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(Accepted 2 October 1981)

Contemporary Themes

Care of the aged in France

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The French and British populations contain similar proportions of aged citizens,¹ but largely because of language difficulties² most British doctors remain ignorant of how the French health and social services are evolving to meet the challenge of the rapid growth of these proportions. I visited establishments in and around four centres of geriatric excellence in southern France and talked to general practitioners, doctors in both general and geriatric medicine, psychiatrists, administrators, nurses, social workers, and remedial therapists in order to share experience and seek fresh ideas. The centres I chose were Toulouse, Limoges, Lyons, and Montpellier, but I must emphasise that this sample may be highly unrepresentative because there seems to be even more regional variation in the provision of services in France than in Britain. I make no attempt to comment on clinical practices, though considerable differences exist.³ Many facets of the British system seem superior to those found in France, but my observations are largely confined to those areas where French experience seems to have certain lessons to offer. Some of these lessons may seem rather political but, as Virchow said, "Medicine is a social science and politics nothing else but medicine on a large scale," and it is unlikely that the change of government in France will rapidly invalidate these observations.

The qualitative factor in scale of provision

Though nowhere near the top of the international league, the French as a people are probably overmedicalised and the British are certainly undermedicalised. In 1976-7 France was credited with 105.5 hospital beds per 10 000 population, while England had 83.1 (Scotland is far better provided for).⁴ The disparity is still greater in terms of expenditure per head on health care and days per head spent in hospital.⁵ The stock of residential accommodation also appears to be more generous in France, where there are over 360 000 beds, which represents 47

per thousand persons over 65, whereas in Britain most localities fall well below the DHSS norm of 25 per thousand.⁶

This difference in quantity makes a tremendous impact on quality. To a Frenchman, waiting a year or more for elective hip replacement surgery is unthinkable. To a French general practitioner in some (but not all) areas the admission of a demented elderly patient to a psychiatric hospital needs one quick telephone call with an immediately favourable response. The frail, isolated, incompetent old lady who is falling about and going off her feet is accepted unquestioningly by the acute medical service. The painful exercise of rationing health care, so familiar to the British general practitioner and geriatrician, scarcely arises in France. The onerous responsibility of providing a service for a given catchment population, as well as to the individual patient, is totally foreign to French geriatric practice. There is an imbalance of beds favouring the acute rather than the extended care sector,⁷ which may result in the elderly patient being taken through a tragic "circuit touristique" of transfers from one institution to another, sometimes finishing up far from home; but these are also disgraceful features of the British scene. At least the two-year wait in totally unsuitable housing with totally inadequate support is generally avoided. The inevitable blocking of acute beds may be as high as 15%⁸ but seems to be tolerated because of the adequate supply. There is little evidence of waste—for instance, a general medical service in the university hospital of Limoges, dealing with an elderly population (21% over 65), maintains an average duration of stay of 8.5 days. There is a policy to reduce the number of hospital beds in France, and no new beds, whether private or public, may be opened without closing old ones on at least a knock-for-knock basis. It may also be noted that the French economy has permitted the construction of general hospitals of 1200 beds and more, which seem to function perfectly satisfactorily.

Financing health care

Health care is, in general, financed by a system of reimbursement by the Sécurité Sociale, a scheme to which substantial contributions are made by both employer and employee. This reimbursement is generally of the order of 70% and is often augmented to 90% or so by occupation-linked insurance

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schemes. It is thought that 100% reimbursement would open the floodgates of public medical incontinence, though in practice most major categories of medical care *are* entirely reimbursed—cancer, serious operations, the elderly. Otherwise, even a consultation with the general practitioner is at least mainly paid for by the patient in the first instance unless the necessary paperwork is undertaken to establish inadequate means. It is a fundamental tenet of French thinking that there should be some sort of barrier, which never prevents any patient in real need from receiving medical attention but is sufficient at least to remind everybody that nothing is ever free and that someone must pay for everything.

To turn to hospital care, the elderly patient is initially admitted to an acute or short-stay bed where the full cost is borne for 20 days, renewable thereafter. If the stay in hospital looks like being more protracted a place may then be found in a medium-stay unit for further rehabilitation, but after 90 days there will be no reimbursement. Within that time the social worker must be able either to engineer discharge home or find a long-stay bed (usually in short supply) either locally or some distance away, or a place in an old people's home—often also in short supply. Once a patient has been classified as long stay even if no physical move occurs and the change is a purely administrative one permitted by the vacation—usually through death—of a long-stay bed, the situation changes. A long-stay patient is reimbursed for her medical and nursing care but not for her board and lodging. The charge for the latter, some 90 to 100 francs a day, is the responsibility of the patient or, if she is of insufficient means, her children or grandchildren, and only in the absence of any other source is it borne by the State. The idea of free permanent lodging, apart from loss of pension, fills the French mind with astonishment, and it is thought that payment for the hotel aspect of extended hospital care adds a financial incentive to the desirability of filial support at home. Though occasionally unjust—for example, where the old woman has been neglectful of her family in the past—this expense probably facilitates discharge from hospital. The administration of psychiatric hospitals is different, and long-term care there attracts total reimbursement. There is anecdotal evidence that these establishments suffer accordingly from familial reluctance to reaccept elderly patients into the community. In general, financing health care through a means not entirely dependent on income tax seems to offer an electorally more attractive means of sustaining quantitatively adequate facilities.

A flourishing private sector

When the public hospital service is unable to cope with demand private clinics and nursing homes can often make good the shortfall, and their beds constitute about 30% of the total. Cold orthopaedic surgery and the relatively unsophisticated care of aged dependent patients on a shorter or longer term basis are examples of the ways in which the private sector contributes to the health and social care of old people. In general, patients are reimbursed according to the same principles that apply in the public hospitals. It is commonly asserted that prices in the private sector are often lower than in the public sector, where they are inevitably inflated by a wide range of very expensive activities. The presence of a thriving private system meets a demonstrable need, and in Montpellier the only identifiable psychogeriatric service is provided by a private clinic. It also, perhaps, provides healthy competition for State institutions, and in many localities obvious efforts are made in public hospitals to create a shop-window effect reflecting the pride of the staff in their establishment. A further strength of private enterprise is its flexibility, so that establishments do not have to declare themselves to be rigidly medical or social in purpose but may fulfil both roles according to the varying needs of their clients and can be staffed accordingly. Unfortunately, there is a tendency towards separation of private and State hospital facilities for political reasons similar to those prevailing in Britain.

Specialty of geriatric medicine

There is no official recognition of geriatrics as a hospital specialty in France in the sense that there is no training programme distinct from general medicine and the existing subspecialties. Nevertheless, several very able doctors address themselves energetically to practising, teaching, and researching in this subject, and courses are held for general practitioners and others. In Britain if there is a discernible trend it might be towards integration of general and geriatric medicine in peripheral hospitals but continued separation in the larger centres. In France it might be the opposite, with the doctor in the teaching centre practising general and geriatric medicine but often only in the acute setting. Interest in the medicine of the elderly is more recent in France, and my personal view would be that the specialty has yet to achieve the widespread improvements in practice that it has generated in Britain. Single-specialty hospitals are still to be found as in this country, often with regular sessions by a wide variety of other specialists who have well-equipped consulting facilities.

Maintenance at home

There is a publicly declared policy to maintain old people in their own homes, on both humanitarian and economic grounds. Though it is widely assumed in Britain that families in other countries are more supportive towards their aged members, there is little evidence that this is so in France, where the proportion of old people living in institutions appears to be similar (5.5% to 7%) and where the proportion in the community who live alone may actually be slightly greater (29% as against 25%).⁹ There are the usual statutory services with the usual uneven spread—community nurses, home helps, and meals-on-wheels for the housebound, and day centres and clubs for the more mobile. One or two ideas seem worthy of special mention, even though similar schemes are in operation in some centres in Britain.

UNIVERSITIES AND CLUBS OF THE THIRD AGE

Since Vellas founded the first University of the Third Age (U3A) in Toulouse in 1973, over 60 others have sprung up in France and many more elsewhere. They are highly successful and highly regarded in that country, and after my visit a committee has been formed to found a U3A in Cambridge with a view to opening in early 1982. Mental activity is probably beneficial, but there is perhaps firmer evidence that physical activity helps to maintain physical health, and the club members take up swimming, cycling, and skiing despite their advanced years.

INGENIOUS USE OF SHELTERED ACCOMMODATION

In one rural community visited several units in a new complex of warden-controlled flatlets are occupied by local old people during the winter, when the difficulties of living alone in isolated houses are formidable. In the summer these units are made available to old people from the big city (Toulouse) who might benefit from the fresh air and countryside.

HOSPITAL-AT-HOME SCHEME

Not specifically for the old, and in most centres restricted in principle to those discharged from hospital, the hospital-at-home scheme is widely developed in France and facilitates discharge for a number of seriously sick patients. It is not intended as a permanent prop for the chronically frail and semi-dependent but it does release acute hospital beds.¹⁰

DOMICILIARY VISITING

Local conditions generate local solutions, and in one small commune the postman is paid a small supplementary salary to visit the old during his rounds and check on their wellbeing. At the opposite extreme a scheme operates in Lyons whereby volunteer medical students regularly visit frail and vulnerable elderly people in their own homes to check on their physical condition and medication and report back to the general practitioner or geriatrician if there are grounds for concern.

HOUSEKEEPING TEAM

A housekeeping team is roughly the social counterpart of the hospital-at-home and comprises a team of home helps and "aides-soignantes" (who are partly nursing auxiliaries, partly care assistants, and partly home-care aides—and are thus very flexible) based on an old people's home. The team visits, on both a regular and an on-demand basis, the homes of very frail, house-bound clients living alone who are unable or unwilling to receive residential care. This service is in its infancy and in most places is still at the drawing-board stage.

HOSPITALISATION À LA CARTE

The name itself imparts something of the flavour of France, and the concept—pioneered by a general psychiatrist with a real interest—proved equally attractive. Extremely flexible arrangements exist with the families of aged victims of dementia who are admitted for holiday relief—or for the weekend, or the day, or the night, depending only on availability of beds within the unit, as in a hotel.

FLEXIBILITY OF INSTITUTIONS

As in Britain it is more realistic to adapt existing structures to current needs than to design new categories of institution, and there is a policy to "medicalise" a quarter of the places in each old people's home. It remains the intention to admit residents who are reasonably mobile and personally independent but to continue to look after them in their own rooms in the same establishments after they have lost their independence. Naturally, if this occurs catastrophically due to a stroke or fractured femoral neck, treatment in hospital is likely to be required initially, but there are nurses and physiotherapists in the home to undertake rehabilitation and, if the outcome is unsuccessful, continue to care for these very heavily dependent people. It is intended to medicalise an increasing number of the places in these homes, and in many cases there is also a nurse on duty in the home for the other 75% of relatively able-bodied residents. Though, as in Britain, institutions are divided into those for health and those for social purposes, this nursing presence is sometimes even to be found in the French equivalent of "sheltered" or "warden-controlled" accommodation. Regular visitors to old people's homes, sheltered accommodation, and even day centres may include medical members of the geriatric or psychiatric team, physiotherapists, psychologists, and beauticians. Conversely it is also not uncommon to find that the smaller peripheral general hospitals and the single-specialty geriatric hospitals still retain a residential section, though the old "hospices" of ill repute are gradually being eliminated. What of the quality of the institutions? There are cultural differences—and it will come as no surprise to Francophiles to learn that the great therapeutic activity of the day is lunch. Great pride is taken in the cuisine, red wine is apparently obligatory, the session lasts an hour and a half, the babble of conversation fills the air, and apathetic faces light up with animation.

Conclusion

The fundamental prerequisite for helping the sick, the disabled, the aged, and the disadvantaged is an economy vigorous enough to sustain adequate health and social services. The other essential feature of these services is adaptability to meet changing needs. The specialty of geriatric medicine in Britain has received its share of international acclaim, but we now face the challenge of extreme old age against an uncertain economic background, and the cracks are beginning to show. France has her share of problems, regional inequalities, and heritage of dilapidated real estate, but she also has able professionals and administrators with much to teach us. Out of the more flexible aspects of the two systems, it would be possible to design a comprehensive service for the elderly with some chance of being equal to the task.

This work was carried out during the tenure of a Medicine Gilliland Travelling Fellowship, administered by the Royal College of Physicians of London and funded by the Medical Education Trust, a charitable trust founded by the Medicine Group, the publishers of *Medicine International*. On both sides of the Channel too many people to mention individually were extremely helpful and, while in France, the kindness and hospitality received were overwhelming.

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(Accepted 15 October 1981)

Is there any recommended treatment for mild pes plano valgus and for simple round shoulders with prominent scapulae? Are exercises of any proved value even if likely to be carried out, and if so what should they be and should a physiotherapist supervise?

I assume that the question refers to postural variation occurring in childhood and that congenital or neurological abnormality has been excluded. Mild pes plano valgus in a child with a painless mobile foot needs no treatment, and physiotherapy is time wasting. The imagination must be stretched to the point of incredulity to believe that a young child with painless mobile feet will pay the slightest attention to their posture when out of sight of the therapist. Strengthening the medial border of the shoe and perhaps a metal plate on the heel may help to relieve the rate of shoe destruction, which may be the main parental worry.

Simple round shoulders or postural kyphosis is common in adolescence, particularly adolescent girls, in whom it may be a response to the embarrassment of developing breasts. With increasing maturity the posture returns to normal. A short course of instruction in back-bracing exercises may help an anxious mother to accept the problem. The condition must be distinguished from the rigid kyphosis of adolescence (Scheuermann's disease). In the former condition the spinal curve can be corrected by the patient's own efforts—in the latter it cannot.—S C GALLANNAUGH, consultant orthopaedic surgeon, Hastings.