IRDES Centre de documentation - Information Centre

Veille scientifique
en économie de la santé

Mars 2018

Sommaire en français

Watch on
Health Economics Literature

March 2018

Contents list in English

IRDES

Veille scientifique
en économie de la santé

Mars 2018

Centre de documentation de l'Irdes

Assurance maladie	Méthodologie – Statistique
E-santé	Politique de santé
Economie de la santé	Prévention
Etat de santé	Prévision - Evaluation
Géographie de la santé	Psychiatrie
Handicap	Soins de santé primaires
Hôpital	Systèmes de santé
Inégalités de santé	Travail et santé
Médicaments	Vieillissement

Institut de recherche et documentation en économie de la santé

Présentation

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

Certaines publications recensées sont disponibles gratuitement en ligne. D'autres, payantes, peuvent être consultées sur rendez-vous au Centre de documentation de l'Irdes ou être commandées auprès des éditeurs concernés. Des copies d'articles peuvent aussi être obtenues auprès des bibliothèques universitaires (Sudoc), de l'Inist (Refdoc) ou de la British Library. En revanche, **aucune photocopie par courrier n'est délivrée par le Centre de documentation**.

La collection des numéros de ***Veille scientifique en économie de la santé*** (anciennement intitulé ***Doc Veille***) est consultable sur le site internet de l'Irdes :
www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html

Veille scientifique en économie de la santé

Directeur de la publication	Denis Raynaud
Documentalistes	Marie-Odile Safon Véronique Suhard
Maquette & Mise en pages	Franck-Séverin Clérembault
Mise en ligne web	Aude Sirvain
ISSN	2556-2827

Institut de recherche et documentation en économie de la santé
117bis rue Manin - 75019 Paris • Tél. : 01 53 93 43 00 • www.irdes.fr

Reproduction sur d'autres sites interdite mais lien vers le document accepté :
www.irdes.fr/documentation/veille-bibliographique-en-economie-de-la-sante.html

Sommaire

Assurance maladie

11 La loi du 13 août 2004 réformant l'assurance maladie plus de dix ans après
Bertrand D. et Marin P.

11 Supply-Side Effects from Public Insurance Expansions: Evidence from Physician Labor Markets
Chen A., *et al.*

11 Demographic Factors and Attitudes that Influence the Support of the General Public for the Introduction of Universal Healthcare in Ireland: A National Survey
Darker C. D., *et al.*

11 Le partage de la couverture maladie entre assurances obligatoire et complémentaires
Franc C.

12 Effects of Health Insurance Coverage on Risky Behaviors
Lee J.

E-santé

12 Direct-To-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending
Ashwood J. S., *et al.*

12 Santé connectée
Benasayag M., *et al.*

12 Evaluating the Implementation of the Champlain BASE™ Econsult Service In A New Region of Ontario, Canada: A Cross-Sectional Study
Liddy C., *et al.*

13 eHealth in Integrated Care Programs for People with Multimorbidity in Europe: Insights from the ICARE4EU Project
Melchiorre M. G., *et al.*

13 Digital Technologies Supporting Person-Centered Integrated Care – A Perspective
Øvretveit J.

Economie de la santé

13 Rising Use of Observation Care Among the Commercially Insured May Lead to Total and Out-Of-Pocket Cost Savings
Adrion E. R., *et al.*

14 Distribution of Lifetime Nursing Home Use and of Out-Of-Pocket Spending
Hurd M. D., *et al.*

14 Resource Use and Cost of Alzheimer's Disease in France: 18-Month Results from the GERAS Observational Study
Rapp T., *et al.*

15 Do Prospective Payment Systems (PPSs) Lead to Desirable Providers' Incentives and Patients' Outcomes? A Systematic Review of Evidence from Developing Countries
Tan S. Y. et Melendez-Torres G. J.

Etat de santé

15 Comprendre la surmortalité périnatale et néonatale tardive en Seine-Saint-Denis
Revue Prescrire

15 The Effect of Physical Activity on Mortality and Cardiovascular Disease in People from 17 High-Income, Middle-Income, and Low-Income Countries: The PURE Study
Lear S. A., *et al.*

Géographie de la santé

16 Désertification tout court : qui va sauver l'Eure-et-Loir ? Qu'en est-il de l'offre de soins ?
Bouf A.

16 Is There a 'Pig Cycle' in the Labour Supply of Doctors? How Training and Immigration Policies Respond to Physician Shortages
Chojnicki X. et Moullan Y.

16 A Scoping Review of the Implementation of Health in All Policies at the Local Level
Guglielmin M., *et al.*

17 **Improving Health Care Service Provision by Adapting to Regional Diversity: An Efficiency Analysis for the Case of Germany**
Herwartz H. et Schley K.

Handicap

17 **La tierce personne : une figure introuvable ? L'incohérence des politiques françaises de l'invalidité et de la perte d'autonomie (1905-2015)**
Capuano C. et Weber F.

17 **Handicap, dépendance, perte d'autonomie : du flou des concepts aux catégories sociales de la politique publique**
Henrard J.-C.

18 **Soins bucco-dentaires pour les patients handicapés**
Pujade C., *et al.*

18 **Vieillesse, pauvreté et handicap dans l'histoire**
Stiker H.-J.

18 **Welfare Reform Act de 2012, fusion des minima sociaux britanniques et prestations handicap**
Velche D.

Hôpital

19 **Quality of Diabetes Follow-Up Care and Hospital Admissions**
Andrade L. F., *et al.*

19 **The Use of Preventable Hospitalization for Monitoring the Performance of Local Health Authorities in Long-Term Care**
Arandelovic A., *et al.*

19 **Mesurer la qualité pour transformer l'hôpital. Analyse sociotechnique d'une discrète quantification**
Bertillot H.

19 **Prévention des risques organisationnels en ambulatoire : une étude comparative de 4 cliniques**
Bruyère C., *et al.*

20 **The French Emergency Medical Services After the Paris and Nice Terrorist Attacks: What Have We Learnt?**
Carli P., *et al.*

20 **L'hôpital de proximité, maillon structurant du parcours de santé**
Gaye C.

20 **Efficacité des filières dédiées à l'Accident Vasculaire Cérébral. Moyens de mesure. Expérience en Bourgogne**
Delpont B., *et al.*

20 **Faut-il changer le statut de l'hôpital public ?**
Grimaldi A.

21 **The Impact of the Financial Crisis and Austerity Policies on the Service Quality of Public Hospitals in Greece**
Keramidou I. et Triantafyllopoulos L.

21 **Understanding the Relationship Between Medicaid Expansions and Hospital Closures**
Lindrooth R. C., *et al.*

21 **Risk Adjustment May Lessen Penalties on Hospitals Treating Complex Cardiac Patients Under Medicare's Bundled Payments**
Markovitz A. A., *et al.*

22 **Medicare ACO Program Savings Not Tied to Preventable Hospitalizations or Concentrated Among High-Risk Patients**
McWilliams J. M., *et al.*

22 **A Failure to Communicate? Doctors and Nurses in American Hospitals**
Michel L.

Inégalités de santé

22 **Sex Differences in Treatments, Relative Survival, and Excess Mortality Following Acute Myocardial Infarction: National Cohort Study Using the SWEDEHEART Registry**
Alabas O. A., *et al.*

23 **International Migrants' Use of Emergency Departments in Europe Compared with Non-Migrants' Use: A Systematic Review**
Crede S. H., *et al.*

23 **Migrant Women Living with HIV in Europe: Are They Facing Inequalities in the Prevention of Mother-To-Child-Transmission of HIV? The European Pregnancy and Paediatric HIV Cohort Collaboration (EPPICC) Study Group in Eurocoord**
Favarato G., *et al.*

23 **Les demandeurs de l'aide médicale d'État pris entre productivisme et gestion spécifique**
Gabarro C.

24 **De la « crise des migrants » à la crise de l'Europe : un éclairage démographique**
Héran F.

24 **Socioeconomic Status and Waiting Times for Health Services: An International Literature Review and Evidence from the Italian National Health System**
Landi S., *et al.*

24 **La santé des migrants : le syndrome d'Ulysse**
Le Ferrand P.

24 **Unhealthy Assimilation or Persistent Health Advantage? A Longitudinal Analysis of Immigrant Health in the United States**
Lu Y., *et al.*

25 **Do Gender Gaps in Education and Health Affect Economic Growth? A Cross-Country Study from 1975 to 2010**
Mandal B., *et al.*

25 **Gypsy, Roma and Traveller Access to and Engagement with Health Services: A Systematic Review**
McFadden A., *et al.*

25 **Primary Care for Refugees and Newly Arrived Migrants in Europe: A Qualitative Study on Health Needs, Barriers and Wishes**
Van Loenen T., *et al.*

Médicaments

26 **La déprescription médicamenteuse, un acte médical de salubrité publique**
Pugnet G., *et al.*

26 **Potentially Inappropriate Medication Among People with Dementia in Eight European Countries**
Renom-Guiteras A., *et al.*

Méthodologie – Statistique

26 **Une simulation sur un modèle d'appariement : l'impact de l'article 4 de l'ANI de 2013 sur la segmentation du marché du travail**
Berson C. et Ferrari N.

Politique de santé

27 **Le soin, une éthique de l'attention**
Baleyle J. M., *et al.*

27 **What's Involved with Wanting to Be Involved? Comparing Expectations For Public Engagement in Health Policy Across Research and Care Contexts**
Barg, C.J. *et al.*

27 **Is User Involvement a Reality or a Dream in LMICs – as Well as in the Rest of the World?**
D'Avanzo, B.

28 **Mieux comprendre le processus d'empowerment du patient**
Fayn M.-G., *et al.*

28 **The Joint Action on Health Workforce Planning and Forecasting: Results of a European Programme to Improve Health Workforce Policies**
Kroezen M., *et al.*

28 **Parcours de santé des enfants confiés à l'Aide Sociale à l'Enfance des Bouches-du-Rhône**
Martin A., *et al.*

28 **Personalized Medicine: A Doorway to an Effective Health Care Delivery System?**
Minvielle E., *et al.*

29 **Assessing Patient Organization Participation in Health Policy: A Comparative Study in France and Italy**
Souliotis K.

Prévention

29 **Changes in Smoking Behavior over Family Transitions: Evidence for Anticipation and Adaptation Effects**
Bricard D., *et al.*

29 **A Two-Step Screening Process Reduces Hip Fractures**
Cauley J. A.

29 **Éducation thérapeutique du patient et éthique : de l'impératif de santé publique aux droits des personnes et des usagers**
Rusch E.

30 **Concevoir une intervention éducative pour prévenir la chute des personnes âgées en logement social : description d'une méthode de recherche**
Trevidy F., *et al.*

Prévision - Evaluation

30 **Design of Effective Interventions for Smoking Cessation Through Financial and Non-Financial Incentives**
Balderrama F. et Longo C. J.

30 **Évaluation des politiques publiques : expérimentation randomisée et méthodes quasi-expérimentales**
Chabé-Ferret S., *et al.*

Psychiatrie

31 **Santé mentale : de l'exception au droit commun?**
Basset B.

31 **Management of First Depression or Generalized Anxiety Disorder Episode in Adults in Primary Care: A Systematic Metareview**
Driot D., *et al.*

31 **National Trends in Specialty Outpatient Mental Health Care Among Adults**
Han B., *et al.*

31 **Unplanned Admissions to Inpatient Psychiatric Treatment and Services Received Prior to Admission**
Ose S. O., *et al.*

32 **Comment les soins psychiatriques sans consentement en ambulatoire se sont imposés en Suède ? Une comparaison socio-politique avec la Norvège, le Royaume-Uni et New York**
Sjöström S.

32 **Consultation ambulatoire en cabinet libéral et en CMP : deux cliniques ou deux patientèles ?**
Winter E.

Soins de santé primaires

32 **La médecine prédictive quinze ans après**
Aymé S.

32 **Exploring the Impact and Use of Patients' Feedback About Their Care Experiences in General Practice Settings-A Realist Synthesis**
Baldie D. J., *et al.*

33 **Chevauchement, interdépendance ou complémentarité ? La collaboration interprofessionnelle entre l'infirmière praticienne et d'autres professionnels de santé en Ontario**
Benoit M., *et al.*

33 **Small Cash Incentives Can Encourage Primary Care Visits by Low-Income People with New Health Care Coverage**
Bradley C. J. et Neumark D.

34 **Les médecins en 2017 : des carrières bouleversées par les changements dans le système de santé ?**
Charpak Y.

34 **Les relations médecin-malade. Des temps modernes à l'époque contemporaine**
Chevandier C.

34 **Quantifier la qualité des soins : une critique de la rationalisation de la médecine libérale française**
Da Silva N.

34 **Burnout des soignants : comment éteindre l'incendie ?**
Dumoulin M., *et al.*

34 **International Variations in Primary Care Physician Consultation Time: A Systematic Review of 67 Countries**
Irving G., *et al.*

35 **Community Care for People with Complex Care Needs: Bridging the Gap Between Health and Social Care**
Kuluski K., *et al.*

35 **The Content and Meaning of Administrative Work: A Qualitative Study of Nursing Practices**
Michel L., *et al.*

35 **Multimorbidity Care Model: Recommendations from the Consensus Meeting of the Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle (JA-CHRODIS)**
Palmer K., *et al.*

36 **Managing Multimorbidity: Profiles of Integrated Care Approaches Targeting People with Multiple Chronic Conditions in Europe**
Rijken M., *et al.*

36 **Se former pour construire son espace d'autonomie professionnelle ? Le cas des Nurses practitioners néerlandaises**
Rosman S.

36 **Point-Of-Care Testing in Primary Care Patients with Acute Cardiopulmonary Symptoms: A Systematic Review**
Schols A. M. R., *et al.*

37 **Relevant Models and Elements of Integrated Care for Multi-Morbidity: Results of a Scoping Review**
Struckmann V., *et al.*

37 **Patient-Centeredness of Integrated Care Programs for People with Multimorbidity. Results from the European ICARE4EU Project**
Van der Heide I., *et al.*

37 **Does Patients' Experience of General Practice Affect the Use of Emergency Departments? Evidence from Australia**
Wong C. Y. et Hall J.

Systèmes de santé

38 **Interventions and Approaches to Integrating HIV and Mental Health Services: A Systematic Review**
Chuah F. L. H., *et al.*

38 **Health Systems Facilitators and Barriers to the Integration of HIV and Chronic Disease Services: A Systematic Review**
Watt N., *et al.*

Travail et santé

39 **Interventions pour le retour et le maintien au travail après un cancer : revue de la littérature**
Caron M., *et al.*

39 **Paid Employment and Common Mental Disorders in 50–64-Year Olds: Analysis of Three Cross-Sectional Nationally Representative Survey Samples in 1993, 2000 and 2007**
Perera G., *et al.*

39 **Replacement Care' for Working Carers? A Longitudinal Study in England**
Pickard L., *et al.*

Vieillissement

40 **Identification of Older Adults with Frailty in the Emergency Department Using a Frailty Index: Results from a Multinational Study**
Brousseau A.-A., *et al.*

40 **La réforme des retraites de 2010 : quel impact sur l'activité des séniors ?**
Dubois Y. et Koubi M.

40 **Vieillissement : des politiques toujours liées à l'âge, et peu de coordination**
Henrard J. C.

41 **Older Americans Were Sicker and Faced More Financial Barriers to Health Care Than Counterparts in Other Countries**
Osborn R., *et al.*

41 **The Association Between Implementation and Outcome of a Complex Care Program for Frail Elderly People**
Ruikes F. G. H., *et al.*

Assurance maladie

▶ La loi du 13 août 2004 réformant l'assurance maladie plus de dix ans après

BERTRAND D. ET MARIN P.

2017

Actualité et Dossier en Santé Publique (100): 70-79.

La loi réformant l'Assurance maladie en 2004 a été une loi « socle » visant à mettre en place les outils permettant de remédier à ses déficits budgétaires, mais aussi en améliorant l'offre des soins, la maîtrise médicalisée et la gouvernance. Cette loi, dont le bilan est présenté dans cet article, sera suivie de deux autres : la loi hôpital, patients santé et territoires en 2009 et la loi de modernisation du système de santé en 2016.

▶ Supply-Side Effects from Public Insurance Expansions: Evidence from Physician Labor Markets

CHEN A., *et al.*

2017

Health Economics: Ahead of print.

Medicaid and the Child Health Insurance Programs (CHIP) are key sources of coverage for U.S. children. Established in 1997, CHIP allocated $40 billion of federal funds across the first 10 years but continued support required reauthorization. After 2 failed attempts in Congress, CHIP was finally reauthorized and significantly expanded in 2009. Although much is known about the demand-side policy effects, much less is understood about the policy's impact on providers. In this paper, we leverage a unique physician dataset to examine if and how pediatricians responded to the expansion of the public insurance program. We find that newly trained pediatricians are 8 percentage points more likely to subspecialize and as much as 17 percentage points more likely to enter private practice after the law passed. There is also suggestive evidence of greater private practice growth in more rural locations. The sharp supply-side changes that we observe indicate that expanding public insurance can have important spillover effects on provider training and practice choices.

▶ Demographic Factors and Attitudes that Influence the Support of the General Public for the Introduction of Universal Healthcare in Ireland: A National Survey

DARKER C. D., *et al.*

2017

Health Policy 122 (2) :147-156

Ireland is still struggling to end the inequitable two-tiered health system and introduce universal healthcare (UHC). Public opinion can influence health policy choice and implementation. However, the public are rarely asked for their views. This study describes the demographic and attitudinal factors that influence the support of the public for the introduction of UHC. It provides data on a nationally representative survey sample of n = 972. There are high levels of support for the introduction of UHC (n = 846 87.0%). Logistic regression analyses indicated that demographic factors, such as, the location of respondent, whether the respondent was in receipt of Government supported healthcare, a purchaser of private health insurance or neither; plus attitudinal factors, such as, opinions on the Government prioritising healthcare, healthcare being free at the point of access, taxes being increased to provide care free at the point of access and how well informed participants felt about UHC were associated with agreeing with the introduction of UHC in Ireland. This paper is timely for policy leaders both in Ireland and internationally as countries with UHC, such as the United Kingdom, are facing difficulties maintaining health services in the public realm.

▶ Le partage de la couverture maladie entre assurances obligatoire et complémentaires

FRANC C.

2017

Med Sci (Paris) 33(12): 1097-1104.

https://doi.org/10.1051/medsci/20173312017

Effects of Health Insurance Coverage on Risky Behaviors

LEE J.

2018

Health Econ. [Epub ahead of print]

Prior to implementation of the Patient Protection and Affordable Care Act, dependent health insurance coverage was typically available only for young adults under the age of 19. As of September 2010, the Affordable Care Act extended dependent health insurance coverage to include young adults up to the age of 26. I use the National Health Interview Survey for the sample period from 2011 to 2013 to analyze the causal relationship between the expansion of dependent coverage and risky behaviors including smoking and drinking as well as preventive care. I employ a regression discontinuity design to estimate the causal effect of health insurance coverage and overcome the endogeneity problem between insurance status and risky behaviors. When young adults become 26 years old, they are 7 to 10 percentage points more likely to lose health insurance than young adults under the age of 26. Although young adults over the age of 26 are generally aged out of insurance coverage, presence or absence of health insurance does not affect their smoking and drinking behaviors and their access to preventive care.

E-santé

Direct-To-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending

ASHWOOD J. S., *et al.*

2017

Health Aff (Millwood) 36(3): 485-491.

The use of direct-to-consumer telehealth, in which a patient has access to a physician via telephone or videoconferencing, is growing rapidly. A key attraction of this type of telehealth for health plans and employers is the potential savings involved in replacing physician office and emergency department visits with less expensive virtual visits. However, increased convenience may tap into unmet demand for health care, and new utilization may increase overall health care spending. We used commercial claims data on over 300,000 patients from three years (2011-13) to explore patterns of utilization and spending for acute respiratory illnesses. We estimated that 12 percent of direct-to-consumer telehealth visits replaced visits to other providers, and 88 percent represented new utilization. Net annual spending on acute respiratory illness increased $45 per telehealth user. Direct-to-consumer telehealth may increase access by making care more convenient for certain patients, but it may also increase utilization and health care spending.

Santé connectée

BENASAYAG M., *et al.*

2017

Pratiques : Les Cahiers De La Medecine Utopique(79)

Les nouvelles technologies permettent le développement de multiples objets connectés dans la santé. Certains offrent des avantages, mais ne sont pas sans effet sur les conditions de soins et l'évolution des pratiques. Les auteurs de ce dossier sur la santé connectée explorent les nouvelles possibilités ainsi ouvertes, les changements qu'elles produisent ainsi que les risques auxquels elles exposent. La banalisation de la diffusion volontaire des données de santé sur les réseaux sociaux, comme l'utilisation par les administrations de données sensibles « anonymisées », nourrissent le « Big Data » dont on est loin d'imaginer la portée réelle sur l'évolution de la société. Ce fascicule apporte des éclairages sur d'autres aspects de la santé.

Evaluating the Implementation of the Champlain BASE™ Econsult Service In A New Region of Ontario, Canada: A Cross-Sectional Study

LIDDY C., *et al.*

2017

Healthcare Policy 13(2): 79-95.

This paper aims to replicate an existing electronic consultation (eConsult) service in a new jurisdiction to test its generalizability. We conducted a cross-sectional study of all eConsults submitted by providers in the region of Mississauga Halton, Ontario, between January 5, 2015, and May 31, 2016. We compared our results to those from the original pilot in Eastern Ontario. The RE-AIM model served as our study framework. Providers submitted 594 patient cases to 46 different specialty groups during the study period. Specialists responded in a median of 1.1 days, with 75% of cases answered within four days. Providers rated the service as having high or very high value for themselves and their patients in 92% of cases. The service yielded a net program cost of $10,321.56: Our findings resembled those of the initial implementation, though with a faster rate of uptake and lower cost because of the avoidance of start-up and administrative costs.

eHealth in Integrated Care Programs for People with Multimorbidity in Europe: Insights from the ICARE4EU Project

MELCHIORRE M. G., *et al.*

2018

Health Policy 122(1): 53-63.

Care for people with multimorbidity requires an integrated approach in order to adequately meet their complex needs. In this respect eHealth could be of help. This paper aims to describe the implementation, as well as benefits and barriers of eHealth applications in integrated care programs targeting people with multimorbidity in European countries, including insights on older people 65+. Within the framework of the ICARE4EU project, in 2014, expert organizations in 24 European countries identified 101 integrated care programs based on selected inclusion criteria. Managers of these programs completed a related on-line questionnaire addressing various aspects including the use of eHealth. In this paper we analyze data from this questionnaire, in addition to qualitative information from six programs which were selected as 'high potential' for their innovative approach and studied in depth through site visits. Findings seems to suggest that eHealth could support integrated care for (older) people with multimorbidity.

Digital Technologies Supporting Person-Centered Integrated Care – A Perspective

ØVRETVEIT J.

2017

Journal of Integrated Care 17(4): 1-4.

Shared electronic health and social care records in some service systems are already showing some of the benefits of digital technology and digital data for integrating health and social care. These records are one example of the beginning "digitalisation" of services that gives a glimpse of the potential of digital technology and systems for building coordinated and individualized integrated care. Yet the promise has been greater than the benefits, and progress has been slow compared to other industries. This paper describes for non-technical readers how information technology was used to support integrated care schemes in six EU services, and suggests practical ways forward to use the new opportunities to build person-centered integrated care.

Economie de la santé

Rising Use of Observation Care Among the Commercially Insured May Lead to Total and Out-Of-Pocket Cost Savings

ADRION E. R., *et al.*

2017

Health Aff (Millwood) 36(12): 2102-2109.

Proponents of hospital-based observation care argue that it has the potential to reduce health care spending and lengths-of-stay, compared to short-stay inpatient hospitalizations. However, critics have raised concerns about the out-of-pocket spending associated with observation care. Recent reports of high out-of-pocket spending among Medicare beneficiaries have received considerable media attention and have prompted direct policy changes. Despite the potential for changed policies to indirectly affect non-Medicare patients, little is known about the use of, and spending

associated with, observation care among commercially insured populations. Using multipayer commercial claims for the period 2009-13, we evaluated utilization and spending among patients admitted for six conditions that are commonly managed with either observation care or short-stay hospitalizations. In our study period, the use of observation care increased relative to that of short-stay hospitalizations. Total and out-of-pocket spending were substantially lower for observation care, though both grew rapidly-and at rates much higher than spending in the inpatient setting-over the study period. Despite this growth, spending on observation care is unlikely to exceed spending for short-stay hospitalizations. As observation care attracts greater attention, policy makers should be aware that Medicare policies that disincentivize observation may have unintended financial impacts on non-Medicare populations, where observation care may be cost saving.

Distribution of Lifetime Nursing Home Use and of Out-Of-Pocket Spending

HURD M. D., *et al.*

2017

Proc Natl Acad Sci USA 114(37): 9838-9842.

Reliable estimates of the lifetime risk of using a nursing home and the associated out-of-pocket costs are important for the saving decisions by individuals and families, and for the purchase of long-term care insurance. We used data on up to 18 y of nursing home use and out-of-pocket costs drawn from the Health and Retirement Study, a longitudinal household survey representative of the older US population. We accumulated the use and spending by individuals over many years, and we developed and used an individual-level matching method to account for use before and after the observation period. In addition, for forecasting, we estimated a dynamic parametric model of nursing home use and spending. We found that 56% of persons aged 57-61 will stay at least one night in a nursing home during their lifetimes, but only 32% of the cohort will pay anything out of pocket. Averaged over all persons, total out-of-pocket expenditures looking forward from age 57 were approximately $7,300, discounted at 3% per year. However, the 95th percentile of spending was almost $47,000. We conclude that the percentage of people ever staying in nursing homes is substantially higher than previous estimates, at least partly due to an increase in nursing home episodes of short duration. Average lifetime out-of-pocket costs may be affordable, but some people will incur much higher costs.

Resource Use and Cost of Alzheimer's Disease in France: 18-Month Results from the GERAS Observational Study

RAPP T., *et al.*

2017

Value in Health. [In press]

http://www.sciencedirect.com/science/article/pii/S1098301517335635

There is little longitudinal data on resource use and costs associated with Alzheimer's disease (AD) in France. This study aims to evaluate resource use and societal costs associated with AD in a French cohort of patients and their caregivers and the effect of patient cognitive decline on costs over an 18-month period. Community-dwelling patients with mild, moderate, or moderately severe/severe AD dementia (n = 419) were followed-up for 18 months. Total societal costs were estimated by applying 2010 unit costs to resource use, including outpatient visits, hospital days, institutionalization, and caregiver hours. Cognitive function was assessed by Mini-Mental State Examination scores. Mean cumulative total costs over the 18-month period were €24,140 for patients with mild AD dementia, €34,287 for those with moderate AD dementia, and €44,171 for those with moderately severe/severe AD dementia (P < 0.001; ANOVA comparison between severity groups). The biggest contributor to total societal costs was caregiver informal care (>50% of total costs at all stages of AD dementia). Cognitive decline (≥3-point decrease in Mini-Mental State Examination score or institutionalization) was associated with a 12.5% increase in total costs (P = 0.02). Significant differences were observed across severity groups for caregiver time (P < 0.001); mean monthly caregiver time increased at each time point over the 18 months in each severity group. Increasing severity of AD dementia in France is associated with increased use of resources as well as increased total societal and patient costs; informal care was the greatest cost contributor. Clinically meaningful cognitive decline is associated with significantly increased costs.

Do Prospective Payment Systems (PPSs) Lead to Desirable Providers' Incentives and Patients' Outcomes? A Systematic Review of Evidence from Developing Countries

TAN S. Y. ET MELENDEZ-TORRES G. J.

2018

Health Policy Plan 33(1): 137-153.

http://dx.doi.org/10.1093/heapol/czx151

The reform of provider payment systems, from retrospective to prospective payment, has been heralded as the right move to contain costs in the light of rising health expenditures in many countries. However, there are concerns on quality trade-off. The heightened attention given to prospective payment system (PPS) reforms and the rise of empirical evidence regarding PPS interventions among developing countries suggest that a systematic review is necessary to understand the effects of PPS reforms in developing countries. A systematic search of 14 databases and a hand search of health policy journals and grey literature from October to November 2016 were carried out, guided by a set of inclusion and exclusion criteria. Data were extracted based on the Consolidated Health Economics Evaluation Reporting Standards checklist. A total of 12 studies reported in China, Thailand and Vietnam were included in this review. Substantial heterogeneity was present in PPS policy design across different localities. PPS interventions were found to have reduced health expenditures on both the supply and demand side, as well as length of stay and readmission rates. In addition, PPS generally improved service quality outcomes by reducing the likelihood or percentage of physicians prescribing unnecessary drugs and diagnostic procedures. PPS is a promising policy tool for middle-income countries to achieve reasonable health policy objectives in terms of cost containment without necessarily compromising the quality of care. More evaluations of PPS will need to be conducted in the future in order to broaden the evidence base beyond middle-income countries.

Etat de santé

Comprendre la surmortalité périnatale et néonatale tardive en Seine-Saint-Denis

REVUE PRESCRIRE

2017

Revue Prescrire 37(410): 939-943.

En 2012, le taux de mortalité infantile dans le département de la Seine-Saint-Denis, qui compte une forte proportion de personnes pauvres et une offre de soins plus faible que dans d'autres départements français, était de 50 % supérieur à celui de la France métropolitaine. En se basant sur les données de l'Inserm sur les causes des morts périnatales et néonatales tardives survenues en Seine-Saint-Denis ainsi que sur différentes enquêtes menées auprès de femmes enceintes en situation de précarité, cet article analyse les raisons de cette mortalité prématurée et émet des recommandations pour un meilleur suivi de ces personnes.

The Effect of Physical Activity on Mortality and Cardiovascular Disease in People from 17 High-Income, Middle-Income, and Low-Income Countries: The PURE Study

LEAR S. A., *et al.*

2017

The Lancet 390(10113): 2643-2654.

http://dx.doi.org/10.1016/S0140-6736(17)31634-3

Physical activity has a protective effect against cardiovascular disease (CVD) in high-income countries, where physical activity is mainly recreational, but it is not known if this is also observed in lower-income countries, where physical activity is mainly non-recreational. We examined whether different amounts and types of physical activity are associated with lower mortality and CVD in countries at different economic levels.

Géographie de la santé

Désertification tout court : qui va sauver l'Eure-et-Loir ? Qu'en est-il de l'offre de soins ?

BOUF A.

2017

Médecine : De la Médecine Factuelle à nos Pratiques 13(9): 421-427.

La démographie médicale, la désertification des zones rurales, la non-installation des jeunes médecins, notamment généralistes, une fois diplômés font régulièrement la une des médias. Nombre de petites communes se désespèrent et voudraient apporter une réponse à leurs administrés. À l'issue de ses longues années d'études dans une ville universitaire, le jeune médecin diplômé, citadin accompli, volontiers parent, en couple avec un autre diplômé dont la carrière décolle dans sa propre profession, ayant déjà un aperçu de la médecine générale au cours de ses stages de fin d'étude, refuse d'endosser l'habit de ses anciens à l'activité souvent débordante. L'appréhension de la lourdeur administrative et de l'engagement financier, voire pour certains un sentiment de difficulté de maintenir une qualité de pratique exigeante hors du cadre hospitalier, expliquent une hésitation à sauter le pas d'un engagement définitif, loin de « ses bases », dans un environnement mal appréhendé. Quelle est la réalité du terrain et de l'offre de soins dans un département comme l'Eure-et-Loir, finalement relativement proche de la capitale, mais aussi plus largement dans toute la région Centre comparativement au reste du territoire ? Quelles sont les raisons de la disparité ? Cet article apporte quelques éléments de réponse.

Is There a 'Pig Cycle' in the Labour Supply of Doctors? How Training and Immigration Policies Respond to Physician Shortages

CHOJNICKI X. ET MOULLAN Y.

2018

Social Science & Medicine 200: 227-237.

https://www.sciencedirect.com/science/article/pii/S0277953618300431

Many OECD countries are faced with the considerable challenge of a physician shortage. This paper investigates the strategies that OECD governments adopt and determines whether these policies effectively address these medical shortages. Due to the amount of time medical training requires, it takes longer for an expansion in medical school capacity to have an effect than the recruitment of foreign-trained physicians. Using data obtained from the OECD (2014) and Bhargava et al. (2011), we constructed a unique country-level panel dataset that includes annual data for 17 OECD countries on physician shortages, the number of medical school graduates and immigration and emigration rates from 1991 to 2004. By calculating panel fixed-effect estimates, we find that after a period of medical shortages, OECD governments produce more medical graduates in the long run but in the short term, they primarily recruit from abroad; however, at the same time, certain practising physicians choose to emigrate. Simulation results show the limits of recruiting only abroad in the long term but also highlight its appropriateness for the short term when there is a recurrent cycle of shortages/surpluses in the labour supply of physicians (pig cycle theory).

A Scoping Review of the Implementation of Health in All Policies at the Local Level

GUGLIELMIN M., *et al.*

2017

Health Policy: [Ahead of print.]

Health in All Policies (HiAP) is an approach to public policies across sectors that systematically takes into account the health implication of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. HiAP implementation can involve engagement from

multiple levels of government; however, factors contributing or hindering HiAP implementation at the local level are largely unexplored. Local is defined as the city or municipal level, wherein government is uniquely positioned to provide leadership for health and where many social determinants of health operate. This paper presents the results of a scoping review on local HiAP implementation. Peer reviewed articles and grey literature were systematically searched using the Arksey and O'Malley framework. Characteristics of articles were then categorized, tallied and described. We conclude that common themes were found in the literature regarding HiAP implementation locally. However, to better clarify these factors to contribute to theory development on HiAP implementation, further research is needed that specifically investigates the facilitators and barriers of HiAP locally within their political and policy context.

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

HERWARTZ H. ET SCHLEY K.

2018

Health Policy: [Ahead of print.]

http://dx.doi.org/10.1016/j.healthpol.2018.01.004

Highlights'Regional patterns in health care utilisation influence the efficiency of health care. Regional access barriers affect the efficiency of health care service provision. Relationship between socio-economic factors and efficiencies as possible transmission channel to health. Regional needs should be considered to improve the allocation of medical infrastructure.

Handicap

La tierce personne : une figure introuvable ? L'incohérence des politiques françaises de l'invalidité et de la perte d'autonomie (1905-2015)

CAPUANO C. ET WEBER F.

2015

Revue d'histoire de la protection sociale 8(1): 106-130.

https://www.cairn.info/revue-d-histoire-de-la-protection-sociale-2015-1-page-106.htm

Retracer l'histoire des politiques des incapacités au travail (invalidité) et au quotidien (perte d'autonomie) en France depuis 1905 montre les hésitations du législateur entre un régime causaliste (où les prestations dépendent des causes des incapacités) et un régime finaliste (où elles dépendent des besoins). La barrière des 60 ans instaurée à partir de 1997 entre les personnes qui dépendent d'une aide humaine pour vivre au quotidien, selon leur âge ou la date d'apparition de leurs incapacités, mêle une logique de revenus (liés à l'invalidité avant 60 ans et à la retraite après 60 ans) à la question de la tierce personne, dont la figure émerge pour de simples raisons de réduction des coûts pour la collectivité. L'article invite à dépasser les questions budgétaires et la nouvelle conceptualisation des droits des personnes handicapées en termes de droits de l'homme pour mieux appréhender les conséquences de ces politiques sur les personnes avec incapacités elles-mêmes et sur leur famille, mais aussi sur certains professionnels de l'aide quotidienne.

Handicap, dépendance, perte d'autonomie : du flou des concepts aux catégories sociales de la politique publique

HENRARD J.-C.

2015

Revue d'histoire de la protection sociale 8(1): 146-166.

https://www.cairn.info/revue-d-histoire-de-la-protection-sociale-2015-1-page-146.htm

Soins bucco-dentaires pour les patients handicapés

PUJADE C., *et al.*

2017

Santé Publique 29(5): 677-684.

https://www.cairn.info/revue-sante-publique-2017-5-page-677.htm

Les patients handicapés représentent une population à besoins spécifiques dont la prise en charge en odontologie soulève une problématique de santé publique. Cet article décrit cette activité de soins au sein d'un service hospitalier d'odontologie pour mettre en évidence les difficultés rencontrées et proposer des axes d'amélioration dans cette prise en charge. Une étude rétrospective descriptive a été menée sur les patients suivis entre 2010 et 2016 dans le cadre du partenariat entre le service d'odontologie de l'hôpital Albert Chenevier et le réseau RHAPSOD'IF. Pour 434 patients handicapés soignés, les séances ont consisté en des consultations (42 à 57 %), les restaurations et les détartrages ont représenté chacun 1/6e des actes effectués (14 à 19 % et 14 à 18 %), et la chirurgie et la radiographie en ont représenté 1/8e (4 à 12 % et 6 à 11 %). La mise en place d'une thérapeutique prothétique est quasi nulle (0 à 1 %). La plupart des séances de soins s'est effectuée sans prémédication (61 à 76 %). Ces soins dentaires nécessitent la formation des familles, des accompagnants, une bonne approche relationnelle et du temps pour instaurer une relation de confiance. L'adhésion à un réseau prend son importance pour aider, accompagner, conseiller le praticien et lui apporter un soutien financier.

Vieillesse, pauvreté et handicap dans l'histoire

STIKER H.-J.

2015

Revue d'histoire de la protection sociale 8(1): 132-144.

https://www.cairn.info/revue-d-histoire-de-la-protection-sociale-2015-1-page-132.htm

Cette contribution s'interroge sur les similitudes entre le sort des infirmes et le sort des personnes âgées dépendantes au cours de l'histoire. Elle questionne ainsi sur le temps long les dissociations ou articulations, selon les milieux sociaux, entre âge biologique, âge social et âge des incapacités définissant les contours d'une vieillesse incapable, comme les infirmes, de travailler. Elle analyse également comment les discours sur la dégradation du corps des « vieux » a contribué à construire une représentation dépréciative et stigmatisante de la vieillesse au fil des siècles, rapprochant encore une fois celle-ci de l'infirmité. Cette étude montre enfin combien ces populations ont été longtemps oubliées par le corps social et négligées par les politiques publiques, dont les actions les ont cantonnées au champ assistantiel. Elles restent encore peu traitées par les études historiennes.

Welfare Reform Act de 2012, fusion des minima sociaux britanniques et prestations handicap

VELCHE D.

2017

Revue française des affaires sociales(3): 109-128.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-3-page-109.htm

Instituant le « crédit universel » fusionnant divers minima sociaux, la loi britannique de réforme de l'assistance sociale adoptée en 2012 affecte les personnes handicapées, directement d'abord par l'absorption progressive de la principale prestation handicap non contributive et sous conditions de ressources, indirectement ensuite par l'incidence d'autres prestations sociales en cours d'extinction, prestations qui souvent prévoyaient divers suppléments handicap. La même réforme rend plus stricte l'attribution des aides à la vie indépendante non incluses dans le crédit universel. À cela s'ajoute l'adoption d'un plafonnement du total des prestations accordées à une même famille. Ces décisions, mises en œuvre dans un contexte généralisé de coupes budgétaires, inquiètent les personnes handicapées et leurs proches. Peuvent-ils craindre une paupérisation ?

Hôpital

Quality of Diabetes Follow-Up Care and Hospital Admissions

ANDRADE L. F., *et al.*

2017

International Journal of Health Economics and Management: [Ahead of print]

https://doi.org/10.1007/s10754-017-9230-z

Diabetes may lead to severe complications. For this reason, disease prevention and improvement of medical follow-up represent major public health issues. The aim of this study was to measure the impact of adherence to French follow-up guidelines on hospitalization of people with diabetes. We used insurance claims data from the years 2010 to 2013 collected for 52,027 people aged over 18, affiliated to a French social security provider and treated for diabetes. We estimated panel data models to explore the association between adherence to guidelines and different measures of hospitalization, controlling for socioeconomic characteristics, diabetes treatment and density of medical supply. The results show that adherence to four guidelines was associated with a significant decrease in hospital admissions, up to approximatively 30% for patients monitored for a complete lipid profile or microalbuminuria during the year. In addition, our analyses confirmed the strong protective effect of income and a significant positive correlation with good supply of hospital care. In conclusion, good adherence to French diabetes guidelines seems to be in line with the prevention of health events, notably complications, that could necessitate hospitalization.

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

ARANDELOVIC A., *et al.*

2018

Health Policy: [Ahead of print]

http://dx.doi.org/10.1016/j.healthpol.2018.01.008

Preventable hospitalization as an indicator for quality performance is proposed. The quality performance improvement may help to reduce preventable hospitalization. Comparing and reporting local health authorities performance could improve quality.

Mesurer la qualité pour transformer l'hôpital. Analyse sociotechnique d'une discrète quantification

BERTILLOT H.

2017

Revue Française de Socio-Économie 19(2): 131-152.

https://www.cairn.info/revue-francaise-de-socio-economie-2017-2-page-131.htm

Depuis le début des années 2000, les pouvoirs publics français déploient des instruments d'évaluation de la qualité dans les établissements de santé. En procédant à la déconstruction sociotechnique des « indicateurs de qualité », cet article analyse une discrète entreprise de quantification. Mesurant des dimensions peu conflictuelles de la qualité, nourris de savoirs pluriels, équivoques dans leurs usages, les indicateurs de qualité sont suffisamment doux pour ne pas brusquer les professionnels, tout en étant suffisamment robustes pour instiller discipline et auditabilité. Au nom de la qualité, cette technologie de gouvernement est ainsi équipée pour rationaliser l'hôpital en douceur.

Prévention des risques organisationnels en ambulatoire : une étude comparative de 4 cliniques

BRUYÈRE C., *et al.*

2017

Journal de gestion et d'économie médicales 35(1): 6-17.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-1-page-6.htm

La chirurgie ambulatoire tend à devenir la norme. Or, la chirurgie ambulatoire est un changement culturel profond et un processus organisationnel complexe invitant à repenser les modes d'accès aux soins et de gouvernance. Dans cette perspective, des travaux initiés par l'ANAP (Agence nationale d'appui à la performance des établissements de santé et médico-sociaux) et l'HAS (Haute autorité de santé) publiés en 2013 visent à guider les acteurs de terrain dans le développement des pratiques ambulatoires, en préconisant une approche Lean comme système organisationnel global. Quel usage en ont les acteurs ? Quelle perception ont-ils du Lean Management ? Et comment se prémunissent-ils des risques organisationnels du Lean

dans un contexte de chirurgie ambulatoire ? Une étude comparative de 4 centres autonomes ambulatoires (4 cliniques privées, seuls centres autonomes à ce jour en France) a permis de mettre en avant les principaux risques perçus par les acteurs – mise en tension et rigidification du travail- ainsi que les moyens techniques, organisationnels et humains pour faire face. Il ressort que les cliniques étudiées ont su se préserver des marges de manœuvre pour adapter le flux aux pressions, préservant ainsi le slack organisationnel nécessaire à la cohabitation d'un standard organisationnel et d'une relation unique.

▶ The French Emergency Medical Services After the Paris and Nice Terrorist Attacks: What Have We Learnt?

CARLI P., *et al.*

2017

The Lancet 390(10113): 2735-2738.

http://dx.doi.org/10.1016/S0140-6736(17)31590-8

▶ L'hôpital de proximité, maillon structurant du parcours de santé

GAYE C.

2017

Techniques Hospitalières(765): 39-40.

L'hôpital de proximité intégré dans son territoire pérennise et aide à structurer un bassin de vie pour l'organisation de la santé, aussi bien dans le domaine curatif que préventif, de l'éducation et de la formation. Il est un point d'appui et d'expertise pour les autres établissements quant au parcours de soin.

▶ Efficacité des filières dédiées à l'Accident Vasculaire Cérébral. Moyens de mesure. Expérience en Bourgogne

DELPONT B., *et al.*

2017

Journal de gestion et d'économie médicales 35(1): 18-31.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-1-page-18.htm

L'AVC reste une maladie fréquente et grave en France (première cause de handicap, deuxième cause de déclin cognitif, troisième cause de décès) malgré des avancées thérapeutiques majeures, expliquant le rôle structurant de sa prise en charge sur le plan hospitalier et inter- hospitalier. Les filières de soins pour AVC décloisonnées permettent au patient de bénéficier d'une prise en charge optimale de son domicile jusqu'à l'Unité Neuro- Vasculaire (UNV). Les recommandations nationales ont préconisé la mise en place de filières pluridisciplinaires avec un numéro téléphonique unique (le 15), transfert par SAMU, prise en charge dans un Service d'Urgences assurant une imagerie cérébrale prioritaire puis passage en Unité Neuro- Vasculaire pour réalisation d'une fibrinolyse et/ou d'une thrombectomie. L'objectif de cette revue est de rapporter les évaluations successives en pratique courante de la filière AVC mise en place en Bourgogne depuis 2003, les réponses apportées aux attentes des patients et des tutelles, et leur transposition aux autres régions sanitaires. L'étude se base sur le registre dijonnais des AVC, qui recense depuis 1985 les AVC des résidents de la ville de Dijon intramuros de façon prospective, spécifique et exhaustive.

▶ Faut-il changer le statut de l'hôpital public ?

GRIMALDI A.

2017

Médecine : De la médecine factuelle à nos pratiques 13(9): 428-431.

La santé s'est invitée dans la campagne des élections présidentielles, mais le débat sur l'hôpital public n'a pas vraiment eu lieu. La Fédération de l'hospitalisation privée (FHP) souhaite revenir à la convergence tarifaire entre l'hôpital public et les cliniques privées, instituant une concurrence entre clinique et hôpital. La Fédération hospitalière de France (FHF) représentant les hôpitaux publics s'oppose à cette « convergence tarifaire » qu'elle juge déloyale dans la mesure où la clinique privée choisit son activité, privilégiant les activités rentables (chirurgie ambulatoire, chirurgie de l'obésité, canal carpien, cataracte, dialyse...), et sélectionne de fait ses clients en raison des dépassements d'honoraires réalisés par 85 % des praticiens qui y travaillent. En revanche, la FHF propose de faire évoluer le statut de l'hôpital public.

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

KERAMIDOU I. ET TRIANTAFYLLOPOULOS L.

2017

Health Policy: [Ahead of print]

The influence of the financial crisis on the efficiency of Greek public hospitals has been widely debated. Despite this increasing interest in such research, the question of to what extent the recent reforms in the Greek National health care system were effective in establishing a health care structure and process that provide better results for patients has yet to be fully investigated. As a step in this direction, the paper focuses on patient's experience with public hospital care quality before and during the economic crisis. A questionnaire survey was carried out among 1872 patients discharged from 110 out of the total of 124 Greek public hospitals. Patients' perceptions were analysed using a structural equation modelling approach. The findings reveal that public hospital service quality is at a medium level (66.2 on a scale from 1 to 100) over 2007-2014, presenting a decreasing trend during the recession. Policies to address the crisis may have contributed to a reduction in hospital expenditures, but at the same time patients were increasingly dissatisfied with the technical care. Consequently, there is a need for reforms aimed at the achievement of productivity gains, responsibility, and transparency in the management of productive resources, by enabling health organisations to reduce their costs without a deterioration in the quality of care.

Understanding the Relationship Between Medicaid Expansions and Hospital Closures

LINDROOTH R. C., *et al.*

2018

Health Aff (Millwood) 37(1): 111-120.

Decisions by states about whether to expand Medicaid under the Affordable Care Act (ACA) have implications for hospitals' financial health. We hypothesized that Medicaid expansion of eligibility for childless adults prevents hospital closures because increased Medicaid coverage for previously uninsured people reduces uncompensated care expenditures and strengthens hospitals' financial position. We tested this hypothesis using data for the period 2008-16 on hospital closures and financial performance. We found that the ACA's Medicaid expansion was associated with improved hospital financial performance and substantially lower likelihoods of closure, especially in rural markets and counties with large numbers of uninsured adults before Medicaid expansion. Future congressional efforts to reform Medicaid policy should consider the strong relationship between Medicaid coverage levels and the financial viability of hospitals. Our results imply that reverting to pre-ACA eligibility levels would lead to particularly large increases in rural hospital closures. Such closures could lead to reduced access to care and a loss of highly skilled jobs, which could have detrimental impacts on local economies.

Risk Adjustment May Lessen Penalties on Hospitals Treating Complex Cardiac Patients Under Medicare's Bundled Payments

MARKOVITZ A. A., *et al.*

2017

Health Aff (Millwood) 36(12): 2165-2174.

To reduce variation in spending, Medicare has considered implementing a cardiac bundled payment program for acute myocardial infarction and coronary artery bypass graft. Because the proposed program does not account for patient risk factors when calculating hospital penalties or rewards ("reconciliation payments"), it might unfairly penalize certain hospitals. We estimated the impact of adjusting for patients' medical complexity and social risk on reconciliation payments for Medicare beneficiaries hospitalized for the two conditions in the period 2011-13. Average spending per episode was $29,394. Accounting for medical complexity substantially narrowed the gap in reconciliation payments between hospitals with high medical severity (from a penalty of $1,809 to one of $820, or a net reduction of $989), safety-net hospitals (from a penalty of $217 to one of $87, a reduction of $130), and minority-serving hospitals (from a penalty of $70 to a reward of $56, an improvement of $126) and their counterparts. Accounting for social risk alone narrowed these gaps but had minimal incremental effects after medical complexity was accounted for. Risk adjustment may preserve incentives to care for patients with complex conditions under Medicare bundled payment programs.

Medicare ACO Program Savings Not Tied to Preventable Hospitalizations or Concentrated Among High-Risk Patients

MCWILLIAMS J. M., *et al.*

2017

Health Aff (Millwood) 36(12): 2085-2093.

It has been widely assumed that better management and coordination of care for chronic conditions and high-risk patients would be the leading mechanisms for achieving savings in accountable care organizations (ACOs), specifically by reducing acute care needs through enhanced outpatient and preventive care. We examined the extent to which changes in spending and hospitalizations for ACO patients in the Medicare Shared Savings Program (MSSP) have been consistent with this expectation. By 2014, participation in the MSSP was associated with significant reductions in total Medicare fee-for-service spending for ACO patients but with proportionately smaller reductions in hospitalizations and some increases in hospitalizations for ambulatory care-sensitive conditions. In addition, spending reductions were not clearly concentrated among high-risk patients: Reductions for those patients accounted for only 38 percent of the total reduction among ACOs entering the MSSP in 2012, and reductions among 2013 MSSP entrants were almost entirely concentrated among lower-risk patients. These findings suggest that, on average, care coordination and management efforts focused on ambulatory care-sensitive conditions and high-risk patients have not been the major drivers of early savings in the MSSP.

A Failure to Communicate? Doctors and Nurses in American Hospitals

MICHEL L.

2017

J Health Polit Policy Law 42(4): 709-717.

This article showcases the realities and challenges of teamwork in American hospitals based on the in situ comparison with France. Drawing on observation of nurse-physician interactions in hospitals in the two nations, this article highlights a troubling conflict between teamwork rhetoric and realities on the ward. Although the use of informatics systems such as electronic health records is supposed to increase cooperation, the observations presented here show that on the contrary, it inhibits communication that is becoming mainly virtual. While the nursing profession is more developed and provides stronger education in the United States, this story highlights the challenges in creating a shared environment of work and suggests the importance of balancing professional autonomy and effective teamwork.

Inégalités de santé

Sex Differences in Treatments, Relative Survival, and Excess Mortality Following Acute Myocardial Infarction: National Cohort Study Using the SWEDEHEART Registry

ALABAS O. A., *et al.*

2017

Journal of the American Heart Association 6(12).

http://jaha.ahajournals.org/content/ahaoa/6/12/e007123.full.pdf

This study assessed sex differences in treatments, all-cause mortality, relative survival, and excess mortality following acute myocardial infarction. A population-based cohort of all hospitals providing acute myocardial infarction care in Sweden (SWEDEHEART [Swedish Web System for Enhancement and Development of Evidence-Based Care in Heart Disease Evaluated According to Recommended Therapies]) from 2003 to 2013 was included in the analysis. Excess mortality rate ratios (EMRRs), adjusted for clinical characteristics and guideline-indicated treatments after matching by age, sex, and year to background mortality data, were estimated. The study concludes that women with acute myocardial infarction did not have statistically different all-cause mortality, but had higher excess mortality compared with men that was attenuated after adjustment for the use of guideline-indicated treatments. This suggests that improved adherence to guideline recommendations for the treatment of acute myocardial infarction may reduce premature cardiovascular death among women.

International Migrants' Use of Emergency Departments in Europe Compared with Non-Migrants' Use: A Systematic Review

CREDE S. H., *et al.*

2018

Eur J Public Health 28(1): 61-73.

International migration across Europe is increasing. High rates of net migration may be expected to increase pressure on healthcare services, including emergency services. However, the extent to which immigration creates additional pressure on emergency departments (EDs) is widely debated. This review synthesizes the evidence relating to international migrants' use of EDs in European Economic Area (EEA) countries as compared with that of non-migrants. MEDLINE, EMBASE, CINAHL, The Cochrane Library and The Web of Science were searched for the years 2000-16. Twenty-two articles (from six host countries) were included. The principal finding of this review is that migrants utilize the ED more, and differently, to the native populations in EEA countries. The higher use of the ED for low-acuity presentations and the use of the ED during unsocial hours suggest that barriers to primary healthcare may be driving the higher use of these emergency services although further research is needed.

Migrant Women Living with HIV in Europe: Are They Facing Inequalities in the Prevention of Mother-To-Child-Transmission of HIV? The European Pregnancy and Paediatric HIV Cohort Collaboration (EPPICC) Study Group in Eurocoord

FAVARATO G., *et al.*

2018

Eur J Public Health 28(1): 55-60.

In pregnancy early interventions are recommended for prevention of mother-to-child-transmission (PMTCT) of HIV. We examined whether pregnant women who live with HIV in Europe and are migrants encounter barriers in accessing HIV testing and care. Methods: Four cohorts within the European Pregnancy and Paediatric HIV Cohort Collaboration provided data for pooled analysis of 11 795 pregnant women who delivered in 2002-12 across ten European countries. We defined a migrant as a woman delivering in a country different from her country of birth and grouped the countries into seven world regions. We compared three suboptimal PMTCT interventions (HIV diagnosis in late pregnancy in women undiagnosed at conception, late anti-retroviral therapy (ART) start in women diagnosed but untreated at conception and detectable viral load (VL) at delivery in women on antenatal ART) in native and migrant women using multivariable logistic regression models. Results: Data included 9421 (79.9%) migrant women, mainly from sub-Saharan Africa (SSA); 4134 migrant women were diagnosed in the current pregnancy, often (48.6%) presenting with CD4 count <350 cells/microl. Being a migrant was associated with HIV diagnosis in late pregnancy [OR for SSA vs. native women, 2.12 (95% CI 1.67, 2.69)] but not with late ART start if diagnosed but not on ART at conception, or with detectable VL at delivery once on ART. Conclusions: Migrant women were more likely to be diagnosed in late pregnancy but once on ART virological response was good. Good access to antenatal care enables the implementation of PMTCT protocols and optimises both maternal and children health outcomes generally.

Les demandeurs de l'aide médicale d'État pris entre productivisme et gestion spécifique

GABARRO C.

2012

Revue Européenne Des Migrations Internationales 28(2): 35-56.

En 2000 est créée l'aide médicale d'État (AME), une couverture maladie réservée aux personnes en situation irrégulière. Dans cet article, nous nous intéressons aux conséquences de cette spécificité sur l'accès aux soins de ces personnes dans trois champs : le droit, l'organisation des caisses d'assurance maladie et les pratiques des agents de ces caisses (aussi bien les agents d'accueil qui reçoivent les demandeurs, que les agents du service AME qui instruisent les dossiers). La combinaison de ces trois angles d'approche permettra d'identifier le parcours effectué par les personnes en situation irrégulière et les embûches rencontrées. Nous verrons que cantonner les personnes en situation irrégulière au sein d'une prestation qui leur est propre crée un système de santé à plusieurs vitesses, favorisant la réception de ce public dans des lieux distincts ou de manières différenciées et limitant son accès aux soins et aux structures. Nous serons particulièrement attentifs à l'impact de la gestion productiviste sur l'accueil de ces personnes et le traitement de leur dossier : les

rendements imposés aux agents des caisses et leur manque de formation les poussent à réclamer aux demandeurs plus de justificatifs, différant toujours plus leur accès aux soins.

De la « crise des migrants » à la crise de l'Europe : un éclairage démographique

HÉRAN F.

2017

In Boucheron P./dir. Migrations, réfugiés, exil. Paris : Odile Jacob: 239-260.

« Il n'est qu'une seule espèce humaine sur la Terre, et cette espèce est migrante. Depuis le début de l'histoire, nous sommes embarqués. Et, aujourd'hui, nous sommes écrasés sous le poids de notre fardeau, celui de notre responsabilité face à l'histoire : car nous savons que nous serons jugés sur notre capacité à affronter la situation des migrants. Ce livre est un appel au calme, un effort de description réaliste. On estime qu'il y a actuellement dans le monde 244 millions de migrants, dont 100 millions sont des migrants forcés. L'Europe est un continent d'immigration au même titre que les États-Unis. Telle est la réalité. On oppose généralement les beaux principes aux dures réalités. Mais nous sommes bien, avec le présent ouvrage, dans le réel. Ce qu'il réclame de nous ? De la considération. »

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

LANDI S., *et al.*

2018

Health Policy: [Ahead of print]

http://dx.doi.org/10.1016/j.healthpol.2018.01.003

Literature review on works examining the relation between SES and waiting times. Only seven out of twenty-eight works do not find any association. Three different health services in a specific country context are analysed (Italy). Horizontal inequalities arise even though care is not rationed through ability to pay. Inequalities are higher in specialist visits and diagnostic tests than elective surgeries.

La santé des migrants : le syndrome d'Ulysse

LE FERRAND P.

2017

Médecine : de la Médecine factuelle à nos pratiques 13(9): 409-417.

Lorsque les médecins sont amenés à rencontrer des migrants en consultation, la demande se fait le plus souvent sur des plaintes somatiques multiples et diffuses et sur une profonde souffrance psychique qu'ils associent à l'état de stress post-traumatique (ESPT). Pourtant le diagnostic de syndrome post-traumatique ne correspond pas toujours aux troubles observés. Dans de très nombreux cas, il s'agit en réalité d'un épuisement psychique ressemblant à une forme de burnout que certains cliniciens ont dénommé « syndrome d'Ulysse ».

Unhealthy Assimilation or Persistent Health Advantage? A Longitudinal Analysis of Immigrant Health in the United States

LU Y., *et al.*

2017

Soc Sci Med 195: 105-114.

Existing evidence on immigrant health assimilation, which is largely based on cross-sectional data, suggests that immigrants' initial health advantage erodes over time. This study uses longitudinal data to directly compare the self-rated health trajectories of immigrants and the native-born population. Data come from four panels of the Survey of Income and Program Participation (1996, 2001, 2004, and 2008), with each panel containing 2-4 years of health information. Results show that immigrants' self-rated health remained stable during the period under study, but there was a concomitant decline in health for the native-born population. This result pointed to a persistent health advantage of immigrants during the period under study. The pattern held for immigrants of different length of residence and was especially salient for those originally from Latin America and Asia. Our findings that immigrants maintain their health advantage do not support the pattern of unhealthy assimilation commonly reported in cross-sectional studies.

Do Gender Gaps in Education and Health Affect Economic Growth? A Cross-Country Study from 1975 to 2010

MANDAL B., *et al.*

2018

Health Economics: Ahead of print.

We use system-generalized method-of-moments to estimate the effect of gender-specific human capital on economic growth in a cross-country panel of 127 countries between 1975 and 2010. There are several benefits of using this methodology. First, a dynamic lagged dependent econometric model is suitable to address persistence in per capita output. Second, the generalized method-of-moments estimator uses dynamic properties of the data to generate appropriate instrumental variables to address joint endogeneity of the explanatory variables. Third, we allow the measurement error to include unobserved country-specific effect and random noise. We include two gender-disaggregated measures of human capital-education and health. We find that gender gap in health plays a critical role in explaining economic growth in developing countries. Our results provide aggregate evidence that returns to investments in health systematically differ across gender and between low-income and high-income countries.

Gypsy, Roma and Traveller Access to and Engagement with Health Services: A Systematic Review

MCFADDEN A., *et al.*

2018

Eur J Public Health 28(1): 74-81.

Gypsy, Roma and Traveller people represent the most disadvantaged minority groups in Europe, having the poorest health outcomes. This systematic review addressed the question of how Gypsy, Roma and Traveller people access healthcare and what are the best ways to enhance their engagement with health services. Searches were conducted in 21 electronic databases complemented by a focused Google search. Studies were included if they had sufficient focus on Gypsy, Roma or Traveller populations; reported data pertinent to healthcare service use or engagement and were published in English from 2000 to 2015. Study findings were analyzed thematically and a narrative synthesis reported. This review provides evidence that Gypsy, Roma and Traveller populations across Europe struggle to exercise their right to healthcare on account of multiple barriers; and related to other determinants of disadvantage such as low literacy levels and experiences of discrimination. Some promising strategies to overcome barriers were reported but the evidence is weak; therefore, rigorous evaluations of interventions to improve access to and engagement with health services for Gypsy, Roma and Traveller people are needed.

Primary Care for Refugees and Newly Arrived Migrants in Europe: A Qualitative Study on Health Needs, Barriers and Wishes

VAN LOENEN T., *et al.*

2018

Eur J Public Health 28(1): 82-87.

In order to provide effective primary care for refugees and to develop interventions tailored to them, we must know their needs. Little is known of the health needs and experiences of recently arrived refugees and other migrants throughout their journey through Europe. We aimed to gain insight into their health needs, barriers in access and wishes regarding primary health care. In the spring of 2016, we conducted a qualitative, comparative case study in seven EU countries in a centre of first arrival, two transit centres, two intermediate-stay centres and two longer-stay centres using a Participatory Learning and Action research methodology. A total of 98 refugees and 25 healthcare workers participated in 43 sessions. The main health problems of the participants related to war and to their harsh journey like common infections and psychological distress. They encountered important barriers in accessing healthcare: time pressure, linguistic and cultural differences and lack of continuity of care. They wish for compassionate, culturally sensitive healthcare workers and for more information on procedures and health promotion. Health of refugees on the move in Europe is jeopardized by their bad living circumstances and barriers in access to healthcare. To address their needs, healthcare workers have to be trained in providing integrated, compassionate and cultural competent healthcare.

Médicaments

La déprescription médicamenteuse, un acte médical de salubrité publique

PUGNET G., *et al.*

2017

Médecine : de la Médecine factuelle à nos pratiques 13(9): 405-408.

Cela fait plus de 20 ans que toutes les études et tous les auteurs se penchant sur ce sujet s'accordent à dire que la consommation médicamenteuse est trop importante dans les pays industrialisés et particulièrement en France. L'importance croissante et la gravité des pathologies iatrogènes médicamenteuses deviennent un enjeu majeur de santé publique. La polymédicamentation en est une des principales responsables. Pour combattre ce fléau, il faut inventer cet acte de responsabilité médicale que l'on pourrait appeler « déprescription médicamenteuse », et qu'il faut donc promouvoir et enseigner. « La thérapeutique est aussi la science de l'art de dé-prescrire ».

Potentially Inappropriate Medication Among People with Dementia in Eight European Countries

RENOM-GUITERAS A., *et al.*

2018

Age Ageing 47(1): 68-74.

The aim of this paper is to evaluate the frequency of potentially inappropriate medication (PIM) prescription among older people with dementia (PwD) from eight countries participating in the European study 'RightTimePlaceCare', and to evaluate factors and adverse outcomes associated with PIM prescription. Survey of 2,004 PwD including a baseline assessment and follow-up after 3 months. Interviewers gathered data on age, sex, prescription of medication, cognitive status, functional status, comorbidity, setting and admission to hospital, fall-related injuries and mortality in the time between baseline and follow-up. The European Union(7)-PIM list was used to evaluate PIM prescription. Multivariate regression analysis was used to investigate factors and adverse outcomes associated with PIM prescription. Overall, 60% of the participants had at least one PIM prescription and 26.4% at least two. The PIM therapeutic subgroups most frequently prescribed were psycholeptics (26% of all PIM prescriptions) and 'drugs for acid-related disorders' (21%). PwD who were 80 years and older, lived in institutional long-term care settings, had higher comorbidity and were more functionally impaired were at higher risk of being prescribed two PIM or more. The prescription of two or more PIM was associated with higher chance of suffering from at least one fall-related injury and at least one episode of hospitalisation in the time between baseline and follow-up. PIM use among PwD is frequent and is associated with institutional long-term care, age, advanced morbidity and functional impairment. It also appears to be associated with adverse outcomes. Special attention should be paid to psycholeptics and drugs for acid-related disorders.

Méthodologie – Statistique

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

BERSON C. ET FERRARI N.

2017

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

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

Le marché du travail français est segmenté entre les personnes bénéficiant d'un emploi stable et celles alternant contrats temporaires et périodes de chômage. À partir de simulations sur un modèle d'appariement calibré sur la France, la réforme issue de l'accord national interprofessionnel de 2013 apparaît pertinente pour réduire cette dualité. L'estimation des effets des majorations de cotisation sur les CDD et des exonérations pour les embauches de jeunes en CDI introduites par l'ANI du 11 janvier 2013 montre en effet

un impact positif mais faible au regard de la réforme relativement similaire dite à l'italienne et étudiée dans Berson et Ferrari. (2015).

Politique de santé

Le soin, une éthique de l'attention

BALEYLE J. M., *et al.*

2017

Éthique & Santé 14(4): 194-1999.

Porter attention à l'autre, comme méthode et comme éthique, mobilise réceptivité et mise en sens. C'est dans les liens, en référence à la métaphore des poupées russes, que la réceptivité est travaillée, aiguisée et restaurée. Elle implique disponibilité, sensibilité, écoute et est simultanément orientée vers l'extérieur et vers l'intérieur de soi-même, dans un double mouvement synergique ; presque un oxymore, l'attention aux processus inconscients serait paradoxale si elle ne suggérait le détour par soi-même pour porter attention à l'autre et le détour par l'autre, par les autres du groupe, pour élucider les processus en soi. La disponibilité et la vitalité des capacités d'attention imposent une capacité de « détoxification », garantie par les liens, travaillée en particulier dans le groupe de supervision. La réceptivité implique d'accepter, tenir sans les évacuer, émotions et pensées irreprésentables ou dérangeantes, sans mobilisation des systèmes de défense agis ou pensés. Elle recommande sobriété d'action et de parole. Chaque situation de soin saura construire les conditions d'une « contenance institutionnelle » garante de la qualité et de la régénération des processus d'attention par les liens, les compétences, les dispositifs et le temps nécessaires. L'attention apparaît ainsi comme une éthique ; elle ouvre simultanément le chemin de la rencontre de l'autre et de soi-même.

What's Involved with Wanting to Be Involved? Comparing Expectations For Public Engagement in Health Policy Across Research and Care Contexts

BARG, C.J. *et al.*

2017

Healthcare Policy 13(2): 40-56.

We explored public preferences for involvement in health policy decisions, across the contexts of medical research and healthcare. We e-surveyed a sample of Canadians, categorizing respondents by preferences for decision control: (1) more authority; (2) more input; (3) status quo. Two generalized ordered logistic regressions assessed influences on preferences. The participation rate was 94%; 1,102 completed responses met quality criteria. The dominant preference was for more input (average = 52.0%), followed by status quo (average = 24.9%) and more authority (average = 21.1%), though preferences for more control were higher in healthcare (57.2%) than medical research (46.8%). Preferences for greater control were associated with constructs related to reduce trust in healthcare systems. The public expects health policy to account for public views, but not base decisions primarily on these views. More involvement was expected in healthcare than medical research policy. As opportunities for public involvement in health research grow, we anticipate increased desired involvement.

Is User Involvement a Reality or a Dream in LMICs – as Well as in the Rest of the World?

D'AVANZO, B.

2017

Epidemiology and Psychiatric Sciences 27(1): 40-41.

https://www.cambridge.org/core/article/is-user-involvement-a-reality-or-a-dream-in-lmics-as-well-as-in-the-rest-of-the-world/C73127CF6485536BDB07E3A9DC54E125

Mieux comprendre le processus d'empowerment du patient

FAYN M.-G., *et al.*

2017

Recherches en Sciences de Gestion 119(2): 55-73.

https://www.cairn.info/revue-recherches-en-sciences-de-gestion-2017-2-page-55.htm

Co-décideur de son traitement, co-rédacteur des lois, le patient est sorti du silence et de l'invisibilité. Sa prise de pouvoir s'étend à la production de connaissances et de solutions nouvelles. Cet article propose une meilleure compréhension du processus d'empowerment du patient chronique. Après une revue de littérature multidisciplinaire autour des concepts d'empowerment et de Patient-Centered-Care, une étude exploratoire a été réalisée auprès de quatre experts. Elle conduit à l'identification de quatre phases structurant le processus d'empowerment du patient : individuel, collectif, collaboratif et productif. Phénomène social, l'empowerment des patients transforme la relation de soin en une nouvelle alliance plus symétrique.

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

KROEZEN M., *et al.*

2018

Health Policy 122 (2) : 87-93

http://dx.doi.org/10.1016/j.healthpol.2017.12.002

The Joint Action Health Workforce Planning and Forecasting (JAHWF) ran from 2013 to 2016. The JAHWF has provided the basic tools and insights to start a planning process. The JAHWF showed that health workforce planning is a context-sensitive process. Investments are needed in the context-sensitivity and evaluation of health workforce planning.

Parcours de santé des enfants confiés à l'Aide Sociale à l'Enfance des Bouches-du-Rhône

MARTIN A., *et al.*

2017

Santé Publique 29(5): 665-675.

https://www.cairn.info/revue-sante-publique-2017-5-page-665.htm

L'objectif de cet article est de décrire le parcours de santé des enfants confiés à l'Aide Sociale à l'Enfance dans les Bouches-du-Rhône et proposer des préconisations pour améliorer le parcours de santé des enfants confiés. Cet article présente des données issues de l'enquête ESSPER-ASE 13, enquête descriptive et transversale menée entre avril 2013 et avril 2014 auprès de 1 092 enfants âgés de moins de 18 ans confiés à l'Aide Sociale à l'Enfance en Maison d'Enfants à Caractère Social ou chez un assistant familial dans les Bouches-du-Rhône. Les données étudiées concernaient l'état de santé somatique, psychique et les modalités du suivi médical des enfants. Cet article se centre sur le parcours de santé. Un médecin généraliste suivait 82 % des enfants alors que la Protection Maternelle et Infantile suivait 15 % des enfants, essentiellement les enfants de moins de six ans confiés à un assistant familial. Le parcours de santé des enfants était constitué de multiples intervenants et était dominé par le suivi psychologique. En moyenne les enfants étaient suivis par deux professionnels (médecin spécialiste ou personnel paramédical) en plus du médecin examinateur. En matière de prévention, les enfants présentaient des taux de couverture vaccinale supérieurs aux taux nationaux. La coordination des nombreux acteurs de la santé des enfants est indispensable, autour notamment de la création d'un médecin référent.

Personalized Medicine: A Doorway to an Effective Health Care Delivery System?

MINVIELLE E., *et al.*

2017

Journal de gestion et d'économie médicales 35(1): 3-5.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-1-page-3.htm

Assessing Patient Organization Participation in Health Policy: A Comparative Study in France and Italy

SOULIOTIS K.

2017

International Journal of Health Policy and Management 7(1): 48-56.

Even though there are many patient organizations across Europe, their role in impacting health policy decisions and reforms has not been well documented. In line with this, the present study endeavours to fill this gap in the international literature. To this end, it aims to validate further a previously developed instrument (the Health Democracy Index - HDI) measuring patient organization participation in health policy decision-making. In addition, by utilizing this tool, it aims to provide a snapshot of the degree and impact of cancer patient organization (CPO) participation in Italy and France. A convenient sample of 188 members of CPOs participated in the study (95 respondents from 10 CPOs in Italy and 93 from 12 CPOs in France). Findings indicate that the index has good internal consistency and the construct it taps is unidimensional. The degree and impact of CPO participation in health policy decision-making were found to be low in both countries; however in Italy they were comparatively lower than in France. In conclusion, the HDI can be effectively used in international policy and research contexts. CPOs participation is low in Italy and France and concerted efforts should be made on upgrading their role in health policy decision-making.

Prévention

Changes in Smoking Behavior over Family Transitions: Evidence for Anticipation and Adaptation Effects

BRICARD D., *et al.*

2017

International Journal of Environmental Research and Public Health 14(6): 610.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5486296/

The study of changes in smoking behaviors over the life course is a promising line of research. This paper aims to analyze the temporal relation between family transitions (partnership formation, first childbirth, separation) and changes in smoking initiation and cessation. We propose a discrete-time logistic model to explore the timing of changes in terms of leads and lags effects up to three years around the event in order to measure both anticipation and adaptation mechanisms. Retrospective biographical data from the Santé et Itinéraires Professionnels (SIP) survey conducted in France in 2006 are used. Partnership formation was followed for both genders by a fall in smoking initiation and an immediate rise in smoking cessation. Childbirth was associated with increased smoking cessation immediately around childbirth, and additionally, females showed an anticipatory increase in smoking cessation up to two years before childbirth. Couple separation was accompanied by an anticipatory increase in smoking initiation for females up to two years prior to the separation, but this effect only occurred in males during separation. Our findings highlight opportunities for more targeted interventions over the life course to reduce smoking, and therefore have relevance for general practitioners and public policy elaboration.

A Two-Step Screening Process Reduces Hip Fractures

CAULEY J. A.

2017

The Lancet

http://dx.doi.org/10.1016/S0140-6736(17)33295-6

Éducation thérapeutique du patient et éthique : de l'impératif de santé publique aux droits des personnes et des usagers

RUSCH E.

2017

Santé Publique 29(5): 601-603.

https://www.cairn.info/revue-sante-publique-2017-5-page-601.htm

Concevoir une intervention éducative pour prévenir la chute des personnes âgées en logement social : description d'une méthode de recherche

TREVIDY F., *et al.*

2017

Santé Publique 29(5): 623-634.

https://www.cairn.info/revue-sante-publique-2017-5-page-623.htm

Dans un environnement social où la prévention de la chute des personnes âgées est devenue un enjeu de santé publique, l'adaptation du logement des habitants âgés prend toute son importance. Partant du modèle de l'identité-logement, notre recherche vise à concevoir un modèle éducatif spécifique au contexte d'une Entreprise Sociale pour l'Habitat (ESH), centré sur le locataire âgé ayant déjà chuté pour lui permettre d'adapter son logement et d'éviter la récidive. Cet article décrit la méthode de recherche collaborative orientée par la conception (RoC) ayant permis au comité de recherche formé de professionnels, locataire et chercheurs, de construire l'intervention éducative à partir de l'étude du contexte de l'ESH.

Prévision - Evaluation

Design of Effective Interventions for Smoking Cessation Through Financial and Non-Financial Incentives

BALDERRAMA F. ET LONGO C. J.

2017

Healthcare Management Forum 30(6): 289-292.

http://journals.sagepub.com/doi/abs/10.1177/0840470417714490

Smoking has a tremendous negative impact on the Canadian economy and contributes to growing costs in the healthcare system. Efforts to reduce smoking rates may therefore reduce strain on the healthcare system and free up scarce resources. Academic literature on economic smoking cessation incentives presents a countless variety of interventions that have met with varying degrees of success. This study reviews six different variables used in the design of incentives in smoking cessation interventions: direction, form, magnitude, certainty, recipient grouping, and target demographic. The purpose of this study is to provide analysis and recommendations about the contribution of each variable into the overall effectiveness of smoking cessation programs and help health leaders design better interventions according to their specific needs.

Évaluation des politiques publiques : expérimentation randomisée et méthodes quasi-expérimentales

CHABÉ-FERRET S., *et al.*

2017

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

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

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

Psychiatrie

Santé mentale : de l'exception au droit commun?

BASSET B.

2017

Actualité et Dossier en Santé Publique(100): 49-55.

Les droits des personnes souffrant de troubles psychiatriques, les pratiques professionnelles ou l'organisation du système de santé mentale ont évolué au cours des décennies. Adsp a abordé la problématique sous des angles différents dans plusieurs dossiers. Cet article fait une rétrospective des approches, mais aussi réformes, dispositifs et mesures mis en œuvre durant ces dernières années, et des préconisations pour que le débat soit transparent et public.

Management of First Depression or Generalized Anxiety Disorder Episode in Adults in Primary Care: A Systematic Metareview

DRIOT D., *et al.*

2017

Presse Med 46(12 Pt 1): 1124-1138.

General Practitioners (GPs) are the leading antidepressants prescribers in Europe and in France. Difficulties in implementing existing recommendations in daily practice have been described. The objective of this study was to elaborate two algorithms to guide GPs in the patient management for a first major depressive disorder (MDD) or generalized anxiety disorder (GAD) episode in primary care. PubMed, Cochrane, and ISI Web of Science were explored using mainly the following keywords: depressive disorder, anxiety disorders, antidepressive agents or antidepressant. A systematic meta-review (overview of reviews) including systematic reviews, meta-analyses, guidelines and clinical practice recommendations, published from January 2002 to December 2015, was performed. The methodological and report qualities were assessed by the AGREE II, PRISMA checklist and R-AMSTAR grid. From the best evidence-based data, we created two algorithms to guide GPs for the management of MDD and or the management of GAD. These algorithms will be implemented through a website available for GPs consultation.

National Trends in Specialty Outpatient Mental Health Care Among Adults

HAN B., *et al.*

2017

Health Aff (Millwood) 36(12): 2062-2068.

We examined national trends in the receipt of specialty outpatient mental health care, using data for 2008-15 from the National Survey on Drug Use and Health. Between 2008-09 and 2014-15 the number of US adults who received outpatient mental health care in the specialty sector rose from 11.3 million to 13.7 million per year, representing an increase from 5.0 percent to 5.7 percent of the adult population. Among those recipients, however, the annual weighted mean number of visits to the specialty sector remained unchanged. We found increases in both numbers and percentages of adults who received care within the specialty sector across age and sex groups and among non-Hispanic whites, people with Medicare, people with private health insurance, and people with family incomes of $20,000-$49,999. Increases in receipt of specialty mental health care during 2012-15 may be related to recent policy initiatives aimed at reducing financial barriers to care.

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

OSE S. O., *et al.*

2017

Health Policy: [Ahead of print]

Inpatient bed numbers are continually being reduced but are not being replaced with adequate alternatives in primary health care. There is a considerable risk that eventually all inpatient treatment will be unplanned, because planned or elective treatments are superseded by urgent needs when capacity is reduced. The aims of this study is to estimate the rate of unplanned admissions to inpatient psychiatric treatment facilities in Norway and analyse the difference between patients with unplanned and planned admissions regarding services received during the three months prior to admission as well as clinical, demographical and socioeconomic characteristics of patients. Unplanned admissions were defined as all urgent and

involuntary admissions including unplanned readmissions. National mapping of inpatients was conducted in all inpatient treatment psychiatric wards in Norway on a specific date in 2012. Patients with high risk of unplanned admission are suffering from severe mental illness, have low functional level indicated by the need for housing services, high risk for suicide attempt and of being violent, low education and born outside Norway. Specialist mental health services should support the local services in their efforts to prevent unplanned admissions by providing counselling, short inpatient stays, outpatient treatment and ambulatory outpatient psychiatry services. This paper suggests the rate of unplanned admissions as a quality indicator and considers the introduction of economic incentives in the income models at both service levels.

Comment les soins psychiatriques sans consentement en ambulatoire se sont imposés en Suède ? Une comparaison socio-politique avec la Norvège, le Royaume-Uni et New York

SJÖSTRÖM S.

2017

L'information psychiatrique 93(10): 847-853.

https://www.cairn.info/revue-l-information-psychiatrique-2017-10-page-847.htm

Cet article s'attache à comprendre une évolution remarquable des politiques de santé mentale au cours des vingt-cinq dernières années : comment expliquer que les soins psychiatriques sans consentement en ambulatoire (compulsory community care ou CCC) soient apparus comme une solution dans tant de contextes sociaux et juridiques différents ? Nous partirons du cas de l'introduction des CCC en Suède, pour le comparer ensuite à celui de la Norvège, de l'Angleterre/du Pays de Galles et de l'État de New York.

Consultation ambulatoire en cabinet libéral et en CMP : deux cliniques ou deux patientèles ?

WINTER E.

2017

L'Informations psychiatriques 93(9): 934-938.

La consultation ambulatoire en CMP et en cabinet libéral se différencient plus par leurs patientèles que par la pratique clinique qui y est exercée. Mais ces généralités cachent des variations importantes entre les psychiatres de même exercice, et surtout au sein même de la consultation de chaque psychiatre quel que soit son exercice. Les patients font appel à l'ensemble des soins accessibles sur leur territoire à des temps différents de leur prise en charge, trouvant parfois un réel intérêt à la diversité de ces cadres. La démographie médicale prévoit néanmoins un avenir plus difficile pour l'effectif des psychiatres libéraux par rapport aux salariés.

Soins de santé primaires

La médecine prédictive quinze ans après

AYMÉ S.

2017

Actualité et Dossier en Santé Publique(100): 13-16.

En 2001, la revue Adsp consacrait un dossier à la médecine prédictive et aux espoirs ou craintes qu'elle suscitait, sans toutefois surestimer l'impact potentiel en santé publique des nouvelles connaissances issues du génome. Pourtant la tendance était la surévaluation de la valeur prédictive des tests, à la croyance dans la contribution majeure du patrimoine génétique à la survenue des maladies. Aujourd'hui la science a progressé, on parle moins de médecine prédictive, et plus de médecine de précision, de médecine personnalisée..

Exploring the Impact and Use of Patients' Feedback About Their Care Experiences in General Practice Settings-A Realist Synthesis

BALDIE D. J., *et al.*

2018

Fam Pract 35(1): 13-21.

Policy encourages health care providers to listen and respond to feedback from patients, expecting that it will enhance care experiences. Enhancement of patients' experiences may not yet be a reality, particularly in primary health care settings. The aim of this study is to identify the issues that influence the use and impact of feedback in this context. Analysis is founded on a realist synthesis of studies of the use of patient feedback within primary health care settings. Structured review of published studies between 1971 and January 2015 were performed. There is little evidence that formal patient feedback led to enhanced experiences. The likelihood of patient feedback to health care staff stimulating improvements in future patients' experiences appears to be influenced predominantly by staff perceptions of the purpose of such feedback; the validity and type of data that is collected; and where, when and how it is presented to primary health care teams or practitioners and teams' capacity to change. There is limited research into how patient feedback has been used in primary health care practices or its usefulness as a stimulant to improve health care experience. Using a realist synthesis approach, we have identified a number of contextual and intervention-related factors that appear to influence the likelihood that practitioners will listen to, act on and achieve improvements in patient experience. Consideration of these may support research and improvement work in this area.

Chevauchement, interdépendance ou complémentarité ? La collaboration interprofessionnelle entre l'infirmière praticienne et d'autres professionnels de santé en Ontario

BENOIT M., *et al.*

2017

Santé Publique 29(5): 693-706.

https://www.cairn.info/revue-sante-publique-2017-5-page-693.htm

Le rapport Naylor de 2015 précise que les infirmières praticiennes (IP) sont sous-utilisées au Canada, et ce, malgré les preuves favorables à leur égard, les avantages qu'elles apporteraient aux systèmes de santé ainsi qu'à la santé de la population plus généralement. Comment expliquer qu'elles ne soient pas plus présentes à pratiquer dans le système de santé canadien ? Une revue de littérature, sociohistorique, a permis de montrer qu'il existe un chevauchement, une interdépendance ou une complémentarité entre le rôle de l'IP et celui d'autres professionnels de la santé et que cela concerne son statut, sa formation autant que l'étendue de sa pratique. Le développement d'une approche collaborative interprofessionnelle, bien que réclamée par la plupart des associations professionnelles d'infirmières au pays, a du mal à s'implanter dans le cadre de la pratique et de la formation des IP. Le présent texte retrace l'émergence du rôle des IP au Canada et fait le point sur la situation actuelle relativement à leur intégration dans le système de santé en se référant à l'exemple ontarien.

Small Cash Incentives Can Encourage Primary Care Visits by Low-Income People with New Health Care Coverage

BRADLEY C. J. ET NEUMARK D.

2017

Health Aff (Millwood) 36(8): 1376-1384.

In a randomized controlled trial, we studied low-income adults newly covered by a primary care program to determine whether a cash incentive could encourage them to make an initial visit to a primary care provider. Subjects were randomly assigned to one of four groups: three groups whose members received $10 to complete a baseline survey during an interview and who were randomized to incentives of $50, $25, or $0 to visit their assigned primary care provider within six months after enrolling in the study; and a nonincentivized control group not contacted by the research team. Subjects in the $50 and $25 incentive groups were more likely to see a primary care provider (77 percent and 74 percent, respectively), compared to subjects in the $0 incentive group (68 percent). The effects of the intervention were about twice as large when we compared the proportions of subjects in the $50 and $25 incentive groups who visited their providers and the proportion in the non incentivized group (61 percent). Cash incentive programs may steer newly covered low-income patients toward primary care, which could result in improved health outcomes and lower costs.

▶ Les médecins en 2017 : des carrières bouleversées par les changements dans le système de santé ?

CHARPAK Y.

2017

Actualité et Dossier en Santé Publique(100): 65-69.

L'exercice médical évolue sans cesse. Face notamment aux patients de plus en plus formés et informés, les médecins doivent ajuster leurs pratiques. Les modes d'exercice se diversifient aussi, avec, des plus en plus, des activités plurielles. Cet article donne un éclairage sur cette évolution à travers des témoignages de professionnels.

▶ Les relations médecin-malade. Des temps modernes à l'époque contemporaine

CHEVANDIER C.

2015

Revue d'histoire de la protection sociale 8(1): 190-192.

https://www.cairn.info/revue-d-histoire-de-la-protection-sociale-2015-1-page-190.htm

Cet article est la reprise d'une communication donnée lors d'un congrès tenu à Paris, en 2010, qui s'intitulait : Regards croisés sur les relations médecins-malades de la fin du Moyen Âge à l'époque contemporaine ». Basé sur une approche multi-disciplinaire, il retrace l'historique de la relation médecins patients en France, des travaux de Michel Foucault jusqu'à nos jours.

▶ Quantifier la qualité des soins : une critique de la rationalisation de la médecine libérale française

DA SILVA N.

2017

Revue Française de socio-économie(19): 111-130.

Avec la logique de quantification de la qualité du travail médical, les patients sont invités à faire confiance aux normes chiffrées déterminées par les agences de santé indépendantes – plutôt que de se fier à la relation personnelle avec leur médecin. Si cette nouvelle régulation ressemble à une rationalisation des pratiques, nous proposons de montrer en quoi il est utile de revenir sur la méthode de production de ces normes du travail médical et de questionner l'usage politique des essais cliniques randomisés. Après avoir rappelé les justifications théoriques et empiriques de la « rationalisation », nous défendons l'idée que la politique de quantification de la qualité des soins repose sur une épistémologie de la maladie arbitraire et une épistémologie des statistiques réductrice. Or cela n'est pas sans conséquences négatives, tant pour les professionnels que pour les patients.

▶ Burnout des soignants : comment éteindre l'incendie ?

DUMOULIN M., *et al.*

2017

Médecine : De la médecine factuelle à nos pratiques 13(9): 396-401.

Les différentes manifestations du burnout, sa prévention et son contexte actuel soulignent l'épidémie silencieuse et le déni trop longtemps persistant de la profession médicale et des pouvoirs publics face à la souffrance au travail de certains soignants. Diverses initiatives et propositions de prévention voient le jour, souvent inspirées des expériences à l'étranger, la quasi-totalité des pays dans le monde étant touchée par ce problème, mais l'évolution législative réclamée n'est toujours pas au rendez-vous et le chemin à parcourir pour aider les médecins à rester en bonne santé ou à faire face à la maladie comme à la souffrance semble encore important. Quelle est l'ampleur de ce problème chez les soignants ? Comment définir, repérer et évaluer le burnout ? De nombreuses publications apportent un éclairage sur cette souffrance liée au travail longtemps restée tabou.

▶ International Variations in Primary Care Physician Consultation Time: A Systematic Review of 67 Countries

IRVING G., *et al.*

2017

BMJ Open 7(10).

http://bmjopen.bmj.com/content/bmjopen/7/10/e017902.full.pdf

The aim of this paper is to describe the average primary care physician consultation length in economically developed and low-income/middle-income countries, and to examine the relationship between consultation length and organisational-level economic, and health

outcomes. A systematic review of published and grey literature was performed from 1946 to 2016, for articles reporting on primary care physician consultation lengths. Data were extracted and analysed for quality, and linear regression models were constructed to examine the relationship between consultation length and health service outcomes. There are international variations in consultation length, and it is concerning that a large proportion of the global population have only a few minutes with their primary care physicians. Such a short consultation length is likely to adversely affect patient healthcare and physician workload and stress.

Community Care for People with Complex Care Needs: Bridging the Gap Between Health and Social Care

KULUSKI K., *et al.*

2017

International Journal for Integrated Care 17(4)

http://doi.org/10.5334/ijic.2944

A growing number of people are living with complex care needs characterized by multimorbidity, mental health challenges and social deprivation. The integration of health and social care is required, beyond traditional health care services, to address social determinants. This study investigates key care components to support complex patients and their families in the community. Conclusions point out that meeting the needs of the population who require health and social care requires time to develop authentic relationships, broadening the membership of the care team, communicating across sectors, co-locating health and social care, and addressing the barriers that prevent providers from engaging in these required practices.

The Content and Meaning of Administrative Work: A Qualitative Study of Nursing Practices

MICHEL L., *et al.*

2017

J Adv Nurs 73(9): 2179-2190.

The aim of this stydy is to investigate the content and meaning of nurses' administrative work. BACKGROUND: Nurses often report that administrative work keeps them away from bedside care. The content and meaning of this work remains insufficiently explored. Founded on comparative case studies, the investigation took place in 2014. It was based on 254 hours of observations and 27 interviews with nurses and staff in two contrasting units: intensive care and long-term care. A time and motion study was also performed over a period of 96 hours. Documentation and Organizational Activities is composed of six categories; documenting the patient record, coordination, management of patient flow, transmission of information, reporting quality indicators, ordering supplies- stock management Equal amounts of time were spent on these activities in each case. Documentation and Organizational Activities are a main component of care. The meaning nurses attribute to them is dependent on organizational context. These activities are often perceived as competing with bedside care, but this does not have to be the case. The challenge for managers is to fully integrate them into nursing practice. Results also suggest that nurses' Documentation and Organizational Activities should be incorporated into informatics strategies.

Multimorbidity Care Model: Recommendations from the Consensus Meeting of the Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle (JA-CHRODIS)

PALMER K., *et al.*

2018

Health Policy 122(1): 4-11.

Patients with multimorbidity have complex health needs but, due to the current traditional disease-oriented approach, they face a highly fragmented form of care that leads to inefficient, ineffective, and possibly harmful clinical interventions. There is limited evidence on available integrated and multidimensional care pathways for multimorbid patients. An expert consensus meeting was held to develop a framework for care of multimorbid patients that can be applied across Europe, within a project funded by the European Union; the Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS). The experts included a diverse group representing care providers and patients, and included general practitioners, family medicine physicians, neurologists, geriatricians, internists, cardiologists, endocrinologists, diabetologists, epidemiologists, psychologists, and representatives from patient organizations. Sixteen com-

ponents across five domains were identified (Delivery of Care; Decision Support; Self-Management Support; Information Systems and Technology; and Social and Community Resources). The description and aim of each component are described in these guidelines, along with a summary of key characteristics and relevance to multimorbid patients. Due to the lack of evidence-based recommendations specific to multimorbid patients, this care model needs to be assessed and validated in different European settings to examine specifically how multimorbid patients will benefit from this care model, and whether certain components have more importance than others.

Managing Multimorbidity: Profiles of Integrated Care Approaches Targeting People with Multiple Chronic Conditions in Europe

RIJKEN M., *et al.*

2018

Health Policy 122(1): 44-52.

In response to the growing populations of people with multiple chronic diseases, new models of care are currently being developed in European countries to better meet the needs of these people. This paper aims to describe the occurrence and characteristics of various types of integrated care practices in European countries that target people with multimorbidity. Data were analysed from multimorbidity care practices participating in the Innovating care for people with multiple chronic conditions (ICARE4EU) project, covering all 28EU Member States, Iceland, Norway and Switzerland. A total of 112 practices in 24 countries were included: 65 focus on patients with any combination of chronic diseases, 30 on patients with a specific chronic disease with all kinds of comorbidities and 17 on patients with a combination of specific chronic diseases. Practices that focus on a specific index disease or a combination of specific diseases are less extensive regarding the type, breadth and degree of integration than practices that focus on any combination of diseases. The latter type is more often seen in countries where more disciplines, e.g. community nurses, physiotherapists, social workers, work in the same primary care practice as the general practitioners. Non-disease specific practices put more emphasis on patient involvement and provide more comprehensive care, which are important preconditions for person-centered multimorbidity care.

Se former pour construire son espace d'autonomie professionnelle ? Le cas des Nurses practitioners néerlandaises

ROSMAN S.

2014

Recherche & formation 76(2): 79-92.

https://www.cairn.info/revue-recherche-et-formation-2014-2-page-79.htm

Cet article s'intéresse au rôle de la formation Master of Advanced Nursing Practice dans la construction d'un espace d'autonomie professionnelle par les infirmières souhaitant devenir Nurse practitioner. Il repose sur une enquête sociologique qualitative (entretiens et observation directe des pratiques) conduite auprès de Nurses practitioners exerçant dans les cabinets de médecine générale. Formées a priori pour réaliser des tâches réservées aux médecins, ont-elles effectivement obtenu un élargissement de leur autonomie professionnelle ? Les résultats de l'enquête montrent que les motivations des infirmières pour suivre la formation, ainsi que les logiques de fonctionnement des cabinets où elles exercent influent sur leur capacité à créer ou à élargir cet espace d'autonomie.

Point-Of-Care Testing in Primary Care Patients with Acute Cardiopulmonary Symptoms: A Systematic Review

SCHOLS A. M. R., *et al.*

2018

Fam Pract 35(1): 4-12.

Point-of-care tests (POCT) can assist general practitioners (GPs) in diagnosing and treating patients with acute cardiopulmonary symptoms, but it is currently unknown if POCT impact relevant clinical outcomes in these patients. The objectives of this study were to assess whether using POCT in primary care patients with acute cardiopulmonary symptoms leads to more accurate diagnosis and impacts clinical management. We performed a systematic review in four bibliographic databases. Articles published before February 2016 were screened by two reviewers. Studies evaluating the effect of GP use of POCT on clinical diagnostic accuracy and/or effect on treatment and referral rate in patients with cardiopulmonary symptoms were included. We concluded that there is currently limited and inconclusive evidence that actual GP use of POCT in primary care patients with acute cardiopulmonary symptoms leads to more accurate diagnosis

and affects clinical management. However, some studies show promising results, especially when a POCT is combined with a clinical decision rule.

Relevant Models and Elements of Integrated Care for Multi-Morbidity: Results of a Scoping Review

STRUCKMANN V., *et al.*

2018

Health Policy 122(1): 23-35.

In order to provide adequate care for the growing group of persons with multi-morbidity, innovative integrated care programmes are appearing. The aims of the current scoping review were to i) identify relevant models and elements of integrated care for multi-morbidity and ii) to subsequently identify which of these models and elements are applied in integrated care programmes for multi-morbidity. A scoping review was conducted in the following scientific databases: Cochrane, Embase, PubMed, PsycInfo, Scopus, Sociological Abstracts, Social Services Abstracts, and Web of Science. A search strategy encompassing a) models, elements and programmes, b) integrated care, and c) multi-morbidity was used to identify both models and elements (aim 1) and implemented programmes of integrated care for multi-morbidity (aim 2). The study conclude that most models and elements found in the literature focus on integrated care in general and do not explicitly focus on multi-morbidity. In line with this, most programmes identified in the literature build on the CCM. A comprehensive framework that better accounts for the complexities resulting from multi-morbidity is needed.

Patient-Centeredness of Integrated Care Programs for People with Multimorbidity. Results from the European ICARE4EU Project

VAN DER HEIDE I., *et al.*

2018

Health Policy 122(1): 36-43.

This paper aims to support the implementation of patient-centered care for people with multimorbidity in Europe, by providing insight into ways in which patient-centeredness is currently shaped in integrated care programs for people with multimorbidity in European countries. In 2014, expert organizations in 31 European countries identified 200 integrated care practices ('programs') in 25 countries of which 123 were included in our study. Managers of 112 programs from 24 countries completed a questionnaire about characteristics and results of the program, including questions on elements of patient-centeredness. Eight programs that were considered especially innovative or promising were analyzed in depth. This paper concludes that in many European countries innovative approaches are applied to increase patient-centeredness of care for people with multimorbidity. To assess their potential benefits and conditions for implementation, thorough process and outcome evaluations of programs are urgently needed.

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

WONG C. Y. ET HALL J.

2017

Health Policy: 122(2) : 126-133

http://dx.doi.org/10.1016/j.healthpol.2017.11.008

We examine whether Emergency Department (ED) use is affected by patients' experience. Patients with better General Practitioner (GP) experience are less likely to visit ED. Availability of zero-cost GP services does not affect likelihood of ED use. Results suggest improving GP quality is important in reducing avoidable hospital use.

Systèmes de santé

Interventions and Approaches to Integrating HIV and Mental Health Services: A Systematic Review

CHUAH F. L. H., *et al.*

2017

Health Policy Plan 32(suppl_4): iv27-iv47.

The frequency in which HIV and AIDS and mental health problems co-exist, and the complex bi-directional relationship between them, highlights the need for effective care models combining services for HIV and mental health. Here, we present a systematic review that synthesizes the literature on interventions and approaches integrating these services. This review was part of a larger systematic review on integration of services for HIV and non-communicable diseases. We identified three models of integration at the meso and micro levels: single-facility integration, multi-facility integration, and integrated care coordinated by a non-physician case manager. Single-site integration enhances multidisciplinary coordination and reduces access barriers for patients. However, the practicality and cost-effectiveness of providing a full continuum of specialized care on-site for patients with complex needs is arguable. Integration based on a collaborative network of specialized agencies may serve those with multiple co-morbidities but fragmented and poorly coordinated care can pose barriers. Integrated care coordinated by a single case manager can enable continuity of care for patients but requires appropriate training and support for case managers. Involving patients as key actors in facilitating integration within their own treatment plan is a promising approach. This review identified much diversity in integration models combining HIV and mental health services, which are shown to have potential in yielding positive patient and service delivery outcomes when implemented within appropriate contexts. Our review revealed a lack of research in low- and middle- income countries, and was limited to most studies being descriptive. Overall, studies that seek to evaluate and compare integration models in terms of long-term outcomes and cost-effectiveness are needed, particularly at the health system level and in regions with high HIV and AIDS burden.

Health Systems Facilitators and Barriers to the Integration of HIV and Chronic Disease Services: A Systematic Review

WATT N., *et al.*

2017

Health Policy Plan 32(suppl_4): iv13-iv26.

Integration of services for patients with more than one diagnosed condition has intuitive appeal but it has been argued that the empirical evidence to support it is limited. We report the findings of a systematic review that sought to identify health system factors, extrinsic to the integration process, which either facilitated or hindered the integration of services for two common disorders, HIV and chronic non-communicable diseases. Findings were initially extracted and organized around a health system framework, followed by a thematic cross-cutting analysis and validation steps. Of the 150 articles included, 67% (n = 102) were from high-income countries. The articles explored integration with services for one or several chronic disorders, the most studied being alcohol or substance use disorders (47.7%), and mental health issues (29.5%). These findings confirm that integration processes in service delivery depend substantially for their success on characteristics of the health systems in which they are embedded.

Travail et santé

Interventions pour le retour et le maintien au travail après un cancer : revue de la littérature

CARON M., *et al.*

2017

Santé Publique 29(5): 655-664.

https://www.cairn.info/revue-sante-publique-2017-5-page-655.htm

La reprise du travail après un cancer peut être un défi et les interventions conçues pour la soutenir sont encore mal comprises. L'objectif de cette étude est d'identifier les interventions visant la reprise et le maintien au travail des personnes ayant reçu un diagnostic de cancer. Une revue de la littérature a été réalisée. La recherche documentaire a principalement été menée dans des bases de données de références bibliographiques. Un processus systématique d'analyse et d'interprétation des résultats a ensuite été complété. Un premier constat est qu'il existe très peu d'interventions spécifiquement élaborées pour soutenir la reprise et le maintien au travail des personnes ayant reçu un diagnostic de cancer et qu'elles sont principalement proposées par des professionnels de la santé et en milieu clinique. Les activités qui sous-tendent ces interventions sont de la guidance, la remise d'informations et la tenue de groupes de soutien/discussion/information. Les équipes impliquées dans de telles interventions sont multidisciplinaires et se composent généralement d'un ou plusieurs professionnels : médecin du travail, travailleur social et infirmière. Un deuxième constat réside en l'absence de mesure d'efficacité des interventions en dépit de protocoles d'études expérimentaux et quasi-expérimentaux.

Paid Employment and Common Mental Disorders in 50–64-Year Olds: Analysis of Three Cross-Sectional Nationally Representative Survey Samples in 1993, 2000 and 2007

PERERA G., *et al.*

2017

Epidemiology and Psychiatric Sciences : [Ahead of print]

http://d.repec.org/n?u=RePEc:ehl:lserod:84652&r=hea

Associations between employment status and mental health are well recognised, but evidence is sparse on the relationship between paid employment and mental health in the years running up to statutory retirement ages using robust mental health measures. In addition, there has been no investigation into the stability over time in this relationship: an important consideration if survey findings are used to inform future policy. The aim of this study is to investigate the association between employment status and common mental disorder (CMD) in 50–64-year old residents in England and its stability over time, taking advantage of three national mental health surveys carried out over a 14-year period. Data were analysed from the British National Surveys of Psychiatric Morbidity of 1993, 2000 and 2007. Paid employment status was the primary exposure of interest and CMD the primary outcome – both ascertained identically in all three surveys (CMD from the revised Clinical Interview Schedule). Multivariable logistic regression models were used.

Replacement Care' for Working Carers? A Longitudinal Study in England

PICKARD L., *et al.*

2017

Social Policy & Administration [Ahead of print]

http://d.repec.org/n?u=RePEc:ehl:lserod:84071&r=age

In the context of rising need for long-term care, reconciling unpaid care and carers' employment is becoming an important social issue. In England, there is increasing policy emphasis on paid services for the person cared for, sometimes known as 'replacement care', to support working carers. Previous research has found an association between 'replacement care' and carers' employment. However, more information is needed on potential causal connections between services and carers' employment. This mixed methods study draws on new longitudinal data to examine service receipt and carers' employment in England. Data were collected from carers who were employed in the public sector, using self-completion questionnaires in 2013 and 2015, and qualitative interviews were conducted with a sub-sample of respondents to the 2015 questionnaire. We find that, where the person cared for did not receive at least one 'key service' (home care, personal assistant, day care, meals, short-term breaks), the carer

was subsequently more likely to leave employment because of caring, suggesting that the absence of services contributed to the carer leaving work. In the interviews, carers identified specific ways in which services helped them to remain in employment. We conclude that, if a policy objective is to reduce the number of carers leaving employment because of caring, there needs to be greater access to publicly-funded services for disabled and older people who are looked after by unpaid carers.

Vieillissement

▶ Identification of Older Adults with Frailty in the Emergency Department Using a Frailty Index: Results from a Multinational Study

BROUSSEAU A.-A., *et al.*

2017

Age and Ageing: 47(2):242-248.

http://dx.doi.org/10.1093/ageing/afx168

Frailty is a central concept in geriatric medicine, yet its utility in the Emergency Department (ED) is not well understood nor well utilised. Our objectives were to develop an ED frailty index (FI-ED), using the Rockwood cumulative deficits model and to evaluate its association with adverse outcomes. This was a large multinational prospective cohort study using data from the interRAI Multinational Emergency Department Study. The FI-ED was developed from the Canadian cohort and validated in the multinational cohort. All patients aged ≥75 years presenting to an ED were included. There were 2,153 participants in the Canadian cohort and 1,750 in the multinational cohort. The distribution of the FI-ED was similar to previous frailty indices. The study concludes that the FI-ED is conformed to characteristics previously reported. A FI, developed and validated from a brief geriatric assessment tool could be used to identify ED patients at higher risk of adverse events.

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

DUBOIS Y. ET KOUBI M.

2017

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

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

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

▶ Vieillissement : des politiques toujours liées à l'âge, et peu de coordination

HENRARD J. C.

2017

Actualité et Dossier en Santé Publique(100): 52-55.

En 1997, la revue Adsp publiait deux dossiers sur le vieillissement. Depuis cette époque, de nombreux débats ont eu lieu, des réformes ont été adoptées, des dispositifs mis en œuvre. Cet article fait un bilan des améliorations et des problèmes qui demeurent : insuffisance de la coordination des dispositifs complexes mis en place, prises en charge déterminées selon l'âge alors que les besoins sont liés à la dépendance, et création d'un cinquième risque, qui assurerait le financement de la dépendance par la solidarité nationale.

Older Americans Were Sicker and Faced More Financial Barriers to Health Care Than Counterparts in Other Countries

OSBORN R., *et al.*

2017

Health Aff (Millwood) 36(12): 2123-2132.

High-income countries are grappling with the challenge of caring for aging populations, many of whose members have chronic illnesses and declining capacity to manage activities of daily living. The 2017 Commonwealth Fund International Health Policy Survey of Older Adults in eleven countries showed that US seniors were sicker than their counterparts in other countries and, despite universal coverage under Medicare, faced more financial barriers to health care. The survey's findings also highlight economic hardship and mental health problems that may affect older adults' health, use of care, and outcomes. They show that in some countries, one in five elderly people have unmet needs for social care services-a gap that can undermine health. New to the survey is a focus on the "high-need" elderly (those with multiple chronic conditions or functional limitations), who reported high rates of emergency department use and care coordination failures. Across all eleven countries, many high-need elderly people expressed dissatisfaction with the quality of health care they had received.

The Association Between Implementation and Outcome of a Complex Care Program for Frail Elderly People

RUIKES F. G. H., *et al.*

2018

Fam Pract 35(1): 47-52.

Over the last 20 years, the effectiveness of complex care programs aiming to prevent adverse outcomes in frail elderly people has been disappointing. Recently, we found no effectiveness of the CareWell primary care program. It is largely unknown to what extent incomplete implementation of these complex interventions influences their outcomes. The aims of this study are to examine the association between the degree of implementation of the CareWell program and the prevention of functional decline in frail elderly people. Methods: Quantitative process evaluation conducted alongside a cluster-controlled trial. Two hundred and four frail elderly participants from six general practitioner practices in the Netherlands received care according to the CareWell program, consisting of four key components: multidisciplinary team meetings, proactive care planning, case management and medication reviews. We measured time registrations of team meetings, case management and medication reviews and care plan data as stored in a digital information portal. These data were aggregated into a total implementation score (TIS) representing the program's overall implementation. The study concludes that a higher degree of implementation of the CareWell program did not lead to the prevention of functional decline in frail elderly people.

IRDES

Watch on
Health Economics Literature

March 2018

IRDES Information Centre

Health Insurance	Methodology - Statistics
E-health	Health Policy
Health Economics	Prevention
Health Status	Prevision - Evaluation
Geography of Health	Pychiatry
Disability	Primary Health Care
Hospitals	Health Systems
Health Inequalities	Occupational Health
Pharmaceuticals	Ageing

Presentation

Produced by the IRDES Information Centre, this publication presents each month a theme-sorted selection of recently published peer-reviewed journal articles, grey literature, books and reports related to Health Policy, Health Systems and Health Economics.

Some documents are available online for free. Paid documents can be consulted at the IRDES Information centre or be ordered from their respective publishers. Copies of journal articles can also be obtained from university libraries (see Sudoc), the Inist Agency (see Refdoc) or the British Library.

Please note that requests for photocopies or scans of documents will not be answered.

All past issues of ***Watch on Health Economics Literature*** (previously titled ***Doc Veille***) are available online for consultation or download:
www.irdes.fr/english/documentation/watch-on-health-economics-literature.html

Watch on Health Economics Literature

Publication Director Denis Raynaud
Information specialists Marie-Odile Safon
Véronique Suhard
Design & Layout Franck-Séverin Clérembault
Web publishing Aude Sirvain
ISSN 2556-2827

Institut de recherche et documentation en économie de la santé
117bis rue Manin - 75019 Paris • Tél. : 01 53 93 43 00 • www.irdes.fr

Any reproduction is prohibited but direct links to the document are allowed:
www.irdes.fr/english/documentation/watch-on-health-economics-literature.html

Contents

Health Insurance

51 **La loi du 13 août 2004 réformant l'assurance maladie plus de dix ans après**
Bertrand D. et Marin P.

51 **Supply-Side Effects from Public Insurance Expansions: Evidence from Physician Labor Markets**
Chen A., *et al.*

51 **Demographic Factors and Attitudes that Influence the Support of the General Public for the Introduction of Universal Healthcare in Ireland: A National Survey**
Darker C. D., *et al.*

51 **Le partage de la couverture maladie entre assurances obligatoire et complémentaires**
Franc C.

52 **Effects of Health Insurance Coverage on Risky Behaviors**
Lee J.

E-health

52 **Direct-To-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending**
Ashwood J. S., *et al.*

52 **Santé connectée**
Benasayag M., *et al.*

52 **Evaluating the Implementation of the Champlain BASE™ Econsult Service In A New Region of Ontario, Canada: A Cross-Sectional Study**
Liddy C., *et al.*

53 **eHealth in Integrated Care Programs for People with Multimorbidity in Europe: Insights from the ICARE4EU Project**
Melchiorre M. G., *et al.*

53 **Digital Technologies Supporting Person-Centered Integrated Care – A Perspective**
Øvretveit J.

Health Economics

53 **Rising Use of Observation Care Among the Commercially Insured May Lead to Total and Out-Of-Pocket Cost Savings**
Adrion E. R., *et al.*

54 **Distribution of Lifetime Nursing Home Use and of Out-Of-Pocket Spending**
Hurd M. D., *et al.*

54 **Resource Use and Cost of Alzheimer's Disease in France: 18-Month Results from the GERAS Observational Study**
Rapp T., *et al.*

55 **Do Prospective Payment Systems (PPSs) Lead to Desirable Providers' Incentives and Patients' Outcomes? A Systematic Review of Evidence from Developing Countries**
Tan S. Y. et Melendez-Torres G. J.

Health Status

55 **Comprendre la surmortalité périnatale et néonatale tardive en Seine-Saint-Denis**
Revue Prescrire

55 **The Effect of Physical Activity on Mortality and Cardiovascular Disease in People from 17 High-Income, Middle-Income, and Low-Income Countries: The PURE Study**
Lear S. A., *et al.*

Geography of Health

56 **Désertification tout court : qui va sauver l'Eure-et-Loir ? Qu'en est-il de l'offre de soins ?**
Bouf A.

56 **Is There a 'Pig Cycle' in the Labour Supply of Doctors? How Training and Immigration Policies Respond to Physician Shortages**
Chojnicki X. et Moullan Y.

56 **A Scoping Review of the Implementation of Health in All Policies at the Local Level**
Guglielmin M., *et al.*

57 **Improving Health Care Service Provision by Adapting to Regional Diversity: An Efficiency Analysis for the Case of Germany**
Herwartz H. et Schley K.

Disability

57 **La tierce personne : une figure introuvable ? L'incohérence des politiques françaises de l'invalidité et de la perte d'autonomie (1905-2015)**
Capuano C. et Weber F.

57 **Handicap, dépendance, perte d'autonomie : du flou des concepts aux catégories sociales de la politique publique**
Henrard J.-C.

58 **Soins bucco-dentaires pour les patients handicapés**
Pujade C., *et al.*

58 **Vieillesse, pauvreté et handicap dans l'histoire**
Stiker H.-J.

58 **Welfare Reform Act de 2012, fusion des minima sociaux britanniques et prestations handicap**
Velche D.

Hospitals

59 **Quality of Diabetes Follow-Up Care and Hospital Admissions**
Andrade L. F., *et al.*

59 **The Use of Preventable Hospitalization for Monitoring the Performance of Local Health Authorities in Long-Term Care**
Arandelovic A., *et al.*

59 **Mesurer la qualité pour transformer l'hôpital. Analyse sociotechnique d'une discrète quantification**
Bertillot H.

59 **Prévention des risques organisationnels en ambulatoire : une étude comparative de 4 cliniques**
Bruyère C., *et al.*

60 **The French Emergency Medical Services After the Paris and Nice Terrorist Attacks: What Have We Learnt?**
Carli P., *et al.*

60 **L'hôpital de proximité, maillon structurant du parcours de santé**
Gaye C.

60 **Efficacité des filières dédiées à l'Accident Vasculaire Cérébral. Moyens de mesure. Expérience en Bourgogne**
Delpont B., *et al.*

60 **Faut-il changer le statut de l'hôpital public ?**
Grimaldi A.

61 **The Impact of the Financial Crisis and Austerity Policies on the Service Quality of Public Hospitals in Greece**
Keramidou I. et Triantafyllopoulos L.

61 **Understanding the Relationship Between Medicaid Expansions and Hospital Closures**
Lindrooth R. C., *et al.*

61 **Risk Adjustment May Lessen Penalties on Hospitals Treating Complex Cardiac Patients Under Medicare's Bundled Payments**
Markovitz A. A., *et al.*

62 **Medicare ACO Program Savings Not Tied to Preventable Hospitalizations or Concentrated Among High-Risk Patients**
McWilliams J. M., *et al.*

62 **A Failure to Communicate? Doctors and Nurses in American Hospitals**
Michel L.

Health Inequalities

62 **Sex Differences in Treatments, Relative Survival, and Excess Mortality Following Acute Myocardial Infarction: National Cohort Study Using the SWEDEHEART Registry**
Alabas O. A., *et al.*

63 **International Migrants' Use of Emergency Departments in Europe Compared with Non-Migrants' Use: A Systematic Review**
Crede S. H., *et al.*

63 **Migrant Women Living with HIV in Europe: Are They Facing Inequalities in the Prevention of Mother-To-Child-Transmission of HIV? The European Pregnancy and Paediatric HIV Cohort Collaboration (EPPICC) Study Group in Eurocoord**
Favarato G., *et al.*

63 **Les demandeurs de l'aide médicale d'État pris entre productivisme et gestion spécifique**
Gabarro C.

64 **De la « crise des migrants » à la crise de l'Europe : un éclairage démographique**
Héran F.

64 **Socioeconomic Status and Waiting Times for Health Services: An International Literature Review and Evidence from the Italian National Health System**
Landi S., *et al.*

64 **La santé des migrants : le syndrome d'Ulysse**
Le Ferrand P.

64 **Unhealthy Assimilation or Persistent Health Advantage? A Longitudinal Analysis of Immigrant Health in the United States**
Lu Y., *et al.*

65 **Do Gender Gaps in Education and Health Affect Economic Growth? A Cross-Country Study from 1975 to 2010**
Mandal B., *et al.*

65 **Gypsy, Roma and Traveller Access to and Engagement with Health Services: A Systematic Review**
McFadden A., *et al.*

65 **Primary Care for Refugees and Newly Arrived Migrants in Europe: A Qualitative Study on Health Needs, Barriers and Wishes**
Van Loenen T., *et al.*

Pharmaceuticals

66 **La déprescription médicamenteuse, un acte médical de salubrité publique**
Pugnet G., *et al.*

66 **Potentially Inappropriate Medication Among People with Dementia in Eight European Countries**
Renom-Guiteras A., *et al.*

Methodology - Statistics

66 **Une simulation sur un modèle d'appariement : l'impact de l'article 4 de l'ANI de 2013 sur la segmentation du marché du travail**
Berson C. et Ferrari N.

Health Policy

67 **Le soin, une éthique de l'attention**
Baleyle J. M., *et al.*

67 **What's Involved with Wanting to Be Involved? Comparing Expectations For Public Engagement in Health Policy Across Research and Care Contexts**
Barg, C.J. *et al.*

67 **Is User Involvement a Reality or a Dream in LMICs – as Well as in the Rest of the World?**
D'Avanzo, B.

68 **Mieux comprendre le processus d'empowerment du patient**
Fayn M.-G., *et al.*

68 **The Joint Action on Health Workforce Planning and Forecasting: Results of a European Programme to Improve Health Workforce Policies**
Kroezen M., *et al.*

68 **Parcours de santé des enfants confiés à l'Aide Sociale à l'Enfance des Bouches-du-Rhône**
Martin A., *et al.*

68 **Personalized Medicine: A Doorway to an Effective Health Care Delivery System?**
Minvielle E., *et al.*

69 **Assessing Patient Organization Participation in Health Policy: A Comparative Study in France and Italy**
Souliotis K.

Prevention

69 **Changes in Smoking Behavior over Family Transitions: Evidence for Anticipation and Adaptation Effects**
Bricard D., *et al.*

69 **A Two-Step Screening Process Reduces Hip Fractures**
Cauley J. A.

69 **Éducation thérapeutique du patient et éthique : de l'impératif de santé publique aux droits des personnes et des usagers**
Rusch E.

70 **Concevoir une intervention éducative pour prévenir la chute des personnes âgées en logement social : description d'une méthode de recherche**
Trevidy F., *et al.*

Prevision - Evaluation

70 **Design of Effective Interventions for Smoking Cessation Through Financial and Non-Financial Incentives**
Balderrama F. et Longo C. J.

70 **Évaluation des politiques publiques : expérimentation randomisée et méthodes quasi-expérimentales**
Chabé-Ferret S., *et al.*

Pychiatry

71 **Santé mentale : de l'exception au droit commun?**
Basset B.

71 **Management of First Depression or Generalized Anxiety Disorder Episode in Adults in Primary Care: A Systematic Metareview**
Driot D., *et al.*

71 **National Trends in Specialty Outpatient Mental Health Care Among Adults**
Han B., *et al.*

71 **Unplanned Admissions to Inpatient Psychiatric Treatment and Services Received Prior to Admission**
Ose S. O., *et al.*

72 **Comment les soins psychiatriques sans consentement en ambulatoire se sont imposés en Suède ? Une comparaison socio-politique avec la Norvège, le Royaume-Uni et New York**
Sjöström S.

72 **Consultation ambulatoire en cabinet libéral et en CMP : deux cliniques ou deux patientèles ?**
Winter E.

Primary Health Care

72 **La médecine prédictive quinze ans après**
Aymé S.

72 **Exploring the Impact and Use of Patients' Feedback About Their Care Experiences in General Practice Settings-A Realist Synthesis**
Baldie D. J., *et al.*

73 **Chevauchement, interdépendance ou complémentarité ? La collaboration interprofessionnelle entre l'infirmière praticienne et d'autres professionnels de santé en Ontario**
Benoit M., *et al.*

73 **Small Cash Incentives Can Encourage Primary Care Visits by Low-Income People with New Health Care Coverage**
Bradley C. J. et Neumark D.

73 **Les médecins en 2017 : des carrières bouleversées par les changements dans le système de santé ?**
Charpak Y.

74 **Les relations médecin-malade. Des temps modernes à l'époque contemporaine**
Chevandier C.

74 **Quantifier la qualité des soins : une critique de la rationalisation de la médecine libérale française**
Da Silva N.

74 **Burnout des soignants : comment éteindre l'incendie ?**
Dumoulin M., *et al.*

74 **International Variations in Primary Care Physician Consultation Time: A Systematic Review of 67 Countries**
Irving G., *et al.*

75 **Community Care for People with Complex Care Needs: Bridging the Gap Between Health and Social Care**
Kuluski K., *et al.*

75 **The Content and Meaning of Administrative Work: A Qualitative Study of Nursing Practices**
Michel L., *et al.*

75 **Multimorbidity Care Model: Recommendations from the Consensus Meeting of the Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle (JA-CHRODIS)**
Palmer K., *et al.*

76 **Managing Multimorbidity: Profiles of Integrated Care Approaches Targeting People with Multiple Chronic Conditions in Europe**
Rijken M., *et al.*

76 **Se former pour construire son espace d'autonomie professionnelle ? Le cas des Nurses practitioners néerlandaises**
Rosman S.

76 **Point-Of-Care Testing in Primary Care Patients with Acute Cardiopulmonary Symptoms: A Systematic Review**
Schols A. M. R., *et al.*

77 **Relevant Models and Elements of Integrated Care for Multi-Morbidity: Results of a Scoping Review**
Struckmann V., *et al.*

77 **Patient-Centeredness of Integrated Care Programs for People with Multimorbidity. Results from the European ICARE4EU Project**
Van der Heide I., *et al.*

77 **Does Patients' Experience of General Practice Affect the Use of Emergency Departments? Evidence from Australia**
Wong C. Y. et Hall J.

Health Systems

78 **Interventions and Approaches to Integrating HIV and Mental Health Services: A Systematic Review**
Chuah F. L. H., *et al.*

78 **Health Systems Facilitators and Barriers to the Integration of HIV and Chronic Disease Services: A Systematic Review**
Watt N., *et al.*

Occupational Health

78 **Interventions pour le retour et le maintien au travail après un cancer : revue de la littérature**
Caron M., *et al.*

79 **Paid Employment and Common Mental Disorders in 50–64-Year Olds: Analysis of Three Cross-Sectional Nationally Representative Survey Samples in 1993, 2000 and 2007**
Perera G., *et al.*

79 **Replacement Care' for Working Carers? A Longitudinal Study in England**
Pickard L., *et al.*

Ageing

80 **Identification of Older Adults with Frailty in the Emergency Department Using a Frailty Index: Results from a Multinational Study**
Brousseau A.-A., *et al.*

80 **La réforme des retraites de 2010 : quel impact sur l'activité des séniors ?**
Dubois Y. et Koubi M.

80 **Vieillissement : des politiques toujours liées à l'âge, et peu de coordination**
Henrard J. C.

80 **Older Americans Were Sicker and Faced More Financial Barriers to Health Care Than Counterparts in Other Countries**
Osborn R., *et al.*

81 **The Association Between Implementation and Outcome of a Complex Care Program for Frail Elderly People**
Ruikes F. G. H., *et al.*

Health Insurance

La loi du 13 août 2004 réformant l'assurance maladie plus de dix ans après

BERTRAND D. ET MARIN P.

2017

Actualité et Dossier en Santé Publique (100): 70-79.

La loi réformant l'Assurance maladie en 2004 a été une loi « socle » visant à mettre en place les outils permettant de remédier à ses déficits budgétaires, mais aussi en améliorant l'offre des soins, la maîtrise médicalisée et la gouvernance. Cette loi, dont le bilan est présenté dans cet article, sera suivie de deux autres : la loi hôpital, patients santé et territoires en 2009 et la loi de modernisation du système de santé en 2016.

Supply-Side Effects from Public Insurance Expansions: Evidence from Physician Labor Markets

CHEN A., *et al.*

2017

Health Economics: Ahead of print.

Medicaid and the Child Health Insurance Programs (CHIP) are key sources of coverage for U.S. children. Established in 1997, CHIP allocated $40 billion of federal funds across the first 10 years but continued support required reauthorization. After 2 failed attempts in Congress, CHIP was finally reauthorized and significantly expanded in 2009. Although much is known about the demand-side policy effects, much less is understood about the policy's impact on providers. In this paper, we leverage a unique physician dataset to examine if and how pediatricians responded to the expansion of the public insurance program. We find that newly trained pediatricians are 8 percentage points more likely to subspecialize and as much as 17 percentage points more likely to enter private practice after the law passed. There is also suggestive evidence of greater private practice growth in more rural locations. The sharp supply-side changes that we observe indicate that expanding public insurance can have important spillover effects on provider training and practice choices.

Demographic Factors and Attitudes that Influence the Support of the General Public for the Introduction of Universal Healthcare in Ireland: A National Survey

DARKER C. D., *et al.*

2017

Health Policy 122 (2) :147-156

Ireland is still struggling to end the inequitable two-tiered health system and introduce universal healthcare (UHC). Public opinion can influence health policy choice and implementation. However, the public are rarely asked for their views. This study describes the demographic and attitudinal factors that influence the support of the public for the introduction of UHC. It provides data on a nationally representative survey sample of n = 972. There are high levels of support for the introduction of UHC (n = 846 87.0%). Logistic regression analyses indicated that demographic factors, such as, the location of respondent, whether the respondent was in receipt of Government supported healthcare, a purchaser of private health insurance or neither; plus attitudinal factors, such as, opinions on the Government prioritising healthcare, healthcare being free at the point of access, taxes being increased to provide care free at the point of access and how well informed participants felt about UHC were associated with agreeing with the introduction of UHC in Ireland. This paper is timely for policy leaders both in Ireland and internationally as countries with UHC, such as the United Kingdom, are facing difficulties maintaining health services in the public realm.

Le partage de la couverture maladie entre assurances obligatoire et complémentaires

FRANC C.

2017

Med Sci (Paris) 33(12): 1097-1104.

https://doi.org/10.1051/medsci/20173312017

Effects of Health Insurance Coverage on Risky Behaviors

LEE J.

2018

Health Econ. [Epub ahead of print]

Prior to implementation of the Patient Protection and Affordable Care Act, dependent health insurance coverage was typically available only for young adults under the age of 19. As of September 2010, the Affordable Care Act extended dependent health insurance coverage to include young adults up to the age of 26. I use the National Health Interview Survey for the sample period from 2011 to 2013 to analyze the causal relationship between the expansion of dependent coverage and risky behaviors including smoking and drinking as well as preventive care. I employ a regression discontinuity design to estimate the causal effect of health insurance coverage and overcome the endogeneity problem between insurance status and risky behaviors. When young adults become 26 years old, they are 7 to 10 percentage points more likely to lose health insurance than young adults under the age of 26. Although young adults over the age of 26 are generally aged out of insurance coverage, presence or absence of health insurance does not affect their smoking and drinking behaviors and their access to preventive care.

E-health

Direct-To-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending

ASHWOOD J. S., *et al.*

2017

Health Aff (Millwood) 36(3): 485-491.

The use of direct-to-consumer telehealth, in which a patient has access to a physician via telephone or videoconferencing, is growing rapidly. A key attraction of this type of telehealth for health plans and employers is the potential savings involved in replacing physician office and emergency department visits with less expensive virtual visits. However, increased convenience may tap into unmet demand for health care, and new utilization may increase overall health care spending. We used commercial claims data on over 300,000 patients from three years (2011-13) to explore patterns of utilization and spending for acute respiratory illnesses. We estimated that 12 percent of direct-to-consumer telehealth visits replaced visits to other providers, and 88 percent represented new utilization. Net annual spending on acute respiratory illness increased $45 per telehealth user. Direct-to-consumer telehealth may increase access by making care more convenient for certain patients, but it may also increase utilization and health care spending.

Santé connectée

BENASAYAG M., *et al.*

2017

Pratiques : Les Cahiers De La Medecine Utopique(79)

Les nouvelles technologies permettent le développement de multiples objets connectés dans la santé. Certains offrent des avantages, mais ne sont pas sans effet sur les conditions de soins et l'évolution des pratiques. Les auteurs de ce dossier sur la santé connectée explorent les nouvelles possibilités ainsi ouvertes, les changements qu'elles produisent ainsi que les risques auxquels elles exposent. La banalisation de la diffusion volontaire des données de santé sur les réseaux sociaux, comme l'utilisation par les administrations de données sensibles « anonymisées », nourrissent le « Big Data » dont on est loin d'imaginer la portée réelle sur l'évolution de la société. Ce fascicule apporte des éclairages sur d'autres aspects de la santé.

Evaluating the Implementation of the Champlain BASE™ Econsult Service In A New Region of Ontario, Canada: A Cross-Sectional Study

LIDDY C., *et al.*

2017

Healthcare Policy 13(2): 79-95.

This paper aims to replicate an existing electronic consultation (eConsult) service in a new jurisdiction to test its generalizability. We conducted a cross-sectional study of all eConsults submitted by providers in the region of Mississauga Halton, Ontario, between January 5, 2015, and May 31, 2016. We compared our results to those from the original pilot in Eastern Ontario. The RE-AIM model served as our study framework. Providers submitted 594 patient cases to 46 different specialty groups during the study period. Specialists responded in a median of 1.1 days, with 75% of cases answered within four days. Providers rated the service as having high or very high value for themselves and their patients in 92% of cases. The service yielded a net program cost of $10,321.56: Our findings resembled those of the initial implementation, though with a faster rate of uptake and lower cost because of the avoidance of start-up and administrative costs.

eHealth in Integrated Care Programs for People with Multimorbidity in Europe: Insights from the ICARE4EU Project

MELCHIORRE M. G., *et al.*

2018

Health Policy 122(1): 53-63.

Care for people with multimorbidity requires an integrated approach in order to adequately meet their complex needs. In this respect eHealth could be of help. This paper aims to describe the implementation, as well as benefits and barriers of eHealth applications in integrated care programs targeting people with multimorbidity in European countries, including insights on older people 65+. Within the framework of the ICARE4EU project, in 2014, expert organizations in 24 European countries identified 101 integrated care programs based on selected inclusion criteria. Managers of these programs completed a related on-line questionnaire addressing various aspects including the use of eHealth. In this paper we analyze data from this questionnaire, in addition to qualitative information from six programs which were selected as 'high potential' for their innovative approach and studied in depth through site visits. Findings seems to suggest that eHealth could support integrated care for (older) people with multimorbidity.

Digital Technologies Supporting Person-Centered Integrated Care – A Perspective

ØVRETVEIT J.

2017

Journal of Integrated Care 17(4): 1-4.

Shared electronic health and social care records in some service systems are already showing some of the benefits of digital technology and digital data for integrating health and social care. These records are one example of the beginning "digitalisation" of services that gives a glimpse of the potential of digital technology and systems for building coordinated and individualized integrated care. Yet the promise has been greater than the benefits, and progress has been slow compared to other industries. This paper describes for non-technical readers how information technology was used to support integrated care schemes in six EU services, and suggests practical ways forward to use the new opportunities to build person-centered integrated care.

Health Economics

Rising Use of Observation Care Among the Commercially Insured May Lead to Total and Out-Of-Pocket Cost Savings

ADRION E. R., *et al.*

2017

Health Aff (Millwood) 36(12): 2102-2109.

Proponents of hospital-based observation care argue that it has the potential to reduce health care spending and lengths-of-stay, compared to short-stay inpatient hospitalizations. However, critics have raised concerns about the out-of-pocket spending associated with observation care. Recent reports of high out-of-pocket spending among Medicare beneficiaries have received considerable media attention and have prompted direct policy changes. Despite the potential for changed policies to indirectly affect non-Medicare patients, little is known about the use of, and spending

associated with, observation care among commercially insured populations. Using multipayer commercial claims for the period 2009-13, we evaluated utilization and spending among patients admitted for six conditions that are commonly managed with either observation care or short-stay hospitalizations. In our study period, the use of observation care increased relative to that of short-stay hospitalizations. Total and out-of-pocket spending were substantially lower for observation care, though both grew rapidly-and at rates much higher than spending in the inpatient setting-over the study period. Despite this growth, spending on observation care is unlikely to exceed spending for short-stay hospitalizations. As observation care attracts greater attention, policy makers should be aware that Medicare policies that disincentivize observation may have unintended financial impacts on non-Medicare populations, where observation care may be cost saving.

Distribution of Lifetime Nursing Home Use and of Out-Of-Pocket Spending

HURD M. D., *et al.*

2017

Proc Natl Acad Sci USA 114(37): 9838-9842.

Reliable estimates of the lifetime risk of using a nursing home and the associated out-of-pocket costs are important for the saving decisions by individuals and families, and for the purchase of long-term care insurance. We used data on up to 18 y of nursing home use and out-of-pocket costs drawn from the Health and Retirement Study, a longitudinal household survey representative of the older US population. We accumulated the use and spending by individuals over many years, and we developed and used an individual-level matching method to account for use before and after the observation period. In addition, for forecasting, we estimated a dynamic parametric model of nursing home use and spending. We found that 56% of persons aged 57-61 will stay at least one night in a nursing home during their lifetimes, but only 32% of the cohort will pay anything out of pocket. Averaged over all persons, total out-of-pocket expenditures looking forward from age 57 were approximately $7,300, discounted at 3% per year. However, the 95th percentile of spending was almost $47,000. We conclude that the percentage of people ever staying in nursing homes is substantially higher than previous estimates, at least partly due to an increase in nursing home episodes of short duration. Average lifetime out-of-pocket costs may be affordable, but some people will incur much higher costs.

Resource Use and Cost of Alzheimer's Disease in France: 18-Month Results from the GERAS Observational Study

RAPP T., *et al.*

2017

Value in Health. [In press]

http://www.sciencedirect.com/science/article/pii/S1098301517335635

There is little longitudinal data on resource use and costs associated with Alzheimer's disease (AD) in France. This study aims to evaluate resource use and societal costs associated with AD in a French cohort of patients and their caregivers and the effect of patient cognitive decline on costs over an 18-month period. Community-dwelling patients with mild, moderate, or moderately severe/severe AD dementia (n = 419) were followed-up for 18 months. Total societal costs were estimated by applying 2010 unit costs to resource use, including outpatient visits, hospital days, institutionalization, and caregiver hours. Cognitive function was assessed by Mini-Mental State Examination scores. Mean cumulative total costs over the 18-month period were €24,140 for patients with mild AD dementia, €34,287 for those with moderate AD dementia, and €44,171 for those with moderately severe/severe AD dementia ($P < 0.001$; ANOVA comparison between severity groups). The biggest contributor to total societal costs was caregiver informal care (>50% of total costs at all stages of AD dementia). Cognitive decline (≥3-point decrease in Mini-Mental State Examination score or institutionalization) was associated with a 12.5% increase in total costs ($P = 0.02$). Significant differences were observed across severity groups for caregiver time ($P < 0.001$); mean monthly caregiver time increased at each time point over the 18 months in each severity group. Increasing severity of AD dementia in France is associated with increased use of resources as well as increased total societal and patient costs; informal care was the greatest cost contributor. Clinically meaningful cognitive decline is associated with significantly increased costs.

Do Prospective Payment Systems (PPSs) Lead to Desirable Providers' Incentives and Patients' Outcomes? A Systematic Review of Evidence from Developing Countries

TAN S. Y. ET MELENDEZ-TORRES G. J.

2018

Health Policy Plan 33(1): 137-153.

http://dx.doi.org/10.1093/heapol/czx151

The reform of provider payment systems, from retrospective to prospective payment, has been heralded as the right move to contain costs in the light of rising health expenditures in many countries. However, there are concerns on quality trade-off. The heightened attention given to prospective payment system (PPS) reforms and the rise of empirical evidence regarding PPS interventions among developing countries suggest that a systematic review is necessary to understand the effects of PPS reforms in developing countries. A systematic search of 14 databases and a hand search of health policy journals and grey literature from October to November 2016 were carried out, guided by a set of inclusion and exclusion criteria. Data were extracted based on the Consolidated Health Economics Evaluation Reporting Standards checklist. A total of 12 studies reported in China, Thailand and Vietnam were included in this review. Substantial heterogeneity was present in PPS policy design across different localities. PPS interventions were found to have reduced health expenditures on both the supply and demand side, as well as length of stay and readmission rates. In addition, PPS generally improved service quality outcomes by reducing the likelihood or percentage of physicians prescribing unnecessary drugs and diagnostic procedures. PPS is a promising policy tool for middle-income countries to achieve reasonable health policy objectives in terms of cost containment without necessarily compromising the quality of care. More evaluations of PPS will need to be conducted in the future in order to broaden the evidence base beyond middle-income countries.

Health Status

Comprendre la surmortalité périnatale et néonatale tardive en Seine-Saint-Denis

REVUE PRESCRIRE

2017

Revue Prescrire 37(410): 939-943.

En 2012, le taux de mortalité infantile dans le département de la Seine-Saint-Denis, qui compte une forte proportion de personnes pauvres et une offre de soins plus faible que dans d'autres départements français, était de 50 % supérieur à celui de la France métropolitaine. En se basant sur les données de l'Inserm sur les causes des morts périnatales et néonatales tardives survenues en Seine-Saint-Denis ainsi que sur différentes enquêtes menées auprès de femmes enceintes en situation de précarité, cet article analyse les raisons de cette mortalité prématurée et émet des recommandations pour un meilleur suivi de ces personnes.

The Effect of Physical Activity on Mortality and Cardiovascular Disease in People from 17 High-Income, Middle-Income, and Low-Income Countries: The PURE Study

LEAR S. A., *et al.*

2017

The Lancet 390(10113): 2643-2654.

http://dx.doi.org/10.1016/S0140-6736(17)31634-3

Physical activity has a protective effect against cardiovascular disease (CVD) in high-income countries, where physical activity is mainly recreational, but it is not known if this is also observed in lower-income countries, where physical activity is mainly non-recreational. We examined whether different amounts and types of physical activity are associated with lower mortality and CVD in countries at different economic levels.

Geography of Health

Désertification tout court : qui va sauver l'Eure-et-Loir ? Qu'en est-il de l'offre de soins ?

BOUF A.

2017

Médecine : De la Médecine Factuelle à nos Pratiques 13(9): 421-427.

La démographie médicale, la désertification des zones rurales, la non-installation des jeunes médecins, notamment généralistes, une fois diplômés font régulièrement la une des médias. Nombre de petites communes se désespèrent et voudraient apporter une réponse à leurs administrés. À l'issue de ses longues années d'études dans une ville universitaire, le jeune médecin diplômé, citadin accompli, volontiers parent, en couple avec un autre diplômé dont la carrière décolle dans sa propre profession, ayant déjà un aperçu de la médecine générale au cours de ses stages de fin d'étude, refuse d'endosser l'habit de ses anciens à l'activité souvent débordante. L'appréhension de la lourdeur administrative et de l'engagement financier, voire pour certains un sentiment de difficulté de maintenir une qualité de pratique exigeante hors du cadre hospitalier, expliquent une hésitation à sauter le pas d'un engagement définitif, loin de « ses bases », dans un environnement mal appréhendé. Quelle est la réalité du terrain et de l'offre de soins dans un département comme l'Eure-et-Loir, finalement relativement proche de la capitale, mais aussi plus largement dans toute la région Centre comparativement au reste du territoire ? Quelles sont les raisons de la disparité ? Cet article apporte quelques éléments de réponse.

Is There a 'Pig Cycle' in the Labour Supply of Doctors? How Training and Immigration Policies Respond to Physician Shortages

CHOJNICKI X. ET MOULLAN Y.

2018

Social Science & Medicine 200: 227-237.

https://www.sciencedirect.com/science/article/pii/S0277953618300431

Many OECD countries are faced with the considerable challenge of a physician shortage. This paper investigates the strategies that OECD governments adopt and determines whether these policies effectively address these medical shortages. Due to the amount of time medical training requires, it takes longer for an expansion in medical school capacity to have an effect than the recruitment of foreign-trained physicians. Using data obtained from the OECD (2014) and Bhargava et al. (2011), we constructed a unique country-level panel dataset that includes annual data for 17 OECD countries on physician shortages, the number of medical school graduates and immigration and emigration rates from 1991 to 2004. By calculating panel fixed-effect estimates, we find that after a period of medical shortages, OECD governments produce more medical graduates in the long run but in the short term, they primarily recruit from abroad; however, at the same time, certain practising physicians choose to emigrate. Simulation results show the limits of recruiting only abroad in the long term but also highlight its appropriateness for the short term when there is a recurrent cycle of shortages/surpluses in the labour supply of physicians (pig cycle theory).

A Scoping Review of the Implementation of Health in All Policies at the Local Level

GUGLIELMIN M., *et al.*

2017

Health Policy: [Ahead of print.]

Health in All Policies (HiAP) is an approach to public policies across sectors that systematically takes into account the health implication of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. HiAP implementation can involve engagement from

multiple levels of government; however, factors contributing or hindering HiAP implementation at the local level are largely unexplored. Local is defined as the city or municipal level, wherein government is uniquely positioned to provide leadership for health and where many social determinants of health operate. This paper presents the results of a scoping review on local HiAP implementation. Peer reviewed articles and grey literature were systematically searched using the Arksey and O'Malley framework. Characteristics of articles were then categorized, tallied and described. We conclude that common themes were found in the literature regarding HiAP implementation locally. However, to better clarify these factors to contribute to theory development on HiAP implementation, further research is needed that specifically investigates the facilitators and barriers of HiAP locally within their political and policy context.

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

HERWARTZ H. ET SCHLEY K.

2018

Health Policy: [Ahead of print.]

http://dx.doi.org/10.1016/j.healthpol.2018.01.004

Highlights'Regional patterns in health care utilisation influence the efficiency of health care. Regional access barriers affect the efficiency of health care service provision. Relationship between socio-economic factors and efficiencies as possible transmission channel to health. Regional needs should be considered to improve the allocation of medical infrastructure.

Disability

▶ La tierce personne : une figure introuvable ? L'incohérence des politiques françaises de l'invalidité et de la perte d'autonomie (1905-2015)

CAPUANO C. ET WEBER F.

2015

Revue d'histoire de la protection sociale 8(1): 106-130.

https://www.cairn.info/revue-d-histoire-de-la-protection-sociale-2015-1-page-106.htm

Retracer l'histoire des politiques des incapacités au travail (invalidité) et au quotidien (perte d'autonomie) en France depuis 1905 montre les hésitations du législateur entre un régime causaliste (où les prestations dépendent des causes des incapacités) et un régime finaliste (où elles dépendent des besoins). La barrière des 60 ans instaurée à partir de 1997 entre les personnes qui dépendent d'une aide humaine pour vivre au quotidien, selon leur âge ou la date d'apparition de leurs incapacités, mêle une logique de revenus (liés à l'invalidité avant 60 ans et à la retraite après 60 ans) à la question de la tierce personne, dont la figure émerge pour de simples raisons de réduction des coûts pour la collectivité. L'article invite à dépasser les questions budgétaires et la nouvelle conceptualisation des droits des personnes handicapées en termes de droits de l'homme pour mieux appréhender les conséquences de ces politiques sur les personnes avec incapacités elles- mêmes et sur leur famille, mais aussi sur certains professionnels de l'aide quotidienne.

▶ Handicap, dépendance, perte d'autonomie : du flou des concepts aux catégories sociales de la politique publique

HENRARD J.-C.

2015

Revue d'histoire de la protection sociale 8(1): 146-166.

https://www.cairn.info/revue-d-histoire-de-la-protection-sociale-2015-1-page-146.htm

Soins bucco-dentaires pour les patients handicapés

PUJADE C., *et al.*

2017

Santé Publique 29(5): 677-684.

https://www.cairn.info/revue-sante-publique-2017-5-page-677.htm

Les patients handicapés représentent une population à besoins spécifiques dont la prise en charge en odontologie soulève une problématique de santé publique. Cet article décrit cette activité de soins au sein d'un service hospitalier d'odontologie pour mettre en évidence les difficultés rencontrées et proposer des axes d'amélioration dans cette prise en charge. Une étude rétrospective descriptive a été menée sur les patients suivis entre 2010 et 2016 dans le cadre du partenariat entre le service d'odontologie de l'hôpital Albert Chenevier et le réseau RHAPSOD'IF. Pour 434 patients handicapés soignés, les séances ont consisté en des consultations (42 à 57 %), les restaurations et les détartrages ont représenté chacun 1/6e des actes effectués (14 à 19 % et 14 à 18 %), et la chirurgie et la radiographie en ont représenté 1/8e (4 à 12 % et 6 à 11 %). La mise en place d'une thérapeutique prothétique est quasi nulle (0 à 1 %). La plupart des séances de soins s'est effectuée sans prémédication (61 à 76 %). Ces soins dentaires nécessitent la formation des familles, des accompagnants, une bonne approche relationnelle et du temps pour instaurer une relation de confiance. L'adhésion à un réseau prend son importance pour aider, accompagner, conseiller le praticien et lui apporter un soutien financier.

Vieillesse, pauvreté et handicap dans l'histoire

STIKER H.-J.

2015

Revue d'histoire de la protection sociale 8(1): 132-144.

https://www.cairn.info/revue-d-histoire-de-la-protection-sociale-2015-1-page-132.htm

Cette contribution s'interroge sur les similitudes entre le sort des infirmes et le sort des personnes âgées dépendantes au cours de l'histoire. Elle questionne ainsi sur le temps long les dissociations ou articulations, selon les milieux sociaux, entre âge biologique, âge social et âge des incapacités définissant les contours d'une vieillesse incapable, comme les infirmes, de travailler. Elle analyse également comment les discours sur la dégradation du corps des « vieux » a contribué à construire une représentation dépréciative et stigmatisante de la vieillesse au fil des siècles, rapprochant encore une fois celle-ci de l'infirmité. Cette étude montre enfin combien ces populations ont été longtemps oubliées par le corps social et négligées par les politiques publiques, dont les actions les ont cantonnées au champ assistantiel. Elles restent encore peu traitées par les études historiennes.

Welfare Reform Act de 2012, fusion des minima sociaux britanniques et prestations handicap

VELCHE D.

2017

Revue française des affaires sociales(3): 109-128.

https://www.cairn.info/revue-francaise-des-affaires-sociales-2017-3-page-109.htm

Instituant le « crédit universel » fusionnant divers minima sociaux, la loi britannique de réforme de l'assistance sociale adoptée en 2012 affecte les personnes handicapées, directement d'abord par l'absorption progressive de la principale prestation handicap non contributive et sous conditions de ressources, indirectement ensuite par l'incidence d'autres prestations sociales en cours d'extinction, prestations qui souvent prévoyaient divers suppléments handicap. La même réforme rend plus stricte l'attribution des aides à la vie indépendante non incluses dans le crédit universel. À cela s'ajoute l'adoption d'un plafonnement du total des prestations accordées à une même famille. Ces décisions, mises en œuvre dans un contexte généralisé de coupes budgétaires, inquiètent les personnes handicapées et leurs proches. Peuvent-ils craindre une paupérisation ?

Hospitals

Quality of Diabetes Follow-Up Care and Hospital Admissions

ANDRADE L. F., *et al.*

2017

International Journal of Health Economics and Management: [Ahead of print]

https://doi.org/10.1007/s10754-017-9230-z

Diabetes may lead to severe complications. For this reason, disease prevention and improvement of medical follow-up represent major public health issues. The aim of this study was to measure the impact of adherence to French follow-up guidelines on hospitalization of people with diabetes. We used insurance claims data from the years 2010 to 2013 collected for 52,027 people aged over 18, affiliated to a French social security provider and treated for diabetes. We estimated panel data models to explore the association between adherence to guidelines and different measures of hospitalization, controlling for socioeconomic characteristics, diabetes treatment and density of medical supply. The results show that adherence to four guidelines was associated with a significant decrease in hospital admissions, up to approximatively 30% for patients monitored for a complete lipid profile or microalbuminuria during the year. In addition, our analyses confirmed the strong protective effect of income and a significant positive correlation with good supply of hospital care. In conclusion, good adherence to French diabetes guidelines seems to be in line with the prevention of health events, notably complications, that could necessitate hospitalization.

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

ARANDELOVIC A., *et al.*

2018

Health Policy: [Ahead of print]

http://dx.doi.org/10.1016/j.healthpol.2018.01.008

Preventable hospitalization as an indicator for quality performance is proposed. The quality performance improvement may help to reduce preventable hospitalization. Comparing and reporting local health authorities performance could improve quality.

Mesurer la qualité pour transformer l'hôpital. Analyse sociotechnique d'une discrète quantification

BERTILLOT H.

2017

Revue Française de Socio-Économie 19(2): 131-152.

https://www.cairn.info/revue-francaise-de-socio-economie-2017-2-page-131.htm

Depuis le début des années 2000, les pouvoirs publics français déploient des instruments d'évaluation de la qualité dans les établissements de santé. En procédant à la déconstruction sociotechnique des « indicateurs de qualité », cet article analyse une discrète entreprise de quantification. Mesurant des dimensions peu conflictuelles de la qualité, nourris de savoirs pluriels, équivoques dans leurs usages, les indicateurs de qualité sont suffisamment doux pour ne pas brusquer les professionnels, tout en étant suffisamment robustes pour instiller discipline et auditabilité. Au nom de la qualité, cette technologie de gouvernement est ainsi équipée pour rationaliser l'hôpital en douceur.

Prévention des risques organisationnels en ambulatoire : une étude comparative de 4 cliniques

BRUYÈRE C., *et al.*

2017

Journal de gestion et d'économie médicales 35(1): 6-17.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-1-page-6.htm

La chirurgie ambulatoire tend à devenir la norme. Or, la chirurgie ambulatoire est un changement culturel profond et un processus organisationnel complexe invitant à repenser les modes d'accès aux soins et de gouvernance. Dans cette perspective, des travaux initiés par l'ANAP (Agence nationale d'appui à la performance des établissements de santé et médico-sociaux) et l'HAS (Haute autorité de santé) publiés en 2013 visent à guider les acteurs de terrain dans le développement des pratiques ambulatoires, en préconisant une approche Lean comme système organisationnel global. Quel usage en ont les acteurs ? Quelle perception ont-ils du Lean Management ? Et comment se prémunissent-ils des risques organisationnels du Lean

dans un contexte de chirurgie ambulatoire ? Une étude comparative de 4 centres autonomes ambulatoires (4 cliniques privées, seuls centres autonomes à ce jour en France) a permis de mettre en avant les principaux risques perçus par les acteurs – mise en tension et rigidification du travail- ainsi que les moyens techniques, organisationnels et humains pour faire face. Il ressort que les cliniques étudiées ont su se préserver des marges de manœuvre pour adapter le flux aux pressions, préservant ainsi le slack organisationnel nécessaire à la cohabitation d'un standard organisationnel et d'une relation unique.

The French Emergency Medical Services After the Paris and Nice Terrorist Attacks: What Have We Learnt?

CARLI P., *et al.*

2017

The Lancet 390(10113): 2735-2738.

http://dx.doi.org/10.1016/S0140-6736(17)31590-8

L'hôpital de proximité, maillon structurant du parcours de santé

GAYE C.

2017

Techniques Hospitalières(765): 39-40.

L'hôpital de proximité intégré dans son territoire pérennise et aide à structurer un bassin de vie pour l'organisation de la santé, aussi bien dans le domaine curatif que préventif, de l'éducation et de la formation. Il est un point d'appui et d'expertise pour les autres établissements quant au parcours de soin.

Efficacité des filières dédiées à l'Accident Vasculaire Cérébral. Moyens de mesure. Expérience en Bourgogne

DELPONT B., *et al.*

2017

Journal de gestion et d'économie médicales 35(1): 18-31.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-1-page-18.htm

L'AVC reste une maladie fréquente et grave en France (première cause de handicap, deuxième cause de déclin cognitif, troisième cause de décès) malgré des avancées thérapeutiques majeures, expliquant le rôle structurant de sa prise en charge sur le plan hospitalier et inter-hospitalier. Les filières de soins pour AVC décloisonnées permettent au patient de bénéficier d'une prise en charge optimale de son domicile jusqu'à l'Unité Neuro-Vasculaire (UNV). Les recommandations nationales ont préconisé la mise en place de filières pluridisciplinaires avec un numéro téléphonique unique (le 15), transfert par SAMU, prise en charge dans un Service d'Urgences assurant une imagerie cérébrale prioritaire puis passage en Unité Neuro-Vasculaire pour réalisation d'une fibrinolyse et/ou d'une thrombectomie. L'objectif de cette revue est de rapporter les évaluations successives en pratique courante de la filière AVC mise en place en Bourgogne depuis 2003, les réponses apportées aux attentes des patients et des tutelles, et leur transposition aux autres régions sanitaires. L'étude se base sur le registre dijonnais des AVC, qui recense depuis 1985 les AVC des résidents de la ville de Dijon intramuros de façon prospective, spécifique et exhaustive.

Faut-il changer le statut de l'hôpital public ?

GRIMALDI A.

2017

Médecine : De la médecine factuelle à nos pratiques 13(9): 428-431.

La santé s'est invitée dans la campagne des élections présidentielles, mais le débat sur l'hôpital public n'a pas vraiment eu lieu. La Fédération de l'hospitalisation privée (FHP) souhaite revenir à la convergence tarifaire entre l'hôpital public et les cliniques privées, instituant une concurrence entre clinique et hôpital. La Fédération hospitalière de France (FHF) représentant les hôpitaux publics s'oppose à cette « convergence tarifaire » qu'elle juge déloyale dans la mesure où la clinique privée choisit son activité, privilégiant les activités rentables (chirurgie ambulatoire, chirurgie de l'obésité, canal carpien, cataracte, dialyse...), et sélectionne de fait ses clients en raison des dépassements d'honoraires réalisés par 85 % des praticiens qui y travaillent. En revanche, la FHF propose de faire évoluer le statut de l'hôpital public.

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

KERAMIDOU I. ET TRIANTAFYLLOPOULOS L.

2017

Health Policy: [Ahead of print]

The influence of the financial crisis on the efficiency of Greek public hospitals has been widely debated. Despite this increasing interest in such research, the question of to what extent the recent reforms in the Greek National health care system were effective in establishing a health care structure and process that provide better results for patients has yet to be fully investigated. As a step in this direction, the paper focuses on patient's experience with public hospital care quality before and during the economic crisis. A questionnaire survey was carried out among 1872 patients discharged from 110 out of the total of 124 Greek public hospitals. Patients' perceptions were analysed using a structural equation modelling approach. The findings reveal that public hospital service quality is at a medium level (66.2 on a scale from 1 to 100) over 2007-2014, presenting a decreasing trend during the recession. Policies to address the crisis may have contributed to a reduction in hospital expenditures, but at the same time patients were increasingly dissatisfied with the technical care. Consequently, there is a need for reforms aimed at the achievement of productivity gains, responsibility, and transparency in the management of productive resources, by enabling health organisations to reduce their costs without a deterioration in the quality of care.

Understanding the Relationship Between Medicaid Expansions and Hospital Closures

LINDROOTH R. C., *et al.*

2018

Health Aff (Millwood) 37(1): 111-120.

Decisions by states about whether to expand Medicaid under the Affordable Care Act (ACA) have implications for hospitals' financial health. We hypothesized that Medicaid expansion of eligibility for childless adults prevents hospital closures because increased Medicaid coverage for previously uninsured people reduces uncompensated care expenditures and strengthens hospitals' financial position. We tested this hypothesis using data for the period 2008-16 on hospital closures and financial performance. We found that the ACA's Medicaid expansion was associated with improved hospital financial performance and substantially lower likelihoods of closure, especially in rural markets and counties with large numbers of uninsured adults before Medicaid expansion. Future congressional efforts to reform Medicaid policy should consider the strong relationship between Medicaid coverage levels and the financial viability of hospitals. Our results imply that reverting to pre-ACA eligibility levels would lead to particularly large increases in rural hospital closures. Such closures could lead to reduced access to care and a loss of highly skilled jobs, which could have detrimental impacts on local economies.

Risk Adjustment May Lessen Penalties on Hospitals Treating Complex Cardiac Patients Under Medicare's Bundled Payments

MARKOVITZ A. A., *et al.*

2017

Health Aff (Millwood) 36(12): 2165-2174.

To reduce variation in spending, Medicare has considered implementing a cardiac bundled payment program for acute myocardial infarction and coronary artery bypass graft. Because the proposed program does not account for patient risk factors when calculating hospital penalties or rewards ("reconciliation payments"), it might unfairly penalize certain hospitals. We estimated the impact of adjusting for patients' medical complexity and social risk on reconciliation payments for Medicare beneficiaries hospitalized for the two conditions in the period 2011-13. Average spending per episode was $29,394. Accounting for medical complexity substantially narrowed the gap in reconciliation payments between hospitals with high medical severity (from a penalty of $1,809 to one of $820, or a net reduction of $989), safety-net hospitals (from a penalty of $217 to one of $87, a reduction of $130), and minority-serving hospitals (from a penalty of $70 to a reward of $56, an improvement of $126) and their counterparts. Accounting for social risk alone narrowed these gaps but had minimal incremental effects after medical complexity was accounted for. Risk adjustment may preserve incentives to care for patients with complex conditions under Medicare bundled payment programs.

Medicare ACO Program Savings Not Tied to Preventable Hospitalizations or Concentrated Among High-Risk Patients

MCWILLIAMS J. M., *et al.*

2017

Health Aff (Millwood) 36(12): 2085-2093.

It has been widely assumed that better management and coordination of care for chronic conditions and high-risk patients would be the leading mechanisms for achieving savings in accountable care organizations (ACOs), specifically by reducing acute care needs through enhanced outpatient and preventive care. We examined the extent to which changes in spending and hospitalizations for ACO patients in the Medicare Shared Savings Program (MSSP) have been consistent with this expectation. By 2014, participation in the MSSP was associated with significant reductions in total Medicare fee-for-service spending for ACO patients but with proportionately smaller reductions in hospitalizations and some increases in hospitalizations for ambulatory care-sensitive conditions. In addition, spending reductions were not clearly concentrated among high-risk patients: Reductions for those patients accounted for only 38 percent of the total reduction among ACOs entering the MSSP in 2012, and reductions among 2013 MSSP entrants were almost entirely concentrated among lower-risk patients. These findings suggest that, on average, care coordination and management efforts focused on ambulatory care-sensitive conditions and high-risk patients have not been the major drivers of early savings in the MSSP.

A Failure to Communicate? Doctors and Nurses in American Hospitals

MICHEL L.

2017

J Health Polit Policy Law 42(4): 709-717.

This article showcases the realities and challenges of teamwork in American hospitals based on the in situ comparison with France. Drawing on observation of nurse-physician interactions in hospitals in the two nations, this article highlights a troubling conflict between teamwork rhetoric and realities on the ward. Although the use of informatics systems such as electronic health records is supposed to increase cooperation, the observations presented here show that on the contrary, it inhibits communication that is becoming mainly virtual. While the nursing profession is more developed and provides stronger education in the United States, this story highlights the challenges in creating a shared environment of work and suggests the importance of balancing professional autonomy and effective teamwork.

Health Inequalities

Sex Differences in Treatments, Relative Survival, and Excess Mortality Following Acute Myocardial Infarction: National Cohort Study Using the SWEDEHEART Registry

ALABAS O. A., *et al.*

2017

Journal of the American Heart Association 6(12).

http://jaha.ahajournals.org/content/ahaoa/6/12/e007123.full.pdf

This study assessed sex differences in treatments, all-cause mortality, relative survival, and excess mortality following acute myocardial infarction. A population-based cohort of all hospitals providing acute myocardial infarction care in Sweden (SWEDEHEART [Swedish Web System for Enhancement and Development of Evidence-Based Care in Heart Disease Evaluated According to Recommended Therapies]) from 2003 to 2013 was included in the analysis. Excess mortality rate ratios (EMRRs), adjusted for clinical characteristics and guideline-indicated treatments after matching by age, sex, and year to background mortality data, were estimated. The study concludes that women with acute myocardial infarction did not have statistically different all-cause mortality, but had higher excess mortality compared with men that was attenuated after adjustment for the use of guideline-indicated treatments. This suggests that improved adherence to guideline recommendations for the treatment of acute myocardial infarction may reduce premature cardiovascular death among women.

▶ International Migrants' Use of Emergency Departments in Europe Compared with Non-Migrants' Use: A Systematic Review

CREDE S. H., *et al.*

2018

Eur J Public Health 28(1): 61-73.

International migration across Europe is increasing. High rates of net migration may be expected to increase pressure on healthcare services, including emergency services. However, the extent to which immigration creates additional pressure on emergency departments (EDs) is widely debated. This review synthesizes the evidence relating to international migrants' use of EDs in European Economic Area (EEA) countries as compared with that of non-migrants. MEDLINE, EMBASE, CINAHL, The Cochrane Library and The Web of Science were searched for the years 2000-16. Twenty-two articles (from six host countries) were included. The principal finding of this review is that migrants utilize the ED more, and differently, to the native populations in EEA countries. The higher use of the ED for low-acuity presentations and the use of the ED during unsocial hours suggest that barriers to primary healthcare may be driving the higher use of these emergency services although further research is needed.

▶ Migrant Women Living with HIV in Europe: Are They Facing Inequalities in the Prevention of Mother-To-Child-Transmission of HIV? The European Pregnancy and Paediatric HIV Cohort Collaboration (EPPICC) Study Group in Eurocoord

FAVARATO G., *et al.*

2018

Eur J Public Health 28(1): 55-60.

In pregnancy early interventions are recommended for prevention of mother-to-child-transmission (PMTCT) of HIV. We examined whether pregnant women who live with HIV in Europe and are migrants encounter barriers in accessing HIV testing and care. Methods: Four cohorts within the European Pregnancy and Paediatric HIV Cohort Collaboration provided data for pooled analysis of 11 795 pregnant women who delivered in 2002-12 across ten European countries. We defined a migrant as a woman delivering in a country different from her country of birth and grouped the countries into seven world regions. We compared three suboptimal PMTCT interventions (HIV diagnosis in late pregnancy in women undiagnosed at conception, late anti-retroviral therapy (ART) start in women diagnosed but untreated at conception and detectable viral load (VL) at delivery in women on antenatal ART) in native and migrant women using multivariable logistic regression models. Results: Data included 9421 (79.9%) migrant women, mainly from sub-Saharan Africa (SSA); 4134 migrant women were diagnosed in the current pregnancy, often (48.6%) presenting with CD4 count <350 cells/microl. Being a migrant was associated with HIV diagnosis in late pregnancy [OR for SSA vs. native women, 2.12 (95% CI 1.67, 2.69)] but not with late ART start if diagnosed but not on ART at conception, or with detectable VL at delivery once on ART. Conclusions: Migrant women were more likely to be diagnosed in late pregnancy but once on ART virological response was good. Good access to antenatal care enables the implementation of PMTCT protocols and optimises both maternal and children health outcomes generally.

▶ Les demandeurs de l'aide médicale d'État pris entre productivisme et gestion spécifique

GABARRO C.

2012

Revue Européenne Des Migrations Internationales 28(2): 35-56.

En 2000 est créée l'aide médicale d'État (AME), une couverture maladie réservée aux personnes en situation irrégulière. Dans cet article, nous nous intéressons aux conséquences de cette spécificité sur l'accès aux soins de ces personnes dans trois champs : le droit, l'organisation des caisses d'assurance maladie et les pratiques des agents de ces caisses (aussi bien les agents d'accueil qui reçoivent les demandeurs, que les agents du service AME qui instruisent les dossiers). La combinaison de ces trois angles d'approche permettra d'identifier le parcours effectué par les personnes en situation irrégulière et les embûches rencontrées. Nous verrons que cantonner les personnes en situation irrégulière au sein d'une prestation qui leur est propre crée un système de santé à plusieurs vitesses, favorisant la réception de ce public dans des lieux distincts ou de manières différenciées et limitant son accès aux soins et aux structures. Nous serons particulièrement attentifs à l'impact de la gestion productiviste sur l'accueil de ces personnes et le traitement de leur dossier : les

rendements imposés aux agents des caisses et leur manque de formation les poussent à réclamer aux demandeurs plus de justificatifs, différant toujours plus leur accès aux soins.

De la « crise des migrants » à la crise de l'Europe : un éclairage démographique

HÉRAN F.

2017

In Boucheron P./dir. Migrations, réfugiés, exil. Paris : Odile Jacob: 239-260.

« Il n'est qu'une seule espèce humaine sur la Terre, et cette espèce est migrante. Depuis le début de l'histoire, nous sommes embarqués. Et, aujourd'hui, nous sommes écrasés sous le poids de notre fardeau, celui de notre responsabilité face à l'histoire : car nous savons que nous serons jugés sur notre capacité à affronter la situation des migrants. Ce livre est un appel au calme, un effort de description réaliste. On estime qu'il y a actuellement dans le monde 244 millions de migrants, dont 100 millions sont des migrants forcés. L'Europe est un continent d'immigration au même titre que les États-Unis. Telle est la réalité. On oppose généralement les beaux principes aux dures réalités. Mais nous sommes bien, avec le présent ouvrage, dans le réel. Ce qu'il réclame de nous ? De la considération. »

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

LANDI S., *et al.*

2018

Health Policy: [Ahead of print]

http://dx.doi.org/10.1016/j.healthpol.2018.01.003

Literature review on works examining the relation between SES and waiting times. Only seven out of twenty-eight works do not find any association. Three different health services in a specific country context are analysed (Italy). Horizontal inequalities arise even though care is not rationed through ability to pay. Inequalities are higher in specialist visits and diagnostic tests than elective surgeries.

La santé des migrants : le syndrome d'Ulysse

LE FERRAND P.

2017

Médecine : de la Médecine factuelle à nos pratiques 13(9): 409-417.

Lorsque les médecins sont amenés à rencontrer des migrants en consultation, la demande se fait le plus souvent sur des plaintes somatiques multiples et diffuses et sur une profonde souffrance psychique qu'ils associent à l'état de stress post-traumatique (ESPT). Pourtant le diagnostic de syndrome post-traumatique ne correspond pas toujours aux troubles observés. Dans de très nombreux cas, il s'agit en réalité d'un épuisement psychique ressemblant à une forme de burnout que certains cliniciens ont dénommé « syndrome d'Ulysse ».

Unhealthy Assimilation or Persistent Health Advantage? A Longitudinal Analysis of Immigrant Health in the United States

LU Y., *et al.*

2017

Soc Sci Med 195: 105-114.

Existing evidence on immigrant health assimilation, which is largely based on cross-sectional data, suggests that immigrants' initial health advantage erodes over time. This study uses longitudinal data to directly compare the self-rated health trajectories of immigrants and the native-born population. Data come from four panels of the Survey of Income and Program Participation (1996, 2001, 2004, and 2008), with each panel containing 2-4 years of health information. Results show that immigrants' self-rated health remained stable during the period under study, but there was a concomitant decline in health for the native-born population. This result pointed to a persistent health advantage of immigrants during the period under study. The pattern held for immigrants of different length of residence and was especially salient for those originally from Latin America and Asia. Our findings that immigrants maintain their health advantage do not support the pattern of unhealthy assimilation commonly reported in cross-sectional studies.

Do Gender Gaps in Education and Health Affect Economic Growth? A Cross-Country Study from 1975 to 2010

MANDAL B., *et al.*

2018

Health Economics: Ahead of print.

We use system-generalized method-of-moments to estimate the effect of gender-specific human capital on economic growth in a cross-country panel of 127 countries between 1975 and 2010. There are several benefits of using this methodology. First, a dynamic lagged dependent econometric model is suitable to address persistence in per capita output. Second, the generalized method-of-moments estimator uses dynamic properties of the data to generate appropriate instrumental variables to address joint endogeneity of the explanatory variables. Third, we allow the measurement error to include unobserved country-specific effect and random noise. We include two gender-disaggregated measures of human capital-education and health. We find that gender gap in health plays a critical role in explaining economic growth in developing countries. Our results provide aggregate evidence that returns to investments in health systematically differ across gender and between low-income and high-income countries.

Gypsy, Roma and Traveller Access to and Engagement with Health Services: A Systematic Review

MCFADDEN A., *et al.*

2018

Eur J Public Health 28(1): 74-81.

Gypsy, Roma and Traveller people represent the most disadvantaged minority groups in Europe, having the poorest health outcomes. This systematic review addressed the question of how Gypsy, Roma and Traveller people access healthcare and what are the best ways to enhance their engagement with health services. Searches were conducted in 21 electronic databases complemented by a focused Google search. Studies were included if they had sufficient focus on Gypsy, Roma or Traveller populations; reported data pertinent to healthcare service use or engagement and were published in English from 2000 to 2015. Study findings were analyzed thematically and a narrative synthesis reported. This review provides evidence that Gypsy, Roma and Traveller populations across Europe struggle to exercise their right to healthcare on account of multiple barriers; and related to other determinants of disadvantage such as low literacy levels and experiences of discrimination. Some promising strategies to overcome barriers were reported but the evidence is weak; therefore, rigorous evaluations of interventions to improve access to and engagement with health services for Gypsy, Roma and Traveller people are needed.

Primary Care for Refugees and Newly Arrived Migrants in Europe: A Qualitative Study on Health Needs, Barriers and Wishes

VAN LOENEN T., *et al.*

2018

Eur J Public Health 28(1): 82-87.

In order to provide effective primary care for refugees and to develop interventions tailored to them, we must know their needs. Little is known of the health needs and experiences of recently arrived refugees and other migrants throughout their journey through Europe. We aimed to gain insight into their health needs, barriers in access and wishes regarding primary health care. In the spring of 2016, we conducted a qualitative, comparative case study in seven EU countries in a centre of first arrival, two transit centres, two intermediate-stay centres and two longer-stay centres using a Participatory Learning and Action research methodology. A total of 98 refugees and 25 healthcare workers participated in 43 sessions. The main health problems of the participants related to war and to their harsh journey like common infections and psychological distress. They encountered important barriers in accessing healthcare: time pressure, linguistic and cultural differences and lack of continuity of care. They wish for compassionate, culturally sensitive healthcare workers and for more information on procedures and health promotion. Health of refugees on the move in Europe is jeopardized by their bad living circumstances and barriers in access to healthcare. To address their needs, healthcare workers have to be trained in providing integrated, compassionate and cultural competent healthcare.

Pharmaceuticals

La déprescription médicamenteuse, un acte médical de salubrité publique

PUGNET G., *et al.*

2017

Médecine : de la Médecine factuelle à nos pratiques 13(9): 405-408.

Cela fait plus de 20 ans que toutes les études et tous les auteurs se penchant sur ce sujet s'accordent à dire que la consommation médicamenteuse est trop importante dans les pays industrialisés et particulièrement en France. L'importance croissante et la gravité des pathologies iatrogènes médicamenteuses deviennent un enjeu majeur de santé publique. La polymédicamentation en est une des principales responsables. Pour combattre ce fléau, il faut inventer cet acte de responsabilité médicale que l'on pourrait appeler « déprescription médicamenteuse », et qu'il faut donc promouvoir et enseigner. « La thérapeutique est aussi la science de l'art de dé-prescrire ».

Potentially Inappropriate Medication Among People with Dementia in Eight European Countries

RENOM-GUITERAS A., *et al.*

2018

Age Ageing 47(1): 68-74.

The aim of this paper is to evaluate the frequency of potentially inappropriate medication (PIM) prescription among older people with dementia (PwD) from eight countries participating in the European study 'RightTimePlaceCare', and to evaluate factors and adverse outcomes associated with PIM prescription. Survey of 2,004 PwD including a baseline assessment and follow-up after 3 months. Interviewers gathered data on age, sex, prescription of medication, cognitive status, functional status, comorbidity, setting and admission to hospital, fall-related injuries and mortality in the time between baseline and follow-up. The European Union(7)-PIM list was used to evaluate PIM prescription. Multivariate regression analysis was used to investigate factors and adverse outcomes associated with PIM prescription. Overall, 60% of the participants had at least one PIM prescription and 26.4% at least two. The PIM therapeutic subgroups most frequently prescribed were psycholeptics (26% of all PIM prescriptions) and 'drugs for acid-related disorders' (21%). PwD who were 80 years and older, lived in institutional long-term care settings, had higher comorbidity and were more functionally impaired were at higher risk of being prescribed two PIM or more. The prescription of two or more PIM was associated with higher chance of suffering from at least one fall-related injury and at least one episode of hospitalisation in the time between baseline and follow-up. PIM use among PwD is frequent and is associated with institutional long-term care, age, advanced morbidity and functional impairment. It also appears to be associated with adverse outcomes. Special attention should be paid to psycholeptics and drugs for acid-related disorders.

Methodology - Statistics

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

BERSON C. ET FERRARI N.

2017

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

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

Le marché du travail français est segmenté entre les personnes bénéficiant d'un emploi stable et celles alternant contrats temporaires et périodes de chômage. À partir de simulations sur un modèle d'appariement calibré sur la France, la réforme issue de l'accord national interprofessionnel de 2013 apparaît pertinente pour réduire cette dualité. L'estimation des effets des majorations de cotisation sur les CDD et des exonérations pour les embauches de jeunes en CDI introduites par l'ANI du 11 janvier 2013 montre en effet

un impact positif mais faible au regard de la réforme relativement similaire dite à l'italienne et étudiée dans Berson et Ferrari. (2015).

Health Policy

▶ Le soin, une éthique de l'attention

BALEYLE J. M., *et al.*

2017

Éthique & Santé 14(4): 194-1999.

Porter attention à l'autre, comme méthode et comme éthique, mobilise réceptivité et mise en sens. C'est dans les liens, en référence à la métaphore des poupées russes, que la réceptivité est travaillée, aiguisée et restaurée. Elle implique disponibilité, sensibilité, écoute et est simultanément orientée vers l'extérieur et vers l'intérieur de soi-même, dans un double mouvement synergique ; presque un oxymore, l'attention aux processus inconscients serait paradoxale si elle ne suggérait le détour par soi-même pour porter attention à l'autre et le détour par l'autre, par les autres du groupe, pour élucider les processus en soi. La disponibilité et la vitalité des capacités d'attention imposent une capacité de « détoxification », garantie par les liens, travaillée en particulier dans le groupe de supervision. La réceptivité implique d'accepter, tenir sans les évacuer, émotions et pensées irreprésentables ou dérangeantes, sans mobilisation des systèmes de défense agis ou pensés. Elle recommande sobriété d'action et de parole. Chaque situation de soin saura construire les conditions d'une « contenance institutionnelle » garante de la qualité et de la régénération des processus d'attention par les liens, les compétences, les dispositifs et le temps nécessaires. L'attention apparaît ainsi comme une éthique ; elle ouvre simultanément le chemin de la rencontre de l'autre et de soi-même.

▶ What's Involved with Wanting to Be Involved? Comparing Expectations For Public Engagement in Health Policy Across Research and Care Contexts

BARG, C.J. *et al.*

2017

Healthcare Policy 13(2): 40-56.

We explored public preferences for involvement in health policy decisions, across the contexts of medical research and healthcare. We e-surveyed a sample of Canadians, categorizing respondents by preferences for decision control: (1) more authority; (2) more input; (3) status quo. Two generalized ordered logistic regressions assessed influences on preferences. The participation rate was 94%; 1,102 completed responses met quality criteria. The dominant preference was for more input (average = 52.0%), followed by status quo (average = 24.9%) and more authority (average = 21.1%), though preferences for more control were higher in healthcare (57.2%) than medical research (46.8%). Preferences for greater control were associated with constructs related to reduce trust in healthcare systems. The public expects health policy to account for public views, but not base decisions primarily on these views. More involvement was expected in healthcare than medical research policy. As opportunities for public involvement in health research grow, we anticipate increased desired involvement.

▶ Is User Involvement a Reality or a Dream in LMICs – as Well as in the Rest of the World?

D'AVANZO, B.

2017

Epidemiology and Psychiatric Sciences 27(1): 40-41.

https://www.cambridge.org/core/article/is-user-involvement-a-reality-or-a-dream-in-lmics-as-well-as-in-the-rest-of-the-world/C73127CF6485536BDB07E3A9DC54E125

Mieux comprendre le processus d'empowerment du patient

FAYN M.-G., *et al.*

2017

Recherches en Sciences de Gestion 119(2): 55-73.

https://www.cairn.info/revue-recherches-en-sciences-de-gestion-2017-2-page-55.htm

Co-décideur de son traitement, co-rédacteur des lois, le patient est sorti du silence et de l'invisibilité. Sa prise de pouvoir s'étend à la production de connaissances et de solutions nouvelles. Cet article propose une meilleure compréhension du processus d'empowerment du patient chronique. Après une revue de littérature multidisciplinaire autour des concepts d'empowerment et de Patient-Centered-Care, une étude exploratoire a été réalisée auprès de quatre experts. Elle conduit à l'identification de quatre phases structurant le processus d'empowerment du patient : individuel, collectif, collaboratif et productif. Phénomène social, l'empowerment des patients transforme la relation de soin en une nouvelle alliance plus symétrique.

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

KROEZEN M., *et al.*

2018

Health Policy 122 (2) : 87-93

http://dx.doi.org/10.1016/j.healthpol.2017.12.002

The Joint Action Health Workforce Planning and Forecasting (JAHWF) ran from 2013 to 2016. The JAHWF has provided the basic tools and insights to start a planning process. The JAHWF showed that health workforce planning is a context-sensitive process. Investments are needed in the context-sensitivity and evaluation of health workforce planning.

Parcours de santé des enfants confiés à l'Aide Sociale à l'Enfance des Bouches-du-Rhône

MARTIN A., *et al.*

2017

Santé Publique 29(5): 665-675.

https://www.cairn.info/revue-sante-publique-2017-5-page-665.htm

L'objectif de cet article est de décrire le parcours de santé des enfants confiés à l'Aide Sociale à l'Enfance dans les Bouches-du-Rhône et proposer des préconisations pour améliorer le parcours de santé des enfants confiés. Cet article présente des données issues de l'enquête ESSPER-ASE 13, enquête descriptive et transversale menée entre avril 2013 et avril 2014 auprès de 1 092 enfants âgés de moins de 18 ans confiés à l'Aide Sociale à l'Enfance en Maison d'Enfants à Caractère Social ou chez un assistant familial dans les Bouches-du-Rhône. Les données étudiées concernaient l'état de santé somatique, psychique et les modalités du suivi médical des enfants. Cet article se centre sur le parcours de santé. Un médecin généraliste suivait 82 % des enfants alors que la Protection Maternelle et Infantile suivait 15 % des enfants, essentiellement les enfants de moins de six ans confiés à un assistant familial. Le parcours de santé des enfants était constitué de multiples intervenants et était dominé par le suivi psychologique. En moyenne les enfants étaient suivis par deux professionnels (médecin spécialiste ou personnel paramédical) en plus du médecin examinateur. En matière de prévention, les enfants présentaient des taux de couverture vaccinale supérieurs aux taux nationaux. La coordination des nombreux acteurs de la santé des enfants est indispensable, autour notamment de la création d'un médecin référent.

Personalized Medicine: A Doorway to an Effective Health Care Delivery System?

MINVIELLE E., *et al.*

2017

Journal de gestion et d'économie médicales 35(1): 3-5.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-1-page-3.htm

Assessing Patient Organization Participation in Health Policy: A Comparative Study in France and Italy

SOULIOTIS K.

2017

International Journal of Health Policy and Management 7(1): 48-56.

Even though there are many patient organizations across Europe, their role in impacting health policy decisions and reforms has not been well documented. In line with this, the present study endeavours to fill this gap in the international literature. To this end, it aims to validate further a previously developed instrument (the Health Democracy Index - HDI) measuring patient organization participation in health policy decision-making. In addition, by utilizing this tool, it aims to provide a snapshot of the degree and impact of cancer patient organization (CPO) participation in Italy and France. A convenient sample of 188 members of CPOs participated in the study (95 respondents from 10 CPOs in Italy and 93 from 12 CPOs in France). Findings indicate that the index has good internal consistency and the construct it taps is unidimensional. The degree and impact of CPO participation in health policy decision-making were found to be low in both countries; however in Italy they were comparatively lower than in France. In conclusion, the HDI can be effectively used in international policy and research contexts. CPOs participation is low in Italy and France and concerted efforts should be made on upgrading their role in health policy decision-making.

Prevention

Changes in Smoking Behavior over Family Transitions: Evidence for Anticipation and Adaptation Effects

BRICARD D., *et al.*

2017

International Journal of Environmental Research and Public Health 14(6): 610.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5486296/

The study of changes in smoking behaviors over the life course is a promising line of research. This paper aims to analyze the temporal relation between family transitions (partnership formation, first childbirth, separation) and changes in smoking initiation and cessation. We propose a discrete-time logistic model to explore the timing of changes in terms of leads and lags effects up to three years around the event in order to measure both anticipation and adaptation mechanisms. Retrospective biographical data from the Santé et Itinéraires Professionnels (SIP) survey conducted in France in 2006 are used. Partnership formation was followed for both genders by a fall in smoking initiation and an immediate rise in smoking cessation. Childbirth was associated with increased smoking cessation immediately around childbirth, and additionally, females showed an anticipatory increase in smoking cessation up to two years before childbirth. Couple separation was accompanied by an anticipatory increase in smoking initiation for females up to two years prior to the separation, but this effect only occurred in males during separation. Our findings highlight opportunities for more targeted interventions over the life course to reduce smoking, and therefore have relevance for general practitioners and public policy elaboration.

A Two-Step Screening Process Reduces Hip Fractures

CAULEY J. A.

2017

The Lancet

http://dx.doi.org/10.1016/S0140-6736(17)33295-6

Éducation thérapeutique du patient et éthique : de l'impératif de santé publique aux droits des personnes et des usagers

RUSCH E.

2017

Santé Publique 29(5): 601-603.

https://www.cairn.info/revue-sante-publique-2017-5-page-601.htm

Concevoir une intervention éducative pour prévenir la chute des personnes âgées en logement social : description d'une méthode de recherche

TREVIDY F., *et al.*

2017

Santé Publique 29(5): 623-634.

https://www.cairn.info/revue-sante-publique-2017-5-page-623.htm

Dans un environnement social où la prévention de la chute des personnes âgées est devenue un enjeu de santé publique, l'adaptation du logement des habitants âgés prend toute son importance. Partant du modèle de l'identité- logement, notre recherche vise à concevoir un modèle éducatif spécifique au contexte d'une Entreprise Sociale pour l'Habitat (ESH), centré sur le locataire âgé ayant déjà chuté pour lui permettre d'adapter son logement et d'éviter la récidive. Cet article décrit la méthode de recherche collaborative orientée par la conception (RoC) ayant permis au comité de recherche formé de professionnels, locataire et chercheurs, de construire l'intervention éducative à partir de l'étude du contexte de l'ESH.

Prevision - Evaluation

Design of Effective Interventions for Smoking Cessation Through Financial and Non-Financial Incentives

BALDERRAMA F. ET LONGO C. J.

2017

Healthcare Management Forum 30(6): 289-292.

http://journals.sagepub.com/doi/abs/10.1177/0840470417714490

Smoking has a tremendous negative impact on the Canadian economy and contributes to growing costs in the healthcare system. Efforts to reduce smoking rates may therefore reduce strain on the healthcare system and free up scarce resources. Academic literature on economic smoking cessation incentives presents a countless variety of interventions that have met with varying degrees of success. This study reviews six different variables used in the design of incentives in smoking cessation interventions: direction, form, magnitude, certainty, recipient grouping, and target demographic. The purpose of this study is to provide analysis and recommendations about the contribution of each variable into the overall effectiveness of smoking cessation programs and help health leaders design better interventions according to their specific needs.

Évaluation des politiques publiques : expérimentation randomisée et méthodes quasi-expérimentales

CHABÉ-FERRET S., *et al.*

2017

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

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

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

Pychiatry

▶ Santé mentale : de l'exception au droit commun?

BASSET B.

2017

Actualité et Dossier en Santé Publique(100): 49-55.

Les droits des personnes souffrant de troubles psychiatriques, les pratiques professionnelles ou l'organisation du système de santé mentale ont évolué au cours des décennies. Adsp a abordé la problématique sous des angles différents dans plusieurs dossiers. Cet article fait une rétrospective des approches, mais aussi réformes, dispositifs et mesures mis en œuvre durant ces dernières années, et des préconisations pour que le débat soit transparent et public.

▶ Management of First Depression or Generalized Anxiety Disorder Episode in Adults in Primary Care: A Systematic Metareview

DRIOT D., *et al.*

2017

Presse Med 46(12 Pt 1): 1124-1138.

General Practitioners (GPs) are the leading antidepressants prescribers in Europe and in France. Difficulties in implementing existing recommendations in daily practice have been described. The objective of this study was to elaborate two algorithms to guide GPs in the patient management for a first major depressive disorder (MDD) or generalized anxiety disorder (GAD) episode in primary care. PubMed, Cochrane, and ISI Web of Science were explored using mainly the following keywords: depressive disorder, anxiety disorders, antidepressive agents or antidepressant. A systematic meta-review (overview of reviews) including systematic reviews, meta-analyses, guidelines and clinical practice recommendations, published from January 2002 to December 2015, was performed. The methodological and report qualities were assessed by the AGREE II, PRISMA checklist and R-AMSTAR grid. From the best evidence-based data, we created two algorithms to guide GPs for the management of MDD and or the management of GAD. These algorithms will be implemented through a website available for GPs consultation.

▶ National Trends in Specialty Outpatient Mental Health Care Among Adults

HAN B., *et al.*

2017

Health Aff (Millwood) 36(12): 2062-2068.

We examined national trends in the receipt of specialty outpatient mental health care, using data for 2008-15 from the National Survey on Drug Use and Health. Between 2008-09 and 2014-15 the number of US adults who received outpatient mental health care in the specialty sector rose from 11.3 million to 13.7 million per year, representing an increase from 5.0 percent to 5.7 percent of the adult population. Among those recipients, however, the annual weighted mean number of visits to the specialty sector remained unchanged. We found increases in both numbers and percentages of adults who received care within the specialty sector across age and sex groups and among non-Hispanic whites, people with Medicare, people with private health insurance, and people with family incomes of $20,000-$49,999. Increases in receipt of specialty mental health care during 2012-15 may be related to recent policy initiatives aimed at reducing financial barriers to care.

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

OSE S. O., *et al.*

2017

Health Policy: [Ahead of print]

Inpatient bed numbers are continually being reduced but are not being replaced with adequate alternatives in primary health care. There is a considerable risk that eventually all inpatient treatment will be unplanned, because planned or elective treatments are superseded by urgent needs when capacity is reduced. The aims of this study is to estimate the rate of unplanned admissions to inpatient psychiatric treatment facilities in Norway and analyse the difference between patients with unplanned and planned admissions regarding services received during the three months prior to admission as well as clinical, demographical and socioeconomic characteristics of patients. Unplanned admissions were defined as all urgent and

involuntary admissions including unplanned readmissions. National mapping of inpatients was conducted in all inpatient treatment psychiatric wards in Norway on a specific date in 2012. Patients with high risk of unplanned admission are suffering from severe mental illness, have low functional level indicated by the need for housing services, high risk for suicide attempt and of being violent, low education and born outside Norway. Specialist mental health services should support the local services in their efforts to prevent unplanned admissions by providing counselling, short inpatient stays, outpatient treatment and ambulatory outpatient psychiatry services. This paper suggests the rate of unplanned admissions as a quality indicator and considers the introduction of economic incentives in the income models at both service levels.

▶ Comment les soins psychiatriques sans consentement en ambulatoire se sont imposés en Suède ? Une comparaison socio-politique avec la Norvège, le Royaume-Uni et New York

SJÖSTRÖM S.

2017

L'information psychiatrique 93(10): 847-853.

https://www.cairn.info/revue-l-information-psychiatrique-2017-10-page-847.htm

Cet article s'attache à comprendre une évolution remarquable des politiques de santé mentale au cours des vingt-cinq dernières années : comment expliquer que les soins psychiatriques sans consentement en ambulatoire (compulsory community care ou CCC) soient apparus comme une solution dans tant de contextes sociaux et juridiques différents ? Nous partirons du cas de l'introduction des CCC en Suède, pour le comparer ensuite à celui de la Norvège, de l'Angleterre/du Pays de Galles et de l'État de New York.

▶ Consultation ambulatoire en cabinet libéral et en CMP : deux cliniques ou deux patientèles ?

WINTER E.

2017

L'Informations psychiatriques 93(9): 934-938.

La consultation ambulatoire en CMP et en cabinet libéral se différencient plus par leurs patientèles que par la pratique clinique qui y est exercée. Mais ces généralités cachent des variations importantes entre les psychiatres de même exercice, et surtout au sein même de la consultation de chaque psychiatre quel que soit son exercice. Les patients font appel à l'ensemble des soins accessibles sur leur territoire à des temps différents de leur prise en charge, trouvant parfois un réel intérêt à la diversité de ces cadres. La démographie médicale prévoit néanmoins un avenir plus difficile pour l'effectif des psychiatres libéraux par rapport aux salariés.

Primary Health Care

▶ La médecine prédictive quinze ans après

AYMÉ S.

2017

Actualité et Dossier en Santé Publique(100): 13-16.

En 2001, la revue Adsp consacrait un dossier à la médecine prédictive et aux espoirs ou craintes qu'elle suscitait, sans toutefois surestimer l'impact potentiel en santé publique des nouvelles connaissances issues du génome. Pourtant la tendance était la surévaluation de la valeur prédictive des tests, à la croyance dans la contribution majeure du patrimoine génétique à la survenue des maladies. Aujourd'hui la science a progressé, on parle moins de médecine prédictive, et plus de médecine de précision, de médecine personnalisée..

▶ Exploring the Impact and Use of Patients' Feedback About Their Care Experiences in General Practice Settings-A Realist Synthesis

BALDIE D. J., *et al.*

2018

Fam Pract 35(1): 13-21.

Policy encourages health care providers to listen and respond to feedback from patients, expecting that it will enhance care experiences. Enhancement of patients' experiences may not yet be a reality, particularly in primary health care settings. The aim of this study is to identify the issues that influence the use and impact of feedback in this context. Analysis is founded on a realist synthesis of studies of the use of patient feedback within primary health care settings. Structured review of published studies between 1971 and January 2015 were performed. There is little evidence that formal patient feedback led to enhanced experiences. The likelihood of patient feedback to health care staff stimulating improvements in future patients' experiences appears to be influenced predominantly by staff perceptions of the purpose of such feedback; the validity and type of data that is collected; and where, when and how it is presented to primary health care teams or practitioners and teams' capacity to change. There is limited research into how patient feedback has been used in primary health care practices or its usefulness as a stimulant to improve health care experience. Using a realist synthesis approach, we have identified a number of contextual and intervention-related factors that appear to influence the likelihood that practitioners will listen to, act on and achieve improvements in patient experience. Consideration of these may support research and improvement work in this area.

▶ Chevauchement, interdépendance ou complémentarité ? La collaboration interprofessionnelle entre l'infirmière praticienne et d'autres professionnels de santé en Ontario

BENOIT M., *et al.*

2017

Santé Publique 29(5): 693-706.

https://www.cairn.info/revue-sante-publique-2017-5-page-693.htm

Le rapport Naylor de 2015 précise que les infirmières praticiennes (IP) sont sous-utilisées au Canada, et ce, malgré les preuves favorables à leur égard, les avantages qu'elles apporteraient aux systèmes de santé ainsi qu'à la santé de la population plus généralement. Comment expliquer qu'elles ne soient pas plus présentes à pratiquer dans le système de santé canadien ? Une revue de littérature, sociohistorique, a permis de montrer qu'il existe un chevauchement, une interdépendance ou une complémentarité entre le rôle de l'IP et celui d'autres professionnels de la santé et que cela concerne son statut, sa formation autant que l'étendue de sa pratique. Le développement d'une approche collaborative interprofessionnelle, bien que réclamée par la plupart des associations professionnelles d'infirmières au pays, a du mal à s'implanter dans le cadre de la pratique et de la formation des IP. Le présent texte retrace l'émergence du rôle des IP au Canada et fait le point sur la situation actuelle relativement à leur intégration dans le système de santé en se référant à l'exemple ontarien.

▶ Small Cash Incentives Can Encourage Primary Care Visits by Low-Income People with New Health Care Coverage

BRADLEY C. J. ET NEUMARK D.

2017

Health Aff (Millwood) 36(8): 1376-1384.

In a randomized controlled trial, we studied low-income adults newly covered by a primary care program to determine whether a cash incentive could encourage them to make an initial visit to a primary care provider. Subjects were randomly assigned to one of four groups: three groups whose members received $10 to complete a baseline survey during an interview and who were randomized to incentives of $50, $25, or $0 to visit their assigned primary care provider within six months after enrolling in the study; and a nonincentivized control group not contacted by the research team. Subjects in the $50 and $25 incentive groups were more likely to see a primary care provider (77 percent and 74 percent, respectively), compared to subjects in the $0 incentive group (68 percent). The effects of the intervention were about twice as large when we compared the proportions of subjects in the $50 and $25 incentive groups who visited their providers and the proportion in the non incentivized group (61 percent). Cash incentive programs may steer newly covered low-income patients toward primary care, which could result in improved health outcomes and lower costs.

Les médecins en 2017 : des carrières bouleversées par les changements dans le système de santé ?

CHARPAK Y.

2017

Actualité et Dossier en Santé Publique(100): 65-69.

L'exercice médical évolue sans cesse. Face notamment aux patients de plus en plus formés et informés, les médecins doivent ajuster leurs pratiques. Les modes d'exercice se diversifient aussi, avec, des plus en plus, des activités plurielles. Cet article donne un éclairage sur cette évolution à travers des témoignages de professionnels.

Les relations médecin-malade. Des temps modernes à l'époque contemporaine

CHEVANDIER C.

2015

Revue d'histoire de la protection sociale 8(1): 190-192.

https://www.cairn.info/revue-d-histoire-de-la-protection-sociale-2015-1-page-190.htm

Cet article est la reprise d'une communication donnée lors d'un congrès tenu à Paris, en 2010, qui s'intitulait : Regards croisés sur les relations médecins-malades de la fin du Moyen Âge à l'époque contemporaine ». Basé sur une approche multi-disciplinaire, il retrace l'historique de la relation médecins patients en France, des travaux de Michel Foucault jusqu'à nos jours.

Quantifier la qualité des soins : une critique de la rationalisation de la médecine libérale française

DA SILVA N.

2017

Revue Française de socio-économie(19): 111-130.

Avec la logique de quantification de la qualité du travail médical, les patients sont invités à faire confiance aux normes chiffrées déterminées par les agences de santé indépendantes – plutôt que de se fier à la relation personnelle avec leur médecin. Si cette nouvelle régulation ressemble à une rationalisation des pratiques, nous proposons de montrer en quoi il est utile de revenir sur la méthode de production de ces normes du travail médical et de questionner l'usage politique des essais cliniques randomisés. Après avoir rappelé les justifications théoriques et empiriques de la « rationalisation », nous défendons l'idée que la politique de quantification de la qualité des soins repose sur une épistémologie de la maladie arbitraire et une épistémologie des statistiques réductrice. Or cela n'est pas sans conséquences négatives, tant pour les professionnels que pour les patients.

Burnout des soignants : comment éteindre l'incendie ?

DUMOULIN M., *et al.*

2017

Médecine : De la médecine factuelle à nos pratiques 13(9): 396-401.

Les différentes manifestations du burnout, sa prévention et son contexte actuel soulignent l'épidémie silencieuse et le déni trop longtemps persistant de la profession médicale et des pouvoirs publics face à la souffrance au travail de certains soignants. Diverses initiatives et propositions de prévention voient le jour, souvent inspirées des expériences à l'étranger, la quasi-totalité des pays dans le monde étant touchée par ce problème, mais l'évolution législative réclamée n'est toujours pas au rendez-vous et le chemin à parcourir pour aider les médecins à rester en bonne santé ou à faire face à la maladie comme à la souffrance semble encore important. Quelle est l'ampleur de ce problème chez les soignants ? Comment définir, repérer et évaluer le burnout ? De nombreuses publications apportent un éclairage sur cette souffrance liée au travail longtemps restée tabou.

International Variations in Primary Care Physician Consultation Time: A Systematic Review of 67 Countries

IRVING G., *et al.*

2017

BMJ Open 7(10).

http://bmjopen.bmj.com/content/bmjopen/7/10/e017902.full.pdf

The aim of this paper is to describe the average primary care physician consultation length in economically developed and low-income/middle-income countries, and to examine the relationship between consultation length and organisational-level economic, and health

outcomes. A systematic review of published and grey literature was performed from 1946 to 2016, for articles reporting on primary care physician consultation lengths. Data were extracted and analysed for quality, and linear regression models were constructed to examine the relationship between consultation length and health service outcomes. There are international variations in consultation length, and it is concerning that a large proportion of the global population have only a few minutes with their primary care physicians. Such a short consultation length is likely to adversely affect patient healthcare and physician workload and stress.

▶ Community Care for People with Complex Care Needs: Bridging the Gap Between Health and Social Care

KULUSKI K., *et al.*

2017

International Journal for Integrated Care 17(4)

http://doi.org/10.5334/ijic.2944

A growing number of people are living with complex care needs characterized by multimorbidity, mental health challenges and social deprivation. The integration of health and social care is required, beyond traditional health care services, to address social determinants. This study investigates key care components to support complex patients and their families in the community. Conclusions point out that meeting the needs of the population who require health and social care requires time to develop authentic relationships, broadening the membership of the care team, communicating across sectors, co-locating health and social care, and addressing the barriers that prevent providers from engaging in these required practices.

▶ The Content and Meaning of Administrative Work: A Qualitative Study of Nursing Practices

MICHEL L., *et al.*

2017

J Adv Nurs 73(9): 2179-2190.

The aim of this stydy is to investigate the content and meaning of nurses' administrative work. BACKGROUND: Nurses often report that administrative work keeps them away from bedside care. The content and meaning of this work remains insufficiently explored. Founded on comparative case studies, the investigation took place in 2014. It was based on 254 hours of observations and 27 interviews with nurses and staff in two contrasting units: intensive care and long-term care. A time and motion study was also performed over a period of 96 hours. Documentation and Organizational Activities is composed of six categories; documenting the patient record, coordination, management of patient flow, transmission of information, reporting quality indicators, ordering supplies- stock management Equal amounts of time were spent on these activities in each case. Documentation and Organizational Activities are a main component of care. The meaning nurses attribute to them is dependent on organizational context. These activities are often perceived as competing with bedside care, but this does not have to be the case. The challenge for managers is to fully integrate them into nursing practice. Results also suggest that nurses' Documentation and Organizational Activities should be incorporated into informatics strategies.

▶ Multimorbidity Care Model: Recommendations from the Consensus Meeting of the Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle (JA-CHRODIS)

PALMER K., *et al.*

2018

Health Policy 122(1): 4-11.

Patients with multimorbidity have complex health needs but, due to the current traditional disease-oriented approach, they face a highly fragmented form of care that leads to inefficient, ineffective, and possibly harmful clinical interventions. There is limited evidence on available integrated and multidimensional care pathways for multimorbid patients. An expert consensus meeting was held to develop a framework for care of multimorbid patients that can be applied across Europe, within a project funded by the European Union; the Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS). The experts included a diverse group representing care providers and patients, and included general practitioners, family medicine physicians, neurologists, geriatricians, internists, cardiologists, endocrinologists, diabetologists, epidemiologists, psychologists, and representatives from patient organizations. Sixteen com-

ponents across five domains were identified (Delivery of Care; Decision Support; Self-Management Support; Information Systems and Technology; and Social and Community Resources). The description and aim of each component are described in these guidelines, along with a summary of key characteristics and relevance to multimorbid patients. Due to the lack of evidence-based recommendations specific to multimorbid patients, this care model needs to be assessed and validated in different European settings to examine specifically how multimorbid patients will benefit from this care model, and whether certain components have more importance than others.

▶ Managing Multimorbidity: Profiles of Integrated Care Approaches Targeting People with Multiple Chronic Conditions in Europe

RIJKEN M., *et al.*

2018

Health Policy 122(1): 44-52.

In response to the growing populations of people with multiple chronic diseases, new models of care are currently being developed in European countries to better meet the needs of these people. This paper aims to describe the occurrence and characteristics of various types of integrated care practices in European countries that target people with multimorbidity. Data were analysed from multimorbidity care practices participating in the Innovating care for people with multiple chronic conditions (ICARE4EU) project, covering all 28EU Member States, Iceland, Norway and Switzerland. A total of 112 practices in 24 countries were included: 65 focus on patients with any combination of chronic diseases, 30 on patients with a specific chronic disease with all kinds of comorbidities and 17 on patients with a combination of specific chronic diseases. Practices that focus on a specific index disease or a combination of specific diseases are less extensive regarding the type, breadth and degree of integration than practices that focus on any combination of diseases. The latter type is more often seen in countries where more disciplines, e.g. community nurses, physiotherapists, social workers, work in the same primary care practice as the general practitioners. Non-disease specific practices put more emphasis on patient involvement and provide more comprehensive care, which are important preconditions for person-centered multimorbidity care.

▶ Se former pour construire son espace d'autonomie professionnelle ? Le cas des Nurses practitioners néerlandaises

ROSMAN S.

2014

Recherche & formation 76(2): 79-92.

https://www.cairn.info/revue-recherche-et-formation-2014-2-page-79.htm

Cet article s'intéresse au rôle de la formation Master of Advanced Nursing Practice dans la construction d'un espace d'autonomie professionnelle par les infirmières souhaitant devenir Nurse practitioner. Il repose sur une enquête sociologique qualitative (entretiens et observation directe des pratiques) conduite auprès de Nurses practitioners exerçant dans les cabinets de médecine générale. Formées a priori pour réaliser des tâches réservées aux médecins, ont-elles effectivement obtenu un élargissement de leur autonomie professionnelle ? Les résultats de l'enquête montrent que les motivations des infirmières pour suivre la formation, ainsi que les logiques de fonctionnement des cabinets où elles exercent influent sur leur capacité à créer ou à élargir cet espace d'autonomie.

▶ Point-Of-Care Testing in Primary Care Patients with Acute Cardiopulmonary Symptoms: A Systematic Review

SCHOLS A. M. R., *et al.*

2018

Fam Pract 35(1): 4-12.

Point-of-care tests (POCT) can assist general practitioners (GPs) in diagnosing and treating patients with acute cardiopulmonary symptoms, but it is currently unknown if POCT impact relevant clinical outcomes in these patients. The objectives of this study were to assess whether using POCT in primary care patients with acute cardiopulmonary symptoms leads to more accurate diagnosis and impacts clinical management. We performed a systematic review in four bibliographic databases. Articles published before February 2016 were screened by two reviewers. Studies evaluating the effect of GP use of POCT on clinical diagnostic accuracy and/or effect on treatment and referral rate in patients with cardiopulmonary symptoms were included. We concluded that there is currently limited and inconclusive evidence that actual GP use of POCT in primary care patients with acute cardiopulmonary symptoms leads to more accurate diagnosis

and affects clinical management. However, some studies show promising results, especially when a POCT is combined with a clinical decision rule.

Relevant Models and Elements of Integrated Care for Multi-Morbidity: Results of a Scoping Review

STRUCKMANN V., *et al.*

2018

Health Policy 122(1): 23-35.

In order to provide adequate care for the growing group of persons with multi-morbidity, innovative integrated care programmes are appearing. The aims of the current scoping review were to i) identify relevant models and elements of integrated care for multi-morbidity and ii) to subsequently identify which of these models and elements are applied in integrated care programmes for multi-morbidity. A scoping review was conducted in the following scientific databases: Cochrane, Embase, PubMed, PsycInfo, Scopus, Sociological Abstracts, Social Services Abstracts, and Web of Science. A search strategy encompassing a) models, elements and programmes, b) integrated care, and c) multi-morbidity was used to identify both models and elements (aim 1) and implemented programmes of integrated care for multi-morbidity (aim 2). The study conclude that most models and elements found in the literature focus on integrated care in general and do not explicitly focus on multi-morbidity. In line with this, most programmes identified in the literature build on the CCM. A comprehensive framework that better accounts for the complexities resulting from multi-morbidity is needed.

Patient-Centeredness of Integrated Care Programs for People with Multimorbidity. Results from the European ICARE4EU Project

VAN DER HEIDE I., *et al.*

2018

Health Policy 122(1): 36-43.

This paper aims to support the implementation of patient-centered care for people with multimorbidity in Europe, by providing insight into ways in which patient-centeredness is currently shaped in integrated care programs for people with multimorbidity in European countries. In 2014, expert organizations in 31 European countries identified 200 integrated care practices ('programs') in 25 countries of which 123 were included in our study. Managers of 112 programs from 24 countries completed a questionnaire about characteristics and results of the program, including questions on elements of patient-centeredness. Eight programs that were considered especially innovative or promising were analyzed in depth. This paper concludes that in many European countries innovative approaches are applied to increase patient-centeredness of care for people with multimorbidity. To assess their potential benefits and conditions for implementation, thorough process and outcome evaluations of programs are urgently needed.

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

WONG C. Y. ET HALL J.

2017

Health Policy: 122(2) : 126-133

http://dx.doi.org/10.1016/j.healthpol.2017.11.008

We examine whether Emergency Department (ED) use is affected by patients' experience. Patients with better General Practitioner (GP) experience are less likely to visit ED. Availability of zero-cost GP services does not affect likelihood of ED use. Results suggest improving GP quality is important in reducing avoidable hospital use.

Health Systems

Interventions and Approaches to Integrating HIV and Mental Health Services: A Systematic Review

CHUAH F. L. H., *et al.*

2017

Health Policy Plan 32(suppl_4): iv27-iv47.

The frequency in which HIV and AIDS and mental health problems co-exist, and the complex bi-directional relationship between them, highlights the need for effective care models combining services for HIV and mental health. Here, we present a systematic review that synthesizes the literature on interventions and approaches integrating these services. This review was part of a larger systematic review on integration of services for HIV and non-communicable diseases. We identified three models of integration at the meso and micro levels: single-facility integration, multi-facility integration, and integrated care coordinated by a non-physician case manager. Single-site integration enhances multidisciplinary coordination and reduces access barriers for patients. However, the practicality and cost-effectiveness of providing a full continuum of specialized care on-site for patients with complex needs is arguable. Integration based on a collaborative network of specialized agencies may serve those with multiple co-morbidities but fragmented and poorly coordinated care can pose barriers. Integrated care coordinated by a single case manager can enable continuity of care for patients but requires appropriate training and support for case managers. Involving patients as key actors in facilitating integration within their own treatment plan is a promising approach. This review identified much diversity in integration models combining HIV and mental health services, which are shown to have potential in yielding positive patient and service delivery outcomes when implemented within appropriate contexts. Our review revealed a lack of research in low- and middle- income countries, and was limited to most studies being descriptive. Overall, studies that seek to evaluate and compare integration models in terms of long-term outcomes and cost-effectiveness are needed, particularly at the health system level and in regions with high HIV and AIDS burden.

Health Systems Facilitators and Barriers to the Integration of HIV and Chronic Disease Services: A Systematic Review

WATT N., *et al.*

2017

Health Policy Plan 32(suppl_4): iv13-iv26.

Integration of services for patients with more than one diagnosed condition has intuitive appeal but it has been argued that the empirical evidence to support it is limited. We report the findings of a systematic review that sought to identify health system factors, extrinsic to the integration process, which either facilitated or hindered the integration of services for two common disorders, HIV and chronic non-communicable diseases. Findings were initially extracted and organized around a health system framework, followed by a thematic cross-cutting analysis and validation steps. Of the 150 articles included, 67% (n = 102) were from high-income countries. The articles explored integration with services for one or several chronic disorders, the most studied being alcohol or substance use disorders (47.7%), and mental health issues (29.5%). These findings confirm that integration processes in service delivery depend substantially for their success on characteristics of the health systems in which they are embedded.

Occupational Health

Interventions pour le retour et le maintien au travail après un cancer : revue de la littérature

CARON M., *et al.*

2017

Santé Publique 29(5): 655-664.

https://www.cairn.info/revue-sante-publique-2017-5-page-655.htm

La reprise du travail après un cancer peut être un défi et les interventions conçues pour la soutenir sont encore mal comprises. L'objectif de cette étude est d'identifier les interventions visant la reprise et le maintien au travail des personnes ayant reçu un diagnostic de cancer. Une revue de la littérature a été réalisée. La recherche documentaire a principalement été menée dans des bases de données de références bibliographiques. Un processus systématique d'analyse et d'interprétation des résultats a ensuite été complété. Un premier constat est qu'il existe très peu d'interventions spécifiquement élaborées pour soutenir la reprise et le maintien au travail des personnes ayant reçu un diagnostic de cancer et qu'elles sont principalement proposées par des professionnels de la santé et en milieu clinique. Les activités qui sous-tendent ces interventions sont de la guidance, la remise d'informations et la tenue de groupes de soutien/discussion/information. Les équipes impliquées dans de telles interventions sont multidisciplinaires et se composent généralement d'un ou plusieurs professionnels : médecin du travail, travailleur social et infirmière. Un deuxième constat réside en l'absence de mesure d'efficacité des interventions en dépit de protocoles d'études expérimentaux et quasi-expérimentaux.

Paid Employment and Common Mental Disorders in 50–64-Year Olds: Analysis of Three Cross-Sectional Nationally Representative Survey Samples in 1993, 2000 and 2007

PERERA G., *et al.*

2017

Epidemiology and Psychiatric Sciences : [Ahead of print]

http://d.repec.org/n?u=RePEc:ehl:lserod:84652&r=hea

Associations between employment status and mental health are well recognised, but evidence is sparse on the relationship between paid employment and mental health in the years running up to statutory retirement ages using robust mental health measures. In addition, there has been no investigation into the stability over time in this relationship: an important consideration if survey findings are used to inform future policy. The aim of this study is to investigate the association between employment status and common mental disorder (CMD) in 50–64-year old residents in England and its stability over time, taking advantage of three national mental health surveys carried out over a 14-year period. Data were analysed from the British National Surveys of Psychiatric Morbidity of 1993, 2000 and 2007. Paid employment status was the primary exposure of interest and CMD the primary outcome – both ascertained identically in all three surveys (CMD from the revised Clinical Interview Schedule). Multivariable logistic regression models were used.

Replacement Care' for Working Carers? A Longitudinal Study in England

PICKARD L., *et al.*

2017

Social Policy & Administration [Ahead of print]

http://d.repec.org/n?u=RePEc:ehl:lserod:84071&r=age

In the context of rising need for long-term care, reconciling unpaid care and carers' employment is becoming an important social issue. In England, there is increasing policy emphasis on paid services for the person cared for, sometimes known as 'replacement care', to support working carers. Previous research has found an association between 'replacement care' and carers' employment. However, more information is needed on potential causal connections between services and carers' employment. This mixed methods study draws on new longitudinal data to examine service receipt and carers' employment in England. Data were collected from carers who were employed in the public sector, using self-completion questionnaires in 2013 and 2015, and qualitative interviews were conducted with a sub-sample of respondents to the 2015 questionnaire. We find that, where the person cared for did not receive at least one 'key service' (home care, personal assistant, day care, meals, short-term breaks), the carer

was subsequently more likely to leave employment because of caring, suggesting that the absence of services contributed to the carer leaving work. In the interviews, carers identified specific ways in which services helped them to remain in employment. We conclude that, if a policy objective is to reduce the number of carers leaving employment because of caring, there needs to be greater access to publicly-funded services for disabled and older people who are looked after by unpaid carers.

Ageing

Identification of Older Adults with Frailty in the Emergency Department Using a Frailty Index: Results from a Multinational Study

BROUSSEAU A.-A., *et al.*

2017

Age and Ageing: 47(2):242-248.

http://dx.doi.org/10.1093/ageing/afx168

Frailty is a central concept in geriatric medicine, yet its utility in the Emergency Department (ED) is not well understood nor well utilised. Our objectives were to develop an ED frailty index (FI-ED), using the Rockwood cumulative deficits model and to evaluate its association with adverse outcomes. This was a large multinational prospective cohort study using data from the interRAI Multinational Emergency Department Study. The FI-ED was developed from the Canadian cohort and validated in the multinational cohort. All patients aged ≥75 years presenting to an ED were included. There were 2,153 participants in the Canadian cohort and 1,750 in the multinational cohort. The distribution of the FI-ED was similar to previous frailty indices. The study concludes that the FI-ED is conformed to characteristics previously reported. A FI, developed and validated from a brief geriatric assessment tool could be used to identify ED patients at higher risk of adverse events.

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

DUBOIS Y. ET KOUBI M.

2017

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

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

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

Vieillissement : des politiques toujours liées à l'âge, et peu de coordination

HENRARD J. C.

2017

Actualité et Dossier en Santé Publique(100): 52-55.

En 1997, la revue Adsp publiait deux dossiers sur le vieillissement. Depuis cette époque, de nombreux débats ont eu lieu, des réformes ont été adoptées, des dispositifs mis en œuvre. Cet article fait un bilan des améliorations et des problèmes qui demeurent : insuffisance de la coordination des dispositifs complexes mis en place, prises en charge déterminées selon l'âge alors que les besoins sont liés à la dépendance, et création d'un cinquième risque, qui assurerait le financement de la dépendance par la solidarité nationale.

Older Americans Were Sicker and Faced More Financial Barriers to Health Care Than Counterparts in Other Countries

OSBORN R., *et al.*

2017

Health Aff (Millwood) 36(12): 2123-2132.

High-income countries are grappling with the challenge of caring for aging populations, many of whose members have chronic illnesses and declining capacity to manage activities of daily living. The 2017 Commonwealth Fund International Health Policy Survey of Older Adults in eleven countries showed that US seniors were sicker than their counterparts in other countries and, despite universal coverage under Medicare, faced more financial barriers to health care. The survey's findings also highlight economic hardship and mental health problems that may affect older adults' health, use of care, and outcomes. They show that in some countries, one in five elderly people have unmet needs for social care services-a gap that can undermine health. New to the survey is a focus on the "high-need" elderly (those with multiple chronic conditions or functional limitations), who reported high rates of emergency department use and care coordination failures. Across all eleven countries, many high-need elderly people expressed dissatisfaction with the quality of health care they had received.

The Association Between Implementation and Outcome of a Complex Care Program for Frail Elderly People

RUIKES F. G. H., *et al.*

2018

Fam Pract 35(1): 47-52.

Over the last 20 years, the effectiveness of complex care programs aiming to prevent adverse outcomes in frail elderly people has been disappointing. Recently, we found no effectiveness of the CareWell primary care program. It is largely unknown to what extent incomplete implementation of these complex interventions influences their outcomes. The aims of this study are to examine the association between the degree of implementation of the CareWell program and the prevention of functional decline in frail elderly people. Methods: Quantitative process evaluation conducted alongside a cluster-controlled trial. Two hundred and four frail elderly participants from six general practitioner practices in the Netherlands received care according to the CareWell program, consisting of four key components: multidisciplinary team meetings, proactive care planning, case management and medication reviews. We measured time registrations of team meetings, case management and medication reviews and care plan data as stored in a digital information portal. These data were aggregated into a total implementation score (TIS) representing the program's overall implementation. The study concludes that a higher degree of implementation of the CareWell program did not lead to the prevention of functional decline in frail elderly people.