Institut de recherche et documentation en économie de la santé
Institute for Research and Information in Health Economics

Veille scientifique
en économie de la santé

Watch on Health Economics Literature

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Assurance maladie	*Health Insurance*
E-santé – Technologies médicales	*E-health – Medical Technologies*
Économie de la santé	*Health Economics*
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Assurance maladie

Health Insurance

Moral Hazard And Selection For Voluntary Deductibles

ALESSIE R. J. M., ANGELINI V., MIERAU J. O., *et al.*

2020

Health Economics 29(10): 1251-1269.

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4134

This paper investigates whether the voluntary deductible in the Dutch health insurance system reduces moral hazard or acts only as a cost reduction tool for low-risk individuals. We use a sample of 14,089 observations, comprising 2,939 individuals over seven waves from the Longitudinal Internet Studies for the Social sciences panel for the analysis. We employ bivariate models that jointly model the choice of a deductible and health care utilization and supplement the identification with an instrumental variable strategy. The results show that the voluntary deductible reduces moral hazard, especially in the decision to visit a doctor (extensive margin) compared with the number of visits (intensive margin). In addition, a robustness test shows that selection on moral hazard is not present in this context.

Long-Term Care Insurance: Information Frictions And Selection

BOYER M. M., DE DONDER P., FLUET C., *et al.*

2020

American Economic Journal: Economic Policy 12(3): 134-169.

https://doi.org/10.1257/pol.20180227

This paper conducts a stated-choice experiment where respondents are asked to rate various insurance products aimed to protect against financial risks associated with long-term care needs. Using exogenous variation in prices from the survey design and individual cost estimates, these stated-choice probabilities are used to predict market equilibrium for long-term care insurance. Our results are twofold. First, information frictions are pervasive. Second, measuring the welfare losses associated with frictions in a framework that also allows for selection, it is found that information frictions reduce equilibrium take-up and lead to large welfare losses, while selection plays little role.

Rapport 19-10. Couverture santé universelle : utopie aujourd’hui, réalité demain. Qu’apporte l’expérience française ?

HOUSSIN D.

2020

Bulletin de l’Académie Nationale de Médecine 204(2): 118-123.

https://doi.org/10.1016/j.banm.2019.12.011

La mise en place de la couverture santé universelle est un des principaux objectifs du développement en santé. Le système d’assurance maladie, peu à peu mis en place dans un pays développé, ne peut pas être transposé tel quel dans un pays en développement. Pour autant, les leçons tirées de cette mise en place peuvent être utiles pour les pays s’engageant vers la couverture santé universelle. Dans un tel but, cinq exigences principales ont été identifiées : la volonté politique ; l’effectivité de l’offre de soins ; la largeur de la population couverte, plutôt que l’exhaustivité des soins pris en charge ; l’obligation assurantielle ; le contrôle des dépenses liées aux soins. / Implementation of universal health coverage is one of the main ambitions towards development in health. The universal health coverage, gradually implemented in a developed country, cannot be transposed as such in a developing country. However, some lessons can be learned from this implementation, which can be useful for developing countries struggling with the installation of a universal health coverage. For such a purpose, five main requirements were identified : political will ; effectivity of the offer of care ; population coverage extent rather than the completeness of the covered cares ; mandatory insurance ; control of health care-related expenses.

Price-Linked Subsidies And Imperfect Competition In Health Insurance

JAFFE S. ET SHEPARD M.

2020

American Economic Journal: Economic Policy 12(3): 279-311.

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Policymakers subsidizing health insurance often face uncertainty about future market prices. We study the implications of one policy response: linking subsidies to prices to target a given postsubsidy premium. We show that these price-linked subsidies weaken competition, raising prices for the government and/or consumers. However, price-linking also ties subsidies to health care cost shocks, which may be desirable. Evaluating this tradeoff empirically, using a model estimated with Massachusetts insurance exchange data, we find that price-linking increases prices 1–6 percent, and much more in less competitive markets. For cost uncertainty reasonable in a mature market, these losses outweigh the benefits of price-linking.

Measuring Universal Health Coverage Based On An Index Of Effective Coverage Of Health Services In 204 Countries And Territories, 1990-2013;2019: A Systematic Analysis For The Global Burden Of Disease Study 2019

LOZANO R., FULLMAN N., MUMFORD J. E., *et al.*

2020

The Lancet 396 (10258) : 1250-1284

https://doi.org/10.1016/S0140-6736(20)30750-9

Achieving universal health coverage (UHC) involves all people receiving the health services they need, of high quality, without experiencing financial hardship. Making progress towards UHC is a policy priority for both countries and global institutions, as highlighted by the agenda of the UN Sustainable Development Goals (SDGs) and WHO's Thirteenth General Programme of Work (GPW13). Measuring effective coverage at the health-system level is important for understanding whether health services are aligned with countries' health profiles and are of sufficient quality to produce health gains for populations of all ages.

Evidences Supporting The Inclusion Of Immigrants In The Universal Healthcare Coverage

PRATS-URIBE A., BRUGUERAS S., COMET D., *et al.*

2020

Eur J Public Health 30(4): 785-787.

https://doi.org/10.1093/eurpub/ckaa020

In 2012, the Spanish government enforced a healthcare exclusion policy against undocumented immigrants. The newly elected government has recently derogated this policy. To analyze how this decree could have affected population health, we looked at primary health patients who would have been excluded and compared with a matched sample of non-excluded patients. Potentially excluded patients had decreased odds of: depression, chronic obstructive pulmonary disease, dyslipidaemia, heart failure and hypertension while diabetes mellitus rates were similar to non-excluded. Infectious diseases were more frequent in potentially excluded population (HIV, tuberculosis and syphilis). The exclusion of patients impedes the control of infectious diseases at a community level.

Re-Thinking Unmet Need For Health Care: Introducing A Dynamic Perspective

SMITH S. ET CONNOLLY S.

2019

Health Economics, Policy and Law 15(4): 440-457.

https://doi.org/10.1017/S1744133119000161

There is an increasing interest in assessing unmet need for health care services particularly in European countries. Despite this there has been relatively little analysis of unmet need in the European or wider international setting. It remains a challenge to pin down what types of unmet need can and should be addressed by health care policymakers, and how to go about identifying and quantifying those unmet needs. The objective of this paper is to propose a new way of thinking about unmet need for health care which can in turn guide analysis of unmet need in terms of potential data sources and analytic approaches. Unmet need is shown to be a complex multi-faceted concept that cannot be captured by a single indicator or measurement. To advance the literature in this field, this paper considers what happens to unmet need over time. By introducing a dynamic perspective, three alternative trajectories for health care needs are outlined: non-use of health care, delayed use of health care and sub-optimal use of health care. These trajectories are discussed with a view to improving the focus, and policy applicability, of empirical research in this field.

Public Satisfaction With Health System Coverage, Empirical Evidence From SHARE Data

TAVARES A. I. ET FERREIRA P. L.

2020

International Journal of Health Economics and Management 20(3): 229-249.

https://doi.org/10.1007/s10754-020-09279-x

People's satisfaction with the health system, including the coverage provided, has been a concern for some years now but research into the main explanatory factors is in progress. This work focuses on European countries plus Israel, using the SHARE database to find what determines people's satisfaction with the basic coverage provided by the health system of each country. On top of the usual individual socioeconomic characteristics, other explanatory factors were also considered. These include, at individual level, trust in others, political positioning, and risk aversion; at country level, they include access to specialist care and the type of health system financing. Estimation of an ordered logistic model found that the main predictors for satisfaction with a health system's basic coverage include trust in others, unmet health needs, self-assessed health, free access to specialists, health system financed through social insurance, and out-of-pocket payments. These results provide the basis for possible policies designed to improve people's satisfaction.

Why Do People Not Switch Insurer In A Market-Based Health Insurance Market? Empirical Evidence From The Netherlands

VAN DER SCHORS W., BRABERS A. E. M. ET DE JONG J. D.

2020

Eur J Public Health 30(4): 633-638.

https://doi.org/10.1093/eurpub/ckaa044

In market-based systems, the possibility to switch is an important precondition for a well-functioning health insurance market. To assess whether such a market works as intended, insight into the considerations and perceived barriers of insured is needed. This study examines the rates and reasons for not switching health insurer in the Netherlands, and whether these reasons differ between the general population and the population of people with a chronic illness.We made use of survey data collected in 2017 among two panels representing the general population (n = 659, response 44%) and the chronically ill population (n = 1593, response 86%).We found differences regarding the reasons for not switching insurer. The chronically ill population seems to attach more importance to reasons related to the coverage of the health plan, whereas the general population is more focused on the level of service. Some people who considered switching experienced barriers, however, these barriers were not significantly more experienced by the chronically ill population. This study reveals differences between the general population and the chronically ill population when examining reasons for not switching related to quality and coverage. A subset from the people who initially considered to switch experienced barriers which might have altered their decision. Further research is recommended to include questions about information search behaviour to examine which consumers make an informed decision for not switching, and for whom barriers limit switching.

E-santé – Technologies médicales

E-health – Medical Technologies

Cadre stratégique pour soutenir l'évaluation des projets complexes et innovants en santé numérique

ALAMI H., FORTIN J.-P., GAGNON M.-P., *et al.*

2020

Santé Publique 32(2): 221-228.

www.cairn.info/revue-sante-publique-2020-2-page-221.htm

Les technologies numériques jouent un rôle central dans les stratégies visant à améliorer l'accès, la qualité et l'efficience des soins et des services de santé. Toutefois, de nombreux projets en santé numérique n'ont pas réussi à devenir pérennes et être diffusés dans les organisations et systèmes de santé. Cette situation est en partie attribuable au fait que ces projets soient généralement développés et évalués en limitant les enjeux à la dimension technologique principalement. Une telle tradition a négligé de prendre en considération le fait que la technologie s'introduit dans des systèmes sociotechniques pluralistes et complexes, tels les organisations et systèmes de santé. L'objectif de cet article est de proposer des éléments de réflexion pratiques et théoriques, non prescriptifs, qui peuvent soutenir l'évaluation des projets complexes et innovants en santé numérique. La réflexion prend appui sur des enseignements tirés de l'application d'un cadre stratégique pour l'évaluation de grands projets complexes et innovants de santé numérique au Québec (Canada), au cours des 15 dernières années.

Patient And Provider Perspectives On Ehealth Interventions In Canada And Australia: A Scoping Review

LEBLANC M., PETRIE S., PASKARAN S., *et al.*

2020

Rural Remote Health 20(3): 5754.

https://doi.org/10.22605/RRH5754

Despite the promises of universal health care in most developed countries, health inequities remain prevalent within and between rural and remote communities. Remote health technologies are often promoted as solutions to increase health system efficiency, to enhance quality of care, and to decrease gaps in access to care for rural and remote communities. However, there is mixed evidence for these interventions, particularly related to how they are received and perceived by health providers and by patients. Health technologies do not always adequately meet the needs of patients or providers. To examine this, a broad-based scoping review was conducted to provide an overview of patient and provider perspectives of eHealth initiatives in rural communities. The unique objective of this review was to prioritize the voices of patients and providers in discussing the disparities between health interventions and needs of people in rural communities. eHealth initiatives were reviewed for rural communities of Australia and Canada, two countries that have similar geographies and comparable health systems at the local level.

Telemental Health And US Rural–Urban Differences In Specialty Mental Health Use, 2010–2017

PATEL S. Y., HUSKAMP H. A., BUSCH A. B., *et al.*

2020

American Journal of Public Health 110 (9): 1308 - 1314

https://doi.org/10.2105/AJPH.2020.305657

The aim of this study is to examine whether growing use of telemental health (TMH) has reduced the rural-urban gap in specialty mental health care use in the United States.Methods. Using 2010-2017 Medicare data, we analyzed trends in the rural-urban difference in rates of specialty visits (in-person and TMH).Results. Among rural beneficiaries diagnosed with schizophrenia or bipolar disorder, TMH use grew by 425% over the 8 years and, in higher-use rural areas, accounted for one quarter of all specialty mental health visits in 2017. Among patients with schizophrenia or bipolar disorder, TMH visits differentially grew in rural areas by 0.14 visits from 2010 to 2017. This growth partially offset the 0.42-visit differential decline in in-person visits in rural areas. In net, the gap between rural and urban patients in specialty visits was larger by 2017. Conclusions. TMH has improved access to specialty care in rural areas, particularly for individuals diagnosed with schizophrenia or bipolar disorder. While growth in TMH use has been insufficient to eliminate the overall rural-urban difference in specialty care use, this difference may have been larger if not for TMH.

Public Health Implications. Targeted policy to extend TMH to underserved areas may help offset declines in in-person specialty care.

Study Protocol: Effects, Costs And Distributional Impact Of Digital Primary Care For Infectious Diseases—An Observational, Registry-Based Study In Sweden

WILKENS J., THULESIUS H., ARVIDSSON E., *et al.*

2020

BMJ Open 10(8): e038618.

https://doi.org/10.1136/bmjopen-2020-038618

The ability to provide primary care with the help of a digital platform raises both opportunities and risks. While access to primary care improves, overuse of services and medication may occur. The use of digital care technologies is likely to continue to increase and evidence of its effects, costs and distributional impacts is needed to support policy-making. Since 2016, the number of digital primary care consultations for a range of conditions has increased rapidly in Sweden. This research project aims to investigate health system effects of this development. The overall research question is to what extent such care is a cost-effective and equitable alternative to traditional, in-office primary care in the context of a publicly funded health system with universal access. Three specific areas of investigation are identified: clinical effect; cost and distributional impact. This protocol describes the investigative approach of the project in terms of aims, design, materials, methods and expected results.Methods and analysis The research project adopts a retrospective study design and aims to apply statistical analyses of patient-level register data on key variables from seven regions of Sweden over the years 2017–2018. In addition to data on three common infectious conditions (upper respiratory tract infection; lower urinary tract infection; and skin and soft-tissue infection), information on other healthcare use, socioeconomic status and demography will be collected.Ethics and dissemination This registry-based study has received ethical approval by the Swedish Ethical Review Authority. Use of data will follow the Swedish legislation and practice with regards to consent. The results will be disseminated both to the research community, healthcare decision makers and to the general public.

Quels sites Internet consultés par les patients et quelle fiabilité accordée aux sources d'informations médicales ?

ZUMSTEIN C., CHAMBE J. ET KAM C.

2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(2): 69-76.

Internet offrant des sources d'information médicale plus ou moins fiables pour les patients, nous avons évalué leurs pratiques de recherche sur Internet. 955 patients issus de cabinets médicaux du Bas-Rhin ont été recrutés aléatoirement pour répondre à un questionnaire concernant leurs pratiques d'utilisation d'Internet dans le domaine médical. Les sites les plus consultés sont Doctissimo.fr (50,5 %) et Wikipedia.org (45,8 %), sites de grande notoriété publique, pourtant jugés moins fiables (6,0 et 6,3/10) que des sites gouvernementaux tels qu'Ameli-sante.fr ou Sante.gouv.fr (7,7 et 7,4/10). Le médecin traitant reste la référence des patients en matière de santé (8,8/10), malgré la recherche d'un deuxième avis médical. Son implication pourrait permettre d'améliorer ces pratiques.

Économie de la santé

Health Economics

Moral Hazard And Selection For Voluntary Deductibles

ALESSIE R. J. M., ANGELINI V., MIERAU J. O., *et al.*

2020

Health Economics 29(10): 1251-1269.

https://doi.org/10.1002/hec.4134

This paper investigates whether the voluntary deductible in the Dutch health insurance system reduces moral hazard or acts only as a cost reduction tool for low-risk individuals. We use a sample of 14,089 observations, comprising 2,939 individuals over seven waves from the Longitudinal Internet Studies for the Social sciences panel for the analysis. We employ bivariate models that jointly model the choice of a deductible and health care utilization and supplement the identification with an instrumental variable strategy. The results show that the voluntary deductible reduces moral hazard, especially in the decision to visit a doctor (extensive margin) compared with the number of visits (intensive margin). In addition, a robustness test shows that selection on moral hazard is not present in this context.

The Relationship Between Physical Activity And Out-Of-Pocket Health Care Costs Of The Elderly In Europe

DALLMEYER S., WICKER P. ET BREUER C.

2020

Eur J Public Health 30(4): 628-632.

https://doi.org/10.1093/eurpub/ckaa045

Increasing health care costs represent an economic burden placed on individuals across many European countries. Against this backdrop, the aim of this study was to examine the relationship between participation in physical activity and out-of-pocket health care costs in Europe.Individual data from the cross-national Survey of Health, Ageing and Retirement (n = 94 267) including 16 European countries were utilized. Two-part models were estimated to investigate how different levels of participation frequency in physical activity are related to out-of-pocket costs (OOPC) for people aged 50 years and older. Only participation in physical activity more than once a week significantly decreases the probability of incurring any OOPC. However, all frequencies of physical activity significantly reduce the level of costs, with the highest savings being generated by participation once a week. The results reveal higher savings for men compared to women. Physical activity can be a useful policy instrument to reduce the economic burden of out-of-pocket health care costs for an aging population in Europe. Public officials should primarily promote physical activity interventions targeting older people who are not active at all.

Financial Integration's Impact On Care Delivery And Payment Reforms: A Survey Of Hospitals And Physician Practices

FISHER E. S., SHORTELL S. M., O'MALLEY A. J., *et al.*

2020

Health Affairs 39(8): 1302-1311.

https://doi.org/10.1377/hlthaff.2019.01813

Health systems continue to grow in size. Financial integration - the ownership of hospitals or physician practices - often has anticompetitive effects that contribute to the higher prices for health care seen in the US. To determine whether the potential harms of financial integration are counterbalanced by improvements in quality, we surveyed nationally representative samples of hospitals (n = 739) and physician practices (n = 2,189), stratified according to whether they were independent or were owned by complex systems, simple systems, or medical groups. The surveys included nine scales measuring the level of adoption of diverse, quality-focused care delivery and payment reforms. Scores varied widely across hospitals and practices, but little of this variation was explained by ownership status. Quality scores favored financially integrated systems for four of nine hospital measures and one of nine practice measures, but in no case favored complex systems. Greater financial integration was generally not associated with better quality.

The Effect Of Increased Cost-Sharing On Low-Value Service Use

GRUBER J., MACLEAN J. C., WRIGHT B., *et al.*

2020

Health Economics 29(10): 1180-1201.

https://doi.org/10.1002/hec.4127

We examine the effect of a value-based insurance design (VBID) program implemented at a large public employer in the state of Oregon. The program substantially increased cost-sharing for several healthcare services likely to be of low value for most patients: diagnostic services (e.g., imaging services) and surgeries (e.g., spinal surgeries for pain). Using a difference-in-differences design coupled with granular, administrative health insurance claims data over the period 2008–2012, we estimate the change in low-value service use among beneficiaries before and after program implementation relative to a comparison group not exposed to the VBID. Our findings suggest that the VBID significantly reduced the use of targeted services, with an implied elasticity of demand of –0.22. We find no evidence that the VBID led to substitution to non-targeted services or increased overall healthcare costs. However, we also observe no evidence that the program led to cost-savings.

Health Care And The Future Of Economic Growth: Exploring Alternative Perspectives

HENSHER M., TISDELL J., CANNY B., *et al.*

2019

Health Economics, Policy and Law 15(4): 419-439.

https://doi.org/10.1017/S1744133119000276

The strong and positive relationship between gross domestic product (GDP) and health expenditure is one of the most extensively explored topics in health economics. Since the global financial crisis, a variety of theories attempting to explain the slow recovery of the global economy have predicted that future economic growth will be slower than in the past. Others have increasingly questioned whether GDP growth is desirable or sustainable in the long term as evidence grows of humanity's impact on the natural environment. This paper reviews recent data on trends in global GDP growth and health expenditure. It examines a range of theories and scenarios concerning future global GDP growth prospects. It then considers the potential implications for health care systems and health financing policy of these different scenarios. In all cases, a core question concerns whether growth in GDP and/or growth in health expenditure in fact increases human health and well-being. Health care systems in low growth or 'post-growth' futures will need to be much more tightly focused on reducing overtreatment and low value care, reducing environmental impact, and on improving technical and allocative efficiency. This will require much more concerted policy and regulatory action to reduce industry rent-seeking behaviours.

Switching Costs In Competitive Health Insurance Markets: The Role Of Insurers' Pricing Strategies

LAMIRAUD K. ET STADELMANN P.

2020

Health Economics 29(9): 992-1012.

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4111

Our article deals with pricing strategies in Swiss health insurance markets and focuses on the relationship between basic and supplementary insurance. We analyzed how firms' pricing strategies (i.e., pricing of basic and supplementary products) can create switching costs in basic health insurance markets, thereby preventing competition in basic insurance from working properly. More specifically, using unique market and survey data, we investigated whether firms use bundling strategies or supplementary products as low-price products to attract and retain basic insurance consumers. To our knowledge, this is the first paper to analyze these pricing strategies in the context of insurance/health insurance. We found no evidence of bundling in the Swiss setting. We did however observe that firms used low-price supplementary products that contributed to lock in consumers. A majority of firms offered at least one of such product at a low price. None offered low-price products in both basic and supplementary markets. Low-price insurance products differed across firms. When buying a low-price supplementary product, consumers always bought their basic contract from the same firm. Furthermore, those who opted for low-price supplementary products were less likely to declare an intention to switch basic insurance firms in the near future. This result was true for all risk category levels.

The Excess Economic Burden Of Mental Disorders: Findings From A Cross-Sectional Prevalence Survey In Austria

ŁASZEWSKA A., WANCATA J., JAHN R., *et al.*

2020

The European Journal of Health Economics 21(7): 1075-1089.

https://doi.org/10.1007/s10198-020-01200-0

Information about the scope of mental disorders (MDs), resource use patterns in health and social care sectors and economic cost is crucial for adequate mental healthcare planning. This study provides the first representative estimates about the overall utilisation of resources by people with MDs and the excess healthcare and productivity loss costs associated with MDs in Austria. Data were collected in a cross-sectional survey conducted on a representative sample (n = 1008) between June 2015 and June 2016. Information on mental health diagnoses, 12-month health and social care use, medication use, comorbidities, informal care, early retirement, sick leave and unemployment was collected via face-to-face interviews. Generalised linear model was used to assess the excess cost of MDs. The healthcare cost was 37% higher ($p = 0.06$) and the total cost was twice as high ($p < 0.001$) for the respondents with MDs compared to those without MDs. Lost productivity cost was over 2.5-times higher ($p < 0.001$) for those with MDs. Participants with severe MDs had over 2.5-times higher health and social care cost ($p < 0.001$) and 9-times higher mental health services cost ($p < 0.001$), compared to those with non-severe MDs. The presence of two or more physical comorbidities was a statistically significant determinant of the total cost. Findings suggest that the overall excess economic burden on health and social care depends on the severity of MDs and the number of comorbidities. Both non-severe and severe MDs contribute to substantially higher loss productivity costs compared to no MDs. Future resource allocation and service planning should take this into consideration.

Effect Of A Prospective Payment Method For Health Facilities On Direct Medical Expenditures In A Low-Resource Setting: A Paired Pre-Post Study

MEDA I. B., KOUANDA S., DUMONT A., *et al.*

2020

Health Policy and Planning 35(7): 775-783.

https://doi.org/10.1093/heapol/czaa039

Almost all sub-Saharan countries have adopted cost-reduction policies to facilitate access to health care. However, several studies underline the reimbursement delays experienced by health facilities, which lead to deficient implementation of these policies. In April 2016, for its free care policy, Burkina Faso shifted from fee-for-service (FFS) paid retrospectively to FFS paid prospectively. This study tested the hypothesis that this new method of payment would be associated with an increase in direct medical expenditures (expenses covered by the policies) associated with deliveries. This paired pre-post study used data from two cross-sectional national surveys. Observations were paired according to the health facility and the type of delivery. We used a combined approach (state and household perspectives) to capture all direct medical expenses (delivery fees, drugs and supplies costs, paraclinical exam costs and hospitalization fees). A Wilcoxon signed-rank test was used to test the hypothesis that the 2016 distribution of direct medical expenditures was greater than that for 2014. A total of 279 pairs of normal deliveries, 66 dystocia deliveries and 48 caesareans were analysed. The direct medical expenditure medians were USD 4.97 [interquartile range (IQR): 4.30–6.02], 22.10 [IQR: 15.59–29.32] and 103.58 [IQR: 85.13–113.88] in 2014 vs USD 5.55 [IQR: 4.55–6.88], 23.90 [IQR: 17.55–48.81] and 141.54 [IQR: 104.10–172.02] in 2016 for normal, dystocia and caesarean deliveries, respectively. Except for dystocia ($P = 0.128$) and medical centres ($P = 0.240$), the 2016 direct medical expenditures were higher than the 2014 expenses, regardless of the type of delivery and level of care. The 2016 expenditures were higher than the 2014 expenditures, regardless of the components considered. In the context of cost-reduction policies in sub-Saharan countries, greater attention must be paid to the provider payment method and cost-control measures because these elements may generate an increase in medical expenditures, which threatens the sustainability of these policies.

Reste à charge et équité du système de santé : le cas du Tadjikistan

PELLET S.

2020

Revue économique 71(5): 865-893.

www.cairn.info/revue-economique-2020-5-page-865.htm

Cet article vise à mesurer les inégalités d'accès et de financement d'un système de santé à fort reste à charge. Malgré l'universalité de son système, le Tadjikistan affiche des taux de reste à charge parmi les plus hauts du monde, de 60 % à 80 % des dépenses ces dix dernières années. À partir des données issues du Tajikistan Living Standards Survey 2007 et de la méthodologie des indices de concentration, nous suggérons que l'accès aux soins n'est pas équitablement réparti dans la population et que les dépenses de santé sont régressives. Les paiements informels reconstruits après contrôle des différences de besoin sont eux aussi régressifs, ce qui invalide l'hypothèse selon laquelle les médecins redistribuent.

Restes à charge sanitaires des personnes âgées dépendantes à domicile

PENNEAU A., PICHETTI S. ET ESPAGNACQ M.

2020

Gérontologie et société 42 / 162(2): 121-140.

www.cairn.info/revue-gerontologie-et-societe-2020-2-page-121.htm

Les personnes âgées dépendantes sont plus souvent confrontées à des dépenses sanitaires élevées. Des dispositifs d'exonération du ticket modérateur (ALD, pension d'invalidité…) leur permettent de réduire leurs restes à charge, mais aucune étude française n'a encore mesuré l'efficacité du système de protection sociale pour ces personnes. Cet article propose une analyse sur les personnes âgées de 60 ans et plus résidant en logement ordinaire. À partir des données de l'enquête Handicap Santé Ménages collectées en 2008, nous classons les assurés en fonction de leur recours à l'aide humaine et analysons les niveaux et la structure de leurs dépenses sanitaires. Malgré une croissance des dépenses avec le niveau de dépendance, le système de protection sociale maintient les restes à charge à un montant moyen de 900 euros annuels quel que soit le niveau de dépendance. Nos résultats montrent également que les postes qui pèsent le plus sur le reste à charge sont bien couverts par les complémentaires. Les inégalités de restes à charge dépendent donc principalement de la capacité des ménages à financer leur assurance complémentaire.

Variation In Out-Of-Pocket Spending Among Low-Income Versus High-Income Commercially Insured Patients With Asthma

SINAIKO A., GAYE M., WU A., *et al.*

2020

Health Services Research 55(S1): 10-11.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13335

Patient cost-sharing has been increasing over the past two decades, in particular due to high-deductible health plans (HDHP). Asthma is a very common, serious, chronic disease in the United States. We analyzed a large, national sample of asthma patients to provide new evidence on OOP spending overall, across types of asthma care, and variation by patient income. Study Design We used 11 years (2004-2014) of enrollment, claims, and geocoded census tract data on income. Annual OOP costs were measured as the sum of actual patient-paid deductible, coinsurance and copayments on all medical care; spending was adjusted to 2014 dollars using the Medical CPI. Annual asthma OOP spending included OOP payments for asthma services (ie, asthma medications, office and emergency department (ED) visits, and hospitalizations with ICD-9 codes for asthma, spacers for inhalers, asthma nebulizers). Patient income was measured using the census tract income associated with the patient's address, and then, patients were categorized into income quintiles based on the distribution of household income across the United States (eg, not within sample). We report the association of OOP spending with patient income based on linear regression models controlling for patient age, sex, state, morbidity and asthma severity (using the Johns Hopkins ACG system), and year; models were stratified by annual HDHP enrollment. Population Studied All patients ages 4-64 years with asthma (defined as having an asthma ICD-9 diagnosis code for an outpatient or ED visit or hospitalization) in a large, national Commercial and Medicare Advantage claims database (n = 2 018 178). Principal Findings More patients in the lowest-income quintile had a HDHP. Within plan type, levels of spending associated with income quintiles were similar but represented a significantly larger proportion of income for the lowest-income quintile (Table). Conclusions : Because patients spent similar amounts of OOP for asthma care, the lowest-income quintile patients experienced greater cost burden. The majority of OOP asthma spending was on asthma medications, but lowest-income quintile patients had greater spending on high acuity care than those in higher income quintiles. Implications for Policy or Practice Efforts should be made to understand whether these differences in cost burden are associated with cost-related underuse of medications or other adverse outcomes to inform policy and insurance benefit design. Primary Funding Source Patient-Centered Outcomes Research Institute.

▶ Cesarean Birth And Maternal Morbidity Among Black Women And White Women After Implementation Of A Blended Payment Policy

SNOWDEN J. M., OSMUNDSON S. S., KAUFMAN M., *et al.*

2020

Health Services Research 55(5) : 729-740

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13319

The aim of this paper is to test whether Minnesota's blended payment policy had differential effects on cesarean use and maternal morbidity among black women and white women in Minnesota, as compared to six control states. Data sources/study setting :Claims data from births to Medicaid fee-for-service beneficiaries, 2006-2012, in Minnesota (policy state) and six control states (Wisconsin, Iowa, Illinois, Oregon, Idaho, and Montana). Study design :The key study intervention was Minnesota's blended payment policy, which established one single payment rate for uncomplicated vaginal and cesarean births in 2009. The primary outcome was cesarean birth, and secondary outcomes were maternal morbidity (composite), postpartum hemorrhage, and chorioamnionitis. Policy effects were assessed using race-stratified comparative interrupted time series analysis. Principal findings :Following policy implementation, cesarean use decreased among both black and white women in Minnesota compared to control states; this decline was larger among black women (–2.88 percent 3-year cumulative decline, from a prepolicy cesarean rate of 22.2 percent) than among white women (–1.32 percent, P = .0013). Postpartum hemorrhage increased, with larger increases among black women (1.20 percent 3-year cumulative increase), compared with white women (0.48 percent, P < .001) in Minnesota compared with control states. Conclusions : Policy-related declines in cesarean use after Minnesota's blended payment policy were larger in black women. Increases in postpartum hemorrhage signal potential unintended consequences of policy-related cesarean reduction.

▶ Early Impact Of The Implementation Of Medicaid Episode-Based Payment Reforms In Arkansas

TOTH M., MOORE P., TANT E., *et al.*

2020

Health Services Research 55(4): 556-567.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13296

The aim of this study is to evaluate episode-based payments for upper respiratory tract infections (URI) and perinatal care in Arkansas's Medicaid population. Study Setting Upper respiratory infection and perinatal episodes among Medicaid-covered individuals in Arkansas and comparison states from fiscal year (FY) 2011 to 2014. Study Design Cross-sectional observational analysis using a difference-in-difference design to examine outcomes associated with URI and perinatal episodes of care (EOC) from 2011 to 2014. Key dependent variables include antibiotic use, emergency department visits, physician visits, hospitalizations, readmission, and preventive screenings. Data Collection Claims data from the Medicaid Analytic Extract for Arkansas, Mississippi, and Missouri from 2010 to 2014 with supplemental county-level data from the Area Health Resource File (AHRF). Principal Findings The URI EOC reduced the probability of antibiotic use (marginal effect [ME] = –1.8, 90% CI: –2.2, –1.4), physician visits (ME = 0.6, 90% CI: –0.8, –0.4), improved the probability of strep tests for children diagnosed with pharyngitis (ME = 9.4, 90% CI: 8.5, 10.3), but also increased the probability of an emergency department (ED) visit (ME = 0.1, 90% CI: 0.1, 0.2), relative to the comparison group. For perinatal EOCs, we found a reduced probability of an ED visit during pregnancy (ME = 0.1, 90% CI: –0.2, –0.0), an increased probability of screening for HIV (ME = 6.2, 90% CI: 4.0, 8.5), chlamydia (ME = 9.5, 90% CI: 7.2, 11.8), and group B strep-test (ME = 2.6, 90% CI: 0.5, 4.6), relative to the comparison group. Predelivery and postpartum hospitalizations also increased (ME = 1.2, 90% CI: 0.4, 2.0; ME = 0.4, 90% CI: 0.0, 0.8, respectively), relative to the comparison group. Conclusion Upper respiratory infection and perinatal EOCs for Arkansas Medicaid beneficiaries produced mixed results. Aligning shared savings with quality metrics and cost-thresholds may help achieve quality targets and disincentivize over utilization within the EOC, but may also have unintended consequences.

The Financial Burden Of Non-Communicable Diseases In The European Union: A Systematic Review

VANDENBERGHE D. ET ALBRECHT J.

2019

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https://doi.org/10.1093/eurpub/ckz073

Non-communicable diseases (NCDs) impose a significant and growing burden on the health care system and overall economy of developed (and developing) countries. Nevertheless, an up-to-date assessment of this cost for the European Union (EU) is missing from the literature. Such an analysis could however have an important impact by motivating policymakers and by informing effective public health policies.Following the PRISMA protocol, we conduct a systematic review of electronic databases (PubMed/Medline, Embase, Web of Science Core Collection) and collect scientific articles that assess the direct (health care-related) and indirect (economic) costs of four major NCDs (cardiovascular disease, cancer, type-2 diabetes mellitus and chronic respiratory disease) in the EU, between 2008 and 2018. Data quality was assessed through the Newcastle–Ottawa Scale.We find 28 studies that match our criteria for further analysis. From our review, we conclude that the four major NCDs in the EU claim a significant share of the total health care budget (at least 25% of health spending) and they impose an important economic loss (almost 2% of gross domestic product).The NCD burden forms a public health risk with a high financial impact; it puts significant pressure on current health care and economic systems, as shown by our analysis. We identify a further need for cost analyses of NCDs, in particular on the impact of comorbidities and other complications. Aside from cost estimations, future research should focus on assessing the mix of public health policies that will be most effective in tackling the NCD burden.

État de santé

Health Status

Use Of Tobacco, Alcohol And Cannabis In Late Adolescence: Roles Of Family Living Arrangement And Socioeconomic Group

KHLAT M., VAN CLEEMPUT O., BRICARD D., *et al.*

2020

BMC Public Health 20(1): 1356.

https://doi.org/10.1186/s12889-020-09476-w

France has one of the highest levels in Europe for early use of legal and illegal psychoactive substances. We investigate in this country disparities in adolescent problematic substance use by family living arrangement and parental socioeconomic group.

Femmes traitées pour un cancer du sein : retentissement sur la qualité de vie de la chimiothérapie

MANISSOLE C., VALLEE J., TROMBERT B., *et al.*

2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(4): 182-186.

Le cancer du sein est le plus souvent traité par chimiothérapie. L'objectif de cette étude était de quantifier et analyser le retentissement sur la qualité de vie (QDV) des effets indésirables (EI) de la chimiothérapie chez des patientes traitées pour un cancer du sein. Une étude descriptive transversale, quantitative, par auto-questionnaire a été réalisée de juin à décembre 2018 auprès de patientes traitées par chimiothérapie et suivies en région Auvergne-Rhône-Alpes. La QDV a été mesurée au moyen des échelles EORTC, QLQC30 et MIF20. Quatre-vingt-deux questionnaires ont été analysés. En moyenne un an après la fin de la chimiothérapie, la QDV globale des participantes est satisfaisante et s'élève à 66/100. Le score de fatigue est assez élevé à 70,85/100 (MIF20). Cette étude met en évidence la persistance de cette fatigue et l'impact non négligeable des anthracyclines sur la QDV des patientes. Le retentissement immédiat et prolongé de ces traitements devrait conduire à l'utilisation de thérapeutique ayant moins d'EI.

Mortality And Healthcare Resource Utilization Following Acute Myocardial Infarction According To Adherence To Recommended Medical Therapy Guidelines

PLAKHT Y., GREENBERG D., GILUTZ H., *et al.*

2020

Health Policy 124 (11) : 1200-1208

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Guideline recommended medical therapy (GRMT) plays a pivotal role in improving long-term outcomes and healthcare burden of acute myocardial infarction (AMI) patients. We evaluated patients' adherence to GRMT following AMI and the association with long-term (up-to 10 years) mortality, healthcare resource utilization and costs.

Géographie de la santé

Geography of Health

Factors Explaining The Shortage And Poor Retention Of Qualified Health Workers In Rural And Remote Areas Of The Kayes, Region Of Mali: A Qualitative Study

AG AHMED M. A., GAGNON M. P. *et al.*

2020

Rural and Remote Health 20 (3) :5772

Shortage of health workers is a worldwide problem but is particularly critical in sub-Saharan Africa. In Mali, the number of health workers is insufficient and their retention is low, particularly in rural and remote areas. Rural postings are unattractive to health workers. Very few studies have examined the factors contributing to the shortage and poor retention of health workers in Mali. The objective of this study is to identify and understand these factors with regards to skilled health workers in two rural health districts (Yélimané and Bafoulabé) in the region of Kayes, Mali. This qualitative study is based on the conceptual framework of Lehman, Dieleman and Martineau. Data were collected through 46 in-depth interviews with health workers and decision-makers. A thematic content analysis was conducted with the support of QDA Miner software. The study identified factors contributing to the insufficient allocation and poor retention of rural health workers in these districts. They are individual-level factors (gender, family situation, age), unattractive living and working conditions, community recognition and participation, quality of leadership, an unfavourable recruitment/assignment process and insufficient financial incentives. It shows that female staff have specific constraints that prevent them from deploying to or staying in rural areas for long periods. In addition, the number of staff recruited at the national level is unpredictable and insufficient, while their recruitment and assignment process is perceived to be inequitable and not very transparent, disadvantaging rural health structures. Some strategies were identified to improve the availability and retention of health workers in these areas. They take into account certain social norms, notably gender roles, and include the improvement of living and working conditions, as well as the strengthening of health workforce management. This study's findings highlight the multifaceted nature of factors contributing to the availability and retention of health workers in rural and remote areas of sub-Saharan Africa and the challenges associated with them. This study identifies some strategies that can be combined to facilitate the retention and availability of health workers in these areas. Some strategies involve actors outside the health sector, requiring joint efforts for their implementation. This research provides decision-makers with evidence to support informed decision making with regards to the retention of health workers in rural areas.

Rural Facility Decline: A Longitudinal Accessibility Analysis Questioning The Focus Of Dutch Depopulation-Policy

CHRISTIAANSE S.

2020

Applied Geography 121: 102251.

https://doi.org/10.1016/j.apgeog.2020.102251

In the debate about rural depopulation it is frequently assumed that population decline goes hand-in-hand with the decline of facilities and services. Hence, spatial policy for rural areas often focuses on the provision of key services of general interest in areas experiencing population decline. However, the actual changes in distribution and accessibility of several services are almost never evaluated longitudinally, and most recent studies focus on measuring access in terms of supply and demand using aggregated data. This paper offers an alternative method, from an equality standpoint, and investigates changes in access and distribution of local facilities for basic needs (food, education and health care) in Fryslân (Netherlands). By doing so, it questions the focus of Dutch spatial policy on depopulating areas. Changes in access to primary schools, general practitioners and supermarkets between 2000 and 2012 are visualised by overlapping network analyses in GIS. The results are discussed in the context of depopulation and the decline of local facilities from smaller towns and villages. This paper concludes that due to the initial high density of basic facilities the accessibility remained quite good. Moreover, major changes in access do not coincide with the areas targeted by the government to deal with effects of population decline. This suggests that spatial policy for facility-decline should focus on people with low mobility in small villages throughout Fryslân, rather than depopulating areas. This research shows the importance of questioning the assumptions behind spatial policy for service-provision, and offers a simple method to do so.

Theoretical Analysis Of Policies To Improve The Recruitment And Retention Of Rural Physicians

DANISH A., CHAMPAGNE F. ET BLAIS R.

2020

Australian Journal of Rural Health n/a(Ahead of pub).

https://onlinelibrary.wiley.com/doi/abs/10.1111/ajr.12666

The lack of success in resolving the shortage of rural physicians in Organisation for Economic Cooperation and Development countries has been attributed to the weakness of implemented policies. This research examines the theoretical plausibility of policies to improve the recruitment and retention of rural physicians, first, by modelling the policies; and then, by describing how they might achieve their intended outcome based on a theoretical analysis. A theory-driven method relying on published research and expert analysis is used. A conceptual model is created to represent the policies and their underlying assumptions. Then, the functional mechanism of the policies is defined. This research demonstrates that financial, educational and tailored interventions might improve rural physician recruitment and retention, but that regulatory interventions are unlikely to do this. The majority of the policies implemented in Organisation for Economic Cooperation and Development countries are therefore theoretically plausible.

De la territorialisation des pratiques de santé aux communautés professionnelles territoriales de santé

DE FONTGALLAND C. ET ROUZAUD-CORNABAS M.

2020

Santé Publique 32(2): 239-246.

www.cairn.info/revue-sante-publique-2020-2-page-239.htm

Les communautés professionnelles territoriales de santé ont notamment vocation à organiser la coordination des professionnels de santé du 1^er^ et 2^e^ recours pour mieux structurer les parcours de soins et améliorer le recours aux soins. Les flux de patients de second recours libéral dessinent des territoires dont l'échelle et l'organisation peuvent servir de base au maillage de ces communautés. Méthode : L'analyse des flux de patientèle des médecins spécialistes libéraux en région Centre-Val de Loire, en 2015 (données du Sniiram), a permis de classer les spécialités médicales selon leur échelle d'attractivité (régionale, départementale, infra-départementale), puis de les fusionner pour identifier des pôles d'attraction communs. Ces pôles empiriques ont été soumis à l'appréciation des professionnels de santé du terrain pour affiner le découpage du territoire. Les bassins de patientèle des Centre Hospitaliers (données du PMSI) ont également été comparés aux bassins de patientèle libéraux. Résultats : Une vingtaine de pôles d'attraction se distinguent sur six départements. Les communes ont été réparties en cinq classes, selon leur degré d'attraction à un pôle. L'ensemble du territoire a été intégré à un maillage en bassins de santé autour de pôles d'attractions, cohérents avec les habitudes de travail des professionnels de santé. La concordance avec les bassins de patientèle hospitaliers a renforcé la pertinence de ce découpage. Conclusion : Les flux de patients répondent à une réelle logique territoriale qui, confrontée aux pratiques des professionnels de santé, dessine des territoires pertinents pour une première approche des CPTS.

▶ Les inégalités départementales d'accès à l'offre en résidences autonomie

DEVAUX C.

2020

Gérontologie et société 42 / 162(2): 181-216.

www.cairn.info/revue-gerontologie-et-societe-2020-2-page-181.htm

120 000 personnes âgées vivent, à la fin 2018, dans une résidence autonomie (RA). Les RA permettent aux résidents de disposer d'un logement privatif tout en bénéficiant d'espaces communs et de services. Anciennement dénommées logements-foyers, les RA ont été réformées par la loi d'adaptation de la société au vieillissement (ASV), qui leur assigne un rôle de préservation de l'autonomie. Pourtant, ces structures sont peu étudiées. C'est cette lacune que cet article souhaite combler en adoptant une entrée par les inégalités. Comment les RA sont-elles réparties sur le territoire ? L'offre disponible est-elle financièrement accessible ? Comment les départements, chefs de file de l'action sociale, pilotent-ils cette offre ? L'approche qualitative par entretiens et analyse documentaire est complétée par des analyses statistiques à partir du fichier exhaustif des établissements (Finess) et d'une base de données inédite des tarifs. Ceci permet d'élaborer un diagnostic territorial complet, montrant que les RA sont implantées de façon inégale sur le territoire, et pratiquent des prix très variables qui ne sont pas toujours légitimés par des différences d'offre de services. Les politiques départementales en matière de RA reposent sur des engagements et des choix très variés selon les territoires, ce qui concourt à renforcer les inégalités entre personnes âgées selon leur lieu de vie.

▶ Regional Variation In Health Care Utilization And Mortality

GODØY A. ET HUITFELDT I.

2020

Journal of Health Economics 71: 102254.

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Geographic variation in health care utilization has raised concerns of possible inefficiencies in health care supply, as differences are often not reflected in health outcomes. Using comprehensive Norwegian microdata, we exploit cross-region migration to analyze regional variation in health care utilization. Our results indicate that place factors account for half of the difference in utilization between high and low utilization regions, while the rest reflects patient demand. We further document heterogeneous impacts of place across socioeconomic groups. Place factors account for 75% of the regional utilization difference for high school dropouts, and 40% for high school graduates; for patients with a college degree, the impact of place is negligible. We find no statistically significant association between the estimated place effects and overall mortality. However, we document a negative association between place effects and utilization-intensive causes of death such as cancer, suggesting high-supply regions may achieve modestly improved health outcomes.

▶ La fabrique intercommunale de l'équité territoriale : tensions et renoncements

HONTA M.

2020

Gérontologie et société 42 / 162(2): 233-248.

www.cairn.info/revue-gerontologie-et-societe-2020-2-page-233.htm

Alors que l'adaptation de la société au vieillissement est érigée au rang d'impératif national, les enjeux de la reconfiguration du paysage institutionnel intercommunal prévue par la dernière réforme territoriale interrogent aujourd'hui les capacités des groupements de communes à assurer l'égalisation de l'accès aux services sanitaires et sociaux tout particulièrement en milieu rural. En Gironde, le cas de la Communauté d'agglomération du Libournais revêt une portée heuristique pour saisir les modalités à travers lesquelles cette intercommunalité cherche à relever ce défi pour les personnes âgées en analysant les marges de manœuvre et les ressources dont elle dispose. Les résultats révèlent qu'elle peine à s'affirmer comme un acteur pilote à même de promouvoir une action intégrée qui s'appuie sur la transversalité des acteurs, des actions et des dispositifs.

▶ How To Address Medicines Shortages: Findings From A Cross-Sectional Study Of 24 Countries

VOGLER S. ET FISCHER S.

2020

Health Policy(Ahead of pub).

https://doi.org/10.1016/j.healthpol.2020.09.001

Shortages of medicines have become a major public health challenge. The aim of this study was to survey national measures to manage and combat these shortages. A questionnaire survey was conducted with public authorities involved in the Pharmaceutical Pricing and Reimbursement Information (PPRI) network. Reponses relating to measures as of March / April 2020 were received from 24 countries (22 European countries, Canada and Israel). In 20 countries, manufacturers are requested to notify – usually on an obligatory basis – upcoming and existing shortages, which are recorded in a register. Further measures include a regular dialogue with relevant stakeholders (18 countries), financial sanctions for manufacturers in cases of non-supply and/or non-compliance with reporting or stocking requirements (15 countries) and simplified regulatory procedures (20 countries). For defined medicines, supply reserves have been established (14 countries), and legal provisions allow the issuing of export bans (10 countries). Some measures have been introduced since the end of 2019 and countries are planning and discussing further action. While governments reacted by taking national measures, the COVID-19 crisis might serve as an opportunity to join forces in cross-country collaboration and develop joint (e.g. European) solutions to address the shortage issue in a sustainable manner. A practical first step could be to work on a harmonisation of the national registers.

▶ Retaining Graduates Of Non-Metropolitan Medical Schools For Practice In The Local Area: The Importance Of Locally Based Postgraduate Training Pathways In Australia And Canada

WOOLLEY T., HOGENBIRK J. C. ET STRASSER R.

2020

Rural Remote Health 20(3): 5835.

ww.ncbi.nlm.nih.gov/pubmed/32862652

The objective of this study was to identify commonalities between one regionally based medical school in Australia and one in Canada regarding the association between postgraduate training location and a doctor's practice location once fully qualified in a medical specialty. METHODS: Data were obtained using a cross-sectional survey of graduates of the James Cook University (JCU) medical school, Queensland, Australia, who had completed advanced training to become a specialist (a 'Fellow') in that field (response rate = 60%, 197 of 326). Medical education, postgraduate training and practice data were obtained for 400 of 409 (98%) fully licensed doctors who completed undergraduate medical education or postgraduate training or both at the Northern Ontario School of Medicine (NOSM), Ontario, Canada. Binary logistic regression used postgraduate training location to predict practice in the school's service region (northern Australia or northern Ontario). Separate analyses were conducted for medical discipline groupings of general/family practitioner, general specialist and subspecialist (JCU only).

Handicap

Disability

Avantages et revers de l'autonomie chez les aides à domicile en emploi direct

CRASSET O.

2020

Gérontologie et société 42 / 162(2): 83-97.

ww.cairn.info/revue-gerontologie-et-societe-2020-2-page-83.htm

Le travail des aides à domicile en emploi direct est une forme d'emploi salarié présentant des caractéristiques qui le rapprochent du travail indépendant. On propose une contribution à la réflexion sur les zones grises de l'emploi en observant comment s'exerce l'autonomie dans leur activité de travail. À partir d'une enquête qualitative auprès d'aides à domicile en emploi direct, on examinera leur entrée dans ce type d'emploi, ses effets sur les inégalités sociales et la dimension collective de l'autonomie.

National Health Care Expenditures Associated With Disability

KHAVJOU O. A., ANDERSON W. L., HONEYCUTT A. A., *et al.*

2020

Medical Care 58(9).

https://doi.org/10.1097/MLR.0000000000001371

In 2003, national disability–associated health care expenditures (DAHE) were $398 billion. Updated estimates will improve our understanding of current DAHE. The objective of this study was to estimate national DAHE for the US adult population and analyze spending by insurance and service categories and to assess changes in spending over the past decade. Research Design: Data from the 2013–2015 Medical Expenditure Panel Survey were used to estimate DAHE for noninstitutionalized adults. These estimates were reconciled with National Health Expenditure Accounts (NHEA) data and adjusted to 2017 medical prices. Expenditures for institutionalized adults were added from NHEA data. Measures: National DAHE in total, by insurance and service categories, and percentage of total expenditures associated with disability. Results: DAHE in 2015 were $868 billion (at 2017 prices), representing 36% of total national health care spending (up from 27% in 2003). DAHE per person with disability increased from $13,395 in 2003 to $17,431 in 2015, whereas nondisability per-person spending remained constant (about $6700). Public insurers paid 69% of DAHE. Medicare paid the largest portion ($324.7 billion), and Medicaid DAHE were $277.2 billion. More than half (54%) of all Medicare expenditures and 72% of all Medicaid expenditures were associated with disability. Conclusions: The share of health care expenditures associated with disability has increased substantially over the past decade. The high proportion of DAHE paid by public insurers reinforces the importance of public programs designed to improve health care for people with disabilities and emphasizes the need for evaluating programs and health services available to this vulnerable population.

The Disability Process: Is There A Place For Frailty?

ZAMUDIO-RODRÍGUEZ A., LETENNEUR L., FÉART C., *et al.*

2020

Age and Ageing 49(5): 764-770.

https://doi.org/10.1093/ageing/afaa031

Frailty and disability are very common in older adults; they share some risk factors and pathophysiological mechanisms. Yet, they are different clinical entities. this study aimed to explore a potential hierarchical relationship between frailty and disability along the continuum of the disablement process.prospective cohort study.the French Three-City (3C) study.the sample included 943 participants aged 75 and older.the Fried frailty phenotype, Instrumental Activities of Daily Living (IADL) and basic Activities of Daily Living (ADL) were used. We distinguished between four mutually excluding groups: (i) robust (no frailty and no disability); (ii) pure frailty (no disability); (iii) frailty with IADL disability (no ADL disability) and (iv) frailty with IADL and ADL disabilities. We used Cox's regression models to study the 4-year mortality risk associated with each status.Eight-two per cent of participants were classified according to the assumed hierarchy: 61.3% was robust, 5.4% frail, 10.5% frail and IADL-disabled and 4.8% frail, IADL and ADL-disabled. An extra group of 17% was identified with IADL-disabled individuals without frailty. This extra group was similar to pure frailty in terms of characteristics and risk of death, placing them along the continuum at an intermediate stage between robustness and the two most disabled sub-groups.our findings suggest that including frailty along the continuum could be relevant to describe the whole disablement process. Frailty would occur upstream of the process and might be relevant to identify an opportune time window, where specific monitoring and clinical interventions could be implemented in order to interrupt the process at a potentially more reversible stage.

Hôpital

Hospitals

Variations in Pediatric Hospitalization in Seven European Countries

ADETUNJI O., OTTINO K., TUCKER A., *et al.*

2020

Health Policy 124(11) :1165-1173

https://doi.org/10.1016/j.healthpol.2020.07.002

The aim of this paper is to compare rates of pediatric hospital utilization across seven European countries. Methods: Secondary data from WHO's European Hospital Morbidity Database from 2009 to 2012. Cross- country comparison of rates of admissions and bed days per 100 person-years by clinical service. We tabulated counts of admissions and bed days by principal diagnosis and age group for Ireland, Austria, Hungary, Belgium, Spain, Germany, and France. ICD 9 or ICD 10 or ISHMT diagnosis codes were allocated to clinical services. Normal newborn admissions were excluded from the analysis. Simple linear regression models, weighted by pediatric population size, were constructed to estimate the relationships between health care utilization and factors that may influence variation in care. Results: Hospital admission across the seven countries ranged from 9.41 (Spain) to 19.59 (Germany) admissions per 100 person-years. Bed days ranged from a low of 52.50 (Spain) to 135.44 (Germany) per 100 person-years. General pediatrics and neonatology led in clinical volume across all countries. Infectious disease admissions were the third most common. Bed supply and nurse supply were positively associated with health care utilization. Out-of-pocket payment was inversely associated with health care utilization. Conclusions :A wide range of utilization of pediatric inpatient care was observed across seven European countries that have universal coverage. Variation in the provision of effective, supply-sensitive, and preference-sensitive care may explain some of the variations. Our study shows that it is probable that preventable hospital admissions are occurring in the pediatric population.

Comment favoriser l'adoption de la pratique avancée dans un service de soin hospitalier ? Une approche par la sociologie de la traduction

ALPHONSE-TILLOY I. ET DEVIENNE E.

2020

Management & Avenir Santé 6(1): 15-38.

ww.cairn.info/revue-management-et-avenir-sante-2020-1-page-15.htm

Les innovations organisationnelles à l'hôpital sont considérées par les autorités de tutelle comme la pierre angulaire de la transformation du système de santé. L'introduction d'une pratique avancée dans une organisation de soin constitue un changement profond en bouleversant les frontières professionnelles. Une recherche- intervention menée au sein d'un service de soin hospitalier a permis d'observer et d'accompagner le processus d'intégration d'une Infirmière de Pratique Avancée au regard de la sociologie de la traduction et du management polyphonique du changement. La recherche permet d'identifier les facteurs facilitant le processus de traduction. Ils sont relatifs à l'adaptabilité de l'instrumentation de gestion, la pluralité des registres d'action du cadre de santé et l'existence de ressources de proximité.

Balancing Hospital Governance: A Systematic Review Of 15 Years Of Empirical Research

DE REGGE M. ET EECKLOO K.

2020

Social Science & Medicine 262: 113252.

https://doi.org/10.1016/j.socscimed.2020.113252

It is crucial that we gain a deeper understanding of the features of organizational governance and how they contribute to hospital performance. Health care governance research has traditionally had a strong focus on the size and composition (i.e., the attributes) of the governing bodies, but less attention has been given to the dynamics, processes, and roles. Furthermore, evidence regarding the interconnection between the board and the executive management is lacking. This systematic literature review is thus intended to give a detailed summary of the attributes, the dynamics, and the processes, as well as the roles of governing bodies, by synthesizing the findings of published empirical studies. The framework of Kane et al. (2009) was used to position the results, taking into account external constraints and outputs/performance. Sixty-three studies were included in the systematic review. The majority of these studies deal with attributes (n = 34) and roles (n = 27); the smallest number of studies (n = 11) focus on dynamics and processes. There is a lack of consistency in the research findings on attributes and there is too little research into the dynamics and processes of hospital governance. However, it has been shown that clinical participation on the hospital board and the focus on quality in hospital board roles can have a beneficial effect. The studies do not provide sufficient direction on what best practice for governing hospitals should be. For this reason, we here provide a useful framework for understanding the aspects of governance and their impact on performance in hospitals and compare these with general corporate governance literature. Therefrom we propose avenues for further research.

Predicting Patients At Risk For Prolonged Hospital Stays

DOCTOROFF L. ET HERZIG S. J.

2020

Medical Care 58(9).

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Background: Patients with prolonged hospitalizations account for 14% of all hospital days in US hospitals. Predicting which medical patients are at risk for prolonged hospitalizations would allow early proactive management to reduce their length of stay. Methods: Using the National Inpatient Sample, we examined risk factors for prolonged hospitalizations among adults hospitalized on the medicine service in 2014. We defined prolonged hospitalizations as those lasting 21 days or longer. We divided the sample into derivation and validation sets, and used logistic regression to identify significant risk factors in the derivation set, which were validated in the validation set. We used the estimates from the model to derive a risk score for prolonged hospitalizations. Results: Our sample included 2,997,249 hospitalizations (median age of 66 y, 53.5% female). 1.2% of hospitalizations were 21 days or longer. Patients with prolonged hospitalizations were younger, and had a greater number of chronic diseases. A prolonged hospitalization risk score, derived from the many significant predictors in our model, performed well in discriminating between prolonged and nonprolonged hospitalizations, with c-statistics of 0.80 in both the derivation and validation sets. Conclusions: Our predictive model using readily available administrative data was able to discriminate between prolonged and nonprolonged hospitalizations in a national sample of medical patients, and performed well on internal validation. If prospectively validated, such a tool could be of use to hospitals and researchers interested in targeting development, testing, and/or deployment of programs to reduce length of stay.

Variability In Cesarean Delivery Rates Among Individual Labor And Delivery Nurses Compared To Physicians At Three Attribution Time Points

EDMONDS J. K., WEISETH A., NEAL B. J., *et al.*

2020

Health Services Research n/a(Ahead of pub).

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13546

The purpose of this paper is to examine the variability in the cesarean delivery (CD) rates of individual labor and delivery nurses compared with physicians at three attribution time points. Data Sources Medical record data from nine hospitals in Washington State from January 2016 through September 2018. Study Design Retrospective, observational cohort design using an aggregated database of birth records. Data Collection/Extraction Methods Chart-abstracted clinical data from a subset of nulliparous, term, singleton, vertex births attributed at admission, labor management, and delivery to nurses and physicians. Two classification methods were used to categorize nurse- and physician-level CD rates at three attribution time points and the reliability of these methods compared. Principal Findings The sample included 12 556 births, 319 nurses, and 126 physicians. Overall, variation in nurse-level CD rates did not differ significantly across the three attribution time points, and the extent of variation was similar to that observed in physicians. However, agreement between attribution time points varied between 35 percent and 65 percent when classifying individual nurses into the top and bottom deciles. The average reliability of nurse-level CD rates was 32 percent at admission (IQR 22.0 percent to 38.7 percent), 32.6 percent at labor (IQR 23.1 percent to 40.9 percent), and 29.3 percent (IQR 20.9 percent to 35.8 percent) at delivery. The average reliability of physician-level CD rates was higher: 54.2 percent (IQR 38.7 percent to 71.4 percent) at admission, 62.5 percent (IQR 49.0 percent to 79.6 percent) at labor management, and 66.1 percent (IQR 53.7 percent to 81.2 percent) at delivery. Conclusion Feedback on nurse-level CD rates as part of routine clinical quality audits can provide insight into nurse performance in the context of other individual-level and unit-level information. To reliably distinguish individual nurse performance, larger sample sizes are needed.

▶ Validity Of A Tool Designed To Assess The Preventability Of Potentially Preventable Hospitalizations For Chronic Conditions

JOHNSTON J. J., LONGMAN J. M., EWALD D. P., *et al.*

2019

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Potentially preventable hospitalizations (PPH) are defined as unplanned hospital admissions which could potentially have been prevented with the provision of effective, timely outpatient care. To better understand and ultimately reduce rates of PPH, a means of identifying those which are actually preventable is required. The Preventability Assessment Tool (PAT) was designed for use by hospital clinicians to assess the preventability of unplanned admissions for chronic conditions. The present study examined the ability of the PAT to distinguish between those unplanned admissions which are preventable and those which are not, compared to the assessments of an Expert Panel.Data were collected between November 2014 and June 2017 at three hospitals in NSW, Australia. Participants were community-dwelling patients with unplanned hospital admissions for congestive heart failure, chronic obstructive pulmonary disease, diabetes complications or angina pectoris. A nurse and a doctor caring for the patient made assessments of the preventability of the admission using the PAT. Expert Panels made assessments of the preventability of each admission based on a comprehensive case report and consensus process. There was little concordance between the hospital doctors and nurses regarding the preventability of admissions, nor between the assessments of the Expert Panel and the hospital nurse or the Expert Panel and the hospital doctor.The PAT demonstrated poor concurrent validity and is not a valid tool for assessing the preventability of unplanned hospital admissions. The use of Expert Panels provides a more rigorous approach to assessing the preventability of such admissions.

▶ Can Vertically Integrated Health Systems Provide Greater Value: The Case Of Hospitals Under The Comprehensive Care For Joint Replacement Model?

MACHTA R. M., RESCHOVSKY J., JONES D. J., *et al.*

2020

Health Services Research 55(4): 541-547.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13313

We aim to assess whether system providers perform better than nonsystem providers under an alternative payment model that incentivizes high-quality, cost-efficient care. We posit that the payment environment and the incentives it provides can affect the relative performance of vertically integrated health systems. To examine this potential influence, we compare system and nonsystem hospitals participating in Medicare's Comprehensive Care for Joint Replacement (CJR) model. Data Sources We used hospital cost and quality data from the Centers for Medicare & Medicaid Services linked to data from the Agency for Healthcare Research and Quality's Compendium of US Health Systems and hospital characteristics from secondary sources. The data include 706 hospitals in 67 metropolitan areas. Study Design We estimated regressions that compared system and nonsystem hospitals' 2017 cost and quality performance providing lower joint replacements among hospitals required to participate in CJR. Principal Findings Among CJR hospitals, system hospitals that provided comprehensive services in their local market had 5.8 percent ($1612) lower episode costs (P = .01) than nonsystem hospitals. System hospitals that did not provide such services had 3.5 percent ($967) lower episode costs (P = .14). Quality differences between system hospitals and nonsystem hospitals were mostly small and statistically insignificant. Conclusions When operating under alternative payment model incentives, vertical integration may enable hospitals to lower costs with similar quality scores.

Coordination des sorties complexes d'hospitalisation à Mayenne

PRESCRIRE

2020

Revue Prescrire 40(439): 379-382.

Le pôle de santé et l'hôpital de la ville de Mayenne ont expérimenté, sur un territoire semi-rural, un dispositif visant à mieux prendre en charge les sorties complexes d'hospitalisation. Ce dispositif repose sur l'organisation d'une coordination et l'amélioration des échanges d'information entre les professionnels de santé de ville, notamment les infirmiers, et ceux de l'hôpital.

Maltraitances de patients au sein des structures de soins : les identifier et les prévenir

PRESCRIRE

2020

Revue Prescrire 40(437): 214-218.

En mai 2018, la Commission nationale consultative des droits de l'homme a rendu un avis sur les maltraitances observées au sein du système de santé français. Elle y fait le constat de souffrance subies par les patients mais aussi par les professionnels de santé, et en expose les causes. Diffuses et diverses, les maltraitances de patients se manifestent par différentes attitudes allant de paroles maladroites ou d'actes inappropriés au non-respect de leurs droits, dont leur consentement aux soins médicaux. Elles constituent un obstacle à l'accès aux soins de qualité et une perte de chance pour de nombreux patients.

Development Of The General Surgery Prioritisation Tool Implemented In New Zealand In 2018

SRIKUMAR G., EGLINTON T. ET MACCORMICK A. D.

2020

Health Policy.

https://doi.org/10.1016/j.healthpol.2020.07.018

Patients waitlisted for elective general surgery in New Zealand used to be prioritised by multiple tools that were inconsistent, did not reflect clinical judgement and were not validated. We describe the development and implementation of a national prioritisation tool for elective general surgery in New Zealand, which could be applicable to other OECD countries. The tool aims to achieve equity of access, transparency, reliability and should be aligned with clinical judgement. The General Surgery Prioritisation Tool Working Group commenced development of a prioritisation tool in 2014 which showed strong correlation with clinical judgement (r = 0.89), excellent test-retest reliability (r = 0.98) and significantly lower variability ($p < 0.001$). Preliminary findings showed no significant difference in scores attributable to age, gender or ethnicity. General Surgeons were in favour of the tool criteria and agreed on the importance of prioritisation; however a minority opposed its introduction. Health organisations and general practitioner groups were in favour, however, along with many surgeons, expressed apprehensions regarding subjectivity, manipulation, equity of access and degree of benefit. Despite reservations, the majority of stakeholders were supportive and through collaboration between clinicians and the government, the tool was implemented in 2018 in New Zealand. Overall, the prioritisation tool is a reliable method of assessing priority, demonstrating transparency and reflecting clinical judgement, with equity of access to be further assessed by evaluation in clinical practice.

Analysis Of Weekend Effect On Mortality By Medical Specialty In Helsinki University Hospital Over A 14-Year Period

TOLVI M., MATTILA K., HAUKKA J., *et al.*

2020

Health Policy 124(11) : 1209-1216

https://doi.org/10.1016/j.healthpol.2020.07.010

Background : The weekend effect, the phenomenon of patients admitted at the weekend having a higher mortality risk, has been widely investigated and documented in both elective and emergency patients.

Research on the issue is scarce in Europe, with the exception of the United Kingdom. We examined the situation in Helsinki University Hospital over a 14-year period from a specialty-specific approach. Materials and Methods : We collected the data for all patient visits for 2000-2013, selecting patients with in-hospital care in the university hospital and extracting patients that died during their hospital stay or within 30 days of discharge. These patients were categorized according to urgency of care and specialty. Results : A total of 1,542,230 in-patients (853,268 emergency patients) met the study criteria, with 47,122 deaths in-hospital or within 30 days of discharge. Of 12 specialties, we found a statistically significant weekend effect for in-hospital mortality in 7 specialties (emergency admissions) and 4 specialties (elective admissions); for 30-day post-discharge mortality in 1 specialty (emergency admissions) and 2 specialties (elective admissions). Surgery, internal medicine, neurology, and gynecology and obstetrics were most sensitive to the weekend effect. Conclusions : The study confirms a weekend effect for both elective and emergency admissions in most specialties. Reducing the number of weekend elective procedures may be necessary. More disease-specific research is needed to find the diagnoses most susceptible.

Insurance Status And Waiting Times For Hospital-Based Services In Ireland

WHYTE R., CONNOLLY S. ET WREN M.-A.

2020

Health Policy. 124(11) : 1174-1181

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In Ireland long waits for public hospital services are a feature of the healthcare system, with limited evidence that waits for private hospital services (delivered in both public and private hospitals) are shorter. In 2008, in an attempt to ensure more equitable access to hospital-based services, a 'common waiting list' for all patients within public hospitals was proposed. The aim of this paper is to analyse waiting times in Ireland for hospital services for patients with and without private health insurance (PHI) and to examine whether the 2008 reform reduced the differential in waiting. The analysis used data from the 2007 and 2010 health module of the Quarterly National Household survey (QNHS). The impact of insurance status on waiting times was analysed for the period before and after the reforms. A higher proportion of those without PHI were waiting more than three months for hospital services relative to those with PHI. There was no evidence that the 2008 reforms reduced the differential. Anecdotal evidence suggests that the proposals were not fully implemented, although expansion of capacity for private patients' treatment in private hospitals is a possible confounding factor.

Impact Of A Follow-Up Telephone Call Program On 30-Day Readmissions (FUTR-30): A Pragmatic Randomized Controlled Real-World Effectiveness Trial

YIADOM M. Y. A. B., DOMENICO H. J., BYRNE D. W., *et al.*

2020

Medical Care 58(9) : 785-792

https://journals.lww.com/lww-medicalcare/Abstract/2020/09000/Impact_of_a_Follow_up_Telephone_Call_Program_on.5.aspx

Background: Telephone call programs are a common intervention used to improve patients' transition to outpatient care after hospital discharge. Objective: To examine the impact of a follow-up telephone call program as a readmission reduction initiative. Research Design: Pragmatic randomized controlled real-world effectiveness trial. Subjects: We enrolled and randomized all patients discharged home from a hospital general medicine service to a follow-up telephone call program or usual care discharge. Patients discharged against medical advice were excluded. The intervention was a hospital program, delivering a semistructured follow-up telephone call from a nurse within 3–7 days of discharge, designed to assess understanding and provide education, and assistance to support discharge plan implementation. Measures: Our primary endpoint was hospital inpatient readmission within 30 days identified by the electronic health record. Secondary endpoints included observation readmission, emergency department revisit, and mortality within 30 days, and patient experience ratings. Results: All 3054 patients discharged home were enrolled and randomized to the telephone call program (n = 1534) or usual care discharge (n = 1520). Using a prespecified intention-to-treat analysis, we found no evidence supporting differences in 30-day inpatient readmissions [14.9% vs. 15.3%; difference –0.4 (95% confidence interval, 95% CI), –2.9 to 2.1; P = 0.76], observation readmissions [3.8% vs. 3.6%; difference 0.2 (95% CI, –1.1 to 1.6); P = 0.74], emergency department revisits [6.1% vs. 5.4%; difference 0.7 (95% CI, –1.0 to 2.3); P = 0.43], or mortality [4.4% vs. 4.9%; difference –0.5 (95% CI, –2.0 to 1.0);

P = 0.51] between telephone call and usual care groups. Conclusions: We found no evidence of an impact on 30-day readmissions or mortality due to the postdischarge telephone call program.

Inégalités de santé

Health Inequalities

Impact Of Fees On Access To Dental Care: Evidence From France

BAS A. C., DOURGNON P., AZOGUI-LEVY S., *et al.*

2020

Eur J Public Health ckaa143

BACKGROUND: For financial reasons, dental prosthetics is one of the major unmet dental healthcare needs [Financial-SUN (F-SUN)]. Private fees for dental prosthetics result in significant out-of-pocket payments for users. This study analyzes the impact of geo-variations in protheses fees on dental F-SUN. METHODS: Using a nationwide French declarative survey and French National Health Insurance administrative data, we empirically tested the impact of prosthetic fees on dental F-SUN, taking into account several other enabling factors. Our empirical strategy was built on the homogeneous quality of the dental prosthesis selected and used to compute our price index. RESULTS: Unmet dental care needs due to financial issues concern not only the poorest but also people with middle incomes. The major finding is the positive association between dental fees and difficulty in gaining access to dental care when other enabling factors are taken into account (median fee in the highest quintile: OR = 1.35; P value = 0.024; 95% CI 1.04-1.76). People with dental F-SUN are those who have to make a greater financial effort due to a low/middle income or a lack of complementary health insurance. For identical financial reasons, the tendency to give up on healthcare increases as health deteriorates. CONCLUSIONS: The results underscore the need for fee regulation regarding dental prosthetics. This is in line with the current French government dental care reform.

Inequality Of Opportunities In Health And Death: An Investigation From Birth To Middle Age In Great Britain

BRICARD D., JUSOT F., TRANNOY A., *et al.*

2020

International Journal of Epidemiology.

https://doi.org/10.1093/ije/dyaa130

We assess the existence of unfair inequalities in health and death using the normative framework of inequality of opportunities, from birth to middle age in Great Britain.We use data from the 1958 National Child Development Study, which provides a unique opportunity to observe individual health from birth to the age of 54, including the occurrence of mortality. We measure health status combining self-assessed health and mortality. We compare and statistically test the differences between the cumulative distribution functions of health status at each age according to one childhood circumstance beyond people's control: the father's occupation.At all ages, individuals born to a 'professional', 'senior manager or technician' father report a better health status and have a lower mortality rate than individuals born to 'skilled', 'partly skilled' or 'unskilled' manual workers and individuals without a father at birth. The gap in the probability to report good health between individuals born into high social backgrounds compared with low, increases from 12 percentage points at age 23 to 26 at age 54. Health gaps are even more marked in health states at the bottom of the health distribution when mortality is combined with self-assessed health.There is increasing inequality of opportunities in health over the lifespan in Great Britain. The tag of social background intensifies as individuals get older. Finally, there is added analytical value to combining mortality with self-assessed health when measuring health inequalities.

Social Determinants Of Health And Inequalities In COVID-19

BURSTRÖM B. ET TAO W.

2020

Eur J Public Health 30(4): 617-618.

https://doi.org/10.1093/eurpub/ckaa095

The COVID-19 pandemic is affecting populations worldwide. Although everyone is susceptible to the virus, there are numerous accounts of the pandemic having a greater impact on lower socioeconomic groups and minorities. Also, in Stockholm, Sweden, the infection rate is 3–4 times higher in some socioeconomically disadvantaged residential areas compared to the regional average. Scientific studies of inequalities in Coronavirus disease 2019 (COVID-19) are lacking at present, but it is reasonable to assume that disparities in social determinants of health have contributed to these early observations and result in differential exposure to the virus, differential vulnerability to the infection and differential consequences of the disease.

Do The Uninsured Demand Less Care? Evidence From Maryland's Hospitals

COOK A.

2020

International Journal of Health Economics and Management 20(3): 251-276.

https://doi.org/10.1007/s10754-020-09280-4

Uninsured individuals receive fewer healthcare services for at least three reasons: responsibility for the entire bill, higher prices, and potential provider reductions for concern of nonpayment. I isolate reductions when uninsured patients are solely financially responsible by capitalizing on Maryland's highly regulated health care system. Prices are set by the state, are uniform across all patients, and hospitals are compensated for free care and bad debt. I use a unique feature of the data, multiple readmissions for patients who gain or lose insurance between visits, to isolate the reductions in quantity demanded when individuals are faced with paying the full price without an insurance contribution. A Blinder–Oaxaca decomposition estimates uninsured individuals receive 6% fewer services after accounting for differences in patient, illness, and hospital characteristics than when these same individuals are insured.

The Impact Of The Affordable Car Act On Health Care Access And Self-Assessed Health In The Trump Era (2017-2018)

COURTEMANCHE C., MARTON J., UKERT B., *et al.*

2020

Health Services Research 55 (S2) : 841– 850

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13549

The aim of this study is to estimate the impact of the major components of the ACA (Medicaid expansion, subsidized Marketplace plans, and insurance market reforms) on health care access and self-assessed health during the first 2 years of the Trump administration (2017 and 2018). Data Source :The 2011-2018 waves of the Behavioral Risk Factor Surveillance System (BRFSS), with the sample restricted to nonelderly adults. The BRFSS is a commonly used data source in the ACA literature due to its large number of questions related to access and self-assessed health. In addition, it is large enough to precisely estimate the effects of state policy interventions, with over 300 000 observations per year. Design :We estimate difference-in-difference-in-differences (DDD) models to separately identify the effects of the private and Medicaid expansion portions of the ACA using an identification strategy initially developed in Courtemanche et al. (2017). The differences come from: (a) time, (b) state Medicaid expansion status, and (c) local area pre-2014 uninsured rates. We examine ten outcome variables, including four measures of access and six measures of self-assessed health. We also examine differences by income and race/ethnicity. Principal Findings: Despite changes in ACA administration and the political debate surrounding the ACA during 2017 and 2018, including these fourth and fifth years of postreform data suggests continued gains in coverage. In addition, the improvements in reported excellent health that emerged with a lag after ACA implementation continued during 2017 and 2018. Conclusions :While gains in access and self-assessed health continued in the first 2 years of the Trump administration, the ongoing debate at both the federal and state level surrounding the future of the ACA suggests the need to continue monitoring how the law impacts these and many other important outcomes over time.

Is Lack Of Causal Evidence Linking Socioeconomic Position With Health An 'Inconvenient Truth'?

LUNDBERG O.

2020

Eur J Public Health 30(4): 619-619.

https://doi.org/10.1093/eurpub/ckaa004

Mackenbach provides a balance sheet for health inequalities research during the past decades, and suggests that our figures are in the red. Health inequalities are still present, and even growing, and even the most ambitious attempts to reduce inequalities appear to have given modest results. This development is not only due to counteracting factors in our societies, Mackenbach argues, but also attributable to the way in which mainstream thinking in the field have avoided to address and handle a set of 'inconvenient truths'. I find this a very important discussion, and have elsewhere discussed a number of other issues that I think need reconsideration, but here I will focus on the alleged lack of evidence for a causal link between socioeconomic position (SEP) and health.

Re-Thinking Health Inequalities Is Necessary

MACKENBACH J. P.

2020

Eur J Public Health 30(4): 622-622.

https://doi.org/10.1093/eurpub/ckaa002

These thoughtful comments by Ramune Kalediene, Alastair Leyland, Olle Lundberg and Johannes Siegrist illustrate how necessary a re-think of the conventional wisdom on health inequalities is. Kalediene seems to mostly agree with me, and there is little in the others' responses to my—somewhat provocative—editorial that suggests that we can do without such a fundamental re-think.Take Leyland's statement 'If it is possible to reduce mortality by x% among an advantaged population then the inability to reduce mortality by at least this amount in a disadvantaged population—despite this being the focus of our greatest efforts—must be seen as a failure'. Has anyone ever seriously considered what it would mean to reduce mortality (or any other adverse health outcome) by at least the same percentage in a disadvantaged population? Everything, from higher rates of comorbidity to less compliance with drug prescriptions, and from higher levels of psychosocial stress to lower health literacy, conspires against such equality of outcomes. 'Proportionate universalism', the currently popular idea that we must allocate remedial efforts according to need, will certainly not be sufficient. In order to achieve equal percentage declines we would need to allocate far more resources per unit of need to disadvantaged populations, which would require a complete re-think of how we run our health and social systems.

Discrimination In Healthcare As A Barrier To Care: Experiences Of Socially Disadvantaged Populations In France From A Nationally Representative Survey

RIVENBARK J. G. ET ICHOU M.

2020

BMC Public Health 20(1): 31.

https://doi.org/10.1186/s12889-019-8124-z

People in socially disadvantaged groups face a myriad of challenges to their health. Discrimination, based on group status such as gender, immigration generation, race/ethnicity, or religion, are a well-documented health challenge. However, less is known about experiences of discrimination specifically within healthcare settings, and how it may act as a barrier to healthcare.

Inégalités sociales de santé. État des lieux, principes pour l'action

SPIRA A.

2020

Bulletin de l'Académie Nationale de Médecine 204(5): 486-492.

https://doi.org/10.1016/j.banm.2020.03.012

Les inégalités de santé découlent des conditions dans lesquelles les personnes naissent, grandissent, sont éduquées, vivent, travaillent et vieillissent. Elles sont sociales, territoriales, environnementales et liées au genre. Leurs déterminants biologiques, sociaux, comportementaux et le faible recours à la prévention et aux services de santé les amplifient. Le niveau de revenus de l'ensemble de la population détermine en partie l'ampleur des inégalités de morbidité et de mortalité, ainsi que le niveau d'éducation, la position professionnelle, les comportements à risque. Les enfants et les femmes sont particulièrement sensibles aux conséquences des conditions de vie précaires sur leur santé. Les immigrés cumulent les désavantages sociaux et les difficultés d'accès aux systèmes de santé, expliquant leur grande vulnérabilité, en particulier dans le domaine de la santé mentale. Les stratégies de lutte pour la préservation de la bonne santé doivent concerner les populations les plus fragiles par des réformes économiques de redistribution fiscale ; des politiques des revenus et de protection sociale dirigées vers les enfants, les personnes fragiles, vulnérables, précaires ; d'amélioration du système éducatif par la prise en compte des inégalités sociales ; d'accès facilité aux services sociaux et sanitaires pour tous. Ces politiques doivent être d'un universalisme proportionné, pour permettre aux plus défavorisés de rattraper les catégories les plus favorisées, alors que le fossé entre les plus pauvres et les plus riches ne cesse de se creuser.

Fertility, Mortality, Migration, And Population Scenarios For 195 Countries And Territories From 2017 To 2100: A Forecasting Analysis For The Global Burden Of Disease Study

VOLLSET S. E., GOREN E., YUAN C.-W., *et al.*

2020

The Lancet 396 (10258),1285-1306

https://doi.org/10.1016/S0140-6736(20)30677-2

Understanding potential patterns in future population levels is crucial for anticipating and planning for changing age structures, resource and health-care needs, and environmental and economic landscapes. Future fertility patterns are a key input to estimation of future population size, but they are surrounded by substantial uncertainty and diverging methodologies of estimation and forecasting, leading to important differences in global population projections. Changing population size and age structure might have profound economic, social, and geopolitical impacts in many countries. In this study, we developed novel methods for forecasting mortality, fertility, migration, and population. We also assessed potential economic and geopolitical effects of future demographic shifts.

Médicaments

Pharmaceuticals

Les ruses de la raison budgétaire. L'expertise de l'OCDE sur le prix du médicament

BRISSAUD C. ET JUVEN P.-A.

2020

Actes de la recherche en sciences sociales 234(4): 34-49.

ww.cairn.info/revue-actes-de-la-recherche-en-sciences-sociales-2020-4-page-34.htm

Cet article revient sur la production, par une organisation internationale – l'OCDE – d'un rapport sur les prix des médicaments « innovants ». Confrontant deux principes historiquement fondateurs de l'engagement de l'OCDE en matière de santé – limiter les dépenses publiques et introduire des « mécanismes de marché » dans des secteurs obéissant à d'autres logiques sociales – l'expertise sur le prix des « médicaments innovants » est prise dans une tension idéologique et un jeu de contraintes structurales que l'article éclaire. D'un côté, les États-Unis, les représentants de l'industrie à l'OCDE (BIAC) et le Département des affaires économiques défendent une lecture « pro-marché », dans laquelle des prix élevés financent l'innovation pharmaceutique. De l'autre, les rédacteurs et rédactrices du rapport principalement membres de la Direction des affaires sociales, plusieurs pays européens, des ONG, et la représentation des syndicats à l'OCDE (TUAC) contestent l'approche économique standard, et remettent en cause les modalités de construction des prix des médicaments « innovants ». En revenant sur le processus de rédaction du rapport et en éclairant les luttes d'intérêt et d'influence à l'œuvre, l'article met au jour les asymétries de position et de ressources entre les deux groupes. Il donne à voir les modalités concrètes de neutralisation de la critique et la tenaille dans laquelle l'OCDE est prise alors que l'extrême profitabilité du secteur pharmaceutique vient heurter l'idéologie de contrôle des dépenses publiques de santé.

▶ Compared With Other Countries, Women In The US Are More Likely Than Men To Forgo Medicines Because Of Cost

DAW J. R. ET LAW M. R.

2020

Health Affairs 39(8): 1334-1342.

https://doi.org/10.1377/hlthaff.2019.01554

Cost-related nonadherence to prescription medicines is a common problem with important implications for population health. Relative to men, women may be more vulnerable to cost-related nonadherence because of higher health needs and lower financial resources. Using data from the Commonwealth Fund International Health Policy Survey, we compared cost-related nonadherence among younger (ages 18-64) and older (ages 65 and older) women and men in eleven high-income countries. Among younger adults, the unadjusted female-male disparity was larger in the US compared with other countries: One in four younger women reported cost-related nonadherence compared with one in seven younger men. This large disparity persisted after adjustment for age, income, and chronic conditions. We also found smaller but significant female-male differences among younger women in Australia and Canada. We did not find significant female-male differences among older adults in adjusted analyses in any country. Higher rates of cost-related nonadherence among younger women, and US women in particular, may produce important sex-related disparities in health outcomes that should be further explored.

▶ Effects Of Pay-For-Performance On Prescription Of Hypertension Drugs Among Public And Private Primary Care Providers In Sweden

ELLEGÅRD L. M.

2020

International Journal of Health Economics and Management 20(3): 215-228.

https://doi.org/10.1007/s10754-020-09278-y

This study exploits policy reforms in Swedish primary care to examine the effect of pay-for-performance (P4P) on compliance with hypertension drug guidelines among public and private health care providers. Using provider-level outcome data for 2005–2013 from the Swedish Prescription Register, providers in regions using P4P were compared to providers in other regions in a difference-in-differences analysis. The results indicate that P4P improved guideline compliance regarding prescription of angiotensin converting enzyme inhibitors and angiotensin receptor blockers. The effect was mainly driven by private providers, suggesting that policy makers should take ownership into account when designing incentives for health care providers.

▶ Do Physician Incentives Increase Patient Medication Adherence?

KONG E., BESHEARS J., LAIBSON D., *et al.*

2020

Health Services Research 55(4): 503-511.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13322

The objective of this study is to test the effectiveness of physician incentives for increasing patient medication adherence in three drug classes: diabetes medication, antihypertensives, and statins. Data Sources :Pharmacy and medical claims from a large Medicare Advantage Prescription Drug Plan from January 2011 to December 2012. Study Design: We conducted a randomized experiment (911 primary care practices and 8,935 nonadherent patients) to test the effect of paying physicians for increasing patient medication adherence in three drug classes: diabetes medication, antihypertensives, and statins. We measured patients' medication adherence for 18 (6) months before (after) the intervention. Data collection/extraction methods :We obtained data directly from the health insurer. Principal Findings We found no evidence that physician incentives increased adherence in any drug class. Our results rule out increases in the proportion of days covered by medication larger than 4.2 percentage points. Conclusions :Physician incentives of $50 per patient per drug class are not effective for increasing patient medication adherence among the drug classes and primary care practices studied. Such incentives may be more likely to improve measures under physicians' direct control rather than those that predominantly reflect patient behaviors. Additional research is warranted to disentangle whether physician effort is not responsive to these types of incentives, or medication adherence is not responsive to physician effort. Our results suggest that significant changes in the incentive amount or program design may be necessary to produce responses from physicians or patients.

Short-Term Impact Of Co-Payment Level Increase On The Use Of Medication And Patient-Reported Outcomes In Finnish Patients With Type 2 Diabetes

LAVIKAINEN P., AARNIO E., NISKANEN L., *et al.*

2020

Health Policy(Ahead of pub).

https://doi.org/10.1016/j.healthpol.2020.08.001

A new reimbursement scheme for non-insulin medications used for treatment of hyperglycemia in type 2 diabetes (T2D) was implemented in Finland on January 1, 2017. The aim of the study was to evaluate the impact of this co-payment increase (i.e. + 35 percentage points) on patient-reported satisfaction for diabetes care, diabetes medication use, and financial difficulties. Baseline data were collected in 114 pharmacies, where patients with T2D were asked to fill in a questionnaire in November 2016. Follow-ups were conducted at 6 and 12 months. In total, 955 participants with T2D attended the baseline examination. During the follow-up, satisfaction with diabetes care decreased significantly ($p < 0.001$). Use of insulin increased (OR 1.16, 95% CI 1.06-1.27) whereas use of metformin and DPP-4 inhibitors decreased (metformin: OR 0.80, 95% CI 0.70-0.90; DPP-4 inhibitors: OR 0.82, 95% CI 0.73-0.93). Financial difficulties with the purchase of diabetes medications were reported more often both at 6 (OR 2.44, 95% CI 1.96-3.03) and at 12 months (OR 2.70, 95% CI 2.18-3.35) than at baseline. These negative short-term effects require future studies. If persistent, the long-term effects of lower treatment satisfaction and increased financial difficulties may imply impaired metabolic control and increased diabetes complication risk and health care costs. Patient perspective should be taken into account in future policy making.

The Impact Of Social Prescribing Services On Service Users: A Systematic Review Of The Evidence

PESCHENY J. V., RANDHAWA G. ET PAPPAS Y.

2019

Eur J Public Health 30(4): 664-673.

https://doi.org/10.1093/eurpub/ckz078

Social prescribing initiatives are widely implemented in the UK National Health Service to integrate health and social care. Social prescribing is a service in primary care that links patients with non-medical needs to sources of support provided by the community and voluntary sector to help improve their health and wellbeing. Such programmes usually include navigators, who work with referred patients and issue onward referrals to sources of non-medical support. This systematic review aimed to assess the evidence of service user outcomes of social prescribing programmes based on primary care and involving navigators. We searched 11 databases, the grey literature, and the reference lists of relevant studies to identify the available evidence on the impact of social prescribing on service users. Searches were limited to literature written in English. No date restrictions were applied, and searches were conducted to June 2018. Findings were synthesized narratively, employing thematic analysis. The Mixed Methods Appraisal Tool Version 2011 was used to evaluate the methodological quality of included studies.Sixteen studies met the inclusion criteria. The evidence base is mixed, some studies found improvements in health and wellbeing, health-related behaviours, self-concepts, feelings, social contacts and day-to-day functioning post-social prescribing, whereas others have not. The review also shows that the evaluation methodologies utilized were variable in quality.In order to assess the success of social prescribing services, more high quality and comparable evaluations need to be conducted in the future. International Prospective Register of Systematic Reviews number: CRD42017079664

Why Do Hospital Prescribers Continue Antibiotics When It Is Safe To Stop? Results Of A Choice Experiment Survey

ROOPE L. S. J., BUCHANAN J., MORRELL L., *et al.*

2020

BMC Medicine 18(1): 196.

https://doi.org/10.1186/s12916-020-01660-4

Deciding whether to discontinue antibiotics at early review is a cornerstone of hospital antimicrobial stewardship practice worldwide. In England, this approach is described in government guidance ('Start Smart then Focus'). However, <10% of hospital antibiotic prescriptions are discontinued at review, despite evidence that 20–30% could be discontinued safely. We aimed to quantify the relative importance of factors influencing prescriber decision-making at review.

Méthodologie – Statistique

Methodology - Statistics

A Mixed Methods Study Of The Association Of Non-Veterans Affairs Care With Veterans' And Clinicians' Experiences Of Care Coordination

BENZER J. K., GUREWICH D., SINGER S. J., *et al.*

2020

Medical Care 58(8): 696-702.

https://doi.org/10.1097/mlr.0000000000001338

Background: Poor coordination between the Department of Veterans Affairs (VA) and non-VA care may negatively impact health care quality. Recent legislation is intended to increase Veterans' access to care, in part through increased use of non-VA care. However, a possible consequence may be diminished patient experiences of coordination. Objective: The objective of this study was to determine VA patients' and clinicians' experiences of coordination across VA and non-VA settings. Design: Observational mixed methods using patient surveys and clinician interviews. Sampled patients were diagnosed with type 2 diabetes mellitus and either cardiovascular or mental health comorbidities. Participants and Measures: Patient perspectives on coordination were elicited between April and September 2016 through a national survey supplemented with VA administrative records (N = 5372). Coordination was measured with the 8-dimension Patient Perceptions of Integrated Care survey. Receipt of non-VA care was measured through patient self-report. Clinician perspectives were elicited through individual interviews (N = 100) between May and October 2017. Results: Veterans who received both VA and non-VA care reported significantly worse care coordination experiences than Veterans who only receive care in VA. Clinicians report limited information exchange capabilities, which, combined with bureaucratic and opaque procedures, adversely impact clinical decision-making. Conclusions:

How Can We Monitor The Impact Of National Health Information Systems? Results From A Scoping Review

DELNORD M., TILLE F., ABBOUD L. A., *et al.*

2019

Eur J Public Health 30(4): 648-659.

https://doi.org/10.1093/eurpub/ckz164

National health information (HI) systems provide data on population health, the determinants of health and health system performance within countries. The evaluation of these systems has traditionally focused on statistical practices and procedures, and not on data use or reuse for policy and practice. This limits the capacity to assess the impact of HI systems on healthcare provision, management and policy-making. On the other hand, the field of Knowledge Translation (KT) has developed frameworks to guide evidence into practice.A scoping review of the KT literature to identify the essential mechanisms and determinants of KT that could help monitor the impact of HI systems.We examined 79 publications and we identified over 100 different KT frameworks but none of these were focused on HI systems per se. There were specific recommendations on disseminating evidence to stakeholders at the institutional and organizational level, and on sustaining the use of evidence in practice and the broader community setting.We developed a new model, the

HI-Impact framework, in which four domains are essential for mapping the impact of national HI systems: (i) HI Evidence Quality, (ii) HI System Responsiveness, (iii) Stakeholder Engagement and (iv) Knowledge Integration. A comprehensive impact assessment of HI systems requires addressing the use of HI in public health decision-making, health service delivery and in other sectors which might have not been considered previously. Monitoring Stakeholder Engagement and Knowledge Integration certifies that the use of HI in all policies is an explicit point of assessment.

A Cardiovascular Disease Risk Prediction Algorithm For Use With The Medicare Current Beneficiary Survey

FOUAYZI H., ASH A. S. ET ROSEN A. K.

2020

Health Services Research 55(4): 568-577.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13290

The objective of this paper is to develop a cardiovascular disease (CVD) risk score that can be used to quantify CVD risk in the Medicare Current Beneficiary Survey (MCBS). Data Sources We used 1999-2013 MCBS data. Study Design We used a backward stepwise approach and cox proportional hazards regressions to build and validate a new CVD risk score, similar to the Framingham Risk Score (FRS), using only information available in MCBS. To assess its performance, we calculated C statistics and examined calibration plots. Data Collection/Extraction Methods We studied 21 968 community-dwelling Medicare beneficiaries aged 65 years or older without pre-existing CVD. We obtained risk factors from both survey and claims data. We used claims data to derive “CVD event within 3 years” following the FRS definition of CVD. Principal Findings About five percent of MCBS participants developed a CVD event over a mean follow-up period of 348 days. Our final MCBS-based model added morbidity burden, reported general health status, and functional limitation to the traditional FRS predictors of CVD. This model had relatively fair discrimination (C statistic = 0.69; 95% confidence interval [CI], 0.67-0.71) and performed well on validation (C = 0.68; CI, 0.66-0.70). More importantly, the plot of observed CVD outcomes versus predicted ones showed that this model had a good calibration. Conclusions Our new CVD risk score can be calculated using MCBS data, thereby extending the survey’s ability to quantify CVD risk in the Medicare population and better inform both health policy and health services research.

Quelle place pour les registres de morbidité à l’ère des données massives de santé ?

FRANCIS F., TERROBA C., PERSOZ C., *et al.*

2020

Revue d’Épidémiologie et de Santé Publique 68(2): 117-123.

https://doi.org/10.1016/j.respe.2019.11.018

La mise à disposition récente de bases de données massives en santé, ainsi que le développement de méthodes et d’outils adaptés à leurs traitements, vient remettre en question le modèle français des registres de morbidité. Mis en place il y a plusieurs dizaines d’années, ils font partie intégrante du système de surveillance et répondent à des missions de recherche et d’évaluation. Sous l’influence d’avancées technologiques récentes, des bases de données massives sont rendues accessibles aux chercheurs et permettent ou permettraient de répondre à des questions initialement dévolues aux registres. Quelle est la place des registres dans ce nouveau contexte : sont-ils obsolètes ou toujours utiles, doit-on les opposer aux nouveaux outils ou en sont-ils complémentaires, et le cas échéant, quelle est désormais leur place dans le nouvel écosystème de la santé publique française ? L’objectif de ce travail a été de réaliser un bilan des rôles et missions des registres existants et de réfléchir à leur positionnement dans ce nouvel environnement. Le modèle français des registres est parfois remis en question pour la lourdeur de ses circuits, nécessitant de nombreux moyens humains. Cependant, les données qui les constituent, validées par un recoupement d’informations à partir de plusieurs sources, sont d’une très grande qualité et permettent de valider les données des nouvelles bases (Système national des données de santé (SNDS) ou entrepôts de données hospitaliers). Registres et nouvelles bases de données sont en fait complémentaires, et loin de mettre en péril ce modèle, l’ouverture récente de ces bases constitue pour les registres, une opportunité de moderniser leur fonctionnement et de répondre à de nouvelles missions.

Comparing Indices Of Relative Deprivation Using Behavioural Evidence

HOUNKPATIN H. O., WOOD A. M. ET BROWN G. D. A.

2020

Social Science & Medicine 259: 112914.

https://doi.org/10.1016/j.socscimed.2020.112914

What measure of relative deprivation best predicts health? While numerous indices of relative deprivation exist, few studies have compared how well different measures account for empirical data. Hounkpatin et al. (2016) demonstrated that the relative ranked position of an individual i's income within a comparison group (their relative rank) was a better predictor of i's health than i's relative deprivation as assessed by the widely-used Yitzhaki index. In their commentary, Stark and Jakubek (2020) argue that both relative rank and relative deprivation may matter, and they develop a composite index. Here we identify some issues with their composite index, develop an alternative based on behavioural evidence, and test the various indices against data. Although almost all existing indices assume that the significance of an income yj to an individual with income yi (yj>yi) will be some increasing function of the difference between yj and yi, we find that the influence of j's income on i's health is actually a reducing function of (yj–yi). This finding — that less significance is assigned to distant higher incomes than to near higher incomes — is consistent with the well-established idea that we compare ourselves primarily to similar others.

Politique de santé

Health Policy

A Public Health Approach To Health Workforce Policy Development In Europe

AZZOPARDI-MUSCAT N.

2020

Eur J Public Health 30(Supplement_4): iv3-iv4.

https://doi.org/10.1093/eurpub/ckaa123

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), better known as COVID-19, placed the health workforce at the centre of a dramatic series of events. As is so often the case in such circumstances, hype and sensationalism places a flitting spotlight on issues likely to make the media headlines, e.g. the tragic premature deaths of doctors and nurses caring for COVID-19 patients, the lack of personal protective equipment, or the strong support for 'healthcare heroes'. Yet, the intensity and brevity of that focus is not well suited to tease out the complexity and chronicity of the challenges facing the health workforce in Europe today. COVID-19 exacerbated and unmasked gaps in health systems in Europe including:

Transitional Care: A New Model Of Care From Young Age To Adulthood

BERT F., CAMUSSI E., GILI R., *et al.*

2020

Health Policy 124(10) : 1121-1128

https://doi.org/10.1016/j.healthpol.2020.08.002

Transition of care represents the transfer from child to adult care. An effective transition maintains continuity of care and presents better clinical outcomes. This process has assumed growing relevance, thanks to improved survivorship of chronic paediatric patients. Actually, there is no a one-size model fitting for all transitions, but each Service organizes its own clinical pathway. Aim : The study proposes an organizational model for transition, differentiated according to patient complexity. Methods :The working group discussed, through regular meetings, the appropriate transitional model for our Hospital. The working group defined a common scheme of transition and elaborated a synthetic document for patients. Then, the common model is adapted, through clinicians' contribution, for different diseases. The complexity assessment includes clinical data, nursing and social information. Results : The working group defined a common model identifying the main information to be included and detailed in each transition report. The team defined two pathways based on patient's complexity. In case of good compensation and autonomous management, the adolescent is addressed towards standard transition process, a smoother transition from paediatric to adult care with direct connection among healthcare professionals. In case of complex clinical and/or social conditions, an Interdisciplinary Transition Group (ITG) is activated. The group preventively evaluates each patient in periodic meetings and provides a personalized planning of care. In order to define the complexity of a patient, clinical and social determinants are considered. Some diseases are considered complex by default, while others require ITG involvement in case of multiple comorbidities, severe clinical situation, concomitant social criticality and/or cognitive impairment. Discussion Transition of care represents an important phase in chronic diseases management. The proposed model assures a multidisciplinary approach, involving all specialists of both paediatric and adult teams. A key determinant of transition is information transmission. Then, the model proposes a common transition report format. Finally, a further perspective study is already in program, in order to assess clinical effectiveness.

▶ Développement professionnel continu (DPC) et émergence de la recertification en France. Évolution législative et commentaires

BERTRAND D. ET BOUET P.

2020

Bulletin de l'Académie Nationale de Médecine 204(6): 589-597.

https://doi.org/10.1016/j.banm.2020.04.006

La formation médicale continue (FMC) est une obligation déontologique et légale en France. L'évaluation des pratiques professionnelles (EPP) a rejoint en 2004 l'obligation d'acquisition des connaissances pour devenir le développement professionnel continu (DPC) en 2009. Actuellement, le dispositif est complet : définition, organisation et validation. Mais l'obligation individuelle pour valider le DPC n'a jamais été appliquée. La recertification prévue par la loi de 2019 ne sera opérationnelle qu'en 2021, au plus tôt. Son pilier essentiel est le DPC. La mission de recertification qui a préparé la loi exclut toutes épreuves de vérification des connaissances. La recertification se fait par une valorisation du parcours professionnel comprenant, outre le DPC, une activité maintenue et régulière, une amélioration de la relation avec le patient, la prise en compte de la santé du médecin et l'absence d'évènements indésirables. L'Ordre veillant sur la compétence des médecins, c'est lui qui reçoit la validation du DPC, comme il recevra celle de la recertification.

▶ Bilan du service sanitaire 2018-2019 de l'Université Grenoble Alpes, inter-filière médecine, pharmacie, maïeutique, kinésithérapie

BUSI A., BOUSSAT B., RIGAUD M., *et al.*

2020

Santé Publique 32(2): 149-159.

ww.cairn.info/revue-sante-publique-2020-2-page-149.htm

Le service sanitaire, instauré en 2018, visait à inclure la prévention dans les cursus de formation initiale des professionnels de santé. Le but de cette étude était d'évaluer les activités du service sanitaire 2018 - 2019 de l'inter- filière médecine, pharmacie, maïeutique et kinésithérapie de l'Université Grenoble Alpes. Méthode : À partir des rapports d'intervention des étudiants, des avis des responsables d'établissements et d'un questionnaire en ligne pour les étudiants, des données ont pu être recueillies sur les groupes d'intervention, les actions, les publics visés et la satisfaction des étudiants et des responsables d'établissements. Résultats : 400 étudiants ont participé au service sanitaire (207 en médecine, 93 en pharmacie, 61 en kinésithérapie et 39 en maïeutique). 92 groupes ont été accueillis dans 91 structures, dont 90 établissements d'enseignement du second degré. 96 % des étudiants étaient dans un groupe d'intervention pluridisciplinaire. 7 926 personnes ont été sensibilisées, dont 99,3 % d'élèves. Les principales thématiques abordées étaient la lutte contre les addictions par le développement des compétences psycho- sociales avec le programme Unplugged (55 établissements), les écrans et le cyberharcèlement (17 établissements). Conclusion : Le service sanitaire a permis la formation en prévention d'étudiants en santé avec la réalisation d'interventions en interprofessionalité, point fort du dispositif. Les points à améliorer étaient la communication et la prise en charge des frais de déplacement.

▶ Will COVID-19 Lead To A Major Change Of The EU Public Health Mandate? A Renewed Approach To EU's Role Is Needed

CLEMENS T. ET BRAND H.

2020

Eur J Public Health 30(4): 624-625.

https://doi.org/10.1093/eurpub/ckaa103

These days we see the first assessments on the EU's role as crisis manager. Commentators differ in their view whether the EU has failed, been late or has finally come to a substantial response. We should bear in mind that there is a limited EU role in crisis response specifically and for Public Health in general. With regard to the first, Member States (MS) and even sub-national levels are the first and key crisis managers addressing the responses to the pandemic. Moreover, despite some responsibilities and institutions for supporting the immediate crisis response (e.g. ECDC, Early Warning Response System, Health Security Committee, Decision on serious cross-border threats), the EU role is with coordination, sharing information and building supporting structures for MS to be prepared better for an emergency response. With regard to Public Health in general, the EU has a narrow mandate3 with limited law-making powers. There is a strong reluctance by MS to hand over responsibilities, because health(care) is close to their citizens.

▶ Quality Of Collaboration And Information Handovers In Palliative Care: A Survey Study On The Perspectives Of Nurses In The Southwest Region Of The Netherlands

ENGEL M., VAN DER ARK A., TAMERUS R., *et al.*

2020

Eur J Public Health 30(4): 720-727.

https://doi.org/10.1093/eurpub/ckaa046

When patients receiving palliative care are transferred between care settings, adequate collaboration and information exchange between health care professionals is necessary to ensure continuity, efficiency and safety of care. Several studies identified deficits in communication and information exchange between care settings. Aim of this study was to get insight in the quality of collaboration and information exchange in palliative care from the perspectives of nurses. We performed a cross-sectional regional survey study among nurses working in different care settings. Nurses were approached via professional networks and media. Respondents were asked questions about collaboration in palliative care in general and about their last deceased patient. Potential associations between quality scores for collaboration and information handovers and characteristics of respondents or patients were tested with Pearson's chi-square test. A total of 933 nurses filled in the questionnaire. Nurses working in nursing homes were least positive about inter-organizational collaboration. Forty-six per cent of all nurses had actively searched for such collaboration in the last year. For their last deceased patient, 10% of all nurses had not received the information handover in time, 33% missed information they needed. An adequate information handover was positively associated with timeliness and completeness of the information and the patient being well-informed, not with procedural characteristics. Nurses report that collaboration between care settings and information exchange in palliative care is suboptimal. This study suggests that health care organizations should give more attention to shared professionalization towards inter-organizational collaboration among nurses in order to facilitate high-quality palliative care.

▶ EU Health Law And Policy In And After The COVID-19 Crisis

GREER S. ET DE RUIJTER A.

2020

Eur J Public Health 30(4): 623-624.

https://doi.org/10.1093/eurpub/ckaa088

The very first shock of COVID-19 might beover, but the crisis continues. We have already learned much about what the European Union can and cannot do to help its Member States and peoples manage the crisis—and what it might be able to do better. The EU's contribution to fighting COVID-19 was initially limited because member states wanted it so. From a treaty article on public health that carefully limits EU competencies, to legislation that avoids authorizing forceful EU action, to a budget that puts little money into health and has no health emergencies line at all, the EU's member states have made it clear that they want the EU to be a limited actor. It can meet zoonoses with forceful action, but once they become human diseases the EU is hamstrung. Public health is a strange place to rein in European integration, for everything we know about the movement of diseases, animals and people show that there already is European public health.

▶ La sédation profonde et continue jusqu'au décès : difficulté d'accès

REVUE PRESCRIRE

2020

Revue Prescrire 40(438): 300-303.

En France, le Centre national des soins palliatifs et de la fin de vie décrit les difficultés pour les patients en fin de vie à obtenir une sédation profonde et continue jusqu'au décès, droit reconnu par la loi Claeys- Leonetti de 2016 et dont le cadre d'organisation générale a été précisé par la Haute Autorité de santé. Il existe des difficultés d’ordre conceptuel et éthique liées notamment : à la confusion avec l’euthanasie ou avec la sédation palliative qui était déjà pratiquée avant la loi de 2016 : à des tensions dans la relation médecin-patient; à des réticences de certains praticiens. Il existe aussi des difficultés d’ordre pratique et organisationnel liées notamment : à l’organisation de la procédure collégiale; aux interrogations sur les notions de douleurs réfractaires et de proximité du décès; à l’indisponibilité des médicaments nécessaires hors hôpital.

▶ Priorities To Improve The Care For Chronic Conditions And Multimorbidity: A Survey Of Patients And Stakeholders Nested Within The Compare E-Cohort

TRAN V.-T., DIARD E. ET RAVAUD P.

2020

BMJ Quality & Safety: bmjqs-2020-011219.

https://doi.org/10.1136/bmjqs-2020-011219

The aim of this study is to set priorities to improve consultations, care structures and the healthcare system from the perspective of patients with chronic conditions, care professionals, hospital administrators and health policy makers. Methods : Adult patients with chronic conditions recruited from the ComPaRe e-cohort in France ranked their 15 most important areas of improvement among 147 previously defined by patients. Priorities at a population level were obtained by using logit models for sets of ranked items in a data set calibrated to represent the French population of patients with chronic conditions. Care professionals, hospital managers and health policy makers rated the complexity involved in improving the areas identified. We calculated the number of patients who considered as a priority at least one of the areas considered easy to implement.Results Between September 2018 and May 2019, 3002 patients (84% women, 47% with multimorbidity) and 149 professionals (including 50 care professionals, 79 hospital directors, 11 health policy decision makers) were recruited. Patients’ top priorities were (1) Transforming care to be holistic and personalised, at a consultation level; (2) Smoothing patients’ journey in the care system, increasing their knowledge of their own health and improving care coordination, at a care structure level (3) Training clinicians in better interpersonal skills and knowledge of specific conditions/treatments, reducing stigma and making care more affordable, at a healthcare system level. In total, 48%, 71% and 57% patients ranked in their top priorities one area considered easy to improve by professionals at consultation, care structure and health system levels, respectively. Conclusion :This is the first comprehensive map of patients’ priorities to improve the management of chronic conditions. Implementing simple actions could benefit a large number of patients.

▶ Health Professional Mobility In The WHO European Region And The WHO Global Code Of Practice: Data From The Joint OECD/EUROSTAT/WHO-Europe Questionnaire

WILLIAMS G. A., JACOB G., RAKOVAC I., *et al.*

2020

Eur J Public Health 30(Supplement_4): iv5-iv11.

https://doi.org/10.1093/eurpub/ckaa124

WHO Member States adopted the Global Code of Practice on the International Recruitment of Health Personnel 10 years ago. This study assesses adherence with the Code’s principles and its continuing relevance in the WHO Europe region with regards to international recruitment of health workers. Data from the joint OECD/EUROSTAT/WHO-Europe questionnaire from 2010 to 2018 are analyzed to determine trends in intra- and inter-regional mobility of foreign-trained doctors and nurses working in case study destination countries in Europe. In 2018, foreign-trained doctors and nurses comprised over a quarter of the physician workforce and 5% of the nursing workforce in five of eight and four of five case study countries, respectively. Since 2010, the proportion of foreign-trained nurses and doctors has risen faster than domestically trained professionals, with increased mobility driven by rising East-West and South-North intra-European migration, especially within the European Union. The number of nurses trained in developing countries but practising in case study countries declined by 26%. Although the number of doctors increased by 27%, this was driven by arrivals from countries experiencing conflict and volatility, suggesting countries generally are increasingly adhering to the Code’s principles on ethical recruitment. To support ethical recruitment practices and sustainable workforce development in the region, data collection and monitoring on health worker mobility should be improved.

Prévention santé

Health Prevention

Prescrire une activité physique à un malade chronique

BARRAULT D. ET ABRAMOVICI F.

2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(1): 13-19.

Les textes législatifs destinés à aider les médecins dans leur prescription d'activités physiques sont composés de l'article 144 de la loi du 26 janvier 2016 de modernisation du système de santé, d'un décret d'application du 30 décembre 2016 et d'une instruction ministérielle du 30 mars 2017. Il faut y ajouter le Guide de promotion, consultation et prescription de l'activité physique, publié en 2019 par la Haute Autorité de santé.

Modelling The Impact Of Physical Activity On Public Health: A Review And Critique

CANDIO P., MEADS D., HILL A. J., *et al.*

2020

Health Policy 124 (10): 1155-1164

https://doi.org/10.1016/j.healthpol.2020.07.015

While several reviews have assessed economic evaluations of physical activity in public health and, in most cases, found the interventions to be cost-effective, the validity of the conclusions reached depends on the appropriateness of the modelling methods used in the individual studies. Objective :To provide an overview and critique of modelling approaches and key structural assumptions used in applied studies to estimate the impact of physical activity on health. Methods : Electronic databases were systematically searched for relevant model-based economic evaluations. A thematic approach was used to assess the modelling studies. The critique determined the appropriateness of the modelling frameworks and plausibility of key structural assumptions. Results : Twenty-five models were identified. Cohort models were most frequently used. High variability in the modelling of downstream diseases was found across studies analysing similar populations. Structural assumptions regarding the dynamics of change of physical activity were unrealistic in most cases. Heterogeneity was addressed in only a few studies, while health equity concerns were, at best, acknowledged by authors. Conclusions : literature is predominantly characterised by modelling approaches that may not adequately address the complexities associated with representing the physical activity behaviour- population health process. A consensus on how to model the impact of physical activity on public health and development of a reference model could help reduce these sources of uncertainty.

Utility Of Emergency Call Centre, Dispatch And Ambulance Data For Syndromic Surveillance Of Infectious Diseases: A Scoping Review

DUIJSTER J. W., DORELEIJERS S. D. A., PILOT E., *et al.*

2019

Eur J Public Health 30(4): 639-647.

https://doi.org/10.1093/eurpub/ckz177

Syndromic surveillance can supplement conventional health surveillance by analyzing less-specific, near-real-time data for an indication of disease occurrence. Emergency medical call centre dispatch and ambulance data are examples of routinely and efficiently collected syndromic data that might assist in infectious disease surveillance. Scientific literature on the subject is scarce and an overview of results is lacking.A scoping review including (i) review of the peer-reviewed literature, (ii) review of grey literature and (iii) interviews with key informants.Forty-four records were selected: 20 peer reviewed and 24 grey publications describing 44 studies and systems. Most publications focused on detecting respiratory illnesses or on outbreak detection at mass gatherings. Most used retrospective data; some described outcomes of temporary systems; only two described continuously active dispatch- and ambulance-based syndromic surveillance. Key informants interviewed valued dispatch- and ambulance-based syndromic surveillance as a potentially useful addition to infectious disease surveillance. Perceived benefits were its potential timeliness, standardization of data and clinical value of the data.Various dispatch- and ambulance-based syndromic surveillance systems for infectious diseases have been reported, although only roughly half are documented in peer-reviewed literature and most concerned retrospective research instead of continuously active surveillance systems. Dispatch- and ambulance-based syndromic data were mostly assessed in relation to respiratory illnesses; reported use for other infectious disease syndromes is limited. They are perceived by experts in the field of emergency surveillance to achieve time gains in detection of infectious disease outbreaks and to provide a useful addition to traditional surveillance efforts.

Quitting Behaviours And Cessation Methods Used In Eight European Countries In 2018: Findings From The EUREST-PLUS ITC Europe Surveys

PAPADAKIS S., KATSAOUNOU P., KYRIAKOS C. N., *et al.*

2020

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We examined quit attempts, use of cessation assistance, quitting beliefs and intentions among smokers who participated in the 2018 International Tobacco Control (ITC) Europe Surveys in eight European Union Member States (England, Germany, Greece, Hungary, the Netherlands, Poland, Romania and Spain).Cross-sectional data from 11 543 smokers were collected from Wave 2 of the ITC Six European Country (6E) Survey (Germany, Greece, Hungary, Poland, Romania and Spain—2018), the ITC Netherlands Survey (the Netherlands—late 2017) and the Four Countries Smoking and Vaping (4CV1) Survey (England—2018). Logistic regression was used to examine associations between smokers' characteristics and recent quit attempts.Quit attempts in the past 12 months were more frequently reported by respondents in the Netherlands (33.0%) and England (29.3%) and least frequently in Hungary (11.5%), Greece (14.7%), Poland (16.7%) and Germany (16.7%). With the exception of England (35.9%), the majority (56–84%) of recent quit attempts was unaided. Making a quit attempt was associated with younger age, higher education and income, having a smoking-related illness and living in England. In all countries, the majority of continuing smokers did not intend to quit in the next 6 months, had moderate to high levels of nicotine dependence and perceived quitting to be difficult.Apart from England and the Netherlands, smokers made few quit attempts in the past year and had low intentions to quit in the near future. The use of cessation assistance was sub-optimal. There is a need to examine approaches to supporting quitting among the significant proportion of tobacco users in Europe and increase the use of cessation support as part of quit attempts

How Is Informed Decision-Making About Breast Cancer Screening Addressed In Europe? An International Survey Of 28 Countries

RITCHIE D., VAN HAL G. ET VAN DEN BROUCKE S.

2020

Health Policy 124(9): 1017-1031.

https://doi.org/10.1016/j.healthpol.2020.05.011

The aim of this study was to develop a typology of approaches towards informed decision-making (IFD) about mammography screening in Europe. All countries collaborating in the European Commission Initiative on Breast Cancer were approached to participate. Experts from 28 European countries responded to a web-based survey providing data on key organisational and policy characteristics of breast screening at the national or regional level. A total of 35 responses were received including data from regionally organised breast screening in several countries. 27 respondents, covering 21 countries, reported the existence of a policy towards IFD and stated that they communicated to women about the benefit and risks. Few countries had attempted to measure the proportion of women making an informed choice. A cluster analysis of the survey responses allowed to identify three categories: countries in a confirmation phase who have adopted a policy specific to mammography screening; countries in an implementation phase with generic polices and limited administrative support dedicated yet to IFD; and countries in a decision phase who are deliberating how to address IFD. To the best of our knowledge, this study is the first to investigate the key policy and organisational characteristics of approaches taken to facilitate IFD in Europe. The results demonstrate a broad adoption of the principle of enabling IFD but indicate heterogeneity of implementation.

Accompagnement collectif pour l'arrêt du tabac : retour d'expérience

SPRIMONT M., LAJZEROWICZ N. ET CASTERA P.

2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(1): 20-27.

Le contexte actuel engendre des demandes d'aide à l'arrêt du tabac croissantes et la nécessité d'y répondre. C'est donc pour augmenter l'offre de prise en charge qu'a été conçue, durant le Moi(s) Sans Tabac 2018, cette expérience collective d'aide à l'arrêt du tabac, associant des séances de groupe hebdomadaires, un coaching infirmier et un lien avec les prescripteurs libéraux de substituts nicotiniques. L'objectif était de mettre en exergue les freins et leviers les plus contributifs de ce dispositif novateur, du point de vue des participants. Cette prise en charge collective pourrait être réitérée en routine pour accompagner efficacement un plus grand nombre de patients dans leur démarche d'arrêt.

Prévision – Evaluation

Prevision - Evaluation

Development Of A Predictive Algorithm To Identify Adults With Mobility Limitations Using VA Health Care Administrative Data

EISENBERG Y., POWELL L. M., ZENK S. N., *et al.*

2020

Medical Care Research and Review: 1077558720950880.

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An estimated 31.5 million Americans have a mobility limitation. Health care administrative data could be a valuable resource for research on this population but methods for cohort identification are lacking. We developed and tested an algorithm to reliably identify adults with mobility limitation in U.S. Department of Veterans Affairs health care data. We linked diagnosis, encounter, durable medical equipment, and demographic data for 964 veterans to their self-reported mobility limitation from the Medicare Current Beneficiary Survey. We evaluated performance of logistic regression models in classifying mobility limitation. The binary approach (yes/no limitation) had good sensitivity (70%) and specificity (79%), whereas the multilevel approach did not perform well. The algorithms for predicting a binary mobility limitation outcome performed well at discriminating between veterans who did and did not have mobility limitation. Future work should focus on multilevel approaches to predicting mobility limitation and samples with greater proportions of women and younger adults.

Well-Being Of Older People (WOOP): Quantitative Validation Of A New Outcome Measure For Use In Economic Evaluations

HACKERT M. Q. N., VAN EXEL J. ET BROUWER W. B. F.

2020

Social Science & Medicine 259: 113109.

https://doi.org/10.1016/j.socscimed.2020.113109

There is a need for comprehensive measures to evaluate the benefits of health and social care services for older people. The newly developed Well-being of Older People measure (WOOP) aims to capture all aspects that older people find important to their well-being. This study explores the validity and test-retest reliability of the WOOP. Between December 2017 and January 2018, an online survey was used to retrieve data from 1113 people aged 65 years and older in the Netherlands. Regression analyses on Cantril's Ladder scores were conducted to explore the relative importance of the items of the WOOP. Dimensionality was checked using exploratory factor analysis. Convergent and discriminant validity were investigated by relating the WOOP to several measures of health and well-being. Test-retest reliability was examined using data from 269 respondents that participated in a second online survey, distributed one week after the first. The items of the WOOP were significantly associated with Cantril's Ladder scores. When regressed simultaneously this was still true for all but the 'social contacts' item and one level of the 'acceptance and resilience' item. The dimensionality analysis revealed three factors, of which two included items of the WOOP and the EQ-5D-5L and the third only items of the WOOP. The WOOP correlated moderately to highly with physical health, and (very) highly with (mental) health and well-being measures. The test-retest reliability in terms of ICC was high, whereas the kappa for the items was fair to good, except for two items. Overall, the WOOP seems to capture aspects relevant to the well-being of older people adequately, and the results of first validity and reliability tests were satisfactory. Before the WOOP can be used in economic evaluations, further validation in a variety of health and social care settings is recommended, and utility weights need to be determined.

A Systematic Review Of Economic Evaluations Of Public Health Interventions Targeting Alcohol, Tobacco, Illicit Drug Use And Problematic Gambling: Using A Case Study To Assess Transferability

NYSTRAND C., GEBRESLASSIE M., SSEGONJA R., *et al.*

2020

Health Policy (Ahead of pub.)

https://doi.org/10.1016/j.healthpol.2020.09.002

The aim of this paper is to identify and assess the cost-effectiveness of public health interventions targeting the use of alcohol, illicit drugs and tobacco, as well as problematic gambling behavior (ANDTS), and consider whether the results from these evaluations are transferable to the Swedish setting. Methods :A systematic review of economic evaluations within the area of ANDTS was conducted including studies published between January 2000 and November 2018, identified through Medline, PsychINFO, Web of Science, the National Health Service Economic Evaluation Database and Health Technology Assessment. The quality of relevant studies and the possibilities of transferring results were assessed using criteria set out by the Swedish Agency for Health Technology Assessment. Results :Out of 54 relevant studies, 38 were of moderate to high quality and included in the review, however none for problematic gambling. Sixty-five out of a total of 73 interventions were cost-effective. The interventions largely focusing on taxed-based policies or screening and brief interventions. Twelve of these studies were deemed to have high potential for transferability, with effect estimates considered relevant, and with good feasibility for implementation in Sweden. Conclusions :Interventions targeting alcohol- and illicit-drug use and tobacco use are cost-effective approaches, and results may be transferred to the Swedish setting. Caution must be taken regarding cost estimates and the quality of the evidence which the studies are based upon.

Psychiatrie

Psychiatry

Les case-managers en santé mentale : des professionnels en quête de définition

BARTOLI A., SEBAI J. ET GOZLAN G.

2020

Management & Avenir Santé 6(1): 83-104.

ww.cairn.info/revue-management-et-avenir-sante-2020-1-page-83.htm

Dans un contexte souvent marqué par le cloisonnement des structures et des institutions et le besoin d'interfaces entre les secteurs médicaux, sanitaires et sociaux, le case-management apparaît de plus en plus comme une approche adaptée pour un accompagnement multidimensionnel et progressif du patient dans son milieu de vie ordinaire en permettant une meilleure coordination des soins et des services. Pour autant, les représentations et traductions opérationnelles de ce concept restent multiformes et sources de confusion. Cet article vise à analyser différentes conceptions et pratiques du case-management et à étudier le rôle des acteurs qui l'incarnent dans le champ particulier de la santé mentale. Partant du constat selon lequel ce concept et ses déclinaisons pratiques viennent essentiellement du monde anglo-saxon, la recherche s'attache à dégager les éventuelles spécificités d'approches développées dans d'autres contextes, à partir de cas de structures françaises et suisse de santé mentale ayant mis en place ces dispositifs, et à interroger l'émergence et la réalité d'un nouveau métier de case-manager en quête de définition.

Discrimination et stigmatisation des patients psychotiques dans les soins somatiques

BOUGEROL C., CHARLES R., BALLY J. N., *et al.*

2020

Médecine 16(7): 305-308.

Les patients psychotiques souffrent de discrimination dans la société, mais également auprès des professionnels de santé. Cette stigmatisation peut conduire à un biais de raisonnement diagnostique et à des soins sub-optimaux. Pour lutter contre cette discrimination, certains centres mettent en place des adaptations du système de soins, notamment ambulatoires.

Impact Of The Affordable Care Act Medicaid Expansion On Utilization Of Mental Health Care

BRESLAU J., HAN B., LAI J., *et al.*

2020

Medical Care 58(9): 757-762.

https://journals.lww.com/lww-medicalcare/Abstract/2020/09000/Impact_of_the_Affordable_Care_Act_Medicaid.1.aspx

The Affordable Care Act's Medicaid expansions (ME) increased insurance coverage for low-income Americans, among whom unmet need for mental health care is high. Empirical evidence regarding the impact of expanding insurance coverage on use of mental health services among low income and minority populations is lacking. Methods: Data on mental health service use collected between 2007 and 2015 by the Medical Expenditures Panel Survey from nationally representative cross-sectional samples of low income (income<138% of the federal poverty line) adults were analyzed. Use trends among people in states that expanded Medicaid (ME states; n = 29,827) were compared with concurrent trends among people in states that did not (non-ME states; n = 22,873), with statistical adjustment for demographic characteristics and psychological distress. Results: Annual outpatient visits for mental health conditions increased by 0.513 (0.053–0.974) visits per person, from a baseline rate in ME states of 0.894 visits per person. However, no significant changes were observed in number of mental health related hospital stays, emergency department visits or prescription fills. The increase outpatient visits was limited to Hispanics and non-Hispanic Whites, with no increase in service use observed among non-Hispanic Blacks. There was no apparent increase in the number of users of outpatient mental health care (AOR = 0.992, P = 0.942) and a marginally significant (P = 0.096) increase of 3.144 visits per user. Discussion:

Assurer les soins aux patients souffrant de troubles psychiques en France pendant l'épidémie à SARS-CoV-2

CHEVANCE A., GOURION D., HOERTEL N., *et al.*

2020

L'Encéphale 46(3, Supplement): S3-S13.

https://doi.org/10.1016/j.encep.2020.03.001

L'absence de préparation du système de soins psychiatriques à l'épidémie de virus SARS-CoV-2 fait redouter un scénario pessimiste pour la santé physique et mentale des patients suivis en psychiatrie. L'objectif de cet article est de proposer des éléments de guidance pour réorganiser les soins psychiatriques dans le contexte de pandémie Covid-19. Méthode Les auteurs ont réalisé une synthèse de la littérature internationale combinée au partage des expériences locales françaises. Résultats : Les patients souffrant de troubles psychiques semblent particulièrement vulnérables à ce virus et à la pandémie : vulnérabilités liées aux comorbidités médicales, à l'âge, aux troubles cognitifs qui peuvent entraver le respect des consignes de confinement et aux complications psychosociales. Plusieurs initiatives ont été prises pour assurer la continuité des soins et contenir l'épidémie : création en psychiatrie d'unité Covid+ co-supervisée par des médecins généralistes ou internistes, restriction des consultations aux cas sévères et redéploiement des soins en téléconsultation, accompagnement de type case-management pour les sorties précoces ou l'impossibilité d'hospitaliser, accompagnements spécifiques pour les complications psychiques du confinement. Les populations suivies en pédopsychiatrie, en psychiatrie du sujet âgé, en addictologie ou détenues en prison doivent bénéficier d'une attention particulière. Plusieurs questions restent en suspens : la question de l'interaction négative ou positive des traitements sur l'infection SARS-CoV-2, l'épidémiologie de l'infection chez les personnes souffrant de troubles psychiques, leur adaptation à un confinement long. Discussion : Une prise de conscience par les décideurs politiques de la grande vulnérabilité de ces populations et des institutions psychiatriques dans cette situation de catastrophe sanitaire est urgente.

Médecine générale, psychiatrie et soins primaires : regard de généraliste

GALLAIS J. L.

2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(2): 77-83.

Au travers de l'analyse qualitative et quantitative du dispositif de médecine générale est éclairée la position d'interface médicale et sociale spécifique et celle d'acteur de santé mentale du médecin généraliste traitant. Parmi les constats négatifs beaucoup sont reliés aux faiblesses des choix de santé publics et aux défauts structurels d'organisation et de régulation du système de santé français. Dans les reformes en cours, le développement du dispositif du médecin traitant et des parcours de soins coordonnés est décrit comme levier essentiel pour des améliorations nécessaires.

Medication Use And Health Care Utilization After A Cost-Sharing Increase In Schizophrenia: A Nationwide Analysis

HAMINA A., TANSKANEN A., TIIHONEN J., *et al.*

2020

Medical Care 58(9): 763-769.

https://doi.org/10.1097/mlr.0000000000001369

Increases in prescription drug cost-sharing may decrease adherence to treatment among persons with schizophrenia and lead to discontinuation of use and an increased risk of hospitalization. Objective: The objective of this study was to investigate the impact of new deductible and increased drug copayments implemented on antipsychotic and other drug purchases and on rates of hospitalizations and primary care contacts among persons with schizophrenia in Finland. Research Design: Interrupted time series analysis. Subjects: All persons with schizophrenia in Finland who were alive at the beginning of 2015 (N = 41,017). Measures: We measured the rates of antipsychotic, other psychotropic and cardiometabolic drug purchasers, hospitalizations, and primary care contacts during 2015 and 2016 with data collected from several nationwide health care registers. Results: During 2016, the proportion of antipsychotic purchasers decreased by −0.26 percentage points per month [95% confidence interval (CI): −0.47 to −0.05] compared with 2015. The trend of other psychotropic purchasers decreased to −0.13 percentage points per month in 2016 (95% CI: −0.22 to −0.04) compared with 2015 and cardiometabolic drug purchases to −0.17 percentage points per month (95% CI: −0.29 to −0.05) compared with 2015. The decreasing trend of psychiatric hospitalizations in 2015 halted in 2016. There were no other significant differences in health care utilization. Conclusions: In our nationwide time-series analysis, we observed decreases in the slopes of antipsychotic and other drug purchases of persons with schizophrenia after prescription drug cost-sharing increase implementation on January 1, 2016. Policymakers need to be aware of the unintended consequences of increasing cost-sharing among people with severe mental disorders.

Patient Referral From Primary Care To Psychological Therapy Services: A Cohort Study

JONKER L., THWAITES R. ET FISHER S. J.

2019

Family Practice 37(3): 395-400.

https://doi.org/10.1093/fampra/cmz094

Improving Access to Psychological Therapy (IAPT) services in England offer psychological therapy for patients with mental health issues such as depression and anxiety disorders.How are primary care patients referred to IAPT, to what degree does this correlate with subsequent attendance, and how is the referral process perceived by patients? Retrospective analysis of medical records covering June 2018–June 2019 in seven general practices servicing 96 000 patients, to identify and survey patients with anxiety and/or depression.Records of 6545 patients were appraised; 2612 patients were deemed suitable for IAPT intervention by the GP. Of those, 1424 (55%) attended at least one IAPT appointment whereas 1188 (45%) did not. These 'attender' and 'non-attender' cohorts did not differ in age, gender or level of deprivation; neither did GP advice to self-refer rather than making a direct GP referral influence the attendance rate. The most common reasons for IAPT non-attendance include symptom improvement (22%), lack of belief in psychotherapy effectiveness (16%) or a patient feeling too unwell to either refer themselves or attend (12%). Neither certain age or gender, nor the mode of patient referral to IAPT is associated with eventual attendance. Future research is indicated to identify in more detail if any specific mental health conditions are more likely to lead to non-attendance. Furthermore, there may be scope for a targeted approach for subgroups of patients, e.g. those who indicate they are feeling mentally too unwell, to enable them to attend IAPT screening and therapy appointments.

Soins sans consentement et mesures d'isolement en psychiatrie adulte : où en est-on ? L'exemple de la région Centre-Val de Loire via le Programme de médicalisation des systèmes d'information 2012–2017

LAURENT O., GODILLON L., BIOTTEAU M., *et al.*

2020

Revue d'Épidémiologie et de Santé Publique 68(3): 155-161.

https://doi.org/10.1016/j.respe.2020.02.001

En France, le cadre légal des soins sans consentement a été modifié par les lois de 2011 et 2013 et celui des pratiques d'isolement par la loi de 2016. L'objectif était de décrire l'évolution des modes légaux de soins et des pratiques d'isolement en région Centre-Val de Loire entre 2012 et 2017, à partir des données du RIM-P. Méthodes : Ont été sélectionnés les adultes (≥ 18 ans) domiciliés en Centre-Val de Loire et hospitalisés en psychiatrie ou suivis en programme de soins (hospitalisations temps partiel ou consultations) de 2012 à 2017. Le numéro anonyme et l'identifiant permanent du patient ont été utilisés pour le chaînage. Le taux régional de soins sans consentement et la durée moyenne des isolements étaient inférieurs aux données nationales (24 % SSC en temps plein en 2015 ; 15 jours d'isolement/patient), alors qu'une augmentation du recours aux soins en péril imminent et la persistance de mesures d'isolement en soins libres (recommandées seulement en dernier recours) étaient retrouvées, devant amener à une analyse des pratiques par les établissements. Les limites du RIM-P sont multiples : absence d'incitation tarifaire, structuration complexe. Les données du registre des pratiques d'isolement et de contention interne aux établissements, complémentaires au PMSI depuis 2018, pourraient permettre une analyse plus fine, notamment pour la contention.

Inequalities In The Economic Consequences Of Depression And Anxiety In Europe: A Systematic Scoping Review

LINDER A., GERDTHAM U.-G., TRYGG N., *et al.*

2019

Eur J Public Health 30(4): 767-777.

https://doi.org/10.1093/eurpub/ckz127

Depression and anxiety are associated with adverse outcomes in educational achievements and economic performances. Moreover, the prevalence of these disorders is unequally distributed among different population subgroups. Our objective is to investigate whether the economic consequences of depression and anxiety differ between population subgroups of different gender, socioeconomic status (SES), ethnicity and age, in Europe. A systematic scoping literature review was performed to identify studies where exposure to depression or anxiety was identified at baseline and consequences in education, sickness absence, disability pension, unemployment and income/earnings were measured at follow-up.S eventeen articles were included in this review and most of these were conducted in the Nordic countries. The consequences of depression and anxiety were stratified by gender in most of the articles. However, only in a few studies, the findings were stratified by SES, age and ethnicity. The negative consequences of depression in educational performance, disability pension and income are larger for men compared to women. Moreover, low SES individuals have more depression- and anxiety-related absence from work than high SES individuals. Our findings imply that the economic consequences of depression differ between population subgroups in Europe. This could have an impact on social stratification, shifting people who experience mental ill-health to lower SES groups or reinforcing an already disadvantaged position. More research is needed on unequal economic consequences of depression and anxiety in different population subgroups in Europe.

Effects Of Macroeconomic Fluctuations On Mental Health And Psychotropic Medicine Consumption

MARTÍNEZ-JIMÉNEZ M. ET VALL CASTELLÓ J.

2020

International Journal of Health Economics and Management 20(3): 277-297.

https://doi.org/10.1007/s10754-020-09281-3

Our aim in this paper is to understand the impact of macroeconomic fluctuations on mental health and psychotropic medicine consumption. In order to do that we exploit differences in the fluctuations of business cycle conditions across regional units in Catalonia. Our findings suggest that, in general, economic fluctuations at the local level had no significant effect on the consumption of psychotropic medicines. However, we show that a deterioration in local labour market conditions is associated with a reduction in the consumption of anxiolytics medicines. We also report an increase in the consumption of anxiolytics in regions with a softer deterioration in the economic situation. Although we report mild improvements in both mental and physical health for some sub-groups of the population, we also find significant reductions on the probability of sleeping 6 h or more. Thus, these elements point towards potential negative effects of local labour market conditions on health in the medium/long term.

Le financement de la psychiatrie hospitalière en Allemagne – modèle ou contre-exemple pour la France ?

MATTHIAS B. ET CLÉMENT M.- C.

2020

L'Information Psychiatrique 96(6): 449-456.

ww.cairn.info/revue-l-information-psychiatrique-2020-6-page-449.htm

À partir d'une lecture à la fois organisationnelle et politique de la réforme du financement de la psychiatrie hospitalière en Allemagne, nous présentons les aléas d'un tel projet de réforme et les leçons possibles pour la France. En 2013, l'Allemagne a instauré un nouveau mode de rémunération mixte pour les établissements de psychiatrie, mêlant tarification au séjour et forfaits journaliers. Après une forte mobilisation des acteurs de soins, le gouvernement allemand a dû promulguer une nouvelle loi, entrée en vigueur en 2017, qui réintroduit la notion de négociation entre établissements de santé et assureurs. Techniquement, la France disposerait de l'ensemble des outils nécessaires à la mise en place d'une réforme similaire : un système de recueil de l'activité, des outils de benchmark et des enquêtes de coût. Cependant, la France ne possède pas d'algorithme de classification médico-économique pour ce champ. Enfin, comme l'a montré l'expérience allemande, il semble indispensable pour qu'une réforme profonde du système de financement puisse être implémentée, qu'un consensus soit obtenu parmi les acteurs concernant les objectifs. Ceci, d'autant plus dans le contexte français où les acteurs sont plus habitués à se mobiliser qu'en Allemagne.

Mental Health And Satisfaction With Primary Care Services In Older Adults: A Study From The Patient Perspective On Four Dimensions Of Care

PITROU I., BERBICHE D. ET VASILIADIS H.-M.

2020

Family Practice 37(4): 459-464.

https://doi.org/10.1093/fampra/cmaa019

Few studies have examined the association between mental health and satisfaction with primary care services in community-dwelling older adults.To examine the association between mental health in older adults and low satisfaction with primary care services within four dimensions of care.This secondary data analysis included 1624 older adults participating in the 'Étude sur la Santé des Aînés Services' (ESA-Services study) and recruited in primary care practices between 2011 and 2013 in the province of Quebec. Patient satisfaction and experience with care were assessed during face-to-face interviews with questions adapted from the Primary Care Assessment Survey. Self-reported mental health indicators included depression, anxiety, suicidal ideation, psychological distress and cognition. We conducted four logistic regressions to examine the associations between mental health and low satisfaction in the following dimensions of care : continuity of care, provider–patient interactions, adequacy of care and physical environment. Nearly half of participants (48.5 %) reported low satisfaction in at least one dimension of care examined. High psychological distress was associated with low satisfaction with provider–patient interactions [odds ratio (OR) = 1.02 ; 95 % confidence interval (CI) = 1.00–1.04] and adequacy of care (OR = 1.04 ; 95 % CI = 1.01–1.06). The presence of an anxiety disorder was associated with low satisfaction in adequacy of care (OR = 1.64 ; 95 % CI = 1.00–2.72). Worse cognitive functioning was associated with low satisfaction in continuity of care, provider–patient interaction and adequacy of care.Mental health was consistently associated with low satisfaction within dimensions of care. Results support the need for increased attention when delivering care to older adults with mental health problems.

Nature And Prevalence Of Combinations Of Mental Disorders And Their Association With Excess Mortality In A Population-Based Cohort Study

PLANA-RIPOLL O., MUSLINER K. L., DALSGAARD S., *et al.*

2020

World Psychiatry 19(3): 339-349.

https://onlinelibrary.wiley.com/doi/abs/10.1002/wps.20802

The nature and prevalence of combinations of mental disorders and their associations with premature mortality have never been reported in a comprehensive way. We describe the most common combinations of mental disorders and estimate excess mortality associated with these combinations. We designed a population-based cohort study including all 7,505,576 persons living in Denmark at some point between January 1, 1995 and December 31, 2016. Information on mental disorders and mortality was obtained from national registers. A total of 546,090 individuals (10.5%) living in Denmark on January 1, 1995 were diagnosed with at least one mental disorder during the 22-year follow-up period. The overall crude rate of diagnosis of mental disorders was 9.28 (95% CI: 9.26-9.30) per 1,000 person-years. The rate of diagnosis of additional mental disorders was 70.01 (95% CI: 69.80-70.26) per 1,000 person-years for individuals with one disorder already diagnosed. At the end of follow-up, two out of five individuals with mental disorders were diagnosed with two or more disorder types. The most prevalent were neurotic/stress-related/somatoform disorders (ICD-10 F40-F48) and mood disorders (ICD-10 F30-F39), which – alone or in combination with other disorders – were present in 64.8% of individuals diagnosed with any mental disorder. Mortality rates were higher for people with mental disorders compared to those without mental disorders. The highest mortality rate ratio was 5.97 (95% CI: 5.52-6.45) for the combination of schizophrenia (ICD-10 F20-F29), neurotic/stress-related/somatoform disorders and substance use disorders (ICD-10 F10-F19). Any combination of mental disorders was associated with a shorter life expectancy compared to the general Danish population, with differences in remaining life expectancy ranging from 5.06 years (95% CI: 5.01-5.11) to 17.46 years (95% CI: 16.86-18.03). The largest excess mortality was observed for combinations that included substance use disorders. This study reports novel estimates related to the “force of comorbidity” and provides new insights into the contribution of substance use disorders to premature mortality in those with comorbid mental disorders.

▶ Optimization Strategies For The Organization Of Mental Healthcare

RABRENOVIC M., SIMONOVIC P. ET COGOLJEVIC D.

2020

International Journal for Quality in Health Care 32(6): 412-413.

https://doi.org/10.1093/intqhc/mzaa061

The aim of this paper is to analyse the main issues and obstacles to optimizing the organization of mental healthcare and the strategies that should be applied by presenting the examples from practice.Outcomes of mental healthcare are in relation with ‘improved legislation’ and the introduction of up-to-date management and economic concepts including continuous treatment model, in addition to the advantages and disadvantages in the provision of mental healthcare within primary and secondary inpatient and outpatient healthcare. Some of these lessons are learned from reforms implemented in Serbia.

▶ Le rôle du médecin généraliste dans la prise en charge des pathologies psychiatriques

TABRIL T., CHEKIRA A., HOUSNI TOUHAMI Y. O., *et al.*

2020

Revue d’Épidémiologie et de Santé Publique 68(3): 185-192.

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Les pathologies psychiatriques sont responsables d’une part majeure de la morbidité dans le monde. Il existe d’importantes lacunes de diagnostic et de traitement pour les troubles psychiatriques. Au Maroc, la constatation d’une pénurie de psychiatres devrait amener logiquement à une collaboration avec les médecins généralistes. Notre objectif est d’analyser la perception de la capacité des médecins généralistes à prendre en charge les troubles psychiatriques, étudier les difficultés rencontrées dans la prise en charge de ces pathologies, et évaluer leur degré de collaboration avec les structures de prise en charge en santé mentale. Méthodes : Il s’agit d’une enquête transversale auprès des médecins généralistes exerçant en milieux urbain et rural, dans les secteurs libéral et public, et ce, à l’échelle nationale du royaume du Maroc.

▶ The Role Of Mental Disease On The Association Between Multimorbidity And Medical Expenditure

YAMANASHI H., NOBUSUE K., NONAKA F., *et al.*

2020

Family Practice 37(4): 453-458.

https://doi.org/10.1093/fampra/cmaa015

Multimorbidity is the presence of two or more chronic diseases and is associated with increased adverse outcomes, including hospitalization, mortality and frequency of use of medical institutions.This study aimed to describe multimorbidity patterns, determine whether multimorbidity was associated with high medical expenditure, and determine whether mental diseases had an interaction effect on this association.We conducted a claims data-based observational study.

Data were obtained for 7526 individuals aged 0–75 years from a medical claims data set for Goto, Japan, over a 12-month period (2016–17). Annual medical expenditure was divided into quintiles; the fifth quintile represented high medical expenditure. Multimorbidity status was defined as the occurrence of two or more health conditions from 17 specified conditions. Odds ratios (OR) and 95% confidence intervals (CI) for high medical expenditure were calculated by number of comorbidities.In total, 5423 (72.1%) participants had multimorbidity. Multimorbidity was significantly associated with high medical expenditure, even after adjustment for age, sex and income category (OR: 10.36, 95% CI: 7.57–14.19; P < 0.001). Mental diseases had a significant interaction effect on the association between multimorbidity and high medical expenditure (P = 0.001).Multimorbidity is associated with high medical expenditure in Japan. Mental diseases may contribute to increased medical costs.

Sociologie de la santé

Sociology of Health

Quelle place pour la subjectivité du malade dans la pratique médicale ?

GUILLEN A. S., GUILLEN A. ET COMBRES L.

2020

Éthique & Santé 17(2): 65-70.

https://doi.org/10.1016/j.etiqe.2020.03.002

La médecine expérimentale produit un savoir sur l'objet maladie, mais nécessite d'exclure la subjectivité du patient. Cette exclusion a été redoublée par la médecine paternaliste qui pouvait laisser le malade en dehors des décisions concernant ses soins. Le sentiment de certains malades de ne pas être entendu les a amenés à réaffirmer leur demande de participer de manière plus active aux soins. Cette demande a été prise en compte par la Loi du 4 mars 2002 : le savoir du médecin doit être mis à la portée du malade. L'éducation thérapeutique connaît dès lors un nouvel essor, car elle donne accès aux connaissances médicales pour acquérir un certain pouvoir sur la maladie. Mais certains patients continuent à ressentir le manque d'un espace pour subjectiver ce qui leur arrive. Il faut donc s'appuyer sur d'autres dispositifs, tels que l'art ou la psychanalyse, pour autoriser et favoriser des constructions subjectives.

Soins de santé primaires

Primary Health Care

Connaissance des directives anticipées en soins primaires

BRUEL S., GUINET L., CHAUX R., *et al.*

2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(3): 125-129.

Les droits des malades en fin de vie ont fait l'objet depuis plusieurs années de nombreuses polémiques médiatiques et controverses éthiques. Les directives anticipées, moyen officiel et légal de faire respecter ses volontés en fin de vie, sont méconnues. L'objectif de cette étude était d'évaluer la connaissance de la population en soins primaires à la suite de la campagne nationale d'information de février 2017. L'objectif secondaire était de rechercher les déterminants pouvant influencer cette connaissance.

Primary Care Competition And Quality Of Care: Empirical Evidence From Medicare

BRUNT C. S., HENDRICKSON J. R. ET BOWBLIS J. R.

2020

Health Economics(Ahead of pub).

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4119

In this paper, we explore the effects of primary care physician (PCP) practice competition on five distinct quality metrics directly tied to screening, follow-up care, and prescribing behavior under Medicare Part B and D. Controlling for physician, practice, and area characteristics as well as zip code fixed effects, we find strong evidence that PCP practices in more concentrated areas provide lower quality of care. More specifically, PCPs in more concentrated areas are less likely to perform screening and follow-up care for high blood pressure, unhealthy bodyweight, and tobacco use. They are also less likely to document current medications. Furthermore, PCPs in more concentrated areas have a higher amount of opioid prescriptions as a fraction of total prescriptions.

General Practitioners' Practical Approach To Initiating End-Of-Life Conversations: A Qualitative Study

DECKX L., THOMAS H. R., SIEBEN N. A., *et al.*

2019

Family Practice 37(3): 401-405.

https://doi.org/10.1093/fampra/cmz074

As doctors who provide care across the life-course, general practitioners (GPs) play a key role in initiating timely end-of-life discussions. Nonetheless, these discussions are often not initiated until close to death. Given the ageing of the population, GPs will be confronted with end-of-life care more often, and this needs to become a core skill for all GPs.To describe GPs' approach to initiating end-of-life discussions. Fifteen GPs or GP trainees from South-East Queensland, Australia, were purposively recruited to participate in a semi-structured interview. We analysed transcripts using a thematic analysis. GPs' approach to initiating end-of-life discussions was summarized by four themes: (1) Preparing the ground; (2) finding an entry point; (3) tailoring communication and (4) involving the family. Emphasis on the doctor–patient relationship; assessing patient readiness for end-of-life discussions; and sensitive information delivery is consistent with factors previously reported to be important to both GPs and patients in this context. Our findings provide a framework for GPs initiating end-of-life discussions, which must be tailored to patient and GP personality factors. Further research is required to evaluate its outcomes.

Prendre soin des professionnels de santé : quelles modalités d'accompagnement pour favoriser la qualité de vie au travail

DUARTE A. P. ET SIBE M.

2020

Actualite Et Dossier En Sante Publique(110)

ww.hcsp.fr/explore.cgi/Adsp?clef=1171

Finalisé en janvier 2020, ce dossier souhaite mettre en lumière l'importance d'un accompagnement favorable à la qualité de vie au travail des professionnels de santé. Entre-temps, la pandémie de la Covid-19 s'est installée, mettant à l'épreuve l'ensemble de la population et de notre système de soins. En soi, la difficulté de l'épidémie n'est peut-être pas tant de gérer le risque (les professionnels y sont préparés et formés), mais davantage d'inventer in vivo un management de l'incertitude liée à un risque inconnu, contraignant à décider malgré des informations contradictoires, parcellaires, fluctuantes.

▶ The Primary Care Workforce In Europe: A Cross-Sectional International Comparison Of Rural And Urban Areas And Changes Between 1993 And 2011

GROENEWEGEN P. P., BOSMANS M. W. G., BOERMA W. G. W., *et al.*

2020

Eur J Public Health 30(Supplement_4): iv12-iv17.

https://doi.org/10.1093/eurpub/ckaa125

Rural areas have problems in attracting and retaining primary care workforce. This might have consequences for the existing workforce. We studied whether general practitioners (GPs) in rural practices differ by age, sex, practice population and workload from those in less rural locations and whether their practices differ in resources and service profiles. We used data from 2 studies: QUALICOPC study collected data from 34 countries, including 7183 GPs in 2011, and Profiles of General Practice in Europe study collected data from 32 countries among 7895 GPs in 1993. Data were analyzed using multilevel analysis. Results show that the share of female GPs has increased in rural areas but is still lower than in urban areas. In rural areas, GPs work more hours and provide more medical procedures to their patients. Apart from these differences between locations, overall ageing of the GP population is evident. Higher workload in rural areas may be related to increased demand for care. Rural practices seem to cope by offering a broad range of services, such as medical procedures. Dedicated human resource policies for rural areas are required with a view to an ageing GP population, to the individual preferences and needs of the GPs, and to decreasing attractiveness of rural areas.

▶ Equity In Access To Zero-Fees And Low-Cost Primary Health Care In Aotearoa New Zealand: Results From Repeated Waves Of The New Zealand Health Survey, 1996-2016: Equity In Access Primary Health Care In Aotearoa New Zealand

JEFFREYS M., IRURZUN LOPEZ M., RUSSELL L., *et al.*

2020

Health Policy 124(11) : 1272-1279

https://doi.org/10.1016/j.healthpol.2020.08.009

Primary Health Care in Aotearoa New Zealand is mainly funded through capitation-based funding to general practices, supplemented by a user co-payment. Funding is designed in part to keep the costs of care low for key groups in the population who have higher health needs. We investigated changes in the socio-demographic determinants of no-cost and low-cost access to Primary Health Care using data from sequential waves of the New Zealand Health Survey (1996/97–2016/17). Fees paid were self-reported and inflated using CPI-adjustment to the value of the 2018NZD. Over the 20-year study period, there was an increase in the population accessing low-cost care. Access to low-cost care was particularly high for Pacific people, but also higher for Māori and Asian people compared to Other/New Zealand European ethnicities. Area-level deprivation was a stronger predictor of access to low-cost care for non-Māori than for Māori. Although Māori were more likely than non-Māori to access low-cost care at all levels of deprivation, this was less evident in more deprived compared to more affluent areas. Given ongoing reported inequity for Māori being less able to afford primary health care, we suggest that future policies to improve access should be fully aligned with the articles of Te Tiriti o Waitangi and should focus on equity.

▶ General Practitioners' Provision Of End-Of-Life Care And Associations With Dying At Home: A Registry-Based Longitudinal Study

KJELLSTADLI C., ALLORE H., HUSEBO B. S., *et al.*

2020

Family Practice 37(3): 340-347.

https://doi.org/10.1093/fampra/cmz059

General practitioners (GPs) may play an important role in providing end-of-life care to community-dwelling people. To investigate patients' contacts with GPs, GPs' interdisciplinary collaboration, out-of-hours services and hospitalizations in the last 13 weeks of life and associations with dying at home. Second, investigate whether GP contacts were associated with fewer out-of-hours contacts or days hospitalized.Individually linked data from the Norwegian Cause of Death Registry, Norwegian Patient Registry, Statistics Norway and Control and Payment of Reimbursement to Health Service Providers database for all 80 813 deceased people in Norway within 2012–13. Outcomes were analyzed with logistic regression and negative binomial multilevel mixed-effect models. Overall, 1% of people received GP home visits in Week 13 and 4.6% in the last week before death. During the last 4 weeks of life, 9.2% received one or more GP home visits. Altogether, 6.6% received one or more home visits when the GP had one or more interdisciplinary collaborations during the last 4 weeks, of which <3% died at home. GP office consultations decreased towards the end of life. The likelihood of home death versus another location increased in relation to GP home visits [one home visit odds ratio (OR) 1.92, confidence interval (CI) 1.71–2.15; two or more OR 3.49, CI 3.08–3.96] and GP interdisciplinary collaboration (one contact OR 1.76, CI 1.59–1.96; two or more OR 2.52, CI 2.32–2.74).GPs play a role in enabling people to die at home by performing home visits and collaborating with other health care personnel. Only a minority received such services in Norway.

Comment améliorer les conditions de travail des infirmiers ?

LAVILLE C.

2020

Actualite Et Dossier En Sante Publique(110).

ww.hcsp.fr/explore.cgi/Adsp?clef=1171

Les conditions de travail des infirmiers se sont nettement détériorées au cours des dix dernières années. Les économies demandées aux établissements de santé en sont principalement la cause. Ces derniers mois, nous constatons une pénurie d'infirmiers dans tous les établissements français par manque d'attractivité du métier. Les professionnels, déjà en place, fuient l'hôpital pour aller travailler dans le secteur libéral voire changer de métier. Les nouveaux diplômés ne sont plus attirés par l'hôpital et ne postulent pas. Cela entraîne l'impossibilité pour les directions de mettre en place une gestion de l'absentéisme efficiente afin de ne pas épuiser les personnels en poste.

Genre et santé : Quelles sont les représentations des médecins généralistes sur les disparités en santé entre les hommes et les femmes ?

LEVOIR C., LEVOIR T. ET VINCENT Y. M.

2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(2): 84-90.

Des écarts de prévalence en termes de maladies entre les hommes et les femmes, que les différences biologiques seules n'expliquent pas, ont pu être mis en évidence dans la dépression et les maladies cardio- vasculaires (MCV). Des travaux de sociologie se sont intéressés à la concordance entre représentations genrées de la santé dans la population générale et les différences de santé entre hommes et femmes. Cette étude vise à explorer les représentations des médecins généralistes (MG) sur les disparités en santé entre hommes et femmes afin de les confronter aux représentations de la santé dans la population générale et à la morbidité différentielle des hommes et des femmes.

Nurse Practitioner Autonomy And Complexity Of Care In Rural Primary Care

NEPRASH H. T., SMITH L. B., SHERIDAN B., *et al.*

2020

Medical Care Research and Review 0(0): 1077558720945913.

https://journals.sagepub.com/doi/abs/10.1177/1077558720945913

The growing ranks of nurse practitioners (NPs) in rural areas of the United States have the potential to help alleviate existing primary care shortages. This study uses a nationwide source of claims- and EHR-data from 2017 to construct measures of NP clinical autonomy and complexity of care. Comparisons between rural and urban primary care practices reveal greater clinical autonomy for rural NPs, who were more likely to have an independent patient panel, to practice with less physician supervision, and to prescribe Schedule II controlled substances. In contrast, rural and urban NPs provided care of similar complexity. These findings provide the first claims- and EHR-based evidence for the commonly held perception that NPs practice more autonomously in rural areas than in urban areas.

▶ Les attentes des médecins généralistes vis-à-vis de la médecine interne

PIGNAL T. ET CATHEBRAS P.

2020

Médecine : De La Médecine Factuelle à Nos Pratiques 16(1): 44-48.

La médecine interne, par sa vision globale, représente idéalement la continuité hospitalière de la médecine générale ambulatoire. Mais ses contours ont évolué au cours du temps. Les objectifs de cette étude étaient d'analyser les attentes des médecins généralistes vis-à-vis de la médecine interne, ainsi que d'évaluer la qualité de la communication entre les deux spécialités.

▶ Rémunération des pharmacies d'officine française : du médicament aux soins

PRESCRIRE

2020

Revue Prescrire 40(440): 456-462.

En France, le médicament remboursable reste une composante majeure de l'économie des pharmacies d'officine. La rémunération des pharmaciens d'officine s'est longtemps appuyée sur le prix de vente des médicaments, telle une pratique commerçante classique. En 2020, elle repose en grande partie sur des honoraires détachés du prix des médicaments, mais encore en partie liés aux volumes de vente. Cette évolution s'est déployée dans le cadre d'une convention entre l'assureur maladie obligatoire et les syndicats des pharmaciens d'officine. Cette convention, maintes fois amendée, définit la prise en charge des honoraires par la Sécurité sociale selon un schéma complexe.

▶ The Physician As A Neoliberal Subject – A Qualitative Study Within A Private-Public Mix Setting

RASOOLY A., DAVIDOVITCH N. ET FILC D.

2020

Social Science & Medicine 259: 113152.

https://doi.org/10.1016/j.socscimed.2020.113152

Research on neoliberalism in health care has insufficiently explored the intermediary role of physicians in neoliberal subjectification. This paper studies the construct of the physician as a neoliberal subject in the Israeli health care system, using qualitative data from in-depth interviews with 21 medical specialists. We interviewed physicians from specialties in which private practice is both less common (infectious disease and intensive care) and more common (orthopedics, cardiology, and cardiothoracic surgery). Our analysis focused on two key issues: the physician's role in society and the value placed on health care. We found a spectrum of views. At one end, some perceived themselves as entrepreneurs, managing themselves both as an enterprise and a product, and perceived health care as a commodity. At the opposite end, we found a professional ethos that considered the physician as a public servant, and health care as a human right. Both views were in constant tension with neoliberal subjectivity. Further research should investigate the association between institutional belonging, whether public or private, and the internalization of the main characteristics of the neoliberal worldview.

▶ Médecine et société : l'exercice de la médecine de campagne dans le sud de la France il y a 150 ans et aujourd'hui

ROQUES LATRILLE C. F.

2020

Bulletin de l'Académie Nationale de Médecine 204(3): 292-298.

https://doi.org/10.1016/j.banm.2019.06.019

Les archives d'un médecin de Mirepoix (Ariège) laissent apparaître, pour l'année 1869, 337 jours travaillés dont 282 jours de déplacements en campagne (8000km en voiture à cheval). Huit cent quatre-vingt-seize patients (387 en campagne), appartenant à 597 familles (306 en campagne) ont été pris en charge par 2108 actes médicaux (696 en campagne) : en moyenne, 2,4 actes médicaux par patient et par an et pour le médecin 6,3 actes par jour de travail. Quarante-huit fois des circonstances particulières ont été identifiées : chirurgie (5), traumatismes ostéo-articulaires (8), plaies (3), hernies (3), drainage d'abcès (3), ponctions (ascite : 10, hygroma 1), cathétérisme vésical (12), obstétricie (2) certificat médical (1). Six mille six cent vingt-sept FF d'honoraires facturés (1605 FF impayés — 100 familles). Les sociétés de secours mutuel ont payé 646 FF pour 104 patients (17 en campagne — 189 FF). Ces revenus représentent 11 fois le salaire annuel d'un ouvrier non qualifié et 6,5 fois le PIB par habitant. Les dépenses consistaient en alimentation (1361 FF), habillement (983 FF), déplacements (846 FF), assurances, impôts et intérêts (330 FF), personnel domestique (servante et cocher : 235 FF), chauffage et éclairage (88 FF). Les médecins actuels de l'Ariège traitent annuellement 1816 patients (5266 actes) pour des honoraires bruts de 143 464 € (8 fois le SMIC et 4 fois le PIB par habitant). Les dépenses du ménage sont constituées par l'alimentation (13 %), l'habillement (3 %), les déplacements (10 %), le logement et l'énergie (24 %).

Utilization And Costs By Primary Care Provider Type: Are There Differences Among Diabetic Patients Of Physicians, Nurse Practitioners, And Physician Assistants?

SMITH V. A., MORGAN P. A., EDELMAN D., *et al.*

2020

Medical Care 58(8): 681-688.

https://doi.org/10.1097/mlr.0000000000001326

The objective of this study was to compare health care utilization and costs among diabetes patients with physician, nurse practitioner (NP), or physician assistant (PA) primary care providers (PCPs). Research Design and Methods: Cohort study using Veterans Affairs (VA) electronic health record data to examine the relationship between PCP type and utilization and costs over 1 year in 368,481 adult, diabetes patients. Relationship between PCP type and utilization and costs in 2013 was examined with extensive adjustment for patient and facility characteristics. Emergency department and outpatient analyses used negative binomial models; hospitalizations used logistic regression. Costs were analyzed using generalized linear models. Results: PCPs were physicians, NPs, and PAs for 74.9% (n = 276,009), 18.2% (n = 67,120), and 6.9% (n = 25,352) of patients respectively. Patients of NPs and PAs have lower odds of inpatient admission [odds ratio for NP vs. physician 0.90, 95% confidence interval (CI) = 0.87–0.93; PA vs. physician 0.92, 95% CI = 0.87–0.97], and lower emergency department use (0.67 visits on average for physicians, 95% CI = 0.65–0.68; 0.60 for NPs, 95% CI = 0.58–0.63; 0.59 for PAs, 95% CI = 0.56–0.63). This translates into NPs and PAs having ~$500–$700 less health care costs per patient per year (P<0.0001). Conclusions: Expanded use of NPs and PAs in the PCP role for some patients may be associated with notable cost savings. In our cohort, substituting care patterns and creating similar clinical situations in which they practice, NPs and PAs may have reduced costs of care by up to 150–190 million dollars in 2013.

Nurse Practitioner Role And Practice Environment In Primary And In Nonprimary Care In California

WINTER S., CHAPMAN S. A., CHAN G. K., *et al.*

2020

Medical Care Research and Review (Ahead of pub).

https://doi.org/10.1177/1077558720942706

Between 2008 and 2016, there was an increase in nurse practitioners in specialty care. This study explores some differences in role and practice environment between primary care and nonprimary care nurse practitioners in the domains of time spent on activities, barriers to providing care, working to scope of practice, full skill utilization, and satisfaction. This cross-sectional quantitative study, based on data from the 2017 Survey of California Nurse Practitioners and Certified Nurse Midwives, found that nurse practitioners in nonprimary care practices have lower odds of reporting time as a barrier to practice, lower odds of reporting practice to full scope, and higher odds of reporting a hierarchical or supervisory relationship with the physician. Future exploration of these differences may shed light on ways to promote nonprimary care practice environments to foster more effective collaboration and fewer barriers to providing care.

Activités des infirmiers de coordination des parcours complexes. Proposition d'une typologie

YATIM F. ET SEBAI J.

2020

Management & Avenir Santé 6(1): 105-125.

ww.cairn.info/revue-management-et-avenir-sante-2020-1-page-105.htm

Les nombreuses mutations que connaissent les systèmes de santé en France comme à l'étranger interrogent l'ensemble des professions de santé. L'enjeu de la coordination en particulier devient incontournable, à la fois en termes de pratiques professionnelles et en termes d'organisation. Pour la profession des infirmiers, des évolutions significatives ont été amorcées au cours des dernières années afin de leur assurer une place de plus en plus importante dans la coordination des prises en charge et garantir l'interface entre les différents professionnels intervenant lors des parcours des patients. Pour le cas particulier des pathologies complexes nécessitant de la part des infirmiers un niveau d'expertise clinique élevé à l'image de la cancérologie, la coordination est présentée comme une compétence « cœur de métier », alliant la dimension clinique et la dimension organisationnelle. Cet article s'intéresse précisément à cette évolution à travers une étude de cas approfondie (enquête qualitative et quantitative) menée dans un centre français spécialisé en cancérologie. Outre la proposition d'une typologie des activités assurées par les infirmiers de coordination, nos analyses nous permettent d' identifier de manière fine la nature et le contenu de ces activités. Nous avons ainsi pu montrer qu'une part importante des activités de coordination est de nature organisationnelle, ce qui implique une réflexion approfondie sur la formation des infirmiers pour acquérir les compétences managériales nécessaires en complément des compétences cliniques.

Système de santé

Health Systems

▶ Skill Mix And Patient Outcomes: A Multi-Country Analysis Of Heart Disease And Breast Cancer Patients

KOPASKER D., ISLAM M. K., GIBSON J., *et al.*

2020

Health Policy 124 (10) : 1074-1082

https://doi.org/10.1016/j.healthpol.2020.07.009

Policymakers are becoming aware that increasing the size of the healthcare workforce is no longer the most viable way to address the increasing demand for healthcare. Consequently, a focus of recent healthcare workforce reform has been extending existing roles and creating new roles for health professionals. However, little is known of the influence on outcomes from this variation in labour inputs within hospital production functions. Using a unique combination of primary and administrative data, this paper provides evidence of associations between the composition of care delivery teams and patient outcomes. The primary data enabled the construction of a task component-based measure of skill mix. This novel measure of skill mix has the advantage of capturing how workforce planning can restructure the relative input of nurses or physicians into task components while keeping the overall level of staff fixed. The analysis focuses on specific care pathways and individual hospitals, thus controlling for an under-investigated source of heterogeneity. Additionally, stratifying by country (England, Scotland, and Norway) enabled analysis of skill mix within different health systems. We provide evidence that variations in labour inputs within the breast cancer and heart disease care pathways are associated with both positive and adverse outcomes. The results illustrate the scope for substitution of task components within care pathways as a potential method of healthcare reform.

▶ Integrated Care Models And Behavioral Health Care Utilization: Quasi-Experimental Evidence From Medicaid Health Homes

MCCLELLAN C., MACLEAN J. C., SALONER B., *et al.*

2020

Health Economics 29(9): 1086-1097.

https://doi.org/10.1002/hec.4027

Integration of behavioral and general medical care can improve outcomes for individuals with behavioral health conditions—serious mental illness (SMI) and substance use disorder (SUD). However, behavioral health care has historically been segregated from general medical care in many countries. We provide the first population-level evidence on the effects of Medicaid health homes (HH) on behavioral health care service use. Medicaid, a public insurance program in the United States, HHs were created under the 2010 Affordable Care Act to coordinate behavioral and general medical care for enrollees with behavioral health conditions. As of 2016, 16 states had adopted an HH for enrollees with SMI and/or SUD. We use data from the National Survey on Drug Use and Health over the period 2010 to 2016 coupled with a two-way fixed-effects model to estimate HH effects on behavioral health care utilization. We find that HH adoption increases service use among enrollees, although mental health care treatment findings are sensitive to specification. Further, enrollee self-reported health improves post-HH.

Patient Experience Of Health Care System Hassles: Dual-System Vs Single-System Users

NOËL P. H., BARNARD J. M., BARRY F. M., *et al.*

2020

Health Services Research 55(4): 548-555.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13291

The aim of this study is to compare health care system problems or "hassles" experienced by Veterans receiving VA health care only versus those receiving dual care from both VA and non-VA community providers. Data Sources : We collected survey data in 2017-2018 from 2444 randomly selected Veterans with four or more primary care visits in the prior year at one of 12 VA primary care clinics located in four geographically diverse regions of the United States. Study Design We used baseline surveys from the Coordination Toolkit and Coaching quality improvement project to explore Veterans' experience of hassles (dependent variable), source of health care, self-rated physical and mental health, and sociodemographics. Data Collection : Participants responded to mailed surveys by mail, telephone, or online. Principal Findings : The number of reported hassles ranged from 0 to 16; 79 percent of Veterans reported experiencing one or more hassles. Controlling for sociodemographic characteristics and self-rated physical and mental health, zero-inflated negative binominal regression indicated that dual care users experienced more hassles than VA-only users (adjusted predicted average 5.5 [CI: 5.2, 5.8] vs 4.3 [CI: 4.1, 4.6] hassles [P < .0001]). Conclusions : Anticipated increases in Veterans accessing community-based care may require new strategies to help VA primary care teams optimize care coordination for dual care users.

Cost And Effects Of Integrated Care: A Systematic Literature Review And Meta-Analysis

ROCKS S., BERNTSON D., GIL-SALMERÓN A., *et al.*

2020

The European Journal of Health Economics 21 : 1211-1221

https://doi.org/10.1007/s10198-020-01217-5

Health and care services are becoming increasingly strained and healthcare authorities worldwide are investing in integrated care in the hope of delivering higher-quality services while containing costs. The cost-effectiveness of integrated care, however, remains unclear. This systematic review and meta-analysis aims to appraise current economic evaluations of integrated care and assesses the impact on outcomes and costs.

Facilitators And Barriers To Access To And Continuity Of French-Language Healthcare And Social Services In Ontario's Champlain Region

SAVARD J. *et al.*, E.

2020

Healthcare Policy 16(1): 78-94.

https://doi.org/10.12927/hcpol.2020.26289

The purpose of this article is to examine access to and continuity of French-language healthcare and social services in Ontario's Champlain region through an analytical framework that incorporates people seeking care, their caregivers and the linguistic component of care into a health and social service system bounded by community, organizational, political and symbolic structures. Experiences of French-speaking seniors seeking care and those of health and social service providers and managers from two qualitative exploratory studies are used to describe trajectories through the system. Participants exposed how, together with community vitality, issues within each of the system's symbolic, political or regulatory and organizational structures influence these trajectories. Conclusions: To meet the needs of francophone seniors, additional work is needed to increase French-language services coordination within the organizational, regulatory and policy structures of the health and social service system.

Patient-Reported Outcome Measures (PROMs): Can They Be Used To Guide Patient-Centered Care And Optimize Outcomes In Total Knee Replacement?

TEW M., DALZIEL K., CLARKE P., *et al.*

2020

Quality of Life Research(Ahead of pub).

https://doi.org/10.1007/s11136-020-02577-4

As patient-reported outcome measures (PROMs) are increasingly integrated into clinical practice, there is a need to translate collected data into valuable information to guide and improve the quality and value of patient care. The purpose of this study was to investigate health-related quality-of-life (QoL) trajectories in the 5 years following total knee replacement (TKR) and the patient characteristics associated with these trajectories. The feasibility of translating QoL trajectories into valuable information for guiding patient-centered care was also explored.

Travail et santé

Occupational Health

▶ The Effects Of Paid Sick Leave On Worker Absenteeism And Health Care Utilization

CHEN J., MEYERHOEFER C. D. ET PENG L.

2020

Health Economics 29(9): 1062-1070.

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4118

We estimate the short-term effects of paid sick leave on worker absenteeism and health care utilization in the United States using data from the 2000–2013 Medical Expenditure Panel Survey. We use both parametric and matching-based difference-in-differences methods to account for nonrandom selection into jobs that offer paid sick leave and estimate the treatment effect separately for workers who gained and lost sick leave benefits. We find consistent evidence of increased absenteeism among female workers who gained paid sick leave but not for other groups. Estimates for office-based visits are mostly statistically insignificant and may not have a causal interpretation due to preexisting trends.

▶ Lifetime Employment Histories And Their Relationship With 10-Year Health Trajectories In Later Life: Evidence From England

DI GESSA G., CORNA L., PRICE D., *et al.*

2020

Eur J Public Health 30(4): 793-799.

https://doi.org/10.1093/eurpub/ckaa008

Employment histories influence health. However, most studies have so far investigated cross-sectional associations between employment histories and health, failing to recognize health as a dynamic process in later life. We use Waves 3–8 of the English Longitudinal Study of Ageing, including retrospective information on respondents' employment activities. We used dynamic hamming distances to summarize lifetime employment histories up to state pension age (64 for men and 59 for women). Multilevel growth curve models were then used to estimate the influence of lifetime employment histories on later life health trajectories over a 10-year period using quality of life (QoL), somatic health, and depression. Net of selection effect and a host of contemporaneous material and social resources, men who exited early started off with poorer health than those with continuous attachment to the labour market but had a very similar health profile by the end of the 10-year period considered. Among women, better somatic health and higher QoL were observed among those who had employment breaks for family care, and this health advantage was maintained over time. Lifetime employment histories are not related to depression for either men or women. Overall, differences in health by employment histories level off only among men who left earlier and those continuously employed. Flexible arrangements for men in poor health who benefit from leaving the labour market early and supporting women who wish to take breaks for family care may help reduce health inequalities in later life.

▶ Psychosocial Determinants Predicting Long-Term Sickness Absence: A Register-Based Cohort Study

GOORTS K., BOETS I., DECUMAN S., *et al.*

2020

Journal of Epidemiology and Community Health: jech-2020-214181.

https://doi.org/10.1136/jech-2020-214181

This study assessed the psychosocial determinants as explanatory variables for the length of the work disability period. The aim was to estimate the predictive value of a selected set of psychosocial determinants from the Quickscan questionnaire for the length of the sick leave period. A comparison was also made with the most common biomedical determinant: diagnosis. Methods In a cohort study of 4 981 insured Belgian patients, the length of the sick leave was calculated using Kaplan–Meier. Predictive psychosocial determinants were selected using backward conditional selection in Cox regression and using concordance index values (C-index) we compared the predictive value of the biomedical to the psychosocial model in a sample subset.Results Fourteen psychosocial determinants were significantly (p< 0.10) related to the length of the sick leave: health perception of the patient, physical workload, social support management, social support colleagues, work–health interference, psychological distress, fear of colleagues' expectations, stressful life-events, autonomy, learning and development opportunities, job satisfaction, workload, work expectations and expectation to return to work. The C-index of this biopsychosocial model including gender, age and labour status was 0.80 (CI: 0.78; 0.81) (n = 4 981). In the subset of 2 868 respondents with diagnostic information, the C-index for the same model was .73 (CI: 0.71; 0.76) compared with 0.63 (CI: 0.61; 0.65) for the biomedical model. Conclusions A set of 14 psychosocial determinants showed good predictive capacity (C-index: 0.80). Also, in a subset of the sample, the selected determinants performed better compared with diagnostic information to predict long-term sick leave (> 6 months).

Relationships Between Informal Caregiving, Health And Work In The Health And Employment After Fifty Study, England

HARRIS E. C., D'ANGELO S., SYDDALL H. E., *et al.*

2020

Eur J Public Health 30(4): 799-806.

https://doi.org/10.1093/eurpub/ckaa078

The purpose of this paper is to investigate the prevalence of caregiving and its relationship with work, health and socio-economic circumstances in the Health and Employment After Fifty (HEAF) study. The HEAF study comprises 8134 men and women aged 50–64 years recruited from 24 general practices. Sociodemographic, lifestyle and health characteristics and hours per week giving personal care were elicited by postal questionnaire. Objective clinical information about diagnoses/medications was retrieved from health records. Work-related and health risk factors for intense caring responsibilities (≥20 h/week vs. no hours) were explored using logistic regression with adjustment for age and social class. In all, 644 (17%) men and 1153 (26%) women reported caring responsibilities, of whom 93 and 199 were intense caregivers, who were more likely to be socio-economically disadvantaged; less likely to be working and, if combining caring with working (41 men and 90 women), more likely to be part-time/working shifts, than non-carers. Men caring ≥20 h/week were more likely to have COPD and to report musculoskeletal pain, poor/fair self-rated health, depression and sleep problems. Among working women, caring ≥20 h/week was associated with these same health outcomes and also with a doctor-diagnosed mental health problem or musculoskeletal pain in the previous year.Caregiving is common and unequal in the HEAF cohort, with more high-intensity informal care provided by those with greater levels of socio-economic deprivation, which could affect their employment and health. Caregivers need support to lead long, healthy lives, rather than becoming care needers themselves. Employers and governments need to take caregiving into account and support it actively.

The Effect Of The 2008 Recession On Well-Being And Employment Status Of People With And Without Mental Health Problems

JÓNSDÓTTIR U., ÞÓRÐARDÓTTIR E. B., ASPELUND T., *et al.*

2019

Eur J Public Health 30(4): 761-766.

https://doi.org/10.1093/eurpub/ckz192

The world was hit hard by the 2008 recession which led to increased unemployment and financial strain. However, how the recession affected people with pre-existing mental health problems has been understudied. This study investigates the effect of the 2008 recession in Iceland on stress, well-being and employment status of people with regard to whether they are suffering from mental health problems. The study cohort included participants (18–69 years old) of the 'Health and Wellbeing of Icelanders', a 3-wave survey conducted before (in 2007) and after (in 2009 and 2012) the recession in 2008. Self-assessed well-being was measured with the Short Warwick-Edinburgh Mental Well-being Scale and the 4-item Perceived Stress Scale. Logistic regression was used to assess the effect of the 2008 recession on self-assessed well-being and employment status in 2009 and 2012, using 2007 as a reference year.Participants with no pre-recession mental health problems were at increased risk of both poor well-being, (with adjusted odds ratio at 1.66, in 2009 and 1.64 in 2012) and higher perceived stress, (with adjusted odds ratio at 1.48 in 2009 and 1.53 in 2012), after the recession. Interestingly, no significant change in well-being and perceived stress was observed among participants suffering from pre-recession mental health problems. Both groups had increased risk of unemployment after the recession. Results indicate that after recessions, the risk of stress and poor well-being increases only among those who do not suffer from pre-recession mental health problems.

Identifying Employed Multiple Sclerosis Patients At-Risk For Job Loss: When Do Negative Work Events Pose A Threat?

KORDOVSKI V. M., FRNDAK S. E., FISHER C. S., *et al.*

2015

Multiple Sclerosis and Related Disorders 4(5): 409-413.

https://doi.org/10.1016/j.msard.2015.07.005

Physical disability and cognitive impairment are significant predictors of unemployment in multiple sclerosis (MS). However, little is known about the frequency of work problems in employed patients, in comparison to employed healthy persons. Objective :Use an online monitoring tool to compare the frequency of negative work events in MS patients and healthy controls, and determine a threshold at which the frequency of work problems is clinically meaningful. Methods :The sample comprised 138 MS patients and 62 healthy controls. All reported on recent negative work events and accommodations using an online survey. The clinical test battery measured depression, motor and cognitive function. Statistical tests compared the frequency of work problems in MS patients and healthy controls. Clinical neuro-performance scales were then assessed in at-risk patients with many work problems, versus those with no work problems. Results :As a group, employed MS patients exhibited deficits in motor ability, verbal memory, and processing speed and were more likely than controls to report negative work events and accommodations. At-risk patients, that is, those reporting more than one negative work event, had more pronounced motor and cognitive deficits than their relatively stable counterparts. Conclusion :The data show that employed MS patients report more negative work events and accommodations than employed healthy persons. Those patients deemed at risk for job loss have more cognitive and motor impairment, suggesting the need for cognitive training and specific accommodation strategies in the work place.

L'impact du chômage sur l'état de santé

RONCHETTI J. ET TERRIAU A.

2020

Revue économique 71(5): 815-839.

www.cairn.info/revue-economique-2020-5-page-815.htm

Nous examinons l'impact du chômage sur l'état de santé en mobilisant les données de l'Enquête santé et protection sociale (ESPS) sur la période 2010- 2014. Nous appliquons d'abord une méthode d'estimation par double différence avec appariement sur score de propension afin de minimiser le biais de sélection, éliminer les effets fixes individuels et les effets temporels communs. Nos résultats suggèrent que l'expérience du chômage n'a pas d'impact significatif sur l'état de santé. Nous estimons ensuite un Probit bivarié dynamique afin d'analyser la double causalité entre état de santé et statut d'emploi. Si le chômage n'a pas d'effet causal significatif sur la santé, on observe que la santé a un effet causal significatif sur le statut d'emploi.

Health Inequalities: The Role Of Work And Employment

SIEGRIST J.

2020

Eur J Public Health 30(4): 620-620.

https://doi.org/10.1093/eurpub/ckaa006

The questions raised by Mackenbach in his commentary are important, and some provocative statements in his text may instigate the intensity of search for answers. One such question concerns the persistence of relative social inequalities in health in economically well-developed Western societies, including Nordic European countries with advanced welfare state policies. Although a high prevalence of health-adverse behaviours in these countries was shown to account for part of the observed social differences, as measured by education, income or occupational position, the scope of this explanation is limited. The same holds true for additionally suggested explanations, such as the contribution of differential patterns of upward social mobility to health inequalities, or the unequal access to health care and to the benefits of health-promoting activities. As we are left without a convincing answer to the question raised, should we then focus our research mainly on 'non-causal' (e.g. genetic) pathways? Or should we strive towards analysing those specific aspects of the social environment that may generate health inequalities by new, formerly unexplored pathways?

Vieillissement

Ageing

Supplemental Income Program Design: A Cluster-Randomized Controlled Trial To Examine The Health And Wellbeing Effects On Older Adults By Gender, Duration, And Payment Frequency

AGUILA E. ET SMITH J. P.

2020

Social Science & Medicine 259: 113139.

https://doi.org/10.1016/j.socscimed.2020.113139

We documented results from a cluster-randomized controlled trial we designed to supplement incomes in poor towns among adults 70 or older. We analyzed effects on health by gender, persistence over time, and variation by payment frequency. Methods We compared supplemental income effects over an 18-month period for two towns in Yucatan, Mexico: Valladolid, where eligible individuals received a monthly income supplement over the entire analysis period, and Motul, a demographically matched control town, where eligible individuals received a bimonthly income supplement over the last 12 months of the analysis period. While differing in frequency of payment, supplements provided similar levels of income. We conducted three surveys of recipients: (1) at baseline, (2) six months after baseline, and (3) 18 months after baseline. Results :The primary outcomes we examined were peak expiratory flow, hemoglobin level, and verbal recall. The secondary outcomes were health care use and food availability. We found health benefits persisted for at least eighteen months for the monthly income supplement, with both males and females benefiting. Bimonthly income supplements had smaller health benefits. Conclusions :Older people in the developing world who lack social security benefits and health care may benefit most from monthly income programs. The greater payment frequency of monthly programs may influence how household resources are allocated. Supplemental income programs are common in low- and middle-income countries; hence, our results have implications for program design in many nations.

Covid et personnes âgées : liaisons dangereuses

BALARD F. ET CORVOL A.

2020

Gérontologie et société 42 / 162(2): 9-16.

ww.cairn.info/revue-gerontologie-et-societe-2020-2-page-9.htm

L'amélioration générale du niveau de vie et de l'état de santé des populations âgées en France est aujourd'hui largement documentée. Pourtant, sur de nombreux aspects, ces constats généraux raisonnent de manière discordante avec les résultats de nombreux travaux en sciences sociales et les récents rapports publics qui pointent l'isolement, l'exclusion sociale, la précarité économique ou la difficulté à accéder à certains soins médicaux ou médico-sociaux d'un nombre significatif de personnes âgées. Un rapport récent de l'OCDE fait en particulier le constat d'un accroissement des inégalités au sein des populations âgées sur différentes dimensions économiques, sociales ou en termes de santé. Si certaines des inégalités sociales dans la vieillesse ne font que prolonger et reproduire des inégalités se forgeant tout au long de la vie, d'autres sont susceptibles de se renforcer, voire de se former durant la vieillesse. À travers 11 contributions, ce numéro de Gérontologie et société nous invite à porter notre attention sur trois dimensions importantes des conditions de vie durant la vieillesse, traitées sous l'angle des inégalités sociales : l'exercice de l'autonomie, la santé et le territoire de vie. Chacun des articles de ce numéro offre une description originale des disparités observées dans l'accès à différentes ressources primaires matérielles ou immatérielles, ainsi qu'une analyse des mécanismes sociaux qui en sont à l'origine. L'ensemble des contributions nous aide, plus fondamentalement, à penser les transformations sociales, sanitaires et économiques susceptibles de corriger, au moins en partie, les injustices créées par les inégalités sociales dans la vieillesse.

Inclusion Of Caregivers In Veterans' Care: A Critical Literature Review

BOUCHER N. A., SHEPHERD-BANIGAN M., MCKENNA K., *et al.*

2020

Medical Care Research and Review(Ahead of pub): 1077558720944283.

https://doi.org/10.1177/1077558720944283

More direct inclusion of informal caregivers (i.e., family, friends) in patients' care will make care more patient- and family-centered and has the potential to improve overall quality of care for patients. We need to understand what potentially comprises "inclusive care" so that we can define what "inclusive care" is and develop targets for care quality metrics. We conducted a critical literature review to identify key components of "caregiver inclusion." Focusing on extant literature from 2005 to 2017, 35 papers met inclusion criteria. Directed content analysis with constant comparison was used to identify major themes related to a concept of "inclusive care." Our analysis indicates that "inclusive care" entails five components: clear definition of caregiver role, system level policies for inclusion, explicit involvement of caregiver, provider assessment of caregiver capability, and mutuality in caregiver–provider communication. We discuss the evidence behind these five components using the Donabedian health care quality conceptual model.

'More Than One Red Herring'? Heterogeneous Effects Of Ageing On Health Care Utilisation

COSTA-FONT J. ET VILAPLANA-PRIETO C.

2020

Health Economics(Ahead of pub).

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4035

We study the effect of ageing, defined as an extra year of life, on health care utilisation. We disentangle the direct effect of ageing, from other alternative explanations such as the presence of comorbidities and endogenous time to death (TTD) that are argued to absorb the effect of ageing (so-called 'red herring' hypothesis). We exploit individual level end of life data from several European countries that record the use of medicine, outpatient and inpatient care and long-term care. Consistently with the 'red herring hypothesis', we find that corrected TTD estimates are significantly different from uncorrected ones, and their effect size exceeds that of an extra year of life, which in turn is moderated by individual comorbidities. Corrected estimates suggest an overall attenuated effect of ageing, which does not influence outpatient care utilisation. These results suggest the presence of 'more than one red herring' depending on the type of health care examined.

Vieillissement et précarité : Des inégalités au regard des représentations

DOUBOVETZKY C.

2020

Gérontologie et société 42 / 162(2): 71-82.

ww.cairn.info/revue-gerontologie-et-societe-2020-2-page-71.htm

L'association « RO », spécialisée dans l'accompagnement, l'hébergement et le logement des personnes en situation de précarité, voit son public vieillir. Ne sachant pas accompagner cette évolution, une démarche réflexive a été lancée sur cette question. Cet article se base sur une enquête qualitative menée sur la Pension de Famille V gérée par cette association. Centré exclusivement sur la parole des résidents ce travail de recherche s'intéressait aux représentations qu'ont ces personnes du vieillissement en général et surtout du leur. Les données présentées ici sont issues d'entretiens semi-directifs, de temps d'observation et d'un atelier collectif. Elles viennent réinterroger les approches théoriques du vieillissement « classique » et suggèrent l'existence d'un vieillissement spécifique de ce public.

Les inégalités sociales dans la vieillesse

FONTAINE R. ET PENNEC S.

2020

Gérontologie et société 42 / 162(2): 19-36.

ww.cairn.info/revue-gerontologie-et-societe-2020-2-page-19.htm

L'amélioration générale du niveau de vie et de l'état de santé des populations âgées en France est aujourd'hui largement documentée. Pourtant, sur de nombreux aspects, ces constats généraux raisonnent de manière discordante avec les résultats de nombreux travaux en sciences sociales et les récents rapports publics qui pointent l'isolement, l'exclusion sociale, la précarité économique ou la difficulté à accéder à certains soins médicaux ou médico-sociaux d'un nombre significatif de personnes âgées. Un rapport récent de l'OCDE fait en particulier le constat d'un accroissement des inégalités au sein des populations âgées sur différentes dimensions économiques, sociales ou en termes de santé. Si certaines des inégalités sociales dans la vieillesse ne font que prolonger et reproduire des inégalités se forgeant tout au long de la vie, d'autres sont susceptibles de se renforcer, voire de se former durant la vieillesse. À travers 11 contributions, ce numéro de Gérontologie et société nous invite à porter notre attention sur trois dimensions importantes des conditions de vie durant la vieillesse, traitées sous l'angle des inégalités sociales : l'exercice de l'autonomie, la santé et le territoire de vie. Chacun des articles de ce numéro offre une description originale des disparités observées dans l'accès à différentes ressources primaires matérielles ou immatérielles, ainsi qu'une analyse des mécanismes sociaux qui en sont à l'origine. L'ensemble des contributions nous aide, plus fondamentalement, à penser les transformations sociales, sanitaires et économiques susceptibles de corriger, au moins en partie, les injustices créées par les inégalités sociales dans la vieillesse.Ce numéro est coordonné par Roméo FONTAINE et Sophie PENNEC (Institut national d'études démographiques – INED).

▶ L'aide aux aidants en France : disparités territoriales de l'offre de répit

GARABIGE A. ET TRABUT L.

2020

Gérontologie et société 42 / 162(2): 161-179.

ww.cairn.info/revue-gerontologie-et-societe-2020-2-page-161.htm

Dans les pays industrialisés, les contraintes démographiques et financières liées au vieillissement convergent pour faire des proches aidants un acteur central de la prise en charge du grand âge. En France, dans un système de prise en charge renforçant l'aide professionnelle à domicile, la reconnaissance d'un statut et de droits aux personnes venant aider une personne âgée en situation de perte d'autonomie a longtemps été éludée. Ce n'est qu'en 2015 qu'une loi sur l'adaptation de la société au vieillissement a reconnu leur statut et développé certains de leurs droits (répit, congé). Mais avant cette reconnaissance juridique, différents dispositifs ont été mis en place aux niveaux infranationaux pour aider ces aidants. Il en résulte une diversité territoriale de l'offre de services que cet article propose d'étudier. À partir de l'étude monographique de trois départements et de l'exploitation de deux enquêtes (Enquête auprès des établissements d'hébergement pour personnes âgées de 2015 et enquête Vie Quotidienne et Santé de 2014), nous décrirons et caractériserons ces disparités territoriales et l'accès à l'offre de services de répit.

▶ L'offre d'habitat adapté aux personnes âgées au cœur des inégalités dans la vieillesse

LE PIOLET S.

2020

Gérontologie et société 42 / 162(2): 217-231.

ww.cairn.info/revue-gerontologie-et-societe-2020-2-page-217.htm

L'habitat adapté aux personnes âgées est prééminent dans la problématique de l'adaptation spatiale des territoires au vieillissement de la société. Cet article, fondé sur le retour d'expérience critique de l'action menée par le Conseil départemental de l'Isère en faveur du déploiement de logements adaptés aux personnes âgées, décrypte les inégalités auxquelles ces dernières font face quant à leur offre de logements. Il expose les enjeux de production d'une offre d'habitat diversifiée adaptée à la pluralité des situations et des aspirations des personnes âgées, et la fragilité du modèle économique de ces produits liée au poids des services intégrés. Ces inégalités sont mises en perspective avec leur accroche au territoire par la notion de « capabilité » des territoires et par l'émergence de stratégies de mutualisation et la convergence de politiques publiques.

▶ The Dynamics Of Frailty And Change In Socio-Economic Conditions: Evidence For The 65+ In Europe

SIRVEN N., DUMONTET M. ET RAPP T.

2020

Eur J Public Health 30(4): 715-719.

https://doi.org/10.1093/eurpub/ckaa068

The frailty phenotype for older people is defined as an increased vulnerability to stressors, leading to adverse health outcomes. It is acknowledged as a specific precursor of disability besides chronic diseases that allows for some reversibility in the loss of autonomy. Although the literature on the socio-economic determinants of frailty is emerging in cross-sectional settings, little is known about the dynamics of this relationship over time. This article examines the joint evolution of frailty and change in economic conditions for the 65+ in Europe.Individual and longitudinal data from SHARE (Survey on Health, Ageing and Retirement in Europe) over the period 2004–12 has been used. The sample contains 31 044 observations from 12 002 respondents aged 65 or more. A fixed effect Poisson model is estimated in order to control for unobserved individual heterogeneity. Three types of explanative economic variables have been considered in turn: income, wealth and a subjective variable of deprivation.Our results indicate that individuals with worsening economic conditions (wealth and subjective deprivation) over time simultaneously experience a rapid increase in the frailty symptoms. Results also show that the nature of economic variable does not affect the frailty process in the same way. Subjective measure of deprivation seems to better evaluate the household's financial difficulties than objective measure. From a public policy perspective, these results show that policies fostering economic conditions of the elderly could have a significant impact on frailty and henceforth, could reduce the risks of disability.

Care Homes As Hospices For The Prevalent Form Of Dying: An Analysis Of Long-Term Care Provision Towards The End Of Life In England

TEGGI D.

2020

Social Science & Medicine 260: 113150.

https://doi.org/10.1016/j.socscimed.2020.113150

In the UK and the Westernised countries, most people die aged 80+ from disabling, chronic and degenerative diseases, having spent several years in poor health. There is thus continuity between long-term care (LTC) and end of life care (EOLC) in old age, but this continuity is poorly understood within policy and almost nothing is known about what determines the modality and intensity of LTC provision in old age towards the end of life. Drawing on multinomial logistic regression analysis of the English Longitudinal Study of Ageing (ELSA), this paper evaluates how health and socio-demographic factors affect the relative probability of receiving care through one of five long-term care arrangements (LTCAs) from the time of need at age ≥50 to death; and assesses the consequences this has for the English LTC and EOLC policy and planning. The study reveals that hospices provide end-of-life LTC for cancer diagnoses and adults aged 50–64, while care homes provide open-ended and end-of-life LTC for non-cancer diagnoses, dementia, severe disability, and adults aged 80+. Further, the informal, formal, mixed and care home LTCAs reflect increasing levels of disability and ill-health, and decreasing levels of family support, with differences concerning education and gender. Finally, dementia and Parkinson's disease are the single strongest determinants of high formal LTC provision, and overall high care needs determine high formal LTC provision. Within the English context, the consequences of this are that: 1) Continued reliance on informal family care is not sustainable; 2) To provide free formal LTC to old adults with high care needs is appropriate; and 3) Hospices do not cater for the prevalent form of dying in old age while care homes do, being the de facto hospices for severely disabled, very old (80+) adults with dementia. Yet this is not represented in English EOLC policy and research.

Frailty, A Multisystem Ageing Syndrome

THILLAINADESAN J., SCOTT I. A. ET LE COUTEUR D. G.

2020

Age and Ageing 49(5): 758-763.

https://doi.org/10.1093/ageing/afaa112

The management of frail older people is a key component of aged care. There has been a plethora of tools developed for the diagnosis and screening of frailty. Some of these tools are entering routine clinical practice at a time when the higher healthcare costs involved in caring for older people who are frail have become a potential target for cost-cutting. Yet there is still only limited evidence to support the widespread adoption of frailty tools, and foundational factors impact on their accuracy and validity. Despite the acceptance of frailty as a valid term in research and clinical practice, older people believe the term carries stigma. Such issues indicate that there may be a need to reconsider current approaches to frailty. Recent advances in the science of ageing biology can provide a new framework for reconfiguring how we screen, diagnose, treat and prevent frailty. Frailty can be considered to be a multisystem ageing syndrome of decreased physiological and functional reserve, where the biological changes of ageing are seen in most tissues and organs and are the pathogenic mechanism for frailty. Likewise age-related chronic disease and multimorbidity are syndromes where ageing changes occur in one or multiple systems, respectively. This model focusses diagnostic criteria for frailty onto the biomarkers of ageing and generates new targets for the prevention and treatment of frailty based on interventions that influence ageing biology.

Informal And Formal Home Care For Older Adults With Disabilities Increased, 2004–16

VAN HOUTVEN C. H., KONETZKA R. T., TAGGERT E., *et al.*

2020

Health Affairs 39(8): 1297-1301.

https://doi.org/10.1377/hlthaff.2019.01800

Rates of informal home care use among older adults with disabilities increased from 2004 to 2016, such that in 2016 almost three-quarters of these adults received informal home care. Informal care remains the most common source of home care, even though formal home care use grew at almost twice the rate, with a 6-percentage-point increase to 36.9 percent in 2016.

Âge prospectif : une approche complémentaire du vieillissement et de ses implications

VANDRESSE M.

2020

Gérontologie et société 42 / 162(2): 141-159.

ww.cairn.info/revue-gerontologie-et-societe-2020-2-page-141.htm

Afin d'objectiver le vieillissement de la population, plusieurs indicateurs démographiques sont traditionnellement proposés dont l'âge moyen de la population, la part des 65 ans et plus dans la population ou encore le ratio de dépendance démographique des âgés. Un âge déterminé est alors repris comme critère de distinction pour définir la population « qui n'est plus en âge de travailler ». Il s'agit d'une notion chronologique de l'âge. Ces indicateurs supposent que les caractéristiques des individus (en particulier l'état de santé), pour un âge donné, sont constantes à travers le temps. En partant du principe que l'évolution à la hausse de l'espérance de vie génère une hausse du nombre d'années restant à vivre, des indicateurs du vieillissement sur la base de l'âge « prospectif » se sont développés. L'âge prospectif est défini par le nombre d'années restant à vivre. L'objectif de cet article est de mettre en avant l'intérêt de l'approche prospective d'un point de vue théorique, tout en illustrant les propos à l'aide d'une application dans le domaine des soins de santé sur la base de données belge.

Changes In The Balance Between Formal And Informal Care Supply In England Between 2001 And 2011: Evidence From Census Data

ZIGANTE V., FERNANDEZ J.-L. ET MAZZOTTA F.

2020

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Informal care plays a crucial role in the social care system in England and is increasingly recognised as a cornerstone of future sustainability of the long-term care (LTC) system. This paper explores the variation in informal care provision over time, and in particular, whether the considerable reduction in publicly-funded formal LTC after 2008 had an impact on the provision of informal care. We used small area data from the 2001 and 2011 English censuses to measure the prevalence and intensity (i.e. the number of hours of informal care provided) of informal care in the population. We controlled for changes in age structure, health, deprivation, income, employment and education. The effects of the change in formal social care provision on informal care were analysed through instrumental variable models to account for the well-known endogeneity. We found that informal care provision had increased over the period, particularly among high-intensity carers (20+ hours per week). We also found that the reduction in publicly-funded formal care provision was associated with significant increases in high-intensity (20+ hours per week) informal care provision, suggesting a substitutive relationship between formal and informal care of that intensity in the English system.

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