechanisms to tackle the older people challenges.

This report is based on documentary research both in French and English and interviews, following a “Snowball Process”, the first documents and contacts were indicated by Public Health Wales, then by the contacts and people interviewed themselves. 13 interviews were carried out, most of them have been made directly on the work place allowing the author to discover the practical reality of the implementation of policies.
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Introduction

This work is based on a two month internship with Public Health Wales in Cardiff by a French Director of Health and Social Services Trainee from the French Public Health School (EHESP). The main goal of the internship was to draw a comparison between Wales and France in their policies and actions for the elderly, especially the mental health of older people. The aim of this work was to compare documents from both countries and to obtain a personal experience of the systems, by several meetings and field analysis (visiting nursing homes, hospital, social services etc.). Indeed as a future professional it seems essential to be able to measure the potential gap between actions plans, strategies and his tangible implementation. It has been helpful to discover that even if the health organisations are not the same, with different tools and approaches to tackle the ageing population, the challenge is common and in numerous cases the different policies and solutions proposed face the same issues.

The report is organised in two parts, firstly a presentation of important characteristics of the countries studied, then a description and an analysis of the elderly care systems with an important focus of the mental health. There is a strong emphasis on the description of the French system which is the most familiar for the author and because it appears that it could usefully enlighten the elements of comparisons. There is also a description of the elderly care system before talking more precisely about the mental health of the elderly because these both subjects are strongly interrelated.
I- **General elements of comparison**

- Presentation of the two countries, some statistics

At first sight, from geographic and demographic aspects it is not easy to find common points of reference between France and Wales. Indeed France is a bigger country with an area of 674 843 Km² and a population of 65 350 000 habitants¹ whereas Wales has an area of 20 779 Km² for a population of 3 064 000². One individual underlined that the population of Wales is equivalent to the population of a single local authority for his English neighbour.

However they both present similarities with a contrasted geography. They have both high concentration of population in urban zones and rural zones less populated, with pockets of deprivation, with problems of access to services and an ageing population³. This generates geographic inequalities, thus in north of France (Nord Pas de Calais) male life expectancy is shorter by 5 years compare to Ile de France (Paris)⁴. These inequalities are often strongly related to the social and economical conditions, for instance in Wales within the city of Cardiff there is a gap of 10 years in life expectancy between the wealthy district of Cyncoed and the more deprived area of Butetown⁵, and in France the life expectancy of a white collar worker is 6.3 years greater than a blue collar worker⁶.

Just like the other OECD countries, France and Wales are facing the challenge of an ageing population. In Wales within the next twenty years 1 out of 3 people will be over 60 years old. In 2010 18.6% of the population was over 60, but with important differences between local authorities (23.1% in Powys, 24.5% in Conwy both are rural areas)⁷. Wales has the highest rate of people over 64 in United Kingdom⁸. In France more than 30% of the population will be over 60 in 2035, it was only 21% of the population in 2007. Between 2007 and 2060 the number of people over 60 years

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¹ "Bilan demographique 2010" Insee Première N°1332 - janvier 2011
² "Wales's Population - A demographic overview, 2010" 
³ « The ageing population is increasing faster in rural authorities than in urban areas” Rural Health Plan, Welsh Assembly Government 2009
⁴ "Dans quelles régions meurt-on le plus tard au début du XXIe siècle?” Insee Première N° 1114 – Decembre 2006
⁵ “Together for health – A five years vision for the NHS in Wales”, 2011, NHS Wales and Welsh Government
⁶ “L’espérance de vie s’accroît, les inégalités sociales face à la mort demeurent” Insee Première N° 1372 - octobre2011
⁷ Older people indicators 2012, Public Health Wales Observatory
⁸ "Healthy ageing Action plan for Wales", Health Challenge Wales, Welsh Assembly Government, 2005
could increase by 80%\(^9\). These figures show the major challenge that care of the elderly will represent in the next few years in both countries which will have to think about how to adapt their systems with new policies, funding and innovative solutions to tackle this issue.

- **Presentation of the two systems**

  France and Wales are two developed democratic countries, members of European Union, who share a number of principles. France is a unitary state with a decentralized organisation of delivery, which means basically that the central power in Paris takes the main political decisions but in precise fields (such as social, transports...) leaves a certain amount of autonomy to the local authority for their implementations. For instance the local authority name “Département” has an important role in social policies, social services and especially for the elderly, indeed the Département is responsible for the universal benefit for the elderly: the Personal Allocation of Autonomy (called APA for Allocation Personnalisée d’autonomie) and some other mean tested benefits for the older people. But all French local authorities have no power as lawmakers, they may adapt a law to the local challenge as a part of their role in the implementation but they cannot bring a new ruling. We may explain that conception of a centralized state by the impact of the French history (Revolution and the Empire of Napoleon were two eras where the state was very unitary and powerful) and the principle of equality which denies any difference of treatment if it is not justified.

  However the French decentralized organization cannot be compared in term of autonomy with the organization of the United Kingdom. The UK is also a unitary state with power centralized within the sovereign Parliament in Westminster, but since the end of the 1990s it has allowed an important devolution of responsibilities to the electorate bodies of Scotland, Wales and Northern Ireland. In 1998 a National Assembly of Wales was established and the 2006 Act gave power to the assembly to make laws in defined areas such as health, social, education. Thus Wales is autonomous in specific areas with a different political vision than England as is encapsulated by a famous quote by Rhodri Morgan, the former welsh Prime minister: “A line of clear red water has been drawn between Wales and England”\(^{10}\) referring to the long tradition of centre left wing position of Wales. Wales is still dependant on some the central government decisions. Wales is organised in 22 Local Authorities, 80% funded by the Welsh government\(^{11}\) to provide statutory services (responsible for housing, social

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\(^9\) “Projections de population à l’horizon 2060 Un tiers de la population âgé de plus de 60 ans” Insee Première N° 1320 – Octobre 2010

\(^{10}\) “Public Health Wales 1800-2012, A brief History” Pamela MICHAEL and Steven THOMPSON, 2012

\(^{11}\) “Governance of Wales”, Assembly of Wales website
services) for which Local Authorities have discretionary power, this is similar to the French system of decentralisation.

Nevertheless, only the UK government is capable of receiving taxes and then redistributing funds and it keeps its power in number of fields within the social welfare and the state benefits. Several people met during this internship noted that the redistribution is problematic. They are unsatisfied with the funding from UK government which is related to the number of the population and not to the needs which are important in this ancient industrialised country. Therefore some UK government reforms which are trying to cut the costs of the state have a strong impact on Wales\(^\text{12}\), especially the Welfare Reform Act 2010-2012, with new severe criteria for social benefits\(^\text{13}\).

- Presentation of the two health systems

Concerning the health system, both France and Wales have a comprehensive health system with strong public funding. According to the OECD, in 2009 health expenditure represented 11.8% of the French GDP (it is the third higher rate in the OECD country) and it is 9.8% of the GDP in UK. In UK 84% of health spending was funded by public resources; it is only 78% in France (then it is 7% for the patient and 13% for private insurance)\(^\text{14}\).

The countries have different organisation and philosophy. Whereas the British National Health Service is universal, providing a free health cover for every citizen with funding based on taxes, the French health system is more hybrid. It was inspired by both the British Beveridge Report of 1942 and the Bismarck insurance system in Germany that can explain the dual characteristics of the French “Sécurité Sociale”. Indeed as the German system, the funding is principally based on the workers and their contributions but the social security cover is not only for the workers and their relatives but universal like the NHS in the UK. That is why with time taxes are becoming an important resource of the Sécurité Sociale.

The French Sécurité Sociale cannot be compared to the British NHS because it has a field of action much wider. It represents the French welfare state as the Sécurité Sociale, not only in charge of health but also of work accidents and disease, retirement pensions and benefits related to the

\(^{12}\) “Wales on the edge : on overview of the current and predicted impact of Welfare Reform on people and communities across Wales” Cuts Watch Cymru, 2012

\(^{13}\) According to the Cuts Watch Cymru Report 1 in 5 of the Welsh population are claiming some form of benefit

\(^{14}\) “Health at a glance 2011 OECD Indicators” OCDE report, 2011
family. To simplify, if we refer to the Gøsta Esping-Andersen classification of Welfare State\(^\text{15}\), we can define the French system as “corporatist-static” (based on the workers but providing a large rank of benefits to the population, the French benefits system is quite generous with universal benefits not mean tested) whereas the UK welfare state is more “liberal” (with a Welfare system working as a safety net, the benefits are for the poorest part of the population). Closing this parenthesis upon the welfare state, the part of the Sécurité Sociale dedicated to the Health is the National Health Insurance called “Assurance Maladie” or AM.

Now that we have described the French specificities it is important to explain that NHS Wales and it’s vision of health is not exactly the same as it is in England, which is the system usually described when international literature talks about the NHS. NHS Wales had an important reform in 2009 with reorganisation of the services perceived as too complex and bureaucratic\(^\text{16}\). Before 2009 there were 22 Local Health Boards and 7 NHS Trusts, and like in England the NHS was based on an internal market where competitions between health providers were supposed to help controlling the cost. The 2009 Reform put an end to the internal market for an approach more coordinate and collaborative, it also simplified the organisations with now only 3 NHS trusts and 7 Local Health Boards responsible for planning and delivering primary, secondary and community services\(^\text{17}\). These Local Health Boards (LHB) have autonomy for their health planning which explain the different solutions existing in each LHB.

However the French and Welsh health systems share two important challenges which are directly interesting to this work: first of all to tackle health inequalities\(^\text{18}\), it is a priority for each country, and to cope with a difficult economic situation. Health and social services represent 40% of the investments of the Welsh government and the document “Five year vision for NHS Wales – Together for Health” insists on the idea of sustainability by “making every penny count” reminding regularly that the funding is now limited. In France the budget deficit of the Sécurité Sociale has been worsened by the economic crisis and had reached 18.2 billion of Euros in 2011\(^\text{19}\) and the debate over the sustainability of the health budget is ongoing.

\(^{15}\) “The Three Worlds of Welfare Capitalism” Gøsta ESPING-ANDERSEN, 1991
\(^{16}\) “Public Health Wales 1800-2012, A brief History” Pamela MICHAEL and Steven THOMPSON, 2012
\(^{17}\) “NHS in Wales, Why we are changing the structure”, NHS Wales and Welsh Assembly Government, October 2009
\(^{18}\) In Wales It is one of the 6 themes of the “Five year vision for NHS Wales – Together for Health”, in France a report (“Rapport les inegalités sociales de santé : sortir de la fatalité” Haut Conseil de la Santé Publique, 2009) points out precisely the weakness of the French system
\(^{19}\) Statistics from the “Projet de Loi de finances de la Sécurité Sociale pour 2012”
II- The mental health of the elderly, a major challenge in the health of the older people

We will begin with a quick overview of both care of the elderly organisations to have a good vision of the organisations’ shapes. Then we will analyse and focus on specific aspects of the national policies and approaches.

A- Presentation of the two eldercare system

In each country the elderly care services are often split between health and social services, care at home or in an institution. Here is a presentation of the situation in France and Wales.

❖ France

In France to mention the problems linked to the lack of autonomy (mentally or physically) of the older people we use the specific word Dependency (“La Dépendance”) which has not really a direct equivalent in international literature but describes the position of someone lacking physical or mental capacity and as a result being dependent.

Panorama of the elderly policies: The official awareness of the looming health challenge associated with the elderly was quite late in France. The first formalised act tackling directly the issue of Dependancy was a 1997 Law\(^{20}\) creating a first benefit for the people lacking in autonomy: the Dependency Specific Allocation (Prestation Spécifique Dépendance PSD). In 2001 a Law\(^{21}\) renovated this benefit with the Personal Allocation of Autonomy (Allocation Personnalisée d’autonomie, APA) a universal allocation for every people over 60 with a lack of autonomy. This year saw also the first Alzheimer disease Plan (Plan Alzheimer 2001-2004). In 2002 an important Law\(^{22}\)

\(^{20}\) Loi 97/60 du 24 janvier 1997 “tendant, dans l’attente du vote de la loi instituant une prestation d’autonomie pour les personnes âgées dépendantes, à mieux répondre aux besoins des personnes âgées par l’institution d’une prestation spécifique dépendance”

\(^{21}\) Loi 2001-647 du 20 juillet 2001 relative à la prise en charge de la perte d’autonomie des personnes âgées et à l’allocation personnalisée d’autonomie

\(^{22}\) Loi 2002-2 du 2 janvier 2002 rénovant l’action sociale et médico-sociale
reorganised the institutions hosting fragile people (children, disabled people, the Elderly) modernising the management and introducing more freedom for the residents and control from the state. It brought a new era for the institutional care of the elderly. The dramatic heat wave of the 2003 summer caused 15000 deaths (the huge majority being elderly). This was a deep shock showing that caring for people in their own home was not protecting them. Since then there have been important National Plans specially targeted on older people with the Alzheimer Plans 2004-2007 and 2008-2012, the healthy ageing Plan 2007-2009 (Plan Bien Vieillir) and the Solidarity advanced age Plan 2007-2010 (Plan Solidarité Grand Age which launched important creation and renovation of places in nursing home). A big debate remains in France about the funding of dependency, indeed the public expenditure for dependency (combining health, housing and the lack of autonomy) in 2010 was 24 billion and it will increase each year. An important reform was planned for 2008, then 2011 but because of the economic crisis it was delayed. The Hollande’s government has announced a text for 2014.

**Benefits:** In France there are two main paths for care of the elderly, at home or in institution. In the past few years there has been a strong emphasis on the strengthening of in-home care as the majority of people wish to stay at home as long as possible. For people over 60 there is a universal financial benefit, the Personal Allocation of Autonomy (APA) it is delivered by the local authority called Departement responsible for the social needs of older people. The APA is not means-tested, and it can be received in home or in institution. The amount given will depend of the income of the person and the degree of dependency of the person. There are six levels of dependency called a GIR, (an Iso Resource Group) from GIR 6 for the lowest to GIR 1 for the most serious problems of autonomy. There are other benefits, but they are mean tested (help for cleaning) or organised locally (meals on wheels). People with low income can be entitled to a benefit from the departement (social help called Aide Sociale du Departement) to help them afford a nursing home.

**Care at home:** The main help comes from the APA, there are 719 000 beneficiaries. A team of professionals assess the needs of the Elderly in order to set up a help plan, the benefit is then calculated to fund this plan. The average amount is 400 Euros a month. There are different services able to deliver the range of services prescribed in the plan; it is a free choice for the beneficiary.

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23 According the INSERM figures
24 "Rapport Accueil et accompagnement des personnes âgées en perte d’autonomie”, groupe Evelyne RATTE, 21 Juin 2011
25 "Rapport sur les perspectives démographiques et financieres de la dépendance" Groupe de Jean Michel CHARPIN, juin 2011
26 Op Cit, Rapport Evelyne RATTE
27 “Prendre en soin les personnes atteintes de la maladie d’Alzheimer : Le reste a charge” Association France Alzheimer, 2010
Even if they are not well recognized officially the carers have an essential role in the system (direct care, support, help for getting information...). Despite these arrangements, lack of autonomy can still have a personal cost for the person. Moreover this system based on local authorities can generate inequalities, indeed difference have been noticed on the methods of assessment between local authorities, also the level of needs and therefore involvement, the quality of the care plan and services can vary depending on the localisation.

**Care in Institution:** France has developed an important offer for institutional care, there are 677 000 places divided between more than 10 000 providers\(^{28}\) the majority of them are run by the public sector. 80\% of these are institutions for dependant people (Etablissement d'Hébergement pour Personnes Agées Dépendantes, EHPAD) with a lack of physical or mental autonomy. They are 3 funders, the Health Insurance for the health needs, the Departement with the APA for those with lack of autonomy (help for eating, dressing, cleaning) and the resident for the accommodation (the food, the room). Therefore the financial contribution can be important for residents; the average cost for them is 1500 Euros a month and 80\% of people in EHPAD have to be financially helped by their relatives\(^{29}\). There are also several kinds of shelter homes (foyer logement) for older people with a good autonomy, this type of institutions represent 20\% of those available.

**Health:** Most of the time older people in home or in institution have their personal doctor (called médecin traitant) to look after their health. They are the main provider of the primary care. For critical situations they usually go to the general hospital. There are also nurse services coming to the home (Services de Soins Infirmiers a Domicile), or in-home hospitalisation for important health issues (hospitalisation a Domicile) and in most of the nursing homes there is a doctor present at least one half day a week to check the health of the residents. However it is important to point out that in France there is a distinction between the sanitary sector (secteur sanitaire, with the hospital for the major health needs) and the medical-social sector (secteur medico social with institutions for the Elderly or the Disabled less equipped in medical care with an important social emphasis). Consequently there are problems of coordination, especially for the Elderly, between both sectors and also with social services most of whom work for the Département.

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\(^{28}\) Op Cit, Rapport Evelyne RATTE

\(^{29}\) “Mission commune d’information sur la prise en charge de la dépendance et la création du cinquième risqué” Rapport du Sénat Alain VASSELLE, janvier 2011
In Wales the term mainly used to talk about the care of the elderly is “long term care”\(^{30}\). The system relies a lot on the individuals and their relatives. Help can be provided by local authorities, but their intervention is specially targeted on people with low income. But there is a bigger emphasis on prevention and healthy behaviours than in France and a strong recognition of carers.

**Panorama of the elderly policies:** The National Health Services and Community Care Act 1990 state that the NHS is relevant for the health needs and that the local authorities are responsible mostly for the assistance and for social needs. The functions of the local authorities were stated in the Care Standards Act 2000 which also set minimum standards for the services and institutions (such as care homes). The rights of the carers have been officially recognized with several National strategies for carers. Wales has the Carers’ Strategies (Wales) Measure 2010 with a right to a needs assessment. The Mental Capacity Act 2005 is an important text which has set the principle of dignity and respect of choice of people included elderly people with mental health problems, it was completed by the Mental Health Wales Measure 2010. The Welsh NHS reform of 2009 tried to bring health and social service closer within the local health board with a unified organisation for primary, secondary and community services in a local community\(^ {31}\). This is the legal framework but there are also important measures in strategies and plans accompanied by guidance and methodologies. Wales has a strategic vision for elderly care, specified in several documents often interconnected with other fields (housing, challenging inequalities) including a health plan “Together for Wales 5 years Vision” of 2011, a “Strategy for older people in Wales”, and “Health Challenge Wales” which brings an important work toward prevention with the “Healthy Ageing Action Plan for Wales 2005”. There is also a strong focus on dementia with the “National Dementia Action Plan for Wales", “National Dementia Vision for Wales" and the program “1000 Lives +”.

**Benefits:** In Wales as in France there is a universal benefit for the older people over 65 years old (it is 60 in France). The Attendance Allowance is granted by the Department of Work and Pension to older people with a lack of autonomy who need help for personal care. There are two rates, £51.85 per week if you need a daily help and £77.45 per week if you need a night and day help. In contrast to the French APA this benefit is usually stopped when people move into a nursing home. There is also a Carers’ Allowance and a Carers’ Credit which are specially shaped for family carers. For people with “primary health need” there is the Continuing NHS Healthcare. This is a package of services to


\(^{31}\) “Setting the Direction: Primary and community Services strategic delivery” Welsh Assembly Government, 2010
meet the health and social needs and is granted by the NHS for beneficiaries in home or in institutions (in this case NHS will pay for the accommodation). This benefit has been criticized for having too strict criteria and generates litigation over the qualification of “primary health need”. One person met during this internship explained that because it is a free comprehensive benefit, a lot of people request assessment against the criteria as it is expensive to look after an elderly. She also added that it can generate tensions between health and social services because if the NHS is in charge social services will not have to pay. There are some benefits granted by local authorities but as social services they are mean tested.

**Care at home:** The local authorities can provide important support to the Elderly who wish to stay in their own home. They can give a “community care assessment” to evaluate the needs of the person and they also have an obligation to assess the carer’s needs. After this first step, local authorities can then shape a care plan adapted to the needs and decide if they will contribute to the dependency’s costs depending on the income of the person. The help provided and the range of services given can vary between areas as each local authority has an important autonomy, these variations are called the “postcode lottery”. This phrase has been mentioned often in interviews and is regularly criticized.

**Care in institution:** In Wales a significant number of the Care Homes for older people are run by private sector ‘for profit’ providers. There are mainly two kinds of institutions Residential Homes are for older people with a good autonomy. They offer support and care if there are health needs they will be provided by the GP or district nurse. This type of institution has no medical staff. Nursing Homes are therefore for people with a lack of autonomy and/or health care needs and it is compulsory for them to have nurses in their staff. Some of those institutions are EMI (Elderly Mentally Infirm) homes suitable for people with dementia or mental health illness. However there is a problem of the capacity of the Care Homes. In Wales there are 14 care homes for 1000 people over 75 years old whereas in England it is 20 for 1000. Several people interviewed pointed out the problem of waiting lists. Also the system is expensive; the prices vary deeply between the different homes. The NHS will pay for the health needs and for people with low income the local authority may pay but the criteria are strict (covering income and the savings), the average is around 500£ a week. The problem of the cost may explain why in Wales the emphasis is put on home based care.

**Health:** Just like in France, in Wales the GPs, and more generally the primary sector, are the main health provider of the Elderly. As there is a strong emphasis on keeping people as long as possible in

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32 “Report 2010/2011 Older People Commissioner for Wales”, Older People Commissioner for Wales point out the problem of the poverty of older people

33 “How to guide Improving dementia Care, 1000 Lives +” NHS Wales, 2010
their home the intermediate care have been well developed with home based care, district nurses, mental health services with a good mobility, providing care within people’s homes. The goal is to avoid hospital admittance. Indeed Wales realises that generally the elderly stay longer in hospital with problems in the planning of hospital discharge\(^{34}\). Several reports point out problem of quality of care for this fragile population\(^{35}\).

**B- Points of comparison about the mental health of the elderly**

The focus will be now on older people with mental health issues and especially those with one of the types of dementia. This overview is based on lectures and interviews. The comparison between both French and Welsh systems will be divide in several key points.

- **Policies approach**

  Wales bases his policies on an acknowledgement that the sustainability of the system is a key issue and it is essential “making every penny counts”\(^{36}\). The idea that people are responsible for their own health is deeply rooted in the Welsh society; the program “Health challenge Wales” reminds that there is a shared responsibility for health between the NHS and citizens. Several interviewees underlined that people have to take an active part in their health. It is quite different in France, the sustainability of the system is an important subject, especially for the elderly care, but there is a reluctance to admit that the funding should be limited. Indeed the people’s attachment to social welfare make almost impossible to reduce the level of support historically provided. Therefore in France debates over dependency are more about finding new resources to fund the system than to change the direction. Health education of the citizen is still a great challenge in Wales where the consumerist behaviour of the patient is often criticized (even if it is acknowledged that this behaviour is generated by the health organisation)\(^{37}\).

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\(^{34}\) “Dignified Care in Hospital: The experience of Older people in hospital in Wales” Older People Commissioner for Wales, 2010
\(^{35}\) “Report 2010/2011 Older People Commissioner for Wales” the Commissioner insists on the necessity of “dignified care in Hospital”; we may also quote “Counting the Cost: Caring for people with dementia on hospital wards” The Alzheimer’s Society, 2009,
\(^{36}\) “Together for health – A five years vision for the NHS in Wales”, 2011, NHS Wales and Welsh Government
\(^{37}\) "Rapport d’information au Sénat fait au nom de la délégation aux collectivités territoriales et à la décentralisation, sur les territoires et la santé" sénateur Marie-Thérèse BRUGUIÈRE, 14 juin 2011
Wales has launched various strategies to tackle elderly issues and especially dementia (the cost of dementia is estimated to 7.2 million a year in Wales\textsuperscript{38}). There is an effort to make each policy interconnected with a large focus on overall population. Welsh strategic documents tackle the challenge of the elderly with a “holistic approach”\textsuperscript{39} including poverty, housing, healthy ageing, and mental well being. Interviewees from the Welsh Government outline a pragmatic holistic approach, explaining that with the economic situation it is necessary to interlink policies. The strategy “Together for Mental Health” is a global and positive vision for population from children to older people to promote mental wellbeing and not only see mental health as mental illnesses. It has special goals for the elderly referring to specific documents such as the “Strategy for older people in Wales” the “National Dementia Action plan For Wales”. Wales has also developed around those policies an important guidance with framework documents, guides and organisations such as the National Leadership and Innovative Agency for Healthcare which supports NHS action, Public Health Wales which gives strategic advises based on data analysis.

In France the approach is much more categorised. Mental health has a negative connotation and refers mainly to psychiatric needs. Learning disabilities and autism are in policies for the Disabled. Concerning the mental health of the Elderly the main strategic document is the Alzheimer Plan which only has a focus on dementia and not other issues such as depression. There are several plans to cope with the elderly person’s needs, but they are often limited in times and are not always involving the same actors therefore the monitoring can be complicated and the continuity is fragile.

Wales is seeking to develop a long term vision for the mental health of the elderly with the concept of “Dementia Supportive community”\textsuperscript{40} which is defined as “Communities which have the capacity to support people affected by dementia so they can enjoy the best possible quality of life”. This vision facilitates communication, brings a long term vision to change the responses to dementia at every level in society and helps to raise awareness and fight prejudice. The goal is to change the perception of dementia with information packs to show that it is possible to live well with dementia symptoms and to ensure that people with dementia remain integrated in the community where citizens and service providers are aware of the symptoms and how they can cope with those. This approach raises a key topic often underestimated in France which is the upkeep of the social activity, the social integration of the elderly with a fight against prejudice upon dementia. But as it was

\textsuperscript{38} “Together for Mental Health A cross Government strategy for mental health and wellbeing in Wales”, Welsh Government, May 2012
\textsuperscript{39} This expression was often used by the individuals interviewed
\textsuperscript{40} “National Dementia Vision For Wales, Dementia Supportive Community” Alzheimer’s Society and Welsh Assembly, February 2011
underlined during the interviews “It is an aspiration”, it is “a 10 years strategy” and the implementation will be an important challenge.

France has not a strategic vision as comprehensive as Wales, however it has an efficient legal framework which set up the principles of the elderly care with uniform statutory obligations for social services and institutions. In Wales, the people interviewed point out that if the strategies are good they are not always well implemented, that the vision is large so it is difficult to make it efficient, and the involvement of the local authorities and health boards can vary as strategies do not impose statutory obligations. But this strategic vision, proactive and targeted, allows Wales to attempt an efficient prevention policy.

❖ Prevention aspects

“Prevent the preventable”\(^{41}\) - Wales has developed a comprehensive prevention policy, as was highlighted in the previous section this includes an idea of collaboration for health between the NHS and the citizen which give a sense of responsibility to the population. Moreover, several official documents\(^ {42}\) and people interviewed noted that sustainability of the system implies to anticipating problems. There are therefore several programs of prevention for various health issues such as alcohol and medicines misuses, upholding of physical, mental and social activities. The national program “1000 lives +” aim to improve the health of the Welsh population and it has a special focus on dementia\(^ {43}\). It shows the strong will of the Welsh government to anticipate health problems as it is believed that escalating current health and social responses to needs is not financially viable in the long term hence the need to focus upon prevention\(^ {44}\). The French health organisation had for long time underestimated the importance of prevention. Some of the plans for the Elderly (Alzheimer Plans or healthy ageing Plan) have a prevention vision but it is limited in time and has often a narrow focus and in contrast to Wales, France has had difficulties in communicating and promoting its promotion campaigns.

Concerning dementia, Wales has a comprehensive proactive approach based on prevention. First of all, the documents (the national dementia vision, 1000 lives +...) insist on early diagnosis.

\(^{41}\) “Chief Medical Office Report” 2008
\(^{42}\) i.e. the “National Dementia Vision For Wales, Dementia Supportive Community” or the “Together for health – A five years vision for the NHS in Wales”
\(^{43}\) “Mental Health 1000+ Improving care for people living with dementia” 1000 lives +, 2012
\(^{44}\) “Review of health and social care in Wales” Welsh Assembly Government, 2003
Indeed “a diagnosis of dementia opens doors”\textsuperscript{45} it can give access to a first treatment, support for the patient and his care givers, it allows planning the future needs. This early diagnosis must be combined with to information campaigns to fight the poor public understanding of dementia with a balance between the seriousness of the disease and the fact that it is possible for many to live independently for some time with the diagnosis. The goal is to make the diagnosis less alarming. Dementia diagnosis is complex, the documents quoted call for better training of GPs and a better funding for memory clinics which are specialised in dementia assessment. They propose alternative solutions e.g. prescription of books on dementia\textsuperscript{46}. The 1000 Lives + program has launched a “how to guide” for health professionals to reduce time between onset of symptoms of dementia and diagnosis\textsuperscript{47}. However according to a 2011 study of the Alzheimer’s Society Wales has the lowest rate of dementia diagnosis in the UK with 37.4\% (the average is 43\% implying under diagnosis in Wales).

In France since the first Alzheimer Plan launched in 2001 there is a focus on diagnosis. This plan created the “consultation mémoire” (memory consultation) to assess cognitive functions. It is organised by professionals, the patient is referred by his personal doctor. The access to diagnosis has been an aim of each Alzheimer Plan.

The French emphasis on Alzheimer diagnosis and anticipating the needs is strong and it is one of the most developed prevention strategies. However, the process is overly focus on Alzheimer’s disease. In Wales, the approach of mental health is more comprehensive and it is a positive notion which includes the mental wellbeing, changing the vision and challenging prejudices. One individual met insisted that it is necessary to ensure that dementia is considered as a normal mental illness and not something unavoidable, related to the ageing. The Welsh prevention approach is more comprehensive because it deals with the different kinds of dementia and not mainly with the Alzheimer’s disease as in France. Indeed if 60\% of the cases are Alzheimer, between 15 and 20\% are vascular dementia related to cerebrovascular accident\textsuperscript{48} and also “pseudo dementia” caused by some forms of depression or toxic infection. These distinctions permit more appropriate responses depending on the form of dementia. Although the Welsh priority is dementia, their programs also tackle mental health issues such as depression\textsuperscript{49}. Depression if it is not well treated can lead to unnecessary stay in hospital and nursing homes and therefore important costs. Therefore some guidance exists and prevention programs insist on mental and social activities and social inclusion

\textsuperscript{45} “Unlocking diagnosis, the key to improving the lives of people with dementia” All Party Parliamentary Group on dementia, 2012

\textsuperscript{46} “Book Prescription Wales Scheme”, Health Challenge Wales, NHS Wales

\textsuperscript{47} “How to guide Improving dementia care” 1000 lives +, 2012

\textsuperscript{48} “Mapping of future dementia prevalence and services implication” National Public Health services for Wales, 2008

\textsuperscript{49} “Depression in older adults” The Royal college of psychiatry, 2009
which may help prevent the symptoms of depression. Several people interviewed underlined that even this is not sufficient and one of them point the lack of engagement of the GPs, but it is a good start. In France mental illness was left behind until a recent study which showed concerning rates of suicide among older people\textsuperscript{50} since when new measures has been taken (e.g. training, helpline).

- The role of the carers

According to a study, a person with a dementia syndrome, who lives with a care giver, sees his probability to enter into a care home reduce 20 times\textsuperscript{51}. The Welsh system is not “Carer-Blind”\textsuperscript{52} believing the idea that good services and support can delay institutionalisation. This approach is deeply rooted in Wales and more generally in UK. There is official recognition of care givers since 1995 and “The Carers Recognition and Services Act” with a national policy of strategies for them such as the “Carers Strategies (Wales) Measure” of 2010 which defines the carer as “an individual who provides a substantial amount of care on a regular basis...” This underlines their contribution to patient care as an essential dimension. In addition to acknowledging the work of carers it is essential to give them advice and support to enhance their autonomy\textsuperscript{53}, and to look after their health and well being. Care givers are identified, they have the right to an assessment of their needs, and they can be entitled to specific benefits. Since the 2010 Measure there is a statutory obligation for local authority to assess the carers’ needs. The main benefits for care givers are the Carer’s Allowance (the amount is limited and it is controlled, the person has to “work” as a carer 35 hours a week) but it acknowledges the carer’s involvement and there is the Direct payment for care, which is designed to fund leisure services, and so it is dedicated to the well being.

In France there is not an official recognition or definition of older people’s care givers (however this exists for disabled people’s care givers\textsuperscript{54}) despite a strong request from carers’ associations and reports underlining how they are essential to the efficiency of the system\textsuperscript{55}. Indirectly there is an acknowledgment of them as the French benefit called APA can be used to pay a relative other than

\textsuperscript{50} “Bulletin Epidémiologique Hebdomadaire : Numéro thématique - Suicide et tentatives de suicide : état des lieux en France” Insitut de Veille Sanitaire, n° 47-48 13 décembre 2011

\textsuperscript{51} “Predictors of institutionalisation in older people with dementia” S. BANERJEE and J. MURRAY, 2003


\textsuperscript{53} “Dementia Ethical issues” Nuffield Council of Bioethics, 2009, Chapter seven of this report is dedicated to “The needs of carers”

\textsuperscript{54} Loi n° 2005-102 du 11 février 2005 pour l’égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées

\textsuperscript{55} “Rapport Accueil et accompagnement des personnes âgées en perte d’autonomie”, groupe Evelyne RATTE, 21 Juin 2011
spouses who gives care (for spouses it is considered they have a duty of mutual support). However APA is not considered sufficient. The Alzheimer’s Plan offers a better support to care givers who are eligible to receive funded training, but as it has been already pointed out in the precedent sections this plan is only targeted to Alzheimer disease which excludes a lot of carers.

However if the French acknowledgment of carers is still poorly developed an important effort have been made, just like in Wales, to support them with carers’ respite. Both countries proposed solutions such as temporary stays in care homes and day centres. In France there are respite structures specially conceived for people with dementia the “Pôles d’Activité et de Soins Adaptés “(PASA, implemented by the Alzheimer Plan) for Activity and Adapted Care Structure which proposed a day care with social and therapeutic activities. In Wales the third sector and especially associations such as Alzheimer’s Society or Age Cymru are doing a lot for supporting carers. They provide services (these Welsh associations have developed means for a real capacity for action, they are much more organised than in France). They organise lunch clubs or Alzheimer’s cafes for enhancing social activities of people with dementia and their care givers (this cafe initiative also exists in France).

The informal role of carers is necessary for the sustainability of the system, however it can generates perverse effects. Indeed the well being of the carer is crucial because the weight of care can be hard to bear, 33% of care givers admit they have lost their temper with their relatives with dementia which is potentially a form of psychological abuse56. Carers are also exposed to risk of depression and to getting poor health57. This suggests that carers’ needs are not yet completely met and improvements are still necessary but it also probably raises the issue of the great expectations of care givers who are often not prepared for their roles. Moreover, on a long term vision there is also the risk of a “care gap”58 in the next decades, which with the ageing population and a shift in life’s habits with a greater mobility of children means a lack of care givers at some point. An individual explained during a meeting that it is an unprepared but probable event. France and Wales are investing on the promotion of in-home care, respecting a strong will of people with dementia, but most of the time this policy is dependant of the presence of informal carers. Therefore, if in home care is to remain as a key element of policy it may be useful to think of alternative solutions.

56 “Dementia Ethical issues” Nuffield Council of Bioethics, 2009
57 “Mental Health 1000+ Improving care for people living with dementia” 1000 lives +, 2012
Promotion of care at home

Care at home seeks to respect the wish of people to remain at home and also it appears to be more economically viable. However in France, like in Wales, the organisation of this is not always simple given the various care needs of the elderly which are both health and social. Another common point is that local authorities have a key role in the system.

Wales insists on a “Patient centred Approach” for people with dementia including social and psychological needs, it is inspired by Thomas Kitwood a pioneer in the culture of care and psychogerontology. Wales has developed Mental Health Services which has no equivalent in France, these services organised locally by mental health team providing health, psychological on social cares to people with mental illness. However it is acknowledge that there are gap between local authorities, indeed some of the Mental Health Services have put a special focus on dementia with Dementia Support Worker. People interviewed who work in Local Health Boards underline these inequalities and the variability of the needs according to the area. The expression “Postcode Lottery” was often quoted to describe these situations of inequality. The challenge of inequality of access to services is also present in France, even if the local authorities, the “Départements” have less autonomy as in Wales. Indeed the main tool of home assistance to the Elderly is based on the APA a benefit built on national criteria (calculation of amounts provided, criteria of assessment of dependency), but despite the strong French principle of equality and the national conception of APA France has to cope with inequalities between département. Indeed some of them can be more generous adding extra services (funded by the local authority) for the Elderly or some are more lenient on the appreciation of the criteria. This challenge may find an explanation with 40 years old theory by the Welsh doctor Julian Tudor Hart: the “Inverse Care Law” who explained that “the availability of good medical care tends to vary inversely with the need for in the population served”.

In France the health care is mainly provided by GP and visiting nurse called in French Service de Soins Infirmiers à Domicile, SSIAD for at home nursing services. There are no visiting teams specialized in mental health, there is an acknowledgment of the lack of this function. However there is a large, comprehensive range of social care, help for eating, dressing, cleaning, which are clearly and directly organised by the care plan scheduled with the APA’s benefit. In France the help,

59 “Mental Health 1000+ Improving care for people living with dementia” 1000 lives +, 2012
60 “Dementia reconsidered: The person come first” Thomas KITWOOD, Buckingham: Open University Press, 1997
61 “NICE SIE Guideline on supporting people with dementia and their carers in health and social care” The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SIE), 2007
scheduled in the care plan, is funded by the local authority whereas in Wales it is dependent on the person’s income. In Wales, the third sector (private or not profit-making) is the main provider of at home care. Several interviewees noted that the Alzheimer’s Society provide services specially adapted for Older people with mental illness (the French equivalent France Alzheimer has not reach yet such degrees of organisation and support capacity). The third sector that already has a very active part for the support to carers including a role for care at home, they can offer a real social support to the Elderly, contributing to maintain the social links. In France if the efficiency of services is recognized there are often only tasks-orientated to the detriment, sometimes, of social contact.

Wales has implemented “intermediate care” in its system earlier than France. The purpose of intermediate care is to help people to recover quickly from a disease and more specially to ensure that people can stay independent in the community. This is strongly related to the care at home which has also been developed earlier in Wales with an emphasis on carers and developing a right to advocacy for the Elderly. Wales is investing in new technologies with the concept of “Telecare” which has a lot of applications: e.g. home security, remind system, falls prevention. Many local authorities have demonstration houses to show those technologies. The enthusiasm shown for Telecare by interviewees in Wales contrasts with France where this is still underdeveloped and as a subject of ethical debates (in Wales the debate exists too but ethical opinion is to “balance freedom and risks”).

△ In institutions

As it was already exposed in the previous part, France has an important accommodation capacity with a majority of nursing homes. State rulings run through institutions, public or private, covering every field (public funding of health care, safety measures, quality standards, respect of residents’ right). This compulsory legal framework has brought modernisation and has built a relatively homogeneity between the different type of institutions which are all defined as a place to live (to contrast with hospitals which are places to get cured). The different plans and texts have experimented with original solutions for hosting challenging residents. Currently the Alzheimer’s Plan has created the Adapted Cares and Activities Ward (pôle d’activités et de soins adaptés PASA) which outlines for residents of a nursing home with dementia syndrome activities care adapted to their illness (cognitive and memory stimulations). In Wales the situation is more diverse. There is a

64 “National Audit of Dementia” Royal College of Psychiatry, 2011
65 “Dementia Ethical issues” Nuffield Council of Bioethics, 2009
large range of retirement homes with nursing homes, residential homes, EMI (Elderly Mentally Infirm) homes, but also adapted accommodations and social housing. Therefore there are original solutions, for instance the representative of Gwalia explained that it is a non-profit making organization specialized in housing adapted for the Elderly who are entitled to housing benefits. The services provided, the capacity and the cost of the institutions vary deeply. When people with low income are entitled to a financial help from local authorities the local authority limits the choice of institutions (with criteria mainly based on costs). France has tried to contain differences of costs and above all of quality between public and private sectors using rulings. However, if cost is more limited in France (possibly due to lower property costs, different regulations and probably also a better accommodation capacity), the issue of the cost for the resident and his family is still a problem for both countries.

Hospitals also have to deal with elderly with dementia syndromes. According to a British study 1 out of 4 hospital beds are for people with dementia. In Wales hospitals are a target of mental health policy, the goal is to improve the staffs training and understanding of dementia diseases. Indeed, in Wales, hospitals lack special rules or processes for hosting older people with a mental illness, only 23% of hospitals have a strategy to cope with dementia challenges. Therefore documents promote the concept of “dignified care” for the Elderly, to implement a culture of dignity and respect for these vulnerable people and fight prejudices. Another aspect of improvement for hospital is the preparation for hospital discharge, it is acknowledged that people with dementia stay longer than necessary in hospital because of a lack of adapted solutions to support discharge and independent living. Sometimes an unprepared discharge can lead to entering a care home, one out of three people with dementia admitted from their own homes to hospital end up in a nursing home at the end of their hospital stay. Some people interviewed explain that the work done to avoid unnecessary hospital admission has became a real part of the policy of care at home, especially as hospital’s stays can be very expensive. If discharge of people with a dementia syndromes can occur one week earlier £80 million could be saved in Uk. France faces too problems of excessive length of stay and unprepared discharge, nevertheless the issue has started to be tackled using financial incentives (because it is expensive for a hospital to keep a patient beyond the...
necessary time) better connections with nursing homes and the developments of follow up care beds which give more flexibility. At the beginning of the new century France become aware of the need for more respect and dignity for patients supported by an important 2002 Law\textsuperscript{72} promoting patients’ rights (information, dignity). This has given a real protective status to the patient and has launched a process of continuing improving in relationships with patients. Inspired by some methods developed in nursing homes, hospitals have implement a policy of “bientraitance” (good care) shaped by a set of principles that must be respected in the institutions and that will be monitored by a health inspectorate.

\textsuperscript{72} Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé
Conclusion

Both France and Wales have efficient but not yet perfect systems with very different answers. It is interesting to draw key ideas that could be implemented in France or Wales.

❖ Lessons for France

What France may learn for Wales.

- The impact of a comprehensive prevention policy with a long term vision on the multi-dimensional challenge of the ageing population and the progression of mental disease related to the age. It seems necessary to have a global vision involving all the population on this society issue.

- The acknowledgement of the fundamental role of care givers, supporting carers at home, who have a need of recognition and training.

- The advantage of having alternative housing solutions adapted to the needs of older people with dementia, from an adapted house with some telecare solutions to EMI nursing homes.

❖ Lessons for Wales

What Wales may learn from France.

- The very structured and constraining organisations of nursing homes. French homes have to address a number of legal obligations (e.g. quality, safety...) reducing the variation in standards of institutions.

- Official recognition of patient rights, with regular updates, has led to staff questioning their practice.
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