

Veille scientifique en économie de la santé

Octobre 2018

[Sommaire en français](#)

Watch on Health Economics Literature

October 2018

[Contents list in English](#)

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Assurance maladie	Politique de santé
E-santé - Technologies médicales	Politique publique
Économie de la santé	Politique sociale
État de santé	Prévention santé
Géographie de la santé	Prévision – Evaluation
Handicap	Psychiatrie
Hôpital	Soins de santé primaires
Inégalités de santé	Systèmes de santé
Médicaments	Travail et santé
Méthodologie – Statistique	Vieillesse

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...

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Sommaire

Index des auteurs.....63

Assurance maladie

- 13 **Quelle complémentarité entre AMO ET AMC ? Actes de la 13^e Matinée thématique du 19 octobre 2017**
Cornu-Pauchet M., Gissot C et Lagasgnier G.
- 13 **Généralisation de la complémentaire santé d'entreprise. Une évaluation ex ante des gains et des pertes de bien-être**
Pierre A., Jusot F., Raynaud D., et al.
- 13 **Universal Coverage Reforms in the USA: from Obamacare Through Trump**
Rice T., Unruh L. Y., van Ginneken E., et al.
- 13 **Development of Voluntary Private Health Insurance in Nordic Countries - An Exploratory Study on Country-Specific Contextual Factors**
Tynkynen L. K., Alexandersen N., Kaarboe O., et al.

- 16 **Implementation of the SMART MOVE Intervention in Primary Care: A Qualitative Study Using Normalisation Process Theory**
Glynn L. G., Glynn F., Casey M., et al.
- 16 **Détection des prescriptions inappropriées, les critères STOPP/START**
Lang P. O., Bourgue C. et Csajka C.
- 16 **Expérimentations de remboursement des actes de télémedecine en plaies et cicatrisation en France**
Lano J., Geri-Trial C., Cabrol M., et al.
- 16 **Santé : la révolution numérique. Dossier**
Leroux V. et Bourgeon L.
- 16 **Ehealth as a Facilitator of Equitable Access to Primary Healthcare: The Case of Caring for Non-Communicable Diseases in Rural and Refugee Settings in Lebanon**
Saleh S., Alameddine M., Farah A., et al.

E-santé - Technologies médicales

- 14 **Motifs de recours à la télémedecine en médecine générale à partir d'une expérimentation en EHPAD**
Bismuth S., Remande A., Découard P., et al.
- 14 **Anticiper les usages et les conséquences des technologies connectées en santé mentale. Une étude de « cas fictif »**
Briffault X. et Morgiève M.
- 15 **La télémedecine, un instrument susceptible de corriger les inégalités de santé ?**
Desbois D.
- 15 **Patient Access to Electronic Health Records: Differences Across Ten Countries**
Essén A., Scandurra I., Gerrits R., et al.
- 15 **Conditions d'adoption du dossier de santé électronique personnel par les professionnels de la première ligne au Québec : perspectives professionnelle et organisationnelle**
Ghandour E. K., Gagnon M.-P. et Fortin J.-P.

Économie de la santé

- 17 **Beyond Activity Based Funding. An Experiment in Denmark**
Bureau V., Dahl H. M., Jensen L. G., et al.
- 17 **A Qualitative Investigation of the Health Economic Impacts of Bariatric Surgery for Obesity and Implications for Improved Practice in Health Economics**
Campbell J. A., Ezzy D., Neil A., et al.
- 18 **The Impact of Pay-For-Performance on the Quality of Care in Ophthalmology: Empirical Evidence from Germany**
Herbst T., Foerster J. et Emmert M.
- 18 **Patients' Attitudes Toward Copayments as a Steering Tool-Results from a Qualitative Study in Norway and Germany**
Herrmann W. J., Haarmann A. et Baerheim A.
- 18 **Organ Recovery Cost Assessment in the French Healthcare System from 2007 to 2014**
Hrífach A., Ganne C., Couray-Targe S., et al.

- 19 **Experts' Perspectives on SwissDRG: Second Class Care for Vulnerable Patient Groups?**
Leu A., Wepf H., Elger B., et al.
- 19 **Physician Perspectives in Year 1 of MACRA and Its Merit-Based Payment System: A National Survey**
Liao J. M., Shea J. A., Weissman A., et al.
- 20 **Health Expenditure Data for Policy: Health Accounts, National Accounts or Both?**
Mosseveld C.V., Polanen Petel W., Hernández-Peña P., et al.
- 20 **Comparison of Hospitals Participating in Medicare's Voluntary and Mandatory Orthopedic Bundle Programs**
Navathe A. S., Liao J. M., Polsky D., et al.
- 20 **Management of Pregnancy Based on Healthcare Consumption of Women Who Delivered in France in 2015: Contribution of the National Health Data System (SNDS)**
Piffaretti C., Looten V., Rey S., et al.
- 21 **Out-Of-Pocket Costs, Primary Care Frequent Attendance and Sample Selection: Estimates from a Longitudinal Cohort Design**
Pymont C., McNamee P. et Butterworth P.
- 21 **Paying Hospital Specialists: Experiences and Lessons from Eight High-Income Countries**
Quentin W., Geissler A., Wittenbecher F., et al.
- 21 **Growing Number of Unsubsidized Part D Beneficiaries with Catastrophic Spending Suggests Need for an Out-Of-Pocket Cap**
Trish E., Xu J. et Joyce G.
- 22 **Future Unrelated Medical Costs Need to Be Considered in Cost Effectiveness Analysis**
Van Baal P., Morton A., Meltzer D., et al.
- 22 **Frequency and Magnitude of Co-Payments Exceeding Prescription Drug Costs**
Van Nuys K., Joyce G., Ribero R., et al.
- 22 **Financial Protection in Europe: A Systematic Review of the Literature and Mapping of Data Availability**
Yerramilli P., Fernandez O. et Thomson S.

État de santé

- 22 **Alcohol Use and Burden for 195 Countries and Territories, 1990–2016: A Systematic Analysis for the Global Burden of Disease Study 2016**
Fullman N., Yearwood J., Abay S. M., et al.
- 23 **Five-Year Risk of Stroke After TIA or Minor Ischemic Stroke**
Amarenco P., Lavallee P. C., Monteiro Tavares L., et al.
- 23 **French and Worldwide Epidemiology of Obesity**
Matta J., Carette C., Rives Lange C., et al.

Géographie de la santé

- 23 **Geographic and Statistic Stability of Deprivation Aggregated Measures at Different Spatial Units in Health Research**
Cebrecos A., Domínguez-Berjón M. F., Duque I., et al.
- 24 **Migration Intentions of Lithuanian Physicians, Nurses, Residents and Medical Students**
Goštautait B., Bu i nien I., Milašauskien Ž., et al.
- 24 **Spatiotemporal Analysis of Regional Socio-Economic Vulnerability Change Associated with Heat Risks in Canada**
Ho H. C., Knudby A., Chi G., et al.
- 24 **An Evaluation of Alternative Measures of Accessibility for Investigating Potential 'Deprivation Amplification' in Service Provision**
Page N., Langford M. et Higgs G.

Handicap

- 25 **L'emploi des personnes handicapées dans la fonction publique. Entre quota et non-discrimination, quelles pratiques des employeurs ?**
Jaffrès F. et Guével M.-R.

Hôpital

- 25 **How Do We Interpret Readmission Rates?**
Ali A. M. et Bottle A.

- 25 **Pathways to DRG-Based Hospital Payment Systems in Japan, Korea, and Thailand**
Annear P. L., Kwon S., Lorenzoni L., et al.
- 26 **Intensité et pénibilités du travail à l'hôpital. Quelles évolutions entre 1998 et 2013 ?**
Benallah S. et Domin J.-P.
- 26 **Patients en situation palliative en hospitalisation à domicile : trajectoires de soins et caractéristiques cliniques**
Boisserie-Lacroix L., Marquestaut O. et de Stampa M.
- 26 **Association of the Hospital Readmissions Reduction Program with Surgical Readmissions**
Borza T., Oerline M. K., Skolarus T. A., et al.
- 27 **Sortir de la T2A par le haut : la mesure de la qualité des soins**
Bras P.-L.
- 27 **Pédiatrie : récupération rapide après chirurgie (RAAC) : l'expérience de l'hôpital Robert-Debré**
Dahmani S. et Jouve M.
- 27 **Doctors, Nurses, and the Optimal Scale Size in the Portuguese Public Hospitals**
Ferreira D. C., Nunes A. M. et Marques R. C.
- 27 **Effect of Systematic Physician Cross-Checking on Reducing Adverse Events in the Emergency Department: The Charmed Cluster Randomized Trial**
Freund Y., Goulet H., Leblanc J., et al.
- 28 **Cooperation Between Hospital Teams and Community-Based Healthcare Professionals**
Le Cossec C., Giacomelli M. et de Chambine S.
- 28 **Developing and Utilising a New Funding Model for Home-Care Services in New Zealand**
Matthew P., Paul R., Laszlo S., et al.
- 29 **Evaluation of Hospital Readmissions for Surgical Site Infections in Italy**
Napolitano F., Tomassoni D., Cascone D., et al.
- 29 **Procédés et effets du pouvoir disciplinaire aux urgences. Le cas de l'accueil des patients alcooliques**
Piriou O. et Thomas J.
- 29 **Use of Hospital Palliative Care According to the Place of Death and Disease One Year Before Death in 2013: A French National Observational Study**
Poulalhon C., Rotelli-Bihet L., Moine S., et al.
- 30 **Optimal Timing of Physician Visits After Hospital Discharge to Reduce Readmission**
Riverin B. D., Strumpf E. C., Naimi A. I., et al.
- 30 **Continuity of Care and Its Effect on Readmissions for COPD Patients: A Comparative Study of Norway and Germany**
Swanson J. O., Vogt V., Sundmacher L., et al.
- 30 **Does Free Choice of Hospital Conflict with Equity of Access to Highly Specialized Hospitals? A Case Study from the Danish Health Care System**
Tayyari Dehbarez N., Gyrd-Hansen D., Uldbjerg N., et al.

Inégalités de santé

- 31 **Measuring Performance on the Healthcare Access and Quality Index for 195 Countries and Territories and Selected Subnational Locations: A Systematic Analysis from the Global Burden of Disease Study 2016**
Fullman N., Yearwood J., Abay S.M., et al.
- 31 **Pauvreté et non-recours aux dispositifs sociaux : l'étude du RSA « socle seul »**
Chareyron S.
- 32 **Healthcare Use Among Immigrants and Natives in Sweden on Disability Pension, Before and After Changes of Regulations**
Di Thiene D., Rahman S., Helgesson M., et al.
- 32 **A Framework for Regional Primary Health Care to Organise Actions to Address Health Inequities**
Freeman T., Javanparast S., Baum F., et al.
- 32 **Residence Permit for Medical Reasons: An Obstacle to Permanent Residence Status. Results of the ANRS Parcours Study**
Gosselin A.
- 33 **Les mineurs isolés étrangers et le système de soins français : étude qualitative**
Guégan M. et Rivollier E.
- 33 **Interventions en littératie en santé et éducation thérapeutique : une revue de la littérature**
Margat A., Gagnayre R., Lombrail P., et al.

- 34 **Health and Health Care Access for Syrian Refugees Living in Istanbul**
Torun P., Mucaz Karaaslan M., Sandikli B., et al.
- 34 **Payment Reform and Health Disparities: Changes in Dialysis Modality Under the New Medicare Dialysis Payment System**
Turenne M., Baker R., Pearson J., et al.
- 34 **Des obstacles à la connaissance des inégalités de santé. Deuxième partie : perspective psycho-sociale**
Vega A., Lecarpentier M. et Naamouni K.
- 34 **Refusal to Provide Healthcare to Sub-Saharan Migrants in France: A Comparison According to Their HIV and HBV Status**
Vignier N., Dray Spira R., Pannetier J., et al.
- 38 **Variations in Non-Prescription Drug Consumption and Expenditure: Determinants and Policy Implications**
Otto M., Armeni P. et Jommi C.
- 38 **The Effects of State-Level Pharmacist Regulations on Generic Substitution of Prescription Drugs**
Song Y. et Barthold D.
- 38 **Antimicrobial Consumption and Resistance in Adult Hospital Inpatients in 53 Countries: Results of an Internet-Based Global Point Prevalence Survey**
Versporten A., Zarb P., Caniaux I., et al.
- 38 **Do Health Professionals Tell Patients What They Want to Know About Their Medicines?**
Young A., Tordoff J., Leitch S., et al.

Médicaments

- 35 **Value-Based Insurance Design Improves Medication Adherence Without an Increase in Total Health Care Spending**
Agarwal R., Gupta A. et Fendrick A. M.
- 35 **Patterns and Predictors of Physician Adoption of New Cardiovascular Drugs**
Anderson T. S., Lo-Ciganic W.-H., Gellad W. F., et al.
- 36 **Prescriptions médicamenteuses potentiellement inappropriées en gériatrie : quels outils utiliser pour les détecter ?**
Desnoyer A., Guignard B., Lang P.-O., et al.
- 36 **Innovative Pharmaceutical Pricing Agreements in Five European Markets: A Survey of Stakeholder Attitudes and Experience**
Dunlop W. C. N., Staufer A., Levy P., et al.
- 36 **Médicaments potentiellement inappropriés (MPI) chez la personne âgée : état des lieux dans un service de cardiologie**
Gaillard M., Mosnier-Thoumas S., Berroneau A., et al.
- 37 **Inappropriate Prescribing in Older Persons: A Systematic Review of Medications Available in Different Criteria**
Lucchetti G. et Lucchetti A. L. G.
- 37 **Expériences médicamenteuses et expériences du cancer. L'appropriation des anticancéreux oraux par les patients**
Marmorat T., Rioufol C., Ranchon F., et al.

Méthodologie – Statistique

- 39 **Bias in Patient Satisfaction Surveys: A Threat to Measuring Healthcare Quality**
Dunsch F., Evans D. K., Macis M., et al.
- 39 **How to Make More Published Research True**
Ioannidis J. P.
- 39 **La malédiction des données**
Lemoine P.
- 40 **L'enquête TeO de l'Ined : Commentaires et problèmes d'interprétation**
Mizrahi A.
- 40 **Paradoxe dans l'enquête de victimisation : racisme perçu et racisme actif**
Mizrahi A.
- 40 **Les données de santé**
Polton D.

Politique de santé

- 41 **Tensions and Uncertainties in Person-Centred Support for People with Long-Term Conditions**
Cribb A., Watt I. S., Skea Z. C., et al.

- 41 **Éduquer le patient ou transformer l'action publique : un espace d'expression pour les patients. Commentaire**
Fournier C. et Troisoefus A.
- 41 **Decoding Disclosure: Comparing Conflict of Interest Policy Among the United States, France, and Australia**
Grundy Q., Habibi R., Shnier A., et al.
- 42 **Should Interventions to Reduce Variation in Care Quality Target Doctors or Hospitals?**
Gutacker N., Bloor K., Bojke C., et al.
- 42 **The Diabetes Self-Management Educational Programs and Their Integration in the Usual Care: A Systematic Literature Review**
Kumah E., Sciolli G., Toraldo M. L., et al.
- 42 **Understanding Delays in Acute Stroke Care: A Systematic Review of Reviews**
Lachkhem Y., Rican S. et Minvielle E.
- 43 **Mapping Existing Hip and Knee Replacement Registries in Europe**
Lubbeke A., Silman A. J., Barea C., et al.
- 43 **Éducation thérapeutique en odontologie pédiatrique : analyse des obstacles et leviers au développement de programmes en France en 2016**
Marquillier T., Trentesaux T. et Gagnayre R.
- 43 **We Need to Talk About Purpose: A Critical Interpretive Synthesis of Health and Social Care Professionals' Approaches to Self-Management Support for People with Long-Term Conditions**
Morgan H. M., Entwistle V. A., Cribb A., et al.
- 44 **L'émergence de la question de la sécurité des patients en France**
Mougeot F., Ocellli P., Buchet-Poyau K., et al.
- 44 **"Was that a Success or Not a Success?" A Qualitative Study of Health Professionals' Perspectives on Support for People with Long-Term Conditions**
Owens J., Entwistle V. A., Cribb A., et al.
- 45 **Éduquer le patient ou transformer l'action publique ? Analyse socio-historique d'une association pour le développement de l'éducation thérapeutique du patient**
Perrier C. et Perrin C.
- 45 **Health Policy and Systems Research: The Future of the Field**
Peters D. H.
- 45 **Space, Place and (Waiting) Time: Reflections on Health Policy and Politics**
Sheard S.
- 46 **Two-Year Management After Renal Transplantation in 2013 in France: Input from the French National Health System Database**
Tuppin P., Bessou A., Legeai C., et al.

Politique publique

- 46 **Développement d'un cours francophone en ligne sur les politiques publiques en santé : une collaboration internationale**
Hébert R., Coppieters Y., Pradier C., et al.

Politique sociale

- 47 **La sécurité sociale entre solidarité et marché**
Bec C.
- 47 **Troubles dans la protection sociale**
Delouette I. et Le Lann Y.

Prévention santé

- 47 **The Practices of French General Practitioners Regarding Screening and Counselling Pregnant Women for Tobacco Smoking and Alcohol Drinking**
Andler R., Cogordan C., Pasquereau A., et al.
- 48 **Promoting Health-Enhancing Physical Activity in Europe: Current State of Surveillance, Policy Development and Implementation**
Breda J., Jakovljevic J., Rathmes G., et al.
- 48 **Étude qualitative auprès des utilisateurs de cigarette électronique : pratiques, usages, représentations**
Fontaine A. et Artigas F.
- 48 **Smoking Cessation Delivery by General Practitioners in Crete, Greece**
Girvalaki C., Papadakis S., Vardavas C., et al.

- 49 **Impact of Public Smoking Bans on Children's Exposure to Tobacco Smoke at Home: A Systematic Review and Meta-Analysis**

Nanninga S., Lhachimi S. K. et Bolte G.

- 49 **Expansion of the 'Antibiotic Guardian' One Health Behavioural Campaign Across Europe to Tackle Antibiotic Resistance: Pilot Phase and Analysis of AMR Knowledge**

Newitt S., Anthierens S., Coenen S., et al.

Prévision – Evaluation

- 49 **A Bayesian Framework for Health Economic Evaluation in Studies with Missing Data**

Mason A. J., Gomes M., Grieve R., et al.

Psychiatrie

- 50 **Women's Mental Health in the Perinatal Period According to Migrant Status: The French Representative ELFE Birth Cohort**

El-Khoury F., Sutter-Dallay A. L., Panico L., et al.

- 50 **The Impact of the Current Economic Crisis on Mental Health in Italy: Evidence from Two Representative National Surveys**

Odone A., Landriscina T., Amerio A., et al.

- 51 **Depressive Disorders in Primary Care: Clinical Features and Sociodemographic Characteristics**

Oneib B., Sabir M., Otheman Y., et al.

- 51 **La réhospitalisation en psychiatrie. Facteurs individuels, facteurs organisationnels**

Plancke L., Amariei A., Flament C., et al.

- 51 **Strengthening Mental Health Care Systems for Syrian Refugees in Europe and the Middle East: Integrating Scalable Psychological Interventions in Eight Countries**

Sijbrandij M., Acarturk C., Bird M., et al.

- 52 **Improving Quality of Psychiatric Care in Latvia by Measuring Patient Experiences**

Taube M. et Berzina-Novikova N.

Soins de santé primaires

- 52 **La place du médecin et de la famille dans la décision pour des patients en fin de vie**

Angelo M. Bismuth M., Oustric S. et al.

- 52 **Effects of Regulation and Payment Policies on Nurse Practitioners' Clinical Practices**

Barnes H., Maier C. B., Altares Sarik D., et al.

- 53 **Uncovering the Wisdom Hidden Between the Lines: The Collaborative Reflexive Deliberative Approach**

Crabtree B. F., Miller W. L., Gunn J. M., et al.

- 53 **Accuracy of Patient Recall for Self-Reported Doctor Visits: Is Shorter Recall Better?**

Dalziel K., Li J., Scott A., et al.

- 53 **Changes in Access to Primary Care in Europe and Its Patterning, 2007-12: A Repeated Cross-Sectional Study**

Dimitrovova K. et Perelman J.

- 54 **Continuing Education for General Practitioners Working in Rural Practice: A Review of the Literature**

Dowling S., Last J., Finnigan H., et al.

- 54 **Comment les médecins généralistes peuvent-ils contribuer à un accès plus équitable à l'éducation thérapeutique ?**

Fournier C., Naiditch M. et Frattini M. O.

- 55 **Accountable Care Organizations and Post-Acute Care: A Focus on Preferred SNF Networks**

Kennedy, G., Lewis, V. A., Kundu, S., et al.

- 55 **Transforming Integration Through General Practice: Learning from a UK Primary Care Improvement Programme**

Miller R.

- 55 **The Application of Triple Aim Framework in the Context of Primary Healthcare: A Systematic Literature Review**

Obucina M., Harris N., Fitzgerald J. A., et al.

- 55 **L'épuisement de la volonté de bien faire chez les médecins : « Y-a-t-il un médecin dans la salle ? »**

Pame P. et Josset J. M.

- 56 **Transforming Primary Care: Scoping Review of Research and Practice**

Robin M., Catherine W. et Steve G.

- 56 **Effects of Access to Radiology in Out-Of-Hours Primary Care in the Netherlands: A Prospective Observational Study**
Rutten M. H., Smits M., Peters Y. A. S., et al.
- 57 **Integrated Care in Switzerland: Results from the First Nationwide Survey**
Schussele Filliettaz S., Berchtold P., Kohler D., et al.
- 57 **Community Orientation of General Practitioners in 34 Countries**
Vermeulen L., Schäfer W., Pavlic D. R., et al.

Systèmes de santé

- 57 **L'innovation organisationnelle, un processus d'apprentissage au service de la transformation du système de santé ?**
Bourgueil Y.
- 57 **Cross-Country Comparative Research: Lessons from Advancing Health System and Policy Research on the Occasion of the European Observatory on Health Systems and Policies 20Th Anniversary**
Busse R. et van Ginneken E.
- 58 **Addressing Overuse of Health Services in Health Systems: A Critical Interpretive Synthesis**
Ellen M. E., Wilson M. G., Vélez M., et al.
- 58 **Competition in Health Care: Lessons from the English Experience**
Propper C.
- 59 **Les réformes des retraites conduites en France depuis 2010 : quels effets sur les inégalités inter et intra générationnelles ?**
Duc C., Martin H. et Treguier J.
- 60 **Why Health and Social Care Support for People with Long-Term Conditions Should Be Oriented Towards Enabling Them to Live Well**
Entwistle V. A., Cribb A. et Owens J.
- 60 **What Happens at the End of Life? Using Linked Administrative Health Data to Understand Healthcare Usage in the Last Year of Life in New Zealand**
Hamblin R., Minko N., Shuker C., et al.
- 60 **Exploring the Collaboration Between Formal and Informal Care from the Professional Perspective—A Thematic Synthesis**
Hengelaar A. H., Hartingsveldt M., Wittenberg Y., et al.
- 61 **Motifs d'adhésion à une activité physique adaptée chez des seniors en ALD**
Morales Gonzales V., Schuft L., Fournier M., et al.
- 61 **Les habits neufs du « vieillissement en bonne santé » : activité et environnement**
Moulaert T.

Travail et santé

- 58 **L'influence des conditions de travail passées sur la santé et la consommation de médicaments auto-déclarés des retraités**
Barnay T. et Defebvre É.
- 59 **Long Working Hours and Sickness Absence—A Fixed Effects Design**
Bernstrøm V. H.

Vieillesse

- 59 **Du domicile à l'institution : évolution des réseaux de sociabilité**
Desquesnes G., Monfreux M. et Rouault M.

Assurance maladie

► **Quelle complémentarité entre AMO ET AMC ? Actes de la 13e Matinée thématique du 19 octobre 2017**

CORNU-PAUCHET M., GISSOT C ET LAGASGNERIE G.
2018

Lettre du Collège (La)(2): 22

La place de l'assurance privée dans le financement des dépenses de santé en France apparaît relativement élevée au regard des comparaisons internationales, et sur longue période, cette part a tendance à augmenter. Au-delà de cette place croissante, ce qui en fait sa singularité est sa nature : il s'agit pour l'essentiel d'une assurance dite complémentaire, c'est-à-dire qui intervient en complément des remboursements de la Sécurité sociale, pour prendre en charge les co-paiements laissés par le système public pour les consommations de soins à tarif réglementé et pour les dépenses excédant les tarifs de responsabilité quand les tarifs sont libres. Cette Lettre rassemble les communications données lors de la 13^e Matinée thématique du 19 octobre 2017 du Collège des économistes de la santé. Elle dresse tout d'abord un état des lieux sur le partage entre l'AMO et l'AMC et sur les dynamiques actuelles ; puis s'interroge sur les solutions futures : ajustements à la marge ou réinterrogation du modèle.

► **Généralisation de la complémentaire santé d'entreprise. Une évaluation ex ante des gains et des pertes de bien-être**

PIERRE A., JUSOT F., RAYNAUD D., *et al.*
2018

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www.cairn.info/revue-economique-2018-3-page-407.htm

Depuis le 1^{er} janvier 2016, les employeurs du secteur privé ont obligation de proposer et de financer partiellement une complémentaire santé à tous leurs salariés. Dans ce travail, nous simulons les gains et les pertes de bien-être à attendre de cette réforme sur l'ensemble de la population en mobilisant la théorie de l'utilité espérée. Les résultats montrent que la réforme augmente le bien-être collectif si et seulement si les salaires et les primes des contrats restent inchangés. En considérant que les primes des contrats individuels augmentent du fait de l'accord national interprofessionnel (ANI), l'impact de la réforme est quasi nul sur le

bien-être collectif. Le gain en bien-être des salariés qui bénéficient de la réforme est alors contrebalancé par la perte de bien-être subie par les personnes couvertes en individuel ou que la réforme oblige à s'assurer. En considérant en sus que les employeurs intègrent le montant de leur subvention aux salaires, l'ANI réduit fortement le bien-être collectif.

► **Universal Coverage Reforms in the USA: from Obamacare Through Trump**

RICE T., UNRUH L. Y., VAN GINNEKEN E., *et al.*
2018

Health Policy 122(7): 698-702

<http://dx.doi.org/10.1016/j.healthpol.2018.05.007>

President Trump's administration is undoing some of the Affordable Care Act's provisions. The individual mandate to purchase coverage has been repealed. Medicaid remains but premiums in insurance exchanges rose considerably in 2018. Political compromise possible in short-run; long-run depends on upcoming elections. In the meantime, prospects are that the number of uninsured will grow.

► **Development of Voluntary Private Health Insurance in Nordic Countries - An Exploratory Study on Country-Specific Contextual Factors**

TYNKKYNNEN L. K., ALEXANDERSEN N., KAARBOE O., *et al.*

2018

Health Policy 122(5): 485-492.

The Nordic countries are healthcare systems with tax-based financing and ambitions for universal access to comprehensive services. This implies that distribution of healthcare resources should be based on individual needs, not on the ability to pay. Despite this ideological orientation, significant expansion in voluntary private health insurance (VPHI) contracts has occurred in recent decades. The development and role of VPHIs are different across the Nordic countries. Complementary VPHI plays a significant role in Denmark and in Finland. Supplementary VPHI is prominent in Norway and Sweden. The aim of this

paper is to explore drivers behind the developments of the VPHI markets in the Nordic countries. We analyze the developments in terms of the following aspects: the performance of the statutory system (real or perceived), lack of coverage in certain areas of healthcare, governmental interventions or inability to reform the system, policy trends and the general socio-cultural environment, and policy responses to voting behavior

or lobbying by certain interest groups. It seems that the early developments in VPHI markets have been an answer to the gaps in the national health systems created by institutional contexts, political decisions, and cultural interpretations on the functioning of the system. However, once the market is created it introduces new dynamics that have less to do with gaps and inflexibilities and more with cultural factors.

E-santé - Technologies médicales

► **Motifs de recours à la télémédecine en médecine générale à partir d'une expérimentation en EHPAD**

BISMUTH S., REMANDE A., DÉCOUARD P., *et al.*
2014

European Research in Telemedicine / La Recherche Européenne en Télémédecine 3(2): 77-83.

<http://www.sciencedirect.com/science/article/pii/S2212764X14000466>

En France, la télémédecine qui consiste à utiliser les technologies de la télécommunication pour le diagnostic médical et les soins de santé est peu développée en médecine générale. Pourtant, les pouvoirs publics et les différents acteurs de cette nouvelle pratique ont conscience que tout se joue maintenant. Nous avons mené une étude rétrospective descriptive de téléconsultations de population âgée à mobilité réduite vivant en EHPAD et nous avons recensé les différents motifs de consultations de médecine générale traités en télémédecine entre le 20 mai 2011 et le 20 décembre 2012. Ces consultations associaient l'image et le son et se déroulaient en présence d'une partie du personnel de l'EHPAD. Dans la quasi-totalité des cas, le patient et/ou la personne de confiance étaient présents. Notre étude a mis en évidence de nombreux motifs de consultation de médecine générale, qu'il s'agisse de dermatologie, d'angiologie, de gastroentérologie, de cardiologie, de néphrologie, de rhumatologie, de diabétologie, de neurologie, de gériatrie, de psychiatrie ou concernant la prescription médicamenteuse. La télémédecine paraît être une pratique adaptée aux pathologies prises en charge en médecine générale. Elle favorise la prise en charge pluridisciplinaire du patient sur son lieu de vie. Cette étude basée sur un petit nombre de cas mérite d'être étendue à d'autres EHPAD et en médecine ambulatoire.

► **Anticiper les usages et les conséquences des technologies connectées en santé mentale. Une étude de « cas fictif »**

BRIFFAULT X. ET MORGIEVE M.
2017

Droit, Santé et Société 3-4(3): 35-46.

<https://www.cairn.info/revue-droit-sante-et-societe-2017-3-page-35.htm>

Le champ de la e-santé (mentale) est particulièrement actif, et produit de nouveaux dispositifs à un rythme extrêmement rapide. Si l'analyse empirique des usages actuels de ces dispositifs est indispensable, il est tout aussi nécessaire d'anticiper sur les bouleversements qui surviendront dans un avenir proche en réfléchissant sur des usages possibles, mais non encore avérés, de ces dispositifs pour les personnes présentant des problématiques psychiques / des troubles mentaux, et sur les problématiques que poseront les données générées par ces nouveaux dispositifs. L'analyse de cas fictif offre de telles possibilités de réfléchir par avance sur des technologies émergentes dont le potentiel « disruptif » – pour reprendre le terme popularisé par différents acteurs du numérique – impose de ne pas se limiter aux usages connus. C'est ce que nous proposons ici avec un cas dont nous situons l'occurrence dans cinq ans. Nous aborderons les usages possibles des dispositifs connectés tout au long d'une journée « typique » d'une personne présentant des problèmes sévères de dysrégulations émotionnelles et de conduites suicidaires. Ils nous serviront de support à une réflexion sur cinq modalités de régulation envisageables pour la propriété et les usages des données générées par ces dispositifs ubiquitaires, qui seront à terme intégrés dans les moindres interstices de nos vies quotidiennes.

► **La télémédecine, un instrument susceptible de corriger les inégalités de santé ?**

DESBOIS D.
2018

Terminal : Technologie de l'Information, Culture & Société(122): 112

Pour la population des pays développés, l'égalité dans l'accès aux soins médicaux sur l'ensemble des territoires constitue l'un des objectifs majeurs des politiques de santé. Aujourd'hui, la concentration des professionnels et des services de santé dans les villes accentue les disparités entre les zones rurales et leurs pôles urbains. En France, de fortes disparités dans l'offre de services de santé sont observées que ce soit au niveau régional selon un gradient Nord-Sud ou au niveau infradépartemental entre pôles urbains et zones rurales mais aussi, au sein des zones urbaines, entre quartiers favorisés et défavorisés. Alors que Paris possède presque 800 médecins pour 100 000 habitants, certains territoires ruraux en comptent moins de 200. Malgré une progression de l'indicateur d'espérance de vie à la naissance entre 2002 et 2015, l'Europe est également concernée par ces inégalités territoriales avec une fracture majeure entre l'Est et l'Ouest, recouvrant les disparités de développement économique. La télémédecine pourrait-elle être une solution pour réduire les inégalités d'accès aux soins au niveau d'un territoire ?

► **Patient Access to Electronic Health Records: Differences Across Ten Countries**

ESSÉN A., SCANDURRA I., GERRITS R., *et al.*
2018

Health Policy and Technology 7(1): 44-56.

<http://dx.doi.org/10.1016/j.hlpt.2017.11.003>

Patient-accessible electronic health records (PAEHRs) are being implemented at international scale. Comparing policies and systems could allow countries to learn from each other to address global and nation-specific challenges. We compare national PAEHR policy (hard and soft regulation) and services in 10 countries.

► **Conditions d'adoption du dossier de santé électronique personnel par les professionnels de la première ligne au Québec : perspectives professionnelle et organisationnelle**

GHANDOUR E. K., GAGNON M.-P. ET FORTIN J.-P.
2017

Santé Publique 29(6): 837-850.

<https://www.cairn.info/revue-sante-publique-2017-6-page-837.htm>

L'objectif de cet article est de décrire et analyser les facteurs influençant l'adoption du dossier de santé électronique personnel (DSE-P) par les professionnels pour le suivi et la gestion des maladies chroniques, tels que perçus par eux-mêmes et par les gestionnaires. Nous avons mené une étude qualitative dans le cadre d'un projet d'expérimentation d'un DSE-P en première ligne de soins au Québec. 11 professionnels et trois gestionnaires ont participé à des entrevues individuelles semi-dirigées. Plusieurs catégories de thèmes liés à des facteurs individuels, organisationnels, liés aux patients et à la technologie offerte, ont représenté des facilitateurs ou des barrières à l'adoption du DSE-P par les professionnels. Principalement sont retenus le leadership des cliniciens et l'historique de leur implication dans les transformations organisationnelles, l'adaptation au contexte de la pratique, la maturité et l'intégration de la technologie aux systèmes d'information disponibles facilitant la communication bidirectionnelle et soutenant le partenariat patient-professionnels et l'adhésion des patients. Les précurseurs organisationnels identifiés réfèrent à l'ouverture de l'organisation envers l'innovation, à l'ajustement aux valeurs dans l'organisation, mais surtout aux pratiques mises en place pour soutenir l'adoption du DSE-P par les cliniciens et leurs patients. Le coût est un enjeu important pour l'implantation et l'adoption du DSE-P. L'identification des facteurs influençant l'adoption du DSE-P aura un intérêt sur les plans stratégique et opérationnel pour le développement de nouvelles pratiques cliniques, organisationnelles et, surtout, de technologies adaptées.

► **Implementation of the SMART MOVE Intervention in Primary Care: A Qualitative Study Using Normalisation Process Theory**

GLYNN L. G., GLYNN F., CASEY M., *et al.*

2018

BMC Family Practice 19(1): 48.

<https://doi.org/10.1186/s12875-018-0737-2>

Problematic translational gaps continue to exist between demonstrating the positive impact of health-care interventions in research settings and their implementation into routine daily practice. The aim of this qualitative evaluation of the SMART MOVE trial was to conduct a theoretically informed analysis, using normalisation process theory, of the potential barriers and levers to the implementation of a mhealth intervention to promote physical activity in primary care.

► **Détection des prescriptions inappropriées, les critères STOPP/START**

LANG P. O., BOURGUE C. ET CSAJKA C.

2018

Actualités Pharmaceutiques 57(572): 26-32.

<http://www.sciencedirect.com/science/article/pii/S0515370017304615>

Les prescriptions médicamenteuses inappropriées sont associées à une diminution de la qualité de vie, une augmentation de la morbi-mortalité et des surcoûts pour les systèmes de santé. Les patients âgés, souvent polypathologiques et polymédiqués, sont à haut risque. Des outils ont été développés pour prévenir ces erreurs. Les critères STOPP/START constituent une aide substantielle et validée pour les praticiens dans une démarche de révision et d'optimisation des prescriptions.

► **Expérimentations de remboursement des actes de télémédecine en plaies et cicatrisation en France**

LANO J., GERI-TRIAL C., CABROL M., *et al.*

2017

Revue Francophone de Cicatrisation 1(4): 58-61.

<http://www.sciencedirect.com/science/article/pii/S2468911417303997>

Les expérimentations de l'article 36 de la loi de financement de la Sécurité sociale pour 2014 (LFSS 2014), visent à définir les modèles de rémunération qui pourraient être mis en place dans le cadre de la télémédecine. Initialement prévue dans neuf régions, cette expérimentation est étendue depuis la LFSS 2017 à l'ensemble du territoire national. Les professionnels requis pour les actes de télémédecine du réseau Cicat-LR, qui fait suite au projet Domoplaies, ont débuté l'expérimentation selon le cahier des charges des expérimentations relatives à la prise en charge par télémédecine des plaies chroniques et complexes permises par la LFSS 2014 et, depuis février 2017, selon les procédures préalables au programme Etapes. Cette expérimentation vise à fixer les dispositions réglementaires et la classification commune des actes de télémédecine pour déterminer le modèle tarifaire adéquat et analyser son impact sur le système de soins. Elle devrait permettre de pérenniser le projet Domoplaies et l'élargir à d'autres régions, mais également d'intégrer la pratique de la télémédecine dans le parcours de santé des patients porteurs de plaies.

► **Santé : la révolution numérique. Dossier**

LEROUX V. ET BOURGEAON L.

2018

Gestions Hospitalières(575): 213-288.

Ce dossier est consacré aux enjeux et aux perspectives de la transformation digitale des institutions et organisations de santé. Différentes problématiques sont abordées, présentées par niveau d'analyse. Le premier niveau concerne le patient et sa relation à la maladie. Le deuxième niveau concerne le patient : en quoi le digital change sa place et, surtout, modifie ses relations avec les professionnels de santé. Le troisième niveau est relatif aux établissements et aux organisations de santé. La façon de soigner ne dépend pas que de l'évolution digitale du soigné mais bien de la rencontre de deux évolutions, à la fois celle des praticiens et de leur réseau interprofessionnel, et celle des personnes et de leur entourage.

► **Ehealth as a Facilitator of Equitable Access to Primary Healthcare: The Case of Caring for Non-Communicable Diseases in Rural and Refugee Settings in Lebanon**

SALEH S., ALAMEDDINE M., FARAH A., *et al.*

2018

Int J Public Health 63(5): 577-588.

The aim of this study is to assess the effect of selected low-cost eHealth tools on diabetes/hypertension detection and referrals rates in rural settings and refugee camps in Lebanon and explore the barriers to showing-up to scheduled appointments at Primary Healthcare Centers (PHC). Community-based screening for diabetes and hypertension was conducted in five rural and three refugee camp PHCs using an eHealth netbook application. Remote referrals were generated based on pre-set criteria. A phone survey was subsequently conducted to assess the rate and causes of no-shows to scheduled appointments. Associations

between the independent variables and the outcome of referrals were then tested. Among 3481 screened individuals, diabetes, hypertension, and comorbidity were detected in 184,356 and 113 per 1000 individuals, respectively. 37.1% of referred individuals reported not showing-up to scheduled appointments, owing to feeling better/symptoms resolved (36.9%) and having another obligation (26.1%). The knowledge of referral reasons and the employment status were significantly associated with appointment show-ups. Low-cost eHealth netbook application was deemed effective in identifying new cases of NCDs and establishing appropriate referrals in underserved communities.

Économie de la santé

► **Beyond Activity Based Funding.
An Experiment in Denmark**

BURAU V., DAHL H. M., JENSEN L. G., *et al.*

2018

Health Policy 122(7): 714-721.

Over past decades Activity Based Funding has been an attractive tool for hospital funding and governance, but there has been growing frustration especially with its unintended effects. There are numerous examples of alternative models, but there is little in-depth knowledge about how these models came about. The aim of our study was to analyse how the discourse of Activity Based Funding was successfully challenged. This contributes insights into how international/national debates are translated into concrete alternative models through specific discursive mechanisms. The analysis used a discursive policy approach and was based on a case study from Denmark ('New Governance'). The data consisted of project and policy documents as well as qualitative interviews with regional and national experts. The analysis identified four discursive mechanisms: the problem definitions underlying 'New Governance' were clear and simple; the underlying assumptions both accepted and challenged the premises of Activity Based Funding; the alternative of 'New Governance' was defined in rather broad terms; and it was produced, disseminated and defended as part of interweaving processes regionally but also nationally. Our study showed that new models of hospital funding and governance need to be carefully engineered and

that they draw on a mix of governance logics. Future research needs to study more examples from a broad range of institutional contexts and points in time.

► **A Qualitative Investigation of the Health Economic Impacts of Bariatric Surgery for Obesity and Implications for Improved Practice in Health Economics**

CAMPBELL J. A., EZZY D., NEIL A., *et al.*

2018

Health Econ 27(8): 1300-1318

Obesity is an economic problem. Bariatric surgery is cost-effective for severe and resistant obesity. Most economic evaluations of bariatric surgery use administrative data and narrowly defined direct medical costs in their quantitative analyses. Demand far outstrips supply for bariatric surgery. Further allocation of health care resources to bariatric surgery (particularly public) could be stimulated by new health economic evidence that supports the provision of bariatric surgery. We postulated that qualitative research methods would elicit important health economic dimensions of bariatric surgery that would typically be omitted from the current economic evaluation framework, nor be reported and therefore not considered by policymakers with sufficient priority. We listened to patients: Focus group data were analysed thematically with software assistance. Key themes were identified induc-

tively through a dialogue between the qualitative data and pre-existing economic theory (perspective, externalities, and emotional capital). We identified the concept of emotional capital where participants described life-changing desires to be productive and participate in their communities postoperatively. After self-funding bariatric surgery, some participants experienced financial distress. We recommend a mixed-methods approach to the economic evaluation of bariatric surgery. This could be operationalised in health economic model conceptualisation and construction, through to the separate reporting of qualitative results to supplement quantitative results.

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

HERBST T., FOERSTER J. ET EMMERT M.
2018

Health Policy 122(6): 667-673.

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

► **Patients' Attitudes Toward Copayments as a Steering Tool-Results from a Qualitative Study in Norway and Germany**

HERRMANN W. J., HAARMANN A. ET BAERHEIM A.
2018

Fam Pract 35(3): 312-317.

Copayments are implemented in many health care systems. The effect of copayments differs between countries. Up to now, patients' attitudes regarding copayments are mainly unknown. Thus, the goal of our analysis was to explore adult patients' attitudes in Germany and Norway towards copayments as a steering tool. We conducted a qualitative comparative study. Episodic interviews were conducted with 40 patients in Germany and Norway. The interviews were analysed by thematic coding in the framework of grounded theory. All text segments related to copayments were analysed in depth for emerging topics and types. We found three dimensions of patients' attitudes towards copayments: the perceived steering effect, the comprehensibility, and the assessment of copayments. The perceived steering effect consists of three types: having been influenced by copayments, not having experienced any influence and the experience of other persons to be influenced. The category comprehensibility describes that not all patients understand rules and regulations of copayments and its caps. The assessment of copayments consists of nine subcategories, three of which are rather negative and six of which are rather positive. In all three dimensions the patterns between the German and Norwegian sub-samples differ considerably. The results of our study point at the importance of communicating clear rules for copayments which are easily comprehensible.

► **Organ Recovery Cost Assessment in the French Healthcare System from 2007 to 2014**

HRIFACH A., GANNE C., COURAY-TARGE S., *et al.*
2018

Eur J Public Health 28(3): 415-420.

Organ recovery costs should be assessed to allow efficient and sustainable integration of these costs into national healthcare budgets and policies. These costs are of considerable interest to health economists, hospitals, financial managers and policy makers in most developed countries. This study assessed organ

recovery costs from 2007 to 2014 in the French health-care system based on the national hospital discharge database and a national cost study. The secondary objective was to describe the variability in the population of deceased organ donors during this period. All stays for organ recovery in French hospitals between January 2007 and December 2014 were quantified from discharge abstracts and valued using a national cost study. Five cost evaluations were conducted to explore all aspects of organ recovery activities. A sensitivity analysis was conducted to test the methodological choice. Trends regarding organ recovery practices were assessed by monitoring indicators. Results: The analysis included 12 629 brain death donors, with 28 482 organs recovered. The mean cost of a hospital stay was €7469 (SD = €10, 894). The mean costs of separate kidney, liver, pancreas, intestine, heart, lung and heart-lung block recovery regardless of the organs recovered were euro1432 (SD = euro1342), €502 (SD = €782), €354 (SD = €475), €362 (SD = €1559), €542 (SD = €955), €977 (SD = €1196) and €737 (SD = €637), respectively. Despite a marginal increase in donors, the number of organs recovered increased primarily due to improved practices. Although cost management is the main challenge for successful organ recovery, other aspects such as organization modalities should be considered to improve organ availability.

► **Experts' Perspectives on SwissDRG: Second Class Care for Vulnerable Patient Groups?**

LEU A., WEPF H., ELGER B., *et al.*

2018

[Health Policy 122\(6\): 577-582.](#)

On the 1st of January 2012, Switzerland introduced the diagnosis-related group hospital tariff structure (SwissDRG). It was recognised that healthcare provided to the most vulnerable patient groups would be a challenge for the new SwissDRG. Coincident with the implementation of SwissDRG, we explored hospital experts' perceptions of which patient groups are vulnerable under the SwissDRG system, what has changed for this group, as well as solutions to ensure adequate access to health care for them. We interviewed 43 experts from 40 Swiss hospitals. Participating experts named several vulnerable patient groups who share some common characteristics. These hospital experts were concerned about the patient groups that are not financially profitable and questioned the practicability

of the current regulation. At the same time, they highlighted the complexity associated with caring for this group under the new SwissDRG and reported measures at the macro, meso, and micro levels to protect vulnerable patient groups from negative effects. To curb negative outcomes for vulnerable patient groups after the introduction of the SwissDRG, the Swiss legislation has introduced various instruments including the acute and transitional care (ATC) measures. We conclude that ATC measures do not produce the expected effect the legislators had hoped for. More health data is needed to identify situations where vulnerable patient groups are more susceptible to inadequate health care access in Switzerland.

► **Physician Perspectives in Year 1 of MACRA and Its Merit-Based Payment System: A National Survey**

LIAO J. M., SHEA J. A., WEISSMAN A., *et al.*

2018

[Health Aff \(Millwood\) 37\(7\): 1079-1086.](#)

We surveyed a national sample of internal medicine physicians in March-May 2017 to explore their beliefs about the newly implemented Merit-based Incentive Payment System (MIPS). Respondents believed that their efforts in the four focus areas identified in the survey would ultimately improve the value of care. When informed that those areas represented the four MIPS domains, the majority remained positive about the likely impact on value. However, expectations varied by physicians' characteristics and sense of control over the desired outcomes, and many respondents believed that unintended consequences could occur. Moreover, respondents generally reported low familiarity with the policy and disagreed with program guidelines for weighting domains in the composite score. These findings indicate the need to educate physicians about MIPS and suggest potentially fruitful approaches. Moving forward, policy makers should monitor for unintended consequences and explore ways to better align program guidelines with physicians' perspectives.

► **Health Expenditure Data for Policy: Health Accounts, National Accounts or Both?**

MOSSEVELD C.V., POLANEN PETEL W., HERNÁNDEZ-PEÑA P., *et al.*

2018

Health Policy 122(8) : 885-891

Reported differences between National Accounts and Health Accounts are scope, treatment of intermediate consumption, valuation of transactions and boundaries. These differences are also found in the Netherlands. The analysis showed commonalities and differences that need an explanation or correction, to increase consistency between the frameworks and compliance with international standards. For analysis and explanation, transparency is a prerequisite, as it permits replicability, and data and metadata should be at hand. Comparability of household spending in Health Accounts and National Accounts household consumption is high, once differences in definitions are sorted out. National Accounts data can be used for judging plausibility of Health Accounts household spending, and might be a good proxy for estimating this spending: In decreasing priority order aggregates of consumption of health products (Q86), consumption of health and social care products (Q) and consumption of all goods and services and their related index numbers can be used. The results of this study are encouraging but may not be generalizable to other countries and need to be replicated especially in Low and Middle-Income Countries for verification purposes.

► **Comparison of Hospitals Participating in Medicare's Voluntary and Mandatory Orthopedic Bundle Programs**

NAVATHE A. S., LIAO J. M., POLSKY D., *et al.*

2018

Health Aff (Millwood) 37(6): 854-863.

We analyzed data from Medicare and the American Hospital Association Annual Survey to compare characteristics and baseline performance among hospitals in Medicare's voluntary (Bundled Payments for Care Improvement initiative, or BPCI) and mandatory (Comprehensive Care for Joint Replacement Model, or CJR) joint replacement bundled payment programs. BPCI hospitals had higher mean patient volume and were larger and more teaching intensive than were CJR hospitals, but the two groups had similar risk expo-

sure and baseline episode quality and cost. BPCI hospitals also had higher cost attributable to institutional postacute care, largely driven by inpatient rehabilitation facility cost. These findings suggest that while both voluntary and mandatory approaches can play a role in engaging hospitals in bundled payment, mandatory programs can produce more robust, generalizable evidence. Either mandatory or additional targeted voluntary programs may be required to engage more hospitals in bundled payment programs.

► **Management of Pregnancy Based on Healthcare Consumption of Women Who Delivered in France in 2015: Contribution of the National Health Data System (SNDS)**

PIFFARETTI C., LOOTEN V., REY S., *et al.*

2018

J Gynecol Obstet Hum Reprod. 47(7):299-307

This study was designed to further our knowledge of the management of pregnant women based on the national health data system (SNDS). Women covered by the national health insurance general scheme or a local mutualist section, who delivered in 2015. Among the 672,182 women included (mean age: 31 years, SD 5.3), 0.3% were under the age of 18 years, 4% lived in a French overseas department (<18 years: 21%), 17% had complementary universal health insurance coverage (<18 years: 75%), 1.2% presented a mental illness, 0.6% had a cancer, and 0.4% had cardiovascular disease. At least one outpatient visit with a gynaecologist or midwife was detected for 93% of women (first trimester (T1): 75%), specific or nonspecific pelvic ultrasound was performed in 98% (T1: 92%), blood glucose assay was performed in 78% (T1: 61%), and an oral glucose tolerance test was performed in 58%. Before delivery, 0.2% of women had at least one admission to the intensive care unit and 22% had at least one hospital stay (<18 years: 38%), for which the principal diagnoses were: false labour (4.5%), threatened preterm labour (2.5%), surveillance of high-risk pregnancy (2.6%), diabetes (2.6%), and hypertension (0.7%). The preterm delivery rate was 6.7% (<18 years: 14%, ≥40 years: 9%). Although 20% of deliveries were performed by caesarean section, 16% of vaginal deliveries required instrumental extraction. SNDS data enrich the data derived from periodic national perinatal surveys, such as the poor follow-up of adolescent girls. These data can promote the elaboration and monitoring of annual indicators.

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

PYMONT C., MCNAMEE P. ET BUTTERWORTH P.
2018

[Health Policy 122\(6\): 652-659.](#)

This paper examines the effect of out-of-pocket costs on subsequent frequent attendance in primary care using data from the Personality and Total Health (PATH) Through Life Project, a representative community cohort study from Canberra, Australia. The analysis sample comprised 1197 respondents with two or more GP consultations, and uses survey data linked to administrative health service use (Medicare) data which provides data on the number of consultations and out-of-pocket costs. Respondents identified in the highest decile of GP use in a year were defined as Frequent Attenders (FAs). Logistic regression models that did not account for potential selection effects showed that out-of-pocket costs incurred during respondents' prior two consultations were significantly associated with subsequent FA status. Respondents who incurred higher costs (\$15-\$35; or >\$35) were less likely to become FAs than those who incurred no or low (<AUS\$15 per consultation) costs, with no difference evident between the no and low-cost groups. However, a counterfactual model that adjusted for factors associated with the selection into payment levels did not find an influence of payment, with only a non-significant gradient in the expected direction. Hence these findings raise doubts that price drives FA behaviour, suggesting that co-payments are unlikely to affect the number of GP consultations amongst frequent attenders.

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

QUENTIN W., GEISLER A., WITTENBECHER F., *et al.*
2018

[Health Policy 122\(5\): 473-484.](#)

Payment systems for specialists in hospitals can have far reaching consequences for the efficiency and quality of care. This article presents a comparative analysis of payment systems for specialists in hospitals of eight high-income countries (Canada, England, France, Germany, Sweden, Switzerland, the Netherlands, and the USA/Medicare system). A theoretical framework

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

► **Growing Number of Unsubsidized Part D Beneficiaries with Catastrophic Spending Suggests Need for an Out-Of-Pocket Cap**

TRISH E., XU J. ET JOYCE G.
2018

[Health Aff \(Millwood\) 37\(7\): 1048-1056.](#)

Medicare Part D has no cap on beneficiaries' out-of-pocket spending for outpatient prescription drugs, and, unlike Medicare Parts A and B, beneficiaries are prohibited from purchasing supplemental insurance that could provide such a cap. Historically, most beneficiaries whose annual Part D spending reached the catastrophic level were protected from unlimited personal liability by the Low-Income Subsidy (LIS). However, we found that the proportion of beneficiaries whose spending reached that level but did not qualify for the subsidy-and therefore remained liable for coinsurance-increased rapidly, from 18 percent in 2007 to 28 percent in 2015. Moreover, average total per person per year spending grew much more rapidly for those who did not qualify for the LIS than for those who did, primarily because of differences in price and utilization trends for the drugs that represented disproportionately large shares of their spending. We estimated that a cap for all Part D enrollees in 2015 would have raised monthly premiums by only \$0.40-\$1.31 per member.

► **Future Unrelated Medical Costs Need to Be Considered in Cost Effectiveness Analysis**

VAN BAAL P., MORTON A., MELTZER D., *et al.*
2018

Eur J Health Econ: [Ahead of print]
<https://www.ncbi.nlm.nih.gov/pubmed/29671143>

New medical technologies that prolong life result in additional health care use in life years gained. Some of these costs in life years gained are considered to be related to the intervention while other costs are considered unrelated. Here, we argue that ignoring these so-called future medical costs in cost effectiveness analysis is contrary to common sense, results in lost health and fails to inform decision makers for whom cost effectiveness is supposed to serve.

► **Frequency and Magnitude of Co-Payments Exceeding Prescription Drug Costs**

VAN NUYS K., JOYCE G., RIBERO R., *et al.*
2018

JAMA 319(10): 1045-1047.
<http://dx.doi.org/10.1001/jama.2018.0102>

A co-payment suggests sharing the total cost between patients and payers. However, drug co-payments sometimes exceed costs, with the insurer or pharmacy benefit manager (PBM) keeping the difference. Furthermore, some pharmacists are contractually prevented from alerting patients when their co-payment exceeds the drug's cash price. Although some have argued that the practice is uncommon, a 2016 survey of independent pharmacists indicates otherwise.³

► **Financial Protection in Europe: A Systematic Review of the Literature and Mapping of Data Availability**

YERRAMILI P., FERNANDEZ O. ET THOMSON S.
2018

Health Policy 122(5): 493-508.

A comprehensive and context-specific approach to monitoring financial protection can provide valuable evidence on progress towards universal health coverage. This article systematically reviews the literature on financial protection in Europe to identify trends across countries and over time. It also maps the availability of data for regular monitoring in 53 countries. Results were extracted from 54 publications and studies analysed in terms of geographical focus, data sources, methods and depth of analysis. Financial protection varies across countries in Europe; substantial changes over time have mainly taken place in the east of the region. Although the data required for regular monitoring are widely available, the literature presents major gaps in geographical scope - most studies focus on middle-income countries; it is not up to date - the latest year of data analysed is 2011; and cross-national comparison is only possible for a handful of countries due to variation in data sources and methods. The literature is also limited in depth. Very few studies go beyond analysing how many people incur catastrophic or impoverishing out-of-pocket payments. Only a small minority analyse who is most likely to experience financial hardship and what drives lack of financial protection. The literature provides little actionable evidence on financial protection in Europe.

État de santé

► **Alcohol Use and Burden for 195 Countries and Territories, 1990–2016: A Systematic Analysis for the Global Burden of Disease Study 2016**

FULLMAN N., YEARWOOD J., ABAY S. M., *et al.*
2018

The Lancet : August 2018 [Ahead of print]

Alcohol use is a leading risk factor for death and disability, but its overall association with health remains complex given the possible protective effects of moderate alcohol consumption on some conditions. With our comprehensive approach to health accounting within the Global Burden of Diseases, Injuries, and Risk Factors Study 2016, we generated improved estimates of alcohol use and alcohol-attributable deaths and disability-adjusted life-years (DALYs) for 195 loca-

tions from 1990 to 2016, for both sexes and for 5-year age groups between the ages of 15 years and 95 years and older.

► **Five-Year Risk of Stroke After TIA or Minor Ischemic Stroke**

AMARENCO P., LAVALLEE P. C., MONTEIRO TAVARES L., *et al.*

2018

N Engl J Med. 378(23):2182-2190

<https://www.ncbi.nlm.nih.gov/pubmed/29766771>

After a transient ischemic attack (TIA) or minor stroke, the long-term risk of stroke and other vascular events is not well known. In this follow-up to a report on 1-year outcomes from a registry of TIA clinics in 21 countries that enrolled 4789 patients with a TIA or minor ischemic stroke from 2009 through 2011, we examined the 5-year risk of stroke and vascular events. We evaluated patients who had had a TIA or minor stroke within 7 days before enrollment in the registry. Among 61 sites that participated in the 1-year outcome study, we selected 42 sites that had follow-up data on more than 50% of their enrolled patients at 5 years. The primary outcome was a composite of stroke, acute coronary syndrome, or death from cardiovascular causes (whichever occurred first), with an emphasis on events that occurred in the second through fifth years. In calculating the cumulative incidence of the primary outcome and secondary outcomes (except death from any cause), we treated death as a competing risk. Results

A total of 3847 patients were included in the 5-year follow-up study; the median percentage of patients with 5-year follow-up data per center was 92.3% (interquartile range, 83.4 to 97.8). In a follow-up to a 1-year study involving patients who had a TIA or minor stroke, the rate of cardiovascular events including stroke in a selected cohort was 6.4% in the first year and 6.4% in the second through fifth years.

► **French and Worldwide Epidemiology of Obesity**

MATTA J., CARETTE C., RIVES LANGE C., *et al.*

2018

Presse Med 47(5): 434-438.

Obesity is a disease characterized by an excessive fat deposition. It is associated to the development of several comorbidities. The worldwide prevalence of obesity has been rising in the past 30 years. Recent results published in 2015 show a global prevalence of 12% in adults, which amounts to 604 million obese adults in the world. The prevalence of obesity has also increased in children since the 1980s to reach 5% globally. Social categories are differently affected by obesity with the most impoverished ones having the highest rate of obesity and obesity increase. In the French ESTEBAN study of 2015, the prevalence of overweight and obesity was the highest among adults with the lowest education level and among children whose caregiver was without diploma.

Géographie de la santé

► **Geographic and Statistic Stability of Deprivation Aggregated Measures at Different Spatial Units in Health Research**

CEBRECOS A., DOMÍNGUEZ-BERJÓN M. F., DUQUE I., *et al.*

2018

Applied Geography 95: 9-18.

Deprivation indices constitute a valuable tool for assessing health inequalities. A key issue when analyzing deprivation is the choice of the geographical scale

and spatial unit of analysis. Our objective was to evaluate statistical and geographical stability of an Area Based Deprivation Index (ABDI) computed at different spatial scales and to study their relation with cardiovascular disease. The present study has been conducted in the city of Madrid, Spain. Madrid divides its territory in three different administrative units nested within each other: census section, neighborhoods and districts. For each unit a deprivation index was calculated through Principal Component Analysis (PCA). The data source was the 2011 national census from where a range of socioeconomic and demographic indicators

were selected. To study statistical and geographical stability of deprivation we used an Exploratory Spatial Data Analysis and bivariate Local Indicators of Spatial Association analysis. We also conducted Pearson correlation analyses to study the change in the relationship between deprivation and the prevalence of cardiovascular disease (CVD) across the three scales.

► **Migration Intentions of Lithuanian Physicians, Nurses, Residents and Medical Students**

GOŠTAUTAITĖ B., BUČIŪNIENĖ I., MILAŠAUSKIENĖ Ž., *et al.*

2018

Health Policy : [Ahead of print.]

<http://dx.doi.org/10.1016/j.healthpol.2018.07.001>

Emigration intentions differ between students, residents, nurses, and physicians. High social worth and positive teamwork climate reduce emigration intentions. Emigration intentions are also related to socio-demographic and financial factors.

► **Spatiotemporal Analysis of Regional Socio-Economic Vulnerability Change Associated with Heat Risks in Canada**

HO H. C., KNUDBY A., CHI G., *et al.*

2018

Applied Geography 95: 61-70.

Excess mortality can be caused by extreme hot weather events, which are increasing in severity and frequency in Canada due to climate change. Individual and social vulnerability factors influence the mortality risk associated with a given heat exposure. We constructed heat vulnerability indices using census data from 2006 to 2011 in Canada, developed a novel design to compare spatiotemporal changes of heat vulnerability, and identified locations that may be increasingly vulnerable to heat. The results suggest that 1) urban areas in Canada are particularly vulnerable to heat, 2) suburban areas and satellite cities around major metropolitan areas show the greatest increases in vulnerability, and 3) heat vulnerability changes are driven primarily by changes in the density of older ages and infants. Our approach is applicable to heat vulnerability analyses in other countries.

► **An Evaluation of Alternative Measures of Accessibility for Investigating Potential 'Deprivation Amplification' in Service Provision**

PAGE N., LANGFORD M. ET HIGGS G.

2018

Applied Geography 95: 19-33.

Studies examining potential social inequities in resource distribution have tended to adopt relatively unsophisticated measures of service supply such as those derived from proximity measures or counts of facilities within given time/distance thresholds. Often such measures do not take into account potential demand for services and the implications this has for understanding socio-spatial patterns in service provision. In this paper, a comparison is made between spatial patterns of accessibility to a range of services by socio-economic gradients for a subset of 'traditional' measures of provision with trends revealed by the use of floating catchment area (FCA) methods. Statistical and visualisation tools are employed to examine variations in access scores across deprivation quintiles for all the services included in an accessibility 'domain' of a policy-relevant Index of Multiple Deprivation. Findings suggest that, whilst the use of proximity or cumulative opportunity approaches consistently point to greater levels of access in more deprived areas, results from the application of FCA methods point to non-linear trends in the relationship between access and socio-economic patterns of deprivation for some key services. This suggests that the use of measures that account for both potential service demand and distance-decay effects demonstrate patterns that are at odds with those revealed by the use of 'traditional' metrics. We conclude by highlighting prospective implications of using different methodological approaches to measuring spatial patterns of accessibility for understanding socio-economic patterns in service provision, and the broader policy relevance of encapsulating potential service demand within socio-spatial investigations of levels of access.

Handicap

► **L'emploi des personnes handicapées dans la fonction publique. Entre quota et non-discrimination, quelles pratiques des employeurs ?**

JAFFRÈS F. ET GUÉVEL M.-R.

2017

Travail et emploi 152(4): 33-57.

<https://www.cairn.info/revue-travail-et-emploi-2017-4-page-33.htm>

Basé sur une enquête de terrain conduite auprès d'employeurs publics, cet article étudie comment ils se saisissent de leurs obligations en matière d'emploi des personnes handicapées. La politique d'emploi des personnes handicapées est en effet traversée en France par une tension entre une logique catégorielle de quota et une logique universaliste de non-discrimination portée par la notion d'« aménagement rai-

sonnable » des emplois. La première logique est bien connue et les obligations qui l'accompagnent sont de mieux en mieux respectées par les employeurs de la fonction publique, comme en témoigne la hausse continue du taux d'emploi des travailleurs handicapés qui y est observée. La deuxième logique est émergente, mais plusieurs indices laissent penser qu'elle pourrait être particulièrement développée dans la fonction publique, qui proposerait plus souvent un environnement de travail adapté à chacun, quel que soit son handicap. Partant de ces hypothèses, nous avons conduit une campagne d'entretiens dans sept établissements publics auprès des acteurs concernés par la politique d'emploi des personnes handicapées. Ces entretiens ont été complétés par un recueil de documents (conventions, plaquettes de communication, etc.) et d'observations.

Hôpital

► **How Do We Interpret Readmission Rates?**

ALI A. M. ET BOTTLE A.

2018

BMJ 362

<https://www.bmj.com/content/bmj/362/bmj.k3104.full.pdf>

Readmission rates are a potentially valuable indicator of hospital performance to spot problems such as the surge in readmissions for preventable conditions reported by the Nuffield Trust. But uncertainty is immense about how much the risk of readmission is determined by patient factors, hospital factors, and the quality of care after discharge across a range of conditions.

Countries in Asia are working towards achieving universal health coverage while ensuring improved quality of care. One element is controlling hospital costs through payment reforms. In this paper we review experiences in using Diagnosis Related Groups (DRG) based hospital payments in three Asian countries and ask if there is an "Asian way to DRGs". We focus first on technical issues and follow with a discussion of implementation challenges and policy questions. We reviewed the literature and worked as an expert team to investigate existing documentation from Japan, Republic of Korea, and Thailand. We reviewed the design of case-based payment systems, their experience with implementation, evidence about impact on service delivery, and lessons drawn for the Asian region. We found that countries must first establish adequate infrastructure, human resource capacity and information management systems. Capping of volumes and prices is sometimes essential along with a high degree of hospital autonomy. Rather than introduce a complete classification system in one stroke, these countries have phased in DRGs, in some cases with hospitals volunteering to participate as a first step (Korea), and in others using a blend of different units for hos-

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

ANNAR P. L., KWON S., LORENZONI L, *et al.*

2018

Health Policy 122(7): 707-713.

pital payment, including length of stay, and fee-for-service (Japan). Case-based payment systems are not a panacea. Their value is dependent on their design and implementation and the capacity of the health system.

► **Intensité et pénibilités du travail à l'hôpital. Quelles évolutions entre 1998 et 2013 ?**

BENALLAH S. ET DOMIN J.-P.

2017

Travail et emploi 152(4): 5-31.

<https://www.cairn.info/revue-travail-et-emploi-2017-4-page-5.htm>

Cet article s'intéresse à l'évolution des conditions de travail à l'hôpital au cours des quinze dernières années. Cette question est importante dans le contexte des réformes menées au sein du secteur depuis le début des années 1990, qui y ont provoqué de profondes réorganisations. Dans un premier temps, nous faisons le point sur l'état des connaissances concernant les conditions de travail à l'hôpital. Nous étudions ensuite, à partir des trois dernières éditions de l'enquête Conditions de travail, l'évolution entre 1998 et 2013 des contraintes de rythme et de diverses formes de pénibilités du travail à l'hôpital, comparativement à d'autres secteurs d'activité. Enfin, nous analysons, toutes choses égales par ailleurs, les spécificités actuelles du secteur en matière d'exposition aux contraintes de rythme, aux horaires décalés, aux pénibilités physiques et à un environnement de travail dégradé. Nous observons, sur la période 1998-2013, une nette augmentation des contraintes de rythme s'exerçant sur les personnels hospitaliers. Celle-ci s'accompagne d'une légère diminution des pénibilités physiques. Mais l'hôpital demeure particulièrement contraint du point de vue des conditions de travail.

► **Patients en situation palliative en hospitalisation à domicile : trajectoires de soins et caractéristiques cliniques**

BOISSERIE-LACROIX L., MARQUESTAUT O. ET DE STAMPA M.

2017

Santé Publique 29(6): 851-859.

<https://www.cairn.info/revue-sante-publique-2017-6-page-851.htm>

Une large majorité de Français expriment le souhait d'une prise en charge à domicile en situation palliative. L'objectif est de décrire les trajectoires de soins et les caractéristiques cliniques des patients en situation palliative pris en charge par l'hospitalisation à domicile. Notre étude a décrit les modalités de prise en charge et les caractéristiques cliniques des patients en situation palliative suivis par une hospitalisation à domicile francilienne. Le recueil des données a été rétrospectif à partir des bases de données du programme de médicalisation des systèmes d'information en 2014. Huit cent dix-sept patients en situation palliative et suivis en hospitalisation à domicile ont été inclus. Ces patients étaient plus âgés, entraient plus souvent en HAD sur prescription du médecin traitant, avaient des durées de séjour plus courtes et décédaient plus fréquemment à domicile comparativement aux patients hors situation palliative. Ils présentaient majoritairement une pathologie cancéreuse et recevaient des soins techniques fréquents. Les patients les plus âgés (≥ 75 ans) présentaient plus souvent des maladies neuro-dégénératives, étaient moins transférés en hospitalisation avec hébergement et décédaient davantage à domicile. La proportion de décès était plus élevée en établissement d'hébergement pour personnes âgées (EHPAD) et les patients décédés à domicile recevaient moins de soins techniques. Cette étude apporte des enseignements importants concernant les modes de prise en charge en hospitalisation à domicile et les changements fréquents de lieux de soins. Elle témoigne de la complexité de l'accompagnement à domicile des patients en situation palliative jusqu'à leur décès.

► **Association of the Hospital Readmissions Reduction Program with Surgical Readmissions**

BORZA T., OERLINE M. K., SKOLARUS T. A., *et al.*

2018

JAMA Surgery 153(3): 243-250.

<http://dx.doi.org/10.1001/jamasurg.2017.4585>

Hospital-level 30-day risk-adjusted rates of readmission and observation stays were calculated using multivariable logistic regression models. Changes in these rates were analyzed for 3 distinct periods (prepolicy [January 1, 2006, to June 30, 2010], performance [July 1, 2010, to June 30, 2013], and penalty [July 1, 2013, to November 30, 2014]) corresponding to the HRRP implementation timeline for major joint surgery using interrupted time series. Results:

Among 672 135 Medicare beneficiaries 66 years or older treated at 2773 hospitals, readmissions for all procedures decreased significantly over the study period. Readmission rates after targeted procedures decreased faster during the performance period (slope, -0.060 ; 95% CI, -0.079 to -0.041) compared with the prepolicy period (slope, -0.012 ; 95% CI, -0.027 to 0.034) ($P < .002$). For the nontargeted procedures, readmission rates were decreasing during the prepolicy period (slope, -0.200 ; 95% CI, -0.240 to -0.160) but stabilized during the performance period (slope, 0.008 ; 95% CI, -0.049 to 0.066) ($P < .001$). The use of observation stays increased slightly, accounting for 11% of the decrease in readmissions. Conclusions and Relevance. The HRRP effectively decreased readmissions for targeted procedures. There were no associated spillover effects for common nontargeted procedures. A better understanding of differences in the association of the policy with medical and surgical discharges will be necessary to further enhance its generalizability.

► **Sortir de la T2A par le haut : la mesure de la qualité des soins**

BRAS P.-L.

2017

Journal de Gestion et d'Économie médicales 35(6): 245-263.

<https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-6-page-245.htm>

Depuis la crise, le rythme d'évolution des ressources des établissements de santé est fortement contraint. Dans un contexte, où l'augmentation de la production des soins reste soutenue, les établissements de santé, dès lors que la T2A révèle leur niveau de performance économique, doivent réaliser des progrès de productivité notamment de productivité du travail. On peut craindre que ces progrès de productivité ne soient obtenus qu'au détriment de la qualité des soins et des conditions de travail des personnels. Il est donc essentiel de se doter sans attendre d'indicateurs permettant d'apprécier la qualité des soins; les indicateurs de processus développés en France n'étant pas à cet égard suffisants. Il faut comme dans de nombreux pays étrangers se doter d'outils pour mesurer l'expérience et la satisfaction des patients, le vécu au travail et l'appréciation de la qualité des soignants et, enfin les résultats cliniques des soins. Se doter de ces instruments de mesure suppose un investissement technique et scientifique qui ne se conçoit que dans le cadre

d'une politique structurée. Cet investissement est un préalable pour envisager des modes de tarification dits « au parcours » ou des modes de paiement à la qualité.

► **Pédiatrie : récupération rapide après chirurgie (RAAC) : l'expérience de l'hôpital Robert-Debré**

DAHMANI S. ET JOUVE M.

2018

Gestions hospitalières(577): 358-361.

L'équipe chirurgicale et anesthésique de l'hôpital Robert-Debré a appliqué les démarches et approches de la récupération rapide après chirurgie (RAAC) à l'ensemble des prises en charge chirurgicales, privilégiant une prise en charge centrée sur le patient structurée autour d'un travail en équipe pluridisciplinaire et pour un même objectif. L'expérience montre qu'un des apports majeurs de la RAAC est une meilleure complémentarité et communication entre ces différents corps de métier.

► **Doctors, Nurses, and the Optimal Scale Size in the Portuguese Public Hospitals**

FERREIRA D. C., NUNES A. M. ET MARQUES R. C.

2018

Health Policy. [Ahead of Print]

<http://dx.doi.org/10.1016/j.healthpol.2018.06.009>

We investigate optimal scale size (and demographic drivers) of Portuguese hospitals. Optimal scale size is centred on 274 FTE doctors and 475 FTE nurses. Roughly half of considered hospitals are oversized, when aiming for scale efficiency. Workforce excess is in the coastline, whereas shortage is in the countryside.

► **Effect of Systematic Physician Cross-Checking on Reducing Adverse Events in the Emergency Department: The Charmed Cluster Randomized Trial**

FREUND Y., GOULET H., LEBLANC J., et al.

2018

JAMA Internal Medicine 178(6): 812-819.

<http://dx.doi.org/10.1001/jamainternmed.2018.0607>

Emergency departments (ED) are environments that are at high risk for medical errors. Previous studies suggested that the proportion of medical errors may decrease when more than 1 physician is involved. The aims of this study are to reduce the proportion of medical errors by implementing systematic cross-checking between emergency physicians. This cluster randomized crossover trial includes a random sample of 14 adult patients (age ≥ 18 years) per day during two 10-day periods in 6 EDs ($n = 1680$ patients) in France. Systematic cross-checking between emergency physicians, 3 times a day, which included a brief presentation of one physician's case to another, followed by the second physician's feedback to the first. Medical error in the ED, defined as an adverse event (either a near miss or a serious adverse event). The primary end point was identified using a 2-level error detection surveillance system, blinded to the strategy allocation. The implementation of systematic cross-checking between emergency physicians was associated with a significant reduction in adverse events, mainly driven by a reduction in near misses.

► **Cooperation Between Hospital Teams and Community-Based Healthcare Professionals**

LE COSSEC C., GIACOPELLI M. ET DE CHAMBINE S.
2018

Santé Publique 30(2): 213-224.

<https://www.ncbi.nlm.nih.gov/pubmed/30148309>

This study aims to identify and classify hospital-community cooperation activities between Greater Paris University Hospitals (GPUH) and community health professionals. A declarative survey was conducted in GPUH clinical departments, which were asked to describe their activities with community health professionals, the type of community professionals involved (e.g. general practitioners, nurses) and a full description of the activity. Activities were classified by the three authors with consistency checks. 261 activities were reported by 138 departments (39 medical specialties). Paediatrics, psychiatry and geriatrics reported the highest number of activities. 37% of activities covered access to hospital care, 25% concerned training of health professionals, 22% concerned continuity of care after hospitalization, 13% shared follow-up and 3% corresponded to public health interventions in the general population. Access to hospital care included facilitating appointments, access to hospital expertise

and specific organizations. Continuity of care included either information transmission or patient referral. Follow-up was shared over specific patients or over a predefined patient population. Training was organized by hospital professionals, community health professionals or as a collaborative initiative. The proposed classification can be used for research studies, or to define a strategy for hospitals initiating collaborations with community health professionals. It describes the concept of "hospital-community medical relations" from a pragmatic health professional point of view.

► **Developing and Utilising a New Funding Model for Home-Care Services in New Zealand**

MATTHEW P., PAUL R., LASZLO S., *et al.*

2018

Health & Social Care in the Community 26(3): 345-355.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.12525>

Worldwide increases in the numbers of older people alongside an accompanying international policy incentive to support ageing-in-place have focussed the importance of home-care services as an alternative to institutionalisation. Despite this, funding models that facilitate a responsive, flexible approach are lacking. Casemix provides one solution, but the transition from the well-established hospital system to community has been problematic. This research seeks to develop a Casemix funding solution for home-care services through meaningful client profile groups and supporting pathways. Unique assessments from 3,135 older people were collected from two health board regions in 2012. Of these, 1,009 arose from older people with non-complex needs using the interRAI-Contact Assessment (CA) and 2,126 from the interRAI-Home-Care (HC) from older people with complex needs. Home-care service hours were collected for 3 months following each assessment and the mean weekly hours were calculated. Data were analysed using a decision tree analysis, whereby mean hours of weekly home-care was the dependent variable with responses from the assessment tools, the independent variables. A total of three main groups were developed from the interRAI-CA, each one further classified into "stable" or "flexible." The classification explained 16% of formal home-care service hour variability. Analysis of the interRAI-HC generated 33 clusters, organised through eight disability "sub" groups and five "lead" groups.

The groupings explained 24% of formal home-care services hour variance. Adopting a Casemix system within home-care services can facilitate a more appropriate response to the changing needs of older people.

► **Evaluation of Hospital Readmissions for Surgical Site Infections in Italy**

NAPOLITANO F., TOMASSONI D., CASCONI D., *et al.*
2018

Eur J Public Health 28(3): 421-425.

The objectives of this investigation are to assess the prevalence of hospital readmissions for surgical site infections (SSIs) in patients aged ≥ 18 in Italy and to describe the clinical characteristics of these patients and evaluate the possible association with readmission for SSIs. A retrospective epidemiological study was conducted between January and May 2015 considering a sample of patients aged ≥ 18 years admitted to the surgical wards of two hospitals in Naples and undergoing surgery in the year 2014. 3.8% of patients had been readmitted and 28.8% of them were readmitted to hospital due to SSIs. The results point to the need that hospital infection prevention strategies are implemented in order to reduce morbidity and mortality for patients. Moreover, the measures taken to prevent infections would lead to a reduction in health spending since almost one third of readmissions to the hospital in our study were due to SSIs.

► **Procédés et effets du pouvoir disciplinaire aux urgences. Le cas de l'accueil des patients alcooliques**

PIRIOU O. ET THOMAS J.
2018

Sciences sociales et santé 36(2): 43-67.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2018-2-page-43.htm>

En s'appuyant sur une enquête ethnographique, cet article vise à comprendre les modalités de mise en œuvre du pouvoir disciplinaire aux urgences de l'hôpital dans la prise en charge de patients alcoolisés. Il étudie les procédés disciplinaires qui étayent cette prise en charge. Puis il confronte ces procédés aux usages qu'en font les patients. L'analyse rend compte du fait que le pouvoir disciplinaire ne s'impose pas massivement ni unilatéralement sur les individus, mais qu'il est

plutôt le résultat de rapports de forces instables qui surgissent de la rencontre entre patients et soignants.

► **Use of Hospital Palliative Care According to the Place of Death and Disease One Year Before Death in 2013: A French National Observational Study**

POULALHON C., ROTELLI-BIHET L., MOINE S., *et al.*
2018

BMC Palliat Care 17(1): 75.

Only limited data are available concerning the diseases managed before death and hospital palliative care (HPC) use according to place of death in France. We therefore conducted an observational study based on administrative health data in a large population to identify the diseases treated one year before death in 2013, the place of stay with or without hospital palliative care, and the place of death. French health insurance general scheme beneficiaries were identified in the National Health data Information System (Snds) with a selection of information. Diseases were identified by algorithms from reimbursement data recorded in the Snds database. 347,253 people were included in this study (61% of all people who died in France). Place of death was short stay hospital for 51%, Rehab (7%), hospital at home (3%), skilled nursing home (13%) and other (26%). Chronic diseases managed in 2013 before death were cardiovascular/neurovascular diseases (56%), cancers (42%), and neurological and degenerative diseases (25%). During the year before death, 84% of people were hospitalized at least once, and 29% had received HPC. HPC was used by 52% of cancer patients (lung cancer: 62%; prostate cancer: 41%). In the absence of cancer, the use of HPC varied according to the disease: acute stroke: 24%, heart failure: 17%, dementia: 17%, multiple sclerosis: 23%. Health administrative data can refine the knowledge of the care pathway prior to death and the HPC utilisation and can be useful to evaluate health policies and improve monitoring and assessment of HPC use.

► **Optimal Timing of Physician Visits After Hospital Discharge to Reduce Readmission**

RIVERIN B. D., STRUMPF E. C., NAIMI A. I., *et al.*
2018

[Health Serv Res. : \[Ahead of print.\]](#)

The aims of this study is to identify the optimal timing of in-person physician visit after hospital discharge to yield the largest reduction in readmission among elderly or chronically ill patients. We extracted insurance billing data on 620,656 admissions for any cause from 2002 to 2009 in Quebec, Canada. We used flexible survival models to estimate inverse probability weights for the precise timing (days) of in-person physician visit after discharge and weighted competing risk outcome models. Readmission reduction associated with in-person physician visits (compared to none) was seen early after discharge, with 67.8 fewer readmissions per 1,000 discharges if physician visit occurred within 7 days (95 percent CI: 66.7-69.0), and 110.0 fewer readmissions within 21 days (95 percent CI: 108.2-111.7). The period of largest contribution to readmission reduction was seen in the first 10 days, while physician visits occurring later than 21 days after discharge did not further contribute to reducing hospital readmissions. Larger risk reductions were observed among patients in the highest morbidity level and for in-person follow-up with a primary care physician rather than a medical specialist. When provided promptly, postdischarge in-person physician visit can prevent many readmissions. The benefits appear optimal when such visit occurs within the first 10 days, or at least within the first 21 days of discharge.

► **Continuity of Care and Its Effect on Readmissions for COPD Patients: A Comparative Study of Norway and Germany**

SWANSON J. O., VOGT V., SUNDMACHER L., *et al.*
2018

[Health Policy 122\(7\): 737-745.](#)

This study compares continuity of care between Germany - a social health insurance country, and Norway - a national health service country with gatekeeping and patient lists for COPD patients before and after initial hospitalization. We also investigate how subsequent readmissions are affected. Continuity of Care Index (COCI), Usual Provider Index (UPC) and

Sequential Continuity Index (SECON) were calculated using insurance claims and national register data (2009-14). These indices were used in negative binomial and logistic regressions to estimate incident rate ratios (IRR) and odds ratios (OR) for comparing readmissions. All continuity indices were significantly lower in Norway. One year readmissions were significantly higher in Germany, whereas 30-day rates were not. All indices measured one year after discharge were negatively associated with one-year readmissions for both countries. Significant associations between indices measured before hospitalization and readmissions were only observed in Norway - all indices for one-year readmissions and SECON for 30-day readmissions. Our findings indicate higher continuity is associated with reductions in readmissions following initial COPD admission. This is observed both before and after hospitalization in a system with gatekeeping and patient lists, yet only after for a system lacking such arrangements. These results emphasize the need for policy strategies to further investigate and promote care continuity in order to reduce hospital readmission burden for COPD patients.

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

TAYYARI DEHBAREZ N., GYRD-HANSEN D.,
ULDBJERG N., *et al.*
2018

[Health Policy 122\(7\): 722-727.](#)

Equity of access to health care is a central objective of European health care systems. In this study, we examined whether free choice of hospital, which has been introduced in many systems to strengthen user rights and improve hospital competition, conflicts with equity of access to highly specialized hospitals. We chose to carry out a study on 134,049 women who had uncomplicated pregnancies from 2005 to 2014 in Denmark because of their homogeneity in terms of need, the availability of behavioral data, and their expected engagement in choice of hospital. Multivariate logistic regression was used to link the dependent variable of bypassing the nearest non-highly specialized public hospital in order to "up-specialize", with independent variables related to socioeconomic status, risk attitude, and choice premises, using administrative registries. Overall, 16,426 (12%) women were observed to

bypass the nearest hospital to up-specialize. Notably, high education level was significantly associated with up-specialization, with an odds ratio of 1.50 (95% CI: 1.40-1.60, $p < 0.001$) compared to low education group.

This confirms our hypothesis that there is a socioeconomic gradient in terms of exercising the right to a free choice of hospital, and so the results indicate that the policy exacerbates inequity of access to health care.

Inégalités de santé

► **Measuring Performance on the Healthcare Access and Quality Index for 195 Countries and Territories and Selected Subnational Locations: A Systematic Analysis from the Global Burden of Disease Study 2016**

FULLMAN N., YEARWOOD J., ABAY S.M., *et al.*
2018

Lancet 391(10136): 2236-2271

A key component of achieving universal health coverage is ensuring that all populations have access to quality health care. Examining where gains have occurred or progress has faltered across and within countries is crucial to guiding decisions and strategies for future improvement. We used the Global Burden of Diseases, Injuries, and Risk Factors Study 2016 (GBD 2016) to assess personal health-care access and quality with the Healthcare Access and Quality (HAQ) Index for 195 countries and territories, as well as subnational locations in seven countries, from 1990 to 2016. Drawing from established methods and updated estimates from GBD 2016, we used 32 causes from which death should not occur in the presence of effective care to approximate personal health-care access and quality by location and over time. GBD 2016 provides a more detailed understanding of past success and current challenges in improving personal health-care access and quality worldwide. Despite substantial gains since 2000, many low-SDI and middle-SDI countries face considerable challenges unless heightened policy action and investments focus on advancing access to and quality of health care across key health services, especially non-communicable diseases. Stagnating or minimal improvements experienced by several low-middle to high-middle SDI countries could reflect the complexities of re-orienting both primary and secondary health-care services beyond the more limited foci of the Millennium Development Goals. Alongside initiatives to strengthen public health programmes, the pursuit of universal health coverage

hinges upon improving both access and quality worldwide, and thus requires adopting a more comprehensive view and subsequent provision of quality health care for all populations.

► **Pauvreté et non-recours aux dispositifs sociaux : l'étude du RSA « socle seul »**

CHAREYRON S.
2018

Economie & prévision 213(1): 41-59.

<https://www.cairn.info/revue-economie-et-prevision-2018-1-page-41.htm>

Cet article s'intéresse au non-recours à la composante « socle seul » du Revenu de Solidarité Active (RSA) laquelle, contrairement à la composante « activité » de ce dispositif, a peu été étudiée. La première partie de l'article est consacrée à l'estimation du taux de non-recours au RSA « socle seul », en prenant en compte la sensibilité de cette estimation aux erreurs dues aux approximations dans le calcul de l'éligibilité au RSA et aux erreurs de déclaration des revenus de l'enquête; l'estimation confirme un niveau élevé de non-recours, avec un taux compris dans une fourchette de 28 % à 35 %. La seconde partie de l'article compare les caractéristiques des foyers bénéficiaires du dispositif et des foyers éligibles mais qui n'y ont pas recours. Différents facteurs de ce phénomène de non-recours sont ainsi mis en évidence : le non-recours touche une proportion élevée de ménages au niveau de vie très modeste, dans une grande pauvreté. L'explication de ce phénomène semble provenir de l'absence de perception de prestation familiale et donc de contact préalable avec les Caf. Le non-recours touche aussi des ménages aux niveaux de vie plus élevés, plus proches du marché du travail dont les gains retirés de la participation au dispositif sont moindres.

► **Healthcare Use Among Immigrants and Natives in Sweden on Disability Pension, Before and After Changes of Regulations**

DI THIENE D., RAHMAN S., HELGESSON M., *et al.*

2018

Eur J Public Health 28(3): 445-451.

There is limited knowledge regarding psychiatric healthcare utilization around the time of granting disability pension (DP) due to common mental disorders (CMD) among immigrants and if this is related to social insurance regulations. The aim was to evaluate patterns of psychiatric healthcare utilization before and after DP due to CMD among immigrants and natives. A second aim was to evaluate if such patterns differed before and after changes in social insurance regulations in Sweden in 2008. All 28 354 individuals living in Sweden with incident DP due to CMD, before (2005-06; n = 24 298) or after (2009-10; n = 4056) changes in regulations of granting DP, were included. Patterns of psychiatric in- and specialized outpatient healthcare utilization during a 7-year window around DP granting were assessed by Generalized Estimating Equations estimating multivariate adjusted odds ratios (OR) and 95% confidence intervals (CI). Prevalence rates of psychiatric inpatient care were comparable among immigrants and natives, lower in non-Western immigrants (Africa, Asia and South-America). Three years after DP, non-Western immigrants in comparison to natives and Western immigrants had a stronger decrease in inpatient psychiatric healthcare: OR 0.48 (CI 0.38-0.62), 0.76 (0.70-0.83) and 1.01 (0.76-1.34), respectively. After 2008, a strong reduction in outpatient psychiatric healthcare after DP granting was observed, similarly in immigrants and natives. Non-Western immigrants showed a different pattern of inpatient specialized healthcare after DP granting in comparison to natives. After changes in social insurance regulations, the decline in outpatient psychiatric healthcare following DP granting was comparable in immigrants and natives.

► **A Framework for Regional Primary Health Care to Organise Actions to Address Health Inequities**

FREEMAN T., JAVANPARAST S., BAUM F., *et al.*

2018

Int J Public Health 63(5): 567-575.

Regional primary health-care organisations plan, co-ordinate, and fund some primary health-care services in a designated region. This article presents a framework for examining the equity performance of regional primary health-care organisations, and applies it to Australian Medicare Locals (funded from 2011 to 2015). The framework was developed based on theory, literature, and researcher deliberation. Data were drawn from Medicare Local documents, an online survey of 210 senior Medicare Local staff, and interviews with 50 survey respondents. The framework encompassed equity in planning, collection of equity data, community engagement, and strategies to address equity in access, health outcomes, and social determinants of health. When the framework was applied to Medicare Locals, their inclusion of equity as a goal, collection of equity data, community engagement, and actions improving equity of access were strong, but there were gaps in broader advocacy, and strategies to address social determinants of health, and equity in quality of care. The equity framework allows a platform for advancing knowledge and international comparison of the health equity efforts of regional primary health-care organisations.

► **Residence Permit for Medical Reasons: An Obstacle to Permanent Residence Status. Results of the ANRS Parcours Study**

GOSSELIN A.

2018

Santé Publique 30(2): 197-201.

<https://www.ncbi.nlm.nih.gov/pubmed/30148307>

Various associations in France have denounced for a long time the difficulties encountered by foreigners with a residence permit for medical reasons to access permanent residence status (10-year resident's card or French nationality). The objective of this study was to determine whether there is a real discrimination towards foreigners with a residence permit for medical reasons, with all other things being equal. This study was based on data from the retrospective quantitative ANRS Parcours survey, conducted in 2012-2013 among 1,705 Sub-Saharan immigrants with HIV/AIDS or Hepatitis B in Ile-de-France. This life-event survey reconstructed the immigrant's permit history. Discrete time logistic models were then used to model the factors associated with obtaining a permanent residence permit and the impact of a residence permit for medi-

cal reasons on this probability. Control variables were used to take into account the level of education, the reason for arrival in France, the period of arrival, the duration of stay. A residence permit for medical reasons has a negative impact on access to permanent residence status (aOr between 0.15 and 0.27 across subgroups, $P < 0.01$). Additionally, the time required to obtain permanent residence status has increased since 2005 compared to before 1996 for all foreigners participating in the survey. The results of this study suggest discrimination towards people with a residence permit for medical reasons in terms of access to permanent residence status, thereby placing their access to health care at stake.

► **Les mineurs isolés étrangers et le système de soins français : étude qualitative**

GUÉGAN M. ET RIVOLLIÉ E.

2017

Santé Publique 29(6): 861-867.

<https://www.cairn.info/revue-sante-publique-2017-6-page-861.htm>

Avant l'obtention de leur assurance maladie, les Mineurs isolés étrangers (MIE) sont susceptibles de consulter dans une Permanence d'accès aux soins de santé (PASS). Cette étude a eu pour objectif d'étudier leurs représentations et ressentis du système de soins français. Une étude qualitative a été réalisée à partir d'entretiens individuels semi-dirigés avec des MIE ayant consulté dans une PASS, puis pris en charge dans le droit commun. La déclaration à la CNIL et validation de la méthodologie ont été validées par un comité éthique. Au total, 21 jeunes ont été interviewés. Ils expriment leur satisfaction à propos des soins, même si le système de soins est vécu comme complexe. L'ordonnance est primordiale car elle permet l'obtention des médicaments, but ultime de leur accès aux soins. L'assurance maladie n'est pas connue de tous. Les PASS sont souvent assimilées à l'hôpital, ses missions et les dépistages sont mal compris. Le médecin généraliste n'est pas toujours identifié et son rôle est mal connu. Les éducateurs apparaissent aux MIE comme des déterminants de l'accès aux soins et sont considérés comme de véritables piliers. La santé est primordiale pour tous. Aucun n'évoque la santé mentale. Les MIE nécessitent une meilleure information sur leurs droits en santé et sur le système de soins de France. Sont à améliorer la formation des éducateurs sur l'accompagnement en santé, leurs connaissances

sur les droits des MIE et sur les rôles des intervenants en santé. Le dépistage des pathologies mentales est à développer.

► **Interventions en littératie en santé et éducation thérapeutique : une revue de la littérature**

MARGAT A., GAGNAYRE R., LOMBRIL P., *et al.*

2017

Santé Publique 29(6): 811-820.

<https://www.cairn.info/revue-sante-publique-2017-6-page-811.htm>

Un faible niveau de Littératie en Santé (LS) constitue un obstacle à l'éducation thérapeutique du patient (ETP) et particulièrement pour les personnes en situation de vulnérabilité qui ont également plus de risques d'être touchées par les maladies chroniques et leurs complications. Il semble donc essentiel de repenser les programmes d'ETP afin de tendre vers plus d'équité. Pour cela, une analyse des caractéristiques des interventions visant la LS et de leurs relations possibles avec l'ETP est nécessaire. Une revue de la littérature de type scoping review a été effectuée entre novembre 2014 et janvier 2016, à partir des moteurs de recherche suivants : MEDLINE / PubMed, Embase, psycinfo, ERIC, Opengrey, SUDOC, thèses.fr, BDSP. Une sélection de 40 études sur 206 a conduit à catégoriser les interventions selon deux grands types : (i) des interventions spécifiques favorisant la compréhension des ressources destinées aux patients; (ii) des interventions, généralement complexes, visant à soutenir et améliorer les compétences en LS. Alors que le niveau de LS influence l'accessibilité des programmes d'ETP, il semblerait pertinent d'une part de rendre les programmes plus accessibles et d'autre part d'appréhender l'ETP comme une opportunité pour répondre, selon ses modalités propres, aux besoins en LS. Il semble que la mise en place de partenariats entre les milieux socio-éducatifs et de la santé puisse être une stratégie efficace, tout comme la formation des soignants-éducateurs à augmenter la LS des patients. Il est possible d'articuler les interventions en LS et l'ETP. Des recherches devraient questionner les modalités pédagogiques à mettre en œuvre pour adapter les programmes d'ETP à la LS.

► **Health and Health Care Access for Syrian Refugees Living in Istanbul**

TORUN P., MUCAZ KARAASLAN M., SANDIKLI B., *et al.*

2018

Int J Public Health 63(5): 601-608.

The study was conducted to assess the health needs of urban refugees living in Istanbul. A mixed methods approach was adopted to interview Syrian women from households, doctors, decision makers and NGO representatives. The data were collected between June and October 2015. The main challenges were the cost of living in Istanbul, increased rent and language barrier. Almost half (49.6%) of the interviewed women did not know about free health care rights for Syrians. In the last 30 days preceding the interview, 58.6% of the participants sought health care primarily through state hospitals, primary health care centres and pharmacies. The participants had difficulty in accessing health care due to the language barrier and a lack of knowledge of the Turkish health care system. Waiting time at hospitals and negative attitudes of health care staff reduced satisfaction in these services. In relation to life in Turkey, the main issues for Syrian refugees were not directly related to health. They have been given the right to access health care, although had many difficulties in understanding and accessing services in a crowded city.

► **Payment Reform and Health Disparities: Changes in Dialysis Modality Under the New Medicare Dialysis Payment System**

TURENNE M., BAKER R., PEARSON J., *et al.*

2018

Health Serv Res 53(3): 1430-1457.

The aims of this study are to evaluate the effect of the Medicare dialysis payment reform on potential disparities in the selection of peritoneal dialysis (PD) for the treatment of end-stage renal disease (ESRD). Data sources are Centers for Medicare & Medicaid Services (CMS) ESRD Medical Evidence Form, Medicare claims, and other CMS data for 2008-2013. We examined the association of patient age, race/ethnicity, urban/rural location, pre-ESRD care, comorbidities, insurance, and other factors with the selection of PD as initial dialysis modality across prereform (2008-2009), interim (2010), and postreform (2011-2013) time periods. Selection of

PD increased among diverse patient subgroups following the payment reform. However, the lower PD selection observed with older age, black race, Hispanic ethnicity, less pre-ESRD care, and Medicaid insurance before the reform largely remained in the initial postreform years. Despite recent growth in PD, there may be ongoing disparities in access to PD that have largely not been mitigated by the payment reform. There is potential for modifying provider financial incentives to achieve policy goals related to cost and quality of care. However, even with a substantial shift in financial incentives, separate initiatives to reduce existing disparities in care may be needed.

► **Des obstacles à la connaissance des inégalités de santé. Deuxième partie : perspective psycho-sociale**

VEGA A., LECARPENTIER M. ET NAAMOUNI K.

2018

Médecine : de la Médecine Factuelle à nos Pratiques 14(3): 116-121.

Les inégalités sociales, qui s'expriment aussi dans la sphère de la santé, restent encore méconnues parce qu'elles remettent en cause le principe d'égalité républicain français. Mais comment ces inégalités se construisent-elles, et pourquoi ont-elles même tendance à s'amplifier en France? Cet article tente de répondre à cette problématique.

► **Refusal to Provide Healthcare to Sub-Saharan Migrants in France: A Comparison According to Their HIV and HBV Status**

VIGNIER N., DRAY SPIRA R., PANNETIER J., *et al.*

2018

Eur J Public Health: [Ahead of print]

<http://dx.doi.org/10.1093/eurpub/cky118>

In this study, we aim to measure and compare the frequency of reported denial of care in sub-Saharan African migrants living in the Paris area, according to their HIV and HBV status and social and migration characteristics. The ANRS-PARCOURS study is a life-event survey conducted in 2012-13 in healthcare facilities in the Paris area, among three groups of sub-Saharan migrants recruited in primary care centres (N = 760; reference group), in dedicated centres for HIV care

(N = 922; HIV group) and in centres for chronic hepatitis B care (N = 777; CHB group). Characteristics associated with refusal of care since arrival in France were identified using a logistic regression model. Compared to the reference group (6%, P < 0.001), the reported refusal of care was twice as high in the HIV group (12%) and the CHB group (10%). In the multivariate analysis, men and women living with HIV were at greater risk of being denied care (aOR = 2.20[1.14-4.25] and 2.24[1.25-4.01]). Women covered by the specific health insurance (HI) for precarious or undocumented migrants were

also at higher risk (aOR = 2.07[1.10-3.89] and 2.69[1.18-6.10], respectively). The risk was also increased in men who remained for at least one year without permit of residence or without HI and among those who were threatened in their country. Refusals to provide health-care are frequent and deleterious situations especially for migrants living with HIV. Health decision makers, public insurance bodies and health professional councils must address this issue to improve equity in the healthcare system.

Médicaments

► Value-Based Insurance Design Improves Medication Adherence Without an Increase in Total Health Care Spending

AGARWAL R., GUPTA A. ET FENDRICK A. M.
2018

Health Aff (Millwood) 37(7): 1057-1064.

Value-based insurance design (VBID) is a strategy that reduces cost sharing for high-value services and increases consumers' out-of-pocket spending for low-value care. VBID has increasingly been implemented by private and public payers and has inspired demonstration programs in Medicare Advantage and TRICARE. Given the recent publication of several studies, we performed an updated systematic review that evaluated the effects of reducing consumer cost sharing on medication adherence and other relevant outcomes. Searches were conducted in key online databases, and the screening of citations yielded twenty-one unique studies, of which eight had not been included in previous reviews. Using the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) system, we found moderate-quality evidence showing improvement (range: 0.1-14.3 percent) in medication adherence with VBID. This increase in adherence was associated with no effect on total health care spending, which suggests that the incremental drug spending was offset by decreases in spending for other health care services.

► Patterns and Predictors of Physician Adoption of New Cardiovascular Drugs

ANDERSON T. S., LO-CIGANIC W.-H., GELLAD W. F.,
et al.
2018

Healthcare 6(1): 33-40.

<http://www.sciencedirect.com/science/article/pii/S2213076417300660>

Little is known about physicians' approaches to adopting new cardiovascular drugs and how adoption varies between drugs of differing novelty. Using data on dispensed prescriptions from IMS Health's Xponent™ database, we created a cohort of all primary care physicians (PCPs) and cardiologists in Pennsylvania who regularly prescribed anticoagulants, antihypertensives and statins from 2007 to 2011. We examined prescribing of three new cardiovascular drugs of differing novelty: dabigatran, aliskiren and pitavastatin. Outcomes were rapid adoption of each new drug, defined by early and sustained monthly prescribing detected by group-based trajectory models, by physicians within the first 15 months of marketplace introduction. 5953 physicians regularly prescribed each drug class. The majority of physicians (63.8%) adopted zero new drugs in the first 15 months, 35.0% rapidly adopted one or two, and 1.2% rapidly adopted all three. Physicians vary in their prescribing of recently-introduced cardiovascular drugs. Though most physicians did not rapidly adopt any new cardiovascular drugs, drug novelty and cardiology training were associated with greater adoption.

► **Prescriptions médicamenteuses potentiellement inappropriées en gériatrie : quels outils utiliser pour les détecter ?**

DESNOYER A., GUIGNARD B., LANG P.-O., *et al.*
2016

La Presse Médicale 45(11): 957-970.

<http://www.sciencedirect.com/science/article/pii/S075549821630207X>

Les prescriptions médicamenteuses inappropriées comprennent les sur-prescriptions (prescription d'un médicament non indiqué), les prescriptions inadaptées (choix de molécules, durée, dose inadaptés, doublon, interactions médicamenteuses potentiellement néfastes, suivi inapproprié) et les sous-prescriptions (omission d'un traitement indiqué). Elles constituent une cause d'événements indésirables médicamenteux évitables et sont associées à des allongements de durées d'hospitalisation, une diminution de la qualité de vie, une augmentation de la morbidité, ou encore à des surcoûts pour les systèmes de santé. Les patients gériatriques, souvent polypathologiques et polymédiqués, sont à haut risque de prescriptions médicamenteuses inappropriées. Depuis une vingtaine d'années, des outils de détection de ces prescriptions ont été développés, afin de diminuer ces erreurs. Cette revue a pour objectifs d'apporter un aperçu comparatif et une analyse critique de ces outils explicites. Une recherche systématique de la littérature menée dans les bases de données PubMed, Embase, Cochrane Library et Google Scholar, sur la période janvier 1991–novembre 2015, a permis d'inclure les articles rédigés en anglais ou en français, décrivant le développement d'une nouvelle liste de critères explicites destinée à la gériatrie. Les caractéristiques, l'organisation et le contenu de ces dernières sont détaillés, ainsi que l'évaluation de leur validité et de leur caractère optimal pour une utilisation en gériatrie. Quatorze outils ont été identifiés. Une organisation par spécialités médicales et pathologies, comme dans les grilles ACOVE, Beers version 5 et STOPP/START permet une utilisation rapide des outils. La faible redondance des critères entre les outils suggère un manque d'exhaustivité pour certains d'entre eux. Les grilles Mimica, ACOVE, PIEA, et STOPP/START sont les plus exhaustives, seules les trois dernières abordent les problèmes de sous-prescriptions. Enfin, la capacité à détecter et diminuer les prescriptions inappropriées n'a été évaluée que pour quelques grilles, seule STOPP/START a montré, dans le cadre d'une étude prospective, sa capacité à les diminuer.

► **Innovative Pharmaceutical Pricing Agreements in Five European Markets: A Survey of Stakeholder Attitudes and Experience**

DUNLOP W. C. N., STAUFER A., LEVY P., *et al.*
2018

Health Policy 122(5): 528-532.

Innovative pricing agreements for medicines have been used in European markets for more than 20 years, and offer an opportunity for payers and pharmaceutical companies to align on value, optimise speed to patients, and share risk. Developing successful agreements requires alignment between key stakeholders, yet there is a lack of summative data on how current innovative agreements are used in the real-world (e.g. the level of realised access to medicines, and rebates and discounts, which are often non-transparent). This research used a web-based survey of payer stakeholders to determine what kinds of innovative agreements are currently used, anticipated future usage, attitudes, and drivers of adoption. Participants included national and regional payers (or former payers) and hospital-level decision makers. Sixty-six payers completed the survey. Respondents expected that the use of innovative pricing agreements will remain the same or increase in the future. Overall, they felt there is a positive attitude towards new schemes, and that innovative agreements are likely to be used when they reduce total costs or reduce uncertainty. Given payer expectations, pharmaceutical companies should continue to take a role in ensuring that they have sufficient capacity to support payers in the design and implementation of innovative pricing agreements.

► **Médicaments potentiellement inappropriés (MPI) chez la personne âgée : état des lieux dans un service de cardiologie**

GAILLARD M., MOSNIER-THOUMAS S., BERRONEAU A., *et al.*
2017

Le Pharmacien Hospitalier et Clinicien 52(1): 3-9.

<http://www.sciencedirect.com/science/article/pii/S2211104216001107>

L'utilisation de médicaments potentiellement inappropriés (MPI) chez la personne âgée est associée à une augmentation de la mortalité et du nombre d'effets indésirables. L'objectif de cet article est d'analyser les

prescriptions des personnes âgées hospitalisées dans un service de cardiologie afin de détecter et d'analyser d'éventuelles prescriptions inappropriées, au moyen d'outils existants. Une analyse prospective a été réalisée de juin à septembre 2015, chez les patients âgés hospitalisés dans le service. La recherche de MPI à l'entrée et à la sortie a été réalisée à partir de la liste de Laroche, des critères STOPP-START et des indicateurs d'alerte de la Haute Autorité de santé. Cent dix-huit patients ont été inclus. Parmi les prescriptions à l'entrée, 58 possédaient au moins un MPI, majoritairement des médicaments de la liste de Laroche. Chez 35 patients, il s'agissait d'une instauration à l'hôpital. L'analyse de l'ordonnance de sortie a montré que 55 d'entre elles possédaient au moins un MPI, majoritairement des médicaments de la liste de Laroche également. L'hospitalisation est souvent l'objet d'une prise en charge spécifique, rendant difficile une optimisation de la prescription chez la personne âgée. Néanmoins, l'intervention du pharmacien hospitalier peut être une aide à une réévaluation du traitement.

► **Inappropriate Prescribing in Older Persons: A Systematic Review of Medications Available in Different Criteria**

LUCCHETTI G. ET LUCCHETTI A. L. G.
2017

Archives of Gerontology and Geriatrics 68: 55-61.

<http://www.sciencedirect.com/science/article/pii/S0167494316301674>

The present study aims to systematically review all potentially inappropriate medications for older persons included in prescribing criteria published in the last decade. A systematic review of published studies was performed. Articles describing the development of criteria for PIM Use in Older Adults published in the last decade and which provided a list of medications that should be considered inappropriate were included. The searches were conducted on Pubmed/Medline for articles published from 1st of January 2006 to 31st of December 2015. We analyzed the medications/classes reported in all criteria, most common classes and how many indications each medication made. From 778 articles, 14 articles were included in our analysis (containing 14 different criteria). Europe was responsible for 8 criteria (57.2% of total) followed by Asia (3 criteria) and USA (2 criteria). More than 85% used a Delphi method. There were 729 different med-

ications/classes reported in all criteria. Diazepam was included in all 14 criteria followed by amitriptyline (13 criteria) and doxepin (12 criteria). We found benzodiazepines, NSAIDs, antihistamines and antipsychotics were the most common drugs reported as potentially inappropriate for older persons. Conclusion The present study systematically compiled all medications included in 14 different criteria published last decade. Benzodiazepines, NSAIDs, antihistamines and antipsychotics were the most common drugs reported as potentially inappropriate for older persons. These results could help health professionals and panel experts to plan future criteria.

► **Expériences médicamenteuses et expériences du cancer. L'appropriation des anticancéreux oraux par les patients**

MARMORAT T., RIOUFOL C., RANCHON F., *et al.*
2018

Sciences Sociales et Santé 36(2): 73-96.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2018-2-page-73.htm>

La part grandissante des thérapies orales fait apparaître une mutation dans l'organisation du projet thérapeutique en cancérologie. Tandis que l'administration d'une chimiothérapie injectable est assurée par une infirmière, et le plus souvent à l'hôpital, il appartient au patient sous anticancéreux oral de prendre son traitement au domicile, en suivant les recommandations médicales qui lui sont associées. Fondée sur une approche psychosociale, cette recherche a pour objectif de saisir la manière dont les savoirs profanes, les normes et les valeurs sociales participent à l'appropriation des anticancéreux oraux par les patients, et le rôle que le médicament joue dans la symbolisation du cancer. L'étude montre le caractère indissociable de la perception des anticancéreux oraux et des représentations que les patients ont de leur maladie. Le sens conféré au suivi de ce traitement renvoie à la valorisation de l'autonomie médicamenteuse, reflétant plusieurs formes de participation au soin et plusieurs types d'attentes concernant l'implication familiale et thérapeutique de l'entourage.

► **Variations in Non-Prescription Drug Consumption and Expenditure: Determinants and Policy Implications**

OTTO M., ARMENI P. ET JOMMI C.

2018

Health Policy 122(6): 614-620.

This paper analyses the determinants of cross-regional variations in expenditure and consumption for non-prescription drugs using the Italian Health Care Service as a case study. This research question has never been posed in other literature contributions. Per capita income, the incidence of elderly people, the presence of distribution points alternative to community pharmacies (para-pharmacies and drug corners in supermarkets), and the disease prevalence were included as possible explanatory variables. A trade-off between consumption of non-prescription and prescription-only drugs was also investigated. Correlation was tested through linear regression models with regional fixed-effects. Demand-driven variables, including the prevalence of the target diseases and income, were found to be more influential than supply-side variables, such as the presence of alternative distribution points. Hence, the consumption of non-prescription drugs appears to respond to needs and is not induced by the supply. The expected trade-off between consumption for prescription-only and non-prescription drugs was not empirically found: increasing the use of non-prescription drugs did not automatically imply savings on prescription-only drugs covered by third payers. Despite some caveats (the short period of time covered by the longitudinal data and some missing monthly data), the regression model revealed a high explanatory power of the variability and a strong predictive ability of future values.

► **The Effects of State-Level Pharmacist Regulations on Generic Substitution of Prescription Drugs**

SONG Y. ET BARTHOLD D.

2018

Health Econ. : [Ahead of print].

Substituting generic for brand name drugs whenever possible has been proposed to control prescription drug expenditure growth in the United States. This work investigates two types of state laws that regulate the procedures under which pharmacists substitute bioequivalent generic versions of brand name drugs.

Mandatory substitution laws require pharmacists to use the generic as a default, and presumed consent laws allow them to assume that the patient agrees to the substitution. Both situations can be overruled by the patient. Using plausibly exogenous changes in states' laws, we use difference-in-differences and a discrete choice model to show that although the mandatory switching laws have little effect, the presumed consent laws reduce consumers' probability of purchasing brand name drugs by 3.2% points. The differential effectiveness of the laws is likely caused by pharmacists' profit motives. These results offer important implications for policies that seek to reduce drug expenditures by incentivizing the use of generic drugs.

► **Antimicrobial Consumption and Resistance in Adult Hospital Inpatients in 53 Countries: Results of an Internet-Based Global Point Prevalence Survey**

VERSPORTEN A., ZARB P., CANIAUX I., *et al.*

2018

The Lancet Global Health 6(6): e619-e629.

[http://dx.doi.org/10.1016/S2214-109X\(18\)30186-4](http://dx.doi.org/10.1016/S2214-109X(18)30186-4)

The Global Point Prevalence Survey (Global-PPS) established an international network of hospitals to measure antimicrobial prescribing and resistance worldwide. We aimed to assess antimicrobial prescribing and resistance in hospital inpatients.

► **Do Health Professionals Tell Patients What They Want to Know About Their Medicines?**

YOUNG A., TORDOFF J., LEITCH S., *et al.*

2018

Health Education Journal

<https://doi.org/10.1177/0017896918763679>

Discussing medicines with patients is the responsibility of prescribers and pharmacists. However, it is not well known whether patients are given the information they want or whether information provision continues when medicines are taken long-term. The aims of this study are to determine how often general practitioners (GPs) and pharmacists provide verbal information to patients about their medicines, and compare the information given with what patients want to know. This study is

based on a cross-sectional surveys related to New Zealand primary healthcare. Two questionnaires were developed and sent to a sample of pharmacists and GPs, and chi-squared analysis was carried out. Open responses were analysed qualitatively to detect further ideas. The paper concludes that patients may not be receiving the information they want to know about their medicines, and there may be an overall lack of

verbal communication about medicines with patients. Some information will only be discussed if the patient actively requests it; the likelihood of this increases with repeat medicines. The use of counselling aids and tools, such as a medicine information leaflet, could help healthcare providers provide patients with the information they need.

Méthodologie – Statistique

► Bias in Patient Satisfaction Surveys: A Threat to Measuring Healthcare Quality

DUNSCH F., EVANS D. K., MACIS M., *et al.*

2018

BMJ Global Health 3(2).

<http://gh.bmj.com/content/bmjgh/3/2/e000694.full.pdf>

Patient satisfaction surveys are an increasingly common element of efforts to evaluate the quality of healthcare. Many patient satisfaction surveys in low/middle-income countries frame statements positively and invite patients to agree or disagree, so that positive responses may reflect either true satisfaction or bias induced by the positive framing. In an experiment with more than 2200 patients in Nigeria, we distinguish between actual satisfaction and survey biases. Patients randomly assigned to receive negatively framed statements expressed significantly lower levels of satisfaction (87%) than patients receiving the standard positively framed statements (95%- $p < 0.001$). Depending on the question, the effect is as high as a 19 percentage point drop ($p < 0.001$). Thus, high reported patient satisfaction likely overstates the quality of health services. Providers and policymakers wishing to gauge the quality of care will need to avoid framing that induces bias and to complement patient satisfaction measures with more objective measures of quality.

► How to Make More Published Research True

IOANNIDIS J. P.

2014

PLoS Med 11(10): e1001747.

In a 2005 paper that has been accessed more than a million times, John Ioannidis explained why most published research findings were false. Here he revisits the topic, this time to address how to improve matters.

► La malédiction des données

LEMOINE P.

2018

Esprit Juin(6): 131-138.

<https://www.cairn.info/revue-esprit-2018-6-page-131.htm>

On dit parfois que les données sont le pétrole du XXI^e siècle. La comparaison est hasardeuse mais elle a au moins ceci de juste que le pétrole est à l'origine de ce que les économistes ont appelé la malédiction de la rente et que nos économies pourraient bien connaître demain la malédiction des données. Parler de malédiction des données, c'est donc rappeler que la donnée n'est créatrice de valeur que si elle est combinée à d'autres facteurs et qu'il serait dangereusement illusoire de vouloir s'en remettre isolément à elle. Pour mesurer ce danger, il n'est pas inutile de prendre un peu de recul et de suivre l'irrésistible ascension de la donnée qui nous a conduit à un certain vertige face au big data.

► **L'enquête TeO de l'Ined : Commentaires et problèmes d'interprétation**

MIZRAHI A.

2018

Argses

http://argses.free.fr/textes/commentaires_TeO.pdf

Ces commentaires suivent d'assez près le plan de l'ouvrage « Trajectoires et Origines Enquête sur la diversité des populations » se limitant aux parties traitant des victimisations. La première partie porte sur le paradoxe dans les enquêtes de victimisations : du fait de la différence d'effectifs, une petite proportion de racistes discriminatoires peut entraîner une grande proportion de personnes discriminées. Les auteurs ne semblent pas avoir vu ce problème et la tonalité générale de leur ouvrage s'en ressent. Dans la deuxième partie sont discutés différents problèmes de vocabulaire (population majoritaire, ethno-racial, minorités visibles, ségrégation). Un vocabulaire pertinent aide en effet à la compréhension des phénomènes; en revanche, des termes, ou des nomenclatures, inadaptés peuvent conduire à masquer certains phénomènes, voire à des biais de raisonnement. Dans la troisième partie, sont analysées les variations de discriminations selon le sexe, si l'un des membres du couple ou des parents est Français, puis en distinguant les immigrés des enfants d'immigrés. La quatrième partie porte sur les lieux de la discrimination.

► **Paradoxe dans l'enquête de victimisation : racisme perçu et racisme actif**

MIZRAHI A.

2018

Argses

http://argses.free.fr/textes/paradoxe_TeO.pdf

Les immigrés et les enfants d'immigrés se déclarent plus souvent discriminés que les Français, peut-on en déduire que les Français manifestent plus fréquemment du racisme que les immigrés? Différents paramètres interfèrent dans ces relations : importance relative de chacun des groupes, (environ 20 % d'immigrés ou d'enfants d'immigrés), discriminations d'un groupe à l'autre ou aussi à l'intérieur des deux groupes qui sont hétérogènes, nombre de discriminations subies par personne ou exercées par raciste. Le problème est abordé à partir des données fournies par l'enquête TeO, « Trajectoires et Origines, Enquête sur la diversité des populations », dans laquelle 35,8 % des immigrés

ou enfants d'immigrés déclarent avoir été discriminés et 18,6 % des Français partir d'un modèle très simple, où chaque personne discriminée l'a été une fois et une seule, et chaque personne discriminant l'a fait une fois et une seule, les taux de racistes seraient respectivement de 77,3 parmi les immigrés et de 8,7 % parmi les Français. On approche la stabilité de ces résultats, en faisant varier la proportion de personnes d'un groupe n'ayant jamais rencontré de personnes de l'autre groupe. Un modèle dual à partir des personnes déclarant ne pas avoir été discriminées, conforte ces premiers résultats. On introduit ensuite différents paramètres de manière à se rapprocher de la réalité et on montre que dans chacun des cas de figure, le taux de racistes (discriminateurs) est plus important parmi les immigrés que parmi les Français.

► **Les données de santé**

POLTON D.

2018

Med Sci (Paris) 34(5): 449-455.

<https://doi.org/10.1051/medsci/20183405018>

En matière de santé comme dans d'autres secteurs, une masse croissante de données numérisées provenant de diverses sources est disponible et exploitable. C'est l'un des domaines où le potentiel du Big data apparaît très prometteur, avec de multiples innovations au bénéfice des patients et du système (accélération de la recherche et développement, connaissance des maladies, des facteurs de risque, médecine personnalisée, aide au diagnostic et au traitement, rôle accru des patients, pharmacovigilance, etc.), même si des inquiétudes s'expriment aussi vis-à-vis des impacts sociétaux, économiques et éthiques que le recours croissant aux algorithmes et à l'intelligence artificielle pourrait induire. Développer l'usage de ces données constitue un objectif stratégique de tous les systèmes de santé, et de ce point de vue le Système national de données de santé (SNDS) constitue pour la France un patrimoine intéressant, mais qui demande à être complété et enrichi.

Politique de santé

► **Tensions and Uncertainties in Person-Centred Support for People with Long-Term Conditions**

CRIBB A., WATT I. S., SKEA Z. C., *et al.*
2018

The more you know, the more you realise it is really challenging to do»» Patient Educ Couns 101(8): 1460-1467

<https://www.ncbi.nlm.nih.gov/pubmed/29622282>

The aims of this study are to identify and examine tensions and uncertainties in person-centred approaches to self-management support - approaches that take patients seriously as moral agents and orient support to enable them to live (and die) well on their own terms. Interviews with 26 UK clinicians about working with people with diabetes or Parkinson's disease, conducted within a broader interdisciplinary project on self-management support. The analysis reported here was informed by philosophical reasoning and discussions with stakeholders. Person-centred approaches require clinicians to balance tensions between the many things that can matter in life, and their own and each patient's perspectives on these. Clinicians must ensure that their supportive efforts do not inadvertently disempower people. When attending to someone's particular circumstances and perspectives, they sometimes face intractable uncertainties, including about what is most important to the person and what, realistically, the person can or could do and achieve. The kinds of professional judgement that person-centred working necessitates are not always acknowledged and supported. Practical and ethical tensions are inherent in person-centred support and need to be better understood and addressed. Professional development and service improvement initiatives should recognise these tensions and uncertainties and support clinicians to navigate them well.

► **Éduquer le patient ou transformer l'action publique : un espace d'expression pour les patients. Commentaire**

FOURNIER C. ET TROISOEUFS A.
2018

Sciences Sociales et Santé 36(2): 33-41.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2018-2-p-33.htm>

L'article relate l'étude socio-historique d'une association porteuse d'une philosophie et de pratiques appelées aujourd'hui en France Éducation thérapeutique du patient (ETP). L'analyse du fonctionnement interne de l'association à différentes époques permet aux auteurs d'illustrer les transformations de ce concept et de ces pratiques au fil du temps.

► **Decoding Disclosure: Comparing Conflict of Interest Policy Among the United States, France, and Australia**

GRUNDY Q., HABIBI R., SHNIER A., *et al.*
2018

Health Policy 122(5): 509-518.

"Sunshine" policy, aimed at making financial ties between health professionals and industry publicly transparent, has recently gone global. Given that transparency is not the sole means of managing conflict of interest, and is unlikely to be effective on its own, it is important to understand why disclosure has emerged as a predominant public policy solution, and what the effects of this focus on transparency might be. We used Carol Bacchi's problem-questioning approach to policy analysis to compare the Sunshine policies in three different jurisdictions, the United States, France and Australia. We found that transparency had emerged as a solution to several different problems including misuse of tax dollars, patient safety and public trust. Despite these differences in the origins of disclosure policies, all were underpinned by the questionable assumption that informed consumers could address conflicts of interest. We conclude that, while transparency reports have provided an unprecedented opportunity to understand the reach of industry within healthcare, policymakers should build upon these insights and begin to develop policy solutions that address systemic commercial influence.

► **Should Interventions to Reduce Variation in Care Quality Target Doctors or Hospitals?**

GUTACKER N., BLOOR K., BOJKE C., *et al.*

2018

Health Policy 122(6): 660-666.

Interventions to reduce variation in care quality are increasingly targeted at both individual doctors and the organisations in which they work. Concerns remain about the scope and consequences for such performance management, the relative contribution of individuals and organisations to observed variation, and whether performance can be measured reliably. This study explores these issues in the context of the English National Health Service by analysing comprehensive administrative data for all patients treated for four clinical conditions (acute myocardial infarction, hip fracture, pneumonia, ischemic stroke) and two surgical procedures (coronary artery bypass, hip replacement) during April 2010-February 2013. Performance indicators are defined as 30-day mortality, 28-day emergency readmission and inpatient length of stay. Three-level hierarchical generalised linear mixed models are estimated to attribute variation in case-mix adjusted indicators to individual doctors and hospital organisations. Except for length of stay after hip replacement, no more than 11% of variation in case-mix adjusted performance indicators can be attributed to doctors and organisations with the rest reflecting random chance and unobserved patient factors. Doctor variation exceeds hospital variation by a factor of 1.2 or more. However, identifying poor performance amongst doctors is hampered by insufficient numbers of cases per doctor to reliably estimate their individual performances. Policy makers and regulators should therefore be cautious when targeting individual doctors in performance improvement initiatives.

► **The Diabetes Self-Management Educational Programs and Their Integration in the Usual Care: A Systematic Literature Review**

KUMAH E., SCIOLLI G., TORALDO M. L., *et al.*

2018

Health Policy 122(8): 866-877.

<http://dx.doi.org/10.1016/j.healthpol.2018.06.003>

Heterogeneous integration levels between usual care and self-management programs exist in literature. Usual care providers define the patients' targets, follow their upgrades, or refer patients to the education centers. Behaviors and health status improve after attending an educational program and independently from the integration levels. Programs appear to produce more positive results when patients perceived that providers are involved.

► **Understanding Delays in Acute Stroke Care: A Systematic Review of Reviews**

LACKHEM Y., RICAN S. ET MINVIELLE E.

2018

Eur J Public Health 28(3): 426-433.

Stroke is the leading cause of adult long-term disability in Western countries. Intravenous thrombolytic therapy with recombinant tissue plasminogen activator is safe and effective within the first 4.5 h after the onset of stroke. Various factors delaying acute stroke care have been identified in the literature. This review aimed to provide an overview of factors delaying acute stroke care and attempted to show how they interact in a synthetic framework. We conducted a systematic review of literature reviews published in Medline and DORIS until 2016 on factors influencing acute stroke pathway timeframe. This review provides a wide overview of factors influencing acute stroke pathway. Since it was observed that the identified factors were inter-related, they needed to be analyzed in a systematic way. We hence created a synthetic framework that combines several categories of factors while assuming that factor weight varies from a study context to another. Better knowledge on underlying mechanisms between factors would provide crucial improvement of the interventions aiming at reducing delays in both pre-hospital and in-hospital stages. For future research, we recommend adopting a systemic perspective on factors influencing acute stroke pathway.

► **Mapping Existing Hip and Knee Replacement Registries in Europe**

LUBBEKE A., SILMAN A. J., BAREA C., *et al.*
2018

Health Policy 122(5): 548-557.

The general shortage of evidence regarding benefits and harms of medical devices has been highlighted following the serious safety concerns with metal-on-metal hip replacements and silicone breast implants and was again pointed out in a recent survey of European Health Technology Assessment institutions. In this context the new European medical device regulation will enforce post-marketing surveillance of existing and new implants. The usefulness of registry data as a source of information for medical device real-world clinical performance and safety has been demonstrated. However, these data might be underused by researchers and policy makers. One reason for this is the insufficient awareness of their existence. The aim of this review is to provide information to relevant stakeholders on the extent and breadth of the data currently collected in European joint replacement registries. We identified 24 registries, most of them of national coverage. Total numbers of primary total hip and knee replacements included were over 3.1 and 2.5 million records, respectively. The current focus of these registries is on whole-lifespan implant surveillance via revision rate monitoring, quality assessment of surgical and perioperative care, and hospital performance assessment. More recently, national and international comparison and benchmarking have increasingly become part of their endeavors.

► **Éducation thérapeutique en odontologie pédiatrique : analyse des obstacles et leviers au développement de programmes en France en 2016**

MARQUILLIER T., TRENTESAUX T. ET GAGNAYRE R.
2017

Santé Publique 29(6): 781-792.

<https://www.cairn.info/revue-sante-publique-2017-6-page-781.htm>

L'éducation thérapeutique du patient (ETP) a investi ces dernières années le champ de la médecine bucco-dentaire. La prise en charge de la carie précoce de l'enfant, reconnue comme une maladie chronique des plus fréquentes, a évolué pour y intégrer une dimension éducative. L'objectif de cette étude était de faire

émerger les leviers et les freins au développement de programmes autorisés d'ETP ainsi que les alternatives. Une étude qualitative exploratoire compréhensive a été menée entre novembre 2015 et juin 2016 sur un échantillon ciblé de 15 personnes sensibilisées à la problématique de l'ETP en médecine bucco-dentaire. L'étude rapporte que la formation d'ETP en odontologie est trop peu développée alors que les bénéfices attendus sont multiples : évolution de la posture du soignant, mise en place de programmes éducatifs structurés, développement de la recherche... Les freins au développement de programmes apparaissent nombreux : manque de moyens, rigidité législative ou encore manque de connaissance de cette pratique. La profession odontologique représente en elle-même un obstacle de par son manque de compréhension et son intégration inhomogène au monde médical. Des leviers émergent de notre étude dont les principaux sont l'évolution de la profession et la mise à disposition de ressources pour développer l'ETP. Si des alternatives aux programmes d'ETP sont présentes (actions éducatives, santé connectée), elles ne peuvent s'y substituer pour autant. Développer davantage les stratégies éducatives en odontologie est possible et nécessaire. Néanmoins il convient d'adapter le cadre à la profession afin qu'elle puisse l'investir pleinement.

► **We Need to Talk About Purpose: A Critical Interpretive Synthesis of Health and Social Care Professionals' Approaches to Self-Management Support for People with Long-Term Conditions**

MORGAN H. M., ENTWISTLE V. A., CRIBB A., *et al.*
2017

Health Expect 20(2): 243-259.

<https://www.ncbi.nlm.nih.gov/pubmed/27075246>

Health policies internationally advocate 'support for self-management', but it is not clear how the promise of the concept can be fulfilled. The aim of this study is to synthesize research into professional practitioners' perspectives, practices and experiences to help inform a reconceptualization of support for self-management. Critical interpretive synthesis is conducted using systematic searches of literature published 2000-2014. The literature illustrates striking variations in approaches to support for self-management and interpretations of associated concepts. We focused particularly on the somewhat neglected question of the purpose of support. We suggest that this can illuminate and explain

important differences between narrower and broader approaches. Narrower approaches support people to manage their condition(s) well in terms of disease control. This purpose can underpin more hierarchical practitioner-patient communication and more limited views of patient empowerment. It is often associated with experiences of failure and frustration. Broader approaches support people to manage well with their condition(s). They can keep work on disease control in perspective as attention focuses on what matters to people and how they can be supported to shape their own lives. Broader approaches are currently less evident in practice. Broader approaches seem necessary to fulfil the promise of support for self-management, especially for patient empowerment. A commitment to enable people to live well with long-term conditions could provide a coherent basis for the forms and outcomes of support that policies aspire to. The implications of such a commitment need further attention.

► **L'émergence de la question de la sécurité des patients en France**

MOUGEOT F., OCCELLI P., BUCHET-POYAU K., *et al.*
2017

Santé Publique 29(6): 869-877.

<https://www.cairn.info/revue-sante-publique-2017-6-page-869.htm>

L'objectif de cet article est de comprendre les conditions d'émergence de la thématique de la sécurité des soins dans le débat public et les limites de sa mise en œuvre dans le système de santé actuel. Une revue narrative de la littérature a été réalisée à partir des bases de données PubMed, Cairn et Persée. L'interrogation des bases de données a référencé 2 206 documents dont 48 ont été retenus. La thématique de la sécurité des patients s'est diffusée à l'échelle mondiale et a émergé tardivement en France. La difficile émergence de la sécurité des soins en France est notamment liée à l'euphémisation du problème de la sécurité des patients, à la difficulté du passage au raisonnement systémique, à la carence en leviers de gestion des ressources humaines et à la place ambiguë des patients dans la sécurité des soins.

► **“Was that a Success or Not a Success?” A Qualitative Study of Health Professionals' Perspectives on Support for People with Long-Term Conditions**

OWENS J., ENTWISTLE V. A., CRIBB A., *et al.*

2017

BMC Fam Pract 18(1): 39.

<https://www.ncbi.nlm.nih.gov/pubmed/28320325>

Support for self-management (SSM) is a prominent strand of health policy internationally, particularly for primary care. It is often discussed and evaluated in terms of patients' knowledge, skills and confidence, health-related behaviours, disease control or risk reduction, and service use and costs. However, these goals are limited, both as guides to professional practice and as indicators of its quality. In order to better understand what it means to support self-management well, we examined health professionals' views of success in their work with people with long-term conditions. This study formed part of a broader project to develop a conceptual account of SSM that can reflect and promote good practice. Participants identified a wide range of interlinked aspects or elements of success relating to: health, wellbeing and quality of life; how well people (can) manage; and professional-patient relationships. They also mentioned a number of considerations that have important implications for assessing the quality of their own performance. These considerations in part reflect variations in what matters and what is realistically achievable for particular people, in particular situations and at particular times, as well as the complexity of questions of attribution. A nuanced assessment of the quality of support for self-management requires attention to the responsiveness of professional practice to a wide, complex range of personal and situational states, as well as actions and interactions over time. A narrow focus on particular indicators can lead to insensitive or even perverse judgements and perhaps counterproductive effects. More open, critical discussions about both success and the assessment of quality are needed to facilitate good professional practice and service improvement initiatives.

► **Éduquer le patient ou transformer l'action publique ? Analyse socio-historique d'une association pour le développement de l'éducation thérapeutique du patient**

PERRIER C. ET PERRIN C.

2018

Sciences sociales et santé 36(2): 5-31.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2018-2-page-5.htm>

En France, l'Éducation Thérapeutique du Patient s'est développée au travers de la formation des professionnels et d'activités de recherche portées par les mondes associatifs et académiques. L'étude socio-historique d'une des associations françaises les plus anciennes (l'Afdet) mobilise conjointement des cadres théoriques de sociologie de la santé et de science politique. Elle analyse le corpus des revues publiées depuis 1990 par l'association et un recueil de vingt-deux entretiens avec des acteurs-clés. Si la posture réformatrice apparaît comme une continuité de l'histoire de l'association, elle fait l'objet de tensions entre les acteurs à l'origine de deux reconfigurations importantes. C'est une conception nouvelle du processus de soin et de santé qu'entend diffuser ce collectif analysé comme un « laboratoire d'ingénierie des idées », révélateur d'une contribution à l'action publique en marge des institutions.

► **Health Policy and Systems Research: The Future of the Field**

PETERS D. H.

2018

Health Research Policy and Systems 16(1): 84.

<https://doi.org/10.1186/s12961-018-0359-0>

Health policy and systems research (HPSR) has changed considerably over the last 20 years, but its main purpose remains to inform and influence health policies and systems. Whereas goals that underpin health systems have endured – such as a focus on health equity – contexts and priorities change, research methods progress, and health organisations continue to learn and adapt, in part by using HPSR. For HPSR to remain relevant, its practitioners need to re-think how health systems are conceptualised, to keep up with rapid changes in how we diagnose and manage disease and use information, and consider factors affecting people's health that go well beyond healthcare systems. The Sustainable Development Goals (SDGs)

represent a shifting paradigm in human development by seeking convergence across sectors. They also offer an opportunity for HPSR to play a larger role, given its pioneering work on applying systems thinking to health, its focus on health equity, and the strength of its multi-disciplinary approaches that make it a good fit for the SDG era.

► **Space, Place and (Waiting) Time: Reflections on Health Policy and Politics**

SHEARD S.

2018

Health Economics, Policy and Law 13(3-4): 226-250.

<https://www.cambridge.org/core/article/space-place-and-waiting-time-reflections-on-health-policy-and-politics/82C2B2CA7E9860D2651920FD3CE95194>

Health systems have repeatedly addressed concerns about efficiency and equity by employing trans-national comparisons to draw out the strengths and weaknesses of specific policy initiatives. This paper demonstrates the potential for explicit historical analysis of waiting times for hospital treatment to add value to spatial comparative methodologies. Waiting times and the size of the lists of waiting patients have become key operational indicators. In the United Kingdom, as National Health Service (NHS) financial pressures intensified from the 1970s, waiting times have become a topic for regular public and political debate. Various explanations for waiting times include the following: hospital consultants manipulate NHS waiting lists to maintain their private practice; there is under-investment in the NHS; and available (and adequate) resources are being used inefficiently. Other countries have also experienced ongoing tensions between the public and private delivery of universal health care in which national and trans-national comparisons of waiting times have been regularly used. The paper discusses the development of key UK policies, and provides a limited Canadian comparative perspective, to explore wider issues, including whether 'waiting crises' were consciously used by policymakers, especially those brought into government to implement new economic and managerial strategies, to diminish the autonomy and authority of the medical professional in the hospital environment.

► **Two-Year Management After Renal Transplantation in 2013 in France: Input from the French National Health System Database**

TUPPIN P., BESSOU A., LEGEAI C., *et al.*

2018

Nephrol Ther. 14(4): 207-216

The objective of this study was to describe the management of patients undergoing renal transplantation in 2013 and over the following two years on the basis of healthcare consumption data. The National Health Insurance Information System was used to identify 1876 general scheme beneficiaries undergoing a first isolated renal transplantation (median age: 53 years; men 63%). Overall, 1.2% of patients died during the transplantation hospital stay (>65 years 3.3%) and 87% of patients had a functional graft at 2 years. Thirty-three percent of patients were readmitted to hospital for 1 day or longer during the first month, 73% the

first year and 55% the second year. At least 10% of patients were hospitalised for antirejection treatment during the first quarter after renal transplantation, 16% the first year and 9% the second year. The first year, 32% of patients were hospitalised for renal disease (12% the second year), 14% were hospitalised for cardiovascular disease (9% the second year), 13% for infectious disease (5% the second year) and 2% for a malignant tumour (2% the second year). Almost 80% of patients consulted their general practitioner each year (almost 50% consulted every quarter). During the second year, 83% of patients were taking antihypertensives, 45% lipid-lowering drugs, 26% antidiabetic drugs, 77% tacrolimus, 18% ciclosporin, 88% mycophenolic acid and 69% corticosteroids. This study highlights the important contribution of healthcare consumption data to a better understanding of the modalities of management of renal transplant recipients in France, allowing improvement of this management in line with guidelines.

Politique publique

► **Développement d'un cours francophone en ligne sur les politiques publiques en santé : une collaboration internationale**

HÉBERT R., COPPIETERS Y., PRADIER C., *et al.*

2017

Santé Publique 29(6): 821-827.

<https://www.cairn.info/revue-sante-publique-2017-6-page-821.htm>

L'objectif de cette étude est de présenter le processus et les défis du développement d'un cours en ligne sur les politiques publiques en santé, conçu en collaboration internationale selon une approche par compétences. Cinq experts de santé publique épaulés d'un

expert en technologie éducative ont travaillé à l'élaboration du cours en adoptant une démarche rigoureuse : analyse des besoins, élaboration des cibles et des compétences visées, développement d'un scénario pédagogique comportant pour chaque module la cible visée, les éléments de contenu, la méthode d'enseignement, les activités d'apprentissage, le matériel à identifier ou à développer et les responsabilités et tâches impliquées. Le cours d'études supérieures de deux crédits (90 heures de travail) comprend six modules dont un module d'intégration. Il est intégré aux programmes d'études supérieures des universités participantes et permet à des étudiants de suivre à distance une formation innovante.

Politique sociale

► La sécurité sociale entre solidarité et marché

BEC C.

2018

Revue Française de Socio-Économie 20(1): 167-185.

<https://www.cairn.info/revue-francaise-de-socio-economie-2018-1-page-167.htm>

Cet article analyse dans une perspective socio-historique un processus de délégitimation politique de la Sécurité sociale. En 1945, dans la continuité du solidarisme, cette institution porte, avec le droit du travail, le projet d'un ordre social nouveau reposant sur une égale protection de tous, indispensable à la liberté et à la citoyenneté de chacun. Elle subit depuis les années 1970 une réorientation philosophique et politique profonde et évolue vers un statut d'organisme payeur invité à se soumettre aux lois du marché. Cette réorientation trouve son origine dans le dilemme, à la Libération, entre une protection conçue comme droit du travailleur ou comme droit de l'homme et donc entre une solidarité catégorielle ou nationale. La généralisation du système se fait de façon différenciée, inégalitaire et porteuse de dualisation. Face aux transformations profondes de la société et au déséquilibre financier, une série de mesures réactives et d'ajustements ont tenu place de débat sur les réformes de fond nécessaires. Elles ont accentué les ambivalences originelles et limité sa portée transformative et démocratique. Le principe de solidarité tend à s'effacer au profit d'une logique prioritairement budgétaire et gestionnaire ouvrant la porte à une marchandisation de la protection.

► Troubles dans la protection sociale

DELOUETTE I. ET LE LANN Y.

2018

Revue Française de Socio-Économie 20(1): 27-38.

<https://www.cairn.info/revue-francaise-de-socio-economie-2018-1-page-27.htm>

Où va la protection sociale ? Quelles sont les nouvelles pratiques de financement, de gestion ou de comptabilisation qui s'établissent depuis une trentaine d'années dans ce champ ? Comment reconfigurent-elles le sens des institutions de la protection sociale ? La protection sociale a émergé en réaction aux crises du capitalisme libéral, comme une instance de dé-marchandisation du travail. Elle s'est construite dans une tension entre autonomie et dépendance avec d'autres secteurs de l'action publique : éducation, emploi, insertion. L'imposition progressive du mode de régulation concurrentiel capitaliste a suscité de profondes interrogations sur la nature des fonctions que doit remplir cette institution. Le paradigme d'activation des politiques sociales comme les mutations de leurs modes de financement interpellent sur son rôle et mènent à une complexification de ses rapports au marché. Ces évolutions entraînent un véritable défi pour l'analyse socio-économique : comment faire évoluer les catégories d'analyse pour mieux appréhender les mutations du système contemporain de protection sociale ? Les articles du dossier explorent ainsi les évolutions statistiques, les transformations des cadres cognitifs de l'action publique, et les réformes juridiques et financières qui provoquent les troubles dans la protection sociale.

Prévention santé

► The Practices of French General Practitioners Regarding Screening and Counselling Pregnant Women for Tobacco Smoking and Alcohol Drinking

ANDLER R., COGORDAN C., PASQUEREAU A., *et al.*

2018

Int J Public Health 63(5): 631-640.

Our study aims to describe French general practitioners' (GPs') practices toward pregnant patients regarding alcohol consumption and smoking and to highlight factors associated with specific practices. In 2015, a representative sample of 1414 French GPs completed a telephone survey based on a stratified random sampling. 61% of GPs declared screening for alcohol use and 82% for smoking at least once with each pregnant patient; quitting was not systematically advised either

for alcohol or for smoking. GPs' practices were significantly better among those who had more recent ongoing training. GPs who drank regularly were less likely to screen for alcohol use and GPs' drinking frequency was inversely related to recommending quitting. Current and former smokers were less likely to recommend quitting to pregnant patients smoking over five cigarettes per day. Screening and counselling practices for substance use during pregnancy are heterogeneous among French GPs and are notably related to their personal consumption. GP's role in preventing substance use during pregnancy could be strengthened by actions regarding their own consumption and by modifications in their initial and ongoing training.

► **Promoting Health-Enhancing Physical Activity in Europe: Current State of Surveillance, Policy Development and Implementation**

BREDA J., JAKOVLJEVIC J., RATHMES G., *et al.*
2018

Health Policy 122(5): 519-527.

This study aims to present information on the surveillance, policy developments, and implementation of physical activity policies in the 28 European Union (EU) countries. Data was collected on the implementation of the EU Recommendation on health-enhancing physical activity (HEPA) across sectors. In line with the monitoring framework proposed in the Recommendation, a questionnaire was designed to capture information on 23 physical activity indicators. Of the 27 EU countries that responded to the survey, 22 have implemented actions on more than 10 indicators, four countries have implemented more than 20 indicators, and one country has fully addressed and implemented all of the 23 indicators of the monitoring framework. The data collected under this HEPA monitoring framework provided, for the first time, an overview of the implementation of HEPA-related policies and actions at the national level throughout the EU. Areas that need more investment are the "Senior Citizens" sector followed by the "Work Environment", and the "Environment, Urban Planning, and Public Safety" sectors. This information also enabled comparison of the state of play of HEPA policy implementation between EU Member States and facilitated the exchange of good practices.

► **Étude qualitative auprès des utilisateurs de cigarette électronique : pratiques, usages, représentations**

FONTAINE A. ET ARTIGAS F.
2017

Santé Publique 29(6): 793-801.

<https://www.cairn.info/revue-sante-publique-2017-6-page-793.htm>

Les cigarettes électroniques sont des dispositifs sans combustion qui permettent de simuler l'acte de fumer du tabac, en vaporisant un « e-liquide » et diffusant un aérosol que l'utilisateur inhale. Même si l'engouement remarqué en 2012-2013 s'est ralenti, la cigarette électronique fait aujourd'hui partie du paysage des fumeurs qui cherchent une alternative au tabac et à l'abstinence et les tabacologues ont à répondre à la demande grandissante des fumeurs et à adopter une position claire face à ce dispositif. Les résultats présentés sont issus d'une étude qualitative réalisée avec le soutien financier de la Direction Générale de la Santé, l'une des directions du ministère des Affaires sociales et de la Santé. Elle a été conduite en France, de septembre 2014 à janvier 2016. Elle se fonde sur un travail de terrain classique en ethnologie : observations lors d'événements regroupant des usagers de cigarettes électroniques et 25 entretiens semi-directifs réalisés avec des profils variés permettant d'explorer un champ encore méconnu. Cette étude contribue à l'observation et à la compréhension d'un phénomène naissant, susceptible de changer durablement notre rapport au tabac. Elle montre la grande variété des profils, parmi les fumeurs, intéressés par la cigarette électronique. Hommes, femmes, jeunes ou anciens fumeurs, adoptent des postures différentes au moment d'essayer ce dispositif et les usages évoluent dans les mois qui suivent cette expérimentation.

► **Smoking Cessation Delivery by General Practitioners in Crete, Greece**

GIRVALAKI C., PAPADAKIS S., VARDAVAS C., *et al.*
2018

Eur J Public Health 28(3): 542-547.

Tobacco dependence treatment in clinical settings is of prime public health importance, especially in Greece, a country experiencing one of the highest rates of tobacco use in Europe. : Our study aimed to examine the characteristics of tobacco users and document rates of tobacco treatment delivery in general practice settings in Crete, Greece. A cross-sectional sample of

patients (n = 2, 261) was screened for current tobacco use in 25 general practices in Crete, Greece in 2015/16. Current tobacco users completed a survey following their clinic appointment that collected information on patient characteristics and rates at which the primary care physician delivered tobacco treatment using the evidence-based 4 A's (Ask, Advise, Assist, Arrange) model during their medical appointment and over the previous 12-month period. Multi-level modeling was used to analyze data and examine predictors of 4 A's delivery. Results: Tobacco use prevalence was 38% among all patients screened. A total of 840 tobacco users completed the study survey [mean age 48.0 (SD 14.5) years, 57.6% male]. Approximately, half of the tobacco users reported their general practitioner 'asked' about their tobacco use and 'advised' them to quit smoking. Receiving 'assistance' with quitting (15.7%) and 'arranging' follow-up support (<3%) was infrequent. Patient education, presence of smoking-related illness, a positive screen for anxiety or depression and the type of medical appointment were associated with 4 A's delivery. Conclusion: Given the fundamental importance of addressing tobacco treatment, increasing the rates of 4 A's treatment in primary care settings in Greece is an important target for improving patient care.

► **Impact of Public Smoking Bans on Children's Exposure to Tobacco Smoke at Home: A Systematic Review and Meta-Analysis**

NANNINGA S., LHACHIMI S. K. ET BOLTE G.
2018

BMC Public Health 18(1): 749.

<https://doi.org/10.1186/s12889-018-5679-z>

Meta-analysis of the impact of public smoking bans on children's exposure to secondhand smoke (SHS) exposure at home.

► **Expansion of the 'Antibiotic Guardian' One Health Behavioural Campaign Across Europe to Tackle Antibiotic Resistance: Pilot Phase and Analysis of AMR Knowledge**

NEWITT S., ANTHIERENS S., COENEN S., *et al.*
2018

Eur J Public Health 28(3): 437-439.

Antimicrobial resistance (AMR) is a major public health threat. The UK Antibiotic Guardian (AG) behavioural change campaign developed to tackle AMR was expanded across Europe through translation into Russian, Dutch and French. Demographics and knowledge of AGs were analyzed between 01 November 2016 and 31 December 2016. A total of 367 pledges were received with the majority from the public and health care professionals. The pilot has significantly increased the proportion of pledges from Europe (excluding UK) ($\chi^2 = 108.7$, $P < 0.001$). AMR knowledge was greater in AGs (including the public) compared to the EU Eurobarometer survey. Further promotion across Europe is required to measure an impact on tackling AMR.

Prévision – Evaluation

► **A Bayesian Framework for Health Economic Evaluation in Studies with Missing Data**

MASON A. J., GOMES M., GRIEVE R., *et al.*
2018

Health Econ. [Ahead of print]

Health economics studies with missing data are increasingly using approaches such as multiple imputation that assume that the data are "missing at random." This assumption is often questionable, as-even given

the observed data-the probability that data are missing may reflect the true, unobserved outcomes, such as the patients' true health status. In these cases, methodological guidelines recommend sensitivity analyses to recognise data may be "missing not at random" (MNAR), and call for the development of practical, accessible approaches for exploring the robustness of conclusions to MNAR assumptions. Little attention has been paid to the problem that data may be MNAR in health economics in general and in cost-effectiveness analyses (CEA) in particular. In this paper, we propose

a Bayesian framework for CEA where outcome or cost data are missing. Our framework includes a practical, accessible approach to sensitivity analysis that allows the analyst to draw on expert opinion. We illustrate

the framework in a CEA comparing an endovascular strategy with open repair for patients with ruptured abdominal aortic aneurysm, and provide software tools to implement this approach.

Psychiatrie

► **Women's Mental Health in the Perinatal Period According to Migrant Status: The French Representative ELFE Birth Cohort**

EL-KHOURY F., SUTTER-DALLAY A. L., PANICO L., *et al.*

2018

[Eur J Public Health 28\(3\): 458-463.](#)

Mental health problems in the perinatal period are common. We examined associations between different categories of migrant status and region of origin in relation to mental health during pregnancy and at 2 months post-partum. We analyzed data from the French nationally representative Etude Longitudinale Francaise depuis l'Enfance birth cohort ($n = 17\ 988$). Migrant status was divided into five categories: 'majority population', 'descendants with one migrant parent', 'descendants with two migrant parents', 'naturalized migrant' and 'non-naturalized migrant women'. Multivariate logistic regression models were implemented to examine associations between migrant status and mental health outcomes: persistent psychological difficulties during pregnancy as well as mother's depression and poor self-reported health at 2 months post-partum. Results: After adjusting for covariates, migrant status was not associated with psychological difficulties during pregnancy. Descendants of migrants had comparable mental health to the majority population. Non-naturalized migrant women were more likely to experience depression (odds ratio (OR) = 1.66, 95% confidence interval (CI): 1.27, 2.20) and poor self-reported health (OR = 1.45, 95%CI: 1.06, 1.98) during the post-partum period. The region of origin was associated with post-partum health independently of migrant status, such that women from Africa and Turkey were most likely to have depression or poor self-rated health. Conclusion: First, but not second, generation migrant women appear to have high levels of mental health difficulties during the post-partum period. Women from North Africa, Sub-Saharan

Africa, and Turkey have higher levels of distress than those from other regions. In particular, non-naturalized migrant appear to be a vulnerable group; they may disproportionately face stressors that increase their risk for post-partum depressive symptoms.

► **The Impact of the Current Economic Crisis on Mental Health in Italy: Evidence from Two Representative National Surveys**

ODONE A., LANDRISCINA T., AMERIO A., *et al.*

2018

[Eur J Public Health 28\(3\): 490-495.](#)

Economic crises pose major threats to health. Research on the association between the current economic crisis and health is accumulating. Scant evidence is available on the impact of economic downturns on mental health in Italy, one of the European countries most affected by the economic crisis. We used data from the 2005 and 2013 'Health Conditions and Use of Health Services' surveys conducted by the Italian National Institute of Statistics to estimate Italian poor mental health prevalence in Italy and we applied Poisson regression analysis to explore how the risk (expressed as Prevalence Rate Ratios; PRR) of poor mental health has been impacted by the ongoing economic crisis, by gender and by different socio-economic strata. Poor mental health prevalence in Italy was 21.5% in 2005 and 25.1% in 2013. The risk of poor mental health increased between 2005 and 2013 by 17% in males (PRR: 1.17; 95%CI: 1.14-1.20) and by 4% in females (PRR: 1.04; 95%CI: 1.02-1.06), the increase being highest for young males (24%). Vulnerable subgroup is at higher risk of poor mental health but not differently affected by the impact of the economic crisis. The economic crisis that hit Italy has posed threats to Italians' mental health and wellbeing, with a higher impact on young male populations. As further evidence from prospective studies is accumulating, our findings sug-

gest strengthened primary and secondary prevention interventions should be planned and implemented by the Italian National Health Service so as to counter economic downturns' impact on population and individual-level health.

► **Depressive Disorders in Primary Care: Clinical Features and Sociodemographic Characteristics**

ONEIB B., SABIR M., OTHEMAN Y., *et al.*

2018

Rev Epidemiol Santé Publique. [Ahead of print]

Our aim was to determine the reason for consultation and the clinical features of depressive disorders according to the diagnostic and statistical manual (DSM) 4th edition IV R in primary care and to identify if there is an association between sociodemographic characteristics and depressive pattern. In a cross-sectional study conducted to determinate the prevalence of depressive disorders in primary care, at three urban centers in two cities Sale and Oujda by five physicians, we recruited primary care 396 patients of whom 58 were depressed, among these patients we screened for depressive disorders, their clinical features, the melancholic characteristics and suicidal ideation using the Mini International Neuropsychiatric Interview. Mean age of the 58 depressive patients was 46+/-15 years. They were predominantly female, inactive and of low socio-economic level. Approximately one-third of the patients were illiterate and single. The symptoms frequently encountered were sadness (63.7%), anhedonia (62%), insomnia (45.7%), anorexia (60.9%), psychomotor retardation (60.9%) and asthenia (73.9%). Somatic symptoms were present 99%, the most common complaint was pain that exhibited 68.6% prevalence. Suicidal ideations were found in 36.2% of these depressive patients. The accuracy of the clinical features of patients with depression in primary care will facilitate the detection of these disorders by general practitioners and improve management of depression.

► **La réhospitalisation en psychiatrie. Facteurs individuels, facteurs organisationnels**

PLANCKE L., AMARIEI A., FLAMENT C., *et al.*

2017

Santé Publique 29(6): 829-836.

<https://www.cairn.info/revue-sante-publique-2017-6-page-829.htm>

La réhospitalisation psychiatrique constitue souvent un critère pour apprécier les effets des traitements médicamenteux, des thérapies ainsi que ceux des changements d'organisation dans le système de soins. Elle est employée pour juger une rechute ou une décompensation. Le but de cette étude est de mesurer les taux de réhospitalisation et rechercher les facteurs individuels et organisationnels qui sont à l'origine de variations significatives. Les réhospitalisations psychiatriques ont été décrites à partir des séjours hospitaliers à temps complet enregistrés dans le Recueil d'informations médicalisé en Psychiatrie (RimP) en 2011 et 2012, concernant des personnes de 18 ans et plus, habitant dans le Nord et le Pas-de-Calais. Des probabilités de réhospitalisation, à différents intervalles de temps, ont été calculées selon la méthode d'analyse de survie de Kaplan-Meier et une analyse multivariée a été menée par le modèle de risques proportionnels de Cox. Environ 30 000 personnes majeures ont été hospitalisées à temps complet en services de psychiatrie pendant la période d'étude. La probabilité de réhospitalisation à 24 mois est de 51,6 % (IC95 % : 50,8-52,3 %). Selon les résultats du modèle de Cox, la schizophrénie (F2 – HR = 1,72 – IC95 % : 1,61-1,84 – p < 0,0001) et les troubles de la personnalité (F6 – HR = 1,45 – IC95 % : 1,32-1,58 – p < 0,0001) sont les diagnostics les plus liés à la réhospitalisation. Celle-ci augmente avec la perte d'autonomie et est plus élevée dans les établissements privés non lucratifs (HR = 1,49 – IC95 % : 1,38-1,60 – p < 0,0001). La réhospitalisation psychiatrique est un événement très fréquent, le risque de sa survenue étant lié non seulement à des facteurs individuels mais également organisationnels.

► **Strengthening Mental Health Care Systems for Syrian Refugees in Europe and the Middle East: Integrating Scalable Psychological Interventions in Eight Countries**

SIJBRANDIJ M., ACARTURK C., BIRD M., *et al.*

2017

Eur J Psychotraumatol 8(sup2): 1388102.

The crisis in Syria has resulted in vast numbers of refugees seeking asylum in Syria's neighbouring countries as well as in Europe. Refugees are at considerable risk

of developing common mental disorders, including depression, anxiety, and posttraumatic stress disorder (PTSD). Most refugees do not have access to mental health services for these problems because of multiple barriers in national and refugee specific health systems, including limited availability of mental health professionals. To counter some of challenges arising from limited mental health system capacity the World Health Organization (WHO) has developed a range of scalable psychological interventions aimed at reducing psychological distress and improving functioning in people living in communities affected by adversity. These interventions, including Problem Management Plus (PM+) and its variants, are intended to be delivered through individual or group face-to-face or smartphone formats by lay, non-professional people who have not received specialized mental health training. We provide an evidence-based rationale for the use of the scalable PM+ oriented programmes being adapted for Syrian refugees and provide information on the newly launched STRENGTHS programme for adapt-

ing, testing and scaling up of PM+ in various modalities in both neighbouring and European countries hosting Syrian refugees.

► **Improving Quality of Psychiatric Care in Latvia by Measuring Patient Experiences**

TAUBE M. ET BERZINA-NOVIKOVA N.
2018

Health Policy 122(7): 765-768.

<http://dx.doi.org/10.1016/j.healthpol.2018.03.011>

International trends and EU funding have supported the introduction of psychiatric quality assessments in Latvia. The PIPEQ-OS instrument has recently been adapted for use in Latvia. Psychiatric patients are interested in participating in the assessment process. More wide-spread use of PIPEQ-OS has the potential to improve psychiatric care in Latvia.

Soins de santé primaires

► **La place du médecin et de la famille dans la décision pour des patients en fin de vie**

ANGELO M. BISMUTH M., OUSTRIC S. ET *et al.*
2018

Médecine : De La Médecine Factuelle à nos Pratiques 14(3): 112-115.

Depuis quelques années, la fin de vie est un sujet sociétal sensible et très médiatisé ayant nécessité de réfléchir à un repositionnement des soignants. En 2005, la loi Léonetti et plus récemment la loi Claeys Léonetti en 2016 ont apporté des éléments de réponses concernant l'accompagnement des patients en fin de vie. Face à une situation complexe de soins palliatifs, parfois face aux pressions de la famille, comment peuvent se positionner les différents acteurs de la décision ? Le patient a-t-il exprimé une volonté particulière concernant sa fin de vie sous la forme de directives anticipées ? De quelle manière et comment rédiger des directives anticipées ? Quel est le cadre législatif concernant la limitation ou l'arrêt les soins curatifs ? Quelle est la place du médecin dans cette décision ? Quelle est la place de l'avis de la famille et/ou de la

personne de confiance dans la décision concernant l'arrêt ou la limitation des soins curatifs ?

► **Effects of Regulation and Payment Policies on Nurse Practitioners' Clinical Practices**

BARNES H., MAIER C. B., ALTARES SARIK D., *et al.*
2017

Med Care Res Rev 74(4): 431-451.

<https://www.ncbi.nlm.nih.gov/pubmed/27178092>

Increasing patient demand following health care reform has led to concerns about provider shortages, particularly in primary care and for Medicaid patients. Nurse practitioners (NPs) represent a potential solution to meeting demand. However, varying state scope of practice regulations and Medicaid reimbursement rates may limit efficient distribution of NPs. Using a national sample of 252,657 ambulatory practices, we examined the effect of state policies on NP employment in primary care and practice Medicaid acceptance. NPs had 13% higher odds of working in primary care in states with full scope of practice; those odds

increased to 20% if the state also reimbursed NPs at 100% of the physician Medicaid fee-for-service rate. Furthermore, in states with 100% Medicaid reimbursement, practices with NPs had 23% higher odds of accepting Medicaid than practices without NPs. Removing scope of practice restrictions and increasing Medicaid reimbursement may increase NP participation in primary care and practice Medicaid acceptance.

► **Uncovering the Wisdom Hidden Between the Lines: The Collaborative Reflexive Deliberative Approach**

CRABTREE B. F., MILLER W. L., GUNN J. M., *et al.*
2018

Fam Pract 35(3): 266-275.

Meta-analysis and meta-synthesis have been developed to synthesize results across published studies; however, they are still largely grounded in what is already published, missing the tacit 'between the lines' knowledge generated during many research projects that are not intrinsic to the main objectives of studies. This study aims to develop a novel approach to expand and deepen meta-syntheses using researchers' experience, tacit knowledge and relevant unpublished materials. We established new collaborations among primary health care researchers from different contexts based on common interests in reforming primary care service delivery and a diversity of perspectives. Over 2 years, the team met face-to-face and via tele- and video-conferences to employ the Collaborative Reflexive Deliberative Approach (CRDA) to discuss and reflect on published and unpublished results from participants' studies to identify new patterns and insights. CRDA focuses on uncovering critical insights, interpretations hidden within multiple research contexts. For the process to work, careful attention must be paid to ensure sufficient diversity among participants while also having people who are able to collaborate effectively. Ensuring there are enough studies for contextual variation also matters. It is necessary to balance rigorous facilitation techniques with the creation of safe space for diverse contributions. The CRDA requires large commitments of investigator time, the expense of convening facilitated retreats, considerable coordination, and strong leadership. The process creates an environment where interactions among diverse participants can illuminate hidden information within the contexts of studies, effectively enhancing theory development and generating new research questions and strategies.

► **Accuracy of Patient Recall for Self-Reported Doctor Visits: Is Shorter Recall Better?**

DALZIEL K., LI J., SCOTT A., *et al.*
2018

Health Econ.: [Ahead of print].

In health economics, the use of patient recall of health care utilisation information is common, including in national health surveys. However, the types and magnitude of measurement error that relate to different recall periods are not well understood. This study assessed the accuracy of recalled doctor visits over 2-week, 3-month, and 12-month periods by comparing self-report with routine administrative Australian Medicare data. Approximately 5,000 patients enrolled in an Australian study were pseudo-randomised using birth dates to report visits to a doctor over three separate recall periods. When comparing patient recall with visits recorded in administrative information from Medicare Australia, both bias and variance were minimised for the 12-month recall period. This may reflect telescoping that occurs with shorter recall periods (participants pulling in important events that fall outside the period). Using shorter recall periods scaled to represent longer periods is likely to bias results. There were associations between recall error and patient characteristics. The impact of recall error is demonstrated with a cost-effectiveness analysis using costs of doctor visits and a regression example predicting number of doctor visits. The findings have important implications for surveying health service utilisation for use in economic evaluation, econometric analyses, and routine national health surveys.

► **Changes in Access to Primary Care in Europe and Its Patterning, 2007-12: A Repeated Cross-Sectional Study**

DIMITROVOVA K. ET PERELMAN J.
2018

Eur J Public Health 28(3): 398-404.

The strengthening of primary care (PC) has been encouraged as a strategy to achieve more efficient and equitable health systems. However, the Great Recession may have reduced access to PC. This paper analyses the change in access to PC and its patterning in 28 European countries between 2007 and 2012. We used data from the 2007 and 2012 waves of the EU-SILC questionnaire (n = 687 170). The dependent

variable was the self-reported access to PC ('easy' vs. 'difficult'). We modelled the access to PC as a function of the year and individual socioeconomic and country-level health system variables, using a mixed effects logistic regression, adjusting for sex, age, civil status, country of birth, chronic condition and self-reported health. Additionally, we interacted the year with socioeconomic and country-level variables. Results: The probability of reporting difficult access to PC services was 4% lower in 2012, in comparison with 2007 (OR = 0.96, $P < 0.01$). People with the lowest educational level (OR = 1.63, $P < 0.01$), high difficulty to make ends meet (OR = 1.94, $P < 0.01$) and with material deprivation (OR = 1.25, $P < 0.01$) experienced a significantly higher likelihood of difficult access. The better access in 2012 was significantly higher in people living in countries with higher health expenditures, a greater number of generalist medical practitioners, and with stronger gatekeeping. Access to PC improved between 2007 and 2012, and this improvement was greater for people living in countries with a higher investment in health and PC. However, the poor access amongst low-SE status people was stable over the period.

► **Continuing Education for General Practitioners Working in Rural Practice: A Review of the Literature**

DOWLING S., LAST J., FINNIGAN H., et al.

2018

Educ Prim Care 29(3): 151-165.

Studies demonstrate that the CME/CPD (continuing medical education/continuing professional development) needs of rural general practitioners (GPs) are unique. Little research has focused specifically on the effectiveness of CME/CPD programmes for rural practice. This study aims to review the literature on CME/CPD for GPs in rural areas, focussing on studies which examined impact on doctor performance or patient outcomes. A search of peer-reviewed English language literature and relevant grey literature was conducted: identified literature was reviewed. Most articles report on participant experience or satisfaction while doctor performance and patient outcomes are seldom reported. Distance learning programmes found it difficult to recruit or engage doctors, two out of six studies found improvements in self-reported knowledge or performance, while none reported measurable changes in doctor performance/patient care.

► **Comment les médecins généralistes peuvent-ils contribuer à un accès plus équitable à l'éducation thérapeutique ?**

FOURNIER C., NAIDITCH M. ET FRATTINI M. O.

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(6): 268-272.

En France, le droit à bénéficier d'une éducation thérapeutique du patient (ETP) est inscrit dans le Code de la santé publique depuis 2009. Le système d'autorisation des programmes d'ETP instauré par la loi Hôpital, patients, santé et territoires (HPST) a abouti à la constitution d'une offre essentiellement hospitalière et l'accès aux programmes d'ETP reste globalement faible : en 2015, 3 736 programmes étaient autorisés pour environ 15 millions de personnes atteintes de maladies chroniques. Dans cet article, nous qualifions d'« ETP » les pratiques mises en œuvre dans le cadre de programmes autorisés et nous appelons « pratiques éducatives » celles développées au sein de consultations médicales. La dimension éducative est repérée lorsque les médecins déclarent s'appuyer sur le vécu et l'expérience du patient pour l'aider à développer des compétences d'auto-soin et d'adaptation, en construisant des objectifs personnalisés réévalués d'une consultation à l'autre. Au-delà de quelques travaux sur l'ETP en ambulatoire et sur son intégration aux soins, les pratiques éducatives individuelles restent peu étudiées et leur formalisation n'a été envisagée que récemment. En parallèle, dans la continuité de la loi HPST, la Loi de santé de 2016 énonce l'objectif de « garantir un accès aux soins équitable ». Or on sait que les personnes appartenant aux catégories les moins favorisées de la population, et qui supportent la plus grande part du fardeau lié aux maladies chroniques, ont un accès moindre à la fois aux soins et à la prévention. Considérant que l'ETP serait à même de contribuer à réduire les inégalités sociales de santé, on peut donc se demander s'il existe des inégalités d'accès à une prise en charge éducative, et si oui, si les médecins généralistes sont en mesure de contribuer à réduire ces inégalités d'accès, comme cela a été montré pour d'autres interventions de santé publique. Cet article synthétise les résultats d'une recherche dans laquelle des médecins ont été interrogés successivement sur : leurs pratiques éducatives ; l'accès donné à d'autres ressources éducatives ; la façon dont ils appréhendent les caractéristiques sociales de leurs patients et l'influence des inégalités sociales sur leur travail éducatif ; les solutions qu'ils développent ou envisagent pour contribuer à plus d'équité d'accès à une démarche éducative ou d'ETP.

► **Accountable Care Organizations and Post-Acute Care: A Focus on Preferred SNF Networks**

KENNEDY, G., LEWIS, V. A., KUNDU, S., *et al.*

Medical Care Research and Reviews [Ahead of print]

Due to high magnitude and variation in spending on, accountable care organizations (ACOs) are focusing on transforming management of hospital discharge through relationships with preferred skilled nursing facilities (SNFs). Using a mixed-methods design, we examined survey data from 366 respondents to the National Survey of ACOs along with 16 semi-structured interviews with ACOs who performed well on cost and quality measures. Survey data revealed that over half of ACOs had no formal relationship with SNFs; however, the majority of ACO interviewees had formed preferred SNF networks. Common elements of networks included a comprehensive focus on care transitions beginning at hospital admission, embedded ACO staff across settings, solutions to support information sharing, and jointly established care protocols. Misaligned incentives, unclear regulations, and a lack of integrated health records remained challenges, yet preferred networks are beginning to transform the ACO post-acute care landscape.

► **Transforming Integration Through General Practice: Learning from a UK Primary Care Improvement Programme**

MILLER R.

2018

International Journal of Integrated Care 18(2): 1-7.

This article addresses the challenge of how to implement integration within primary care services. It shares learning from a UK based improvement programme which reflected international interest in transferring activities from hospital and community and developing holistic primary care that responds to the needs of the local community. Programme components included additional per capita funding for involved practices, monthly learning sets between pilot leads, and a formative evaluation. Practices had flexibility in how to use the additional funding to meet local needs and were selected through a competitive process. The programme successfully delivered diagnostic and treatment activities previously provided in acute hospital. Some practices also introduces new holistic

approaches which were mostly sustained at the end of the twelve month period. The programme demonstrates that transformation of primary care requires a change in the internal paradigms held by clinicians and purchasers, careful design of learning opportunities, responding to multiple levels of motivation, and deployment of relevant change infrastructures and improvement methodologies.

► **The Application of Triple Aim Framework in the Context of Primary Healthcare: A Systematic Literature Review**

OBUCINA M., HARRIS N., FITZGERALD J. A., *et al.*

2018

Health Policy. 122(8): 900-907

<http://dx.doi.org/10.1016/j.healthpol.2018.06.006>

The Triple Aim framework is an increasingly popular tool for designing and assessing quality improvements in the health care sector. We systematically reviewed the empirical evidence on the application of the Triple Aim framework within primary healthcare settings since its inception almost a decade ago. Results show that primary healthcare providers varied in their interpretation of the Triple Aim framework and generally struggled with a lack of guidance and an absence of composite sets of measures for performance assessment. Greater clarity around application of the Triple Aim framework in primary healthcare is needed, especially around the selection and implementation of purposeful measures from locally available data. This review highlights areas for improvement and makes recommendations intended to guide future applications of the Triple Aim in the context of primary healthcare.

► **L'épuisement de la volonté de bien faire chez les médecins : « Y-a-t-il un médecin dans la salle ? »**

PAME P. ET JOSSET J. M.

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(3).

De quelle manière l'identité professionnelle du médecin peut-elle être source d'épuisement ? Notre hypothèse est que la fatigue ressentie par les médecins provient non seulement d'un contexte professionnel

exigeant mais aussi de la charge à assumer en permanence une image héroïque. C'est ce que nous allons nous efforcer d'explorer dans cet article. Tout d'abord nous nous intéresserons à la genèse de cette image, en questionnant le « hidden curriculum » des médecins interrogés, mais aussi leur rapport aux termes du serment d'Hippocrate. Dans un deuxième temps, dans une perspective « goffmanienne », nous décrivons la dramaturgie de cette tension, révélée par la situation où, alors qu'il est au repos, le praticien est interpellé par la classique annonce : « Y a-t-il un médecin dans la salle ? ». Enfin, nous montrerons comment les médecins tentent de s'accommoder de cette tension par des règles de vie qui tiennent souvent de la protection rituelle.

► **Transforming Primary Care: Scoping Review of Research and Practice**

ROBIN M., CATHERINE W. ET STEVE G.

2018

Journal of Integrated Care 26(3): 176-188.

<https://www.emeraldinsight.com/doi/abs/10.1108/JICA-03-2018-0023>

The purpose of this paper is to reflect on research evidence and practice experience of transforming primary care to a more integrated and holistic model. It is based on a scoping review which has been guided by primary care stakeholders and synthesises research evidence and practice experience from ten international case studies. Adopting an inter-professional, community-orientated and population-based primary care model requires a fundamental transformation of thinking about professional roles, relationships and responsibilities. Team-based approaches can replicate existing power dynamics unless medical clinicians are willing to embrace less authoritarian leadership styles. Engagement of patients and communities is often limited due to a lack of capacity and belief that will make an impact. Internal (relationships, cultures, experience of improvement) and external (incentives, policy intentions, community pressure) contexts can encourage or derail transformation efforts. Practical implications Transformation requires a co-ordinated programme that incorporates the following elements – external facilitation of change; developing clinical and non-clinical leaders; learning through training and reflection; engaging community and professional stakeholders; transitional funding; and formative and summative evaluation. Originality/value This paper

combines research evidence and international practice experience to guide future programmes to transform primary care.

► **Effects of Access to Radiology in Out-Of-Hours Primary Care in the Netherlands: A Prospective Observational Study**

RUTTEN M. H., SMITS M., PETERS Y. A. S., *et al.*

2018

Fam Pract 35(3): 253-258.

In the Netherlands, out-of-hours primary care is provided in general-practitioner-cooperatives (GPCs). These are increasingly located on site with emergency departments (ED), forming Emergency-Care-Access-Points (ECAP). A more efficient and economical organization of out-of-hours primary emergency care could be realized by increased collaboration at an ECAP. In this study, we compared the effects of different models with respect to access to (hospital) radiology by the GPC. We investigated patient and care characteristics, indication for diagnostics and outcomes at GPCs with and without access to radiology. A prospective observational record review study of patients referred for conventional radiology for trauma by one of five GPCs in the period April 2014-October 2015, covering three organizational models. The mean age was 31 years and 56% was female. Extremities were predominately involved (91%). There was a medical indication for radiology in 85% and the assessed risk by requesting GPs on abnormalities was high in 66%. There was a significant difference in outcomes between models. Radiological abnormalities (fractures/luxations) were present in 51% without direct access and in 35% with partial and unlimited access. Overall, 61% of the included patients were referred to the ED; 100% in the models without access and 38% in the models with (partial) access. GPC access to radiology is beneficial for patients and professionals. The diagnostics were adequately used. With access to radiology, unnecessary referrals and specialist care are prevented. This may lead to a decrease in ED attendance and overcrowding.

► **Integrated Care in Switzerland: Results from the First Nationwide Survey**

SCHUSSELE FILLIETTAZ S., BERCHTOLD P., KOHLER D., *et al.*

2018

Health Policy 122(6): 568-576.

Due to fragmentation of care delivery, health systems are under pressure and integrated care is advocated for. Compared to the numerous existing integrated care initiatives in Europe and elsewhere, Switzerland seems to lag behind. The objective of the survey was to produce a comprehensive overview of integrated care initiatives in Switzerland. To be included, initiatives needed to meet four criteria: present some type of formalization, consider >2 different groups of healthcare professionals, integrate >2 healthcare levels, be ongoing. We systematically contacted major health system organizations at federal, cantonal and local level. Between 2015 and 2016, we identified 172 integrated care initiatives and sent them a questionnaire. Despite Switzerland's federalist structure and organization of healthcare, and only recent incentives to develop integrated care, initiatives are frequent and diverse. Stakeholders should support existing initiatives and

facilitate their development. They should also promote innovative avenues, experiment alternative payment models for integrated care, foster people-centeredness and incentivize interprofessional models. This will require systems thinking and contributions from all actors of the healthcare system.

► **Community Orientation of General Practitioners in 34 Countries**

VERMEULEN L., SCHÄFER W., PAVLIC D. R., *et al.*

2018

Health Policy. [Ahead of print]

<http://dx.doi.org/10.1016/j.healthpol.2018.06.012>

There is a large international variation in community orientation between GPs. In countries with a defined patient list GPs are more community oriented. GPs more active in prevention and multidisciplinary cooperation are more community oriented. GPs using medical records to make overviews are more community oriented. GPs in areas with more ethnic minority people are more community oriented.

Systèmes de santé

► **L'innovation organisationnelle, un processus d'apprentissage au service de la transformation du système de santé ?**

BOURGUEIL Y.

2017

Santé Publique 29(6): 777-779.

<https://www.cairn.info/revue-sante-publique-2017-6-page-777.htm>

L'innovation en santé est une notion ancienne et très actuelle. Souvent confondue avec l'invention, l'innovation s'en distingue néanmoins dans la mesure où elle constitue avant tout le processus par lequel l'invention qu'elle soit de produit, de procédé ou de service est reconnue socialement et trouve sa place dans les marchés, les institutions, les pratiques professionnelles et les usages sociaux. Toutes les inventions ne conduisent pas nécessairement à des innovations comme certains médicaments, techniques chirurgicales, pratiques nouvelles, projets expérimentaux de

réseaux de soins ou plus récemment les très nombreuses applications digitales en santé pour smartphones. Cependant, ces échecs trop souvent perçus négativement et malheureusement peu publiés contribuent également beaucoup au processus plus large d'innovation et ce d'autant plus qu'ils sont étudiés et partagés dans un contexte plus général de soutien explicite à l'innovation.

► **Cross-Country Comparative Research: Lessons from Advancing Health System and Policy Research on the Occasion of the European Observatory on Health Systems and Policies 20Th Anniversary**

BUSSE R. ET VAN GINNEKEN E.

2018

Health Policy 122(5): 453-456.

<http://dx.doi.org/10.1016/j.healthpol.2018.05.005>

This issue of Health Policy is dedicated to the 20th anniversary of the European Observatory on Health Systems and Policies and particularly the Observatory's contribution to shaping comparative health system and policy research in Europe – the domain of this journal too. Below, we will briefly outline the origin and functions of the Observatory as well as its contribution to research over the past two decades. We then put the selected papers in this issue into perspective and provide an overview on comparative papers published in Health Policy since 2014, i.e. analyse which topics and which countries have been covered. Several of these articles are actually authored by Observatory staff and its networks and fit into the tradition of comparative health system research that the Observatory helped develop.

► **Addressing Overuse of Health Services in Health Systems: A Critical Interpretive Synthesis**

ELLEN M. E., WILSON M. G., VÉLEZ M., *et al.*
2018

Health Research Policy and Systems 16(1): 48.
<https://doi.org/10.1186/s12961-018-0325-x>

Health systems are increasingly focusing on the issue of 'overuse' of health services and how to address it. We developed a framework focused on (1) the rationale and context for health systems prioritising addressing overuse, (2) elements of a comprehensive process and

approach to reduce overuse and (3) implementation considerations for addressing overuse.

► **Competition in Health Care: Lessons from the English Experience**

PROPPER C.
2018

Health Economics, Policy and Law 13(3-4): 492-508.
<https://www.cambridge.org/core/article/competition-in-health-care-lessons-from-the-english-experience/890139067190E952CEEA22B431555516>

The use of competition and the associated increase in choice in health care is a popular reform model, adopted by many governments across the world. Yet it is also a hotly contested model, with opponents seeing it, at best, as a diversion of energy or a luxury and, at worst, as leading to health care inequality and waste. This paper subjects the use of competition in health care to scrutiny. It begins by examining the theoretical case and then argues that only by looking at evidence can we understand what works and when. The body of the paper examines the evidence for England. For 25 years the United Kingdom has been subject to a series of policy changes which exogenously introduced and then downplayed the use of competition in health care. This makes England a very useful test bed. The paper presents the UK reforms and then discusses the evidence of their impact, examining changes in outcomes, including quality, productivity and the effect on the distribution of health care resources across socio-economic groups. The final section reflects on what can be learnt from these findings.

Travail et santé

► **L'influence des conditions de travail passées sur la santé et la consommation de médicaments auto-déclarés des retraités**

BARNAY T. ET DEFEBVRE É.
2018

Economie & prévision 213(1): 61-84.
<https://www.cairn.info/revue-economie-et-prevision-2018-1-page-61.htm>

Cet article vise à mesurer l'effet propre des conditions de travail physiques et psychosociales rencon-

trées durant l'ensemble de la carrière professionnelle sur la santé physique et mentale auto-déclarée et la consommation de médicaments des retraités. Pour ce faire, nous mobilisons les données de l'enquête Santé et itinéraire professionnel (Sip). Nous contrôlons nos résultats des caractéristiques socio-économiques, d'itinéraire professionnel et de caractéristiques individuelles antérieures à l'entrée sur le marché du travail mais également de l'état de santé dans l'enfance et à l'âge adulte. Nos résultats mettent en évidence le rôle négatif des conditions de travail passées sur la

santé physique et mentale des retraités avec un lien clair entre contraintes physiques et santé physique d'une part et risques psychosociaux et santé mentale (incluant la consommation de médicaments) d'autre part. Ce résultat témoigne du caractère pénalisant de long terme des conditions de travail pénibles sur la santé des retraités.

► **Long Working Hours and Sickness Absence—A Fixed Effects Design**

BERNSTRØM V. H.

2018

BMC Public Health 18(1): 578.

<https://doi.org/10.1186/s12889-018-5473-y>

While long working hours seem to lead to impaired health, several studies have also shown that long working hours are related to lower levels of sickness absence. Previous studies on the relationship between long working hours and sickness absence have compared those who work long hours to those who do not, looking only at between-individual correlations. Those results might therefore reflect relatively stable differences between employees who typically work long hours and employees who typically do not. The aim of the present study is to examine within-individual correlations between long working hours and sickness absence.

Vieillessement

► **Du domicile à l'institution : évolution des réseaux de sociabilité**

DESQUESNES G., MONFREUX M. ET ROUAULT M.

2018

Gérontologie et société 40 / 156(2): 217-231.

<https://www.cairn.info/revue-gerontologie-et-societe-2018-2-page-217.htm>

Les recherches sociologiques sur la sociabilité des vieilles personnes sont relativement abondantes depuis le début des années 2000, en revanche la perspective d'analyse en termes de dynamique des réseaux de relations personnelles (Bidart, Degenne et Grossetti, 2011), couplée à l'étude du soutien social circulant à travers les liens, est beaucoup moins fréquente. Le présent article a pour objet d'explorer et de caractériser l'évolution des réseaux de relations de personnes vieillissantes selon une procédure narrative rétrospective, c'est-à-dire avant et après leur entrée en établissement d'hébergement pour personnes âgées. La réflexion proposée ici s'appuie sur un matériau empirique récolté dans le cadre de seize entretiens de recherche menés auprès de vieilles personnes vivant actuellement dans des lieux d'hébergement pour personnes âgées. Les résultats de recherche montrent l'intérêt heuristique de cette « approche réseau » et les diverses restructurations qui affectent le « petit monde » ou l'entourage social des individus vieillissants une fois entrés en institution.

► **Les réformes des retraites conduites en France depuis 2010 : quels effets sur les inégalités inter et intra générationnelles ?**

DUC C., MARTIN H. ET TREGUIER J.

2018

Economie & prévision 213(1): 85-120.

<https://www.cairn.info/revue-economie-et-prevision-2018-1-page-85.htm>

Les réformes entreprises en France depuis 2010 ont modifié de nombreux paramètres du système de retraite. Les bornes d'âge du système (âge d'ouverture des droits et âge d'annulation de la décote), la durée requise pour le taux plein, les modalités de calcul des pensions (valeur de service du point dans les régimes complémentaires, date de revalorisation des pensions, calcul du minimum contributif) mais aussi les taux de cotisation ont évolué. Dans le même temps, le profil des assurés évolue au fil des générations. Entre autres, l'entrée sur le marché du travail est de plus en plus tardive et le taux d'activité des femmes s'accroît. Dans ce contexte, cette contribution s'interroge sur l'impact des modifications réglementaires récentes sur l'équité inter et intra générationnelle du système de retraite. Elle s'appuie sur le modèle de microsimulation TRAJECTOIRE de la DREES (Direction de la recherche, des études, de l'évaluation et des statistiques). Les résultats sont partagés : au prisme de certains indicateurs (durée de retraite) l'équité entre les générations semble assurée alors qu'elle se dégrade à

l'aune d'autres indicateurs (taux de cotisation et taux de remplacement).

► **Why Health and Social Care Support for People with Long-Term Conditions Should Be Oriented Towards Enabling Them to Live Well**

ENTWISTLE V. A., CRIBB A. ET OWENS J.

2018

Health Care Anal 26(1): 48-65.

<https://www.ncbi.nlm.nih.gov/pubmed/27896539>

There are various reasons why efforts to promote “support for self-management” have rarely delivered the kinds of sustainable improvements in healthcare experiences, health and wellbeing that policy leaders internationally have hoped for. This paper explains how the basis of failure is in some respects built into the ideas that underpin many of these efforts. When (the promotion of) support for self-management is narrowly oriented towards educating and motivating patients to adopt the behaviours recommended for disease control, it implicitly reflects and perpetuates limited and somewhat instrumental views of patients. It tends to: restrict the pursuit of respectful and enabling ‘partnership working’; run the risk of undermining patients’ self-evaluative attitudes (and then of failing to notice that as harmful); limit recognition of the supportive value of clinician-patient relationships; and obscure the practical and ethical tensions that clinicians face in the delivery of support for self-management. We suggest that a focus on enabling people to live (and die) well with their long-term conditions is a promising starting point for a more adequate conception of support for self-management. We then outline the theoretical advantages that a capabilities approach to thinking about living well can bring to the development of an account of support for self-management, explaining, for example, how it can accommodate the range of what matters to people (both generally and more specifically) for living well, help keep the importance of disease control in perspective, recognize social influences on people’s values, behaviours and wellbeing, and illuminate more of the rich potential and practical and ethical challenges of supporting self-management in practice.

► **What Happens at the End of Life? Using Linked Administrative Health Data to Understand Healthcare Usage in the Last Year of Life in New Zealand**

HAMBLIN R., MINKO N., SHUKER C., *et al.*

2018

Health Policy 122(7): 783-790.

The end of life is often associated with increased use of healthcare services. This increased use can include over-medicalisation, or over-treatment with interventions designed to cure that are likely futile in people who are dying. This is an issue with medical, ethical, and financial dimensions, and has implications for health policy, funding and the structure of care delivery. We measured the annual use of nine pre-defined public healthcare services between 1 January 2008 and 31 December 2012 by elderly New Zealanders (65-99 years old) in their last year of life and compared it with that of the cohort of elderly New Zealanders who used healthcare in the period but did not die. We used linked, encrypted unique patient identifiers to reorganise and filter records in routinely collected national healthcare utilisation and mortality administrative datasets. We found that, in New Zealand, people do seem to use more of most health services in their last year of life than those of the same age who are not in their last year of life. However, as they advance in age, particularly after the age of 90, this difference diminishes for most measures, although it is still substantial for days spent in hospital as an inpatient, and for pharmaceutical dispensings.

► **Exploring the Collaboration Between Formal and Informal Care from the Professional Perspective—A Thematic Synthesis**

HENGELAAR A. H., HARTINGSVELDT M.,

WITTENBERG Y., *et al.*

2018

Health & Social Care in the Community 26(4): 474-485.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.12503>

In Dutch policy and at the societal level, informal caregivers are ideally seen as essential team members when creating, together with professionals, co-ordinated support plans for the persons for whom they care. However, collaboration between professionals and informal caregivers is not always effective. This

can be explained by the observation that caregivers and professionals have diverse backgrounds and frames of reference regarding providing care. This thematic synthesis sought to examine and understand how professionals experience collaboration with informal caregivers to strengthen the care triad. PubMed, Medline, PsycINFO, Embase, Cochrane/Central and CINAHL were searched systematically until May 2015, using specific key words and inclusion criteria. Twenty-two articles were used for thematic synthesis. Seven themes revealed different reflections by professionals illustrating the complex, multi-faceted and dynamic interface of professionals and informal care. Working in collaboration with informal caregivers requires professionals to adopt a different way of functioning. Specific attention should be paid to the informal caregiver, where the focus now is mainly on the client for whom they care. This is difficult to attain due to different restrictions experienced by professionals on policy and individual levels. Specific guidelines and training for the professionals are necessary in the light of the current policy changes in the Netherlands, where an increased emphasis is placed on informal care structures.

► **Motifs d'adhésion à une activité physique adaptée chez des seniors en ALD**

MORALES GONZALES V., SCHUFT L., FOURNIER M., et al.

2018

Gérontologie et société (40)156 : 143-159.

<https://www.cairn.info/revue-gerontologie-et-societe-2018-2-page-143.htm>

Dans un contexte de vieillissement des populations et d'accroissement des maladies chroniques, l'activité physique adaptée (APA) émerge de plus en plus comme une modalité de prise en charge de la santé. L'efficacité des APA dépend de l'adhésion des participants. Cet article aborde les motifs d'adhésion de seniors atteints de maladies cardiovasculaires dans un programme APA en région PACA. L'enquête a été menée au travers d'entretiens semi-directifs auprès de 33 seniors participant ou ayant participé au programme. Les résultats montrent des différences de motifs entre les phases d'initiation et de maintien dans l'AP : il semblerait que si on vient pour la santé physique, on y reste pour le bien-être, notamment social. Si l'objectif de « guérison » est partagé par toutes et tous dans le démarrage du programme APA, le partage de

lien social, l'absence de compétition et le cadre bienveillant et sécuritaire sont énoncés comme les raisons importantes d'adhésion maintenue au programme.

► **Les habits neufs du « vieillissement en bonne santé » : activité et environnement**

MOULAERT T.

2018

Gérontologie et société (40) 156: 19-34.

<https://www.cairn.info/revue-gerontologie-et-societe-2018-2-page-19.htm>

Cet article retrace la genèse du référentiel international d'action publique « Healthy ageing/vieillessement en bonne santé » dans les travaux de l'Organisation mondiale de la santé (OMS). Venant remplacer celui du « active ageing/vieillessement actif » dans le dernier rapport mondial sur le vieillissement et la santé de 2015 de l'OMS, ce « vieillissement en bonne santé » prend distance avec la seule promotion de l'activité physique focalisée sur l'individu par l'action sur le lifestyle, approche initiale du « vieillissement en bonne santé » dès 1996. Nous appuyant sur le concept de biolégitimité défini par Didier Fassin comme « la manière dont les problèmes sociaux trouvent, non pas leur solution, mais leur expression la plus autorisée dans le langage de la santé publique », nous soutenons la thèse selon laquelle l'OMS promeut aujourd'hui une extension sanitaire des domaines du vivant en matière de vieillissement en s'appuyant sur la notion large d'environnement, sans pour autant abandonner celle d'activité. Pour cela, l'OMS déplace son attention des capacités fonctionnelles (intrinsèques) de l'individu au soutien des « aptitudes fonctionnelles ». Ainsi, l'activité physique, si elle n'est pas effacée, devient un facteur de potentialité parmi d'autres afin de permettre aux personnes âgées d'« être et [de] réaliser ce qu'elles ont des raisons de valoriser ».

Index

A

Abay S. M.....	22
Abay S.M.	31
Acarturk C.....	51
Agarwal R.	35
Alameddine M.....	16
Alexandersen N.	13
Ali A. M.....	25
Altares Sarik D.	52
Amarenco P.....	23
Amariei A.....	51
Amerio A.....	50
Anderson T. S.	35
Andler R.....	47
Angelo M.	52
Annear P. L.....	25
Anthierens S.	49
Armeni P.	38
Artigas F.....	48

B

Baerheim A.....	18
Baker R.	34
Barea C.	43
Barnay T.....	58
Barnes H.	52
Barthold D.	38
Baum F.....	32
Bec C.....	47
Benallah S.....	26
Berchtold P.....	57
Bernstrøm V. H.	59
Berroneau A.	36
Berzina-Novikova N.	52
Bessou A.....	46

Bird M.....	51
Bismuth M.	52
Bismuth S.....	14
Bloor K.	42
Boisserie-Lacroix L.	26
Bojke C.....	42
Bolte G.....	49
Borza T.	26
Bottle A.....	25
Bourgeon L.	16
Bourgue C.....	16
Bourgueil Y.....	57
Bras P-L.....	27
Breda J.....	48
Briffault X.....	14
Buchet-Poyau K.	44
Bučičūnienė I.....	24
Bureau V.	17
Busse R.	57
Butterworth P.	21

C

Cabrol M.....	16
Campbell J. A.	17
Caniaux I.....	38
Carette C.....	23
Cascone D.....	29
Casey M.....	16
Catherine W.....	56
Cebrecos A.....	23
Chareyron S.	31
Chi G.	24
Coenen S.....	49
Cogordan C.	47
Coppieters Y.....	46
Cornu-Pauchet M.	13

Couray-Targe S.	18
Crabtree B. F.	53
Cribb A.	41 , 43 , 44 , 60
Csajka C.	16

D

Dahl H. M.	17
Dahmani S.	27
Dalziel K.	53
de Chambine S.	28
Découard P.	14
Defebvre É.	58
Delouette I.	47
Desbois D.	15
Desnoyer A.	36
Desquesnes G.	59
de Stampa M.	26
Dimitrovova K.	53
Di Thiene D.	32
Domínguez-Berjón M. F.	23
Domin J.-P.	26
Dowling S.	54
Dray Spira R.	34
Duc C.	59
Dunlop W. C. N.	36
Dunsch F.	39
Duque I.	23

E

Elger B.	19
El-Khoury F.	50
Ellen M. E.	58
Emmert M.	18
Entwistle V. A.	43 , 44 , 60
Essén A.	15
Evans D. K.	39
Ezzy D.	17

F

Farah A.	16
Fendrick A. M.	35
Fernandez O.	22
Ferreira D. C.	27
Finnigan H.	54
Fitzgerald J. A.	55
Flament C.	51
Foerster J.	18
Fontaine A.	48
Fortin J.-P.	15
Fournier C.	41 , 54
Fournier M.	61
Frattini M. O.	54
Freeman T.	32
Freund Y.	27
Fullman N.	22 , 31

G

Gagnayre R.	33 , 43
Gagnon M.-P.	15
Gaillard M.	36
Ganne C.	18
Geissler A.	21
Gellad W. F.	35
Geri-Trial C.	16
Gerrits R.	15
Ghandour E. K.	15
Giacopelli M.	28
Girvalaki C.	48
Glynn F.	16
Glynn L. G.	16
Gomes M.	49
Gosselin A.	32
Goštautaitė B.	24
Goulet H.	27
Grieve R.	49
Grundy Q.	41
Guégan M.	33

Guével M.-R.	25
Guignard B.	36
Gunn J. M.	53
Gupta A.	35
Gutacker N.	42
Gyrd-Hansen D.	30

H

Haarmann A.	18
Habibi R.	41
Hamblin R.	60
Harris N.	55
Hartingsveldt M.	60
Hébert R.	46
Helgesson M.	32
Hengelaar A. H.	60
Herbst T.	18
Hernández-Peña P.	20
Herrmann W. J.	18
Higgs G.	24
Ho H. C.	24
Hrifach A.	18

I

Ioannidis J. P.	39
----------------------	----

J

Jaffrès F.	25
Jakovljevic J.	48
Javanparast S.	32
Jensen L. G.	17
Jommi C.	38
Josset J. M.	55
Jouve M.	27
Joyce G.	21 , 22
Jusot F.	13

K

Kaarboe O.	13
Kennedy, G.	55
Knudby A.	24
Kohler D.	57
Kumah E.	42
Kundu, S.	55
Kwon S.	25

L

Lachkhem Y.	42
Lagasnerie G.	13
Landriscina T.	50
Langford M.	24
Lang P. O.	16
Lang P.-O.	36
Lano J.	16
Last J.	54
Laszlo S.	28
Lavallee P. C.	23
Leblanc J.	27
Lecarpentier M.	34
Le Cossec C.	28
Legeai C.	46
Leitch S.	38
Le Lann Y.	47
Lemoine P.	39
Leroux V.	16
Leu A.	19
Levy P.	36
Lewis, V. A.	55
Lhachimi S. K.	49
Liao J. M.	19 , 20
Li J.	53
Lo-Ciganic W.-H.	35
Lombrail P.	33
Looten V.	20
Lorenzoni L.	25
Lubbeke A.	43

Lucchetti A. L. G.....	37
Lucchetti G.....	37

M

Macis M.....	39
Maier C. B.....	52
Margat A.....	33
Marmorat T.....	37
Marques R. C.	27
Marquestaut O.	26
Marquillier T.	43
Martin H.	59
Mason A. J.	49
Matta J.....	23
Matthew P.	28
McNamee P.	21
Meltzer D.....	22
Milašauskienė Ž.....	24
Miller R.	55
Miller W. L.	53
Minko N.....	60
Minvielle E.....	42
Mizrahi A.	40
Moine S.	29
Monfreux M.	59
Monteiro Tavares L.....	23
Morales Gonzales V.	61
Morgan H. M.	43
Morgiève M.....	14
Morton A.	22
Mosnier-Thoumas S.....	36
Mosseveld C.V.....	20
Mougeot F.	44
Moulaert T.....	61
Mucaz Karaaslan M.	34

N

Naamouni K.....	34
-----------------	----

Naiditch M.....	54
Naimi A. I.....	30
Nanninga S.....	49
Napolitano F.	29
Navathe A. S.	20
Neil A.	17
Newitt S.	49
Nunes A. M.....	27

O

Obucina M.....	55
Occelli P.	44
Odone A.	50
Oerline M. K.	26
Oneib B.....	51
Otheman Y.....	51
Otto M.....	38
Oustric S.	52
Owens J.	44 , 60

P

Page N.	24
Pame P.....	55
Panico L.	50
Pannetier J.....	34
Papadakis S.....	48
Pasquereau A.....	47
Paul R.....	28
Pavlic D. R.	57
Pearson J.....	34
Perelman J.	53
Perrier C.....	45
Perrin C.....	45
Peters D. H.....	45
Peters Y. A. S.	56
Pierre A.....	13
Piffaretti C.....	20
Piriou O.....	29

Plancke L.....	51
Polanen Petel W.....	20
Polsky D.	20
Polton D.....	40
Poulalhon C.	29
Pradier C.....	46
Propper C.....	58
Pymont C.	21

Q

Quentin W.	21
-----------------	----

R

Rahman S.....	32
Ranchon F.....	37
Rathmes G.	48
Raynaud D.	13
Remande A.....	14
Rey S.	20
Ribero R.....	22
Rican S.	42
Rice T.	13
Rioufol C.	37
Riverin B. D.....	30
Rives Lange C.....	23
Rivollier E.....	33
Robin M.....	56
Rotelli-Bihet L.	29
Rouault M.....	59
Rutten M. H.....	56

S

Sabir M.	51
Saleh S.	16
Sandikli B.	34
Scandurra I.	15
Schäfer W.....	57

Schufft L.....	61
Schussele Filliettaz S.....	57
Sciolli G.	42
Scott A.	53
Shea J. A.	19
Sheard S.....	45
Shnier A.	41
Shuker C.....	60
Sijbrandij M.	51
Silman A. J.	43
Skea Z. C.	41
Skolarus T. A.	26
Smits M.	56
Song Y.	38
Staufer A.....	36
Steve G.	56
Strumpf E. C.....	30
Sundmacher L.....	30
Sutter-Dallay A. L.	50
Swanson J. O.....	30

T

Taube M.....	52
Tayyari Dehbaraz N.....	30
Thomas J.....	29
Thomson S.....	22
Tomassoni D.	29
Toraldo M. L.....	42
Tordoff J.....	38
Torun P.....	34
Treguier J.	59
Trentesaux T.....	43
Trish E.	21
Troisoeufs A.....	41
Tuppin P.	46
Turenne M.....	34
Tynkkynen L. K.....	13

U

Uldbjerg N.	30
Unruh L. Y.	13

V

Van Baal P.	22
van Ginneken E.	13 , 57
Van Nuys K.	22
Vardavas C.	48
Vega A.	34
Vélez M.	58
Vermeulen L.	57
Versporten A.	38
Vignier N.	34
Vogt V.	30

W

Watt I. S.	41
Weissman A.	19
Wepf H.	19
Wilson M. G.	58
Wittenbecher F.	21
Wittenberg Y.	60

X

Xu J.	21
------------	----

Y

Yearwood J.	22 , 31
Yerramilli P.	22
Young A.	38

Z

Zarb P.	38
--------------	----

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Contents

Author index.....129

Health Insurance

- 79 **Quelle complémentarité entre AMO ET AMC ? Actes de la 13e Matinée thématique du 19 octobre 2017**
Cornu-Pauchet M., Gissot C et Lagasgnierie G.
- 79 **Généralisation de la complémentaire santé d'entreprise. Une évaluation ex ante des gains et des pertes de bien-être**
Pierre A., Jusot F., Raynaud D., et al.
- 79 **Universal Coverage Reforms in the USA: from Obamacare Through Trump**
Rice T., Unruh L. Y., van Ginneken E., et al.
- 79 **Development of Voluntary Private Health Insurance in Nordic Countries - An Exploratory Study on Country-Specific Contextual Factors**
Tynkkynen L. K., Alexandersen N., Kaarboe O., et al.

- 82 **Implementation of the SMART MOVE Intervention in Primary Care: A Qualitative Study Using Normalisation Process Theory**
Glynn L. G., Glynn F., Casey M., et al.
- 82 **Détection des prescriptions inappropriées, les critères STOPP/START**
Lang P. O., Bourgue C. et Csajka C.
- 82 **Expérimentations de remboursement des actes de télémedecine en plaies et cicatrisation en France**
Lano J., Geri-Trial C., Cabrol M., et al.
- 82 **Santé : la révolution numérique. Dossier**
Leroux V. et Bourgeaon L.
- 82 **Ehealth as a Facilitator of Equitable Access to Primary Healthcare: The Case of Caring for Non-Communicable Diseases in Rural and Refugee Settings in Lebanon**
Saleh S., Alameddine M., Farah A., et al.

E-Health – Medical technologies

- 80 **Motifs de recours à la télémedecine en médecine générale à partir d'une expérimentation en EHPAD**
Bismuth S., Remande A., Découard P., et al.
- 80 **Anticiper les usages et les conséquences des technologies connectées en santé mentale. Une étude de « cas fictif »**
Briffault X. et Morgiève M.
- 81 **La télémedecine, un instrument susceptible de corriger les inégalités de santé ?**
Desbois D.
- 81 **Patient Access to Electronic Health Records: Differences Across Ten Countries**
Essén A., Scandurra I., Gerrits R., et al.
- 81 **Conditions d'adoption du dossier de santé électronique personnel par les professionnels de la première ligne au Québec : perspectives professionnelle et organisationnelle**
Ghandour E. K., Gagnon M.-P. et Fortin J.-P.

Health Economics

- 83 **Beyond Activity Based Funding. An Experiment in Denmark**
Bureau V., Dahl H. M., Jensen L. G., et al.
- 83 **A Qualitative Investigation of the Health Economic Impacts of Bariatric Surgery for Obesity and Implications for Improved Practice in Health Economics**
Campbell J. A., Ezzy D., Neil A., et al.
- 84 **The Impact of Pay-For-Performance on the Quality of Care in Ophthalmology: Empirical Evidence from Germany**
Herbst T., Foerster J. et Emmert M.
- 84 **Patients' Attitudes Toward Copayments as a Steering Tool-Results from a Qualitative Study in Norway and Germany**
Herrmann W. J., Haarmann A. et Baerheim A.
- 84 **Organ Recovery Cost Assessment in the French Healthcare System from 2007 to 2014**
Hrífach A., Ganne C., Couray-Targe S., et al.

- 85 **Experts' Perspectives on SwissDRG: Second Class Care for Vulnerable Patient Groups?**
Leu A., Wepf H., Elger B., et al.
- 85 **Physician Perspectives in Year 1 of MACRA and Its Merit-Based Payment System: A National Survey**
Liao J. M., Shea J. A., Weissman A., et al.
- 86 **Health Expenditure Data for Policy: Health Accounts, National Accounts or Both?**
Mosseveld C.V., Polanen Petel W., Hernández-Peña P., et al.
- 86 **Comparison of Hospitals Participating in Medicare's Voluntary and Mandatory Orthopedic Bundle Programs**
Navathe A. S., Liao J. M., Polsky D., et al.
- 86 **Management of Pregnancy Based on Healthcare Consumption of Women Who Delivered in France in 2015: Contribution of the National Health Data System (SNDS)**
Piffaretti C., Looten V., Rey S., et al.
- 87 **Out-Of-Pocket Costs, Primary Care Frequent Attendance and Sample Selection: Estimates from a Longitudinal Cohort Design**
Pymont C., McNamee P. et Butterworth P.
- 87 **Paying Hospital Specialists: Experiences and Lessons from Eight High-Income Countries**
Quentin W., Geissler A., Wittenbecher F., et al.
- 87 **Growing Number of Unsubsidized Part D Beneficiaries with Catastrophic Spending Suggests Need for an Out-Of-Pocket Cap**
Trish E., Xu J. et Joyce G.
- 88 **Future Unrelated Medical Costs Need to Be Considered in Cost Effectiveness Analysis**
Van Baal P., Morton A., Meltzer D., et al.
- 88 **Frequency and Magnitude of Co-Payments Exceeding Prescription Drug Costs**
Van Nuys K., Joyce G., Ribero R., et al.
- 88 **Financial Protection in Europe: A Systematic Review of the Literature and Mapping of Data Availability**
Yerramilli P., Fernandez O. et Thomson S.

Health Status

- 88 **Alcohol Use and Burden for 195 Countries and Territories, 1990–2016: A Systematic Analysis for the Global Burden of Disease Study 2016**
Fullman N., Yearwood J., Abay S. M., et al.
- 89 **Five-Year Risk of Stroke After TIA or Minor Ischemic Stroke**
Amarenco P., Lavallee P. C., Monteiro Tavares L., et al.
- 89 **French and Worldwide Epidemiology of Obesity**
Matta J., Carette C., Rives Lange C., et al.

Geography of Health

- 89 **Geographic and Statistic Stability of Deprivation Aggregated Measures at Different Spatial Units in Health Research**
Cebrecos A., Domínguez-Berjón M. F., Duque I., et al.
- 90 **Migration Intentions of Lithuanian Physicians, Nurses, Residents and Medical Students**
Goštautait B., Bu i nien I., Milašauskien Ž., et al.
- 90 **Spatiotemporal Analysis of Regional Socio-Economic Vulnerability Change Associated with Heat Risks in Canada**
Ho H. C., Knudby A., Chi G., et al.
- 90 **An Evaluation of Alternative Measures of Accessibility for Investigating Potential 'Deprivation Amplification' in Service Provision**
Page N., Langford M. et Higgs G.

Disability

- 91 **L'emploi des personnes handicapées dans la fonction publique. Entre quota et non-discrimination, quelles pratiques des employeurs ?**
Jaffrès F. et Guével M.-R.

Hospitals

- 91 **How Do We Interpret Readmission Rates?**
Ali A. M. et Bottle A.

- 91 **Pathways to DRG-Based Hospital Payment Systems in Japan, Korea, and Thailand**
Annear P. L., Kwon S., Lorenzoni L., et al.
- 92 **Intensité et pénibilités du travail à l'hôpital. Quelles évolutions entre 1998 et 2013 ?**
Benallah S. et Domin J.-P.
- 92 **Patients en situation palliative en hospitalisation à domicile : trajectoires de soins et caractéristiques cliniques**
Boisserie-Lacroix L., Marquestaut O. et de Stampa M.
- 92 **Association of the Hospital Readmissions Reduction Program with Surgical Readmissions**
Borza T., Oerline M. K., Skolarus T. A., et al.
- 93 **Sortir de la T2A par le haut : la mesure de la qualité des soins**
Bras P.-L.
- 93 **Pédiatrie : récupération rapide après chirurgie (RAAC) : l'expérience de l'hôpital Robert-Debré**
Dahmani S. et Jouve M.
- 93 **Doctors, Nurses, and the Optimal Scale Size in the Portuguese Public Hospitals**
Ferreira D. C., Nunes A. M. et Marques R. C.
- 94 **Effect of Systematic Physician Cross-Checking on Reducing Adverse Events in the Emergency Department: The Charmed Cluster Randomized Trial**
Freund Y., Goulet H., Leblanc J., et al.
- 94 **Cooperation Between Hospital Teams and Community-Based Healthcare Professionals**
Le Cossec C., Giacomelli M. et de Chambine S.
- 94 **Developing and Utilising a New Funding Model for Home-Care Services in New Zealand**
Matthew P., Paul R., Laszlo S., et al.
- 95 **Evaluation of Hospital Readmissions for Surgical Site Infections in Italy**
Napolitano F., Tomassoni D., Cascone D., et al.
- 95 **Procédés et effets du pouvoir disciplinaire aux urgences. Le cas de l'accueil des patients alcooliques**
Piriou O. et Thomas J.
- 95 **Use of Hospital Palliative Care According to the Place of Death and Disease One Year Before Death in 2013: A French National Observational Study**
Poulalhon C., Rotelli-Bihet L., Moine S., et al.
- 96 **Optimal Timing of Physician Visits After Hospital Discharge to Reduce Readmission**
Riverin B. D., Strumpf E. C., Naimi A. I., et al.
- 96 **Continuity of Care and Its Effect on Readmissions for COPD Patients: A Comparative Study of Norway and Germany**
Swanson J. O., Vogt V., Sundmacher L., et al.
- 96 **Does Free Choice of Hospital Conflict with Equity of Access to Highly Specialized Hospitals? A Case Study from the Danish Health Care System**
Tayyari Dehbarez N., Gyrd-Hansen D., Uldbjerg N., et al.

Health Inequalities

- 97 **Measuring Performance on the Healthcare Access and Quality Index for 195 Countries and Territories and Selected Subnational Locations: A Systematic Analysis from the Global Burden of Disease Study 2016**
Fullman N., Yearwood J., Abay S.M., et al.
- 97 **Pauvreté et non-recours aux dispositifs sociaux : l'étude du RSA « socle seul »**
Chareyron S.
- 98 **Healthcare Use Among Immigrants and Natives in Sweden on Disability Pension, Before and After Changes of Regulations**
Di Thiene D., Rahman S., Helgesson M., et al.
- 98 **A Framework for Regional Primary Health Care to Organise Actions to Address Health Inequities**
Freeman T., Javanparast S., Baum F., et al.
- 98 **Residence Permit for Medical Reasons: An Obstacle to Permanent Residence Status. Results of the ANRS Parcours Study**
Gosselin A.
- 99 **Les mineurs isolés étrangers et le système de soins français : étude qualitative**
Guégan M. et Rivollier E.
- 99 **Interventions en littératie en santé et éducation thérapeutique : une revue de la littérature**
Margat A., Gagnayre R., Lombrail P., et al.

100 Health and Health Care Access for Syrian Refugees Living in Istanbul

Torun P., Mucaz Karaaslan M., Sandikli B., et al.

100 Payment Reform and Health Disparities: Changes in Dialysis Modality Under the New Medicare Dialysis Payment System

Turenne M., Baker R., Pearson J., et al.

100 Des obstacles à la connaissance des inégalités de santé. Deuxième partie : perspective psycho-sociale

Vega A., Lecarpentier M. et Naamouni K.

100 Refusal to Provide Healthcare to Sub-Saharan Migrants in France: A Comparison According to Their HIV and HBV Status

Vignier N., Dray Spira R., Pannetier J., et al.

104 Variations in Non-Prescription Drug Consumption and Expenditure: Determinants and Policy Implications

Otto M., Armeni P. et Jommi C.

104 The Effects of State-Level Pharmacist Regulations on Generic Substitution of Prescription Drugs

Song Y. et Barthold D.

104 Antimicrobial Consumption and Resistance in Adult Hospital Inpatients in 53 Countries: Results of an Internet-Based Global Point Prevalence Survey

Versporten A., Zarb P., Caniaux I., et al.

104 Do Health Professionals Tell Patients What They Want to Know About Their Medicines?

Young A., Tordoff J., Leitch S., et al.

Pharmaceuticals

101 Value-Based Insurance Design Improves Medication Adherence Without an Increase in Total Health Care Spending

Agarwal R., Gupta A. et Fendrick A. M.

101 Patterns and Predictors of Physician Adoption of New Cardiovascular Drugs

Anderson T. S., Lo-Ciganic W.-H., Gellad W. F., et al.

102 Prescriptions médicamenteuses potentiellement inappropriées en gériatrie : quels outils utiliser pour les détecter ?

Desnoyer A., Guignard B., Lang P.-O., et al.

102 Innovative Pharmaceutical Pricing Agreements in Five European Markets: A Survey of Stakeholder Attitudes and Experience

Dunlop W. C. N., Staufer A., Levy P., et al.

102 Médicaments potentiellement inappropriés (MPI) chez la personne âgée : état des lieux dans un service de cardiologie

Gaillard M., Mosnier-Thoumas S., Berroneau A., et al.

103 Inappropriate Prescribing in Older Persons: A Systematic Review of Medications Available in Different Criteria

Lucchetti G. et Lucchetti A. L. G.

103 Expériences médicamenteuses et expériences du cancer. L'appropriation des anticancéreux oraux par les patients

Marmorat T., Rioufol C., Ranchon F., et al.

Methodology -Statistics

105 Bias in Patient Satisfaction Surveys: A Threat to Measuring Healthcare Quality

Dunsch F., Evans D. K., Macis M., et al.

105 How to Make More Published Research True

Ioannidis J. P.

105 La malédiction des données

Lemoine P.

106 L'enquête TeO de l'Ined : Commentaires et problèmes d'interprétation

Mizrahi A.

106 Paradoxe dans l'enquête de victimisation : racisme perçu et racisme actif

Mizrahi A.

106 Les données de santé

Polton D.

Health Policy

107 Tensions and Uncertainties in Person-Centred Support for People with Long-Term Conditions

Cribb A., Watt I. S., Skea Z. C., et al.

- 107 **Éduquer le patient ou transformer l'action publique : un espace d'expression pour les patients. Commentaire**
Fournier C. et Troisoefus A.
- 107 **Decoding Disclosure: Comparing Conflict of Interest Policy Among the United States, France, and Australia**
Grundy Q., Habibi R., Shnier A., et al.
- 108 **Should Interventions to Reduce Variation in Care Quality Target Doctors or Hospitals?**
Gutacker N., Bloor K., Bojke C., et al.
- 108 **The Diabetes Self-Management Educational Programs and Their Integration in the Usual Care: A Systematic Literature Review**
Kumah E., Sciolli G., Toraldo M. L., et al.
- 108 **Understanding Delays in Acute Stroke Care: A Systematic Review of Reviews**
Lachkhem Y., Rican S. et Minvielle E.
- 109 **Mapping Existing Hip and Knee Replacement Registries in Europe**
Lubbeke A., Silman A. J., Barea C., et al.
- 109 **Éducation thérapeutique en odontologie pédiatrique : analyse des obstacles et leviers au développement de programmes en France en 2016**
Marquillier T., Trentesaux T. et Gagnayre R.
- 109 **We Need to Talk About Purpose: A Critical Interpretive Synthesis of Health and Social Care Professionals' Approaches to Self-Management Support for People with Long-Term Conditions**
Morgan H. M., Entwistle V. A., Cribb A., et al.
- 110 **L'émergence de la question de la sécurité des patients en France**
Mougeot F., Ocellli P., Buchet-Poyau K., et al.
- 110 **"Was that a Success or Not a Success?" A Qualitative Study of Health Professionals' Perspectives on Support for People with Long-Term Conditions**
Owens J., Entwistle V. A., Cribb A., et al.
- 111 **Éduquer le patient ou transformer l'action publique ? Analyse socio-historique d'une association pour le développement de l'éducation thérapeutique du patient**
Perrier C. et Perrin C.
- 111 **Health Policy and Systems Research: The Future of the Field**
Peters D. H.
- 111 **Space, Place and (Waiting) Time: Reflections on Health Policy and Politics**
Sheard S.
- 112 **Two-Year Management After Renal Transplantation in 2013 in France: Input from the French National Health System Database**
Tuppin P., Bessou A., Legeai C., et al.

Public Policy

- 112 **Développement d'un cours francophone en ligne sur les politiques publiques en santé : une collaboration internationale**
Hébert R., Coppieters Y., Pradier C., et al.

Social Policy

- 113 **La sécurité sociale entre solidarité et marché**
Bec C.
- 113 **Troubles dans la protection sociale**
Delouette I. et Le Lann Y.

Health Prevention

- 113 **The Practices of French General Practitioners Regarding Screening and Counselling Pregnant Women for Tobacco Smoking and Alcohol Drinking**
Andler R., Cogordan C., Pasquereau A., et al.
- 114 **Promoting Health-Enhancing Physical Activity in Europe: Current State of Surveillance, Policy Development and Implementation**
Breda J., Jakovljevic J., Rathmes G., et al.
- 114 **Étude qualitative auprès des utilisateurs de cigarette électronique : pratiques, usages, représentations**
Fontaine A. et Artigas F.
- 114 **Smoking Cessation Delivery by General Practitioners in Crete, Greece**
Girvalaki C., Papadakis S., Vardavas C., et al.

- 115 Impact of Public Smoking Bans on Children's Exposure to Tobacco Smoke at Home: A Systematic Review and Meta-Analysis**

Nanninga S., Lhachimi S. K. et Bolte G.

- 115 Expansion of the 'Antibiotic Guardian' One Health Behavioural Campaign Across Europe to Tackle Antibiotic Resistance: Pilot Phase and Analysis of AMR Knowledge**

Newitt S., Anthierens S., Coenen S., et al.

Prevision - Evaluation

- 115 A Bayesian Framework for Health Economic Evaluation in Studies with Missing Data**

Mason A. J., Gomes M., Grieve R., et al.

Psychiatry

- 116 Women's Mental Health in the Perinatal Period According to Migrant Status: The French Representative ELFE Birth Cohort**

El-Khoury F., Sutter-Dallay A. L., Panico L., et al.

- 116 The Impact of the Current Economic Crisis on Mental Health in Italy: Evidence from Two Representative National Surveys**

Odone A., Landriscina T., Amerio A., et al.

- 117 Depressive Disorders in Primary Care: Clinical Features and Sociodemographic Characteristics**

Oneib B., Sabir M., Otheman Y., et al.

- 117 La réhospitalisation en psychiatrie. Facteurs individuels, facteurs organisationnels**

Plancke L., Amariei A., Flament C., et al.

- 117 Strengthening Mental Health Care Systems for Syrian Refugees in Europe and the Middle East: Integrating Scalable Psychological Interventions in Eight Countries**

Sijbrandij M., Acarturk C., Bird M., et al.

- 118 Improving Quality of Psychiatric Care in Latvia by Measuring Patient Experiences**

Taube M. et Berzina-Novikova N.

Primary Health Care

- 118 La place du médecin et de la famille dans la décision pour des patients en fin de vie**

Angelo M. Bismuth M., Oustric S. et al.

- 118 Effects of Regulation and Payment Policies on Nurse Practitioners' Clinical Practices**

Barnes H., Maier C. B., Altares Sarik D., et al.

- 119 Uncovering the Wisdom Hidden Between the Lines: The Collaborative Reflexive Deliberative Approach**

Crabtree B. F., Miller W. L., Gunn J. M., et al.

- 119 Accuracy of Patient Recall for Self-Reported Doctor Visits: Is Shorter Recall Better?**

Dalziel K., Li J., Scott A., et al.

- 119 Changes in Access to Primary Care in Europe and Its Patterning, 2007-12: A Repeated Cross-Sectional Study**

Dimitrova K. et Perelman J.

- 120 Continuing Education for General Practitioners Working in Rural Practice: A Review of the Literature**

Dowling S., Last J., Finnigan H., et al.

- 120 Comment les médecins généralistes peuvent-ils contribuer à un accès plus équitable à l'éducation thérapeutique ?**

Fournier C., Naiditch M. et Frattini M. O.

- 121 Accountable Care Organizations and Post-Acute Care: A Focus on Preferred SNF Networks**

Kennedy, G., Lewis, V. A., Kundu, S., et al.

- 121 Transforming Integration Through General Practice: Learning from a UK Primary Care Improvement Programme**

Miller R.

- 121 The Application of Triple Aim Framework in the Context of Primary Healthcare: A Systematic Literature Review**

Obucina M., Harris N., Fitzgerald J. A., et al.

- 121 L'épuisement de la volonté de bien faire chez les médecins : « Y-a-t-il un médecin dans la salle ? »**

Pame P. et Josset J. M.

- 122 Transforming Primary Care: Scoping Review of Research and Practice**

Robin M., Catherine W. et Steve G.

- 122 **Effects of Access to Radiology in Out-Of-Hours Primary Care in the Netherlands: A Prospective Observational Study**
Rutten M. H., Smits M., Peters Y. A. S., et al.
- 123 **Integrated Care in Switzerland: Results from the First Nationwide Survey**
Schussele Filliettaz S., Berchtold P., Kohler D., et al.
- 123 **Community Orientation of General Practitioners in 34 Countries**
Vermeulen L., Schäfer W., Pavlic D. R., et al.
- 125 **Les réformes des retraites conduites en France depuis 2010 : quels effets sur les inégalités inter et intra générationnelles ?**
Duc C., Martin H. et Treguier J.
- 126 **Why Health and Social Care Support for People with Long-Term Conditions Should Be Oriented Towards Enabling Them to Live Well**
Entwistle V. A., Cribb A. et Owens J.
- 126 **What Happens at the End of Life? Using Linked Administrative Health Data to Understand Healthcare Usage in the Last Year of Life in New Zealand**
Hamblin R., Minko N., Shuker C., et al.

Health Systems

- 123 **L'innovation organisationnelle, un processus d'apprentissage au service de la transformation du système de santé ?**
Bourgueil Y.
- 123 **Cross-Country Comparative Research: Lessons from Advancing Health System and Policy Research on the Occasion of the European Observatory on Health Systems and Policies 20Th Anniversary**
Busse R. et van Ginneken E.
- 124 **Addressing Overuse of Health Services in Health Systems: A Critical Interpretive Synthesis**
Ellen M. E., Wilson M. G., Vélez M., et al.
- 124 **Competition in Health Care: Lessons from the English Experience**
Propper C.
- 126 **Exploring the Collaboration Between Formal and Informal Care from the Professional Perspective—A Thematic Synthesis**
Hengelaar A. H., Hartingsveldt M., Wittenberg Y., et al.
- 127 **Motifs d'adhésion à une activité physique adaptée chez des seniors en ALD**
Morales Gonzales V., Schuft L., Fournier M., et al.
- 127 **Les habits neufs du « vieillissement en bonne santé » : activité et environnement**
Moulaert T.

Occupational Health

- 124 **L'influence des conditions de travail passées sur la santé et la consommation de médicaments auto-déclarés des retraités**
Barnay T. et Defebvre É.
- 125 **Long Working Hours and Sickness Absence—A Fixed Effects Design**
Bernstrøm V. H.

Ageing

- 125 **Du domicile à l'institution : évolution des réseaux de sociabilité**
Desquesnes G., Monfreux M. et Rouault M.

Health Insurance

► **Quelle complémentarité entre AMO ET AMC ? Actes de la 13e Matinée thématique du 19 octobre 2017**

CORNU-PAUCHET M., GISSOT C ET LAGASGNERIE G.
2018

Lettre du Collège (La)(2): 22

La place de l'assurance privée dans le financement des dépenses de santé en France apparaît relativement élevée au regard des comparaisons internationales, et sur longue période, cette part a tendance à augmenter. Au-delà de cette place croissante, ce qui en fait sa singularité est sa nature : il s'agit pour l'essentiel d'une assurance dite complémentaire, c'est-à-dire qui intervient en complément des remboursements de la Sécurité sociale, pour prendre en charge les co-paiements laissés par le système public pour les consommations de soins à tarif réglementé et pour les dépenses excédant les tarifs de responsabilité quand les tarifs sont libres. Cette Lettre rassemble les communications données lors de la 13^e Matinée thématique du 19 octobre 2017 du Collège des économistes de la santé. Elle dresse tout d'abord un état des lieux sur le partage entre l'AMO et l'AMC et sur les dynamiques actuelles ; puis s'interroge sur les solutions futures : ajustements à la marge ou réinterrogation du modèle.

► **Généralisation de la complémentaire santé d'entreprise. Une évaluation ex ante des gains et des pertes de bien-être**

PIERRE A., JUSOT F., RAYNAUD D., *et al.*
2018

Revue économique 69(3): 407-441.

www.cairn.info/revue-economique-2018-3-page-407.htm

Depuis le 1^{er} janvier 2016, les employeurs du secteur privé ont obligation de proposer et de financer partiellement une complémentaire santé à tous leurs salariés. Dans ce travail, nous simulons les gains et les pertes de bien-être à attendre de cette réforme sur l'ensemble de la population en mobilisant la théorie de l'utilité espérée. Les résultats montrent que la réforme augmente le bien-être collectif si et seulement si les salaires et les primes des contrats restent inchangés. En considérant que les primes des contrats individuels augmentent du fait de l'accord national interprofessionnel (ANI), l'impact de la réforme est quasi nul sur le

bien-être collectif. Le gain en bien-être des salariés qui bénéficient de la réforme est alors contrebalancé par la perte de bien-être subie par les personnes couvertes en individuel ou que la réforme oblige à s'assurer. En considérant en sus que les employeurs intègrent le montant de leur subvention aux salaires, l'ANI réduit fortement le bien-être collectif.

► **Universal Coverage Reforms in the USA: from Obamacare Through Trump**

RICE T., UNRUH L. Y., VAN GINNEKEN E., *et al.*
2018

Health Policy 122(7): 698-702

<http://dx.doi.org/10.1016/j.healthpol.2018.05.007>

President Trump's administration is undoing some of the Affordable Care Act's provisions. The individual mandate to purchase coverage has been repealed. Medicaid remains but premiums in insurance exchanges rose considerably in 2018. Political compromise possible in short-run; long-run depends on upcoming elections. In the meantime, prospects are that the number of uninsured will grow.

► **Development of Voluntary Private Health Insurance in Nordic Countries - An Exploratory Study on Country-Specific Contextual Factors**

TYNKKYNNEN L. K., ALEXANDERSEN N., KAARBOE O., *et al.*

2018

Health Policy 122(5): 485-492.

The Nordic countries are healthcare systems with tax-based financing and ambitions for universal access to comprehensive services. This implies that distribution of healthcare resources should be based on individual needs, not on the ability to pay. Despite this ideological orientation, significant expansion in voluntary private health insurance (VPHI) contracts has occurred in recent decades. The development and role of VPHIs are different across the Nordic countries. Complementary VPHI plays a significant role in Denmark and in Finland. Supplementary VPHI is prominent in Norway and Sweden. The aim of this

paper is to explore drivers behind the developments of the VPHI markets in the Nordic countries. We analyze the developments in terms of the following aspects: the performance of the statutory system (real or perceived), lack of coverage in certain areas of healthcare, governmental interventions or inability to reform the system, policy trends and the general socio-cultural environment, and policy responses to voting behavior

or lobbying by certain interest groups. It seems that the early developments in VPHI markets have been an answer to the gaps in the national health systems created by institutional contexts, political decisions, and cultural interpretations on the functioning of the system. However, once the market is created it introduces new dynamics that have less to do with gaps and inflexibilities and more with cultural factors.

E-Health – Medical technologies

► **Motifs de recours à la télémedecine en médecine générale à partir d'une expérimentation en EHPAD**

BISMUTH S., REMANDE A., DÉCOUARD P., *et al.*
2014

European Research in Telemedicine / La Recherche Européenne en Télémedecine 3(2): 77-83.

<http://www.sciencedirect.com/science/article/pii/S2212764X14000466>

En France, la télémedecine qui consiste à utiliser les technologies de la télécommunication pour le diagnostic médical et les soins de santé est peu développée en médecine générale. Pourtant, les pouvoirs publics et les différents acteurs de cette nouvelle pratique ont conscience que tout se joue maintenant. Nous avons mené une étude rétrospective descriptive de téléconsultations de population âgée à mobilité réduite vivant en EHPAD et nous avons recensé les différents motifs de consultations de médecine générale traités en télémedecine entre le 20 mai 2011 et le 20 décembre 2012. Ces consultations associaient l'image et le son et se déroulaient en présence d'une partie du personnel de l'EHPAD. Dans la quasi-totalité des cas, le patient et/ou la personne de confiance étaient présents. Notre étude a mis en évidence de nombreux motifs de consultation de médecine générale, qu'il s'agisse de dermatologie, d'angiologie, de gastroentérologie, de cardiologie, de néphrologie, de rhumatologie, de diabétologie, de neurologie, de gériatrie, de psychiatrie ou concernant la prescription médicamenteuse. La télémedecine paraît être une pratique adaptée aux pathologies prises en charge en médecine générale. Elle favorise la prise en charge pluridisciplinaire du patient sur son lieu de vie. Cette étude basée sur un petit nombre de cas mérite d'être étendue à d'autres EHPAD et en médecine ambulatoire.

► **Anticiper les usages et les conséquences des technologies connectées en santé mentale. Une étude de « cas fictif »**

BRIFFAULT X. ET MORGIEVE M.
2017

Droit, Santé et Société 3-4(3): 35-46.

<https://www.cairn.info/revue-droit-sante-et-societe-2017-3-page-35.htm>

Le champ de la e-santé (mentale) est particulièrement actif, et produit de nouveaux dispositifs à un rythme extrêmement rapide. Si l'analyse empirique des usages actuels de ces dispositifs est indispensable, il est tout aussi nécessaire d'anticiper sur les bouleversements qui surviendront dans un avenir proche en réfléchissant sur des usages possibles, mais non encore avérés, de ces dispositifs pour les personnes présentant des problématiques psychiques / des troubles mentaux, et sur les problématiques que poseront les données générées par ces nouveaux dispositifs. L'analyse de cas fictif offre de telles possibilités de réfléchir par avance sur des technologies émergentes dont le potentiel « disruptif » – pour reprendre le terme popularisé par différents acteurs du numérique – impose de ne pas se limiter aux usages connus. C'est ce que nous proposons ici avec un cas dont nous situons l'occurrence dans cinq ans. Nous aborderons les usages possibles des dispositifs connectés tout au long d'une journée « typique » d'une personne présentant des problèmes sévères de dysrégulations émotionnelles et de conduites suicidaires. Ils nous serviront de support à une réflexion sur cinq modalités de régulation envisageables pour la propriété et les usages des données générées par ces dispositifs ubiquitaires, qui seront à terme intégrés dans les moindres interstices de nos vies quotidiennes.

► **La télémédecine, un instrument susceptible de corriger les inégalités de santé ?**

DESBOIS D.
2018

Terminal : Technologie de l'Information, Culture & Société(122): 112

Pour la population des pays développés, l'égalité dans l'accès aux soins médicaux sur l'ensemble des territoires constitue l'un des objectifs majeurs des politiques de santé. Aujourd'hui, la concentration des professionnels et des services de santé dans les villes accentue les disparités entre les zones rurales et leurs pôles urbains. En France, de fortes disparités dans l'offre de services de santé sont observées que ce soit au niveau régional selon un gradient Nord-Sud ou au niveau infradépartemental entre pôles urbains et zones rurales mais aussi, au sein des zones urbaines, entre quartiers favorisés et défavorisés. Alors que Paris possède presque 800 médecins pour 100 000 habitants, certains territoires ruraux en comptent moins de 200. Malgré une progression de l'indicateur d'espérance de vie à la naissance entre 2002 et 2015, l'Europe est également concernée par ces inégalités territoriales avec une fracture majeure entre l'Est et l'Ouest, recouvrant les disparités de développement économique. La télémédecine pourrait-elle être une solution pour réduire les inégalités d'accès aux soins au niveau d'un territoire ?

► **Patient Access to Electronic Health Records: Differences Across Ten Countries**

ESSÉN A., SCANDURRA I., GERRITS R., *et al.*
2018

Health Policy and Technology 7(1): 44-56.
<http://dx.doi.org/10.1016/j.hlpt.2017.11.003>

Patient-accessible electronic health records (PAEHRs) are being implemented at international scale. Comparing policies and systems could allow countries to learn from each other to address global and nation-specific challenges. We compare national PAEHR policy (hard and soft regulation) and services in 10 countries.

► **Conditions d'adoption du dossier de santé électronique personnel par les professionnels de la première ligne au Québec : perspectives professionnelle et organisationnelle**

GHANDOUR E. K., GAGNON M.-P. ET FORTIN J.-P.
2017

Santé Publique 29(6): 837-850.

<https://www.cairn.info/revue-sante-publique-2017-6-page-837.htm>

L'objectif de cet article est de décrire et analyser les facteurs influençant l'adoption du dossier de santé électronique personnel (DSE-P) par les professionnels pour le suivi et la gestion des maladies chroniques, tels que perçus par eux-mêmes et par les gestionnaires. Nous avons mené une étude qualitative dans le cadre d'un projet d'expérimentation d'un DSE-P en première ligne de soins au Québec. 11 professionnels et trois gestionnaires ont participé à des entrevues individuelles semi-dirigées. Plusieurs catégories de thèmes liés à des facteurs individuels, organisationnels, liés aux patients et à la technologie offerte, ont représenté des facilitateurs ou des barrières à l'adoption du DSE-P par les professionnels. Principalement sont retenus le leadership des cliniciens et l'historique de leur implication dans les transformations organisationnelles, l'adaptation au contexte de la pratique, la maturité et l'intégration de la technologie aux systèmes d'information disponibles facilitant la communication bidirectionnelle et soutenant le partenariat patient-professionnels et l'adhésion des patients. Les précurseurs organisationnels identifiés réfèrent à l'ouverture de l'organisation envers l'innovation, à l'ajustement aux valeurs dans l'organisation, mais surtout aux pratiques mises en place pour soutenir l'adoption du DSE-P par les cliniciens et leurs patients. Le coût est un enjeu important pour l'implantation et l'adoption du DSE-P. L'identification des facteurs influençant l'adoption du DSE-P aura un intérêt sur les plans stratégique et opérationnel pour le développement de nouvelles pratiques cliniques, organisationnelles et, surtout, de technologies adaptées.

► **Implementation of the SMART MOVE Intervention in Primary Care: A Qualitative Study Using Normalisation Process Theory**

GLYNN L. G., GLYNN F., CASEY M., *et al.*

2018

BMC Family Practice 19(1): 48.

<https://doi.org/10.1186/s12875-018-0737-2>

Problematic translational gaps continue to exist between demonstrating the positive impact of health-care interventions in research settings and their implementation into routine daily practice. The aim of this qualitative evaluation of the SMART MOVE trial was to conduct a theoretically informed analysis, using normalisation process theory, of the potential barriers and levers to the implementation of a mhealth intervention to promote physical activity in primary care.

► **Détection des prescriptions inappropriées, les critères STOPP/START**

LANG P. O., BOURGUE C. ET CSAJKA C.

2018

Actualités Pharmaceutiques 57(572): 26-32.

<http://www.sciencedirect.com/science/article/pii/S0515370017304615>

Les prescriptions médicamenteuses inappropriées sont associées à une diminution de la qualité de vie, une augmentation de la morbi-mortalité et des surcoûts pour les systèmes de santé. Les patients âgés, souvent polypathologiques et polymédiqués, sont à haut risque. Des outils ont été développés pour prévenir ces erreurs. Les critères STOPP/START constituent une aide substantielle et validée pour les praticiens dans une démarche de révision et d'optimisation des prescriptions.

► **Expérimentations de remboursement des actes de télémédecine en plaies et cicatrisation en France**

LANO J., GERI-TRIAL C., CABROL M., *et al.*

2017

Revue Francophone de Cicatrisation 1(4): 58-61.

<http://www.sciencedirect.com/science/article/pii/S2468911417303997>

Les expérimentations de l'article 36 de la loi de financement de la Sécurité sociale pour 2014 (LFSS 2014), visent à définir les modèles de rémunération qui pourraient être mis en place dans le cadre de la télémédecine. Initialement prévue dans neuf régions, cette expérimentation est étendue depuis la LFSS 2017 à l'ensemble du territoire national. Les professionnels requis pour les actes de télémédecine du réseau Cicat-LR, qui fait suite au projet Domoplaies, ont débuté l'expérimentation selon le cahier des charges des expérimentations relatives à la prise en charge par télémédecine des plaies chroniques et complexes permises par la LFSS 2014 et, depuis février 2017, selon les procédures préalables au programme Etapes. Cette expérimentation vise à fixer les dispositions réglementaires et la classification commune des actes de télémédecine pour déterminer le modèle tarifaire adéquat et analyser son impact sur le système de soins. Elle devrait permettre de pérenniser le projet Domoplaies et l'élargir à d'autres régions, mais également d'intégrer la pratique de la télémédecine dans le parcours de santé des patients porteurs de plaies.

► **Santé : la révolution numérique. Dossier**

LEROUX V. ET BOURGEAON L.

2018

Gestions Hospitalières(575): 213-288.

Ce dossier est consacré aux enjeux et aux perspectives de la transformation digitale des institutions et organisations de santé. Différentes problématiques sont abordées, présentées par niveau d'analyse. Le premier niveau concerne le patient et sa relation à la maladie. Le deuxième niveau concerne le patient : en quoi le digital change sa place et, surtout, modifie ses relations avec les professionnels de santé. Le troisième niveau est relatif aux établissements et aux organisations de santé. La façon de soigner ne dépend pas que de l'évolution digitale du soigné mais bien de la rencontre de deux évolutions, à la fois celle des praticiens et de leur réseau interprofessionnel, et celle des personnes et de leur entourage.

► **Ehealth as a Facilitator of Equitable Access to Primary Healthcare: The Case of Caring for Non-Communicable Diseases in Rural and Refugee Settings in Lebanon**

SALEH S., ALAMEDDINE M., FARAH A., *et al.*

2018

Int J Public Health 63(5): 577-588.

The aim of this study is to assess the effect of selected low-cost eHealth tools on diabetes/hypertension detection and referrals rates in rural settings and refugee camps in Lebanon and explore the barriers to showing-up to scheduled appointments at Primary Healthcare Centers (PHC). Community-based screening for diabetes and hypertension was conducted in five rural and three refugee camp PHCs using an eHealth netbook application. Remote referrals were generated based on pre-set criteria. A phone survey was subsequently conducted to assess the rate and causes of no-shows to scheduled appointments. Associations

between the independent variables and the outcome of referrals were then tested. Among 3481 screened individuals, diabetes, hypertension, and comorbidity were detected in 184,356 and 113 per 1000 individuals, respectively. 37.1% of referred individuals reported not showing-up to scheduled appointments, owing to feeling better/symptoms resolved (36.9%) and having another obligation (26.1%). The knowledge of referral reasons and the employment status were significantly associated with appointment show-ups. Low-cost eHealth netbook application was deemed effective in identifying new cases of NCDs and establishing appropriate referrals in underserved communities.

Health Economics

► **Beyond Activity Based Funding. An Experiment in Denmark**

BURAU V., DAHL H. M., JENSEN L. G., *et al.*

2018

Health Policy 122(7): 714-721.

Over past decades Activity Based Funding has been an attractive tool for hospital funding and governance, but there has been growing frustration especially with its unintended effects. There are numerous examples of alternative models, but there is little in-depth knowledge about how these models came about. The aim of our study was to analyse how the discourse of Activity Based Funding was successfully challenged. This contributes insights into how international/national debates are translated into concrete alternative models through specific discursive mechanisms. The analysis used a discursive policy approach and was based on a case study from Denmark ('New Governance'). The data consisted of project and policy documents as well as qualitative interviews with regional and national experts. The analysis identified four discursive mechanisms: the problem definitions underlying 'New Governance' were clear and simple; the underlying assumptions both accepted and challenged the premises of Activity Based Funding; the alternative of 'New Governance' was defined in rather broad terms; and it was produced, disseminated and defended as part of interweaving processes regionally but also nationally. Our study showed that new models of hospital funding and governance need to be carefully engineered and

that they draw on a mix of governance logics. Future research needs to study more examples from a broad range of institutional contexts and points in time.

► **A Qualitative Investigation of the Health Economic Impacts of Bariatric Surgery for Obesity and Implications for Improved Practice in Health Economics**

CAMPBELL J. A., EZZY D., NEIL A., *et al.*

2018

Health Econ 27(8): 1300-1318

Obesity is an economic problem. Bariatric surgery is cost-effective for severe and resistant obesity. Most economic evaluations of bariatric surgery use administrative data and narrowly defined direct medical costs in their quantitative analyses. Demand far outstrips supply for bariatric surgery. Further allocation of health care resources to bariatric surgery (particularly public) could be stimulated by new health economic evidence that supports the provision of bariatric surgery. We postulated that qualitative research methods would elicit important health economic dimensions of bariatric surgery that would typically be omitted from the current economic evaluation framework, nor be reported and therefore not considered by policymakers with sufficient priority. We listened to patients: Focus group data were analysed thematically with software assistance. Key themes were identified induc-

tively through a dialogue between the qualitative data and pre-existing economic theory (perspective, externalities, and emotional capital). We identified the concept of emotional capital where participants described life-changing desires to be productive and participate in their communities postoperatively. After self-funding bariatric surgery, some participants experienced financial distress. We recommend a mixed-methods approach to the economic evaluation of bariatric surgery. This could be operationalised in health economic model conceptualisation and construction, through to the separate reporting of qualitative results to supplement quantitative results.

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

HERBST T., FOERSTER J. ET EMMERT M.
2018

Health Policy 122(6): 667-673.

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

► **Patients' Attitudes Toward Copayments as a Steering Tool-Results from a Qualitative Study in Norway and Germany**

HERRMANN W. J., HAARMANN A. ET BAERHEIM A.
2018

Fam Pract 35(3): 312-317.

Copayments are implemented in many health care systems. The effect of copayments differs between countries. Up to now, patients' attitudes regarding copayments are mainly unknown. Thus, the goal of our analysis was to explore adult patients' attitudes in Germany and Norway towards copayments as a steering tool. We conducted a qualitative comparative study. Episodic interviews were conducted with 40 patients in Germany and Norway. The interviews were analysed by thematic coding in the framework of grounded theory. All text segments related to copayments were analysed in depth for emerging topics and types. We found three dimensions of patients' attitudes towards copayments: the perceived steering effect, the comprehensibility, and the assessment of copayments. The perceived steering effect consists of three types: having been influenced by copayments, not having experienced any influence and the experience of other persons to be influenced. The category comprehensibility describes that not all patients understand rules and regulations of copayments and its caps. The assessment of copayments consists of nine subcategories, three of which are rather negative and six of which are rather positive. In all three dimensions the patterns between the German and Norwegian sub-samples differ considerably. The results of our study point at the importance of communicating clear rules for copayments which are easily comprehensible.

► **Organ Recovery Cost Assessment in the French Healthcare System from 2007 to 2014**

HRIFACH A., GANNE C., COURAY-TARGE S., *et al.*
2018

Eur J Public Health 28(3): 415-420.

Organ recovery costs should be assessed to allow efficient and sustainable integration of these costs into national healthcare budgets and policies. These costs are of considerable interest to health economists, hospitals, financial managers and policy makers in most developed countries. This study assessed organ

recovery costs from 2007 to 2014 in the French health-care system based on the national hospital discharge database and a national cost study. The secondary objective was to describe the variability in the population of deceased organ donors during this period. All stays for organ recovery in French hospitals between January 2007 and December 2014 were quantified from discharge abstracts and valued using a national cost study. Five cost evaluations were conducted to explore all aspects of organ recovery activities. A sensitivity analysis was conducted to test the methodological choice. Trends regarding organ recovery practices were assessed by monitoring indicators. Results: The analysis included 12 629 brain death donors, with 28 482 organs recovered. The mean cost of a hospital stay was €7469 (SD = €10, 894). The mean costs of separate kidney, liver, pancreas, intestine, heart, lung and heart-lung block recovery regardless of the organs recovered were euro1432 (SD = euro1342), €502 (SD = €782), €354 (SD = €475), €362 (SD = €1559), €542 (SD = €955), €977 (SD = €1196) and €737 (SD = €637), respectively. Despite a marginal increase in donors, the number of organs recovered increased primarily due to improved practices. Although cost management is the main challenge for successful organ recovery, other aspects such as organization modalities should be considered to improve organ availability.

► **Experts' Perspectives on SwissDRG: Second Class Care for Vulnerable Patient Groups?**

LEU A., WEPF H., ELGER B., *et al.*

2018

[Health Policy 122\(6\): 577-582.](#)

On the 1st of January 2012, Switzerland introduced the diagnosis-related group hospital tariff structure (SwissDRG). It was recognised that healthcare provided to the most vulnerable patient groups would be a challenge for the new SwissDRG. Coincident with the implementation of SwissDRG, we explored hospital experts' perceptions of which patient groups are vulnerable under the SwissDRG system, what has changed for this group, as well as solutions to ensure adequate access to health care for them. We interviewed 43 experts from 40 Swiss hospitals. Participating experts named several vulnerable patient groups who share some common characteristics. These hospital experts were concerned about the patient groups that are not financially profitable and questioned the practicability

of the current regulation. At the same time, they highlighted the complexity associated with caring for this group under the new SwissDRG and reported measures at the macro, meso, and micro levels to protect vulnerable patient groups from negative effects. To curb negative outcomes for vulnerable patient groups after the introduction of the SwissDRG, the Swiss legislation has introduced various instruments including the acute and transitional care (ATC) measures. We conclude that ATC measures do not produce the expected effect the legislators had hoped for. More health data is needed to identify situations where vulnerable patient groups are more susceptible to inadequate health care access in Switzerland.

► **Physician Perspectives in Year 1 of MACRA and Its Merit-Based Payment System: A National Survey**

LIAO J. M., SHEA J. A., WEISSMAN A., *et al.*

2018

[Health Aff \(Millwood\) 37\(7\): 1079-1086.](#)

We surveyed a national sample of internal medicine physicians in March-May 2017 to explore their beliefs about the newly implemented Merit-based Incentive Payment System (MIPS). Respondents believed that their efforts in the four focus areas identified in the survey would ultimately improve the value of care. When informed that those areas represented the four MIPS domains, the majority remained positive about the likely impact on value. However, expectations varied by physicians' characteristics and sense of control over the desired outcomes, and many respondents believed that unintended consequences could occur. Moreover, respondents generally reported low familiarity with the policy and disagreed with program guidelines for weighting domains in the composite score. These findings indicate the need to educate physicians about MIPS and suggest potentially fruitful approaches. Moving forward, policy makers should monitor for unintended consequences and explore ways to better align program guidelines with physicians' perspectives.

► **Health Expenditure Data for Policy: Health Accounts, National Accounts or Both?**

MOSSEVELD C.V., POLANEN PETEL W., HERNÁNDEZ-PEÑA P., *et al.*

2018

Health Policy 122(8) : 885-891

Reported differences between National Accounts and Health Accounts are scope, treatment of intermediate consumption, valuation of transactions and boundaries. These differences are also found in the Netherlands. The analysis showed commonalities and differences that need an explanation or correction, to increase consistency between the frameworks and compliance with international standards. For analysis and explanation, transparency is a prerequisite, as it permits replicability, and data and metadata should be at hand. Comparability of household spending in Health Accounts and National Accounts household consumption is high, once differences in definitions are sorted out. National Accounts data can be used for judging plausibility of Health Accounts household spending, and might be a good proxy for estimating this spending: In decreasing priority order aggregates of consumption of health products (Q86), consumption of health and social care products (Q) and consumption of all goods and services and their related index numbers can be used. The results of this study are encouraging but may not be generalizable to other countries and need to be replicated especially in Low and Middle-Income Countries for verification purposes.

► **Comparison of Hospitals Participating in Medicare's Voluntary and Mandatory Orthopedic Bundle Programs**

NAVATHE A. S., LIAO J. M., POLSKY D., *et al.*

2018

Health Aff (Millwood) 37(6): 854-863.

We analyzed data from Medicare and the American Hospital Association Annual Survey to compare characteristics and baseline performance among hospitals in Medicare's voluntary (Bundled Payments for Care Improvement initiative, or BPCI) and mandatory (Comprehensive Care for Joint Replacement Model, or CJR) joint replacement bundled payment programs. BPCI hospitals had higher mean patient volume and were larger and more teaching intensive than were CJR hospitals, but the two groups had similar risk expo-

sure and baseline episode quality and cost. BPCI hospitals also had higher cost attributable to institutional postacute care, largely driven by inpatient rehabilitation facility cost. These findings suggest that while both voluntary and mandatory approaches can play a role in engaging hospitals in bundled payment, mandatory programs can produce more robust, generalizable evidence. Either mandatory or additional targeted voluntary programs may be required to engage more hospitals in bundled payment programs.

► **Management of Pregnancy Based on Healthcare Consumption of Women Who Delivered in France in 2015: Contribution of the National Health Data System (SNDS)**

PIFFARETTI C., LOOTEN V., REY S., *et al.*

2018

J Gynecol Obstet Hum Reprod. 47(7):299-307

This study was designed to further our knowledge of the management of pregnant women based on the national health data system (SNDS). Women covered by the national health insurance general scheme or a local mutualist section, who delivered in 2015. Among the 672,182 women included (mean age: 31 years, SD 5.3), 0.3% were under the age of 18 years, 4% lived in a French overseas department (<18 years: 21%), 17% had complementary universal health insurance coverage (<18 years: 75%), 1.2% presented a mental illness, 0.6% had a cancer, and 0.4% had cardiovascular disease. At least one outpatient visit with a gynaecologist or midwife was detected for 93% of women (first trimester (T1): 75%), specific or nonspecific pelvic ultrasound was performed in 98% (T1: 92%), blood glucose assay was performed in 78% (T1: 61%), and an oral glucose tolerance test was performed in 58%. Before delivery, 0.2% of women had at least one admission to the intensive care unit and 22% had at least one hospital stay (<18 years: 38%), for which the principal diagnoses were: false labour (4.5%), threatened preterm labour (2.5%), surveillance of high-risk pregnancy (2.6%), diabetes (2.6%), and hypertension (0.7%). The preterm delivery rate was 6.7% (<18 years: 14%, ≥40 years: 9%). Although 20% of deliveries were performed by caesarean section, 16% of vaginal deliveries required instrumental extraction. SNDS data enrich the data derived from periodic national perinatal surveys, such as the poor follow-up of adolescent girls. These data can promote the elaboration and monitoring of annual indicators.

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

PYMONT C., MCNAMEE P. ET BUTTERWORTH P.
2018

[Health Policy 122\(6\): 652-659.](#)

This paper examines the effect of out-of-pocket costs on subsequent frequent attendance in primary care using data from the Personality and Total Health (PATH) Through Life Project, a representative community cohort study from Canberra, Australia. The analysis sample comprised 1197 respondents with two or more GP consultations, and uses survey data linked to administrative health service use (Medicare) data which provides data on the number of consultations and out-of-pocket costs. Respondents identified in the highest decile of GP use in a year were defined as Frequent Attenders (FAs). Logistic regression models that did not account for potential selection effects showed that out-of-pocket costs incurred during respondents' prior two consultations were significantly associated with subsequent FA status. Respondents who incurred higher costs (\$15-\$35; or >\$35) were less likely to become FAs than those who incurred no or low (<AUS\$15 per consultation) costs, with no difference evident between the no and low-cost groups. However, a counterfactual model that adjusted for factors associated with the selection into payment levels did not find an influence of payment, with only a non-significant gradient in the expected direction. Hence these findings raise doubts that price drives FA behaviour, suggesting that co-payments are unlikely to affect the number of GP consultations amongst frequent attenders.

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

QUENTIN W., GEISLER A., WITTENBECHER F., *et al.*
2018

[Health Policy 122\(5\): 473-484.](#)

Payment systems for specialists in hospitals can have far reaching consequences for the efficiency and quality of care. This article presents a comparative analysis of payment systems for specialists in hospitals of eight high-income countries (Canada, England, France, Germany, Sweden, Switzerland, the Netherlands, and the USA/Medicare system). A theoretical framework

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

► **Growing Number of Unsubsidized Part D Beneficiaries with Catastrophic Spending Suggests Need for an Out-Of-Pocket Cap**

TRISH E., XU J. ET JOYCE G.
2018

[Health Aff \(Millwood\) 37\(7\): 1048-1056.](#)

Medicare Part D has no cap on beneficiaries' out-of-pocket spending for outpatient prescription drugs, and, unlike Medicare Parts A and B, beneficiaries are prohibited from purchasing supplemental insurance that could provide such a cap. Historically, most beneficiaries whose annual Part D spending reached the catastrophic level were protected from unlimited personal liability by the Low-Income Subsidy (LIS). However, we found that the proportion of beneficiaries whose spending reached that level but did not qualify for the subsidy-and therefore remained liable for coinsurance-increased rapidly, from 18 percent in 2007 to 28 percent in 2015. Moreover, average total per person per year spending grew much more rapidly for those who did not qualify for the LIS than for those who did, primarily because of differences in price and utilization trends for the drugs that represented disproportionately large shares of their spending. We estimated that a cap for all Part D enrollees in 2015 would have raised monthly premiums by only \$0.40-\$1.31 per member.

► **Future Unrelated Medical Costs Need to Be Considered in Cost Effectiveness Analysis**

VAN BAAL P., MORTON A., MELTZER D., *et al.*
2018

Eur J Health Econ: [Ahead of print]

<https://www.ncbi.nlm.nih.gov/pubmed/29671143>

New medical technologies that prolong life result in additional health care use in life years gained. Some of these costs in life years gained are considered to be related to the intervention while other costs are considered unrelated. Here, we argue that ignoring these so-called future medical costs in cost effectiveness analysis is contrary to common sense, results in lost health and fails to inform decision makers for whom cost effectiveness is supposed to serve.

► **Frequency and Magnitude of Co-Payments Exceeding Prescription Drug Costs**

VAN NUYS K., JOYCE G., RIBERO R., *et al.*
2018

JAMA 319(10): 1045-1047.

<http://dx.doi.org/10.1001/jama.2018.0102>

A co-payment suggests sharing the total cost between patients and payers. However, drug co-payments sometimes exceed costs, with the insurer or pharmacy benefit manager (PBM) keeping the difference. Furthermore, some pharmacists are contractually prevented from alerting patients when their co-payment exceeds the drug's cash price. Although some have argued that the practice is uncommon, a 2016 survey of independent pharmacists indicates otherwise.³

► **Financial Protection in Europe: A Systematic Review of the Literature and Mapping of Data Availability**

YERRAMILLI P., FERNANDEZ O. ET THOMSON S.
2018

Health Policy 122(5): 493-508.

A comprehensive and context-specific approach to monitoring financial protection can provide valuable evidence on progress towards universal health coverage. This article systematically reviews the literature on financial protection in Europe to identify trends across countries and over time. It also maps the availability of data for regular monitoring in 53 countries. Results were extracted from 54 publications and studies analysed in terms of geographical focus, data sources, methods and depth of analysis. Financial protection varies across countries in Europe; substantial changes over time have mainly taken place in the east of the region. Although the data required for regular monitoring are widely available, the literature presents major gaps in geographical scope - most studies focus on middle-income countries; it is not up to date - the latest year of data analysed is 2011; and cross-national comparison is only possible for a handful of countries due to variation in data sources and methods. The literature is also limited in depth. Very few studies go beyond analysing how many people incur catastrophic or impoverishing out-of-pocket payments. Only a small minority analyse who is most likely to experience financial hardship and what drives lack of financial protection. The literature provides little actionable evidence on financial protection in Europe.

Health Status

► **Alcohol Use and Burden for 195 Countries and Territories, 1990–2016: A Systematic Analysis for the Global Burden of Disease Study 2016**

FULLMAN N., YEARWOOD J., ABAY S. M., *et al.*
2018

The Lancet : August 2018 [Ahead of print]

Alcohol use is a leading risk factor for death and disability, but its overall association with health remains complex given the possible protective effects of moderate alcohol consumption on some conditions. With our comprehensive approach to health accounting within the Global Burden of Diseases, Injuries, and Risk Factors Study 2016, we generated improved estimates of alcohol use and alcohol-attributable deaths and disability-adjusted life-years (DALYs) for 195 loca-

tions from 1990 to 2016, for both sexes and for 5-year age groups between the ages of 15 years and 95 years and older.

► **Five-Year Risk of Stroke After TIA or Minor Ischemic Stroke**

AMARENCO P., LAVALLEE P. C., MONTEIRO TAVARES L., *et al.*

2018

N Engl J Med. 378(23):2182-2190

<https://www.ncbi.nlm.nih.gov/pubmed/29766771>

After a transient ischemic attack (TIA) or minor stroke, the long-term risk of stroke and other vascular events is not well known. In this follow-up to a report on 1-year outcomes from a registry of TIA clinics in 21 countries that enrolled 4789 patients with a TIA or minor ischemic stroke from 2009 through 2011, we examined the 5-year risk of stroke and vascular events. We evaluated patients who had had a TIA or minor stroke within 7 days before enrollment in the registry. Among 61 sites that participated in the 1-year outcome study, we selected 42 sites that had follow-up data on more than 50% of their enrolled patients at 5 years. The primary outcome was a composite of stroke, acute coronary syndrome, or death from cardiovascular causes (whichever occurred first), with an emphasis on events that occurred in the second through fifth years. In calculating the cumulative incidence of the primary outcome and secondary outcomes (except death from any cause), we treated death as a competing risk. Results

A total of 3847 patients were included in the 5-year follow-up study; the median percentage of patients with 5-year follow-up data per center was 92.3% (interquartile range, 83.4 to 97.8). In a follow-up to a 1-year study involving patients who had a TIA or minor stroke, the rate of cardiovascular events including stroke in a selected cohort was 6.4% in the first year and 6.4% in the second through fifth years.

► **French and Worldwide Epidemiology of Obesity**

MATTA J., CARETTE C., RIVES LANGE C., *et al.*

2018

Presse Med 47(5): 434-438.

Obesity is a disease characterized by an excessive fat deposition. It is associated to the development of several comorbidities. The worldwide prevalence of obesity has been rising in the past 30 years. Recent results published in 2015 show a global prevalence of 12% in adults, which amounts to 604 million obese adults in the world. The prevalence of obesity has also increased in children since the 1980s to reach 5% globally. Social categories are differently affected by obesity with the most impoverished ones having the highest rate of obesity and obesity increase. In the French ESTEBAN study of 2015, the prevalence of overweight and obesity was the highest among adults with the lowest education level and among children whose caregiver was without diploma.

Geography of Health

► **Geographic and Statistic Stability of Deprivation Aggregated Measures at Different Spatial Units in Health Research**

CEBRECOS A., DOMÍNGUEZ-BERJÓN M. F., DUQUE I., *et al.*

2018

Applied Geography 95: 9-18.

Deprivation indices constitute a valuable tool for assessing health inequalities. A key issue when analyzing deprivation is the choice of the geographical scale

and spatial unit of analysis. Our objective was to evaluate statistical and geographical stability of an Area Based Deprivation Index (ABDI) computed at different spatial scales and to study their relation with cardiovascular disease. The present study has been conducted in the city of Madrid, Spain. Madrid divides its territory in three different administrative units nested within each other: census section, neighborhoods and districts. For each unit a deprivation index was calculated through Principal Component Analysis (PCA). The data source was the 2011 national census from where a range of socioeconomic and demographic indicators

were selected. To study statistical and geographical stability of deprivation we used an Exploratory Spatial Data Analysis and bivariate Local Indicators of Spatial Association analysis. We also conducted Pearson correlation analyses to study the change in the relationship between deprivation and the prevalence of cardiovascular disease (CVD) across the three scales.

► **Migration Intentions of Lithuanian Physicians, Nurses, Residents and Medical Students**

GOŠTAUTAITĖ B., BUČIŪNIENĖ I., MILAŠAUSKIENĖ Ž., *et al.*

2018

Health Policy : [Ahead of print.]

<http://dx.doi.org/10.1016/j.healthpol.2018.07.001>

Emigration intentions differ between students, residents, nurses, and physicians. High social worth and positive teamwork climate reduce emigration intentions. Emigration intentions are also related to socio-demographic and financial factors.

► **Spatiotemporal Analysis of Regional Socio-Economic Vulnerability Change Associated with Heat Risks in Canada**

HO H. C., KNUDBY A., CHI G., *et al.*

2018

Applied Geography 95: 61-70.

Excess mortality can be caused by extreme hot weather events, which are increasing in severity and frequency in Canada due to climate change. Individual and social vulnerability factors influence the mortality risk associated with a given heat exposure. We constructed heat vulnerability indices using census data from 2006 to 2011 in Canada, developed a novel design to compare spatiotemporal changes of heat vulnerability, and identified locations that may be increasingly vulnerable to heat. The results suggest that 1) urban areas in Canada are particularly vulnerable to heat, 2) suburban areas and satellite cities around major metropolitan areas show the greatest increases in vulnerability, and 3) heat vulnerability changes are driven primarily by changes in the density of older ages and infants. Our approach is applicable to heat vulnerability analyses in other countries.

► **An Evaluation of Alternative Measures of Accessibility for Investigating Potential 'Deprivation Amplification' in Service Provision**

PAGE N., LANGFORD M. ET HIGGS G.

2018

Applied Geography 95: 19-33.

Studies examining potential social inequities in resource distribution have tended to adopt relatively unsophisticated measures of service supply such as those derived from proximity measures or counts of facilities within given time/distance thresholds. Often such measures do not take into account potential demand for services and the implications this has for understanding socio-spatial patterns in service provision. In this paper, a comparison is made between spatial patterns of accessibility to a range of services by socio-economic gradients for a subset of 'traditional' measures of provision with trends revealed by the use of floating catchment area (FCA) methods. Statistical and visualisation tools are employed to examine variations in access scores across deprivation quintiles for all the services included in an accessibility 'domain' of a policy-relevant Index of Multiple Deprivation. Findings suggest that, whilst the use of proximity or cumulative opportunity approaches consistently point to greater levels of access in more deprived areas, results from the application of FCA methods point to non-linear trends in the relationship between access and socio-economic patterns of deprivation for some key services. This suggests that the use of measures that account for both potential service demand and distance-decay effects demonstrate patterns that are at odds with those revealed by the use of 'traditional' metrics. We conclude by highlighting prospective implications of using different methodological approaches to measuring spatial patterns of accessibility for understanding socio-economic patterns in service provision, and the broader policy relevance of encapsulating potential service demand within socio-spatial investigations of levels of access.

Disability

► **L'emploi des personnes handicapées dans la fonction publique. Entre quota et non-discrimination, quelles pratiques des employeurs ?**

JAFFRÈS F. ET GUÉVEL M.-R.

2017

Travail et emploi 152(4): 33-57.

<https://www.cairn.info/revue-travail-et-emploi-2017-4-page-33.htm>

Basé sur une enquête de terrain conduite auprès d'employeurs publics, cet article étudie comment ils se saisissent de leurs obligations en matière d'emploi des personnes handicapées. La politique d'emploi des personnes handicapées est en effet traversée en France par une tension entre une logique catégorielle de quota et une logique universaliste de non-discrimination portée par la notion d'« aménagement rai-

sonnable » des emplois. La première logique est bien connue et les obligations qui l'accompagnent sont de mieux en mieux respectées par les employeurs de la fonction publique, comme en témoigne la hausse continue du taux d'emploi des travailleurs handicapés qui y est observée. La deuxième logique est émergente, mais plusieurs indices laissent penser qu'elle pourrait être particulièrement développée dans la fonction publique, qui proposerait plus souvent un environnement de travail adapté à chacun, quel que soit son handicap. Partant de ces hypothèses, nous avons conduit une campagne d'entretiens dans sept établissements publics auprès des acteurs concernés par la politique d'emploi des personnes handicapées. Ces entretiens ont été complétés par un recueil de documents (conventions, plaquettes de communication, etc.) et d'observations.

Hospitals

► **How Do We Interpret Readmission Rates?**

ALI A. M. ET BOTTLE A.

2018

BMJ 362

<https://www.bmj.com/content/bmj/362/bmj.k3104.full.pdf>

Readmission rates are a potentially valuable indicator of hospital performance to spot problems such as the surge in readmissions for preventable conditions reported by the Nuffield Trust. But uncertainty is immense about how much the risk of readmission is determined by patient factors, hospital factors, and the quality of care after discharge across a range of conditions.

Countries in Asia are working towards achieving universal health coverage while ensuring improved quality of care. One element is controlling hospital costs through payment reforms. In this paper we review experiences in using Diagnosis Related Groups (DRG) based hospital payments in three Asian countries and ask if there is an "Asian way to DRGs". We focus first on technical issues and follow with a discussion of implementation challenges and policy questions. We reviewed the literature and worked as an expert team to investigate existing documentation from Japan, Republic of Korea, and Thailand. We reviewed the design of case-based payment systems, their experience with implementation, evidence about impact on service delivery, and lessons drawn for the Asian region. We found that countries must first establish adequate infrastructure, human resource capacity and information management systems. Capping of volumes and prices is sometimes essential along with a high degree of hospital autonomy. Rather than introduce a complete classification system in one stroke, these countries have phased in DRGs, in some cases with hospitals volunteering to participate as a first step (Korea), and in others using a blend of different units for hos-

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

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

2018

Health Policy 122(7): 707-713.

pital payment, including length of stay, and fee-for-service (Japan). Case-based payment systems are not a panacea. Their value is dependent on their design and implementation and the capacity of the health system.

► **Intensité et pénibilités du travail à l'hôpital. Quelles évolutions entre 1998 et 2013 ?**

BENALLAH S. ET DOMIN J.-P.

2017

Travail et emploi 152(4): 5-31.

<https://www.cairn.info/revue-travail-et-emploi-2017-4-page-5.htm>

Cet article s'intéresse à l'évolution des conditions de travail à l'hôpital au cours des quinze dernières années. Cette question est importante dans le contexte des réformes menées au sein du secteur depuis le début des années 1990, qui y ont provoqué de profondes réorganisations. Dans un premier temps, nous faisons le point sur l'état des connaissances concernant les conditions de travail à l'hôpital. Nous étudions ensuite, à partir des trois dernières éditions de l'enquête Conditions de travail, l'évolution entre 1998 et 2013 des contraintes de rythme et de diverses formes de pénibilités du travail à l'hôpital, comparativement à d'autres secteurs d'activité. Enfin, nous analysons, toutes choses égales par ailleurs, les spécificités actuelles du secteur en matière d'exposition aux contraintes de rythme, aux horaires décalés, aux pénibilités physiques et à un environnement de travail dégradé. Nous observons, sur la période 1998-2013, une nette augmentation des contraintes de rythme s'exerçant sur les personnels hospitaliers. Celle-ci s'accompagne d'une légère diminution des pénibilités physiques. Mais l'hôpital demeure particulièrement contraint du point de vue des conditions de travail.

► **Patients en situation palliative en hospitalisation à domicile : trajectoires de soins et caractéristiques cliniques**

BOISSERIE-LACROIX L., MARQUESTAUT O. ET DE STAMPA M.

2017

Santé Publique 29(6): 851-859.

<https://www.cairn.info/revue-sante-publique-2017-6-page-851.htm>

Une large majorité de Français expriment le souhait d'une prise en charge à domicile en situation palliative. L'objectif est de décrire les trajectoires de soins et les caractéristiques cliniques des patients en situation palliative pris en charge par l'hospitalisation à domicile. Notre étude a décrit les modalités de prise en charge et les caractéristiques cliniques des patients en situation palliative suivis par une hospitalisation à domicile francilienne. Le recueil des données a été rétrospectif à partir des bases de données du programme de médicalisation des systèmes d'information en 2014. Huit cent dix-sept patients en situation palliative et suivis en hospitalisation à domicile ont été inclus. Ces patients étaient plus âgés, entraient plus souvent en HAD sur prescription du médecin traitant, avaient des durées de séjour plus courtes et décédaient plus fréquemment à domicile comparativement aux patients hors situation palliative. Ils présentaient majoritairement une pathologie cancéreuse et recevaient des soins techniques fréquents. Les patients les plus âgés (≥ 75 ans) présentaient plus souvent des maladies neuro-dégénératives, étaient moins transférés en hospitalisation avec hébergement et décédaient davantage à domicile. La proportion de décès était plus élevée en établissement d'hébergement pour personnes âgées (EHPAD) et les patients décédés à domicile recevaient moins de soins techniques. Cette étude apporte des enseignements importants concernant les modes de prise en charge en hospitalisation à domicile et les changements fréquents de lieux de soins. Elle témoigne de la complexité de l'accompagnement à domicile des patients en situation palliative jusqu'à leur décès.

► **Association of the Hospital Readmissions Reduction Program with Surgical Readmissions**

BORZA T., OERLINE M. K., SKOLARUS T. A., et al.

2018

JAMA Surgery 153(3): 243-250.

<http://dx.doi.org/10.1001/jamasurg.2017.4585>

Hospital-level 30-day risk-adjusted rates of readmission and observation stays were calculated using multivariable logistic regression models. Changes in these rates were analyzed for 3 distinct periods (prepolicy [January 1, 2006, to June 30, 2010], performance [July 1, 2010, to June 30, 2013], and penalty [July 1, 2013, to November 30, 2014]) corresponding to the HRRP implementation timeline for major joint surgery using interrupted time series. Results:

Among 672 135 Medicare beneficiaries 66 years or older treated at 2773 hospitals, readmissions for all procedures decreased significantly over the study period. Readmission rates after targeted procedures decreased faster during the performance period (slope, -0.060 ; 95% CI, -0.079 to -0.041) compared with the prepolicy period (slope, -0.012 ; 95% CI, -0.027 to 0.034) ($P < .002$). For the nontargeted procedures, readmission rates were decreasing during the prepolicy period (slope, -0.200 ; 95% CI, -0.240 to -0.160) but stabilized during the performance period (slope, 0.008 ; 95% CI, -0.049 to 0.066) ($P < .001$). The use of observation stays increased slightly, accounting for 11% of the decrease in readmissions. Conclusions and Relevance. The HRRP effectively decreased readmissions for targeted procedures. There were no associated spillover effects for common nontargeted procedures. A better understanding of differences in the association of the policy with medical and surgical discharges will be necessary to further enhance its generalizability.

► **Sortir de la T2A par le haut : la mesure de la qualité des soins**

BRAS P.-L.

2017

Journal de Gestion et d'Économie médicales 35(6): 245-263.

<https://www.cairn.info/revue-journal-de-gestion-et-d-economie-medicales-2017-6-page-245.htm>

Depuis la crise, le rythme d'évolution des ressources des établissements de santé est fortement contraint. Dans un contexte, où l'augmentation de la production des soins reste soutenue, les établissements de santé, dès lors que la T2A révèle leur niveau de performance économique, doivent réaliser des progrès de productivité notamment de productivité du travail. On peut craindre que ces progrès de productivité ne soient obtenus qu'au détriment de la qualité des soins et des conditions de travail des personnels. Il est donc essentiel de se doter sans attendre d'indicateurs permettant d'apprécier la qualité des soins; les indicateurs de processus développés en France n'étant pas à cet égard suffisants. Il faut comme dans de nombreux pays étrangers se doter d'outils pour mesurer l'expérience et la satisfaction des patients, le vécu au travail et l'appréciation de la qualité des soignants et, enfin les résultats cliniques des soins. Se doter de ces instruments de mesure suppose un investissement technique et scientifique qui ne se conçoit que dans le cadre

d'une politique structurée. Cet investissement est un préalable pour envisager des modes de tarification dits « au parcours » ou des modes de paiement à la qualité.

► **Pédiatrie : récupération rapide après chirurgie (RAAC) : l'expérience de l'hôpital Robert-Debré**

DAHMANI S. ET JOUVE M.

2018

Gestions hospitalières(577): 358-361.

L'équipe chirurgicale et anesthésique de l'hôpital Robert-Debré a appliqué les démarches et approches de la récupération rapide après chirurgie (RAAC) à l'ensemble des prises en charge chirurgicales, privilégiant une prise en charge centrée sur le patient structurée autour d'un travail en équipe pluridisciplinaire et pour un même objectif. L'expérience montre qu'un des apports majeurs de la RAAC est une meilleure complémentarité et communication entre ces différents corps de métier.

► **Doctors, Nurses, and the Optimal Scale Size in the Portuguese Public Hospitals**

FERREIRA D. C., NUNES A. M. ET MARQUES R. C.

2018

Health Policy. [Ahead of Print]

<http://dx.doi.org/10.1016/j.healthpol.2018.06.009>

We investigate optimal scale size (and demographic drivers) of Portuguese hospitals. Optimal scale size is centred on 274 FTE doctors and 475 FTE nurses. Roughly half of considered hospitals are oversized, when aiming for scale efficiency. Workforce excess is in the coastline, whereas shortage is in the countryside.

► **Effect of Systematic Physician Cross-Checking on Reducing Adverse Events in the Emergency Department: The Charmed Cluster Randomized Trial**

FREUND Y., GOULET H., LEBLANC J., *et al.*

2018

JAMA Internal Medicine 178(6): 812-819.

<http://dx.doi.org/10.1001/jamainternmed.2018.0607>

Emergency departments (ED) are environments that are at high risk for medical errors. Previous studies suggested that the proportion of medical errors may decrease when more than 1 physician is involved. The aims of this study are to reduce the proportion of medical errors by implementing systematic cross-checking between emergency physicians. This cluster randomized crossover trial includes a random sample of 14 adult patients (age ≥ 18 years) per day during two 10-day periods in 6 EDs ($n = 1680$ patients) in France. Systematic cross-checking between emergency physicians, 3 times a day, which included a brief presentation of one physician's case to another, followed by the second physician's feedback to the first. Medical error in the ED, defined as an adverse event (either a near miss or a serious adverse event). The primary end point was identified using a 2-level error detection surveillance system, blinded to the strategy allocation. The implementation of systematic cross-checking between emergency physicians was associated with a significant reduction in adverse events, mainly driven by a reduction in near misses.

► **Cooperation Between Hospital Teams and Community-Based Healthcare Professionals**

LE COSSEC C., GIACOPELLI M. ET DE CHAMBINE S.

2018

Santé Publique 30(2): 213-224.

<https://www.ncbi.nlm.nih.gov/pubmed/30148309>

This study aims to identify and classify hospital-community cooperation activities between Greater Paris University Hospitals (GPUH) and community health professionals. A declarative survey was conducted in GPUH clinical departments, which were asked to describe their activities with community health professionals, the type of community professionals involved (e.g. general practitioners, nurses) and a full description of the activity. Activities were classified by the three authors with consistency checks. 261 activities

were reported by 138 departments (39 medical specialties). Paediatrics, psychiatry and geriatrics reported the highest number of activities. 37% of activities covered access to hospital care, 25% concerned training of health professionals, 22% concerned continuity of care after hospitalization, 13% shared follow-up and 3% corresponded to public health interventions in the general population. Access to hospital care included facilitating appointments, access to hospital expertise and specific organizations. Continuity of care included either information transmission or patient referral. Follow-up was shared over specific patients or over a predefined patient population. Training was organized by hospital professionals, community health professionals or as a collaborative initiative. The proposed classification can be used for research studies, or to define a strategy for hospitals initiating collaborations with community health professionals. It describes the concept of "hospital-community medical relations" from a pragmatic health professional point of view.

► **Developing and Utilising a New Funding Model for Home-Care Services in New Zealand**

MATTHEW P., PAUL R., LASZLO S., *et al.*

2018

Health & Social Care in the Community 26(3): 345-355.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.12525>

Worldwide increases in the numbers of older people alongside an accompanying international policy incentive to support ageing-in-place have focussed the importance of home-care services as an alternative to institutionalisation. Despite this, funding models that facilitate a responsive, flexible approach are lacking. Casemix provides one solution, but the transition from the well-established hospital system to community has been problematic. This research seeks to develop a Casemix funding solution for home-care services through meaningful client profile groups and supporting pathways. Unique assessments from 3,135 older people were collected from two health board regions in 2012. Of these, 1,009 arose from older people with non-complex needs using the interRAI-Contact Assessment (CA) and 2,126 from the interRAI-Home-Care (HC) from older people with complex needs. Home-care service hours were collected for 3 months following each assessment and the mean weekly hours were calculated. Data were analysed using a decision

tree analysis, whereby mean hours of weekly home-care was the dependent variable with responses from the assessment tools, the independent variables. A total of three main groups were developed from the interRAI-CA, each one further classified into “stable” or “flexible.” The classification explained 16% of formal home-care service hour variability. Analysis of the interRAI-HC generated 33 clusters, organised through eight disability “sub” groups and five “lead” groups. The groupings explained 24% of formal home-care services hour variance. Adopting a Casemix system within home-care services can facilitate a more appropriate response to the changing needs of older people.

► **Evaluation of Hospital Readmissions for Surgical Site Infections in Italy**

NAPOLITANO F., TOMASSONI D., CASCONI D., *et al.*
2018

[Eur J Public Health 28\(3\): 421-425.](#)

The objectives of this investigation are to assess the prevalence of hospital readmissions for surgical site infections (SSIs) in patients aged ≥ 18 in Italy and to describe the clinical characteristics of these patients and evaluate the possible association with readmission for SSIs. A retrospective epidemiological study was conducted between January and May 2015 considering a sample of patients aged ≥ 18 years admitted to the surgical wards of two hospitals in Naples and undergoing surgery in the year 2014. 3.8% of patients had been readmitted and 28.8% of them were readmitted to hospital due to SSIs. The results point to the need that hospital infection prevention strategies are implemented in order to reduce morbidity and mortality for patients. Moreover, the measures taken to prevent infections would lead to a reduction in health spending since almost one third of readmissions to the hospital in our study were due to SSIs.

► **Procédés et effets du pouvoir disciplinaire aux urgences. Le cas de l'accueil des patients alcooliques**

PIRIOU O. ET THOMAS J.
2018

[Sciences sociales et santé 36\(2\): 43-67.](#)

<https://www.cairn.info/revue-sciences-sociales-et-sante-2018-2-page-43.htm>

En s'appuyant sur une enquête ethnographique, cet article vise à comprendre les modalités de mise en œuvre du pouvoir disciplinaire aux urgences de l'hôpital dans la prise en charge de patients alcoolisés. Il étudie les procédés disciplinaires qui étayent cette prise en charge. Puis il confronte ces procédés aux usages qu'en font les patients. L'analyse rend compte du fait que le pouvoir disciplinaire ne s'impose pas massivement ni unilatéralement sur les individus, mais qu'il est plutôt le résultat de rapports de forces instables qui surgissent de la rencontre entre patients et soignants.

► **Use of Hospital Palliative Care According to the Place of Death and Disease One Year Before Death in 2013: A French National Observational Study**

POULALHON C., ROTELLI-BIHET L., MOINE S., *et al.*
2018

[BMC Palliat Care 17\(1\): 75.](#)

Only limited data are available concerning the diseases managed before death and hospital palliative care (HPC) use according to place of death in France. We therefore conducted an observational study based on administrative health data in a large population to identify the diseases treated one year before death in 2013, the place of stay with or without hospital palliative care, and the place of death. French health insurance general scheme beneficiaries were identified in the National Health data Information System (Snds) with a selection of information. Diseases were identified by algorithms from reimbursement data recorded in the Snds database. 347,253 people were included in this study (61% of all people who died in France). Place of death was short stay hospital for 51%, Rehab (7%), hospital at home (3%), skilled nursing home (13%) and other (26%). Chronic diseases managed in 2013 before death were cardiovascular/neurovascular diseases (56%), cancers (42%), and neurological and degenerative diseases (25%). During the year before death, 84% of people were hospitalized at least once, and 29% had received HPC. HPC was used by 52% of cancer patients (lung cancer: 62%; prostate cancer: 41%). In the absence of cancer, the use of HPC varied according to the disease: acute stroke: 24%, heart failure: 17%, dementia: 17%, multiple sclerosis: 23%. Health administrative data can refine the knowledge of the care pathway prior to death and the HPC utilisation and can be useful to evaluate health policies and improve monitoring and assessment of HPC use.

► **Optimal Timing of Physician Visits After Hospital Discharge to Reduce Readmission**

RIVERIN B. D., STRUMPF E. C., NAIMI A. I., *et al.*
2018

[Health Serv Res. : \[Ahead of print.\]](#)

The aims of this study is to identify the optimal timing of in-person physician visit after hospital discharge to yield the largest reduction in readmission among elderly or chronically ill patients. We extracted insurance billing data on 620,656 admissions for any cause from 2002 to 2009 in Quebec, Canada. We used flexible survival models to estimate inverse probability weights for the precise timing (days) of in-person physician visit after discharge and weighted competing risk outcome models. Readmission reduction associated with in-person physician visits (compared to none) was seen early after discharge, with 67.8 fewer readmissions per 1,000 discharges if physician visit occurred within 7 days (95 percent CI: 66.7-69.0), and 110.0 fewer readmissions within 21 days (95 percent CI: 108.2-111.7). The period of largest contribution to readmission reduction was seen in the first 10 days, while physician visits occurring later than 21 days after discharge did not further contribute to reducing hospital readmissions. Larger risk reductions were observed among patients in the highest morbidity level and for in-person follow-up with a primary care physician rather than a medical specialist. When provided promptly, postdischarge in-person physician visit can prevent many readmissions. The benefits appear optimal when such visit occurs within the first 10 days, or at least within the first 21 days of discharge.

► **Continuity of Care and Its Effect on Readmissions for COPD Patients: A Comparative Study of Norway and Germany**

SWANSON J. O., VOGT V., SUNDMACHER L., *et al.*
2018

[Health Policy 122\(7\): 737-745.](#)

This study compares continuity of care between Germany - a social health insurance country, and Norway - a national health service country with gatekeeping and patient lists for COPD patients before and after initial hospitalization. We also investigate how subsequent readmissions are affected. Continuity of Care Index (COCI), Usual Provider Index (UPC) and

Sequential Continuity Index (SECON) were calculated using insurance claims and national register data (2009-14). These indices were used in negative binomial and logistic regressions to estimate incident rate ratios (IRR) and odds ratios (OR) for comparing readmissions. All continuity indices were significantly lower in Norway. One year readmissions were significantly higher in Germany, whereas 30-day rates were not. All indices measured one year after discharge were negatively associated with one-year readmissions for both countries. Significant associations between indices measured before hospitalization and readmissions were only observed in Norway - all indices for one-year readmissions and SECON for 30-day readmissions. Our findings indicate higher continuity is associated with reductions in readmissions following initial COPD admission. This is observed both before and after hospitalization in a system with gatekeeping and patient lists, yet only after for a system lacking such arrangements. These results emphasize the need for policy strategies to further investigate and promote care continuity in order to reduce hospital readmission burden for COPD patients.

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

TAYYARI DEHBAREZ N., GYRD-HANSEN D.,
ULDBJERG N., *et al.*
2018

[Health Policy 122\(7\): 722-727.](#)

Equity of access to health care is a central objective of European health care systems. In this study, we examined whether free choice of hospital, which has been introduced in many systems to strengthen user rights and improve hospital competition, conflicts with equity of access to highly specialized hospitals. We chose to carry out a study on 134,049 women who had uncomplicated pregnancies from 2005 to 2014 in Denmark because of their homogeneity in terms of need, the availability of behavioral data, and their expected engagement in choice of hospital. Multivariate logistic regression was used to link the dependent variable of bypassing the nearest non-highly specialized public hospital in order to "up-specialize", with independent variables related to socioeconomic status, risk attitude, and choice premises, using administrative registries. Overall, 16,426 (12%) women were observed to

bypass the nearest hospital to up-specialize. Notably, high education level was significantly associated with up-specialization, with an odds ratio of 1.50 (95% CI: 1.40-1.60, $p < 0.001$) compared to low education group.

This confirms our hypothesis that there is a socioeconomic gradient in terms of exercising the right to a free choice of hospital, and so the results indicate that the policy exacerbates inequity of access to health care.

Health Inequalities

► **Measuring Performance on the Healthcare Access and Quality Index for 195 Countries and Territories and Selected Subnational Locations: A Systematic Analysis from the Global Burden of Disease Study 2016**

FULLMAN N., YEARWOOD J., ABAY S.M., *et al.*
2018

Lancet 391(10136): 2236-2271

A key component of achieving universal health coverage is ensuring that all populations have access to quality health care. Examining where gains have occurred or progress has faltered across and within countries is crucial to guiding decisions and strategies for future improvement. We used the Global Burden of Diseases, Injuries, and Risk Factors Study 2016 (GBD 2016) to assess personal health-care access and quality with the Healthcare Access and Quality (HAQ) Index for 195 countries and territories, as well as subnational locations in seven countries, from 1990 to 2016. Drawing from established methods and updated estimates from GBD 2016, we used 32 causes from which death should not occur in the presence of effective care to approximate personal health-care access and quality by location and over time. GBD 2016 provides a more detailed understanding of past success and current challenges in improving personal health-care access and quality worldwide. Despite substantial gains since 2000, many low-SDI and middle-SDI countries face considerable challenges unless heightened policy action and investments focus on advancing access to and quality of health care across key health services, especially non-communicable diseases. Stagnating or minimal improvements experienced by several low-middle to high-middle SDI countries could reflect the complexities of re-orienting both primary and secondary health-care services beyond the more limited foci of the Millennium Development Goals. Alongside initiatives to strengthen public health programmes, the pursuit of universal health coverage

hinges upon improving both access and quality worldwide, and thus requires adopting a more comprehensive view and subsequent provision of quality health care for all populations.

► **Pauvreté et non-recours aux dispositifs sociaux : l'étude du RSA « socle seul »**

CHAREYRON S.
2018

Economie & prévision 213(1): 41-59.

<https://www.cairn.info/revue-economie-et-prevision-2018-1-page-41.htm>

Cet article s'intéresse au non-recours à la composante « socle seul » du Revenu de Solidarité Active (RSA) laquelle, contrairement à la composante « activité » de ce dispositif, a peu été étudiée. La première partie de l'article est consacrée à l'estimation du taux de non-recours au RSA « socle seul », en prenant en compte la sensibilité de cette estimation aux erreurs dues aux approximations dans le calcul de l'éligibilité au RSA et aux erreurs de déclaration des revenus de l'enquête; l'estimation confirme un niveau élevé de non-recours, avec un taux compris dans une fourchette de 28 % à 35 %. La seconde partie de l'article compare les caractéristiques des foyers bénéficiaires du dispositif et des foyers éligibles mais qui n'y ont pas recours. Différents facteurs de ce phénomène de non-recours sont ainsi mis en évidence : le non-recours touche une proportion élevée de ménages au niveau de vie très modeste, dans une grande pauvreté. L'explication de ce phénomène semble provenir de l'absence de perception de prestation familiale et donc de contact préalable avec les Caf. Le non-recours touche aussi des ménages aux niveaux de vie plus élevés, plus proches du marché du travail dont les gains retirés de la participation au dispositif sont moindres.

► **Healthcare Use Among Immigrants and Natives in Sweden on Disability Pension, Before and After Changes of Regulations**

DI THIENE D., RAHMAN S., HELGESSON M., *et al.*

2018

Eur J Public Health 28(3): 445-451.

There is limited knowledge regarding psychiatric healthcare utilization around the time of granting disability pension (DP) due to common mental disorders (CMD) among immigrants and if this is related to social insurance regulations. The aim was to evaluate patterns of psychiatric healthcare utilization before and after DP due to CMD among immigrants and natives. A second aim was to evaluate if such patterns differed before and after changes in social insurance regulations in Sweden in 2008. All 28 354 individuals living in Sweden with incident DP due to CMD, before (2005-06; n = 24 298) or after (2009-10; n = 4056) changes in regulations of granting DP, were included. Patterns of psychiatric in- and specialized outpatient healthcare utilization during a 7-year window around DP granting were assessed by Generalized Estimating Equations estimating multivariate adjusted odds ratios (OR) and 95% confidence intervals (CI). Prevalence rates of psychiatric inpatient care were comparable among immigrants and natives, lower in non-Western immigrants (Africa, Asia and South-America). Three years after DP, non-Western immigrants in comparison to natives and Western immigrants had a stronger decrease in inpatient psychiatric healthcare: OR 0.48 (CI 0.38-0.62), 0.76 (0.70-0.83) and 1.01 (0.76-1.34), respectively. After 2008, a strong reduction in outpatient psychiatric healthcare after DP granting was observed, similarly in immigrants and natives. Non-Western immigrants showed a different pattern of inpatient specialized healthcare after DP granting in comparison to natives. After changes in social insurance regulations, the decline in outpatient psychiatric healthcare following DP granting was comparable in immigrants and natives.

► **A Framework for Regional Primary Health Care to Organise Actions to Address Health Inequalities**

FREEMAN T., JAVANPARAST S., BAUM F., *et al.*

2018

Int J Public Health 63(5): 567-575.

Regional primary health-care organisations plan, co-ordinate, and fund some primary health-care services in a designated region. This article presents a framework for examining the equity performance of regional primary health-care organisations, and applies it to Australian Medicare Locals (funded from 2011 to 2015). The framework was developed based on theory, literature, and researcher deliberation. Data were drawn from Medicare Local documents, an online survey of 210 senior Medicare Local staff, and interviews with 50 survey respondents. The framework encompassed equity in planning, collection of equity data, community engagement, and strategies to address equity in access, health outcomes, and social determinants of health. When the framework was applied to Medicare Locals, their inclusion of equity as a goal, collection of equity data, community engagement, and actions improving equity of access were strong, but there were gaps in broader advocacy, and strategies to address social determinants of health, and equity in quality of care. The equity framework allows a platform for advancing knowledge and international comparison of the health equity efforts of regional primary health-care organisations.

► **Residence Permit for Medical Reasons: An Obstacle to Permanent Residence Status. Results of the ANRS Parcours Study**

GOSSELIN A.

2018

Santé Publique 30(2): 197-201.

<https://www.ncbi.nlm.nih.gov/pubmed/30148307>

Various associations in France have denounced for a long time the difficulties encountered by foreigners with a residence permit for medical reasons to access permanent residence status (10-year resident's card or French nationality). The objective of this study was to determine whether there is a real discrimination towards foreigners with a residence permit for medical reasons, with all other things being equal. This study was based on data from the retrospective quantitative ANRS Parcours survey, conducted in 2012-2013 among 1,705 Sub-Saharan immigrants with HIV/AIDS or Hepatitis B in Ile-de-France. This life-event survey reconstructed the immigrant's permit history. Discrete time logistic models were then used to model the factors associated with obtaining a permanent residence permit and the impact of a residence permit for medi-

cal reasons on this probability. Control variables were used to take into account the level of education, the reason for arrival in France, the period of arrival, the duration of stay. A residence permit for medical reasons has a negative impact on access to permanent residence status (aOr between 0.15 and 0.27 across subgroups, $P < 0.01$). Additionally, the time required to obtain permanent residence status has increased since 2005 compared to before 1996 for all foreigners participating in the survey. The results of this study suggest discrimination towards people with a residence permit for medical reasons in terms of access to permanent residence status, thereby placing their access to health care at stake.

► **Les mineurs isolés étrangers et le système de soins français : étude qualitative**

GUÉGAN M. ET RIVOLLIÉ E.

2017

Santé Publique 29(6): 861-867.

<https://www.cairn.info/revue-sante-publique-2017-6-page-861.htm>

Avant l'obtention de leur assurance maladie, les Mineurs isolés étrangers (MIE) sont susceptibles de consulter dans une Permanence d'accès aux soins de santé (PASS). Cette étude a eu pour objectif d'étudier leurs représentations et ressentis du système de soins français. Une étude qualitative a été réalisée à partir d'entretiens individuels semi-dirigés avec des MIE ayant consulté dans une PASS, puis pris en charge dans le droit commun. La déclaration à la CNIL et validation de la méthodologie ont été validées par un comité éthique. Au total, 21 jeunes ont été interviewés. Ils expriment leur satisfaction à propos des soins, même si le système de soins est vécu comme complexe. L'ordonnance est primordiale car elle permet l'obtention des médicaments, but ultime de leur accès aux soins. L'assurance maladie n'est pas connue de tous. Les PASS sont souvent assimilées à l'hôpital, ses missions et les dépistages sont mal compris. Le médecin généraliste n'est pas toujours identifié et son rôle est mal connu. Les éducateurs apparaissent aux MIE comme des déterminants de l'accès aux soins et sont considérés comme de véritables piliers. La santé est primordiale pour tous. Aucun n'évoque la santé mentale. Les MIE nécessitent une meilleure information sur leurs droits en santé et sur le système de soins de France. Sont à améliorer la formation des éducateurs sur l'accompagnement en santé, leurs connaissances

sur les droits des MIE et sur les rôles des intervenants en santé. Le dépistage des pathologies mentales est à développer.

► **Interventions en littératie en santé et éducation thérapeutique : une revue de la littérature**

MARGAT A., GAGNAYRE R., LOMBRIL P., *et al.*

2017

Santé Publique 29(6): 811-820.

<https://www.cairn.info/revue-sante-publique-2017-6-page-811.htm>

Un faible niveau de Littératie en Santé (LS) constitue un obstacle à l'éducation thérapeutique du patient (ETP) et particulièrement pour les personnes en situation de vulnérabilité qui ont également plus de risques d'être touchées par les maladies chroniques et leurs complications. Il semble donc essentiel de repenser les programmes d'ETP afin de tendre vers plus d'équité. Pour cela, une analyse des caractéristiques des interventions visant la LS et de leurs relations possibles avec l'ETP est nécessaire. Une revue de la littérature de type scoping review a été effectuée entre novembre 2014 et janvier 2016, à partir des moteurs de recherche suivants : MEDLINE / PubMed, Embase, psycinfo, ERIC, Opengrey, SUDOC, thèses.fr, BDSP. Une sélection de 40 études sur 206 a conduit à catégoriser les interventions selon deux grands types : (i) des interventions spécifiques favorisant la compréhension des ressources destinées aux patients; (ii) des interventions, généralement complexes, visant à soutenir et améliorer les compétences en LS. Alors que le niveau de LS influence l'accessibilité des programmes d'ETP, il semblerait pertinent d'une part de rendre les programmes plus accessibles et d'autre part d'appréhender l'ETP comme une opportunité pour répondre, selon ses modalités propres, aux besoins en LS. Il semble que la mise en place de partenariats entre les milieux socio-éducatifs et de la santé puisse être une stratégie efficace, tout comme la formation des soignants-éducateurs à augmenter la LS des patients. Il est possible d'articuler les interventions en LS et l'ETP. Des recherches devraient questionner les modalités pédagogiques à mettre en œuvre pour adapter les programmes d'ETP à la LS.

► **Health and Health Care Access for Syrian Refugees Living in Istanbul**

TORUN P., MUCAZ KARAASLAN M., SANDIKLI B., *et al.*

2018

Int J Public Health 63(5): 601-608.

The study was conducted to assess the health needs of urban refugees living in Istanbul. A mixed methods approach was adopted to interview Syrian women from households, doctors, decision makers and NGO representatives. The data were collected between June and October 2015. The main challenges were the cost of living in Istanbul, increased rent and language barrier. Almost half (49.6%) of the interviewed women did not know about free health care rights for Syrians. In the last 30 days preceding the interview, 58.6% of the participants sought health care primarily through state hospitals, primary health care centres and pharmacies. The participants had difficulty in accessing health care due to the language barrier and a lack of knowledge of the Turkish health care system. Waiting time at hospitals and negative attitudes of health care staff reduced satisfaction in these services. In relation to life in Turkey, the main issues for Syrian refugees were not directly related to health. They have been given the right to access health care, although had many difficulties in understanding and accessing services in a crowded city.

► **Payment Reform and Health Disparities: Changes in Dialysis Modality Under the New Medicare Dialysis Payment System**

TURENNE M., BAKER R., PEARSON J., *et al.*

2018

Health Serv Res 53(3): 1430-1457.

The aims of this study are to evaluate the effect of the Medicare dialysis payment reform on potential disparities in the selection of peritoneal dialysis (PD) for the treatment of end-stage renal disease (ESRD). Data sources are Centers for Medicare & Medicaid Services (CMS) ESRD Medical Evidence Form, Medicare claims, and other CMS data for 2008-2013. We examined the association of patient age, race/ethnicity, urban/rural location, pre-ESRD care, comorbidities, insurance, and other factors with the selection of PD as initial dialysis modality across prereform (2008-2009), interim (2010), and postreform (2011-2013) time periods. Selection of

PD increased among diverse patient subgroups following the payment reform. However, the lower PD selection observed with older age, black race, Hispanic ethnicity, less pre-ESRD care, and Medicaid insurance before the reform largely remained in the initial postreform years. Despite recent growth in PD, there may be ongoing disparities in access to PD that have largely not been mitigated by the payment reform. There is potential for modifying provider financial incentives to achieve policy goals related to cost and quality of care. However, even with a substantial shift in financial incentives, separate initiatives to reduce existing disparities in care may be needed.

► **Des obstacles à la connaissance des inégalités de santé. Deuxième partie : perspective psycho-sociale**

VEGA A., LECARPENTIER M. ET NAAMOUNI K.

2018

Médecine : de la Médecine Factuelle à nos Pratiques 14(3): 116-121.

Les inégalités sociales, qui s'expriment aussi dans la sphère de la santé, restent encore méconnues parce qu'elles remettent en cause le principe d'égalité républicain français. Mais comment ces inégalités se construisent-elles, et pourquoi ont-elles même tendance à s'amplifier en France? Cet article tente de répondre à cette problématique.

► **Refusal to Provide Healthcare to Sub-Saharan Migrants in France: A Comparison According to Their HIV and HBV Status**

VIGNIER N., DRAY SPIRA R., PANNETIER J., *et al.*

2018

Eur J Public Health: [Ahead of print]

<http://dx.doi.org/10.1093/eurpub/cky118>

In this study, we aim to measure and compare the frequency of reported denial of care in sub-Saharan African migrants living in the Paris area, according to their HIV and HBV status and social and migration characteristics. The ANRS-PARCOURS study is a life-event survey conducted in 2012-13 in healthcare facilities in the Paris area, among three groups of sub-Saharan migrants recruited in primary care centres (N = 760; reference group), in dedicated centres for HIV care

(N = 922; HIV group) and in centres for chronic hepatitis B care (N = 777; CHB group). Characteristics associated with refusal of care since arrival in France were identified using a logistic regression model. Compared to the reference group (6%, P < 0.001), the reported refusal of care was twice as high in the HIV group (12%) and the CHB group (10%). In the multivariate analysis, men and women living with HIV were at greater risk of being denied care (aOR = 2.20[1.14-4.25] and 2.24[1.25-4.01]). Women covered by the specific health insurance (HI) for precarious or undocumented migrants were

also at higher risk (aOR = 2.07[1.10-3.89] and 2.69[1.18-6.10], respectively). The risk was also increased in men who remained for at least one year without permit of residence or without HI and among those who were threatened in their country. Refusals to provide health-care are frequent and deleterious situations especially for migrants living with HIV. Health decision makers, public insurance bodies and health professional councils must address this issue to improve equity in the healthcare system.

Pharmaceuticals

► Value-Based Insurance Design Improves Medication Adherence Without an Increase in Total Health Care Spending

AGARWAL R., GUPTA A. ET FENDRICK A. M.
2018

Health Aff (Millwood) 37(7): 1057-1064.

Value-based insurance design (VBID) is a strategy that reduces cost sharing for high-value services and increases consumers' out-of-pocket spending for low-value care. VBID has increasingly been implemented by private and public payers and has inspired demonstration programs in Medicare Advantage and TRICARE. Given the recent publication of several studies, we performed an updated systematic review that evaluated the effects of reducing consumer cost sharing on medication adherence and other relevant outcomes. Searches were conducted in key online databases, and the screening of citations yielded twenty-one unique studies, of which eight had not been included in previous reviews. Using the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) system, we found moderate-quality evidence showing improvement (range: 0.1-14.3 percent) in medication adherence with VBID. This increase in adherence was associated with no effect on total health care spending, which suggests that the incremental drug spending was offset by decreases in spending for other health care services.

► Patterns and Predictors of Physician Adoption of New Cardiovascular Drugs

ANDERSON T. S., LO-CIGANIC W.-H., GELLAD W. F.,
et al.
2018

Healthcare 6(1): 33-40.

<http://www.sciencedirect.com/science/article/pii/S2213076417300660>

Little is known about physicians' approaches to adopting new cardiovascular drugs and how adoption varies between drugs of differing novelty. Using data on dispensed prescriptions from IMS Health's Xponent™ database, we created a cohort of all primary care physicians (PCPs) and cardiologists in Pennsylvania who regularly prescribed anticoagulants, antihypertensives and statins from 2007 to 2011. We examined prescribing of three new cardiovascular drugs of differing novelty: dabigatran, aliskiren and pitavastatin. Outcomes were rapid adoption of each new drug, defined by early and sustained monthly prescribing detected by group-based trajectory models, by physicians within the first 15 months of marketplace introduction. 5953 physicians regularly prescribed each drug class. The majority of physicians (63.8%) adopted zero new drugs in the first 15 months, 35.0% rapidly adopted one or two, and 1.2% rapidly adopted all three. Physicians vary in their prescribing of recently-introduced cardiovascular drugs. Though most physicians did not rapidly adopt any new cardiovascular drugs, drug novelty and cardiology training were associated with greater adoption.

► **Prescriptions médicamenteuses potentiellement inappropriées en gériatrie : quels outils utiliser pour les détecter ?**

DESNOYER A., GUIGNARD B., LANG P.-O., *et al.*
2016

La Presse Médicale 45(11): 957-970.

<http://www.sciencedirect.com/science/article/pii/S075549821630207X>

Les prescriptions médicamenteuses inappropriées comprennent les sur-prescriptions (prescription d'un médicament non indiqué), les prescriptions inadaptées (choix de molécules, durée, dose inadaptés, doublon, interactions médicamenteuses potentiellement néfastes, suivi inapproprié) et les sous-prescriptions (omission d'un traitement indiqué). Elles constituent une cause d'événements indésirables médicamenteux évitables et sont associées à des allongements de durées d'hospitalisation, une diminution de la qualité de vie, une augmentation de la morbidité, ou encore à des surcoûts pour les systèmes de santé. Les patients gériatriques, souvent polypathologiques et polymédiqués, sont à haut risque de prescriptions médicamenteuses inappropriées. Depuis une vingtaine d'années, des outils de détection de ces prescriptions ont été développés, afin de diminuer ces erreurs. Cette revue a pour objectifs d'apporter un aperçu comparatif et une analyse critique de ces outils explicites. Une recherche systématique de la littérature menée dans les bases de données PubMed, Embase, Cochrane Library et Google Scholar, sur la période janvier 1991–novembre 2015, a permis d'inclure les articles rédigés en anglais ou en français, décrivant le développement d'une nouvelle liste de critères explicites destinée à la gériatrie. Les caractéristiques, l'organisation et le contenu de ces dernières sont détaillés, ainsi que l'évaluation de leur validité et de leur caractère optimal pour une utilisation en gériatrie. Quatorze outils ont été identifiés. Une organisation par spécialités médicales et pathologies, comme dans les grilles ACOVE, Beers version 5 et STOPP/START permet une utilisation rapide des outils. La faible redondance des critères entre les outils suggère un manque d'exhaustivité pour certains d'entre eux. Les grilles Mimica, ACOVE, PIEA, et STOPP/START sont les plus exhaustives, seules les trois dernières abordent les problèmes de sous-prescriptions. Enfin, la capacité à détecter et diminuer les prescriptions inappropriées n'a été évaluée que pour quelques grilles, seule STOPP/START a montré, dans le cadre d'une étude prospective, sa capacité à les diminuer.

► **Innovative Pharmaceutical Pricing Agreements in Five European Markets: A Survey of Stakeholder Attitudes and Experience**

DUNLOP W. C. N., STAUFER A., LEVY P., *et al.*
2018

Health Policy 122(5): 528-532.

Innovative pricing agreements for medicines have been used in European markets for more than 20 years, and offer an opportunity for payers and pharmaceutical companies to align on value, optimise speed to patients, and share risk. Developing successful agreements requires alignment between key stakeholders, yet there is a lack of summative data on how current innovative agreements are used in the real-world (e.g. the level of realised access to medicines, and rebates and discounts, which are often non-transparent). This research used a web-based survey of payer stakeholders to determine what kinds of innovative agreements are currently used, anticipated future usage, attitudes, and drivers of adoption. Participants included national and regional payers (or former payers) and hospital-level decision makers. Sixty-six payers completed the survey. Respondents expected that the use of innovative pricing agreements will remain the same or increase in the future. Overall, they felt there is a positive attitude towards new schemes, and that innovative agreements are likely to be used when they reduce total costs or reduce uncertainty. Given payer expectations, pharmaceutical companies should continue to take a role in ensuring that they have sufficient capacity to support payers in the design and implementation of innovative pricing agreements.

► **Médicaments potentiellement inappropriés (MPI) chez la personne âgée : état des lieux dans un service de cardiologie**

GAILLARD M., MOSNIER-THOUMAS S., BERRONEAU A., *et al.*
2017

Le Pharmacien Hospitalier et Clinicien 52(1): 3-9.

<http://www.sciencedirect.com/science/article/pii/S2211104216001107>

L'utilisation de médicaments potentiellement inappropriés (MPI) chez la personne âgée est associée à une augmentation de la mortalité et du nombre d'effets indésirables. L'objectif de cet article est d'analyser les

prescriptions des personnes âgées hospitalisées dans un service de cardiologie afin de détecter et d'analyser d'éventuelles prescriptions inappropriées, au moyen d'outils existants. Une analyse prospective a été réalisée de juin à septembre 2015, chez les patients âgés hospitalisés dans le service. La recherche de MPI à l'entrée et à la sortie a été réalisée à partir de la liste de Laroche, des critères STOPP-START et des indicateurs d'alerte de la Haute Autorité de santé. Cent dix-huit patients ont été inclus. Parmi les prescriptions à l'entrée, 58 possédaient au moins un MPI, majoritairement des médicaments de la liste de Laroche. Chez 35 patients, il s'agissait d'une instauration à l'hôpital. L'analyse de l'ordonnance de sortie a montré que 55 d'entre elles possédaient au moins un MPI, majoritairement des médicaments de la liste de Laroche également. L'hospitalisation est souvent l'objet d'une prise en charge spécifique, rendant difficile une optimisation de la prescription chez la personne âgée. Néanmoins, l'intervention du pharmacien hospitalier peut être une aide à une réévaluation du traitement.

► **Inappropriate Prescribing in Older Persons: A Systematic Review of Medications Available in Different Criteria**

LUCCHETTI G. ET LUCCHETTI A. L. G.
2017

Archives of Gerontology and Geriatrics 68: 55-61.

<http://www.sciencedirect.com/science/article/pii/S0167494316301674>

The present study aims to systematically review all potentially inappropriate medications for older persons included in prescribing criteria published in the last decade. A systematic review of published studies was performed. Articles describing the development of criteria for PIM Use in Older Adults published in the last decade and which provided a list of medications that should be considered inappropriate were included. The searches were conducted on Pubmed/Medline for articles published from 1st of January 2006 to 31st of December 2015. We analyzed the medications/classes reported in all criteria, most common classes and how many indications each medication made. From 778 articles, 14 articles were included in our analysis (containing 14 different criteria). Europe was responsible for 8 criteria (57.2% of total) followed by Asia (3 criteria) and USA (2 criteria). More than 85% used a Delphi method. There were 729 different med-

ications/classes reported in all criteria. Diazepam was included in all 14 criteria followed by amitriptyline (13 criteria) and doxepin (12 criteria). We found benzodiazepines, NSAIDs, antihistamines and antipsychotics were the most common drugs reported as potentially inappropriate for older persons. Conclusion The present study systematically compiled all medications included in 14 different criteria published last decade. Benzodiazepines, NSAIDs, antihistamines and antipsychotics were the most common drugs reported as potentially inappropriate for older persons. These results could help health professionals and panel experts to plan future criteria.

► **Expériences médicamenteuses et expériences du cancer. L'appropriation des anticancéreux oraux par les patients**

MARMORAT T., RIOUFOL C., RANCHON F., *et al.*
2018

Sciences Sociales et Santé 36(2): 73-96.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2018-2-page-73.htm>

La part grandissante des thérapies orales fait apparaître une mutation dans l'organisation du projet thérapeutique en cancérologie. Tandis que l'administration d'une chimiothérapie injectable est assurée par une infirmière, et le plus souvent à l'hôpital, il appartient au patient sous anticancéreux oral de prendre son traitement au domicile, en suivant les recommandations médicales qui lui sont associées. Fondée sur une approche psychosociale, cette recherche a pour objectif de saisir la manière dont les savoirs profanes, les normes et les valeurs sociales participent à l'appropriation des anticancéreux oraux par les patients, et le rôle que le médicament joue dans la symbolisation du cancer. L'étude montre le caractère indissociable de la perception des anticancéreux oraux et des représentations que les patients ont de leur maladie. Le sens conféré au suivi de ce traitement renvoie à la valorisation de l'autonomie médicamenteuse, reflétant plusieurs formes de participation au soin et plusieurs types d'attentes concernant l'implication familiale et thérapeutique de l'entourage.

► **Variations in Non-Prescription Drug Consumption and Expenditure: Determinants and Policy Implications**

OTTO M., ARMENI P. ET JOMMI C.

2018

Health Policy 122(6): 614-620.

This paper analyses the determinants of cross-regional variations in expenditure and consumption for non-prescription drugs using the Italian Health Care Service as a case study. This research question has never been posed in other literature contributions. Per capita income, the incidence of elderly people, the presence of distribution points alternative to community pharmacies (para-pharmacies and drug corners in supermarkets), and the disease prevalence were included as possible explanatory variables. A trade-off between consumption of non-prescription and prescription-only drugs was also investigated. Correlation was tested through linear regression models with regional fixed-effects. Demand-driven variables, including the prevalence of the target diseases and income, were found to be more influential than supply-side variables, such as the presence of alternative distribution points. Hence, the consumption of non-prescription drugs appears to respond to needs and is not induced by the supply. The expected trade-off between consumption for prescription-only and non-prescription drugs was not empirically found: increasing the use of non-prescription drugs did not automatically imply savings on prescription-only drugs covered by third payers. Despite some caveats (the short period of time covered by the longitudinal data and some missing monthly data), the regression model revealed a high explanatory power of the variability and a strong predictive ability of future values.

► **The Effects of State-Level Pharmacist Regulations on Generic Substitution of Prescription Drugs**

SONG Y. ET BARTHOLD D.

2018

Health Econ. : [Ahead of print].

Substituting generic for brand name drugs whenever possible has been proposed to control prescription drug expenditure growth in the United States. This work investigates two types of state laws that regulate the procedures under which pharmacists substitute bioequivalent generic versions of brand name drugs.

Mandatory substitution laws require pharmacists to use the generic as a default, and presumed consent laws allow them to assume that the patient agrees to the substitution. Both situations can be overruled by the patient. Using plausibly exogenous changes in states' laws, we use difference-in-differences and a discrete choice model to show that although the mandatory switching laws have little effect, the presumed consent laws reduce consumers' probability of purchasing brand name drugs by 3.2% points. The differential effectiveness of the laws is likely caused by pharmacists' profit motives. These results offer important implications for policies that seek to reduce drug expenditures by incentivizing the use of generic drugs.

► **Antimicrobial Consumption and Resistance in Adult Hospital Inpatients in 53 Countries: Results of an Internet-Based Global Point Prevalence Survey**

VERSPORTEN A., ZARB P., CANIAUX I., *et al.*

2018

The Lancet Global Health 6(6): e619-e629.

[http://dx.doi.org/10.1016/S2214-109X\(18\)30186-4](http://dx.doi.org/10.1016/S2214-109X(18)30186-4)

The Global Point Prevalence Survey (Global-PPS) established an international network of hospitals to measure antimicrobial prescribing and resistance worldwide. We aimed to assess antimicrobial prescribing and resistance in hospital inpatients.

► **Do Health Professionals Tell Patients What They Want to Know About Their Medicines?**

YOUNG A., TORDOFF J., LEITCH S., *et al.*

2018

Health Education Journal

<https://doi.org/10.1177/0017896918763679>

Discussing medicines with patients is the responsibility of prescribers and pharmacists. However, it is not well known whether patients are given the information they want or whether information provision continues when medicines are taken long-term. The aims of this study are to determine how often general practitioners (GPs) and pharmacists provide verbal information to patients about their medicines, and compare the information given with what patients want to know. This study is

based on a cross-sectional surveys related to New Zealand primary healthcare. Two questionnaires were developed and sent to a sample of pharmacists and GPs, and chi-squared analysis was carried out. Open responses were analysed qualitatively to detect further ideas. The paper concludes that patients may not be receiving the information they want to know about their medicines, and there may be an overall lack of

verbal communication about medicines with patients. Some information will only be discussed if the patient actively requests it; the likelihood of this increases with repeat medicines. The use of counselling aids and tools, such as a medicine information leaflet, could help healthcare providers provide patients with the information they need.

Methodology -Statistics

► **Bias in Patient Satisfaction Surveys: A Threat to Measuring Healthcare Quality**

DUNSCH F., EVANS D. K., MACIS M., *et al.*

2018

BMJ Global Health 3(2).

<http://gh.bmj.com/content/bmjgh/3/2/e000694.full.pdf>

Patient satisfaction surveys are an increasingly common element of efforts to evaluate the quality of healthcare. Many patient satisfaction surveys in low/middle-income countries frame statements positively and invite patients to agree or disagree, so that positive responses may reflect either true satisfaction or bias induced by the positive framing. In an experiment with more than 2200 patients in Nigeria, we distinguish between actual satisfaction and survey biases. Patients randomly assigned to receive negatively framed statements expressed significantly lower levels of satisfaction (87%) than patients receiving the standard positively framed statements (95%- $p<0.001$). Depending on the question, the effect is as high as a 19 percentage point drop ($p<0.001$). Thus, high reported patient satisfaction likely overstates the quality of health services. Providers and policymakers wishing to gauge the quality of care will need to avoid framing that induces bias and to complement patient satisfaction measures with more objective measures of quality.

► **How to Make More Published Research True**

IOANNIDIS J. P.

2014

PLoS Med 11(10): e1001747.

In a 2005 paper that has been accessed more than a million times, John Ioannidis explained why most published research findings were false. Here he revisits the topic, this time to address how to improve matters.

► **La malédiction des données**

LEMOINE P.

2018

Esprit Juin(6): 131-138.

<https://www.cairn.info/revue-esprit-2018-6-page-131.htm>

On dit parfois que les données sont le pétrole du XXI^e siècle. La comparaison est hasardeuse mais elle a au moins ceci de juste que le pétrole est à l'origine de ce que les économistes ont appelé la malédiction de la rente et que nos économies pourraient bien connaître demain la malédiction des données. Parler de malédiction des données, c'est donc rappeler que la donnée n'est créatrice de valeur que si elle est combinée à d'autres facteurs et qu'il serait dangereusement illusoire de vouloir s'en remettre isolément à elle. Pour mesurer ce danger, il n'est pas inutile de prendre un peu de recul et de suivre l'irrésistible ascension de la donnée qui nous a conduit à un certain vertige face au big data.

► **L'enquête TeO de l'Ined : Commentaires et problèmes d'interprétation**

MIZRAHI A.

2018

Argses

http://argses.free.fr/textes/commentaires_TeO.pdf

Ces commentaires suivent d'assez près le plan de l'ouvrage « Trajectoires et Origines Enquête sur la diversité des populations » se limitant aux parties traitant des victimisations. La première partie porte sur le paradoxe dans les enquêtes de victimisations : du fait de la différence d'effectifs, une petite proportion de racistes discriminateurs peut entraîner une grande proportion de personnes discriminées. Les auteurs ne semblent pas avoir vu ce problème et la tonalité générale de leur ouvrage s'en ressent. Dans la deuxième partie sont discutés différents problèmes de vocabulaire (population majoritaire, ethno-racial, minorités visibles, ségrégation). Un vocabulaire pertinent aide en effet à la compréhension des phénomènes; en revanche, des termes, ou des nomenclatures, inadaptés peuvent conduire à masquer certains phénomènes, voire à des biais de raisonnement. Dans la troisième partie, sont analysées les variations de discriminations selon le sexe, si l'un des membres du couple ou des parents est Français, puis en distinguant les immigrés des enfants d'immigrés. La quatrième partie porte sur les lieux de la discrimination.

► **Paradoxe dans l'enquête de victimisation : racisme perçu et racisme actif**

MIZRAHI A.

2018

Argses

http://argses.free.fr/textes/paradoxe_TeO.pdf

Les immigrés et les enfants d'immigrés se déclarent plus souvent discriminés que les Français, peut-on en déduire que les Français manifestent plus fréquemment du racisme que les immigrés? Différents paramètres interfèrent dans ces relations : importance relative de chacun des groupes, (environ 20 % d'immigrés ou d'enfants d'immigrés), discriminations d'un groupe à l'autre ou aussi à l'intérieur des deux groupes qui sont hétérogènes, nombre de discriminations subies par personne ou exercées par raciste. Le problème est abordé à partir des données fournies par l'enquête TeO, « Trajectoires et Origines, Enquête sur la diversité des populations », dans laquelle 35,8 % des immigrés

ou enfants d'immigrés déclarent avoir été discriminés et 18,6 % des Français partir d'un modèle très simple, où chaque personne discriminée l'a été une fois et une seule, et chaque personne discriminant l'a fait une fois et une seule, les taux de racistes seraient respectivement de 77,3 parmi les immigrés et de 8,7 % parmi les Français. On approche la stabilité de ces résultats, en faisant varier la proportion de personnes d'un groupe n'ayant jamais rencontré de personnes de l'autre groupe. Un modèle dual à partir des personnes déclarant ne pas avoir été discriminées, conforte ces premiers résultats. On introduit ensuite différents paramètres de manière à se rapprocher de la réalité et on montre que dans chacun des cas de figure, le taux de racistes (discriminateurs) est plus important parmi les immigrés que parmi les Français.

► **Les données de santé**

POLTON D.

2018

Med Sci (Paris) 34(5): 449-455.

<https://doi.org/10.1051/medsci/20183405018>

En matière de santé comme dans d'autres secteurs, une masse croissante de données numérisées provenant de diverses sources est disponible et exploitable. C'est l'un des domaines où le potentiel du Big data apparaît très prometteur, avec de multiples innovations au bénéfice des patients et du système (accélération de la recherche et développement, connaissance des maladies, des facteurs de risque, médecine personnalisée, aide au diagnostic et au traitement, rôle accru des patients, pharmacovigilance, etc.), même si des inquiétudes s'expriment aussi vis-à-vis des impacts sociétaux, économiques et éthiques que le recours croissant aux algorithmes et à l'intelligence artificielle pourrait induire. Développer l'usage de ces données constitue un objectif stratégique de tous les systèmes de santé, et de ce point de vue le Système national de données de santé (SNDS) constitue pour la France un patrimoine intéressant, mais qui demande à être complété et enrichi.

Health Policy

► **Tensions and Uncertainties in Person-Centred Support for People with Long-Term Conditions**

CRIBB A., WATT I. S., SKEA Z. C., *et al.*
2018

The more you know, the more you realise it is really challenging to do»» Patient Educ Couns 101(8): 1460-1467

<https://www.ncbi.nlm.nih.gov/pubmed/29622282>

The aims of this study are to identify and examine tensions and uncertainties in person-centred approaches to self-management support - approaches that take patients seriously as moral agents and orient support to enable them to live (and die) well on their own terms. Interviews with 26 UK clinicians about working with people with diabetes or Parkinson's disease, conducted within a broader interdisciplinary project on self-management support. The analysis reported here was informed by philosophical reasoning and discussions with stakeholders. Person-centred approaches require clinicians to balance tensions between the many things that can matter in life, and their own and each patient's perspectives on these. Clinicians must ensure that their supportive efforts do not inadvertently disempower people. When attending to someone's particular circumstances and perspectives, they sometimes face intractable uncertainties, including about what is most important to the person and what, realistically, the person can or could do and achieve. The kinds of professional judgement that person-centred working necessitates are not always acknowledged and supported. Practical and ethical tensions are inherent in person-centred support and need to be better understood and addressed. Professional development and service improvement initiatives should recognise these tensions and uncertainties and support clinicians to navigate them well.

► **Éduquer le patient ou transformer l'action publique : un espace d'expression pour les patients. Commentaire**

FOURNIER C. ET TROISOEUFS A.
2018

Sciences Sociales et Santé 36(2): 33-41.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2018-2-p-33.htm>

L'article relate l'étude socio-historique d'une association porteuse d'une philosophie et de pratiques appelées aujourd'hui en France Éducation thérapeutique du patient (ETP). L'analyse du fonctionnement interne de l'association à différentes époques permet aux auteurs d'illustrer les transformations de ce concept et de ces pratiques au fil du temps.

► **Decoding Disclosure: Comparing Conflict of Interest Policy Among the United States, France, and Australia**

GRUNDY Q., HABIBI R., SHNIER A., *et al.*
2018

Health Policy 122(5): 509-518.

Sunshine" policy, aimed at making financial ties between health professionals and industry publicly transparent, has recently gone global. Given that transparency is not the sole means of managing conflict of interest, and is unlikely to be effective on its own, it is important to understand why disclosure has emerged as a predominant public policy solution, and what the effects of this focus on transparency might be. We used Carol Bacchi's problem-questioning approach to policy analysis to compare the Sunshine policies in three different jurisdictions, the United States, France and Australia. We found that transparency had emerged as a solution to several different problems including misuse of tax dollars, patient safety and public trust. Despite these differences in the origins of disclosure policies, all were underpinned by the questionable assumption that informed consumers could address conflicts of interest. We conclude that, while transparency reports have provided an unprecedented opportunity to understand the reach of industry within healthcare, policymakers should build upon these insights and begin to develop policy solutions that address systemic commercial influence.

► **Should Interventions to Reduce Variation in Care Quality Target Doctors or Hospitals?**

GUTACKER N., BLOOR K., BOJKE C., *et al.*

2018

Health Policy 122(6): 660-666.

Interventions to reduce variation in care quality are increasingly targeted at both individual doctors and the organisations in which they work. Concerns remain about the scope and consequences for such performance management, the relative contribution of individuals and organisations to observed variation, and whether performance can be measured reliably. This study explores these issues in the context of the English National Health Service by analysing comprehensive administrative data for all patients treated for four clinical conditions (acute myocardial infarction, hip fracture, pneumonia, ischemic stroke) and two surgical procedures (coronary artery bypass, hip replacement) during April 2010-February 2013. Performance indicators are defined as 30-day mortality, 28-day emergency readmission and inpatient length of stay. Three-level hierarchical generalised linear mixed models are estimated to attribute variation in case-mix adjusted indicators to individual doctors and hospital organisations. Except for length of stay after hip replacement, no more than 11% of variation in case-mix adjusted performance indicators can be attributed to doctors and organisations with the rest reflecting random chance and unobserved patient factors. Doctor variation exceeds hospital variation by a factor of 1.2 or more. However, identifying poor performance amongst doctors is hampered by insufficient numbers of cases per doctor to reliably estimate their individual performances. Policy makers and regulators should therefore be cautious when targeting individual doctors in performance improvement initiatives.

► **The Diabetes Self-Management Educational Programs and Their Integration in the Usual Care: A Systematic Literature Review**

KUMAH E., SCIOLLI G., TORALDO M. L., *et al.*

2018

Health Policy 122(8): 866-877.

<http://dx.doi.org/10.1016/j.healthpol.2018.06.003>

Heterogeneous integration levels between usual care and self-management programs exist in literature. Usual care providers define the patients' targets, follow their upgrades, or refer patients to the education centers. Behaviors and health status improve after attending an educational program and independently from the integration levels. Programs appear to produce more positive results when patients perceived that providers are involved.

► **Understanding Delays in Acute Stroke Care: A Systematic Review of Reviews**

LACKHEM Y., RICAN S. ET MINVIELLE E.

2018

Eur J Public Health 28(3): 426-433.

Stroke is the leading cause of adult long-term disability in Western countries. Intravenous thrombolytic therapy with recombinant tissue plasminogen activator is safe and effective within the first 4.5 h after the onset of stroke. Various factors delaying acute stroke care have been identified in the literature. This review aimed to provide an overview of factors delaying acute stroke care and attempted to show how they interact in a synthetic framework. We conducted a systematic review of literature reviews published in Medline and DORIS until 2016 on factors influencing acute stroke pathway timeframe. This review provides a wide overview of factors influencing acute stroke pathway. Since it was observed that the identified factors were inter-related, they needed to be analyzed in a systematic way. We hence created a synthetic framework that combines several categories of factors while assuming that factor weight varies from a study context to another. Better knowledge on underlying mechanisms between factors would provide crucial improvement of the interventions aiming at reducing delays in both pre-hospital and in-hospital stages. For future research, we recommend adopting a systemic perspective on factors influencing acute stroke pathway.

► **Mapping Existing Hip and Knee Replacement Registries in Europe**

LUBBEKE A., SILMAN A. J., BAREA C., *et al.*
2018

Health Policy 122(5): 548-557.

The general shortage of evidence regarding benefits and harms of medical devices has been highlighted following the serious safety concerns with metal-on-metal hip replacements and silicone breast implants and was again pointed out in a recent survey of European Health Technology Assessment institutions. In this context the new European medical device regulation will enforce post-marketing surveillance of existing and new implants. The usefulness of registry data as a source of information for medical device real-world clinical performance and safety has been demonstrated. However, these data might be underused by researchers and policy makers. One reason for this is the insufficient awareness of their existence. The aim of this review is to provide information to relevant stakeholders on the extent and breadth of the data currently collected in European joint replacement registries. We identified 24 registries, most of them of national coverage. Total numbers of primary total hip and knee replacements included were over 3.1 and 2.5 million records, respectively. The current focus of these registries is on whole-lifespan implant surveillance via revision rate monitoring, quality assessment of surgical and perioperative care, and hospital performance assessment. More recently, national and international comparison and benchmarking have increasingly become part of their endeavors.

► **Éducation thérapeutique en odontologie pédiatrique : analyse des obstacles et leviers au développement de programmes en France en 2016**

MARQUILLIER T., TRENTESAUX T. ET GAGNAYRE R.
2017

Santé Publique 29(6): 781-792.

<https://www.cairn.info/revue-sante-publique-2017-6-page-781.htm>

L'éducation thérapeutique du patient (ETP) a investi ces dernières années le champ de la médecine bucco-dentaire. La prise en charge de la carie précoce de l'enfant, reconnue comme une maladie chronique des plus fréquentes, a évolué pour y intégrer une dimension éducative. L'objectif de cette étude était de faire

émerger les leviers et les freins au développement de programmes autorisés d'ETP ainsi que les alternatives. Une étude qualitative exploratoire comprehensive a été menée entre novembre 2015 et juin 2016 sur un échantillon ciblé de 15 personnes sensibilisées à la problématique de l'ETP en médecine bucco-dentaire. L'étude rapporte que la formation d'ETP en odontologie est trop peu développée alors que les bénéfices attendus sont multiples : évolution de la posture du soignant, mise en place de programmes éducatifs structurés, développement de la recherche... Les freins au développement de programmes apparaissent nombreux : manque de moyens, rigidité législative ou encore manque de connaissance de cette pratique. La profession odontologique représente en elle-même un obstacle de par son manque de compréhension et son intégration inhomogène au monde médical. Des leviers émergent de notre étude dont les principaux sont l'évolution de la profession et la mise à disposition de ressources pour développer l'ETP. Si des alternatives aux programmes d'ETP sont présentes (actions éducatives, santé connectée), elles ne peuvent s'y substituer pour autant. Développer davantage les stratégies éducatives en odontologie est possible et nécessaire. Néanmoins il convient d'adapter le cadre à la profession afin qu'elle puisse l'investir pleinement.

► **We Need to Talk About Purpose: A Critical Interpretive Synthesis of Health and Social Care Professionals' Approaches to Self-Management Support for People with Long-Term Conditions**

MORGAN H. M., ENTWISTLE V. A., CRIBB A., *et al.*
2017

Health Expect 20(2): 243-259.

<https://www.ncbi.nlm.nih.gov/pubmed/27075246>

Health policies internationally advocate 'support for self-management', but it is not clear how the promise of the concept can be fulfilled. The aim of this study is to synthesize research into professional practitioners' perspectives, practices and experiences to help inform a reconceptualization of support for self-management. Critical interpretive synthesis is conducted using systematic searches of literature published 2000-2014. The literature illustrates striking variations in approaches to support for self-management and interpretations of associated concepts. We focused particularly on the somewhat neglected question of the purpose of support. We suggest that this can illuminate and explain

important differences between narrower and broader approaches. Narrower approaches support people to manage their condition(s) well in terms of disease control. This purpose can underpin more hierarchical practitioner-patient communication and more limited views of patient empowerment. It is often associated with experiences of failure and frustration. Broader approaches support people to manage well with their condition(s). They can keep work on disease control in perspective as attention focuses on what matters to people and how they can be supported to shape their own lives. Broader approaches are currently less evident in practice. Broader approaches seem necessary to fulfil the promise of support for self-management, especially for patient empowerment. A commitment to enable people to live well with long-term conditions could provide a coherent basis for the forms and outcomes of support that policies aspire to. The implications of such a commitment need further attention.

► **L'émergence de la question de la sécurité des patients en France**

MOUGEOT F., OCCELLI P., BUCHET-POYAU K., *et al.*
2017

Santé Publique 29(6): 869-877.

<https://www.cairn.info/revue-sante-publique-2017-6-page-869.htm>

L'objectif de cet article est de comprendre les conditions d'émergence de la thématique de la sécurité des soins dans le débat public et les limites de sa mise en œuvre dans le système de santé actuel. Une revue narrative de la littérature a été réalisée à partir des bases de données PubMed, Cairn et Persée. L'interrogation des bases de données a référencé 2 206 documents dont 48 ont été retenus. La thématique de la sécurité des patients s'est diffusée à l'échelle mondiale et a émergé tardivement en France. La difficile émergence de la sécurité des soins en France est notamment liée à l'euphémisation du problème de la sécurité des patients, à la difficulté du passage au raisonnement systémique, à la carence en leviers de gestion des ressources humaines et à la place ambiguë des patients dans la sécurité des soins.

► **“Was that a Success or Not a Success?” A Qualitative Study of Health Professionals' Perspectives on Support for People with Long-Term Conditions**

OWENS J., ENTWISTLE V. A., CRIBB A., *et al.*

2017

BMC Fam Pract 18(1): 39.

<https://www.ncbi.nlm.nih.gov/pubmed/28320325>

Support for self-management (SSM) is a prominent strand of health policy internationally, particularly for primary care. It is often discussed and evaluated in terms of patients' knowledge, skills and confidence, health-related behaviours, disease control or risk reduction, and service use and costs. However, these goals are limited, both as guides to professional practice and as indicators of its quality. In order to better understand what it means to support self-management well, we examined health professionals' views of success in their work with people with long-term conditions. This study formed part of a broader project to develop a conceptual account of SSM that can reflect and promote good practice. Participants identified a wide range of interlinked aspects or elements of success relating to: health, wellbeing and quality of life; how well people (can) manage; and professional-patient relationships. They also mentioned a number of considerations that have important implications for assessing the quality of their own performance. These considerations in part reflect variations in what matters and what is realistically achievable for particular people, in particular situations and at particular times, as well as the complexity of questions of attribution. A nuanced assessment of the quality of support for self-management requires attention to the responsiveness of professional practice to a wide, complex range of personal and situational states, as well as actions and interactions over time. A narrow focus on particular indicators can lead to insensitive or even perverse judgements and perhaps counterproductive effects. More open, critical discussions about both success and the assessment of quality are needed to facilitate good professional practice and service improvement initiatives.

► **Éduquer le patient ou transformer l'action publique ? Analyse socio-historique d'une association pour le développement de l'éducation thérapeutique du patient**

PERRIER C. ET PERRIN C.

2018

Sciences sociales et santé 36(2): 5-31.

<https://www.cairn.info/revue-sciences-sociales-et-sante-2018-2-page-5.htm>

En France, l'Éducation Thérapeutique du Patient s'est développée au travers de la formation des professionnels et d'activités de recherche portées par les mondes associatifs et académiques. L'étude socio-historique d'une des associations françaises les plus anciennes (l'Afdet) mobilise conjointement des cadres théoriques de sociologie de la santé et de science politique. Elle analyse le corpus des revues publiées depuis 1990 par l'association et un recueil de vingt-deux entretiens avec des acteurs-clés. Si la posture réformatrice apparaît comme une continuité de l'histoire de l'association, elle fait l'objet de tensions entre les acteurs à l'origine de deux reconfigurations importantes. C'est une conception nouvelle du processus de soin et de santé qu'entend diffuser ce collectif analysé comme un « laboratoire d'ingénierie des idées », révélateur d'une contribution à l'action publique en marge des institutions.

► **Health Policy and Systems Research: The Future of the Field**

PETERS D. H.

2018

Health Research Policy and Systems 16(1): 84.

<https://doi.org/10.1186/s12961-018-0359-0>

Health policy and systems research (HPSR) has changed considerably over the last 20 years, but its main purpose remains to inform and influence health policies and systems. Whereas goals that underpin health systems have endured – such as a focus on health equity – contexts and priorities change, research methods progress, and health organisations continue to learn and adapt, in part by using HPSR. For HPSR to remain relevant, its practitioners need to re-think how health systems are conceptualised, to keep up with rapid changes in how we diagnose and manage disease and use information, and consider factors affecting people's health that go well beyond healthcare systems. The Sustainable Development Goals (SDGs)

represent a shifting paradigm in human development by seeking convergence across sectors. They also offer an opportunity for HPSR to play a larger role, given its pioneering work on applying systems thinking to health, its focus on health equity, and the strength of its multi-disciplinary approaches that make it a good fit for the SDG era.

► **Space, Place and (Waiting) Time: Reflections on Health Policy and Politics**

SHEARD S.

2018

Health Economics, Policy and Law 13(3-4): 226-250.

<https://www.cambridge.org/core/article/space-place-and-waiting-time-reflections-on-health-policy-and-politics/82C2B2CA7E9860D2651920FD3CE95194>

Health systems have repeatedly addressed concerns about efficiency and equity by employing trans-national comparisons to draw out the strengths and weaknesses of specific policy initiatives. This paper demonstrates the potential for explicit historical analysis of waiting times for hospital treatment to add value to spatial comparative methodologies. Waiting times and the size of the lists of waiting patients have become key operational indicators. In the United Kingdom, as National Health Service (NHS) financial pressures intensified from the 1970s, waiting times have become a topic for regular public and political debate. Various explanations for waiting times include the following: hospital consultants manipulate NHS waiting lists to maintain their private practice; there is under-investment in the NHS; and available (and adequate) resources are being used inefficiently. Other countries have also experienced ongoing tensions between the public and private delivery of universal health care in which national and trans-national comparisons of waiting times have been regularly used. The paper discusses the development of key UK policies, and provides a limited Canadian comparative perspective, to explore wider issues, including whether 'waiting crises' were consciously used by policymakers, especially those brought into government to implement new economic and managerial strategies, to diminish the autonomy and authority of the medical professional in the hospital environment.

► **Two-Year Management After Renal Transplantation in 2013 in France: Input from the French National Health System Database**

TUPPIN P., BESSOU A., LEGEAI C., *et al.*

2018

Nephrol Ther. 14(4): 207-216

The objective of this study was to describe the management of patients undergoing renal transplantation in 2013 and over the following two years on the basis of healthcare consumption data. The National Health Insurance Information System was used to identify 1876 general scheme beneficiaries undergoing a first isolated renal transplantation (median age: 53 years; men 63%). Overall, 1.2% of patients died during the transplantation hospital stay (>65 years 3.3%) and 87% of patients had a functional graft at 2 years. Thirty-three percent of patients were readmitted to hospital for 1 day or longer during the first month, 73% the

first year and 55% the second year. At least 10% of patients were hospitalised for antirejection treatment during the first quarter after renal transplantation, 16% the first year and 9% the second year. The first year, 32% of patients were hospitalised for renal disease (12% the second year), 14% were hospitalised for cardiovascular disease (9% the second year), 13% for infectious disease (5% the second year) and 2% for a malignant tumour (2% the second year). Almost 80% of patients consulted their general practitioner each year (almost 50% consulted every quarter). During the second year, 83% of patients were taking antihypertensives, 45% lipid-lowering drugs, 26% antidiabetic drugs, 77% tacrolimus, 18% ciclosporin, 88% mycophenolic acid and 69% corticosteroids. This study highlights the important contribution of healthcare consumption data to a better understanding of the modalities of management of renal transplant recipients in France, allowing improvement of this management in line with guidelines.

Public Policy

► **Développement d'un cours francophone en ligne sur les politiques publiques en santé : une collaboration internationale**

HÉBERT R., COPPIETERS Y., PRADIER C., *et al.*

2017

Santé Publique 29(6): 821-827.

<https://www.cairn.info/revue-sante-publique-2017-6-page-821.htm>

L'objectif de cette étude est de présenter le processus et les défis du développement d'un cours en ligne sur les politiques publiques en santé, conçu en collaboration internationale selon une approche par compétences. Cinq experts de santé publique épaulés d'un

expert en technologie éducative ont travaillé à l'élaboration du cours en adoptant une démarche rigoureuse : analyse des besoins, élaboration des cibles et des compétences visées, développement d'un scénario pédagogique comportant pour chaque module la cible visée, les éléments de contenu, la méthode d'enseignement, les activités d'apprentissage, le matériel à identifier ou à développer et les responsabilités et tâches impliquées. Le cours d'études supérieures de deux crédits (90 heures de travail) comprend six modules dont un module d'intégration. Il est intégré aux programmes d'études supérieures des universités participantes et permet à des étudiants de suivre à distance une formation innovante.

Social Policy

► La sécurité sociale entre solidarité et marché

BEC C.
2018

Revue Française de Socio-Économie 20(1): 167-185.
<https://www.cairn.info/revue-francaise-de-socio-economie-2018-1-page-167.htm>

Cet article analyse dans une perspective socio-historique un processus de délégitimation politique de la Sécurité sociale. En 1945, dans la continuité du solidarisme, cette institution porte, avec le droit du travail, le projet d'un ordre social nouveau reposant sur une égale protection de tous, indispensable à la liberté et à la citoyenneté de chacun. Elle subit depuis les années 1970 une réorientation philosophique et politique profonde et évolue vers un statut d'organisme payeur invité à se soumettre aux lois du marché. Cette réorientation trouve son origine dans le dilemme, à la Libération, entre une protection conçue comme droit du travailleur ou comme droit de l'homme et donc entre une solidarité catégorielle ou nationale. La généralisation du système se fait de façon différenciée, inégalitaire et porteuse de dualisation. Face aux transformations profondes de la société et au déséquilibre financier, une série de mesures réactives et d'ajustements ont tenu place de débat sur les réformes de fond nécessaires. Elles ont accentué les ambivalences originelles et limité sa portée transformative et démocratique. Le principe de solidarité tend à s'effacer au profit d'une logique prioritairement budgétaire et gestionnaire ouvrant la porte à une marchandisation de la protection.

► Troubles dans la protection sociale

DELOUETTE I. ET LE LANN Y.
2018

Revue Française de Socio-Économie 20(1): 27-38.
<https://www.cairn.info/revue-francaise-de-socio-economie-2018-1-page-27.htm>

Où va la protection sociale? Quelles sont les nouvelles pratiques de financement, de gestion ou de comptabilisation qui s'établissent depuis une trentaine d'années dans ce champ? Comment reconfigurent-elles le sens des institutions de la protection sociale? La protection sociale a émergé en réaction aux crises du capitalisme libéral, comme une instance de dé-marchandisation du travail. Elle s'est construite dans une tension entre autonomie et dépendance avec d'autres secteurs de l'action publique: éducation, emploi, insertion. L'imposition progressive du mode de régulation concurrentiel capitaliste a suscité de profondes interrogations sur la nature des fonctions que doit remplir cette institution. Le paradigme d'activation des politiques sociales comme les mutations de leurs modes de financement interpellent sur son rôle et mènent à une complexification de ses rapports au marché. Ces évolutions entraînent un véritable défi pour l'analyse socio-économique: comment faire évoluer les catégories d'analyse pour mieux appréhender les mutations du système contemporain de protection sociale? Les articles du dossier explorent ainsi les évolutions statistiques, les transformations des cadres cognitifs de l'action publique, et les réformes juridiques et financières qui provoquent les troubles dans la protection sociale.

Health Prevention

► The Practices of French General Practitioners Regarding Screening and Counselling Pregnant Women for Tobacco Smoking and Alcohol Drinking

ANDLER R., COGORDAN C., PASQUEREAU A., *et al.*
2018

Int J Public Health 63(5): 631-640.

Our study aims to describe French general practitioners' (GPs') practices toward pregnant patients regarding alcohol consumption and smoking and to highlight factors associated with specific practices. In 2015, a representative sample of 1414 French GPs completed a telephone survey based on a stratified random sampling. 61% of GPs declared screening for alcohol use and 82% for smoking at least once with each pregnant patient; quitting was not systematically advised either

for alcohol or for smoking. GPs' practices were significantly better among those who had more recent ongoing training. GPs who drank regularly were less likely to screen for alcohol use and GPs' drinking frequency was inversely related to recommending quitting. Current and former smokers were less likely to recommend quitting to pregnant patients smoking over five cigarettes per day. Screening and counselling practices for substance use during pregnancy are heterogeneous among French GPs and are notably related to their personal consumption. GP's role in preventing substance use during pregnancy could be strengthened by actions regarding their own consumption and by modifications in their initial and ongoing training.

► **Promoting Health-Enhancing Physical Activity in Europe: Current State of Surveillance, Policy Development and Implementation**

BREDA J., JAKOVLJEVIC J., RATHMES G., *et al.*
2018

Health Policy 122(5): 519-527.

This study aims to present information on the surveillance, policy developments, and implementation of physical activity policies in the 28 European Union (EU) countries. Data was collected on the implementation of the EU Recommendation on health-enhancing physical activity (HEPA) across sectors. In line with the monitoring framework proposed in the Recommendation, a questionnaire was designed to capture information on 23 physical activity indicators. Of the 27 EU countries that responded to the survey, 22 have implemented actions on more than 10 indicators, four countries have implemented more than 20 indicators, and one country has fully addressed and implemented all of the 23 indicators of the monitoring framework. The data collected under this HEPA monitoring framework provided, for the first time, an overview of the implementation of HEPA-related policies and actions at the national level throughout the EU. Areas that need more investment are the "Senior Citizens" sector followed by the "Work Environment", and the "Environment, Urban Planning, and Public Safety" sectors. This information also enabled comparison of the state of play of HEPA policy implementation between EU Member States and facilitated the exchange of good practices.

► **Étude qualitative auprès des utilisateurs de cigarette électronique : pratiques, usages, représentations**

FONTAINE A. ET ARTIGAS F.
2017

Santé Publique 29(6): 793-801.

<https://www.cairn.info/revue-sante-publique-2017-6-page-793.htm>

Les cigarettes électroniques sont des dispositifs sans combustion qui permettent de simuler l'acte de fumer du tabac, en vaporisant un « e-liquide » et diffusant un aérosol que l'utilisateur inhale. Même si l'engouement remarqué en 2012-2013 s'est ralenti, la cigarette électronique fait aujourd'hui partie du paysage des fumeurs qui cherchent une alternative au tabac et à l'abstinence et les tabacologues ont à répondre à la demande grandissante des fumeurs et à adopter une position claire face à ce dispositif. Les résultats présentés sont issus d'une étude qualitative réalisée avec le soutien financier de la Direction Générale de la Santé, l'une des directions du ministère des Affaires sociales et de la Santé. Elle a été conduite en France, de septembre 2014 à janvier 2016. Elle se fonde sur un travail de terrain classique en ethnologie : observations lors d'événements regroupant des usagers de cigarettes électroniques et 25 entretiens semi-directifs réalisés avec des profils variés permettant d'explorer un champ encore méconnu. Cette étude contribue à l'observation et à la compréhension d'un phénomène naissant, susceptible de changer durablement notre rapport au tabac. Elle montre la grande variété des profils, parmi les fumeurs, intéressés par la cigarette électronique. Hommes, femmes, jeunes ou anciens fumeurs, adoptent des postures différentes au moment d'essayer ce dispositif et les usages évoluent dans les mois qui suivent cette expérimentation.

► **Smoking Cessation Delivery by General Practitioners in Crete, Greece**

GIRVALAKI C., PAPADAKIS S., VARDAVAS C., *et al.*
2018

Eur J Public Health 28(3): 542-547.

Tobacco dependence treatment in clinical settings is of prime public health importance, especially in Greece, a country experiencing one of the highest rates of tobacco use in Europe. : Our study aimed to examine the characteristics of tobacco users and document rates of tobacco treatment delivery in general practice settings in Crete, Greece. A cross-sectional sample of

patients (n = 2, 261) was screened for current tobacco use in 25 general practices in Crete, Greece in 2015/16. Current tobacco users completed a survey following their clinic appointment that collected information on patient characteristics and rates at which the primary care physician delivered tobacco treatment using the evidence-based 4 A's (Ask, Advise, Assist, Arrange) model during their medical appointment and over the previous 12-month period. Multi-level modeling was used to analyze data and examine predictors of 4 A's delivery. Results: Tobacco use prevalence was 38% among all patients screened. A total of 840 tobacco users completed the study survey [mean age 48.0 (SD 14.5) years, 57.6% male]. Approximately, half of the tobacco users reported their general practitioner 'asked' about their tobacco use and 'advised' them to quit smoking. Receiving 'assistance' with quitting (15.7%) and 'arranging' follow-up support (<3%) was infrequent. Patient education, presence of smoking-related illness, a positive screen for anxiety or depression and the type of medical appointment were associated with 4 A's delivery. Conclusion: Given the fundamental importance of addressing tobacco treatment, increasing the rates of 4 A's treatment in primary care settings in Greece is an important target for improving patient care.

► **Impact of Public Smoking Bans on Children's Exposure to Tobacco Smoke at Home: A Systematic Review and Meta-Analysis**

NANNINGA S., LHACHIMI S. K. ET BOLTE G.
2018

BMC Public Health 18(1): 749.

<https://doi.org/10.1186/s12889-018-5679-z>

Meta-analysis of the impact of public smoking bans on children's exposure to secondhand smoke (SHS) exposure at home.

► **Expansion of the 'Antibiotic Guardian' One Health Behavioural Campaign Across Europe to Tackle Antibiotic Resistance: Pilot Phase and Analysis of AMR Knowledge**

NEWITT S., ANTHIERENS S., COENEN S., *et al.*
2018

Eur J Public Health 28(3): 437-439.

Antimicrobial resistance (AMR) is a major public health threat. The UK Antibiotic Guardian (AG) behavioural change campaign developed to tackle AMR was expanded across Europe through translation into Russian, Dutch and French. Demographics and knowledge of AGs were analyzed between 01 November 2016 and 31 December 2016. A total of 367 pledges were received with the majority from the public and health care professionals. The pilot has significantly increased the proportion of pledges from Europe (excluding UK) ($\chi^2 = 108.7, P < 0.001$). AMR knowledge was greater in AGs (including the public) compared to the EU Eurobarometer survey. Further promotion across Europe is required to measure an impact on tackling AMR.

Prevision - Evaluation

► **A Bayesian Framework for Health Economic Evaluation in Studies with Missing Data**

MASON A. J., GOMES M., GRIEVE R., *et al.*
2018

Health Econ. [Ahead of print]

Health economics studies with missing data are increasingly using approaches such as multiple imputation that assume that the data are "missing at random." This assumption is often questionable, as-even given

the observed data-the probability that data are missing may reflect the true, unobserved outcomes, such as the patients' true health status. In these cases, methodological guidelines recommend sensitivity analyses to recognise data may be "missing not at random" (MNAR), and call for the development of practical, accessible approaches for exploring the robustness of conclusions to MNAR assumptions. Little attention has been paid to the problem that data may be MNAR in health economics in general and in cost-effectiveness analyses (CEA) in particular. In this paper, we propose

a Bayesian framework for CEA where outcome or cost data are missing. Our framework includes a practical, accessible approach to sensitivity analysis that allows the analyst to draw on expert opinion. We illustrate

the framework in a CEA comparing an endovascular strategy with open repair for patients with ruptured abdominal aortic aneurysm, and provide software tools to implement this approach.

Psychiatry

► **Women's Mental Health in the Perinatal Period According to Migrant Status: The French Representative ELFE Birth Cohort**

EL-KHOURY F., SUTTER-DALLAY A. L., PANICO L., *et al.*

2018

[Eur J Public Health 28\(3\): 458-463.](#)

Mental health problems in the perinatal period are common. We examined associations between different categories of migrant status and region of origin in relation to mental health during pregnancy and at 2 months post-partum. We analyzed data from the French nationally representative Etude Longitudinale Francaise depuis l'Enfance birth cohort ($n = 17\,988$). Migrant status was divided into five categories: 'majority population', 'descendants with one migrant parent', 'descendants with two migrant parents', 'naturalized migrant' and 'non-naturalized migrant women'. Multivariate logistic regression models were implemented to examine associations between migrant status and mental health outcomes: persistent psychological difficulties during pregnancy as well as mother's depression and poor self-reported health at 2 months post-partum. Results: After adjusting for covariates, migrant status was not associated with psychological difficulties during pregnancy. Descendants of migrants had comparable mental health to the majority population. Non-naturalized migrant women were more likely to experience depression (odds ratio (OR) = 1.66, 95% confidence interval (CI): 1.27, 2.20) and poor self-reported health (OR = 1.45, 95%CI: 1.06, 1.98) during the post-partum period. The region of origin was associated with post-partum health independently of migrant status, such that women from Africa and Turkey were most likely to have depression or poor self-rated health. Conclusion: First, but not second, generation migrant women appear to have high levels of mental health difficulties during the post-partum period. Women from North Africa, Sub-Saharan

Africa, and Turkey have higher levels of distress than those from other regions. In particular, non-naturalized migrant appear to be a vulnerable group; they may disproportionately face stressors that increase their risk for post-partum depressive symptoms.

► **The Impact of the Current Economic Crisis on Mental Health in Italy: Evidence from Two Representative National Surveys**

ODONE A., LANDRISCINA T., AMERIO A., *et al.*

2018

[Eur J Public Health 28\(3\): 490-495.](#)

Economic crises pose major threats to health. Research on the association between the current economic crisis and health is accumulating. Scant evidence is available on the impact of economic downturns on mental health in Italy, one of the European countries most affected by the economic crisis. We used data from the 2005 and 2013 'Health Conditions and Use of Health Services' surveys conducted by the Italian National Institute of Statistics to estimate Italian poor mental health prevalence in Italy and we applied Poisson regression analysis to explore how the risk (expressed as Prevalence Rate Ratios; PRR) of poor mental health has been impacted by the ongoing economic crisis, by gender and by different socio-economic strata. Poor mental health prevalence in Italy was 21.5% in 2005 and 25.1% in 2013. The risk of poor mental health increased between 2005 and 2013 by 17% in males (PRR: 1.17; 95%CI: 1.14-1.20) and by 4% in females (PRR: 1.04; 95%CI: 1.02-1.06), the increase being highest for young males (24%). Vulnerable subgroup is at higher risk of poor mental health but not differently affected by the impact of the economic crisis. The economic crisis that hit Italy has posed threats to Italians' mental health and wellbeing, with a higher impact on young male populations. As further evidence from prospective studies is accumulating, our findings sug-

gest strengthened primary and secondary prevention interventions should be planned and implemented by the Italian National Health Service so as to counter economic downturns' impact on population and individual-level health.

► **Depressive Disorders in Primary Care: Clinical Features and Sociodemographic Characteristics**

ONEIB B., SABIR M., OTHEMAN Y., *et al.*

2018

Rev Epidemiol Santé Publique. [Ahead of print]

Our aim was to determine the reason for consultation and the clinical features of depressive disorders according to the diagnostic and statistical manual (DSM) 4th edition IV R in primary care and to identify if there is an association between sociodemographic characteristics and depressive pattern. In a cross-sectional study conducted to determinate the prevalence of depressive disorders in primary care, at three urban centers in two cities Sale and Oujda by five physicians, we recruited primary care 396 patients of whom 58 were depressed, among these patients we screened for depressive disorders, their clinical features, the melancholic characteristics and suicidal ideation using the Mini International Neuropsychiatric Interview. Mean age of the 58 depressive patients was 46+/-15 years. They were predominantly female, inactive and of low socio-economic level. Approximately one-third of the patients were illiterate and single. The symptoms frequently encountered were sadness (63.7%), anhedonia (62%), insomnia (45.7%), anorexia (60.9%), psychomotor retardation (60.9%) and asthenia (73.9%). Somatic symptoms were present 99%, the most common complaint was pain that exhibited 68.6% prevalence. Suicidal ideations were found in 36.2% of these depressive patients. The accuracy of the clinical features of patients with depression in primary care will facilitate the detection of these disorders by general practitioners and improve management of depression.

► **La réhospitalisation en psychiatrie. Facteurs individuels, facteurs organisationnels**

PLANCKE L., AMARIEI A., FLAMENT C., *et al.*

2017

Santé Publique 29(6): 829-836.

<https://www.cairn.info/revue-sante-publique-2017-6-page-829.htm>

La réhospitalisation psychiatrique constitue souvent un critère pour apprécier les effets des traitements médicamenteux, des thérapies ainsi que ceux des changements d'organisation dans le système de soins. Elle est employée pour juger une rechute ou une décompensation. Le but de cette étude est de mesurer les taux de réhospitalisation et rechercher les facteurs individuels et organisationnels qui sont à l'origine de variations significatives. Les réhospitalisations psychiatriques ont été décrites à partir des séjours hospitaliers à temps complet enregistrés dans le Recueil d'informations médicalisé en Psychiatrie (RimP) en 2011 et 2012, concernant des personnes de 18 ans et plus, habitant dans le Nord et le Pas-de-Calais. Des probabilités de réhospitalisation, à différents intervalles de temps, ont été calculées selon la méthode d'analyse de survie de Kaplan-Meier et une analyse multivariée a été menée par le modèle de risques proportionnels de Cox. Environ 30 000 personnes majeures ont été hospitalisées à temps complet en services de psychiatrie pendant la période d'étude. La probabilité de réhospitalisation à 24 mois est de 51,6 % (IC95 % : 50,8-52,3 %). Selon les résultats du modèle de Cox, la schizophrénie (F2 – HR = 1,72 – IC95 % : 1,61-1,84 – p < 0,0001) et les troubles de la personnalité (F6 – HR = 1,45 – IC95 % : 1,32-1,58 – p < 0,0001) sont les diagnostics les plus liés à la réhospitalisation. Celle-ci augmente avec la perte d'autonomie et est plus élevée dans les établissements privés non lucratifs (HR = 1,49 – IC95 % : 1,38-1,60 – p < 0,0001). La réhospitalisation psychiatrique est un événement très fréquent, le risque de sa survenue étant lié non seulement à des facteurs individuels mais également organisationnels.

► **Strengthening Mental Health Care Systems for Syrian Refugees in Europe and the Middle East: Integrating Scalable Psychological Interventions in Eight Countries**

SIJBRANDIJ M., ACARTURK C., BIRD M., *et al.*

2017

Eur J Psychotraumatol 8(sup2): 1388102.

The crisis in Syria has resulted in vast numbers of refugees seeking asylum in Syria's neighbouring countries as well as in Europe. Refugees are at considerable risk

of developing common mental disorders, including depression, anxiety, and posttraumatic stress disorder (PTSD). Most refugees do not have access to mental health services for these problems because of multiple barriers in national and refugee specific health systems, including limited availability of mental health professionals. To counter some of challenges arising from limited mental health system capacity the World Health Organization (WHO) has developed a range of scalable psychological interventions aimed at reducing psychological distress and improving functioning in people living in communities affected by adversity. These interventions, including Problem Management Plus (PM+) and its variants, are intended to be delivered through individual or group face-to-face or smartphone formats by lay, non-professional people who have not received specialized mental health training. We provide an evidence-based rationale for the use of the scalable PM+ oriented programmes being adapted for Syrian refugees and provide information on the newly launched STRENGTHS programme for adapt-

ing, testing and scaling up of PM+ in various modalities in both neighbouring and European countries hosting Syrian refugees.

► **Improving Quality of Psychiatric Care in Latvia by Measuring Patient Experiences**

TAUBE M. ET BERZINA-NOVIKOVA N.
2018

Health Policy 122(7): 765-768.

<http://dx.doi.org/10.1016/j.healthpol.2018.03.011>

International trends and EU funding have supported the introduction of psychiatric quality assessments in Latvia. The PIPEQ-OS instrument has recently been adapted for use in Latvia. Psychiatric patients are interested in participating in the assessment process. More wide-spread use of PIPEQ-OS has the potential to improve psychiatric care in Latvia.

Primary Health Care

► **La place du médecin et de la famille dans la décision pour des patients en fin de vie**

ANGELO M. BISMUTH M., OUSTRIC S. ET *et al.*
2018

Médecine : De La Médecine Factuelle à nos Pratiques 14(3): 112-115.

Depuis quelques années, la fin de vie est un sujet sociétal sensible et très médiatisé ayant nécessité de réfléchir à un repositionnement des soignants. En 2005, la loi Léonetti et plus récemment la loi Claeys Leonetti en 2016 ont apporté des éléments de réponses concernant l'accompagnement des patients en fin de vie. Face à une situation complexe de soins palliatifs, parfois face aux pressions de la famille, comment peuvent se positionner les différents acteurs de la décision? Le patient a-t-il exprimé une volonté particulière concernant sa fin de vie sous la forme de directives anticipées? De quelle manière et comment rédiger des directives anticipées? Quel est le cadre législatif concernant la limitation ou l'arrêt les soins curatifs? Quelle est la place du médecin dans cette décision? Quelle est la place de l'avis de la famille et/ou de la

personne de confiance dans la décision concernant l'arrêt ou la limitation des soins curatifs?

► **Effects of Regulation and Payment Policies on Nurse Practitioners' Clinical Practices**

BARNES H., MAIER C. B., ALTARES SARIK D., *et al.*
2017

Med Care Res Rev 74(4): 431-451.

<https://www.ncbi.nlm.nih.gov/pubmed/27178092>

Increasing patient demand following health care reform has led to concerns about provider shortages, particularly in primary care and for Medicaid patients. Nurse practitioners (NPs) represent a potential solution to meeting demand. However, varying state scope of practice regulations and Medicaid reimbursement rates may limit efficient distribution of NPs. Using a national sample of 252,657 ambulatory practices, we examined the effect of state policies on NP employment in primary care and practice Medicaid acceptance. NPs had 13% higher odds of working in primary care in states with full scope of practice; those odds

increased to 20% if the state also reimbursed NPs at 100% of the physician Medicaid fee-for-service rate. Furthermore, in states with 100% Medicaid reimbursement, practices with NPs had 23% higher odds of accepting Medicaid than practices without NPs. Removing scope of practice restrictions and increasing Medicaid reimbursement may increase NP participation in primary care and practice Medicaid acceptance.

► **Uncovering the Wisdom Hidden Between the Lines: The Collaborative Reflexive Deliberative Approach**

CRABTREE B. F., MILLER W. L., GUNN J. M., *et al.*
2018

Fam Pract 35(3): 266-275.

Meta-analysis and meta-synthesis have been developed to synthesize results across published studies; however, they are still largely grounded in what is already published, missing the tacit 'between the lines' knowledge generated during many research projects that are not intrinsic to the main objectives of studies. This study aims to develop a novel approach to expand and deepen meta-syntheses using researchers' experience, tacit knowledge and relevant unpublished materials. We established new collaborations among primary health care researchers from different contexts based on common interests in reforming primary care service delivery and a diversity of perspectives. Over 2 years, the team met face-to-face and via tele- and video-conferences to employ the Collaborative Reflexive Deliberative Approach (CRDA) to discuss and reflect on published and unpublished results from participants' studies to identify new patterns and insights. CRDA focuses on uncovering critical insights, interpretations hidden within multiple research contexts. For the process to work, careful attention must be paid to ensure sufficient diversity among participants while also having people who are able to collaborate effectively. Ensuring there are enough studies for contextual variation also matters. It is necessary to balance rigorous facilitation techniques with the creation of safe space for diverse contributions. The CRDA requires large commitments of investigator time, the expense of convening facilitated retreats, considerable coordination, and strong leadership. The process creates an environment where interactions among diverse participants can illuminate hidden information within the contexts of studies, effectively enhancing theory development and generating new research questions and strategies.

► **Accuracy of Patient Recall for Self-Reported Doctor Visits: Is Shorter Recall Better?**

DALZIEL K., LI J., SCOTT A., *et al.*
2018

Health Econ.: [Ahead of print].

In health economics, the use of patient recall of health care utilisation information is common, including in national health surveys. However, the types and magnitude of measurement error that relate to different recall periods are not well understood. This study assessed the accuracy of recalled doctor visits over 2-week, 3-month, and 12-month periods by comparing self-report with routine administrative Australian Medicare data. Approximately 5,000 patients enrolled in an Australian study were pseudo-randomised using birth dates to report visits to a doctor over three separate recall periods. When comparing patient recall with visits recorded in administrative information from Medicare Australia, both bias and variance were minimised for the 12-month recall period. This may reflect telescoping that occurs with shorter recall periods (participants pulling in important events that fall outside the period). Using shorter recall periods scaled to represent longer periods is likely to bias results. There were associations between recall error and patient characteristics. The impact of recall error is demonstrated with a cost-effectiveness analysis using costs of doctor visits and a regression example predicting number of doctor visits. The findings have important implications for surveying health service utilisation for use in economic evaluation, econometric analyses, and routine national health surveys.

► **Changes in Access to Primary Care in Europe and Its Patterning, 2007-12: A Repeated Cross-Sectional Study**

DIMITROVOVA K. ET PERELMAN J.
2018

Eur J Public Health 28(3): 398-404.

The strengthening of primary care (PC) has been encouraged as a strategy to achieve more efficient and equitable health systems. However, the Great Recession may have reduced access to PC. This paper analyses the change in access to PC and its patterning in 28 European countries between 2007 and 2012. We used data from the 2007 and 2012 waves of the EU-SILC questionnaire (n = 687 170). The dependent

variable was the self-reported access to PC ('easy' vs. 'difficult'). We modelled the access to PC as a function of the year and individual socioeconomic and country-level health system variables, using a mixed effects logistic regression, adjusting for sex, age, civil status, country of birth, chronic condition and self-reported health. Additionally, we interacted the year with socioeconomic and country-level variables. Results: The probability of reporting difficult access to PC services was 4% lower in 2012, in comparison with 2007 (OR = 0.96, $P < 0.01$). People with the lowest educational level (OR = 1.63, $P < 0.01$), high difficulty to make ends meet (OR = 1.94, $P < 0.01$) and with material deprivation (OR = 1.25, $P < 0.01$) experienced a significantly higher likelihood of difficult access. The better access in 2012 was significantly higher in people living in countries with higher health expenditures, a greater number of generalist medical practitioners, and with stronger gatekeeping. Access to PC improved between 2007 and 2012, and this improvement was greater for people living in countries with a higher investment in health and PC. However, the poor access amongst low-SE status people was stable over the period.

► **Continuing Education for General Practitioners Working in Rural Practice: A Review of the Literature**

DOWLING S., LAST J., FINNIGAN H., et al.

2018

Educ Prim Care 29(3): 151-165.

Studies demonstrate that the CME/CPD (continuing medical education/continuing professional development) needs of rural general practitioners (GPs) are unique. Little research has focused specifically on the effectiveness of CME/CPD programmes for rural practice. This study aims to review the literature on CME/CPD for GPs in rural areas, focussing on studies which examined impact on doctor performance or patient outcomes. A search of peer-reviewed English language literature and relevant grey literature was conducted: identified literature was reviewed. Most articles report on participant experience or satisfaction while doctor performance and patient outcomes are seldom reported. Distance learning programmes found it difficult to recruit or engage doctors, two out of six studies found improvements in self-reported knowledge or performance, while none reported measurable changes in doctor performance/patient care.

► **Comment les médecins généralistes peuvent-ils contribuer à un accès plus équitable à l'éducation thérapeutique ?**

FOURNIER C., NAIDITCH M. ET FRATTINI M. O.

2018

Médecine : De La Médecine Factuelle à nos Pratiques 14(6): 268-272.

En France, le droit à bénéficier d'une éducation thérapeutique du patient (ETP) est inscrit dans le Code de la santé publique depuis 2009. Le système d'autorisation des programmes d'ETP instauré par la loi Hôpital, patients, santé et territoires (HPST) a abouti à la constitution d'une offre essentiellement hospitalière et l'accès aux programmes d'ETP reste globalement faible : en 2015, 3 736 programmes étaient autorisés pour environ 15 millions de personnes atteintes de maladies chroniques. Dans cet article, nous qualifions d'« ETP » les pratiques mises en œuvre dans le cadre de programmes autorisés et nous appelons « pratiques éducatives » celles développées au sein de consultations médicales. La dimension éducative est repérée lorsque les médecins déclarent s'appuyer sur le vécu et l'expérience du patient pour l'aider à développer des compétences d'auto-soin et d'adaptation, en construisant des objectifs personnalisés réévalués d'une consultation à l'autre. Au-delà de quelques travaux sur l'ETP en ambulatoire et sur son intégration aux soins, les pratiques éducatives individuelles restent peu étudiées et leur formalisation n'a été envisagée que récemment. En parallèle, dans la continuité de la loi HPST, la Loi de santé de 2016 énonce l'objectif de « garantir un accès aux soins équitable ». Or on sait que les personnes appartenant aux catégories les moins favorisées de la population, et qui supportent la plus grande part du fardeau lié aux maladies chroniques, ont un accès moindre à la fois aux soins et à la prévention. Considérant que l'ETP serait à même de contribuer à réduire les inégalités sociales de santé, on peut donc se demander s'il existe des inégalités d'accès à une prise en charge éducative, et si oui, si les médecins généralistes sont en mesure de contribuer à réduire ces inégalités d'accès, comme cela a été montré pour d'autres interventions de santé publique. Cet article synthétise les résultats d'une recherche dans laquelle des médecins ont été interrogés successivement sur : leurs pratiques éducatives ; l'accès donné à d'autres ressources éducatives ; la façon dont ils appréhendent les caractéristiques sociales de leurs patients et l'influence des inégalités sociales sur leur travail éducatif ; les solutions qu'ils développent ou envisagent pour contribuer à plus d'équité d'accès à une démarche éducative ou d'ETP.

► **Accountable Care Organizations and Post-Acute Care: A Focus on Preferred SNF Networks**

KENNEDY, G., LEWIS, V. A., KUNDU, S., *et al.*

Medical Care Research and Reviews [Ahead of print]

Due to high magnitude and variation in spending on, accountable care organizations (ACOs) are focusing on transforming management of hospital discharge through relationships with preferred skilled nursing facilities (SNFs). Using a mixed-methods design, we examined survey data from 366 respondents to the National Survey of ACOs along with 16 semi-structured interviews with ACOs who performed well on cost and quality measures. Survey data revealed that over half of ACOs had no formal relationship with SNFs; however, the majority of ACO interviewees had formed preferred SNF networks. Common elements of networks included a comprehensive focus on care transitions beginning at hospital admission, embedded ACO staff across settings, solutions to support information sharing, and jointly established care protocols. Misaligned incentives, unclear regulations, and a lack of integrated health records remained challenges, yet preferred networks are beginning to transform the ACO post-acute care landscape.

► **Transforming Integration Through General Practice: Learning from a UK Primary Care Improvement Programme**

MILLER R.

2018

International Journal of Integrated Care 18(2): 1-7.

This article addresses the challenge of how to implement integration within primary care services. It shares learning from a UK based improvement programme which reflected international interest in transferring activities from hospital and community and developing holistic primary care that responds to the needs of the local community. Programme components included additional per capita funding for involved practices, monthly learning sets between pilot leads, and a formative evaluation. Practices had flexibility in how to use the additional funding to meet local needs and were selected through a competitive process. The programme successfully delivered diagnostic and treatment activities previously provided in acute hospital. Some practices also introduces new holistic

approaches which were mostly sustained at the end of the twelve month period. The programme demonstrates that transformation of primary care requires a change in the internal paradigms held by clinicians and purchasers, careful design of learning opportunities, responding to multiple levels of motivation, and deployment of relevant change infrastructures and improvement methodologies.

► **The Application of Triple Aim Framework in the Context of Primary Healthcare: A Systematic Literature Review**

OBUCINA M., HARRIS N., FITZGERALD J. A., *et al.*

2018

Health Policy. 122(8): 900-907

<http://dx.doi.org/10.1016/j.healthpol.2018.06.006>

The Triple Aim framework is an increasingly popular tool for designing and assessing quality improvements in the health care sector. We systematically reviewed the empirical evidence on the application of the Triple Aim framework within primary healthcare settings since its inception almost a decade ago. Results show that primary healthcare providers varied in their interpretation of the Triple Aim framework and generally struggled with a lack of guidance and an absence of composite sets of measures for performance assessment. Greater clarity around application of the Triple Aim framework in primary healthcare is needed, especially around the selection and implementation of purposeful measures from locally available data. This review highlights areas for improvement and makes recommendations intended to guide future applications of the Triple Aim in the context of primary healthcare.

► **L'épuisement de la volonté de bien faire chez les médecins : « Y-a-t-il un médecin dans la salle ? »**

PAME P. ET JOSSET J. M.

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(3).

De quelle manière l'identité professionnelle du médecin peut-elle être source d'épuisement? Notre hypothèse est que la fatigue ressentie par les médecins provient non seulement d'un contexte professionnel

exigeant mais aussi de la charge à assumer en permanence une image héroïque. C'est ce que nous allons nous efforcer d'explorer dans cet article. Tout d'abord nous nous intéresserons à la genèse de cette image, en questionnant le « hidden curriculum » des médecins interrogés, mais aussi leur rapport aux termes du serment d'Hippocrate. Dans un deuxième temps, dans une perspective « goffmanienne », nous décrivons la dramaturgie de cette tension, révélée par la situation où, alors qu'il est au repos, le praticien est interpellé par la classique annonce : « Y a-t-il un médecin dans la salle ? ». Enfin, nous montrerons comment les médecins tentent de s'accommoder de cette tension par des règles de vie qui tiennent souvent de la protection rituelle.

► **Transforming Primary Care: Scoping Review of Research and Practice**

ROBIN M., CATHERINE W. ET STEVE G.

2018

Journal of Integrated Care 26(3): 176-188.

<https://www.emeraldinsight.com/doi/abs/10.1108/JICA-03-2018-0023>

The purpose of this paper is to reflect on research evidence and practice experience of transforming primary care to a more integrated and holistic model. It is based on a scoping review which has been guided by primary care stakeholders and synthesises research evidence and practice experience from ten international case studies. Adopting an inter-professional, community-orientated and population-based primary care model requires a fundamental transformation of thinking about professional roles, relationships and responsibilities. Team-based approaches can replicate existing power dynamics unless medical clinicians are willing to embrace less authoritarian leadership styles. Engagement of patients and communities is often limited due to a lack of capacity and belief that will make an impact. Internal (relationships, cultures, experience of improvement) and external (incentives, policy intentions, community pressure) contexts can encourage or derail transformation efforts. Practical implications Transformation requires a co-ordinated programme that incorporates the following elements – external facilitation of change; developing clinical and non-clinical leaders; learning through training and reflection; engaging community and professional stakeholders; transitional funding; and formative and summative evaluation. Originality/value This paper

combines research evidence and international practice experience to guide future programmes to transform primary care.

► **Effects of Access to Radiology in Out-Of-Hours Primary Care in the Netherlands: A Prospective Observational Study**

RUTTEN M. H., SMITS M., PETERS Y. A. S., *et al.*

2018

Fam Pract 35(3): 253-258.

In the Netherlands, out-of-hours primary care is provided in general-practitioner-cooperatives (GPCs). These are increasingly located on site with emergency departments (ED), forming Emergency-Care-Access-Points (ECAP). A more efficient and economical organization of out-of-hours primary emergency care could be realized by increased collaboration at an ECAP. In this study, we compared the effects of different models with respect to access to (hospital) radiology by the GPC. We investigated patient and care characteristics, indication for diagnostics and outcomes at GPCs with and without access to radiology. A prospective observational record review study of patients referred for conventional radiology for trauma by one of five GPCs in the period April 2014-October 2015, covering three organizational models. The mean age was 31 years and 56% was female. Extremities were predominately involved (91%). There was a medical indication for radiology in 85% and the assessed risk by requesting GPs on abnormalities was high in 66%. There was a significant difference in outcomes between models. Radiological abnormalities (fractures/luxations) were present in 51% without direct access and in 35% with partial and unlimited access. Overall, 61% of the included patients were referred to the ED; 100% in the models without access and 38% in the models with (partial) access. GPC access to radiology is beneficial for patients and professionals. The diagnostics were adequately used. With access to radiology, unnecessary referrals and specialist care are prevented. This may lead to a decrease in ED attendance and overcrowding.

► **Integrated Care in Switzerland: Results from the First Nationwide Survey**

SCHUSSELE FILLIETTAZ S., BERCHTOLD P., KOHLER D., *et al.*

2018

[Health Policy 122\(6\): 568-576.](#)

Due to fragmentation of care delivery, health systems are under pressure and integrated care is advocated for. Compared to the numerous existing integrated care initiatives in Europe and elsewhere, Switzerland seems to lag behind. The objective of the survey was to produce a comprehensive overview of integrated care initiatives in Switzerland. To be included, initiatives needed to meet four criteria: present some type of formalization, consider >2 different groups of healthcare professionals, integrate >2 healthcare levels, be ongoing. We systematically contacted major health system organizations at federal, cantonal and local level. Between 2015 and 2016, we identified 172 integrated care initiatives and sent them a questionnaire. Despite Switzerland's federalist structure and organization of healthcare, and only recent incentives to develop integrated care, initiatives are frequent and diverse. Stakeholders should support existing initiatives and

facilitate their development. They should also promote innovative avenues, experiment alternative payment models for integrated care, foster people-centeredness and incentivize interprofessional models. This will require systems thinking and contributions from all actors of the healthcare system.

► **Community Orientation of General Practitioners in 34 Countries**

VERMEULEN L., SCHÄFER W., PAVLIC D. R., *et al.*

2018

[Health Policy. \[Ahead of print\]](#)

<http://dx.doi.org/10.1016/j.healthpol.2018.06.012>

There is a large international variation in community orientation between GPs. In countries with a defined patient list GPs are more community oriented. GPs more active in prevention and multidisciplinary cooperation are more community oriented. GPs using medical records to make overviews are more community oriented. GPs in areas with more ethnic minority people are more community oriented.

Health Systems

► **L'innovation organisationnelle, un processus d'apprentissage au service de la transformation du système de santé ?**

BOURGUEIL Y.

2017

[Santé Publique 29\(6\): 777-779.](#)

<https://www.cairn.info/revue-sante-publique-2017-6-page-777.htm>

L'innovation en santé est une notion ancienne et très actuelle. Souvent confondue avec l'invention, l'innovation s'en distingue néanmoins dans la mesure où elle constitue avant tout le processus par lequel l'invention qu'elle soit de produit, de procédé ou de service est reconnue socialement et trouve sa place dans les marchés, les institutions, les pratiques professionnelles et les usages sociaux. Toutes les inventions ne conduisent pas nécessairement à des innovations comme certains médicaments, techniques chirurgicales, pratiques nouvelles, projets expérimentaux de

réseaux de soins ou plus récemment les très nombreuses applications digitales en santé pour smartphones. Cependant, ces échecs trop souvent perçus négativement et malheureusement peu publiés contribuent également beaucoup au processus plus large d'innovation et ce d'autant plus qu'ils sont étudiés et partagés dans un contexte plus général de soutien explicite à l'innovation.

► **Cross-Country Comparative Research: Lessons from Advancing Health System and Policy Research on the Occasion of the European Observatory on Health Systems and Policies 20Th Anniversary**

BUSSE R. ET VAN GINNEKEN E.

2018

[Health Policy 122\(5\): 453-456.](#)

<http://dx.doi.org/10.1016/j.healthpol.2018.05.005>

This issue of Health Policy is dedicated to the 20th anniversary of the European Observatory on Health Systems and Policies and particularly the Observatory's contribution to shaping comparative health system and policy research in Europe – the domain of this journal too. Below, we will briefly outline the origin and functions of the Observatory as well as its contribution to research over the past two decades. We then put the selected papers in this issue into perspective and provide an overview on comparative papers published in Health Policy since 2014, i.e. analyse which topics and which countries have been covered. Several of these articles are actually authored by Observatory staff and its networks and fit into the tradition of comparative health system research that the Observatory helped develop.

► **Addressing Overuse of Health Services in Health Systems: A Critical Interpretive Synthesis**

ELLEN M. E., WILSON M. G., VÉLEZ M., *et al.*
2018

Health Research Policy and Systems 16(1): 48.
<https://doi.org/10.1186/s12961-018-0325-x>

Health systems are increasingly focusing on the issue of 'overuse' of health services and how to address it. We developed a framework focused on (1) the rationale and context for health systems prioritising addressing overuse, (2) elements of a comprehensive process and

approach to reduce overuse and (3) implementation considerations for addressing overuse.

► **Competition in Health Care: Lessons from the English Experience**

PROPPER C.
2018

Health Economics, Policy and Law 13(3-4): 492-508.
<https://www.cambridge.org/core/article/competition-in-health-care-lessons-from-the-english-experience/890139067190E952CEEA22B431555516>

The use of competition and the associated increase in choice in health care is a popular reform model, adopted by many governments across the world. Yet it is also a hotly contested model, with opponents seeing it, at best, as a diversion of energy or a luxury and, at worst, as leading to health care inequality and waste. This paper subjects the use of competition in health care to scrutiny. It begins by examining the theoretical case and then argues that only by looking at evidence can we understand what works and when. The body of the paper examines the evidence for England. For 25 years the United Kingdom has been subject to a series of policy changes which exogenously introduced and then downplayed the use of competition in health care. This makes England a very useful test bed. The paper presents the UK reforms and then discusses the evidence of their impact, examining changes in outcomes, including quality, productivity and the effect on the distribution of health care resources across socio-economic groups. The final section reflects on what can be learnt from these findings.

Occupational Health

► **L'influence des conditions de travail passées sur la santé et la consommation de médicaments auto-déclarés des retraités**

BARNAY T. ET DEFEBVRE É.
2018

Economie & prévision 213(1): 61-84.
<https://www.cairn.info/revue-economie-et-prevision-2018-1-page-61.htm>

Cet article vise à mesurer l'effet propre des conditions de travail physiques et psychosociales rencon-

trées durant l'ensemble de la carrière professionnelle sur la santé physique et mentale auto-déclarée et la consommation de médicaments des retraités. Pour ce faire, nous mobilisons les données de l'enquête Santé et itinéraire professionnel (Sip). Nous contrôlons nos résultats des caractéristiques socio-économiques, d'itinéraire professionnel et de caractéristiques individuelles antérieures à l'entrée sur le marché du travail mais également de l'état de santé dans l'enfance et à l'âge adulte. Nos résultats mettent en évidence le rôle négatif des conditions de travail passées sur la

santé physique et mentale des retraités avec un lien clair entre contraintes physiques et santé physique d'une part et risques psychosociaux et santé mentale (incluant la consommation de médicaments) d'autre part. Ce résultat témoigne du caractère pénalisant de long terme des conditions de travail pénibles sur la santé des retraités.

► **Long Working Hours and Sickness Absence—A Fixed Effects Design**

BERNSTRØM V. H.

2018

BMC Public Health 18(1): 578.

<https://doi.org/10.1186/s12889-018-5473-y>

While long working hours seem to lead to impaired health, several studies have also shown that long working hours are related to lower levels of sickness absence. Previous studies on the relationship between long working hours and sickness absence have compared those who work long hours to those who do not, looking only at between-individual correlations. Those results might therefore reflect relatively stable differences between employees who typically work long hours and employees who typically do not. The aim of the present study is to examine within-individual correlations between long working hours and sickness absence.

Ageing

► **Du domicile à l'institution : évolution des réseaux de sociabilité**

DESQUESNES G., MONFREUX M. ET ROUAULT M.

2018

Gérontologie et société 40 / 156(2): 217-231.

<https://www.cairn.info/revue-gerontologie-et-societe-2018-2-page-217.htm>

Les recherches sociologiques sur la sociabilité des vieilles personnes sont relativement abondantes depuis le début des années 2000, en revanche la perspective d'analyse en termes de dynamique des réseaux de relations personnelles (Bidart, Degenne et Grossetti, 2011), couplée à l'étude du soutien social circulant à travers les liens, est beaucoup moins fréquente. Le présent article a pour objet d'explorer et de caractériser l'évolution des réseaux de relations de personnes vieillissantes selon une procédure narrative rétrospective, c'est-à-dire avant et après leur entrée en établissement d'hébergement pour personnes âgées. La réflexion proposée ici s'appuie sur un matériau empirique récolté dans le cadre de seize entretiens de recherche menés auprès de vieilles personnes vivant actuellement dans des lieux d'hébergement pour personnes âgées. Les résultats de recherche montrent l'intérêt heuristique de cette « approche réseau » et les diverses restructurations qui affectent le « petit monde » ou l'entourage social des individus vieillissants une fois entrés en institution.

► **Les réformes des retraites conduites en France depuis 2010 : quels effets sur les inégalités inter et intra générationnelles ?**

DUC C., MARTIN H. ET TREGUIER J.

2018

Economie & prévision 213(1): 85-120.

<https://www.cairn.info/revue-economie-et-prevision-2018-1-page-85.htm>

Les réformes entreprises en France depuis 2010 ont modifié de nombreux paramètres du système de retraite. Les bornes d'âge du système (âge d'ouverture des droits et âge d'annulation de la décote), la durée requise pour le taux plein, les modalités de calcul des pensions (valeur de service du point dans les régimes complémentaires, date de revalorisation des pensions, calcul du minimum contributif) mais aussi les taux de cotisation ont évolué. Dans le même temps, le profil des assurés évolue au fil des générations. Entre autres, l'entrée sur le marché du travail est de plus en tardive et le taux d'activité des femmes s'accroît. Dans ce contexte, cette contribution s'interroge sur l'impact des modifications réglementaires récentes sur l'équité inter et intra générationnelle du système de retraite. Elle s'appuie sur le modèle de microsimulation TRAJECTOIRE de la DREES (Direction de la recherche, des études, de l'évaluation et des statistiques). Les résultats sont partagés : au prisme de certains indicateurs (durée de retraite) l'équité entre les générations semble assurée alors qu'elle se dégrade à

l'aune d'autres indicateurs (taux de cotisation et taux de remplacement).

► **Why Health and Social Care Support for People with Long-Term Conditions Should Be Oriented Towards Enabling Them to Live Well**

ENTWISTLE V. A., CRIBB A. ET OWENS J.

2018

Health Care Anal 26(1): 48-65.

<https://www.ncbi.nlm.nih.gov/pubmed/27896539>

There are various reasons why efforts to promote “support for self-management” have rarely delivered the kinds of sustainable improvements in healthcare experiences, health and wellbeing that policy leaders internationally have hoped for. This paper explains how the basis of failure is in some respects built into the ideas that underpin many of these efforts. When (the promotion of) support for self-management is narrowly oriented towards educating and motivating patients to adopt the behaviours recommended for disease control, it implicitly reflects and perpetuates limited and somewhat instrumental views of patients. It tends to: restrict the pursuit of respectful and enabling ‘partnership working’; run the risk of undermining patients’ self-evaluative attitudes (and then of failing to notice that as harmful); limit recognition of the supportive value of clinician-patient relationships; and obscure the practical and ethical tensions that clinicians face in the delivery of support for self-management. We suggest that a focus on enabling people to live (and die) well with their long-term conditions is a promising starting point for a more adequate conception of support for self-management. We then outline the theoretical advantages that a capabilities approach to thinking about living well can bring to the development of an account of support for self-management, explaining, for example, how it can accommodate the range of what matters to people (both generally and more specifically) for living well, help keep the importance of disease control in perspective, recognize social influences on people’s values, behaviours and wellbeing, and illuminate more of the rich potential and practical and ethical challenges of supporting self-management in practice.

► **What Happens at the End of Life? Using Linked Administrative Health Data to Understand Healthcare Usage in the Last Year of Life in New Zealand**

HAMBLIN R., MINKO N., SHUKER C., *et al.*

2018

Health Policy 122(7): 783-790.

The end of life is often associated with increased use of healthcare services. This increased use can include over-medicalisation, or over-treatment with interventions designed to cure that are likely futile in people who are dying. This is an issue with medical, ethical, and financial dimensions, and has implications for health policy, funding and the structure of care delivery. We measured the annual use of nine pre-defined public healthcare services between 1 January 2008 and 31 December 2012 by elderly New Zealanders (65-99 years old) in their last year of life and compared it with that of the cohort of elderly New Zealanders who used healthcare in the period but did not die. We used linked, encrypted unique patient identifiers to reorganise and filter records in routinely collected national healthcare utilisation and mortality administrative datasets. We found that, in New Zealand, people do seem to use more of most health services in their last year of life than those of the same age who are not in their last year of life. However, as they advance in age, particularly after the age of 90, this difference diminishes for most measures, although it is still substantial for days spent in hospital as an inpatient, and for pharmaceutical dispensings.

► **Exploring the Collaboration Between Formal and Informal Care from the Professional Perspective—A Thematic Synthesis**

HENGELAAR A. H., HARTINGSVELDT M.,

WITTENBERG Y., *et al.*

2018

Health & Social Care in the Community 26(4): 474-485.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.12503>

In Dutch policy and at the societal level, informal caregivers are ideally seen as essential team members when creating, together with professionals, co-ordinated support plans for the persons for whom they care. However, collaboration between professionals and informal caregivers is not always effective. This

can be explained by the observation that caregivers and professionals have diverse backgrounds and frames of reference regarding providing care. This thematic synthesis sought to examine and understand how professionals experience collaboration with informal caregivers to strengthen the care triad. PubMed, Medline, PsycINFO, Embase, Cochrane/Central and CINAHL were searched systematically until May 2015, using specific key words and inclusion criteria. Twenty-two articles were used for thematic synthesis. Seven themes revealed different reflections by professionals illustrating the complex, multi-faceted and dynamic interface of professionals and informal care. Working in collaboration with informal caregivers requires professionals to adopt a different way of functioning. Specific attention should be paid to the informal caregiver, where the focus now is mainly on the client for whom they care. This is difficult to attain due to different restrictions experienced by professionals on policy and individual levels. Specific guidelines and training for the professionals are necessary in the light of the current policy changes in the Netherlands, where an increased emphasis is placed on informal care structures.

► **Motifs d'adhésion à une activité physique adaptée chez des seniors en ALD**

MORALES GONZALES V., SCHUFT L., FOURNIER M., et al.

2018

Gérontologie et société (40)156 : 143-159.

<https://www.cairn.info/revue-gerontologie-et-societe-2018-2-page-143.htm>

Dans un contexte de vieillissement des populations et d'accroissement des maladies chroniques, l'activité physique adaptée (APA) émerge de plus en plus comme une modalité de prise en charge de la santé. L'efficacité des APA dépend de l'adhésion des participants. Cet article aborde les motifs d'adhésion de seniors atteints de maladies cardiovasculaires dans un programme APA en région PACA. L'enquête a été menée au travers d'entretiens semi-directifs auprès de 33 seniors participant ou ayant participé au programme. Les résultats montrent des différences de motifs entre les phases d'initiation et de maintien dans l'AP : il semblerait que si on vient pour la santé physique, on y reste pour le bien-être, notamment social. Si l'objectif de « guérison » est partagé par toutes et tous dans le démarrage du programme APA, le partage de

lien social, l'absence de compétition et le cadre bienveillant et sécuritaire sont énoncés comme les raisons importantes d'adhésion maintenue au programme.

► **Les habits neufs du « vieillissement en bonne santé » : activité et environnement**

MOULAERT T.

2018

Gérontologie et société (40) 156: 19-34.

<https://www.cairn.info/revue-gerontologie-et-societe-2018-2-page-19.htm>

Cet article retrace la genèse du référentiel international d'action publique « Healthy ageing/vieillessement en bonne santé » dans les travaux de l'Organisation mondiale de la santé (OMS). Venant remplacer celui du « active ageing/vieillessement actif » dans le dernier rapport mondial sur le vieillissement et la santé de 2015 de l'OMS, ce « vieillissement en bonne santé » prend distance avec la seule promotion de l'activité physique focalisée sur l'individu par l'action sur le lifestyle, approche initiale du « vieillissement en bonne santé » dès 1996. Nous appuyant sur le concept de bio-légitimité défini par Didier Fassin comme « la manière dont les problèmes sociaux trouvent, non pas leur solution, mais leur expression la plus autorisée dans le langage de la santé publique », nous soutenons la thèse selon laquelle l'OMS promeut aujourd'hui une extension sanitaire des domaines du vivant en matière de vieillissement en s'appuyant sur la notion large d'environnement, sans pour autant abandonner celle d'activité. Pour cela, l'OMS déplace son attention des capacités fonctionnelles (intrinsèques) de l'individu au soutien des « aptitudes fonctionnelles ». Ainsi, l'activité physique, si elle n'est pas effacée, devient un facteur de potentialité parmi d'autres afin de permettre aux personnes âgées d'« être et [de] réaliser ce qu'elles ont des raisons de valoriser ».

Author index

A

Abay S. M.....	22
Abay S.M.	31
Acarturk C.....	52
Agarwal R.	35
Alameddine M.....	16
Alexandersen N.	13
Ali A. M.....	25
Altares Sarik D.	53
Amarenco P.....	23
Amariei A.....	51
Amerio A.....	50
Anderson T. S.	35
Andler R.....	47
Angelo M.	52
Annear P. L.....	25
Anthierens S.	49
Armeni P.	38
Artigas F.....	48

B

Baerheim A.....	18
Baker R.	34
Barea C.	43
Barnay T.....	59
Barnes H.	53
Barthold D.	38
Baum F.....	32
Bec C.....	47
Benallah S.....	26
Berchtold P.....	57
Bernstrøm V. H.	59
Berroneau A.	36
Berzina-Novikova N.	52
Bessou A.....	46

Bird M.....	52
Bismuth M.	52
Bismuth S.....	14
Bloor K.	42
Boisserie-Lacroix L.	26
Bojke C.....	42
Bolte G.....	49
Borza T.	26
Bottle A.....	25
Bourgeon L.	16
Bourgue C.....	16
Bourgueil Y.....	58
Bras P-L.....	27
Breda J.....	48
Briffault X.....	14
Buchet-Poyau K.	44
Bučičienė I.....	24
Bureau V.	17
Busse R.	58
Butterworth P.	20

C

Cabrol M.....	16
Campbell J. A.	17
Caniaux I.....	38
Carette C.....	23
Cascone D.....	29
Casey M.....	15
Catherine W.....	56
Cebrecos A.....	23
Chareyron S.	31
Chi G.	24
Coenen S.....	49
Cogordan C.	47
Coppieters Y.....	46
Cornu-Pauchet M.	13

Couray-Targe S.....	18
Crabtree B. F.....	53
Cribb A.....	41 , 43 , 44 , 60
Csajka C.....	16

D

Dahl H. M.....	17
Dahmani S.....	27
Dalziel K.....	53
de Chambine S.....	28
Découard P.....	14
Defebvre É.....	59
Delouette I.....	47
Desbois D.....	15
Desnoyer A.....	36
Desquesnes G.....	59
de Stampa M.....	26
Dimitrovova K.....	54
Di Thiene D.....	32
Domínguez-Berjón M. F.....	23
Domin J.-P.....	26
Dowling S.....	54
Dray Spira R.....	34
Duc C.....	60
Dunlop W. C. N.....	36
Dunsch F.....	39
Duque I.....	23

E

Elger B.....	19
El-Khoury F.....	50
Ellen M. E.....	58
Emmert M.....	18
Entwistle V. A.....	43 , 44 , 60
Essén A.....	15
Evans D. K.....	39
Ezzy D.....	17

F

Farah A.....	16
Fendrick A. M.....	35
Fernandez O.....	22
Ferreira D. C.....	27
Finnigan H.....	54
Fitzgerald J. A.....	56
Flament C.....	51
Foerster J.....	18
Fontaine A.....	48
Fortin J.-P.....	15
Fournier C.....	41 , 54
Fournier M.....	61
Frattini M. O.....	54
Freeman T.....	32
Freund Y.....	27
Fullman N.....	22 , 31

G

Gagnayre R.....	33 , 43
Gagnon M.-P.....	15
Gaillard M.....	36
Ganne C.....	18
Geissler A.....	21
Gellad W. F.....	35
Geri-Trial C.....	16
Gerrits R.....	15
Ghandour E. K.....	15
Giacopelli M.....	28
Girvalaki C.....	48
Glynn F.....	15
Glynn L. G.....	15
Gomes M.....	49
Gosselin A.....	32
Goštautaitė B.....	24
Goulet H.....	27
Grieve R.....	49
Grundy Q.....	41
Guégan M.....	33

Guével M.-R.	25
Guignard B.	36
Gunn J. M.	53
Gupta A.	35
Gutacker N.	42
Gyrd-Hansen D.	30

H

Haarmann A.	18
Habibi R.	41
Hamblin R.	61
Harris N.	56
Hartingsveldt M.	61
Hébert R.	46
Helgesson M.	32
Hengelaar A. H.	61
Herbst T.	18
Hernández-Peña P.	19
Herrmann W. J.	18
Higgs G.	24
Ho H. C.	24
Hrifach A.	18

I

Ioannidis J. P.	39
----------------------	----

J

Jaffrès F.	25
Jakovljevic J.	48
Javanparast S.	32
Jensen L. G.	17
Jommi C.	38
Josset J. M.	56
Jouve M.	27
Joyce G.	21 , 22
Jusot F.	13

K

Kaarboe O.	13
Kennedy, G.	55
Knudby A.	24
Kohler D.	57
Kumah E.	42
Kundu, S.	55
Kwon S.	25

L

Lachkhem Y.	42
Lagasnerie G.	13
Landriscina T.	50
Langford M.	24
Lang P. O.	16
Lang P.-O.	36
Lano J.	16
Last J.	54
Laszlo S.	28
Lavallee P. C.	23
Leblanc J.	27
Lecarpentier M.	34
Le Cossec C.	28
Legeai C.	46
Leitch S.	38
Le Lann Y.	47
Lemoine P.	39
Leroux V.	16
Leu A.	19
Levy P.	36
Lewis, V. A.	55
Lhachimi S. K.	49
Liao J. M.	19 , 20
Li J.	53
Lo-Ciganic W.-H.	35
Lombrail P.	33
Looten V.	20
Lorenzoni L.	25
Lubbeke A.	43

Lucchetti A. L. G.....	37
Lucchetti G.....	37

M

Macis M.....	39
Maier C. B.....	53
Margat A.....	33
Marmorat T.....	37
Marques R. C.	27
Marquestaut O.	26
Marquillier T.	43
Martin H.	60
Mason A. J.	49
Matta J.....	23
Matthew P.	28
McNamee P.	20
Meltzer D.....	22
Milašauskienė Ž.....	24
Miller R.	55
Miller W. L.	53
Minko N.....	61
Minvielle E.....	42
Mizrahi A.	40
Moine S.	29
Monfreux M.	59
Monteiro Tavares L.....	23
Morales Gonzales V.	61
Morgan H. M.	43
Morgiève M.....	14
Morton A.	22
Mosnier-Thoumas S.....	36
Mosseveld C.V.....	19
Mougeot F.	44
Moulaert T.....	62
Mucaz Karaaslan M.	34

N

Naamouni K.....	34
-----------------	----

Naiditch M.....	54
Naimi A. I.....	30
Nanninga S.....	49
Napolitano F.	29
Navathe A. S.	20
Neil A.	17
Newitt S.	49
Nunes A. M.....	27

O

Obucina M.....	56
Occelli P.	44
Odone A.	50
Oerline M. K.	26
Oneib B.....	51
Otheman Y.....	51
Otto M.....	38
Oustric S.	52
Owens J.	44 , 60

P

Page N.	24
Pame P.....	56
Panico L.	50
Pannetier J.....	34
Papadakis S.....	48
Pasquereau A.....	47
Paul R.....	28
Pavlic D. R.	57
Pearson J.....	34
Perelman J.	54
Perrier C.....	45
Perrin C.....	45
Peters D. H.....	45
Peters Y. A. S.	57
Pierre A.....	13
Piffaretti C.....	20
Piriou O.....	29

Plancke L.....	51
Polanen Petel W.....	19
Polsky D.	20
Polton D.....	40
Poulalhon C.	29
Pradier C.....	46
Propper C.....	58
Pymont C.	20

Q

Quentin W.	21
-----------------	----

R

Rahman S.....	32
Ranchon F.....	37
Rathmes G.	48
Raynaud D.	13
Remande A.....	14
Rey S.	20
Ribero R.....	22
Rican S.	42
Rice T.	13
Rioufol C.	37
Riverin B. D.....	30
Rives Lange C.....	23
Rivollier E.....	33
Robin M.....	56
Rotelli-Bihet L.	29
Rouault M.....	59
Rutten M. H.....	57

S

Sabir M.	51
Saleh S.	16
Sandikli B.	34
Scandurra I.	15
Schäfer W.....	57

Schufft L.....	61
Schussele Filliettaz S.....	57
Sciolli G.	42
Scott A.	53
Shea J. A.	19
Sheard S.....	45
Shnier A.	41
Shuker C.....	61
Sijbrandij M.	52
Silman A. J.	43
Skea Z. C.	41
Skolarus T. A.	26
Smits M.	57
Song Y.	38
Staufer A.....	36
Steve G.	56
Strumpf E. C.....	30
Sundmacher L.....	30
Sutter-Dallay A. L.	50
Swanson J. O.....	30

T

Taube M.....	52
Tayyari Dehbarez N.....	30
Thomas J.....	29
Thomson S.....	22
Tomassoni D.	29
Toraldo M. L.....	42
Tordoff J.....	38
Torun P.....	34
Treguier J.	60
Trentesaux T.....	43
Trish E.	21
Troisoeufs A.	41
Tuppin P.	46
Turenne M.....	34
Tynkkynen L. K.....	13

U

Uldbjerg N.	30
Unruh L. Y.	13

V

Van Baal P.	22
van Ginneken E.	13 , 58
Van Nuys K.	22
Vardavas C.	48
Vega A.	34
Vélez M.	58
Vermeulen L.	57
Versporten A.	38
Vignier N.	34
Vogt V.	30

W

Watt I. S.	41
Weissman A.	19
Wepf H.	19
Wilson M. G.	58
Wittenbecher F.	21
Wittenberg Y.	61

X

Xu J.	21
------------	----

Y

Yearwood J.	22 , 31
Yerramilli P.	22
Young A.	38

Z

Zarb P.	38
--------------	----