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

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Novembre 2019 / November 2019

Assurance maladie	*Health Insurance*
E-santé –Technologies médicales	*E-health- Medical Technologies*
Économie de la santé	*Health Economics*
État de santé	*Health Status*
Géographie de la santé	*Geography of Health*
Handicap	*Disability*
Hôpital	*Hospitals*
Inégalités de santé	*Health Inequalities*
Médicaments	*Pharmaceuticals*
Méthodologie – Statistique	*Methodology - Statistics*
Politique de santé	*Health Policy*
Prévention	*Prevention*
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Psychiatrie	*Psychiatry*
Sociologie de la santé	*Sociology of Health*
Soins de santé primaires	*Primary Health Care*
Systèmes de santé	*Health Systems*
Travail et santé	*Occupational Health*
Vieillissement	*Ageing*

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Assurance maladie

Health Insurance

Do Health Insurance and Hospital Market Concentration Influence Hospital Patients' Experience of Care?

HANSON C., HERRING B. ET TRISH E.

2019

Health Services Research 54(4): 805-815.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13168

The objective of this pape is to examine the effects of insurance and hospital market concentration on hospital patients' experience of care, as hospitals may compete on quality for favorable insurance contracts. Data Sources/Study are setting secondary data for 2008-2015 on patient experience from Hospital Compare's patient survey data, hospital characteristics from the American Hospital Association (AHA) Annual Survey, and insurance market characteristics from HealthLeaders-InterStudy. Hospital/year-level regressions predict each hospital's patient experience measure as a function of insurance and hospital market concentration and hospital fixed effects. The model is identified by longitudinal variation in insurance and hospital concentration. Changes in patient satisfaction are positively associated with increases in insurance concentration and negatively associated with increases in hospital concentration. Moving from a market with 20th percentile insurance concentration and 80th percentile hospital concentration to a market with 80th percentile insurance concentration and 20th percentile hospital concentration increases the share of patients that rated the hospital highly from 66.9 percent (95% CI: 66.5-67.2 percent) to 67.9 percent (95% CI: 67.5-68.3 percent) and the share of patients that definitely recommend the hospital from 69.7 percent (95% CI: 69.4-70.0 percent) to 70.8 percent (95% CI: 70.5-71.2 percent). The relationship for insurance concentration is stronger in more concentrated hospital markets, while the relationship for hospital concentration is stronger in less concentrated hospital markets. This paper concludes that these findings add to the evidence on the harms of hospital consolidation but suggest that insurer consolidation may improve patient experience.

Health Insurance and Out-Of-Pocket Costs in the Last Year of Life Among Decedents Utilizing the ICU

KHANDELWAL N., WHITE L., CURTIS J. R., *et al.*

2019

Critical Care Medicine 47(6): 749-756.

https://journals.lww.com/ccmjournal/Fulltext/2019/06000/Health_Insurance_and_Out_of_Pocket_Costs_in_the.2.aspx

Use of intensive care is increasing in the United States and may be associated with high financial burden on patients and their families near the end of life. Our objective was to estimate out-of-pocket costs in the last year of life for individuals who required intensive care in the months prior to death and examine how these costs vary by insurance coverage. Design: Observational cohort study using seven waves of post-death interview data (2002–2014). Participants: Decedents (n = 2,909) who spent time in the ICU at some point between their last interview and death. Interventions: None. Measurements and Main Results: Two-part models were used to estimate out-of-pocket costs for direct medical care and health-related services by type of care and insurance coverage. Decedents with only traditional Medicare fee-for-service coverage have the highest out-of-pocket spending in the last year of life, estimated at $12,668 (95% CI, $9,744–15,592), second to only the uninsured. Medicare Advantage and private insurance provide slightly more comprehensive coverage. Individuals who spend-down to Medicaid coverage have 4× the out-of-pocket spending as those continuously on Medicaid. Conclusions: Across all categories of insurance coverage, out-of-pocket spending in the last 12 months of life is high and represents a significant portion of assets for many patients requiring intensive care and their families. Medicare fee-for-service alone does not insulate individuals from the financial burden of high-intensity care, due to lack of an out-of-pocket maximum and a relatively high co-payment for hospitalizations. Medicaid plays an important role in the social safety net, providing the most complete hospital coverage of all the insurance groups, as well as significantly financing long-term care.

Health Insurance for the Healthy?—Voluntary Health Insurance in Sweden

KULLBERG L., BLOMQVIST P. ET WINBLAD U.

2019

Health Policy. 123 (8) :737-748

In Sweden, voluntary health insurance is held only by a very small part of the population, but uptake has grown rapidly since 2000. So far, little is known about who purchases this insurance and what the insurance plans contain. The aim of this pape ris to provide a comprehensive description of the coverage and content of voluntary health insurance in Sweden. Data from a national survey (Riks-SOM 2016) were used to estimate insurance coverage in different population groups. Additionally, a qualitative content analysis of the voluntary health insurance plans from seven of the largest insurance companies in Sweden was conducted. Voluntary health insurance was found to be more common among high income-earners, individuals employed in the private sector, business owners, and white-collar workers. Insurance benefits varied from visiting a general practitioner to more specialised treatments like knee or hip surgery. Pre-existing medical conditions, emergency medicine, highly specialised care and ongoing chronic care was excluded from the insurance plans. Work-related factors like employment sector, occupation and income appeared to be key determinants for VHI uptake in Sweden. Since the insurance plans included several restrictions, individuals with high care needs are excluded. Taken together, the results indicate that voluntary health insurance in Sweden provide benefits foremost for the healthy and wealthy.

E-santé – Technologies médicales

E-health - Medical Technologies

Digitalisation de la santé au Sud : quand les firmes du numérique décident de l'accès au soin

AL DAHDAH M.

2019

Mouvements 98(2): 120-132.

https://www.cairn.info/revue-mouvements-2019-2-page-120.htm

Le mobile, et plus généralement les infrastructures numériques, sont désormais mis en avant comme un élément fondamental de réponse aux besoins de santé au Nord, mais aussi de plus en plus au Sud où la digitalisation est placée au centre des initiatives de couverture « universelle », c'est-à-dire d'accès sans frais à des interventions prenant pour cible les besoins de base. Marine Al Dahdah enquête sur deux initiatives de ce type, au Kenya et en Inde, qui privilégient les partenariats entre État et opérateurs privés ainsi que la capacité des usager.ères à faire le tri dans leurs besoins. Son analyse montre que si ces programmes promettent une couverture santé pour tou.tes, leurs infrastructures numériques compliquent l'accès aux services de santé, révèlent de nouveaux schémas d'exclusion et affaiblissent les infrastructures publiques de santé en détournant une partie des fonds publics.

Conditions organisationnelles et systémiques à l'implication des citoyens-patients dans le développement de la télésanté au Québec

ALAMI H., GAGNON M.-P. ET FORTIN J.-P.

2019

Santé Publique 31(1): 125-135.

https://www.cairn.info/revue-sante-publique-2019-1-page-125.htm

Impliquer les citoyens-patients dans les décisions concernant les services de télésanté contribuerait à mieux répondre aux besoins et contextes des individus et communautés. Cette étude vise à explorer les conditions organisationnelles et systémiques à l'implication des citoyens-patients dans le développement de la télésanté au Québec. Une étude qualitative basée sur des entrevues semi-dirigées avec 29 informateurs clés a été menée. Une analyse thématique déductive-inductive a été effectuée à partir d'un cadre intégrateur dérivé des théories de diffusion des innovations. L'implication des citoyens-patients dans le développement de la télésanté est tributaire de nombreuses conditions organisationnelles et systémiques. Au niveau organisationnel, cette implication pourrait affecter les dynamiques, cultures, règles et fonctionnements dans les organisations, d'où le besoin de ressources humaines et matérielles adéquates ainsi que la disponibilité du soutien au changement. Au niveau systémique, l'idéologie, le contexte sociopolitique et les décisions en faveur (ou non) d'une appropriation citoyenne de la prise de décision sont centraux. Des questionnements sur les preuves scientifiques, la formation et sur le rôle des fédérations professionnelles et des groupes de citoyens-patients ont également émergé. Les niveaux organisationnels et systémiques sont interdépendants. Les contextes organisationnels et systémiques expliquent une partie du contraste entre le discours en faveur de l'implication des citoyens-patients dans la prise de décision et la réalité observée au Québec. Cette étude constitue une assise pour des études futures sur l'implication des citoyens-patients dans le développement des services sous l'angle de changements organisationnels et systémiques.

▶ Téléradiologie : pour un égal accès aux soins

CHAMPSAUR P. ET BUYER L.

2019

Gestions Hospitalières(587): 382-383.

Les moyens techniques autorisent désormais d'envisager l'échange et le partage des dossiers radiologiques et le recours à la télé radiologie un peu partout en France, dans tous les territoires. La télé radiologie doit permettre de maintenir et d'améliorer les parcours et l'égal accès à des soins de qualité dans l'ensemble des territoires.

▶ Use of Mobile Health (Mhealth) Technologies and Interventions Among Community. Health Workers Globally: A Scoping Review

EARLY J., GONZALEZ C., GORDON-DSEAGU V., *et al.*

2019

Health Promotion Practice:Ahead of pub.

https://doi.org/10.1177/1524839919855391

There is mounting evidence to show that community health workers (CHWs) play a positive role in improving population health by connecting people to information, resources, and services. However, barriers faced by CHWs include not being able to access information quickly and in a language tailored to the communities they serve. Mobile health (mHealth) shows promise of bridging this gap. Although there are a number of studies published on mHealth interventions, there is a need to synthesize the literature specific to mHealth and CHWs globally. Therefore, the primary goals of this review are to identify and describe over ten years of studies on the use, effectiveness, and potential of mHealth involving CHWs. Findings provide evidence-based strategies for designing and implementing mHealth tools for and with CHWs. We used criteria and methodology for scoping reviews established by the Joanna Briggs Institute as well as PRISMA protocols. We searched scholarly databases for peer-reviewed articles published between 2007 and 2018. The initial search yielded 207 published articles; after applying inclusion criteria, the sample totaled 64. While research about mHealth use among CHWs is still emerging, we found out that large-scale, longitudinal, and clinical studies are lacking. The existing evidence indicates that interventions, which include both CHWs and mHealth tools, are effective. Challenges include the scarcity of culturally relevant mHealth interventions, lack of a consistent methodology to assess mHealth outcomes, the need for effective training for CHWs to adopt mHealth tools, and improved communication within health care teams working with CHWs.

▶ What Is the Role of Smartphones on Physical Activity Promotion? A Systematic Review and Meta-Analysis

FETER N., DOS SANTOS T. S., CAPUTO E. L., *et al.*

2019

International Journal of Public Health 64(5): 679-690.

https://doi.org/10.1007/s00038-019-01210-7

The aim of this paper is to identify and evaluate the effect of interventions that used cell phones as a means to promote physical activity (PA).

An International Perspective on Health Information Exchange: Adoption in OECD Countries with Different Health Care System Configurations

GUERRAZZI C.

2019

Medical Care Research and Review 0(0): Ahead of pub.

https://journals.sagepub.com/doi/abs/10.1177/1077558719858245

The sharing of information among various care providers is becoming an essential feature of health care systems, and many countries are now adopting policies to foster health information exchange, defined as the electronic transfer of data or information among health care organizations involved in the delivery of care. Given the increasing adoption of this type of policy in several Organization for Economic Cooperation and Development countries, it is important to compare experiences from different countries, because policy adoption in one country can be explained more comprehensively and coherently through comparison with similar policies adopted in other nations. To make a more meaningful cross-country comparison, this article identifies a taxonomy of health systems, and it analyzes institutional and resource-based factors related to health information exchange adoption and how they differ in three main types of health systems: the National Health Service, social health insurance, and private health insurance.

TéléPallia©. Retour sur trois années de télémédecine au service du déploiement d'une Équipe Mobile de Soins Palliatifs en Établissement d'Hébergement pour Personnes Âgées Dépendantes en France

MULOT M., DUMINY B. ET LEMAIRE A.

2019

Revue internationale de soins palliatifs 34(2): 53-57.

https://www.cairn.info/revue-infokara-2019-2-page-53.htm

Les évolutions législatives insistent sur la formalisation d'un volet soins palliatifs dans le projet d'établissement des Établissements d'Hébergement pour Personnes Âgées Dépendantes (EHPAD) en France. TéléPallia© a été le premier projet de télémédecine dédié aux soins palliatifs en France, à l'initiative de l'Équipe Mobile de Soins Palliatifs (EMSP) du Centre Hospitalier de Valenciennes (CHV), et auprès de huit EHPAD pilotes.

Cette expérimentation a permis, depuis 2015, l'optimisation du parcours de soin des résidents en fin de vie, l'amélioration de leur qualité de vie, la mise en œuvre de la collégialité, la formation et l'acculturation des soignants d'EHPAD à la démarche palliative, ainsi que le soutien des soignants et des proches.

La prise de rendez-vous par internet : avis des patients

SCHLICK C. ET BALLY J. N.

2019

Médecine : De la Médecine Factuelle à nos Pratiques 15(6): 277-282.

Dans un contexte de prise de rendez-vous (RDV) difficile, les sites internet spécialisés prennent une place importante. Cette étude qualitative par entretiens individuels semi-dirigés se proposait d'étudier l'impact de la prise de RDV par Internet sur le ressenti du patient. Au-delà des avantages organisationnels, l'utilisation des sites Internet de prise de RDV interroge sur l'accessibilité d'une population précaire. Les urgences ressenties peuvent disparaître du champ des soins premiers. En médecine générale, un système de prise de RDV exclusif par Internet modifierait à l'évidence le paradigme professionnel du médecin généraliste en créant sans le vouloir une médecine de tri.

Économie de la santé

Health Economics

The Financial Burden of Paid Home Care on Older Adults: Oldest and Sickest Are Least Likely to Have Enough Income

JOHNSON R.W., *et al.*

2019

Health Affairs 38(6): 994-1002.

https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00025

Paid home care can significantly improve the lives of older adults with disabilities and their families, but recipients often incur substantial out-of-pocket spending. We simulated the financial burden of paid home care for a nationally representative sample of non-Medicaid community-dwelling adults ages sixty-five and older. We found that 74 percent could fund at least two years of a moderate amount of paid home care if they liquidated all of their assets, and 58 percent could fund at least two years of an extensive amount of paid home care. Among older adults with significant disabilities, however, only 57 percent could fund at least two years of moderate paid home care by liquidating all of their assets, and 40 percent could fund at least two years of extensive paid home care. Paid home care could become less affordable if growing labor shortages raise future costs.

The Effects of the Economic Recession on Spending on Private Health Insurance in Spain

ARTABE A. ET SIGÜENZA W.

2019

International Journal of Health Economics and Management 19(2): 155-191.

https://doi.org/10.1007/s10754-018-9251-2

The paper seeks to analyse the evolution of expenditure on private health insurance (PHI) in Spain. We consider the factors that influence PHI demand and level of spending before and during the economic recession, along with identifying the effect of the recession on these factors. The data is obtained from the Spanish Family Budget Survey (SFBS) for 2006 and 2012. Due to the data structure and the demand function, the analysis is performed using a sample selection model in order to avoid sample selection bias. We estimate three models: a pre-recession model (2006), a model for the recession period (2012) and a third one covering both periods (2006 and 2012) and where we include a dummy variable that establishes the effect of the economic recession. The results show that the effect of the economic recession on PHI demand is not significant, but it is on the level of spending.

La valeur monétaire de l'aide informelle pour les personnes fragiles. Commentaire

BELLANGER M.

2019

Sciences sociales et santé 37(2): 101-109.

https://www.cairn.info/revue-sciences-sociales-et-sante-2019-2-page-101.html

L'article de Papa Mamadou Diagne et Anne Lovell mobilise une approche constructiviste de la division du travail en milieu psychiatrique hospitalier au Sénégal. La substitution de l'accompagnant rémunéré à l'accompagnant familial ou à celui d'un proche, pour assurer le suivi du patient hospitalisé, marque une rupture, à partir de la fin des années 1970, dans la tradition de l'accompagnement du patient en psychiatrie. Cette dernière avait été assurée par la famille et la communauté, grâce à l'approche de l'Ecole de Fann (ou de Dakar) développée par Collomb et ses confrères. L'accompagnant rémunéré est aussi appelé « mercenaire », puisqu'il travaille pour un salaire ou dans l'espoir de celui- ci. Diagne et Lovell rappellent que ce changement dans l'accompagnement des patients hospitalisés en psychiatrie a été associé aux contraintes budgétaires des hôpitaux suite à la crise économique de la fin des années 1970 et aux conséquences économiques imposées par la Banque Mondiale et le Fonds Monétaire International dans le cadre des Programme d'Ajustement Structurel (PAS). Avec les changements économiques imposés par le contexte économique global, une nouvelle forme d'organisation et de valorisation du travail d'accompagnant ou d'aidant au sein de l'hôpital psychiatrique au Sénégal a été mise en place. Les auteurs de l'article comparent le rôle de l'accompagnant mercenaire à celui de l'aide- soignant en France, du fait du contenu des activités réalisées et de leur niveau de technicité. C'est plutôt sur les aidants informels et l'aide et le soutien qu'ils apportent à des personnes âgées fragiles, comme celles atteintes de troubles de démence, comme la maladie d'Alzheimer, que ce commentaire va être centré.

▶ Value-Based Provider Payment Initiatives Combining Global Payments with Explicit Quality Incentives: A Systematic Review

CATTEL D. ET EIJKENAAR F.

2019

Medical Care Research and Review 0(0): Ahead of pub.

An essential element in the pursuit of value-based health care is provider payment reform. This article aims to identify and analyze payment initiatives comprising a specific manifestation of value-based payment reform that can be expected to contribute to value in a broad sense: (a) global base payments combined with (b) explicit quality incentives. We conducted a systematic review of the literature, consulting four scientific bibliographic databases, reference lists, the Internet, and experts. We included and compared 18 initiatives described in 111 articles/documents on key design features and impact on value. The initiatives are heterogeneous regarding the operationalization of the two payment components and associated design features. Main commonalities between initiatives are a strong emphasis on primary care, the use of "virtual" spending targets, and the application of risk adjustment and other risk-mitigating measures. Evaluated initiatives generally show promising results in terms of lower spending growth with equal or improved quality.

▶ Catastrophic Risk Associated with Out-Of-Pocket Payments for Long Term Care in Spain

DEL POZO-RUBIO R. ET JIMÉNEZ-RUBIO D.

2019

Health Policy 123(6): 582-589.

http://www.sciencedirect.com/science/article/pii/S0168851019300843

This study analyses the financial burden associated with the introduction of copayment for long-term care (LTC) in Spain in 2012 for dependent individuals. We analyse and identify households for which the dependency-related out-of-pocket payment exceeds the defined catastrophic threshold (incidence), and the gap between the copayment and the threshold for the catastrophic copayment (intensity), for the full population sample and for subsamples based on the level of long-term care dependency and on regional characteristics (regional income and political ideology of party ruling the region). Results The results obtained show there is a higher risk of impoverishment due to copayment among relatively well-off dependents, although the financial burden falls more heavily on less well-off households. Our findings also reveal interesting regional patterns of inequity in financing and access to long-term care services, which appear to be explained by an uneven development of LTC services (monetary transfers versus formal services) and varying levels of copayment across regions. The new copayment for long-term care dependency in Spain is an important factor of catastrophic risk, and more attention should be addressed to policies aimed at improving the progressivity of out-of-pocket payments for LTC services within and between regions. In addition, formal services should be prioritised in all regions in order to guarantee equal access for equal need.

▶ Catastrophic Long-Term Care Expenditure: Associated Socio-Demographic and Economic Factors

DEL POZO-RUBIO R., MÍNGUEZ-SALIDO R., PARDO-GARCÍA I., *et al.*

2019

The European Journal of Health Economics 20(5): 691-701.

https://doi.org/10.1007/s10198-019-01031-8

An increasing number of persons across the world require long-term care (LTC). In Spain, access to LTC involves individuals incurring out-of-pocket (OOP) expenditure. There is a large body of literature on the incidence of catastrophic OOP payments in access and participation in health systems, but not in the field of LTC nor the determinants of these expenses. Our aim was to analyse the socio-demographic and economic factors associated with different levels of catastrophic LTC expenditure in the form of private out-of-pocket payments among dependent persons in Spain.

The Reimbursement of New Medical Technologies in German Inpatient Care: What Factors Explain Which Hospitals Receive Innovation Payments?

EX P., VOGT V., BUSSE R., *et al.*

2019

Health Economics, Policy and Law: June 4 : 1-15.

https://www.ncbi.nlm.nih.gov/pubmed/31159902

Most hospital payment systems based on diagnosis-related groups (DRGs) provide payments for newly approved technologies. In Germany, they are negotiated between individual hospitals and health insurances. The aim of our study is to assess the functioning of temporary reimbursement mechanisms. We used multilevel logistic regression to examine factors at the hospital and state levels that are associated with agreeing innovation payments. Dependent variable was whether or not a hospital had successfully negotiated innovation payments in 2013 (n = 1532). Using agreement data of the yearly budget negotiations between each German hospital and representatives of the health insurances, the study comprises all German acute hospitals and innovation payments on all diagnoses. In total, 32.9% of the hospitals successfully negotiated innovation payments in 2013. We found that the chance of receiving innovation payments increased if the hospital was located in areas with a high degree of competition and if they were large, had university status and were private for-profit entities. Our study shows an implicit self-controlled selection of hospitals receiving innovation payments. While implicitly encouraging safety of patient care, policy makers should favour a more direct and transparent process of distributing innovation payments in prospective payment systems.

Pay for Performance for Specialised Care in England: Strengths and Weaknesses

FENG Y., KRISTENSEN S. R., LORGELLY P., *et al.*

2019

Health Policy : Ahead of pub.

http://www.sciencedirect.com/science/article/pii/S0168851019301678

Pay-for-Performance (P4P) schemes have become increasingly common internationally, yet evidence of their effectiveness remains ambiguous. P4P has been widely used in England for over a decade both in primary and secondary care. A prominent P4P programme in secondary care is the Commissioning for Quality and Innovation (CQUIN) framework. The most recent addition to this framework is Prescribed Specialised Services (PSS) CQUIN, introduced into the NHS in England in 2013. This study offers a review and critique of the PSS CQUIN scheme for specialised care. A key feature of PSS CQUIN is that whilst it is centrally developed, performance targets are agreed locally. This means that there is variation across providers in: the schemes selected from the national menu, the achievement level needed to earn payment, and the proportion of the overall payment attached to each scheme. Specific schemes vary in terms of what is incentivised – structure, process and/or outcome – and how they are incentivised. Centralised versus decentralised decision making, the nature of the performance measures, the tiered payment structure and the dynamic nature of the schemes have created a sophisticated but complex P4P programme which requires evaluation to understand the effect of such incentives on specialised care.

Insights on Multimorbidity and Associated Health Service Use and Costs from Three Population-Based Studies of Older Adults in Ontario with Diabetes, Dementia and Stroke

GRIFFITH L. E., GRUNEIR A., FISHER K., *et al.*

2019

BMC health services research 19(1): 313-313.

https://www.ncbi.nlm.nih.gov/pubmed/31096989

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6524233/

Most studies that examine comorbidity and its impact on health service utilization focus on a single index-condition and are published in disease-specific journals, which limit opportunities to identify patterns across conditions/disciplines. These comparisons are further complicated by the impact of using different study designs, multimorbidity definitions and data sources. The aim of this paper is to share insights on multimorbidity and associated health services use and costs by reflecting on the common patterns across 3 parallel studies in distinct disease cohorts (diabetes, dementia, and stroke) that used the same study design and were conducted in the same health jurisdiction over the same time period. We present findings that lend to broader Insights regarding multimorbidity based on the relationship between comorbidity and health service use and costs seen across three distinct disease cohorts. These cohorts were originally created using multiple linked administrative databases to identify community-dwelling residents of Ontario, Canada with one of diabetes, dementia, or stroke in 2008 and each was followed for health service use and associated costs. We identified 376,434 indviduals wtih diabetes, 95,399 with dementia, and 29,671 with stroke. Four broad insights were identified from considering the similarity in comorbidity, utilization and cost patterns across the three cohorts: 1) the most prevalent comorbidity types were hypertension and arthritis, which accounted for over 75% of comorbidity in each cohort; 2) overall utilization increased consistently with the number of comorbidities, with the vast majority of services attributed to comorbidity rather than the index conditions; 3) the biggest driver of costs for those with lower levels of comorbidity was community-based care, e.g., home care, GP visits, but at higher levels of comorbidity the driver was acute care services; 4) service-specific comorbidity and age patterns were consistent across the three cohorts. Despite the differences in population demographics and prevalence of the three index conditions, there are common patterns with respect to comorbidity, utilization, and costs. These common patterns may illustrate underlying needs of people with multimorbidity that are often obscured in literature that is still single disease-focused.

The Incremental Health Care Costs of Frailty Among Home Care Recipients with and Without Dementia in Ontario, Canada: A Cohort Study

MONDOR L., MAXWELL C. J., HOGAN D. B., *et al.*

2019

Medical Care 57(7): 512-520.

https://journals.lww.com/lww-medicalcare/Fulltext/2019/07000/The_Incremental_Health_Care_Costs_of_Frailty_Among.5.aspx

In this study, we investigated the incremental 1-year direct costs of health care associated with frailty among home care recipients in Ontario with and without dementia.: We conducted a cohort study of 159,570 home care clients aged 50 years and older in Ontario, Canada in 2014/2015. At index home care assessment, we ascertained dementia status using a validated algorithm and frailty level (robust, prefrail, frail) based on the proportion of accumulated to potential health deficits. Clients were followed for 1-year during which we obtained direct overall and sector-specific publicly-funded health care costs (in 2015 Canadian dollars). We estimated the incremental effect of frailty level on costs using a 3-part survival- and covariate-adjusted estimator. All analyses were stratified by dementia status. Results: Among those with dementia (n = 42,828), frailty prevalence was 32.1% and the average 1-year cost was $30,472. The incremental cost of frailty (vs. robust) was $10,845 [95% confidence interval (CI): $10,112–$11,698]. Among those without dementia (n = 116,742), frailty prevalence was 25.6% and the average 1-year cost was $28,969. Here, the incremental cost of frailty (vs. robust) was $12,360 (95% CI: $11,849–$12,981). Large differences in survival between frailty levels reduced incremental cost estimates, particularly for the dementia group (survival effect: –$2742; 95% CI: –$2914 to –$2554). Conclusions: Frailty was associated with greater 1-year health care costs for persons with and without dementia. This difference was driven by a greater intensity of health care utilization among frail clients. Mortality differences across the frailty levels mitigated the association especially among those with dementia.

Social Capital and Physical Health: An Updated Review of the Literature for 2007–2018

RODGERS J., VALUEV A. V., HSWEN Y., *et al.*

2019

Social Science & Medicine 236: 112360.

https://www.ncbi.nlm.nih.gov/pubmed/31352315

Social capital is frequently indicated as a determinant of population health. Despite an increase in the frequency of public health studies including such measures, our understanding of social capital's effects on health remains unclear. In 2008, a systematic review of the "first decade" of research on social capital and health was published in the textbook Social Capital and Health. Our study intends to update and expand upon this original review to account for developments in the literature over the second decade of research on social capital and health. We employed a systematic review of empirical studies investigating the relationship between measures of social capital and physical health outcomes published between January 1, 2007 and December 31, 2018. To identify potential studies, we conducted searches of PubMed, Embase, and PsychINFO databases in January 2019 using combinations of "social capital" and "physical health" search terms. Results We identified 1,608 unique articles and reviewed 145 studies meeting our inclusion criteria.

The most frequently examined health condition was self-reported health (57%), followed by mortality (12%), cardiovascular diseases (10%), obesity (7%), diabetes (6%), infectious diseases (5%), and cancers (3%). Of these studies, 127 (88%) reported at least partial support for a protective association between social capital and health. However, only 41 (28%) reported exclusively positive findings. The majority (59%) of results were mixed, suggesting a nuanced relationship between social capital and health. This finding could also be indicative of differences in study design, which showed substantial variation. Despite limitations in the literature, our review chronicles an evolution in the field of social capital and health in terms of size and sophistication. Overall, these studies suggest that social capital may be an important protective factor for some physical health outcomes, but further research is needed to confirm and clarify these findings.

Healthcare Use by 30,000 Patients with Irritable Bowel Syndrome (IBS) in France: A 5-Year Retrospective and One-Year Prospective National Observational Study

SABATE J. M., RIVIERE S., JOUET P., *et al.*

2019

BMC Gastroenterol 19(1): 111.

Irritable bowel syndrome (IBS) can be responsible for alteration in quality of life and economic burden. The aim of this study was to evaluate healthcare use related to this disorder in France. The French health data system was used to select adults covered by the general health scheme (87% of population) through their first IBS hospitalization in 2015. We studied the healthcare refunded during the previous 5 years, 1 year before and after hospitalization. Among 43.7 million adults who used refunded healthcare in 2015, 29,509 patients were identified (0.07, 33% males, 67% females, mean age 52 years, 30% admitted through emergency room). During their hospitalization, 33% had upper endoscopy and 64% colonoscopy. Over the five previous years, 3% had at least one hospitalization with an IBS diagnosis, 58% had abdominal ultrasonography, 27% CT scan, 21% upper endoscopy, 13% colonoscopy and 83% a gastroenterologist visit. The year before, these rates were respectively: 0, 36, 16, 6, 4 and 78%. Some of those rates decreased the year after the hospitalization with respectively: 1, 27, 13, 5, 4 and 19%. The year before, 65% had at least one CRP dosage (13% three or more), 58% a TSH dosage (7%) and 8% a test for coeliac diseases (1%) and the year after: 44% (8%), 43% (5%) and 3% (0.3%). At least one refund of a drug used to treat IBS was found for 85% of patients 5 years before, 65% one year before and 51% one year after. This first study using French health data system for healthcare consumption assessment in IBS points out the repetition of outpatient visits, examinations and in particular radiological examinations, without a strong decrease after hospitalization for IBS and gastroenterologist visit.

Relationship Between Healthcare Utilization and Household Out-Of-Pocket Healthcare Expenditure: Evidence from an Emerging Economy with a Free Healthcare Policy

SISIRA KUMARA A. ET SAMARATUNGE R.

2019

Social Science & Medicine 235: 112364.

https://www.sciencedirect.com/science/article/abs/pii/S0277953619303491

Despite the free public healthcare policy in Sri Lanka, households' out-of-pocket healthcare expenditures are steadily increasing. Parallel to this, there is an emerging private healthcare sector based on a user-pays approach. This study, therefore, examines the relationship between healthcare utilization and out-of-pocket healthcare expenses at household level. Using a double-hurdle model with 42,288 household observations drawn from the household income and expenditure survey (2012/2013 and 2016 waves), we find that out- and in-patient care in public hospitals under 'free healthcare policy' is positively associated with household out-of-pocket healthcare expenses, imposing a significant financial burden on the family budget. This relationship is even greater for utilization of private out- and in-patient care. The recent regulatory and fiscal interventions of the government have favourably moderated this relationship for out-patient care but not for in-patient care. The results recommend introducing public policies to further strengthen the monitoring process for private healthcare sector while ensuring the sustainability of free healthcare policy. The paper provides policy implications for richly categorized out-of-pocket healthcare expenditure and healthcare utilization types.

▶ Measuring Catastrophic Medical Expenditures: Reflections on Three Issues

WAGSTAFF A.

2019

Health Economics 28(6): 765-781.

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3881

In the "basic" approach, medical expenses are catastrophic if they exceed a prespecified percentage of consumption or income; the approach tells us if expenses cause a large percentage reduction in living standards. The ability-to-pay (ATP) approach defines expenses as catastrophic if they exceed a prespecified percentage of consumption less expenses on nonmedical necessities or an allowance for them. The paper argues that the ATP approach does not tell us whether expenses are large enough to undermine a household's ability to purchase nonmedical necessities. The paper compares the income-based and consumption-based variants of the basic approach, and shows that if the individual is a borrower after a health shock, the income-based ratio will exceed the consumption-based ratio, and both will exceed the more theoretically correct Flores et al. ratio; whereas if the individual continues to be a saver after a health shock, the ordering is reversed and the income-based ratio may not overestimate Flores et al.'s ratio. Last, the paper proposes a lifetime money metric utility (LMMU) approach defining medical expenses as catastrophic in terms of their lifetime consequences. Under certain assumptions, the LMMU and Flores et al. approaches are identical, and neither requires data on how households finance their medical expenses.

État de santé

Health Status

▶ Risque à 3 mois, 1 an et 5 ans des accidents ischémiques transitoires et infarctus cérébraux mineurs dans une cohorte contemporaine, multicentrique, multinationale, multicontinentale de 4879 patients

AMARENCO P.

2019

Bulletin de l'Académie Nationale de Médecine 203(5): 315-320.

L'accident ischémique cérébral (ou rétinien) transitoire (AIT) et l'infarctus cérébral mineur (sans handicap) offrent l'opportunité d'éviter un nouvel AVC ischémique avec handicap si le patient est exploré aussi rapidement que possible pour détecter la cause et la traiter sans délai. Le risque est très élevé dans les 90 premiers jours, notamment dans les 10–20 premiers jours, puis a tendance à beaucoup diminuer, donnant l'impression d'un risque faible à long-terme. Ce risque à long-terme a été, cependant, peu étudié. Le registre TIAregistry.org avait pour objectif de déterminer le risque à court et long-terme de patients avec AIT ou infarctus cérébral mineur. Les patients ont été inclus consécutivement dans 61 unités neurovasculaires organisées pour la prise en charge des AIT en urgence, dans 21 pays en Europe, Moyen-Orient, Asie et Amérique Latine, aussitôt que possible et jusqu'à 7 jours après l'épisode qualifiant, et suivis 5 ans. Le critère de jugement primaire était la survenue d'un AVC, infarctus du myocarde ou mort vasculaire. Au total, 4739 patients ont été inclus dont 80 % dans les 24 heures suivant les premiers symptômes, dont 3847 ont été suivis 5 ans. En dépit d'une prise en charge thérapeutique optimale tout au long du suivi, le risque de récidive à 3 mois, 1 an, et 5 ans était de 4 %, 6,2 % [IC à 95 %, 5,5–7,0 %], et 12,9 % [IC à 95 %, 11,8–14,1 %], respectivement. La moitié de ce risque était observé la première année post-AIT/infarctus cérébral mineur, et la moitié entre 1 an et 5 ans. À 5 ans, le risque de décès toutes causes, de décès cardiovasculaire, d'hémorragie majeure et d'hémorragie intracrânienne étaient respectivement de 10,6 %, 2,7 %, 1,5 %, et 1,1 %. Le risque de récidive d'AVC fatal ou non était de 9,5 %. Le risque à 5 ans d'AVC avec handicap (mRS > 1) était de 7,9 % [IC à 95 %, 7,1–8,9 %]. En conclusion, le risque vasculaire après un AIT ou un infarctus cérébral mineur est de 6,5 % à un an et de 13 % à 5 ans, et ce risque est maximal durant les premiers jours, puis s'accroît de façon continue jusqu'à 5 ans, et 60 % de ce risque concerne des AVC avec handicap significatif. De nouvelles mesures de prévention sont nécessaires pour diminuer ce risque.

Skilled Nursing Facility Partnerships May Decrease 90-Day Costs in a Total Joint Arthroplasty Episode Under the Bundled Payments for Care Improvement Initiative

BEHERY O. A., KOUK S., CHEN K. K., *et al.*

2018

The Journal of Arthroplasty 33(3): 639-642.

http://www.sciencedirect.com/science/article/pii/S0883540317309075

The Bundled Payments for Care Improvement initiative was developed to reduce costs associated with total joint arthroplasty through a single payment for all patient care from index admission through a 90-day post-discharge period, including care at skilled nursing facilities (SNFs). The aim of this study is to investigate whether forming partnerships between hospitals and SNFs could lower the post-discharge costs. We hypothesize that institutionally aligned SNFs have lower post-discharge costs than non-aligned SNFs. Methods A cohort of 615 elective, primary total hip and knee arthroplasty subjects discharged to an SNF under the Bundled Payments for Care Improvement from 2014 to 2016 were included in our analysis. Patients were grouped into one of the 3 categories of SNF alignment: group 1: non-partners; group 2: agreement-based partners; group 3: institution-owned partners. Demographics, comorbidities, length of stay (LOS) at SNF, and associated costs during the 90-day post-operative period were compared between the 3 groups. Results Mean index hospital LOS was statistically shortest in group 3 (mean 2.7 days vs 3.5 for groups 1 and 2, P = .001). SNF LOS was also shortest in group 3 (mean 11 days vs 19 and 21 days in groups 2 and 1 respectively, P < .001). Total SNF costs and total 90-day costs were both significantly lower in group 3 compared with groups 1 and 2 (P < .001 for all), even after controlling for medical comorbidities. Conclusion Institution-owned partner SNFs demonstrated the shortest patient LOS, and the lowest SNF and total 90-day costs, without increased risk of readmissions, compared with other SNFs.

Prevalence of Major Depression in France in the General Population and in Specific Populations from 2000 to 2018: A Systematic Review of the Literature

FOND G., LANCON C., AUQUIER P., *et al.*

2019

Presse Med 48(4): 365-375.

The aim of this study is to synthetize the data on the prevalence of major depressive disorders (MDD) in France in general population and in specific populations. A systematic review following the PRISMA criteria has been carried out. MEDLINE, google scholar, Isi web of science, PsychInfo et Cochrane library have been explored, from 2000 to April 2018. The prevalence of major depression in France over the last 12 months was around 8% in the 2000s and seems to have increased to 10% in the 2010s. Studies on national databases tend to underestimate this prevalence (<2%), retaining only the most severe depressions, hospitalized and treated with antidepressants. In specific populations, data has been published in HIV, epilepsy, some cancers and cardiovascular disease, cannabis and tobacco smokers. The prevalence of depression seems to have increased between the years 2000 and 2010 in France. Further studies should be published, especially in alcohol use disorder, cancers, cardiovascular diseases and immuno-inflammatory illnesses, due to their high prevalence and their specific relationships with MDD. Another study in the general French population should also be carried out. This data should help developing precision medicine to improve the care of MDD in France.

Cigarette Consumption Estimates for 71 Countries from 1970 to 2015: Systematic Collection of Comparable Data to Facilitate Quasi-Experimental Evaluations of National and Global Tobacco Control Interventions

HOFFMAN S. J., MAMMONE J., ROGERS VAN KATWYK S., *et al.*

2019

BMJ 365: l2231.

https://www.bmj.com/content/bmj/365/bmj.l2231.full.pdf

The objectives of this pape ris to collect, appraise, select, and report the best available national estimates of cigarette consumption since 1970. 71 of 214 countries for which searches for national cigarette consumption data were conducted, representing over

95% of global cigarette consumption and 85% of the world's population. Validated cigarette consumption data covering 1970-2015 were identified for 71 countries. Data quality appraisal was conducted by two research team members in duplicate, with greatest weight given to official government sources. All data were standardised into units of cigarettes consumed per year in each country, a detailed accounting of data quality and sourcing was prepared, and all collected data and metadata were made freely available in an open access dataset. Cigarette consumption fell in most countries over the past three decades but trends in country specific consumption were highly variable.

The Great Recession, Financial Strain and Self-Assessed Health in Ireland

MAZEIKAITE G., O'DONOGHUE C. ET SOLOGON D. M.

2019

The European Journal of Health Economics 20(4): 579-596.

https://doi.org/10.1007/s10198-018-1019-6

In this paper, we study the effects of the 2008 economic crisis on general health in one of the most severely affected EU economies—Ireland. We examine the relationship between compositional changes in demographic and socio-economic factors, such as education, income, and financial strain, and changes in the prevalence of poor self-assessed health over a 5-year period (2008–2013). We apply a generalised Oaxaca–Blinder decomposition approach for non-linear regression models proposed by Fairlie (1999, 2005). Results show that the increased financial strain explained the largest part of the increase in poor health in the Irish population and different sub-groups. Changes in the economic activity status and population structure also had a significant positive effect. The expansion of education had a significant negative effect, preventing further increases in poor health. Wealthier and better educated individuals experienced larger relative increases in poor health, which led to reduced socio-economic health inequalities.

Smoking and School Absenteeism Among 15- to 16-Year-Old Adolescents: A Cross-Section Analysis on 36 European Countries

PERELMAN J., LEÃO T. ET KUNST A. E.

2019

European Journal of Public Health 29(4): 778-784.

https://doi.org/10.1093/eurpub/ckz110

Schools have a crucial role to play in preventing youth smoking. However, the well-known long-term health consequences of youth smoking may be insufficient to convince education stakeholders to devote efforts to implement school-based programmes. However, if youth smoking were to have short-term consequences, this evidence could prompt education stakeholders' action. In this article, we investigate the link between smoking and school absenteeism. We used data from the 2011 wave of the European School Survey Project on Alcohol and Other Drugs, on adolescents aged 15–16. We applied logistic models to assess the risk of more than 3 missed school days, by cause, as function of smoking intensity, adjusting for age, sex, socioeconomic status, academic performance, parental involvement and other risk behaviours (alcohol and cannabis consumption). Consistency was assessed by replicating the analyses for each sex and age group and further adjusting for depression and self-esteem. Smoking more than five cigarettes per day was significantly linked to school absenteeism, with a 55% excess risk of missing more than 3 school days per month due to illness (OR = 1.55, 95% CI 1.46–1.64), and a more than two times excess risk due to skipping (OR = 2.29; 95% CI 2.16–2.43). These findings were consistent across age and sex groups. We observed an association between smoking intensity and absenteeism among youth in Europe. This implies that, to the extent that this association is causal, school tobacco control policies may reduce the short-term consequences of smoking on adolescents' education and health.

Épuisement professionnel, burn out

SALEMBIER-TRICHARD A.

2019

L'information psychiatrique 95(5): 311-315.

https://www.cairn.info/revue-l-information-psychiatrique-2019-5-page-311.htm

Le syndrome d'épuisement professionnel, équivalent en français du terme anglais burnout, n'est pas reconnu comme une maladie dans les classifications de référence (CIM 11, DSM V). L'apparition du syndrome s'organise autour de quatre étapes : l'enthousiasme, le surinvestissement, la désillusion et la dernière phase correspond au burn out proprement dit. L'individu perd tout intérêt pour son travail et pour son entourage professionnel, voire personnel. Il a brûlé toutes ses réserves et se sent totalement épuisé et découragé. Ce syndrome peut se traduire par des manifestations variées de type émotionnelles, cognitives, comportementales, motivationnelles, voire physiques non spécifiques, d'installation progressive, en rupture avec l'état antérieur. Au-delà du repérage individuel, le repérage collectif est possible par l'équipe santé travail qui va repérer l'ensemble des signaux liés au fonctionnement de la structure (absentéisme ou présentéisme, turn-over fréquent, mouvements du personnel, qualité de l'activité et des relations sociales) ou à la santé et à la sécurité des travailleurs (accidents du travail, maladies professionnelles, visites médicales spontanées, inaptitudes).La prise en charge vise à traiter le trouble identifié ainsi qu'à agir sur le contexte socioprofessionnel à l'origine du trouble. L'épuisement professionnel est une réalité mais pas une fatalité. Cette pathologie peut être reconnue, mais également prévenue en privilégiant les actions centrées sur la qualité de vie au travail

Géographie de la santé

Geography of Health

▶ Quantifying Accessibility to Health Care Using Two-Step Floating Catchment Area Method (2SFCA): A Case Study in Rajasthan

KANUGANTI S., SARKAR A. K. ET SINGH A. P.

2016

Transportation Research Procedia 17: 391-399.

http://www.sciencedirect.com/science/article/pii/S2352146516306949

Spatial isolation of the villages from health facilities is a concern in rural areas. Quantifying accessibility to health care helps in interpreting the performance of health care system in a region. Thus in this paper a technique named two-step floating catchment area (2SFCA) method was used to measure level of accessibility. GIS platform was used to execute 2SFCA method. A case study was carried out in Alwar district of Rajasthan to quantify the accessibility of different habitations to health care. The outcome of the study helps the policy makers to identify the habitations not having access to health care and also to know the level of accessibility of the villages having access to health care. This will help to take appropriate measures in terms of improving road network and construction of new health care centers to improve the overall health care facilities in the district.

▶ Enhancing Equitable Access to Assistive Technologies in Canada: Insights from Citizens and Stakeholders

MATTISON C. A., WILSON M. G., WANG R. H., *et al.*

2019

Canadian Journal on Aging / La Revue canadienne du vieillissement: 1-20.

https://www.ncbi.nlm.nih.gov/pubmed/30968788

The need for assistive technologies in Canada is increasing, but access is inconsistent and fragmented which can result in unmet needs. We aimed to identify citizens' values and preferences for how to enhance equitable access to assistive technologies and to engage policymakers, stakeholders, and researchers in deliberations to spark action. In spring 2017, we convened three citizen panels and a stakeholder dialogue. Key panel findings were included in an evidence brief that informed dialogue participants. Thirty-seven citizens participated in panels and emphasized the need for access to reliable information, equitable access to assistive technologies regardless of ability to pay, and the need for collaboration. Twenty-two dialogue participants focused on the need for a guiding framework that supports fundamental change across the country. The proposed policy framework can enhance access to assistive technologies through enabling simplified policies and programs, along with fostering robust data collection and evaluation to support countrywide innovation and accountability.

Exercice coordonné sur un territoire : les communautés professionnelles territoriales de santé

ROGEZ R. ET BOUYGARD A.

2019

Actualité Et Dossier En Santé Publique(107): 38-41.

La loi de modernisation de notre système de santé 2016 a introduit de nouveaux dispositifs visant à améliorer la structuration des parcours de santé, notamment par la promotion des soins primaires et le renforcement des liens entre les différents secteurs sanitaire, médico-social et social. Les communautés professionnelles de santé (CPTS) sont l'un des dispositifs pouvant concourir à une meilleure organisation des soins et des parcours. Cet article rend compte du développement des CPTS dans la région Centre-Val de Loire.

Community Health Centers and Access to Care Among Underserved Populations: A Synthesis Review

SALONER B., WILK A. S. ET LEVIN J.

2019

Medical Care Research and Review 0(0): 1077558719848283. Ahead of pub.

Community health centers (CHCs) deliver affordable health services to underserved populations, especially uninsured and Medicaid enrollees. Since the early 2000s, CHCs have grown because of federal investments in CHC capacity and expansions of Medicaid eligibility. We review 24 relevant studies from 2000 to 2017 to evaluate the relationship between CHCs, policies that invest in services for low-income individuals, and access to care. Most included studies use quasi-experimental designs. Greater spending on CHCs improves access to care, especially for low-income and minority individuals. Medicaid expansions also increase CHC use. Some studies indicate that CHC investments complement Medicaid expansions to increase access cost-effectively. Further research should explore patient preferences and patterns of CHC utilization versus other sites of care and population subgroups for which expanding CHC capacity improves access to care most. Researchers should endeavor to use measures and sample definitions that facilitate comparisons with other estimates in the literature.

Handicap

Disability

An Evaluation of the 1987 French Disabled Workers Act: Better Paying Than Hiring

BARNAY T., DUGUET E., LE CLAINCHE C., *et al.*

2019

The European Journal of Health Economics 20(4): 597-610.

https://doi.org/10.1007/s10198-018-1020-0

This paper presents the first evaluation of the French Disabled Workers Act of 1987, which aimed to promote the employment of disabled people in the private sector. We use a panel data set, which includes both the health and the labour market histories of workers. We account both for unobserved heterogeneity and for the change in the disabled population over time. We find that the law had a negative impact on the employment of disabled workers in the private sector. This counterproductive effect likely comes from the possibility to pay a fine instead of hiring disabled workers.

Une réponse accompagnée pour tous : une démarche qui met le pouvoir d'agir au service de la continuité des parcours

DROBI M.

2019

Pratiques en santé mentale 65e année(2): 27-35.

https://www.cairn.info/revue-pratique-en-sante-mentale-2019-2-page-27.htm

En 2014, Denis Piveteau a écrit un rapport connu sous la forme abrégée « Zéro sans solution ». En résulte « La Réponse accompagnée pour tous ». Marina Drobi, actuellement responsable de la mise en œuvre de ce projet, l'expose selon trois aspects. D'abord, elle en identifie les deux piliers : accessibilité universelle et accompagnement adapté, visant la pleine insertion sociale. Par exemple, face à une demande sans solution, une Maison départementale des personnes handicapées (MDPH) se doit de concevoir « un plan B ». Ensuite, la mise en confiance des personnes concernées, l'accès à leurs droits constituent le socle du pouvoir d'agir. Enfin, ce dernier bénéficie des savoirs expérientiels des pairs accompagnants. Leur action permet une relation plus féconde tant pour les personnes accompagnées que pour les professionnels. En somme, « La réponse accompagnée pour tous » garantit de faire du projet d'autonomie et de citoyenneté une réalité.

▶ 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.

▶ Association Between Workers' Compensation Claim Processing Times and Work Disability Duration: Analysis of Population Level Claims Data

GRAY S. E., LANE T. J., SHEEHAN L., *et al.*

2019

Health Policy : 123(10) : 982-991

https://www.ncbi.nlm.nih.gov/pubmed/31301866

Delays in workers' compensation claim processing (CP) times have been associated with reduced recovery and delayed return-to-work. This study aimed to (1) determine the injury, worker, and workplace factors associated with CP delays and (2) investigate whether CP delays are associated with longer disability duration after adjusting for these factors. Retrospective cohort analysis of Australian workers' compensation claims was conducted from 1st July 2009 to 30th June 2016 for objective (1) and to 30th June 2014 for objective (2). CP times were derived by calculating differences in days between: injury and lodgement dates (lodgement); lodgement and decision dates (decision) and; injury and decision dates (total). All CP times were shorter for younger workers and those with fractures or traumatic injury, and longer for those with neurological or mental health conditions, and other diseases. Claims from self-insured employers had shorter decision times. With increasing lodgement, decision and total time there was significantly higher hazard of longer disability duration. Findings suggest the need for more efficient claims management to ensure fewer barriers to claim lodgement or approval. This in turn should reduce disability duration and ensure improved return-to-work outcomes.

▶ La condition des handicapés psychiques âgés

JOVELET G. ET CHARAZAC P.

2019

Gérontologie et société 41 / 159(2): 85-99.

https://www.cairn.info/revue-gerontologie-et-societe-2019-2-page-85.htm

La condition des handicapés psychiques est analysée sous l'angle des particularités cliniques et existentielles de la psychose, de leur identité sociale et de leur accès aux aides et soins après 60 ans. Constatant qu'ils échappent aux politiques publiques en matière de santé mentale, de vieillesse et de dépendance, les auteurs plaident pour l'intégration de ces patients dans une loi-cadre pour la psychiatrie, pour le décloisonnement de leurs dispositifs d'accompagnement et la formation des personnels des établissements d'hébergement vers lesquels ils sont orientés.

Vieillir avec un handicap physique à la lumière d'enjeux politiques : retour d'expérience

NUSS M.

2019

Gérontologie et société 41 / 159(2): 165-174.

https://www.cairn.info/revue-gerontologie-et-societe-2019-2-page-165.htm

Grâce à des progrès médicaux et technologiques constants et impressionnants (les premiers « respirateurs », en l'occurrence les poumons d'acier, sont apparus très rapidement après la guerre de 1939-1945), la population des personnes en situation de grande dépendance, souvent plurihandicapées, a vu son espérance de vie doubler, voire tripler, en l'espace d'une quarantaine d'années environ. Ce vieillissement, que les pouvoirs publics n'avaient pas anticipé, est devenu un défi sociétal et social, dont les enjeux et les difficultés sont multiples. D'où une gestion et une appréhension problématiques et délicates pour les professionnels de santé, du médico-social, les familles et les personnes concernées elles-mêmes. De surcroît, si la qualité de vie de ces personnes a été considérablement améliorée, en contrepartie, leur prise en charge et les choix qu'elle implique représentent un coût budgétaire et humain particulièrement conséquent. Sont-ils clairement perçus et assumés par toutes les parties prenantes ? Quelles sont les perspectives et les impératifs de cette (r)évolution médicale et sociétale ? Cet article s'appuie sur l'expérience vécue de l'auteur.

Socioeconomic Inequalities in Disability in Europe: Contribution of Behavioral, Work-Related and Living Conditions

PÉREZ-HERNÁNDEZ B., RUBIO-VALVERDE J. R., NUSSELDER W. J., *et al.*

2019

European Journal of Public Health 29(4): 640-647.

https://doi.org/10.1093/eurpub/ckz009

Previous studies have shown the existence of social inequalities in disability in many European countries. However, it is not clear what factors are associated with these inequalities. The aim of this study was to assess the contribution of behavioral factors, work-related factors and living conditions to educational inequalities in disability. We pooled data from the seventh wave of the European Social Survey (2014) which included self-reported disability measured with the Global Activity Limitations Indicator for 19 European countries. We used multivariate logistic regression to determine the contributions of behavioral factors, work-related and living conditions to educational inequalities in disability among respondents aged 30–79. We found that adjusting simultaneously for three groups of determinants (behavioral, work-related and living conditions) reduces the greatest proportion of inequalities in disability in both men and women, in a range >70%. Each group of determinants contributes substantially to explain inequalities in disability. Inequalities in disability are a major challenge for public health in most European countries. Our findings suggest that these inequalities can be reduced by diminishing inequalities in exposure to well-known health determinants.

Représentations du handicap dans les organisations de personnes aînées : conditions et limites de l'inclusion

RAYMOND É. ET LANTAGNE LOPEZ M.

2019

Gérontologie et société 41 / 159(2): 133-147.

https://www.cairn.info/revue-gerontologie-et-societe-2019-2-page-133.htm

Bien que la participation sociale des aînés ait fait l'objet d'une attention soutenue, les connaissances sur les réalités des personnes aînées ayant des incapacités en matière de participation sont encore limitées. Il est pressant de se pencher sur les manières de mieux encourager leur inclusion dans la vie collective, notamment par le biais de milieux associatifs plus accueillants. Formées d'opinions socialement construites relativement à un objet donné, les représentations sociales du handicap apparaissent susceptibles de soutenir ou encore de freiner la participation sociale des personnes aînées ayant des incapacités. L'article a pour objectif de documenter les représentations sociales existant dans les milieux associatifs d'aînés à l'égard de la participation de ce groupe. Utilisant une méthode de recherche mixte, un devis séquentiel exploratoire a été mené, dans lequel une première phase qualitative a permis de réaliser 4 groupes de discussion, tandis qu'une deuxième phase quantitative a consisté en un questionnaire administré à 86 répondants. Les résultats sont présentés selon les quatre fonctions des représentations sociales, soit les fonctions 1) de savoir, 2) identitaires, 3) d'orientation, et 4) justificatrices. L'interprétation des résultats suggère des balises pour déconstruire et modifier les aspects représentationnels défavorables à l'inclusion.

Les personnes handicapées vieillissantes : évolutions récentes

REYNAUD F.

2019

Gérontologie et société 41 / 159(2): 21-43.

https://www.cairn.info/revue-gerontologie-et-societe-2019-2-page-21.htm

En 2014, 69 600 personnes de 50 ans ou plus dont 15 200 de 60 ans ou plus sont accueillies dans un établissement pour adultes handicapés. De plus, 18 400 personnes handicapées de 50 ans ou plus dont 4 900 de 60 ans ou plus sont accompagnées à domicile par un service dédié. Entre 2010 et 2014, la croissance du nombre de personnes au-delà de ces seuils d'âge est plus élevée dans les établissements et services d'accompagnement pour adultes handicapés que dans l'ensemble de la population française. La part des établissements qui accueillent des personnes handicapées vieillissantes a augmenté de 39,9 % à 58,8 % en quatre ans. Les personnes handicapées de 60 ans ou plus, dont le nombre de déficiences augmente, résident pour moitié dans les maisons d'accueil spécialisées (MAS) et les foyers d'accueil médicalisés (FAM). Aux personnes handicapées qui avancent en âge dans les établissements et services médico-sociaux du champ du handicap, s'ajoutent celles avec un handicap reconnu avant 60 ans qui résident dans un établissement pour personnes âgées : elles sont au moins 25 800 en 2015. Malgré les limites des enquêtes, l'étude semble mettre en évidence trois parcours types en lien avec le processus de vieillissement : un parcours où les personnes restent principalement hébergées à domicile tout en travaillant en ESAT ou en bénéficiant d'un accompagnement, un autre où elles sont principalement en institution et un dernier où elles ont un handicap reconnu mais pas de contact avec les établissements du champ du handicap. Les premières entreraient fréquemment en EHPA, mais pas directement après avoir arrêté de travailler en ESAT ou bénéficié d'un service d'accompagnement. Les secondes, à mesure qu'elles deviendraient de plus en plus dépendantes en avançant en âge, iraient d'établissements pour personnes handicapées en établissements pour personnes handicapées accueillant des personnes toujours plus dépendantes. Les dernières n'ont jamais vécu en institution et entrent en EHPA en vieillissant.

Handicap, vieillissement et vieillesse. Revue de la littérature à partir de la France

SCHNITZLER M.

2019

Gérontologie et société 41 / 159(2): 45-60.

https://www.cairn.info/revue-gerontologie-et-societe-2019-2-page-45.htm

En partant de la distinction entre le vieillissement, processus physique et psychologique socialement construit, et la vieillesse, un âge de la vie déterminé par le passage à la retraite, cette contribution revient sur les grandes thématiques de la littérature autour de l'avancée en âge des personnes en situation de handicap : la définition de la catégorie « personnes handicapées vieillissantes », le passage à la retraite et l'habitat. Il ne s'agit pas de justifier les politiques catégorielles, mais de saisir dans quelle mesure ces deux dynamiques éclairent la littérature existante. Premièrement, il s'agira de montrer la variation des définitions de la catégorie « personnes handicapées vieillissantes ». Ce point permet de revenir sur la notion de vieillissement précoce. Deuxièmement, la question de la retraite sera étudiée en mettant en évidence deux questions distinctes, à savoir la gestion d'une main-d'œuvre vieillissante et le changement de statut associé à la retraite. La dernière section approfondira la question du logement des personnes en situation de handicap vieillissantes, en lien avec le vieillissement des aidants familiaux et des professionnels.

Hôpital

Hospitals

Mesurer la qualité pour rationaliser l'hôpital. La genèse des indicateurs de qualité et de sécurité des soins en France

BERTILLOT H.

2018

Informations sociales 198(3): 38-44.

https://www.cairn.info/revue-informations-sociales-2018-3-page-38.htm

Ces dernières décennies, le secteur hospitalier français a fait l'objet de nombreuses réformes, avec l'ambition affichée de rationaliser son fonctionnement. Parmi ces réformes, le déploiement de nouveaux instruments de tarification à l'activité (T2A) fait l'objet de toutes les attentions et de toutes les critiques. Pourtant, dans l'ombre de ces réformes à forte visibilité se joue, depuis la fin des années 1990, un autre mouvement majeur, opérant à bas bruit autour du déploiement d'instruments d'évaluation de la qualité des soins. En retraçant la genèse des indicateurs de qualité et de sécurité des soins déployés dans le secteur hospitalier depuis le milieu des années 2000, cet article montre comment la qualité peut être utilisée comme une modalité douce de rationalisation.

La médiation pour les professionnels des établissements hospitaliers et médico-sociaux publics : un service émergent face à de grands défis

COUTY É.

2019

L'information psychiatrique 95(5): 317-322.

https://www.cairn.info/revue-l-information-psychiatrique-2019-5-page-317.htm

L'hôpital et les établissements médico-sociaux connaissent des conflits interpersonnels qui peuvent durer des années, s'exprimer parfois avec violence, sous forme de maltraitance, de harcèlement ou de relations exécrables entre deux ou plusieurs professionnels donnant lieu à des contentieux ordinaux, pénaux ou administratifs quand l'institution est impliquée. Ces conflits sont toujours douloureux pour ceux qui les vivent et ils ont des conséquences sur le fonctionnement du service, du pôle ou de l'établissement dans lesquels ils se déroulent. Ils pèsent sur la qualité de la prise en charge des patients. La souffrance au travail qu'ils génèrent et leur caractère délétère pour toute une équipe dégradent la qualité de vie au travail et nuisent à la bonne qualité des soins. Analyser les causes de ces conflits et tenter de les prévenir est aujourd'hui un enjeu majeur. La mise en place d'un service de médiation pour les personnels des établissements est, avec la conciliation locale à structurer, un outil de traitement de ces conflits. Un réseau de médiateurs régionaux, animé par un médiateur national va être mis en place en 2019. L'objectif est de traiter précocement et de régler des conflits pour aider à mieux les connaître pour mieux les prévenir. Il n'y a pas de bons soins sans une bonne qualité de vie au travail, pas de bonne qualité de vie au travail sans reconnaissance de la bonne qualité des soins et reconnaissance des efforts de la recherche collective de l'efficience et enfin pas de recherche d'efficience possible sans bonne qualité des soins et bonne qualité de vie au travail.

La fabrique du travail en équipe dans les établissements de santé

CRISTOFALO P., PETIT DIT DARIEL O. ET MINVIELLE É.

2019

Journal de gestion et d'économie de la santé 3(3): 259-282.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2019-3-page-259.htm

Dans les établissements de santé en France et à travers le monde, l'amélioration du travail en équipe est présentée comme une réponse au problème de la sécurité des soins. Cette politique est portée par la Haute Autorité de santé (HAS) et prend forme dans un programme fournissant divers supports à des équipes volontaires désirant améliorer leur fonctionnement. L'article saisit la mise en œuvre de ce programme comme un terrain opportun pour étudier comment les professionnels de santé, au sein des services, pratiquent le travail en équipe. Notre analyse repose sur une méthodologie qualitative (entretiens, observations) auprès de trois services. Nous avons construit une grille d'analyse à partir du concept de Teaming d'Edmondson (2012), que nous traduisons par faire-équipe. Ce concept identifie cinq dimensions décisives : l'existence de représentations partagées du travail, la création d'un climat de confiance entre membres de l'équipe, la capacité à affronter les échecs pour mieux les surmonter, la capacité à enjamber les frontières de l'équipe et la production d'un leadership pour articuler ces différentes dimensions. Cette grille permet d'observer comment les professionnels tentent de développer et d'améliorer de manière durable leur travail en équipe. Les résultats montrent qu'au-delà de l'enthousiasme initial, faire équipe s'avère laborieux. Les dimensions considérées comme nécessaires au travail en équipe ne sont souvent pas présentes. En outre, diverses contraintes d'ordre structurel pointent les limites des politiques d'équipe pensées à l'échelle d'un service.

The Introduction of Hospital Networks in Belgium: The Path from Policy Statements to the 2019 Legislation

DE REGGE M., DE POURCQ K., VAN DE VOORDE C., *et al.*

2019

Health Policy 123(7): 601-605.

http://www.sciencedirect.com/science/article/pii/S0168851019301277

In April 2015, the Belgian Federal Minister for Social Affairs and Public Health launched an Action Plan to reform the hospital landscape. With the creation of "local regional clinical hospital networks" with their own governance structures, the plan follows the international trend towards hospital consolidation and collaboration. The major complicating factors in the Belgian context are (1) that policy instruments for the redesign of the hospital service delivery system are divided between the federal government and the federated authorities, which can result in an asymmetric hospital landscape with a potentially better distribution of clinical services in the Flanders hospital collaborations than in the other federated entities; and (2) the current regulations stipulate that only hospitals (and not networks) are entitled to hospital budgets. Although the reform is the most significant and drastic transformation of the Belgian hospital sector in the last three decades, networks mainly offer a framework in which hospitals can collaborate. More regulation and policy measures are needed to enhance collaboration and distribution of clinical services.

Migration Intentions Among Physicians Working in Polish Hospitals - Insights from Survey Research

DOMAGAŁA A. ET DUBAS-JAKÓBCZYK K.

2019

Health Policy : Ahead of pub.

Health workforce shortages could lead to burnout, excessive workload, dissatisfaction and consequently to migration. In Poland the exact scale of physician migration is unknown due to insufficient data. A quantitative, cross-sectional survey of physicians working in Polish hospitals was conducted between March and June, 2018. 15 Polish hospitals were included in the study (7 general, 5 specialist, 3 university). The data was gathered via an on-line, self-administered questionnaire, sent to physicians working in the included hospitals. Associations between the intention to migrate and demographic characteristics as well as work-related variables and overall satisfaction were measured. Simple and multivariable logistic regression analysis was conducted to determine significant predictors of migration. Results 1,003 questionnaires were analyzed (response rate: 38%). 273 doctors declared the intention to migrate: 4.5% answering 'definitely yes' and 22.7% 'probably yes'. The main reasons were: higher earnings, better working conditions and better work-life balance abroad. Age and higher career satisfaction were negatively related to the intention to migrate: OR = 0.94 (95% CI 0,92-0,95) and OR = 0.44 (95% CI, 0.34-0.56) respectively. Women were 54% less likely to intend to migrate than men (OR = 0.46, 95% CI 0.33-0.65). Almost 62% of physicians intending to migrate considered a temporary stay abroad. Special attention should be paid to improving working conditions, including salary, but also reducing bureaucracy, improvement of work-climate and training opportunities.

The Closer the Better: Does Better Access to Outpatient Care Prevent Hospitalization?

ELEK P., MOLNÁR T. ET VÁRADI B.

2019

The European Journal of Health Economics 20(6): 801-817.

https://doi.org/10.1007/s10198-019-01043-4

In 2010–2012, new outpatient service locations were established in poor Hungarian micro-regions. We exploit this quasi-experiment to estimate the extent of substitution between outpatient and inpatient care. Fixed-effects Poisson models on individual-level panel data for years 2008–2015 show that the number of outpatient visits increased by 19% and the number of inpatient stays decreased by 1.6% as a result, driven by a marked reduction of potentially avoidable hospitalization (PAH) (5%). In our dynamic specification, PAH effects occur in the year after the treatment, whereas non-PAH only decreases with a multi-year lag. The instrumental variable estimates suggest that a one euro increase in outpatient care expenditures produces a 0.6 euro decrease in inpatient care expenditures. Our results (1) strengthen the claim that bringing outpatient care closer to a previously underserved population yields considerable health benefits, and (2) suggest that there is a strong substitution element between outpatient and inpatient care.

Home Health Care for Children with Medical Complexity: Workforce Gaps, Policy, and Future Directions

FOSTER C. C., AGRAWAL R. K. ET DAVIS M. M.

2019

Health Affairs 38(6): 987-993.

With the medical and surgical advances of recent decades, a growing proportion of children rely on home-based care for daily health monitoring and care tasks. However, a dearth of available home health care providers with pediatric training to serve children and youth with medical complexity markedly limits the current capacity of home health care to meet the needs of patients and their families. In this article we analyze the workforce gaps, payment models, and policy challenges unique to home health care for children and youth with medical complexity, including legal challenges brought by families because of home nursing shortages. We propose a portfolio of solutions to address the current failures, including payment reform, improved coordination of services and pediatric home health training through partnerships with child-focused health systems, telehealth-enabled opportunities to bridge current workforce gaps, and the better alignment of pediatric care with the needs of adult-focused long-term services and supports.

« En consultation, je regarde l'ordinateur, pas ma patiente ». Entretien avec Anne Gervais

GAUDILLIÈRE J.-P.

2019

Mouvements 98(2): 23-31.

https://www.cairn.info/revue-mouvements-2019-2-page-23.htm

Hépatologue, praticienne à l'hôpital Bichat, Anne Gervais a accepté de partager avec Mouvements ses réflexions sur les transformations de l'hôpital, sa pratique quotidienne, les nouvelles formes de management et leur impact sur le travail de soin. Au-delà du constat d'un hôpital surchargé par la conjonction de la pression budgétaire et des défaillances de la médecine de ville, elle rappelle toute la difficulté à définir et imposer des alternatives lorsque la première réponse des personnels, en premier lieu non-médicaux, est la fuite.

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.

▶ Co-Ordination of Health Care: The Case of Hospital Emergency Admissions

ISLAM M. K. ET KJERSTAD E.

2019

The European Journal of Health Economics 20(4): 525-541.

https://doi.org/10.1007/s10198-018-1015-x

The recognition that chronic care delivery is suboptimal has led many health authorities around the world to redesign it. In Norway, the Department of Health and Care Services implemented the Coordination Reform in January 2012. One policy instrument was to build emergency bed capacity (EBC) as an integrated part of primary care service provided by municipalities. The explicit aim was to reduce the rate of avoidable admissions to state-owned hospitals. Using five different sources of register data and a quasi-experimental framework—the "difference-in-differences" regression approach—we estimated the association between changes in EBC on changes in aggregate emergency hospital admissions for eight ambulatory care sensitive conditions (ACSC). The results show that EBC is negatively associated with changes in aggregate ACSC emergency admissions. The associations are largely consistent with alternative model specifications. We also estimated the relationship between changes in EBC on changes in each ACSC condition separately. Our results are mixed. EBC is negatively associated with emergency hospital admissions for asthma, angina and chronic obstructive pulmonary disease but not congestive heart failure and diabetes. The main implication of the study is that EBC within primary care is potentially a sensible way of redesigning chronic care.

▶ Choosing Wisely Canada Needs to Start Helping Doctors to Understand How Commercial Influences Affect Their Prescribing

JOEL L.

2019

HealthcarePapers 18(1): 30-34.

https://www.longwoods.com/content/25871

Choosing Wisely Canada is making an important contribution to ensuring that Canadian doctors use resources in the best interest of their patients' health. However, one area that has been neglected so far is the influence of the pharmaceutical industry on the way that doctors prescribe. Marketing of drugs such as rofecoxib and long-acting oxycodone has been linked to significant morbidity and mortality. Companies aggressively promote their products to doctors through sales representatives and giving away free samples. Both of these tactics are linked to poorer prescribing. In addition to promotion, companies also influence doctors by controlling the knowledge that doctors receive. Companies are responsible for almost all clinical trials, and their sponsorship is much more likely to produce positive results and conclusions compared to any other source of funding. Financial conflict of interest is widespread in guideline committees that produce Canadian clinical practice guidelines, and the policies that professional medical associations use to guard against commercial bias in the continuing medical education that they sponsor are weak. Overall, the more that doctors rely on information from pharmaceutical companies, the poorer their prescribing. Choosing Wisely Canada needs to expand its mandate to educate doctors about commercial influences.

L'hôpital public : par pertes et profits

JUVEN P.-A.

2019

Mouvements 98(2): 13-22.

https://www.cairn.info/revue-mouvements-2019-2-page-13.htm

L'hôpital public va mal. Même la ministre de la Santé Agnès Buzyn en convient, elle qui déclarait : « L'hôpital entreprise, c'est fini » en annonçant à la fin 2017 la mise en place de la commission Aubert, chargée de faire des propositions. Pierre-André Juven revient ici sur la place qu'a prise l'hôpital dans le système de santé français. À l'encontre des pourfendeurs de l'hospitalo-centrisme, ne voyant dans la crise que la conséquence d'une accumulation de tâches et de moyens qui lui sont dévoués, il rappelle que les nouveaux modes de gestion et de financement l'ont progressivement étouffé. Mais il plaide aussi pour une critique qui n'oublie pas que s'il faut effectivement débloquer des moyens publics pour résorber la dette, financer les centres de santé et les structures de proximité, et revaloriser les salaires les plus bas à l'hôpital, il est tout aussi urgent de réfléchir à la façon dont on y travaille, et pour répondre à quels besoins.

Reflecting on Choosing Wisely Canada at Five Years: Accomplishments, Challenges and Opportunities for Reducing Overuse and Improving Quality

KAREN BORN T. H. ET WENDY L.

2019

HealthcarePapers 18(1): 9-17.

https://www.longwoods.com/content/25874/healthcarepapers/reflecting-on-choosing-wisely-canada-at-five-years-accomplishments-challenges-and-opportunities-fo

Overuse is a significant and long-standing issue within Canadian healthcare. Previous efforts to curb overuse have relied predominantly on top-down mechanisms to shape clinician behaviour. In 2014, the Choosing Wisely Canada campaign was launched, with a refreshing, grassroots approach premised on clinicians taking leadership on overuse. Five years later, and by many accounts, Choosing Wisely Canada has fulfilled that original mission, with significant penetration among clinicians. However, the overuse problem still persists and continues to be a challenge for clinicians, administrators, decision makers and patients. Although it is necessary for the clinician community to take leadership on overuse, this alone is not a sufficient condition for change. Many factors contributing to overuse are beyond what most individual clinicians can affect. These are system-level factors, including poorly designed information systems that drive overuse, lack of clinician feedback, outdated organizational processes, misaligned incentives and insufficient training within medical education and institutions on addressing overuse. This article proposes that it is time for a concerted approach to tackling overuse, one that is built on the foundation of strong clinician leadership, in combination with systemic actions to make it easier to do the right things at the front lines of care.

Understanding the Role of Physicians Within the Managerial Structure of Russian Hospitals

KUHLMANN E., SHISHKIN S., RICHARDSON E., *et al.*

2019

Health Policy : 123(8) : 773-781

https://www.sciencedirect.com/science/article/abs/pii/S0168851019301393

This article examines the role of physicians within the managerial structure of Russian hospitals. A comparative qualitative methodology with a structured assessment framework is used to conduct case studies that allow for international comparison. The research is exploratory in nature and comprises 63 individual interviews and 49 focus groups with key informants in 15 hospitals, complemented by document analysis. The material was collected between February and April 2017 in five different regions of the Russian Federation. The results reveal three major problems of hospital management in the Russian Federation. First, hospitals exhibit a leaky system of coordination with a lack of structures for horizontal exchange of information within the hospitals (meso-level). Second, at the macro-level, the governance system includes implementation gaps, lacking mechanisms for coordination between hospitals that may reinforce existing inequalities in service provision. Third, there is little evidence of a learning culture, and consequently, a risk that the same mistakes could be made repeatedly. We argue for a new approach to governing hospitals that can guide implementation of structures and processes that allow systematic and coherent coordination within and among Russian hospitals, based on modern approaches to accountability and organisational learning.

Quality Indicator Rates for Seriously Ill Home Care Clients: Analysis of Resident Assessment Instrument for Home Care Data in Six Canadian Provinces

GUTHRIE D. M., HARMAN L. E., BARBERA L., *et al.*

2019

Journal of Palliative Medicine : Ahead of pub.

https://www.liebertpub.com/doi/abs/10.1089/jpm.2019.0022

Few measures exist to assess the quality of care received by home care clients, especially at the end of life. This project examined the rates across a set of quality indicators (QIs) for seriously ill home care clients. This was a cross-sectional descriptive analysis of secondary data collected using a standardized assessment tool, the Resident Assessment Instrument for Home Care (RAI-HC). Setting/Subjects: The sample included RAI-HC data for 66,787 unique clients collected between January 2006 and March 2018 in six provinces. Individuals were defined as being seriously ill if they experienced a high level of health instability, had a prognosis of less than six months, and/or had palliative care as a goal of care. Measurements: We compared individuals with cancer (n = 21,119) with those without cancer (n = 47,668) on demographic characteristics, health-related outcomes, and on 11 QIs. Regardless of diagnosis, home care clients experienced high rates (i.e., poor performance) on several QIs, namely the prevalence of falls (cancer = 42.4%; noncancer = 55%), daily pain (cancer = 48.3%; noncancer = 43.2%), and hospital admissions (cancer = 48%; noncancer = 46.6%). The QI rates were significantly lower (i.e., better performance) for the cancer group for three out of the 11 QIs: falls (absolute standardized difference [SD] = 0.25), caregiver distress (SD = 0.28), and delirium (SD = 0.23). On several potential QIs, seriously ill home care clients experience high rates, pointing to potential areas for quality improvement across Canada.

Mieux soigner et accompagner ? Transformer l'obligation des démarches qualité en opportunité pluri-professionnelle

MISPELBLOM BEYER F.

2018

Informations sociales 198(3): 104-111.

https://www.cairn.info/revue-informations-sociales-2018-3-page-104.htm

À l'heure où les groupements hospitaliers de territoire suscitent la création de « parcours de soins et de vie » reliant l'hôpital à la médecine de ville et aux acteurs territoriaux du domaine social et de la santé, les démarches qualité et les indicateurs de gestion qui leur sont imposés par les tutelles sont des obligations qui peuvent aussi représenter des opportunités. Elles peuvent ainsi favoriser le rapprochement entre le secteur de la santé et le secteur social ; dans la mise en œuvre de ces démarches et l'application des grilles d'évaluation, aider à se questionner réciproquement pour mieux définir ce que l'on fait et le valoriser ; dans les contraintes communes, permettre de trouver des alliés dans des secteurs voisins pour faire front ensemble au nom de l'intérêt des usagers. Et faire de l'hétérogénéité des problèmes de ceux-ci et des intervenants qui s'en occupent le moteur d'une dynamique innovante.

Choosing Wisely: An Important Step in the Right Direction to Addressing Overuse of Health Services

MORIAH E. E. ET MICHAEL G. W.

2019

HealthcarePapers 18(1): 35-40.

https://www.longwoods.com/content/25870/healthcarepapers/choosing-wisely-an-important-step-in-the-right-direction-to-addressing-overuse-of-health-services

Overuse in healthcare is a complex problem requiring a multifaceted, comprehensive approach that spans all levels of health systems. Choosing Wisely has made great strides by identifying areas of overuse through its lists and building comprehensive efforts to address overuse through bottom-up approaches. However, moving forward, the solutions to ending overuse must be implemented simultaneously at various levels and must balance the micro and macro aspects of the issue as those may be in conflict. Bottom-up approaches, as are already promoted by Choosing Wisely, can include educating the public and providers and promoting shared decision making. Top-down approaches at the organizational and system levels include changes in lab-order sets, re-evaluating services for disinvestment and using quality indicators appropriately. Choosing Wisely has done an excellent job of bringing attention to the issue, engaging providers and changing the overall culture to enable meaningful dialogue about addressing overuse. To enhance health outcomes and strengthen health systems, the way forward will need to include an interdisciplinary approach that meaningfully engages patients and focuses on rapid cycles of identifying and diagnosing areas of overuse and implementing and evaluating approaches to address them.

Choosing Wisely Italy: Online Survey on Opinions and Behaviors of 1006 People and 355 Volunteers of Healthcare Advocacy Associations

MOSCONI P., ROBERTO A., BRAGA F., *et al.*

2018

European Journal of Public Health 29(3): 396-401.

https://doi.org/10.1093/eurpub/cky236

In the framework of 'Doing more does not mean doing better - Choosing Wisely Italy' health professionals, general population and healthcare advocacy associations are widely involved. PartecipaSalute-Mario Negri IRCCS and Altronconsumo organized a survey in order to assess the opinions and behaviors of people toward unnecessary tests and drugs. An online survey was distributed by Altroconsumo to a voluntary panel of 6304 Italian citizens covering the whole of the country and by PartecipaSalute-Mario Negri IRCCS through the PartecipaSalute website, e-mail lists, website articles, lay journals and Facebook.In all 1006 people reached by Altroconsumo, and 355 volunteers of healthcare advocacy associations reached by PartecipaSalute responded. Respondents usually decides on their treatment together with the physician, respectively 50% for general population and 64% for volunteers of healthcare advocacy associations. The respondents are aware of the question of over-use of drugs and tests (80%), more often among the volunteers of healthcare advocacy associations (86%). Over-use is considered a problem mostly for economic reasons among the general population, while in the advocacy associations the risks for patients' health is considered more important. These findings suggest that patients do not always ask for more, especially if they receive an answer to their questions and clarifications about unnecessary treatments. There is a need for further understanding of the factors influencing decision-making aimed at achieving good care. Engaging the public and patients at all levels of healthcare is essential for a valuable use of health resources.

Focus – La commission des usagers au sein des établissements de santé : donner la parole aux usagers pour améliorer la qualité de la prise en charge

MOURGUES A.

2018

Informations sociales 198(3): 69-72.

https://www.cairn.info/revue-informations-sociales-2018-3-page-69.htm

De-implementation of Low-Value Care : Audit and Feedback Wisely

NOAH M. I. ET LAURA D.

2019

HealthcarePapers 18(1): 41-47.

https://www.longwoods.com/content/25869/healthcarepapers/de-implementation-of-low-value-care-audit-and-feedback-wisely

Low-value care is common, and addressing this requires more than list making because guidelines do not self-implement. A concerted effort is needed to address system-, provider- and patient-level factors that play a role. In this commentary, we argue that a foundational element of any systematic approach to de-implement low-value care will include a carefully planned, ongoing process of measurement against standards (i.e., audit) and provision of the resulting data to health professionals (i.e., feedback). Audit and feedback can work well but do not always lead to substantial changes the devil is in the details regarding how the initiative is designed and delivered. Currently, most physicians do not consider active reflection on practice data and working with colleagues to make changes to practice patterns based on that data to be a core function of their job. If we are to be successful in addressing low-value care, this must change. Fortunately, there is an abundance of evidence upon which to draw to develop effective audit and feedback initiatives. We describe a vision: a physician-led program in data-driven continuing professional development that could lead to sustainable improvement in quality of care.

Reducing Length of Hospital Stay for Older Elective Surgical Inpatients: Findings of a Systematic Review

NUNNS M., SHAW L., BRISCOE S., *et al.*

2019

Age and Ageing 48(Supplement_2): ii24-ii26.

https://doi.org/10.1093/ageing/afz061.09

We identified 10448 potentially relevant records, yielding 218 included studies. We prioritised 73 studies for synthesis, predominantly regarding colorectal surgery and lower limb arthroplasty. Enhanced Recovery Programmes and Prehabilitation interventions were most common, often leading to improved recovery or reduced LOS, without detriment to other outcomes. Non-clinical outcomes were rarely reported and patient follow-up beyond 30 days was largely absent. Interventions to reduce LOS and/or improve recovery following elective surgery can be effective in older adults. Future trials should focus on identifying factors influencing implementation and consistent uptake of interventions across institutions. In-hospital patient voice and longer-term implications of reduced LOS for patient recovery and the wider health and social care system, must be considered.

Urgent Care Centres Reduce Emergency Department and Primary Care Same-Day Visits: A Natural Experiment

PACHECO J., CUADRADO C. ET MARTÍNEZ-GUTIÉRREZ M. S.

2019

Health Policy and Planning 34(3): 170-177.

https://doi.org/10.1093/heapol/czz023

The aim of this study is to evaluate the impact of urgent care centres' (UCCs) implementation on emergency department (ED) and same-day visits in primary care in a Chilean public healthcare network. Quasi-experimental design study assessing changes in patient visits after UCC implementation in a local health district. Ten family health centres (FHC), nine UCCs and three EDs in the Talcahuano Health District, Chile. A total of 1 603 055 same-day visits to FHC, 1 528 319 visits to UCCs and 1 727 429 visits to EDs, monthly grouped, from 2008 to 2014. Data were obtained from the Monthly Statistical Register Database. We used quasi-experimental methods to evaluate the impact of UCC implementation on ED visits and same-day visits to FHC. We used a difference-in-difference analysis with seasonal adjustments to control potential confounders. We used a triple difference model to test for potential short-term effects. We used as an intervention a group of FHCs and EDs that implemented UCCs from 2008 to 2014 and, as a comparison group, the FHCs and EDs that implemented UCCs before that period. We observed a 5.70% (95% CI: −11.05 to −0.35) decrease in the same-day visits rate to FHCs and a 2.69% (95% CI: −3.96 to −1.43) reduction in ED visits after UCC implementation. The negative trend in same-day visits was more pronounced in children and adolescents (−14.18%; 95% CI: −20.10 to −8.25). The negative trend in ED visits was more pronounced in adult (−4.15%; 95% CI: −5.46 to −2.83) and elderly population (−2.24%; 95% CI: −4.00 to −0.48). We also confirmed that our results are not driven by transient short-term effects after the intervention. UCC implementation reduced ED visits. However, they also reduced same-day visits to primary care centres. This could have a negative impact on the quality of primary care provided.

Changes in Hospital Service Demand, Cost, and Patient Illness Severity Following Health Reform

PICKENS G., KARACA Z., GIBSON T. B., *et al.*

2019

Health Services Research 54(4): 739-751.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13165

The aim of this study is to estimate the effects of the health insurance exchange and Medicaid coverage expansions on hospital inpatient and emergency department (ED) utilization rates, cost, and patient illness severity, and also to test the association between changes in outcomes and the size of the uninsured population eligible for coverage in states. Data Sources result from the Healthcare Cost and Utilization Project State Inpatient and Emergency Department Databases, 2011-2015, Nielsen Demographic Data, and the American Community Survey. Retrospective study using fixed-effects regression to estimate the effects in expansion and nonexpansion states by age/sex demographic groups. In Medicaid expansion states, rates of uninsured inpatient discharges and ED visits fell sharply in many demographic groups. For example, uninsured inpatient discharge rates across groups, except young females, decreased by ≥39 percent per capita on average in expansion states. In nonexpansion states, uninsured utilization rates remained unchanged or increased slightly (0-9.2 percent). Changes in all-payer and private insurance rates were more muted. Changes in inpatient costs per discharge were negative, and all-payer inpatient costs per discharge declined <6 percent in most age/sex groups. The size of the uninsured population eligible for coverage was strongly associated with changes in outcomes. For example, among males aged 35-54 years in expansion states, there was a 0.793 percent decrease in the uninsured discharge rate per unit increase in the coverage expansion ratio (the ratio of the size of the population eligible for coverage to the size of the previously covered population within an age/sex/payer/geographic group). Significant shifts in cost per discharge and patient severity were consistent with selective take-up of insurance. The "treatment intensity" of expansions may be useful for anticipating future effects.

Choosing Wisely in the Context of Corporate Influence

QUINN G.

2019

HealthcarePapers 18(1): 25-29.

https://www.longwoods.com/content/25872/healthcarepapers/choosing-wisely-in-the-context-of-corporate-influence

Corporations are arguably the most powerful social and economic institutions globally, with unprecedented power to shape public policy and consumption patterns. Medically related industries, including pharmaceutical, medical device and health technology corporations, seek to maximize shareholder value and demonstrate sustained growth over time, which necessitates the promotion of hyperconsumption. Clinicians and patients attempting to choose wisely; are doing so within the context of multiple industry influences that are implicated in overuse. From the early days of medical education, to direct-to-consumer advertising, to sponsorship of clinical practice guidelines, Choosing Wisely advocates must contend with promotional efforts to expand markets and increase the volume of prescribing and purchasing. Curbing overuse will require systematic approaches that directly address and curtail the marketing, lobbying and public relations activities of medically related corporations.

Home and Community-Based Workforce for Patients with Serious Illness Requires Support to Meet Growing Needs

SPETZ J., STONE R. I. ET CHAPMAN S. A.

2019

Health Affairs 38(6): 902-909.

Home health and personal care aides are one of the largest groups of health care workers in the US, with nearly three million people providing direct care for people with serious illness living in the community. These home care workers face challenges in recruitment, training, retention, and regulation, and there is a lack of data and research to support evidence-based policy change. Personal care aides receive little formal training, and they experience low pay and a lack of respect for the skill required for their jobs. High turnover and occupational injury rates are widely reported. There is little research on the factors associated with higher-quality home care, the extent to which worker training affects client outcomes, and how regulations affect access to and quality of home care. Health care leaders should seek to fill these gaps in knowledge, support the establishment of training standards and programs, implement Medicaid reimbursement strategies that incentivize improvements in pay and working conditions, reform regulations that now prevent the full utilization of home care workers, and create sustainable career pathways in home care policies.

The Determinants of the Technical Efficiency of Acute Inpatient Care in Canada

WANG L., GRIGNON M., PERRY S., *et al.*

2018

Health Serv Res 53(6): 4829-4847.

The aim is the study is to evaluate the technical efficiency of acute inpatient care at the pan-Canadian level and to explore the factors associated with inefficiency-why hospitals are not on their production frontier. Data come from Canadian Management Information System (MIS) database (CMDB) and Discharge Abstract Database (DAD) for the fiscal year of 2012-2013. We use a nonparametric approach (data envelopment analysis) applied to three peer groups (teaching, large, and medium hospitals, focusing on their acute inpatient care only). The double bootstrap procedure (Simar and Wilson 2007) is adopted in the regression. Information on inpatient episodes of care (number and quality of outcomes) was extracted from the DAD. The cost of the inpatient care was extracted from the CMDB. PRINCIPAL FINDINGS: On average, acute hospitals in Canada are operating at about 75 percent efficiency, and this could thus potentially increase their level of outcomes (quantity and quality) by addressing inefficiencies. In some cases, such as for teaching hospitals, the factors significantly correlated with efficiency scores were not related to management but to the social composition of the caseload. In contrast, for large and medium nonteaching hospitals, efficiency related more to the ability to discharge patients to postacute care facilities. The efficiency of medium hospitals is also positively related to treating more clinically noncomplex patients. The main drivers of efficiency of acute inpatient care vary by hospital peer groups. Thus, the results provide different policy and managerial implications for teaching, large, and medium hospitals to achieve efficiency gains.

Inégalités de santé

Health Inequalities

Disparities in Access to Health Care Among US-Born and Foreign-Born US Adults by Mental Health Status, 2013–2016

DEDANIA R. ET GONZALES G.

2019

American Journal of Public Health 109(S3): S221-S227.

https://doi.org/10.2105/AJPH.2019.305149

The aim of this study is to compare access to care between US-born and foreign-born US adults by mental health status. Methods. We analyzed data on nonelderly adults (n? = ?100?428) from the 2013?2016 National Health Interview Survey. We used prevalence estimates and multivariable logistic regression models to compare issues of affordability and accessibility between US-born and foreign-born individuals. Approximately 22.2% of US-born adults and 18.1% of foreign-born adults had symptoms of moderate to severe psychological distress. Compared with US-born adults with no psychological distress, and after adjustment for sociodemographic characteristics, US-born and foreign-born adults with psychological distress were much more likely to report multiple emergency room visits and unmet medical care, mental health care, and prescription medications because of cost. Our study found that adults with moderate to severe psychological distress, regardless of their immigration status, were at greater risk for reporting issues of affordability when accessing health care compared with US-born adults with no psychological distress. Public Health Implications. Health care and mental health reforms should focus on reducing health care costs and establishing innovative efforts to broaden access to care to diverse populations.

Adult Mortality Among Second-Generation Immigrants in France: Results from a Nationally Representative Record Linkage Study

GUILLOT M., KHLAT M. ET WALLACE M.

2019

Demographic Research 40(54): 1603-1644.

https://www.demographic-research.org/volumes/vol40/54/

France has a large population of second-generation immigrants (i.e., native-born children of immigrants) who are known to experience important socioeconomic disparities by country of origin. The extent to which they also experience disparities in mortality, however, has not been previously examined. We used a nationally representative sample of individuals 18 to 64 years old in 1999 with mortality follow-up via linked death records until 2010. We compared mortality levels for second-generation immigrants with their first-generation counterparts and with the reference (neither first- nor second-generation) population using mortality hazard ratios as well as probabilities of dying between age 18 and 65. We also adjusted hazard ratios using educational attainment reported at baseline. We found a large amount of excess mortality among second-generation males of North African origin compared to the reference population with no migrant background. This excess mortality was not present among second-generation males of southern European origin, for whom we instead found a mortality advantage, nor among North African–origin males of the first-generation. This excess mortality remained large and significant after adjusting for educational attainment. In these first estimates of mortality among second-generation immigrants in France, males of North African origin stood out as a subgroup experiencing a large amount of excess mortality. This finding adds a public health dimension to the various disadvantages already documented for this subgroup. Overall, our results highlight the importance of second-generation status as a significant and previously unknown source of health disparity in France.

▶ Healthcare Access for Refugees in Greece: Challenges and Opportunities

GUNST M., JARMAN K., YARWOOD V., *et al.*

2019

Health Policy : 123(9) : 818-824

The arrival of more than one million refugees and migrants in Europe in 2015, most of whom transited through Greece, has placed significant strains on local health systems and demonstrated the need for preparedness to meet the immediate and longer-term health needs of arrivals in EU countries. Population movements will continue to occur and the need for cost effective, appropriate provision of both primary and secondary health services to meet these needs is key. The Global Compact on Migration was ratified in 2018 and forms an overarching, international agreement to address safe, orderly and regular migration which benefits refugees and migrants as well as host communities; however, it did not give due emphasis to health. In this manuscript, we explore the evolution of the health response for refugees in Greece over the last three years, the challenges faced at different times of the response and the efforts to integrate refugees into Greece's health system.

▶ Socioeconomic and Health-Related Childhood and Adolescence Predictors of Entry into Paid Employment

HALONEN J. I., VIRTANEN M., ALA-MURSULA L., *et al.*

2018

European Journal of Public Health 29(3): 555-561.

https://doi.org/10.1093/eurpub/cky221

Most studies on prolonging working careers have explored later career, while less is known about social and particularly health-related determinants of entry into labour market. We examined social and health-related factors from childhood and adolescence as predictors of age at entry into paid employment and early occupational class, and whether own education moderates these associations. The Northern Finland Birth Cohort 1986 was followed from birth until the end of 2015. We included 8542 participants (52% male) who had had a minimum of 6-month employment that was defined by registered earning periods. As socioeconomic predictors, we examined low parental education at age 7 and low household income at age 16. Behaviour- and health-related factors at age 16 included smoking, alcohol use, physical inactivity, overweight, length of sleep and not having breakfast, while mental health problems included symptoms of anxiety and depression, attention problems and social problems. The analyses for significant predictors were further stratified by register-based level of completed own education by age 28–29 (low/high).After adjustments, low parental education, smoking and having been drunk were significant predictors of early entry into paid employment (≤18 vs. ≥24 years), especially among those who later obtained high education. Low parental education and smoking were predictors of low or non-specified (vs. high) occupational class in the first job. Mental health problems were not associated with either outcome. Socioeconomic background and unhealthy lifestyle contribute to early entry into the labour market and low occupational status in the first job.

▶ La médiation en santé : une innovation sociale ? Obstacles, formations et besoins

HASCHAR-NOÉ N. ET BÉRAULT F.

2019

Santé Publique 31(1): 31-42.

https://www.cairn.info/revue-sante-publique-2019-1-page-31.htm

Notre étude se focalise sur la médiation en santé comme réponse au défi que pose la réduction des inégalités sociales de santé, objectif phare de la loi de modernisation du système de santé de 2016. Faire de la médiation en santé nécessite que se rencontrent et collaborent deux « mondes sociaux », celui des professions de santé et celui de l'action sociale, parfois éloignés l'un de l'autre. En faisant l'hypothèse que la formation constituerait un levier facilitant leur collaboration, l'objectif de la recherche vise à caractériser l'offre actuelle des formations dans le domaine de la médiation sociale et en santé, à dégager les besoins non satisfaits et à formuler des propositions relevant de l'innovation sociale permettant d'y répondre. Nos méthodes d'investigation reposent sur un triple recueil de données quantitatives et qualitatives : une revue de la littérature de première main, la réalisation d'un état des lieux des formations sur le territoire national, des focus groups et entretiens avec des médiateurs et des institutions œuvrant dans ce domaine. Nos résultats montrent qu'un certain nombre d'obstacles tendent à maintenir des cloisonnements entre les « mondes » de la santé et du social parmi lesquels une forte asymétrie de l'offre de formation au profit du secteur social, une répartition territoriale inégalitaire et une hétérogénéité de ses contenus. Les besoins exprimés permettent d'avancer un certain nombre de principes consensuels et relevant de l'innovation sociale pour consolider la coopération entre professionnels du social et de la santé.

▶ « J'ai dit "je n'ai pas de Sécurité sociale", et il a retiré ses mains ». Entretien avec Noëlle Lasne

JAMI I.

2019

Mouvements 98(2): 155-174.

https://www.cairn.info/revue-mouvements-2019-2-page-155.htm

Noëlle Lasne est médecin généraliste. Après avoir exercé en cabinet de ville, elle a, en 1990, rejoint la mission France de Médecins Sans Frontières dont la création représentait un tournant majeur dans les activités de l'ONG humanitaire internationale. Il s'agissait d'un retour « à domicile » motivé par la multiplication des situations de non-accès aux soins que ce soit pour les étranger.ères sans-papiers, les travailleur.euses en fin de droits ou les victimes des nouvelles formes de précarité. Elle en a assuré la coordination tout au long des années 1990 alors que le travail de soin de la mission était en prise directe sur les initiatives et mobilisations qui aboutirent à la création de la Couverture Maladie Universelle et de l'Aide Médicale d'État pour les étrangers sans-papiers. Elle revient pour Mouvements sur cette expérience.

▶ Disability-Related Disparities in Access to Health Care Before (2008–2010) and After (2015–2017) The Affordable Care Act

KAYE H. S.

2019

American Journal of Public Health 109(7): 1015-1021.

https://doi.org/10.2105/AJPH.2019.305056

The aim of this study is to explore the effect of the Affordable Care Act (ACA) on disparities in access to health care based on disability status, as well as age, income, race, and ethnicity. In this study, I used logistic regression to analyze nationally representative data from 128?000 respondents to the US National Health Interview Survey from 2008 to 2010 and 2015 to 2017. Outcome variables were uninsurance over the previous 12 months, delayed or forgone health care for reasons of cost, and having a regular provider at a doctor's office or health clinic.Results. Over the period when the ACA was implemented, large existing disparities in access to health care were reduced for people with certain types of disabilities, young adults aged 19 to 25 years, and low-income families. The ACA improved overall access to health care and reduced some disparities, but substantial disparities persist. Disability status remains associated with much greater risk of delayed or forgone care, and mental health disability is associated with greater likelihood of uninsurance. The ACA partially achieved its goals and must not be weakened or rolled back. Further policy efforts are needed to address the remaining disparities.

▶ Inequality and Discrimination in Access to Urgent Care in France Ethnographies of Three Healthcare Structures and Their Audiences

MOREL S.

2019

Social Science & Medicine 232: 25-32.

In the social imagination, there is no wait for a so-called "medical emergency," because it seems obvious to everyone that "saving lives" is not up for discussion. In the context of such social consensus, it is unthinkable to question access to emergency healthcare through the prism of discrimination and social inequality. Yet these social representations of emergency do not withstand ethnographic inquiry. Several years spent behind the scenes in this world revealed that there do in fact exist social selection practices in the realm of emergency care in France. More specifically, this study shows that medical interests and the interests of both public and private institutions have led to the production of socially differentiated pathways of access to emergency care. The first pathway is through private, for-profit clinics, the second is through public hospitals, a third occurs by "bypassing" the emergency department, and a final one groups the non-governmental social and health assistance structures. In this article, we discuss the specific mechanisms they have for selecting patients, and show how the organization of emergency care in France contributes to reproducing or even aggravating inequalities in health and access to healthcare.

▶ No Unmet Needs Without Needs! Assessing the Role of Social Capital Using Data from European Social Survey 2014

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

2019

Health Policy : 123(8): 747-755

https://www.ncbi.nlm.nih.gov/pubmed/31213332

This paper examines the determinants of unmet healthcare needs in Europe. Special emphasis is put on the impact of social capital. Data come from the European Social Survey, 2014. Our study includes 32,868 respondents in 20 countries. Because unmet needs are observed only in those individuals who are exposed to, and recognise, the need of medical care, sample selection can be an issue. To address it, we analyse the data using the bivariate sample selection model. When there is no need, there is no assessment of access to healthcare. Accordingly, in this situation, our model assumes that unmet need is unobserved. The magnitude and statistical significance of the error correlation support our modelling strategy. A high proportion (18.4%) of individuals in need in Europe reported unmet needs. Informal connections seem to mitigate barriers to access as well as trust in other people and institutions, particularly in health services. Financial strain still is a strong predictor of unmet needs. Other vulnerable groups include informal carers, minorities and individuals feeling discriminated. Unmet needs might also arise due to persistent needs of healthcare as it seems to be the case of individuals with lower health status and chronic conditions. A result that merits further research concerns the positive impact of civic engagement on unmet needs.

▶ Shaping Access to Health Care for Refugees on the Local Level in Germany – Mixed-Methods Analysis of Official Statistics and Perspectives of Gatekeepers

ROLKE K., WENNER J. ET RAZUM O.

2019

Health Policy : 123(9) : 845-850

https://www.ncbi.nlm.nih.gov/pubmed/31326127

Background Analyses of refugee reception in European countries are increasingly focusing on the local level. We analyzed how gatekeepers can shape access to health care on a local level, taking as an example the federal state of North Rhine-Westphalia (NRW), Germany, where municipalities have implemented different local access models for newly arrived refugees. Methods We assessed the details of and the rationale for the implementation of local access models (implementation analysis), and the potential access to health care for refugees in municipalities (local policy analysis). We covered three municipalities with a health care voucher model and three with an electronic health card model. We combined data from official reports and semi-structured interviews (N = 21) with gatekeepers. Results Larger municipalities are more likely to implement the eHC. Gatekeepers report that costs, workload and control are the major aspects underlying the choice of a model in municipalities. Access plays only a minor role – even though some of the gatekeepers claim that the eHC can facilitate access. Regardless of the implemented model, gatekeepers on the local level can contribute to facilitating the access to health care for refugees. Conclusion Potential access of newly arrived refugees is – among others – determined by the gatekeepers' support and the implementation of the access models. Within the legal framework, municipalities implement the models differently.

▶ La santé des migrants : dossier

SPIRA A., GALLOIS L., KEROUEDAN D., *et al.*

2019

Bulletin de l'Académie Nationale de Médecine 203(1-2): 9-41.

Après un aperçu statistique sur la population migrante dans le monde, ce dossier rassemble une série d'articles sur l'état de santé et le recours aux soins des migrants en France et sur la crise de solidarité actuelle existant dans l'ensemble des pays européens.

The Association Between Social Exclusion or Inclusion and Health in EU and OECD Countries: A Systematic Review

VAN BERGEN A. P. L., WOLF J. R. L. M., BADOU M., *et al.*

2018

European Journal of Public Health 29(3): 575-582.

https://doi.org/10.1093/eurpub/cky143

Social exclusion (SE), or the inability to participate fully in society, is considered one of the driving forces of health inequalities. Systematic evidence on this subject is pertinent but scarce. This review aims to systematically summarise peer reviewed studies examining the association between the multidimensional concepts of SE and social inclusion (SI) and health among adults in EU and OECD countries. The protocol was registered on Prospero (CRD42017052718). Three major medical databases were searched to identify studies published before January 2018, supplemented by reference and citation tracking. Articles were included if they investigated SE or SI as a multidimensional concept with at least two out of the four dimensions of SE/SI, i.e. economic, social, political and cultural. A qualitative synthesis was conducted. Twenty-two observational studies were included. In the general population, high SE/low SI was associated with adverse mental and general health. For physical health, the evidence was inconclusive. In groups at high risk of SE, support was found for the association between high SE/low SI and adverse mental health but no conclusions could be drawn for physical and general health. This review found evidence for the association between high SE/low SI and adverse health outcomes, particularly mental health outcomes. The evidence is mainly based on cross-sectional studies using simple and often ad hoc indicators of SE/SI. The development and use of validated measures of SE/SI and more longitudinal research is needed to further substantiate the evidence base and gain better understanding of the causal pathways.

Do Ethnic Inequalities in Multimorbidity Reflect Ethnic Differences in Socioeconomic Status? The HELIUS Study

VEREST W. J. G. M., GALENKAMP H., SPEK B., *et al.*

2019

European Journal of Public Health 29(4): 687-693.

https://doi.org/10.1093/eurpub/ckz012

The burden of multimorbidity is likely higher in ethnic minority populations, as most individual diseases are more prevalent in minority groups. However, information is scarce. We examined ethnic inequalities in multimorbidity, and investigated to what extent they reflect differences in socioeconomic status (SES).We included Healthy Life in an Urban Setting study participants of Dutch (N = 4582), South-Asian Surinamese (N = 3258), African Surinamese (N = 4267), Ghanaian (N = 2282), Turkish (N = 3879) and Moroccan (N = 4094) origin (aged 18–70 years). Educational level, employment status, income situation and multimorbidity were defined based on questionnaires. We described the prevalence and examined age-adjusted ethnic inequalities in multimorbidity with logistic regression analyses. To assess the contribution of SES, we added SES indicators to the age-adjusted model.The prevalence of multimorbidity ranged from 27.1 to 53.4% in men and from 38.5 to 69.6% in women. The prevalence of multimorbidity in most ethnic minority groups was comparable to the prevalence among Dutch participants who were 1–3 decades older. After adjustment for SES, the odds of multimorbidity remained significantly higher in ethnic minority groups. For instance, age-adjusted OR for multimorbidity for the Turkish compared to the Dutch changed from 4.43 (3.84–5.13) to 2.34 (1.99–2.75) in men and from 5.35 (4.69–6.10) to 2.94 (2.54–3.41) in women after simultaneous adjustment for all SES indicators.We found a significantly higher prevalence of multimorbidity in ethnic minority men and women compared to Dutch, and results pointed to an earlier onset of multimorbidity in ethnic minority groups. These inequalities in multimorbidity were not fully accounted for by differences in SES.

Médicaments

Pharmaceuticals

▶ The Impact of Price Regulation on the Availability of New Drugs in Germany

STERN A. D, PIETRULLA F., HERR A.

2019

Health Affairs 38(7): 1182-1187.

The 2011 German Pharmaceutical Market Restructuring Act subjected brand-name drugs for nonrare diseases to price regulation based on an assessment of their clinical benefit. Indication-specific assessment outcomes range from major added benefit to less benefit than the appropriate comparator(s) and affect price negotiations beyond the first year on the market. Using data on drugs that entered the market in the period 2012–16, we evaluated benefit assessment findings, subsequent drug exits, and their correlates. We considered 171 drug-indication pairs, corresponding to 138 different drugs. Of these, 66 drug-indication pairs (55 different drugs) were found to have added benefit. Almost all drugs with a positive benefit assessment (98 percent) remained on the market, while drugs without a positive benefit assessment were over ten times more likely to exit (25 percent versus 2 percent). US policy makers considering how to address rapidly increasing drug costs may draw valuable lessons from the German experience.

▶ Financial Incentives and Physician Prescription Behavior: Evidence from Dispensing Regulations

BURKHARD D., SCHMID C. P. R. ET WÜTHRICH K.

2019

Health Economics 28(9). 1114-1129

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3893

In many health care markets, physicians can respond to changes in reimbursement schemes by changing the volume (volume response) and the composition of services provided (substitution response). We examine the relative importance of these two behavioral responses in the context of physician drug dispensing in Switzerland. We find that dispensing increases drug costs by 52% for general practitioners and 56% for specialists. This increase is mainly due to a volume increase. The substitution response is negative on average, but not significantly different from zero for large parts of the distribution. In addition, our results reveal substantial effect heterogeneity.

▶ Alternative Access Schemes for Pharmaceuticals in Europe: Towards an Emerging Typology

LÖBLOVÁ O., CSANÁDI M., OZIERAŃSKI P., *et al.*

2019

Health Policy 123(7): 630-634.

https://www.sciencedirect.com/science/article/abs/pii/S0168851019301290

European governments employ sophisticated health technology assessment and regulatory procedures to identify which pharmaceuticals to fund publicly. However, there are persisting demands from patients for those drugs excluded from positive reimbursement lists, leading to the emergence of what are here termed “alternative access schemes”. This paper presents a purposive review of these schemes based on available scholarly and grey literature, illustrated with real-world examples from recent practice. It puts forward an original typology of alternative access schemes based on their marketing authorization (regulation) and reimbursement (redistribution) status. We describe the complex, multidimensional policy trade-offs between the principles of patient freedom of choice, clinical autonomy, encouragement of innovation, evidence-informed decisions on safety and quality, access to treatment, and financial sustainability, involved in marketing authorization and reimbursement decisions. We discuss the ways in which alternative access schemes differ and conclude that our typology can illuminate salient policy dilemmas raised by alternative access schemes in national drug reimbursement systems.

Estimating Disease Prevalence from Drug Utilization Data Using the Random Forest Algorithm

SLOBBE L. C. J., FÜSSENICH K., WONG A., *et al.*

2019

European Journal of Public Health 29(4): 615-621.

https://doi.org/10.1093/eurpub/cky270

Aggregated claims data on medication are often used as a proxy for the prevalence of diseases, especially chronic diseases. However, linkage between medication and diagnosis tend to be theory based and not very precise. Modelling disease probability at an individual level using individual level data may yield more accurate results. Individual probabilities of having a certain chronic disease were estimated using the Random Forest (RF) algorithm. A training set was created from a general practitioners database of 276 723 cases that included diagnosis and claims data on medication. Model performance for 29 chronic diseases was evaluated using Receiver-Operator Curves, by measuring the Area Under the Curve (AUC).The diseases for which model performance was best were Parkinson's disease (AUC = .89, 95% CI = .77–1.00), diabetes (AUC = .87, 95% CI = .85–.90), osteoporosis (AUC = .87, 95% CI = .81–.92) and heart failure (AUC = .81, 95% CI = .74–.88). Five other diseases had an AUC >.75: asthma, chronic enteritis, COPD, epilepsy and HIV/AIDS. For 16 of 17 diseases tested, the medication categories used in theory-based algorithms were also identified by our method, however the RF models included a broader range of medications as important predictors. Data on medication use can be a useful predictor when estimating the prevalence of several chronic diseases. To improve the estimates, for a broader range of chronic diseases, research should use better training data, include more details concerning dosages and duration of prescriptions, and add related predictors like hospitalizations.

New Model for Prioritised Adoption and Use of Hospital Medicine in Denmark Since 2017: Challenges and Perspectives

WADMANN S. ET KJELLBERG J.

2019

Health Policy 123(7): 606-610.

https://www.sciencedirect.com/science/article/pii/S0168851019301149

Technological innovation creates new treatment opportunities, while also putting healthcare budgets under strain. To deal with the rising costs of hospital medicines, the regional governments in Denmark have developed a new model for prioritising the adoption and use of hospital medicine. Marking a shift from previous policies, the new model formalises the evaluation of clinical benefit, adds an assessment of treatment costs and ensures a relatively high degree of direct stakeholder involvement. In international comparison, the new model is ambitious in terms of stakeholder involvement and adherence with principles advocated to ensure procedural justice and fair decision-making processes. However, these procedural innovations have also created new challenges. Notably, the newly formed assessment body, the Danish Medicines Council, is faced with a very high caseload and limited options to prioritise the use of its analytical resources.

Méthodologie – Statistique

Methodology - Statistics

Evaluation of the French Reactive Mortality Surveillance System Supporting Decision Making

BAGHDADI Y., GALLAY A., CASERIO-SCHÖNEMANN C., *et al.*

2018

European Journal of Public Health 29(4): 601-607.

https://doi.org/10.1093/eurpub/cky251

In France, a mortality syndromic surveillance system was set up with objectives of early detection and reactive evaluation of the impact of expected and unexpected events to support decision makers. This study aims to describe the characteristics of the system and its usefulness for decision makers. Anonymized data from the administrative part of death certificates were daily collected from 3062 computerized city halls and were transmitted to Santé publique France in routine. Coverage of the system was measured as the proportion of deaths registered by the system among the complete number of deaths and analyzed by age, month and region. Deaths were described by gender, age and geographical level using proportion. The excess periods of deaths were described based on the comparison of the weekly observed and expected numbers of deaths between 2012 and 2016.The system recorded 77.5% of the national mortality covering the whole territory. About 81% of deaths were aged 65 years old and more. The surveillance system identified mortality variations mainly during winter and summer, for some concomitant with influenza epidemic or heatwave period, and thus provided information for decision makers. The ability of the system to detect and follow mortality outbreaks in routine in the whole territory has been demonstrated. It is a useful tool to provide early evaluation of the impact of threats on mortality and alert decision makers to adapt control measures. However, the absence of information on medical causes of death may limit the ability to target recommendations.

La modélisation des systèmes urbains : une approche par la physique statistique

BARTHELEMY M.

2019

Revue économique 70(3): 327-343.

https://www.cairn.info/revue-economique-2019-3-page-327.htm

La disponibilité croissante de données dans divers domaines a permis d'entrevoir ou de renouveler les approches quantitatives pour de nombreux phénomènes. Cela est particulièrement vrai pour les systèmes urbains pour lesquels différents dispositifs à différentes échelles produisent une très grande quantité de données potentiellement utiles pour construire une « nouvelle science des villes ». Un nouveau problème que nous devons résoudre est alors d'extraire des informations utiles de ces énormes ensembles de données et de construire des modèles théoriques pour expliquer les observations empiriques. Dans cet article, nous discutons une approche inspirée par la physique statistique et l'illustrons d'exemples de la répartition spatiale de l'activité dans les villes et de la mobilité urbaine.

Le Health Data Hub, un an après

COMBES S. *et al.*,.

2019

Revue Hospitalière de France(589).

À la suite du rapport Villani, présenté le 29 mars 2018 au Collège de France, la création d'un Health Data Hub fut annoncée par le président de la République, Emmanuel Macron. Cette plate-forme vise à enrichir et à valoriser le Système national de données de santé (SNDS) en incluant l'ensemble de celles dont la collecte est soutenue par la solidarité nationale. Créé par la loi de modernisation du système de santé, le SNDS est actuellement composé des données de l'assurance maladie, des données de facturation hospitalière, des causes médicales de décès, des données médico-sociales des personnes handicapées et d'un échantillon de données de remboursement des organismes complémentaires. Dans un cadre qui garantit le respect des droits fondamentaux de chacun, cette structure contribuera à lever les freins à l'usage des données de santé. La dynamique engagée renforce nos capacités à innover et contribuera à faire de la France un leader dans l'intelligence artificielle en santé.

The MIPEX Health Strand: A Longitudinal, Mixed-Methods Survey of Policies on Migrant Health in 38 Countries

INGLEBY D., CONSORTIUM T. M. H. S., PETROVA-BENEDICT R., *et al.*

2018

European Journal of Public Health 29(3): 458-462.

https://doi.org/10.1093/eurpub/cky233

Within health systems, equity between migrants and native-born citizens is still a long way from being achieved. Benchmarking the equitability of policies on migrant health is essential for monitoring progress and identifying positive and negative aspects of national policies. For this purpose, the 2015 round of the Migrant Integration Policy Index (MIPEX) was expanded to include a strand on health, in a collaborative project carried out between 2013 and 2017 in 38 countries. Indicators of policies to promote equity were derived from the 2011 Recommendations of the Council of Europe on 'mobility, migration and access to health care' and used to construct a questionnaire compatible with MIPEX methodology. This yielded scores for Entitlement, Accessibility, Responsiveness and Measures to achieve change. As a measuring instrument, the questionnaire has a high degree of internal consistency, while exploratory factor analysis showed a coherent relationship between its statistical structure and the four scales it comprises. Measures to achieve change were strongly associated with Responsiveness, but not at all with Entitlements and only slightly with Accessibility. Examining the results from the sub-sample of 34 'European' countries, wide variations in the equitability of policies were found: these were mainly associated with a country's wealth (GDP), but differences between EU13 and EU15 countries were too extreme to explain completely in such terms. The MIPEX Health strand is a robust measurement tool that has already yielded a number of important results and is providing a valuable resource for both researchers and policy-makers.

Systematic Reviews and Meta-Analyses in the Health Sciences: Best Practice Methods for Research Syntheses

JOHNSON B. T. ET HENNESSY E. A.

2019

Social Science & Medicine 233: 237-251.

https://www.sciencedirect.com/science/article/abs/pii/S0277953619302990

Rationale The journal Social Science & Medicine recently adopted the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al., 2009) as guidelines for authors to use when disseminating their systematic reviews (SRs). Approach After providing a brief history of evidence synthesis, this article describes why reporting standards are important, summarizes the sequential steps involved in conducting SRs and meta-analyses, and outlines additional methodological issues that researchers should address when conducting and reporting results from their SRs. Results and conclusions Successful SRs result when teams of reviewers with appropriate expertise use the highest scientific rigor in all steps of the SR process. Thus, SRs that lack foresight are unlikely to prove successful. We advocate that SR teams consider potential moderators (M) when defining their research problem, along with Time, Outcomes, Population, Intervention, Context, and Study design (i.e., TOPICS + M). We also show that, because the PRISMA reporting standards only partially overlap dimensions of methodological quality, it is possible for SRs to satisfy PRISMA standards yet still have poor methodological quality. As well, we discuss limitations of such standards and instruments in the face of the assumptions of the SR process, including meta-analysis spanning the other SR steps, which are highly synergistic: Study search and selection, coding of study characteristics and effects, analysis, interpretation, reporting, and finally, re-analysis and criticism. When a SR targets an important question with the best possible SR methods, its results can become a definitive statement that guides future research and policy decisions for years to come.

Using National Electronic Health Care Registries for Comparing the Risk of Psychiatric Re-Hospitalisation in Six European Countries: Opportunities and Limitations

KATSCHNIG H., STRASSMAYR C., ENDEL F., *et al.*

2019

Health Policy : Ahead of pub.

Psychiatric re-hospitalisation rates have been of longstanding interest as health care quality metric for planners and policy makers, but are criticized for not being comparable across hospitals and countries due to measurement unclarities. The objectives of the present study were to explore the interoperability of national electronic routine health care registries of six European countries (Austria, Finland, Italy, Norway, Romania, Slovenia) and, by using variables found to be comparable, to calculate and compare re-hospitalisation rates and the associated risk factors. A "Methods Toolkit" was developed for exploring the interoperability of registry data and protocol led pilot studies were carried out. Problems encountered in this process are described. Using restricted but comparable data sets, up to twofold differences in psychiatric re-hospitalisation rates were found between countries for both a 30- and 365-day follow-up period. Cumulative incidence curves revealed noteworthy additional differences. Health system characteristics are discussed as potential causes for the differences. Using logistic regression analyses younger age and a diagnosis of schizophrenia/mania/bipolar disorder consistently increased the probability of psychiatric re-hospitalisation across countries. It is concluded that the advantage of having large unselected study populations of national electronic health care registries needs to be balanced against the considerable efforts to examine the interoperability of databases in cross-country comparisons.

A Flow-Based Statistical Model Integrating Spatial and Nonspatial Dimensions to Measure Healthcare Access

TANG J.-H., CHIU Y.-H., CHIANG P.-H., *et al.*
2017
Health & Place 47: 126-138.

Assessing access to healthcare for an entire healthcare system involves accounting for demand, supply, and geographic variation. In order to capture the interaction between healthcare services and populations, various measures of healthcare access have been utilized, including the popular two-step floating catchment area (2SFCA) method. However, despite the many advantages of 2SFCA, the problems, such as inappropriate assumption of healthcare demand and failure to capture cascading effects across the system have not been satisfactorily addressed. In this paper, a statistical model for evaluating flows of individuals was added to the 2SFCA method (hereafter we refer to it as F2SFCA) in order to overcome limitations associated with its current restriction. The proposed F2SFCA model can incorporate both spatial and nonspatial dimensions and thus synthesizes them into one framework. Moreover, the proposed F2SFCA model can be easily adapted to measure access for different types of individuals, over different service provider types, or with capacity constraints in a healthcare system. We implemented the proposed model in a case study assessing access to healthcare for the elderly in Taipei City, Taiwan, and compared the weaknesses and strengths to the 2SFCA method and its variations.

Big data et statistiques. 1ère partie

TASSI P., BORTOLI C., COMBES S., *et al.*
2018
Economie Et Statistique(505-506): 193.
https://www.insee.fr/fr/statistiques/3706255

La révolution, somme toute récente, due à la convergence numérique et aux objets connectés, a permis de mettre sous forme homogène des informations que l'histoire considérait comme de nature différente : données numériques, textes, son, images fixes, images mobiles. Ceci a favorisé le phénomène des Big Data – données massives ou mégadonnées – dont la volumétrie comporte deux paramètres joints : quantité et fréquence d'acquisition, la quantité pouvant aller jusqu'à l'exhaustivité, la fréquence pouvant aller jusqu'au temps réel. Ce numéro spécial présente un ensemble d'articles qui en examinent les usages et les enjeux pour la production statistique. Comme toute innovation, les données massives offrent des avantages et soulèvent des questions. Parmi les avantages perceptibles, un « plus » de connaissances : une meilleure description statistique de l'économie et de la société, notamment par la statistique publique. Ces données sont aussi un vecteur de développement en informatique au sens large, et en mathématiques appliquées. On ne peut cependant pas faire l'économie d'une certaine vigilance, car les Big Data et leurs usages peuvent avoir des effets sur les individus, leurs libertés et la préservation de leur vie privée.

Combining the Power of Artificial Intelligence with the Richness of Healthcare Claims Data: Opportunities and Challenges

THESMAR D., SRAER D., PINHEIRO L., *et al.*
2019
PharmacoEconomics 37(6): 745-752.
https://doi.org/10.1007/s40273-019-00777-6

Combinations of healthcare claims data with additional datasets provide large and rich sources of information. The dimensionality and complexity of these combined datasets can be challenging to handle with standard statistical analyses. However, recent developments in artificial intelligence (AI) have led to algorithms and systems that are able to learn and extract complex patterns from such data. AI has already been applied successfully to such combined datasets, with applications such as improving the insurance claim processing pipeline and reducing estimation biases in retrospective studies. Nevertheless, there is still the potential to do much more. The identification of complex patterns within high dimensional datasets may find new predictors for early onset of diseases or lead to a more proactive offering of personalized preventive services. While there are potential risks and challenges associated with the use of AI, these are not insurmountable. As with the introduction of any innovation, it will be necessary to be thoughtful and responsible as we increasingly apply AI methods in healthcare.

Assessing the Potential Utility of Commercial ‘Big Data’ for Health Research: Enhancing Small-Area Deprivation Measures with Experian™ Mosaic Groups

WAMI W. M., DUNDAS R., MOLAODI O. R., *et al.*

2019

Health & Place 57: 238-246.

https://www.sciencedirect.com/science/article/pii/S1353829218311328

In contrast to area-based deprivation measures, commercial datasets remain infrequently used in health research and policy. Experian collates numerous commercial and administrative data sources to produce Mosaic groups which stratify households into 15 groups for marketing purposes. We assessed the potential utility of Mosaic groups for health research purposes by investigating their relationships with Indices of Multiple Deprivation (IMD) for the British population. Mosaic groups showed significant associations with IMD quintiles. Correspondence Analysis revealed variations in patterns of association, with Mosaic groups either showing increasing, decreasing, or some mixed trends with deprivation quintiles. These results suggest that Experian’s Mosaics additionally measure other aspects of socioeconomic circumstances to those captured by deprivation measures. These commercial data may provide new insights into the social determinants of health at a small area level.

Imputing Race and Ethnic Information in Administrative Health Data

XUE Y., HAREL O. ET ASELTINE JR., R. H.

2019

Health Services Research 54(4) : 957-963

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13171

The aim of this study is to improve on existing methods to infer race/ethnicity in health care data through an analysis of birth records from Connecticut. A total of 162 467 Connecticut birth records from 2009 to 2013. We developed a logistic model to predict race/ethnicity using data from US Census and patient-level information. Model performance was tested and compared to previous studies. Five performance measures were used for comparison. Principal Findings Our full model correctly classifies 81 percent of subjects and shows improvement over extant methods. We achieved substantially improved sensitivity in predicting black race. Predictive models using Census information and patients’ demographic characteristics can be used to accurately populate race/ethnicity information in health care databases, enhancing opportunities to investigate and address disparities in access to, utilization of, and outcomes of care.

Politique de santé

Health Policy

A Systematic Review of the Validity and Reliability of Patient-Reported Experience Measures

BULL C., BYRNES J., HETTIARACHCHI R., *et al.*

2019

Health Services Research : 54 (5) : 1023-1035

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13187

The aim of this paper is to identify patient-reported experience measures (PREMs), assess their validity and reliability, and assess any bias in the study design of PREM validity and reliability testing. A systematic review was conducted on MEDLINE, CINAHL and Scopus databases up to March 13, 2018. Eighty-eight PREMs were identified, spanning across four main health care contexts. PREM validity and reliability was supported by appropriate study designs. Internal consistency (n = 58, 65.2 percent), structural validity (n = 49, 55.1 percent), and content validity (n = 34, 38.2 percent) were the most frequently reported validity and reliability tests. Conclusions Careful consideration should be given when selecting PREMs, particularly as seven of the 10 validity and reliability criteria were not undertaken in ≥50 percent of the PREMs. Testing PREM responsiveness should be prioritized for the application of PREMs where the end user is measuring change over time. Assessing measurement error/agreement of PREMs is important to understand the clinical relevancy of PREM scores used in a health care evaluation capacity.

Alcohol Deregulation: Considering the Hidden Costs

DILLEY J. A.

2019

American Journal of Public Health 109(6): 840-842.

https://doi.org/10.2105/AJPH.2019.305104

Involving the Public in Decision-Making About Large-Scale Changes to Health Services: A Scoping Review

DJELLOULI N., JONES L., BARRATT H., *et al.*

2019

Health Policy 123(7): 635-645.

Public involvement in large-scale changes (LSC) to health services is strongly promoted – and even mandated – in several health systems. This scoping review aimed to describe the evidence about how public involvement is conceptualised and conducted in LSC, with what impact, and how different stakeholders perceived this process. Methods After searching eight databases, 34 publications were included. Data were extracted and charted using a standardised form. Findings from the literature were discussed with frontline stakeholders. Results Public involvement remains poorly defined and its aims lack clarity in LSC. Public meetings are most often used to gather public views but raise the issue of representativeness. However, evidence in the literature is scarce about which involvement methods – informative and deliberative – are appropriate for the different stages of the LSC and with what impact. In several cases, the involved public felt they had no influence on decision-making regarding LSC proposals, sometimes leading to an environment of mistrust. In those instances, the public understood the technical arguments for change and actively questioned them, opposed LSC plans and sought alternative routes to voice their views. More research and consideration are needed regarding who should be involved, with what purpose and how. We argue that in practice two models of involvement, invited and uninvited participation, coexist and therefore interactions between the two should be given further consideration in LSC.

Impact of the WHO Framework Convention on Tobacco Control on Global Cigarette Consumption: Quasi-Experimental Evaluations Using Interrupted Time Series Analysis and In-Sample Forecast Event Modelling

HOFFMAN S. J., POIRIER M. J. P., ROGERS VAN KATWYK S., *et al.*

2019

BMJ 365: l2287.

https://www.bmj.com/content/bmj/365/bmj.l2287.full.pdf

The aim of this study is to evaluate the impact of the WHO Framework Convention on Tobacco Control (FCTC) on global cigarette consumption Two quasi-experimental impact evaluations, using interrupted time series analysis (ITS) and in-sample forecast event modelling. 71 countries for which verified national estimates of cigarette consumption from 1970 to 2015 were available, representing over 95% of the world's cigarette consumption and 85% of the world's population. The FCTC is an international treaty adopted in 2003 that aims to reduce harmful tobacco consumption and is legally binding on the 181 countries that have ratified it. Main outcomes were annual national estimates of cigarette consumption per adult from 71 countries since 1970, allowing global, regional, and country comparisons of consumption levels and trends before and after 2003, with counterfactual control groups modelled using pre-intervention linear time trends (for ITS) and in-sample forecasts (for event modelling). No significant change was found in the rate at which global cigarette consumption had been decreasing after the FCTC's adoption in 2003, using either ITS or event modelling. Results were robust after realigning data to the year FCTC negotiations commenced (1999), or to the year when the FCTC first became legally binding in each country. By contrast to global consumption, high income and European countries showed a decrease in annual consumption by over 1000 cigarettes per adult after 2003, whereas low and middle income and Asian countries showed an increased annual consumption by over 500 cigarettes per adult when compared with a counterfactual event model. This study finds no evidence to indicate that global progress in reducing cigarette consumption has been accelerated by the FCTC treaty mechanism. This null finding, combined with regional differences, should caution against complacency in the global tobacco control community, motivate greater implementation of proven tobacco control policies, encourage assertive responses to tobacco industry activities, and inform the design of more effective health treaties.

Une crise sanitaire du Sud dans un pays du Nord ? L'intervention des ONG médicales internationales en France

IZAMBERT C.

2019

Mouvements 98(2): 95-105.

https://www.cairn.info/revue-mouvements-2019-2-page-95.htm

Ouvrir des dispensaires en France ? Pour des organisations humanitaires spécialistes de l'intervention d'urgence dans les pays du Sud global, la proposition n'avait rien d'évident. C'est pourtant ce choix qu'ont fait Médecins du monde et Médecins sans frontières à la fin des années 1980. Dans cet article, Caroline Izambert interroge les relations entre ces actions « à domicile » et l'expérience de l'urgence et de la pénurie dans les Suds qu'avaient ces ONG. Comment ces circulations Sud-Nord ont-elles sensibilisé aux conséquences sanitaires de la précarité et contribué à définir le travail d'organisation de l'accès aux soins et l'action politique de ces ONG – qui ont joué un rôle important dans la mise en place de la Couverture maladie universelle et de l'Aide médicale d'État pour les migrant.es ?

Effective Healthcare Cost-Containment Policies: A Systematic Review

STADHOUDERS N., KRUSE F., TANKE M., *et al.*

2019

Health Policy 123(1): 71-79.

http://www.sciencedirect.com/science/article/pii/S0168851018306341

Unsustainable growth in healthcare expenditure demands effective cost-containment policies. We review policy effectiveness using total payer expenditure as primary outcome measure. We included all OECD member states from 1970 onward. After a rigorous quality appraisal, we included 43 original studies and 18 systematic reviews that cover 341 studies. Policies most often evaluated were payment reforms (10 studies), managed care (8 studies) and cost sharing (6 studies). Despite the importance of this topic, for many widely-used policies very limited evidence is available on their effectiveness in containing healthcare costs. We found no evidence for 21 of 41 major groups of cost-containment policies. Furthermore, many evaluations displayed a high risk of bias. Therefore, policies should be more routinely and rigorously evaluated after implementation. The available high-quality evidence suggests that the cost curve may best be bent using a combination of cost sharing, managed care competition, reference pricing, generic substitution and tort reform.

Association of Medicare's Bundled Payments for Care Improvement Initiative with Patient-Reported Outcomes

TROMBLEY M. J., MCCLELLAN S. R., KAHVECIOGLU D. C., *et al.*

2019

Health Services Research 54(4): 793-804.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13159

The objective of this paper is to determine whether the Bundled Payments for Care Improvement (BPCI) initiative affected patient-reported measures of quality. Data Sources come from Surveys of Medicare fee-for-service beneficiaries discharged from acute care hospitals participating in BPCI Model 2 and comparison hospitals between October 2014 and June 2017. Variables from Medicare administrative data and the Provider of Services file were used for sampling and risk adjustment. We estimated risk-adjusted differences in patient-reported measures of care experience and changes in functional status, for beneficiaries treated by BPCI and comparison hospitals. We selected a stratified random sample of BPCI and matched comparison beneficiaries. We fielded nine waves of surveys using a mail and phone protocol, yielding 29 193 BPCI and 29 913 comparison respondents. Most BPCI and comparison survey respondents reported a positive care experience and high satisfaction. BPCI respondents were slightly less likely than comparison respondents to report positive care experience or high satisfaction. Despite these differences in care experience, there was no difference between BPCI and comparison respondents in self-reported functional status approximately 90 days after hospital discharge. These findings reduce concerns that BPCI may have unintentionally harmed patient health but suggest room for improvement in patient care experience.

Prévention

Prevention

Impulser une stratégie de plaidoyer et de partenariats pour accompagner les campagnes nationales de communication : l'exemple de Mois sans tabac

DAVIES J., SMADJA O., LOISY S., *et al.*

2019

Actualité et dossier en Santé Publique(106): 4-6.

La campagne médiatique « Mois sans tabac » est accompagnée sur le terrain d'actions qui reposent sur une stratégie d'implication des acteurs relais. La qualité de cette collaboration fait le succès de la campagne.

Retour d'expérience sur la mise en œuvre d'une action départementale d'activité physique pour les seniors

FERRÉ N., RACINE A. N., FUENTE D., *et al.*

2019

Santé Publique 31(1): 53-60.

https://www.cairn.info/revue-sante-publique-2019-1-page-53.htm

La pratique régulière d'une activité physique (AP) est aujourd'hui reconnue comme un des éléments clés du bien vieillir. Cependant, en France, le niveau d'AP diminue avec l'âge. L'objectif de cette étude était d'étudier la mise en œuvre et l'impact d'un programme d'activité physique destinés aux plus de 60 ans insuffisamment actifs, co-construit avec les acteurs locaux sur plusieurs communes. Le programme « Prévention active senior » (PAS), coordonné par un centre de ressources, consistait en la conception et la mise en œuvre d'un programme d'AP structuré, pour des personnes de plus de 60 ans. Pour chaque commune, le programme était conduit par un éducateur sportif « implanté » localement en partenariat avec un agent de la collectivité concernée. Il était composé de trois séances d'AP hebdomadaires (deux encadrées et une en autonomie) pendant trois mois. Les données ont été recueillies grâce aux outils développés pour l'évaluation. Le programme a été conduit dans 27 communes. Il a réuni 586 participants inscrits et 439 ont réalisé l'évaluation finale. Celui-ci a permis une amélioration significative des trois principales qualités physiques (endurance, force musculaire et équilibre) chez les pratiquants. À l'issue du programme, plus de la moitié des communes ont mis en place ou soutenu une offre d'AP pérenne. Cette étude a permis de souligner la nécessité d'adapter ce type d'intervention au contexte territorial. Elle confirme l'intérêt de combiner une approche individuelle et populationnelle ainsi qu'un travail intersectoriel pour créer des conditions favorables à la pratique de l'activité physique.

Alerte en santé publique : dossier

MARANO F., ZMIROU-NAVIER D. *et al.*

2019

Actualité et dossier en Santé Publique 106): 7-57.

L'alerte permet de signaler un danger imminent : menaces d'agents infectieux (dengue, Ebola...), pouvant se propager rapidement mais aussi risques liés à l'environnement (amiante, polluants...). Il y a des différences entre l'alerte pour les risques imminents, infectieux ou chimiques voire physiques, et celle relative à des expositions diffuses, complexes dont les effets sont décalés dans le temps. Cette alerte est plus difficile à mettre en place et le lanceur d'alerte va relayer celle des scientifiques et exercer des pressions sur les décideurs pour que les incertitudes de la science ne constituent pas des arguments en faveur du « attendre et ne rien faire ». Ce dossier repart des scandales sanitaires qui ont conduit à la mise en place d'une réforme du système de sécurité sanitaire qui organise et donne toute sa force à l'alerte.

Prévision – Évaluation

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.

The Criterion Validity of Willingness to Pay Methods: A Systematic Review and Meta-Analysis of the Evidence

KANYA L., SANGHERA S., LEWIN A., *et al.*

2019

Social Science & Medicine 232: 238-261.

https://www.ncbi.nlm.nih.gov/pubmed/31108330

The contingent valuation (CV) method is used to estimate the willingness to pay (WTP) for services and products to inform cost benefit analyses (CBA). A long-standing criticism that stated WTP estimates may be poor indicators of actual WTP, calls into question their validity and the use of such estimates for welfare evaluation, especially in the health sector. Available evidence on the validity of CV studies so far is inconclusive. We systematically reviewed the literature to (1) synthesize the evidence on the criterion validity of WTP/willingness to accept (WTA), (2) undertake a meta-analysis, pooling evidence on the extent of variation between stated and actual WTP values and, (3) explore the reasons for the variation. Eight electronic databases were searched, along with citations and reference reviews. 50 papers detailing 159 comparisons were identified and reviewed using a standard proforma. Two reviewers each were involved in the paper selection, review and data extraction. Meta-analysis was conducted using random effects models for ratios of means and percentage differences separately. Meta-bias was investigated using funnel plots. Hypothetical WTP was on average 3.2 times greater than actual WTP, with a range of 0.7–11.8 and 5.7 (0.0–13.6) for ratios of means and percentage differences respectively. However, key methodological differences between surveys of hypothetical and actual values were found. In the meta-analysis, high levels of heterogeneity existed. The overall effect size for mean summaries was 1.79 (1.56–2.04) and 2.37 (1.93–2.80) for percent summaries. Regression analyses identified mixed results on the influence of the different experimental protocols on the variation between stated and actual WTP values. Results indicating publication bias did not account for differences in study design. The evidence on the criterion validity for CV studies is more mixed than authors are representing because substantial differences in study design between hypothetical and actual WTP/WTA surveys are not accounted for.

Applying an Implementation Framework to the Use of Evidence from Economic Evaluations in Making Healthcare Decisions

MERLO G., PAGE K., ZARDO P., *et al.*

2019

Applied Health Economics and Health Policy 17(4): 533-543.

https://doi.org/10.1007/s40258-019-00477-4

There is a need for the application of theory in understanding the use of evidence from economic evaluations in healthcare decision making. The purpose of this study is to review the published literature on the use of evidence from economic evaluations for healthcare decision making and to map the findings to the Consolidated Framework for Implementation Research (CFIR).

Psychiatrie

Psychiatry

Unmet Needs in Primary Care of Older Clients with Mental Health Concerns

ALVES S., TEIXEIRA L., AZEVEDO M. J., *et al.*

2018

International Journal for Quality in Health Care 31(4): 312-318.

https://doi.org/10.1093/intqhc/mzy154

The aim of this study is to examine the unmet needs of older clients with perceived mental health problems who attend primary healthcare services. Unmet needs were derived from (i) the health concerns and caregiver network availability provided by a General Practitioner (GPs) and from (ii) a qualitative analysis of an open question about needs completed by informal caregivers (ICs) of those clients. The sample comprised 436 clients with mean age of 75.2 years and 110 ICs with mean age of 56.7 years. Primary healthcare centers in the North of Portugal. The Community Assessment of Risk Instrument—CARI (Clarnette RM, Ryan JP, O'Herlihy E, et al. The community assessment of risk instrument: investigation of inter-rater reliability of an instrument measuring risk of adverse outcomes. J Frailty Aging 2015;4: 80-9; O'Caoimh R, Healy E, Connell EO, et al. The Community Assessment of Risk Tool (CART): investigation of inter-rater reliability for a new instrument measuring risk of adverse outcomes in community dwelling older adults. Irish J Med Sci 2012.) and qualitative data about needs. Several needs were observed in relation to (1) mental state (e.g. cognition, anxiety/depression); (2) functionality (e.g. IADLS, bathing, mobility); (3) medical state (e.g. chronic diseases, vision deficits) and (4) IC ability to meet clients' needs. From the categorical analysis of the ICs' answers, an amount of unmet needs not only health related but also related with referrals and legal issues were found. This study shows a large number of unmet needs of older people. The evaluation of the clients combined with the evaluation of the testimonials of ICs enables the understanding of difficulties of both clients and caregivers, and which needs should be prioritized.

Beyond Access: Psychosocial Barriers to Undocumented Students' Use of Mental Health Services

CHA B. S., ENRIQUEZ L. E. ET RO A.

2019

Social Science & Medicine 233: 193-200.

https://www.sciencedirect.com/science/article/abs/pii/S0277953619303259

Rationale Little is known about how undocumented immigrants navigate healthcare utilization issues apart from access. Objective We examine a unique population of undocumented immigrants who have access to healthcare - college students at the University of California - to identify how immigration status hinders mental health service utilization in the absence of barriers related to eligibility and insurance coverage. Method We conducted semistructured interviews between March and July 2017 with 30 undocumented students at a University of California campus. Results We argue that undocumented immigration status informs mental health-related illness cognitions to negatively affect students' ability to assess their own mental health and need for services. Students expressed low perceived need because they normalized mental strain as a natural product of their unstable immigration status. Many viewed treatment as futile because it could not address underlying immigration-related issues. They also anticipated stigmas associated with mental illness as well as their own undocumented status. Conclusion Solutions to address utilization disparities must go beyond eliminating formal barriers to health access and address such psychosocial barriers, as well as the larger political and social context that produces them.

▶ How Do Economic Downturns Affect the Mental Health of Children? Evidence from the National Health Interview Survey

GOLBERSTEIN E., GONZALES G. ET MEARA E.

2019

Health Economics 28(8): 955-970.

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3885

Research linking economic conditions and health often does not consider children's mental health problems, which are the most common and consequential health issues for children and adolescents. We examine the effects of unemployment rates and housing prices on well-validated child and adolescent mental health outcomes and use of special education services for emotional problems in the 2001–2013 National Health Interview Survey. We find that the effects of economic conditions on children's mental health are clinically and economically meaningful; children's mental health outcomes worsen as the economy weakens. The effects of economic conditions on child and adolescent mental health are pervasive, found in almost every subgroup that we examine. The use of special education services for emotional problems also rises when economic conditions worsen. Our analyses of possible mechanisms that link economic conditions to child mental health suggest that parental unemployment cannot fully explain the relationship between economic conditions and child mental health.

▶ Therapeutic Education: A Lever to Change Perceptions of Bipolar Disorder in Family Caregivers

M'BAILARA K., MINOIS I., ZANOUY L., *et al.*

2019

Encéphale 45(3): 239-244.

The patient with bipolar disorder and his family are caught in a reciprocal interaction: on one hand, the pathology leads to family sufferings and on the other hand, family behavior affects the disease of the patient and its development. Therefore, it seems of core importance that the psychologist should work with the family on their perception of bipolar disorder, that is to say, on their knowledge and psychological representations of the pathology. The aim of our study is to assess whether the initial perception of bipolar disorder evolves after a therapeutic education program. Our research was conducted at the Bipolar Expertise Centre in Bordeaux/Centre Expert Bipolaire in Bordeaux on a sample of 145 participants (78patients and 67 family caregivers). They were all interviewed before and after the therapeutic education program (12 sessions in 6months). The Brief Illness Perception Questionnaire Revised (Moss-Morris, 2002) measures the perception of bipolar disorder and the BP Quizz (Fondation Fondamental) assesses the degree of knowledge of the disorder. Results show that therapeutic education helps families to level up their knowledge about bipolar disorder. Furthermore, representations on bipolar disorder have globally changed so that on average, bipolar disorder is viewed as less threatening by families after 12 sessions of therapeutic education. More precisely, after the program, families have a better understanding and a better insight of the disorder, which is then perceived as being less severe. On the emotional level, anxiety and stress have decreased. So there are an increase of knowledge and a change in perception. Our study shows that the therapeutic education program enables families to change their perception of the disease, that is to say, their knowledge but also their representations of the disease, which is a fundamental element according to the models of therapeutic education. Our results point out one of the active processes of therapeutic education at work in the sessions: in the perception of the disease, which is composed of both knowledge and representations of the disease, just a change in representations constitutes a lever for therapeutic education. Therefore, working on representations should be a therapeutic target. As a conclusion, we can say that therapeutic education of families cannot be reduced to an educational dimension which would only consist of gaining knowledge. Then, the right posture of the psychologist is to hold each participant's own development and changing process of representations.

Sociologie de la santé

Sociology of Health

Validation of a Tool to Assess Patient Satisfaction, Waiting Times, Healthcare Utilization, and Cost

EUBANK B. H., LAFAVE M. R., MOHTADI N. G., *et al.*

2019

Primary Health Care Research & Development 20: e47.

https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/validation-of-a-tool-to-assess-patient-satisfaction-waiting-times-healthcare-utilization-and-cost/C5F13EED7F1E9EF810E7C781ABCD8C8B

Patients' experience of the quality of care received throughout their continuum of care can be used to direct quality improvement efforts in areas where they are most needed. This study aims to establish validity and reliability of the Healthcare Access and Patient Satisfaction Questionnaire (HAPSQ) – a tool that collects patients' experience that quantifies aspect of care used to make judgments about quality from the perspective of the Alberta Quality Matrix for Health (AQMH).Background The AQMH is a framework that can be used to assess and compare the quality of care in different healthcare settings. The AQMH provides a common language, understanding, and approach to assessing quality. The HAPSQ is one tool that is able to assess quality of care according to five of six AQMH's dimensions. This was a prospective methodologic study. Between March and October 2015, a convenience sample of patients presenting with chronic full-thickness rotator cuff tears was recruited prospectively from the University of Calgary Sport Medicine Centre in Calgary, Alberta, Canada. Reliability of the HAPSQ was assessed using test–retest reliability [interclass correlation coefficient (ICC)>;0.70]. Validity was assessed through content validity (patient interviews, floor and ceiling effects), criterion validity (percent agreement >70%), and construct validity (hypothesis testing). Reliability testing was completed on 70 patients; validity testing occurred on 96 patients. The mean duration of symptoms was three years (SD: 5.0, range: 0.1–29). Only out-of-pocket utilization possessed an ICC<;0.70. Patients reported that items were relevant and appropriate to measuring quality of care. No floor or ceiling effects were present. Criterion validity was reached for all items assessed. A priori hypotheses were confirmed. The HAPSQ represents an inexpensive, reliable, and valid approach toward collecting clinical information across a patient's continuum of care.

Towards Explaining Time Trends in Adolescents' Alcohol Use: A Multilevel Analysis of Swedish Data from 1988 to 2011

KIM Y., EVANS B. E. ET HAGQUIST C.

2019

European Journal of Public Health 29(4): 729-735.

https://doi.org/10.1093/eurpub/ckz023

Alcohol use has decreased among Swedish adolescents in the past few decades. We examined peer and parent factors (i.e. time spent with peers, time spent with parents and parental monitoring) that could contribute to explaining this trend by investigating their main effects and interaction effects with investigation years on alcohol use. We furthermore examined whether municipality-level socioeconomic conditions could contribute to explaining the trend. We used data from a repeated cross-sectional study that took place eight times between 1988 and 2011. The study targeted all ninth grade students (15–16 years old) in Värmland County, Sweden. Adolescents (N = 22 257) reported their monthly alcohol use, time spent with peers and parents and parental monitoring. Municipality-level socioeconomic conditions were based on parent education levels. Logistic multilevel regression analyses showed that peer and parent factors and municipality-level socioeconomic conditions were associated with alcohol use among adolescents. The interaction effects between peer and parent factors and investigation years were not significant. The decreased trend in time spent with peers was associated with the decreased trend in frequency of alcohol use over time. The findings of the current study provide an indication that the decreased trend in alcohol use that has been observed in Swedish adolescents over the past few decades may be related to changes in adolescents' social interactions with peers.

L'analyse des parcours. Saisir la multidimensionalité du social pour penser l'action sociale

SANTELLI E.

2019

Sociologie 10(2): 153-171.

https://www.cairn.info/revue-sociologie-2019-2-page-153.htm

La notion de parcours est de plus en plus présente dans les travaux sociologiques français. Employée le plus souvent dans l'expression « parcours de vie », en référence au concept du life course, l'auteure s'attache en introduction à montrer le foisonnement de travaux qui reposent sur cette démarche. L'objet de cet article est ensuite de présenter sa démarche de recherche qu'elle qualifie d'analyse des parcours ; elle apparaît comme un sous-courant d'une sociologie des parcours. L'article vise à décrire ce qu'engage une analyse des parcours : que signifie faire une analyse des parcours ? Quel type de matériau cela nécessite-t-il de recueillir ? Pour y répondre, l'article propose tout d'abord de décrire les dynamiques temporelles et les logiques d'interdépendance qui sont au cœur de l'analyse des parcours. Ces dernières forment les deux principes de la démarche méthodologique. L'exemple empirique développé met en évidence le fait que pour saisir les dynamiques temporelles et les logiques d'interdépendance, il est nécessaire de distinguer, lors de l'observation, puis au cours de l'analyse, les niveaux micro-, meso- et macro-social. Cette articulation conduit à faire apparaître la multidimensionalité du social. La fin de l'article s'attache à montrer de quelle manière les contraintes sont « agissantes » et l'action nécessairement à resituer dans son contexte. Cette tension, dans les conditions de l'action sociale, est qualifiée d'individualisme contraint. Et c'est sur cette proposition d'interprétation du social que l'article se conclut.

Quand des malades transforment leur expérience du cancer en expertise disponible pour la collectivité. L'exemple d'un parcours diplômant à l'université des patients

TOURETTE-TURGIS C., PEREIRA PAULO L. ET VANNIER M.-P.

2019

Vie sociale 25-26(1): 159-177.

https://www.cairn.info/revue-vie-sociale-2019-1-page-159.htm

Cet article présente un programme de formation à l'université des patients à destination des malades qui désirent transformer leur expérience du cancer en expertise disponible pour la collectivité. Après avoir rappelé les fondements de l'université des patients et les enjeux de la création du diplôme, les auteures présentent le référentiel de formation en explicitant les choix pédagogiques qui le sous-tendent. Les problèmes que ce type d'innovation soulève dans les universités qui ne disposent pas d'une culture institutionnelle de l'accueil de publics malades et vulnérables sont également discutés ainsi que les conditions pédagogiques les plus propices à l'émergence des savoirs expérientiels, quand ceux-ci ont pour objectif d'aider des publics malades à transformer cette expérience en expertise disponible, légitimée et reconnue.

Soins de santé primaires

Primary Health Care

La permanence des soins non programmés : place du médecin généraliste à la lumière d'une expérience en Martinique

ASSOUVIE S., CRIQUET-HAYOT A., TIGNAC S., *et al.*

2019

Médecine : De la Médecine Factuelle à nos pratiques 15(4): 178-185.

Pourquoi les patients, en Martinique, privilégient-ils l'appel au centre 15 en journée pour les soins non programmés ? La régulation libérale est un acte médical, c'est la prise en charge des appels téléphoniques des patients ou de leurs proches pour une demande de soins non programmés. La régulation régionale de tous les appels urgents est assurée par le SAMU-Centre 15. Les médecins régulateurs hospitaliers du SAMU-Centre 15 de la Martinique allèguent un nombre important d'appels de médecine libérale en journée. Pour répondre à cette problématique, une phase d'expérimentation a été décidée par l'ARS pour étendre les plages de régulation libérale de 7 h à 17 h, hors permanence des soins ambulatoires libérale. L'objectif de notre étude est d'identifier les critères de choix qui conduisent les patients à privilégier l'appel au centre 15 en journée, dans le cadre des soins non programmés.

▶ Les facteurs de satisfaction professionnelle favorisant le maintien dans la profession des médecins généralistes libéraux français : revue systématique de la littérature

BISMUTH M., BIREBENT J., DRIOT D., *et al.*

2019

Médecine : De la Médecine Factuelle à nos pratiques 15(3): 138-144.

Le contexte actuel de crise des soins premiers, combiné aux nouvelles aspirations et responsabilités familiales des praticiens, sont à l'origine d'une pénurie en acteurs des soins de premier recours. Pour solutionner cette problématique, une nouvelle dynamique tend à s'intéresser aux aspects « positifs » de la Médecine générale. Pour cela il est important d'identifier les facteurs de satisfaction professionnelle des médecins généralistes libéraux français, favorisant leur maintien dans la profession.

▶ Soins de proximité : quels enjeux ?

BOURGUEIL Y.

2019

Actualité Et Dossier en Santé Publique(107): 18-21.

Réorganiser les soins de premiers recours passe par une transformation des modes de rémunération, la création de nouveaux métiers et la mise à la disposition d'outils permettant la coordination des soins et l'accompagnement des patients. Cet article porte une analyse sur l'ensemble de ces aspects.

▶ Effectiveness of Pro-Active Organizational Models in Primary Care for Diabetes Patients

BUJA A., FUSINATO R., CLAUS M., *et al.*

2019

Health Policy : 123(8) : 797-802

https://www.ncbi.nlm.nih.gov/pubmed/31176460

Demographic changes and chronicity are posing new challenges to health care systems. Our study aimed to examine how effectively the three different types of proactive primary care models adopted by three different regional health care systems in Italy were improving the quality of diabetes management by general practitioners. A coordinated Italian nationwide project to compare systematically the new proactive organizational models implemented at regional and local level (the MEDINA Project) involved several regions and their local health units (LHUs). A quasi-experimental study was conducted on a large dataset obtained by processing administrative databases. A combined indicator was developed to assess the quality of care delivered by primary care physicians, based on adherence to recommendations concerning patient monitoring and treatment. The study concerned 602 Italian general practitioners (GPs), 174 of them female, who were caring for a total of 753,366 patients (47,575 of them diabetic). Analyzing a total score, representing global adherence to a quality management of patients with diabetes, confirmed that GPs who had adopted the new model of care for their diabetic patients obtained better results than those who had not, so the new policy was generally effective. Our study showed that introducing new, proactive primary care models could sustain efforts made around the world to guarantee good-quality chronic disease management in the primary care setting.

▶ Service sanitaire : retour sur la première année de mise en oeuvre en Bourgogne-Franche-Comté

COURTOIS-DUBRESSON C., MANCA M. F., SIZARET A., *et al.*

2019

Actualité Et Dossier en Santé Publique 107): 4-8.

L'Ireps de Bourgogne Franche-Comté a organisé et accompagné sur le plan pédagogique la mise en oeuvre du service sanitaire des étudiants en santé. Cet article dresse un bilan de cette première année.

Primary Care Doctors' Understandings of and Strategies to Tackle Health Inequalities: A Qualitative Study

EXWORTHY M. ET MORCILLO V.

2019

Primary Health Care Research & Development 20: e20.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6536748/

The aim of this paper is to examine general practitioners' knowledge of and their role in tackling health inequalities, in relation to their professional responsibilities. Primary care is often seen as being in the frontline of addressing health inequalities and the social determinants of health (SDH). A qualitative study with a maximum variety sample of English General Practitioners (GPs). In-depth, semi-structured interviews were held with 13 GPs in various geographical settings; they lasted between 30 and 70 min. Interviews were audio-recorded and transcribed. The analysis involved a constant comparison process undertaken by both authors to reveal key themes. GPs' understanding of health inequalities reflected numerous perspectives on the SDH and they employ various different strategies in tackling them. This study revealed that GPs' strategies were changing the nature of (medical) professionalism in primary care. We locate these findings in relation to Gruen's model of professional responsibility (comprising a distinction between obligation and aspiration, and between patient advocacy, community participation and political involvement). We conclude that these GPs do not exploit the full potential of their contribution to tackling health inequalities. These findings have implication for policy and practice in other practitioners and in other health systems, as they seek to tackle health inequalities.

Construction et impact d'une coopération entre médecins généralistes et infirmières : le dispositif Asalée

FOURNIER C. ET MOUSQUES J.

2019

Actualité Et Dossier en Santé Publique (107): 31-33.

La coopération entre médecins généralistes et infirmières est considérée comme un levier pour améliorer les conditions, l'organisation et la qualité du travail en soins de premier recours, voire la performance. En France, le dispositif action de santé libérale en équipe (Asalée) expérimente depuis 2004 la coopération entre médecins généralistes et infirmières Asalée. Il offre un cadre pour le développement de pratiques avancées infirmières, comprenant notamment des tâches de dépistage, de suivi et d'éducation thérapeutique. À travers une synthèse des enseignements tirés des travaux de recherche évaluative conduits sur le dispositif, cet article a pour objet de discuter de l'opportunité et des conditions de développement de telles pratiques dans un contexte prévoyant en 2019, suite à la reconnaissance en 2018 d'un métier et d'un diplôme d'infirmier en pratiques avancées, de nouvelles mesures relatives à leurs rémunérations et à la modalité d'exercice en maisons et centres de santé pluri-professionnels.

Is There a Golden Recipe? A Scoping Review of Public Health Workforce Development

GERSHUNI O., CZABANOWSKA K., BURAZERI G., *et al.*

2018

European Journal of Public Health 29(3): 401-408.

https://doi.org/10.1093/eurpub/cky247

This study intended to design a suitable and comprehensive approach for a public health workforce development plan with the ultimate goal of meeting the health objectives in different European Region countries. We performed a scoping review, including an accurate and exhaustive country-specific hand-search process, mapping the key concepts and practices used in public health workforce development based on the available evidence worldwide. We identified nine comparative measures, based on common features from a scoping literature review, for the assessment of public health workforce development plans available in selected countries. This list of nine comparative measures includes: (i) Alignment between the 10 Essential Public Health Operations (EPHOs) or core public health functions and organizational resources and public health priority areas; (ii) Regulations and Norms; (iii) Capacity Assessment; (iv) Datasets and Databases; (v) Workforce Development Strategies, Planning and Management; (vi) Education, Training, Core Competencies and Models; (vii) Licensing, Accreditation and Credentialing; (viii) Forecasting Strategies for Enumerating and Quotas and (ix) Ethical and Professional Codes of Conduct. These measures are essential to develop, sustain and modernize the public health workforce effectively. We propose a well-balanced set of measures for countries aiming to improve or develop their public health workforce based on instruments that are successfully used and applied in a wide range of countries with different public health systems. However, the implementation should be tailored and adopted according to the specific country context and available recourses.

Représentations et expériences des soins premiers chez les migrants bénéficiaires de l'aide médicale de l'Etat

JEGO-SABLIER M., T., VERGAN S., *et al.*

2019/06

Exercer(154): 244-249.

Les migrants en situation irrégulière ont un état de santé dégradé par rapport à la population générale. Malgré le dispositif d'aide médicale de l'État (AME) permettant le remboursement de leurs soins de santé, ils font face à de multiples barrières à l'accès aux soins. L'objectif de cette étude est d'explorer les représentations et expériences des soins premiers des migrants bénéficiaires de l'AME. Une étude qualitative a été menée auprès de migrants bénéficiaires de l'AME, recrutés par échantillonnage raisonné via leurs médecins généralistes et lors de consultations de Protection maternelle et infantile, entre décembre 2016 et avril 2017. Des entretiens semi-dirigés ont exploré les représentations des soins et attentes des bénéficiaires de l'AME vis-à-vis de leur médecin généraliste (MG). Ils ont fait l'objet d'une analyse de contenu inductive. Au total, 14 patients ont été interviewés. L'irrégularité de séjour, associée à la vulnérabilité sociale et sanitaire de ces patients, façonnaient leurs représentations sur les soins de santé. Le recours aux soins premiers dépendait de la qualité du tissu social spécifique (associations, liens communautaires, travailleurs sociaux) sur lequel s'appuyaient ces patients. Les patients attendaient du MG des compétences principalement relationnelles et une prise en charge adaptée à leur contexte social. Bien que théoriquement non concernés par le parcours médecin traitant, ils identifiaient souvent ou souhaitaient pouvoir identifier leur MG comme « médecin traitant ». Le tissu social spécifique des migrants bénéficiaires de l'AME est déterminant dans leur recours aux soins premiers. L'approche centrée sur le patient, intégrant la prise en compte de leur condition sociale, et favorisant une relation médecin-patient de qualité, est un positionnement particulièrement nécessaire pour améliorer l'expérience des soins de ces patients.

Rôle des médecins dans l'éducation pour la santé à l'école. Analyse d'une expérience pluri-professionnelle originale

LE GLATIN C., GUERIN X., BERRY P., *et al.*

2019

Santé Publique 31(2): 203-212.

https://www.cairn.info/revue-sante-publique-2019-2-page-203.htm

L'Espace Santé Jeune (ESJ) est un projet d'éducation pour la santé menée depuis 2008 dans un collège français. Les collégiens sont invités à participer à des espaces de parole sur la santé, animés par un médecin généraliste (MG) accompagné d'un animateur jeunesse de la commune ou d'un enseignant. Cette étude cherche à comprendre le rôle des médecins et à identifier les leviers du projet à partir du vécu des acteurs. Une étude de méthode mixte a été menée de janvier à juin 2015 par entretiens collectifs, individuels et questionnaire. Les résultats de l'analyse inductive par théorisation ancrée ont été confrontés aux résultats quantitatifs. 30 participants ont été inclus dans l'enquête qualitative (20 élèves, 5 enseignants, 4 MG, 1 animateur jeunesse) et 107 élèves ont répondu au questionnaire (taux de réponse 71 %). L'ESJ est un espace centré sur la parole des jeunes, vécu comme un moment de liberté et apprécié par 70 % des participants. Le rôle des MG pendant les séances oscille entre « animation des débats » et « expertise », et la complémentarité des compétences avec les professionnels éducatifs facilite leur intervention. Au-delà des séances, la présence des MG est perçue comme indispensable car leur statut amène une légitimité globale au projet. L'intervention repose sur l'engagement des professionnels, la pluri-professionnalité, la coordination et le partage d'une culture commune de la prévention. L'ESJ est une expérience originale encourageant l'investissement de MG dans des actions locales de santé publique.

Le nombre de consultations dans l'année est-il un signe objectif de troubles somatoformes ?

MEDERER C., KANDEL O. ET EL OUAZZANI H.

2019

Médecine : De La Médecine Factuelle à nos pratiques 15(5): 228-232.

Le médecin de premier recours organise sa pensée clinique selon la fréquence des maladies. Il envisage de prime abord les hypothèses les moins rares. La notion de diagnostic d'élimination est donc chronophage et régulièrement anxiogène pour les patients. C'est le cas des troubles psychosomatiques qui représenteraient plus d'un tiers des étiologies. Bénéficier d'un signe clinique objectif, facile à constater, serait précieux pour oser évoquer plus sereinement cette étiologie fréquente. Cette étude s'est attachée à savoir si le nombre de consultations dans l'année pourrait être un signe objectif de troubles somatoformes ? Il suffirait alors de compter en début de consultation le nombre d'actes dans l'année écoulée.

▶ Gender Differences in the Incomes of Self-Employed French Physicians: The Role of Family Structure

MIKOL F. ET FRANC C.

2019

Health Policy 123(7): 666-674.

https://www.sciencedirect.com/science/article/abs/pii/S0168851019301095

In most developed countries, the average income of female physicians remains much lower than that of their male counterparts. This paper analyses how much of the gender earnings gap among French self-employed physicians can be attributed to women's family responsibilities, choice of medical specialty, and opportunity to charge extra billings. The question is of growing concern for regulators because it may influence patients' future access to care. We used an exhaustive administrative database that merges information on the medical activity, earnings, and family structure of self-employed doctors in 2005, 2008, and 2011. Using the 2011 database, results suggest that when demographic and professional characteristics are controlled, female physicians still exhibit an annual earnings gap that varies according to family structure: having young children worsens the situation of female physicians, particularly GPs. Using our panel datasets from 2005, we show that there is a 'carer effect' of having children for female doctors that exacerbates the gender income gap, particularly for GPs. We do not highlight any real strategic behaviour of female specialists authorised to charge extra fees to increase their extra billings after a birth to maintain their previous income.

▶ Erratum to "Gender Differences in the Incomes of Self-Employed French Physicians: The Role of Family Structure" [Health Policy 123 (2019) 666–674]

MIKOL F. ET FRANC C.

2019

Health Policy : Ahead of pub.

http://www.sciencedirect.com/science/article/pii/S0168851019301605

▶ Are People's Health Care Needs Better Met when Primary Care Is Strong? A Synthesis of the Results of the QUALICOPC Study in 34 Countries

SCHÄFER W. L. A., BOERMA W. G. W., VAN DEN BERG M. J., *et al.*

2019

Primary Health Care Research & Development 20: e104.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6609545/

This article synthesises the results of a large international study on primary care (PC), the QUALICOPC study. Since the Alma Ata Declaration, strengthening PC has been high on the policy agenda. PC is associated with positive health outcomes, but it is unclear how care processes and structures relate to patient experiences. Survey data were collected during 2011–2013 from approximately 7000 PC physicians and 70 000 patients in 34, mainly European, countries. The data on the patients are linked to data on the PC physicians within each country and analysed using multilevel modelling. Patients had more positive experiences when their PC physician provided a broader range of services. However, a broader range of services is also associated with higher rates of hospitalisations for uncontrolled diabetes, but rates of avoidable diabetes-related hospitalisations were lower in countries where patients had a continuous relationship with PC physicians. Additionally, patients with a long-term relationship with their PC physician were less likely to attend the emergency department. Capitation payment was associated with more positive patient experiences. Mono- and multidisciplinary co-location was related to improved processes in PC, but the experiences of patients visiting multidisciplinary practices were less positive. A stronger national PC structure and higher overall health care expenditures are related to more favourable patient experiences for continuity and comprehensiveness. The study also revealed inequities: patients with a migration background reported less positive experiences. People with lower incomes more often postponed PC visits for financial reasons. Comprehensive and accessible care processes are related to less postponement of care. The study revealed room for improvement related to patient-reported experiences and highlighted the importance of core PC characteristics including a continuous doctor–patient relationship as well as a broad range of services offered by PC physicians.

Continuity of GP Care After the Last Hospitalization for Patients Who Died from Cancer, Chronic Obstructive Pulmonary Disease or Heart Failure: A Retrospective Cohort Study Using Administrative Data

VAN DER PLAS A. G. M., OOSTERVELD-VLUG M. G., PASMAN H. R., *et al.*

2018

Family Practice 36(3): 304-309.

https://doi.org/10.1093/fampra/cmy065

Discharge from hospital to home can be a stressful experience for patients and carers. Contact with the GP is important to ensure continuity of care. To investigate timing of contact with the GP and locum after the last hospitalization in the last year of life and to investigate patient and care characteristics related to contact with the GP within 2 days after discharge. Health insurance data were combined with data from Statistics Netherlands on patients who mainly received care at home in the last 4 months of life. Patients who died from cancer (n = 3014), chronic obstructive pulmonary disease (COPD, n = 195) or heart failure (n = 171) were compared. First contact after hospital discharge was within 2 days for 51.7% of patients and within a week for 77.8% of patients. Patients who died from COPD or heart failure had contact less often than patients with cancer. Characteristics related to having contact within 2 days after discharge were older age, cause of death cancer, home death, timing of last hospitalization closer to death and contact with a locum in the week after discharge. Results may indicate that the GP is likely to visit patients with more care needs sooner. This would be in accordance with the finding that contact with the GP was more likely after a hospitalization closer to death and that contact within 2 days was related to contact with a locum within a week after discharge. Proactive care is necessary. This is a joint responsibility of GPs and medical specialists.

Soins de proximité : vers un exercice d'équipe

VARROUD-VIAL M., BOURGUEIL Y., RIVET E., *et al.*

2019

Actualité Et Dossier en Santé Publique (107): 9-47.

Garantir l'accès aux soins, c'est permettre aux habitants d'un territoire, quel qu'il soit, de bénéficier de services pertinents et de qualité. Chacun doit pouvoir avoir un médecin traitant, avoir accès à une consultation spécialisée dans des délais appropriés ; bénéficier d'un suivi et d'une orientation en cas de de pathologie chronique. Un réel trait d'union entre médecine de ville et établissements de santé renforcera la qualité et l'efficience de la prise en charge en proximité. Ce dossier présente les organisations mises en place pour favoriser le travail d'équipe.

Skilled Nursing Facility Participation in Medicare's Bundled Payments for Care Improvement Initiative: A Retrospective Study

WEISSBLUM L., HUCKFELDT P., ESCARCE J., *et al.*

2019

Archives of Physical Medicine and Rehabilitation 100(2): 307-314.

https://www.ncbi.nlm.nih.gov/pubmed/30291827

The aim of this study is to investigate differences in facility characteristics, patient characteristics, and outcomes between skilled nursing facilities (SNFs) that participated in Medicare's voluntary Bundled Payments for Care Improvement (BPCI) initiative and nonparticipants, prior to BPCI. Retrospective, cross-sectional comparison of BPCI participants and nonparticipants was conducted. All Medicare-certified SNFs (N = 15,172) and their 2011-2012 episodes of care for chronic obstructive pulmonary disease, congestive heart failure, femur and hip/pelvis fracture, hip and femur procedures, lower extremity joint replacement, and pneumonia (N = 873,739). Participation consisted in a bundled payment program that included taking financial responsibility for care within a 90-day episode. This study investigates the characteristics of bundled payment participants and their patient characteristics and outcomes relative to nonparticipants prior to BPCI, to understand the implications of a broader implementation of bundled payments. SNFs participating in BPCI were more likely to be in urban areas (80.8%-98.4% vs 69.5%) and belong to a chain or system (73.8%-85.5% vs 55%), and were less likely to be located in the south (13.1%-20.2% vs 35.4%). Quality performance was similar or higher in most cases for SNFs participating in BPCI relative to nonparticipants. In addition, BPCI participants admitted higher socioeconomic status patients with similar clinical characteristics. Initial SNF length of stay was shorter and hospital readmission rates were lower for BPCI patients compared to nonparticipant patients. We found that SNFs participating in the second financial risk-bearing phase of BPCI represented a diversity of SNF types, regions, and levels of quality and the results may provide insight into a broader adoption of bundled payment for postacute providers.

▶ Predicting Primary Care Use Among Patients in a Large Integrated Health System: The Role of Patient Experience Measures

WONG E. S., MACIEJEWSKI M. L., HEBERT P. L., *et al.*

2019

Medical Care 57(8): 608-614.

https://journals.lww.com/lww-medicalcare/Fulltext/2019/08000/Predicting_Primary_Care_Use_Among_Patients_in_a.6.aspx

Most Veterans Affairs (VA) Health Care System enrollees age 65+ also have the option of obtaining care through Medicare. Reliance upon VA varies widely and there is a need to optimize its prediction in an era of expanding choice for veterans to obtain care within or outside of VA. We examined whether survey-based patient-reported experiences improved prediction of VA reliance. VA and Medicare claims in 2013 were linked to construct VA reliance (proportion of all face-to-face primary care visits), which was dichotomized (= 1 if reliance >50%). We predicted reliance in 83,143 Medicare-eligible veterans as a function of 61 baseline characteristics in 2012 from claims and the 2012 Survey of Healthcare Experiences of Patients. We estimated predictive performance using the cross-validated area under the receiver operating characteristic (AUROC) curve, and assessed variable importance using the Shapley value decomposition. In 2012, 68.9% were mostly VA reliant. The AUROC for the model including claims-based predictors was 0.882. Adding patient experience variables increased AUROC to 0.890. The pseudo R2 for the full model was 0.400. Baseline reliance and patient experiences accounted for 72.0% and 11.1% of the explained variation in reliance. Patient experiences related to the accessibility of outpatient services were among the most influential predictors of reliance. The addition of patient experience variables slightly increased predictive performance. Understanding the relative importance of patient experience factors is critical for informing what VA reform efforts should be prioritized following the passage of the 2018 MISSION Act.

Systèmes de santé

Health Systems

▶ A Path to High-Quality Team-Based Care for People with Serious Illness

VAN HOUTVEN C.H., HASTING S.N., COLON EMERIC C.

2019

Health Affairs 38(6): 934-940.

Although most care for people with serious illness is delivered by multiple providers and agencies, there is no gold standard for how to assemble, train, unify, and sustain strong teams. Using lessons from complexity science, a way of studying complex systems, we propose improving team connections; the quality, quantity, and timeliness of information flow; and the purposeful seeking of diverse perspectives to interpret information and make decisions as a means of driving effective self-organization of teams and leading to high-quality outcomes. We highlight an adaptable intervention that helped improve connections, information flow, and cognitive diversity and resulted in effective self-organization in the Department of Veterans Affairs health care system. Finally, we describe challenges to building teams across systems and sectors, and we present research priorities for spreading a complexity science–based approach to optimize teams that care for people with serious illness.

▶ Uncomfortable Trade-Offs: Canadian Policy Makers' Perspectives on Setting Objectives for Their Health Systems

ABELSON J., ALLIN S., GRIGNON M., *et al.*

2017

Health Policy 121(1): 9-16.

https://www.ncbi.nlm.nih.gov/pubmed/27894606

Although a wide range of health system performance indicators are commonly reported on, there has been little effort to establish their relevance to the objectives that health systems actually pursue. The aim of this study was to identify, explore and better understand health policy makers' views regarding the objectives and outcomes for their health systems, how they are prioritized, and the underlying processes that yield them to inform the development of health system efficiency measures. A descriptive, qualitative methodology was employed using key informant interviews with 17 current and former senior health ministry officials in 8 Canadian provinces and 2 territories. Health ministries have clearly stated objectives for health systems focused on the achievement of health system delivery and population health goals and, increasingly, public, patient and financial accountability. Acute care objectives are routinely prioritized over population health objectives and viewed as resulting from challenges associated with difficult trade-off decisions shaped by organized interests and the media rather than explicit, evidence-based processes. This study provides insights beyond publicly available documents to explore the processes that underlie simple statements of health system objectives. Our findings suggest that despite respondents giving priority to improving individual and population health, it is more commonly portrayed as an ideal objective than as a realistic one. By understanding what lies behind statements about what health systems are striving for, we offer a more robust avenue for increasing the uptake of future studies of health system performance.

▶ Worlds of Healthcare: A Healthcare System Typology of OECD Countries

REIBLING N., ARIAANS M. ET WENDT C.

2019

Health Policy 123(7): 611-620.

http://www.sciencedirect.com/science/article/pii/S0168851019301083

In this paper, we present an extended typology of OECD healthcare systems. Our theoretical framework integrates the comparative-institutional perspective of existing classifications with current ideas from the international health policy research debate. We argue that combining these two perspectives provides a more comprehensive picture of modern healthcare systems and takes the past decade's dynamic of reforms into account. Moreover, this approach makes the typology more beneficial in terms of understanding and explaining cross-national variation in population health and health inequalities. Empirically, we combine indicators on supply, public-private mix, and institutional access regulations from earlier typologies with information on primary care orientation and performance management in prevention and quality of care. The results from a series of cluster analyses indicate that at least five distinct types of healthcare systems can be identified. Moreover, we provide quantitative information on the consistency of cluster membership for individual countries via system types.

Travail et santé

Occupational Health

Qualité de vie au travail de jeunes médecins hospitaliers : satisfaits malgré tout...

ALCARAZ-MOR R., VIGOUROUX A., URCUN A., *et al.*

2019

Santé Publique 31(1): 113-123.

https://www.cairn.info/revue-sante-publique-2019-1-page-113.htm

Les prévalences de dépression, d'idées suicidaires et de syndrome d'épuisement professionnel sont plus élevées chez les médecins par rapport à la population générale. Alors que les jeunes médecins semblent davantage concernés, en France, peu de travaux se sont intéressés spécifiquement aux facteurs de qualité de vie au travail de cette population. L'objectif de cette étude est d'identifier les facteurs de stress liés à l'organisation du travail et aux relations sociales au travail, tels qu'ils sont perçus par les jeunes médecins hospitaliers. Une enquête qualitative par entretiens semi-dirigés a été réalisée auprès de praticiens hospitaliers ayant moins de 10 années d'exercice. Une analyse manuelle du contenu des entretiens a été réalisée par trois enquêteurs et complétée par une analyse lexicale informatisée. Dix-huit praticiens ont été interrogés. Cinq grandes catégories de contraintes psycho-sociales et organisationnelles ont été identifiées. Le travail en équipe et la communication sont globalement associés à un ressenti positif. Le rythme de travail, le statut professionnel, les facteurs organisationnels et les conditions matérielles sont jugés insatisfaisants. Les jeunes médecins sont cependant satisfaits du contenu de leur travail, notamment du fait de l'émulation scientifique et du développement des compétences. Les résultats de cette étude devraient permettre de mieux cibler les actions de prévention afin d'améliorer les conditions de travail des jeunes médecins. Il apparaît prioritaire de réduire leur charge de travail ou de réglementer leur temps d'activité, d'offrir une meilleure stabilité à leur emploi et de leur procurer de meilleures conditions matérielles d'exercice.

Inequities in Occupational Diseases Recognition in France

GEHANNO J. F., LETALON S., GISLARD A., *et al.*

2019

Rev Epidemiol Sante Publique 67(4): 247-252.

In France, complex cases of occupational disease (OD) are submitted to regional committees who are in charge of accepting, or rejecting, the claim. Their mean annual acceptance rate varies from one region to another, which may reflect differences in the cases, or discrepancies between committees. The objective of this study was to assess the comparability of the decisions of the committees on the basis of standardized cases. Three experienced occupational physicians specialized in OD were asked to develop 28 clinical cases representative of claims for compensation usually seen in these committees. The cases, in the form of short vignettes, were submitted to the 18 French regional committees, asking if they would recognise each case as an OD. RESULTS: All committees participated. The acceptance rate (recognition of the case as an OD) varied, ranging from 18% to 70%. All the committees took the same decision for only 7 out of the 28 cases, but half accepted and half refused for 3 cases. For 10 cases, one quarter of the committees gave a decision different than the other 75%. The highest discordance rates were observed for the cases concerning musculoskeletal disorders and asbestos related diseases. The committees take very different decisions in terms of recognition of OD, especially for the most frequently compensated OD in France, i.e. musculoskeletal disorders and asbestos related diseases. This is a major source of injustice for the employees who seek compensation and there is a need to develop methods to harmonize decisions between committees.

L'inaptitude médicale en France et en Espagne

MARTINEZ-GIJON MACHUCA M.A..

2019

Droit Social(7/8): 599-607.

Tandis que le licenciement pour inaptitude médicale en France suit une procédure précise, où le médecin du travail et le reclassement joue un rôle essentiel, le droit espagnol est plus informel et relatif. Les deux régimes juridiques sont à ce jour en pleine évolution, le premier rendant vers une plus grande flexibilité, le second rattrapé par la jurisprudence communautaire et sa politique d'aménagements du poste de travail avant le licenciement.

Consulter un patient en situation de perte d'emploi. Partie 1 : entrevoir le contexte et différentier les typologies des pertes d'emploi

OUALI I., DEBOUT M., FONTANA L., *et al.*

2019

Médecine : De la Médecine Factuelle à nos pratiques 15(3): 131-137.

Le médecin généraliste (MG) est régulièrement consulté par des personnes en situation de perte d'emploi. Des estimations modélisent que le chômage serait responsable en France de 14 000 morts par an et de quelques centaines de suicides. Dans ce premier article, nous nous emploierons à faire une revue de la littérature afin de mettre en lumière le développement du chômage de masse, de définir la crise de la perte d'emploi et ses typologies. Puis, dans un deuxième article, nous décrirons l'épidémiologie du phénomène. Enfin, un troisième nous permettra d'élaborer un référentiel de pratique en MG et décrira la place des différents acteurs impliqués dans l'accompagnement et le soutien de la personne en situation de perte d'emploi. Ce travail configure une sorte de médecine du chômage à l'instar de la médecine du travail.

Consulter un patient en situation de perte d'emploi. Partie 2 : de la situation à risque à la pathologie

OUALI I., DEBOUT M., FONTANA L., *et al.*

2019

Médecine : De la Médecine Factuelle à nos pratiques 15(4): 173-177.

Le médecin généraliste (MG) est régulièrement consulté par des personnes en situation de perte d'emploi. Des estimations modélisent que le chômage serait responsable en France de 14 000 morts par an et de quelques centaines de suicides. Dans un premier article, nous nous sommes employés à faire une revue de la littérature afin de mettre en lumière le développement du chômage de masse, de définir la crise de la perte d'emploi et ses typologies. Dans ce deuxième article, nous décrivons l'épidémiologie du phénomène. Enfin, un troisième nous permettra d'élaborer un référentiel de pratique en MG et décrira la place des différents acteurs impliqués dans l'accompagnement et le soutien de la personne en situation de perte d'emploi. Ce travail configure une sorte de médecine du chômage à l'instar de la médecine du travail.

Hausse des troubles psychiques reconnus d'origine professionnelle

REVUE PRESCRIRE

2019

Revue Prescrire 39(430): 617-619.

En France, les troubles psychiques reconnus comme accidents du travail ou maladies professionnelles sont en hausse. En 2016, 10 000 cas de troubles psychiques (dépressions, troubles anxieux, états de stress post-traumatique, etc.) ont été reconnus au titre des accidents du travail, et 600 au titre des maladies professionnelles. Les arrêts de travail sont en moyenne de 112 jours pour les troubles psychiques reconnus comme accidents du travail (soit deux fois plus longtemps que pour l'ensemble des accidents du travail, toutes causes confondues), et de 400 jours en cas de maladie professionnelle. Dans environ 6 cas sur 10, les troubles psychiques concernent des femmes, parce qu'elles sont davantage présentes dans des métiers exposant davantage aux risques psychosociaux. Le secteur médico-social, le transport de voyageurs et le commerce de détail concentrent près de la moitié des troubles psychiques reconnus comme accidents du travail. Ces données ont des limites, notamment parce qu'elles ne portent que sur une fraction des salariés, principalement du secteur privé, et que tous les troubles psychiques liés au travail ne sont pas déclarés. Selon des estimations établies notamment par l'Institut national de la santé et de la recherche médicale (Inserm), 120 000 à 400 000 personnes seraient atteintes de troubles psychiques liés au travail. La sous-déclaration résulte de plusieurs facteurs : opposition des employeurs à faire la déclaration, craintes des salariés pour leur emploi, réticence ou information insuffisante des médecins. Ces diverses limites ne permettent pas de savoir quelle part de l'augmentation constatée des troubles psychiques reconnus comme liés au travail relève d'une hausse réelle des risques psycho-sociaux, ou d'une plus grande prise de conscience de la part des travailleurs et des médecins.

Impact of Unemployment on Self-Perceived Health

RONCHETTI J. ET TERRIAU A.

2019

The European Journal of Health Economics 20(6): 879-889.

https://doi.org/10.1007/s10198-019-01050-5

This article investigates the impact of unemployment on self-perceived health using the French Longitudinal Labour Force Survey over the period 2013–2016. We apply a difference-in-difference propensity score matching approach to identify the health effect of unemployment. By combining both methods, we minimise selection bias and remove unobserved individual fixed effects that are time-invariant as well as common period effects. In the French context, characterised by high and persistent unemployment and relatively long unemployment spells, we show that the experience of unemployment has no significant effect on self-perceived health. Moreover, we find no heterogenous effect by carrying out separate analyses by age, gender, marital status, education, occupation, employment contract, local unemployment rate, or past labour market history. Robustness checks, performed by testing alternative types of matching technology, different definitions of the unemployment experience, and other measures of health confirm our findings. Health selection and confounding factors appear to be important determinants of the cross-sectional association between unemployment and poor health.

Arrêts de travail pour maladie : souhaits et propositions des médecins généralistes

TETE M., TROMBERT B. ET VALLEE J.

2019

Médecine : De la Médecine Factuelle à nos pratiques 15(4): 163-170.

La prescription des arrêts de travail pour maladie (ATM) pose problème aux médecins généralistes (MG). L'objectif de cette étude est d'analyser l'opinion des MG sur des propositions issues de deux enquêtes concernant la gestion des ATM et les référentiels d'ATM de l'assurance-maladie. Les MG prescrivant 75 % des ATM en ville, la gestion, la réglementation, l'harmonisation des ATM pourraient être uniformisées dans les différents régimes sociaux, à l'aide de propositions consensuelles : autocertification, délégation des ATM de longues durées, délai de carence.

Perceived Job Insecurity and Self-Rated Health: Testing Reciprocal Relationships in a Five-Wave Study

URBANAVICIUTE I., DE WITTE H. ET ROSSIER J.

2019

Social Science & Medicine 233: 201-207.

The present study aims to investigate the pattern of cross-lagged relationships between job insecurity and self-rated health over a period of five years. While health complaints are usually seen as one of the detrimental outcomes of job insecurity, the question of the direction of the job insecurity-health relationship has not yet been fully resolved. Only a few longitudinal studies have explicitly aimed to test the possibility of reciprocal or reverse effects, and even fewer studies have used multi-wave designs to examine the pattern of these relationships. Objective The current study aims to address this gap by testing how cross-lagged relationships between job insecurity and self-rated health status unfold over time. We conducted this study with a sample of the working population in Switzerland (N = 928), using the data from five consecutive measurement occasions, each separated by a one year lag. Cross-lagged structural equation modelling was performed to examine the direction of the effects. The results revealed an interchangeable direction of the relationship between job insecurity and health over time. T1 job insecurity predicted lower ratings of health at T2, which then predicted job insecurity at T3, which, in turn, was related to lower health at T4. The only exception was observed in the last follow-up (i.e., T4 to T5), where no evidence of cross-lagged relationships between job insecurity and self-rated health was found. These findings contribute to the literature suggesting that, not only may job insecurity predict later health impairment, but that in some cases; the reverse may be possible too. Researchers and policy makers need to consider this important message because the observed lagged reciprocal effects between job insecurity and health seem to form a negative cycle over time, thereby implying a dual process in the development of workplace vulnerabilities.

Vieillissement

Ageing

The 2015 Long-Term Care Reform in the Netherlands: Getting the Financial Incentives Right?

ALDERS P. ET SCHUT F. T.

2019

Health Policy 123(3): 312-316.

In 2015 the system of long-term care (LTC) financing and provision in the Netherlands was profoundly reformed. The benefits covered by the former comprehensive public LTC insurance scheme were split up and allocated to three different financing regimes. The objectives of the reform were to improve the coordination between LTC, medical care and social care, and to reinforce incentives for an efficient provision of care by making risk-bearing health insurers and municipalities responsible for procurement. Unintentionally, the reform also created a number of major incentive problems, however, resulting from the way: (i) LTC benefits were split up across the three financing regimes; (ii) the various third party purchasers were compensated; and (iii) co-payments for the beneficiaries were designed. These incentive problems may result in cost shifting, lack of coordination between various LTC providers, inefficient use of LTC services and quality skimping. We discuss several options to get the financial incentives better aligned with the objectives of the reform.

Advance Directives in European Long-Term Care Facilities: A Cross-Sectional Survey

ANDREASEN P., FINNE-SOVERI U. H., DELIENS L., *et al.*

2019

BMJ Supportive & Palliative Care:Ahead of pub

End-of-life care practices in long-term care facilities (LTCFs) are the focus of growing attention in Europe, due to rapidly increasing number of older persons living in LTCFs. The knowledge about end-of-life discussions or existence of written advance directives in the European LTCFs is scarce. This study's aim is to investigate the prevalence of written advance directives and their sociodemographic associates, among recently deceased LTCF residents, in six European countries. Data from the European Union-funded PACE database were collected from 322 LTCFs in six European countries in 2014. The assessments were performed by using two questionnaires designed for LTCF administrative staff and for staff member. LTCFs were selected within each country by using proportional stratified random sampling procedure. Facilities with certain types and sizes were included from each country. Multilevel multivariate analyses were performed to evaluate associations between written advance directives and selected predictors. In total, 32.5% of the 1384 deceased LTCF residents had a written advance directive with a range from 0% to 77% between countries. The proportion of the most common advance directive, 'Do not resuscitate in case of cardiac or respiratory arrest (DNR)', varied correspondingly from 0% to 75%.LTCF type (OR 2.86 95% CI 1.59 to 5.23) and capability of expressing at the time of admission (OR 3.26 95% CI 2.26 to 4.71) were the independent predictors for advance directive. Residents living in LTCFs where physician was available were less likely to have advance directive compared with residents from LTCFs where physician was not available. Extensive differences for prevalence of written advance directive exist between countries among older LTCF residents in Europe. Timely and appropriate response to LTCF resident's health needs and preferences efforts advance care planning.

Aging at Home: A Portrait of Home-Based Primary Care Across Canada

AKHTAR S., LOGANATHAN M., NOWACZYNSKI M., *et al.* (2019

2019

Healthcare Quarterly 22(1): 30-35.

https://www.ncbi.nlm.nih.gov/pubmed/31244465

Older adults and their families often struggle in navigating an increasingly fragmented healthcare system when it becomes increasingly difficult to receive care beyond their homes in the face of advanced illness, frailty and complex care needs. The provision of integrated home-based primary care has demonstrated improved patient and caregiver experiences and reduced healthcare costs when primary care providers collaborate in delivering care as part of larger interprofessional teams. In this trans-Canada portrait of five urban home-based primary care programs, their core features are highlighted to provide a roadmap on how to integrate this form of care into a Patient's Medical Home in partnership with acute and home-care providers.

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. Une recherche qualitative a été conduite 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). 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.

Vieillissement en ville et villes en vieillissement

BUHNIK S.

2019

L'Information géographique 83(2): 122-139.

https://www.cairn.info/revue-l-information-geographique-2019-2-page-122.htm

Le vieillissement transforme la physionomie des villes et des sociétés contemporaines ; il ne reçoit pourtant pas l'écho scientifique et médiatique accordé à d'autres transitions (comme le réchauffement climatique ou la transition numérique). Partant du constat d'un déficit de recherche théorique sur les interactions entre vieillissement et production urbaine, cet article rappelle d'abord le caractère multidimensionnel des relations entre ville et vieillissement. La complexité de ces interactions est liée d'une part à la pluralisation des expériences individuelles de l'avancée en âge, d'autre part à une diversification des territoires où la part des seniors augmente. En s'appuyant sur des recherches critiques envers la promotion du « vieillissement actif » dans les politiques publiques, nous montrons ensuite comment un fort taux de vieillissement met les collectivités territoriales aux prises, non seulement avec des besoins d'adaptation des tissus bâtis, mais encore avec un problème de continuité résidentielle. En effet, assurer l'accès des habitants âgés à des ressources de proximité suppose un dynamisme intergénérationnel à l'échelle des quartiers. Or c'est justement dans les parcs immobiliers où les occupants sont en majorité des propriétaires âgés, que cette condition s'avère la plus difficile à remplir.

Care Management for Older Adults: The Roles of Nurses, Social Workers, and Physicians

DONELAN K., CHANG Y., BERRETTE-ABEBE J., *et al.*

2019

Health Affairs 38(6): 941-949.

Care management programs have become more widely adopted as health systems try to improve the coordination and integration of services across the continuum of care, especially for frail older adults. Several models of care suggest the inclusion of registered nurses (RNs) and social workers to assist in these activities. In a 2018 national survey of 410 clinicians in 363 primary care and geriatrics practices caring for frail older adults, we found that nearly 40 percent of practices had no social workers or RNs. However, when both types of providers did work in a practice, social workers were more likely than RNs to be reported to participate in social needs assessment and RNs more likely than social workers to participate in care coordination. Physicians' involvement in social needs assessment and care coordination declined significantly when social workers, RNs, or both were employed in the practice.

▶ Trouver des systèmes de production qui respectent d'abord les plus fragiles. Entretien avec Alfred Spira

GAUDILLIÈRE J.-P.

2019

Mouvements 98(2): 83-94.

https://www.cairn.info/revue-mouvements-2019-2-page-83.htm

Alfred Spira a dirigé les unités de recherche « Santé publique, épidémiologie, reproduction humaine » (1986-1997), puis « Recherches en santé publique » (1998-2001) à l'Inserm et créé en 2007 l'Institut de recherche en Santé publique (IReSP). Il a notamment coordonné avec Nathalie Bajos, de 1988 à 2000, la grande enquête ACSF (« analyse des comportements sexuels en France ») dans le cadre de la mise en place de la prévention du sida. Ses recherches ont aussi porté sur les conditions environnementales de la fertilité masculine – en particulier l'exposition aux perturbateurs endocriniens. Il a développé une réflexion méthodologique sur l'usage des statistiques en biologie et en épidémiologie. Conseiller de la mairie de Paris de 2000 à 2007, il a créé un atelier parisien de santé publique qui s'est penché sur les conséquences sanitaires de la canicule de 2003. Depuis janvier 2014, il est médecin bénévole au Secours populaire et au Samu social de Paris. Il a conseillé Benoît Hamon pour les questions de santé lors de la campagne présidentielle de 2017 et, de décembre 2017 à septembre 2018, été l'un des animateurs du pôle « idées » et référent du pôle santé au sein de la coordination politique provisoire de Génération.s. Il défend une position pluridisciplinaire et politique de la santé publique, insistant sur les liens entre changement des connaissances et mobilisation politique. La place aujourd'hui accordée aux perturbateurs endocriniens, à la fois comme objet politique et comme facteur central d'explication de l'incidence croissante de nombreuses maladies chroniques en témoigne.

▶ The Mortality Effects of Changing Public Funding for Home Health Care: An Empirical Analysis of Medicare Home Health Care in the United States

ORSINI C.

2019

Health Economics 28(7): 921-936.

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3896

Abstract In light of population aging, it is important to understand whether limiting public in-kind transfers to the elderly affects elderly mortality. I focus on home health care—a popular in-kind transfer—and I exploit variation in the Medicare home health care reimbursement that arose in 1997 in the United States to study whether cuts to government coverage of home health care affected elderly mortality. Under the identifying assumptions of the DID model, I find that the cuts affected total mortality for some men but not women, suggesting that changes in home health care can affect elderly mortality and differences in mortality between men and women. For men aged between 65 and 74, the Interim Payment System was associated with an increase in mortality equal to 0.6%, an effect in absolute value comparable to the mortality response to a one percentage point change in unemployment rates and within the range of other estimates of the impact of health insurance on elderly mortality.

▶ Des services de qualité pour les proches aidants. Coconstruire des plans d'aide personnalisés et structurer une offre territoriale

SARDAS J.-C., GAND S. ET HÉNAUT L.

2018

Informations sociales 198(3): 58-67.

https://www.cairn.info/revue-informations-sociales-2018-3-page-58.htm

Les personnes qui aident au quotidien un proche âgé, appelées ici les proches aidants ou les aidants, sont de plus en plus nombreuses. Elles ont parfois des difficultés à assumer leur rôle dans la durée sans nécessairement manifester un besoin ou une envie de se faire aider elles-mêmes. En s'appuyant sur les résultats d'une recherche conduite en 2010-2011 sur les services d'aide aux proches aidants développés dans six territoires français, l'article montre que la qualité des services pour cette population repose, d'une part, sur la co-construction de plans d'aide personnalisés intégrant tous les aspects du rôle d'aidant et adaptables aux besoins évolutifs de l'aidant ; d'autre part, sur la structuration d'une offre territoriale de services variés et coordonnés.

▶ Empowerment individuel et grand âge

VANDENDOREN B., GEURTS H. ET HAELEWYCK M.-C.

2019

Gérontologie et société 41 / 159(2): 213-226.

https://www.cairn.info/revue-gerontologie-et-societe-2019-2-page-213.htm

Cette enquête exploratoire s'intéresse au concept d'empowerment individuel dans le champ de la vieillesse et concerne des répondants âgés de 84 à 104 ans en situation de dépendance. Les données qualitatives issues d'entretiens semi-directifs mettent en évidence l'importance de l'environnement comme garant de la possibilité pour la personne d'exercer le contrôle sur sa vie et d'exprimer ses choix au sein de la relation aidant-aidé. Les verbatim soulignent des processus de déresponsabilisation, de surprotection, voire d'infantilisation, mettant en évidence la conscience que les personnes ont du contexte parfois délétère dans lequel elles évoluent. Ces résultats suggèrent de poursuivre la recherche afin de mieux comprendre le rôle de l'environnement structurel et social dans le déploiement de l'empowerment individuel dans l'âge avancé.

▶ Care for America's Elderly and Disabled People Relies on Immigrant Labor

ZALLMAN L., FINNEGAN K. E., HIMMELSTEIN D. U., *et al.*

2019

Health Affairs 38(6): 919-926.

https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05514

As the US wrestles with immigration policy and caring for an aging population, data on immigrants' role as health care and long-term care workers can inform both debates. Previous studies have examined immigrants' role as health care and direct care workers (nursing, home health, and personal care aides) but not that of immigrants hired by private households or nonmedical facilities such as senior housing to assist elderly and disabled people or unauthorized immigrants' role in providing these services. Using nationally representative data, we found that in 2017 immigrants accounted for 18.2 percent of health care workers and 23.5 percent of formal and nonformal long-term care sector workers. More than one-quarter (27.5 percent) of direct care workers and 30.3 percent of nursing home housekeeping and maintenance workers were immigrants. Although legal noncitizen immigrants accounted for 5.2 percent of the US population, they made up 9.0 percent of direct care workers. Naturalized citizens, 6.8 percent of the US population, accounted for 13.9 percent of direct care workers. In light of the current and projected shortage of health care and direct care workers, our finding that immigrants fill a disproportionate share of such jobs suggests that policies curtailing immigration will likely compromise the availability of care for elderly and disabled Americans.

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