

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Mars 2020 / March 2020

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| E-santé – Technologies médicales | <i>E-health – Medical Technologies</i> |
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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

Health Insurance

► **Coverage Expansions And Utilization Of Physician Care: Evidence From The 2014 Affordable Care Act And 1966 Medicare/Medicaid Expansions**

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The aim of this paper is to evaluate the effects of the 2 major coverage expansions in US history - Medicare/Medicaid in 1966 and the Affordable Care Act (ACA) in 2014? - on the utilization of physician care. Using the National Health Interview Survey (1963-1969; 2011-2016), we analyzed trends in utilization of physician services society-wide and by targeted subgroups. Following Medicare/Medicaid's implementation, soci-

ety-wide utilization remained unchanged. While visits by low-income persons increased 6.2% ($P<0.01$) and surgical procedures among the elderly increased 14.7% ($P<0.01$), decreases among nontargeted groups offset these increases. After the ACA, society-wide utilization again remained unchanged. Increased utilization among targeted low-income groups (e.g., a 3.5-percentage-point increase in the proportion of persons earning less than or equal to 138% of the federal poverty level with at least 1 office visit [$P<0.001$]) was offset by small, nonsignificant reductions among the nontargeted population. Past coverage expansions in the United States have redistributed physician care, but have not increased society-wide utilization in the short term, possibly because of the limited supply of physicians. Public Health Implications. These findings suggest that future expansions may not cause unaffordable surges in utilization.

E-santé – Technologies médicales

E-health – Medical Technologies

► **Renforcement des droits des individus sur leurs données personnelles : quelles conséquences sur l'utilisation du numéro d'inscription au répertoire national d'identification des personnes physiques (NIR) ?**

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2019

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<https://www.cairn.info/revue-regards-2019-1-page-149.htm>

Le Règlement européen Général sur la Protection des Données (RGPD), en plaçant la personne concernée au centre de l'utilisation de ses données, avec des droits renforcés et une place prépondérante conférée à son consentement, est venu percuter l'équilibre juridique propre à l'utilisation du NIR, qui au fil des années a toujours fait l'objet de dispositions spécifiques encadrant ses usages, sans que le législateur et les opérateurs ne se préoccupent particulièrement de la transparence

vis-à-vis des personnes concernées. Certes le cadre juridique propre à l'utilisation du NIR était devenu depuis 2004 (Loi n° 2004-801 du 6 août 2004 relative à la protection des données) et au fil des années, d'une lecture et mise en œuvre complexes. Le RGPD permet, par la suppression générale des formalités préalables et la possibilité spécifique offerte aux Etats de prévoir un régime particulier pour les identifiants nationaux, saisie en France pour encadrer les utilisations du NIR, une plus grande lisibilité et simplification des conditions d'usage de ce numéro. Cette transparence nouvelle répond en outre à un autre objectif du RGPD : un meilleur contrôle de ses données par la personne concernée, qui repose avant tout sur l'information relative aux traitements dont ses données sont l'objet. Cette information sur les traitements comportant l'usage du NIR, accessible notamment grâce au décret du 19 avril 2019 laisse percer de nouvelles interrogations, que nous soulèverons dans la première partie. Nous examinerons ensuite la manière dont ce régime juridique



spécifique peut s'articuler avec le renforcement des droits des personnes sur leurs données personnelles.

► **Technologies de la santé et de l'autonomie et vécus du vieillissement**

KLEIN A.

2019

Gérontologie et société 41 / 160(3): 33-45.

<https://www.cairn.info/revue-gerontologie-et-societe-2019-3-page-33.htm>

En France, les Technologies de la Santé et de l'Autonomie (TSA) sont depuis le début des années 2000 fréquemment évoquées pour l'accompagnement de l'avancée en âge. Si elles étaient à l'origine principalement liées à la perte d'autonomie, les TSA soutiennent aujourd'hui une vision plus globale de l'avancée en âge en lien avec la prise en compte plus systématique de la diversité des trajectoires du vieillissement dans les politiques et les actions publiques. Elles sont de plus en plus institutionnalisées et se propagent rapidement à l'image des TIC. Cet article vise donc à mieux comprendre les usages des TSA par les personnes âgées et s'articule autour de deux objectifs principaux. Le premier est de caractériser le processus d'acceptabilité des TSA au prisme des reconfigurations sociales qui s'opèrent avec le temps. Le second est de montrer que l'usage de la technologie est un élément révélateur des vécus individuels du vieillissement. À partir de l'analyse d'une soixantaine d'entretiens semi-directifs réalisés dans le cadre d'une thèse de doctorat, il a été possible de dégager trois positionnements face au vieillissement : le vieillissement fataliste, le vieillissement passif et le vieillissement combatif.

► **The Socio-Legal Relevance Of Artificial Intelligence**

LARSSON S.

2019

Droit et société 103(3): 573-593.

<https://www.cairn.info/revue-droit-et-societe-2019-3-page-573.htm>

L'article propose une analyse sociojuridique des questions d'équité, de responsabilité et de transparence posées par les applications d'intelligence artificielle (IA) employées actuellement dans nos sociétés et de machine learning. Pour rendre compte de ces défis juridiques et normatifs, nous analysons des cas problématiques, comme la reconnaissance d'images fondée sur des bases de données qui présentent des biais de genre. Nous envisageons ensuite sept aspects de la transparence qui permettent de compléter les notions d'explainable AI (XAI) dans la recherche en sciences informatiques. L'article examine aussi l'effet de miroir normatif provoqué par l'usage des valeurs humaines et des structures sociétales comme données d'entraînement pour les technologies d'apprentissage. Enfin, nous plaçons pour une approche multidisciplinaire dans la recherche, le développement et la gouvernance en matière d'IA.

► **Prevalence Of Problematic Smartphone Usage And Associated Mental Health Outcomes Amongst Children And Young People: A Systematic Review, Meta-Analysis And GRADE Of The Evidence**

SOHN S., REES P., WILDRIDGE B., *et al.*

2019

BMC Psychiatry 19(1): 356.

<https://doi.org/10.1186/s12888-019-2350-x>

Over the past decade, smartphone use has become widespread amongst today's children and young people (CYP) which parallels increases in poor mental health in this group. Simultaneously, media concern abounds about the existence of 'smartphone addiction' or problematic smartphone use. There has been much recent research concerning the prevalence of problematic smartphone use in children and young people who use smartphones, and how this syndrome relates to mental health outcomes, but this has not been synthesized and critically evaluated.

Health Economics

► Value-Based Provider Payment: Towards A Theoretically Preferred Design

CATTEL D., EIJKENAAR F. ET SCHUT F. T.
2018

Health Economics, Policy and Law 15(1): 94-112.
<https://doi.org/10.1017/S1744133118000397>

Worldwide, policymakers and purchasers are exploring innovative provider payment strategies promoting value in health care, known as value-based payments (VBP). What is meant by 'value', however, is often unclear and the relationship between value and the payment design is not explicated. This paper aims at: (1) identifying value dimensions that are ideally stimulated by VBP and (2) constructing a framework of a theoretically preferred VBP design. Based on a synthesis of both theoretical and empirical studies on payment incentives, we conclude that VBP should consist of two components: a relatively large base payment that implicitly stimulates value and a relatively small payment that explicitly rewards measurable aspects of value (pay-for-performance). Being the largest component, the base payment design is essential, but often neglected when it comes to VBP reform. We explain that this base payment ideally (1) is paid to a multidisciplinary provider group (2) for a cohesive set of care activities for a predefined population, (3) is fixed, (4) is adjusted for the population's risk profile and (5) includes risk-mitigating measures. Finally, some important trade-offs in the practical operationalisation of VBP are discussed.

► Reducing Low Value Services In Surgical Inpatients In Taiwan: Does Diagnosis-Related Group Payment Work?

CHIEN L.-C., CHOU Y.-J., HUANG Y.-C., *et al.*
2020

Health Policy 124(1): 89-96
<https://doi.org/10.1016/j.healthpol.2019.10.005>

Reducing low-value care is a top priority in health care. However, how prospective payment methods such as diagnosis-related group (DRG) payment scheme reduce the use of low-value services is unclear. This study aimed to assess frequency of low-value preoperative

testing services among surgical inpatients over time and to investigate whether the 2010 Tw-DRG policy has reduced utilization of these services under the National Health Insurance program in Taiwan. The nationwide National Health Insurance claims data in Taiwan from 2008 to 2013 were used. The difference-in-differences (DID) method was adopted. Utilization of three low-value preoperative testing services (chest x-ray, echocardiogram, and stress testing) were assessed. The prevalence of the three preoperative tests ranged from 0.13 per 100 admissions (preoperative stress testing) to 78.12 per 100 admissions (preoperative chest x-ray). Following the implementation of the Tw-DRG policy, the predicted probability of low-value care use was significantly reduced from 67.91% to 64.93% in the DRG group but remained relatively stable in the comparison group (from 69.44% to 68.43%) in 2010. The use of three selected preoperative tests had only a minor temporary reduction in 2010, but later increased over time. The 2010 Tw-DRG policy did not significantly moderate the growth of low-value preoperative use. Hospital financial incentives alone may be insufficient for reducing the provision of low-value care.

► Heterogeneity In The Drivers Of Health Expenditures Financed By Health Insurance In A Fragmented Health System: The Case Of Switzerland

EGGLI Y., STADELMANN P., PIAGET-ROSSEL R., *et al.*
2019

Health Policy 123(12): 1275-1281.
<https://doi.org/10.1016/j.healthpol.2019.10.010>

Switzerland is the world's second largest spender on health care, both per capita and as a share of the Gross Domestic Product (GDP). The Swiss health care system is a federation of 26 cantonal systems with highly fragmented provision and financing of care, leading to important geographical disparities in expenditures. We propose a simple conceptual framework to guide the decomposition of health care expenditures into five core components (i.e. demography, propensity to use health services, substitution between domains of care, quantity of services delivered, and unit price of these services), with the objective of better understanding

the drivers of geographic variation. We illustrate this framework using aggregated insurance data from 85% of the 2006 insured population and measure cross-cantonal variation disaggregated into these five components. Results obtained indicated a West-East gradient of controllable costs after adjusting for demography and propensity to use health services. Moreover, we found specific explanations for cost overruns: visits to physicians in private practice in some cantons, and, e.g., outpatient hospital care or variations in drug related expenses in others. This shows that the simple proposed approach provides interesting insights into the drivers of cost differences between regions, specifically in terms of substitution among health services, quantity of delivered services, and their prices.

► **Health Economics Methods For Public Health Resource Allocation: A Qualitative Interview Study Of Decision Makers From An English Local Authority**

FREW E. ET BREHENY K.

2019

Health Economics, Policy and Law 15(1): 128-140.

<https://doi.org/10.1017/S174413311800052X>

Local authorities in England have responsibility for public health, however, in recent years, budgets have been drastically reduced placing decision makers under unprecedented financial pressure. Although health economics can offer support for decision making, there is limited evidence of it being used in practice. The aim of this study was to undertake in-depth qualitative research within one local authority to better understand the context for public health decision making; what, and how economics evidence is being used; and invite suggestions for how methods could be improved to better support local public health decision making. The study included both observational methods and in-depth interviews. Key meetings were observed and semi-structured interviews conducted with participants who had a decision-making role to explore views on economics, to understand the barriers to using evidence and to invite suggestions for improvements to methods. Despite all informants valuing the use of health economics, many barriers were cited: including a perception of a narrow focus on the health sector; lack of consideration of population impact; and problems with translating long timescales to short term impact. Methodological suggestions included the broadening of frameworks; increased

use of natural experiments; and capturing wider non-health outcomes that resonate with the priorities of multiple stakeholders.

► **Effects Of Pay-For-Performance For Primary Care Physicians On Diabetes Outcomes In Single-Payer Health Systems: A Systematic Review**

GUPTA N. ET AYLES H. M.

2019

The European Journal of Health Economics 20(9): 1303-1315.

<https://doi.org/10.1007/s10198-019-01097-4>

Although pay-for-performance (P4P) for diabetes care is increasingly common, evidence of its effectiveness in improving population health and health system sustainability is deficient. This information gap is attributable in part to the heterogeneity of healthcare financing, covered medical conditions, care settings, and provider remuneration arrangements within and across countries. We systematically reviewed the literature concentrating on whether P4P for physicians in primary and community care leads to better diabetes outcomes in single-payer national health insurance systems.

► **National Health Care Spending In 2018: Growth Driven By Accelerations In Medicare And Private Insurance Spending**

HARTMAN M., MARTIN A. B., BENSON J., *et al.*

2020

Health Affairs 39 (1) : 8-17

<https://doi.org/10.1377/hlthaff.2019.01451>

US health care spending increased 4.6 percent to reach \$3.6 trillion in 2018, a faster growth rate than the rate of 4.2 percent in 2017 but the same rate as in 2016. The share of the economy devoted to health care spending declined to 17.7 percent in 2018, compared to 17.9 percent in 2017. The 0.4-percentage-point acceleration in overall growth in 2018 was driven by faster growth in both private health insurance and Medicare, which were influenced by the reinstatement of the health insurance tax. For personal health care spending (which accounted for 84 percent of national health care spending), growth in 2018 remained unchanged

from 2017 at 4.1 percent. The total number of uninsured people increased by 1.0 million for the second year in a row, to reach 30.7 million in 2018.

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

HENSHER M., TISDELL J., CANNY B., *et al.*
2019

Health Economics, Policy and Law: 1-21.
<https://doi.org/10.1017/S1744133119000276>

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

► **Economic Burden Of Stroke Across Europe: A Population-Based Cost Analysis**

LUENGO-FERNANDEZ R., VIOLATO M., CANDIO P., *et al.*
2019

European Stroke Journal: Ahead of pub.
<https://doi.org/10.1177/2396987319883160>

In 2017, 1.5 million people were diagnosed with stroke, 9 million were living with stroke and 0.4 million died

because of stroke in 32 European countries. We estimate the economic burden of stroke across these countries in 2017. In a population-based cost analysis, we evaluated the cost of stroke. We estimated overall health and social care costs from expenditure on care in the primary, outpatient, emergency, inpatient and nursing/residential care settings, and pharmaceuticals. Additionally, we estimated the costs of unpaid care provided by relatives or friends of patients, lost earnings due to premature death and costs associated with individuals who temporarily or permanently left employment because of illness. In 2017 stroke cost the 32 European countries under analysis €60 billion, with health care accounting for €27 billion (45%), representing 1.7% of health expenditure. Adding the costs of social care (€5 billion), annual stroke-related care costs were equivalent to €59 per citizen, varying from €11 in Bulgaria to €140 in Finland. Productivity losses cost €12 billion, equally split between early death and lost working days. A total of €1.3 billion hours of informal care were provided to stroke survivors, costing Europe €16 billion. Our study provides a snapshot of the economic consequences posed by stroke to 32 European countries in 2017. It also strengthens and updates the evidence we have gathered over the last 15 years, indicating that the costs of stroke are rising, partly due to an ageing population.

► **The Effects Of Copayment In Primary Health Care: Evidence From A Natural Experiment**

MAYNOU L., COLL-DE-TUERO G. ET SAEZ M.
2019

The European Journal of Health Economics 20(8): 1237-1248.

<https://doi.org/10.1007/s10198-019-01089-4>

The aim of this study is to evaluate the effects of the 'euro per prescription' on primary health care services (number of doctor visits), through a retrospective cohort study of health care users in Catalonia (Spain). This policy, implemented in Catalonia on 23 June 2012, only lasted 6 months. This policy was introduced to improve budgetary imbalances in Spain and boost the regional and national governments' budgets.

► **Incremental Healthcare Utilisation And Costs Among New Senior High-Cost Users In Ontario, Canada: A Retrospective Matched Cohort Study**

MURATOV S., LEE J., HOLBROOK A., *et al.*

2019

BMJ Open 9(10): e028637.

<https://bmjopen.bmj.com/content/bmjopen/9/10/e028637.full.pdf>

The objectives of this paper is to describe healthcare use and spending before and on becoming a new (incident) senior high-cost user (HCU) compared with senior non-HCUs; to estimate the incremental costs, overall and by service category, attributable to HCU status; and to quantify its monetary impact on the provincial healthcare budget in Ontario, Canada. We conducted a retrospective, population-based comparative cohort study using administrative healthcare records. Incremental healthcare utilisation and costs were determined using the method of recycled predictions allowing adjustment for preincident and incident year values, and covariates. Estimated budget impact was computed as the product of the mean annual total incremental cost and the number of senior HCUs. Incident senior HCUs were defined as Ontarians aged ≥ 66 years who were in the top 5% of healthcare cost users during fiscal year 2013 (FY2013) but not during FY2012. The incident HCU cohort was matched with senior non-HCUs in a ratio of 1 HCU:3 non-HCU. Senior HCUs ($n=175\ 847$) reached the annual HCU threshold of CAD\$10 192 through different combinations of incurred costs. Although HCUs had higher healthcare utilisation and costs at baseline, HCU status was associated with a substantial spike in both, with prolonged hospitalisations playing a major role. Twelve per cent of HCUs reached the HCU expenditure threshold without hospitalisation. Compared with non-HCUs ($n=5\ 27\ 541$), HCUs incurred an additional CAD\$25 527 per patient in total healthcare costs; collectively CAD\$4.5 billion or 9% of the 2013 Ontario healthcare budget. Inpatient care had the highest incremental costs: CAD\$13 427, 53% of the total incremental spending. Costs attributable to incident senior HCU status accounted for almost 1/10 of the provincial healthcare budget. Prolonged hospitalisations made a major contribution to the total incremental costs. A subgroup of patients that became HCU without hospitalisation requires further investigation.

► **How Relevant Are Social Costs In Economic Evaluations? The Case Of Alzheimer's Disease**

PEÑA-LONGBARDO L. M., RODRÍGUEZ-SÁNCHEZ B., OLIVA-MORENO J., *et al.*

2019

The European Journal of Health Economics 20(8): 1207-1236.

<https://doi.org/10.1007/s10198-019-01087-6>

The main objective of this study was to analyse how the inclusion (exclusion) of social costs can alter the results and conclusions of economic evaluations in the field of Alzheimer's disease interventions.

► **Economic Modelling Of Chronic Kidney Disease: A Systematic Literature Review To Inform Conceptual Model Design**

SUGRUE D. M., WARD T., RAI S., *et al.*

2019

PharmacoEconomics 37(12): 1451-1468.

<https://doi.org/10.1007/s40273-019-00835-z>

Chronic kidney disease (CKD) is a progressive condition that leads to irreversible damage to the kidneys and is associated with an increased incidence of cardiovascular events and mortality. As novel interventions become available, estimates of economic and clinical outcomes are needed to guide payer reimbursement decisions.

Health Status

► Patterns Of Alcohol Consumption And Alcohol-Related Harm Among European University Students

COOKE R., BECCARIA F., DEMANT J., *et al.*
2019

European Journal of Public Health 29(6): 1125-1129.
<https://doi.org/10.1093/eurpub/ckz067>

The aim of this paper is to compare patterns of alcohol consumption and alcohol-related harm from a survey of university students sampled from universities in Denmark, England, Germany, Italy, Portugal and Switzerland. A total of 2191 university students (70% female, 90% white ethnic group, age range 18–25) completed the survey. Participants completed measures of demographic variables (age, age of onset, ethnic group and sex) and the Alcohol Use Disorders Identification Test (AUDIT), which was the primary outcome. Sixty-three percent of the sample scored negative for harmful drinking on the AUDIT (<8), with 30% categorized as hazardous drinkers, 4% harmful drinkers and 3% with probable dependence. Analysis of variance, including demographic factors as covariates, identified a main effect of country on AUDIT scores $F(5, 2086) = 70.97$, $P > 0.001$, partial eta square = 0.15. AUDIT scores were highest in England ($M = 9.99$; $SD = 6.17$) and Denmark ($M = 9.52$; $SD = 4.86$) and lowest in Portugal ($M = 4.90$; $SD = 4.60$). Post hoc tests indicated large effect size differences between scores in Denmark and England and scores in all other countries ($0.79 < d < 0.94$; all P 's > 0.001). European university students in our sample mainly reported low risk patterns of alcohol consumption and alcohol-related harm. However, students from Northern European countries had significantly higher AUDIT scores compared with students from Central and Southern European countries. Research is needed to replicate the present study using nationally representative samples to estimate the prevalence of alcohol use disorders among university students in different European countries.

► Inconsistencies In Self-Reported Health Conditions: Results Of A Nationwide Panel Study

JENSEN H. A. R., DAVIDSEN M., CHRISTENSEN A. I.,
et al.
2019

International Journal of Public Health 64(8): 1243-1246.
<https://doi.org/10.1007/s00038-019-01287-0>

Self-reported data on health conditions are frequently used in epidemiological studies since such information often cannot be gathered by other means (Barber et al. 2010). Thus, it is of utmost importance that surveys provide accurate and reliable estimates. Previous studies have indicated that inconsistencies in self-reported morbidity over time vary across health conditions (Beckett et al. 2000; Klabunde et al. 2005; Cigolle et al. 2018). However, the studies are few and have mainly been carried out in specific populations, which makes it difficult to generalize to the entire adult population. The aim of the study was to examine the inconsistencies in 18 health conditions using data from two surveys 4 years apart.

► The Visibility Of Smoking In Europe And Its Relationship With Youth's Positive Beliefs About Smoking

LAGERWEIJ N. A., KUIPERS M. A. G., SCHREUDERS M.,
et al.
2019

International Journal of Public Health 64(9): 1335-1344.
<https://doi.org/10.1007/s00038-019-01288-z>

The aim of this paper is to determine adolescent-reported visibility of smoking in different public and private spaces in Europe and associations between smoking visibility and beliefs about the benefits of smoking. We used SILNE-R cross-sectional survey data (2016/2017) of 10,798 14–16-year-old students from 55 secondary schools in seven European cities. Respondents reported for private and public spaces whether they had seen others smoke there in the last 6 months. Beliefs about the benefits of smoking were

measured on a 7-item scale; higher scores indicated more positive beliefs. Multilevel linear regression analyses determined associations while controlling for potential confounders and stratifying by smoking status. Most students reported observing others smoke in public spaces, especially at train/bus stations (84%). Positive beliefs about smoking of never smokers were positively associated with seeing others smoke in train/bus stations and leisure/sports facilities, but not at home, a friend's home, restaurants or bars, when fully adjusted. Associations were of similar magnitude for ever smokers. Smoking in several public places is highly visible to adolescents. Reducing this visibility might weaken positive beliefs that adolescents have about smoking.

► **Synthèse sur les interventions probantes favorisant le vieillissement en bonne santé**

LAMBOY B., COTTON N., HAMEL E., *et al.*

2019

Gérontologie et société 41 / 160(3): 97-120.

<https://www.cairn.info/revue-gerontologie-et-societe-2019-3-page-97.htm>

Cet article présente l'état des connaissances scientifiques sur les interventions validées et prometteuses qui favorisent le vieillissement en bonne santé auprès de la population générale de 55 ans et plus, autonome et vivant à domicile. Il s'appuie sur les dernières synthèses et a été réalisé selon une démarche méthodologique systématique. C'est ainsi que 31 documents ont été sélectionnés et analysés en double codage (5 synthèses Cochrane, 3 rapports de santé publique et 23 articles de synthèse). Ils ont contribué à identifier 10 types d'interventions probantes permettant d'impacter l'état de santé des personnes âgées et/ou un déterminant majeur du vieillissement. Parmi elles, 6 sont des interventions de prévention universelles s'adressant à toutes les personnes âgées sans risque particulier : les programmes d'exercices physiques, les interventions psychocorporelles, les interventions de stimulation cognitive, les interventions intergénérationnelles, les interventions s'appuyant sur les technologies de l'information et de la communication (TIC) et les interventions culturelles. 3 interventions ciblent une population présentant un risque sanitaire et/ou social : les visites à domicile, les groupes d'activités et d'entraide et les interventions d'aide alimentaire. Enfin, les interventions de counselling ont fait leur preuve aussi bien dans le cadre d'une prévention universelle

que d'une prévention ciblée. Cette synthèse a ainsi permis d'identifier un nombre relativement restreint d'interventions probantes et de déterminants de santé visés, dont très peu de déterminants environnementaux (sociaux et physiques). Ces quelques interventions validées et prometteuses agissent sur plusieurs déterminants, états et problèmes de santé à la fois, justifiant ainsi une approche globale et populationnelle dans le champ de la prévention et de la promotion de la santé des aînés.

► **Changes In Tobacco-Related Morbidity And Mortality In French Women: Worrying Trends**

OLIÉ V., PASQUEREAU A., ASSOGBA F. A. G., *et al.*

2019

European Journal of Public Health: Ahead of pub.

<https://doi.org/10.1093/eurpub/ckz171>

The high prevalence of smoking among French women since the 1970s has been reflected over the past decade by a strong impact on the health of women. This paper describes age and gender differences in France of the impact of smoking on morbidity and mortality trends since the 2000s. Smoking prevalence trends were based on estimates from national surveys from 1974 to 2017. Lung cancer incidence were estimated from 2002–12 cancer registry data. Morbidity data for chronic obstructive pulmonary disease (COPD) exacerbation and myocardial infarction were assessed through hospital admissions data, 2002–15. For each disease, number of deaths between 2000 and 2014 came from the national database on medical causes of death. The tobacco-attributable mortality (all causes) was obtained using a population-attributable fraction methodology. The incidence of lung cancer and COPD increased by 72% and 100%, respectively, among women between 2002 and 2015. For myocardial infarction before the age of 65, the incidence increased by 50% between 2002 and 2015 in women vs. 16% in men and the highest increase was observed in women of 45–64-year-olds. Mortality from lung cancer and COPD increased by 71% and 3%, respectively, among women. The estimated number of women who died as a result of smoking has more than doubled between 2000 and 2014 (7% vs. 3% of all deaths). The increase in the prevalence of smoking among women has a major impact on the morbidity and mortality of tobacco-related diseases in women and will continue to increase for a number of years.

► **Doping Among High School Students: Findings From The French ESPAD Survey**

SHAH J., JANSSEN E., LE NÉZET O., *et al.*
2019

European Journal of Public Health 29(6): 1135-1140.
<https://doi.org/10.1093/eurpub/ckz116>

The increasing use of doping by youth is a growing public health concern. The present study aimed to calculate robust estimates of the prevalence of doping among French high school students and study factors related to the use of licit vs. banned agents. The European School Project on Alcohol and other Drugs (ESPAD), a nationally representative school-based survey, was distributed across France from April to May 2015, generating a final sample size of 6642 students. Multilevel modelling was used to examine covariates of doping to enhance athletic performance in sport in

this population. Overall, 2.3% of students used banned agents, and 6.1% used licit and banned substances to improve athletic performance. Significant gender differences existed for both, with males more prone to doping than females. Our findings provide support for the existing gateway hypothesis that nutritional supplementation leads to doping banned agents. Multilevel modelling revealed the presence of both school and class-level influences on individual use of licit substances, vs. solely class-level factors impacting the use of banned agents, suggesting a strong peer-effect. These findings support the need to engage in early doping prevention through high schools. Programmes should draw attention to the role of licit substances, including nutritional supplementation, in the progression to using banned agents and encompass the continuum of adolescent risk taking through a behaviour-based approach to doping prevention.

Géographie de la santé

Geography of Health

► **Higher US Rural Mortality Rates Linked To Socioeconomic Status, Physician Shortages, And Lack Of Health Insurance**

GONG G., PHILLIPS S. G., HUDSON C., *et al.*
2019

Health Affairs 38(12): 2003-2010.
<https://doi.org/10.1377/hlthaff.2019.00722>

All-cause mortality rates in rural areas have exceeded those in urban areas of the US since the 1980s, and the gap continues to widen. Yet no definitive causes of this difference are known, and within-state differences that might be amenable to state-level policy have not been explored. An analysis of 2016 state-level data indicated that rural mortality exceeded urban mortality in all but three states, with substantial variability in both rates across states. Overall, higher rural mortality at the state level can be mainly explained by three factors: socioeconomic deprivation, physician shortages, and lack of health insurance. To a certain degree, these factors reflect a state's health policies, such as expansion of eligibility for Medicaid, health infrastructure, and socioeconomic conditions. Our findings suggest that state and federal policy efforts to address rural-urban disparities in these areas could alleviate the higher rates of all-cause mortality faced by rural US residents.

► **Lack Of Access To Specialists Associated With Mortality And Preventable Hospitalizations Of Rural Medicare Beneficiaries**

JOHNSTON K. J., WEN H. ET JOYNT MADDOX K. E.
2019

Health Affairs 38(12): 1993-2002.
<https://doi.org/10.1377/hlthaff.2019.00838>

People living in rural areas have worse health outcomes than their urban counterparts do. Understanding what factors account for this could inform policy interventions for reducing rural-urban disparities in health. We examined a nationally representative survey of Medicare beneficiaries with one or more complex chronic conditions, which represented 61 percent of rural and 57 percent of urban Medicare beneficiaries. We found that rural residence was associated with a 40 percent higher preventable hospitalization rate and a 23 percent higher mortality rate, compared to urban residence. Having one or more specialist visits during the previous year was associated with a 15.9 percent lower preventable hospitalization rate and a 16.6 percent lower mortality rate for people with chronic conditions, after we controlled for having one or more primary care provider visits. Access to special-

ists accounted for 55 percent and 40 percent of the rural-urban difference in preventable hospitalizations and mortality, respectively. Medicare should consider interventions for rural beneficiaries who lack access to specialist care to reduce rural-urban disparities in health outcomes.

► **Comportements et pratiques des médecins : exercer dans les zones les moins dotées, cela fait-il une différence ?**

SILHOL J., VENTELOU B., ZAYTSEVA A., *et al.*
2019

Revue française des affaires sociales(2): 213-249.
<https://www.cairn.info/revue-francaise-des-affaires-sociales-2019-2-page-213.htm>

Selon les projections récentes, les effectifs de médecins libéraux diminueront de 30 % d'ici à 2027 et la densité standardisée diminuerait jusqu'en 2023, créant des poches de sous-densité relativement nombreuses sur le territoire français métropolitain. L'article s'intéresse aux ajustements que les médecins généralistes de ville mettent en œuvre lorsque, sur leur territoire, ils sont d'ores et déjà confrontés à cette raréfaction. Les données utilisées sont celles du troisième panel des médecins généralistes enrichies d'indicateurs fournis par la Cnamts. Nous nous sommes appuyés sur l'indicateur d'accessibilité potentielle localisé, développé par l'Irdes et la Drees, pour définir les zones les moins dotées en généralistes. En comparant les comportements des généralistes exerçant dans les zones les moins dotées à leurs homologues des zones mieux dotées, il est apparu d'abord que le planning d'activité du médecin tend à s'intensifier plutôt qu'à s'allonger. Nos données semblent en effet montrer que les rythmes de consultation dans les zones les moins dotées sont plus élevés, alors que le temps de travail global des généralistes s'avère quant à lui peu réactif à la densité en médecins alentour. On note aussi quelques différences statistiquement significatives sur les pratiques médicales : usage accru de certains médicaments, moins de renvoi vers des soins paramédicaux, suivis gynécologique probablement un peu moins réguliers, etc. Cependant, il semble que les différences ne sont pas statistiquement significatives pour les indicateurs de qualité des pratiques rattachés au dispositif de rémunération sur objectifs de santé publique (ROSP).

► **L'observation socio-territoriale par les acteurs du secteur social : catégories d'analyse et choix méthodologiques**

TERRIER E.
2019

Espaces et sociétés 176-177(1): 15-32.
<https://www.cairn.info/revue-espaces-et-societes-2019-1-page-15.htm>

La territorialisation de l'action sociale en France a favorisé le développement de l'analyse spatiale des réalités sociales locales. Cet article s'intéresse à la manière dont l'observation des territoires est actuellement abordée au sein des institutions de l'action sociale. Il s'agit de mieux comprendre les approches théoriques et méthodologiques qui sont actuellement privilégiées par différents acteurs du secteur social : qu'ils soient spécialistes de l'observation sociale locale, cadres de l'action sociale ou travailleurs sociaux. Cette réflexion s'appuie sur les résultats de plusieurs recherches-actions menées avec des départements. L'évaluation des travaux existants au sein des collectivités et au niveau national montre une prédominance de l'approche statistique et cartographique des données socio-économiques.

► **Is Accessibility In The Eye Of The Beholder? Social Inequalities In Spatial Accessibility To Health-Related Resources In Montréal, Canada**

VALLÉE J., SHARECK M., LE ROUX G., *et al.*
2019

Social Science & Medicine: Ahead of pub.
<https://doi.org/10.1016/j.socscimed.2019.112702>

Neighbourhood resources are often considered to be spatially accessible to people when they are located close to their place of residence, a perspective which overlooks individuals' unique lived experience of their neighbourhood and how they define it. Drawing on the relational approach to place and on Sen's capability approach, we explore spatial accessibility to health-related resources, and the social gradient therein, in light of people's place experiences. Using data from 1101 young adults from Montreal (Canada) who participated in the Interdisciplinary Study of Inequalities in Smoking (ISIS), we compare the social gradients in the presence of health-related resources located (i) within uniform areas (defined as circular buffers and road-network buffers) around participants' place of

residence; and (ii) within participants' self-defined neighbourhoods. Social inequalities in accessibility to a diversity of health-related resources (grocery stores, fruit and vegetable stores, eating and drinking places, recreational sports centres, civic, social, and fraternal organizations, bike paths, parks, social services,

libraries, dental offices, physician offices) were more pronounced in self-defined neighbourhoods than in uniform buffer areas. Neglecting the variability in people's place experiences may distort the assessment of social inequalities in accessibility, and ultimately, of neighbourhood effects on health inequalities.

Disability

► **Déficience intellectuelle et dépistage organisé des cancers**

DOUTRE-LECLERCQ E. ET CHARLES R.

2019

Médecine : De La Médecine Factuelle à Nos Pratiques 15(9): 417-422.

Les personnes avec une déficience intellectuelle ont un risque plus élevé de développer un cancer colique; le cancer du sein survient plus tôt et est plus souvent disséminé. Le taux de réalisation du dépistage organisé des cancers reste inférieur à la population générale. Cet article tente de comprendre les particularités du dépistage organisé des cancers chez les personnes avec une déficience intellectuelle et d'effectuer un focus sur une action de promotion en Auvergne- Rhône-Alpes.

► **Géographie de la population des enfants en situation de handicap en France métropolitaine**

ETCHEGARAY A., BOURGAREL S., MAZUREK H., *et al.*

2019

Santé Publique 31(2): 255-267.

<https://www.cairn.info/revue-sante-publique-2019-2-page-255.htm>

L'adéquation entre offre et demande de service ou d'équipement pour les enfants handicapés n'est pas aisée à déterminer car d'une part, la distribution du handicap n'est pas homogène sur le territoire, et d'autre part il existe une diversité de bases de données qui ne fournit pas une estimation réelle de la demande. Nous proposons dans un premier temps une discussion sur les sources de données disponibles pour approcher la répartition géographique des enfants en situation

de handicap. Dans un second temps nous proposons un modèle de répartition sur la base d'une analyse statistique spatiale des déterminants du handicap. Notre objectif est de comprendre de quelles façons les données disponibles peuvent être, en évaluant leur convergence, indicatrices de la répartition de la population des enfants en situation de handicap sur le territoire. Une discussion critique est nécessaire sur les lacunes des dispositifs de mesure et d'appréciation du handicap afin d'améliorer le lien entre l'estimation de la population et l'offre de service.

► **Le PCPE : un nouveau dispositif pour les personnes en situation de handicap**

OSINSKI G.

2020

Le Journal des psychologues 373(1): 74-77.

<https://www.cairn.info/revue-le-journal-des-psychologues-2020-1-page-74.htm>

Dans cet article, l'auteure nous livre son expérience en tant que psychologue au sein d'un nouveau dispositif : le Pôle de compétences et de prestations externalisées (pcpe) de Nîmes. Conçu comme un nouvel outil dans le champ du médico-social, il offre aux personnes porteuses de handicap confrontées à des ruptures au sein de leurs parcours de soins une réponse individualisée. Le but : relancer la dynamique du lien, et restaurer la place du sujet au sein de la société.

Hospitals

► **Crise à l'hôpital et dans les EHPAD, même combat : abattons les murs !**

BAUDIER F.

2019

Santé Publique 31(2): 293-295.

<https://www.cairn.info/revue-sante-publique-2019-2-page-293.htm>

La crise dans les hôpitaux publics et les établissements d'hébergement pour personnes âgées (EHPAD) se focalise sur les problématiques de gouvernance et les moyens internes (notamment financiers), alors que les réponses se trouvent dans une fluidité organisée et consolidée entre le monde des institutions hospitalières ou médico-sociales et celui des lieux de vie habituelle de la population. Sur le plan hospitalier, les principales difficultés sont dues à un transfert régulièrement annoncé, mais non réalisé, entre les activités de ces établissements et la médecine ambulatoire. La solution se trouve certainement dans un pilotage unique de la politique de santé, actuellement partagé entre l'État et l'Assurance maladie. Pour les EHPAD, l'institutionnalisation des personnes âgées fragiles et/ou en voie de dépendance, ainsi que la multiplication non aboutie de multiples expérimentations de leur prise en charge à domicile, conduisent, d'une part, à une offre de plus en plus complexe, peu lisible pour tout le monde, et d'autre part, à faire reposer principalement sur le généraliste la coordination de cette prise en charge. La solution se trouve certainement dans une offre universelle, relevant du droit commun et permettant aux personnes âgées de rester le plus longtemps possible chez elle, ce qu'elles souhaitent le plus. *Health Economics : Ahead of pub.*

► **Adherence To Medical Follow-Up Recommendations Reduces Hospital Admissions: Evidence From Diabetic Patients In France**

BUSSIERE C. ET SIRVEN N.

2020

The aim of this study was to document the extent to which diabetic patients who adhered to required medical follow-ups in France experienced reduced hospi-

tal admissions over time. The main assumption was that enhanced monitoring and follow-up of diabetic patients in the primary care setting could be a substitute for hospital use. Using longitudinal claim data of diabetic patients between 2010 and 2015 from MGEN, a leading mutuelle insurance company in France, we estimated a dynamic logit model with lagged measures of the quality of adherence to eight medical follow-up recommendations. This model allowed us to disentangle follow-up care in hospitals from other forms of inpatient care that could occur simultaneously. We found that a higher adherence to medical guidance is associated with a lower probability of hospitalization and that the take-up of each of the eight recommendations may help reduce the rates of hospital admission. The reasons for the variation in patient adherence and implications for health policy are discussed.

► **Why are there long waits at English emergency departments?**

GAUGHAN J., KASTERIDIS P., MASON A., *et al.*

2019

Eur J Health Econ.: Ahead of pub.

A core performance target for the English National Health Service (NHS) concerns waiting times at Emergency Departments (EDs), with the aim of minimising long waits. We investigate the drivers of long waits. We analyse weekly data for all major EDs in England from April 2011 to March 2016. A Poisson model with ED fixed effects is used to explore the impact on long (> 4 h) waits of variations in demand (population need and patient case-mix) and supply (emergency physicians, introduction of a Minor Injury Unit (MIU), inpatient bed occupancy, delayed discharges and long-term care). We assess overall ED waits and waits on a trolley (gurney) before admission. We also investigate variation in performance among EDs. The rate of long overall waits is higher in EDs serving older patients (4.2%), where a higher proportion of attendees leave without being treated (15.1%), in EDs with a higher death rate (3.3%) and in those located in hospitals with greater bed occupancy (1.5%). These factors are also significantly associated with higher rates of long trolley waits. The introduction of a co-located MIU is

significantly and positively associated with long overall waits, but not with trolley waits. There is substantial variation in waits among EDs that cannot be explained by observed demand and supply characteristics. The drivers of long waits are only partially understood but addressing them is likely to require a multi-faceted approach. EDs with high rates of unexplained long waits would repay further investigation to ascertain how they might improve.

► **Soins en HAD : aspects cliniques, complexité et modalités d'intervention des soignants**

GENTIN M., MARQUESTAUT O. ET DE STAMPA M.
2019

Santé Publique 31(2): 269-276.

<https://www.cairn.info/revue-sante-publique-2019-2-page-269.htm>

Le nombre de patients âgés suivi en hospitalisation à domicile (HAD) est en forte augmentation en France. Notre objectif est de décrire les caractéristiques cliniques, les modalités d'interventions et la complexité des soins de patients âgés en HAD. Il s'agit d'une étude transversale sur un échantillon de 50 patients âgés de 75 ans et plus vivant à domicile et suivis à l'HAD de l'Assistance Publique-Hôpitaux de Paris en 2016. Le recueil des données a utilisé l'outil d'évaluation multidimensionnel interRAI-CA (Resident Assessment Instrument - Contact Assessment). L'âge moyen était de 84 ans avec 48 % de femmes, 26 % vivait seul et 96 % avait un aidant qui présentait des difficultés dans 1/3 des cas. Les patients étaient poly-pathologiques, avaient des difficultés cognitives dans 68 % des cas et des incapacités fonctionnelles fréquentes. Une large majorité se déclarait douloureux et 52 % présentait une situation clinique instable. Les modalités d'interventions étaient polyvalentes (pansements complexes, soins de support et soins palliatifs) avec des soins techniques et la mobilisation de plus de 3 professionnels dans 80 % des cas. Enfin, les soins avaient un haut niveau de complexité pour 74 % des patients. Les patients âgés suivis en HAD présentaient une complexité médico-psycho-sociale avec des soins polyvalents et techniques nécessitant une coordination des intervenants et le soutien des aidants. Le développement de l'HAD permet le transfert d'une partie des soins gériatriques de l'hospitalisation conventionnelle vers le domicile et permet de structurer l'expertise gérontologique auprès de l'offre de service de proximité.

► **Chirurgie de l'obésité en France : la qualité de la prise en charge est-elle toujours au rendez-vous ?**

GERSON M.
2019

Médecine : De La Médecine Factuelle à Nos Pratiques 15(9): 388-390.

Ces dernières années, les rapports sur la pratique de la chirurgie bariatrique se sont multipliés, dressant des états des lieux convergents. L'analyse des données du PMSI (Programme de Médicalisation des Systèmes d'Information) concernant les séjours pour chirurgie bariatrique en établissement de santé a donné lieu à plusieurs publications. En France, le taux de recours à la chirurgie bariatrique a été multiplié par 2,6 entre 2008 et 2014 avec une croissance beaucoup plus rapide de la sleeve gastrectomie (SG), alias gastrectomie longitudinale : la part de cette intervention est passée de 16,9 % en 2008 à 60,6 % en 2014. Sur une période plus longue (1997 à 2007), le nombre d'interventions a été multiplié par plus de 20, passant de 2 800 en 1997 à 59 300 en 2016 avec un taux d'hospitalisation qui a progressé de 0,5 à 8,9 séjours pour 10 000 personnes. L'analyse de ces données montre de nombreuses défaillances dans la prise en charge des patients : bilan préopératoire incomplet, information insuffisante des médecins généralistes, différences importantes d'un département à l'autre... Cet article fait le point sur la question.

► **Nationwide Incidence Of Patients Hospitalized For A Valvular Heart Disease According To Etiology: Patient Characteristics And Temporal Trends In France 2006–2016**

GRAVE C., TRIBOUILLOY C., JUILLIÈRE Y., *et al.*
2020

Archives of Cardiovascular Diseases Supplements 12(1): 84.

<http://www.sciencedirect.com/science/article/pii/S1878648019306950>

The main etiologies of valvular heart disease (VHD) are rheumatic fever and age-related degeneration. In 2016, the prevalence of patients managed for a VHD was 0,6% of the French population (341,500people). However, few recent incidence data are available in France. Purpose Estimate the annual incidence of patients hospitalized for VHD in France according to

their etiology, describe their characteristics and the temporal trends. Methods All patients hospitalized for VHD in France between 2006 and 2016 were identified using data from the national hospital discharge database (PMSI-MCO) integrated into the national health data system (SNDS). The first stay of the year in which the patient was hospitalized with a principal or related diagnosis of VHD was selected. Descriptive analyses of patients' demographic and medical characteristics and trends from 2006–2016 were stratified according to the origin of valvular heart disease. Results In 2016 38,875 patients were hospitalized for a VHD in France. Of these, 89% were hospitalized for non-rheumatic VHD (52.1/100,000 person-year (PY)) with an average age of 74 years; 5% for rheumatic VHD (3.1/100,000PY) with an average age of 67 years; 3% for congenital VHD (1.1/100,000PY) with an average age of 29 years; and 3% for unspecified origin. The incidence of patients hospitalized for non-rheumatic VHD increased by 43% between 2006 and 2016, particularly in older patients. It has decreased by 42% for rheumatic VHD. Departmental disparities were observed for these disorders, with a high incidence of hospitalization for rheumatic VHD in the Ile-de-France, the French overseas departments and territories and the south-east. Conclusion The improvement in the management of streptococcal A angina, the increase in life expectancy and the expansion of indications for the management of aortic stenosis and mitral regurgitation by transcatheter valve replacement have reshaped the distribution of types of VHD hospitalized since 2006.

► **Preventable Hospitalizations From Ambulatory Care Sensitive Conditions In Nursing Homes: Evidence From Switzerland**

MUENCH U., SIMON M., GUERBAAI R.-A., *et al.*

2019

International Journal of Public Health 64(9): 1273-1281.

<https://doi.org/10.1007/s00038-019-01294-1>

Reducing nursing home hospitalizations for ambulatory care sensitive conditions (ACSC) has been identified as an opportunity to improve patient well-being and reduce costs. The aim of this study was to identify number of hospitalizations for ACSCs for nursing home residents in a Swiss national sample, examine demographic characteristics of nursing home hospitalizations due to ACSCs, and calculate hospital expenses from these hospitalizations.

► **Diminuer les réhospitalisations des patients âgés polymédiqués : une expérimentation prometteuse en Meurthe-et-Moselle**

PRESCRIRE

2020

Revue Prescrire(435): 57-61.

Cet article rend compte d'une expérimentation menée à Lunéville par des professionnels de santé pour réduire la réhospitalisation des personnes âgées polymédiqués. Au sein d'un programme dénommé Médisis, les patients bénéficient d'un parcours de soins comportant notamment une conciliation médicamenteuse à l'entrée d'une hospitalisation, l'évaluation de la pertinence des prescriptions ainsi que des séances d'accompagnement thérapeutique à l'hôpital et en ville. Au moyen de différents indicateurs, les professionnels de ce programme ont mesuré l'impact sur la qualité des soins.

► **Ambulatory Care-Sensitive Emergency Department Cases: A Mixed Methods Approach To Systemize And Analyze Cases In Germany**

SCHUETTIG W. ET SUNDMACHER L.

2019

European Journal of Public Health 29(6): 1024-1030.

<https://doi.org/10.1093/eurpub/ckz081>

Internationally, emergency departments (ED) are treating increasing numbers of patients with conditions that could have been managed appropriately in ambulatory care (AC) settings. The aim of our study was to develop the first consensus-based list of AC-sensitive conditions commonly seen in German EDs and explore predictors of these visits. Our study used a Delphi survey of 30 physicians to compile a list of conditions they agreed were amenable to AC treatment. The group identified reasons why patients visit EDs instead of AC. We used the results to inform spatial regression models analysing the association of patient characteristics and attributes of AC with AC-sensitive ED visits based on 2015 district-level data. Our study provides a list of AC-sensitive conditions based on the German ED context. Results suggest that, up to the age of 70 years, the older the patients, the less likely they seek EDs for these conditions. Results of our regression analyses suggest that AC-sensitive ED rates were significantly higher in districts with lower physician density. Patients' urgency

perception and preferences were identified as main drivers of AC-sensitive ED visits. Future policy measures should aim to help guide patients through the health-care system so that they receive the best care in place that is most appropriate in terms of quality, safety and continuity of care. A list of AC-sensitive ED conditions can be used as a monitoring instrument and for further analyses of routine data to inform policy makers seeking to improve resource use and allocation.

► **Quality Improvement In Hospitals In The Russian Federation, 2000–2016: A Systematic Review – ADDENDUM**

VLASSOV V. V., BATES K. ET MCKEE M.
2019

Health Economics, Policy and Law: Ahead of pub.
<https://doi.org/10.1017/S1744133119000252>

We reviewed published evidence on quality improvement in hospitals in the Russian Federation since 2000.

We used three data sources: MEDLINE, ‘Rossiiskaia Meditsina’ (Central Scientific Medical Library), and elibrary.ru using specific search terms. No language or study design restrictions were imposed. In total, 1717 articles were identified; 51 met the inclusion criteria and were thematically analysed. Russian legislation, government acts and grey literature were sourced to contextualise identified themes. Since 2010, the Federal Ministry of Health has increasingly sought to improve quality of care, providing additional resources and new initiatives across the health system. These include clinical practice guidelines, pay for performance schemes, electronic medical records, more specialist care, paraclinical care, and quality control systems. Quality of care, increasingly a concern of the Russian government, is said to be improving. Yet most initiatives have rarely been evaluated. This reflects the limited capacity for health services research in Russia. It seems likely that the full potential for improvements in quality of care in Russia is still to be realised.

Inégalités de santé

Health Inequalities

► **Relevance Of The “Immigrant Health Paradox” For The Health Of Arab Americans In California**

ABUELEZAM N. N., EL-SAYED A. M. ET GALEA S.
2019

American Journal of Public Health 109(12): 1733-1738.

<https://doi.org/10.2105/AJPH.2019.305308>

The aim of this paper is to assess the validity of the immigrant health paradox among Arab Americans in California. We used data from the 2003 to 2017 California Health Interview Survey (n = 1425). We used survey-weighted χ^2 and logistic regression analyses to compare Arabs by immigrant generation on socio-economic indicators, health behaviors, and health outcomes. Second-generation Arab Americans had higher odds of binge drinking (adjusted odds ratio [AOR] = 3.26; 95% confidence interval [CI] = 1.53, 6.94) in the past year than did first-generation Arab Americans. Third-generation Arab Americans had greater odds of receiving the influenza vaccine in the

past year (AOR = 3.29; 95% CI = 1.09, 9.98) than did second-generation Arab Americans. Third-generation Arab Americans had increased odds of being overweight or obese when compared with first- (AOR = 2.59; 95% CI = 1.02, 6.58) and second-generation Arab Americans (AOR = 3.22; 95% CI = 1.25, 8.29), respectively. Alcohol use increased across immigrant generations, and we observed no differences in health outcomes, other than obesity. The immigrant health paradox does not appear to apply to Arab Americans in California; mechanisms that generate health in this population should be studied further. First-generation immigrants to the United States—those born in another country who immigrate to the United States—have generally been shown to have better health outcomes and behaviors than second-generation (born in the United States to immigrant parents) and third-generation (born in the United States to US-born parents with immigrant heritage) counterparts of the same ethnic background.^{1,2} This phenomenon has been termed the “immigrant health paradox” or the “healthy immigrant paradox.”

► **A “Healthy Immigrant Effect” Or A “Sick Immigrant Effect”? Selection And Policies Matter**

CONSTANT A. F., GARCÍA-MUÑOZ T., NEUMAN S., *et al.*

2018

The European Journal of Health Economics 19(1): 103-121.

<https://doi.org/10.1007/s10198-017-0870-1>

Previous literature on a variety of countries has documented a “healthy immigrant effect” (HIE). Accordingly, immigrants arriving in the host country are, on average, healthier than comparable natives. However, their health status dissipates with additional years in the country. HIE is explained through the positive self-selection of healthy immigrants as well as the positive selection, screening and discrimination applied by host countries. In this article we study the health trajectories of immigrants within the context of selection and migration policies. Using SHARE data we examine the HIE, comparing Israel and 16 European countries that have fundamentally different migration policies. Israel has virtually unrestricted open gates for Jewish people around the world, who in turn have ideological rather than economic considerations to move. European countries have selective policies with regards to the health, education and wealth of migrants, who also self-select themselves. Our results provide evidence that (1) immigrants who move to Israel have compromised health and are significantly less healthy than comparable natives. Their health disadvantage persists for up to 20 years of living in Israel, after which they become similar to natives; (2) immigrants who move to Europe have significantly better health than comparable natives. Their health advantage remains positive for many years. Even though during some time lapses they are not significantly different from natives, their health status never becomes worse than that of natives. Our results are important for migration policy and relevant for domestic health policy.

► **Social Inequalities In Multimorbidity, Frailty, Disability, And Transitions To Mortality: A 24-Year Follow-Up Of The Whitehall II Cohort Study**

DUGRAVOT A., FAYOSSE A., DUMURGIER J., *et al.*

2019

Lancet Public Health: Ahead of pub.

Social inequalities in mortality persist in high-income countries with universal health care, and the mechanisms by which these inequalities are generated remain unclear. We aimed to examine whether social inequalities were present before or after the onset of adverse health conditions (multimorbidity, frailty, and disability). Our analysis was based on data from the ongoing Whitehall II cohort study, which enrolled British civil servants aged 35-55 years in 1985-88. Participants were assessed for three indicators of socioeconomic status (education, occupational position, and literacy) at age 50 years. Participants underwent clinical examinations (in 2002-04, 2007-09, 2012-13, and 2015-16) for assessment of frailty (two or more of low physical activity, slow walking speed, poor grip strength, weight loss, and exhaustion) and disability (two or more difficulties in bathing, dressing, going to the toilet, transferring, feeding, and walking). In addition, electronic health records were used to assess the incidence of multimorbidity (two or more of diabetes, coronary heart disease, stroke, chronic obstructive pulmonary disease, depression, arthritis, cancer, dementia, and Parkinson’s disease) and mortality. In analyses adjusted for sociodemographic factors, we used multistate models to examine social inequalities in transitions from healthy state to adverse health conditions and subsequently to mortality. FINDINGS: Of 10 308 individuals in the Whitehall II study cohort, 6425 had relevant data available at 50 years and to the end of follow-up on Aug 31, 2017, and were included in our analysis. Participants were followed up for a median of 23.6 years (IQR 19.6-28.9). 1694 (26.4%) of 6425 participants developed multimorbidity, 1733 (27.0%) became frail, 692 (10.8%) had a disability, and 611 (9.5%) died. Multimorbidity (hazard ratio [HR] 4.12 [95% CI 3.41-4.98]), frailty (HR 2.38 [95% CI 1.93-2.93]), and disability (HR 1.73 [95% CI 1.34-2.22]) were associated with increased risk of mortality; these associations were not modified by socioeconomic status. In multistate models, occupation was the socioeconomic status indicator that was most strongly associated with inequalities in the transition from healthy state to multimorbidity (HR 1.54 [95% CI 1.37-1.73]), to frailty (HR 2.08 [95% CI 1.85-2.33]), and to disability (HR 1.44 [95% CI 1.18-1.74]). Socioeconomic status indicators did not affect transitions to mortality in those with multimorbidity, frailty, or disability. INTERPRETATION: Socioeconomic status affects the risk of multimorbidity, frailty, and disability, but does not affect the risk of mortality after the onset of these adverse health conditions. Therefore, primary prevention is key to reducing social inequalities in mortality. Of the three adverse health condi-

tions, multimorbidity had the strongest association with mortality, making it a central target for improving population health. FUNDING: UK Medical Research Council; National Institute on Aging, National Institutes of Health; British Heart Foundation.

► **Accès aux soins primaires des mineurs isolés étrangers dits «mineurs non accompagnés»**

DUPONT E.
2019

Médecine : De La Médecine Factuelle à Nos Pratiques 15(10): 445-451.

Les mineurs non accompagnés (MNA) constituent un groupe vulnérable significatif. Ils nécessitent un accompagnement médical individualisé prenant en compte leur parcours et leur environnement : les médecins généralistes pourraient être des interlocuteurs privilégiés. Cependant, la complexité de leurs parcours et la situation administrative inhabituelle dans laquelle ils se trouvent peuvent être à l'origine d'inquiétudes chez les médecins. Un bilan de santé est recommandé dès l'étape d'évaluation de leur minorité effectuée par les conseils départementaux. Se pose alors la question de la possibilité de ces soins sans le consentement des titulaires de l'autorité parentale ou d'un représentant légal.

► **La pauvreté subjective comme mesure de l'insécurité sociale. Une comparaison des différents indicateurs de pauvreté**

DUVOUX N. ET PAPUCHON A.
2019

Savoir/Agir 49(3): 87-93.

<https://www.cairn.info/revue-savoir-agir-2019-3-page-87.htm>

Ce deuxième volet du dossier sur les classes sociales aborde quelques-uns des enjeux conceptuels et politiques d'une approche en terme de « classes ». Postulant qu'en délaissant cette approche la sociologie s'est privée d'un ensemble de questionnements, de notions et de résultats forgés par une longue tradition de recherche, il propose une série de contributions démontrant, à partir de points de vue variés, la fécondité des outils conceptuels « classistes » pour saisir et analyser les dynamiques sociales du présent. Il soulève enfin quelques questions plus immédiatement

politiques, en interrogeant la capacité de mobilisation (partisane et syndicale) des « classes populaires », et en reposant, contre les fausses évidences de la stratégie « populiste », la (vieuse) question des « alliances de classes ».

► **Reintegrating Contexts Into Quantitative Intersectional Analyses Of Health Inequalities**

EVANS C. R.
2019

Health & Place 60: 102214.

<https://doi.org/10.1016/j.healthplace.2019.102214>

Quantitative intersectional analyses often overlook the roles of contexts in shaping intersectional experiences and outcomes. This study advances a novel approach for integrating quantitative intersectional methods with models of contextual-level determinants of health inequalities. Building on recent methodological advancements, I propose an adaptation of intersectional MAIHDA (multilevel analysis of individual heterogeneity and discriminatory accuracy) where respondents are nested hierarchically in social strata defined by gender, race/ethnicity and socioeconomic classifications interacted with contextual classifications. To demonstrate this approach I examine past-month adolescent cigarette use intersectionally by school- and neighborhood-poverty status in Wave 1 of the National Longitudinal Study of Adolescent to Adult Health (N = 17,234). I conclude by discussing the adaptability of this approach to a variety of research questions, including intersectional effects that vary by contextual exposures over time, positions in social networks, and exposures to social policies.

► **Les inégalités se mesurent, les discriminations se constatent**

JUGNOT S.
2019

La Revue de l'Ires 98(2): 3-28.

<https://www.cairn.info/revue-de-l-ires-2019-2-page-3.htm>

La loi « pour la liberté de choisir son avenir professionnel », votée en 2018, cherche à passer d'une obligation de moyens à une obligation de résultats sur les écarts de rémunération entre les femmes et les hommes. Elle s'appuie sur l'idée que les discriminations pourraient se

mesurer, offrant ainsi des quantifications pour piloter l'action. Cet article rappelle qu'en réalité, cette prétention est illusoire d'un point de vue statistique en revenant sur les deux approches les plus souvent mobilisées : les analyses statistiques dites « toutes choses égales par ailleurs » et les testings statistiques. Il explique en quoi ces outils ne permettent pas de quantifier l'ampleur des discriminations, sans en remettre en cause l'intérêt. L'absence de mesure n'oblige pas à renoncer à l'action. Elle doit plutôt être une invitation à la réflexion et aux approches interdisciplinaires qui ne font pas du chiffre la pierre angulaire de la preuve.

► **Facilitateurs et barrières pour l'accès aux soins chez les requérants d'asile du canton de Vaud en Suisse et recommandations**

MAILLEFER F., BOVET É., JATON L., *et al.*
2019

Recherche en soins infirmiers 137(2): 26-40.
<https://www.cairn.info/revue-recherche-en-soins-infirmiers-2019-2-page-26.htm>

Face à un afflux exceptionnel de requérants d'asile en Suisse en 2015, les soignants ont dû faire face à de nouvelles problématiques. Il manque des travaux locaux ayant investigué parallèlement le vécu des requérants d'asile en lien avec le système de santé et les perceptions des professionnels de santé en contact avec les requérants d'asile. Objectifs : avoir une meilleure compréhension des besoins spécifiques des RA puis mettre en place des actions concrètes afin d'améliorer l'accès aux soins et augmenter l'efficacité de la prise en charge. La méthode est fondée sur une étude qualitative comprenant des entretiens individuels et de groupe avec des requérants d'asile et trois focus group avec des soignants et des interprètes. Résultats : les résultats concernent l'accès aux soins dans le pays d'origine, les représentations sur les conditions de vie en Suisse, les effets du parcours migratoire sur la santé, les représentations vis-à-vis de la psychiatrie et de la bonne santé, la fréquentation des urgences, les motifs des rendez-vous manqués, l'aide par les pairs. L'information, la confiance, suffisamment de temps, sont les éléments-clé identifiés pour créer un lien qui optimise l'accès aux soins. Cette recherche a permis une meilleure compréhension des besoins spécifiques. Des recommandations pour la pratique ont été émises.

► **Vieillesse et migration : les salariées immigrées dans le secteur du care en Espagne**

MORÉ P.
2018

Retraite et société 80(2): 13-33.
<https://www.cairn.info/revue-retraite-et-societe-2018-2-page-13.htm>

L'Espagne se trouve dans une situation de vieillissement progressif de sa population. Elle doit par conséquent faire face à une demande croissante d'accompagnement et de soins chez les personnes âgées. Depuis les années 1990, ce secteur emploie une main-d'œuvre majoritairement féminine et immigrée, notamment issue des pays d'Amérique latine. Puisque certaines de ces femmes se trouvent actuellement proches de l'âge de la retraite, cet article analyse la façon dont elles envisagent leur avenir, certaines en tant que personnes âgées en terre d'immigration, d'autres souhaitant plutôt retourner dans leur pays d'origine. À partir d'une méthodologie qualitative, cet article explore dans une première partie l'influence du travail salarié sur le vieillissement et la santé des femmes équatoriennes qui travaillent auprès des personnes âgées à Madrid. Il aborde ensuite l'évolution des projets migratoires qu'elles forment dans la perspective de leur propre vieillesse. Enfin, il analyse l'accès à la retraite de ces femmes, dans le contexte de leurs trajectoires migratoires et de leurs parcours de travail dans le secteur du care.

► **Unmet Needs Across Europe: Disclosing Knowledge Beyond The Ordinary Measure**

RAMOS L. M., QUINTAL C., LOURENÇO Ó., *et al.*
2019

Health Policy 123(12): 1155-1162.
<https://doi.org/10.1016/j.healthpol.2019.09.013>

Unmet healthcare needs (or foregone healthcare) is a widely used intermediate indicator to evaluate healthcare systems attainment since it relates to health outcomes, financial risk protection, improved efficiency and responsiveness to the individuals' legitimate expectations. This paper discusses the ordinary measure of this indicator used so far, prevalence of unmet needs in the whole population, based on the level of healthcare needs among the population. The prevalence of needs and the prevalence of unmet needs among those in need are key aspects that have not yet been fully explored when it comes to foregone

healthcare. We break down the ordinary measure into prevalence of needs and prevalence of unmet needs among those in need based on data taken from the European Social Survey 2014. Afterwards, we analyse these different measures in a cross-country perspective. We also discuss the link between them and the implicit relative assessment of healthcare systems considering the whole population and the sub-group of the population aged 65 or more. Comparisons across countries show different attainment levels unveiling varying challenges across European countries, depending on the combination of levels of need and levels of unmet needs for those in need.

► **Innovations pour l'amélioration de l'accès aux soins des personnes vulnérables dans les pays de l'OCDE**

SAMB O. M., LOIGNON C. ET CONTANDRIOPOULOS-PRIEST H.

2019

Santé Publique 31(4): 497-505.

<https://www.cairn.info/revue-sante-publique-2019-4-page-497.htm>

Cette étude présente les résultats d'une revue systématique mixte qui visait à élaborer une cartographie ainsi qu'à comprendre les éléments essentiels au succès des innovations visant à améliorer l'accès aux soins des personnes en situation de vulnérabilité sociale. Une revue systématique mixte de la littérature a été conduite. La recherche documentaire qui a été réalisée à partir de plusieurs bases de données (Medline, Cinahl, Embase, Social Work, SocIndex) a couvert l'ensemble des pays de l'OCDE et a porté sur une période de 10 ans (2005-2015). Un total de 26 articles a été inclus dans la revue. La synthèse thématique a permis d'identifier plusieurs catégories d'innovations comme les services de navigation, l'offre de soins en « stratégie avancée » et les cliniques offrant des soins adaptés. Elle a aussi permis de mettre en exergue des caractéristiques essentielles qui ont contribué à la performance de ces innovations et à la satisfaction des patients comme, la connaissance et la maîtrise du contexte par l'intervenant, la collaboration inter-organisationnelle et interprofessionnelle, le respect dans la fourniture des soins et enfin la pérennité du financement. L'un des principaux enseignements de cette revue est que l'offre de soins donnée de façon compatissante est un déterminant de l'accès aux soins des personnes vulnérables.

► **Héran François, Avec l'immigration. Mesurer, débattre, agir**

SCHOR R.

2018

Revue européenne des migrations internationales 34(4): 233-234.

<https://www.cairn.info/revue-europeenne-des-migrations-internationales-2018-4-page-233.htm>

Dans un contexte de migrations juvéniles en pleine évolution, ce dossier de la Revue européenne des migrations internationales vise à interroger les dynamiques participant à la construction des expériences scolaires des enfants et des jeunes migrants. Inscrit dans une optique pluridisciplinaire, il est composé de travaux de sociologues, de géographes et de juristes. Différentes échelles d'analyse sont mobilisées et visent à analyser notamment les politiques publiques, les réalités et pratiques institutionnelles ou leurs effets sur les parcours sociaux d'enfants et de jeunes migrants à l'école ou au collège. C'est ainsi que les différentes contributions proposent, d'une part, des pistes d'analyses juridiques et sociodémographiques, macro sociales. D'autre part, elles offrent des clés de réflexion quant aux modalités concrètes d'agencement des situations socio-scolaires dans différents contextes. Elles portent également une attention spécifique aux manières d'enquêter sur les mineurs, dans et hors l'école, d'un point de vue qualitatif. A ce titre, les enquêtes auprès d'enfants et de jeunes migrants posent la question épistémologique et éthique de la place du chercheur, mais aussi celle des modalités de recueil des données, situation toujours liminaire qui nécessite des formes méthodologiques contingentes et hybrides.

► **Healthcare Utilisation And Health Literacy Among Young Adults Seeking Care In Sweden: Findings From A Cross-Sectional And Retrospective Study With Questionnaire And Registry-Based Data**

VIKTORSSON L., YNGMAN-UHLIN P., TÖRNVALL E., *et al.*

2019

Primary Health Care Research & Development 20: e151.

<https://doi.org/10.1017/S1463423619000859>

The objective of this study was to examine young adults' healthcare utilisation and its possible association with health literacy. Many countries struggle with

insufficient accessibility at emergency departments (EDs) and primary healthcare centres (PHCs). Young adults, aged 20–29 years old, account for a substantial number of unnecessary doctor visits where health literacy could be an explanatory factor. This study incorporated a combined retrospective and cross-sectional study design with analysis of registry data, including all registered outpatient doctor visits between 2004 and 2014 ($n=1\ 086\ 432$), and strategic sample questionnaire data ($n=207$), focusing on socio-demographics, symptoms and information-seeking behaviour. Mean differences between first-year and last-year doctor visits for each age group were calculated using registry data. Fischer's exact test was applied to questionnaire data to analyse group differences between ED and PHC visitors as well as between patients with sufficient health literacy and insufficient health literacy. Binary logistic regression was used to investigate covariation. Healthcare utilisation has increased among young

adults during the past decade, however, not comparatively more than for other age groups. ED patients ($n=49$) compared to PHC patients ($n=158$) were more likely to seek treatment for gastrointestinal symptoms ($P=0.001$), had shorter duration of symptoms ($P=0.001$) and sought care more often on the recommendation of a healthcare professional ($P=0.001$). Insufficient/problematic health literacy among young adults was associated with having lower reliance on the healthcare system ($P=0.03$) and with a greater likelihood of seeking treatment for psychiatric symptoms ($P=0.002$). Young adults do not account for the increase in healthcare utilisation during the last decade to a greater extent than other age groups. Young adults' reliance on the healthcare system is associated with health literacy, an indicator potentially important for consideration when studying health literacy and its relationship to more effective use of healthcare services.

Médicaments

Pharmaceuticals

► **Using Health Technology Assessment To Assess The Value Of New Medicines: Results Of A Systematic Review And Expert Consultation Across Eight European Countries**

ANGELIS A., LANGE A. ET KANAVOS P.

2018

The European Journal of Health Economics 19(1): 123-152.

<https://doi.org/10.1007/s10198-017-0871-0>

Although health technology assessment (HTA) systems base their decision making process either on economic evaluations or comparative clinical benefit assessment, a central aim of recent approaches to value measurement, including value based assessment and pricing, points towards the incorporation of supplementary evidence and criteria that capture additional dimensions of value.

► **Barriers And Facilitators Of Patient Access To Medical Devices In Europe: A Systematic Literature Review**

BECK A. C. C., RETÈL V. P., BHAIROSING P. A., *et al.*
2019

Health Policy 123(12): 1185-1198.

<https://doi.org/10.1016/j.healthpol.2019.10.002>

A large number of medical devices (MDs) is available in Europe. Procedures for market approval and reimbursement have been adopted over recent years to promote accelerating patient access to innovative MDs. However, there remains uncertainty and non-transparency regarding these procedures. We provide a structured overview of market approval and reimbursement procedures and practices regarding access to MDs in the EU. Market approval procedures were found to be uniformly described. Data on reimbursement procedures and practices was both heterogeneous and incomplete. Time to MD access was mainly determined by reimbursement procedures. The influence of the patient on time to access was not reported. Prescription practices varied among device types. Barriers to and facilitators of early patient access

that set the agenda for policy implications were also analyzed. Barriers were caused by unclear European legislation, complex market approval procedures, lack of data collection, inconsistency in evidence requirements between countries, regional reimbursement and provision, and factors influencing physicians' prescription including the device costs, waiting times and hospital-physician relationships. Facilitators were: available evidence that meets country-specific requirements for reimbursement, diagnosis-related groups, additional payments and research programs. Further research needs to focus on creating a complete overview of reimbursement procedures and practices by extracting further information from sources such as grey literature and interviews with professionals, and defining clear criteria to objectify time to access.

► **Investigation Of A Possible Association Of Potentially Inappropriate Medication For Older Adults And Frailty In A Prospective Cohort Study From Germany**

MUHLACK D. C., HOPPE L. K., SAUM K.-U., *et al.*
2019

Age and Ageing 49(1): 20-25.

<https://doi.org/10.1093/ageing/afz127>

Potentially inappropriate medications (PIMs) are commonly defined as drugs that should be avoided in older adults because they are considered to have a negative risk-benefit ratio. PIMs are suspected to increase the risk for frailty, but this has yet to be examined. prospective population-based cohort study. a German cohort of community-dwelling older adults (≥ 60 years) was followed from October 2008 to September 2016. in propensity score-adjusted logistic and Cox regression models, associations between baseline PIM use and prevalent/incident frailty were investigated. Frailty was assessed using the definition by Fried and co-workers, PIM were defined with the 2015 BEERS criteria, the BEERS criteria to avoid in cognitively impaired patients (BEERS dementia PIM), the EU(7)-PIM and the PRISCUS list. of 2,865 participants, 261 were frail at baseline and 423 became frail during follow-up. Only BEERS dementia PIM use was statistically significantly associated with prevalent frailty (odds ratio (95% confidence interval), 1.51 (1.04–2.17)). The strength of the association was comparable for all frailty components. Similarly, in longitudinal analyses, only BEERS dementia PIM use was associated with inci-

dent frailty albeit not statistically significant (hazard ratio, 1.19 (0.84–1.68)). the association of PIM use and frailty seems to be restricted to drug classes, which can induce frailty symptoms (anticholinergics, benzodiazepines, z-substances and antipsychotics). Physicians are advised to perform frailty assessments before and after prescribing these drug classes to older patients and to reconsider treatment decisions in case of negative performance changes.

► **Enrichir et mettre à jour sa panoplie thérapeutique : le tri 2019**

PRESCRIRE

2020

Revue Prescrire 38(435): 32-55.

Dans cet article, Prescrire présente, comme chaque année, son bilan thérapeutique pour 2019. Ce bilan répond à l'objectif suivant : pour des soins de qualité il est utile de trier en permanence, sans confondre progrès thérapeutiques et nouveautés commerciales, sans confondre les informations fausses, biaisées ou inutiles avec les informations solides, prouvées, opérationnelles.

► **Financial Burden Of Prescribed Medicines Included In Outpatient Benefits Package Schemes: Comparative Analysis Of Co-Payments For Reimbursable Medicines In European Countries**

VOGLER S., DEDET G. ET PEDERSEN H. B.

2019

Applied Health Economics and Health Policy 17(6): 803-816.

<https://doi.org/10.1007/s40258-019-00509-z>

The study aimed to analyse the financial burden that co-payments for prescribed and reimbursed medicines pose on patients in European countries.

► **Is The European Health Interview Survey Online Yet? Response And Net Sample Composition Of A Web-Based Data Collection**

BRAEKMAN E., CHARAFEDDINE R., DEMAREST S., *et al.*

2019

European Journal of Public Health: Ahead of pub.

<https://doi.org/10.1093/eurpub/ckz206>

The European Health Interview Survey (EHIS) provides cross-national data on health status, health care and health determinants. So far, 10 of the 30 member states (MS) opted for web-based questionnaires within mixed-mode designs but none used it as the sole mode. In the context of future EHIS, the response rate and net sample composition of a web-only approach was tested. A Belgian study with a target sample size of 1000 (age: 16–85) was organized using the EHIS wave 3 model questionnaire. The sample was selected according to a multistage, clustered sampling procedure with geographical stratification. Field substitution was applied; non-participating households were replaced by similar households regarding statistical sector, sex and age. There was one reminder letter and a €10 conditional incentive. Considering all substitutions, a 16% response rate was obtained after sending one reminder. Elderly, Brussels Capital inhabitants, people living without a partner and those with a non-Belgian nationality were less responding. By design, there were no differences between the initial and final net sample regarding substitution characteristics. Nevertheless, people living without a partner, non-Belgians and lower educated people remain underrepresented. There was a low response rate, particularly for some population groups. The response rate was lower than those of MS using mixed-mode designs including web, especially these comprising interviewer-based approaches. Despite the long and complex questionnaire, there was a low break off rate. So far, web-only data collection is not an acceptable strategy for population-based health surveys but efforts to increase the response should be further explored.

► **Development And Application Of A Survey Instrument To Measure Collaboration Among Health Care And Social Services Organizations**

BREWSTER A. L., TAN A. X. ET YUAN C. T.

2019

Health Services Research 54(6): 1246-1254.

<https://doi.org/10.1111/1475-6773.13206>

The aim of this paper is to measure strategies of inter-organizational collaboration among health care and social service organizations that serve older adults. The study is founded on twenty Hospital Service Areas (HSAs) in the United States. We developed and validated a novel scale to characterize interorganizational collaboration, and then tested its application by assessing whether the scale differentiated between HSAs with high vs low performance on potentially avoidable health care use and spending for Medicare beneficiaries. Data Collection Health care and social service organizations (N = 173 total) in each HSA completed a 12-item collaboration scale, three questions about collaboration behaviors, and a detailed survey documenting collaborative network ties. We identified two distinguishable subscales of interorganizational collaboration: (a) Aligning Strategy and (b) Coordinating Current Work. Each subscale demonstrated convergent validity with the organization's position in the collaborative network, and with collaboration behaviors. The full scale and Coordinating Current Work subscale did not differentiate high- vs low-performing HSAs, but the Aligning Strategy subscale was significantly higher in high-performing HSAs than in low-performing HSAs ($P = .01$). Cross-sector collaboration - and particularly Aligning Strategy - is associated with health care use and spending for older adults. This new survey measure could be used to track the impact of interventions to foster interorganizational collaboration.

► **Associations Of Mail Survey Length And Layout With Response Rates**

BURKHART Q., ORR N., BROWN J. A., *et al.*
2019

Med Care Res Rev: Ahead of pub.

<https://journals.sagepub.com/doi/abs/10.1177/1077558719888407?journalCode=mcrd>

We assess the association between survey layout and response rates (RRs) in the 2017 Medicare Advantage Consumer Assessment of Healthcare Providers and Systems mail survey. Among 438 Medicare Advantage plans surveyed by six vendors, there was latitude in survey layout, and plans could add up to 12 supplemental items. Regression models predicted survey response from survey characteristics (page count, number of supplemental items, and survey attractiveness), and beneficiary sociodemographics. Beneficiary-age-by-survey-characteristic interactions assessed whether survey characteristics were more strongly related to RRs among older beneficiaries. We found that surveys with more supplemental items and less attractive layouts had lower adjusted odds of response. RRs were more sensitive to format among older beneficiaries. The difference in adjusted RRs for the most favorable versus the least favorable survey design was 14.5%. For a 65-year-old, this difference was 13.6%; for an 80-year-old, it was 21.0%. These findings suggest that even within a relatively standardized survey, formatting can substantially influence RRs.

► **Les algorithmes dans le droit : illusions et (r)évolutions. Présentation du dossier**

DUBOIS C. ET SCHOENAERS F.
2019

Droit et société 103(3): 501-515.

<https://www.cairn.info/revue-droit-et-societe-2019-3-page-501.htm>

Depuis les premières étapes du World Wide Web au début des années 1990, les technologies algorithmiques sont utilisées pour collecter, comparer et calculer des données. Les algorithmes sont composés de suites d'instructions univoques guidant un ordinateur vers l'exécution d'une tâche, laquelle consiste en la résolution d'un problème. Ils permettent, entre autres choses, le traçage de l'information et sa décomposition en quelques entités élémentaires en vue d'un traitement mathématique. Les algorithmes se caractérisent par leur puissance combinatoire et leur capacité

de réinvention permanente. Compte tenu des divers risques écologiques, financiers, politiques et sociaux de notre époque, l'usage des algorithmes soulève de nouveaux problèmes de gouvernance en raison de leur opacité et de leur invisibilité, mais aussi divers problèmes de régulation notamment en matière de propriété intellectuelle, de protection des données personnelles, de légitimité des instances de normalisation internationale, de gouvernance des noms de domaine ou encore de politiques des réseaux sociaux.

► **Knowledge Management Infrastructure To Support Quality Improvement: A Qualitative Study Of Maternity Services In Four European Hospitals**

KARLTUN A., SANNE J. M., AASE K., *et al.*
2019

Health Policy: Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2019.11.005>

The influence of multilevel healthcare system interactions on clinical quality improvement (QI) is still largely unexplored. Through the lens of knowledge management (KM) theory, this study explores how hospital managers can enhance the conditions for clinical QI given the specific multilevel and professional interactions in various healthcare systems. The research used an in-depth multilevel analysis in maternity departments in four purposively sampled European hospitals (Portugal, England, Norway and Sweden). The study combines analysis of macro-level policy documents and regulations with semi-structured interviews (96) and non-participant observations (193 hours) of hospital and clinical managers and clinical staff in maternity departments. There are four main conclusions: First, the unique multilevel configuration of national healthcare policy, hospital management and clinical professionals influence the development of clinical QI efforts. Second, these different configurations provide various and often insufficient support and guidance which affect professionals' action strategies in QI efforts. Third, hospital managers' opportunities and capabilities for developing a consistent KM infrastructure with reinforcing enabling conditions which merge national policies and guidelines with clinical reality is crucial for clinical QI. Fourth, understanding these interrelationships provides an opportunity for improvement of the KM infrastructure for hospital managers through tailored interventions.

► **How Well Do Discrete Choice Experiments Predict Health Choices? A Systematic Review And Meta-Analysis Of External Validity**

QUAIFE M., TERRIS-PRESTHOLT F., DI TANNA G. L., *et al.*

2018

The European Journal of Health Economics 19(8): 1053-1066.

<https://doi.org/10.1007/s10198-018-0954-6>

Discrete choice experiments (DCEs) are economic tools that elicit the stated preferences of respondents. Because of their increasing importance in informing the design of health products and services, it is critical to understand the extent to which DCEs give reliable predictions outside of the experimental context. We

systematically reviewed the literature of published DCE studies comparing predictions to choices made in reality; we extracted individual-level data to estimate a bivariate mixed-effects model of pooled sensitivity and specificity. Eight studies met the inclusion criteria, and six of these gave sufficient data for inclusion in a meta-analysis. Pooled sensitivity and specificity estimates were 88% (95% CI 81, 92%) and 34% (95% CI 23, 46%), respectively, and the area under the SROC curve (AUC) was 0.60 (95% CI 0.55, 0.64). Results indicate that DCEs can produce reasonable predictions of health-related behaviors. There is a great need for future research on the external validity of DCEs, particularly empirical studies assessing predicted and revealed preferences of a representative sample of participants.

Politique de santé

Health Policy

► **Community Involvement In The Development And Implementation Of Chronic Condition Programmes Across The Continuum Of Care In High-And Upper-Middle Income Countries: A Systematic Review**

HALDANE V., SINGH S. R., SRIVASTAVA A., *et al.*

2019

Health Policy: Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2019.11.012>

Community involvement is an important component of health programme development and implementation, including those focused on chronic condition treatment and management. Yet, few studies explore the manifestations of community involvement in chronic care programmes. Our review aims to examine the evidence on how communities are involved in planning and implementing chronic condition programmes in high and upper-middle income countries. Methods Eligible studies included those that involved the community in the planning, implementation, monitoring and evaluation of health services, policy or health interventions. We searched Medline, Embase, Global Health, Scopus, and LILACs from 2000 to 2016, independently screened articles for inclusion, conducted

data extraction, and assessed studies for risk of bias. Results 27,232 records were identified and after screening, 32 met inclusion criteria. We conducted a narrative synthesis to report on the forms and processes of community involvement used across mental health programmes and contrast this with the paucity of evidence on comparable programmes addressing other chronic conditions. Challenges reported included user factors, organisational factors, and social challenges such as stigma. Conclusion Our review adds to the evidence supporting community involvement in chronic condition management and the processes that contribute to successful and sustainable involvement. We report on a model, derived from inductive analysis, that considers social and cultural components, organisational factors and stakeholder relationships as underpinning the development of community interventions across the care continuum.

► **Emergence Of Lyme Disease As A Social Problem: Analysis Of Discourse Using The Media Content**

PASCAL C., ARQUEMBOURG J., VORILHON P., *et al.*
2019

European Journal of Public Health.

<https://doi.org/10.1093/eurpub/ckz198>

Chronic Lyme disease (LD) is a matter of debate worldwide and has emerged as a social problem. We aim to analyze the media content and describe the transformation process of a collective pain into a social problem in France. Using social science methodology, a corpus of articles from 20 newspapers and videos from seven major TV stations from 1987 to 2017 were analyzed for discourse content. The speaking times and the frequency of interventions between doctors supporting the official guidelines and those against them were compared using the Mann–Whitney test and the Chi-square test, respectively. In France, the media discourse is carried through testimonials from patient organizations and a professor of infectiology who acted as a whistleblower (WB). We showed that the emergence of the LD alert in the media corresponds to the process described by social sciences as ‘naming, blaming, claiming’. Since his first article in 2014, the WB has featured in 24% (22/89) of newspaper articles compared with 20% (18/89) for doctors defending the official guidelines ($P = 0.52$). Since his first appearance on a TV newscast in 2014, the WB has appeared in 45% (22/49) of news reports on LD with 24% of the speaking time compared with 22% (11/49) for doctors defending the official guidelines ($P = 0.018$). Media coverage of LD has been unbalanced since 2014 and promotes associations as well as the WB, who seems to be better identified than any of the different doctors defending the official guidelines.

► **Applying Priority-Setting Frameworks: A Review Of Public And Vulnerable Populations’ Participation In Health-System Priority Setting**

RAZAVI S. D., KAPIRIRI L., WILSON M., *et al.*

2019

Health Policy: Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2019.12.005>

There is a growing body of literature that describes, applies, and evaluates applications of health-system priority-setting frameworks in different contexts. However, little explicit focus has been given to examining operationalization of the stakeholder participation component of these frameworks. The literature identifies the public as a stakeholder group and recommends their participation when applying the frameworks. **Methods** We conducted a scoping review to search the PubMed, EMBASE, HealthSTAR, Medline, and PsycINFO databases for cases where priority-setting frameworks were applied (2000-2017). We aimed to synthesize current literature to examine the degree to which the public and vulnerable populations have been engaged through applications of these frameworks. **Findings** The following stakeholders commonly participated: managers, administrators/coordinators, clinicians/physicians, non-physician health care providers, health economists, academics/researchers, experts, decision-makers, and policy-makers. Few papers reported on public participation, and even fewer identified vulnerable groups that participate. Stakeholders were most commonly reported to participate in identifying areas for prioritization. **Conclusions** While the frameworks were developed with stakeholder participation in mind, in practice not all stakeholders are participating in priority-setting processes as envisioned by the frameworks. The public and vulnerable groups do not consistently participate, challenging the utility of the participation component of frameworks in guiding stakeholder participation in health-system priority setting. Frameworks can be more explicit about which stakeholders should participate and detailing how their participation should be operationalized.

Health Prevention

► **Les déterminants du recours au dépistage du cancer du col de l'utérus : une analyse départementale**

KONOPKA A.-M., BARNAY T., BILLAUDEAU N., *et al.*
2019

Économie & prévision 216(2): 43-63.

<https://www.cairn.info/revue-economie-et-prevision-2019-2-page-43.htm>

L'objectif de cette étude est d'analyser les déterminants des disparités géographiques de recours au dépistage du cancer du col en France. L'échantillon étudié est composé de femmes âgées de 25 à 65 ans, assurées à la Mutuelle Générale de l'Éducation Nationale (MGEN) au moins en Régime Obligatoire (RO) sur la période du 1^{er} janvier 2012 au 31 décembre 2014. Les modèles multiniveaux confirment l'existence d'inégalités territoriales de recours au dépistage. Par ailleurs, ils montrent que l'âge, le tarif de la consultation de gynécologie et un contexte socio-économique défavorisé sont associés à une diminution de la probabilité de se faire dépister. Au contraire, le fait d'être en couple, d'être couverte en Régime Complémentaire (RC) par la MGEN, d'avoir eu un suivi pour une contraception ou une grossesse, de s'être faite dépister pour le cancer du sein (mammographie) et la densité de professionnels de santé sont associés à une augmentation du recours au dépistage. Différents leviers d'action sont discutés au regard du rôle majeur joué par les professionnels de santé dans l'accès au dépistage.

► **The Impact Of Tobacco Control Policies On Smoking Initiation In Eleven European Countries**

PALALI A. ET VAN OURS J. C.
2019

The European Journal of Health Economics 20(9): 1287-1301.

<https://doi.org/10.1007/s10198-019-01090-x>

We investigate the effect of tobacco control policies on smoking initiation in eleven European countries. Based on individual data about age of onset of smoking, we use hazard rate models to study smoking initiation. Thus, we are able to take into account observed and

unobserved personal characteristics as well as the effect of the introduction of a variety of tobacco control policies including price and non-price policies, i.e., bans on tobacco advertisements, smoke-free air regulation, health warnings on packages of cigarettes, and treatment programs to help smokers quit smoking. We find that higher tobacco prices have a negative effect on the initiation into smoking for males but not for females. We find no effect of non-price tobacco control policies on smoking initiation.

► **Economic Impact Of Disease Prevention In A Morbidity-Based Financing System: Does Prevention Pay Off For A Statutory Health Insurance Fund In Germany?**

WEINHOLD I., SCHINDLER C., KOSSACK N., *et al.*
2019

The European Journal of Health Economics 20(8): 1181-1193.

<https://doi.org/10.1007/s10198-019-01086-7>

Preventable chronic diseases account for the greatest burden in the German health system and statutory health insurance (SHI) funds play a crucial role in implementing and financing prevention strategies. On the contrary, the morbidity-based scheme to distribute financial resources from the Central Reallocation Pool among the different sickness funds may counteract efforts of effective prevention from an economic perspective. We assessed financial impacts of prevention from a sickness funds perspective in a retrospective controlled study. Claims data of 6,247,275 persons were analyzed and outcomes between two propensity-matched groups (n = 852,048) of prevention users and non-users were compared in a 4-year follow-up. Using a difference-in-differences approach, we analyzed healthcare expenditures, the development of morbidity, financial transfers from the Central Reallocation Pool, and contribution margins. The group of prevention users develops less morbidity (incidences and disease aggravations) compared to the control group. Healthcare expenditures increase in both groups within 4 years, whereas the increase is lower for prevention users compared to non-users (€568.04 vs. €640.60, p < 0.0001). Taking morbidity-based finan-

cial transfers into account, the decrease in contribution margins is stronger for prevention users (–€188.44 vs. –€138.73, $p < 0.0001$). This study demonstrates an economic disincentive from a sickness funds' perspective. In the semi-competitive SHI market, sickness funds will

be discouraged from effective prevention strategies if investments are not worth it financially. Their efforts and knowledge are, however, crucial for joint action to foster prevention over cure in the health system.

Prévision – Evaluation

Prévision - Evaluation

► **Évaluation de la grille Fragire à partir des données de l'enquête Share**

DUMONTET M. ET SIRVEN N.

2018

Retraite et société 80(2): 121-149.

<https://www.cairn.info/revue-retraite-et-societe-2018-2-page-121.htm>

En 2014, la direction de l'Action sociale de la Cnav a décidé de se doter d'un nouvel outil de détection de la fragilité pour améliorer le ciblage des personnes à risque de perte d'autonomie et leur proposer des programmes de prévention mieux adaptés à leurs besoins. Ce nouvel outil de détection de la fragilité, nommé grille Fragire, a été développé par le pôle de gérontologie interrégional de Bourgogne Franche-Comté (PGI) à partir d'une cohorte clinique. Dans cette étude, nous souhaitons évaluer dans quelle mesure le score Fragire est 1) reproductible en population générale, 2) capable d'identifier des personnes âgées fragiles en utilisant le phénotype de Fried comme indicateur de référence, et 3) prédictif de l'entrée en perte d'autonomie (apparition de restrictions dans les activités de la vie quotidienne et développement de l'aide à la personne). Nous utilisons les données de panel de l'enquête Share (enquête européenne sur la santé, le vieillissement et la retraite auprès des 50 ans et plus), représentatives de la population en ménage ordinaire en France métropolitaine, entre 2004 et 2010. Ces données permettent de reconstruire l'algorithme de la grille Fragire selon la méthodologie développée par le PGI, et de mesurer l'association du score Fragire avec différentes variables liées à la perte d'autonomie à deux et quatre ans d'intervalle. Nos résultats indiquent que, sans être parfait, ce score permet de bien détecter les personnes fragiles. Il permet également d'anticiper le recours à l'aide et les incapacités futures. Ces résultats soulignent l'importance de ce nouvel indicateur de

fragilité pour développer des politiques de prévention efficaces permettant de cibler les individus à risque de perte d'autonomie.

► **New Composite Measure For ADL Limitations: Application To Predicting Nursing Home Placement For Michigan MI Choice Clients**

HONG H. G., AN H. S., SARZYNSKI E., *et al.*

2019

Med Care Res Rev: Ahead of pub.

<https://journals.sagepub.com/doi/abs/10.1177/1077558719886735>

Functional status measured by activities of daily living (ADL) may be used to predict nursing home placement. Scoring of ADL measures is summarized for convenience, yet this is accompanied by losing detail regarding deficits. We sought to determine whether a revised composite measure tailored to Michigan Medicaid beneficiaries would better identify those at risk for nursing home admission. We compared composite ADL measures created by exploratory factor analysis and additive modeling to Medicaid Enrollment, MI Choice Waiver program, and Nursing Facility claims data from 2013 to 2017. There were moderate to high levels of correlation between ADLs (.4-.82). Exploratory factor analysis extracted two factors, corresponding to domains of mobility or self-care tasks. Application of the self-care-based ADL limitations composite measure provided prediction power equivalent to an additive measure incorporating all ADL limitations for nursing home admission. This approach demonstrated improved interpretability with the need for just five measures.

► **Review Of 128 Quality Of Care Mechanisms: A Framework And Mapping For Health System Stewards**

TELLO J. E., BARBAZZA E. ET WADDELL K.

2019

Health Policy: Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2019.11.006>

Health system stewards have the critical task to identify quality of care deficiencies and resolve underlying system limitations. Despite a growing evidence-base on the effectiveness of certain mechanisms for improving quality of care, frameworks to facilitate the oversight function of stewards and the use of mechanisms to improve outcomes remain underdeveloped. This review set out to catalogue a wide range of quality of care mechanisms and evidence on their effectiveness, and to map these in a framework along two dimen-

sions: (i) governance subfunctions; and (ii) targets of quality of care mechanisms. To identify quality of care mechanisms, a series of searches were run in Health Systems Evidence and PubMed. Additional grey literature was reviewed. A total of 128 quality of care mechanisms were identified. For each mechanism, searches were carried out for systematic reviews on their effectiveness. These findings were mapped in the framework defined. The mapping illustrates the range and evidence for mechanisms varies and is more developed for some target areas such as the health workforce. Across the governance sub-functions, more mechanisms and with evidence of effectiveness are found for setting priorities and standards and organizing and monitoring for action. This framework can support system stewards to map the quality of care mechanisms used in their systems and to uncover opportunities for optimization backed by systems thinking.

Psychiatrie

Psychiatry

► **Solutions To Tackle The Mental Health Consequences Of The Economic Recession: A Qualitative Study Integrating Primary Health Care Users And Professionals' Perspectives**

ANTUNES A., FRASQUILHO D., ZÓZIMO J. R., *et al.*

2019

Health Policy 123(12): 1267-1274.

<https://doi.org/10.1016/j.healthpol.2019.10.003>

This qualitative study explores solutions proposed by primary health care users and professionals to address the consequences of the economic recession and austerity measures on populations' mental health and delivery of care in Portugal. Qualitative data were collected in three primary health care centres in the Lisbon Metropolitan Area. Five focus groups with 26 users and semistructured interviews with 27 health professionals were conducted. Interviews were audio-recorded, transcribed verbatim and underwent thematic analysis. Solutions proposed by users focused on improvements in accessibility and management of services, socioeconomic and living conditions, human resources for health, and investment in mental health. Health professionals focused on improvements in inte-

gration and articulation of services, infrastructure and structural barriers to primary care, recruitment and retention of human resources, and socioeconomic and living conditions. The themes from both groups were integrated and organized into three axes for action: 1) increasing investment and reversing austerity measures in health and social sectors; 2) coordination and integration of mental health care; and 3) tackling the social determinants of mental health. The findings provide an assessment of the needs and priorities set by primary health care users and professionals, reflecting their contextspecific experiences. These complementary perspectives highlight the need for inter-sectoral efforts in policy-making to improve delivery of care and to mitigate social inequalities in health across the Portuguese population.

► **The Mental Health Of Hispanic/
Latino Americans Following National
Immigration Policy Changes: United
States, 2014–2018**

BRUZELIUS E. ET BAUM A.

2019

American Journal of Public Health 109(12): 1786-1788.

<https://doi.org/10.2105/AJPH.2019.305337>

The aim of this study is to examine the relationship between aggressive enforcement of anti-immigration policies and mental health among Hispanics/Latinos in the United States before and after major national immigration policy changes. Data were drawn from Behavioral Risk Factor Surveillance System surveys administered from 2014 to 2018. The exposure was the rate of immigration arrests in the 2 months before the survey date within the respondent's state of residence. Outcomes included past-month reporting of (1) number of days of poor mental health, (2) at least 1 day of poor mental health, and (3) frequent mental distress. There was no relationship between arrest rates and mental health among Hispanic/Latino respondents across the overall period. After consideration of policy changes, however, a 1-percentage-point increase in a state's immigration arrest rate in the postpolicy period was significantly associated with each mental health morbidity outcome. We found evidence supporting an association between worsening mental health among Hispanics/Latinos and increased arrest rates following the announcement of several restrictive immigration policies. The potential public health effects of aggressive immigration enforcement must be better acknowledged and addressed in immigration debates.

► **Risk Factors
For Return Visits And Rehospitalizations
To The Child Emergency Psychiatric
Unit: A Retrospective Study Over 2 Years
At Saint-Etienne University Hospital**

GAY A., PEYRARD M., PINEAU P., *et al.*

2019

Encephale 45(6): 468-473.

This retrospective study aimed to achieve a better understanding of risk factors leading children and adolescents hospitalized in an emergency psychiatric ward to return visits, and to propose preventive devices. From January 2, 2010 through February 29, 2012, 180

children and adolescents younger than 17 years were hospitalized in a total of 261 stays in the emergency psychiatric ward of University hospital of Saint-Etienne (France). We assessed clinical and sociodemographic characteristics of these patients and traced any of their return visits to the same unit through December 31, 2012. Risk factors for patients' repeated visits were calculated using multivariate analysis, and the cumulative incidence of returns using the Kaplan-Meier method for censored data. We used confidence interval of relative risk, considering 0.05 to reflect significance. RESULTS: Over the 2 years of the study, 77 (42.8%) of the 180 patients revisited the emergency psychiatric ward; 62 (80.7%) of these required further hospitalizations. Multivariate analysis linked the patients' psychiatric history (RR=2.5) and pursuit of vocational education (RR=4) with the risk of return. Return visits rose from 27.2% at 6 months to 41.2% at 2 years. Knowledge of risk factors would allow implementation of secondary or tertiary preventive devices. Students could undergo early screening of psychiatric pathologies using mobile screening teams which would save money, avoid hospitalizations, and when necessary, facilitate both hospitalization and return visits.

► **Réalité virtuelle et santé mentale.
La fin d'un art de faire ?**

KLEIN N. ET BORELLE C.

2019

Revue d'anthropologie des connaissances 13, 2(2): 613-639.

<https://www.cairn.info/revue-anthropologie-des-connaissances-2019-2-page-613.htm>

Cet article s'appuie sur l'approche proposée par Madeleine Akrich et Cécile Méadel (2004) de l'arrivée des TIC dans le domaine de la santé. À partir d'une enquête de terrain sur les usages de la TERV (thérapie d'exposition à la réalité virtuelle), il interroge les effets des usages des nouvelles technologies sur les pratiques professionnelles en santé mentale. Cet article soulève la question suivante : dans quelle mesure le recours à la TERV signe-t-il la fin d'un « art de faire » (De Certeau, 1990) des psycho-praticiens ? La TERV semble a priori impliquer une homogénéisation des pratiques, autour d'un discours stabilisé, d'un protocole standardisé et d'un cadrage de la réalité virtuelle comme outil thérapeutique. Néanmoins, une étude plus fine des pratiques permet de dépasser ce diagnostic initial en éclairant comment ce dispositif,

loin de signifier la fin d'un art de faire, vient plutôt l'enrichir et le renouveler. Les praticiens déploient un art de faire de la thérapie avec la réalité virtuelle, dans le face-à-face avec la technique, dans les interactions avec les patients et dans la pratique du dispositif. Cet art se structure notamment autour d'un enjeu central : l'articulation entre réel et virtuel.

► **Healthcare System Performance In Continuity Of Care For Patients With Severe Mental Illness: A Comparison Of Five European Countries**

NICAISE P., GIACCO D., SOLTMANN B., *et al.*
2019

Health Policy: Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2019.11.004>

Most healthcare systems struggle to provide continuity of care for people with chronic conditions, such as patients with severe mental illness. In this study, we reviewed how system features in two national health systems (NHS) – England and Veneto (Italy) – and three regulated-market systems (RMS) – Germany, Belgium, and Poland –, were likely to affect continuing care delivery and we empirically assessed system performance. 6418 patients recruited from psychiatric hospitals were followed up one year after admission. We collected data on their use of services and contact with professionals and assessed care continuity using indicators on the gap between hospital discharge and outpatient care, access to services, number of contacts with care professionals, satisfaction with care continuity, and helping alliance. Multivariate regressions were used to control for patients' characteristics. Important differences were found between healthcare systems. NHS countries had more effective longitudinal and cross-sectional care continuity than RMS countries, though Germany had similar results to England. Relational continuity seemed less affected by organisational mechanisms. This study provides straightforward empirical indicators for assessing healthcare system performance in care continuity. Despite systems' complexity, findings suggest that stronger regulation of care provision and financing at a local level should be considered for effective care continuity.

► **[Use Of Psychotherapy Among Adults With A History Of Suicide Attempt: Results Form A Large Population-Based Study]**

REVRANCHE M., HUSKY M. ET KOVLESS-MASFETY V.
2019

Encephale 45(6): 513-521.

The current study aims to identify the factors associated with the use of psychotherapy among adults with a history of suicide attempt. A large cross-sectional survey (N = 22,138) was conducted in four regions of France to characterize mental health care needs in the general population. Data were collected between April and June 2005 by trained interviewers using a computer-assisted telephone interviewing system (CATI). Sociodemographics, past-year mental disorders, lifetime and 12-month history of suicide attempts, and use of psychotherapy were assessed. Overall, 7.1% of adults reported having undergone psychotherapy in the course of their life, and 2.0% in the previous 12 months. While 8.3% of adults with a lifetime suicide attempt (prior to the previous 12 months) underwent a psychotherapy in the previous 12 months, 27.5% of adults with a past-year suicide attempt underwent a psychotherapy in the previous 12 months. Psychotherapy was provided by psychiatrists (49.5%), psychologists (28.2%), and psychoanalysts (10.6%). Among adults with a prior suicide attempt, increased odds of undergoing a psychotherapy in the course of their life was predicted by higher education [AOR = 2.81 (1.56-5.06)], living in the Paris region [AOR = 2.06 (1.32-3.23)], and being a woman [AOR = 1.50 (1.08-2.09)]. Increased odds of undergoing a psychotherapy in the previous 12 months was predicted by a major depressive disorder [AOR = 2.59 (1.57-4.27)], any anxiety disorder [AOR = 1.79 (1.07-2.97)], higher education [AOR = 3.60 (1.29-10.0)], living in a city of 20,000 to 100,000 inhabitants [AOR = 2.71 (1.13-6.50)] and more [AOR = 2.50 (1.12-5.57)] (outside of the Paris region), a 2000 to 3000 euros monthly income [AOR = 2.37 (1.15-4.85)]. DISCUSSION: One third of adults with a lifetime suicide attempt and close to half of those with a past-year attempt have received some form of psychotherapy in the course of their life. In line with prior work, higher education and income level predicted past-year use of psychotherapy among adults with a prior suicide attempt. These findings highlight the association between major depressive disorder or anxiety disorders and increased odds of undergoing psychotherapy in the previous 12 months among adults with prior attempt. While pharmacological treatment, inpatient hospitalizations for mental

health problems, visits with a general practitioner or specialized physician are free of charge in France, psychotherapy provided by psychologists or psychotherapists is currently not covered by the French Social Security health care system. As the treatment of mental disorders plays an important role in the reduction of suicide risk, supporting evidence-based psychotherapy through its reimbursement appears to be an important public health issue.

► **Impact Of Family Practice Continuity Of Care On Unplanned Hospital Use For People With Serious Mental Illness**

RIDE J., KASTERIDIS P., GUTACKER N., *et al.*
2019

Health Services Research 54(6): 1316-1325.
<https://doi.org/10.1111/1475-6773.13211>

The objective of this study is to investigate whether continuity of care in family practice reduces unplanned hospital use for people with serious mental illness (SMI). Data Sources Linked administrative data on family practice and hospital utilization by people with SMI in England, 2007-2014. Study Design This observational cohort study used discrete-time survival analysis to investigate the relationship between continuity of care in family practice and unplanned hospital use: emergency department (ED) presentations, and unplanned admissions for SMI and ambulatory care-sensitive conditions (ACSC). The analysis distinguishes between relational continuity and management/informational continuity (as captured by care plans) and accounts for unobserved confounding by examining deviation from long-term averages. Data Collection/Extraction Methods Individual-level family practice administrative data linked to hospital administrative data. Principal Findings Higher relational continuity was associated with 8-11 percent lower risk of ED presentation and 23-27 percent lower risk of ACSC admissions. Care plans were associated with 29 percent lower risk of ED presentation, 39 percent lower risk of SMI admissions, and 32 percent lower risk of ACSC admissions. Conclusions Family practice continuity of care can reduce unplanned hospital use for physical and mental health of people with SMI.

► **La psychothérapie institutionnelle, terreau d'intelligence collective**

ROBIN M., CASSINI L., CORNAC X., *et al.*
2019

L'information psychiatrique 95(8): 653-660.
<https://www.cairn.info/revue-l-information-psychiatrique-2019-8-page-653.htm>

La psychothérapie institutionnelle est moribonde, appauvrie entre autres par la financiarisation des soins et l'ultrahygiénisme. Parallèlement à cette dynamique préoccupante de rapports de pouvoir laissant le soin relationnel pour compte, le contexte social laisse apparaître un mouvement de transition citoyenne qui contient dans ses principes comme dans son organisation la notion centrale d'intelligence collective. Cette forme d'organisation des groupes repose sur des bases anciennes, réactualisées depuis les années 90. L'article développe l'idée que cette forme d'intelligence sociale fait appel à des concepts très proches de ceux qui ont défini la psychothérapie institutionnelle. La clinique de l'adolescent en crise sera dans le texte le support pour mettre en lumière cette analogie selon trois axes : les liens entre les membres du groupe, l'horizontalisation des rapports de pouvoir et enfin la notion de processus émergent.

Sociology of Health

► **À la croisée des sciences infirmières et de gestion : la revalorisation de l'émotionnel et du compassionnel au Royaume-Uni comme exemple d'impact de la recherche sur la recherche et les pratiques**

DICKASON R.

2019

Journal de gestion et d'économie de la santé 4(4): 291-315.

<https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2019-4-page-291.htm>

À l'aune de transformations importantes du champ de la santé (innovations liées aux produits de santé, télé-médecine, Big Data, etc.), les sciences de gestion – et plus particulièrement le management de la santé et des organisations de santé – sont amenées à produire des recherches susceptibles d'affecter les pratiques et les politiques publiques. Alors que les productions scientifiques dans le champ de la santé sont foisonnantes, se pose le double enjeu de leur diffusion et de la manière dont il est possible de garantir leur impact. En effet, si la proximité avec les organisations de santé semble un levier pertinent pour faciliter la production de recherches pouvant influencer sur les pratiques de gestion, voire les politiques publiques, l'on peut constater un problème de diffusion au sein du champ. Outre les sciences de gestion, les organisations de santé font (in)directement l'objet de recherches en sciences infirmières, une discipline qui traite de la population infirmière ou aide-soignante (en particulier dans les pays anglophones). L'objet de cet article est donc d'éclairer la question de l'impact de la recherche en nous appuyant sur un cas spécifique, issu des sciences infirmières, pour repérer quels enseignements en retirer pour les sciences de gestion, particulièrement à l'endroit des organisations de santé. Pour ce faire, nous avons étudié l'impact interne et externe des recherches en sciences infirmières sur le travail émotionnel infirmier (la gestion de ses émotions et de celles du patient) et sur les composantes émotionnelles, compassionnelles et relationnelles du travail infirmier dans les hôpitaux britanniques. À cet effet, nous avons analysé la littérature sur le sujet et examiné une documentation professionnelle, institutionnelle et gouvernementale. Nos résultats mettent en évidence trois dispositifs singuliers : (a) l'importance

des sciences infirmières en tant que champ disciplinaire distinct, (b) l'utilisation de policy papers et (c) le rôle des think tanks.

► **The Effectiveness Of Nudges In Improving The Self-Management Of Patients With Chronic Diseases: A Systematic Literature Review**

MÖLLENKAMP M., ZEPPERNICK M. ET SCHREYÖGG J.

2019

Health Policy 123(12): 1199-1209.

<https://doi.org/10.1016/j.healthpol.2019.09.008>

In this systematic literature review, we identify evidence on the effectiveness of nudges in improving the self-management of adults with chronic diseases and derive policy recommendations. We included empirical studies of any design published up to April 12th, 2018. We synthesized the results of the studies narratively by comparing statistical significance and direction of different nudge types' effects on primary study outcomes. Lastly, we categorized the nudges according to their degree of manipulation and transparency. We identified 26 studies, where 13 were of high or moderate quality. The most commonly tested nudges were reminders, planning prompts, small financial incentives, and feedback. Overall, 8 of 9 studies with a high or moderate quality ranking, focused on self-management outcomes, i.e., physical activity, attendance, self-monitoring, and medication adherence, found that nudges had significant positive effects. However, only 1 of 4 studies of high or moderate quality, analyzing disease control outcomes (e.g., glycemic control), found that nudges had a significant positive effect for one intervention arm. In summary, this review demonstrates that nudges can improve chronic disease self-management, but there is hardly any evidence to date that these interventions lead to improved disease control. Reminders, feedback, and planning prompts appear to improve chronic disease self-management most consistently and are among the least controversial types of nudges. Accordingly, they can generally be recommended to policymakers.

► **De l'expérience singulière médiatisée de la maladie à la construction de savoirs expérientiels**

NOËL-HUREAUX E.
2019

Recherche en soins infirmiers 138(3): 65-74.

<https://www.cairn.info/revue-recherche-en-soins-infirmiers-2019-3-page-65.htm>

À travers la figure publique et charismatique d'un acteur et écrivain célèbre, Bernard Giraudeau, nous proposons d'explorer en quoi une telle expérience singulière médiatisée et confrontée à d'autres peut devenir source de savoirs expérientiels. Pour ce faire, nous analyserons les différentes formes de communication associées à des supports aussi variés que la presse écrite ou les blogs rendant visibles l'empowerment dans l'agencement des interactions.

► **Maladie sans diagnostic ou ultra-rare : de la quête de réponses au chemin de l'acceptation**

RIBEIRO M., BONNEAU D., FERTE M., *et al.*
2019

Le Journal des psychologues 372(10): 63-67.

<https://www.cairn.info/revue-le-journal-des-psychologues-2019-10-page-63.htm>

Sentiment d'isolement, culpabilité, incompréhension, confusion, autant d'éprouvés soulevés par les patients affectés par une maladie sans diagnostic ou ultra-rare et, avec l'errance médicale qui la caractérise, par les professionnels. Face à cet inconnu, les laissant aux prises avec leur imaginaire et leurs projections, seul un accompagnement spécifique serait à même d'aider la personne et sa famille à évoluer avec la maladie. La Plateforme régionale d'information et d'orientation pour les maladies rares (Prior) et l'Équipe relais handicaps rares (Erhr) de la région Pays de la Loire accompagnent des personnes qui connaissent des situations de vie particulières, souvent complexes, en relation avec une maladie ou un handicap rares. Parmi celles-ci se trouvent des personnes touchées par des maladies sans diagnostic précis ou dont la prévalence est extrêmement faible. Nous aidons ces personnes et leurs familles, au décours des questionnements multiples qui jalonnent leur parcours marqué par la rareté et, par conséquent, par une forme de solitude, voire d'isolement.

Soins de santé primaires

Primary Health Care

► **Primary Care Physicians' Role In Coordinating Medical And Health-Related Social Needs In Eleven Countries**

DOTY M. M., TIKKANEN R., SHAH A., *et al.*
2019

Health Affairs: Ahead of pub.

<https://doi.org/10.1377/hlthaff.2019.01088>

Primary care physicians in the US, like their colleagues in several other high-income countries, are increasingly tasked with coordinating services delivered not just by specialists and hospitals but also by home care professionals and social service agencies. To

inform efforts to improve care coordination, the 2019 Commonwealth Fund International Health Policy Survey of Primary Care Physicians queried primary care physicians in eleven high-income countries about their ability to coordinate patients' medical care with specialists, across settings of care, and with social service providers. Compared to physicians in other countries, substantial proportions of US physicians did not routinely receive timely notification or the information needed for managing ongoing care from specialists, after-hours care centers, emergency departments, or hospitals. Primary care practices in a handful of countries, including the US, are not routinely exchanging

information electronically outside the practice. Top-performing countries demonstrate the feasibility of improving two-way communication between primary care and other sites of care. The surveyed countries share the challenge of coordinating with social service providers, and the results call for solutions to support primary care physicians.

► **Maison médicale de garde de Libourne**

FLACASSIER C., SIRAZ S., DAHLEM L., *et al.*
2019

Médecine : De La Médecine Factuelle à Nos Pratiques 15(9): 423-426.

En France, la Permanence des Soins Ambulatoires s'organise dans un schéma régional autour d'un cahier des charges défini par l'Agence Régionale de Santé (ARS). L'objectif est de maintenir un accès aux soins de premier recours en dehors des horaires d'ouverture usuels des cabinets médicaux. À l'initiative de l'ARS Aquitaine et des médecins libéraux, la Maison Médicale de Garde (MMG) de Libourne a ouvert ses portes le 1^{er} janvier 2015, mutualisant plusieurs secteurs de garde du Libournais. Cette étude quantitative observationnelle transversale avait pour objectif d'évaluer l'impact de la mise en place de la MMG de Libourne sur les opinions, la satisfaction et les pratiques déclarées des médecins généralistes du secteur et l'influence d'une telle structure sur les projets d'installation des médecins remplaçants.

► **Rémunération des médecins généralistes en France : une combinaison complexe d'incitations économiques**

FRANC K.
2019

Actualité Et Dossier En Santé Publique(108): 4-7.

Les dispositifs de paiement à la performance complètent la rémunération des médecins libéraux selon les résultats obtenus par rapport à des objectifs de qualité des soins et de santé publique. Cet article présente ces dispositifs et en analyse les résultats obtenus.

► **How To Engage French Professionals To Undertake Social Responsibility At A Local Level?**

GAUTIER S. ET BOURGUEIL Y.
2019

European Journal of Public Health 29(Supplement_4).

<https://doi.org/10.1093/eurpub/ckz186.361>

In France, primary care is organised according to the principles of private practice: independent providers, payment by fee for service, freedom of settlement... Successive reforms have introduced more regulation i.e. gatekeeping role for GPs, better recognition of professional groups, new forms of payment and promotion of team work and multi-professional practices. Today, the concept of Health Territorial and Professional Communities (HTPC) is becoming a key element of health care reform encouraging primary care professionals to meet with specialists and social workers at a larger level than practice. HTPC should address issues such as access to services, coordination of care and promoting of preventive actions toward populations. This implies change in the roles, skills, methods and resources needed on both professional and regulatory sides. This study explores levers of the professional commitment in the HTPC and resources necessary for it. We conducted a qualitative multiple case study in three French regions. Data was collected from thirty semi-structured interviews with key national informants, regional regulators and health professionals themselves. Professional commitment emerges at a local level on a territory defined by the collaboration practices and habits following a bottom-up process. The integration of care relies on the size of the HTPC which allows them to know each other and to work together to improve access to care and patient's disease management. In order to achieve that, professionals claim to have access to administrative health data and to be able to analyze it. They need to develop new skills in management and group animation. The function and training of coordination professionals appear to be essential. The professional commitment in HTPC relies on professional empowerment toward collective activities. This requires autonomy, skills and new roles both for professionals and regulatory authorities. French government relies on professionals' investment at the territorial level by implementing HTPC to guarantee access to care and respond to population needs in primary care. HTPC implementation implies radical change for the professionals to undertake social and

populational responsibility for which public health professionals should help to meet the challenge.

► **Nurse Practitioner Scope Of Practice Regulations And Nurse Practitioner Supply**

KANDRACK R., BARNES H. ET MARTSOLF G. R.
2019

Med Care Res Rev: Ahead of pub.

Adopting full scope of practice (SOP) for nurse practitioners (NPs) is associated with improved access to care. One possible mechanism for these improvements is increased NP supply. Using county-level data, we fit cross-sectional and panel regression models to estimate the association between adopting full NP SOP and NP supply in general, and in rural and health professional shortage area-designated counties in particular. In cross-sectional analyses, we estimated positive associations between NP SOP and NP supply, though these relationships were only statistically significant when analyzing health professional shortage areas. In the panel regression models with county fixed effects, the estimated effects were attenuated toward zero and sometimes switched signs. Our findings suggest that improvements in access to care following adoption of full SOP may not be driven by increased NP supply but rather by increased capacity of NPs and physicians to provide care.

► **Pratiques avancées : les protocoles infirmiers de soins d'urgence**

KROL A., BULLARD S., FEY G., *et al.*
2019

Médecine : De La Médecine Factuelle à Nos Pratiques 15(10): 463-467.

En collaboration avec les équipes de SMUR, les infirmiers sapeurs-pompiers (ISP) participent activement aux missions de secours d'urgence aux personnes grâce notamment aux protocoles infirmiers de soins d'urgence (PISU), au nombre de 24 au sein du service départemental d'incendie et de secours de la Loire (SDIS 42). Cette évaluation des pratiques professionnelles ouvre sur des questions d'organisation des soins d'urgence pré hospitalière.

► **Consultations avancées de médecins hospitaliers en centres de santé : impacts et difficultés identifiées**

LE COSSEC C., DE CHAMBINE S. ET TUGAYE A.
2019

Santé Publique 31(2): 287-292.

<https://www.cairn.info/revue-sante-publique-2019-2-page-287.htm>

Des consultations avancées avaient été identifiées lors d'un état des lieux des coopérations ville- hôpital réalisé en 2016 à l'Assistance publique – Hôpitaux de Paris. L'étude réalisée vise à apprécier leurs avantages et inconvénients. Des entretiens ont été menés avec les praticiens réalisant les consultations, les chefs de service, les directions (hôpitaux et centres de santé). Un recueil quantitatif a été réalisé pour sept consultations. Ces consultations proposaient des soins en secteur 1 dans des zones défavorisées, le recours à une structure de taille plus humaine que l'hôpital et des délais de rendez-vous parfois plus courts. Pour les praticiens, elles permettaient une diversification de l'activité et une découverte de la médecine de ville. Pour le service hospitalier, elles engendraient le recrutement éventuel de patients et un déport du suivi vers le centre de santé pour les patients vivant à proximité. Il ressort que ces consultations permettent de renforcer des liens ville- hôpital déjà existants et informels. Parmi les difficultés, on note l'absence d'interopérabilité des systèmes d'information, la difficulté à mobiliser certains professionnels et une augmentation de la charge de travail. La mise en place de consultations avancées, si elle peut constituer une première étape dans l'organisation des liens entre la ville et l'hôpital, ne permet pas à elle seule d'assurer un maillage territorial. Les partenariats doivent s'élargir à plusieurs centres mais aussi à d'autres structures de ville. Par ailleurs, des partenariats plus larges permettent de formaliser des parcours de soins.

► **L'étendue effective de la pratique des infirmières dans les services de proximité en région éloignée**

MORIN M. ET LESSARD L.

2019

Recherche en soins infirmiers 138(3): 75-93.

<https://www.cairn.info/revue-recherche-en-soins-infirmiers-2019-3-page-75.htm>

Les infirmières peuvent contribuer à accroître l'accessibilité aux services de santé et la qualité des soins à condition d'occuper pleinement leur champ de pratique. Cette étude réalisée au Québec dans une région éloignée des grands centres urbains vise à 1) mesurer l'étendue effective de la pratique infirmière dans les services de proximité et 2) déterminer les caractéristiques individuelles, professionnelles, organisationnelles et contextuelles l'influençant. Quarante-quatre (44) infirmières pratiquant dans différents types d'infrastructures de services de proximité ont répondu à une version électronique du Questionnaire sur l'étendue de la pratique infirmière portant sur 26 activités regroupées en six dimensions. Les résultats indiquent une étendue effective de la pratique infirmière sous-optimale. La dimension « optimisation de la qualité et de la sécurité des soins » obtient le score le plus faible tandis que celles liées à « l'évaluation et la planification des soins », à « l'enseignement aux personnes et leurs familles » et à « la mise à jour et l'utilisation des connaissances » obtiennent des scores plus élevés. Aucune caractéristique n'influence globalement l'étendue effective de la pratique infirmière, mais des scores significativement plus élevés ont été dénotés pour certaines dimensions chez les femmes, chez les infirmières travaillant à temps plein et pour les régions plus proches des grands centres. Cette étude lève en partie le voile sur la pratique infirmière dans les services de proximité en région éloignée afin de formuler des recommandations adaptées à ces contextes.

► **Rationalisation des pratiques professionnelles en maisons de santé pluriprofessionnelles. Le paradoxe d'un exercice libéral sous contraintes**

MOYAL A.

2019

Revue française de science politique 69(5): 821-843.

<https://www.cairn.info/revue-francaise-de-science-politique-2019-5-page-821.htm>

Cet article s'intéresse à un nouvel instrument d'action publique qui vise à rationaliser les pratiques des professionnels de santé libéraux dans le secteur des soins primaires en France, les maisons de santé pluri-professionnelles (MSP), et a pour objectif d'analyser ses effets sur l'exercice libéral et l'autonomie professionnelle. À travers une étude qualitative dans six MSP, nous montrons que les professionnels libéraux s'approprient cet instrument de rationalisation et, ce faisant, parviennent à maintenir leurs pratiques existantes, voire à en développer de nouvelles que les autorités publiques n'ont pas anticipées. Ce processus conduit à un renforcement de la relation d'interdépendance entre professionnels libéraux et autorités publiques : d'un côté, les autorités publiques acceptent l'appropriation des professionnels libéraux car elles dépendent de leur adhésion pour assurer le développement des MSP; de l'autre, les professionnels libéraux consentent à rendre des comptes aux autorités publiques car ils ont besoin de leur reconnaissance pour assurer la pérennité de leurs pratiques. De cette interdépendance renforcée naît ce que nous appelons un nouveau statut libéral sous contraintes.

► **Étude descriptive de la consultation infirmière de deuxième ligne en plaies et cicatrisation : une situation didactique en construction**

PALMIER S.

2019

Recherche en soins infirmiers 137(2): 49-61.

<https://www.cairn.info/revue-recherche-en-soins-infirmiers-2019-2-page-49.htm>

Dans l'activité des Infirmières spécialisées en plaies et cicatrisation (ISPC), la consultation infirmière dite de deuxième ligne est l'occasion d'offrir aux requérants l'occasion d'un temps formatif. Ce travail s'inscrit dans une perspective exploratoire. L'objectif de l'étude est d'interroger la dimension didactique de cette typologie de consultation. Pour aborder la problématique, l'attention est portée sur l'analyse de l'activité de l'ISPC. Deux entretiens d'autoconfrontation simple d'une ISPC sont analysés à partir de consultations vidéoscopées. Même si les résultats énoncés restent incomplets, les entretiens étant basés sur un seul individu, nous montrons dans cet article comment l'ISPC, à l'issue des entretiens, est en mesure de formuler des rectifications à venir pour sa pratique. La première piste réside dans la mise en évidence d'une nécessaire transformation

du discours tenu par l'ISPC lors des consultations. Ensuite, c'est le moment de suivi post consultation qui se retrouve interrogé dans sa modalité.

► **Convenient Primary Care And Emergency Hospital Utilisation**

PINCHBECK E. W.
2019

Journal of Health Economics 68: 102242.
<https://doi.org/10.1016/j.jhealeco.2019.102242>

Participation and utilisation decisions lie at the heart of many public policy questions. I contribute new evidence by using hospital records to examine how access to primary care services affects utilisation of hospital Emergency Departments in England. Using a natural experiment in the roll out of services, I first show that access to primary care reduces Emergency Department visits. Additional strategies then allow me to separate descriptively four aspects of primary care access: proximity, opening hours, need to make an appointment, and eligibility. Convenience-oriented services divert three times as many patients from emergency visits, largely because patients can attend without appointments.

► **HRSA-Funded Health Centers Are An Important Source Of Care And Reduce Unmet Needs In Primary Care Services**

POURAT N., CHEN X., LEE C., *et al.*
2019

Medical Care 57(12): 996-1001.
<https://doi.org/10.1097/mlr.0000000000001206>

Evidence indicates the unmet need for primary care services including medical, mental health, and dental care is greater among uninsured and Medicaid beneficiaries than privately insured individuals, many of whom use Health Resources and Services Administration-funded health centers (HRSA HCs). We examined differences in rates of unmet need between low-income uninsured and Medicaid patients of HRSA HCs and safety-net clinics in general or private physicians. Research Design: We used logistic regression models to compare the predicted probabilities of unmet need for uninsured and Medicaid individuals whose usual source of care is HRSA HCs versus clinics in general or private phy-

sicians. We used a nationally representative survey of low income, adult patients who identified HRSA HCs as their usual source of care. We used the National Health Interview Survey to independently identify low-income individuals whose usual source of care was clinics (National Health Interview Survey clinics) or physicians (National Health Interview Survey physicians) in the general population. Dependent variables were unmet need and delay in medical care, and unmet need for prescription medications, mental health, and dental care. The primary independent variable of interest was the usual source of care. We controlled for potential confounders. We found the probability of unmet need for medical and dental care to be lower among HRSA HC patients than individuals whose usual source of care were not HRSA HCs. HRSA HC patients have lower probabilities of unmet need for medical and dental care. This is likely because HRSA HCs provide accessible, affordable, and comprehensive primary care services. Expanding capacity of these organizations will help reduce unmet need and its consequences.

► **Barriers To Implementing Patient-Centred Care: An Exploration Of Guidance Provided By Ontario's Health Regulatory Colleges**

RANDALL G. E., WAKEFIELD P. A., BARR N. G., *et al.*
2019

Health Care Analysis.
<https://doi.org/10.1007/s10728-019-00386-6>

The philosophy of patient-centred care has become widely embraced but its implementation is dependent on interrelated factors. A factor that has received limited attention is the role of policy tools. In Ontario, one method government can use to promote healthcare priorities is through health regulatory colleges, which set the standard of practice for health professionals. The degree to which government policy in support of patient-centered care has influenced the direction provided by health regulatory colleges to their members, and ultimately impacted actual patient care, remains unclear. This study investigates the extent to which Ontario's health regulatory colleges have provided explicit written guidance to members related to the importance of patient-centred care. It also explores applied and theoretical explanations that may further our understanding of why patient-centred care has not been more fully embraced. Findings reveal that guidance provided by Ontario's health regulatory colleges

varies widely. Institutional barriers and the choice of policy tools for disseminating government preferences may hinder full implementation of the principles of patient-centred care. More fully understanding the role health regulatory colleges' play in facilitating the implementation of health policy will contribute positively to dialogue and to efforts to achieve positive health system reforms.

► **Examining Differences In Out-Of-Hours Primary Care Use In Belgium And The Netherlands: A Cross-Sectional Study**

SMITS M., COLLIERS A., JANSEN T., *et al.*

2019

European Journal of Public Health 29(6): 1018-1024.

<https://doi.org/10.1093/eurpub/ckz083>

The organizational model of out-of-hours primary care is likely to affect healthcare use. We aimed to examine differences in the use of general practitioner cooperatives for out-of-hours care in the Netherlands and Belgium (Flanders) and explore if these are related to organizational differences. A cross-sectional observational study using routine electronic health record data of the year 2016 from 77 general practitioner cooperatives in the Netherlands and 5 general practitioner cooperatives in Belgium (Flanders). Patient age, gender and health problem were analyzed using descriptive statistics. The number of consultations per 1000 residents was 2.3 times higher in the Netherlands than in Belgium. Excluding telephone consultations, which are not possible in Belgium, the number of consultations was 1.4 times higher. In Belgium, the top 10 of health problems was mainly related to infections, while in the Netherlands there were a larger variety of health problems. In addition, the health problem codes in the Dutch top 10 were more often symptoms, while the codes in the Belgian top 10 were more often diagnoses. In both countries, a relatively large percentage of GPC patients were young children and female patients. Differences in the use of general practitioner cooperatives seem to be related to the gatekeeping role of general practitioners in the Netherlands and to organizational differences such as telephone triage, medical advice by telephone, financial thresholds and number of years of experience with the system. The information can benefit policy decisions about the organization of out-of-hours primary care.

► **Production Of Physician Services Under Fee-For-Service And Blended Fee-For-Service: Evidence From Ontario, Canada**

SOMÉ N. H., DEVLIN R. A., MEHTA N., *et al.*

2019

Health Economics 28(12): 1418-1434.

<https://doi.org/10.1002/hec.3951>

We examine family physicians' responses to financial incentives for medical services in Ontario, Canada. We use administrative data covering 2003-2008, a period during which family physicians could choose between the traditional fee for service (FFS) and blended FFS known as the Family Health Group (FHG) model. Under FHG, FFS physicians are incentivized to provide comprehensive care and after-hours services. A two-stage estimation strategy teases out the impact of switching from FFS to FHG on service production. We account for the selection into FHG using a propensity score matching model, and then we use panel-data regression models to account for observed and unobserved heterogeneity. Our results reveal that switching from FFS to FHG increases comprehensive care, after-hours, and nonincentivized services by 3%, 15%, and 4% per annum. We also find that blended FFS physicians provide more services by working additional total days as well as the number of days during holidays and weekends. Our results are robust to a variety of specifications and alternative matching methods. We conclude that switching from FFS to blended FFS improves patients' access to after-hours care, but the incentive to nudge service production at the intensive margin is somewhat limited.

► **Community Nurses' Self-Management Support In Older Adults: A Qualitative Study On Views, Dilemmas And Strategies**

VAN HET BOLSCHER-NIEHUIS M. J. T., UITDEHAAG M. J. ET FRANCKE A. L.

2020

Health & Social Care in the Community 28(1): 195-203.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.12853>

Providing self-management support is an appropriate task for community nurses. However, the support of self-management sometimes triggers tensions in practice. The aim of this study was to explore community nurses' views of self-management, the dilemmas community nurses face when providing support of

self-management by older adults and the strategies they use to solve these challenges. A qualitative study was performed to collect data. Twenty-one community nurses from the eastern part of the Netherlands were recruited through purposive sampling. The interviews were audiotaped, transcribed verbatim and a thematic analysis was carried out. The results show that community nurses find it difficult to give a clear, definitive description of the concept of self-management. They relate self-management to 'taking control of your own life', 'making your own choices and decisions' and 'being self-reliant'. Situations in which older adults exhibit considerable or little self-direction or self-reli-

ance can lead to conflicts in self-management support, namely: 1) 'striving for optimal health and well-being versus respecting older adults' choices' and 2) 'stimulating self-reliance and self-direction versus accepting a dependent attitude'. Different strategies are applied to resolve these scenarios. In the first case, strategies of 'adapting', 'persuading' and 'taking control' are used, and for the second case 'empowering', challenging' and 'tolerating' are used. Creating a clear and shared understanding of 'self-management' and facilitating community nurses to reflect on their dilemmas and strategies might help them in supporting self-management by older adults.

Systèmes de santé

Health Systems

► **Re-Examining Access Points To The Different Levels Of Health Care: A Cross-Sectional Series In Austria**

HOFFMANN K., GEORGE A., JIROVSKY E., *et al.*
2019

European Journal of Public Health 29(6): 1005-1010.
<https://doi.org/10.1093/eurpub/ckz050>

There is high variation in service utilization behaviour, health equity and outcomes among countries based upon the organization of access to primary and secondary care levels. Austria is a country with universal health coverage and access without clear delineation between access to primary and secondary care. The aim of this study was to investigate development of access points to the Austrian system over time and subsequent utilization. The databases used were the Austrian Health Interview Surveys 2006/2007 and 2014, including 15 747 and 15 771 persons, respectively. Descriptive analysis of health services utilization behaviour and demographic factors were conducted. Logistic regression models were applied. Furthermore, differences between the two periods are shown. Utilization of all services assessed was high in 2014 when compared to 2006/2007. Between these periods, a 6–7% increase in use of secondary care services was found. There was a 10.8% increase in access to specialist care services and 4.1% increase in hospital outpatient visits, each without prior General Practitioner (GP) visits. The largest increases were found in those

groups that had previously demonstrated the lowest utilization behaviour of accessing specialist consultations and consultations without a prior GP visit. Despite the lack of change to the health care system or access to care, there was an increase in utilization of secondary care services, with a lower percentage of patients seeking direct GP consultation. This is concerning for systems development, cost containment and quality of care, as it demonstrates a possible trend shifting away from primary care as initial access point.

► **Public Spillovers From Private Insurance Contracting: Physician Responses To Managed Care**

RICHARDS M.R., ET TELLO-TRILLO D. S.
2019

American Economic Journal: Economic Policy 11(4): 375-403.

<https://ideas.repec.org/a/aea/aejpol/v11y2019i4p375-403.html>

Managed care is rebounding as more emphasis is placed on cost containment. These efforts may benefit consumers but challenge providers; however, empirical evidence on how supply-side managed care influences physicians is incomplete. We leverage a quasi-experiment in which a commercial insurer imposed a new contract regime on behavioral health providers in

response to recent policy shifts. We demonstrate spillovers in the form of negative effects on local physician supply and positive effects on Medicare and Medicaid participation in areas where the insurer has market power. Commercially insured patients are also not obviously harmed but receive less intense services in some settings.

► **Managing The Performance Of General Practitioners And Specialists Referral Networks: A System For Evaluating The Heart Failure Pathway**

NUTI S., FERRÉ F., SEGHERI C., *et al.*
2019

Health Policy: Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2019.11.001>

High quality chronic disease management requires coordinated care across different healthcare settings, involving multidisciplinary teams of professionals, and performance evaluation systems able to measure this care. Inter-organizational performance should be measured considering the professional relationships between general practitioners (GPs) and specialists, who are usually linked through informal referral networks. The aim of this paper is to identify and evaluate the performance of naturally occurring networks of GPs and hospital-based specialists providing care for congestive heart failure (CHF) patients in Tuscany, Italy. The analysis focuses on the identification and classification of networks, following CHF patients (n = 15,841) through primary care and inpatient care using administrative data, and on the assessment of process and outcome indicators for CHF patients in these referral networks. We demonstrate the existence of informal links between GPs and hospitals based on patterns of patient flow. These networks which are not geographically based vary in the intensity of relationships and quality of care. Such referral networks may represent the most effective accountability level for chronic disease management, since they encompass the multiple care settings experienced by patients. Overall, an integrated approach to evaluation and performance management that considers the naturally occurring links between professionals working in different settings may enable more efficient, integrated care and quality improvements.

► **Physician Practices In Accountable Care Organizations Are More Likely To Collect And Use Physician Performance Information, Yet Base Only A Small Proportion Of Compensation On Performance Data**

ROSENTHAL M., SHORTELL S., SHAH N. D., *et al.*
2019

Health Services Research 54(6): 1214-1222.

<https://doi.org/10.1111/1475-6773.13238>

Importance It is critical to develop a better understanding of the strategies provider organizations use to improve the performance of frontline clinicians and whether ACO participation is associated with differential adoption of these tools. The aim of this paper is to characterize the strategies that physician practices use to improve clinician performance and determine their association with ACOs and other payment reforms. The National Survey of Healthcare Organizations and the National Survey of ACOs fielded 2017-2018 (response rates = 47 percent and 48 percent). Study Design Descriptive analysis for practices participating and not participating in ACOs among 2190 physician practice respondents. Linear regressions to examine characteristics associated with counts of performance domains for which a practice used data for feedback, quality improvement, or physician compensation as dependent variables. Logistic and fractional regression to examine characteristics associated with use of peer comparison and shares of primary care and specialist compensation accounted for by performance bonuses, respectively. ACO-affiliated practices feed back clinician-level information and use it for quality improvement and compensation on more performance domains than non-ACO-affiliated practices. Performance measures contribute little to physician compensation irrespective of ACO participation. ACO-affiliated practices are using more performance improvement strategies than other practices, but base only a small fraction of compensation on quality or cost.

► **L'impact et le développement de la recherche en gestion des organisations de santé**

SAULPIC O.
2019

Journal de gestion et d'économie de la santé 4(4): 287-290.

<https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2019-4-page-287.htm>

La question de l'impact de la recherche se pose dans tous les domaines des sciences de gestion. Les débats autour de ces questions indiquent qu'il est difficile de cerner les contributions de la recherche aux pratiques de gestion. Comme le montrent Carton & Mouricou, de nombreuses solutions sont proposées mais ce sont les mêmes depuis plus de 20 ans. Cela indique en creux

que le problème de l'impact reste entier. Bien que dans le domaine de la santé et des établissements de santé, les travaux de recherche soient souvent justifiés, à juste titre, par les enjeux de transformations dans ce secteur – l'existence même d'une communauté de recherche spécialisée dans le secteur des organisations de santé, Aramos, se justifie notamment par le fait qu'elle peut aider à répondre à ces enjeux – la question de leur impact sur ces transformations n'a à notre connaissance pas été posée en France à ce jour. C'est d'autant plus surprenant que, dans ce secteur, les transformations se font notamment sous l'impulsion de politiques publiques qui visent à introduire des changements dans la gouvernance des établissements ou les dispositifs de gestion. Or la communauté académique n'est que peu impliquée dans l'analyse de leurs effets.

Travail et santé

Occupational Health

► **Gender Differences In The Influence Of Mental Health On Job Retention**

BARNAY T. ET DEFEBVRE É.
2019

Labour 33(4): 507-532.

<https://doi.org/10.1111/labr.12154>

We measure gender differences in the causal impact of the 2006 self-assessed mental health status (anxiety disorders and depressive episodes) on job retention in 2010. We use data from the French Health and Professional Career Path survey. To control for endogeneity biases, we use bivariate probit models to simultaneously explain employment status and mental health. Anxiety disorders reduce men's job retention capacity by up to 12 percentage points (pp). Depressive episodes affect both genders almost equally (around 11 pp). More severe cases of both mental health conditions are relevant in determining the capacity of individuals to remain in employment.

► **Les évolutions de l'emploi et leurs conséquences sur la protection sociale**

BONNAND G.
2019

Regards 55(1): 75-86.

<https://www.cairn.info/revue-regards-2019-1-page-75.htm>

Le monde du travail est en grande mutation. Notre système de protection sociale qui a vu le jour et s'est développé concomitamment avec la révolution industrielle et le développement de l'industrie est fragilisé par la déstabilisation de la société salariale. Notre système de protection sociale français est un système, qui a fait du travail et de son statut, la pierre angulaire d'un système hybride empruntant à Bismarck sa logique assurancielle assis sur le statut des travailleurs et à Beveridge sa vocation universelle. Les perturbations que connaît le monde du travail avec ses effets sur l'emploi, nécessitent de repenser la protection sociale dans une logique de parcours, afin d'assurer des protections aux individus tout au long de leur vie et activité, marquée par des mobilités professionnelles, statutaires, géographiques. Pour faire face à ces nouveaux défis, nous devons favoriser le passage d'un système structuré autour des droits rattachés au statut, à un système structuré autour de droits ratta-

chés à la personne, répondant à la fois aux besoins de « communs protecteurs » et à un besoin de spécificité au regard de la diversité des situations vécues, et d'une réponse personnalisée.

► **Who Gains The Most From Improving Working Conditions? Health-Related Absenteeism And Presenteeism Due To Stress At Work**

BRUNNER B., IGIC I., KELLER A. C., *et al.*

2019

The European Journal of Health Economics 20(8): 1165-1180.

<https://doi.org/10.1007/s10198-019-01084-9>

Work stress-related productivity losses represent a substantial economic burden. In this study, we estimate the effects of social and task-related stressors and resources at work on health-related productivity losses caused by absenteeism and presenteeism. We also explore the interaction effects between job stressors, job resources and personal resources and estimate the costs of work stress. Work stress is defined as exposure to an unfavorable combination of high job stressors and low job resources. The study is based on a repeated survey assessing work productivity and workplace characteristics among Swiss employees. We use a representative cross-sectional data set and a longitudinal data set and apply both OLS and fixed effects models. We find that an increase in task-related and social job stressors increases health-related productivity losses, whereas an increase in social job resources and personal resources (measured by occupational self-efficacy) reduces these losses. Moreover, we find that job stressors have a stronger effect on health-related productivity losses for employees lacking personal and job resources, and that employees with high levels of job stressors and low personal resources will profit the most from an increase in job resources. Productivity losses due to absenteeism and presenteeism attributable to work stress are estimated at 195 Swiss francs per person and month. Our study has implications for interventions aiming to reduce health absenteeism and presenteeism.

► **Trajectories Of Sickness Absence, Disability Pension And Unemployment In Young Immigrants With Common Mental Disorders**

DI THIENE D., MITTENDORFER-RUTZ E., RAHMAN S., *et al.*

2019

European Journal of Public Health 29(6): 1055-1062.

<https://doi.org/10.1093/eurpub/ckz046>

The aims were to elucidate if trajectories of labour market marginalization (LMM), measured as sickness absence (SA)/disability pension (DP) or unemployment, differed between young immigrants and natives before and after an incident diagnosis of a common mental disorder (CMD), and to investigate if educational level, psychiatric comorbidity and duration of residence in Sweden (in immigrants) had different associations with subsequent LMM in natives compared with immigrants. A total of 28 971 young adults (19–30 years), with an incident CMD (inpatient or specialized outpatient healthcare due to CMDs or dispensed prescribed antidepressants during 2007) were included. Group-based trajectory models were utilized to identify trajectories of annual months of LMM 3 years before and 6 years after the diagnosis. The associations of risk factors with different trajectories were investigated by multinomial logistic regression, χ^2 -test and Nagelkerke R² to measure the associations' strength. Immigrants were categorized into Western and non-Western immigrants. Young natives and immigrants showed similar trajectories of SA/DP. A higher proportion of non-Western immigrants (20.5%) followed trajectories of high levels of unemployment (≥ 2 annual months) compared with Western immigrants (15%) and natives (16.5%). Educational level and duration of residence in Sweden (in immigrants) discriminated trajectories of both SA/DP and unemployment, whereas psychiatric comorbidity only discriminated trajectories of SA/DP. Differences in trajectories of unemployment between young natives and immigrants with an incident CMD were found. Educational level and psychiatric comorbidity provided information on differences between natives and immigrants and duration of residence gave information for subgroups of immigrants.

► **Underemployment And Psychological Distress: Propensity Score And Fixed Effects Estimates From Two Large UK Samples**

MOUSTERI V., DALY M. ET DELANEY L.

2020

Social Science & Medicine 244: 112641.

<https://doi.org/10.1016/j.socscimed.2019.112641>

The share of workers who work part-time because full-time jobs are not available remains larger compared to the period prior to the 2008 crisis. For part-time workers, being available to work more hours than offered may have negative mental health implications. Drawing on two nationally representative British surveys, we tested whether working less than 30 hours per week while preferring to work longer hours (underemployment) is associated with increased psychological distress. Distress was assessed using responses to the 12-item General Health Questionnaire in both samples. Results in the National Child Development Study (N=6,295), propensity score estimates indicated that the hours-underemployed workers experienced higher levels of psychological distress ($\beta=0.25$, $p<0.001$) than full-time workers matched on observable characteristics, including prior distress levels. Fixed effects estimates using 18 years of the British Household Panel Survey (N=8,665) showed that transitioning from full-time employment to underemployment predicted an increase in distress levels ($\beta=0.19$, $p<0.01$). Conversely, transitioning from underemployment to full-time employment forecasted a reduction in distress ($\beta=-0.18$, $p<0.001$). On average, job earnings and perceptions of job security explained a small (= 10%) portion of the potential psychological impact of hours-underemployment. These findings highlight the possibility that underemployment among part-time workers may have detrimental psychological consequences. Policy interventions geared towards improving career opportunities for part-time workers would potentially ameliorate losses in psychological well-being experienced by this group.

► **Validation complémentaire d'une mesure de satisfaction au travail**

TAVANI J. L., LO MONACO G. ET COLLANGE J.

2019

Santé Publique 31(2): 223-232.

<https://www.cairn.info/revue-sante-publique-2019-2-page-223.htm>

En France, il existe un intérêt grandissant pour les déterminants des dimensions positives de santé au travail qui contribuent à la qualité de vie au travail des salariés. Parmi ces dimensions, la satisfaction au travail est celle qui a été la plus étudiée. Néanmoins, peu de mesures validées en langue française sont disponibles, et parmi elles nous nous intéresserons à la mesure de la satisfaction en un item (Job Satisfaction Single Item – JSSI). L'objectif de cet article est d'apporter des éléments empiriques complémentaires visant à valider une mesure de satisfaction au travail composée d'un seul item. Nous avons examiné la sensibilité et la validité de critère de la JSSI. Plus précisément, nous avons examiné les liens entre la JSSI et, d'une part, d'autres échelles de satisfaction au travail, et d'autre part, avec des mesures de santé et motivation au travail, telles que le stress perçu, la satisfaction de vie, le bonheur, la perception de soutien social donné et reçu, et enfin d'engagement organisationnel. Nous avons également vérifié que la JSSI engendrait un gain de temps significatif dans sa complétion par rapport à des mesures plus longues de satisfaction au travail. Les résultats témoignent que la mesure de satisfaction au travail en un item présente à la fois une sensibilité adéquate et une bonne validité de critère aussi bien avec des mesures de santé au travail positives que des mesures négatives. Enfin, la JSSI permet un gain de temps significatif par rapport aux mesures en cinq et vingt items. Les preuves empiriques présentées ici réaffirment les bonnes qualités psychométriques de cette mesure. La JSSI est une mesure appropriée et permettant un gain de la satisfaction au travail, et ce plus particulièrement dans les études visant à examiner la variabilité intra-individuelle.

Ageing

► **Les aidants de personnes âgées non dépendantes ont-ils des spécificités ? Étude auprès de 876 dyades personnes âgées-aidants**

ARLOTTO S., BONIN-GUILLAUME S., DENICOLAI S.,
et al.

2019

Revue d'Épidémiologie et de Santé Publique 67(6): 403-412.

<https://doi.org/10.1016/j.respe.2019.07.006>

L'augmentation de l'espérance de vie et le vieillissement de la population a un impact important sur les soins informels délivrés par les proches aidants. La prévention d'un fardeau excessif pour cette population est devenue une priorité en matière de santé publique. La majorité des études sur les aidants ne ciblent que ceux de personnes âgées dépendantes. L'objectif de cet article est de décrire les caractéristiques des aidants de personnes âgées non dépendantes, leurs difficultés et le niveau de fardeau. Une étude transversale a été conduite auprès de 876 dyades (personne âgée de plus de 70 ans, autonome, vivant à domicile, ayant fait une demande d'aide auprès de la Carsat Sud-Est et son aidant). Deux questionnaires ont été administrés : un pour la personne âgée (incluant la grille « Frailty Groupe Iso-Ressource Evaluation ») et un pour l'aidant (incluant le mini-Zarit). Une analyse en composantes multiples et une régression logistique ont été réalisées. Résultats Les personnes âgées sont des femmes (77,6 %) avec un âge moyen de 82,2±5,8 ans, et sont fragiles (94,7 %). Les aidants sont le plus souvent des femmes (64,5 %) âgées en moyenne de 62,7±13,7 ans. Pour l'analyse à composantes multiples, trois catégories d'aidants ont été définies : les conjoints, les enfants et une catégorie « autres ». Les conjoints réalisent le plus de tâches (4,8±2,6) et ont un fardeau élevé. Les autres sont ceux ayant le moins de fardeau et sont les moins impactés dans leur vie quotidienne. Les enfants sont divisés en deux sous-groupes : un dont les spécificités se rapprochent des aidants « autres » et l'autre groupe des aidants conjoints. Les variables associées à un fardeau modéré ou sévère sont l'impact sur la vie quotidienne, la qualité de la relation avec la personne âgée et le fait d'éprouver de plus en plus de difficultés à remplir son rôle d'aidant. Cette étude confirme et affine la grande hétérogénéité des profils d'aidants

et montre que les aidants des personnes âgées autonomes fragiles sont assez similaires dans leurs caractéristiques et sur le niveau de fardeau ressenti des aidants de personnes âgées dépendantes.

► **Déterminants du recours au répit pour les proches aidants de malades atteints de démence**

BANNEROT F., LEOCADIE M.-C. ET ROTHAN-TONDEUR M.

2019

Santé Publique 31(2): 277-286.

<https://www.cairn.info/revue-sante-publique-2019-2-page-277.htm>

L'évolution démographique et le vieillissement de la population concourent à l'augmentation des maladies d'Alzheimer ou apparentées. Encouragé par les politiques de santé, le maintien à domicile des patients souffrant de ces pathologies est souvent dépendant de la contribution de proches aidants. L'exigence de ce rôle peut fragiliser les personnes concernées et favoriser chez elles l'apparition d'un sentiment de fardeau nécessitant le recours à des périodes de répit. Étude ancillaire d'un programme de recherche mené sur l'agglomération de Genève, notre travail vise à caractériser les déterminants d'un recours aux dispositifs de répit pour les proches aidants de patients atteints de démence ; À cet effet, une recherche qualitative a été menée par la méthode de focus groupes, auprès des proches aidants de patients atteints de démence. Trois focus groupes ont été menés, avec 12 participants dans les agglomérations de Genève (Suisse) et Rouen (France). Résultats : Notre étude relève la concomitance de l'évolution des troubles de la personne aidée et l'émergence d'un sentiment de fardeau chez l'aidant, lié à la durée et l'intensité de l'aide prodiguée. Nos résultats permettent de distinguer les déterminants d'un recours aux dispositifs de répit qui dépendent de l'aidant ou des institutions et d'en proposer une modélisation. Les dispositifs de répit doivent bénéficier d'une coordination et s'adapter aux exigences des bénéficiaires, en termes de format et de qualité, afin d'en faciliter le recours aux populations les plus fragiles et d'éviter qu'il ne soit trop tardif.

► **Informal Care. European Situation And Approximation Of A Reality**

ESTRADA FERNÁNDEZ M. E., GIL LACRUZ A. I., GIL LACRUZ M., *et al.*

2019

Health Policy 123(12): 1163-1172.

<https://doi.org/10.1016/j.healthpol.2019.09.007>

In European countries, the increasing of dependency affects individual, family-level and political aspects. The purpose is to analyse the effects on the health of informal carers living with a dependent person and the number of hours taken up by this care. Results between genders will be compared with other situations (time, energy commitments, influential socio-economic factors and differences among countries). This research is a cross-sectional study analysing secondary data and is carried out as part of the European Social Survey (ESS), 2014/2015. A total of 32,992 participants aged over 25 years took part in the ESS. Using an empirical framework, we have selected a simple logit model (logit) and a logit model with a multilevel structure ranking by country of residence (Xtmelogit). Being a carer is associated with a decrease in health indicators. Moreover, being a woman is related to an intense load of hours of care, no level of studies and living with difficulties. Living in southern or eastern European countries can also be considered a risk factor for carers. There are also important north-south political differences. Political implications These results show the need to apply gender policies to reconcile and regulate the distribution of the income of economically more vulnerable families, as well as the provision of social services to help dependents.

► **La perception de la qualité au prisme des temporalités. Les temps de l'aide à domicile**

GUCHER C., LAFORGUE D. ET ALVAREZ S.

2019

Gérontologie et société 41 / 160(3): 47-59.

<https://www.cairn.info/revue-gerontologie-et-societe-2019-3-page-47.htm>

Pour quelles raisons certaines personnes âgées dépendantes portent-elles un jugement négatif sur la qualité de l'aide qui leur est apportée à domicile et en conséquence manifestent une adhésion limitée aux formes d'intervention qui leur sont proposées dans le cadre de l'Allocation Personnalisée à l'Autonomie ? Le

cadre d'un appel à projets de recherche DREES-CNSA a permis aux auteurs d'interpréter en partie ces phénomènes au prisme des temporalités. Il en ressort que les interventions des aides à domicile soutiennent diversement la dynamique temporelle des personnes aidées et que l'appréciation de l'aide apportée est relativement associée à cet élément. À partir d'une approche qualitative, cet article met ainsi en évidence différentes configurations de situations d'aide en montrant comment elles résultent d'un jeu entre une pluralité de temporalités constitutives de l'identité des vieilles personnes et de l'intervention professionnelle.

► **Traduction du référentiel du vieillissement actif au Québec et enjeux d'activation du vieillir**

MARCHAND I.

2018

Retraite et société 80(2): 97-119.

<https://www.cairn.info/revue-retraite-et-societe-2018-2-page-97.htm>

À partir d'une analyse documentaire, cet article expose le développement historique du référentiel du vieillissement actif et sa traduction dans la province du Québec (Canada). Au regard de ce cadre référentiel, trois types de politiques d'activation du vieillissement sont identifiées : celles ayant trait à l'allongement des carrières et des mesures graduelles de sortie d'emploi ; celles concernant la prise en charge des proches ; celles à propos de la participation sociale. La discussion met l'accent sur les rapports de pouvoir véhiculés à travers les discours sous-jacents au vieillir actif, ainsi que sur la notion d'activité. La conclusion propose un changement de paradigme, d'un référentiel d'activation du vieillissement vers un référentiel en mesure de mieux prendre en charge les fragilités de l'avancée en âge.

► **L'émergence de « politiques de l'autonomie » à l'échelle locale : entre innovations et prégnance des filières d'action sociale**

MARTIN P. ET POUCHADON M.-L.

2019

Revue française des affaires sociales Hors-série 1(HS): 63-86.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2019-HS-page-63.htm>

Un nouveau vocable est apparu pour désigner l'action sociale et médico-sociale en direction des personnes âgées et des personnes handicapées : on parle aujourd'hui de « politiques de l'autonomie ». Il s'agit non seulement d'embrasser de manière plus large les traditionnelles filières, mais aussi de situer l'action dans sa dimension locale, territoriale et, par-là, de la référer au paradigme de la société inclusive. Assiste-on pour autant à une véritable transformation cognitive du côté des acteurs de terrain ? Sur la base d'une étude empirique des politiques, des dispositifs et des pratiques d'accompagnement des personnes âgées et des personnes handicapées dans deux départements français, le présent article propose une réponse nuancée : les politiques locales envers ces publics semblent bien mues par des volontés d'innovation et de transformation des modes traditionnels de prise en charge. Les organisations et les services se décroissent, se rapprochent des usagers ; les territoires se mobilisent. Ces dynamiques se heurtent toutefois aux logiques de filières spécialisées, toujours prégnantes, et il s'avère difficile en pratique de construire une action en partant de l'individu, de ses besoins propres et de son projet de vie.

► **Disparités départementales dans l'accompagnement des personnes âgées fragiles : un état des lieux**

ROQUEBERT Q.

2019

Revue française des affaires sociales Hors-série 1(HS): 87-103.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2019-HS-page-87.htm>

Si l'accompagnement des personnes âgées fragiles par l'action publique est dessiné au niveau national, sa mise en œuvre repose sur les conseils départementaux. Cet accompagnement repose sur deux volets : le

financement de la demande d'aide qui s'adresse aux aidants professionnels et la régulation de ces producteurs d'aide sur le marché. Cet article propose un état des lieux des connaissances documentant l'ampleur des variations des pratiques départementales sur ces deux volets et leurs effets sur les propriétés des dispositifs tournés vers les personnes âgées fragiles. Si le cadre national s'annonce a priori contraignant, les missions confiées explicitement aux conseils départementaux et les zones d'incertitude que laisse le cadre légal permettent la construction de politiques locales hétérogènes. On montre comment cette construction se décline dans les trois dimensions de la politique – l'ouverture des droits, le choix du producteur et le prix de l'aide – et affecte in fine les propriétés du dispositif qui s'adresse aux personnes âgées fragiles.

► **The Experience Of Transitions In Care In Very Old Age: Implications For General Practice**

SCHEIBL F., FLEMING J., BUCK J., *et al.*

2019

Family Practice 36(6): 778-784.

<https://doi.org/10.1093/fampra/cmz014>

It can be challenging for general practitioners to support their oldest old patients through the complex process of relocation. This study aims to provide a typology of the experiences of moving in very old age that is clinically useful for practitioners navigating very old people's relocation. Qualitative analysis of data from a mixed-methods UK population-based longitudinal study, Cambridge City over-75s Cohort (CC75C), from Year 21 follow-up onwards was conducted. Interviews with participants aged ≥ 95 years old and proxy informants (Year 21: 44/48, 92%, subsequent attrition all deaths). Thematic analysis of qualitative data available from 26/32 participants who moved before they died. Individuals who moved voluntarily in with family experienced gratitude, and those who moved into sheltered house or care homes voluntarily had no regrets. One voluntary move into care was experienced with regret, loss and increased isolation as it severed life-long community ties. Regret and loss were key experiences for those making involuntary moves into care, but acceptance, relief and appreciation of increased company were also observed. The key experience of family members was trauma. Establishing connections with people or place ahead of moving, for example through previous respite care, eased moving. A check-

list for practitioners based on the resulting typology of relocation is proposed. Most of the sample moved into residential care. This study highlights the importance of connections to locality, people and place along with good family relationships as the key facilitators of a healthy transition into care for the oldest old. The proposed checklist may have clinical utility.

► **Frailty Transitions And Health Care Use In Europe**

SICSIC J. ET RAPP T.
2019

Health Services Research 54(6): 1305-1315.
<https://doi.org/10.1111/1475-6773.13208>

There is relative consensus that chronic conditions, disability, and time-to-death are key drivers of age-related health care expenditures. In this paper, we analyze the specific impact of frailty transitions on a wide range of health care outcomes comprising hospital, ambulatory care, and dental care use. Five regular waves of the SHARE survey collected between 2004 and 2015. We estimate dynamic panel data models on the balanced panel (N = 6078; NT = 30 390 observations). Our models account for various sources of selection into frailty, that is, observed and unobserved time-varying and time-invariant characteristics. We confirm previous evidence showing that frailty transitions have a statistically significant and positive impact on hospital use. We find new evidence on ambulatory and dental care use. Becoming frail has greater impact on specialist compared to GP visit, and frail elderly are less likely to access dental care. Conclusions By preventing transitions toward frailty, policy planners could prevent hospital and ambulatory care uses. Further research is needed to investigate the relationship between frailty and dental care by controlling for reverse causation.

► **Le prix de l'aide à domicile : genèse d'une convention de valorisation**

VATAN S.
2019

Revue Française de Socio-Économie 23(2): 119-139.
<https://www.cairn.info/revue-francaise-de-socio-economie-2019-2-page-119.htm>

Cette contribution montre comment la mise en œuvre d'une nouvelle tarification administrée des services

d'aide à domicile a constitué un levier d'alignement des pratiques tarifaires entre les services d'aide à domicile à but lucratif et ceux relevant du champ associatif ou du secteur public. Surtout, elle met en avant la façon dont une nouvelle convention de valorisation s'est construite, relevant à la fois des principes de la nouvelle gestion publique, mais s'appuyant également sur la construction socio-historique du financement de l'aide à domicile.

► **C'est la vie... Jamais j'aurais cru. Ressentis lors de l'entrée en établissement**

VILLAIN A.-S., DONNIO I., VILLAIN A., *et al.*
2019

Gérontologie et société 41 / 160(3): 135-153.
<https://www.cairn.info/revue-gerontologie-et-societe-2019-3-page-135.htm>

Professionnels et société civile se questionnent au sujet de la grande vieillesse évoquant la crainte que leur volonté, comme celle des personnes âgées aujourd'hui, ne soit pas entendue lors de l'entrée en établissement. Notamment parce que, le plus souvent, la décision d'entrer en établissement n'est pas prise par la personne âgée elle-même, posant ainsi la question du respect de sa volonté et de son accompagnement. Cet article vise à rapporter l'expérience des personnes âgées sur la prise de décision d'entrée en établissement. Il s'appuie sur les données d'une étude qualitative réalisée en 2015-2016 auprès de 17 personnes entrées depuis moins de 3 mois ou sur liste d'attente pour un établissement. L'étude des déterminants de l'entrée permet de mettre en évidence la notion d'équilibre, de compromis nécessaire entre les risques et les avantages. La temporalité et l'absence d'alternatives apparaissent comme des facteurs extrinsèques mais influençant fortement la prise de décision. L'analyse questionne la gestion des risques, la notion de choix, le caractère collectif ou personnel de la décision et l'intention versus la résignation lors de la prise de décision. L'anticipation de la réflexion permettrait de mieux accompagner les personnes âgées, à une condition : que la société soit prête à accepter les choix, donc les risques pour les personnes âgées.

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