French High Council for Public Health

Assessment of the French National Plan on Healthy Ageing 2007-2009
Synthesis and recommendations
December 2010

The French National Plan on Healthy Ageing 2007-2009 (PNBV) follows on from the National Programme on Healthy Ageing initiated by Hubert Falco in 2003 and extended in 2005. It was part of the three-year multinational project "Healthy Ageing" launched by the EU public health programme in 2004. Three ministerial departments were responsible for overseeing it: the Directorate-General for Health (DGS), Directorate for Sports and Directorate-General for Social Action (now the Directorate-General for Social Cohesion [DGCS]), which also assumed the secretariat duties.

The aim of the project was to put forward measures enabling as many people as possible to "age well", in terms of both personal health and social relations, by promoting the organisation and implementation of suitable prevention schemes. It therefore presented some avenues aimed at fostering strategies for preventing chronic illness complications, promoting healthy habits, improving the personal and collective environment and strengthening the social role of older people through their participation.

The "age well" theme central to the PNBV is eminently relevant given the French demographic context. It is also ambitious since it addresses a broad section of the French population and is based on a preventive approach.

But in spite of the ambition and relevance of the theme and objectives, the plan has been sorely lacking in governance, organisation and resources. This dearth is a result of the way the plan was drawn up – on the basis of pertinent ideas being brought together rather than a logical construction of a problem. In this regard, it is more a series of measures than a plan in the strict sense of the term. The actions defined mostly focused on the development of tools, with no support or use having been organised for these. This initial oversight then impacted the definition and attribution of responsibilities, regional application of measures, allocation of resources and the assessment. This was further compounded by the lack of any actual overall responsibility at administrative level.

The interministerial and intersectoral nature of the efficient support theme of "healthy ageing", together with the lack of governance, made it all but impossible to manage and monitor the plan under such conditions – despite the professionalism of the stakeholders running the projects.

Summary table

Key points	PNBV
Strategic planning	No overall strategy linking the different sections/objectives
Organisation	No structure given to the various courses of action
Activity monitoring	Non-existent, or very inconsistent No approved report available
Budgetary monitoring	Non-existent, or very inconsistent No operating statement available
Pre-assessment	A progress table concerning the measures was submitted by the corresponding departments

The assessment stage was not factored into the plan during the drafting stages.

Lastly, it is deplorable that social inequalities concerning older people's health have not been taken into consideration, given that ageing increases inequalities of all types.

To sum up, the difficulties identified with regard to measures and their follow-up are:

- the lack of governance,
- the turn-over of stakeholders,
- the lack of attention to assessment away from the action.

Recommendations

Based on the assessment carried out, recommendations can be made for consideration during discussions on the second PNBV.

According to the interviews held, the drafting of the new plan already seems to be well under way. However, there are a number of points that need clearing up to increase the efficiency of the public expenditure.

Executing a plan on "healthy ageing" is a sure sign of a real shift in mentalities and that palpable action in terms of public health is taking place upstream of illness itself and its treatment. But even more important than mere action in this regard is a successful handling of this shift if convincing results are to be obtained.

Three stakes are affected by such a policy:

The first concerns the type of structures carrying out the action, since they must accept and support coordination between organisations.

The second has to do with the conditions for involving stakeholders. The uncertainties surrounding the follow-up of actions undermine the involvement of stakeholders and can

hamper the conversion of experimental resources into a sustainable transformation of the ways in which treatment and practices are organised.

The third regards the fragmentation of the healthcare system: the central level must teach local stakeholders, who in turn must accept the vision laid out by the policy – as long as this vision is underpinned by a form of governance that enables interaction.

1 - Keep the concept going

The assessment committee began by questioning whether it was really necessary to prepare a second plan. Some arguments pointed to not renewing the experience: the lack of governance, of resources attributed and the redundancy with the other national plans. However, several points that cropped up during the interviews prompt us not to recommend suspending the PNBV 2 project. First, because the plan could be a communication tool and teaching aid on prevention in a crucial field for the population, and what's more has been identified as such by users; secondly, because the very existence of a plan is a strong argument for carrying out measures at interministerial level. Lastly, it may well be that a plan has a limited lifespan in the time scale of public health policy, but repeating it over a longer period of time can make it more effective. Accordingly, it appears that, since the first Healthy Ageing programme, the repetition of some measures and their dissemination in a range of plans (on nutrition for example) and health programmes has made progress possible on the topic of ageing prevention. At this stage, the assessment committee thus recommends that a series of concerted and intersectoral actions – in plan or other form – extend the PNBV.

Some conditions do appear necessary to ensure they have efficient reach, however.

2 - Adapt the method

In the next plan, a distinction must be made between its management – by the public authorities – and its implementation, which must be entrusted to the right operators according to protocol.

Prevention is, by nature, intersectoral and, as a result, the implementation of measures in this field needs to be overseen by a single interministerial manager demonstrating open political commitment. Prevention of ageing in the workplace – not just preparation for retirement – is an essential subject for discussion with the French Labour Ministry. The same applies for the adaptation of town and city planning, the living environment and housing which must be carried out with the French Ministry for Ecology, Energy, Sustainable Development and Land Planning. The French Ministry for Culture may also make a contribution to some themes.

The very nature of the theme in question – making it more difficult to manage since an overarching approach is required – renders certain aspects non-negotiable, namely:

Shared governance that reports to an interministerial steering committee with a universally recognised chairperson and which meets at regular intervals;

A coordinating policy officer appointed by the steering committee who reports to the latter for the duration of the plan and is the point of contact for interministerial operators as regards the implementation and follow-up of measures;

Maintenance of a close link with regional stakeholders so that the plan's policy is pursued by the regional health agencies, whilst ensuring the close, coordinated and uniform monitoring of actions between regions;

Anticipation and implementation of the assessment of objectives and actions from the plan's creation in keeping with the public health objectives set upstream.

Naming of a national policy officer for two reasons:

Give all stakeholders a clearly identified point of contact;

Present progress reports concerning the actions to the steering committee.

The assessment committee also considers it important for the same stakeholders to stay the course as far as possible, or at the very least for a transfer of skills to take place if changes are unavoidable.

Tools should be developed that can give the strategy structure. It is essential to define and quantify the monitoring indicators.

The key monitoring indicators for the objectives and actions taken must also be drawn up at the outset, their management and funding specified and regular meetings arranged. Multiannual funding with budgetary programming may be a useful tool under the call for proposals (objective 7, measure 7.1).

3 - Include the question of social health inequalities

As the work of the French National Institute for Demographic Studies (INED) has shown, social health inequalities are revealed through the difference in life expectancy, at 35, of seven years between manual workers and senior executives, when both these categories have a job, housing and are socially integrated [2]. Social health inequalities do not therefore set vulnerable, excluded or precarious groups against a section of society whose state of health would improve in a uniform manner; they permeate the whole of the population.

Social inequalities concerning death rates are broader in France than elsewhere in Europe, particularly for men, and they have tended to get wider still in recent years. On top of this are inequalities in quality of life as a result of diverse disabilities. There is therefore a "double injustice" concerning both life expectancy and quality of life. These inequalities concern virtually all diseases, risk factors and states of health.

In its report on social health inequalities [1], the French High Council for Public Health (HCSP) shows that the issue of health determining factors was long addressed from the sole angle of personal care, in the context of patient-doctor relations. The French debates therefore focused primarily on access to healthcare, ensured by the health insurance and social protection schemes. Many studies have brought other determining factors to light, outside of the healthcare system, defining an intersectoral approach to health which goes beyond just the consequences of the healthcare system. Close attention must be paid to socio-economic determining factors, insofar as little consideration has been afforded them in French health policies, yet they are essential if social health inequalities are to be reduced.

To give an example, the InVS' (French Institute for Public Health Surveillance) FADO-sein survey (on the Factors of Adherence to Organised Screening) [3] is for women targeted by organised breast cancer screening, i.e. 50 to 74 year-old females who are offered a free mammogram every two years, with double reading in the event of a negative finding. This

comprehensive study revealed a marked gradient between the different groups studied, despite everything else being equal. For the group of women with access to individual breast cancer screening (mammogram within the two years prior to receiving the self-questionnaire), the sociodemographic level is higher and medical follow-up better – gynaecological check-ups in particular are more frequent, and screening practices common. For the group of women who did not have any breast cancer screening (no mammogram within the two years prior to receiving the self-questionnaire), the sociodemographic level is lower, medical follow-up irregular and screening practices are rare. The group subject to compulsory breast cancer screening lies somewhere between the two groups above. The participation factors for women in breast cancer screening are mainly those relating to medical follow-up and access to health care.

Health is therefore a marker. If prevention measures take no notice of social differences, they only risk widening the existing gaps further.

In the PNBV, the measure pertaining to cancer screening in older people (objective 4, measure 4.5) is an example of how health inequalities have been missed off the agenda. And yet it has been shown that the equality gap affects all screening programmes. This may reside in knowledge, in the services on offer or in patients' access to tailored health care early enough following screening. This particular measure has been assessed as part of the Cancer Plan.

The future law on public health in France has identified this as a defining issue, for it is an essential aspect of ageing prevention and should not be reduced merely to the prevention of social isolation or to measures focusing only on a handful of precarious population groups – even if these objectives are all justified. As recommended in the HCSP report, it is particularly crucial to act on all health determining factors if we are to reduce the social and regional gradient of states of health. This objective calls for measures differentiated by large sub-populations as well as measures at the most local geographical level. The French National Institute for Health Education and Prevention (INPES) has described some of these levers for action in a guidance document for regional health agency directors on the subject [4].

4 - Take a structured approach to the issue and integrate the notion of "healthy ageing" in a policy with both an individual and collective angle

The PNBV is based on an ambiguous, fragmented approach to ageing. Its operational objectives refer to wholly unconnected themes: retirement, nutrition, physical exercise and sport, quality of life (risk factors/diseases), medicines, solidarity between generations, local solidarity, research/innovation and the European dimension.

European projects have thrown up two key courses of action: first, the "healthy ageing" for each person and secondly, the society supporting this "healthy ageing". A second plan could be organised along these two lines.

It is therefore possible to act on both individual and collective factors.

Regarding individual factors, to encourage behavioural changes in response to risk factors requires health prevention and promotion and a tailoring of the message to the different population groups depending on their social context.

Regarding action at societal level, we consider it important to prioritise action targeting relationships and the different causes of social health inequalities:

- In terms of health, actions through health professionals (doctors/carers/third parties);
- In terms of quality of life, adaptation of the physical environment, research and innovation;
- In social terms, work on the social environment, networks, social support services, social utility and participation;
- Lastly, focus on working conditions and the way work is organised, as well as lifelong training to prevent ageing in the workplace.

The health plans must be coordinated at international level (EU/WHO). Common indicators and objectives must be chosen by consensus and then reflected in the different national plans.

Responsibility must be shared (EU/WHO), particularly concerning management. They must involve all levels: EU, national, regional and local, for policies must be decentralised when considering the findings.

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