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Veille scientifique
en économie de la santé

Juillet-août 2018

Sommaire en français

Watch on
Health Economics Literature

July-August 2018

Contents list in English

Institut de recherche et documentation en économie de la santé

IRDES

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en économie de la santé

Juillet-août 2018

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Assurance maladie
E-santé – Technologies médicales
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Cette publication mensuelle, réalisée par les documentalistes de l'Irdes, rassemble de façon thématique les résultats de la veille documentaire sur les systèmes et les politiques de santé ainsi que sur l'économie de la santé : articles, littérature grise, ouvrages, rapports…

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Assurance maladie

▶ The Impact of Expanding Medicaid on Health Insurance Coverage and Labor Market Outcomes

FRISVOLD D. E. ET JUNG Y.

2018

Int J Health Econ Manag 18(2): 99-121.

Expansions of public health insurance have the potential to reduce the uninsured rate, but also to reduce coverage through employer-sponsored insurance (ESI), reduce labor supply, and increase job mobility. In January 2014, twenty-five states expanded Medicaid as part of the Affordable Care Act to low-income parents and childless adults. Using data from the 2011-2015 March Current Population Survey Supplements, we compare the changes in insurance coverage and labor market outcomes over time of adults in states that expanded Medicaid and in states that did not. Our estimates suggest that the recent expansion significantly increased Medicaid coverage with little decrease in ESI. Overall, the expansion did not impact labor market outcomes, including labor force participation, employment, and hours worked.

▶ L'universalité en droit de la protection sociale

ISIDRO L.

2018

Droit Social(4): 378-388.

L'universalité est-il le maître mot de la protection sociale ? De la sécurité sociale créée en 1945 à l'idée de revenu universel, en passant par l'adoption du compte personnel d'activité, et des réformes à venir en termes de chômage et de retraite, l'universalité est constamment invoquée. Elle n'en est pas moins porteuse à chaque époque de représentations différentes qui éclairent les chemins empruntés par le système de protection sociale français.

▶ What Characterises the Privately Insured in Universal Health Care Systems? A Review of the Empirical Evidence

KIIL A.

2012

Health Policy 106(1): 60-75.

This paper reviews the empirical literature on what characterises individuals with voluntary private health insurance (VPHI) in universal health care systems and assesses how well the empirical evidence corresponds with the theoretical predictions. Empirical studies were identified by performing searches in electronic databases. The literature search identified a total of 24 articles and 15 working papers, the majority of which were published within the recent decade. Socioeconomic characteristics are generally found to be important determinants of VPHI coverage. In accordance with economic theory, the probability of taking out VPHI on an individual basis is consistently found to increase with income. Likewise, the empirical evidence generally supports the theoretical prediction of individuals selecting themselves into duplicate VPHI based on the quality of care available within the universal health care system, just as the demand for VPHI is consistently found to be negatively affected by the insurance premium. On the contrary, the empirical evidence on the importance of risk preferences is sparse and points in different directions. Finally, with a few exceptions, the privately insured are found to be in equal or better health compared to the remaining population. In most settings, the positive association between health and VPHI coverage may be attributed to risk rating of insurance premiums and eligibility requirements, while it may be interpreted as evidence of advantageous selection in their absence.

▶ What Should Health Insurance Cover? A Comparison of Israeli and US Approaches to Benefit Design Under National Health Reform

NISSANHOLTZ GANNOT R., CHINITZ D. P. ET ROSENBAUM S.

2018

Health Econ Policy Law 13(2): 189-208.

What health insurance should cover and pay for represents one of the most complex questions in national health policy. Israel shares with the US reliance on a regulated insurance market and we compare the approaches of the two countries regarding determining health benefits. Based on review and analysis of literature, laws and policy in the United States and Israel. The Israeli experience consists of selection of a starting point for defining coverage; calculating the expected cost of covered benefits; and creating a mechanism for updating covered benefits within a defined budget. In implementing the Affordable Care Act, the US rejected a comprehensive and detailed approach to essential health benefits. Instead, federal regulators established broadly worded minimum standards that can be supplemented through more stringent state laws and insurer discretion. Notwithstanding differences between the two systems, the elements of the Israeli approach to coverage, which has stood the test of time, may provide a basis for the United States as it renews its health reform debate and considers delegating decisions about coverage to the states. Israel can learn to emulate the more forceful regulation of supplemental and private insurance that characterizes health policy in the United States.

E-santé – Technologies médicales

▶ L'e-santé : l'empowerment du patient connecté

CASES A.-S.

2017

Journal de gestion et d'économie médicales 35(4): 137-158.

www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-4-page-137.htm

L'objectif de cette recherche est de mieux comprendre les apports du numérique dans la sphère médicale avec une approche centrée autour du patient. Aujourd'hui, Internet a transformé la façon dont le patient a accès à l'information santé, ce patient dit « connecté » est de plus en plus informé et devient un acteur de sa santé. Conjointement, certains dispositifs numériques de santé contribuent également à impliquer les patients dans le processus de soin. Aussi, le concept d'empowerment du patient prend tout son sens avec l'arrivée des technologies numériques. Une revue de la littérature relative au concept d'empowerment du client puis du patient a été menée et complétée par deux études qualitatives complémentaires. Il s'agit d'identifier les sources de pouvoir associées au numérique et à l'empowerment du patient ainsi que les bénéfices et les risques de ce gain de pouvoir ressenti par ces derniers.

▶ E-Health in Switzerland: The Laborious Adoption of the Federal Law on Electronic Health Records (EHR) and Health Information Exchange (HIE) Networks

DE PIETRO C. ET FRANCETIC I.

2018

Health Policy 122(2): 69-74.

Within the framework of a broader e-health strategy launched a decade ago, in 2015 Switzerland passed a new federal law on patients' electronic health records (EHR). The reform requires hospitals to adopt interoperable EHRs to facilitate data sharing and cooperation among healthcare providers, ultimately contributing to improvements in quality of care and efficiency in the health system. Adoption is voluntary for ambulatories and private practices, that may however be pushed towards EHRs by patients. The latter have complete discretion in the choice of the health information to share. Moreover, careful attention is given to data security issues. Despite good intentions, the high institutional and organisational fragmentation of the Swiss healthcare system, as well as the lack of full agreement with stakeholders on some critical points of the reform, slowed the process of adoption of the law. In particular, pilot projects made clear that the participation of ambulatories is doomed to be low unless appropriate incentives are put in place. Moreover, most stakeholders point at the strategy proposed to finance technical implementation and management of EHRs as a major drawback. After two years of intense preparatory work, the law entered into force in April 2017.

Economie de la santé

How Much Do Cancer Specialists Earn? A Comparison of Physician Fees and Remuneration in Oncology and Radiology in High-Income Countries

BOYLE S., PETCH J., BATT K., DURAND-ZALESKI I. ET THOMSON S.

2018

Health Policy 122(2): 94-101.

The main driver of higher spending on health care in the US is believed to be substantially higher fees paid to US physicians in comparison with other countries. We aim to compare physician incomes in radiology and oncology considering differences in relation to fees paid, physician capacity and volume of services provided in five countries: the United States, Canada, Australia, France and the United Kingdom. The fee for a consultation with a specialist in oncology varies threefold across countries, and more than fourfold for chemotherapy. There is also a three to fourfold variation in fees for ultrasound and CT scans. Physician earnings in the US are greater than in other countries in both oncology and radiology, more than three times higher than in the UK; Canadian oncologists and radiologists earn considerably more than their European counterparts. Although challenging, benchmarking earnings and fees for similar health care activities across countries, and understanding the factors that explain any differences, can provide valuable insights for policy makers trying to enhance efficiency and quality in service delivery, especially in the face of rising care costs.

Paiement à l'acte/capitation : une réforme ébauchée mais avortée

BRAS P. L.

2017

Sève : Les Tribunes de la Santé(57): 71-89.

Depuis le 19e siècle, les médecins français libéraux sont rémunérés à l'acte. Le paiement à l'acte est un des principes fondamentaux inscrit dans la charte de 1927. Cet article, qui ne traite que des généralistes, interroge ce mode de rémunération et en compare les mérites avec la capitation. Il présente les caractéristiques de ces deux modes de paiement, décrit les modes de rémunération des généralistes français, rappelle les incitations que ces deux modes de paiement adressent aux médecins. Il souligne également que l'argument traditionnellement mobilisé pour la capitation - la maîtrise des dépenses - est aujourd'hui caduc mais que ce mode de rémunération mérite considération du fait de ses effets structurels sur l'organisation des soins. Il reste, qu'avant 2000, du fait de l'attachement des médecins au paiement à l'acte, aucune évolution des modalités de leur rémunération n'était possible; les initiatives prises au cours des années 2000-2010 pouvaient laisser envisager une transition progressive vers la capitation mais celle-ci semble stoppée après la convention de 2016.

Beyond Activity Based Funding. An experiment in Denmark

BURAU V., DAHL H. M., JENSEN L. G. ET LOU S.

2018 (Ahead of print)

Health Policy

The study identifies discursive mechanisms for successfully challenging Activity Based Funding. They include problem definitions, underlying assumptions, policy processes and solutions. New models require careful engineering in terms of process and substance.

Inpatient Care Expenditure of the Elderly with Chronic Diseases Who Use Public Health Insurance: Disparity in Their Last Year of Life

CHANDOEVWIT W. ET PHATCHANA P.

2018

Soc Sci Med 207: 64-70.

The Thai elderly are eligible for the Civil Servant Medical Benefit Scheme (CS) or Universal Coverage Scheme (UCS) depending on their pre-retirement or their children work status. This study aimed to investigate the disparity in inpatient care expenditures in the last year of life among Thai elderly individuals who used the two public health insurance schemes. Using death registration and inpatient administrative data from 2007 to 2011, our subpopulation group included the elderly with four chronic disease groups: diabetes mellitus, hypertension and cardiovascular disease,

heart disease, and cancer. Among 1,242,150 elderly decedents, about 40% of them had at least one of the four chronic disease conditions and were hospitalized in their last year of life. The results showed that the means of inpatient care expenditures in the last year of life paid by CS and UCS per decedent were 99,672 Thai Baht and 52,472 Thai Baht, respectively. On average, UCS used higher healthcare resources by diagnosis-related group relative weight measure per decedent compared with CS. In all cases, the rates of payment for inpatient treatment per diagnosis-related group adjusted relative weight were higher for CS than UCS. This study found that the disparities in inpatient care expenditures in the last year of life stemmed mainly from the difference in payment rates. To mitigate this disparity, unified payment rates for various types of treatment that reflect costs of hospital care across insurance schemes were recommended.

▶ Reste à charge et santé : dossier

COM-RUELLE L., CZERNICHOW P. *et al.*

2018/03

Actualité dossier en santé publique(102): 11-54.

En France, les restes à charge des assurés, après remboursements de l'assurance maladie obligatoire, représentent près d'un quart des dépenses de santé. Ces restes à charge sont payés par une assurance maladie complémentaire ou par les ménages. Après remboursement des assurances complémentaires, la part directement à la charge des patients est de 7 %. Ces RAC varient selon le type de soins, peuvent s'avérer très élevés pour certaines personnes et être un véritable frein à l'accès aux soins. Ce dossier fait le point sur cette problématique.

▶ The Complexity of Billing and Paying for Physician Care

GOTTLIEB J. D., SHAPIRO A. H. ET DUNN A.

2018

Health Aff (Millwood) 37(4): 619-626.

The administrative costs of providing health insurance in the US are very high, but their determinants are poorly understood. We advance the nascent literature in this field by developing new measures of billing complexity for physician care across insurers and over time, and by estimating them using a large sample of detailed insurance «remittance data» for the period 2013-15. We found dramatic variation across different types of insurance. Fee-for-service Medicaid is the most challenging type of insurer to bill, with a claim denial rate that is 17.8 percentage points higher than that for fee-for-service Medicare. The denial rate for Medicaid managed care was 6 percentage points higher than that for fee-for-service Medicare, while the rate for private insurance appeared similar to that of Medicare Advantage. Based on conservative assumptions, we estimated that the health care sector deals with $11 billion in challenged revenue annually, but this number could be as high as $54 billion. These costs have significant implications for analyses of health insurance reforms.

▶ The Impact of Pay-For-Performance on the Quality of Care in Ophthalmology: Empirical Evidence from Germany

HERBST T., FOERSTER J. ET EMMERT M.

2018 (Ahead of print)

Health Policy

Pay-for-performance (P4P) has become a popular approach to increase effectiveness and efficiency in healthcare. So far, there is little evidence regarding the potential of P4P in the German healthcare setting. The aim of this study was to determine the impact of P4P on the quality of care in cataract surgery. METHODS: In 2012, a P4P program was implemented in a German surgical centre for ophthalmology. Five quality measures regarding process quality, outcomes, and patient satisfaction were measured over a period of 4.5 years. The P4P scheme consisted of bonus and penalty payments accounting for five per cent of total compensation. Overall, 1657 P4P cases were examined and compared with 4307 control cases. Interrupted time series and group comparisons were conducted to identify quality and spill-over effects. RESULTS: We found a positive impact on process quality and patient satisfaction before the implementation of the P4P scheme, but declining trends during and after the implementation. Our findings did not show an impact of P4P on outcome measures. Furthermore, P4P did not result in better quality of care, compared with the German hospital-based reimbursement scheme. CONCLUSION: This study did not show any positive long-term effects of the implementation of P4P on quality of care. Therefore, our results do not support the hypothesis that P4P leads to significant improvements in quality of care.

Effect of Incentive Payments on Chronic Disease Management and Health Services Use in British Columbia, Canada: Interrupted Time Series Analysis

LAVERGNE M. R., LAW M. R., PETERSON S., GARRISON S., HURLEY J., CHENG L. ET MCGRAIL K.

2018

Health Policy 122(2): 157-164.

We studied the effects of incentive payments to primary care physicians for the care of patients with diabetes, hypertension, and Chronic Obstructive Pulmonary Disease (COPD) in British Columbia, Canada. We used linked administrative health data to examine monthly primary care visits, continuity of care, laboratory testing, pharmaceutical dispensing, hospitalizations, and total h health care spending. We examined periods two years before and two years after each incentive was introduced, and used segmented regression to assess whether there were changes in level or trend of outcome measures across all eligible patients following incentive introduction, relative to pre-intervention periods. We observed no increases in primary care visits or continuity of care after incentives were introduced. Rates of ACR testing and antihypertensive dispensing increased among patients with hypertension, but none of the other modest increases in laboratory testing or prescriptions dispensed reached statistical significance. Rates of hospitalizations for stroke and heart failure among patients with hypertension fell relative to pre-intervention patterns, while hospitalizations for COPD increased. Total hospitalizations and hospitalizations via the emergency department did not change. Health care spending increased for patients with hypertension. This large-scale incentive scheme for primary care physicians showed some positive effects for patients with hypertension, but we observe no similar changes in patient management, reductions in hospitalizations, or changes in spending for patients with diabetes and COPD.

Health Care Spending in the United States and Other High-Income Countries

PAPANICOLAS I., WOSKIE L. R. ET JHA A. K.

2018

JAMA 319(10): 1024-1039.

Health care spending in the United States is a major concern and is higher than in other high-income countries, but there is little evidence that efforts to reform US health care delivery have had a meaningful influence on controlling health care spending and costs. This aim of this study is to compare potential drivers of spending, such as structural capacity and utilization, in the United States with those of 10 of the highest-income countries (United Kingdom, Canada, Germany, Australia, Japan, Sweden, France, the Netherlands, Switzerland, and Denmark) to gain insight into what the United States can learn from these nations. Analysis of data was primarily provided from 2013-2016 from key international organizations including the Organisation for Economic Co-operation and Development (OECD), comparing underlying differences in structural features, types of health care and social spending, and performance between the United States and 10 high-income countries. When data were not available for a given country or more accurate country-level estimates were available from sources other than the OECD, country-specific data sources were used.

Out-Of-Pocket Costs, Primary Care Frequent Attendance and Sample Selection: Estimates from a Longitudinal Cohort Design

PYMONT C., MCNAMEE P. ET BUTTERWORTH P.

2018 (Ahead of print)

Health Policy

This paper examines the effect of out-of-pocket costs on subsequent frequent attendance in primary care using data from the Personality and Total Health (PATH) Through Life Project, a representative community cohort study from Canberra, Australia. The analysis sample comprised 1197 respondents with two or more GP consultations, and uses survey data linked to administrative health service use (Medicare) data which provides data on the number of consultations and out-of-pocket costs. Respondents identified in the highest decile of GP use in a year were defined as Frequent Attenders (FAs). Logistic regression models that did not account for potential selection effects showed that out-of-pocket costs incurred during respondents' prior two consultations were significantly associated with subsequent FA status. Respondents who incurred higher costs ($15-$35; or >$35) were less likely to become FAs than those who incurred no or low (<AUS$15 per consultation) costs, with no difference evident between the no and low-cost groups.

However, a counterfactual model that adjusted for factors associated with the selection into payment levels did not find an influence of payment, with only a non-significant gradient in the expected direction. Hence these findings raise doubts that price drives FA behaviour, suggesting that co-payments are unlikely to affect the number of GP consultations amongst frequent attenders.

Paying Hospital Specialists: Experiences and Lessons from Eight High-Income Countries

QUENTIN W., GEISSLER A., WITTENBECHER F., BALLINGER G., BERENSON R., *et al.*

2018 (Ahead of print)

Health Policy

Payment systems for specialists in hospitals can have far reaching consequences for the efficiency and quality of care. This article presents a comparative analysis of payment systems for specialists in hospitals of eight high-income countries (Canada, England, France, Germany, Sweden, Switzerland, the Netherlands, and the USA/Medicare system). A theoretical framework highlighting the incentives of different payment systems is used to identify potentially interesting reform approaches. In five countries, most specialists work as employees - but in Canada, the Netherlands and the USA, a majority of specialists are self-employed. The main findings of our review include: (1) many countries are increasingly shifting towards blended payment systems; (2) bundled payments introduced in the Netherlands and Switzerland as well as systematic bonus schemes for salaried employees (most countries) contribute to broadening the scope of payment; (3) payment adequacy is being improved through regular revisions of fee levels on the basis of more objective data sources (e.g. in the USA) and through individual payment negotiations (e.g. in Sweden and the USA); and (4) specialist payment has so far been adjusted for quality of care only in hospital specific bonus programs. Policy-makers across countries struggle with similar challenges, when aiming to reform payment systems for specialists in hospitals. Examples from our reviewed countries may provide lessons and inspiration for the improvement of payment systems internationally.

Le remboursement des frais dentaires

YENI I., ESLOUS L., SIMON-DELAVELLE F. *et al.*

2017

Sève : Les Tribunes de la Santé (57): 63-70

Bien que les soins dentaires soient des soins médicaux, leur prise en charge par la sécurité sociale reste à l'écart des principes de cette dernière. Les patients financent 63 % de la dépense totale de soins dentaires à travers de ce qui reste à leur charge ou leur cotisation à une complémentaire. Ils en sont les premiers financeurs. Du fait du renoncement aux soins, dû notamment aux dépassements d'honoraires perçus par les chirurgiens-dentistes, cette charge réagit sur l'état de santé bucco-dentaire. Ces conditions de prise en charge sont antiredistributives et favorisent les inégalités territoriales et sociales. Elles sont en outre inefficaces au regard de la santé publique puisque l'état de santé bucco-dentaire en France est considéré comme médiocre. Ainsi, serait-il souhaitable que les soins bucco-dentaires bénéficient, comme les soins médicaux, à nouveau du régime de droit commun de la sécurité sociale contre le risque maladie pour qu'un meilleur état de santé bucco-dentaire de la population puisse concourir à l'amélioration de l'état de santé général.

État de santé

Prevalence of Adult Overweight and Obesity in 20 European Countries, 2014

MARQUES A., PERALTA M., NAIA A., LOUREIRO N. ET DE MATOS M. G.

2018

European Journal of Public Health 28(2): 295-300.

Monitoring obesity and overweight prevalence is important for assessing interventions aimed at preventing or reducing the burden of obesity. This study aimed to provide current data regarding the prevalence of overweight and obesity of adults, from 20 European countries. Participants were 34 814 (16 482 men) adults with mean age 50.8 ± 17.7. Data from European Social Survey round 7, 2014, were analysed. Body mass index (BMI) was calculated from self-reported height and weight. The proportion of underweight was only 2%, and 44.9% for normal weight. Overweight and obese accounted for 53.1%. More men than women were overweight (44.7% vs. 30.5%). Older adults were significantly more overweight (42.4%) and obese (20.9%) than middle age and younger adults. Retired people account for a greater proportion of overweight (42.0%) and obese (21.5%), when compared with employed, unemployed and students. People from rural areas were significantly more overweight (39.1 vs. 36.1%) and obese (17.0 vs. 15.3%) than those who lived in urban areas. The estimates indicate that the highest prevalence of overweight was in Czech Republic (45.2%), Hungary (43.7%) and Lithuania (41.7%). For obesity, Slovenia (20.8%), Estonia (19.7%) and the United Kingdom (19.2%) were the countries with the highest prevalence. Even though data was self-reported, and individuals tend to overestimate their height and underestimate their weight, the prevalence of overweight and obesity is considered high. More than half of the European population is overweight and obese. This study strengthens and updates the claims of an excessive weight epidemic in Europe.

Retrospective Cohort Study of Breast Cancer Incidence, Health Service Use and Outcomes in Europe: A Study of Feasibility

WILLIAMS L. J., FLETCHER E., DOUGLAS A., ANDERSON E. D. C., *et al.*

2018

European Journal of Public Health 28(2): 327-332.

Comparisons of outcomes of health care in different systems can be used to inform health policy. The EuroHOPE (European Healthcare Outcomes, Performance and Efficiency) project investigated the feasibility of comparing routine data on selected conditions including breast cancer across participating European countries. Routine data on incidence, treatment and mortality by age and clinical characteristics for breast cancer in women over 24 years of age were obtained (for a calendar year) from linked hospital discharge records, cancer and death registers from Finland, the Turin metropolitan area, Scotland and Sweden (all 2005), Hungary (2006) and Norway. (2009). Age-adjusted breast cancer incidence and 1-year survival were estimated for each country/region. In total, 24 576 invasive breast cancer cases were identified from cancer registries from over 13 million women. Age-adjusted incidence ranged from 151.1 (95%CI 147.2–155.0) in Hungary to 234.7 (95%CI 227.4–242.0)/100 000 in Scotland. One-year survival ranged from 94.1% (95%CI 93.5–94.7%) in Scotland to 97.1% (95%CI 96.2–98.1%) in Italy. Scotland had the highest proportions of poor prognostic factors in terms of tumour size, nodal status and metastases. Significant variations in data completeness for prognostic factors prevented adjustment for case mix. Incidence of and survival from breast cancer showed large differences between countries. Substantial improvements in the use of internationally recognised common terminology, standardised data coding and data completeness for prognostic indicators are required before international comparisons of routine data can be used to inform health policy.

Géographie de la santé

Vieillissement et territoires : cadres théoriques et enjeux empiriques

BLANCHET M., PIHET C. ET CHAPON P.-M.

2017

Retraite et société 76(1): 19-41.

www.cairn.info/revue-retraite-et-societe-2017-1-page-19.htm

Du latin territorium, le territoire désigne selon Guy Di Méo (1998) « une appropriation à la fois économique, idéologique et politique (sociale, donc) de l'espace par des groupes qui se donnent une représentation particulière d'eux-mêmes, de leur histoire » (Di Méo, 1998, p. 42). Édifice matériel et idéel, le territoire ne fonctionne pas comme un support neutre et univoque et varie selon différents processus d'appropriation. Dans un contexte de vieillissement de la population, géographiquement différencié, et de politiques gérontologiques sectorisées et individualisées, le territoire s'est progressivement imposé comme un moyen de compréhension des problématiques gérontologiques et un levier d'action sur le plan politique. Aujourd'hui, l'intérêt pour la notion de « territoire » est visible au sein de la gérontologie, à travers des programmes mondiaux comme celui de l'Organisation mondiale de la santé (OMS) en faveur des « villes et communautés-amies des aînés » (Vada) ou dans la loi relative à l'adaptation de la société au vieillissement (décembre 2015). Fort de cette orientation, l'objectif de l'article consiste à présenter la force du concept de « territoire » dans l'appréhension des dynamiques gérontologiques, notamment en montrant en quoi une approche systémique de cette notion s'avère propice à la compréhension des processus de production, d'organisation, d'inclusion et d'exclusion dans le domaine gérontologique.

Le vieillissement dans les territoires : un phénomène multiforme

DE LAPASSE B. ET PILON C.

2017

Retraite et société 76(1): 125-133.

www.cairn.info/revue-retraite-et-societe-2017-1-page-125.htm

Entre 2000 et 2050, le nombre de personnes âgées de 60 ans et plus passera de 600 millions à près de 2 milliards (ONU, 2011 et 2013). Dans le même temps, 2,5 milliards de personnes supplémentaires sont attendues dans les milieux urbains. Ces évolutions obligent à repenser les modes d'urbanisation, l'adaptation du périurbain et du milieu rural. Ils questionnent l'avenir des solidarités formelles et informelles et le rôle structurant des politiques publiques. La conjonction des transitions démographiques et des mutations territoriales s'opérant au niveau mondial impose donc de revisiter les cadres d'analyse ordinaires pour anticiper et accompagner les effets du vieillissement sur les territoires. S'appuyant sur des travaux et expérimentations menés en France et à l'étranger, le premier numéro de ce dossier, composé de deux volets, propose une série de pistes en matière d'aménagement des territoires et de construction d'espaces démocratiques, pour tenter de relever ces nombreux défis auxquels la société doit faire face.

La démarche des « chartes territoriales de solidarité » pour un développement sanitaire et social des territoires ruraux

LAGNEAU A.

2017

Retraite et société 76(1): 135-144.

www.cairn.info/revue-retraite-et-societe-2017-1-page-135.htm

S'appuyant sur des travaux et expérimentations menés en France et à l'étranger, le premier numéro de ce dossier, composé de deux volets, propose une série de pistes en matière d'aménagement des territoires et de construction d'espaces démocratiques, pour tenter de relever ces nombreux défis auxquels la société doit faire face. Cet article traite des chartes territoriales de solidarité proposées en 2011 par la Mutualité sociale agricole et reconduites sur la période 2016-2020.

Niveaux de vie et ségrégation dans douze métropoles françaises

FLOCH J. M.

2018

Economie Et Statistique (497-498): 73-97.

www.insee.fr/fr/statistiques/3317906?sommaire = 3317927

Les politiques publiques urbaines sont amenées à concilier des mesures ciblées, et des mesures plus globales favorisant la mixité, et à arbitrer entre agglomérations, et entre quartiers au sein des agglomérations. Les données localisées sur les revenus fiscaux et sociaux (Filosofi, Insee) sont utilisées pour calculer des indicateurs de ségrégation permettant de comparer les aires urbaines, leurs villes-centres, banlieues et couronnes périurbaines. La construction d'une typologie assez simple rend possible la cartographie des quartiers, riches ou pauvres, contribuant le plus aux disparités sociales. L'article présente ces analyses pour douze métropoles. La ségrégation est plus élevée dans les villes-centres et les banlieues qu'en périphérie. Elle est plus marquée pour les hauts niveaux de vie. Elle est la plus prononcée dans les aires urbaines de Lille, Paris et Aix-Marseille. Selon les cas, la ségrégation est plus marquée dans la ville-centre (Aix-Marseille, Strasbourg, Nantes) ou dans la banlieue (Paris, Lyon, Lille). Ces différences tiennent souvent à l'histoire urbaine locale et aux politiques du logement.

Maillage territorial des établissements de santé : apport des modèles issus de la théorie des graphes

LE MEUR N., FERRAT L., GAO F., QUIDU F. ET LOUAZEL M.

2017

Journal de gestion et d'économie médicales 35(4): 197-208.

www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-4-page-197.htm

La recomposition hospitalière observable depuis plus de 20 ans en France résulte de décisions prises dans le cadre des politiques de planification et des stratégies adoptées par les établissements. Au-delà de ses conséquences, comment dans un premier temps rendre compte du maillage territorial des établissements de santé ? Pour identifier les facteurs caractérisant la topologie du maillage, les statistiques de test conventionnelles sont inadaptées. Aussi nous proposons dans cet article méthodologique, d'étudier l'utilité des modèles issus de la théorie des graphes pour la modélisation des transferts de patients entre établissements de courts séjours (i.e. Médecine-Chirurgie-Obstétrique, MCO) et établissements de soins de suites et réadaptation (SSR) à partir du Programme de Médicalisation des Systèmes d'Information (PMSI). Les modèles Erdös-Renyi (ER) et les modèles à séquences contraintes sur les degrés (Constrainted Degree Sequence Model, CDSM) testent la significativité des mesures d'assortativité. Dans notre étude, ils démontrent entre autre la propension des établissements de même statut juridique à échanger des patients entre eux. Les modèles en blocs permettent de créer des clusters d'établissements sur la base des caractéristiques communes. Dans notre contexte, ils soulignent notamment la dynamique territoriale des échanges entre établissements. Enfin, les modèles à graphes aléatoires exponentiels (Exponential Random Graph Models ou ERGM) et la mesure d'assortativité mesurent l'influence simultanée de la proximité géographique et des statuts juridiques dans la relation entre les établissements. En conclusion, les méthodes issues de la théorie des graphes offrent des perspectives pour identifier et quantifier l'impact de facteurs pouvant influencer la topologie des relations hospitalières.

Commentaire - Ségrégation par le revenu dans les villes : réflexions sur les écarts entre concept et mesure

MORENO-MONROY A.

2018

Economie Et Statistique (497-498): 99-103.

www.insee.fr/fr/statistiques/3317910?sommaire = 3317927

Dans son étude portant sur douze métropoles françaises, Jean-Michel Floch montre que la ségrégation, à savoir la séparation spatiale de groupes ayant des niveaux de vie différents au sein des villes, est plus élevée dans les villes-centres et les banlieues qu'en périphérie. Elle est également plus marquée pour les niveaux de vie plus élevés. Ce commentaire fait valoir que la ségrégation par le revenu dans les villes françaises est faible au regard des niveaux internationaux. S'appuyant sur des questions de mesure et de comparabilité des indices de ségrégation par le revenu, trois points sont développés. Tout d'abord, contrairement aux idées généralement répandues, la ségrégation des populations pauvres a peu d'influence sur la ségrégation urbaine dans son ensemble, alors que la forte

contribution de la ségrégation des populations aisées ne fait pas suffisamment débat. Ensuite, il convient d'adopter un seuil empirique ou normatif en matière de ségrégation pour cadrer les discussions sur la ségrégation « excessive ». Enfin, la mesure de la ségrégation par le revenu, en l'état, n'évalue pas véritablement le degré réel de déconnexion physique entre les diverses catégories de revenus, ni d'ailleurs entre ces catégories de revenus et les commodités et services urbains, ce qui limite l'utilité de telles mesures pour l'élaboration de politiques publiques (résumé d'auteur).

Explaining Regional Variation in Home Care Use by Demand and Supply Variables

VAN NOORT O., SCHOTANUS F., VAN DE KLUNDERT J. ET TELGEN J.

2018

Health Policy 122(2): 140-146.

In the Netherlands, home care services like district nursing and personal assistance are provided by private service provider organizations and covered by private health insurance companies which bear legal responsibility for purchasing these services. To improve value for money, their procurement increasingly replaces fee-for-service payments with population based budgets. Setting appropriate population budgets requires adaptation to the legitimate needs of the population, whereas historical costs are likely to be influenced by supply factors as well, not all of which are necessarily legitimate. Our purpose is to explain home care costs in terms of demand and supply factors. This allows for adjusting historical cost patterns when setting population based budgets. Using expenses claims of 60 Dutch municipalities, we analyze eight demand variables and five supply variables with a multiple regression model to explain variance in the number of clients per inhabitant, costs per client and costs per inhabitant. Our models explain 69 % of variation in the number of clients per inhabitant, 28 % of costs per client and 56 % of costs per inhabitant using demand factors. Moreover, we find that supply factors explain an additional 17-23 % of variation. Predictors of higher utilization are home care organizations that are integrated with intramural nursing homes, higher competition levels among home care organizations and the availability of complementary services.

Hôpital

Pathways to DRG-Based Hospital Payment Systems in Japan, Korea, and Thailand

ANNEAR P. L., KWON S., LORENZONI L., DUCKETT S., *et al.*

2018 (Ahead of print)

Health Policy

Asian countries are facing rising health utilization and costs. Innovative case-based payment systems have emerged as a hospital funding mechanism. Frontier features include a phased-in approach and linking payment to quality outcomes. Case-based payment systems are not a panacea.

The Use of Preventable Hospitalization for Monitoring the Performance of Local Health Authorities in Long-Term Care

ARANDELOVIC A., ACAMPORA A., FEDERICO B., PROFILI F., FRANCESCONI P., RICCIARDI W. ET DAMIANI G.

2018

Health Policy 122(3): 309-314.

The objective of the study was to examine whether there are differences in the performance of long-term care programs between local health authorities, using preventable hospitalization as an indicator. A retrospective cohort study compared the rate of preventable hospitalization for local health authorities in Tuscany (Italy) between January 2012 and September 2016. Several administrative datasets for the patients in long-term care programs were linked at the individual (patient) level. Elderly disabled patients 65 years of age and older in long-term care programs in Tuscany

from both types of programs: nursing homes (n = 4196) and home care (n = 15659) were included in the study. RESULTS: The rate of preventable hospitalization differed considerably between local health authorities. Three out twelve local health authorities had a significantly lower and one had a significantly higher preventable hospitalization rate than the regional average. There was a large variation in the rate of preventable hospitalization among the local health authorities. Applying preventable hospitalization as an indicator for quality, with implications for periodical audit can be used for monitoring the performance of a long-term care program.

Control of Hospitals and Nursing Homes in France: The 2016 Reform May Indirectly Improve a Dysfunctional System

BERTEZENE S.

2018

Health Policy 122(4): 329-333.

In France, the supervisory bodies require hospitals and nursing homes to undergo various control procedures. A stack of legislation and control measures has piled up, with no provision for their interconnection being included in any of the legislation. The purpose of the article is to point to the prospects for better control opened up by the legislation modernising the health system adopted on 26 January 2016. The reform will neither directly change the partitioning between the supervisory bodies preventing the sharing of information and the harmonisation of the practices in terms of control, nor change the internal partitioning within the supervisory body. But in hospitals, the reform will improve the interconnection of control of quality/control inspections/control of strategy using a common medical project and pooling certain cross-cutting functions, and implementing the control of quality for the new local hospital groupings as a whole. In nursing homes, the generalisation of multi-year aims and means contracts would allow a better interconnection of the control of strategy and the control of quality since it provides managers with the means of constructing projects for the evolution of their establishments over a period of time, and accompanies changes in the socio-medical offer to improve the provision of care. These changes would allow a more credible, coherent, useful, and equitable control.

La T2A dans les établissements de santé de court séjour : réforme inachevées

CASH R.

2017

Sève : Tribunes de la Santé 57): 35-55.

La tarification à l'activité dans les établissements de santé a été mise en place en France dans le secteur de court séjour en 2004-2005, après une vingtaine d'années d'études et de travaux de simulation. Cet article revient sur l'historique de la T2A, sur ses caractéristiques fondamentales et ses objectifs initiaux ainsi que ses impacts. Il examine ensuite les débats intervenus ces dernières années et les modifications apportées au système, avant de terminer sur les perspectives.

Reducing Excess Hospital Readmissions: Does Destination Matter

CHEN M.

2018

Int J Health Econ Manag 18(1): 67-82.

Reducing excess hospital readmissions has become a high policy priority to lower health care spending and improve quality. The Affordable Care Act (ACA) penalizes hospitals with higher-than-expected readmission rates. This study tracks patient-level admissions and readmissions to Florida hospitals from 2006 to 2014 to examine whether the ACA has reduced readmission effectively. We compare not only the change in readmissions in targeted conditions to that in non-targeted conditions, but also changes in sites of readmission over time and differences in outcomes based on destination of readmission. We find that the drop in readmissions is largely owing to the decline in readmissions to the original hospital where they received operations or treatments (i.e., the index hospital). Patients readmitted into a different hospital experienced longer hospital stays. The results suggest that the reduction in readmission is likely achieved via both quality improvement and strategic admission behavior.

Impact des patients « bed blockers » sur les coûts hospitaliers et évaluation des obstacles à la sortie, étude prospective au sein de quatre hôpitaux belges

DE FOOR J., LECLERCQ P., VAN DEN BULCKE J. ET PIRSON M.

2017

Journal de gestion et d'économie médicales 35(4): 179-196.

www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-4-page-179.htm

Les hôpitaux constatent régulièrement que la durée de séjour à l'hôpital de certains patients est prolongée bien que leur présence ne soit plus justifiée par des raisons médicales. Le manque d'infrastructures extra-hospitalières pouvant accueillir des patients après une hospitalisation peut avoir un impact sur les coûts des hôpitaux. L'objectif de l'étude est d'établir les profils des patients bed blockers, d'identifier les obstacles à leur sortie, le besoin en structures d'accueil adéquates après l'hospitalisation, de calculer la durée excédentaire du séjour, et d'en évaluer le coût pour les hôpitaux. Une enquête a été réalisée dans quatre hôpitaux belges. Les patients qui sont toujours hospitalisés, alors que l'autorisation médicale de sortie remonte à plus de 24 heures, ont été recensés sur une période de 21 ou 30 jours. L'étude se concentre sur 93 patients. Les résultats montrent la nécessité de développer des lits de revalidation et de maisons de repos comme première solution permettant la sortie de patients dans des délais raisonnables.

The Importance of Population Differences: Influence of Individual Characteristics on the Australian Public's Preferences for Emergency Care

HARRIS P., WHITTY J. A., KENDALL E., RATCLIFFE J., WILSON A., *et al.*

2018

Health Policy 122(2): 115-125.

A better understanding of the public's preferences and what factors influence them is required if they are to be used to drive decision-making in health. This is particularly the case for service areas undergoing continual reform such as emergency and primary care. Accordingly, this study sought to determine if attitudes, socio-demographic characteristics and healthcare experiences influence the public's intentions to access care and their preferences for hypothetical emergency care alternatives. A discrete choice experiment was used to elicit the preferences of Australian adults (n = 1529). Mixed logit regression analyses revealed the influence of a range of individual characteristics on preferences and service uptake choices across three different presenting scenarios. Age was associated with service uptake choices in all contexts, whilst the impact of other sociodemographics, health experience and attitudinal factors varied by context. The improvements in explanatory power observed from including these factors in the models highlight the need to further clarify their influence with larger populations and other presenting contexts, and to identify other determinants of preference heterogeneity. The results suggest social marketing programs undertaken as part of demand management efforts need to be better targeted if decision-makers are seeking to increase community acceptance of emerging service models and alternatives. Other implications for health policy, service planning and research, including for workforce planning and the possible introduction of a system of co-payments are discussed.

Patient and Public Involvement in Hospital Policy-Making: Identifying Key Elements for Effective Participation

MALFAIT S., VAN HECKE A., DE BODT G., PALSTERMAN N. ET EECKLOO K.

2018

Health Policy 122(4): 380-388.

The involvement of patients and the public in healthcare decisions becomes increasingly important. Although patient involvement on the level of the individual patient-healthcare worker relationship is well studied, insight in the process of patient and public involvement on a more strategic level is limited. This study examines the involvement of patient and public (PPI) in decision-making concerning policy in six Flemish hospitals. The hospitals organized a stakeholder committee which advised the hospital on strategic policy planning. A three-phased mixed- methods study design with individual questionnaires (n = 69), observations (n = 10) and focus groups (n = 4) was used to analyze, summarize and integrate the findings. The results of this study indicate that: (1) PPI on hospital level should include the possibility to choose topics, like operational issues; (2) PPI-stakeholders should be able to have proper preparation; (3) PPI-stakeholders

should be externally supported by a patient organization; (4) more autonomy should be provided for the stakeholder committee. Additionally, the study indicates that the influence of national legislation on stakeholder initiatives in different countries is limited. In combination with the growing importance of PPI and the fact that the recommendations presented are not claimed to be exhaustive, more transnational and conceptual research is needed in the future.

Deaths in France: Characteristics, Place of Death, Hospitalisations and Use of Palliative Care During the Year Before Death

POULALHON C., ROTELLI-BIHET L., RASO C., AUBRY R., FAGOT-CAMPAGNA A. ET TUPPIN P.

2018

Revue d'Épidémiologie et de Santé Publique 66(1): 33-42.

Il existe peu d'informations à un niveau national sur les pathologies prises en charge et le parcours hospitalier avant le décès. Le but de cette étude était de décrire les pathologies, hospitalisations, recours aux soins palliatifs un an avant le décès et le lieu de décès en France. Les personnes décédées en 2013 et couvertes par le régime général d'Assurance maladie ont été repérées dans le système national d'information inter-régimes de l'Assurance maladie (Sniiram) avec une sélection des informations sur leurs différents séjours hospitaliers, en soins palliatifs hospitaliers (SPH) et en établissement d'hébergement pour personnes âgées dépendantes (Ehpad). Les pathologies ont été identifiées par des algorithmes à partir de la consommation de soins rapportée dans le Sniiram. Les informations médico-administratives du Sniiram doivent permettre d'approfondir la connaissance du parcours de soins en amont du décès et le recours aux SPH et d'aider à évaluer le nouveau plan gouvernemental sur les soins palliatifs récemment mis en place en France.

Does Free Choice of Hospital Conflict with Equity of Access to Highly Specialized Hospitals? A Case Study from the Danish Health Care System

TAYYARI DEHBAREZ N., GYRD-HANSEN D., ULDBJERG N. ET SØGAARD R.

2018 (Ahead of print)

Health Policy

Free choice of hospital conflicts with horizontal equity of access to hospitals. There is an educational gradient regarding exercising free choice of hospital. Risk aversion is associated with choosing a highly specialized hospital.

Le management au défi du stress des professionnels dans les établissements d'accueil des personnes âgées dépendantes

VINOT A. ET VINOT D.

2017

Journal de gestion et d'économie médicales 35(4): 159-177.

www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-4-page-159.htm

L'objectif de cet article est de proposer un outil de mesure de perception du stress au sein de structures médico-sociales et à en analyser les résultats. Cette recherche a été menée au sein de 26 Établissements d'Hébergement pour Personnes Âgées Dépendantes (EHPAD) répartis sur toute la France et intègre des structures citadines, rurales, de tailles, de statuts et de niveau de dépendance différents. La population étudiée concerne tous les professionnels présents au sein de l'établissement au moment de l'étude. Le questionnaire a été construit à partir de de trois structures pilote. La recherche porte sur 914 professionnels qui ont participé à cette étude. Le questionnaire comporte 42 questions portant sur des variables spécifiques aux conditions de travail et d'autres plus spécifiques aux critères identifiés lors des phases de pré test. L'alpha de Cronbach fait apparaître un coefficient de .893, quant aux 13 questions relatives aux conditions de travail, et de .848 quant aux 21 questions spécifiques au stress identifiées en focus group. Les résultats mettent en exergue 8 facteurs propres au rythme de travail, à la clarté des missions, aux interruptions des activités, au sens au travail, à la relation avec les résidents ou avec les collègues, aux ordres contradictoires et à l'enca-

drement. Certains facteurs tels que la relation avec les familles n'interviennent pas dans l'analyse des causes du stress, mettant en avant des facteurs organisationnels plus marqués, qui sont de réels leviers d'actions pour le manager.

Did Case-Based Payment Influence Surgical Readmission Rates in France? A Retrospective Study

VUAGNAT A., YILMAZ E., ROUSSOT A., RODWIN V., GADREAU M., BERNARD A., CREUZOT-GARCHER C. ET QUANTIN C.

2018

BMJ Open 8(2): e018164.

The aims of this study is to determine whether implementation of a case-based payment system changed all-cause readmission rates in the 30 days following discharge after surgery, we analysed all surgical procedures performed in all hospitals in France before (2002-2004), during (2005-2008) and after (2009-2012) its implementation. SETTING: Our study is based on claims data for all surgical procedures performed in all acute care hospitals with >300 surgical admissions per year (740 hospitals) in France over 11 years (2002-2012; n = 51.6 million admissions). We analysed all-cause 30-day readmission rates after surgery using a logistic regression model and an interrupted time series analysis. The overall 30-day all-cause readmission rate following discharge after surgery increased from 8.8% to 10.0% (P<0.001) for the public sector and from 5.9% to 8.6% (P<0.001) for the private sector. Interrupted time series models revealed a significant linear increase in readmission rates over the study period in all types of hospitals. However, the implementation of case-based payment was only associated with a significant increase in rehospitalisation rates for private hospitals (P<0.001). CONCLUSION: In France, the increase in the readmission rate appears to be relatively steady in both the private and public sector but appears not to have been affected by the introduction of a case-based payment system after accounting for changes in care practices in the public sector.

Choice of Reserve Capacity by Hospitals: A Problem for Prospective Payment

WIDMER P. K., TROTTMANN M. ET ZWEIFEL P.

2018

Eur J Health Econ 19(5): 663-673.

This contribution analyzes the impact of prospective payment on hospital decisions with regard to reserve capacity, using Swiss hospital data covering the years 2004-2009. This data set is unique because it permits distinguishing of institutional characteristics (e.g., ownership status) from the mode of payment as determinants of hospital efficiency, due to the fact that some Swiss cantons introduced prospective payment early while others waited for federal legislation to be enacted in 2012. Since a hospital's choice of reserve capacity depends also on the risk preferences of management while affecting the cost function, heterogeneity is predicted even in the presence of identical technology and factor prices. For estimating hospitals' marginal costs, we employ the flexible representation of risk preferences by Pope and Chavas [Am J Agric Econ 76, 196-204 (1994)]. Production uncertainty is measured as the difference between actual admissions and admissions predicted by an autoregressive moving average model. Its effect on hospital cost is analyzed using a multilevel stochastic cost frontier model with random coefficients reflecting unobserved differences in technology. Public hospitals are found to opt for a higher probability of meeting unexpected demand, as predicted. Their operating cost is 1.1% higher than for private hospitals and even 1.9% higher than for teaching hospitals, creating an incentive to turn away patients or to keep them waiting for treatment.

Does Patients' Experience of General Practice Affect the Use of Emergency Departments? Evidence from Australia

WONG C. Y. ET HALL J.

2018

Health Policy 122(2): 126-133.

AS Emergency Department (ED) attendances have been growing rapidly, various strategies have been employed in Australia to improve access to General Practitioner (GP) care, particularly after normal working hours, in order to reduce the demand for ED. However, there has been little attention paid to the quality of GP care and whether that influences ED attendances. This paper investigates whether ED use

is affected by patients' experience of GP care, using the logit model to analyse data from a survey of Australian consumers (1758 individuals). Not surprisingly, we find that people with poor health status and a greater number of chronic conditions are more likely to visit the ED. We also find that, after correcting for health status and sociodemographic factors, patients with a better GP experience are less likely to visit the ED. This suggests that policies aimed at improving the quality of primary care are also important in reducing unplanned hospital use.

Inégalités de santé

Les consultations au sein d'une permanence d'accès aux soins de santé

BOYER J. B., DE BECQ A., CHAMPS-LEGER H. ET *et al.*

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(2): 76-80.

Créée par la loi du 29 juillet 1998, la Permanence d'Accès aux Soins de Santé (PASS) a pour mission de lutter contre l'exclusion en favorisant l'accès aux soins des personnes les plus démunies. Elle s'insère dans un dispositif plus large de lutte contre la pauvreté. Les PASS travaillent en étroite collaboration avec les intervenants sanitaires, sociaux ou agissant dans le domaine de la précarité au sens large. L'activité peut se réduire à des consultations de médecine générale ou d'autres spécialités, mais aussi se déployer de façon plus transversale en intégrant des services sociaux afin de répondre aux besoins plus globaux de ses usagers.

Characteristics and Health Status of Homeless Women Born in France and Abroad: Results of Insee-Ined 2012 Survey

GOMES DO ESPIRITO SANTO M. E., PERRINE A. L., BONALDI C. ET GUSEVA-CANU I.

2018

Rev Epidemiol Santé Publique 66(2): 135-144.

French national surveys among the homeless population in 2001 and 2012 provided a general description of the homeless beneficiaries of medical and social aids. However, given the increasing number of women in this population, mostly born abroad and accompanied by their children, a descriptive study of homeless women according to the fact of being born in France or abroad was conducted. METHODS: A probability sample of 1470 French-speaking homeless women was recruited for the Insee-Ined 2012 survey. Sociodemographic characteristics, life trajectories, work and employment over the last 12 months, perceived health, reported morbidity, use of care and medical coverage have been described, comparing homeless women born abroad with those born in France. This study suggests that homeless women often have to deal with chronic health problems that are not treated. Homeless women born abroad are characterized by more precarious living conditions that women born in France. Although younger, with an overall favorable perception of their health and declaring less often an addiction, their general state of health appears to be as fragile as for women born in France. Actions towards homeless women should be implemented to promote their access to care.

Economic and Public Health Consequences of Delayed Access to Medical Care for Migrants Living with HIV in France

GUILLON M., CELSE M. ET GEOFFARD P. Y.

2018

Eur J Health Econ 19(3): 327-340.

In 2013, migrants accounted for 46% of newly diagnosed cases of HIV (human immunodeficiency virus) infection in France. These populations meet with specific obstacles leading to late diagnosis and access to medical care. Delayed access to care (ATC) for HIV-infected migrants reduces their life expectancy and quality of life. Given the reduction of infectivity under antiretroviral (ARV) treatment, delayed ATC for HIV-infected migrants may also hinder the control of the HIV epidemic. The objective of this study is to measure the public health and economic consequences of

delayed ATC for migrants living with HIV in France. Using a healthcare payer perspective, our model compares the lifetime averted infections and costs of early vs. late ATC for migrants living with HIV in France. Early and late ATC are defined by an entry into care with a CD4 cell count of 350 and 100/mm (3), respectively. Our results show that an early ATC is dominant, even in the worst-case scenario. In the most favorable scenario, early ATC generates an average net saving of €198, 000 per patient, and prevents 0.542 secondary infection. In the worst-case scenario, early ATC generates an average net saving of €32,000 per patient, and prevents 0.299 secondary infection. These results are robust to various adverse changes in key parameters and to a definition of late ATC as an access to care at a CD4 level of 200/mm(3). In addition to individual health benefits, improving ATC for migrants living with HIV proves efficient in terms of public health and economics. These results stress the benefit of ensuring early ATC for all individuals living with HIV in France.

Creating a 'Hostile Environment for Migrants': The British Government's Use of Health Service Data to Restrict Immigration Is a Very Bad Idea

HIAM L., STEELE S. ET MCKEE M.

2018

Health Economics, Policy and Law 13(2): 107-117.

In January 2017, the UK Government made public a Memorandum of Understanding (MoU) between the Department of Health, National Health Service (NHS) Digital and the Home Office. This Memorandum allows for the more expedited sharing of a patient's non-clinical data, specifically from the NHS England to the Home Office. The Government justified the MoU as in the 'public interest to support effective immigration enforcement'. In this review, we seek to unpack this justification by providing, first, a background to the MoU, placing it in the context of creating a 'hostile environment' for migrants – a project initially sought by Theresa May in her time as Home Secretary. We then explore the potential impact of data sharing on individual health, public health and on health professionals. We conclude that the MoU could threaten both individual and public health, while placing health professionals in an unworkable position both practically and in terms of their duties to patients around confidentiality. As such, we agree with colleagues' position that it should be suspended, at least until a full consultation and health impact assessment can be carried out.

The Impact of the Great Recession on Health-Related Risk Factors, Behaviour and Outcomes in England

JOFRE-BONET M., SERRA-SASTRE V. ET VANDOROS S.

2018

Soc Sci Med 197: 213-225.

This paper examines the impact that the Great Recession had on individuals' health behaviours and risk factors such as diet choices, smoking, alcohol consumption, and Body Mass Index, as well as on intermediate health outcomes in England. We exploit data on about 9000 households from the Health Survey for England for the period 2001-2013 and capture the change in macroeconomic conditions using regional unemployment rates and an indicator variable for the onset of the recession. Our findings indicate that the recession is associated with a decrease in the number of cigarettes smoked - which translated into a moderation in smoking intensity - and a reduction in alcohol intake. The recession indicator itself is associated with a decrease in fruit intake, a shift of the BMI distribution towards obesity, an increase in medicines consumption, and the likelihood of suffering from diabetes and mental health problems. These associations are often stronger for the less educated and for women. When they exist, the associations with the unemployment rate (UR) are nevertheless similar before and after 2008. Our results suggest that some of the health risks and intermediate health outcomes changes may be due to mechanisms not captured by worsened URs. We hypothesize that the uncertainty and the negative expectations generated by the recession may have influenced individual health outcomes and behaviours beyond the adjustments induced by the worsened macroeconomic conditions. The net effect translated into the erosion of the propensity to undertake several health risky behaviours but an exacerbation of some morbidity indicators. Overall, we find that the recession led to a moderation in risky behaviours but also to worsening of some risk factors and health outcomes.

Socioeconomic Status and Waiting Times for Health Services: An International Literature Review and Evidence from the Italian National Health System

LANDI S., IVALDI E. ET TESTI A.

2018

Health Policy 122(4): 334-351.

In the absence of priority criteria, waiting times are an implicit rationing instrument where the absence or limited use of prices creates an excess of demand. Even in the presence of priority criteria, waiting times may be unfair because they reduce health care demand of patients in lower socio-economic conditions due to high opportunity costs of time or a decay in their health level. Significant evidence has shown a relationship between socioeconomic status and the length of waiting time. The first phase of the study involved an extensive review of the existent literature for the period of 2002-2016 in the main databases (Scopus, PubMed and Science Direct). Twenty-eight met the eligibility criteria. The 27 papers were described and classified. The empirical objective of this study was to determine whether socioeconomic characteristics affect waiting time for different health services in the Italian national health system. The services studied were specialist visits, diagnostics tests and elective surgeries. A classification tree and logistic regression models were implemented. Data from the 2013 Italian Health National Survey were used. The analysis found heterogeneous results for different types of service. Individuals with lower education and economic resources have a higher risk of experiencing excessive waiting times for diagnostic and specialist visits. For elective surgery, socioeconomic inequalities are present but appear to be lower.

Connections Between Unemployment Insurance, Poverty and Health: A Systematic Review

RENAHY E., MITCHELL C., MOLNAR A., MUNTANER C., NG E., ALI F. ET O'CAMPO P.

2018

European Journal of Public Health 28(2): 269-275.

Since the global economic crisis in 2007, unemployment rates have escalated in most European and North American countries. Unemployment protection policies, particularly the unemployment insurance (UI) system, have become a weighty issue for many modern welfare states. Decades of research have established concrete findings on the adverse impacts of unemployment on poverty- and health-related outcomes. This provided a foundation for further exploration into the potential protective effects of UI in offsetting these adverse outcomes. Methods : We developed a systematic review protocol in four stages (literature search, study selection, data extraction and quality appraisal) to ensure a rigorous data collection and inter-rated reliability. We examined the full body of empirical research published between 2000 and 2013 on the pathways by which UI impacts poverty and health. Whether UI impacts differ by age and region might be explored further in future research. The complex mediating relationship between unemployment, UI, poverty and health should further be assessed in light of economic and historical contexts. This could inform decision-making processes during future periods of economic recession.

Droit au séjour pour raisons médicales : analyse de la Case de santé à Toulouse

REVUE PRESCRIRE

2018

Revue Prescrire 38(415): 380-382.

Centre de santé à Toulouse, la Case de santé a mis en place un protocole pluridisciplinaire visant à accompagner des personnes malades étrangères en situation irrégulière, pour connaître et faire valider leur droit au séjour pour raisons médicales. D'après son rapport d'observation, 53 personnes ont sollicité la Case de santé en 2015, afin de demander un titre de séjour pour raisons médicales. Cet article revient sur l'imbroglio dans l'attribution des titres de séjour au niveau de la Préfecture.

Précarité, pauvreté et santé

SPIRA A.

2017

Bulletin de l'Académie Nationale de Médecine(4-5-6): 567-587.

Après une présentation des populations précaires et des dispositifs mis au point en France à leur encontre, cet article souligne l'insuffisance des politiques menées et émet plusieurs recommandations pour améliorer leur situation sanitaire et sociale.

Equity in Access to Care in the Era of Health System Reforms in Turkey

YARDIM M. S. ET UNER S.

2018 (Ahead of print)

Health Policy

The aim of this study is to evaluate access to healthcare from an equity perspective on the way toward Universal Health Coverage in Turkey. The country representative data from 2006 to 2013 Turkey Income and Living Conditions Surveys were analyzed. Private household residents aged fifteen and older were asked for self-reported unmet need for medical care in the past twelve months. The dependent variable had three categories: no unmet need, unmet need due to cost, and unmet need due to availability (waiting list and distance problems). Predictors of unmet need were assessed by a multinomial logistic regression analysis. The prevalence of unmet need declined between 2006 and 2013. While educational inequalities in declared unmet need also decreased, the income gradient becomes more important. In 2013, controlling for other factors, the propensity to report unmet need was 10 times higher for those in the poorest-income quintile compared to the richest (versus 7 times in 2006). CONCLUSION: Overall access to healthcare has gradually improved in Turkey in the health reform process, but 9% of people still declared unmet need due to cost in 2013, after the implementation of Universal Health Insurance. This was nearly four times the EU average. Unfavourable economic and labour market conditions can be challenges for effective universal health coverage.

Médicaments

Global Increase and Geographic Convergence in Antibiotic Consumption Between 2000 and 2015

KLEIN E. Y., VAN BOECKEL T. P., MARTINEZ E. M., PANT S., *et al.*

2018

Proc Natl Acad Sci U S A.

Tracking antibiotic consumption patterns over time and across countries could inform policies to optimize antibiotic prescribing and minimize antibiotic resistance, such as setting and enforcing per capita consumption targets or aiding investments in alternatives to antibiotics. In this study, we analyzed the trends and drivers of antibiotic consumption from 2000 to 2015 in 76 countries and projected total global antibiotic consumption through 2030. Between 2000 and 2015, antibiotic consumption, expressed in defined daily doses (DDD), increased 65% (21.1-34.8 billion DDDs), and the antibiotic consumption rate increased 39% (11.3-15.7 DDDs per 1,000 inhabitants per day). The increase was driven by low- and middle-income countries (LMICs), where rising consumption was correlated with gross domestic product per capita (GDPPC) growth (P = 0.004). In high-income countries (HICs), although overall consumption increased modestly, DDDs per 1,000 inhabitants per day fell 4%, and there was no correlation with GDPPC. Of particular concern was the rapid increase in the use of last-resort compounds, both in HICs and LMICs, such as glycylcyclines, oxazolidinones, carbapenems, and polymyxins. Projections of global antibiotic consumption in 2030, assuming no policy changes, were up to 200% higher than the 42 billion DDDs estimated in 2015. Although antibiotic consumption rates in most LMICs remain lower than in HICs despite higher bacterial disease burden, consumption in LMICs is rapidly converging to rates similar to HICs. Reducing global consumption is critical for reducing the threat of antibiotic resistance, but reduction efforts must balance access limitations in LMICs and take account of local and global resistance patterns.

Introduction of Therapeutic Reference Pricing in Slovenia and Its Economic Consequences

MARDETKO N. ET KOS M.

2018

Eur J Health Econ 19(4): 571-584.

The aim of this study is to evaluate the economic outcomes that arose from the introduction of therapeutic reference pricing (TRP) into Slovenian practice in 2013, based on the first three therapeutic classes, namely

proton-pump inhibitors (PPIs), angiotensin-converting-enzyme inhibitors (ACEIs), and lipid-lowering agents (LLAs). National health claims data on prescription medicines from January 2011 to December 2015 were analyzed. Monthly medicine expenditure, medicine consumption, changes in medicine use, and market competition (Herfindahl-Hirschman index) were determined to assess the TRP impact on market dynamics. Interrupted time series analysis was used to assess the TRP cost-saving potential. The Slovenian TRP system was established as an effective cost-containment measure. However, pitfalls arising from a country-specific TRP should be considered when introducing this policy.

De l'(in)observance au prendre soin de soi

MISPELBLOM BEYER F.

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(2): 70-75.

Les progrès de la recherche médicale qui ont transformé des maladies mortelles en maladies chroniques, ont aussi permis de passer de traitements administrés à l'hôpital aux thérapies ambulatoires sous la responsabilité des patients eux-mêmes. Ce passage a fait découvrir un phénomène jusqu'alors peu perçu et connu : la non-observance, le fait que des patients ne suivent pas leurs traitements, et ce, même dans le cas de pathologies potentiellement mortelles. Ce phénomène a alerté les soignants mais aussi les autorités sanitaires, car des traitements prescrits, achetés, remboursés, qui ne sont pas réellement suivis ou pas suivis comme il le faudrait, entraînent des manques d'efficacité qui selon certaines études se traduisent en milliers de morts évitables et se chiffrent par milliards de pertes dans les comptes de la Nation.

Assessing Medicare's Approach to Covering New Drugs in Bundled Payments for Oncology

MULDOON L. D., PELIZZARI P. M., LANG K. A., VANDIGO J. ET PYENSON B. S.

2018

Health Aff (Millwood) 37(5): 743-750.

New oncology therapies can contribute to survival or quality of life, but payers and policy makers have raised concerns about the cost of these therapies. Similar concerns extend beyond cancer. In seeking a solution, payers are increasingly turning toward value-based payment models in which providers take financial risk for costs and outcomes. These models, including episode payment and bundled payment, create financial gains for providers who reduce cost, but they also create concerns about potential stinting on necessary treatments. One approach, which the Centers for Medicare and Medicaid Services adopted in the Oncology Care Model (OCM), is to partially adjust medical practices' budgets for their use of novel therapies, defined in this case as new oncology drugs or new indications for existing drugs approved after December 31, 2014. In an analysis of the OCM novel therapies adjustment using historical Medicare claims data, we found that the adjustment may provide important financial protection for practices. In a simulation we performed, the adjustment reduced the average loss per treatment episode by $758 (from $807 to $49) for large practices that use novel therapies often. Lessons from the OCM can have implications for other alternative payment models.

Les patients se font-ils prescrire leurs médicaments d'automédication par leur médecin généraliste

REVUE PRESCRIRE

2018

Revue Prescrire 38(415): 384-385.

Cet article analyse les résultats d'une enquête présentée lors des Rencontres Prescrire 2017, dont l'objectif était d'évaluer la pression des malades sur la prescription des médecins généralistes. En 1998, Ostermann avait défini la rédaction d'ordonnances sous la dictée des patients comme « l'automédication sur ordonnances suggérées ».

Méthodologie – Statistique

Une simulation sur un modèle d'appariement : l'impact de l'article 4 de l'ANI de 2013 sur la segmentation du marché du travail

BERSON C. ET FERRARI N.

2017

Economie & prévision 211-212(2): 115-137.

www.cairn.info/revue-economie-et-prevision-2017-2-page-115.htm

Le marché du travail français est segmenté entre les personnes bénéficiant d'un emploi stable et celles alternant contrats temporaires et périodes de chômage. À partir de simulations sur un modèle d'appariement calibré sur la France, la réforme issue de l'accord national interprofessionnel de 2013 apparaît pertinente pour réduire cette dualité. L'estimation des effets des majorations de cotisation sur les CDD et des exonérations pour les embauches de jeunes en CDI introduites par l'ANI du 11 janvier 2013 montre en effet un impact positif mais faible au regard de la réforme relativement similaire dite à l'italienne et étudiée dans Berson et Ferrari. (2015).

Sources de données, données utilisées et modalité de recueil

MERCIER G., COSTA N., DUTOT C. ET RICHE V. P.

2018

Revue d'Épidémiologie et de Santé Publique 66: S73-S91.

Les méthodes de costing hospitalier nécessitent d'avoir recours à des sources de données diverses, que l'on travaille selon une approche micro-costing ou gross-costing, le choix de la méthodologie reposant sur un compromis entre coût de recueil, précision et transférabilité. Ce travail décrit les sources de données disponibles en France, les modalités d'accès pratiques ainsi que les principaux avantages et inconvénients : (1) des coûts unitaires locaux, (2) de la comptabilité analytique hospitalière, (3) de la base d'Angers, (4) de l'Étude nationale des coûts, (5) des bases de données inter CHR/U, (6) du programme de médicalisation des systèmes d'information, (7) des bases de données de l'Assurance Maladie.

Méthodes d'analyse et de traitement des données de coût : approches par micro-costing » et « gross-costing »

MORELLE M., PLANTIER M., DERVAUX B., PAGÈS A., DENIÈS F., HAVET N. ET PERRIER L.

2018

Revue d'Épidémiologie et de Santé Publique 66: S101-S118.

Ce travail traite de l'analyse des données de coût individuelles dans le cadre d'études interventionnelles ou observationnelles à l'aide de logiciels d'analyse de données et de traitement statistique dès lors que les coûts par patient ont été estimés. Il est, en effet, nécessaire de pouvoir les présenter et les décrire de façon appropriée dans chacune des stratégies de santé étudiées et de tester si la différence de coût observée entre les groupes de traitement est due au hasard ou non. De plus, l'analyse des données de coût se distingue des analyses statistiques « classiques » par un certain nombre de caractéristiques propres à ces données ainsi qu'à leur utilisation par les décideurs de santé. Ce travail présente également les difficultés que posent généralement les distributions de coût, explique pourquoi la moyenne arithmétique constitue la seule mesure pertinente pour les économistes, et décrit quelles analyses sont nécessaires pour la comparaison des coûts entre les stratégies. Il s'intéresse aussi à la question des données manquantes ou censurées, spécificités souvent inhérentes aux informations collectées sur les coûts et aux analyses de sensibilité.

Politique de santé

[Medical Human Resources Planning in Europe: A Literature Review of the Forecasting Models]

BENAHMED N., DELIEGE D., DE WEVER A. ET PIRSON M.

2018

Rev Epidemiol Santé Publique 66(1): 63-73.

Healthcare is a labor-intensive sector in which half of the expenses are dedicated to human resources. Therefore, policy makers, at national and internal levels, attend to the number of practicing professionals and the skill mix. This paper aims to analyze the European forecasting model for supply and demand of physicians. To describe the forecasting tools used for physician planning in Europe, a grey literature search was done in the OECD, WHO, and European Union libraries. Electronic databases such as Pubmed, Medline, Embase and Econlit were also searched.To conclude : Medical human resource planning in Europe is inconsistent. Political implementation of the results of forecasting projections is essential to insure efficient planning. However, crucial elements such as mobility data between Member States are poorly understood, impairing medical supply regulation policies. These policies are commonly limited to training regulations, while horizontal and vertical substitution is less frequently taken into consideration.

Public Acceptability of Financial Incentives to Reward Pregnant Smokers Who Quit Smoking: A United Kingdom-France Comparison

BERLIN N., GOLDZAHL L., BAULD L., HODDINOTT P. ET BERLIN I.

2018

Eur J Health Econ 19(5): 697-708.

A substantial amount of research has been conducted on financial incentives to increase abstinence from smoking among pregnant smokers. If demonstrated to be effective, financial incentives could be proposed as part of health care interventions to help pregnant smokers quit. Public acceptability is important; as such interventions could be publicly funded. Concerns remain about the acceptability of these interventions in the general population. We aimed to assess the acceptability of financial incentives to reward pregnant smokers who stop smoking using a survey conducted in the UK and then subsequently in France, two developed countries with different cultural and social backgrounds. More French than British respondents agreed with financial incentives for rewarding quitting smoking during pregnancy, not smoking after delivery, keeping a smoke-free household, health service payment for meeting target and the maximum amount of the reward. However, fully adjusted models showed significant differences only for the two latter items. More British than French respondents were neutral toward financial incentives. Differences between the representative samples of French and British individuals demonstrate that implementation of financial incentive policies may not be transferable from one country to another.

La recherche qualitative en santé publique : intérêt, méthodes et perspectives

CERVELLO S.

2018

Lettre de Psychiatrie Française (La)(255): 19-21.

Après une définition du concept «Recherches qualitatives», cet article aborde les méthodologies utilisées, les relations avec la qualité et les applications aux domaines de la santé mentale.

Medicare's Acute Care Episode Demonstration: Effects of Bundled Payments on Costs and Quality of Surgical Care

CHEN L. M., RYAN A. M., SHIH T., THUMMA J. R. ET DIMICK J. B.

2018

Health Services Research 53(2): 632-648.

The aim of this study is to evaluate whether participation in Medicare's Acute Care Episode (ACE) Demonstration Program—an early, small, voluntary episode-based payment program—was associated with a change in expenditures or quality of care. Data Sources/Study Setting Medicare claims for patients

who underwent cardiac or orthopedic surgery from 2007 to 2012 at ACE or control hospitals. Study Design We used a difference-in-differences approach, matching on baseline and pre-enrollment volume, risk-adjusted Medicare payments, and clinical outcomes to identify controls. Principal Findings Participation in the ACE Demonstration was not significantly associated with 30-day Medicare payments (for orthopedic surgery : –$358 with 95 percent CI : –$894, + $178 ; for cardiac surgery : + $514 with 95 percent CI : –$1,517, + $2,545), or 30-day mortality (for orthopedic surgery : –0.10 with 95 percent CI : –0.50, 0.31 ; for cardiac surgery : –0.27 with 95 percent CI : –1.25, 0.72). Program participation was associated with a decrease in total 30-day post-acute care payments (for cardiac surgery : –$718 ; 95 percent CI : –$1,431, –$6 ; and for orthopedic surgery : –$591 ; 95 percent CI : $-$1,161, –$22). Conclusions Participation in Medicare's ACE Demonstration Program was not associated with a change in 30-day episode-based Medicare payments or 30-day mortality for cardiac or orthopedic surgery, but it was associated with lower total 30-day post-acute care payments.

Promoting Normal Birth and Reducing Caesarean Section Rates: An Evaluation of the Rapid Improvement Programme

COOKSON G. ET LALIOTIS I.

2018

Health Economics 27(4): 675-689.

This paper evaluates the impact of the 2008 Rapid Improvement Programme that aimed at promoting normal birth and reducing caesarean section rates in the English National Health Service. Using Hospital Episode Statistics maternity records for the period 2001–2013, a panel data analysis was performed to determine whether the implementation of the programme reduced caesarean sections rates in participating hospitals. The results obtained using either the unadjusted sample of hospitals or a trimmed sample determined by a propensity score matching approach indicate that the impact of the programme was small. More specifically there were 2.3 to 3.4 fewer caesarean deliveries in participating hospitals, on average, during the postprogramme period offering a limited scope for cost reduction. This result mainly comes from the reduction in the number of emergency caesareans as no significant effect was uncovered for planned caesarean deliveries.

Insights from the Design and Implementation of a Single-Entry Model of Referral for Total Joint Replacement Surgery: Critical Success Factors and Unanticipated Consequences

DAMANI Z., MACKEAN G., BOHM E., NOSEWORTHY T., *et al.*

2018

Health Policy 122(2): 165-174.

Single- entry models (SEMs) in healthcare allow patients to see the next- available provider and have been shown to improve waiting times, access and patient flow for preference- sensitive, scheduled services. The Winnipeg Central Intake Service (WCIS) for hip and knee replacement surgery was implemented to improve access in the Winnipeg Regional Health Authority. This paper describes the system's design/ implementation ; successes, challenges, and unanticipated consequences. On two occasions, during and following implementation, we interviewed all members of the WCIS project team, including processing engineers, waiting list coordinators, administrators and policy- makers regarding their experiences. We used semi- structured telephone interviews to collect data and qualitative thematic analysis to analyze and interpret the findings. Respondents indicated that the overarching objectives of the WCIS were being met. Benefits included streamlined processes, greater patient access, improved measurement and monitoring of outcomes. Challenges included low awareness, change readiness, and initial participation among stakeholders. Unanticipated consequences included workload increases, confusion around stakeholder expectations and under- reporting of data by surgeons' offices. Critical success factors for implementation included a requirement for clear communication, robust data collection, physician leadership and patience by all, especially implementation teams. Although successfully implemented, key lessons and critical success factors were learned related to change management, which if considered and applied, can reduce unanticipated consequences, improve uptake and benefit new models of care.

Involving Citizens in Disinvestment Decisions: What Do Health Professionals Think? Findings from a Multi-Method Study in the English NHS

DANIELS T., WILLIAMS I., BRYAN S., MITTON C. ET ROBINSON S.

2017

Health Economics, Policy and Law 13(2): 162-188.

Public involvement in disinvestment decision making in health care is widely advocated, and in some cases legally mandated. However, attempts to involve the public in other areas of health policy have been accused of tokenism and manipulation. This paper presents research into the views of local health care leaders in the English National Health Service (NHS) with regards to the involvement of citizens and local communities in disinvestment decision making. The research includes a Q study and follow-up interviews with a sample of health care clinicians and managers in senior roles in the English NHS. It finds that whilst initial responses suggest high levels of support for public involvement, further probing of attitudes and experiences shows higher levels of ambivalence and risk aversion and a far more cautious overall stance. This study has implications for the future of disinvestment activities and public involvement in health care systems faced with increased resource constraint. Recommendations are made for future research and practice.

Doing Patient-Centredness Versus Achieving Public Health Targets: A Critical Review of Interactional Dilemmas in ART Adherence Support

DE KOK B. C., WIDDICOMBE S., PILNICK A. ET LAURIER E.

2018

Soc Sci Med 205: 17-25.

Anti-retroviral Therapy (ART) transformed HIV into a chronic disease but its individual and public health benefits depend on high levels of adherence. The large and rising number of people on ART, now also used as prevention, puts considerable strain on health systems and providers in low and middle as well as high-income countries, which are our focus here. Delivering effective adherence support is thus crucial but challenging, especially given the promotion of patient-centredness and shared decision making in HIV care. To illuminate the complexities of ART adherence support delivered in and through clinical encounters, we conducted a multi-disciplinary interpretative literature review. We reviewed and synthesized 82 papers published post 1997 (when ART was introduced) belonging to three bodies of literature: public health and psychological studies of ART communication; anthropological and sociological studies of ART; and conversation analytic studies of patient-centredness and shared decision-making. We propose three inter-related tensions which make patient-centredness particularly complex in this infectious disease context: achieving trust versus probing about adherence; patient-centredness versus reaching public health targets; and empowerment versus responsibilisation as 'therapeutic citizens'. However, there is a dearth of evidence concerning how precisely ART providers implement patient-centredness, shared-decision making in practice, and enact trust and therapeutic citizenship. We show how conversation analysis could lead to new, actionable insights in this respect.

Asthma: Adapting the Therapeutic Follow-Up According to the Medical and Psychosocial Profiles

DECCACHE A., DIDIER A., MAYRAN P., JEZIORSKI A. ET RAHERISON C.

2018

Rev Mal Respir 35(3): 313-323.

This work is based on the data of REALISE, a survey conducted among 8000 European patients to identify the profiles of adult asthma patients and how these are linked with treatment adherence behaviors. A cluster analysis was performed by combining data in three ways: control of asthma, attitude towards the disease, compliance with treatment. A multidisciplinary group analyzed the results for the 1024 French survey respondents. RESULTS: Four patient profiles were identified: «rather confident» (28% of patients), rather young patients with a low level of concern about their asthma. «Rather committed» (23%) patients considering themselves to be mostly healthy, reporting better therapeutic declared. «Rather questing» (26%), patients poorly controlled, seeking to manage their asthma themselves. «Rather concerned» profile (23%), a bit older, with poor clinical control, considering their asthma to be severe. Cluster analysis provides a multidimensional approach to understand the therapeutic behavior of the different patient profiles better and

so adjust communication by and education of healthcare professionals.

▶ Should interventions to reduce variation in care quality target doctors or hospitals?

GUTACKER N., BLOOR K., BOJKE C. ET WALSHE K.

2018 (Ahead of print)

Health Policy

Performance management initiatives are increasingly targeting individual doctors as well as hospitals. Less than 25% of variation in clinical outcomes is attributable to providers. More variation in clinical outcomes is associated with doctors than with hospitals. Performance estimates for individual doctors are unreliable due to small samples.

▶ Improving Health Care Service Provision by Adapting to Regional Diversity: An Efficiency Analysis for the Case of Germany

HERWARTZ H. ET SCHLEY K.

2018

Health Policy 122(3): 293-300.

The provision of health care in Germany exhibits sizeable geographic variation with a heterogeneous allocation of medical services in rural and urban areas. Furthermore, distinct utilisation patterns and access barriers due to the socio-economic environment might cause inefficiencies in the provision of health care services. Accordingly, an improved understanding of factors governing inefficiencies in health care provision is likely to benefit an efficient spatial allocation of health care infrastructure. We analyse how socio-economic factors influence the regional distribution of (in)efficiencies in the provision of health care services by means of a stochastic frontier analysis. Our results highlight that regional deprivation relates to inefficient provision of health care services. As a consequence, policies should also consider socio-economic conditions to improve the allocation of medical services and overall health.

▶ Les accès à l'exercice de la médecine en France

HUGUIER M., BERTRAND D. ET MILHAUD G.

2017

Bulletin de l'Académie Nationale de Médecine 201(4-6): 513-527

En France, le nombre d'étudiants admis en deuxième année d'études (numerus clausus) est déterminé en fonction des possibilités de formation pratique hospitalière et des évolutions démographiques. L'objectif est d'avoir un nombre de médecins nécessaire, mais aussi suffisant. La situation s'est compliquée du fait de possibilités d'accès aux études médicales en dehors du NC, d'accords de l'Union européenne et de l'occupation de postes hospitaliers vacants par des médecins étrangers hors UE, ouvrant des autorisations ministérielles d'exercice. Ainsi, environ 20 % des médecins autorisés à exercer en France s'ajoutent au NC. Ce rapport recommande que les accès aux études médicales soient tous inclus dans le NC, que des décisions de l'UE soient prises pour faire évoluer le NC vers une certaine harmonisation quantitative dans les pays membres et que la réglementation hospitalière contrôle beaucoup mieux les dévoiements indirect du NC que constitue l'embauche de médecins hors UE sur des postes laissés vacants.

▶ The Impact of the Financial Crisis and Austerity Policies on the Service Quality of Public Hospitals in Greece

KERAMIDOU I. ET TRIANTAFYLLOPOULOS L.

2018

Health Policy 122(4): 352-358.

The influence of the financial crisis on the efficiency of Greek public hospitals has been widely debated. Despite this increasing interest in such research, the question of to what extent the recent reforms in the Greek National health care system were effective in establishing a health care structure and process that provide better results for patients has yet to be fully investigated. As a step in this direction, the paper focuses on patient's experience with public hospital care quality before and during the economic crisis. A questionnaire survey was carried out among 1872 patients discharged from 110 out of the total of 124 Greek public hospitals. Patients' perceptions were analysed using a structural equation modelling approach. The findings reveal that public hospital service quality

is at a medium level (66.2 on a scale from 1 to 100) over 2007-2014, presenting a decreasing trend during the recession. Policies to address the crisis may have contributed to a reduction in hospital expenditures, but at the same time patients were increasingly dissatisfied with the technical care. Consequently, there is a need for reforms aimed at the achievement of productivity gains, responsibility, and transparency in the management of productive resources, by enabling health organisations to reduce their costs without a deterioration in the quality of care.

The Joint Action on Health Workforce Planning and Forecasting: Results of a European Programme to Improve Health Workforce Policies

KROEZEN M., VAN HOEGAERDEN M. ET BATENBURG R.

2018

Health Policy 122(2): 87-93.

Health workforce (HWF) planning and forecasting is faced with a number of challenges, most notably a lack of consistent terminology, a lack of data, limited model-, demand-based- and future-based planning, and limited inter-country collaboration. The Joint Action on Health Workforce Planning and Forecasting (JAHWF, 2013-2016) aimed to move forward on the HWF planning process and support countries in tackling the key challenges facing the HWF and HWF planning. This paper synthesizes and discusses the results of the JAHWF. It is shown that the JAHWF has provided important steps towards improved HWF planning and forecasting across Europe, among others through the creation of a minimum data set for HWF planning and the 'Handbook on Health Workforce Planning Methodologies across EU countries'. At the same time, the context-sensitivity of HWF planning was repeatedly noticeable in the application of the tools through pilot- and feasibility studies. Further investments should be made by all actors involved to support and stimulate countries in their HWF efforts, among others by implementing the tools developed by the JAHWF in diverse national and regional contexts. Simultaneously, investments should be made in evaluation to build a more robust evidence base for HWF planning methods.

L'émergence du patient-acteur dans la sécurité des soins en France : une revue narrative de la littérature entre sciences sociales et santé publique

MOUGEOT F., ROBELET M., RAMBAUD C., OCCELLI P., BUCHET-POYAU K., TOUZET S. ET MICHEL P.

2018

Santé Publique 30(1): 73-81.

www.cairn.info/revue-sante-publique-2018-1-page-73.htm

Depuis une quarantaine d'années, les patients sont incités à prendre leur part dans la prise en charge de leur maladie et sont appelés à participer à l'amélioration de la qualité et de la sécurité des soins. Ce phénomène invite à penser les conditions d'émergence de ce nouveau rôle de patient ainsi qu'à penser ses implications en matière de santé publique. Une revue narrative de la littérature a été réalisée. Les bases de données Medline, Cairn et Persée ont été interrogées. L'interrogation des bases de données a référencé 2 206 documents dont 106 ont été retenus. L'émergence du patient-acteur est un phénomène lié aux crises sanitaires sous l'impulsion de collectifs associatifs tels que le Lien en matière de sécurité des patients. Ce mouvement induit une transformation du rôle du patient qui va au-delà de la sécurité des soins puisqu'il révolutionne sa contribution au système de santé et à la santé en général. Cette revue narrative de la littérature permet de mettre en évidence la manière dont les crises sanitaires ont permis l'émergence d'une nouvelle figure : celle du patient-acteur. Cette figure s'accompagne d'une sémantique nouvelle sur le pouvoir des malades. Dans le domaine de la sécurité des soins, le patient occupe une place spécifique. En complémentarité des personnels de santé, il doit être une ressource pour l'amélioration de la sécurité des patients. Les différentes contributions des patients sont détaillées et un questionnement sur l'acceptabilité de la participation des patients est proposé.

Health Policies for the Reduction of Obstetric Interventions in Singleton Full-Term Births in Catalonia

PUEYO M. J., ESCURIET R., PEREZ-BOTELLA M., DE MOLINA I., *et al.*

2018

Health Policy 122(4): 367-372.

The aim of this paper is to explore the effect of hospital's characteristics in the proportion of obstetric

interventions (OI) performed in singleton fullterm births (SFTB) in Catalonia (2010-2014), while incentives were employed to reduce C-sections. Data about SFTB assisted at 42 public hospitals were extracted from the dataset of hospital discharges. Hospitals were classified according to the level of complexity, the volume of births attended, and the adoption of a non-medicalized delivery (NMD) strategy. The annual average change in the percentage for OI was calculated based on Poisson regression models. To conclude : the proportion of OI, including C-sections, remained stable in spite of public incentives to reduce them. The adoption of the NMD strategy could help in decreasing the rate of OI. To reduce the OI rate, new strategies should be launched as the development of low-risk pregnancies units, alignment of incentives and hospital payment, increased value of incentives and encouragement of a cultural shift towards non-medicalized births.

▶ Putting Performance Measurement Recommendations into Practice: Building on Current Practices

ROSE MCCLOSKEY R., JARRETT J. ET YETMAN L.

2017

HealthcarePapers 17(2): 65-71.

Improving performance measurement within the Canadian healthcare system is proving to be challenging despite advances in evidence-informed care and best practices for healthcare delivery. Perhaps what is most challenging is the need to meet requirements to measure what most Canadians hold dear - being seen as a person during a healthcare encounter. Measures of healthcare delivery have typically been developed to capture patient satisfaction during isolated healthcare encounters. Such measures simply do not get to the essence of what matters to patients and their families. This paper outlines a response to the paper by Kuluski and colleagues (2017) that calls for a thorough review of the way data are currently captured on patients' experiences with healthcare. Using geriatric medicine as a context, the authors highlight elements of our current care delivery models that must be preserved, modified or created to allow patients and families to play a larger role in improving our healthcare system.</p>

▶ A la recherche d'une fin de vie apaisée

STASSE F.

2017

Sève : Les Tribunes de la Santé (57): 91-96.

La loi du 2 février 2016 accroît fortement les droits du patient à décider de l'arrêt des soins qui lui sont prodigués en fin de vie. Elle autorise, également, sous certaines conditions, les médecins à pratiquer une sédation afin que le patient achève sa vie sans souffrir. Ces importantes évolutions juridiques constituent-elles un point d'équilibre durable dans la législation française ? Les exemples étrangers ne permettent pas de trancher avec certitude.

Prévention

▶ Alcool : la culture ou la santé

BASSET B.

2017

Sève : Les Tribunes de la Santé (57): 57-61.

Alors que les dommages sanitaires et sociaux de la consommation d'alcool dans notre pays sont parfaitement établi et considérables, aucune politique cohérente et efficace ne peut être mise en œuvre. En effet, les groupes d'intérêt liés au secteur économique de l'alcool sont non seulement puissants, mais ils ont réussi à placer le débat sur le champ de la défense de la culture. Les moyens d'une politique efficace sont connus. Tout l'enjeu pour les acteurs de santé publique est de revenir à la question qui se pose vraiment : comment replacer au premier rang les enjeux de santé publique ?

Prévision – Evaluation

Évaluation des Politiques Publiques : expérimentation randomisée et méthodes quasi-expérimentales

CHABÉ-FERRET S., DUPONT-COURTADE L. ET TREICH N.

2017

Economie & prévision 211-212(2): 1-34.

www.cairn.info/revue-economie-et-prevision-2017-2-page-1.htm

Dans cet article, nous proposons une introduction aux méthodes d'évaluation expérimentales et quasi-expérimentales. L'objectif de ces méthodes est d'identifier économétriquement les effets causaux des politiques publiques. Nous présentons les concepts et les intuitions à partir d'exemples numériques simples, complétés par des tableaux et des graphiques, sans recourir à des techniques économétriques avancées. Nous illustrons la discussion avec des exemples concrets, incluant par exemple la politique de revenu de solidarité active (RSA), un projet de construction de barrage, un programme de formation professionnelle, et des mesures agro-environnementales. Nous discutons systématiquement les biais principaux et les problèmes potentiels associés à chaque méthode.

Estimation du coût hospitalier : approches par « micro-costing » et « gross-costing »

GUERRE P., HAYES N. ET BERTAUX A. C.

2018

Revue d'Épidémiologie et de Santé Publique 66: S65-S72.

Les évaluations économiques se multiplient dans les établissements de santé ces dernières années, s'appuyant sur la théorie économique. La première étape, quelle que soit la finalité du costing à l'hôpital, est le point de vue ou la perspective adopté(e) : doit-on évaluer les coûts du point de vue de l'établissement de santé ? De l'Assurance maladie ? Se pose ensuite la question de la méthode à retenir : il en existe plusieurs, mais les deux majoritairement utilisées pour estimer les coûts hospitaliers de prise en charge des patients en France sont : la méthode du micro-costing et celle du « gross-costing ». Ce travail a pour objectif de décrire chacune d'entre elles (modalités de recueil et de valorisation monétaire des consommations de ressources), ainsi que leurs avantages et inconvénients liés aux difficultés rencontrées dans leur mise en œuvre à l'hôpital, de présenter une revue de la littérature comparant les deux méthodes et leur possible combinaison, et de proposer des pistes quant aux questions qui doivent être posées en amont du recueil des consommations de ressources et de valorisation des coûts à l'hôpital. Un schéma final, tenant lieu de conclusion, synthétise les méthodologies à privilégier en fonction de la stratégie à évaluer et de ses impacts sur la prise en charge du patient.

Coûts unitaires standards ou coûts unitaires spécifiques : quels critères de choix pour l'évaluation économique de stratégies de santé dans les études multicentriques ?

MARGIER J., BAFFERT S. ET LE CORROLLER-SORIANO A. G.

2018

Revue d'Épidémiologie et de Santé Publique 66: S93-S99.

La question de la valorisation des ressources consommées, c'est-à-dire du choix du coût unitaire, est majeure en termes d'impact sur les résultats des évaluations économiques. Cette question méthodologique ne fait à ce jour pas l'objet de consensus et les choix réalisés par les méthodologistes et leurs impacts sur les résultats des analyses ne sont que très rarement explicités. Ce travail aborde le cadre théorique des évaluations de stratégies en santé qui peuvent être menées, soit dans le cadre normatif de l'approche économique classique du bien-être, dite welfariste, soit dans celui d'une approche dite extra welfariste. Il apporte également des éléments permettant d'éclairer le choix des coûts unitaires hospitaliers dans le calcul des coûts des stratégies de santé afin d'harmoniser les pratiques et d'améliorer la comparabilité des études. Est-il préférable d'opter pour un coût unitaire spécifique par hôpital ou pour un coût unitaire standard appliqué à tous les établissements ? Comment calculer ce coût standard ? Est-il opportun de calculer une moyenne des coûts unitaires, comme le préconisent certains guides ? Les avantages et des limites des différents modes de valorisation des ressources hospitalières dans le cadre d'essais multicentriques y sont discutés.

Psychiatrie

Santé mentale : les enjeux de demain

JEAN A. *et al.*,

2018/01

Gestions hospitalières(572): 36-53.

À l'heure où l'évolution des besoins de santé et des représentations de la psychiatrie modifie les réponses de l'offre de soins, la coordination et la complémentarité des acteurs des champs sanitaire, social et médico-social sont plus que jamais nécessaire. La santé mentale est l'un des éléments fondamentaux de la qualité de vie des patients. En France, près d'une personne sur cinq souffre de maladie psychiatrique. Ainsi, l'estimation des coûts directs et indirects des maladies mentales - s'élevant à plus de 100 milliards d'euros - constitue un défi organisationnel et financier. Ce dossier porte sur les enjeux et perspectives de la santé mentale. Il s'articule autour des aspects : petite histoire de la prise en charge psychiatrique, soins psychiatriques sans consentement, les révolutions de la pédopsychiatrie, réhabilitation psychosociale...

Unplanned Admissions to Inpatient Psychiatric Treatment and Services Received Prior to Admission

OSE S. O., KALSETH J., ADNANES M., TVEIT T. ET LILLEENG S. E.

2018

Health Policy 122(4): 359-366.

Inpatient bed numbers are continually being reduced but are not being replaced with adequate alternatives in primary health care. There is a considerable risk that eventually all inpatient treatment will be unplanned, because planned or elective treatments are superseded by urgent needs when capacity is reduced. The aims of this study were to estimate the rate of unplanned admissions to inpatient psychiatric treatment facilities in Norway and analyse the difference between patients with unplanned and planned admissions regarding services received during the three months prior to admission as well as clinical, demographical and socioeconomic characteristics of patients. Unplanned admissions were defined as all urgent and involuntary admissions including unplanned readmissions. National mapping of inpatients was conducted in all inpatient treatment psychiatric wards in Norway on a specific date in 2012. Binary logit regressions were performed to compare patients who had unplanned admissions with patients who had planned admissions (i.e., the analyses were conditioned on admission to inpatient psychiatric treatment). Patients with high risk of unplanned admission are suffering from severe mental illness, have low functional level indicated by the need for housing services, high risk for suicide attempt and of being violent, low education and born outside Norway. Specialist mental health services should support the local services in their efforts to prevent unplanned admissions by providing counselling, short inpatient stays, outpatient treatment and ambulatory outpatient psychiatry services.

Soins de santé primaires

Travailler à l'articulation soins premiers et second recours : Pourquoi, Comment

BOURGUEIL Y. ET KANHONOU N.

2017

Sève : Les Tribunes De La Sante(57): 23-33.

L'objet de cet article, essentiellement méthodologique, est de présenter le contexte, les objectifs, la méthode adoptée et les résultats de travaux menés dans le cadre d'un groupe de travail initié par le HCAAM pour analyser les fonctionnements des relations médecins de second recours et médecins de premier recours. Ces travaux ont nourri plusieurs notes du Haut Conseil visant à proposer des pistes pour orienter l'action publique.

Sauver le médecin généraliste

CASASSUS P., ABRAMOVICI F., GALAM E. ET *et al.*

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(1): 4-6.

Voici le titre d'un ouvrage qui vient de paraître sous la plume conjointe de Patrice Queneau et Claude de Bourguignon, un universitaire membre de l'Académie de Médecine et un généraliste. Comment en est-on arrivé à devoir choisir un tel titre ? La France si souvent – et justement – donnée en exemple pour son système de santé subit une crise médicale grave. La désertification médicale est criante. Elle est le fruit du départ à la retraite massif des médecins issus du « baby-boom » de l'Après-guerre et de la décision de quelques habiles énarques de ministère qui, dans les années 1970-1980, devant le gouffre croissant du déficit de la Sécurité sociale, ont eu la judicieuse idée de réduire le nombre du principal fautif : le médecin prescripteur... Ainsi, en diminuant (de plus de la moitié) le nombre de médecins, ils espéraient logiquement diminuer le nombre de prescriptions et donc de dépenses de santé. Ils ont seulement oublié de réduire aussi le nombre de malades... Grossière erreur aggravée désormais par deux autres paramètres insuffisamment pris en compte par l'administration qui a relevé depuis une dizaine d'années le fameux numerus clausus à l'entrée en faculté de médecine : l'allongement important de la durée de vie (avec une augmentation franche du nombre de sujets âgés, aux besoins médicaux élevés) et un pourcentage croissant de femmes parmi les étudiants (qui atteint souvent les 75 %). Or – ce n'est ni une critique, ni désobligeant pour elles – les femmes médecins ont souvent une activité volontairement réduite en temps, certaines même commençant par une période de quelques années consacrées à leurs enfants avant de se lancer à plein dans leur carrière : cela exigerait d'en tenir compte dans l'évaluation du nombre de médecins à former...

Preferences of General Practitioners in Metropolitan France with Regard to the Delegation of Medico-Administrative Tasks to Secretaries Assisting Medico-Social Workers: Study in Conjoint Analysis

CHANU A., CARON A., FICHEUR G., BERKHOUT C., DUHAMEL A. ET ROCHOY M.

2018

Rev Epidemiol Santé Publique 66(3): 171-180.

A general practitioner's office is an economic unit where task delegation is an essential component in improving the quality and performance of work. AIM: To classify the preferences of general practitioners regarding the delegation of medical-administrative tasks to assistant medical-social secretaries. Conjoint analysis was applied to a random sample of 175 general practitioners working in metropolitan France. Ten scenarios were constructed based on seven attributes: training for medical secretaries, logistical support during the consultation, delegation of management planning, medical records, accounting, maintenance, and taking initiative on the telephone. A factorial design was used to reduce the number of scenarios. Physicians' socio-demographic variables were collected. One hundred and three physicians responded and the analysis included 90 respondents respecting the transitivity of preferences hypothesis. Perceived difficulty was scored 2.8 out of 5. The high rates of respondents (59%; 95% CI [51.7-66.3]) and transitivity (87.5%; 95% CI [81.1-93.9]) showed physicians' interest in this topic. Delegation of tasks concerning management planning (OR = 2.91; 95% CI [2.40-13.52]) and medical records (OR = 1.88; 95% CI [1.56-2.27]) were the two most important attributes for physicians. The only variable for which the choice of a secretary was not taken into account was logistical support. This is a first study examining the choices of general practitioners concerning the delegation of tasks to assistants. These findings are helpful to better understand the determinants of practitioners' choices in delegating certain tasks or not. They reveal doctors' desire to limit their ancillary tasks in order to favor better use of time for «medical» tasks. They also expose interest for training medical secretaries and widening their field of competence, suggesting the emergence of a new professional occupation that could be called «medical assistant».

▶ Exposition au risque infectieux en médecine générale : Projet ECOGEN

CUSSAC F., DUQUENNE I., GELLY J. ET *et al.*

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(1): 37-39.

Le risque infectieux associé aux soins est bien évalué au sein des établissements de santé, mais aucune étude n'a porté sur le risque infectieux des médecins exerçant en ambulatoire. L'objectif principal de cette étude était de décrire la prévalence de l'exposition au risque infectieux pour les médecins généralistes en ambulatoire.

▶ Au fait docteur... ? : la demande de fin de consultation. Étude qualitative auprès des patients consultant en médecine générale

GUILLEMIN T., BALLY J. N., GOCKO X. ET *et al.*

2018

Médecine : De La Médecine Factuelle a Nos Pratiques 14(1): 32-36.

L'entretien entre le patient et le médecin généraliste peut être perturbé par une demande de fin de consultation. L'objectif de cette étude consistait à analyser à travers leurs récits les mécanismes conduisant les patients à des demandes de fin de consultation.

▶ No-Shows in Appointment Scheduling - A Systematic Literature Review

DANTAS L. F., FLECK J. L., CYRINO OLIVEIRA F. L. ET HAMACHER S.

2018

Health Policy 122(4): 412-421.

No-show appointments significantly impact the functioning of healthcare institutions, and much research has been performed to uncover and analyze the factors that influence no-show behavior. In spite of the growing body of literature on this issue, no synthesis of the state-of-the-art is presently available and no systematic literature review (SLR) exists that encompasses all medical specialties. This paper provides a SLR of no-shows in appointment scheduling in which the characteristics of existing studies are analyzed, results regarding which factors have a higher impact on missed appointment rates are synthetized, and comparisons with previous findings are performed. A total of 727 articles and review papers were retrieved from the Scopus database (which includes MEDLINE), 105 of which were selected for identification and analysis. The results indicate that the average no-show rate is of the order of 23%, being highest in the African continent (43.0%) and lowest in Oceania (13.2%). Our analysis also identified patient characteristics that were more frequently associated with no-show behavior: adults of younger age; lower socioeconomic status; place of residence is distant from the clinic; no private insurance. Furthermore, the most commonly reported significant determinants of no-show were high lead time and prior no-show history.

▶ General Practitioners' Strategies in Consultations with Immigrants in Norway-Practice-Based Shared Reflections Among Participants in Focus Groups

HJORLEIFSSON S., HAMMER E. ET DIAZ E.

2018

Fam Pract 35(2): 216-221.

Immigrants comprise 16.8% of the population in Norway and meet General Practitioners (GPs) as their first point of contact with most health care services as do others in Norway. While Norwegian GPs are not trained in cultural competence, little is known about the extent to which they see good care for immigrants as relying on specific strategies. Objectives: To explore the thoughts of GPs in Norway about strategies they might use with immigrant patients. Methods: We performed focus groups posing the question 'What strategies do you use when meeting immigrant patients?' to three groups of GPs working in Norway. Two groups comprised 10 trainee GPs each; the final group comprised eight certified GPs. Verbatim transcripts were analysed by systematic text condensation. Results: Strategies for consultations with immigrants emerged gradually throughout the focus groups, coalescing around (i) Respect and learn about immigrant culture. (ii) Particularize diagnosis and care, accommodating epidemiological and cultural knowledge for a given group, while keeping a keen eye on the individual. (iii) Inform about Norwegian health care. (iv) Organize resources such as time, translators and interdisciplinary teams. Other core elements of cultural competence, including reflections on the GP's own cultural background, were conspicuously absent, however.

Conclusion: Given the growing numbers of immigrants and the early transfer of refugees to general practice, our study points to the urgent need of supplementing teaching in patient-centred clinical method with cultural competence. Our study also highlights the potential of educational GP groups to develop strategies for cross-cultural consultations.

The Effect of Copayments on the Utilization of the GP Service in Norway

LANDSEM M. M. ET MAGNUSSEN J.

2018

Soc Sci Med 205: 99-106.

We examine the effect of copayment on the utilization of the GP service in Norway. We use a regression discontinuity design to study two key aspects of the policy. First, we examine the overall effect of copayments on total utilization of the GP service. Second, we look at how this effect varies across different patient groups according to medical necessity. Data consists of 5,5 million GP visits for youths aged 10-20 over the 6 year period 2009-2014. We find that the introduction of a co-payment leads to an overall reduction of GP visits of 10-15%. The effect is heterogeneous across patient groups. Patients with an acute condition exhibit low price sensitivity. Patients with general complaints and symptoms, chronic diseases and psychological diseases all react strongly to the copayment. The two latter groups capture patients with conditions that typically warrant medical attention. This paper thus suggests that the current flat fee copayment policy is inefficient at targeting unnecessary use of the GP service at the cost of patients with real medical concerns.

Savoir reconnaître le savoir expérientiel des patients : une humilité et une force pour le médecin généraliste

PERNIN T., SAHIER C., MONOTUKA S. ET *et al.*

2018

Médecine : De La Médecine Factuelle a Nos Pratiques 14(1): 19-22.

Bien que formulée par les textes réglementaires, l'implication de patients dans les activités d'éducation thérapeutique du patient (ETP) reste faible en France. De nombreuses publications internationales soulignent le savoir expérientiel des patients- ressources, la construction de partenariats avec les soignants et l'amélioration de l'état de santé de patients ciblés grâce à leur intervention. Le réseau Paris Diabète (RPD) intègre des patients dans sa gouvernance et cherche à les impliquer dans l'animation de ses programmes d'ETP.

Multidisciplinary Collaboration in Primary Care: A Systematic Review

SAINT-PIERRE C., HERSKOVIC V. ET SEPULVEDA M.

2018

Fam Pract 35(2): 132-141.

Background: Several studies have discussed the benefits of multidisciplinary collaboration in primary care. However, what remains unclear is how collaboration is undertaken in a multidisciplinary manner in concrete terms. Objective: To identify how multidisciplinary teams in primary care collaborate, in regards to the professionals involved in the teams and the collaborative activities that take place, and determine whether these characteristics and practices are present across disciplines and whether collaboration affects clinical outcomes. Methods: A systematic literature review of past research, using the MEDLINE, ScienceDirect and Web of Science databases. Results: Four types of team composition were identified: specialized teams, highly multidisciplinary teams, doctor-nurse-pharmacist triad and physician-nurse centred teams. Four types of collaboration within teams were identified: co-located collaboration, non-hierarchical collaboration, collaboration through shared consultations and collaboration via referral and counter-referral. Two combinations were commonly repeated: non-hierarchical collaboration in highly multidisciplinary teams and co-located collaboration in specialist teams. Fifty-two per cent of articles reported positive results when comparing collaboration against the non-collaborative alternative, whereas 16% showed no difference and 32% did not present a comparison. Conclusion: Overall, collaboration was found to be positive or neutral in every study that compared collaboration with a non-collaborative alternative. A collaboration typology based on objective measures was devised, in contrast to typologies that involve interviews, perception-based questionnaires and other subjective instruments.

▶ Most Primary Care Physicians Provide Appointments, but Affordability Remains a Barrier for the Uninsured

SALONER B., HEMPSTEAD K., RHODES K., POLSKY D., PAN C. ET KENNEY G. M.

2018

Health Aff (Millwood) 37(4): 627-634.

The US uninsurance rate has nearly been cut in half under the Affordable Care Act, and access to care has improved for the newly insured, but less is known about how the remaining uninsured have fared. In 2012-13 and again in 2016 we conducted an experiment in which trained auditors called primary care offices, including federally qualified health centers, in ten states. The auditors portrayed uninsured patients seeking appointments and information on the cost of care and payment arrangements. In both time periods, about 80 percent of uninsured callers received appointments, provided they could pay the full cash amount. However, fewer than one in seven callers in both time periods received appointments for which they could make a payment arrangement to bring less than the full amount to the visit. Visit prices in both time periods averaged about $160. Trends were largely similar across states, despite their varying changes in the uninsurance rate. Federally qualified health centers provided the highest rates of primary care appointment availability and discounts for uninsured low-income patients.

▶ Perception de l'information médicale en salle d'attente du médecin généraliste

SAVALI A., MICHELET T. ET VALLEE J.

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(1): 40-45.

Les patients attendraient beaucoup de leur médecin généraliste (MG) en termes d'information médicale. La salle d'attente (SA) du MG constitue la première étape avant la consultation ; elle est parfois utilisée comme vecteur de cette information. Cette étude propose d'explorer la perception par les patients de l'information médicale délivrée dans la SA du MG. La réception d'une information médicale en SA dépend de différents facteurs. Une relation patient-médecin jugée satisfaisante par le patient favorise la réception d'informations. En fonction du motif de consultation ou si l'attente est jugée trop longue les patients peuvent adopter une attitude d'attente anxieuse ou déplaisante peu propice pour s'informer. La SA est un espace d'interactions sociales qui peuvent entraver la perception de l'information. Selon les patients, il faudrait une plus grande implication du MG, qu'il valide l'information, qu'elle soit en quantité limitée, sur un espace dédié, renouvelée, sur des sujets d'actualité, de prévention ou sur le réseau associatif local. Non imposée, l'information devrait être proposée dans la continuité de la relation patient-médecin.

▶ Les maisons de santé pluriprofessionnelles en France : une dynamique réelle mais un modèle organisationnel à construire

SEBAI J. ET YATIM F.

2017

Revue française d'administration publique 164(4): 887-902.

www.cairn.info/revue-francaise-d-administration-publique-2017-4-page-887.htm

En France, les maisons de santé pluriprofessionnelles (MSP) sont présentées comme une réponse efficace aux nouveaux besoins en matière de santé. Le but de cet article est de proposer des éléments d'analyse pour un premier bilan de l'ensemble des structures de ce type en France, et plus particulièrement sur le plan organisationnel. Nous nous appuyons sur les données de l'enquête nationale réalisée en 2014 par la Direction générale de l'offre de soins. Nous montrons ainsi qu'il existe une réelle dynamique d'implantation des maisons de santé pluriprofessionnelles sans que cette dynamique ne s'accompagne des évolutions organisationnelles attendues.

▶ Primary Care Supply and Quality of Care in England

VALLEJO-TORRES L. ET MORRIS S.

2018

Eur J Health Econ 19(4): 499-519.

We investigated the relationship between primary care supply and quality of care in England. We analysed 35 process measures of quality of care covering 13 medical conditions using English Longitudinal Study of Aging data linked to area of residence indicators. Greater GP density had a statistically significant and

positive association with quality of care, and distance to GP practice had a statistically significant and negative association. The effects were concentrated in indicators of care related to cardiovascular diseases and arthritis, and on specific indicators for diabetes, incontinence and hearing problems. The results suggest that better primary care supply can improve quality of care.

Primary Care: A Definition of the Field to Develop Research

VERGA-GERARD A.

2018

Rev Epidemiol Santé Publique 66(2): 157-162.

Research in the field of primary care has dramatically increased in France in recent years, especially since 2013 with the introduction of primary care as a thematic priority for research proposals launched by the Ministry of Health (Direction Générale de l'Offre de Soins. The RECaP (Research in Clinical Epidemiology and Public Health) network is a French research network supported by Inserm, which recently implemented a specific working group focusing on research in primary care, based on a multidisciplinary approach. Researchers from different specialties participate in this group. The first aim of the group was to reach a common definition of the perimeter and of the panel of healthcare professionals and structures potentially involved in the field of primary care. For this purpose, a selection of different data sets of sources defining primary care was analyzed by the group, each participant collecting a set of sources, from which a synthesis was made and discussed. A definition of primary care at different levels (international, European and French) was summarized. A special attention was given to the French context in order to adapt the perimeter to the characteristics of the French healthcare system, notably by illustrating the different key elements of the definition with the inclusion of primary care actors and the type of practice premises. CONCLUSION: In conclusion, this work illustrates the diversity of primary care in France and the potential offered for research purposes.

Systèmes de santé

Demander un titre de séjour pour raison de santé : que sait-on des systèmes de santé des pays d'origine

CHARPAK Y., CHAIX-COUTURIER C. ET DANZON M.

2017

Sève : Les Tribunes de la Santé (57): 97-106.

L'obtention d'un titre de séjour pour raisons de santé comprend deux critères médicaux d'évaluation des demandeurs dont l'un est une appréciation de la capacité ou non du pays d'origine à pouvoir le cas échéant fournir les soins nécessaires. Selon la loi, les médecins de l'Office français de l'immigration et de l'intégration (OFII), organisés en collège de trois sont chargés de cette évaluation médicale. L'OFII a donc souhaité mettre en place pour ses médecins une Bibliothèque d'Information Santé sur les Pays d'Origine (BISPO). L'article décrit les prérequis d'une telle information, les étapes de l'élaboration d'un outil pertinent et opérationnel pour la mise en œuvre de cette politique publique spécifique et les questions qui restent posées pour le futur.

Travail et santé

Physicians, sick leave certificates, and patients' subsequent employment outcomes

AHAMMER A.

Health Economics 27(6): 923-936.

onlinelibrary.wiley.com/doi/abs/10.1002/hec.3646

This paper analyzes how general practitioners (GPs) indirectly affect their patients' employment outcomes by deciding the length of sick leaves. The author uses an instrumental variables framework where spell durations are identified through supply-side certification measures. He finds that a day of sick leave certified only because the worker's GP has a high propensity to certify sick leaves decreases the employment probability persistently by 0.45–0.69 percentage points, but increases the risk of becoming unemployed by 0.28–0.44 percentage points. These effects are mostly driven by workers with low job tenure. Several robustness checks show that endogenous matching between patients and GPs does not impair identification. These results bear important implications for doctors: Whenever medically justifiable, certifying shorter sick leaves to protect the employment status of the patient may be beneficial.

Psychopathologie du travail : quand c'est le travail qui est malade

KHAYL N.

2017

Cahiers de Santé Publique et de Protection Sociale (Les)(27): 17-24.

Cet article a été rédigé d'après les notes de cours (PSY 206 au CNAM Toulouse) et un exposé présenté à l'occasion d'une formation sur les maladies professionnelles organisée par le FNPCEPPCS à Malakoff. Les problèmes de santé liés au travail s'invitent de plus en plus souvent dans les cabinets des médecins généralistes. Les médecins sont donc de plus en plus interpellés par ce sujet et les rencontres sont plus marquées entre médecins généralistes et médecins du travail. L'étude Heraklès montre l'implication des médecins généralistes de l'Ile-de-France dans la prise en charge de ces problèmes. Avant d'analyser le lien entre la santé et le travail et de donner un aperçu des troubles psychiques liés au travail, cet article précise quel sens donner au terme « travail ».

Teacher Sick Leave: Prevalence, Duration, Reasons and Covariates

VERCAMBRE-JACQUOT M. N., GILBERT F. ET BILLAUDEAU N.

2018

Rev Epidemiol Santé Publique 66(1): 19-31.

Absences from work have considerable social and economic impact. In the education sector, the phenomenon is particularly worrying since teacher sick leave has an impact on the overall performance of the education system. Yet, available data are scarce. In April-June 2013, 2653 teachers responded to a population-based postal survey on their quality of life (enquête Qualité de vie des enseignants, MGEN Foundation/Ministry of education, response rate 53%). Besides questions on work environment and health, teachers were asked to describe their eventual sick leave(s) since the beginning of the school year: duration, type and medical reasons. Self-reported information was reinforced by administrative data from ministerial databases and weighted to be extrapolated to all French teachers. Tobit models adjusted for individual factors of a private nature were used to investigate different occupational risk factors of teacher sick leave, taking into account both the estimated effect on the probability of sick leave and the length of it. Our study provides objective evidence about the issue of sick leave among French teachers, highlighting the usefulness of implementing actions to minimize its weight. To this end, the study findings point-out the importance of considering not only the probability of sick leave, but also its duration.

Vieillissement

How Does Retirement Affect Healthcare Expenditures? Evidence from a Change in the Retirement Age

BÍRÓ A. ET ELEK P.

2018

Health Economics 27(5): 803-818.

Using individual-level administrative panel data from Hungary, we estimate causal effects of retirement on outpatient and inpatient care expenditures and pharmaceutical expenditures. Our identification strategy is based on an increase in the official early retirement age of women, using that the majority of women retire upon reaching that age. According to our descriptive results, people who are working before the early retirement age have substantially lower healthcare expenditures than nonworkers, but the expenditure gap declines after retirement. Our causal estimates from a two-part (hurdle) model show that the shares of women with positive outpatient care, inpatient care, and pharmaceutical expenditures, respectively, decrease by 3.0, 1.4, and 1.3 percentage points in the short run due to retirement. These results are driven by the relatively healthy, by those who spent some time on sick leave and by the less educated. The effect of retirement on the size of positive healthcare expenditures is generally not significant.

Intérêt et limites du concept de déprise. Retour sur un parcours de recherche

CARADEC V.

2018

Gérontologie et société 40155(1): 139-147.

www.cairn.info/revue-gerontologie-et-societe-2018-1-page-139.htm

Cet article revient sur le parcours de recherche de l'auteur, marqué par le concept de déprise qu'il a utilisé et travaillé, avant de prendre quelque peu ses distances avec lui. Il évoque tout d'abord les raisons pour lesquelles la déprise a constitué, au tournant du XXIe siècle, un opérateur analytique précieux pour passer de l'étude sociologique de la vieillesse à celle du vieillissement. Puis, l'auteur décrit trois prolongements qu'il a proposés au concept de déprise : l'identification de plusieurs « déclencheurs » du processus de déprise ; l'élaboration d'une typologie des stratégies de déprise ; la mise en regard du concept de déprise avec celui d'« optimisation sélective avec compensation ». Enfin, dans un troisième temps, il explique pourquoi il y a moins recours aujourd'hui. D'une part, il a cherché une formulation plus satisfaisante et a mis en avant, plutôt que la déprise, l'enjeu pour les vieilles personnes du maintien de « prises » sur le monde. D'autre part, il a proposé une conceptualisation plus large du vieillissement individuel en se fondant sur le concept d'épreuve, la déprise devenant l'un des aspects de l'épreuve du vieillir. Dans sa conclusion, l'article souligne que l'approche de la déprise est solidaire d'une stratégie analytique particulière, aujourd'hui concurrencée par d'autres.

Ageing and Healthcare Expenditures: Exploring the Role of Individual Health Status

CARRERAS M., IBERN P. ET INORIZA J. M.

2018

Health Economics 27(5): 865-876.

In 1999, Zweifel, Felder, and Meiers questioned conventional wisdom on ageing and healthcare expenditure (HCE). According to these authors, the positive association between age and HCE is due to an increasing age-specific mortality and the high cost of dying. After a weighty academic debate, a new consensus was reached on the importance of proximity to death when analysing HCE. Nevertheless, the influence of individual health status remains unknown. The objective of our study is to analyse the influence individual health status has on HCE, when compared to proximity to death and demographic effects and considering a comprehensive view of healthcare services and costs. We examined data concerning different HCE components of N = 61,473 persons aged 30 to 95 years old. Using 2-part models, we analysed the probability of use and positive HCE. Regardless of the specific group of healthcare services, HCE at the end of life depends mainly on the individual health status. Proximity to death approximates individual morbidity when it is excluded from the model. The inclusion of morbidity generally improves the goodness of fit. These results provide implications for the analysis of ageing population and its impact on HCE that should be taken into account.

Demand of Long-Term Care and Benefit Eligibility Across European Countries

CARRINO L., ORSO C. E. ET PASINI G.

2018

Health Econ : Ahead of print.

In this paper, we study how elderly individuals adjust their informal long-term care utilization to changes in the provision of formal care. Despite this is crucial to design effective policies of formal elderly care, empirical evidence is scant due to the lack of credible identification strategies to account for the endogeneity of formal care. We propose a novel instrument, an index that captures individuals' eligibility status for the long-term care programs implemented in the region of residence. Our estimates, which are robust to a number of different specifications, suggest that higher formal care provision would lead to an increase in informal care utilization as well. In the context of current theoretical economic model of care use, this result points to the existence of a substantial unmet demand of care among older people in Europe.

La réforme des retraites de 2010 : quel impact sur l'activité des séniors

DUBOIS Y. ET KOUBI M.

2017

Economie & prévision 211-212(2): 61-90.

www.cairn.info/revue-economie-et-prevision-2017-2-page-61.htm

Cette étude s'intéresse à l'évolution du taux d'activité des seniors les années suivant l'augmentation des âges légaux de la retraite programmée par la réforme de 2010. À âge et autres caractéristiques égales par ailleurs, le taux d'activité des salariés impactés par la réforme serait entre 19 et 22 points plus élevé que celui des salariés non impactés. Ce surcroît d'activité se traduit surtout par un accroissement de l'emploi mais également par un accroissement du chômage. L'inactivité (hors retraite) augmente également. Les principales difficultés posée par l'évaluation de l'effet de l'augmentation des âges légaux sont les interactions de la réforme évaluée (celle des âges) avec deux autres réformes : l'augmentation de la durée de cotisation nécessaire pour obtenir le taux plein (réforme 2003 et extension 2014) et le dispositif des carrières longues.

La déprise comme interrogations : autonomie, identité, humanité

GAGNON É.

2018

Gérontologie et société 40155(1): 33-44.

www.cairn.info/revue-gerontologie-et-societe-2018-1-page-33.htm

La déprise est une notion éclairante : elle dévoile et aide à comprendre différentes dimensions de l'expérience du vieillissement. Elle permet une description fine des conduites et de l'organisation de la vie quotidienne des personnes âgées. Mais surtout elle permet de soulever des interrogations touchant l'autonomie et la dépendance, l'identité et le maintien de soi dans le temps, la socialité et ce qui fait notre humanité. Le présent article s'efforce de clarifier la signification de la déprise et les interrogations auxquelles elle conduit, sa richesse et sa pertinence.

Vieillir chez soi dans la diversité des formes urbaines et rurales du Québec, Canada. Une exploration des enjeux d'aménagement des territoires vus par leurs habitants

LORD S., NEGRON-POBLETE P. ET DESPRÉS M.

2017

Retraite et société 76(1): 43-66.

www.cairn.info/revue-retraite-et-societe-2017-1-page-43.htm

Dans le cadre de la démarche « Municipalités-amies des aînés » (Mada), les municipalités québécoises sont appelées à développer une réflexion, avec un protocole d'évaluation commun, visant la mise en place d'aménagements et services qui permettraient un vieillissement plus inclusif et actif. Dans ce contexte, si la mobilité est fortement tributaire des caractéristiques individuelles, les attributs du territoire ont aussi une incidence sur le potentiel de mobilité de ses habitants et sur leurs possibilités de participation sociale. Ainsi, la relative mixité fonctionnelle, la densité résidentielle et l'accessibilité territoriale des quartiers centraux des grandes villes sont souvent présentées comme plus favorables au vieillissement que les milieux suburbains. Mais qu'en est-il des villes moyennes, des territoires périurbains, ou des zones rurales ? Est-ce que l'on serait en présence d'enjeux d'aménagement significativement différents, voire contrastés, qui nécessiteraient une démarche Mada particulière ? Dans cet article, nous nous penchons

sur le rôle que jouent l'aménagement et l'urbanisme dans la construction et la consolidation de territoires favorables au vieillissement selon différents milieux de vie. D'abord, nous proposons une typologie de formes résidentielles déclinée dans six régions québécoises faisant ressortir des enjeux communs, mais souvent contrastés. Ensuite, nous débattons de ces enjeux à la lumière de huit groupes de discussion menés avec des aînés de ces territoires. Si la complexité des enjeux apparaît déterminante, leur dénominateur commun qu'est le couple proximité/accessibilité ressort comme un objet de réflexion et d'intervention multidisciplinaire privilégié et fondamental.

▶ Vivre le vieillir : autour du concept de déprise

MEIDANI A. ET CAVALLI S.

2018

Gérontologie et société 40155(1): 9-23.

www.cairn.info/revue-gerontologie-et-societe-2018-1-page-9.htm

Né à Toulouse, il y a déjà 30 ans, le concept de déprise se veut un outil analytique visant à rendre compte de l'expérience du vieillir. Plus précisément, la déprise désigne un travail d'aménagement du parcours de vie, et parfois même de la personne, qui s'appuie sur une série de tentatives de substitution d'activités ou de relations. Ces dernières surgissent après diverses expériences de ruptures (retraite, veuvage, maladie, etc.) qui accentuent le sentiment de la fragilité et de la perte de prise sur le monde. Ce travail de négociation de soi avec soi, les autres et l'environnement opère par sélection, économie des forces et réorientation. De telles stratégies de reconversion constituent aussi un moyen de préserver son intégrité face à l'irréversibilité du temps. Porté par différentes disciplines, le présent numéro explore les conditions de genèse du concept, discute sa pertinence, son évolution et son ancrage empirique et examine ses limites. En accord avec cet objectif et en en faisant le point de départ de leur réflexion, les auteurs adoptent une posture originale : ils rendent compte du caractère opérationnel de la déprise et donnent à voir l'intérêt du concept pour les professionnels de la gérontologie, tout en montrant que son potentiel analytique n'est pensable qu'à l'aune de ce qui lui fait obstacle et qu'il cherche à dépasser.

▶ Aptitudes fonctionnelles, environnement et données probantes pour vieillir en bonne santé

OFFICER A.

2017

Retraite et société 76(1): 117-124.

www.cairn.info/revue-retraite-et-societe-2017-1-page-117.htm

Entre 2000 et 2050, le nombre de personnes âgées de 60 ans et plus passera de 600 millions à près de 2 milliards (ONU, 2011 et 2013). Dans le même temps, 2,5 milliards de personnes supplémentaires sont attendues dans les milieux urbains. Ces évolutions obligent à repenser les modes d'urbanisation, l'adaptation du périurbain et du milieu rural. Ils questionnent l'avenir des solidarités formelles et informelles et le rôle structurant des politiques publiques. La conjonction des transitions démographiques et des mutations territoriales s'opérant au niveau mondial impose donc de revisiter les cadres d'analyse ordinaires pour anticiper et accompagner les effets du vieillissement sur les territoires. S'appuyant sur des travaux et expérimentations menés en France et à l'étranger, le premier numéro de ce dossier, composé de deux volets, propose une série de pistes en matière d'aménagement des territoires et de construction d'espaces démocratiques, pour tenter de relever ces nombreux défis auxquels la société doit faire face.

▶ A Multilevel Analysis of the Determinants of Emergency Care Visits by the Elderly in France

OR, Z. ET PENNEAU, A.

2018 (Ahead of print)

Health Policy

Rising numbers of visits to emergency departments (EDs), especially amongst the elderly, is a source of pressure on hospitals and on the healthcare system. This study aims to establish the determinants of ED visits in France at a territorial level with a focus on the impact of ambulatory care organisation on ED visits by older adults aged 65 years and over. We use multilevel regressions to analyse how the organisation of healthcare provision at municipal and wider 'department' levels impacts ED utilisation by the elderly while controlling for the local demographic, socioeconomic and health context of the area in which patients live. ED visits vary significantly by health context and economic level of municipalities. Controlling for demand-

side factors, ED rates by the elderly are lower in areas where accessibility to primary care is high, measured as availability of primary care professionals, out-of-hours care and home visits in an area. Proximity (distance) and size of ED are drivers of ED use. High rates of ED visits are partly linked to inadequate accessibility of health services provided in ambulatory settings. Redesigning ambulatory care at local level, in particular by Improving accessibility and continuity of primary and social care services for older adults could reduce ED visits and, therefore, improve the efficient use of available healthcare resources.

Defining and Estimating Healthy Aging in Spain: A Cross-Sectional Study

RODRIGUEZ-LASO A., MCLAUGHLIN S. J., URDANETA E. ET YANGUAS J.

2018

Gerontologist 58(2): 388-398.

Using an operational continuum of healthy aging developed by U.S. researchers, we sought to estimate the prevalence of healthy aging among older Spaniards, inform the development of a definition of healthy aging in Spain, and foster cross-national research on healthy aging. Design and Methods: The ELES pilot study is a nationwide, cross-sectional survey of community-dwelling Spaniards 50 years and older. The prevalence of healthy aging was calculated for the 65 and over population using varying definitions. To evaluate their validity, we examined the association of healthy aging with the 8 foot up & go test, quality of life scores and self-perceived health using multiple linear and logistic regression. The estimated prevalence of healthy aging varied across the operational continuum, from 4.5% to 49.2%. Prevalence figures were greater for men and those aged 65 to 79 years and were higher than in the United States. Predicted mean physical performance scores were similar for 3 of the 4 definitions, suggesting that stringent definitions of healthy aging offer little advantage over a more moderate one. Implications: Similar to U.S. researchers, we recommend a definition of healthy aging that incorporates measures of functional health and limiting disease as opposed to definitions requiring the absence of all disease in studies designed to assess the effect of policy initiatives on healthy aging.

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July-August 2018

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Health Insurance

▶ The Impact of Expanding Medicaid on Health Insurance Coverage and Labor Market Outcomes

FRISVOLD D. E. ET JUNG Y.

2018

Int J Health Econ Manag 18(2): 99-121.

Expansions of public health insurance have the potential to reduce the uninsured rate, but also to reduce coverage through employer-sponsored insurance (ESI), reduce labor supply, and increase job mobility. In January 2014, twenty-five states expanded Medicaid as part of the Affordable Care Act to low-income parents and childless adults. Using data from the 2011-2015 March Current Population Survey Supplements, we compare the changes in insurance coverage and labor market outcomes over time of adults in states that expanded Medicaid and in states that did not. Our estimates suggest that the recent expansion significantly increased Medicaid coverage with little decrease in ESI. Overall, the expansion did not impact labor market outcomes, including labor force participation, employment, and hours worked.

▶ L'universalité en droit de la protection sociale

ISIDRO L.

2018

Droit Social(4): 378-388.

L'universalité est-il le maître mot de la protection sociale ? De la sécurité sociale créée en 1945 à l'idée de revenu universel, en passant par l'adoption du compte personnel d'activité, et des réformes à venir en termes de chômage et de retraite, l'universalité est constamment invoquée. Elle n'en est pas moins porteuse à chaque époque de représentations différentes qui éclairent les chemins empruntés par le système de protection sociale français.

▶ What Characterises the Privately Insured in Universal Health Care Systems? A Review of the Empirical Evidence

KIIL A.

2012

Health Policy 106(1): 60-75.

This paper reviews the empirical literature on what characterises individuals with voluntary private health insurance (VPHI) in universal health care systems and assesses how well the empirical evidence corresponds with the theoretical predictions. Empirical studies were identified by performing searches in electronic databases. The literature search identified a total of 24 articles and 15 working papers, the majority of which were published within the recent decade. Socioeconomic characteristics are generally found to be important determinants of VPHI coverage. In accordance with economic theory, the probability of taking out VPHI on an individual basis is consistently found to increase with income. Likewise, the empirical evidence generally supports the theoretical prediction of individuals selecting themselves into duplicate VPHI based on the quality of care available within the universal health care system, just as the demand for VPHI is consistently found to be negatively affected by the insurance premium. On the contrary, the empirical evidence on the importance of risk preferences is sparse and points in different directions. Finally, with a few exceptions, the privately insured are found to be in equal or better health compared to the remaining population. In most settings, the positive association between health and VPHI coverage may be attributed to risk rating of insurance premiums and eligibility requirements, while it may be interpreted as evidence of advantageous selection in their absence.

▶ What Should Health Insurance Cover? A Comparison of Israeli and US Approaches to Benefit Design Under National Health Reform

NISSANHOLTZ GANNOT R., CHINITZ D. P. ET ROSENBAUM S.

2018

Health Econ Policy Law 13(2): 189-208.

What health insurance should cover and pay for represents one of the most complex questions in national health policy. Israel shares with the US reliance on a regulated insurance market and we compare the approaches of the two countries regarding determining health benefits. Based on review and analysis of literature, laws and policy in the United States and Israel. The Israeli experience consists of selection of a starting point for defining coverage; calculating the expected cost of covered benefits; and creating a mechanism for updating covered benefits within a defined budget. In implementing the Affordable Care Act, the US rejected a comprehensive and detailed approach to essential health benefits. Instead, federal regulators established broadly worded minimum standards that can be supplemented through more stringent state laws and insurer discretion. Notwithstanding differences between the two systems, the elements of the Israeli approach to coverage, which has stood the test of time, may provide a basis for the United States as it renews its health reform debate and considers delegating decisions about coverage to the states. Israel can learn to emulate the more forceful regulation of supplemental and private insurance that characterizes health policy in the United States.

E-health – Medical technologies

▶ L'e-santé : l'empowerment du patient connecté

CASES A.-S.

2017

Journal de gestion et d'économie médicales 35(4): 137-158.

www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-4-page-137.htm

L'objectif de cette recherche est de mieux comprendre les apports du numérique dans la sphère médicale avec une approche centrée autour du patient. Aujourd'hui, Internet a transformé la façon dont le patient a accès à l'information santé, ce patient dit « connecté » est de plus en plus informé et devient un acteur de sa santé. Conjointement, certains dispositifs numériques de santé contribuent également à impliquer les patients dans le processus de soin. Aussi, le concept d'empowerment du patient prend tout son sens avec l'arrivée des technologies numériques. Une revue de la littérature relative au concept d'empowerment du client puis du patient a été menée et complétée par deux études qualitatives complémentaires. Il s'agit d'identifier les sources de pouvoir associées au numérique et à l'empowerment du patient ainsi que les bénéfices et les risques de ce gain de pouvoir ressenti par ces derniers.

▶ E-Health in Switzerland: The Laborious Adoption of the Federal Law on Electronic Health Records (EHR) and Health Information Exchange (HIE) Networks

DE PIETRO C. ET FRANCETIC I.

2018

Health Policy 122(2): 69-74.

Within the framework of a broader e-health strategy launched a decade ago, in 2015 Switzerland passed a new federal law on patients' electronic health records (EHR). The reform requires hospitals to adopt interoperable EHRs to facilitate data sharing and cooperation among healthcare providers, ultimately contributing to improvements in quality of care and efficiency in the health system. Adoption is voluntary for ambulatories and private practices, that may however be pushed towards EHRs by patients. The latter have complete discretion in the choice of the health information to share. Moreover, careful attention is given to data security issues. Despite good intentions, the high institutional and organisational fragmentation of the Swiss healthcare system, as well as the lack of full agreement with stakeholders on some critical points of the reform, slowed the process of adoption of the law. In particular, pilot projects made clear that the participation of ambulatories is doomed to be low unless appropriate incentives are put in place. Moreover, most stakeholders point at the strategy proposed to finance technical implementation and management of EHRs as a major drawback. After two years of intense preparatory work, the law entered into force in April 2017.

Health Economics

How Much Do Cancer Specialists Earn? A Comparison of Physician Fees and Remuneration in Oncology and Radiology in High-Income Countries

BOYLE S., PETCH J., BATT K., DURAND-ZALESKI I. ET THOMSON S.

2018

Health Policy 122(2): 94-101.

The main driver of higher spending on health care in the US is believed to be substantially higher fees paid to US physicians in comparison with other countries. We aim to compare physician incomes in radiology and oncology considering differences in relation to fees paid, physician capacity and volume of services provided in five countries: the United States, Canada, Australia, France and the United Kingdom. The fee for a consultation with a specialist in oncology varies threefold across countries, and more than fourfold for chemotherapy. There is also a three to fourfold variation in fees for ultrasound and CT scans. Physician earnings in the US are greater than in other countries in both oncology and radiology, more than three times higher than in the UK; Canadian oncologists and radiologists earn considerably more than their European counterparts. Although challenging, benchmarking earnings and fees for similar health care activities across countries, and understanding the factors that explain any differences, can provide valuable insights for policy makers trying to enhance efficiency and quality in service delivery, especially in the face of rising care costs.

Paiement à l'acte/capitation : une réforme ébauchée mais avortée

BRAS P. L.

2017

Sève : Les Tribunes de la Santé(57): 71-89.

Depuis le 19e siècle, les médecins français libéraux sont rémunérés à l'acte. Le paiement à l'acte est un des principes fondamentaux inscrit dans la charte de 1927. Cet article, qui ne traite que des généralistes, interroge ce mode de rémunération et en compare les mérites avec la capitation. Il présente les caractéristiques de ces deux modes de paiement, décrit les modes de rémunération des généralistes français, rappelle les incitations que ces deux modes de paiement adressent aux médecins. Il souligne également que l'argument traditionnellement mobilisé pour la capitation - la maîtrise des dépenses - est aujourd'hui caduc mais que ce mode de rémunération mérite considération du fait de ses effets structurels sur l'organisation des soins. Il reste, qu'avant 2000, du fait de l'attachement des médecins au paiement à l'acte, aucune évolution des modalités de leur rémunération n'était possible; les initiatives prises au cours des années 2000-2010 pouvaient laisser envisager une transition progressive vers la capitation mais celle-ci semble stoppée après la convention de 2016.

Beyond Activity Based Funding. An experiment in Denmark

BURAU V., DAHL H. M., JENSEN L. G. ET LOU S.

2018 (Ahead of print)

Health Policy

The study identifies discursive mechanisms for successfully challenging Activity Based Funding. They include problem definitions, underlying assumptions, policy processes and solutions. New models require careful engineering in terms of process and substance.

Inpatient Care Expenditure of the Elderly with Chronic Diseases Who Use Public Health Insurance: Disparity in Their Last Year of Life

CHANDOEVWIT W. ET PHATCHANA P.

2018

Soc Sci Med 207: 64-70.

The Thai elderly are eligible for the Civil Servant Medical Benefit Scheme (CS) or Universal Coverage Scheme (UCS) depending on their pre-retirement or their children work status. This study aimed to investigate the disparity in inpatient care expenditures in the last year of life among Thai elderly individuals who used the two public health insurance schemes. Using death registration and inpatient administrative data from 2007 to 2011, our subpopulation group included the elderly with four chronic disease groups: diabetes mellitus, hypertension and cardiovascular disease,

heart disease, and cancer. Among 1,242,150 elderly decedents, about 40% of them had at least one of the four chronic disease conditions and were hospitalized in their last year of life. The results showed that the means of inpatient care expenditures in the last year of life paid by CS and UCS per decedent were 99,672 Thai Baht and 52,472 Thai Baht, respectively. On average, UCS used higher healthcare resources by diagnosis-related group relative weight measure per decedent compared with CS. In all cases, the rates of payment for inpatient treatment per diagnosis-related group adjusted relative weight were higher for CS than UCS. This study found that the disparities in inpatient care expenditures in the last year of life stemmed mainly from the difference in payment rates. To mitigate this disparity, unified payment rates for various types of treatment that reflect costs of hospital care across insurance schemes were recommended.

Reste à charge et santé : dossier

COM-RUELLE L., CZERNICHOW P. *et al.*

2018/03

Actualité dossier en santé publique(102): 11-54.

En France, les restes à charge des assurés, après remboursements de l'assurance maladie obligatoire, représentent près d'un quart des dépenses de santé. Ces restes à charge sont payés par une assurance maladie complémentaire ou par les ménages. Après remboursement des assurances complémentaires, la part directement à la charge des patients est de 7 %. Ces RAC varient selon le type de soins, peuvent s'avérer très élevés pour certaines personnes et être un véritable frein à l'accès aux soins. Ce dossier fait le point sur cette problématique.

The Complexity of Billing and Paying for Physician Care

GOTTLIEB J. D., SHAPIRO A. H. ET DUNN A.

2018

Health Aff (Millwood) 37(4): 619-626.

The administrative costs of providing health insurance in the US are very high, but their determinants are poorly understood. We advance the nascent literature in this field by developing new measures of billing complexity for physician care across insurers and over time, and by estimating them using a large sample of detailed insurance «remittance data» for the period 2013-15. We found dramatic variation across different types of insurance. Fee-for-service Medicaid is the most challenging type of insurer to bill, with a claim denial rate that is 17.8 percentage points higher than that for fee-for-service Medicare. The denial rate for Medicaid managed care was 6 percentage points higher than that for fee-for-service Medicare, while the rate for private insurance appeared similar to that of Medicare Advantage. Based on conservative assumptions, we estimated that the health care sector deals with $11 billion in challenged revenue annually, but this number could be as high as $54 billion. These costs have significant implications for analyses of health insurance reforms.

The Impact of Pay-For-Performance on the Quality of Care in Ophthalmology: Empirical Evidence from Germany

HERBST T., FOERSTER J. ET EMMERT M.

2018 (Ahead of print)

Health Policy

Pay-for-performance (P4P) has become a popular approach to increase effectiveness and efficiency in healthcare. So far, there is little evidence regarding the potential of P4P in the German healthcare setting. The aim of this study was to determine the impact of P4P on the quality of care in cataract surgery. METHODS: In 2012, a P4P program was implemented in a German surgical centre for ophthalmology. Five quality measures regarding process quality, outcomes, and patient satisfaction were measured over a period of 4.5 years. The P4P scheme consisted of bonus and penalty payments accounting for five per cent of total compensation. Overall, 1657 P4P cases were examined and compared with 4307 control cases. Interrupted time series and group comparisons were conducted to identify quality and spill-over effects. RESULTS: We found a positive impact on process quality and patient satisfaction before the implementation of the P4P scheme, but declining trends during and after the implementation. Our findings did not show an impact of P4P on outcome measures. Furthermore, P4P did not result in better quality of care, compared with the German hospital-based reimbursement scheme. CONCLUSION: This study did not show any positive long-term effects of the implementation of P4P on quality of care. Therefore, our results do not support the hypothesis that P4P leads to significant improvements in quality of care.

Effect of Incentive Payments on Chronic Disease Management and Health Services Use in British Columbia, Canada: Interrupted Time Series Analysis

LAVERGNE M. R., LAW M. R., PETERSON S., GARRISON S., HURLEY J., CHENG L. ET MCGRAIL K.

2018

Health Policy 122(2): 157-164.

We studied the effects of incentive payments to primary care physicians for the care of patients with diabetes, hypertension, and Chronic Obstructive Pulmonary Disease (COPD) in British Columbia, Canada. We used linked administrative health data to examine monthly primary care visits, continuity of care, laboratory testing, pharmaceutical dispensing, hospitalizations, and total h health care spending. We examined periods two years before and two years after each incentive was introduced, and used segmented regression to assess whether there were changes in level or trend of outcome measures across all eligible patients following incentive introduction, relative to pre-intervention periods. We observed no increases in primary care visits or continuity of care after incentives were introduced. Rates of ACR testing and antihypertensive dispensing increased among patients with hypertension, but none of the other modest increases in laboratory testing or prescriptions dispensed reached statistical significance. Rates of hospitalizations for stroke and heart failure among patients with hypertension fell relative to pre-intervention patterns, while hospitalizations for COPD increased. Total hospitalizations and hospitalizations via the emergency department did not change. Health care spending increased for patients with hypertension. This large-scale incentive scheme for primary care physicians showed some positive effects for patients with hypertension, but we observe no similar changes in patient management, reductions in hospitalizations, or changes in spending for patients with diabetes and COPD.

Health Care Spending in the United States and Other High-Income Countries

PAPANICOLAS I., WOSKIE L. R. ET JHA A. K.

2018

JAMA 319(10): 1024-1039.

Health care spending in the United States is a major concern and is higher than in other high-income countries, but there is little evidence that efforts to reform US health care delivery have had a meaningful influence on controlling health care spending and costs. This aim of this study is to compare potential drivers of spending, such as structural capacity and utilization, in the United States with those of 10 of the highest-income countries (United Kingdom, Canada, Germany, Australia, Japan, Sweden, France, the Netherlands, Switzerland, and Denmark) to gain insight into what the United States can learn from these nations. Analysis of data was primarily provided from 2013-2016 from key international organizations including the Organisation for Economic Co-operation and Development (OECD), comparing underlying differences in structural features, types of health care and social spending, and performance between the United States and 10 high-income countries. When data were not available for a given country or more accurate country-level estimates were available from sources other than the OECD, country-specific data sources were used.

Out-Of-Pocket Costs, Primary Care Frequent Attendance and Sample Selection: Estimates from a Longitudinal Cohort Design

PYMONT C., MCNAMEE P. ET BUTTERWORTH P.

2018 (Ahead of print)

Health Policy

This paper examines the effect of out-of-pocket costs on subsequent frequent attendance in primary care using data from the Personality and Total Health (PATH) Through Life Project, a representative community cohort study from Canberra, Australia. The analysis sample comprised 1197 respondents with two or more GP consultations, and uses survey data linked to administrative health service use (Medicare) data which provides data on the number of consultations and out-of-pocket costs. Respondents identified in the highest decile of GP use in a year were defined as Frequent Attenders (FAs). Logistic regression models that did not account for potential selection effects showed that out-of-pocket costs incurred during respondents' prior two consultations were significantly associated with subsequent FA status. Respondents who incurred higher costs ($15-$35; or >$35) were less likely to become FAs than those who incurred no or low (<AUS$15 per consultation) costs, with no difference evident between the no and low-cost groups.

However, a counterfactual model that adjusted for factors associated with the selection into payment levels did not find an influence of payment, with only a non-significant gradient in the expected direction. Hence these findings raise doubts that price drives FA behaviour, suggesting that co-payments are unlikely to affect the number of GP consultations amongst frequent attenders.

Paying Hospital Specialists: Experiences and Lessons from Eight High-Income Countries

QUENTIN W., GEISSLER A., WITTENBECHER F., BALLINGER G., BERENSON R., *et al.*

2018 (Ahead of print)

Health Policy

Payment systems for specialists in hospitals can have far reaching consequences for the efficiency and quality of care. This article presents a comparative analysis of payment systems for specialists in hospitals of eight high-income countries (Canada, England, France, Germany, Sweden, Switzerland, the Netherlands, and the USA/Medicare system). A theoretical framework highlighting the incentives of different payment systems is used to identify potentially interesting reform approaches. In five countries, most specialists work as employees - but in Canada, the Netherlands and the USA, a majority of specialists are self-employed. The main findings of our review include: (1) many countries are increasingly shifting towards blended payment systems; (2) bundled payments introduced in the Netherlands and Switzerland as well as systematic bonus schemes for salaried employees (most countries) contribute to broadening the scope of payment; (3) payment adequacy is being improved through regular revisions of fee levels on the basis of more objective data sources (e.g. in the USA) and through individual payment negotiations (e.g. in Sweden and the USA); and (4) specialist payment has so far been adjusted for quality of care only in hospital specific bonus programs. Policy-makers across countries struggle with similar challenges, when aiming to reform payment systems for specialists in hospitals. Examples from our reviewed countries may provide lessons and inspiration for the improvement of payment systems internationally.

Le remboursement des frais dentaires

YENI I., ESLOUS L., SIMON-DELAVELLE F. *et al.*

2017

Sève : Les Tribunes de la Santé (57): 63-70

Bien que les soins dentaires soient des soins médicaux, leur prise en charge par la sécurité sociale reste à l'écart des principes de cette dernière. Les patients financent 63 % de la dépense totale de soins dentaires à travers de ce qui reste à leur charge ou leur cotisation à une complémentaire. Ils en sont les premiers financeurs. Du fait du renoncement aux soins, dû notamment aux dépassements d'honoraires perçus par les chirurgiens-dentistes, cette charge réagit sur l'état de santé bucco-dentaire. Ces conditions de prise en charge sont antiredistributives et favorisent les inégalités territoriales et sociales. Elles sont en outre inefficaces au regard de la santé publique puisque l'état de santé bucco-dentaire en France est considéré comme médiocre. Ainsi, serait-il souhaitable que les soins bucco-dentaires bénéficient, comme les soins médicaux, à nouveau du régime de droit commun de la sécurité sociale contre le risque maladie pour qu'un meilleur état de santé bucco-dentaire de la population puisse concourir à l'amélioration de l'état de santé général.

Health Status

Prevalence of Adult Overweight and Obesity in 20 European Countries, 2014

MARQUES A., PERALTA M., NAIA A., LOUREIRO N. ET DE MATOS M. G.

2018

European Journal of Public Health 28(2): 295-300.

Monitoring obesity and overweight prevalence is important for assessing interventions aimed at preventing or reducing the burden of obesity. This study aimed to provide current data regarding the prevalence of overweight and obesity of adults, from 20 European countries. Participants were 34 814 (16 482 men) adults with mean age 50.8 ± 17.7. Data from European Social Survey round 7, 2014, were analysed. Body mass index (BMI) was calculated from self-reported height and weight. The proportion of underweight was only 2%, and 44.9% for normal weight. Overweight and obese accounted for 53.1%. More men than women were overweight (44.7% vs. 30.5%). Older adults were significantly more overweight (42.4%) and obese (20.9%) than middle age and younger adults. Retired people account for a greater proportion of overweight (42.0%) and obese (21.5%), when compared with employed, unemployed and students. People from rural areas were significantly more overweight (39.1 vs. 36.1%) and obese (17.0 vs. 15.3%) than those who lived in urban areas. The estimates indicate that the highest prevalence of overweight was in Czech Republic (45.2%), Hungary (43.7%) and Lithuania (41.7%). For obesity, Slovenia (20.8%), Estonia (19.7%) and the United Kingdom (19.2%) were the countries with the highest prevalence. Even though data was self-reported, and individuals tend to overestimate their height and underestimate their weight, the prevalence of overweight and obesity is considered high. More than half of the European population is overweight and obese. This study strengthens and updates the claims of an excessive weight epidemic in Europe.

Retrospective Cohort Study of Breast Cancer Incidence, Health Service Use and Outcomes in Europe: A Study of Feasibility

WILLIAMS L. J., FLETCHER E., DOUGLAS A., ANDERSON E. D. C., *et al.*

2018

European Journal of Public Health 28(2): 327-332.

Comparisons of outcomes of health care in different systems can be used to inform health policy. The EuroHOPE (European Healthcare Outcomes, Performance and Efficiency) project investigated the feasibility of comparing routine data on selected conditions including breast cancer across participating European countries. Routine data on incidence, treatment and mortality by age and clinical characteristics for breast cancer in women over 24 years of age were obtained (for a calendar year) from linked hospital discharge records, cancer and death registers from Finland, the Turin metropolitan area, Scotland and Sweden (all 2005), Hungary (2006) and Norway. (2009). Age-adjusted breast cancer incidence and 1-year survival were estimated for each country/region. In total, 24 576 invasive breast cancer cases were identified from cancer registries from over 13 million women. Age-adjusted incidence ranged from 151.1 (95%CI 147.2–155.0) in Hungary to 234.7 (95%CI 227.4–242.0)/100 000 in Scotland. One-year survival ranged from 94.1% (95%CI 93.5–94.7%) in Scotland to 97.1% (95%CI 96.2–98.1%) in Italy. Scotland had the highest proportions of poor prognostic factors in terms of tumour size, nodal status and metastases. Significant variations in data completeness for prognostic factors prevented adjustment for case mix. Incidence of and survival from breast cancer showed large differences between countries. Substantial improvements in the use of internationally recognised common terminology, standardised data coding and data completeness for prognostic indicators are required before international comparisons of routine data can be used to inform health policy.

Geography of Health

Vieillissement et territoires : cadres théoriques et enjeux empiriques

BLANCHET M., PIHET C. ET CHAPON P.-M.

2017

Retraite et société 76(1): 19-41.

www.cairn.info/revue-retraite-et-societe-2017-1-page-19.htm

Du latin territorium, le territoire désigne selon Guy Di Méo (1998) « une appropriation à la fois économique, idéologique et politique (sociale, donc) de l'espace par des groupes qui se donnent une représentation particulière d'eux-mêmes, de leur histoire » (Di Méo, 1998, p. 42). Édifice matériel et idéel, le territoire ne fonctionne pas comme un support neutre et univoque et varie selon différents processus d'appropriation. Dans un contexte de vieillissement de la population, géographiquement différencié, et de politiques gérontologiques sectorisées et individualisées, le territoire s'est progressivement imposé comme un moyen de compréhension des problématiques gérontologiques et un levier d'action sur le plan politique. Aujourd'hui, l'intérêt pour la notion de « territoire » est visible au sein de la gérontologie, à travers des programmes mondiaux comme celui de l'Organisation mondiale de la santé (OMS) en faveur des « villes et communautés-amies des aînés » (Vada) ou dans la loi relative à l'adaptation de la société au vieillissement (décembre 2015). Fort de cette orientation, l'objectif de l'article consiste à présenter la force du concept de « territoire » dans l'appréhension des dynamiques gérontologiques, notamment en montrant en quoi une approche systémique de cette notion s'avère propice à la compréhension des processus de production, d'organisation, d'inclusion et d'exclusion dans le domaine gérontologique.

Le vieillissement dans les territoires : un phénomène multiforme

DE LAPASSE B. ET PILON C.

2017

Retraite et société 76(1): 125-133.

www.cairn.info/revue-retraite-et-societe-2017-1-page-125.htm

Entre 2000 et 2050, le nombre de personnes âgées de 60 ans et plus passera de 600 millions à près de 2 milliards (ONU, 2011 et 2013). Dans le même temps, 2,5 milliards de personnes supplémentaires sont attendues dans les milieux urbains. Ces évolutions obligent à repenser les modes d'urbanisation, l'adaptation du périurbain et du milieu rural. Ils questionnent l'avenir des solidarités formelles et informelles et le rôle structurant des politiques publiques. La conjonction des transitions démographiques et des mutations territoriales s'opérant au niveau mondial impose donc de revisiter les cadres d'analyse ordinaires pour anticiper et accompagner les effets du vieillissement sur les territoires. S'appuyant sur des travaux et expérimentations menés en France et à l'étranger, le premier numéro de ce dossier, composé de deux volets, propose une série de pistes en matière d'aménagement des territoires et de construction d'espaces démocratiques, pour tenter de relever ces nombreux défis auxquels la société doit faire face.

La démarche des « chartes territoriales de solidarité » pour un développement sanitaire et social des territoires ruraux

LAGNEAU A.

2017

Retraite et société 76(1): 135-144.

www.cairn.info/revue-retraite-et-societe-2017-1-page-135.htm

S'appuyant sur des travaux et expérimentations menés en France et à l'étranger, le premier numéro de ce dossier, composé de deux volets, propose une série de pistes en matière d'aménagement des territoires et de construction d'espaces démocratiques, pour tenter de relever ces nombreux défis auxquels la société doit faire face. Cet article traite des chartes territoriales de solidarité proposées en 2011 par la Mutualité sociale agricole et reconduites sur la période 2016-2020.

Niveaux de vie et ségrégation dans douze métropoles françaises

FLOCH J. M.

2018

Economie Et Statistique (497-498): 73-97.

www.insee.fr/fr/statistiques/3317906?sommaire = 3317927

Les politiques publiques urbaines sont amenées à concilier des mesures ciblées, et des mesures plus globales favorisant la mixité, et à arbitrer entre agglomérations, et entre quartiers au sein des agglomérations. Les données localisées sur les revenus fiscaux et sociaux (Filosofi, Insee) sont utilisées pour calculer des indicateurs de ségrégation permettant de comparer les aires urbaines, leurs villes-centres, banlieues et couronnes périurbaines. La construction d'une typologie assez simple rend possible la cartographie des quartiers, riches ou pauvres, contribuant le plus aux disparités sociales. L'article présente ces analyses pour douze métropoles. La ségrégation est plus élevée dans les villes-centres et les banlieues qu'en périphérie. Elle est plus marquée pour les hauts niveaux de vie. Elle est la plus prononcée dans les aires urbaines de Lille, Paris et Aix-Marseille. Selon les cas, la ségrégation est plus marquée dans la ville-centre (Aix-Marseille, Strasbourg, Nantes) ou dans la banlieue (Paris, Lyon, Lille). Ces différences tiennent souvent à l'histoire urbaine locale et aux politiques du logement.

Maillage territorial des établissements de santé : apport des modèles issus de la théorie des graphes

LE MEUR N., FERRAT L., GAO F., QUIDU F. ET LOUAZEL M.

2017

Journal de gestion et d'économie médicales 35(4): 197-208.

www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-4-page-197.htm

La recomposition hospitalière observable depuis plus de 20 ans en France résulte de décisions prises dans le cadre des politiques de planification et des stratégies adoptées par les établissements. Au-delà de ses conséquences, comment dans un premier temps rendre compte du maillage territorial des établissements de santé ? Pour identifier les facteurs caractérisant la topologie du maillage, les statistiques de test conventionnelles sont inadaptées. Aussi nous proposons dans cet article méthodologique, d'étudier l'utilité des modèles issus de la théorie des graphes pour la modélisation des transferts de patients entre établissements de courts séjours (i.e. Médecine-Chirurgie-Obstétrique, MCO) et établissements de soins de suites et réadaptation (SSR) à partir du Programme de Médicalisation des Systèmes d'Information (PMSI). Les modèles Erdös-Renyi (ER) et les modèles à séquences contraintes sur les degrés (Constrainted Degree Sequence Model, CDSM) testent la significativité des mesures d'assortativité. Dans notre étude, ils démontrent entre autre la propension des établissements de même statut juridique à échanger des patients entre eux. Les modèles en blocs permettent de créer des clusters d'établissements sur la base des caractéristiques communes. Dans notre contexte, ils soulignent notamment la dynamique territoriale des échanges entre établissements. Enfin, les modèles à graphes aléatoires exponentiels (Exponential Random Graph Models ou ERGM) et la mesure d'assortativité mesurent l'influence simultanée de la proximité géographique et des statuts juridiques dans la relation entre les établissements. En conclusion, les méthodes issues de la théorie des graphes offrent des perspectives pour identifier et quantifier l'impact de facteurs pouvant influencer la topologie des relations hospitalières.

Commentaire - Ségrégation par le revenu dans les villes : réflexions sur les écarts entre concept et mesure

MORENO-MONROY A.

2018

Economie Et Statistique (497-498): 99-103.

www.insee.fr/fr/statistiques/3317910?sommaire = 3317927

Dans son étude portant sur douze métropoles françaises, Jean-Michel Floch montre que la ségrégation, à savoir la séparation spatiale de groupes ayant des niveaux de vie différents au sein des villes, est plus élevée dans les villes-centres et les banlieues qu'en périphérie. Elle est également plus marquée pour les niveaux de vie plus élevés. Ce commentaire fait valoir que la ségrégation par le revenu dans les villes françaises est faible au regard des niveaux internationaux. S'appuyant sur des questions de mesure et de comparabilité des indices de ségrégation par le revenu, trois points sont développés. Tout d'abord, contrairement aux idées généralement répandues, la ségrégation des populations pauvres a peu d'influence sur la ségrégation urbaine dans son ensemble, alors que la forte

contribution de la ségrégation des populations aisées ne fait pas suffisamment débat. Ensuite, il convient d'adopter un seuil empirique ou normatif en matière de ségrégation pour cadrer les discussions sur la ségrégation « excessive ». Enfin, la mesure de la ségrégation par le revenu, en l'état, n'évalue pas véritablement le degré réel de déconnexion physique entre les diverses catégories de revenus, ni d'ailleurs entre ces catégories de revenus et les commodités et services urbains, ce qui limite l'utilité de telles mesures pour l'élaboration de politiques publiques (résumé d'auteur).

Explaining Regional Variation in Home Care Use by Demand and Supply Variables

VAN NOORT O., SCHOTANUS F., VAN DE KLUNDERT J. ET TELGEN J.

2018

Health Policy 122(2): 140-146.

In the Netherlands, home care services like district nursing and personal assistance are provided by private service provider organizations and covered by private health insurance companies which bear legal responsibility for purchasing these services. To improve value for money, their procurement increasingly replaces fee-for-service payments with population based budgets. Setting appropriate population budgets requires adaptation to the legitimate needs of the population, whereas historical costs are likely to be influenced by supply factors as well, not all of which are necessarily legitimate. Our purpose is to explain home care costs in terms of demand and supply factors. This allows for adjusting historical cost patterns when setting population based budgets. Using expenses claims of 60 Dutch municipalities, we analyze eight demand variables and five supply variables with a multiple regression model to explain variance in the number of clients per inhabitant, costs per client and costs per inhabitant. Our models explain 69 % of variation in the number of clients per inhabitant, 28 % of costs per client and 56 % of costs per inhabitant using demand factors. Moreover, we find that supply factors explain an additional 17-23 % of variation. Predictors of higher utilization are home care organizations that are integrated with intramural nursing homes, higher competition levels among home care organizations and the availability of complementary services.

Hospitals

Pathways to DRG-Based Hospital Payment Systems in Japan, Korea, and Thailand

ANNEAR P. L., KWON S., LORENZONI L., DUCKETT S., *et al.*

2018 (Ahead of print)

Health Policy

Asian countries are facing rising health utilization and costs. Innovative case-based payment systems have emerged as a hospital funding mechanism. Frontier features include a phased-in approach and linking payment to quality outcomes. Case-based payment systems are not a panacea.

The Use of Preventable Hospitalization for Monitoring the Performance of Local Health Authorities in Long-Term Care

ARANDELOVIC A., ACAMPORA A., FEDERICO B., PROFILI F., FRANCESCONI P., RICCIARDI W. ET DAMIANI G.

2018

Health Policy 122(3): 309-314.

The objective of the study was to examine whether there are differences in the performance of long-term care programs between local health authorities, using preventable hospitalization as an indicator. A retrospective cohort study compared the rate of preventable hospitalization for local health authorities in Tuscany (Italy) between January 2012 and September 2016. Several administrative datasets for the patients in long-term care programs were linked at the individual (patient) level. Elderly disabled patients 65 years of age and older in long-term care programs in Tuscany

from both types of programs: nursing homes (n = 4196) and home care (n = 15659) were included in the study. RESULTS: The rate of preventable hospitalization differed considerably between local health authorities. Three out twelve local health authorities had a significantly lower and one had a significantly higher preventable hospitalization rate than the regional average. There was a large variation in the rate of preventable hospitalization among the local health authorities. Applying preventable hospitalization as an indicator for quality, with implications for periodical audit can be used for monitoring the performance of a long-term care program.

Control of Hospitals and Nursing Homes in France: The 2016 Reform May Indirectly Improve a Dysfunctional System

BERTEZENE S.

2018

Health Policy 122(4): 329-333.

In France, the supervisory bodies require hospitals and nursing homes to undergo various control procedures. A stack of legislation and control measures has piled up, with no provision for their interconnection being included in any of the legislation. The purpose of the article is to point to the prospects for better control opened up by the legislation modernising the health system adopted on 26 January 2016. The reform will neither directly change the partitioning between the supervisory bodies preventing the sharing of information and the harmonisation of the practices in terms of control, nor change the internal partitioning within the supervisory body. But in hospitals, the reform will improve the interconnection of control of quality/control inspections/control of strategy using a common medical project and pooling certain cross-cutting functions, and implementing the control of quality for the new local hospital groupings as a whole. In nursing homes, the generalisation of multi-year aims and means contracts would allow a better interconnection of the control of strategy and the control of quality since it provides managers with the means of constructing projects for the evolution of their establishments over a period of time, and accompanies changes in the socio-medical offer to improve the provision of care. These changes would allow a more credible, coherent, useful, and equitable control.

La T2A dans les établissements de santé de court séjour : réforme inachevées

CASH R.

2017

Sève : Tribunes de la Santé 57): 35-55.

La tarification à l'activité dans les établissements de santé a été mise en place en France dans le secteur de court séjour en 2004-2005, après une vingtaine d'années d'études et de travaux de simulation. Cet article revient sur l'historique de la T2A, sur ses caractéristiques fondamentales et ses objectifs initiaux ainsi que ses impacts. Il examine ensuite les débats intervenus ces dernières années et les modifications apportées au système, avant de terminer sur les perspectives.

Reducing Excess Hospital Readmissions: Does Destination Matter

CHEN M.

2018

Int J Health Econ Manag 18(1): 67-82.

Reducing excess hospital readmissions has become a high policy priority to lower health care spending and improve quality. The Affordable Care Act (ACA) penalizes hospitals with higher-than-expected readmission rates. This study tracks patient-level admissions and readmissions to Florida hospitals from 2006 to 2014 to examine whether the ACA has reduced readmission effectively. We compare not only the change in readmissions in targeted conditions to that in non-targeted conditions, but also changes in sites of readmission over time and differences in outcomes based on destination of readmission. We find that the drop in readmissions is largely owing to the decline in readmissions to the original hospital where they received operations or treatments (i.e., the index hospital). Patients readmitted into a different hospital experienced longer hospital stays. The results suggest that the reduction in readmission is likely achieved via both quality improvement and strategic admission behavior.

Impact des patients « bed blockers » sur les coûts hospitaliers et évaluation des obstacles à la sortie, étude prospective au sein de quatre hôpitaux belges

DE FOOR J., LECLERCQ P., VAN DEN BULCKE J. ET PIRSON M.

2017

Journal de gestion et d'économie médicales 35(4): 179-196.

www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-4-page-179.htm

Les hôpitaux constatent régulièrement que la durée de séjour à l'hôpital de certains patients est prolongée bien que leur présence ne soit plus justifiée par des raisons médicales. Le manque d'infrastructures extra-hospitalières pouvant accueillir des patients après une hospitalisation peut avoir un impact sur les coûts des hôpitaux. L'objectif de l'étude est d'établir les profils des patients bed blockers, d'identifier les obstacles à leur sortie, le besoin en structures d'accueil adéquates après l'hospitalisation, de calculer la durée excédentaire du séjour, et d'en évaluer le coût pour les hôpitaux. Une enquête a été réalisée dans quatre hôpitaux belges. Les patients qui sont toujours hospitalisés, alors que l'autorisation médicale de sortie remonte à plus de 24 heures, ont été recensés sur une période de 21 ou 30 jours. L'étude se concentre sur 93 patients. Les résultats montrent la nécessité de développer des lits de revalidation et de maisons de repos comme première solution permettant la sortie de patients dans des délais raisonnables.

The Importance of Population Differences: Influence of Individual Characteristics on the Australian Public's Preferences for Emergency Care

HARRIS P., WHITTY J. A., KENDALL E., RATCLIFFE J., WILSON A., *et al.*

2018

Health Policy 122(2): 115-125.

A better understanding of the public's preferences and what factors influence them is required if they are to be used to drive decision-making in health. This is particularly the case for service areas undergoing continual reform such as emergency and primary care. Accordingly, this study sought to determine if attitudes, socio-demographic characteristics and healthcare experiences influence the public's intentions to access care and their preferences for hypothetical emergency care alternatives. A discrete choice experiment was used to elicit the preferences of Australian adults (n = 1529). Mixed logit regression analyses revealed the influence of a range of individual characteristics on preferences and service uptake choices across three different presenting scenarios. Age was associated with service uptake choices in all contexts, whilst the impact of other sociodemographics, health experience and attitudinal factors varied by context. The improvements in explanatory power observed from including these factors in the models highlight the need to further clarify their influence with larger populations and other presenting contexts, and to identify other determinants of preference heterogeneity. The results suggest social marketing programs undertaken as part of demand management efforts need to be better targeted if decision-makers are seeking to increase community acceptance of emerging service models and alternatives. Other implications for health policy, service planning and research, including for workforce planning and the possible introduction of a system of co-payments are discussed.

Patient and Public Involvement in Hospital Policy-Making: Identifying Key Elements for Effective Participation

MALFAIT S., VAN HECKE A., DE BODT G., PALSTERMAN N. ET EECKLOO K.

2018

Health Policy 122(4): 380-388.

The involvement of patients and the public in healthcare decisions becomes increasingly important. Although patient involvement on the level of the individual patient-healthcare worker relationship is well studied, insight in the process of patient and public involvement on a more strategic level is limited. This study examines the involvement of patient and public (PPI) in decision-making concerning policy in six Flemish hospitals. The hospitals organized a stakeholder committee which advised the hospital on strategic policy planning. A three-phased mixed- methods study design with individual questionnaires (n = 69), observations (n = 10) and focus groups (n = 4) was used to analyze, summarize and integrate the findings. The results of this study indicate that: (1) PPI on hospital level should include the possibility to choose topics, like operational issues; (2) PPI-stakeholders should be able to have proper preparation; (3) PPI-stakeholders

should be externally supported by a patient organization; (4) more autonomy should be provided for the stakeholder committee. Additionally, the study indicates that the influence of national legislation on stakeholder initiatives in different countries is limited. In combination with the growing importance of PPI and the fact that the recommendations presented are not claimed to be exhaustive, more transnational and conceptual research is needed in the future.

Deaths in France: Characteristics, Place of Death, Hospitalisations and Use of Palliative Care During the Year Before Death

POULALHON C., ROTELLI-BIHET L., RASO C., AUBRY R., FAGOT-CAMPAGNA A. ET TUPPIN P.

2018

Revue d'Épidémiologie et de Santé Publique 66(1): 33-42.

Il existe peu d'informations à un niveau national sur les pathologies prises en charge et le parcours hospitalier avant le décès. Le but de cette étude était de décrire les pathologies, hospitalisations, recours aux soins palliatifs un an avant le décès et le lieu de décès en France. Les personnes décédées en 2013 et couvertes par le régime général d'Assurance maladie ont été repérées dans le système national d'information inter-régimes de l'Assurance maladie (Sniiram) avec une sélection des informations sur leurs différents séjours hospitaliers, en soins palliatifs hospitaliers (SPH) et en établissement d'hébergement pour personnes âgées dépendantes (Ehpad). Les pathologies ont été identifiées par des algorithmes à partir de la consommation de soins rapportée dans le Sniiram. Les informations médico-administratives du Sniiram doivent permettre d'approfondir la connaissance du parcours de soins en amont du décès et le recours aux SPH et d'aider à évaluer le nouveau plan gouvernemental sur les soins palliatifs récemment mis en place en France.

Does Free Choice of Hospital Conflict with Equity of Access to Highly Specialized Hospitals? A Case Study from the Danish Health Care System

TAYYARI DEHBAREZ N., GYRD-HANSEN D., ULDBJERG N. ET SØGAARD R.

2018 (Ahead of print)

Health Policy

Free choice of hospital conflicts with horizontal equity of access to hospitals. There is an educational gradient regarding exercising free choice of hospital. Risk aversion is associated with choosing a highly specialized hospital.

Le management au défi du stress des professionnels dans les établissements d'accueil des personnes âgées dépendantes

VINOT A. ET VINOT D.

2017

Journal de gestion et d'économie médicales 35(4): 159-177.

www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-4-page-159.htm

L'objectif de cet article est de proposer un outil de mesure de perception du stress au sein de structures médico-sociales et à en analyser les résultats. Cette recherche a été menée au sein de 26 Établissements d'Hébergement pour Personnes Âgées Dépendantes (EHPAD) répartis sur toute la France et intègre des structures citadines, rurales, de tailles, de statuts et de niveau de dépendance différents. La population étudiée concerne tous les professionnels présents au sein de l'établissement au moment de l'étude. Le questionnaire a été construit à partir de de trois structures pilote. La recherche porte sur 914 professionnels qui ont participé à cette étude. Le questionnaire comporte 42 questions portant sur des variables spécifiques aux conditions de travail et d'autres plus spécifiques aux critères identifiés lors des phases de pré test. L'alpha de Cronbach fait apparaître un coefficient de .893, quant aux 13 questions relatives aux conditions de travail, et de .848 quant aux 21 questions spécifiques au stress identifiées en focus group. Les résultats mettent en exergue 8 facteurs propres au rythme de travail, à la clarté des missions, aux interruptions des activités, au sens au travail, à la relation avec les résidents ou avec les collègues, aux ordres contradictoires et à l'enca-

drement. Certains facteurs tels que la relation avec les familles n'interviennent pas dans l'analyse des causes du stress, mettant en avant des facteurs organisationnels plus marqués, qui sont de réels leviers d'actions pour le manager.

Did Case-Based Payment Influence Surgical Readmission Rates in France? A Retrospective Study

VUAGNAT A., YILMAZ E., ROUSSOT A., RODWIN V., GADREAU M., BERNARD A., CREUZOT-GARCHER C. ET QUANTIN C.

2018

BMJ Open 8(2): e018164.

The aims of this study is to determine whether implementation of a case-based payment system changed all-cause readmission rates in the 30 days following discharge after surgery, we analysed all surgical procedures performed in all hospitals in France before (2002-2004), during (2005-2008) and after (2009-2012) its implementation. SETTING: Our study is based on claims data for all surgical procedures performed in all acute care hospitals with >300 surgical admissions per year (740 hospitals) in France over 11 years (2002-2012; n = 51.6 million admissions). We analysed all-cause 30-day readmission rates after surgery using a logistic regression model and an interrupted time series analysis. The overall 30-day all-cause readmission rate following discharge after surgery increased from 8.8% to 10.0% (P<0.001) for the public sector and from 5.9% to 8.6% (P<0.001) for the private sector. Interrupted time series models revealed a significant linear increase in readmission rates over the study period in all types of hospitals. However, the implementation of case-based payment was only associated with a significant increase in rehospitalisation rates for private hospitals (P<0.001). CONCLUSION: In France, the increase in the readmission rate appears to be relatively steady in both the private and public sector but appears not to have been affected by the introduction of a case-based payment system after accounting for changes in care practices in the public sector.

Choice of Reserve Capacity by Hospitals: A Problem for Prospective Payment

WIDMER P. K., TROTTMANN M. ET ZWEIFEL P.

2018

Eur J Health Econ 19(5): 663-673.

This contribution analyzes the impact of prospective payment on hospital decisions with regard to reserve capacity, using Swiss hospital data covering the years 2004-2009. This data set is unique because it permits distinguishing of institutional characteristics (e.g., ownership status) from the mode of payment as determinants of hospital efficiency, due to the fact that some Swiss cantons introduced prospective payment early while others waited for federal legislation to be enacted in 2012. Since a hospital's choice of reserve capacity depends also on the risk preferences of management while affecting the cost function, heterogeneity is predicted even in the presence of identical technology and factor prices. For estimating hospitals' marginal costs, we employ the flexible representation of risk preferences by Pope and Chavas [Am J Agric Econ 76, 196-204 (1994)]. Production uncertainty is measured as the difference between actual admissions and admissions predicted by an autoregressive moving average model. Its effect on hospital cost is analyzed using a multilevel stochastic cost frontier model with random coefficients reflecting unobserved differences in technology. Public hospitals are found to opt for a higher probability of meeting unexpected demand, as predicted. Their operating cost is 1.1% higher than for private hospitals and even 1.9% higher than for teaching hospitals, creating an incentive to turn away patients or to keep them waiting for treatment.

Does Patients' Experience of General Practice Affect the Use of Emergency Departments? Evidence from Australia

WONG C. Y. ET HALL J.

2018

Health Policy 122(2): 126-133.

AS Emergency Department (ED) attendances have been growing rapidly, various strategies have been employed in Australia to improve access to General Practitioner (GP) care, particularly after normal working hours, in order to reduce the demand for ED. However, there has been little attention paid to the quality of GP care and whether that influences ED attendances. This paper investigates whether ED use

is affected by patients' experience of GP care, using the logit model to analyse data from a survey of Australian consumers (1758 individuals). Not surprisingly, we find that people with poor health status and a greater number of chronic conditions are more likely to visit the ED. We also find that, after correcting for health status and sociodemographic factors, patients with a better GP experience are less likely to visit the ED. This suggests that policies aimed at improving the quality of primary care are also important in reducing unplanned hospital use.

Health Inequalities

Les consultations au sein d'une permanence d'accès aux soins de santé

BOYER J. B., DE BECQ A., CHAMPS-LEGER H. ET *et al.*

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(2): 76-80.

Créée par la loi du 29 juillet 1998, la Permanence d'Accès aux Soins de Santé (PASS) a pour mission de lutter contre l'exclusion en favorisant l'accès aux soins des personnes les plus démunies. Elle s'insère dans un dispositif plus large de lutte contre la pauvreté. Les PASS travaillent en étroite collaboration avec les intervenants sanitaires, sociaux ou agissant dans le domaine de la précarité au sens large. L'activité peut se réduire à des consultations de médecine générale ou d'autres spécialités, mais aussi se déployer de façon plus transversale en intégrant des services sociaux afin de répondre aux besoins plus globaux de ses usagers.

Characteristics and Health Status of Homeless Women Born in France and Abroad: Results of Insee-Ined 2012 Survey

GOMES DO ESPIRITO SANTO M. E., PERRINE A. L., BONALDI C. ET GUSEVA-CANU I.

2018

Rev Epidemiol Santé Publique 66(2): 135-144.

French national surveys among the homeless population in 2001 and 2012 provided a general description of the homeless beneficiaries of medical and social aids. However, given the increasing number of women in this population, mostly born abroad and accompanied by their children, a descriptive study of homeless women according to the fact of being born in France or abroad was conducted. METHODS: A probability sample of 1470 French-speaking homeless women was recruited for the Insee-Ined 2012 survey. Sociodemographic characteristics, life trajectories, work and employment over the last 12 months, perceived health, reported morbidity, use of care and medical coverage have been described, comparing homeless women born abroad with those born in France. This study suggests that homeless women often have to deal with chronic health problems that are not treated. Homeless women born abroad are characterized by more precarious living conditions that women born in France. Although younger, with an overall favorable perception of their health and declaring less often an addiction, their general state of health appears to be as fragile as for women born in France. Actions towards homeless women should be implemented to promote their access to care.

Economic and Public Health Consequences of Delayed Access to Medical Care for Migrants Living with HIV in France

GUILLON M., CELSE M. ET GEOFFARD P. Y.

2018

Eur J Health Econ 19(3): 327-340.

In 2013, migrants accounted for 46% of newly diagnosed cases of HIV (human immunodeficiency virus) infection in France. These populations meet with specific obstacles leading to late diagnosis and access to medical care. Delayed access to care (ATC) for HIV-infected migrants reduces their life expectancy and quality of life. Given the reduction of infectivity under antiretroviral (ARV) treatment, delayed ATC for HIV-infected migrants may also hinder the control of the HIV epidemic. The objective of this study is to measure the public health and economic consequences of

delayed ATC for migrants living with HIV in France. Using a healthcare payer perspective, our model compares the lifetime averted infections and costs of early vs. late ATC for migrants living with HIV in France. Early and late ATC are defined by an entry into care with a CD4 cell count of 350 and 100/mm (3), respectively. Our results show that an early ATC is dominant, even in the worst-case scenario. In the most favorable scenario, early ATC generates an average net saving of €198, 000 per patient, and prevents 0.542 secondary infection. In the worst-case scenario, early ATC generates an average net saving of €32,000 per patient, and prevents 0.299 secondary infection. These results are robust to various adverse changes in key parameters and to a definition of late ATC as an access to care at a CD4 level of 200/mm(3). In addition to individual health benefits, improving ATC for migrants living with HIV proves efficient in terms of public health and economics. These results stress the benefit of ensuring early ATC for all individuals living with HIV in France.

Creating a 'Hostile Environment for Migrants': The British Government's Use of Health Service Data to Restrict Immigration Is a Very Bad Idea

HIAM L., STEELE S. ET MCKEE M.

2018

Health Economics, Policy and Law 13(2): 107-117.

In January 2017, the UK Government made public a Memorandum of Understanding (MoU) between the Department of Health, National Health Service (NHS) Digital and the Home Office. This Memorandum allows for the more expedited sharing of a patient's non-clinical data, specifically from the NHS England to the Home Office. The Government justified the MoU as in the 'public interest to support effective immigration enforcement'. In this review, we seek to unpack this justification by providing, first, a background to the MoU, placing it in the context of creating a 'hostile environment' for migrants – a project initially sought by Theresa May in her time as Home Secretary. We then explore the potential impact of data sharing on individual health, public health and on health professionals. We conclude that the MoU could threaten both individual and public health, while placing health professionals in an unworkable position both practically and in terms of their duties to patients around confidentiality. As such, we agree with colleagues' position that it should be suspended, at least until a full consultation and health impact assessment can be carried out.

The Impact of the Great Recession on Health-Related Risk Factors, Behaviour and Outcomes in England

JOFRE-BONET M., SERRA-SASTRE V. ET VANDOROS S.

2018

Soc Sci Med 197: 213-225.

This paper examines the impact that the Great Recession had on individuals' health behaviours and risk factors such as diet choices, smoking, alcohol consumption, and Body Mass Index, as well as on intermediate health outcomes in England. We exploit data on about 9000 households from the Health Survey for England for the period 2001-2013 and capture the change in macroeconomic conditions using regional unemployment rates and an indicator variable for the onset of the recession. Our findings indicate that the recession is associated with a decrease in the number of cigarettes smoked - which translated into a moderation in smoking intensity - and a reduction in alcohol intake. The recession indicator itself is associated with a decrease in fruit intake, a shift of the BMI distribution towards obesity, an increase in medicines consumption, and the likelihood of suffering from diabetes and mental health problems. These associations are often stronger for the less educated and for women. When they exist, the associations with the unemployment rate (UR) are nevertheless similar before and after 2008. Our results suggest that some of the health risks and intermediate health outcomes changes may be due to mechanisms not captured by worsened URs. We hypothesize that the uncertainty and the negative expectations generated by the recession may have influenced individual health outcomes and behaviours beyond the adjustments induced by the worsened macroeconomic conditions. The net effect translated into the erosion of the propensity to undertake several health risky behaviours but an exacerbation of some morbidity indicators. Overall, we find that the recession led to a moderation in risky behaviours but also to worsening of some risk factors and health outcomes.

Socioeconomic Status and Waiting Times for Health Services: An International Literature Review and Evidence from the Italian National Health System

LANDI S., IVALDI E. ET TESTI A.

2018

Health Policy 122(4): 334-351.

In the absence of priority criteria, waiting times are an implicit rationing instrument where the absence or limited use of prices creates an excess of demand. Even in the presence of priority criteria, waiting times may be unfair because they reduce health care demand of patients in lower socio-economic conditions due to high opportunity costs of time or a decay in their health level. Significant evidence has shown a relationship between socioeconomic status and the length of waiting time. The first phase of the study involved an extensive review of the existent literature for the period of 2002-2016 in the main databases (Scopus, PubMed and Science Direct). Twenty-eight met the eligibility criteria. The 27 papers were described and classified. The empirical objective of this study was to determine whether socioeconomic characteristics affect waiting time for different health services in the Italian national health system. The services studied were specialist visits, diagnostics tests and elective surgeries. A classification tree and logistic regression models were implemented. Data from the 2013 Italian Health National Survey were used. The analysis found heterogeneous results for different types of service. Individuals with lower education and economic resources have a higher risk of experiencing excessive waiting times for diagnostic and specialist visits. For elective surgery, socioeconomic inequalities are present but appear to be lower.

Connections Between Unemployment Insurance, Poverty and Health: A Systematic Review

RENAHY E., MITCHELL C., MOLNAR A., MUNTANER C., NG E., ALI F. ET O'CAMPO P.

2018

European Journal of Public Health 28(2): 269-275.

Since the global economic crisis in 2007, unemployment rates have escalated in most European and North American countries. Unemployment protection policies, particularly the unemployment insurance (UI) system, have become a weighty issue for many modern welfare states. Decades of research have established concrete findings on the adverse impacts of unemployment on poverty- and health-related outcomes. This provided a foundation for further exploration into the potential protective effects of UI in offsetting these adverse outcomes. Methods : We developed a systematic review protocol in four stages (literature search, study selection, data extraction and quality appraisal) to ensure a rigorous data collection and inter-rated reliability. We examined the full body of empirical research published between 2000 and 2013 on the pathways by which UI impacts poverty and health. Whether UI impacts differ by age and region might be explored further in future research. The complex mediating relationship between unemployment, UI, poverty and health should further be assessed in light of economic and historical contexts. This could inform decision-making processes during future periods of economic recession.

Droit au séjour pour raisons médicales : analyse de la Case de santé à Toulouse

REVUE PRESCRIRE

2018

Revue Prescrire 38(415): 380-382.

Centre de santé à Toulouse, la Case de santé a mis en place un protocole pluridisciplinaire visant à accompagner des personnes malades étrangères en situation irrégulière, pour connaître et faire valider leur droit au séjour pour raisons médicales. D'après son rapport d'observation, 53 personnes ont sollicité la Case de santé en 2015, afin de demander un titre de séjour pour raisons médicales. Cet article revient sur l'imbroglio dans l'attribution des titres de séjour au niveau de la Préfecture.

Précarité, pauvreté et santé

SPIRA A.

2017

Bulletin de l'Académie Nationale de Médecine(4-5-6): 567-587.

Après une présentation des populations précaires et des dispositifs mis au point en France à leur encontre, cet article souligne l'insuffisance des politiques menées et émet plusieurs recommandations pour améliorer leur situation sanitaire et sociale.

Equity in Access to Care in the Era of Health System Reforms in Turkey

YARDIM M. S. ET UNER S.

2018 (Ahead of print)

Health Policy

The aim of this study is to evaluate access to healthcare from an equity perspective on the way toward Universal Health Coverage in Turkey. The country representative data from 2006 to 2013 Turkey Income and Living Conditions Surveys were analyzed. Private household residents aged fifteen and older were asked for self-reported unmet need for medical care in the past twelve months. The dependent variable had three categories: no unmet need, unmet need due to cost, and unmet need due to availability (waiting list and distance problems). Predictors of unmet need were assessed by a multinomial logistic regression analysis. The prevalence of unmet need declined between 2006 and 2013. While educational inequalities in declared unmet need also decreased, the income gradient becomes more important. In 2013, controlling for other factors, the propensity to report unmet need was 10 times higher for those in the poorest-income quintile compared to the richest (versus 7 times in 2006). CONCLUSION: Overall access to healthcare has gradually improved in Turkey in the health reform process, but 9% of people still declared unmet need due to cost in 2013, after the implementation of Universal Health Insurance. This was nearly four times the EU average. Unfavourable economic and labour market conditions can be challenges for effective universal health coverage.

Pharmaceuticals

Global Increase and Geographic Convergence in Antibiotic Consumption Between 2000 and 2015

KLEIN E. Y., VAN BOECKEL T. P., MARTINEZ E. M., PANT S., *et al.*

2018

Proc Natl Acad Sci U S A.

Tracking antibiotic consumption patterns over time and across countries could inform policies to optimize antibiotic prescribing and minimize antibiotic resistance, such as setting and enforcing per capita consumption targets or aiding investments in alternatives to antibiotics. In this study, we analyzed the trends and drivers of antibiotic consumption from 2000 to 2015 in 76 countries and projected total global antibiotic consumption through 2030. Between 2000 and 2015, antibiotic consumption, expressed in defined daily doses (DDD), increased 65% (21.1-34.8 billion DDDs), and the antibiotic consumption rate increased 39% (11.3-15.7 DDDs per 1,000 inhabitants per day). The increase was driven by low- and middle-income countries (LMICs), where rising consumption was correlated with gross domestic product per capita (GDPPC) growth (P = 0.004). In high-income countries (HICs), although overall consumption increased modestly, DDDs per 1,000 inhabitants per day fell 4%, and there was no correlation with GDPPC. Of particular concern was the rapid increase in the use of last-resort compounds, both in HICs and LMICs, such as glycylcyclines, oxazolidinones, carbapenems, and polymyxins. Projections of global antibiotic consumption in 2030, assuming no policy changes, were up to 200% higher than the 42 billion DDDs estimated in 2015. Although antibiotic consumption rates in most LMICs remain lower than in HICs despite higher bacterial disease burden, consumption in LMICs is rapidly converging to rates similar to HICs. Reducing global consumption is critical for reducing the threat of antibiotic resistance, but reduction efforts must balance access limitations in LMICs and take account of local and global resistance patterns.

Introduction of Therapeutic Reference Pricing in Slovenia and Its Economic Consequences

MARDETKO N. ET KOS M.

2018

Eur J Health Econ 19(4): 571-584.

The aim of this study is to evaluate the economic outcomes that arose from the introduction of therapeutic reference pricing (TRP) into Slovenian practice in 2013, based on the first three therapeutic classes, namely

proton-pump inhibitors (PPIs), angiotensin-converting-enzyme inhibitors (ACEIs), and lipid-lowering agents (LLAs). National health claims data on prescription medicines from January 2011 to December 2015 were analyzed. Monthly medicine expenditure, medicine consumption, changes in medicine use, and market competition (Herfindahl-Hirschman index) were determined to assess the TRP impact on market dynamics. Interrupted time series analysis was used to assess the TRP cost-saving potential. The Slovenian TRP system was established as an effective cost-containment measure. However, pitfalls arising from a country-specific TRP should be considered when introducing this policy.

De l'(in)observance au prendre soin de soi

MISPELBLOM BEYER F.

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(2): 70-75.

Les progrès de la recherche médicale qui ont transformé des maladies mortelles en maladies chroniques, ont aussi permis de passer de traitements administrés à l'hôpital aux thérapies ambulatoires sous la responsabilité des patients eux-mêmes. Ce passage a fait découvrir un phénomène jusqu'alors peu perçu et connu : la non-observance, le fait que des patients ne suivent pas leurs traitements, et ce, même dans le cas de pathologies potentiellement mortelles. Ce phénomène a alerté les soignants mais aussi les autorités sanitaires, car des traitements prescrits, achetés, remboursés, qui ne sont pas réellement suivis ou pas suivis comme il le faudrait, entraînent des manques d'efficacité qui selon certaines études se traduisent en milliers de morts évitables et se chiffrent par milliards de pertes dans les comptes de la Nation.

Assessing Medicare's Approach to Covering New Drugs in Bundled Payments for Oncology

MULDOON L. D., PELIZZARI P. M., LANG K. A., VANDIGO J. ET PYENSON B. S.

2018

Health Aff (Millwood) 37(5): 743-750.

New oncology therapies can contribute to survival or quality of life, but payers and policy makers have raised concerns about the cost of these therapies. Similar concerns extend beyond cancer. In seeking a solution, payers are increasingly turning toward value-based payment models in which providers take financial risk for costs and outcomes. These models, including episode payment and bundled payment, create financial gains for providers who reduce cost, but they also create concerns about potential stinting on necessary treatments. One approach, which the Centers for Medicare and Medicaid Services adopted in the Oncology Care Model (OCM), is to partially adjust medical practices' budgets for their use of novel therapies, defined in this case as new oncology drugs or new indications for existing drugs approved after December 31, 2014. In an analysis of the OCM novel therapies adjustment using historical Medicare claims data, we found that the adjustment may provide important financial protection for practices. In a simulation we performed, the adjustment reduced the average loss per treatment episode by $758 (from $807 to $49) for large practices that use novel therapies often. Lessons from the OCM can have implications for other alternative payment models.

Les patients se font-ils prescrire leurs médicaments d'automédication par leur médecin généraliste

REVUE PRESCRIRE

2018

Revue Prescrire 38(415): 384-385.

Cet article analyse les résultats d'une enquête présentée lors des Rencontres Prescrire 2017, dont l'objectif était d'évaluer la pression des malades sur la prescription des médecins généralistes. En 1998, Ostermann avait défini la rédaction d'ordonnances sous la dictée des patients comme « l'automédication sur ordonnances suggérées ».

Methodology - Statistics

Une simulation sur un modèle d'appariement : l'impact de l'article 4 de l'ANI de 2013 sur la segmentation du marché du travail

BERSON C. ET FERRARI N.

2017

Economie & prévision 211-212(2): 115-137.

www.cairn.info/revue-economie-et-prevision-2017-2-page-115.htm

Le marché du travail français est segmenté entre les personnes bénéficiant d'un emploi stable et celles alternant contrats temporaires et périodes de chômage. À partir de simulations sur un modèle d'appariement calibré sur la France, la réforme issue de l'accord national interprofessionnel de 2013 apparaît pertinente pour réduire cette dualité. L'estimation des effets des majorations de cotisation sur les CDD et des exonérations pour les embauches de jeunes en CDI introduites par l'ANI du 11 janvier 2013 montre en effet un impact positif mais faible au regard de la réforme relativement similaire dite à l'italienne et étudiée dans Berson et Ferrari. (2015).

Sources de données, données utilisées et modalité de recueil

MERCIER G., COSTA N., DUTOT C. ET RICHE V. P.

2018

Revue d'Épidémiologie et de Santé Publique 66: S73-S91.

Les méthodes de costing hospitalier nécessitent d'avoir recours à des sources de données diverses, que l'on travaille selon une approche micro-costing ou gross-costing, le choix de la méthodologie reposant sur un compromis entre coût de recueil, précision et transférabilité. Ce travail décrit les sources de données disponibles en France, les modalités d'accès pratiques ainsi que les principaux avantages et inconvénients : (1) des coûts unitaires locaux, (2) de la comptabilité analytique hospitalière, (3) de la base d'Angers, (4) de l'Étude nationale des coûts, (5) des bases de données inter CHR/U, (6) du programme de médicalisation des systèmes d'information, (7) des bases de données de l'Assurance Maladie.

Méthodes d'analyse et de traitement des données de coût : approches par micro-costing » et « gross-costing »

MORELLE M., PLANTIER M., DERVAUX B., PAGÈS A., DENIÈS F., HAVET N. ET PERRIER L.

2018

Revue d'Épidémiologie et de Santé Publique 66: S101-S118.

Ce travail traite de l'analyse des données de coût individuelles dans le cadre d'études interventionnelles ou observationnelles à l'aide de logiciels d'analyse de données et de traitement statistique dès lors que les coûts par patient ont été estimés. Il est, en effet, nécessaire de pouvoir les présenter et les décrire de façon appropriée dans chacune des stratégies de santé étudiées et de tester si la différence de coût observée entre les groupes de traitement est due au hasard ou non. De plus, l'analyse des données de coût se distingue des analyses statistiques « classiques » par un certain nombre de caractéristiques propres à ces données ainsi qu'à leur utilisation par les décideurs de santé. Ce travail présente également les difficultés que posent généralement les distributions de coût, explique pourquoi la moyenne arithmétique constitue la seule mesure pertinente pour les économistes, et décrit quelles analyses sont nécessaires pour la comparaison des coûts entre les stratégies. Il s'intéresse aussi à la question des données manquantes ou censurées, spécificités souvent inhérentes aux informations collectées sur les coûts et aux analyses de sensibilité.

Health Policy

[Medical Human Resources Planning in Europe: A Literature Review of the Forecasting Models]

BENAHMED N., DELIEGE D., DE WEVER A. ET PIRSON M.

2018

Rev Epidemiol Santé Publique 66(1): 63-73.

Healthcare is a labor-intensive sector in which half of the expenses are dedicated to human resources. Therefore, policy makers, at national and internal levels, attend to the number of practicing professionals and the skill mix. This paper aims to analyze the European forecasting model for supply and demand of physicians. To describe the forecasting tools used for physician planning in Europe, a grey literature search was done in the OECD, WHO, and European Union libraries. Electronic databases such as Pubmed, Medline, Embase and Econlit were also searched.To conclude : Medical human resource planning in Europe is inconsistent. Political implementation of the results of forecasting projections is essential to insure efficient planning. However, crucial elements such as mobility data between Member States are poorly understood, impairing medical supply regulation policies. These policies are commonly limited to training regulations, while horizontal and vertical substitution is less frequently taken into consideration.

Public Acceptability of Financial Incentives to Reward Pregnant Smokers Who Quit Smoking: A United Kingdom-France Comparison

BERLIN N., GOLDZAHL L., BAULD L., HODDINOTT P. ET BERLIN I.

2018

Eur J Health Econ 19(5): 697-708.

A substantial amount of research has been conducted on financial incentives to increase abstinence from smoking among pregnant smokers. If demonstrated to be effective, financial incentives could be proposed as part of health care interventions to help pregnant smokers quit. Public acceptability is important; as such interventions could be publicly funded. Concerns remain about the acceptability of these interventions in the general population. We aimed to assess the acceptability of financial incentives to reward pregnant smokers who stop smoking using a survey conducted in the UK and then subsequently in France, two developed countries with different cultural and social backgrounds. More French than British respondents agreed with financial incentives for rewarding quitting smoking during pregnancy, not smoking after delivery, keeping a smoke-free household, health service payment for meeting target and the maximum amount of the reward. However, fully adjusted models showed significant differences only for the two latter items. More British than French respondents were neutral toward financial incentives. Differences between the representative samples of French and British individuals demonstrate that implementation of financial incentive policies may not be transferable from one country to another.

La recherche qualitative en santé publique : intérêt, méthodes et perspectives

CERVELLO S.

2018

Lettre de Psychiatrie Française (La)(255): 19-21.

Après une définition du concept «Recherches qualitatives», cet article aborde les méthodologies utilisées, les relations avec la qualité et les applications aux domaines de la santé mentale.

Medicare's Acute Care Episode Demonstration: Effects of Bundled Payments on Costs and Quality of Surgical Care

CHEN L. M., RYAN A. M., SHIH T., THUMMA J. R. ET DIMICK J. B.

2018

Health Services Research 53(2): 632-648.

The aim of this study is to evaluate whether participation in Medicare's Acute Care Episode (ACE) Demonstration Program—an early, small, voluntary episode-based payment program—was associated with a change in expenditures or quality of care. Data Sources/Study Setting Medicare claims for patients

who underwent cardiac or orthopedic surgery from 2007 to 2012 at ACE or control hospitals. Study Design We used a difference-in-differences approach, matching on baseline and pre-enrollment volume, risk-adjusted Medicare payments, and clinical outcomes to identify controls. Principal Findings Participation in the ACE Demonstration was not significantly associated with 30-day Medicare payments (for orthopedic surgery : –$358 with 95 percent CI : –$894, + $178 ; for cardiac surgery : + $514 with 95 percent CI : –$1,517, + $2,545), or 30-day mortality (for orthopedic surgery : –0.10 with 95 percent CI : –0.50, 0.31 ; for cardiac surgery : –0.27 with 95 percent CI : –1.25, 0.72). Program participation was associated with a decrease in total 30-day post-acute care payments (for cardiac surgery : –$718 ; 95 percent CI : –$1,431, –$6 ; and for orthopedic surgery : –$591 ; 95 percent CI : $-$1,161, –$22). Conclusions Participation in Medicare's ACE Demonstration Program was not associated with a change in 30-day episode-based Medicare payments or 30-day mortality for cardiac or orthopedic surgery, but it was associated with lower total 30-day post-acute care payments.

Promoting Normal Birth and Reducing Caesarean Section Rates: An Evaluation of the Rapid Improvement Programme

COOKSON G. ET LALIOTIS I.

2018

Health Economics 27(4): 675-689.

This paper evaluates the impact of the 2008 Rapid Improvement Programme that aimed at promoting normal birth and reducing caesarean section rates in the English National Health Service. Using Hospital Episode Statistics maternity records for the period 2001–2013, a panel data analysis was performed to determine whether the implementation of the programme reduced caesarean sections rates in participating hospitals. The results obtained using either the unadjusted sample of hospitals or a trimmed sample determined by a propensity score matching approach indicate that the impact of the programme was small. More specifically there were 2.3 to 3.4 fewer caesarean deliveries in participating hospitals, on average, during the postprogramme period offering a limited scope for cost reduction. This result mainly comes from the reduction in the number of emergency caesareans as no significant effect was uncovered for planned caesarean deliveries.

Insights from the Design and Implementation of a Single-Entry Model of Referral for Total Joint Replacement Surgery: Critical Success Factors and Unanticipated Consequences

DAMANI Z., MACKEAN G., BOHM E., NOSEWORTHY T., *et al.*

2018

Health Policy 122(2): 165-174.

Single- entry models (SEMs) in healthcare allow patients to see the next- available provider and have been shown to improve waiting times, access and patient flow for preference- sensitive, scheduled services. The Winnipeg Central Intake Service (WCIS) for hip and knee replacement surgery was implemented to improve access in the Winnipeg Regional Health Authority. This paper describes the system's design/implementation ; successes, challenges, and unanticipated consequences. On two occasions, during and following implementation, we interviewed all members of the WCIS project team, including processing engineers, waiting list coordinators, administrators and policy- makers regarding their experiences. We used semi- structured telephone interviews to collect data and qualitative thematic analysis to analyze and interpret the findings. Respondents indicated that the overarching objectives of the WCIS were being met. Benefits included streamlined processes, greater patient access, improved measurement and monitoring of outcomes. Challenges included low awareness, change readiness, and initial participation among stakeholders. Unanticipated consequences included workload increases, confusion around stakeholder expectations and under- reporting of data by surgeons' offices. Critical success factors for implementation included a requirement for clear communication, robust data collection, physician leadership and patience by all, especially implementation teams. Although successfully implemented, key lessons and critical success factors were learned related to change management, which if considered and applied, can reduce unanticipated consequences, improve uptake and benefit new models of care.

Involving Citizens in Disinvestment Decisions: What Do Health Professionals Think? Findings from a Multi-Method Study in the English NHS

DANIELS T., WILLIAMS I., BRYAN S., MITTON C. ET ROBINSON S.

2017

Health Economics, Policy and Law 13(2): 162-188.

Public involvement in disinvestment decision making in health care is widely advocated, and in some cases legally mandated. However, attempts to involve the public in other areas of health policy have been accused of tokenism and manipulation. This paper presents research into the views of local health care leaders in the English National Health Service (NHS) with regards to the involvement of citizens and local communities in disinvestment decision making. The research includes a Q study and follow-up interviews with a sample of health care clinicians and managers in senior roles in the English NHS. It finds that whilst initial responses suggest high levels of support for public involvement, further probing of attitudes and experiences shows higher levels of ambivalence and risk aversion and a far more cautious overall stance. This study has implications for the future of disinvestment activities and public involvement in health care systems faced with increased resource constraint. Recommendations are made for future research and practice.

Doing Patient-Centredness Versus Achieving Public Health Targets: A Critical Review of Interactional Dilemmas in ART Adherence Support

DE KOK B. C., WIDDICOMBE S., PILNICK A. ET LAURIER E.

2018

Soc Sci Med 205: 17-25.

Anti-retroviral Therapy (ART) transformed HIV into a chronic disease but its individual and public health benefits depend on high levels of adherence. The large and rising number of people on ART, now also used as prevention, puts considerable strain on health systems and providers in low and middle as well as high-income countries, which are our focus here. Delivering effective adherence support is thus crucial but challenging, especially given the promotion of patient-centredness and shared decision making in HIV care. To illuminate the complexities of ART adherence support delivered in and through clinical encounters, we conducted a multi-disciplinary interpretative literature review. We reviewed and synthesized 82 papers published post 1997 (when ART was introduced) belonging to three bodies of literature: public health and psychological studies of ART communication; anthropological and sociological studies of ART; and conversation analytic studies of patient-centredness and shared decision-making. We propose three inter-related tensions which make patient-centredness particularly complex in this infectious disease context: achieving trust versus probing about adherence; patient-centredness versus reaching public health targets; and empowerment versus responsibilisation as 'therapeutic citizens'. However, there is a dearth of evidence concerning how precisely ART providers implement patient-centredness, shared-decision making in practice, and enact trust and therapeutic citizenship. We show how conversation analysis could lead to new, actionable insights in this respect.

Asthma: Adapting the Therapeutic Follow-Up According to the Medical and Psychosocial Profiles

DECCACHE A., DIDIER A., MAYRAN P., JEZIORSKI A. ET RAHERISON C.

2018

Rev Mal Respir 35(3): 313-323.

This work is based on the data of REALISE, a survey conducted among 8000 European patients to identify the profiles of adult asthma patients and how these are linked with treatment adherence behaviors. A cluster analysis was performed by combining data in three ways: control of asthma, attitude towards the disease, compliance with treatment. A multidisciplinary group analyzed the results for the 1024 French survey respondents. RESULTS: Four patient profiles were identified: «rather confident» (28% of patients), rather young patients with a low level of concern about their asthma. «Rather committed» (23%) patients considering themselves to be mostly healthy, reporting better therapeutic declared. «Rather questing» (26%), patients poorly controlled, seeking to manage their asthma themselves. «Rather concerned» profile (23%), a bit older, with poor clinical control, considering their asthma to be severe. Cluster analysis provides a multidimensional approach to understand the therapeutic behavior of the different patient profiles better and

so adjust communication by and education of health-care professionals.

Should interventions to reduce variation in care quality target doctors or hospitals?

GUTACKER N., BLOOR K., BOJKE C. ET WALSHE K.

2018 (Ahead of print)

Health Policy

Performance management initiatives are increasingly targeting individual doctors as well as hospitals. Less than 25% of variation in clinical outcomes is attributable to providers. More variation in clinical outcomes is associated with doctors than with hospitals. Performance estimates for individual doctors are unreliable due to small samples.

Improving Health Care Service Provision by Adapting to Regional Diversity: An Efficiency Analysis for the Case of Germany

HERWARTZ H. ET SCHLEY K.

2018

Health Policy 122(3): 293-300.

The provision of health care in Germany exhibits sizeable geographic variation with a heterogeneous allocation of medical services in rural and urban areas. Furthermore, distinct utilisation patterns and access barriers due to the socio-economic environment might cause inefficiencies in the provision of health care services. Accordingly, an improved understanding of factors governing inefficiencies in health care provision is likely to benefit an efficient spatial allocation of health care infrastructure. We analyse how socio-economic factors influence the regional distribution of (in)efficiencies in the provision of health care services by means of a stochastic frontier analysis. Our results highlight that regional deprivation relates to inefficient provision of health care services. As a consequence, policies should also consider socio-economic conditions to improve the allocation of medical services and overall health.

Les accès à l'exercice de la médecine en France

HUGUIER M., BERTRAND D. ET MILHAUD G.

2017

Bulletin de l'Académie Nationale de Médecine 201(4-6): 513-527

En France, le nombre d'étudiants admis en deuxième année d'études (numerus clausus) est déterminé en fonction des possibilités de formation pratique hospitalière et des évolutions démographiques. L'objectif est d'avoir un nombre de médecins nécessaire, mais aussi suffisant. La situation s'est compliquée du fait de possibilités d'accès aux études médicales en dehors du NC, d'accords de l'Union européenne et de l'occupation de postes hospitaliers vacants par des médecins étrangers hors UE, ouvrant des autorisations ministérielles d'exercice. Ainsi, environ 20 % des médecins autorisés à exercer en France s'ajoutent au NC. Ce rapport recommande que les accès aux études médicales soient tous inclus dans le NC, que des décisions de l'UE soient prises pour faire évoluer le NC vers une certaine harmonisation quantitative dans les pays membres et que la réglementation hospitalière contrôle beaucoup mieux les dévoiements indirect du NC que constitue l'embauche de médecins hors UE sur des postes laissés vacants.

The Impact of the Financial Crisis and Austerity Policies on the Service Quality of Public Hospitals in Greece

KERAMIDOU I. ET TRIANTAFYLLOPOULOS L.

2018

Health Policy 122(4): 352-358.

The influence of the financial crisis on the efficiency of Greek public hospitals has been widely debated. Despite this increasing interest in such research, the question of to what extent the recent reforms in the Greek National health care system were effective in establishing a health care structure and process that provide better results for patients has yet to be fully investigated. As a step in this direction, the paper focuses on patient's experience with public hospital care quality before and during the economic crisis. A questionnaire survey was carried out among 1872 patients discharged from 110 out of the total of 124 Greek public hospitals. Patients' perceptions were analysed using a structural equation modelling approach. The findings reveal that public hospital service quality

is at a medium level (66.2 on a scale from 1 to 100) over 2007-2014, presenting a decreasing trend during the recession. Policies to address the crisis may have contributed to a reduction in hospital expenditures, but at the same time patients were increasingly dissatisfied with the technical care. Consequently, there is a need for reforms aimed at the achievement of productivity gains, responsibility, and transparency in the management of productive resources, by enabling health organisations to reduce their costs without a deterioration in the quality of care.

The Joint Action on Health Workforce Planning and Forecasting: Results of a European Programme to Improve Health Workforce Policies

KROEZEN M., VAN HOEGAERDEN M. ET BATENBURG R.

2018

Health Policy 122(2): 87-93.

Health workforce (HWF) planning and forecasting is faced with a number of challenges, most notably a lack of consistent terminology, a lack of data, limited model-, demand-based- and future-based planning, and limited inter-country collaboration. The Joint Action on Health Workforce Planning and Forecasting (JAHWF, 2013-2016) aimed to move forward on the HWF planning process and support countries in tackling the key challenges facing the HWF and HWF planning. This paper synthesizes and discusses the results of the JAHWF. It is shown that the JAHWF has provided important steps towards improved HWF planning and forecasting across Europe, among others through the creation of a minimum data set for HWF planning and the 'Handbook on Health Workforce Planning Methodologies across EU countries'. At the same time, the context-sensitivity of HWF planning was repeatedly noticeable in the application of the tools through pilot- and feasibility studies. Further investments should be made by all actors involved to support and stimulate countries in their HWF efforts, among others by implementing the tools developed by the JAHWF in diverse national and regional contexts. Simultaneously, investments should be made in evaluation to build a more robust evidence base for HWF planning methods.

L'émergence du patient-acteur dans la sécurité des soins en France : une revue narrative de la littérature entre sciences sociales et santé publique

MOUGEOT F., ROBELET M., RAMBAUD C., OCCELLI P., BUCHET-POYAU K., TOUZET S. ET MICHEL P.

2018

Santé Publique 30(1): 73-81.

www.cairn.info/revue-sante-publique-2018-1-page-73.htm

Depuis une quarantaine d'années, les patients sont incités à prendre leur part dans la prise en charge de leur maladie et sont appelés à participer à l'amélioration de la qualité et de la sécurité des soins. Ce phénomène invite à penser les conditions d'émergence de ce nouveau rôle de patient ainsi qu'à penser ses implications en matière de santé publique. Une revue narrative de la littérature a été réalisée. Les bases de données Medline, Cairn et Persée ont été interrogées. L'interrogation des bases de données a référencé 2 206 documents dont 106 ont été retenus. L'émergence du patient-acteur est un phénomène lié aux crises sanitaires sous l'impulsion de collectifs associatifs tels que le Lien en matière de sécurité des patients. Ce mouvement induit une transformation du rôle du patient qui va au-delà de la sécurité des soins puisqu'il révolutionne sa contribution au système de santé et à la santé en général. Cette revue narrative de la littérature permet de mettre en évidence la manière dont les crises sanitaires ont permis l'émergence d'une nouvelle figure : celle du patient-acteur. Cette figure s'accompagne d'une sémantique nouvelle sur le pouvoir des malades. Dans le domaine de la sécurité des soins, le patient occupe une place spécifique. En complémentarité des personnels de santé, il doit être une ressource pour l'amélioration de la sécurité des patients. Les différentes contributions des patients sont détaillées et un questionnement sur l'acceptabilité de la participation des patients est proposé.

Health Policies for the Reduction of Obstetric Interventions in Singleton Full-Term Births in Catalonia

PUEYO M. J., ESCURIET R., PEREZ-BOTELLA M., DE MOLINA I., *et al.*

2018

Health Policy 122(4): 367-372.

The aim of this paper is to explore the effect of hospital's characteristics in the proportion of obstetric

interventions (OI) performed in singleton fullterm births (SFTB) in Catalonia (2010-2014), while incentives were employed to reduce C-sections. Data about SFTB assisted at 42 public hospitals were extracted from the dataset of hospital discharges. Hospitals were classified according to the level of complexity, the volume of births attended, and the adoption of a non-medicalized delivery (NMD) strategy. The annual average change in the percentage for OI was calculated based on Poisson regression models. To conclude : the proportion of OI, including C-sections, remained stable in spite of public incentives to reduce them. The adoption of the NMD strategy could help in decreasing the rate of OI. To reduce the OI rate, new strategies should be launched as the development of low-risk pregnancies units, alignment of incentives and hospital payment, increased value of incentives and encouragement of a cultural shift towards non-medicalized births.

▶ Putting Performance Measurement Recommendations into Practice: Building on Current Practices

ROSE MCCLOSKEY R., JARRETT J. ET YETMAN L.

2017

HealthcarePapers 17(2): 65-71.

Improving performance measurement within the Canadian healthcare system is proving to be challenging despite advances in evidence-informed care and best practices for healthcare delivery. Perhaps what is most challenging is the need to meet requirements to measure what most Canadians hold dear - being seen as a person during a healthcare encounter. Measures of healthcare delivery have typically been developed to capture patient satisfaction during isolated healthcare encounters. Such measures simply do not get to the essence of what matters to patients and their families. This paper outlines a response to the paper by Kuluski and colleagues (2017) that calls for a thorough review of the way data are currently captured on patients' experiences with healthcare. Using geriatric medicine as a context, the authors highlight elements of our current care delivery models that must be preserved, modified or created to allow patients and families to play a larger role in improving our healthcare system.</p>

▶ A la recherche d'une fin de vie apaisée

STASSE F.

2017

Sève : Les Tribunes de la Santé (57): 91-96.

La loi du 2 février 2016 accroît fortement les droits du patient à décider de l'arrêt des soins qui lui sont prodigués en fin de vie. Elle autorise, également, sous certaines conditions, les médecins à pratiquer une sédation afin que le patient achève sa vie sans souffrir. Ces importantes évolutions juridiques constituent-elles un point d'équilibre durable dans la législation française ? Les exemples étrangers ne permettent pas de trancher avec certitude.

Prevention

▶ Alcool : la culture ou la santé

BASSET B.

2017

Sève : Les Tribunes de la Santé (57): 57-61.

Alors que les dommages sanitaires et sociaux de la consommation d'alcool dans notre pays sont parfaitement établi et considérables, aucune politique cohérente et efficace ne peut être mise en œuvre. En effet, les groupes d'intérêt liés au secteur économique de l'alcool sont non seulement puissants, mais ils ont réussi à placer le débat sur le champ de la défense de la culture. Les moyens d'une politique efficace sont connus. Tout l'enjeu pour les acteurs de santé publique est de revenir à la question qui se pose vraiment : comment replacer au premier rang les enjeux de santé publique ?

Prevision - Evaluation

▶ Évaluation des Politiques Publiques : expérimentation randomisée et méthodes quasi-expérimentales

CHABÉ-FERRET S., DUPONT-COURTADE L. ET TREICH N.

2017

Economie & prévision 211-212(2): 1-34.

www.cairn.info/revue-economie-et-prevision-2017-2-page-1.htm

Dans cet article, nous proposons une introduction aux méthodes d'évaluation expérimentales et quasi-expérimentales. L'objectif de ces méthodes est d'identifier économétriquement les effets causaux des politiques publiques. Nous présentons les concepts et les intuitions à partir d'exemples numériques simples, complétés par des tableaux et des graphiques, sans recourir à des techniques économétriques avancées. Nous illustrons la discussion avec des exemples concrets, incluant par exemple la politique de revenu de solidarité active (RSA), un projet de construction de barrage, un programme de formation professionnelle, et des mesures agro-environnementales. Nous discutons systématiquement les biais principaux et les problèmes potentiels associés à chaque méthode.

▶ Estimation du coût hospitalier : approches par « micro-costing » et « gross-costing »

GUERRE P., HAYES N. ET BERTAUX A. C.

2018

Revue d'Épidémiologie et de Santé Publique 66: S65-S72.

Les évaluations économiques se multiplient dans les établissements de santé ces dernières années, s'appuyant sur la théorie économique. La première étape, quelle que soit la finalité du costing à l'hôpital, est le point de vue ou la perspective adopté(e) : doit-on évaluer les coûts du point de vue de l'établissement de santé ? De l'Assurance maladie ? Se pose ensuite la question de la méthode à retenir : il en existe plusieurs, mais les deux majoritairement utilisées pour estimer les coûts hospitaliers de prise en charge des patients en France sont : la méthode du micro-costing et celle du « gross-costing ». Ce travail a pour objectif de décrire chacune d'entre elles (modalités de recueil et de valorisation monétaire des consommations de ressources), ainsi que leurs avantages et inconvénients liés aux difficultés rencontrées dans leur mise en œuvre à l'hôpital, de présenter une revue de la littérature comparant les deux méthodes et leur possible combinaison, et de proposer des pistes quant aux questions qui doivent être posées en amont du recueil des consommations de ressources et de valorisation des coûts à l'hôpital. Un schéma final, tenant lieu de conclusion, synthétise les méthodologies à privilégier en fonction de la stratégie à évaluer et de ses impacts sur la prise en charge du patient.

▶ Coûts unitaires standards ou coûts unitaires spécifiques : quels critères de choix pour l'évaluation économique de stratégies de santé dans les études multicentriques ?

MARGIER J., BAFFERT S. ET LE CORROLLER-SORIANO A. G.

2018

Revue d'Épidémiologie et de Santé Publique 66: S93-S99.

La question de la valorisation des ressources consommées, c'est-à-dire du choix du coût unitaire, est majeure en termes d'impact sur les résultats des évaluations économiques. Cette question méthodologique ne fait à ce jour pas l'objet de consensus et les choix réalisés par les méthodologistes et leurs impacts sur les résultats des analyses ne sont que très rarement explicités. Ce travail aborde le cadre théorique des évaluations de stratégies en santé qui peuvent être menées, soit dans le cadre normatif de l'approche économique classique du bien-être, dite welfariste, soit dans celui d'une approche dite extra welfariste. Il apporte également des éléments permettant d'éclairer le choix des coûts unitaires hospitaliers dans le calcul des coûts des stratégies de santé afin d'harmoniser les pratiques et d'améliorer la comparabilité des études. Est-il préférable d'opter pour un coût unitaire spécifique par hôpital ou pour un coût unitaire standard appliqué à tous les établissements ? Comment calculer ce coût standard ? Est-il opportun de calculer une moyenne des coûts unitaires, comme le préconisent certains guides ? Les avantages et des limites des différents modes de valorisation des ressources hospitalières dans le cadre d'essais multicentriques y sont discutés.

Psychiatry

Santé mentale : les enjeux de demain

JEAN A. *et al.*,

2018/01

Gestions hospitalières(572): 36-53.

À l'heure où l'évolution des besoins de santé et des représentations de la psychiatrie modifie les réponses de l'offre de soins, la coordination et la complémentarité des acteurs des champs sanitaire, social et médico-social sont plus que jamais nécessaire. La santé mentale est l'un des éléments fondamentaux de la qualité de vie des patients. En France, près d'une personne sur cinq souffre de maladie psychiatrique. Ainsi, l'estimation des coûts directs et indirects des maladies mentales - s'élevant à plus de 100 milliards d'euros - constitue un défi organisationnel et financier. Ce dossier porte sur les enjeux et perspectives de la santé mentale. Il s'articule autour des aspects : petite histoire de la prise en charge psychiatrique, soins psychiatriques sans consentement, les révolutions de la pédopsychiatrie, réhabilitation psychosociale...

Unplanned Admissions to Inpatient Psychiatric Treatment and Services Received Prior to Admission

OSE S. O., KALSETH J., ADNANES M., TVEIT T. ET LILLEENG S. E.

2018

Health Policy 122(4): 359-366.

Inpatient bed numbers are continually being reduced but are not being replaced with adequate alternatives in primary health care. There is a considerable risk that eventually all inpatient treatment will be unplanned, because planned or elective treatments are superseded by urgent needs when capacity is reduced. The aims of this study were to estimate the rate of unplanned admissions to inpatient psychiatric treatment facilities in Norway and analyse the difference between patients with unplanned and planned admissions regarding services received during the three months prior to admission as well as clinical, demographical and socioeconomic characteristics of patients. Unplanned admissions were defined as all urgent and involuntary admissions including unplanned readmissions. National mapping of inpatients was conducted in all inpatient treatment psychiatric wards in Norway on a specific date in 2012. Binary logit regressions were performed to compare patients who had unplanned admissions with patients who had planned admissions (i.e., the analyses were conditioned on admission to inpatient psychiatric treatment). Patients with high risk of unplanned admission are suffering from severe mental illness, have low functional level indicated by the need for housing services, high risk for suicide attempt and of being violent, low education and born outside Norway. Specialist mental health services should support the local services in their efforts to prevent unplanned admissions by providing counselling, short inpatient stays, outpatient treatment and ambulatory outpatient psychiatry services.

Primary Health Care

Travailler à l'articulation soins premiers et second recours : Pourquoi, Comment

BOURGUEIL Y. ET KANHONOU N.

2017

Sève : Les Tribunes De La Sante(57): 23-33.

L'objet de cet article, essentiellement méthodologique, est de présenter le contexte, les objectifs, la méthode adoptée et les résultats de travaux menés dans le cadre d'un groupe de travail initié par le HCAAM pour analyser les fonctionnements des relations médecins de second recours et médecins de premier recours. Ces travaux ont nourri plusieurs notes du Haut Conseil visant à proposer des pistes pour orienter l'action publique.

Sauver le médecin généraliste

CASASSUS P., ABRAMOVICI F., GALAM E. ET *et al.*

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(1): 4-6.

Voici le titre d'un ouvrage qui vient de paraître sous la plume conjointe de Patrice Queneau et Claude de Bourguignon, un universitaire membre de l'Académie de Médecine et un généraliste. Comment en est-on arrivé à devoir choisir un tel titre ? La France si souvent – et justement – donnée en exemple pour son système de santé subit une crise médicale grave. La désertification médicale est criante. Elle est le fruit du départ à la retraite massif des médecins issus du « baby-boom » de l'Après-guerre et de la décision de quelques habiles énarques de ministère qui, dans les années 1970-1980, devant le gouffre croissant du déficit de la Sécurité sociale, ont eu la judicieuse idée de réduire le nombre du principal fautif : le médecin prescripteur... Ainsi, en diminuant (de plus de la moitié) le nombre de médecins, ils espéraient logiquement diminuer le nombre de prescriptions et donc de dépenses de santé. Ils ont seulement oublié de réduire aussi le nombre de malades... Grossière erreur aggravée désormais par deux autres paramètres insuffisamment pris en compte par l'administration qui a relevé depuis une dizaine d'années le fameux numerus clausus à l'entrée en faculté de médecine : l'allongement important de la durée de vie (avec une augmentation franche du nombre de sujets âgés, aux besoins médicaux élevés) et un pourcentage croissant de femmes parmi les étudiants (qui atteint souvent les 75 %). Or – ce n'est ni une critique, ni désobligeant pour elles – les femmes médecins ont souvent une activité volontairement réduite en temps, certaines même commençant par une période de quelques années consacrées à leurs enfants avant de se lancer à plein dans leur carrière : cela exigerait d'en tenir compte dans l'évaluation du nombre de médecins à former...

Preferences of General Practitioners in Metropolitan France with Regard to the Delegation of Medico-Administrative Tasks to Secretaries Assisting Medico-Social Workers: Study in Conjoint Analysis

CHANU A., CARON A., FICHEUR G., BERKHOUT C., DUHAMEL A. ET ROCHOY M.

2018

Rev Epidemiol Santé Publique 66(3): 171-180.

A general practitioner's office is an economic unit where task delegation is an essential component in improving the quality and performance of work. AIM: To classify the preferences of general practitioners regarding the delegation of medical-administrative tasks to assistant medical-social secretaries. Conjoint analysis was applied to a random sample of 175 general practitioners working in metropolitan France. Ten scenarios were constructed based on seven attributes: training for medical secretaries, logistical support during the consultation, delegation of management planning, medical records, accounting, maintenance, and taking initiative on the telephone. A factorial design was used to reduce the number of scenarios. Physicians' socio-demographic variables were collected. One hundred and three physicians responded and the analysis included 90 respondents respecting the transitivity of preferences hypothesis. Perceived difficulty was scored 2.8 out of 5. The high rates of respondents (59%; 95% CI [51.7-66.3]) and transitivity (87.5%; 95% CI [81.1-93.9]) showed physicians' interest in this topic. Delegation of tasks concerning management planning (OR = 2.91; 95% CI [2.40-13.52]) and medical records (OR = 1.88; 95% CI [1.56-2.27]) were the two most important attributes for physicians. The only variable for which the choice of a secretary was not taken into account was logistical support. This is a first study examining the choices of general practitioners concerning the delegation of tasks to assistants. These findings are helpful to better understand the determinants of practitioners' choices in delegating certain tasks or not. They reveal doctors' desire to limit their ancillary tasks in order to favor better use of time for «medical» tasks. They also expose interest for training medical secretaries and widening their field of competence, suggesting the emergence of a new professional occupation that could be called «medical assistant».

Exposition au risque infectieux en médecine générale : Projet ECOGEN

CUSSAC F., DUQUENNE I., GELLY J. ET *et al.*

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(1): 37-39.

Le risque infectieux associé aux soins est bien évalué au sein des établissements de santé, mais aucune étude n'a porté sur le risque infectieux des médecins exerçant en ambulatoire. L'objectif principal de cette étude était de décrire la prévalence de l'exposition au risque infectieux pour les médecins généralistes en ambulatoire.

Au fait docteur… ? : la demande de fin de consultation. Étude qualitative auprès des patients consultant en médecine générale

GUILLEMIN T., BALLY J. N., GOCKO X. ET *et al.*

2018

Médecine : De La Médecine Factuelle a Nos Pratiques 14(1): 32-36.

L'entretien entre le patient et le médecin généraliste peut être perturbé par une demande de fin de consultation. L'objectif de cette étude consistait à analyser à travers leurs récits les mécanismes conduisant les patients à des demandes de fin de consultation.

No-Shows in Appointment Scheduling - A Systematic Literature Review

DANTAS L. F., FLECK J. L., CYRINO OLIVEIRA F. L. ET HAMACHER S.

2018

Health Policy 122(4): 412-421.

No-show appointments significantly impact the functioning of healthcare institutions, and much research has been performed to uncover and analyze the factors that influence no-show behavior. In spite of the growing body of literature on this issue, no synthesis of the state-of-the-art is presently available and no systematic literature review (SLR) exists that encompasses all medical specialties. This paper provides a SLR of no-shows in appointment scheduling in which the characteristics of existing studies are analyzed, results regarding which factors have a higher impact on missed appointment rates are synthetized, and comparisons with previous findings are performed. A total of 727 articles and review papers were retrieved from the Scopus database (which includes MEDLINE), 105 of which were selected for identification and analysis. The results indicate that the average no-show rate is of the order of 23%, being highest in the African continent (43.0%) and lowest in Oceania (13.2%). Our analysis also identified patient characteristics that were more frequently associated with no-show behavior: adults of younger age; lower socioeconomic status; place of residence is distant from the clinic; no private insurance. Furthermore, the most commonly reported significant determinants of no-show were high lead time and prior no-show history.

General Practitioners' Strategies in Consultations with Immigrants in Norway-Practice-Based Shared Reflections Among Participants in Focus Groups

HJORLEIFSSON S., HAMMER E. ET DIAZ E.

2018

Fam Pract 35(2): 216-221.

Immigrants comprise 16.8% of the population in Norway and meet General Practitioners (GPs) as their first point of contact with most health care services as do others in Norway. While Norwegian GPs are not trained in cultural competence, little is known about the extent to which they see good care for immigrants as relying on specific strategies. Objectives: To explore the thoughts of GPs in Norway about strategies they might use with immigrant patients. Methods: We performed focus groups posing the question 'What strategies do you use when meeting immigrant patients?' to three groups of GPs working in Norway. Two groups comprised 10 trainee GPs each; the final group comprised eight certified GPs. Verbatim transcripts were analysed by systematic text condensation. Results: Strategies for consultations with immigrants emerged gradually throughout the focus groups, coalescing around (i) Respect and learn about immigrant culture. (ii) Particularize diagnosis and care, accommodating epidemiological and cultural knowledge for a given group, while keeping a keen eye on the individual. (iii) Inform about Norwegian health care. (iv) Organize resources such as time, translators and interdisciplinary teams. Other core elements of cultural competence, including reflections on the GP's own cultural background, were conspicuously absent, however.

Conclusion: Given the growing numbers of immigrants and the early transfer of refugees to general practice, our study points to the urgent need of supplementing teaching in patient-centred clinical method with cultural competence. Our study also highlights the potential of educational GP groups to develop strategies for cross-cultural consultations.

▶ The Effect of Copayments on the Utilization of the GP Service in Norway

LANDSEM M. M. ET MAGNUSSEN J.

2018

Soc Sci Med 205: 99-106.

We examine the effect of copayment on the utilization of the GP service in Norway. We use a regression discontinuity design to study two key aspects of the policy. First, we examine the overall effect of copayments on total utilization of the GP service. Second, we look at how this effect varies across different patient groups according to medical necessity. Data consists of 5,5 million GP visits for youths aged 10-20 over the 6 year period 2009-2014. We find that the introduction of a co-payment leads to an overall reduction of GP visits of 10-15%. The effect is heterogeneous across patient groups. Patients with an acute condition exhibit low price sensitivity. Patients with general complaints and symptoms, chronic diseases and psychological diseases all react strongly to the copayment. The two latter groups capture patients with conditions that typically warrant medical attention. This paper thus suggests that the current flat fee copayment policy is inefficient at targeting unnecessary use of the GP service at the cost of patients with real medical concerns.

▶ Savoir reconnaître le savoir expérientiel des patients : une humilité et une force pour le médecin généraliste

PERNIN T., SAHIER C., MONOTUKA S. ET *et al.*

2018

Médecine : De La Médecine Factuelle a Nos Pratiques 14(1): 19-22.

Bien que formulée par les textes réglementaires, l'implication de patients dans les activités d'éducation thérapeutique du patient (ETP) reste faible en France. De nombreuses publications internationales soulignent le savoir expérientiel des patients- ressources, la construction de partenariats avec les soignants et l'amélioration de l'état de santé de patients ciblés grâce à leur intervention. Le réseau Paris Diabète (RPD) intègre des patients dans sa gouvernance et cherche à les impliquer dans l'animation de ses programmes d'ETP.

▶ Multidisciplinary Collaboration in Primary Care: A Systematic Review

SAINT-PIERRE C., HERSKOVIC V. ET SEPULVEDA M.

2018

Fam Pract 35(2): 132-141.

Background: Several studies have discussed the benefits of multidisciplinary collaboration in primary care. However, what remains unclear is how collaboration is undertaken in a multidisciplinary manner in concrete terms. Objective: To identify how multidisciplinary teams in primary care collaborate, in regards to the professionals involved in the teams and the collaborative activities that take place, and determine whether these characteristics and practices are present across disciplines and whether collaboration affects clinical outcomes. Methods: A systematic literature review of past research, using the MEDLINE, ScienceDirect and Web of Science databases. Results: Four types of team composition were identified: specialized teams, highly multidisciplinary teams, doctor-nurse-pharmacist triad and physician-nurse centred teams. Four types of collaboration within teams were identified: co-located collaboration, non-hierarchical collaboration, collaboration through shared consultations and collaboration via referral and counter-referral. Two combinations were commonly repeated: non-hierarchical collaboration in highly multidisciplinary teams and co-located collaboration in specialist teams. Fifty-two per cent of articles reported positive results when comparing collaboration against the non-collaborative alternative, whereas 16% showed no difference and 32% did not present a comparison. Conclusion: Overall, collaboration was found to be positive or neutral in every study that compared collaboration with a non-collaborative alternative. A collaboration typology based on objective measures was devised, in contrast to typologies that involve interviews, perception-based questionnaires and other subjective instruments.

Most Primary Care Physicians Provide Appointments, but Affordability Remains a Barrier for the Uninsured

SALONER B., HEMPSTEAD K., RHODES K., POLSKY D., PAN C. ET KENNEY G. M.

2018

Health Aff (Millwood) 37(4): 627-634.

The US uninsurance rate has nearly been cut in half under the Affordable Care Act, and access to care has improved for the newly insured, but less is known about how the remaining uninsured have fared. In 2012-13 and again in 2016 we conducted an experiment in which trained auditors called primary care offices, including federally qualified health centers, in ten states. The auditors portrayed uninsured patients seeking appointments and information on the cost of care and payment arrangements. In both time periods, about 80 percent of uninsured callers received appointments, provided they could pay the full cash amount. However, fewer than one in seven callers in both time periods received appointments for which they could make a payment arrangement to bring less than the full amount to the visit. Visit prices in both time periods averaged about $160. Trends were largely similar across states, despite their varying changes in the uninsurance rate. Federally qualified health centers provided the highest rates of primary care appointment availability and discounts for uninsured low-income patients.

Perception de l'information médicale en salle d'attente du médecin généraliste

SAVALI A., MICHELET T. ET VALLEE J.

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(1): 40-45.

Les patients attendraient beaucoup de leur médecin généraliste (MG) en termes d'information médicale. La salle d'attente (SA) du MG constitue la première étape avant la consultation ; elle est parfois utilisée comme vecteur de cette information. Cette étude propose d'explorer la perception par les patients de l'information médicale délivrée dans la SA du MG. La réception d'une information médicale en SA dépend de différents facteurs. Une relation patient-médecin jugée satisfaisante par le patient favorise la réception d'informations. En fonction du motif de consultation ou si l'attente est jugée trop longue les patients peuvent adopter une attitude d'attente anxieuse ou déplaisante peu propice pour s'informer. La SA est un espace d'interactions sociales qui peuvent entraver la perception de l'information. Selon les patients, il faudrait une plus grande implication du MG, qu'il valide l'information, qu'elle soit en quantité limitée, sur un espace dédié, renouvelée, sur des sujets d'actualité, de prévention ou sur le réseau associatif local. Non imposée, l'information devrait être proposée dans la continuité de la relation patient-médecin.

Les maisons de santé pluriprofessionnelles en France : une dynamique réelle mais un modèle organisationnel à construire

SEBAI J. ET YATIM F.

2017

Revue française d'administration publique 164(4): 887-902.

www.cairn.info/revue-francaise-d-administration-publique-2017-4-page-887.htm

En France, les maisons de santé pluriprofessionnelles (MSP) sont présentées comme une réponse efficace aux nouveaux besoins en matière de santé. Le but de cet article est de proposer des éléments d'analyse pour un premier bilan de l'ensemble des structures de ce type en France, et plus particulièrement sur le plan organisationnel. Nous nous appuyons sur les données de l'enquête nationale réalisée en 2014 par la Direction générale de l'offre de soins. Nous montrons ainsi qu'il existe une réelle dynamique d'implantation des maisons de santé pluriprofessionnelles sans que cette dynamique ne s'accompagne des évolutions organisationnelles attendues.

Primary Care Supply and Quality of Care in England

VALLEJO-TORRES L. ET MORRIS S.

2018

Eur J Health Econ 19(4): 499-519.

We investigated the relationship between primary care supply and quality of care in England. We analysed 35 process measures of quality of care covering 13 medical conditions using English Longitudinal Study of Aging data linked to area of residence indicators. Greater GP density had a statistically significant and

positive association with quality of care, and distance to GP practice had a statistically significant and negative association. The effects were concentrated in indicators of care related to cardiovascular diseases and arthritis, and on specific indicators for diabetes, incontinence and hearing problems. The results suggest that better primary care supply can improve quality of care.

Primary Care: A Definition of the Field to Develop Research

VERGA-GERARD A.

2018

Rev Epidemiol Santé Publique 66(2): 157-162.

Research in the field of primary care has dramatically increased in France in recent years, especially since 2013 with the introduction of primary care as a thematic priority for research proposals launched by the Ministry of Health (Direction Générale de l'Offre de Soins. The RECaP (Research in Clinical Epidemiology and Public Health) network is a French research network supported by Inserm, which recently implemented a specific working group focusing on research in primary care, based on a multidisciplinary approach. Researchers from different specialties participate in this group. The first aim of the group was to reach a common definition of the perimeter and of the panel of healthcare professionals and structures potentially involved in the field of primary care. For this purpose, a selection of different data sets of sources defining primary care was analyzed by the group, each participant collecting a set of sources, from which a synthesis was made and discussed. A definition of primary care at different levels (international, European and French) was summarized. A special attention was given to the French context in order to adapt the perimeter to the characteristics of the French healthcare system, notably by illustrating the different key elements of the definition with the inclusion of primary care actors and the type of practice premises. CONCLUSION: In conclusion, this work illustrates the diversity of primary care in France and the potential offered for research purposes.

Health Systems

Demander un titre de séjour pour raison de santé : que sait-on des systèmes de santé des pays d'origine

CHARPAK Y., CHAIX-COUTURIER C. ET DANZON M.

2017

Sève : Les Tribunes de la Santé (57): 97-106.

L'obtention d'un titre de séjour pour raisons de santé comprend deux critères médicaux d'évaluation des demandeurs dont l'un est une appréciation de la capacité ou non du pays d'origine à pouvoir le cas échéant fournir les soins nécessaires. Selon la loi, les médecins de l'Office français de l'immigration et de l'intégration (OFII), organisés en collège de trois sont chargés de cette évaluation médicale. L'OFII a donc souhaité mettre en place pour ses médecins une Bibliothèque d'Information Santé sur les Pays d'Origine (BISPO). L'article décrit les prérequis d'une telle information, les étapes de l'élaboration d'un outil pertinent et opérationnel pour la mise en œuvre de cette politique publique spécifique et les questions qui restent posées pour le futur.

Occupational health

Physicians, sick leave certificates, and patients' subsequent employment outcomes

AHAMMER A.

Health Economics 27(6): 923-936.

onlinelibrary.wiley.com/doi/abs/10.1002/hec.3646

This paper analyzes how general practitioners (GPs) indirectly affect their patients' employment outcomes by deciding the length of sick leaves. The author uses an instrumental variables framework where spell durations are identified through supply-side certification measures. He finds that a day of sick leave certified only because the worker's GP has a high propensity to certify sick leaves decreases the employment probability persistently by 0.45–0.69 percentage points, but increases the risk of becoming unemployed by 0.28–0.44 percentage points. These effects are mostly driven by workers with low job tenure. Several robustness checks show that endogenous matching between patients and GPs does not impair identification. These results bear important implications for doctors: Whenever medically justifiable, certifying shorter sick leaves to protect the employment status of the patient may be beneficial.

Psychopathologie du travail : quand c'est le travail qui est malade

KHAYL N.

2017

Cahiers de Santé Publique et de Protection Sociale (Les)(27): 17-24.

Cet article a été rédigé d'après les notes de cours (PSY 206 au CNAM Toulouse) et un exposé présenté à l'occasion d'une formation sur les maladies professionnelles organisée par le FNPCEPPCS à Malakoff. Les problèmes de santé liés au travail s'invitent de plus en plus souvent dans les cabinets des médecins généralistes. Les médecins sont donc de plus en plus interpellés par ce sujet et les rencontres sont plus marquées entre médecins généralistes et médecins du travail. L'étude Heraklès montre l'implication des médecins généralistes de l'Ile-de-France dans la prise en charge de ces problèmes. Avant d'analyser le lien entre la santé et le travail et de donner un aperçu des troubles psychiques liés au travail, cet article précise quel sens donner au terme « travail ».

Teacher Sick Leave: Prevalence, Duration, Reasons and Covariates

VERCAMBRE-JACQUOT M. N., GILBERT F. ET BILLAUDEAU N.

2018

Rev Epidemiol Santé Publique 66(1): 19-31.

Absences from work have considerable social and economic impact. In the education sector, the phenomenon is particularly worrying since teacher sick leave has an impact on the overall performance of the education system. Yet, available data are scarce. In April-June 2013, 2653 teachers responded to a population-based postal survey on their quality of life (enquête Qualité de vie des enseignants, MGEN Foundation/Ministry of education, response rate 53%). Besides questions on work environment and health, teachers were asked to describe their eventual sick leave(s) since the beginning of the school year: duration, type and medical reasons. Self-reported information was reinforced by administrative data from ministerial databases and weighted to be extrapolated to all French teachers. Tobit models adjusted for individual factors of a private nature were used to investigate different occupational risk factors of teacher sick leave, taking into account both the estimated effect on the probability of sick leave and the length of it. Our study provides objective evidence about the issue of sick leave among French teachers, highlighting the usefulness of implementing actions to minimize its weight. To this end, the study findings point-out the importance of considering not only the probability of sick leave, but also its duration.

Ageing

How Does Retirement Affect Healthcare Expenditures? Evidence from a Change in the Retirement Age

BÍRÓ A. ET ELEK P.

2018

Health Economics 27(5): 803-818.

Using individual-level administrative panel data from Hungary, we estimate causal effects of retirement on outpatient and inpatient care expenditures and pharmaceutical expenditures. Our identification strategy is based on an increase in the official early retirement age of women, using that the majority of women retire upon reaching that age. According to our descriptive results, people who are working before the early retirement age have substantially lower healthcare expenditures than nonworkers, but the expenditure gap declines after retirement. Our causal estimates from a two-part (hurdle) model show that the shares of women with positive outpatient care, inpatient care, and pharmaceutical expenditures, respectively, decrease by 3.0, 1.4, and 1.3 percentage points in the short run due to retirement. These results are driven by the relatively healthy, by those who spent some time on sick leave and by the less educated. The effect of retirement on the size of positive healthcare expenditures is generally not significant.

Intérêt et limites du concept de déprise. Retour sur un parcours de recherche

CARADEC V.

2018

Gérontologie et société 40155(1): 139-147.

www.cairn.info/revue-gerontologie-et-societe-2018-1-page-139.htm

Cet article revient sur le parcours de recherche de l'auteur, marqué par le concept de déprise qu'il a utilisé et travaillé, avant de prendre quelque peu ses distances avec lui. Il évoque tout d'abord les raisons pour lesquelles la déprise a constitué, au tournant du XXIe siècle, un opérateur analytique précieux pour passer de l'étude sociologique de la vieillesse à celle du vieillissement. Puis, l'auteur décrit trois prolongements qu'il a proposés au concept de déprise : l'identification de plusieurs « déclencheurs » du processus de déprise ; l'élaboration d'une typologie des stratégies de déprise ; la mise en regard du concept de déprise avec celui d'« optimisation sélective avec compensation ». Enfin, dans un troisième temps, il explique pourquoi il y a moins recours aujourd'hui. D'une part, il a cherché une formulation plus satisfaisante et a mis en avant, plutôt que la déprise, l'enjeu pour les vieilles personnes du maintien de « prises » sur le monde. D'autre part, il a proposé une conceptualisation plus large du vieillissement individuel en se fondant sur le concept d'épreuve, la déprise devenant l'un des aspects de l'épreuve du vieillir. Dans sa conclusion, l'article souligne que l'approche de la déprise est solidaire d'une stratégie analytique particulière, aujourd'hui concurrencée par d'autres.

Ageing and Healthcare Expenditures: Exploring the Role of Individual Health Status

CARRERAS M., IBERN P. ET INORIZA J. M.

2018

Health Economics 27(5): 865-876.

In 1999, Zweifel, Felder, and Meiers questioned conventional wisdom on ageing and healthcare expenditure (HCE). According to these authors, the positive association between age and HCE is due to an increasing age-specific mortality and the high cost of dying. After a weighty academic debate, a new consensus was reached on the importance of proximity to death when analysing HCE. Nevertheless, the influence of individual health status remains unknown. The objective of our study is to analyse the influence individual health status has on HCE, when compared to proximity to death and demographic effects and considering a comprehensive view of healthcare services and costs. We examined data concerning different HCE components of N = 61,473 persons aged 30 to 95 years old. Using 2-part models, we analysed the probability of use and positive HCE. Regardless of the specific group of healthcare services, HCE at the end of life depends mainly on the individual health status. Proximity to death approximates individual morbidity when it is excluded from the model. The inclusion of morbidity generally improves the goodness of fit. These results provide implications for the analysis of ageing population and its impact on HCE that should be taken into account.

Demand of Long-Term Care and Benefit Eligibility Across European Countries

CARRINO L., ORSO C. E. ET PASINI G.

2018

Health Econ : Ahead of print.

In this paper, we study how elderly individuals adjust their informal long-term care utilization to changes in the provision of formal care. Despite this is crucial to design effective policies of formal elderly care, empirical evidence is scant due to the lack of credible identification strategies to account for the endogeneity of formal care. We propose a novel instrument, an index that captures individuals' eligibility status for the long-term care programs implemented in the region of residence. Our estimates, which are robust to a number of different specifications, suggest that higher formal care provision would lead to an increase in informal care utilization as well. In the context of current theoretical economic model of care use, this result points to the existence of a substantial unmet demand of care among older people in Europe.

La réforme des retraites de 2010 : quel impact sur l'activité des séniors

DUBOIS Y. ET KOUBI M.

2017

Economie & prévision 211-212(2): 61-90.

www.cairn.info/revue-economie-et-prevision-2017-2-page-61.htm

Cette étude s'intéresse à l'évolution du taux d'activité des seniors les années suivant l'augmentation des âges légaux de la retraite programmée par la réforme de 2010. À âge et autres caractéristiques égales par ailleurs, le taux d'activité des salariés impactés par la réforme serait entre 19 et 22 points plus élevé que celui des salariés non impactés. Ce surcroît d'activité se traduit surtout par un accroissement de l'emploi mais également par un accroissement du chômage. L'inactivité (hors retraite) augmente également. Les principales difficultés posée par l'évaluation de l'effet de l'augmentation des âges légaux sont les interactions de la réforme évaluée (celle des âges) avec deux autres réformes : l'augmentation de la durée de cotisation nécessaire pour obtenir le taux plein (réforme 2003 et extension 2014) et le dispositif des carrières longues.

La déprise comme interrogations : autonomie, identité, humanité

GAGNON É.

2018

Gérontologie et société 40155(1): 33-44.

www.cairn.info/revue-gerontologie-et-societe-2018-1-page-33.htm

La déprise est une notion éclairante : elle dévoile et aide à comprendre différentes dimensions de l'expérience du vieillissement. Elle permet une description fine des conduites et de l'organisation de la vie quotidienne des personnes âgées. Mais surtout elle permet de soulever des interrogations touchant l'autonomie et la dépendance, l'identité et le maintien de soi dans le temps, la socialité et ce qui fait notre humanité. Le présent article s'efforce de clarifier la signification de la déprise et les interrogations auxquelles elle conduit, sa richesse et sa pertinence.

Vieillir chez soi dans la diversité des formes urbaines et rurales du Québec, Canada. Une exploration des enjeux d'aménagement des territoires vus par leurs habitants

LORD S., NEGRON-POBLETE P. ET DESPRÉS M.

2017

Retraite et société 76(1): 43-66.

www.cairn.info/revue-retraite-et-societe-2017-1-page-43.htm

Dans le cadre de la démarche « Municipalités-amies des aînés » (Mada), les municipalités québécoises sont appelées à développer une réflexion, avec un protocole d'évaluation commun, visant la mise en place d'aménagements et services qui permettraient un vieillissement plus inclusif et actif. Dans ce contexte, si la mobilité est fortement tributaire des caractéristiques individuelles, les attributs du territoire ont aussi une incidence sur le potentiel de mobilité de ses habitants et sur leurs possibilités de participation sociale. Ainsi, la relative mixité fonctionnelle, la densité résidentielle et l'accessibilité territoriale des quartiers centraux des grandes villes sont souvent présentées comme plus favorables au vieillissement que les milieux suburbains. Mais qu'en est-il des villes moyennes, des territoires périurbains, ou des zones rurales ? Est-ce que l'on serait en présence d'enjeux d'aménagement significativement différents, voire contrastés, qui nécessiteraient une démarche Mada particulière ? Dans cet article, nous nous penchons

sur le rôle que jouent l'aménagement et l'urbanisme dans la construction et la consolidation de territoires favorables au vieillissement selon différents milieux de vie. D'abord, nous proposons une typologie de formes résidentielles déclinée dans six régions québécoises faisant ressortir des enjeux communs, mais souvent contrastés. Ensuite, nous débattons de ces enjeux à la lumière de huit groupes de discussion menés avec des aînés de ces territoires. Si la complexité des enjeux apparaît déterminante, leur dénominateur commun qu'est le couple proximité/accessibilité ressort comme un objet de réflexion et d'intervention multidisciplinaire privilégié et fondamental.

Vivre le vieillir : autour du concept de déprise

MEIDANI A. ET CAVALLI S.

2018

Gérontologie et société 40155(1): 9-23.

www.cairn.info/revue-gerontologie-et-societe-2018-1-page-9.htm

Né à Toulouse, il y a déjà 30 ans, le concept de déprise se veut un outil analytique visant à rendre compte de l'expérience du vieillir. Plus précisément, la déprise désigne un travail d'aménagement du parcours de vie, et parfois même de la personne, qui s'appuie sur une série de tentatives de substitution d'activités ou de relations. Ces dernières surgissent après diverses expériences de ruptures (retraite, veuvage, maladie, etc.) qui accentuent le sentiment de la fragilité et de la perte de prise sur le monde. Ce travail de négociation de soi avec soi, les autres et l'environnement opère par sélection, économie des forces et réorientation. De telles stratégies de reconversion constituent aussi un moyen de préserver son intégrité face à l'irréversibilité du temps. Porté par différentes disciplines, le présent numéro explore les conditions de genèse du concept, discute sa pertinence, son évolution et son ancrage empirique et examine ses limites. En accord avec cet objectif et en en faisant le point de départ de leur réflexion, les auteurs adoptent une posture originale : ils rendent compte du caractère opérationnel de la déprise et donnent à voir l'intérêt du concept pour les professionnels de la gérontologie, tout en montrant que son potentiel analytique n'est pensable qu'à l'aune de ce qui lui fait obstacle et qu'il cherche à dépasser.

Aptitudes fonctionnelles, environnement et données probantes pour vieillir en bonne santé

OFFICER A.

2017

Retraite et société 76(1): 117-124.

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Entre 2000 et 2050, le nombre de personnes âgées de 60 ans et plus passera de 600 millions à près de 2 milliards (ONU, 2011 et 2013). Dans le même temps, 2,5 milliards de personnes supplémentaires sont attendues dans les milieux urbains. Ces évolutions obligent à repenser les modes d'urbanisation, l'adaptation du périurbain et du milieu rural. Ils questionnent l'avenir des solidarités formelles et informelles et le rôle structurant des politiques publiques. La conjonction des transitions démographiques et des mutations territoriales s'opérant au niveau mondial impose donc de revisiter les cadres d'analyse ordinaires pour anticiper et accompagner les effets du vieillissement sur les territoires. S'appuyant sur des travaux et expérimentations menés en France et à l'étranger, le premier numéro de ce dossier, composé de deux volets, propose une série de pistes en matière d'aménagement des territoires et de construction d'espaces démocratiques, pour tenter de relever ces nombreux défis auxquels la société doit faire face.

A Multilevel Analysis of the Determinants of Emergency Care Visits by the Elderly in France

OR, Z. ET PENNEAU, A.

2018 (Ahead of print)

Health Policy

Rising numbers of visits to emergency departments (EDs), especially amongst the elderly, is a source of pressure on hospitals and on the healthcare system. This study aims to establish the determinants of ED visits in France at a territorial level with a focus on the impact of ambulatory care organisation on ED visits by older adults aged 65 years and over. We use multilevel regressions to analyse how the organisation of healthcare provision at municipal and wider 'department' levels impacts ED utilisation by the elderly while controlling for the local demographic, socioeconomic and health context of the area in which patients live. ED visits vary significantly by health context and economic level of municipalities. Controlling for demand-

side factors, ED rates by the elderly are lower in areas where accessibility to primary care is high, measured as availability of primary care professionals, out-of-hours care and home visits in an area. Proximity (distance) and size of ED are drivers of ED use. High rates of ED visits are partly linked to inadequate accessibility of health services provided in ambulatory settings. Redesigning ambulatory care at local level, in particular by Improving accessibility and continuity of primary and social care services for older adults could reduce ED visits and, therefore, improve the efficient use of available healthcare resources.

Defining and Estimating Healthy Aging in Spain: A Cross-Sectional Study

RODRIGUEZ-LASO A., MCLAUGHLIN S. J., URDANETA E. ET YANGUAS J.

2018

Gerontologist 58(2): 388-398.

Using an operational continuum of healthy aging developed by U.S. researchers, we sought to estimate the prevalence of healthy aging among older Spaniards, inform the development of a definition of healthy aging in Spain, and foster cross-national research on healthy aging. Design and Methods: The ELES pilot study is a nationwide, cross-sectional survey of community-dwelling Spaniards 50 years and older. The prevalence of healthy aging was calculated for the 65 and over population using varying definitions. To evaluate their validity, we examined the association of healthy aging with the 8 foot up & go test, quality of life scores and self-perceived health using multiple linear and logistic regression. The estimated prevalence of healthy aging varied across the operational continuum, from 4.5% to 49.2%. Prevalence figures were greater for men and those aged 65 to 79 years and were higher than in the United States. Predicted mean physical performance scores were similar for 3 of the 4 definitions, suggesting that stringent definitions of healthy aging offer little advantage over a more moderate one. Implications: Similar to U.S. researchers, we recommend a definition of healthy aging that incorporates measures of functional health and limiting disease as opposed to definitions requiring the absence of all disease in studies designed to assess the effect of policy initiatives on healthy aging.