

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Janvier 2020 / January 2020

Assurance maladie	<i>Health Insurance</i>
Démographie	<i>Demography</i>
E-santé – Technologies médicales	<i>E-health – Medical Technologies</i>
Économie de la santé	<i>Health Economics</i>
État de santé	<i>Health Status</i>
Géographie de la santé	<i>Geography of Health</i>
Handicap	<i>Disability</i>
Hôpital	<i>Hospitals</i>
Inégalités de santé	<i>Health Inequalities</i>
Médicaments	<i>Pharmaceuticals</i>
Méthodologie – Statistique	<i>Methodology – Statistics</i>
Politique de santé	<i>Health Policy</i>
Politique publique	<i>Public Policy</i>
Prévention	<i>Prevention</i>
Prévision – Evaluation	<i>Prevision - Evaluation</i>
Psychiatrie	<i>Psychiatry</i>
Soins de santé primaires	<i>Primary Health Care</i>
Systèmes de santé	<i>Health Policy</i>
Travail et santé	<i>Occupational Health</i>
Vieillesse	<i>Ageing</i>

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

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



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

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

Watch on Health Economics Literature

Publication Director

Information specialists

Design & Layout

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

Sommaire Contents

Assurance maladie

Health Insurance

- 11** **Once Covered, Forever Covered: The Actuarial Challenges Of The Belgian Private Health Insurance System**
Hanbali H., Claassens H., Denuit M., et al.
- 11** **Private Health Expenditure In Ireland: Assessing The Affordability Of Private Financing Of Health Care**
Johnston B. M., Burke S., Barry S., et al.
- 11** **'Falling Off The Radar' Of Public Health: The Case Of Uninsured Chinese Patients In Vienna, Austria**
Seidler Y., Novak-Zezula S. et Trummer U.
- 12** **Access To Care Among Medicaid And Uninsured Patients In Community Health Centers After The Affordable Care Act**
Seo V., Baggett T. P., Thorndike A. N., et al.
- 12** **Commentaire : l'auto-assurance du risque dépendance est-elle une solution ?**
Wittwer J.

Démographie

Demography

- 12** **L'immigration en Europe au milieu des années 2010 : « une crise migratoire » ?**
Dumont G.-F.
- 12** **Tous les pays du monde. (2019)**
Pison G.
- 13** **La France a la plus forte fécondité d'Europe. Est-ce dû aux immigrées ?**
Volant S., Pison G. et Heran F.

E-santé – Technologies médicales

E-health – Medical Technologies

- 13** **E-santé : entre progrès et vigilance**
Cambon L.

- 13** **Le patient et son médecin à l'ère du numérique**

Le Noc Y.

- 13** **Éthique et téléconsultation, des grands principes à une approche humaniste ancrée dans la pratique**

Tourneur-Bagot O.

Économie de la santé

Health Economics

- 14** **Financial Incentives And Physician Prescription Behavior: Evidence From Dispensing Regulations**
Burkhard D., Schmid C. P. R. et Wüthrich K.
- 14** **Payment Models In Primary Health Care: A Driver Of The Quantity And Quality Of Medical Laboratory Utilization**
Chami N. et Sweetman A.
- 14** **La tarification à l'activité a redirigé des séjours chirurgicaux des cliniques privées vers les hôpitaux publics sans augmenter l'activité totale**
Chone P. et Wilner L.
- 15** **Effet des préférences individuelles sur la réussite à long terme des incitations financières à la réalisation d'objectifs de santé**
Crainich D.
- 15** **Barriers To Payment Reform: Experiences From Nine Dutch Population Health Management Sites**
De Vries E. F., Drewes H. W., Struijs J. N., et al.
- 15** **Assessing Progressivity And Catastrophic Effect Of Out-Of-Pocket Payments For Healthcare In Canada: 2010–2015**
Edmonds S. et Hajizadeh M.
- 16** **Bundled Payments For Surgical Care—More Questions Than Answers**
Ferraris V. A.
- 16** **Les Journées des économistes de la santé 2019 : Introduction**
Franc C., Paraponaris A. et Ventelou B.

- 16 Rémunération des médecins généralistes en France : une combinaison complexe d'incitations économiques**
Franc K.
- 17 Réduire les barrières financières à l'accès aux soins**
Jusot F., Carré B. et Wittwer J.
- 17 Le coût social des drogues licites et illicites en France**
Kopp P. A.
- 18 Choosing Doctors Wisely: Can Assisted Choice Enhance Patients' Selection Of Clinicians?**
Martino S. C., Grob R., Davis S., et al.
- 18 The Relationship Between Health Spending And Social Spending In High-Income Countries: How Does The US Compare?**
Papanicolas I., Woskie L. R. et Orlander D.
- 18 Sécurité sociale : de l'art de transformer des excédents en déficits**
Rigaudiat J.

État de santé Health Status

- 19 Sex Differences In Comorbidity And Frailty In Europe**
Ahrenfeldt L. J., Möller S., Thinggaard M., et al.
- 19 Epidemiological Transition And The Wealth Of Nations: The Case Of HIV/AIDS In A Microsimulation Model**
Arrighi Y. et Ventelou B.
- 19 Impact d'un choc de santé sur les modes de vie, exploitation de la cohorte Gazel**
Marsaudon A. et Rochaix L.
- 19 Comparaison de survie de cohortes entre les pays d'Europe centrale et orientale et les pays à longévité élevée**
Nepomuceno M. R. et Canudas-Romo V.
- 20 Climat et santé**
Pascal M., Paquet C., Jourdain F., et al.

Géographie de la santé Geography of Health

- 20 Recherche médecin désespérément**
Gauchet J., Andriantsehoanarinala L. et Colle S.
- 20 How To Engage French Professionals To Undertake Social Responsibility At A Local Level?**
Gautier S. et Bourgueil Y.
- 21 Accès aux soins premiers à la Réunion et en Métropole**
Poudroux M. et Valee J.
- 21 Comportements et pratiques des médecins : exercer dans les zones les moins dotées, cela fait-il une différence ?**
Silhol J., Ventelou B. et Marbot C.
- 21 The Migration Of UK Trained GPs To Australia: Does Risk Attitude Matter?**
Van der Pol M., Scott A. et Irvine A.

Handicap Disability

- 22 Le parcours de santé et la prise en charge de la personne polyhandicapée en Italie et en Norvège**
Rousseau M. C., Humbertclaude E., Laukseecker C., et al.

Hôpital Hospitals

- 22 Patterns Of Ninety-Day Readmissions Following Total Joint Replacement In A Bundled Payment Initiative**
Behery O. A., Kester B. S., Williams J., et al.
- 23 Patterns Of Emergency Department Attendance Among Older People In The Last Three Months Of Life And Factors Associated With Frequent Attendance: A Mortality Follow-Back Survey**
Bone A. E., Evans C. J., Henson L. A., et al.
- 23 Difficulties In Providing Palliative Care In Identified Palliative Care Beds: An Exploratory Survey**
Calvel L., Blondet L. V., Chedotal I., et al.

- 24** **Characteristics Of Patients Who Received An Indication Of Involuntary Admission, With Or Without The Involvement Of A Third Party, In A Parisian Psychiatric Emergency Unit**
Dauriac-Le Masson V., Peiffer C., Barruel D., et al.
- 24** **Do Financial Incentives Influence The Hospitalization Rate Of Nursing Home Residents? Evidence From Germany**
Kümpel C.
- 25** **Healthcare Quality, Patients' Satisfaction, And Hospital Incentives In France**
Lescher M. et Sirven N.
- 25** **Factors Associated With Inappropriate Use Of Emergency Departments: Findings From A Cross-Sectional National Study In France**
Naouri D., Ranchon G., Vuagnat A., et al.
- 26** **Hospital Length Of Stay Reduction Over Time And Patient Readmission For Severe Adverse Events Following Surgery**
Pascal L., Polazzi S., Piriou V., et al.
- 26** **Le dispositif français de déclaration des événements indésirables en 2019**
Revue Prescrire
- 26** **L'attractivité des structures hospitalières pour les internes et jeunes praticiens : revue de littérature**
Reydellet A., Riom I., Fontaine A., et al.
- 28** **Healthcare Access For Refugees In Greece: Challenges And Opportunities**
Gunst M., Jarman K., Yarwood V., et al.
- 28** **Moving Upstream: Changing Policy Scripts On Migrant And Ethnic Minority Health**
Ingleby D.
- 29** **Barriers To Health Care Access And Service Utilization Of Refugees In Austria: Evidence From A Cross-Sectional Survey**
Kohlenberger J., Buber-Ennsner I., Rengs B., et al.
- 29** **Unmet Needs Across Europe: Disclosing Knowledge Beyond The Ordinary Measure**
Ramos L. M., Quintal C., Lourenço Ó., et al.
- 30** **Shaping Access To Health Care For Refugees On The Local Level In Germany – Mixed-Methods Analysis Of Official Statistics And Perspectives Of Gatekeepers**
Rolke K., Wenner J. et Razum O.
- 30** **Refugee Crisis In Finland: Challenges To Safeguarding The Right To Health For Asylum Seekers**
Tuomisto K., Tiittala P., Keskimäki I., et al.

Inégalités de santé

Health Inequalities

- 27** **Infectious Disease Health Services For Refugees And Asylum Seekers During A Time Of Crisis: A Scoping Study Of Six European Union Countries**
Bozorgmehr K., Samuilova M., Petrova-Benedict R., et al.
- 27** **Les déterminants du renoncement aux soins pour raisons financières des étudiants – une analyse à partir de l'étude i-Share**
Castray M., Wittwer J., Montagni I., et al.
- 28** **Health Records For Migrants And Refugees: A Systematic Review**
Chiesa V., Chiarenza A., Mosca D., et al.
- 28** **Précarité de la migration : autour des notions de santé et de capacités**
Gauld C.
- 31** **Barriers And Facilitators Of Patient Access To Medical Devices In Europe: A Systematic Literature Review**
Beck A. C. C., Retèl V. P., Bhairosing P. A., et al.
- 31** **Association Between Gifts From Pharmaceutical Companies To French General Practitioners And Their Drug Prescribing Patterns In 2016: Retrospective Study Using The French Transparency In Healthcare And National Health Data System Databases**
Goupil B., Balusson F., Naudet F., et al.
- 32** **Why Do Health Technology Assessment Drug Reimbursement Recommendations Differ Between Countries? A Parallel Convergent Mixed Methods Study**
Nicod E., Maynou L., Visintin E., et al.
- 32** **Agir au quotidien pour réduire les effets indésirables des médicaments**
Revue Prescrire

Médicaments

Pharmaceuticals

33 Désastre du Mediator : beaucoup de temps perdu et de vies gâchées
Revue Prescrire

33 Pharmaceutical Policies: Effects Of Educational Or Regulatory Policies Targeting Prescribers
Suleman F. et Movik E.

Méthodologie – Statistique Methodology – Statistics

34 Practical Mixed Methods Strategies Used To Integrate Qualitative And Quantitative Methods In Community-Based Primary Health Care Research
Kaur N., Vedel I., El Sherif R., et al.

34 Use Of Medicare Data To Identify Team-Based Primary Care: Is It Possible?
Kuo Y.-F., Raji M. A., Lin Y.-L., et al.

35 A Mixed Methods Study Of Change Processes Enabling Effective Transition To Team-Based Care
Kyle M. A., Aveling E.-L. et Singer S.

35 Les études portant sur les bases de données médico-administratives sont-elles reproductibles ? L'hypothèse d'une inconduite éthique en santé publique
Looten V.

35 Faut-il en finir avec le Finess ?
Loubat J. R.

35 Approaches And Alternatives To The Wealth Index To Measure Socioeconomic Status Using Survey Data: A Critical Interpretive Synthesis
Poirier M. J. P., Grépin K. A. et Grignon M.

36 Qualité du codage des diagnostics et motifs de prise en charge (principal et associés) dans le recueil d'informations médicalisé en psychiatrie (RIM-P) en 2015 et 2016, France
Richaud-Eyraud E., Ellini A., Clément M. C., et al.

36 Is My Patient Overwhelmed?
Tran V.-T., Montori V. M. et Ravaud P.

Politique de santé Health Policy

37 Loi de santé : feu vert pour la mise en œuvre
Brouet P.

37 Austerity And Health In Europe: Disentangling The Causal Links
Forster T. et Kentikelenis A. E.

37 Conditions Influencing The Adoption Of A Soda Tax For Public Health: Analysis Of The French Case (2005–2012)
Le Bodo Y., Etilé F., Gagnon F., et al.

38 Social Preferences For Prioritising The Treatment Of Disabled And Chronically Ill Patients: Beyond The Order Effect
McKie J. et Richardson J.

38 The Effectiveness Of Nudges In Improving The Self-Management Of Patients With Chronic Diseases: A Systematic Literature Review
Möllenkamp M., Zeppernick M. et Schreyögg J.

Politique publique Public Policy

39 Les étapes du financement de la recherche académique : de la soumission en partenariat jusqu'à l'attribution et aux publications
Banal-Estañol A., Macho-Stadler I. et Pérez-Castrillo D.

39 L'évaluation des politiques de santé publique
Brunner N., Luciola E., Netter P., et al.

Prévention Prevention

40 L'enfant, l'adolescent, la famille et les écrans : appel à une vigilance raisonnée sur les technologies numériques
Ades J., Agid Y., Bach J. F., et al.

40 The Effect Of The United Kingdom Smoking Ban On Alcohol Spending: Evidence From The Living Costs And Food Survey
Pryce R.

Prévision – Evaluation

Prevision - Evaluation

- 41** Effect Of Financial Incentives On Breast, Cervical And Colorectal Cancer Screening Delivery Rates: Results From A Systematic Literature Review
Mauro M., Rotundo G. et Giacotti M.
- 41** How To Value Safety In Economic Evaluations In Health Care? A Review Of Applications In Different Sectors
Perry-Duxbury M., Van Exel J. et Brouwer W.

Psychiatrie

Psychiatry

- 42** Solutions To Tackle The Mental Health Consequences Of The Economic Recession: A Qualitative Study Integrating Primary Health Care Users And Professionals' Perspectives
Antunes A., Frasilho D., Zózimo J. R., et al.
- 42** Les suivis sociosanitaires des personnes présentant un trouble mental sévère et persistant : expérimentation PASSVers à Versailles
Bazin N.
- 42** Cost-Utility Of Screening For Depression Among Asylum Seekers: A Modelling Study In Germany
Biddle L., Miners A. et Bozorgmehr K.
- 43** Network Analyses: Are We Moving Toward A New Conceptualization And Treatment Of Mental Disorder?
Bortolon C. et Raffard S.
- 43** Médico-social en santé mentale : histoire et réalités institutionnelles
Broutin S.
- 43** Chronique de la psychiatrie à l'ère hypermoderne
Cloës C.
- 44** A Review Of Mental Health And Mental Health Care Disparities Research: 2011-2014
Cook B. L., Hou S. S., Lee-Tauler S. Y., et al.
- 44** Le dispositif d'appartenance de coordination thérapeutique « Un chez-soi d'abord »
Estecahandy P.
- 44** La santé mentale des enfants placés. Une revue de la littérature
Even M. et Sutter-Dallay A. L.
- 45** Penser l'avenir de la pédopsychiatrie dans le monde : bilan de 4 années de présidence de l'International Association of Child and Adolescent Psychiatry and the Allied Professions (IACAPAP)
Falissard B.
- 45** Du TAPS Project au virage ambulatoire. Comment retrouver le chemin de la désinstitutionnalisation ?
Fonsegrive G. et Plantevin M.
- 45** Experimenting Locally With A Stepped-Care Approach For The Treatment Of Mild To Moderate Mental Disorders In France: Challenges And Opportunities
Gandré C., Rosenberg S., Coldefy M., et al.
- 45** Using National Electronic Health Care Registries For Comparing The Risk Of Psychiatric Re-Hospitalisation In Six European Countries: Opportunities And Limitations
Katschnig H., Straßmayr C., Endel F., et al.
- 46** L'accompagnement, c'est du soin
Leguay D.
- 46** Asylum Seekers' Mental Health And Treatment Utilization In A Three Months Follow-Up Study After Transfer From A State Registration-And Reception-Center In Germany
Nikendei C., Kindermann D., Brandenburg-Ceynowa H., et al.
- 47** Articulation et synergie des soins et de l'accompagnement : les données probantes dans les troubles mentaux sévères et persistants
Passerieux C.
- 47** Liens entre troubles psychiques et recours aux dispositifs du champ du handicap en France
Quidu F. et Roussel P.
- 47** Un partenariat patients schizophrènes-soignants pour conduire un programme d'éducation en santé orale
Rat C., Peteuil A., Reynaud M., et al.
- 48** La santé psychique des internes en psychiatrie de France et leurs consommations de substances psychoactives. Étude épidémiologique transversale descriptive
Robin C.

48 Mental Health Care Utilisation And Access Among Refugees And Asylum Seekers In Europe: A Systematic Review

Satinsky E., Fuhr D. C., Woodward A., et al.

Soins de santé primaires

Primary Health Care

49 General Practitioners Training About Suicide Prevention And Risk: A Systematic Review Of Literature

Audouard-Marzin Y., Kopp-Bigault C., Scouarnec P., et al.

49 Specialist Palliative Care Services For Older People In Primary Care: A Systematic Review Using Narrative Synthesis

De Nooijer K., Penders Y. W., Pivodic L., et al.

50 Redesigning The Role Of Medical Assistants In Primary Care: Challenges And Strategies During Implementation

Dill J., Morgan J. C., Chuang E., et al.

50 Motivations And Willingness Of General Practitioners In France To Participate In Primary Care Research As Investigators

Ferrand Devouge E., Biard M., Beuzeboc J., et al.

50 Improving Interorganizational Coordination Between Primary Care And Oncology: Adapting A Chronic Care Management Model For Patients With Cancer

Flieger S. P., Thomas C. P. et Prottas J.

51 L'éducation interprofessionnelle des équipes de soins critiques par la simulation : concept, mise en œuvre et évaluation

Houzé-Cerfon C.-H., Boet S., Marhar F., et al.

51 Impact de l'expérimentation de coopération entre médecin généraliste et infirmière Asalée sur l'activité des médecins

Loussouarn C., Franc C., Videau Y., et al.

51 Quand l'éducation thérapeutique interroge le «cœur de métier» des médecins généralistes

Panot S., Mispelblom-Beyer F. et Girardot L.

52 Infirmière en pratique avancée : un nouveau métier au sein de l'équipe de soins

Revue Prescrire

52 Palliative Care In Primary Care: European Forum For Primary Care Position Paper

Rotar Pavlič D., Aarendonk D., Wens J., et al.

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

Somé N. H., Devlin R. A., Mehta N., et al.

53 Exploring Improvement Plans Of Fourteen European Integrated Care Sites For Older People With Complex Needs

Stoop A., de Bruin S. R., Wistow G., et al.

53 Interdisciplinary Team Working In The Irish Primary Healthcare System: Analysis Of 'Invisible' Bottom Up Innovations Using Normalisation Process Theory

Tierney E., Hannigan A., Kinneen L., et al.

54 Disease Management In Diabetes Care: When Involving GPs Improves Patient Compliance And Health Outcomes

Ugolini C., Lippi Bruni M., Leucci A. C., et al.

Systeme de santé

Health Policy

54 Much Ado About Nothing? The Responsiveness Of The Healthcare System In Poland Through Patients' Eyes

Polak P., Świątkiewicz-Mośny M. et Wagner A.

54 Accountable Care? An Analysis Of National Reporting On Local Health And Social Care Service Integration

Tunney S. et Thomas J.

55 Le système de santé italien

Vincent G., Ceruti M., Ripert B., et al.

55 Five-Year Impact Of A Commercial Accountable Care Organization On Health Care Spending, Utilization, And Quality Of Care

Zhang H., Cowling D. W., Graham J. M., et al.

Travail et santé Occupational Health

- 56 Association Between Workers' Compensation Claim Processing Times And Work Disability Duration: Analysis Of Population Level Claims Data**
Gray S. E., Lane T. J., Sheehan L., et al.
- 56 County-Level Unemployment Rates And Service Intensity In Primary Care Physician Offices For Medicare Patients**
Li J., Chen A., Parks M., et al.
- 56 Réduire le temps assis en milieu professionnel : l'étude « Sédentarité au travail » (SAuT)**
Marchant G., Nicaise V., Chastin S., et al.
- 57 L'influence des accidents de la route sur les trajectoires professionnelles des personnels en fin de carrière, à partir de la cohorte Gazel**
Sanchez M.-A., Barnay T., Marsaudon A., et al.
- 57 Élaboration et qualités psychométriques d'une échelle de bien-être au travail. Étude SERENAT auprès de salariés vus en médecine du travail**
Servant D., Drumez E., Raynal S., et al.

- 59 Do Family Caregivers Offset Healthcare Costs For Older Adults? A Mapping Review On The Costs Of Care For Older Adults With Versus Without Caregivers**
Friedman E. M., Rodakowski J., Schulz R., et al.
- 60 Financing Long-Term Care: Lessons From Japan**
Igekami N.
- 60 Frailty Transitions And Health Care Use In Europe**
Sicsic J. et Rapp T.

Vieillesse Ageing

- 58 L'entrée des personnes âgées en institution : passer le deuil**
Blanc L. et Charles R.
- 58 The Impact Of Informal Caregiving For Older Adults On The Health Of Various Types Of Caregivers: A Systematic Review**
Bom J., Bakx P., Schut F., et al.
- 58 Financer sa perte d'autonomie : rôle potentiel du revenu, du patrimoine et des prêts viagers hypothécaires**
Bonnet C., Juin S. et Laferrere A.
- 59 Practice Variation In Long-Term Care Access And Use: The Role Of The Ability To Pay**
Duell D., Lindeboom M., Koolman X., et al.
- 59 Informal Care. European Situation And Approximation Of A Reality**
Estrada Fernández M. E., Gil Lacruz A. I., Gil Lacruz M., et al.

Health Insurance**► Once Covered, Forever Covered:
The Actuarial Challenges Of The Belgian
Private Health Insurance System**

HANBALI H., CLAASSENS H., DENUIT M., *et al.*
2019

Health Policy 123(10): 970-975.

<https://doi.org/10.1016/j.healthpol.2019.07.005>

The Belgian Law of 20 July 2007 has drastically changed the Belgian private health insurance sector by making individual contracts lifelong with the technical basis (i.e. actuarial assumptions) fixed at policy issue. The goal of the Law is to ensure the accessibility to supplementary health coverage in order to protect policyholders from discrimination and exclusion, essentially when these operate on the basis of age. Due to the unpredictable nature of medical inflation risk and the difficulty to model future increases of health claims, the legislator introduced medical indices together with a specific updating mechanism, which aim at establishing standardized and fair premium adjustments across the sector. This paper considers two major issues of the current Belgian system. The first one is related to the transferability of the reserves, whereas the second one is related to age-discrimination. We discuss these issues and their interplay, and we address the conflict between the goal of the Law and the practical problems arising in the light of the actuarial techniques.

**► Private Health Expenditure In Ireland:
Assessing The Affordability Of Private
Financing Of Health Care**

JOHNSTON B. M., BURKE S., BARRY S., *et al.*
2019

Health Policy 123(10) : 963-969.

<https://doi.org/10.1016/j.healthpol.2019.08.002>

This paper investigates the affordability of private health expenditure among Irish households and the services contributing towards financial hardship. We use data from the Irish Household Budget Survey, a representative survey of household spending in Ireland, covering 2009-10 and 2015-16. Private health expenditure comprises out-of-pocket payments for health and social care services and private health insurance (PHI)

premiums. The poverty threshold is 60% of median total equivalised consumption and households with consumption below this level were defined as poor. Households were classified as having unaffordable health expenditure if: 1) they were poor and reported any spending; 2) they were pushed below poverty threshold by health spending; or 3) their spending on health exceeded 40% of capacity to pay. Despite signs of economic recovery, the incidence of unaffordable private health spending increased over the years—from 15% in 2009-10 to 18.8% in 2015-16. People on low incomes were disproportionately affected. The largest component of unaffordable spending for poorer households is PHI and not user charges, which have actually fallen as a cause of hardship. Our findings indicate that reliance on private health expenditure as a funding mechanism undermines the fundamental goals of equity and appropriate access within the health care system.

**► ‘Falling Off The Radar’ Of Public Health:
The Case Of Uninsured Chinese Patients
In Vienna, Austria**

SEIDLER Y., NOVAK-ZEZULA S. ET TRUMMER U.
2019

Health Policy 123(9): 840-844.

<https://doi.org/10.1016/j.healthpol.2019.04.002>

In public health policy debates, the 2015–2016 refugee crisis made visible that even in European welfare states with (close to) universal health coverage there are specific vulnerable groups with highly limited access to health care. Among them is a population of so-called ‘undocumented’ or ‘irregular’ migrants who have no regular status of residence and falls off the radar of publicly funded health care services and thus from the public health surveillance systems. The aim of our study is to provide the first-of-its-kind evidence on the characteristics, health problems and health care needs of one such vulnerable group in Austria – Chinese migrants residing in Vienna without a regular status. Medical records of 74 uninsured assumingly undocumented Chinese patients were analysed. The data was provided by a Non-governmental organisation (NGO) which delivers primary care to uninsured

people in Vienna. The most frequently diagnosed health problems clustered around cardiovascular and metabolic-related diseases (hypertension and diabetics) and there was a high burden of multiple chronic non-communicable diseases. Further efforts and resources are needed for collecting more data in a systematic way. A trusting relationship between science and practice and a cooperative relationship between and among the government agencies and NGOs are essential for evidence-based public health policy making.

► **Access To Care Among Medicaid And Uninsured Patients In Community Health Centers After The Affordable Care Act**

SEO V., BAGGETT T. P., THORNDIKE A. N., *et al.*
2019

BMC Health Services Research 19(1): 291.
<https://doi.org/10.1186/s12913-019-4124-z>

The Affordable Care Act expanded Medicaid and increased federal funding for Community Health Centers (CHCs). To examine the role of Medicaid coverage on care patterns for those with available safety net care, we assessed differences in access to care for CHC patients with continuous Medicaid coverage vs. gaps in insurance coverage in the last year.

► **Commentaire : L'auto-assurance du risque dépendance est-elle une solution ?**

WITTEWER J.
2019

Economie Et Statistique (507-508): 27-32.
<https://www.insee.fr/fr/statistiques/4173154?sommaire=4173181>

Le risque financier associé à la dépendance est partiellement couvert en France et dans l'ensemble des pays européens, partout sensiblement moins bien que le risque sanitaire. La couverture publique varie sensiblement d'un pays à l'autre mais laisse la plupart du temps un reste-à-charge important aux ménages. Le risque dépendance survenant en fin de vie, la mobilisation du patrimoine financier et immobilier des ménages pour financer leur dépendance, autrement dit l'auto-assurance, peut apparaître comme une solution. L'article de Carole Bonnet, Sandrine Juin et Anne Laferrère propose, en mobilisant les données de l'enquête SHARE, de considérer frontalement cette question et d'évaluer dans quelle mesure l'auto-assurance peut répondre aux besoins de financement de la dépendance en Europe. Ce commentaire revient sur la démarche des auteures puis discute les implications de leur analyse.

Démographie

Demography

► **L'immigration en Europe au milieu des années 2010 : « une crise migratoire » ?**

DUMONT G.-F.
2019

Population & Avenir 744(4): 3-3.
<https://www.cairn.info/revue-population-et-avenir-2019-4-page-3.htm>

Les flux d'immigration reçus en Europe au milieu des années 2010 ont conduit nombre de discours à recourir à la formulation de « crise migratoire ». Cette dernière est-elle justifiée au plan quantitatif ? L'est-elle au plan qualitatif ? Cet article tente de répondre à ces interrogations.

► **Tous les pays du monde. (2019)**

PISON G.
2019

Population Et Sociétés (569)
<https://www.ined.fr/fr/publications/editions/population-et-societes/tous-les-pays-du-monde-2019/>

Tous les deux ans, Population & Sociétés publie un numéro intitulé « Tous les pays du monde » présentant un tableau de la population mondiale. Celle-ci compte 7,7 milliards d'habitants en 2019. Elle a été multipliée par plus de sept au cours des deux derniers siècles, et devrait continuer à croître jusqu'à atteindre peut-être 11 milliards à la fin du XXI^e siècle.

► **La France a la plus forte fécondité d'Europe. Est-ce dû aux immigrées ?**

VOLANT S., PISON G. ET HERAN F.
2019

Population Et Sociétés (568)

<https://www.ined.fr/fr/publications/editions/population-et-societes/france-plus-forte-fecondite-europe-immigrees/>

Les immigrées contribuent aux naissances en France dans une proportion de 19 %. L'indicateur conjoncturel de fécondité des immigrées est plus élevé que celui des natives (2,6 enfants contre 1,8 en 2017), mais comme ce surcroît ne concerne qu'une minorité au sein de la population, il relève seulement de 0,1 enfant le taux de fécondité national, qui passe ainsi de 1,8 à 1,9 enfant par femme en 2017. Immigration ou pas, la fécondité de la France reste l'une des plus élevées d'Europe.

E-santé – Technologies médicales

E-health – Medical Technologies

► **E-santé : entre progrès et vigilance**

CAMBON L.
2019

Actualité et Dossier en Santé Publique (108): 14-52.

Les services du numérique sont une opportunité de développement et d'amélioration des systèmes de santé. On entend par services numériques les moyens et services liés à la santé qui utilisent les technologies de l'information et de la communication. L'e-santé regroupe un ensemble de domaines dont la robotique et la télésanté, notamment la télémédecine, la télésurveillance, la domotique, les applications pour smartphones ou encore les objets connectés. Porteuse de beaucoup d'espoirs, il conviendra néanmoins de veiller à ce que l'e-santé soit accessible à tous et la protection des données garantie. Ce dossier dresse un panorama des possibles et des craintes.

les changements de mode de vie et de comportement des populations et parallèlement le développement rapide des nouvelles technologies de la communication. Des expériences étrangères présentent leurs modèles, notamment la Suède qui envisage d'installer des centres de télémédecine au sein des hôpitaux. De telles initiatives tendent à se mettre en place au sein d'hôpitaux français.

► **Le patient et son médecin à l'ère du numérique**

LE NOC Y.
2019

Médecine : De La Médecine Factuelle à nos Pratiques 15(8): 340-342.

La télémédecine est présentée comme un atout majeur pour répondre aux enjeux actuels et à venir du système de santé : la démographie médicale en baisse avec comme corollaire les inégalités d'accès aux soins, le vieillissement de la population et ses conséquences en termes d'accroissement des pathologies chroniques,

► **Éthique et téléconsultation, des grands principes à une approche humaniste ancrée dans la pratique**

TOURNEUR-BAGOT O.
2019

Éthique & Santé 16(3): 120-124.

<https://doi.org/10.1016/j.etiqe.2019.07.001>

À partir de notre expérience pratique de la téléconsultation, nous proposons une réflexion éthique, à la lumière de Paul Ricœur qui la définit comme « la visée d'une vie bonne avec et pour les autres dans des institutions justes ». La visée nous renvoie à l'idéal du serment d'Hippocrate prêté par tout médecin. La question de la vie bonne, déjà posée par Aristote et Kant, et celle du Bien et du Mal qui fonde nos civilisations judéo-chrétienne et islamique, trouvent leur résonance dans les concepts de bienfaisance et non-malfaisance de l'éthique moderne. Au-delà de ces deux concepts, nous invoquons la bienveillance pour le soigné certes, mais aussi pour le soignant. Nous avançons que la relation à l'autre, — au sens d'Emmanuel Levinas —, fondement du colloque singulier, ne perd rien de son humanité

malgré, voire grâce à la médiation de l'écran. Enfin, à partir de notre devise nationale de liberté, égalité et fraternité, nous analysons les exigences éthiques de la diffusion de la télémédecine pour un vivre-ensemble dans des institutions justes. En conclusion, il apparaît que la téléconsultation est conforme à l'éthique médi-

cale et qu'elle apporte un surcroît d'humanité par la primauté donnée à la parole et au regard. From my practical experience of teleconsultation, I propose an ethical reflection, in the light of Paul Ricœur who defines it as "the aim of a good life with and for others in just institutions".

Économie de la santé

Health Economics

► Financial Incentives And Physician Prescription Behavior: Evidence From Dispensing Regulations

BURKHARD D., SCHMID C. P. R. ET WÜTHRICH K.
2019

Health Economics 28(9): 1114-1129.

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

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

► Payment Models In Primary Health Care: A Driver Of The Quantity And Quality Of Medical Laboratory Utilization

CHAMI N. ET SWEETMAN A.
2019

Health Economics 28(10): 1166-1178.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3927>

Physician payment models' incentives regarding many aspects of primary health care are not well understood. We focus on the case of medical laboratory utilization and examine how physicians' laboratory test ordering patterns change following a switch to a blended

capitation payment model from one with fee for service enhanced with pay for performance. Also, within blended capitation, we examine differences between traditional staffing and interdisciplinary teams. Using a propensity score weighted fixed-effects specification to address selection, it is estimated that the switch to capitation leads to a short-run average of 3% fewer laboratory requisitions per patient. Patients' laboratory utilization also becomes more concentrated with the rostering physician. More importantly, using diabetes-related laboratory tests as a case study, after joining the blended model, physicians order 3% fewer inappropriate/redundant tests, and the addition of an interdisciplinary care team makes the reduction about 9%. Advances in both continuity and quality seem to be associated with blended capitation.

► La tarification à l'activité a redirigé des séjours chirurgicaux des cliniques privées vers les hôpitaux publics sans augmenter l'activité totale

CHONE P. ET WILNER L.
2019

Insee Analyses (47)

<https://www.insee.fr/fr/statistiques/4221735>

La tarification à l'activité (T2A) a été introduite graduellement entre 2004 et 2008 dans les hôpitaux publics; elle était déjà en vigueur dans les cliniques privées. L'activité a augmenté dans les établissements concernés par la réforme; néanmoins, il reste à savoir si cette hausse a résulté d'une augmentation de l'activité globale du secteur ou si l'activité a été redirigée des cliniques privées vers les hôpitaux publics. Cette étude se concentre sur la chirurgie entre 2005 et 2008,

une période qui permet une évaluation de la réforme. L'étude simule la situation qui aurait prévalu en 2005 si les incitations tarifaires liées à la T2A avaient été intégralement mises en place afin de pouvoir la comparer à la situation observée et d'en inférer l'impact causal de la T2A. La reconstitution de cette situation contrefactuelle nécessite en particulier de neutraliser les évolutions, observables ou non, inhérentes à la patientèle et à l'offre de soins. La T2A aurait principalement redirigé des actes chirurgicaux des cliniques privées vers les hôpitaux publics, sans en créer davantage. Elle aurait bénéficié aux patients en permettant d'améliorer l'attractivité des hôpitaux publics. Néanmoins, cette amélioration aurait entraîné une augmentation substantielle de l'effort des établissements en direction de leurs patients, pouvant occasionner des coûts financiers ou non financiers.

► **Effet des préférences individuelles sur la réussite à long terme des incitations financières à la réalisation d'objectifs de santé**

CRAINICH D.
2019

Revue d'économie politique 129(4): 447-465.
<https://www.cairn.info/revue-d-economie-politique-2019-4-page-447.htm>

L'article propose une analyse théorique des programmes d'incitations financières à la réalisation d'objectifs comportementaux liés à santé en distinguant leurs effets à court terme (pendant la durée du programme) et à long terme (après le programme). Notre modèle met en évidence le fait que ces programmes conduisent à l'adoption de comportements plus sains à court terme et à long terme lorsque la richesse n'augmente pas l'utilité marginale de la qualité de vie. Dans le cas contraire, c'est-à-dire lorsque la richesse et la qualité de vie sont des arguments complémentaires de la fonction d'utilité, nous montrons que ces incitations financières peuvent engendrer, une fois le programme terminé, des comportements opposés à ceux pour lesquelles elles ont été introduites.

► **Barriers To Payment Reform: Experiences From Nine Dutch Population Health Management Sites**

DE VRIES E. F., DREWES H. W., STRUIJS J. N., *et al.*
2019

Health Policy 123(11): 1100-1107.
<https://doi.org/10.1016/j.healthpol.2019.09.006>

Population health management (PHM) initiatives aim for better population health, quality of care and reduction of expenditure growth by integrating and optimizing services across domains. Reforms shifting payment of providers from traditional fee-for-service towards value-based payment models may support PHM. We aimed to gain insight into payment reform in nine Dutch PHM sites. Specifically, we investigated 1) the type of payment models implemented, and 2) the experienced barriers towards payment reform. Between October 2016 and February 2017, we conducted 36 (semi-)structured interviews with program managers, hospitals, insurers and primary care representatives of the sites. We addressed the structure of payment models and barriers to payment reform in general. After three years of PHM, we found that four shared savings models for pharmaceutical care and five extensions of existing (bundled) payment models adding providers into the model were implemented. Interviewees stated that reluctance to shift financial accountability to providers was partly due to information asymmetry, a lack of trust and conflicting incentives between providers and insurers, and last but not least a lack of a sense of urgency. Small steps to payment reform have been taken in the Dutch PHM sites, which is in line with other international PHM initiatives. While acknowledging the autonomy of PHM sites, governmental stewardship (e.g. long-term vision, supporting knowledge development) can further stimulate value-based payment reforms.

► **Assessing Progressivity And Catastrophic Effect Of Out-Of-Pocket Payments For Healthcare In Canada: 2010–2015**

EDMONDS S. ET HAJIZADEH M.
2019

The European Journal of Health Economics 20(7): 1001-1011.

<https://doi.org/10.1007/s10198-019-01074-x>

Equity in healthcare is an important policy objective of the Canadian healthcare system. Out-of-pocket

payments for healthcare (OPPH) by Canadian households account for a substantial share of total healthcare expenditures. Using data from Statistics Canada's Survey of Household Spending (SHS, n = 33,367), this study examined the progressivity and catastrophic effect of OPPH in Canada over the period 2010 to 2015 inclusive. The Kakwani Progressivity Index (KPI) was used to measure the progressivity of OPPH for each year of the study period. The catastrophic effect of OPPH was calculated using a threshold of 10% of total household consumption. The computed KPI indicated that OPPH are a regressive source of healthcare funding in Canada and the regressivity of OPPH has increased over the study period. This indicates that the distribution of OPPH in Canada is not equitable and the percentage contribution of households from their total consumption to healthcare as OPPH decreases as their consumption increase. The results also suggested that 7% of Canadian households face catastrophic out-of-pocket payments for healthcare (COPPH) over the study period. The proportion of households with COPPH was higher in rural areas compared with urban areas over the study period. Policies to enhance financial risk protection among low-income and rural households are required to improve equity in healthcare financing in Canada.

► **Bundled Payments For Surgical Care—
More Questions Than Answers**

FERRARIS V. A.
2019

Seminars in Thoracic and Cardiovascular Surgery
31(1): 38-39.

<https://doi.org/10.1053/j.semtcvs.2018.09.023>

Bundled payment models assign financial responsibility for extended episodes of care up to 90 days after operation. The report by Koeckert et al, in this issue, describes 376 patients having either transcatheter aortic valve replacements or surgical aortic valve replacements. They investigated the impact of readmissions on the Bundled Payments for Care Improvement initiative (BPCI) payment for Medicare valve patients. The authors' hospital was designated as a BPCI institution that linked reimbursement to the different phases of care (in-patient, outpatient follow-up, emergency visits, and other postacute care) up to 90 days after operation. They found that bundled costs were significantly increased above BPCI reimbursements in readmitted patients, especially transcatheter aortic valve

replacements patients who were readmitted late up to 90 days after operation. This apparent disconnect between BPCI reimbursement and actual costs raises questions about BPCI reimbursement.

► **Les Journées des économistes de la santé
2019 : Introduction**

FRANC C., PARAPONARIS A. ET VENTELOU B.
2019

Revue d'économie politique 129(4): 441-445.

<https://www.cairn.info/revue-d-economie-politique-2019-4-page-441.htm>

Les Journées des Économistes de la Santé Français (JESF) constituent, depuis près de quarante ans, le point de rencontre annuel de la communauté des économistes de la santé. La conférence est organisée dans l'un des grands centres universitaires partenaires en France (Marseille, Bordeaux, Lyon, Paris, Lille, etc.) par le Collège des Économistes de la Santé, dont il revient au conseil d'administration de former le comité scientifique; elle réunit en général une cinquantaine de communications retenues après un processus de sélection s'appuyant sur les rapports de deux membres du comité scientifique. Depuis une quinzaine d'années, les éditions des JESF donnent lieu, tous les deux ans, à la publication d'un numéro spécial dans une revue scientifique généraliste. La Revue d'Économie Politique publie les communications des Journées 2019.

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

FRANC K.
2019

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

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

► **Réduire les barrières financières à l'accès aux soins**

JUSOT F., CARRÉ B. ET WITTEWER J.
2019

Revue française d'économie XXXIV (1): 133-181.
<https://www.cairn.info/revue-francaise-d-economie-2019-1-page-133.htm>

En France, le principe d'équité horizontale dans l'accès aux soins est au cœur du pacte de 1945, selon la maxime « De chacun selon ses moyens, à chacun selon ses besoins ». Pour autant, le système d'assurance maladie laisse depuis sa création une part du coût des soins à la charge des patients, afin notamment de les responsabiliser. Toutefois, ces instruments constituent des barrières financières à l'accès aux soins, qui sont autant de sources d'inégalités sociales de recours aux soins. Afin d'améliorer l'équité dans l'accès financier aux soins, diverses politiques ont été mises en œuvre au cours des dernières décennies. Cet article propose d'en tirer les leçons et de dresser le bilan des connaissances sur les inégalités de recours aux soins en France. L'essentiel des dispositifs ont consisté à introduire la gratuité de certains soins ou à réduire le coût de la complémentaire santé pour les ménages les plus modestes. Les évaluations disponibles démontrent l'efficacité de la gratuité, que celle-ci s'applique aux soins ou à l'assurance, même si elle peut conduire à une moindre qualité perçue ou à des discriminations lorsqu'elle est assortie de tarifs plafonnés. La littérature converge également sur l'inefficacité des subventions à l'assurance. Les réformes les plus récentes, non encore évaluées, visent quant à elles à modérer les prix des soins mal couverts par l'assurance maladie. En dépit de ces dispositifs, il subsiste des inégalités de recours aux soins, à besoins de soins donnés, particulièrement importantes pour les soins de spécialistes, les soins dentaires et d'optique et les soins préventifs. La réduction des barrières financières est donc une condition nécessaire mais non suffisante pour atteindre l'équité en santé.

► **Le coût social des drogues licites et illicites en France**

KOPP P. A.
2019

Bulletin de l'Académie Nationale de Médecine 203(3): 193-200.
<https://doi.org/10.1016/j.banm.2018.09.001>

Le coût social des drogues en France mesure le coût monétaire des conséquences de la consommation et du trafic des drogues légales (alcool et tabac) et illégales. Le coût social est composé du coût externe (valeur des vies humaines perdues, perte de la qualité de vie, pertes de production) et du coût pour les finances publiques (dépenses de prévention, répression et soins, économie de retraites non versées, et recettes des taxes prélevées sur l'alcool et le tabac). Les paramètres de calculs suivent les recommandations du Rapport Quinet en 2013 et les données sanitaires ont été collectées dans la littérature scientifique. Le « coût social » de l'alcool et celui du tabac sont proches de 120 milliards d'euros, suivi par les drogues illicites (8,7 milliards d'euros). Le coût social engendré par le tabac peut être rapproché des 13,4 millions de fumeurs et le coût social de l'alcool des 3,8 millions « d'usagers à risques d'alcool ». Les drogues illicites engendrent un faible « coût social » total, en comparaison de l'alcool et du tabac, parce qu'elles sont moins consommées. Le « coût externe » représente l'essentiel du « coût social » pour l'alcool, le tabac et les drogues illicites (respectivement 96,1 %, 86,4 % et 67,9 %). L'importance de cette composante s'explique par le nombre très important de vies perdues (respectivement environ 49 000, 79 000, 1600) et par la valeur de l'année de vie perdue (115 000 euros) qu'il est recommandé d'utiliser en France dans les calculs socioéconomiques. Le « coût externe » de l'alcool est 8 % plus élevé que celui du tabac bien que le nombre des décès par le tabac soit plus important que ceux engendrés par l'alcool. Cette différence s'explique par un âge moyen au décès plus jeune pour l'alcool que pour le tabac (63 ans vs 71 ans) et par le fait que de nombreux décès accidentels engendrés par l'alcool interviennent précocement. Le « coût des drogues pour les finances publiques » est élevé (1,0 % du PIB). Chaque année, l'État doit payer respectivement pour l'alcool, le tabac et les drogues illicites, 3,9 milliards, 13,8 milliards et 2,4 milliards d'euros. Ainsi, 33 % du déficit budgétaire français serait constitué par le poids négatif des drogues sur les finances publiques. Les recettes de taxation sont inférieures au « coût des soins » (respectivement 8,5 et 25,9 milliards d'euros). La taxation sur les alcools ne représente que 37 % du coût des soins des maladies engendrées par l'alcool tandis que les taxes sur le tabac sont également insuffisantes à couvrir le coût des soins engendrés par ce dernier et représentent 40 % des recettes de taxation.

► **Choosing Doctors Wisely: Can Assisted Choice Enhance Patients' Selection Of Clinicians?**

MARTINO S. C., GROB R., DAVIS S., *et al.*

2019

Med Care Res Rev 76(5): 572-596.

We conducted a simulated clinician-choice experiment, comparing choices and decision-making processes of participants (N=688) randomized among four experimental arms: a conventional website reporting only quantitative performance information, a website reporting both qualitative (patient comments) and quantitative information, the second website augmented by a decision aid (labeling of patient comments), and the decision-aided website further augmented by the presence of a trained navigator. Introducing patient comments enhanced engagement with the quality information but led to a decline in decision quality, particularly the consistency of choices with consumers' stated preferences. Labeling comments helped erase the decline in decision quality, although the highest percentage of preference-congruent choices was seen in the navigator arm. Engagement with the quality information and satisfaction with choices available were likewise highest in the navigator arm. Findings held for high- and low-skilled decision makers. Thus, navigator assistance may be a promising strategy for equitably promoting higher quality choices in information-rich contexts.

► **The Relationship Between Health Spending And Social Spending In High-Income Countries: How Does The US Compare?**

PAPANICOLAS I., WOSKIE L. R. ET ORLANDER D.

2019

Health Affairs 38(9): 1567-1575.

<https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05187>

There is broad consensus that the US spends too much on health care. One proposed driver of the high US spending is low investment in social services. We examined the relationship between health spending and social spending across high-income countries. We found that US social spending (at 16.1 percent of gross domestic product [GDP] in 2015) is slightly below the average for Organization for Economic Cooperation and Development (OECD) countries (17.0 percent of

GDP) and above that average when education spending is included (US: 19.7 percent of GDP; OECD: 17.7 percent of GDP). We found that countries that spent more on social services tended to spend more on health care. Adjusting for poverty and unemployment rates and the proportion of people older than age sixty-five did not meaningfully change these associations. In addition, when we examined changes over time, we found additional evidence for a positive relationship between social and health spending: Countries with the greatest increases in social spending also had larger increases in health care spending.

► **Sécurité sociale : de l'art de transformer des excédents en déficits**

RIGAUDIAT J.

2019

Cahiers de la Santé Publique et de la Protection Sociale (Les)(33): 15-17.

Cet article démontre que le déficit de la sécurité sociale est dû d'une part à un artifice de présentation des comptes de la sécurité sociale et à un choix politique (le fonds de solidarité vieillesse) et d'autre part à l'incertitude du financement des mesures sociales prises suite au mouvement des Gilets jaunes en France.

Health Status

► Sex Differences In Comorbidity And Frailty In Europe

AHRENFELDT L. J., MÖLLER S., THINGGAARD M., *et al.*
2019

International Journal of Public Health 64(7): 1025-1036.

<https://doi.org/10.1007/s00038-019-01270-9>

This aim of this study is to examine sex differences in prevalent comorbidity and frailty across age and European regions.

► Epidemiological Transition And The Wealth Of Nations: The Case Of HIV/AIDS In A Microsimulation Model

ARRIGHI Y. ET VENTELOU B.
2019

Revue d'économie politique 129(4): 591-618.

<https://www.cairn.info/revue-d-economie-politique-2019-4-page-591.htm>

Cet article vise à décomposer l'effet de programmes curatifs sur la performance macroéconomique de pays en développement en phase de transition épidémiologique. Il est largement admis dans la littérature que les programmes d'accès aux soins génèrent des gains de productivité chez les travailleurs en mauvaise santé. Cependant, ces programmes modifient par nature la taille et la composition de la population active en augmentant la proportion d'individus souffrant de maladies chroniques, atténuant ainsi l'effet sur la productivité moyenne. Après avoir défini les conditions théoriques nécessaires à ce que cet effet de structure supplante l'effet productif de l'accès aux soins, nous transposons cette investigation au cas des programmes de traitements antirétroviraux dans trois pays d'Afrique subsaharienne touchés par le VIH/SIDA. Un modèle de microsimulation est utilisé pour générer ex-ante les trajectoires de santé et de production d'individus représentatifs, selon qu'ils aient ou non accès aux antirétroviraux. Nous utilisons le modèle pour générer un « contrefactuel » (en l'absence de l'effet de composition) et constatons que l'effet productif l'emporte sur l'effet épidémiologique négatif. Bien entendu, cette approche n'est qu'un indicateur des performances éco-

nomiques et, en tout état de cause, ne doit pas constituer un critère de décision sur la nécessité éthique de l'accès aux soins.

► Impact d'un choc de santé sur les modes de vie, exploitation de la cohorte Gazel

MARSAUDON A. ET ROCHAIX L.
2019

Revue française d'économie XXXIV (1): 183-225.

<https://www.cairn.info/revue-francaise-d-economie-2019-1-page-183.htm>

Dans cet article, les auteurs étudient l'impact d'un « choc de santé », c'est-à-dire la survenue brutale d'un accident ayant entraîné un recours aux soins sur la consommation hebdomadaire de tabac, d'alcool ainsi que sur l'Indice de masse corporelle (IMC). En utilisant un modèle à effets fixes et des données de panel provenant de la cohorte Gazel, les résultats montrent que le choc de santé a un impact significatif sur ces comportements de santé. Plus précisément, il induit une baisse significative et durable de la consommation de tabac et d'alcool pendant, respectivement, 5 ans et 3 ans, mais n'influence pas l'IMC. Ces résultats sont à mettre en exergue avec ceux des tentatives d'arrêt ou de diminution de la consommation de tabac qui durent, en moyenne, 2,4 mois. Ce qui est 25 fois moins long que la diminution effective suite à un choc de santé. Ainsi, les résultats montrent que subir un choc de santé est un déterminant majeur de la durée de réduction de la consommation de tabac.

► Comparaison de survie de cohortes entre les pays d'Europe centrale et orientale et les pays à longévité élevée

NEPOMUCENO M. R. ET CANUDAS-ROMO V.
2019

Population 74(3): 299-322.

<https://www.cairn.info/revue-population-2019-3-page-299.htm>

Malgré les progrès récents et notables de la survie en Europe centrale et orientale, cette région reste loin derrière les populations des pays les plus développés.

En se plaçant dans une perspective de cohorte pour étudier l'écart de mortalité entre les pays d'Europe centrale et orientale et un groupe de pays dont la longévité actuelle est élevée, cet article montre comment la survie des cohortes contribue au différentiel de mortalité global. La décomposition de la « durée de vie moyenne transversale sur données tronquées » permet d'isoler les contributions des âges et des cohortes à l'écart de mortalité. À partir de données concernant la période 1959-2013 et issues de la Base de données sur la mortalité humaine, on constate que, par rapport à leurs homologues vivant dans des pays à longévité élevée, la plupart des cohortes d'Europe centrale et orientale nées en 1959 et après ont des taux de mortalité plus élevés, de la naissance à l'âge atteint en 2013. Toutefois, certaines cohortes d'Europe centrale

et orientale bénéficient d'un avantage de survie. C'est par exemple le cas des cohortes tchèques nées au début des années 1960 et des cohortes nées dans des pays de l'ex-URSS durant cette même décennie.

► **Climat et santé**

PASCAL M., PAQUET C., JOURDAIN F., *et al.*
2019

Sève : Les Tribunes de La Santé (61): 23-88

Ce numéro propose un dossier consacré aux questions majeures posées par les évolutions du climat et les bouleversements de l'environnement.

Géographie de la santé

Geography of Health

► **Cherche médecin désespérément**

GAUCHET J., ANDRIANTSEHENOHARINALA L. ET COLLE S.
2019

Pratiques : Les Cahiers De La Médecine Utopique (87): 101.

Les déserts médicaux s'étendent, la médecine libérale est en crise, les hôpitaux sont étranglés. Comment les soignants peuvent-ils garder le sens de leurs métiers? Comment répondre aux besoins de la population? Ce numéro spécial de la revue Pratiques tente de répondre à ces questions.

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

GAUTIER S. ET BOURGUEIL Y.
2019

European Journal of Public Health 29(Supplement_4).

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

In France, primary care is organised according to the principles of private practice: independent providers,

payment by fee for service, freedom of settlement... Successive reforms have introduced more regulation i.e. gatekeeping role for GPs, better recognition of professional groups, new forms of payment and promotion of team work and multi-professional practices. Today, the concept of Health Territorial and Professional Communities (HTPC) is becoming a key element of health care reform encouraging primary care professionals to meet with specialists and social workers at a larger level than practice. HTPC should address issues such as access to services, coordination of care and promoting of preventive actions toward populations. This implies change in the roles, skills, methods and resources needed on both professional and regulatory sides. This study explores levers of the professional commitment in the HTPC and resources necessary for it. We conducted a qualitative multiple case study in three French regions. Data was collected from thirty semi-structured interviews with key national informants, regional regulators and health professionals themselves. Professional commitment emerges at a local level on a territory defined by the collaboration practices and habits following a bottom-up process. The integration of care relies on the size of the HTPC which allows them to know each other and to work together to improve access to care and patient's disease management. In order to achieve that, profession-

als claim to have access to administrative health data and to be able to analyze it. They need to develop new skills in management and group animation. The function and training of coordination professionals appear to be essential. The professional commitment in HTPC relies on professional empowerment toward collective activities. This requires autonomy, skills and new roles both for professionals and regulatory authorities. French government relies on professionals' investment at the territorial level by implementing HTPC to guarantee access to care and respond to population needs in primary care. HTPC implementation implies radical change for the professionals to undertake social and populational responsibility for which public health professionals should help to meet the challenge.

► **Accès aux soins premiers à la Réunion et en Métropole**

POUDROUX M. ET VALEE J.

2019

Médecine : De La Médecine Factuelle à Nos Pratiques 15(7): 330-335.

La Réunion, département français, se démarque sur le plan sanitaire par la prévalence de certaines maladies chroniques et sur le plan social par plus de précarité. Cette revue narrative de littérature essaie de comparer l'activité des médecins généralistes libéraux (MGL) réunionnais à celle des métropolitains et d'analyser l'accès aux soins premiers des Réunionnais. Quinze documents ont été retenus. La densité des MGL réunionnais excède celle de la métropole. En 2016, avec une patientèle plus importante, ils réalisaient 49 % de plus de consultations et moins de visites à domicile. Les consultations duraient en moyenne 15 minutes contre 18. Le temps de travail hebdomadaire avoisinait 42 h versus 54 h. Majoration de tarification spécifique au DOM-TOM comprise, le bénéfice non commercial moyen est plus élevé en présence d'un secrétariat qui gère le tiers payant généralisé réalisé par 97 % des MGL réunionnais. L'accès aux MGL est meilleur à la Réunion. Si l'offre de soins et l'accès aux MGL sont meilleurs à la Réunion, l'efficacité des soins auprès de la population reste incertaine.

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

SILHOL J., VENTELOU B. ET MARBOT C.

2019

Revue Française Des Affaires Sociales (2): 215-249.

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

► **The Migration Of UK Trained GPs To Australia: Does Risk Attitude Matter?**

VAN DER POL M., SCOTT A. ET IRVINE A.

2019

Health Policy 123(11): 1093-1099.

<https://doi.org/10.1016/j.healthpol.2019.09.003>

Little is known about the drivers of migration of GPs. Risk attitude may play an important role as migration is

fundamentally a risky decision that balances the risks of staying with the risks associated with leaving. This paper examines the association between risk attitudes and the migration of UK GPs to Australia. Methods GPs who qualified in the UK but work in Australia and who responded to the Medicine in Australia: Balancing Employment and Life (MABEL) national longitudinal survey of doctors, were compared with GPs based in Scotland who responded to a survey. Risk attitudes were elicited for financial risks, career and professional risks and clinical risks on a scale from 1 to 5. Results

GPs in Scotland and UK trained GPs in Australia have similar risk attitudes for financial risk. However, UK trained GPs in Australia are less willing to take clinical and career risks. Conclusion GPs who migrated to Australia after qualifying in the UK were more risk averse about their career and clinical risks. This may suggest that more risk averse GPs migrate to Australia due to pull factors such as less uncertainty around career and clinical outcomes in Australia. The uncertain NHS climate may push more risk averse doctors away from the UK.

Handicap

Disability

► **Le parcours de santé et la prise en charge de la personne polyhandicapée en Italie et en Norvège**

ROUSSEAU M. C., HUMBERTCLAUDE E., LAUKSECKER C., *et al.*

2019

Éthique & Santé 16(3): 100-110.

<https://doi.org/10.1016/j.etiqe.2019.06.005>

Le polyhandicap (PLH) se définit par l'association d'une déficience mentale profonde et d'un déficit moteur grave entraînant une réduction extrême de l'autonomie. En France, le système de soins repose sur la prise en charge hospitalière, médico-sociale ou ambulatoire. Ce parcours de santé n'est pas toujours optimal et peut manquer de fluidité. Il existe d'autres modèles de parcours de soin pour ces patients : en Norvège et

en Italie où les personnes handicapées sont prises en charge hors institutions. Un groupe pluridisciplinaire d'experts français du domaine est allé en Norvège et en Italie observer le parcours de santé des patients polyhandicapés hors institution et identifier des pistes d'amélioration transposables en France. Les forces du modèle norvégien sont : une aide aux familles compensant réellement les conséquences du handicap de leur proche, le transfert de compétences vers les intervenants locaux. Les forces du parcours coordonné Italien sont d'apporter aux patients une réponse rapide, coordonnée et suivie à chaque problématique médicale. Ces deux modèles apportent des solutions potentiellement inspirantes pour notre système de soins qui tentent de répondre aux questions éthiques tant politiques que cliniques que ces personnes dans leur vulnérabilité extrême amènent.

Hôpital

Hospital

► **Patterns Of Ninety-Day Readmissions Following Total Joint Replacement In A Bundled Payment Initiative**

BEHERY O. A., KESTER B. S., WILLIAMS J., *et al.*

2017

The Journal of Arthroplasty 32(4): 1080-1084.

<https://doi.org/10.1016/j.arth.2016.10.027>

Alternative payment models aim to improve quality and decrease costs associated with total joint replacement. Postoperative readmissions within 90 days are of interest to clinicians and administrators as there

is no additional reimbursement beyond the episode bundled payment target price. The aim of this study is to improve the understanding of the patterns of readmission which would better guide perioperative patient management affecting readmissions. We hypothesize that readmissions have different timing, location, and patient health profile patterns based on whether the readmission is related to a medical or surgical diagnosis. A retrospective cohort of 80 readmissions out of 1412 total joint replacement patients reimbursed through a bundled payment plan was analyzed. Patients were grouped by readmission diagnosis (surgical or medical) and the main variables analyzed were time to readmission, location of readmission, and baseline Perioperative Orthopaedic Surgical Home and American Society of Anesthesiologists scores capturing pre-existing state of health. Nonparametric tests and multivariable regressions were used to test associations. Surgical readmissions occurred earlier than medical readmissions (mean 18 vs 33 days, $P = .011$), and were more likely to occur at the hospital where the surgery was performed ($P = .035$). Perioperative Orthopaedic Surgical Home and American Society of Anesthesiologists scores did not predict medical vs surgical readmissions ($P = .466$ and $.879$) after adjusting for confounding variables. Readmissions appear to follow different patterns depending on whether they are surgical or medical. Surgical readmissions occur earlier than medical readmissions, and more often at the hospital where the surgery was performed. The results of this study suggest that these 2 types of readmissions have different patterns with different implications toward perioperative care and follow-up after total joint replacement.

► **Patterns Of Emergency Department Attendance Among Older People In The Last Three Months Of Life And Factors Associated With Frequent Attendance: A Mortality Follow-Back Survey**

BONE A. E., EVANS C. J., HENSON L. A., *et al.*
2019

Age Ageing 48(5) : 680-687

<https://doi.org/10.1093/ageing/afz043>

Frequent emergency department (ED) attendance at the end of life disrupts care continuity and contradicts most patients' preference for home-based care. The aim of this study is to examine factors associated

with frequent (≥ 3) end of life ED attendances among older people to identify opportunities to improve care. Pooled data from two mortality follow-back surveys in England. Respondents were family members of people aged ≥ 65 who died four to ten months previously. We used multivariable modified Poisson regression to examine illness, service and sociodemographic factors associated with ≥ 3 ED attendances, and directed content analysis to explore free-text responses. 688 respondents (responses from 42.0%); most were sons/daughters (60.5%). Mean age at death was 85 years. 36.5% had a primary diagnosis of cancer and 16.3% respiratory disease. 80/661 (12.1%) attended ED ≥ 3 times, accounting for 43% of all end of life attendances. From the multivariable model, respiratory disease (reference cancer) and ≥ 2 comorbidities (reference 0) were associated with frequent ED attendance (adjusted prevalence ratio 2.12, 95% CI 1.21-3.71 and 1.81, 1.07-3.06). Those with ≥ 7 community nursing contacts (reference 0 contacts) were more likely to frequently attend ED (2.65, 1.49-4.72), whereas those identifying a key health professional were less likely (0.58, 0.37-0.88). Analysis of free-text found inadequate community support, lack of coordinated care and untimely hospital discharge were key issues. Assigning a key health professional to older people at increased risk of frequent end of life ED attendance, e.g. those with respiratory disease and/or multiple comorbidities, may reduce ED attendances by improving care coordination.

► **Difficulties In Providing Palliative Care In Identified Palliative Care Beds: An Exploratory Survey**

CALVEL L., BLONDET L. V., CHEDOTAL I., *et al.*
2019

La Presse Médicale 48(7, Part 1): e209-e215.

<https://doi.org/10.1016/j.lpm.2018.10.020>

Identified Palliative Care Beds (Lits Identifiés Soins Palliatifs – LISP) is a French specificity. Primarily created to integrate palliative care culture into conventional hospital units, the relevance of this measure became a controversial issue. Nowadays, hospital teams continue to frequently encounter complex situations regarding medical care for palliative patients. To the best of our knowledge, there is only one study, a quantitative one, bridging the gap about that subject. It showed failure in practicing palliative care work around LISP. Our study is based on a qualitative method that complements the quantitative study.

It aimed to describe difficulties that limit palliative care practices in managing adult patients in LISP. This qualitative exploratory survey was conducted with a sample of health service professionals (n=20), from senior physicians to caregivers. Each semi-structured interview included open questions regarding their experiences, feelings and difficulties with palliative care practices on LISP. It also included closed questions concerning interviewee's demographics and career course. The data for this research were submitted to a two-stage analysis: first, a global review of each interview was performed to identify trends. Then, a detailed breakdown, question by question, was implemented. Results From a quantitative perspective, the interviews revealed 305 difficulties, indicating the gaps and barriers limiting the implementation of a palliative approach in these services. From a qualitative perspective, five topics raised our attention by their recurrence in discourses: (1) partial knowledge about palliative care definition and legislation mostly due to a lack of training; (2) need for time; (3) need for human resources; (4) need for communication; (5) hard time in transitioning from curative to palliative care. Perspective This survey gives the opportunity to understand health service professionals' difficulties in practicing palliative care in conventional medical services. It raises the central issue of the pricing reform on the health institutes activity. It also provides angles of inquiry to improve LISP effectiveness. This qualitative and descriptive study was designed to explore difficulties in practicing palliative care around LISP. Nevertheless, according to the size of the sample, results will need to be confirmed by a more extensive qualitative survey.

► **Characteristics Of Patients Who Received An Indication Of Involuntary Admission, With Or Without The Involvement Of A Third Party, In A Parisian Psychiatric Emergency Unit**

DAURIAC-LE MASSON V., PEIFFER C., BARRUEL D., *et al.*

2019

Encephale 45(5): 405-412.

The French mental health law, first enacted on July 5, 2011, introduced the possibility of psychiatric commitment in case of extreme urgency (imminent peril - ASPPI). The decision of involuntary admission can then be made by the hospital director based on a

medical certificate, without the need of a third party request. This procedure was intended to be applied on an exceptional basis, but its use is steadily increasing against the other types of involuntary care. Our study aimed at comparing the characteristics of patients who had received an indication for involuntary admission due to imminent peril (ASPPI) or at the request of a third party (ASPDT/u) in a psychiatric emergency ward, according to sociodemographic and clinical characteristics and regarding the potential implication of a third party. An observational study was conducted among patients from the Centre Psychiatrique d'Orientation et d'Accueil (CPOA), located at Sainte-Anne hospital in Paris, from August 1st to 31st, 2016. One hundred and fifty patients with an indication for involuntary commitment were included, 101 of whom for ASPDT/u (67%) and 49 for ASPPI (33%). For more than half of the patients from the ASPPI group, a third party had been identified with (39%) or without (17%) contact information. Compared to ASPDT/u patients, ASPPI individuals were more socially vulnerable, showed more negligence, and had a lower mean functioning score. The indication for ASPPI status was also associated with behavioural quirks, prior psychiatric hospitalization (especially as an ASPPI patient) and with the diagnosis of chronic psychosis instead of mood disorder. Our exploratory results help to better understand how the ASPPI procedure is used in psychiatric emergency wards six years after enactment of the law. They highlight the differences between ASPPI patients and ASPDT/u and raise ethical issues regarding involuntary psychiatric care.

► **Do Financial Incentives Influence The Hospitalization Rate Of Nursing Home Residents? Evidence From Germany**

KÜMPEL C.

2019

Health Economics 28(11). 1235-1247

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3930>

Efficient health-care provision for nursing home residents is a concern in many OECD (Organization for Economic Cooperation and Development) countries. This paper analyzes whether nursing homes respond to financial incentives when deciding whether to hospitalize their residents. In Germany, reimbursements for nursing homes are reduced after a defined number of days when a resident stays in a hospital instead of a nursing home. As a result of a federal law introduced in

2008, some German states had to change the point at which reimbursements to nursing homes are reduced so that reductions are made from Day 4 instead of Day 1 of a resident's absence. This exogenously raised an incentive for the nursing homes affected to hospitalize residents especially for an expected short-term stay. This analysis exploits the introduction of the law in a difference-in-difference approach, using market-wide German-DRG files covering all hospital patients discharged from hospitals to nursing homes from 2007 to 2011. The results suggest an increase of approximately 11% in short-term hospital stays as a consequence of the longer reimbursement period introduced by the law.

► **Healthcare Quality, Patients' Satisfaction, And Hospital Incentives In France**

LESCHER M. ET SIRVEN N.

2019

Revue d'économie politique 129(4): 525-551.

<https://www.cairn.info/revue-d-economie-politique-2019-4-page-525.htm>

Les autorités sanitaires françaises ont récemment produit et mis à disposition du public un large éventail de mesures de la qualité des soins hospitaliers, régulièrement mises à jour (www.scopesante.fr). La théorie économique appliquée aux marchés des soins de santé prédit que les coûts de surveillance engagés par les autorités de santé au bénéfice du patient (le principal) pour signaler la qualité des hôpitaux (les agents) devraient inciter ces derniers à améliorer les indicateurs de qualité et de sécurité des soins (IQSS). Cependant, les patients se réfèrent rarement à l'information clinique, technique de qualité des soins afin de discriminer les hôpitaux; et sont davantage enclins à utiliser des évaluations subjectives (telles que le bouche-à-oreille) dont la satisfaction des patients peut être un indicateur indirect. À l'aide d'un échantillon unique de données concernant 2 323 hôpitaux en France métropolitaine et en surmontant les problèmes de sélection inhérents à notre échantillon, nous trouvons une forte corrélation entre une mesure standardisée de la satisfaction des patients, e-satis, et diverses mesures des IQSS. Nos résultats suggèrent que, puisque les patients utilisent un signal qui transmet des informations sur la qualité, les hôpitaux pourraient être incités à améliorer la qualité des soins.

► **Factors Associated With Inappropriate Use Of Emergency Departments: Findings From A Cross-Sectional National Study In France**

NAOURI D., RANCHON G., VUAGNAT A., *et al.*

2019

BMJ Quality & Safety: bmjqs-2019-009396.

<https://qualitysafety.bmj.com/content/ghc/early/2019/10/29/bmjqs-2019-009396.full.pdf>

Inappropriate visits to emergency departments (EDs) could represent from 20% to 40% of all visits. Inappropriate use is a burden on healthcare costs and increases the risk of ED overcrowding. The aim of this study was to explore socioeconomic and geographical determinants of inappropriate ED use in France. The French Emergency Survey was a nationwide cross-sectional survey conducted on June 11 2013, simultaneously in all EDs in France and covered characteristics of patients, EDs and counties. The survey included 48 711 patient questionnaires and 734 ED questionnaires. We focused on adult patients (≥ 15 years old). The appropriateness of the ED visit was assessed by three measures: caring physician appreciation of appropriateness (numeric scale), caring physician appreciation of whether or not the patient could have been managed by a general practitioner and ED resource utilisation. Descriptive statistics and multilevel logistic regression were used to examine determinants of inappropriate ED use, estimating adjusted ORs and 95% CIs. Among the 29 407 patients in our sample, depending on the measuring method, 13.5% to 27.4% ED visits were considered inappropriate. Regardless of the measure method used, likelihood of inappropriate use decreased with older age and distance from home to the ED > 10 km. Not having a private supplementary health insurance, having universal supplementary health coverage and symptoms being several days old increased the likelihood of inappropriate use. Likelihood of inappropriate use was not associated with county medical density. Inappropriate ED use appeared associated with socioeconomic vulnerability (such as not having supplementary health coverage or having universal coverage) but not with geographical characteristics. It makes us question the appropriateness of the concept of inappropriate ED use as it does not consider the distress experienced by the patient, and segments of society seem to have few other choices to access healthcare than the ED.

► **Hospital Length Of Stay Reduction Over Time And Patient Readmission For Severe Adverse Events Following Surgery**

PASCAL L., POLAZZI S., PIRIOU V., *et al.*

2019

Ann Surg: Ahead of print.

The aim of the study was to investigate whether patients who undergo surgery in hospitals experiencing significant length of stay (LOS) reductions over time are exposed to a higher risk of severe adverse events in the postoperative period. Surgical care innovation has encouraged hospitals to shorten LOS under financial pressures with uncertain impact on patient outcomes. We selected all patients who underwent elective colectomy or urgent hip fracture repair in French hospitals between 2013 and 2016. For each procedure, hospitals were categorized into 3 groups according to variations in their median LOS as follows: major decrease, moderate decrease, and no decrease. These groups were matched using propensity scores based on patients' and hospitals' potential confounders. Potentially avoidable readmission for severe adverse events and death at 6 months were compared between groups using Cox regressions. We considered 98,713 patients in 540 hospitals for colectomy and 206,812 patients in 414 hospitals for hip fracture repair before matching. After colectomy, patient outcomes were not negatively impacted when hospitals reduced their LOS [hazard ratio (95% confidence interval): 0.93 (0.78-1.10)]. After hip fracture repair, patients in hospitals with major decreases in LOS had a higher risk of severe adverse events [1.22 (1.11-1.34)] and death [1.17 (1.04-1.32)]. CONCLUSIONS: Patients who underwent surgical procedures in hospitals experiencing major decreases in LOS were demonstrated worse postoperative outcomes after urgent hip fracture repair and not after elective colectomy. Development of care bundles to enhance recovery after emergency surgeries may allow better control of LOS reduction and patient outcomes.

► **Le dispositif français de déclaration des événements indésirables en 2019**

REVUE PRESCRIRE

2019

Revue Prescrire 39(431): 694-698.

Les autorités sanitaires françaises ont modernisé le dispositif des « vigilances sanitaires ». En pratique, les modalités d'accès aux déclarations d'événements indésirables associés aux soins sont simplifiées par un portail internet d'accès public (signalement.social-sante.gouv.fr) qui oriente soignants et patients et distribue les déclarations électroniques aux autorités et organismes compétents. Beaucoup d'événements indésirables peuvent être déclarés par les patients sur signalement.social-sante.gouv.fr en fonction de leur origine supposée. Des pics de déclaration tels ceux concernant le dispositif intra-utérin Mirena® à base de lévonorgestrel, dès le lancement du site, ou encore à la suite de la révélation du changement de formule du Lévothyrox (lévothyroxine), montrent que les patients et leur entourage savent s'en saisir, ce qui demande aux équipes gérant ces signalements de s'adapter à ces afflux massifs.

► **L'attractivité des structures hospitalières pour les internes et jeunes praticiens : revue de littérature**

REYDELLET A., RIOM I., FONTAINE A., *et al.*

2019

Gestions Hospitalières (589): 509-512.

Les structures hospitalières privées et publiques sont soumises à une pression salariale forte. La raréfaction des ressources du marché, conséquence de la régulation médicale des trois dernières décennies, peine à être endiguée par l'ouverture aux diplômés de l'Union européenne. Une raréfaction des ressources et des tensions en ressources humaines qui interrogent sur l'efficacité du recrutement pour maintenir l'offre de soins. Dans ce contexte, le sujet de l'attractivité hospitalière dans la littérature internationale peut éclairer le débat français. Les auteurs présentent ici une synthèse des connaissances issues de cinq sources – PubMed, Scopus, Cairn, Science Direct et Google Scholar – via différentes combinaisons de mots clés : attractivity, human ressources, medical ressources, resident, magnet hospital, intern, hospital management, hospital-physician relations, medical staff, hospital, physician.

Health Inequalities**► Infectious Disease Health Services For Refugees And Asylum Seekers During A Time Of Crisis: A Scoping Study Of Six European Union Countries**BOZORGMEHR K., SAMUILOVA M., PETROVA-BENEDICT R., *et al.*

2019

Health Policy 123(9): 882-887.<https://doi.org/10.1016/j.healthpol.2018.04.003>

Systematic information on infectious disease services provided to refugees and asylum seekers in the European Union (EU) is sparse. We conducted a scoping study of experts in six EU countries in order to map health system responses related to infectious disease prevention and control among refugees and asylum seekers. We conducted 27 semi-structured in-depth interviews with first-line staff and health officials to collect information about existing guidelines and practices at each stage of reception in first-entry (Greece/Italy), transit (Croatia/Slovenia), and destination countries (Austria/Sweden). Thematic coding was used to perform a content analysis of interview material. Guidance on infectious disease screening and health assessments lack standardisation across and—partly—within countries. Data collection on notifiable infectious diseases is mainly reported to be performed by national public health institutions, but is not stratified by migrant status. Health-related information is not transferred in a standardized way between facilities within a single country. International exchange of medical information between countries along the migration route is irregular. Services were reported to be fragmented, and respondents mentioned no specific coordination bodies beyond health authorities at different levels. Infectious disease health services provided to refugees and asylum seekers lack standardisation in health assessments, data collection, transfer of health-related information and (partly) coordination. This may negatively affect health system performance including public health emergency preparedness.

► Les déterminants du renoncement aux soins pour raisons financières des étudiants – une analyse à partir de l'étude i-ShareCASTRY M., WITWER J., MONTAGNI I., *et al.*
2019**Revue d'économie politique 129(4): 467-488.**<https://www.cairn.info/revue-d-economie-politique-2019-4-page-467.htm>

Nos connaissances sur l'accès et le recours aux soins des étudiants en France sont très parcellaires, alors que la population étudiante est confrontée pour une partie d'entre elle à des situations de précarité économique. A partir de l'exploitation des données de l'étude i-Share (Internet-based students health research enterprise), cet article propose d'analyser les déterminants du renoncement aux soins pour raisons financières des étudiants français. Trois types de soins sont considérés : la consultation d'un médecin (généraliste ou spécialiste), celle d'un dentiste et l'achat de lunettes. Les résultats sont cohérents avec ceux de la littérature et suggèrent l'existence d'inégalités marquées d'accès aux soins au sein de la population étudiante. Les analyses réalisées montrent que l'avancée en âge des étudiants est liée à une plus forte probabilité de renoncer à des soins pour raisons financières. Elles mettent également en évidence que le renoncement financier est lié à un ensemble de variables caractérisant la situation matérielle, sociale et financière des étudiants (type de logement, activité rémunérée, aides financière de la famille, statut de boursier, etc.). Ces résultats invitent à évaluer l'impact à moyen et long terme de ces difficultés d'accès aux soins ainsi qu'à suggérer des politiques publiques adaptées, notamment en améliorant le recours des étudiants à leurs droits et à l'obtention d'une complémentaire santé.

► **Health Records For Migrants And Refugees: A Systematic Review**

CHIESA V., CHIARENZA A., MOSCA D., *et al.*
2019

Health Policy 123(9): 888-900.

<https://doi.org/10.1016/j.healthpol.2019.07.018>

One of the challenges facing migrants and refugees is access to medical records. The aim of this study was to identify Health Records (HRs) developed specifically for migrants and refugees, describe their characteristics, and discuss their reported strengths and weaknesses. A systematic review of articles focusing on HRs implemented exclusively for migrants and refugees was undertaken. Publications were identified by searching the scientific databases Embase, Medline, Scopus and Cochrane, the grey literature and by checking the reference lists of articles. The literature search yielded an initial list of 1432 records, with 58 articles remaining after screening of title and abstract. Following full-text screening, 33 articles were retained. Among the 33 articles reviewed, 20 different HRs were identified. Our findings suggest that HRs, especially electronic ones, might be efficient and effective tools for registering, monitoring and improving the health of migrants and refugees. However, some of the evidence base is narrative or institutional and needs to be backed up by scientific studies. Health records, implemented specifically for migrants and refugees, seem to have the potential to address some of the challenges that they face in accessing health care, in particular in strategic hotspots, cross-border settings and for migrants on the move.

► **Précarité de la migration : autour des notions de santé et de capacités**

GAULD C.
2019

Sève : Les Tribunes de La Santé (61): 89-93.

En se plaçant dans un cadre particulier de la philosophie de la médecine, qui considère la santé selon une approche dit « holistique » et globale, la maladie peut être conçue comme une perte de capacités « de second ordre ». Celles-ci correspondent à la faculté d'acquiescer la faculté d'agir fonctionnellement dans le monde physique et social. Le migrant précaire, lorsqu'il met le pied sur le territoire d'accueil, ne semble pas avoir accès à ces capacités particulières. Or cette perte permet de distinguer ce qui discerne la maladie de la

santé : est considéré comme malade le sujet qui ne peut exprimer ses capacités de second ordre. Cette distinction peut être comprise en terme de handicap psychique. Mais le migrant en situation de précarité en est-il malade pour autant, d'un point de vue normativiste ? Cette approche de la santé conçue en termes de capacité sera discutée dans cet article. Elle sera mise en lumière par la condition du migrant en situation de précarité. Cette vision ne pourrait-elle pas constituer le socle d'une lutte pour la reconnaissance de sa situation ? (résumé de l'auteur).

► **Healthcare Access For Refugees In Greece: Challenges And Opportunities**

GUNST M., JARMAN K., YARWOOD V., *et al.*
2019

Health Policy 123(9): 818-824.

<https://doi.org/10.1016/j.healthpol.2019.06.003>

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

► **Moving Upstream: Changing Policy Scripts On Migrant And Ethnic Minority Health**

INGLEBY D.
2019

Health Policy 123(9): 809-817.

<https://doi.org/10.1016/j.healthpol.2019.07.015>

This article uses the concept of 'policy scripts' to explore the aims and assumptions underlying poli-

cies on migrant and ethnic minority health. Firstly, it analyses the shift in health policies from ‘downstream’ approaches (emphasising health care for the sick and injured) to ‘upstream’ ones (emphasising health protection for the whole population). The field of migrant health has been relatively slow to move upstream. Two factors appear to have impeded this shift: (a) the reluctance of the ‘social determinants of health’ movement to regard migrant status and ethnicity as important causes of health inequities; and (b) the one-sided emphasis on short-term emergency health provisions for migrants arising from the recent increase in forced migration worldwide, in particular the sudden peak in mixed migration to the EU in 2015. The article contends that (a) the usual arguments against treating migration and ethnicity as health determinants do not stand up to critical examination; and (b) the overwhelming emphasis on unauthorised entrants which characterises current discussions of migration policy, including health, is out of all proportion to their volume relative to that of other migrants. Fortunately, recent policy initiatives at UN level have the potential to restore the balance between ‘upstream’ and ‘downstream’ approaches, as well as between unauthorised entry and ‘routine’ migration.

► **Barriers To Health Care Access And Service Utilization Of Refugees In Austria: Evidence From A Cross-Sectional Survey**

KOHLBERGER J., BUBER-ENNSER I., RENG S., *et al.*

2019

[Health Policy 123\(9\): 833-839.](#)

<https://doi.org/10.1016/j.healthpol.2019.01.014>

This paper provides evidence on (1) refugees’ subjective well-being, (2) their access and barriers to health care utilization and (3) their perception of health care provision in Austria, one of the countries most heavily affected by the European ‘refugee crisis.’ It is based on primary data from the Refugee Health and Integration Survey (ReHIS), a cross-sectional survey of roughly five hundred Syrian, Iraqi and Afghan refugees. Results indicate that refugees’ self-rated health falls below the resident population’s, in particular for female and Afghan refugees. Whereas respondents state overall high satisfaction with the Austrian health system, two in ten male and four in ten female refugees report

unmet health needs. Most frequently cited barriers include scheduling conflicts, long waiting lists, lack of knowledge about doctors, and language. Although treatment costs were not frequently considered as barriers, consultation of specialist medical services frequently associated with co-payment by patients, in particular dental care, are significantly less often consulted by refugees than by Austrians. Refugees reported comparably high utilization of hospital services, with daycare treatment more common than inpatient stays. We recommend to improve refugees’ access to health care in Austria by a) improving the information flow about available treatment, in particular specialists, b) fostering dental health care for refugees, and c) addressing language barriers by providing (web-based) interpretation services.

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

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

2019

[Health Policy 123\(12\):1155-1162](#)

<https://doi.org/10.1016/j.healthpol.2019.09.013>

Unmet healthcare needs (or foregone healthcare) is a widely used intermediate indicator to evaluate healthcare systems attainment since it relates to health outcomes, financial risk protection, improved efficiency and responsiveness to the individuals’ legitimate expectations. This paper discusses the ordinary measure of this indicator used so far, prevalence of unmet needs in the whole population, based on the level of healthcare needs among the population. The prevalence of needs and the prevalence of unmet needs among those in need are key aspects that have not yet been fully explored when it comes to foregone healthcare. We break down the ordinary measure into prevalence of needs and prevalence of unmet needs among those in need based on data taken from the European Social Survey 2014. Afterwards, we analyse these different measures in a cross-country perspective. We also discuss the link between them and the implicit relative assessment of healthcare systems considering the whole population and the sub-group of the population aged 65 or more. Comparisons across countries show different attainment levels unveiling varying challenges across European countries, depending on the combination of levels of need and levels of unmet needs for those in need.

► **Shaping Access To Health Care For Refugees On The Local Level In Germany – Mixed-Methods Analysis Of Official Statistics And Perspectives Of Gatekeepers**

ROLKE K., WENNER J. ET RAZUM O.
2019

Health Policy 123(9): 845-850.

<https://doi.org/10.1016/j.healthpol.2019.07.001>

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

► **Refugee Crisis In Finland: Challenges To Safeguarding The Right To Health For Asylum Seekers**

TUOMISTO K., TIITTALA P., KESKIMÄKI I., *et al.*
2019

Health Policy 123(9): 825-832.

<https://doi.org/10.1016/j.healthpol.2019.07.014>

In 2015 Finland received an unprecedented number of asylum seekers, ten times more than in any previous year. This surge took place at a time the Finnish Government was busily undergoing a wide-range health and social care reform amid growing nationalist and populist sentiments. Our aim is to explore the governance of a parallel health system for asylum seekers with a right-to-health approach. We concentrated on three right to health features most related to the governance of asylum seeker health care, namely Formal recognition of the right to health, Standards and Coordination mechanisms. Through our qualitative review, we identified three major hurdles in the governance of the system for asylum seekers: 1) Ineffectual and reactive national level coordination and stewardship; 2) Inadequate legislative and supervisory frameworks leading to ineffective governance; 3) Discrepancies between constitutional rights to health, legal entitlements to services and guidance available. This first-time large-scale implementation of the policies exposed weaknesses in the legal framework and the parallel health system. We recommend the removal of the parallel system and the integration of asylum seekers' health services to the national public health care system.

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

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

Health Policy 123(12):1185-1198

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

A large number of medical devices (MDs) is available in Europe. Procedures for market approval and reimbursement have been adopted over recent years to promote accelerating patient access to innovative MDs. However, there remains uncertainty and non-transparency regarding these procedures. We provide a structured overview of market approval and reimbursement procedures and practices regarding access to MDs in the EU. Market approval procedures were found to be uniformly described. Data on reimbursement procedures and practices was both heterogeneous and incomplete. Time to MD access was mainly determined by reimbursement procedures. The influence of the patient on time to access was not reported. Prescription practices varied among device types. Barriers to and facilitators of early patient access that set the agenda for policy implications were also analyzed. Barriers were caused by unclear European legislation, complex market approval procedures, lack of data collection, inconsistency in evidence requirements between countries, regional reimbursement and provision, and factors influencing physicians' prescription including the device costs, waiting times and hospital-physician relationships. Facilitators were: available evidence that meets country-specific requirements for reimbursement, diagnosis-related groups, additional payments and research programs. Further research needs to focus on creating a complete overview of reimbursement procedures and practices by extracting further information from sources such as grey literature and interviews with professionals, and defining clear criteria to objectify time to access.

► Association Between Gifts From Pharmaceutical Companies To French General Practitioners And Their Drug Prescribing Patterns In 2016: Retrospective Study Using The French Transparency In Healthcare And National Health Data System Databases

GOUPIL B., BALUSSON F., NAUDET F., *et al.*
2019

BMJ 367: l6015.

<https://www.bmj.com/content/bmj/367/bmj.l6015.full.pdf>

The aim of this paper is to evaluate the association between gifts from pharmaceutical companies to French general practitioners (GPs) and their drug prescribing patterns. Retrospective study using data from two French databases (National Health Data System, managed by the French National Health Insurance system, and Transparency in Healthcare) were used Primary care, France. Participants 41 257 GPs who in 2016 worked exclusively in the private sector and had at least five registered patients. The GPs were divided into six groups according to the monetary value of the received gifts reported by pharmaceutical, medical device, and other health related companies in the Transparency in Healthcare database. The main outcome measures were the amount reimbursed by the French National Health Insurance for drug prescriptions per visit (to the practice or at home) and 11 drug prescription efficiency indicators used by the National Health Insurance to calculate the performance related financial incentives of the doctors. Doctor and patient characteristics were used as adjustment variables. The significance threshold was 0.001 for statistical analyses. The amount reimbursed by the National Health Insurance for drug prescriptions per visit was lower in the GP group with no gifts reported in the Transparency in Healthcare database in 2016 and since its launch in 2013 (no gift group) compared with the GP groups with at least one gift in 2016 (–€5.33 (99.9% confidence interval –€6.99 to –€3.66) compared with the GP group with gifts valued at €1000 or more reported in 2016) ($P < 0.001$). The no gift group also more frequently prescribed generic antibiotics (2.17%, 1.47% to 2.88% compared with the \geq €1000 group), antihypertensives (4.24%, 3.72% to 4.77% compared with the \geq €1000 group), and statins (12.14%, 11.03% to 13.26% com-

pared with the $\geq\text{€}1000$ group) than GPs with at least one gift between 2013 and 2016 ($P<0.001$). The no gift group also prescribed fewer benzodiazepines for more than 12 weeks (-0.68% , -1.13% to -0.23% compared with the $\text{€}240\text{--}\text{€}999$ group) and vasodilators (-0.15% , -0.28% to -0.03% compared with the $\geq\text{€}1000$ group) than GPs with gifts valued at $\text{€}240$ or more reported in 2016, and more angiotensin converting enzyme (ACE) inhibitors compared with all ACE and sartan prescriptions (1.67% , 0.62% to 2.71%) compared with GPs with gifts valued at $\text{€}1000$ or more reported in 2016 ($P<0.001$). Differences were not significant for the prescription of aspirin and generic antidepressants and generic proton pump inhibitors. The findings suggest that French GPs who do not receive gifts from pharmaceutical companies have better drug prescription efficiency indicators and less costly drug prescriptions than GPs who receive gifts. This observational study is susceptible to residual confounding and therefore no causal relation can be concluded.

► **Why Do Health Technology Assessment Drug Reimbursement Recommendations Differ Between Countries? A Parallel Convergent Mixed Methods Study**

NICOD E., MAYNOU L., VISINTIN E., *et al.*
2019

Health Economics, Policy and Law: 1-17.

Using quantitative and qualitative research designs, respectively, two studies investigated why countries make different health technology assessment (HTA) drug reimbursement recommendations. Building on these, the objective of this study was to (a) develop a conceptual framework integrating the factors explaining these decisions, (b) explore their relationship and (c) assess if they are congruent, complementary or discrepant. A parallel convergent mixed methods design was used. Countries included in both previous studies were selected (England, Sweden, Scotland and France). A conceptual framework that integrated and organised the factors explaining the decisions from the two studies was developed. Relationships between factors were explored and illustrated through case studies. The framework distinguishes macro-level factors from micro-level ones. Only two of the factors common to both studies were congruent, while two others reached discrepant conclusions (stakeholder input and external review of the evidence processes). The remaining factors identified within one or both studies

were complementary. Bringing together these findings contributed to generating a more complete picture of why countries make different HTA recommendations. Results were mostly complementary, explaining and enhancing each other. We conclude that differences often result from a combination of factors, with an important component relating to what occurs during the deliberative process.

► **Agir au quotidien pour réduire les effets indésirables des médicaments**

REVUE PRESCRIRE
2019

Revue Prescrire 39(431): 694-69702-69705.

Faire face aux effets indésirables des médicaments et si possible les éviter font partie de la pratique quotidienne de chaque professionnel de santé. Des soignants abonnés à Prescrire se sont engagés dans une démarche d'amélioration de leurs pratiques avec le programme Médicaments en Questions, afin de contribuer à protéger les patients des effets indésirables des médicaments. Ce programme vise à aider les soignants à prendre davantage en compte dans leur pratique quotidienne les effets indésirables des médicaments et à mieux y faire face, dans le but de les réduire. Il est destiné principalement aux médecins, pharmaciens et infirmiers. Depuis 2014, les participants à ce programme Prescrire ont renseigné environ 2 000 observations d'effets indésirables médicamenteux. Dans plus de 450 discussions du forum en ligne, ils ont abordé des troubles suspectés d'avoir une origine médicamenteuse. Des participants ont relaté leurs stratégies, ainsi que les moyens mis en œuvre, pour : penser plus systématiquement au rôle éventuel d'un médicament dans la survenue d'un trouble de santé; davantage notifier les effets indésirables observés et tirer profit des réponses de leurs correspondants des centres de pharmacovigilance; mieux prévenir les effets indésirables, notamment en écartant des soins les médicaments à balance bénéfices- risques défavorable.

► **Désastre du Mediator : beaucoup de temps perdu et de vies gâchées**

REVUE PRESCRIRE
2019

[Revue Prescrire 39\(432\): 782-784.](#)

En septembre 2019 s'est ouvert en France le procès au pénal de la firme Servier, de l'Agence française du médicament et de certains de leurs membres, mis en cause notamment pour le retrait trop tardif de Mediator aux effets indésirables particulièrement graves. Cet article revient sur les différents articles publiés dans la Revue Prescrire depuis 1986, qui permettent de comprendre les enjeux du procès.

► **Pharmaceutical Policies: Effects Of Educational Or Regulatory Policies Targeting Prescribers**

SULEMAN F. ET MOVIK E.
2019

[Cochrane Database Syst Rev 2019\(11\).](#)

https://www.cochrane.org/CD013478/EPOC_effects-educational-or-regulatory-policies-targeting-medicine-prescribers

<https://www.ncbi.nlm.nih.gov/pubmed/31721159>

Pharmaceuticals make an important contribution to people's health. Medicines, however, are frequently not used appropriately. Improving the use of medicines can improve health outcomes and save resources. On the other hand, regulatory and educational policies may have unintended effects on health and costs. OBJECTIVES: To assess the effects of pharmaceutical educational and regulatory policies targeting prescribers on medicine use, healthcare utilisation, health outcomes and costs (expenditures). We searched CENTRAL, MEDLINE, Embase, and two trial registries in March 2018 and several other databases between 2014 and 2018. Randomised trials, non-randomised trials, interrupted time series studies, repeated measures studies and controlled beforeafter studies of policies regulating who can prescribe medicines and other policies targeted at prescribers. We included in this category monitoring and enforcement of restrictions, generic prescribing, programmes to implement treatment guidelines, system-wide policies regarding monitoring medicine safety, and legislated or mandatory continuing education or quality improvement specifically targeted at prescribing. We defined 'policies' in this review as laws, rules, financial and administra-

tive orders made by governments, non-governmental organisations or private insurers. We excluded interventions applied at the level of a single facility. For us to include a study, it had to include an objective measure of at least one of the following outcomes: medicine use, healthcare utilization, health outcomes, or costs. DATA COLLECTION AND ANALYSIS: Two review authors independently reviewed abstracts and reference lists of relevant reports, assessed full-text studies for inclusion, extracted data, and assessed risk of bias and certainty of the evidence (GRADE). For all the steps in the above process we resolved disagreements by discussion. We identified two studies that met our selection criteria: a controlled interrupted time series study evaluating a regulatory policy involving the monitoring of prescribing of benzodiazepines; and a controlled beforeafter study of an educational policing involving mailed educational materials on prescribing for physicians and Health Maintenance Organization (HMO) members as well as an intervention to regulate drug reimbursement. We are uncertain about the effects on medicine use of a regulatory policy involving the monitoring of prescribing with triplicate prescriptions, compared with no regulatory intervention (very low certainty evidence). We are also uncertain about the effects on medicine use, assessed through doctors' prescribing, and costs of an educational policy involving mailed educational materials on prescribing for physicians and HMO members, compared to no educational intervention or an intervention to regulate drug reimbursement (very low certainty evidence). Neither of the included studies measured healthcare utilization, health outcomes, or additional costs, if any, to patients. We are uncertain of the effects of educational or regulatory policies targeting prescribers due to very limited evidence of very low certainty. The impacts of these policies therefore need to be evaluated rigorously using appropriate study designs. Evaluations are needed across a range of settings, including low- and middle-income countries, and across different types of prescribers and medicines.

Methodology – Statistics

► **Practical Mixed Methods Strategies Used To Integrate Qualitative And Quantitative Methods In Community-Based Primary Health Care Research**

KAUR N., VEDEL I., EL SHERIF R., *et al.*

2019

Family Practice 36(5): 666-671.

<https://doi.org/10.1093/fampra/cmz010>

Mixed methods (MM) are common in community-based primary health care (CBPHC) research studies. Several strategies have been proposed to integrate qualitative and quantitative components in MM, but they are seldom well conceptualized and described. The purpose of the present review was to identify and describe practical MM strategies and combinations of strategies used to integrate qualitative and quantitative methods in CBPHC research. A methodological review with qualitative synthesis (grouping) was performed. Records published in English in 2015 were retrieved from the Scopus bibliographic database. Eligibility criteria were: CBPHC empirical study, MM research with detailed description of qualitative and quantitative methods and their integration. Data were extracted from included studies and grouped using a conceptual framework comprised of three theoretical types of MM integration, the seven combinations of these types and nine practical strategies (three per type of integration) and multiple combinations of strategies. Among the 151 articles reporting CBPHC and MM studies retrieved, 54 (35.7%) met the inclusion criteria for this review. The included studies provided examples of the three theoretical types of MM integration, the seven combinations of these types as well as the nine practical strategies. Overall, 15 combinations of these strategies were observed. No emerging strategy was observed that was not predicted by the conceptual framework. This review can provide guidance to CBPHC researchers for planning, conducting and reporting practical strategies and combinations of strategies used for integrating qualitative and quantitative methods in MM research.

► **Use Of Medicare Data To Identify Team-Based Primary Care: Is It Possible?**

KUO Y.-F., RAJI M. A., LIN Y.-L., *et al.*

2019

Medical Care 57(11): 905-912.

https://journals.lww.com/lww-medicalcare/Fulltext/2019/11000/Use_of_Medicare_Data_to_Identify_Team_based.10.aspx

It is unclear whether Medicare data can be used to identify type and degree of collaboration between primary care providers (PCPs) [medical doctors (MDs), nurse practitioners, and physician assistants] in a team care model. Methods: We surveyed 63 primary care practices in Texas and linked the survey results to 2015 100% Medicare data. We identified PCP dyads of 2 providers in Medicare data and compared the results to those from our survey. Sensitivity, specificity, and positive predictive value (PPV) of dyads in Medicare data at different threshold numbers of shared patients were reported. We also identified PCPs who work in the same practice by Social Network Analysis (SNA) of Medicare data and compared the results to the surveys. Results: With a cutoff of sharing at least 30 patients, the sensitivity of identifying dyads was 27.8%, specificity was 91.7%, and PPV 72.2%. The PPV was higher for MD-nurse practitioner/physician assistant pairs (84.4%) than for MD-MD pairs (61.5%). At the same cutoff, 90% of PCPs identified in a practice from the survey were also identified by SNA in the corresponding practice. In 5 of 8 surveyed practices with at least 3 PCPs, about $\leq 20\%$ PCPs identified in the practices by SNA of Medicare data were not identified in the survey. Conclusions: Medicare data can be used to identify shared care with low sensitivity and high PPV. Community discovery from Medicare data provided good agreement in identifying members of practices. Adapting network analyses in different contexts needs more validation studies.

► **A Mixed Methods Study Of Change Processes Enabling Effective Transition To Team-Based Care**

KYLE M. A., AVELING E.-L. ET SINGER S.
 2019

Medical Care Research and Review: [Ahead of print]
<https://doi.org/10.1177/1077558719881854>

Team-based care is considered central to achieving value in primary care, yet results of large-scale primary care transformation initiatives have been mixed. We explore how underlying change processes influence the effectiveness of transition to team-based care. We studied 12 academically affiliated primary care practices participating in a learning collaborative, using longitudinal staff survey data to measure progress toward team-based care and qualitative interviews with practice staff to understand practice transformation. Transformation efforts focused on team formation and capacity building for quality improvement. Using thematic analysis, we explored types of change processes undertaken and the relationship between change processes and effective team-based care. We identified three prototypical approaches to change: pursuing functional and cultural change processes, functional only, and cultural only. Practice sites prioritizing both change processes formed the most effective teams: simultaneous functional and cultural change spurred a mutually reinforcing virtuous cycle. We describe implications for research, practice, and policy.

► **Les études portant sur les bases de données médico-administratives sont-elles reproductibles ? L'hypothèse d'une inconduite éthique en santé publique**

LOOTEN V.
 2019

Médecine Sciences: (35): 689–692.
<https://doi.org/10.1051/medsci/2019134>

La reproductibilité méthodologique fait référence à la capacité à obtenir exactement les mêmes résultats, en reproduisant le même protocole d'étude sur les mêmes données. Nous avons voulu évaluer la reproductibilité méthodologique des études publiées entre 2008 et 2017 dans la Revue d'épidémiologie et de santé publique, qui font appel à des données issues du système national des données de santé. Nos résultats suggèrent que seules 49 % des études portant sur

ce système national pourraient être reproduites sans le recours aux auteurs initiaux. L'absence de partage systématique des programmes peut révéler un manque de préoccupation quant à la finalité de la recherche en santé publique. Il est difficile d'attribuer la responsabilité de ce manque de reproductibilité aux seuls chercheurs, et nous faisons donc l'hypothèse d'une inconduite éthique instituée.

► **Faut-il en finir avec le Finess ?**

LOUBAT J. R.
 2019

Gestions Hospitalières (588): 406-407.

À l'heure où l'on parle de transformation de l'offre de soins en matière d'action médico-sociale, de transition ou de mutation systémiques, de changement de paradigme, de logique de parcours et d'inclusion, nombre d'opérateurs bien disposés expérimentent et innove, tant au plan de leurs organisations que de leurs modalités d'accompagnement des personnes bénéficiaires. Mais tous ces efforts sont rendus sinon vains du moins non aboutis si les conditions administratives de ces reconfigurations ne sont pas réunies. Par exemple, des associations ou fondations mettent en place des plateformes de service mais la plupart des maisons départementales des personnes handicapées continuent de prononcer des orientations en direction d'établissements ou de services traditionnels, tandis que les agences régionales de santé ou les conseil départementaux continuent largement de raisonner en termes de budgets par établissements ou service.

► **Approaches And Alternatives To The Wealth Index To Measure Socioeconomic Status Using Survey Data: A Critical Interpretive Synthesis**

POIRIER M. J. P., GRÉPIN K. A. ET GRIGNON M.
 2019

Social Indicators Research: Ahead of print.
<https://doi.org/10.1007/s11205-019-02187-9>

Monitoring progress towards the Sustainable Development Goals by 2030 requires the global community to disaggregate targets along socio-economic lines, but little has been published critically analyzing the appropriateness of wealth indices to measure socioeconomic status in low- and middle-income

countries. This critical interpretive synthesis analyzes the appropriateness of wealth indices for measuring social health inequalities and provides an overview of alternative methods to calculate wealth indices using data captured in standardized household surveys. Our aggregation of all published associations of wealth indices indicates a mean Spearman's rho of 0.42 and 0.55 with income and consumption, respectively. Context-specific factors such as country development level may affect the concordance of health and educational outcomes with wealth indices and urban–rural disparities can be more pronounced using wealth indices compared to income or consumption. Synthesis of potential future uses of wealth indices suggests that it is possible to quantify wealth inequality using household assets, that the index can be used to study SES across national boundaries, and that technological innovations may soon change how asset wealth is measured. Finally, a review of alternative approaches to constructing household asset indices suggests lack of evidence of superiority for count measures, item response theory, and Mokken scale analysis, but points to evidence-based advantages for multiple correspondence analysis, polychoric PCA and predicted income. In sum, wealth indices are an equally valid, but distinct measure of household SES from income and consumption measures, and more research is needed into their potential applications for international health inequality measurement.

► **Qualité du codage des diagnostics et motifs de prise en charge (principal et associés) dans le recueil d'informations médicalisé en psychiatrie (RIM-P) en 2015 et 2016, France**

RICHAUD-EYRAUD E., ELLINI A., CLÉMENT M. C., *et al.*

2019

Revue d'Épidémiologie et de Santé Publique 67(5): 337-344.

<https://doi.org/10.1016/j.respe.2019.05.007>

Based on the observation of the misuse of ICD-10 to code the diagnoses in the RIM-P (lack of completeness, conformity and diversity), the Technical Agency for information on Hospital Care (ATIH), which provides tools for collecting medical information, conducted two actions in 2016. First, a chapter devoted to the instructions of coding has been written in the methodological guide of production of the RIM-P, second, a

variable “type psy” was added to the ICD-10 nomenclature's file framing ICD-10 coding in the RIM-P. The purpose of this study is to describe the quality of diagnosis coding using ICD-10 in the RIM-P in 2015 and 2016. **Methods** The quality of diagnosis coding using ICD-10 in the summaries of activity of the RIM-P national databases was described in 2015 and 2016. The study focused on the completeness, the conformity and the diversity of coding. **Results** Between 2015 and 2016, the percentage of summaries without primary diagnosis (“DP”) decreased slightly for full-time (5.2% vs. 3.8%), part-time (6.3% vs. 4.9%) inpatient stays and outpatient care (9.9% vs. 8.9%). ICD-10 codes used to code DP or associated diagnosis (“DA”), while prohibited, mainly belong to Chapter V Mental and behavioral disorders. Per year, only one-third of the summaries and one-half of patients had two or more ICD-10 codes reported for inpatient stays (one-fifth of the summaries and one-fourth of the patients for outpatient care). In addition, per year and per facility, the average number of distinct ICD-10 codes used to fill “DP” or “DA” was approximately half as important in part-time hospitalization, as in full-time hospitalization or for outpatient care. Moreover, 90% of the health facilities used <550 distinct ICD-10 codes in full-time inpatient stays, <270 in part-time inpatient stays and <950 for outpatient care to code the “DP” or the “DA”. The diversity of ICD-10 codes used was low and similar between 2015 and 2016, especially to describe the socio-economic environment, resistance to treatment or non-compliance. **Conclusion** This study emphasizes the need for a collective effort to improve the diversity of the diagnoses' coding in the RIM-P.

► **Is My Patient Overwhelmed?**

TRAN V.-T., MONTORI V. M. ET RAVAUD P.

2019

Mayo Clinic Proceedings.

<https://doi.org/10.1016/j.jmayocp.2019.09.004>

The aim of this paper is to estimate the highest burden of treatment beyond which patients with chronic conditions consider their current investments of time and effort in health care unsustainable. We used data collected between January 1, 2017 and October 1, 2018 in the Community of Patients for Research (ComPaRe), an ongoing e-cohort of adult patients with chronic conditions in France. We matched participants' answers to the Treatment Burden Questionnaire (TBQ) and to a Yes/No anchor question: “Think about all the things

you do to care for yourself. Do you think you could continue investing the same amount of time, energy, and money in your health care lifelong?” We defined the Patient Acceptable Symptom State (PASS) for the burden of treatment as the TBQ score below which 75% of patients reported an acceptable burden state. We analyzed data for 2413 patients (1781 [73.8%] women, 1248 [51.7%] multimorbid, median age: 48 (interquartile range, 36-59] years) enrolled in ComPaRe. Of these, 38% (917 of 2413) reported that they would be unable to continue the same investment of energy, time, and

money in health care lifelong. The PASS for the burden of treatment was at 39% of the maximal score (ie, TBQ score = 59/150; 95% CI, 52-64) Using these results, clinicians can detect patients at risk for becoming overwhelmed by their medical care by identifying patients with TBQ scores of 59 or higher. About 40% of patients with chronic conditions report being unable to sustain current investments of energy, time, and money in health care lifelong. The PASS for treatment burden provides a practical yardstick to help clinicians and researchers interpret scores for burden of treatment.

Politique de santé

Health Policy

► **Loi de santé : feu vert pour la mise en œuvre**

BROUET P.
2019

Médecins : Bulletin de L'Ordre national des médecins (63): 18-25.

La loi relative à l'organisation et à la transformation du système de santé est promulguée depuis l'été 2019. Ce texte indispensable pour réformer le système de santé était réclamé par l'Ordre national des médecins depuis plus de quatre ans. Cet article fait un tour d'horizon des principales mesures et des positions que l'Ordre continuera à défendre.

► **Austerity And Health In Europe: Disentangling The Causal Links**

FORSTER T. ET KENTIKELLENIS A. E.
2019

European Journal of Public Health 29(5): 808-809.
<https://doi.org/10.1093/eurpub/cky249>

The global financial crisis of 2007/08 put increased financial strain on health systems across Europe, and many countries enacted fiscal consolidation measures, commonly referred to as 'austerity.' A large body of evidence has documented the consequences of these reforms on population health, and the role of health systems as key mediating institutions.¹⁻⁴ Nonetheless, these studies insufficiently disentangle

how different levels of policymaking influence health outcomes, and often focus on the short-term effects of austerity. To develop a better understanding of the links between austerity and health, we introduce a framework that integrates distinct levels of analysis with different time periods (see Figure 1). Three levels of policymaking—transnational, national and local—determine the policy space in which public authorities debate, design and implement policy reforms. To be sure, these levels do not exist in isolation but are interdependent. For instance, European, or transnational, forces ultimately have national- and local-level manifestations. Further, this framework draws attention to how the consequences of these policy reforms evolve over time. We distinguish between three periods—short-, medium- and long-run.

► **Conditions Influencing The Adoption Of A Soda Tax For Public Health: Analysis Of The French Case (2005–2012)**

LE BODO Y., ETILÉ F., GAGNON F., *et al.*
2019

Food Policy 88: 101765.
<https://doi.org/10.1016/j.foodpol.2019.101765>

Although over 40 jurisdictions have adopted a tax on sugar-sweetened beverages (SSBs) for public health worldwide, it is still debated in many places. Policy processes can influence the prospect of an SSB tax, its design and its public health benefits. To get an insight

into such processes, we undertook a case study of the soda tax enacted in France on the 1st of January 2012. Newspaper articles (2003–2013) and institutional documents (2007–2012) were identified using keywords and search engines. Qualitative data extraction and analyses were performed on a thematic and chronological basis, with guidance from Kingdon's multiple streams theory (MST). Triangulation was enhanced by using complementary sources. This study shows that in August 2011, the French government surprisingly announced a €3.58 cent/L excise tax on SSBs, excluding juices with no added sugars and non-calorically sweetened beverages (NCSBs). As part of a large budgetary plan, the proposal aimed to reduce SSB consumption and raise revenue that was earmarked for health care. Several conditions contributed to opening a policy window: The announcement occurred in the context of severe budgetary deficits; soda tax scenarios had already been discussed at a high level; and the bill was supported by convinced political leaders. Subsequently, the tax successfully passed through the legislative process due to a series of unexpected events, but its public health rationale and design were weakened. The first event was the disorganised reaction by the food industry, despite their sharp opposition to the tax. The next event was the support of the soda tax that came from a majority of Deputies, provided that the revenues would serve another purpose: relieving wage costs in the farming sector. Finally, policy entrepreneurs favoured a compromise to make the tax politically acceptable and legally viable: The tax rate doubled, the scope was extended to NCSBs and revenues were split between health care and agriculture. This study sheds light on influence factors that could be taken into account by public health actors willing to influence soda tax policy processes.

► **Social Preferences For Prioritising The Treatment Of Disabled And Chronically Ill Patients: Beyond The Order Effect**

MCKIE J. ET RICHARDSON J.
2018

[Health Economics, Policy and Law 14\(4\): 443-467.](https://www.ncbi.nlm.nih.gov/pubmed/29734969)
<https://www.ncbi.nlm.nih.gov/pubmed/29734969>

Previous evidence suggests that members of the public value life saving services differently when they are for patients with a pre-existing permanent disability and when they are for patients who become disabled

at the onset of treatment – for example, as a result of treatment that is not entirely effective. However, the valuation of services in these two cases has also been found to differ with the order in which they are presented in a population survey. This casts doubt upon the validity of the results and leaves unresolved the nature of the public's true preferences. The study reported here had three main objectives: (i) to determine the considered, underlying preferences of a sample of the Australian public with respect to the treatment of the permanently disabled and chronically ill, (ii) to gain insight into the reasons for respondent's distributive preferences and (iii) to eliminate or significantly reduce the order effect. Eight semi-structured, small-group discussions were held with 66 members of the public in Victoria, Australia. Order effects were effectively eliminated. The study found substantial support among participants for the equal treatment of the permanently disabled and chronically ill regardless of when the problem commenced.

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

MÖLLENKAMP M., ZEPPERNICK M. ET SCHREYÖGG J.
2019

[Health Policy 123 \(12\) : 1199-1209](https://doi.org/10.1016/j.healthpol.2019.09.008)
<https://doi.org/10.1016/j.healthpol.2019.09.008>

In this systematic literature review, we identify evidence on the effectiveness of nudges in improving the self-management of adults with chronic diseases and derive policy recommendations. We included empirical studies of any design published up to April 12th, 2018. We synthesized the results of the studies narratively by comparing statistical significance and direction of different nudge types' effects on primary study outcomes. Lastly, we categorized the nudges according to their degree of manipulation and transparency. We identified 26 studies, where 13 were of high or moderate quality. The most commonly tested nudges were reminders, planning prompts, small financial incentives, and feedback. Overall, 8 of 9 studies with a high or moderate quality ranking, focused on self-management outcomes, i.e., physical activity, attendance, self-monitoring, and medication adherence, found that nudges had significant positive effects. However, only 1 of 4 studies of high or moderate quality, analyzing disease control outcomes (e.g., glycemic control),

found that nudges had a significant positive effect for one intervention arm. In summary, this review demonstrates that nudges can improve chronic disease self-management, but there is hardly any evidence to date that these interventions lead to improved disease

control. Reminders, feedback, and planning prompts appear to improve chronic disease self-management most consistently and are among the least controversial types of nudges. Accordingly, they can generally be recommended to policymakers.

Politique publique

Public Policy

► **Les étapes du financement de la recherche académique : de la soumission en partenariat jusqu'à l'attribution et aux publications**

BANAL-ESTAÑOL A., MACHO-STADLER I. ET PÉREZ-CASTRILLO D.

2019

Revue économique 70(5): 625-653.

<https://www.cairn.info/revue-economique-2019-5-page-625.htm>

Les agences de financement de la recherche allouent des ressources (rares) selon un processus bottom-up concurrentiel. Cet article analyse les déterminants et les conséquences des choix réalisés à chaque étape du processus de financement. En mobilisant des recherches passées (Banal-Estañol, Macho-Stadler et Pérez-Castrillo [2013], [2018] et [2019]), nous présentons de nouveaux résultats en utilisant une base de données provenant de l'une des plus grandes agences de financement dans le monde, l'Agence anglaise de recherche en sciences physiques et de l'ingénieur (EPSRC).

► **L'évaluation des politiques de santé publique**

BRUNNER N., LUCIOLI E., NETTER P., *et al.*

2019

Bulletin de l'Académie Nationale de Médecine 203(6): 449-456.

La Cour des comptes est compétente depuis la réforme constitutionnelle de 2008 pour effectuer des évaluations de politiques publiques. L'évaluation, qui est une mission distincte du contrôle, vise à apprécier l'impact d'une politique et à émettre un jugement sur la valeur

de cette politique, au regard de ses effets constatés par rapport aux objectifs que les pouvoirs publics lui ont assignés. En matière de santé, ses évaluations récentes, qui ont porté sur les politiques concernant le tabac, les consommations nocives d'alcool, l'autisme ou la vaccination, reposent sur une procédure et une méthodologie spécifiques, fondée notamment sur l'association des parties prenantes à la démarche évaluative. Les mesures qui ont été prises par les pouvoirs publics pour faire suite aux recommandations de la Cour font apparaître des résultats contrastés de ces évaluations d'une politique à l'autre.

Prevention**► L'enfant, l'adolescent, la famille et les écrans : appel à une vigilance raisonnée sur les technologies numériques**ADES J., AGID Y., BACH J. F., *et al.*

2019

Bulletin de l'Académie Nationale de Médecine 203(6): 381-393.

Depuis moins de trois décennies, une nouvelle science s'est développée, la science informatique. Une transformation profonde des sociétés et des rapports humains en résulte, désignée de façon globale comme la révolution numérique et qui peut prendre de multiples formes, concernant tous les âges de la vie. Longtemps, les écrans de cinéma puis de télévision ont été l'interface principale entre les sens du spectateur et la signification des images proposées à son regard. Aujourd'hui, les écrans du smartphone, de la tablette, de l'ordinateur, de la console de jeux, du casque de réalité virtuelle constituent l'interface principale avec l'immensité des contenus qu'ils mettent à disposition et qui se jouent derrière eux : réseaux sociaux, jeux, « applis » informatiques, photos et films, simulations, Internet. Le propos du présent Appel ne saurait être d'évoquer la totalité de ce qu'il est convenu d'appeler « le monde numérique », de ses enjeux, de ses vertus et de ses ombres : les écrans n'en sont que le point d'entrée, visible et omniprésent. C'est à ce titre que les trois Académies se saisissent de cette question, en portant une attention particulière à l'enfance et l'adolescence, dans la continuité de l'Avis émis par l'une d'entre elles en 2013. Cet article dresse un bilan de leur réflexion sur l'impact des écrans sur les enfants et les adolescents et appelle à une vigilance sur l'utilisation des nouveaux outils du numériques (téléphonie...) à l'instar du cinéma, de la radio et de la télévision.

► The Effect Of The United Kingdom Smoking Ban On Alcohol Spending: Evidence From The Living Costs And Food Survey

PRYCE R.

2019

Health Policy 123 (10) : 936-940.<https://doi.org/10.1016/j.healthpol.2019.08.001>

The effect of smoking bans on alcohol consumption is unclear, and this is especially true of the differing effect on smokers and non-smokers. This paper uses spending survey data to examine the effect of the United Kingdom smoking bans on alcohol spending. It finds the introduction of a smoking ban decreased alcohol expenditure, specifically in the on-trade (pubs and restaurants) and amongst smoking households. Smoking households are estimated to have reduced their weekly on-premise alcohol expenditure by £1.70 (approximately 15–20%), whilst non-smoking households do not significantly change their expenditure. The smoking ban may therefore have affected on-premise outlets through a reduction in revenue. This study provides further evidence that tobacco policies affect drinking behaviour.

Prevision - Evaluation**► Effect Of Financial Incentives On Breast, Cervical And Colorectal Cancer Screening Delivery Rates: Results From A Systematic Literature Review**MAURO M., ROTUNDO G. ET GIANCOTTI M.
2019**Health Policy 123 (12) : 1210-1220.**<https://doi.org/10.1016/j.healthpol.2019.09.012>

Preventive care, such as screening, is important for reducing the risk of cancer, a leading cause of death worldwide. Indeed, some type of cancers are detected through screening programs, which in most countries run for colorectal, breast, and cervical cancers. In this context, general practitioners play a key role in increasing the participation rate in cancer screening programs. To improve cancer screening delivery rates, performance incentives have increasingly been implemented in primary care by healthcare payers and organizations in different countries. The effects of these tools are still not clear. We conducted a systematic literature review in order to answer the following research question: What is the evidence in the literature for the effects of financial incentives on the delivery rates of breast, cervical and colorectal cancer screening in general practice? We performed a literature search in Web of Science, PubMed, Cochrane Library and Google Scholar, according to the PRISMA guidelines. 18 studies were selected, classified and discussed according to the health preventive services investigated. Most of studies showed partial or no effects of financial incentives on breast and cervical cancer screening delivery rates. Few positive or partial effects were found regarding colorectal cancer screening. Ongoing monitoring of incentive programs is critical to determining the effectiveness of financial incentives and their effects on the improvement of cancer screening delivery rates.

► How To Value Safety In Economic Evaluations In Health Care? A Review Of Applications In Different SectorsPERRY-DUXBURY M., VAN EXEL J. ET BROUWER W.
2019**The European Journal of Health Economics 20(7): 1041-1061.**<https://doi.org/10.1007/s10198-019-01076-9>

Improving (feelings of) safety is an important goal of many health systems, especially in the context of recurrent threats of pandemics, and natural disasters. Measures to improve safety should be cost-effective, raising the issue of how to value safety. This is a complex task due to the intangible nature of safety. We aim to synthesize the current empirical literature on the evaluation of safety to gain insights into current methodological practices. After a thorough literature search in two databases for papers from the fields of life sciences, social sciences, physical sciences and health sciences that empirically measure the value of increasing safety, 33 papers were found and summarized. The focus of the research was to investigate the methodologies used. Attention was also paid to theoretical papers and the methodological issues they present, and the relationship between safety and three categories of covariate results: individual characteristics, individual relationship with risk, and study design. The field of research in which the most papers were found was environmental economics, followed by transportation and health. There appeared to be two main methods for valuating safety: Contingent Valuation and Discrete Choice Experiments, within which there were also differences—for example the use of open or dichotomous choice questions. Overall this paper finds that there still appears to be a long way ahead before consensus can be attained about a standardised methodology for valuating safety. Safety valuation research would benefit from learning from previous experience and the development of more standardised methods.

Psychiatry

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

ANTUNES A., FRASQUILHO D., ZÓZIMO J. R., *et al.*
2019

Health Policy 123 (12) : 1267-1274

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

This qualitative study explores solutions proposed by primary health care users and professionals to address the consequences of the economic recession and austerity measures on populations' mental health and delivery of care in Portugal. Qualitative data were collected in three primary health care centres in the Lisbon Metropolitan Area. Five focus groups with 26 users and semistructured interviews with 27 health professionals were conducted. Interviews were audio-recorded, transcribed verbatim and underwent thematic analysis. Solutions proposed by users focused on improvements in accessibility and management of services, socioeconomic and living conditions, human resources for health, and investment in mental health. Health professionals focused on improvements in integration and articulation of services, infrastructure and structural barriers to primary care, recruitment and retention of human resources, and socioeconomic and living conditions. The themes from both groups were integrated and organized into three axes for action: 1) increasing investment and reversing austerity measures in health and social sectors; 2) coordination and integration of mental health care; and 3) tackling the social determinants of mental health. The findings provide an assessment of the needs and priorities set by primary health care users and professionals, reflecting their context specific experiences. These complementary perspectives highlight the need for inter-sectoral efforts in policy-making to improve delivery of care and to mitigate social inequalities in health across the Portuguese population.

► **Les suivis sociosanitaires des personnes présentant un trouble mental sévère et persistant : expérimentation PASSVers à Versailles**

BAZIN N.

2019

L'information psychiatrique 95(7): 509-513.

<https://www.cairn.info/revue-l-information-psychiatrique-2019-7-page-509.htm>

En s'appuyant sur le rapport publié par le Centre de preuves de psychiatrie et santé mentale, nous avons mis en place un dispositif de suivi socio-sanitaire sur notre secteur de psychiatrie. Ce dispositif a été implémenté au sein du CMP, en accueillant trois travailleurs sociaux qui restent rattachés à leur institution d'origine, sociale ou médico-sociale. L'impact de ce dispositif est important à la fois pour les patients, pour les soignants et pour les travailleurs sociaux, favorisant le processus de rétablissement et la déstigmatisation à travers un décloisonnement des institutions et un croisement de regards. Il peut facilement être implémenté dans les secteurs en France, vers une amélioration du parcours de vie des patients souffrant de troubles psychiatriques sévères.

► **Cost-Utility Of Screening For Depression Among Asylum Seekers: A Modelling Study In Germany**

BIDDLE L., MINERS A. ET BOZORGMEHR K.

2019

Health Policy 123(9): 873-881.

<https://doi.org/10.1016/j.healthpol.2019.05.011>

Asylum seekers have a high burden of mental illness owing to traumatic experiences before, during and after flight. Screening has been suggested to identify asylum seekers with psychosocial needs. However, little is known about the costs of screening relative to expected gains. We assessed the cost-utility of population-based screening for depression in German asylum reception centres compared to case-finding by self-referral. Methods Explorative modelling study using a decision tree over 15 months to estimate the incremental cost per quality-adjusted life-year gained. Data points were taken from the published literature.

Deterministic and probabilistic sensitivity analyses were used to address uncertainty around parameter estimates. Value of information analyses were performed to indicate the value of future research. Results The model demonstrates a high probability ($p = 83\%$) of the screening intervention being cost-effective at a € 50,000/QALY threshold. Cost-utility depends on the process of care following screening: when acceptability and adherence parameters were decreased by 40%, the resulting ICER increased by 27–131%. Eliminating uncertainty was most valuable for the screening process and cost parameters, at € 3.0 and € 4.4 million respectively. Conclusions Screening asylum seekers for depression may be a cost-effective strategy to identify those in need of care. However, there is considerable value in conducting further research in this area, especially regarding resource requirements and the process of care following screening.

► **Network Analyses: Are We Moving Toward A New Conceptualization And Treatment Of Mental Disorder?**

BORTOLON C. ET RAFFARD S.

2019

L'Encéphale 45(5): 433-440.

In a break with categorical and dimensional approaches and thus the classical medical model, the network approach applied to psychopathology constitutes a holistic approach to mental disorders. In this approach, mental disorders are conceived as an interconnected system of symptoms in which symptoms are the cause of each other. It is suggested that the interaction between the different symptoms would result in a feedback loop that leads to the installation and maintenance of these symptoms/disorders. In addition, this approach proposes that co-morbidities are the result of symptom-symptom interactions that cross the diagnostic boundary and interact with symptoms from other psychiatric disorders. A growing number of studies have applied the network approach to elucidate causal interactions within the symptoms of depression, post-traumatic stress disorder, schizophrenia, or anxiety disorders. The overall objective of this review is to raise awareness among researchers and clinicians in psychiatry and clinical psychology of the network approach applied to psychopathology. To do this, we present the main concepts and principles of the network approach and its application in post-traumatic stress disorder. We also discuss recent criticisms of this approach and its clinical applications.

► **Médico-social en santé mentale : histoire et réalités institutionnelles**

BROUTIN S.

2019

L'information psychiatrique 95(7): 496-502.

<https://www.cairn.info/revue-l-information-psychiatrique-2019-7-page-496.htm>

Notre propos aujourd'hui est l'histoire du secteur médico-social en santé mentale et ses réalités institutionnelles, du point de vue non pas d'une historienne mais de celui de la directrice générale de l'Œuvre Falret, association créée en 1841, au moment de l'institutionnalisation de la psychiatrie (1838). Cette histoire commune du secteur médico-social ayant œuvré pour les personnes vivant avec des troubles psychiques et la psychiatrie – tantôt liée, tantôt séparée – nous invite à en évoquer, de notre place, les enjeux passés et actuels. Pour retracer cette histoire commune, nous ferons en premier lieu un rappel sur l'évolution du secteur médico-social et de la psychiatrie, en passant par l'inscription du trouble psychique dans le champ du handicap en 2005, puis nous nous arrêterons sur les quinze dernières années qui ont vu l'offre médico-sociale dans le champ de la santé mentale largement se déployer.

► **Chronique de la psychiatrie à l'ère hypermoderne**

CLOËS C.

2019

Le Journal des psychologues 370(8): 72-78.

<https://www.cairn.info/revue-le-journal-des-psychologues-2019-8-page-72.htm>

La psychiatrie actuelle connaît de profondes mutations. L'auteure propose ici d'explorer les effets de l'hypermodernité au sein des établissements de santé mentale. L'accélération du temps social impose un nouveau rythme dans les prises en charge, avec comme credo le traitement le plus rapide possible des troubles psychiques. Comment ce nouveau modèle s'articule-t-il avec la chronicité réputée de la psychose et avec les pratiques soignantes ? À quoi ressemble la figure contemporaine du « fou » devenu « usager » en santé mentale ?

► **A Review Of Mental Health And Mental Health Care Disparities Research: 2011-2014**

COOK B. L., HOU S. S., LEE-TAULER S. Y., *et al.*
2018

Med Care Res Rev 76 (6) : 683-710
<https://doi.org/10.1177/1077558718780592>

Racial/ethnic minorities in the United States are more likely than Whites to have severe and persistent mental disorders and less likely to access mental health care. This comprehensive review evaluates studies of mental health and mental health care disparities funded by the National Institute of Mental Health (NIMH) to provide a benchmark for the 2015 NIMH revised strategic plan. A total of 615 articles were categorized into five pathways underlying mental health care and three pathways underlying mental health disparities. Identified studies demonstrate that socioeconomic mechanisms and demographic moderators of disparities in mental health status and treatment are well described, as are treatment options that support diverse patient needs. In contrast, there is a need for studies that focus on community- and policy-level predictors of mental health care disparities, link discrimination- and trauma-induced neurobiological pathways to disparities in mental illness, assess the cost effectiveness of disparities reduction programs, and scale up culturally adapted interventions.

► **Le dispositif d'appartement de coordination thérapeutique « Un chez-soi d'abord »**

ESTECAHANDY P.
2019

L'information psychiatrique 95(7): 514-519.
<https://www.cairn.info/revue-l-information-psychiatrique-2019-7-page-514.htm>

L'expérimentation « Un chez-soi d'abord » conduite par l'État sur 4 villes entre 2011 et 2016 répond à la question des personnes sans-abri souffrant de troubles psychiatriques sévères et qui le plus souvent échappent aux prises en charge habituelles. Inspiré du modèle « housing first » largement diffusé outre-Atlantique depuis les années 1990, le programme français a montré son efficacité et il est maintenant pérennisé sous la forme d'un établissement médico-social inscrit dans le Code de l'action sociale et des familles (CASF)

sous la dénomination de dispositif d'appartement de coordination thérapeutique « Un chez-soi d'abord ».

► **La santé mentale des enfants placés. Une revue de la littérature**

EVEN M. ET SUTTER-DALLAY A. L.
2019

L'Encéphale 45(4): 340-344.
<https://doi.org/10.1016/j.encep.2019.03.006>

En France, plus de 140 000 enfants sont placés hors du domicile parental sous la responsabilité de l'Aide Sociale à l'Enfance. Ces enfants ont souvent un parcours de vie chaotique, marqué par des environnements peu propices à leur bon développement, et des séparations, qui ne peut pas être sans conséquence sur leur développement psychique. Une revue de la littérature a été effectuée pour identifier le profil de ces enfants, les facteurs de risque de troubles mentaux et les pathologies psychiatriques qu'ils présentent. Le pourcentage d'enfants placés, les types et les motifs de placement varient selon les territoires. Plus de la moitié de ces enfants ont vécu des maltraitances avant le placement, ce qui semble être un facteur de risque. Par rapport aux enfants de même classe d'âge, ils présentent plus de troubles internalisés et externalisés, plus d'addictions, plus de comportements suicidaires, mais les prévalences dépendent du lieu d'accueil. L'accès aux soins reste par ailleurs difficile pour ces enfants. Des facteurs de protection ont cependant été identifiés, comme l'âge précoce du placement ou sa stabilité. Des études de cohorte françaises réalisées avec des outils validés sont cependant nécessaires pour préciser et confirmer les résultats, et amener à la mise en place des recommandations nationales pour le dépistage des troubles mentaux et l'organisation des soins, ainsi que la validation de protocoles de soins spécifiques aux enfants placés.

► **Penser l'avenir de la pédopsychiatrie dans le monde : bilan de 4 années de présidence de l'International Association of Child and Adolescent Psychiatry and the Allied Professions (IACAPAP)**

FALISSARD B.
2019

Bulletin de l'Académie Nationale de Médecine 203(6): 457-461.

<https://doi.org/10.1016/j.banm.2019.02.013>

Alors que les questions de santé mentale interpellent toutes les sociétés, la psychiatrie a toujours autant de mal à trouver sa place dans le système de soin, en particulier chez les enfants et les adolescents. Cette situation paradoxale vient d'un flou sémantique plus ou moins entretenu autour de trois concepts fondamentalement différents : la santé mentale, qui s'intéresse au bien-être; le handicap, qui vise à mieux intégrer des sujets différents dans la société; la psychiatrie, qui soigne des humains en rupture et en souffrance du fait de leur fonctionnement psychique. À l'évidence ces trois domaines doivent apprendre à travailler ensemble. Mais comme les trois brins d'une tresse, ils doivent d'abord être considérés séparément avant de les entrelacer. Le tout ne sera que plus solide.

► **Du TAPS Project au virage ambulatoire. Comment retrouver le chemin de la désinstitutionnalisation ?**

FONSEGRIVE G. ET PLANTEVIN M.
2019

L'information psychiatrique 95(7): 503-508.

<https://www.cairn.info/revue-l-information-psychiatrique-2019-7-page-503.htm>

En France, les pouvoirs publics appellent de leurs vœux un « virage ambulatoire ». Pensé comme une politique de santé non spécifique à la psychiatrie, quels en sont les enjeux pour cette discipline dont l'organisation est déjà largement territorialisée et ambulatoire au regard des autres champs de la santé en France ? À l'appui de cette expérience française, les auteurs s'interrogent sur ce que recouvre le terme de « désinstitutionnalisation », partout employé mais finalement incarné par des réalités très hétérogènes. L'absence de modélisation constatée apparaît comme un frein et conduit à affirmer l'impératif de critères, communs pour garantir les progrès de la désinstitutionnalisation.

► **Experimenting Locally With A Stepped-Care Approach For The Treatment Of Mild To Moderate Mental Disorders In France: Challenges And Opportunities**

GANDRÉ C., ROSENBERG S., COLDEFY M., *et al.*
2019

Health Policy 123(11): 1021-1027.

<https://doi.org/10.1016/j.healthpol.2019.08.006>

In France, publicly funded mental care services are mostly hospital-based and focused on treating severe illnesses. Mild to moderate mental disorders are typically managed by general practitioners (GP) who often lack specific training to treat these conditions. Antidepressant prescribing levels for mild to moderate conditions are inadequately high. Public reimbursement for psychotherapies provided by psychologists is generally not available. This paper presents a local experiment with a stepped-care approach for the treatment of mild to moderate mental disorders in four French départements launched in 2018. The experiment includes the introduction of a standardized assessment protocol for GPs, clear referral guidelines, and full reimbursement of visits to psychologists upon GP referral. Seemingly simple, the policy raises several issues related to the regulation, training and reimbursement of psychologists, and illustrates the need for careful preparation and workforce planning to ensure success and stakeholder support. An independent evaluation of the local experiments is planned, which provides the opportunity to fine-tune the policy before any broader rollout. The issues raised in France and the on-going debate is relevant for other countries preparing similar policies for improving mental care.

► **Using National Electronic Health Care Registries For Comparing The Risk Of Psychiatric Re-Hospitalisation In Six European Countries: Opportunities And Limitations**

KATSCHNIG H., STRASSMAYR C., ENDEL F., *et al.*
2019

Health Policy 123(11): 1028-1035.

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

Psychiatric re-hospitalisation rates have been of longstanding interest as health care quality metric for planners and policy makers, but are criticized for not being comparable across hospitals and countries due to measurement unclarity. The objectives of the

present study were to explore the interoperability of national electronic routine health care registries of six European countries (Austria, Finland, Italy, Norway, Romania, Slovenia) and, by using variables found to be comparable, to calculate and compare re-hospitalisation rates and the associated risk factors. A “Methods Toolkit” was developed for exploring the interoperability of registry data and protocol led pilot studies were carried out. Problems encountered in this process are described. Using restricted but comparable data sets, up to twofold differences in psychiatric re-hospitalisation rates were found between countries for both a 30- and 365-day follow-up period. Cumulative incidence curves revealed noteworthy additional differences. Health system characteristics are discussed as potential causes for the differences. Multi-level logistic regression analyses showed that younger age and a diagnosis of schizophrenia/mania/bipolar disorder consistently increased the probability of psychiatric re-hospitalisation across countries. It is concluded that the advantage of having large unselected study populations of national electronic health care registries needs to be balanced against the considerable efforts to examine the interoperability of databases in cross-country comparisons.

► L’accompagnement, c’est du soin

LEGUAY D.

2019

L’information psychiatrique 95(7): 471-472.

<https://www.cairn.info/revue-l-information-psychiatrique-2019-7-page-471.htm>

Les contributions qui vont suivre dans ce numéro de l’Information Psychiatrique rendent compte des présentations faites lors de la « Journée de l’accompagnement », qui s’est tenue en fin d’année 2018 à Nantes, dans le cadre du Congrès français de psychiatrie. L’idée d’organiser cette journée de l’accompagnement est venue du constat qu’ont été mises en œuvre, spécialement depuis la désinstitutionnalisation des années 80, et en fonction à la fois de la réglementation et des ressources localement existantes, toute une série d’actions d’accompagnement des personnes présentant des troubles psychiques sévères et persistants. Ces actions étaient le fait soit des acteurs du champ sanitaire, avec le secteur psychiatrique, soit de ceux du champ médico-social, avec les établissements et dispositifs relevant du code de l’action sociale. Et cela sans que ces deux champs ne se parlent trop. Cet accom-

pagnement, implicitement, prenait acte de l’existence tangible du handicap, avec un message apparemment contradictoire : il y a un handicap à constater : c’est le handicap psychique qu’il faut compenser ; mais il y a aussi une pathologie, évolutive, qui requiert un suivi, des soins, lesquels sont susceptibles de diminuer le handicap et ne doivent donc pas être interrompus.

► Asylum Seekers’ Mental Health And Treatment Utilization In A Three Months Follow-Up Study After Transfer From A State Registration-And Reception-Center In Germany

NIKENDEI C., KINDERMANN D., BRANDENBURG-CEYNOWA H., *et al.*

2019

Health Policy 123(9): 864-872.

<https://doi.org/10.1016/j.healthpol.2019.07.008>

Even though asylum seekers show a high prevalence of trauma-related disorders and comorbid psychological stress symptoms, little is known about how their mental health develops during the asylum process and what options of care are provided. We aimed to investigate the mental health and treatment utilization of asylum seekers after they were transferred from a state registration- and reception-center to municipal shelters in Germany. N = 228 asylum seekers with on-going asylum procedure were recruited in the psychosocial walk-in clinic located in a state registration- and reception-center. We firstly captured symptoms of posttraumatic stress, depression, anxiety disorders, quality of life, as well as alcohol or drug abuse. Subsequently we performed a follow-up after three months to evaluate a potential shift in symptoms and determining rates of access to treatment. In the pre-post psychometric assessment, there were statistically significant changes in depression (PHQ-2), panic (PHQ-PD) and psychosocial well-being scores (WHO-5). However, all these scores still remained within a clinical relevant range, respectively. Traumatic stress (PC-PTSD-5) and general anxiety scores (GAD-2) did not change significantly. Although N = 44 (66%) of the interviewed patients had been referred to psychotherapy initially, none (0%) of them had received outpatient psychotherapeutic treatment after three months. Our results emphasize a strong need for low-threshold, cultural adapted psychotherapeutic treatment for asylum seekers.

► **Articulation et synergie des soins et de l'accompagnement : les données probantes dans les troubles mentaux sévères et persistants**

PASSERIEUX C.

2019

L'information psychiatrique 95(7): 489-495.

<https://www.cairn.info/revue-l-information-psychiatrique-2019-7-page-489.htm>

Alors que le constat de l'importance d'associer soins et accompagnements dès le début d'un trouble psychiatrique sévère est largement partagé, la mise en place des coopérations entre les acteurs sanitaires, sociaux et médico-sociaux reste complexe en France. Cet article propose de recenser les éléments de preuve allant dans le sens de la nécessité de cette coopération pour améliorer le devenir des personnes concernées. Sont envisagés les limites des soins lorsqu'ils sont proposés isolément et différents domaines où la synergie des soins et des accompagnements apparaît convaincante. Enfin, la question cruciale de la place de la personne dans ces modalités coopératives est abordée au travers de la pratique de la décision partagée.

► **Liens entre troubles psychiques et recours aux dispositifs du champ du handicap en France**

QUIDU F. ET ROUSSEL P.

2019

Santé Publique 31(3): 417-426.

<https://www.cairn.info/revue-sante-publique-2019-3-page-417.htm>

Les prestations et modalités d'accompagnement des personnes (dans les domaines du travail, de la vie quotidienne et sociale et du logement) sont nombreuses et diversifiées dans le champ du handicap. Les personnes atteintes de troubles psychiques graves sont souvent considérées comme bénéficiant moins que d'autres des diverses formes de compensation mise en place dans le cadre de la solidarité nationale. L'objectif de cette étude était d'étudier, pour ces personnes, les recours aux différentes formes de compensation et d'identifier les caractéristiques de celles qui y recourent le plus. En procédant à une classification hiérarchique ascendante à partir des données de l'enquête Handicap-Santé représentative de la population nationale en 2008-2009, et en étudiant les caractéristiques de ces groupes au regard des prestations propo-

sées dans le champ du handicap, nous avons souhaité éclairer les motifs de recours. Résultats : L'utilisation des prestations et accompagnements divers est la plus marquée dans les deux groupes dont les déficiences psychiques s'accompagnent d'autres déficiences et dont les activités sont les plus limitées. Un troisième groupe, dont le recours au champ du handicap est moindre sans être négligeable se singularise par un entrelacs de difficultés sociales et médicales variées, sans que l'on puisse être assuré de l'antériorité des unes sur les autres. Cette enquête déclarative comporte des données inévitablement approximatives en matière de diagnostics et déficiences, mais la diversité des informations apportées est unique et elle permet de mettre en lumière l'intrication des troubles physiques et psychiques présente chez de très nombreux bénéficiaires des prestations du champ du handicap.

► **Un partenariat patients schizophrènes-soignants pour conduire un programme d'éducation en santé orale**

RAT C., PETEUIL A., REYNAUD M., *et al.*

2019

Santé Publique 31(3): 405-415.

<https://www.cairn.info/revue-sante-publique-2019-3-page-405.htm>

La mauvaise santé orale des patients schizophrènes est un problème de santé publique qui concernerait 600 000 personnes en France. Le but de cet article est de présenter les différentes étapes de la construction d'un programme d'éducation en santé orale, spécifique aux patients schizophrènes et tenant compte de leur savoir expérientiel, ainsi que les résultats de l'étude pilote ce programme. La méthode des groupes de discussion (focus groups) a été appliquée à un groupe de professionnels de santé et d'usagers afin de faire émerger un corpus exploratoire pour la construction d'un programme d'éducation en santé orale. Un groupe expert composé pour partie de patients schizophrènes a validé les thématiques et les outils de ce programme. Une étude pilote de faisabilité a ensuite été réalisée auprès d'un groupe témoin composé de sept patients schizophrènes. Au total, 26 personnes ont participé à cette étude. Les thématiques principales retenues par le groupe expert visent à favoriser l'action consistant à prendre soin de sa santé, à améliorer la pénétrabilité du système de soins et à promouvoir une approche sanitaire globale. L'étude a montré la capacité des acteurs à coconstruire un programme et à faire évoluer

les représentations que les patients schizophrènes ont de ce problème de santé. La plupart des outils éducatifs ont été jugés pertinents. Conclusion : Un programme d'éducation en santé orale a été construit dans le cadre d'un partenariat patients-soignants et a montré sa faisabilité. Une étude randomisée multicentrique est en cours pour évaluer l'efficacité de ce programme avec un haut niveau de preuve.

► **La santé psychique des internes en psychiatrie de France et leurs consommations de substances psychoactives. Étude épidémiologique transversale descriptive**

ROBIN C.
2019

L'information psychiatrique 95(7): 559-568.

<https://www.cairn.info/revue-l-information-psychiatrique-2019-7-page-559.htm>

La santé psychique des internes est alarmante. En psychiatrie, les internes semblent consommer plus de psychotropes que leurs confrères des autres spécialités. Notre étude, menée au printemps 2018, a pour objectif d'évaluer la souffrance psychique de ces futurs médecins et de décrire leurs usages de psychotropes, à travers un questionnaire auquel 200 d'entre eux ont répondu. Les résultats montrent de fortes prévalences de symptômes en lien avec une souffrance psychique, ainsi que des consommations régulières de substances psychotropes, licites ou illicites. Plus d'un interne sur 5 répond aux critères de l'anxiété et plus d'un sur trois souffre d'au moins une dimension du burn out. Près d'un interne sur trois a eu des idées suicidaires pendant les études médicales, et plus du quart des répondants ont envisagé de stopper leur formation. Les résultats suggèrent l'existence de motivations « utiles » en réponse à des facteurs de stress spécifiques à la psychiatrie, spécialité particulière parmi les disciplines médicales. Il est urgent d'évoquer les solutions existantes dans une optique de soins et de formation.

► **Mental Health Care Utilisation And Access Among Refugees And Asylum Seekers In Europe: A Systematic Review**

SATINSKY E., FUHR D. C., WOODWARD A., *et al.*
2019

Health Policy 123(9): 851-863.

<https://doi.org/10.1016/j.healthpol.2019.02.007>

Refugees and asylum seekers often have increased mental health needs, yet may face barriers in accessing mental health and psychosocial support (MHPSS) services in destination countries. The aim of this systematic review is to examine evidence on MHPSS service utilisation and access among refugees and asylum seekers in European Union Single Market countries. Methods Four peer-reviewed and eight grey literature databases were searched for quantitative and qualitative literature from 2007 to 2017. Access was categorised according to Penchansky and Thomas' framework and descriptive analyses were conducted. Quality of studies was assessed by the Newcastle-Ottawa scale and the Critical Appraisal Skills Programme checklist. Twenty-seven articles were included. The findings suggest inadequate MHPSS utilisation. Major barriers to accessing care included language, help-seeking behaviours, lack of awareness, stigma, and negative attitudes towards and by providers. Refugees and asylum seekers have high mental health needs but under-utilise services in European host countries. This underutilisation may be explained by cultural-specific barriers which need to be tackled to increase treatment demand. Training health providers on cultural models of mental illness may facilitate appropriate identification, referral, and care. Based on these findings, it is crucial to review policies regarding MHPSS provision across the EU.

Primary Health Care**► General Practitioners Training About Suicide Prevention And Risk: A Systematic Review Of Literature**AUDOUARD-MARZIN Y., KOPP-BIGAULT C., SCOUARNEC P., *et al.*

2019

La Presse Médicale 48(7, Part 1): 767-779.<https://doi.org/10.1016/j.lpm.2019.05.028>

Il est constaté qu'en France, trop peu de médecins généralistes (MG) se forment à la prévention du risque suicidaire. Ce travail consiste en une revue de littérature de publications internationales traitant de la formation des MG à la prévention du risque suicidaire. L'objectif est de s'informer sur les différentes pratiques de formation de par le monde afin de découvrir de nouvelles méthodes pédagogiques qui pourraient être pertinentes sur notre territoire et susciter davantage l'intérêt des MG. Méthode : Une recherche bibliographique méticuleuse a été menée, sélectionnant toutes les études relatives à la formation des MG à la prévention du risque suicidaire dans le monde, suivant la méthode PRISMA. Les études retenues s'appliquent à des MG libéraux en exercice ayant une patientèle hétérogène, et excluent les travaux relatifs à des groupes homogènes de patients. La durée de formation, le programme éducatif, son contenu, l'évaluation de la formation, les outils pédagogiques utilisés, les méthodes de formation de formateurs mises en œuvre ainsi que le niveau d'évaluation selon Kirkpatrick des formations ont été précisés pour chaque étude sélectionnée. Résultats : Ces travaux révèlent qu'il n'existe aucun consensus dans la réalisation de ces formations, que ce soit au niveau du programme ou de son évaluation. Néanmoins, une similarité de contenu est retrouvée avec une partie théorique cognitive et des ateliers interactifs. Conclusion : Il semble difficilement réalisable de proposer une standardisation de ces formations de par le monde, celles-ci étant nécessairement adaptées au territoire et sa culture. Néanmoins, une standardisation des outils d'évaluation serait pertinente : cela permettrait une réelle comparaison de l'efficacité de ces formations. Par ailleurs, sur le plan pratique, cette revue nous a incité à proposer des formations in situ en réalisant une étude expérimentale comparative de deux formats pédagogiques, et à réaliser une traduction française d'une échelle d'évaluation des

compétences cliniques en suicidologie, premier outil d'évaluation dans ce domaine en France.

► Specialist Palliative Care Services For Older People In Primary Care: A Systematic Review Using Narrative SynthesisDE NOOIJER K., PENDERS Y. W., PIVODIC L., *et al.*

2019

Palliat Med: [Ahead of print]<https://doi.org/10.1177/0269216319874978>

There is recognition that older people with incurable conditions should have access to specialist palliative care services. However, it remains unclear which activities and outcomes these services entail for older people in primary care and to which patients they are provided. The aim of this review was to identify the criteria for referral to specialist services; who provides specialist palliative care; through which activities and with which frequency; which outcomes are reported; and which suggestions are made to improve services. Systematic review of the literature and narrative synthesis. Quality appraisal and selection of studies were performed independently by two researchers. Participant characteristics, intervention features, outcome data and suggestions for improvement were retrieved. Embase, Medline, Web of Science, Cochrane, Google Scholar, PsycINFO and CINAHL EBSCO databases (until June 2019). Ten eligible articles, three qualitative, three quantitative, three mixed-method and one narrative review, were identified. Referral criteria were mainly based on patient characteristics such as diagnosis. The specialist services involved a variety of activities and outcomes and descriptions were often lacking. Services could be improved regarding the information flow between healthcare professionals, greater in-depth palliative care knowledge for case managers and social workers, identification of a key worker and support for family carers. The limited evidence available shows areas for improvement of the quality of and access to specialist services for older people, such as support for family carers. In addition, this review underscores the need for comprehensive reporting of interventions and the use of consensus-based outcome measures.

► **Redesigning The Role Of Medical Assistants In Primary Care: Challenges And Strategies During Implementation**

DILL J., MORGAN J. C., CHUANG E., *et al.*

2019

Med Care Res Rev [Ahead of print]

<https://doi.org/10.1177/1077558719869143>

Efforts to reform primary care increasingly focus on redesigning care in ways that utilize nonprovider staff such as medical assistants (MAs), but the implementation of MA role redesign efforts remains understudied in the U.S. health care literature. This article draws on rich, longitudinal case study data collected from four health care systems across the United States to examine critical challenges in the planning, implementation, and early sustainment of MA role redesign efforts in primary care. During the planning period, challenges included recruitment of highly trained MAs, compliance with organizational and state regulations regarding MA scope of practice, provision of consistent training across primary care clinics, and creation of career ladders that provided tiered compensation for MAs. During active implementation, challenges included provider training and preventing MA burnout. Strategies for addressing challenges in MA role redesign efforts are discussed, as well as early sustainment of program practices and organizational policies.

► **Motivations And Willingness Of General Practitioners In France To Participate In Primary Care Research As Investigators**

FERRAND DEVOUGE E., BIARD M., BEUZÉBOC J., *et al.*

2019

Family Practice 36(5): 552-559.

<https://doi.org/10.1093/fampra/cm126>

Clinical research is mostly conducted among hospitalized patients, which restricts the generalizability of research results. The involvement of GPs in research has been consistently highlighted as a factor associated with successful study recruitment. To assess GPs' motivations and willingness to participate in primary care research as investigators and to identify factors associated with their willingness. We conducted an observational, cross-sectional study in Normandy, France, with a self-questionnaire sent to 3002 GPs. We collected data on GPs' socio-demographic characteristics, their experiences and their expectations regarding research, and their reasons for non-partic-

ipation. Overall, 489 questionnaires were collected. Two hundred and forty-six GPs (50.3%) were interested in participating in clinical research as investigators. The two main conditions for participation as investigators were the relevance of the study topic for clinical practice (80.5%) and the feedback of study results (80.1%). The two main reasons for non-participation were lack of time (79.4%) and administrative burden (43.6%). Age between 27 and 34 years (adjusted odds ratio [AOR] = 2.86, P = 0.004) and GP trainer status (AOR = 2.41, P < 0.001) were associated with willingness to participate in primary care research. Age between 60 and 70 years (AOR = 0.53, P = 0.03) and locum status (AOR = 0.40, P = 0.04) were associated with non-participation in research. Based on our results, we were able to establish a profile of GPs willing to participate in primary care research as investigators. GPs' involvement should be based on their preferred areas of research. Different incentives such as a dedicated clinical research nurse or financial support could also be considered.

► **Improving Interorganizational Coordination Between Primary Care And Oncology: Adapting A Chronic Care Management Model For Patients With Cancer**

FLIEGER S. P., THOMAS C. P. ET PROTAS J.

2019

Med Care Res Rev [Ahead of print].

<https://doi.org/10.1177/1077558719870699>

The objective of this study was to explore the implementation of a payment and delivery system innovation to improve coordination and communication between primary care and oncology. We employed a qualitative case study approach, conducting interviews (n=18), and reviewing archival materials. Chronic care coordinators and the cancer center social worker acted as boundary spanners. The chronic care coordinator role built on medical home infrastructure, applying the chronic care model to cancer care. Coordination from primary care to oncology became more routinized, with information sharing prompted by specific events. These new boundary spanner roles enabled greater coordination around uncertain and interdependent tasks. Recommendations for scaling up include the following: establish systematic approaches to learning from implementation, leverage existing capacity for scalability, and attend to the content and purpose of information sharing.

► **L'éducation interprofessionnelle des équipes de soins critiques par la simulation : concept, mise en œuvre et évaluation**

HOUZÉ-CERFON C.-H., BOET S., MARHAR F., *et al.*
2019

La Presse Médicale 48(7, Part 1): 780-787.

<https://doi.org/10.1016/j.lpm.2019.07.001>

La simulation interprofessionnelle est une technique pédagogique efficace pour développer les compétences non-techniques en soins critiques et renforcer la collaboration interprofessionnelle des équipes afin d'améliorer la qualité des soins et le devenir du patient. L'implémentation de la simulation interprofessionnelle en formation initiale et continue est facilitée par un « référent simulation » dans chaque discipline/profession afin de motiver, planifier et coordonner les équipes. Il est essentiel lors d'une simulation interprofessionnelle de considérer les aspects sociologiques (hiérarchie, pouvoir, autorité, conflits interprofessionnels, genre, accès à l'information, identité professionnelle) qui peuvent affecter la communication interprofessionnelle et le travail d'équipe mais également les processus d'apprentissage. Des outils d'évaluation spécifique du travail d'équipe lors des formations par simulation interprofessionnelle doivent être utilisés pour aider à structurer le débriefing et améliorer la performance des équipes. Le lieux de la simulation interprofessionnelle (in-situ ou intra-centre) doit servir les objectifs pédagogiques tout en intégrant la disponibilité de l'équipe et des locaux de l'unité de soins.

► **Impact de l'expérimentation de coopération entre médecin généraliste et infirmière Asalée sur l'activité des médecins**

LOUSSOUARN C., FRANC C., VIDEAU Y., *et al.*
2019

Revue d'économie politique 129(4): 489-524.

<https://www.cairn.info/revue-d-economie-politique-2019-4-page-489.htm>

Dans de nombreux pays, les politiques et réformes ont explicitement encouragé l'intégration des organisations de soins primaires et la coopération pluri-professionnelle afin d'améliorer l'efficacité productive et allocative de l'offre de soins et lutter contre l'inégale répartition géographique des médecins. En France, la Direction de la Sécurité sociale et une associa-

tion dénommée Asalée (« Action de santé libérale en équipe », depuis 2004) ont mis en place une expérimentation destinée à favoriser l'intégration verticale et le travail en équipe entre médecins généralistes et infirmières par la mise en place de nouveaux modes de rémunération et la formation d'infirmières sélectionnées. Cet article évalue l'extension de cette expérimentation sur la période 2010-2016 en étudiant l'influence de cette coopération, mais aussi de l'organisation et des incitations financières à l'œuvre, sur l'activité des médecins généralistes appréhendée à partir de trois indicateurs : le nombre de jours travaillés, de patients rencontrés (en file active et, parmi eux, ceux inscrits médecin traitant) et d'actes (consultations au cabinet et visites à domicile). Nous contrôlons autant que possible des biais d'endogénéité et de sélection en recourant à un design cas-témoins, selon une méthode d'appariement exact, et des méthodes d'estimation en différence de différences sur données de panel. Dans ce cadre, nous montrons un effet positif du dispositif mais relativement modeste sur le nombre de jours travaillés par les médecins (+1,2 %) et un effet plus marqué sur le nombre de patients rencontrés (+7,55 %) et inscrits médecin traitant (+6,87 %). En revanche, aucun effet significatif n'est mis en évidence sur le nombre de consultations et visites.

► **Quand l'éducation thérapeutique interroge le « cœur de métier » des médecins généralistes**

PANOT S., MISPELBLOM-BEYER F. ET GIRARDOT L.
2019

Médecine : De La Médecine Factuelle à nos Pratiques 15(7): 318-323.

L'éducation thérapeutique des patients (ETP), souvent dispensée sous forme de programmes dans le cadre de réseaux de santé, met en lien le Médecin généraliste (MG) avec de nombreux autres professionnels de santé. Elle suggère des modifications dans la façon d'exercer au quotidien, d'adopter une posture éducative plutôt que prescriptive, d'interagir différemment et plus étroitement avec les autres professionnels de santé, de se familiariser avec de nouveaux outils de communication entre professionnels. Cet article s'intéresse aux interrogations et doutes des MG lors de cette mise en pratique de l'ETP au sein d'un dispositif dédié à la prise en charge de patients diabétiques ou, plus généralement, présentant des facteurs de risques cardiovasculaires. Globalement l'ETP questionne les

pratiques, interpelle les MG dans l'idée qu'ils se font de leur métier, de ce qui leur est légitime de faire ou non, amène des changements effectifs de postures, et modifie en « mieux » les rapports avec les autres professionnels de santé.

► **Infirmière en pratique avancée : un nouveau métier au sein de l'équipe de soins**

REVUE PRESCRIRE

2019

Revue Prescrire 39(432): 773-778.

En France, la pratique avancée des auxiliaires médicaux, créée par la loi de santé 2016, a été définie pour les infirmières dans les textes réglementaires en 2018 et 2019. L'IPA est une infirmière au champ de compétences élargi et à l'autonomie accrue. Il s'agit pour la profession d'un nouveau métier, sans être une nouvelle spécialité. La pratique avancée est possible en équipe. En dépit des textes officiels qui définissent cette fonction et de l'obtention des premiers diplômes, le flou demeure sur plusieurs aspects de l'exercice à venir des IPA.

► **Palliative Care In Primary Care: European Forum For Primary Care Position Paper**

ROTAR PAVLIČ D., AARENDONK D., WENS J., *et al.*

2019

Primary Health Care Research & Development 20: e133.

The aim of this position paper is to assist primary health care (PHC) providers, policymakers, and researchers by discussing the current context in which palliative health care functions within PHC in Europe. The position paper gives examples for improvements to palliative care models from studies and international discussions at European Forum for Primary Care (EFPC) workshops and conferences. Palliative care is a holistic approach that improves the quality of life of patients and their families facing problems associated with terminal illness, through the prevention and relief of suffering by means of early identification and diligent assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual. Unfortunately, some Europeans, unless they have cancer, still do not have access to generalist or specialist

palliative care. A draft of this position paper was distributed electronically through the EFPC network in 2015, 2016, and 2017. Active collaboration with the representatives of the International Primary Palliative Care Network was established from the very beginning and more recently with the EAPC Primary Care Reference Group. Barriers, opportunities, and examples of good and bad practices were discussed at workshops focusing on palliative care at the international conferences of Southeastern European countries in Ljubljana (2015) and Budva (2017), at regular conferences in Amsterdam (2015) and Riga (2016), at the WONCA Europe conferences in Istanbul (2015), Copenhagen (2016), and Prague (2017), and at the EAPC conference in Madrid. (2017). There is great diversity in the extent and type of palliative care provided in primary care by European countries. Primary care teams (PCTs) are well placed to encourage timely palliative care. We collected examples from different countries. We found numerous barriers influencing PCTs in preparing care plans with patients. We identified many facilitators to improve the organization of palliative care.

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

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

2019

Health Economics 28 (12) : 1418-1434

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3951>

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

weekends. Our results are robust to a variety of specifications and alternative matching methods. We conclude that switching from FFS to blended FFS improves patients' access to after-hours care, but the incentive to nudge service production at the intensive margin is somewhat limited.

► **Exploring Improvement Plans Of Fourteen European Integrated Care Sites For Older People With Complex Needs**

STOOP A., DE BRUIN S. R., WISTOW G., *et al.*

2019

Health Policy : 123(12):1135-1154

<https://doi.org/10.1016/j.healthpol.2019.09.009>

Integrated care programmes are increasingly being put in place to provide care to older people living at home. However, knowledge about further improving integrated care is limited. In fourteen integrated care sites in Europe, plans to improve existing ways of working were designed, implemented and evaluated to enlarge the understanding of what works and with what outcomes when improving integrated care. This paper provides insight into the existing ways that the sites were working with respect to integrated care, their perceived difficulties and their plans for working towards improvement. The seven components of the Expanded Chronic Care Model provided a conceptual framework for describing the fourteen sites. Although sites were spread across Europe and differed in basic characteristics and existing ways of working, a number of difficulties in delivering integrated care were similar. Existing ways of working and improvement plans mostly focused on three components of the Expanded Chronic Care Model: delivery system design; decision support; self-management. Two components were represented less frequently in existing ways of working and improvement plans: building healthy public policy; building community capacity. These findings suggest that broadly-based prevention efforts, population health promotion and community involvement remain limited. From the Expanded Chronic Care Model perspective, therefore, opportunities for improving integrated care outcomes may continue to be restricted by the narrow focus of developed improvement plans.

► **Interdisciplinary Team Working In The Irish Primary Healthcare System: Analysis Of 'Invisible' Bottom Up Innovations Using Normalisation Process Theory**

TIERNEY E., HANNIGAN A., KINNEEN L., *et al.*

2019

Health Policy 123 (11) : 1083-1092

<https://doi.org/10.1016/j.healthpol.2019.09.002>

Interdisciplinary team working in primary care is a key policy goal across healthcare jurisdictions. The National Primary Care Strategy (2001) in Ireland is a top down policy for primary healthcare reform, which prioritised the development and implementation of interdisciplinary Primary Care Teams. The number of Primary Care Teams and features of their clinical meetings have been the key metric in Ireland for appraising progress with the implementation of the strategy. However, these have been challenging to organise in practice. The aim of this paper is to analyse empirical evidence of other forms of interdisciplinary working in Irish primary care, using Normalisation Process Theory. Drawing on data from an on-line survey (71 GPs and 498 other healthcare professionals), and an interview study (37 participants; 8 GPs, 7 practice managers/admin support and 22 health care professionals) in three of the four Health Service Executive (HSE) regions in Ireland, we analyse the nature of these other forms of interdisciplinary working and describe innovations for service delivery that have been developed 'from the ground up' as a result. We examine levers and barriers to the implementation of these bottom up innovations. The levers are that these innovations make sense to professionals, are based on local needs and focus on preventive patient-centred care. They are driven forward by small groups of professionals from different backgrounds with complementary skills. The evaluations show positive impacts of the innovative services for patients, however, many have ceased to operate due to negative effects of the recent economic recession on the Irish healthcare system. These flexible and localised innovations were shaped in part by the reforms set out in the 2001 Primary Care Strategy but also represent unintended effects of that policy because they are the result of bottom up interdisciplinary working that occurs alongside, or instead of, Primary Care Team clinical meetings. Furthermore, as they not captured by existing metrics, the interdisciplinary work and resultant services have been 'invisible' to senior management and policy makers. If appropri-

ately acknowledged and supported, they can shape primary care in the future.

► **Disease Management In Diabetes Care: When Involving GPs Improves Patient Compliance And Health Outcomes**

UGOLINI C., LIPPI BRUNI M., LEUCCI A. C., *et al.*
2019

Health Policy 123(10): 955-962.

<https://doi.org/10.1016/j.healthpol.2019.08.014>

Although the study of the association between interventions in primary care and health outcomes continues to produce mixed findings, programs designed to promote the greater compliance of General Practitioners and their diabetic patients with guidelines have been increasingly introduced worldwide, in an attempt to achieve better quality diabetes care through the

enhanced standardisation of patient supervision. In this study, we use clinical data from the Diabetes Register of one large Local Health Authority (LHAs) in Italy's Emilia-Romagna Region for the period 2012-2015. Firstly, we investigate whether GPs' participation in the local Diabetes Management Program (DMP) leads to improved patient compliance with regional guidelines. Secondly, we test whether the monitoring activities prescribed for diabetics by the Regional diabetes guidelines have a positive impact on patients' health outcomes and increase appropriateness in health care utilization. Our results show that such a Program, which aims to increase GPs' involvement and cooperation in following the Regional guidelines, achieves its goal of improved patient compliance with the prescribed actions. In turn, through the implementation of the DMP and the greater involvement of physicians, Regional policies have succeeded in promoting better health outcomes and improved appropriateness of health care utilization.

Systèmes de santé

Health Care Systems

► **Much Ado About Nothing? The Responsiveness Of The Healthcare System In Poland Through Patients' Eyes**

POLAK P., ŚWIĄTKIEWICZ-MOŚNY M. ET WAGNER A.
2019

Health Policy 123 (12): 1259-1266

<https://doi.org/10.1016/j.healthpol.2019.09.011>

This article analyzes the outcomes of the key healthcare reforms undertaken in Poland and assesses how successful they have been. Contrary to the governmental perspective on success, understood in terms of economic efficiency, we define it in terms of patient satisfaction. As such, health policy is treated as a political system's response to the problems emerging in the public agenda. The analysis therefore focuses on the responsiveness of the healthcare system through patients' eyes. This analysis takes three main reforms undertaken in post-1989 Poland as reference points. These were: Regional Sickness Funds (Kasy Chorych, 1999); the National Health Fund (Narodowy Fundusz Zdrowia, 2003/2004); and the waiting lists package and the oncological package (pakiet kolejkowy and

pakiet onkologiczny, 2015). Each introduced key institutional changes, but also sparked media interest, public attention, and mass discourse. The article presents the main goals and the most important consequences of the reforms for patients. For the purposes of the analysis, the following patient-oriented indicators of reform success were chosen: (1) public satisfaction with healthcare, (2) waiting times, (3) number of health professionals. The assembled data from national and international databases leads to the conclusion that the reforms have not succeeded.

► **Accountable Care? An Analysis Of National Reporting On Local Health And Social Care Service Integration**

TUNNEY S. ET THOMAS J.
2019

Social Theory & Health 17(3): 331-347.

<https://doi.org/10.1057/s41285-018-00083-9>

This paper analyses how the UK national press has covered local decision-making on options for the

integration of health and social care. In England, as part of a major restructuring of health services, the UK government has devolved significant decisions on reorganising services to local areas. This increasing 'localism' in healthcare has been a global trend, albeit an uneven one. The article assesses the insights of Amitai Etzioni and others, as applied to national newspaper coverage of local decisions. It finds Etzioni's analysis to be not fully supported. Following other journalism research on the NHS, we show that contentious points of wider public interest were little reported on, such as international corporate influence and the potential for fragmentation across a national health service.

► **Le système de santé italien**

VINCENT G., CERUTI M., RIPERT B., *et al.*
2019

Gestions Hospitalières (588): 436-441.

Présentée lors de Graph Europe 2019, groupe de recherche et d'applications hospitalière, cette communication décrit le système de santé italien qui - s'il présente des différences fondamentales avec le système de santé français - est confronté à plusieurs défis, certains similaires, d'autres spécifiques.

► **Five-Year Impact Of A Commercial Accountable Care Organization On Health Care Spending, Utilization, And Quality Of Care**

ZHANG H., COWLING D. W., GRAHAM J. M., *et al.*
2019

Medical Care 57(11): 845-854.

https://journals.lww.com/lww-medicalcare/Fulltext/2019/11000/Five_year_Impact_of_a_Commercial_Accountable_Care.2.aspx

Accountable Care Organizations (ACOs) have proliferated after the passage of the Affordable Care Act in 2010. Few longitudinal ACO studies with continuous enrollees exist and most are short term. Objective: The objective of this study was to evaluate the long-term impact of a commercial ACO on health care spending, utilization, and quality outcomes among continuously enrolled members: Retrospective cohort study design and propensity-weighted difference-in-differences approach were applied to examine performance changes in 2 ACO cohorts relative to 1 non-ACO

cohort during the commercial ACO implementation in 2010–2014. Subjects: A total of 40,483 continuously enrolled members of a commercial health maintenance organization from 2008 to 2014. Measures: Cost, use, and quality metrics for various type of services in outpatient and inpatient settings. The ACO cohorts had (1) increased inpatient and outpatient total spending in the first 2 years of ACO operation, but insignificant differential changes for the latter 3 years; (2) decreased outpatient spending in the latter 2 years through reduced primary care visits and lowered spending on specialists, testing, and imaging; (3) no differential changes in inpatient hospital spending, utilization, and quality measures for most of the 5 years; (4) favorable results for several quality measures in preventive and diabetes care domains in at least one of the 5 years. The commercial ACO improved outpatient process quality measures modestly and slowed outpatient spending growth by the fourth year of operation, but had a negligible impact on inpatient hospital cost, use, and quality measures.

Occupational Health

► **Association Between Workers' Compensation Claim Processing Times And Work Disability Duration: Analysis Of Population Level Claims Data**

GRAY S. E., LANE T. J., SHEEHAN L., *et al.*
2019

Health Policy 123(10): 982-991.

<https://doi.org/10.1016/j.healthpol.2019.06.010>

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

► **County-Level Unemployment Rates And Service Intensity In Primary Care Physician Offices For Medicare Patients**

LI J., CHEN A., PARKS M., *et al.*
2019

Med Care Res Rev: 1077558719872864.

The macroeconomic environment has been shown to affect health-care service utilization. We examined the relationship between unemployment rate and service

intensity among a nationally representative sample of primary care office visits from Medicare patients by merging data from the 2006-2012 National Ambulatory Medical Care Survey with unemployment data from the Bureau of Labor Statistics. Multispecialty practices demonstrated increases in the number of electrocardiogram tests prescribed and the number of return appointments scheduled. In contrast, single-specialty practices did not respond on those margins and instead increased the likelihood of administering diagnostic and screening examinations. We found no significant relationship between unemployment rates and the number of laboratory and imaging services, magnetic resonance imaging use, referrals, or medication prescribing. These results were robust to controlling for extensive visit characteristics and county-, year-, and month-fixed effects. Our results suggest that physicians responded to the Great Recession by changing their practice behavior.

► **Réduire le temps assis en milieu professionnel : l'étude « Sédentarité au travail » (SAuT)**

MARCHANT G., NICAISE V., CHASTIN S., *et al.*
2019

Santé Publique 31(3): 377-385.

<https://www.cairn.info/revue-sante-publique-2019-3-page-377.htm>

La présente recherche a pour but d'évaluer les effets d'une intervention sur la réduction du temps passé en position assise en contexte professionnel. L'intervention consistait en une présentation collective sur la sédentarité et les pauses actives au travail, suivie d'une phase individuelle de planification. Les participants étaient ensuite invités à utiliser un logiciel d'alerte pendant quatre semaines. L'intervention a duré six semaines; 38 personnes âgées de 29 à 59 ans ont participé (80 % de femmes). Avant et après l'intervention, les comportements (sédentarité et activité physique) ont été évalués avec des accéléromètres, et le degré d'automatisme envers la position assise et les pauses actives a été mesuré par questionnaire. Suite à l'intervention, le temps passé en position assise au cours d'une journée de travail a diminué de façon

significative. Plus précisément, le temps passé assis a davantage diminué chez les personnes âgées entre 29 et 43 ans, qui avaient décidé de faire des pauses d'une durée d'au moins cinq minutes chacune, et qui présentaient des séquences de temps assis plus longues avant l'intervention. Cette étude a démontré que le fait de combiner une stratégie informationnelle avec des alertes générées par ordinateur ou téléphone portable permet de réduire le temps de sédentarité au travail. Cette intervention est peu coûteuse pour les salariés et les entreprises. Une perspective intéressante pourrait être de comparer ces effets à ceux d'interventions basées sur une modification de l'environnement physique de travail, telles que l'installation de bureaux réglables.

► **L'influence des accidents de la route sur les trajectoires professionnelles des personnels en fin de carrière, à partir de la cohorte Gazel**

SANCHEZ M.-A., BARNAY T., MARSAUDON A., *et al.*
2019

Revue d'économie politique 129(4): 553-589.

<https://www.cairn.info/revue-d-economie-politique-2019-4-page-553.htm>

L'objectif de cet article est d'évaluer l'effet des accidents de la route sur les trajectoires professionnelles des employés de court et moyen terme d'EDF-GDF en fin de carrière, à partir de la cohorte Gazel sur la période 2002-2014. Cette étude permet d'identifier les stratégies d'adaptation de l'entreprise et de l'accidenté, qui conduisent à modifier la trajectoire professionnelle à la suite d'un tel choc exogène. Elle permet d'apprécier les marges de manœuvre dont disposent réellement les acteurs, dans un contexte marqué par la volonté de réformer les retraites, tout particulièrement pour les régimes spéciaux, comme c'est le cas pour EDF-GDF. La base Gazel permet de caractériser les différents types d'accidents de la route afin de distinguer leurs impacts sur les changements de trajectoires professionnelles des individus en fin de carrière. La méthode des doubles différences avec appariement par score de propension est utilisée. Au total, 4066 individus ont été victimes d'accidents de la route sur la période d'étude. En moyenne plus âgées, les victimes sont issues de catégories socio-professionnelles plus défavorisées et les hommes sont surreprésentés. Les résultats suggèrent une sortie plus précoce du marché du travail possible grâce à des mécanismes

de reclassement qui permettraient d'ouvrir des droits à un départ anticipé du marché. Par ailleurs, les victimes d'accidents de la route subissent moins de changements de trajectoire à la suite d'un accident de la route sans impact sur la santé.

► **Élaboration et qualités psychométriques d'une échelle de bien-être au travail. Étude SERENAT auprès de salariés vus en médecine du travail**

SERVANT D., DRUMEZ E., RAYNAL S., *et al.*
2019

Revue d'Épidémiologie et de Santé Publique 67(5): 303-309.

<https://doi.org/10.1016/j.respe.2019.05.011>

Le bien-être au travail est aujourd'hui un enjeu majeur de santé publique. Il comprend, entre autres, l'absence de symptômes psychologiques (anxiodépressifs), des conditions de travail positives perçues (environnement et organisation), le bonheur et une bonne qualité de vie au travail. De nombreuses études ont montré que le soutien social et le contrôle au travail protègent la santé mentale alors que les exigences élevées et le déséquilibre effort-récompense sont des facteurs de risque d'anxiété et de dépression. Il n'existe actuellement aucun indicateur global permettant de mesurer à la fois l'état de santé mentale et les conditions de travail. L'objectif de cette étude est de construire puis d'étudier les qualités psychométriques d'une échelle de bien-être au travail, l'échelle Serenat, dans le but de sa validation. L'échelle Serenat est un auto-questionnaire composé de 20 items évalués selon une échelle de Likert de 0 à 3 pour un score total allant de 0 à 60. Les items ont été construits à partir des données de la littérature et d'une évaluation qualitative préalable auprès de salariés. De janvier 2014 à mai 2017, 193 sujets vus en médecine du travail ont été inclus dans cette étude transversale. La validation comprend un diagnostic de qualité des items et de structure des données, la consistance interne, la reproductibilité intra-observateur et la consistance externe. L'échelle Serenat a montré une très bonne qualité des items, avec un taux de non-réponse maximal de 0,01 % par item, et aucun effet plateau mis en évidence. L'analyse factorielle permet de conclure à l'unidimensionnalité de l'échelle. Le coefficient α de Cronbach mesurant la consistance interne était de 0,89. Le coefficient de corrélation intra-classe pour la reproductibilité intra-observateur était de 0,89. L'échelle Serenat était

corrélée aux scores HADS ($r = -0,54$; $p < 0,001$), STAI-Y ($r = -0,78$; $p < 0,001$) et BDI-13 ($r = -0,57$; $p < 0,001$). L'échelle de bien-être au travail Serenat montre de

bonnes propriétés psychométriques en vue de sa validation définitive. Elle pourrait être utile aux médecins du travail dans le dépistage individuel et collectif.

Vieillesse

Ageing

► L'entrée des personnes âgées en institution : passer le deuil

BLANC L. ET CHARLES R.

2019

Médecine : De La Médecine Factuelle à Nos Pratiques 15(8): 354-359.

Avec le vieillissement de la population française, le nombre des personnes âgées institutionnalisées augmente. Si la majorité dit bien vivre en résidence, les syndromes dépressifs ne sont pas rares. La littérature a identifié de nombreux facteurs influençant le vécu de l'entrée en institution, mais il n'existe pas de trajectoire stéréotypée permettant le succès de ce processus. Cet article a pour objectif de décrire quelques expériences singulières et de mieux comprendre cette transition.

► The Impact Of Informal Caregiving For Older Adults On The Health Of Various Types Of Caregivers: A Systematic Review

BOM J., BAKX P., SCHUT F., *et al.*

2018

The Gerontologist 59(5): e629-e642.

<https://doi.org/10.1093/geront/gny137>

Informal care, the provision of unpaid care to dependent friends or family members, is often associated with physical and mental health effects. As some individuals are more likely to provide caregiving tasks than others, estimating the causal impact of caregiving is difficult. This systematic literature review provides an overview of all studies aimed at estimating the causal effect of informal caregiving on the health of various subgroups of caregivers. A structured literature search, following PRISMA guidelines, was conducted in 4 databases. Three independent researchers assessed studies for eligibility based on predefined criteria. Results from the studies included in the review were summa-

rized in a predefined extraction form and synthesized narratively. The systematic search yielded a total of 1,331 articles of which 15 are included for synthesis. The studies under review show that there is evidence of a negative impact of caregiving on the mental and physical health of the informal caregiver. The presence and intensity of these health effects strongly differ per subgroup of caregivers. Especially female, and married caregivers, and those providing intensive care appear to incur negative health effects from caregiving. The findings emphasize the need for targeted interventions aimed at reducing the negative impact of caregiving among different subgroups. As the strength and presence of the caregiving effect differ between subgroups of caregivers, policymakers should specifically target those caregivers that experience the largest health effect of informal caregiving.

► Financer sa perte d'autonomie : rôle potentiel du revenu, du patrimoine et des prêts viagers hypothécaires

BONNET C., JUIN S. ET LAFERRERE A.

2019

Economie Et Statistique (507-508): 5-26.

<https://www.insee.fr/fr/statistiques/4173154?sommaire=4173181>

Dans quelle mesure les Européens âgés seraient-ils capables de financer les dépenses liées à leur perte d'autonomie à partir de leurs seuls revenus et patrimoine, en l'absence d'aide informelle et d'assurance publique ? Pour répondre à cette question, nous développons un modèle de microsimulation et estimons, à partir des données de l'enquête SHARE (Survey of Health, Ageing and Retirement in Europe), les trajectoires de dépendance des personnes âgées de 65 ans et plus dans neuf pays européens. Nous portons une attention particulière au rôle potentiel des prêts

viagers hypothécaires comme outils d'extraction de la valeur des biens immobiliers. Selon les simulations, 57 % des personnes de 65 ans et plus seront confrontées à une perte d'autonomie. Pour elles, la durée moyenne de dépendance sera de 4,4 ans. Parmi les personnes dépendantes sans conjoint, 6 % seraient en mesure de couvrir leurs dépenses de perte d'autonomie grâce à leur seul revenu, chiffre qui atteint 22 % si elles mobilisent l'intégralité de leur patrimoine, à l'exception de leur logement. Cette proportion doublerait, pour atteindre 49 %, si ces personnes contractaient un prêt viager hypothécaire sur leur résidence principale. Toutefois, un quart d'entre elles ne pourraient financer que moins de 10 % de leurs dépenses de perte d'autonomie.

► **Practice Variation In Long-Term Care Access And Use: The Role Of The Ability To Pay**

DUELL D., LINDEBOOM M., KOOLMAN X., *et al.*
2019

Health Economics 28(11) : 1277-1292

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3940>

Practice variation in publicly financed long-term care (LTC) may be inefficient and inequitable, similarly to practice variation in the health care sector. Although most OECD countries spend an increasing share of their gross domestic product on LTC, it has received comparatively little attention to date compared with the health care sector. This paper contributes to the literature by assessing and comparing regional practice variation in both access to and use of institutional LTC and investigating its relation with income and out-of-pocket payment. For this, we have access to unique individual-level data covering the entire Dutch population. Even though we found practice variation in the use of LTC once access was granted, the variation between regions was still relatively small compared with international standards. In addition, we showed how a co-payment measure could be used to reduce practice variation across care office regions and income classes making the LTC system not only more efficient but also more equitable.

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

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

2019

Health Policy 123(12) : 1163-1172

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

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

► **Do Family Caregivers Offset Healthcare Costs For Older Adults? A Mapping Review On The Costs Of Care For Older Adults With Versus Without Caregivers**

FRIEDMAN E. M., RODAKOWSKI J., SCHULZ R., *et al.*
2019

The Gerontologist 59(5): e535-e551.

<https://doi.org/10.1093/geront/gny182>

Older adults face significant long-term care and health care costs. But some of these costs can potentially be offset through family caregivers who may serve as substitutes for formal care or directly improve the care recipient's health and reduce health care utilization and expenditures. This article reviews the current lit-

erature to determine whether it is possible through existing work to compare the costs of care for individuals with versus without family caregivers and, if not, where the data, measurement, and other methodological challenges lie. A mapping review of published works containing information on health care utilization and expenditures and caregiving was conducted. A narrative approach was used to review and identify methodological challenges in the literature. Our review identified 47 articles that met our criteria and had information on caregiving and health care costs or utilization. Although findings were mixed, for the most part, having a family caregiver was associated with reduced health care utilization and a decreased risk of institutionalization however, the precise difference in health care expenditures for individuals with caregivers compared to those without was rarely examined, and findings were inconsistent across articles reviewed. The number of family caregivers providing care to loved ones is expected to grow with the aging of the Baby Boomers. Various programs and policies have been proposed to support these caregivers, but they could be costly. These costs can potentially be offset if family caregivers reduce health care spending. More research is needed, however, to quantify the savings stemming from family caregiving.

► **Financing Long-Term Care: Lessons From Japan**

IGEKAMI N.
2019

International Journal of Health Policy and Management 8(8): 462–466.

Long-term care (LTC) must be carefully delineated when expenditures are compared across countries because how LTC services are defined and delivered differ in each country. LTC's objectives are to compensate for functional decline and mitigate the care burden of the family. Governments have tended to focus on the poor but Germany opted to make LTC universally available in 1995/1996. The applicant's level of dependence is assessed by the medical team of the social insurance plan. Japan basically followed this model but, unlike Germany where those eligible may opt for cash benefits, they are limited to services. Benefits are set more generously in Japan because, prior to its implementation in 2000, health insurance had covered long-stays in hospitals and there had been major expansions of social services. These service

levels had to be maintained and be made universally available for all those meeting the eligibility criteria. As a result, efforts to contain costs after the implementation of the LTC Insurance have had only marginal effects. This indicates it would be more efficient and equitable to introduce public LTC Insurance at an early stage before benefits have expanded as a result of ad hoc policy decisions.

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

SICSIC J. ET RAPP T.
2019

Health Services Research 54(6) : 1305-1315

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13208>

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

Index des auteurs Author index

A

Aarendonk D.....	52
Ades J.....	40
Agid Y.....	40
Ahrenfeldt L. J.....	19
Andriantsehoanarinala L.	20
Antunes A.....	42
Arrighi Y.....	19
Audouard-Marzin Y.....	49
Aveling E.-L.....	35

B

Bach J. F.....	40
Baggett T. P.....	12
Bakx P.....	58
Balusson F.....	31
Banal-Estañol A.....	39
Barnay T.....	57
Barruel D.....	24
Barry S.....	11
Bazin N.....	42
Beck A. C. C.....	31
Behery O. A.....	22
Beuzeboc J.....	50
Bhairoosing P. A.....	31
Biard M.....	50
Biddle L.....	42
Blanc L.....	58
Blondet L. V.....	23
Boet S.....	51
Bom J.....	58
Bone A. E.....	23
Bonnet C.....	58
Bortolon C.....	43
Bourgueil Y.....	20
Bozorgmehr K.....	27, 42
Brandenburg-Ceynowa H.....	46
Brouet P.....	37
Broutin S.....	43
Brouwer W.....	41
Brunner N.....	39

Buber-Ennser I.....	29
Burke S.....	11
Burkhard D.....	14

C

Calvel L.....	23
Cambon L.....	13
Canudas-Romo V.....	19
Carré B.....	17
Castray M.....	27
Ceruti M.....	55
Chami N.....	14
Charles R.....	58
Chastin S.....	56
Chedotal I.....	23
Chen A.....	56
Chiarenza A.....	28
Chiesa V.....	28
Chone P.....	14
Chuang E.....	50
Claassens H.....	11
Clément M. C.....	36
Cloës C.....	43
Coldefy M.....	45
Colle S.....	20
Cook B. L.....	44
Cowling D. W.....	55
Crainich D.....	15

D

Dauriac-Le Masson V.....	24
Davis S.....	18
de Bruin S. R.....	53
De Nooijer K.....	49
Denuit M.....	11
Devlin R. A.....	52
De Vries E. F.....	15
Dill J.....	50
Drewes H. W.....	15
Drumez E.....	57
Duell D.....	59

Dumont G.-F. 12

E

Edmonds S. 15
 Ellini A. 36
 El Sherif R. 34
 Endel F. 45
 Estecahandy P. 44
 Estrada Fernández M. E. 59
 Etilé F. 37
 Evans C. J. 23
 Even M. 44

F

Falissard B. 45
 Ferrand Devouge E. 50
 Ferraris V. A. 16
 Flieger S. P. 50
 Fonsegrive G. 45
 Fontaine A. 26
 Forster T. 37
 Franc C. 16, 51
 Franc K. 16
 Frasquilho D. 42
 Friedman E. M. 59
 Fuhr D. C. 48

G

Gagnon F. 37
 Gandré C. 45
 Gauchet J. 20
 Gauld C. 28
 Gautier S. 20
 Giancotti M. 41
 Gil Lacruz A. I. 59
 Gil Lacruz M. 59
 Girardot L. 51
 Goupil B. 31
 Graham J. M. 55
 Gray S. E. 56
 Grépin K. A. 35
 Grignon M. 35
 Grob R. 18
 Gunst M. 28

H

Hajizadeh M. 15
 Hanbali H. 11
 Hannigan A. 53
 Henson L. A. 23
 Heran F. 13
 Hou S. S. 44
 Houzé-Cerfon C.-H. 51
 Humbertclaude E. 22

I

Igekami N. 60
 Ingleby D. 28
 Irvine A. 21

J

Jarman K. 28
 Johnston B. M. 11
 Jourdain F. 20
 Juin S. 58
 Jusot F. 17

K

Katschnig H. 45
 Kaur N. 34
 Kentikelenis A. E. 37
 Keskimäki I. 30
 Kester B. S. 22
 Kindermann D. 46
 Kinneen L. 53
 Kohlenberger J. 29
 Koolman X. 59
 Kopp-Bigault C. 49
 Kopp P. A. 17
 Kümpel C. 24
 Kuo Y.-F. 34
 Kyle M. A. 35

L

Laferrere A. 58
 Lane T. J. 56

Lauksecker C.....	22
Le Bodo Y.....	37
Lee-Tauler S. Y.	44
Leguay D.....	46
Le Noc Y.....	13
Lescher M.....	25
Leucci A. C.....	54
Li J.....	56
Lindeboom M.....	59
Lin Y.-L.	34
Lippi Bruni M.	54
Looten V.....	35
Loubat J. R.	35
Lourenço Ó.....	29
Loussouarn C.....	51
Lucioli E.....	39

M

Macho-Stadler I.	39
Marbot C.	21
Marchant G.	56
Marhar F.....	51
Marsaudon A.	19, 57
Martino S. C.	18
Mauro M.....	41
Maynou L.....	32
McKie J.....	38
Mehta N.	52
Miners A.....	42
Mispelblom-Beyer F.....	51
Möllenkamp M.	38
Möller S.....	19
Montagni I.....	27
Montori V. M.....	36
Morgan J. C.	50
Mosca D.	28
Movik E.....	33

N

Naouri D.....	25
Naudet F.....	31
Nepomuceno M. R.	19
Netter P.....	39
Nicaise V.	56
Nicod E.	32
Nikendei C.....	46
Novak-Zezula S.....	11

O

Orlander D.	18
------------------	----

P

Panot S.	51
Papanicolas I.	18
Paquet C.....	20
Paraponaris A.....	16
Parks M.....	56
Pascal L.	26
Pascal M.....	20
Passerieux C.	47
Peiffer C.	24
Penders Y. W.....	49
Pérez-Castrillo D.	39
Perry-Duxbury M.....	41
Peteuil A.....	47
Petrova-Benedict R.	27
Piriou V.	26
Pison G.....	12, 13
Pivodic L.....	49
Plantevin M.	45
Poirier M. J. P.....	35
Polak P.....	54
Polazzi S.....	26
Poudroux M.	21
Prottas J.....	50
Pryce R.....	40

Q

Quidu F.	47
Quintal C.	29

R

Raffard S.....	43
Raji M. A.....	34
Ramos L. M.	29
Ranchon G.....	25
Rapp T.....	60
Rat C.....	47
Ravaud P.....	36
Raynal S.	57
Razum O.....	30

Rengs B.	29
Retèl V. P.	31
Revue Prescrire	26 , 32 , 33 , 52
Reydellet A.	26
Reynaud M.	47
Richardson J.	38
Richaud-Eyraud E.	36
Rigaudiat J.	18
Riom I.	26
Ripert B.	55
Robin C.	48
Rochaix L.	19
Rodakowski J.	59
Rolke K.	30
Rosenberg S.	45
Rotar Pavlič D.	52
Rotundo G.	41
Rousseau M. C.	22
Roussel P.	47

S

Samuilova M.	27
Sanchez M.-A.	57
Satinsky E.	48
Schmid C. P. R.	14
Schreyögg J.	38
Schulz R.	59
Schut F.	58
Scott A.	21
Scouarnec P.	49
Seidler Y.	11
Seo V.	12
Servant D.	57
Sheehan L.	56
Sicsic J.	60
Silhol J.	21
Singer S.	35
Sirven N.	25
Somé N. H.	52
Stoop A.	53
Straßmayr C.	45
Struijs J. N.	15
Suleman E.	33
Sutter-Dallay A. L.	44
Sweetman A.	14
Świątkiewicz-Mośny M.	54

T

Thinggaard M.	19
Thomas C. P.	50
Thomas J.	54
Thorndike A. N.	12
Tierney E.	53
Tiittala P.	30
Tourneur-Bagot O.	13
Tran V.-T.	36
Trummer U.	11
Tunney S.	54
Tuomisto K.	30

U

Ugolini C.	54
-----------------	----

V

Valee J.	21
Van der Pol M.	21
Van Exel J.	41
Vedel I.	34
Ventelou B.	16 , 19 , 21
Videau Y.	51
Vincent G.	55
Visintin E.	32
Volant S.	13
Vuagnat A.	25

W

Wagner A.	54
Wenner J.	30
Wens J.	52
Williams J.	22
Wilner L.	14
Wistow G.	53
Wittwer J.	12 , 17 , 27
Woodward A.	48
Woskie L. R.	18
Wüthrich K.	14

Y

Yarwood V. 28

Z

Zeppernick M. 38
Zhang H. 55
Zózimo J. R. 42

