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Sommaire

Assurance maladie / Health Insurance 7

Bock, J.-O., et al. (2016). "A Longitudinal Investigation of Willingness to Pay for Health Insurance in Germany." 7

Call, K. T., et al. (2015). "Coverage Gains After the Affordable Care Act Among the Uninsured in Minnesota." 7

Chanu, P.-Y. (2016). "Modernité de la Sécurité sociale." 7

van Winssen, K. P. M., et al. (2016). "The demand for health insurance and behavioural economics." 7

Economie de la santé / Health Economics 7

Bousquet, F. (2016). "Panorama des dépenses de psychiatrie en France." 7

Dieleman, J. L., et al. "National spending on health by source for 184 countries between 2013 and 2040." 8

Li, B., et al. (2016). "Predicting hospital costs for patients receiving renal replacement therapy to inform an economic evaluation." 8

Palladino, R., et al. (2016). "The Great Recession And Increased Cost Sharing In European Health Systems." 8

Etat de santé / Health Status 8

Filipovic-Pierucci, A., et al. (2016). "L'état de santé des populations des départements d'outre-mer en 2012, comparativement à la métropole : une analyse de la base nationale de l'Assurance maladie." 8

Géographie de la santé / Geography of Health 8

Olié, J. P., et al. (2016). "Attractivité territoriale vs attractivité médicale." 8

Rechel, B., et al. "Hospitals in rural or remote areas: An exploratory review of policies in 8 high-income countries." 9

Siegel, M., et al. (2016). "Developing a composite index of spatial accessibility across different health care sectors: A German example." 9

Handicap / Disability 9

Ben-Shalom, Y. et Stapleton, D. C. (2016). "Predicting Disability among Community-Dwelling Medicare Beneficiaries Using Claims-Based Indicators." 9

Mossello, E., et al. (2016). "Postal screening can identify frailty and predict poor outcomes in older adults: longitudinal data from INTER-FRAIL study." 9

Portegijs, E., et al. (2016). "Is frailty associated with life-space mobility and perceived autonomy in participation outdoors? A longitudinal study." 10

Hôpital / Hospitals 10

Loirat, P., et al. (2016). "Should payment for performance depend on mortality?" 10

Sirven, N. et Rapp, T. (2016). "The Dynamics of Hospital Use among Older People Evidence for Europe Using SHARE Data." 10

Inégalités de santé / Health Inequalities 11

Abdus, S., et al. (2015). "Racial and Ethnic Disparities in Services and the Patient Protection and Affordable Care Act." 11

Agrawal, P. et Venkatesh, A. K. (2016). "Refugee Resettlement Patterns and State-Level Health Care Insurance Access in the United States." 11

Drewniak, D., et al. (2016). "The influence of patients' immigration background and residence permit status on treatment decisions in health care. Results of a factorial survey among general practitioners in Switzerland." 11

García-Pérez, M. (2016). "Converging to American: Healthy Immigrant Effect in Children of Immigrants." 12

Giannoni, M., et al. (2016). "Migrant integration policies and health inequalities in Europe." ... 12

Han, K.-T., et al. "Unmet healthcare needs and community health center utilization among the low-income population based on a nationwide community health survey." 12

Hanssens, L. G. M., et al. (2016). "Access, treatment and outcomes of care: a study of ethnic minorities in Europe." 12

Médicaments / Pharmaceuticals 12

Elliott, R. A. et Lee, C. Y. (2016). "Poor uptake of interdisciplinary medicine reviews for older people is a barrier to deprescribing." 12

Koulayev, S., et al. (2016). "Can Physicians Affect Patient Adherence With Medication?" 13

Michel-Lepage, A. et Ventelou, B. (2016). "The true impact of the French pay-for-performance program on physicians' benzodiazepines prescription behavior." 13

Park, S. et Han, E. (2016). "Do Physicians Change Prescription Practice in Response to Financial Incentives?" 13

Méthodologie – Statistique / Methodology - Statistics 13

de Lagasnerie, G. (2016). "Assurance maladie obligatoire et demande de soins : une analyse par microsimulation." 13

Doat, S., et al. (2016). "Estimation de l'incidence des cancers du sein, de la prostate et du côlon-rectum à partir des bases de l'assurance maladie" 14

Eggink, E., et al. (2016). "Forecasting the use of elderly care: a static micro-simulation model." 14

Semere, W., et al. (2016). "Challenges in Identifying Refugees in National Health Data Sets." ... 14

Ntic - Technologies médicales / E-Health – Medical Technologies 15

Boire, J.-Y. (2016). "Quelles politiques publiques pour favoriser le développement de hautes technologies en santé ?" 15

Postel-Vinay, G. (2016). "Santé et innovation." 15

Trinh-Duc, A., et al. (2016). "[The pharmaceutical record in an emergency department: Assessment of its accessibility and its impact on the level of knowledge of the patient's treatment]." 15

Politique de santé / Health Policy 15

Birch, S., et al. (2016). "Will the Need-Based Planning of Health Human Resources Currently Undertaken in Several Countries Lead to Excess Supply and Inefficiency? A Comment on Basu and Pak." 15

Guiner, S. (2016). "De "la santé dans toutes les politiques" à "toutes les politiques dans la santé" : le régme de visibilité de la prise en compte de la santé dans les politiques de l'Union européenne. ." 16

Politique publique / Public Policy 16

Blanchet, D., et al. (2016). "Évaluation des politiques publiques, ex post et ex ante : l'apport de la microsimulation. Introduction." 16

Smits, P., et al. (2016). "Prendre en compte la santé dans les politiques publiques :Etude d'un régime de gouvernementalité au Québec." 16

Politique sociale / Social Policy 16

von Lennep, F. (2016). "Économie, croissance et protection sociale : comment améliorer le bien-être ?" 16

Prévention / Prevention 16

Bossard, C., et al. (2016). "Surveillance des suicides liés au travail en France : une étude exploratoire." 16

Freitag, S. et Schmidt, S. (2016). "Prevention of frailty through narrative intervention." 16

Prévision – Evaluation / Prevision - Evaluation 17

Shearer, J., et al. (2016). "Economic Evaluation of Mental Health Interventions: A Guide to Costing Approaches." 17

Psychiatrie / Psychiatry....................17

Benamouzig, D. et Ulrich, V. (2016). "Numéro spécial sur la psychiatrie : Avant-propos." 17

Chambon, N. et Le Goff, G. (2016). "Enjeux et controverses de la prise en charge des migrants précaires en psychiatrie." 17

Coldefy, M. (2016). "Les soins en psychiatrie : organisation et évolutions législatives récentes." 18

Coldefy, M., et al. (2016). "L'hospitalisation sans consentement en psychiatrie en 2010 : analyse et déterminants de la variabilité territoriale." 18

Gandré, C., et al. (2016). "Qualité des prises en charge et alternatives à l'hospitalisation à temps plein en psychiatrie. Étude de l'association entre la variabilité des critères illustrant la qualité des prises en charge et le niveau de développement des alternatives à l'hospitalisation à temps plein." 18

Hirsch, V. et Strizyk, A. (2016). "Du secteur au territoire : l'offre de soins ambulatoire au sein de la Communauté hospitalière de territoire pour la psychiatrie parisienne." 18

Lafaye, C. G. (2016). "L'hospitalisation sous contrainte, une source de conflits normatifs." 18

Quantin, C., et al. (2016). "Étude des algorithmes de repérage de la dépression dans le SNIIRAM par le réseau REDSIAM." 19

Soins de santé primaires / Primary Health Care....................19

Agamaliyev, E., et al. (2016). "Les déterminants de l'opinion des médecins généralistes sur la délégation de tâches vers les infirmiers de leur cabinet." 19

Ayanian, J. Z. et Hamel, M. B. (2016). "Transforming Primary Care — We Get What We Pay For." 20

Gulland, A. (2016). "Would Brexit stop the flow of doctors and patients between EU countries?" 20

Marchildon, G. P. et Hutchison, B. "Primary care in Ontario, Canada: New proposals after 15 years of reform." 20

Mayor, S. (2016). "Seven day GP service reduces hospital emergency visits, study finds." 20

Mazumdar, S., et al. (2016). "How useful are Primary Care Service Areas? Evaluating PCSAs as a tool for measuring Primary Care Practitioner access." 20

McWilliams, J. M., et al. (2016). "Early Performance of Accountable Care Organizations in Medicare." 20

Neil, A. L., et al. "The new Australian after-hours general practice incentive payment mechanism: equity for rural general practice?" 21

Schulz, M. (2016). "Do Gatekeeping Schemes Influence Health Care Utilization Behavior Among Patients With Different Educational Background? An Analysis of 13 European Countries." 21

Vernus, A. L., et al. "Maisons et pôles de santé pluriprofessionnels incluant des pharmaciens : un état des lieux." 21

Systèmes de santé / Health Systems 21

Gulland, A. (2016). "What would the NHS look like if the UK left the EU?" 21

Sutherland, J. M. et Busse, R. "Canada: Focus on a country's health system with provincial diversity." 22

Travail et santé / Occupational Health 22

Barnay, T. (2016). "Health, work and working conditions: a review of the European economic literature." 22

Bossard, D., et al. (2016). "Surveillance des suicides liés au travail en France : une étude exploratoire." 22

Curnock, E., et al. (2016). "The impact on health of employment and welfare transitions for those receiving out-of-work disability benefits in the UK." 22

Heggebo, K. (2016). "Health Effects of Unemployment in Denmark, Norway and Sweden 2007-2010: Differing Economic Conditions, Differing Results?" 23

Murcia López, G., et al. (2016). "Has the Spanish economic crisis affected the duration of sickness absence episodes?" 23

Skagen, K. et Collins, A. M. (2016). "The consequences of sickness presenteeism on health and wellbeing over time: A systematic review." 23

Vieillissement / Ageing 24

Moberg, L., et al. (2016). "User choice in Swedish eldercare – conditions for informed choice and enhanced service quality." 24

Assurance maladie / Health Insurance

Bock, J.-O., et al. (2016). "A Longitudinal Investigation of Willingness to Pay for Health Insurance in Germany." Health Serv Res, Ahead of print.
http://dx.doi.org/10.1111/1475-6773.12522

Objective To investigate factors affecting willingness to pay (WTP) for health insurance of older adults in a longitudinal setting in Germany. Data Sources Survey data from a cohort study in Saarland, Germany, from 2008–2010 and 2011–2014 (n1 = 3,124; n2 = 2,761) were used. Study Design Panel data were taken at two points from an observational, prospective cohort study. Data Collection WTP estimates were derived using a contingent valuation method with a payment card. Participants provided data on sociodemographics, lifestyle factors, morbidity, and health care utilization. Principal Findings Fixed effects regression models showed higher individual health care costs to increase WTP, which in particular could be found for members of private health insurance. Changes in income and morbidity did not affect WTP among members of social health insurance, whereas these predictors affected WTP among members of private health insurance. Conclusions The fact that individual health care costs affected WTP positively might indicate that demanding (expensive) health care services raises the awareness of the benefits of health insurance. Thus, measures to increase WTP in old age should target at improving transparency of the value of health insurances at the moment when individual health care utilization and corresponding costs are still relatively low.

Call, K. T., et al. (2015). "Coverage Gains After the Affordable Care Act Among the Uninsured in Minnesota." Am J Public Health **105 Suppl 5**: S658-664.

OBJECTIVES: We determined whether and how Minnesotans who were uninsured in 2013 gained health insurance coverage in 2014, 1 year after the Affordable Care Act (ACA) expanded Medicaid coverage and enrollment. METHODS: Insurance status and enrollment experiences came from the Minnesota Health Insurance Transitions Study (MH-HITS), a follow-up telephone survey of children and adults in Minnesota who had no health insurance in the fall of 2013. RESULTS: ACA had a tempered success in Minnesota. Outreach and enrollment efforts were effective; one half of those previously uninsured gained coverage, although many reported difficulty signing up (nearly 62%). Of the previously uninsured who gained coverage, 44% obtained their coverage through MNsure, Minnesota's insurance marketplace. Most of those who remained uninsured heard of MNsure and went to the Web site. Many still struggled with the enrollment process or reported being deterred by the cost of coverage. CONCLUSIONS: Targeting outreach, simplifying the enrollment process, focusing on affordability, and continuing funding for in-person assistance will be important in the future.

Chanu, P.-Y. (2016). "Modernité de la Sécurité sociale." Revue française des affaires sociales **5**(1): 333-342.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-1-page-333.htm

Le 6 octobre dernier a été marqué par la célébration du 70e anniversaire de la création de la Sécurité sociale, en présence du président de la République et de la ministre des Affaires sociales et de la Santé.Ces célébrations décennales sont devenues rituelles. Dès 1955, le syndicat Force ouvrière organisait des journées d'étude de la Sécurité sociale autour du thème « la Sécurité sociale a 10 ans ».

van Winssen, K. P. M., et al. (2016). "The demand for health insurance and behavioural economics." The European Journal of Health Economics **17**(6): 653-657.
http://dx.doi.org/10.1007/s10198-016-0776-3

Economie de la santé / Health Economics

Bousquet, F. (2016). "Panorama des dépenses de psychiatrie en France." Revue française des affaires sociales **6**(2): 31-34.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-2-page-31.htm

Dieleman, J. L., et al. "National spending on health by source for 184 countries between 2013 and 2040." The Lancet **387**(10037): 2521-2535.

http://dx.doi.org/10.1016/S0140-6736(16)30167-2

BackgroundA general consensus exists that as a country develops economically, health spending per capita rises and the share of that spending that is prepaid through government or private mechanisms also rises. However, the speed and magnitude of these changes vary substantially across countries, even at similar levels of development. In this study, we use past trends and relationships to estimate future health spending, disaggregated by the source of those funds, to identify the financing trajectories that are likely to occur if current policies and trajectories evolve as expected.

Li, B., et al. (2016). "Predicting hospital costs for patients receiving renal replacement therapy to inform an economic evaluation." The European Journal of Health Economics **17**(6): 659-668.

http://dx.doi.org/10.1007/s10198-015-0705-x

To develop a model to predict annual hospital costs for patients with established renal failure, taking into account the effect of patient and treatment characteristics of potential relevance for conducting an economic evaluation, such as age, comorbidities and time on treatment. The analysis focuses on factors leading to variations in inpatient and outpatient costs and excludes fixed costs associated with dialysis, transplant surgery and high cost drugs.

Palladino, R., et al. (2016). "The Great Recession And Increased Cost Sharing In European Health Systems." Health Affairs **35**(7): 1204-1213.

http://content.healthaffairs.org/content/35/7/1204.abstract

European health systems are increasingly adopting cost-sharing models, potentially increasing out-of-pocket expenditures for patients who use health care services or buy medications. Government policies that increase patient cost sharing are responding to incremental growth in cost pressures from aging populations and the need to invest in new health technologies, as well as to general constraints on public expenditures resulting from the Great Recession (2007–09). We used data from the Survey of Health, Ageing and Retirement in Europe to examine changes from 2006–07 to 2013 in out-of-pocket expenditures among people ages fifty and older in eleven European countries. Our results identify increases both in the proportion of older European citizens who incurred out-of-pocket expenditures and in mean out-of-pocket expenditures over this period. We also identified a significant increase over time in the percentage of people who incurred catastrophic health expenditures (greater than 30 percent of the household income) in the Czech Republic, Italy, and Spain. Poorer populations were less likely than those in the highest income quintile to incur an out-of-pocket expenditure and reported lower mean out-of-pocket expenditures, which suggests that measures are in place to provide poorer groups with some financial protection. These findings indicate the substantial weakening of financial protection for people ages fifty and older in European health systems after the Great Recession.

Etat de santé / Health Status

Filipovic-Pierucci, A., et al. (2016). "L'état de santé des populations des départements d'outre-mer en 2012, comparativement à la métropole : une analyse de la base nationale de l'Assurance maladie." Revue d'Epidmiologie et de Santé Publique **64**(3): 175-183.

Géographie de la santé / Geography of Health

Olié, J. P., et al. (2016). "Attractivité territoriale vs attractivité médicale." Revue Territoire & Santé (La)(2).

Près de 70 % des maires des petites villes ont rencontré des difficultés pour trouver des remplaçants

aux médecins quittant la commune. Quelles solutions apporter ? Le déploiement du numérique peut-il favoriser l'accès aux soins de ceeux qui en sont le plus éloignés ?

Rechel, B., et al. "Hospitals in rural or remote areas: An exploratory review of policies in 8 high-income countries." Health Policy **120**(7): 758-769.

http://dx.doi.org/10.1016/j.healthpol.2016.05.011

?Australia and Canada have policies on hospitals in rural or remote areas at the sub-national level.?The United States has used a number of federal policy levers.?Common challenges include financial sustainability, medical education, telemedicine and transport.

Siegel, M., et al. (2016). "Developing a composite index of spatial accessibility across different health care sectors: A German example." Health Policy **120**(2): 205-212.

The evolving lack of ambulatory care providers especially in rural areas increasingly challenges the strict separation between ambulatory and inpatient care in Germany. Some consider allowing hospitals to treat ambulatory patients to tackle potential shortages of ambulatory care in underserved areas. In this paper, we develop an integrated index of spatial accessibility covering multiple dimensions of health care. This index may contribute to the empirical evidence concerning potential risks and benefits of integrating the currently separated health care sectors. Accessibility is measured separately for each type of care based on official data at the district level. Applying an Improved Gravity Model allows us to factor in potential cross-border utilization. We combine the accessibilities for each type of care into a univariate index by adapting the concept of regional multiple deprivation measurement to allow for a limited substitutability between health care sectors. The results suggest that better health care accessibility in urban areas persists when taking a holistic view. We believe that this new index may provide an empirical basis for an inter-sectoral capacity planning.

Handicap / Disability

Ben-Shalom, Y. et Stapleton, D. C. (2016). "Predicting Disability among Community-Dwelling Medicare Beneficiaries Using Claims-Based Indicators." Health Serv Res **51**(1): 262-281.

OBJECTIVES: To assess the feasibility of using existing claims-based algorithms to identify community-dwelling Medicare beneficiaries with disability based solely on the conditions for which they are being treated, and improving on these algorithms by combining them in predictive models. DATA SOURCE: Data on 12,415 community-dwelling fee-for-service Medicare beneficiaries who first responded to the Medicare Current Beneficiary Survey (MCBS) in 2003-2006. STUDY DESIGN: Logistic regression models in which six claims-based disability indicators are used to predict self-reported disability. Receiver operating characteristic (ROC) curves were used to assess the performance of the predictive models. PRINCIPAL FINDINGS: The predictive performance of the regression-based models is better than that of the individual claims-based indicators. At a predicted probability threshold chosen to maximize the sum of sensitivity and specificity, sensitivity is 0.72 for beneficiaries age 65 or older and specificity is 0.65. For those under 65, sensitivity is 0.54 and specificity is 0.67. The findings also suggest ways to improve predictive performance for specific disability populations of interest to researchers. CONCLUSIONS: Predictive models that incorporate multiple claims-based indicators provide an improved tool for researchers seeking to identify people with disabilities in claims data.

Mossello, E., et al. (2016). "Postal screening can identify frailty and predict poor outcomes in older adults: longitudinal data from INTER-FRAIL study." Age and Ageing **45**(4): 469-474.

http://ageing.oxfordjournals.org/content/45/4/469.abstract

Objective: identification of older individuals at risk for health-related adverse outcomes (HRAO) is necessary for population-based preventive interventions. Aim of this study was to improve a previously validated postal screening questionnaire for frailty in non-disabled older subjects and to test its prognostic validity in a vast sample of older community-dwellers.Methods: individuals aged 70+ underwent a mass postal screening. Physical frailty phenotype (PFP) was assessed in the

unselected subsample of the first responders. After a 1-year follow-up, HRAO were recorded in the whole sample, including survival, access to Emergency Department, hospitalisation and Long-Term Care admission.Results: the questionnaire was mailed to 17,273 subjects, whose response rate was 55%. Among the first 1,037 responders without overt disability, the revised questionnaire was 75% sensitive and 69% specific for PFP (ROC 0.772). Non-disabled subjects who screened positive had a higher risk of HRAO in comparison with those who screened negative and similar to non-responders. Risk of adverse outcome was highest among disabled subjects.Conclusions: a simple questionnaire delivered by mail has good accuracy in detecting PFP in non-disabled older subjects and is able to predict HRAO.

Portegijs, E., et al. (2016). "Is frailty associated with life-space mobility and perceived autonomy in participation outdoors? A longitudinal study." Age and Ageing **45**(4): 550-553.
http://ageing.oxfordjournals.org/content/45/4/550.abstract

Background: essential aspects of independence in community mobility among older people concern the control over where, when and how to participate (perceived autonomy), and actual mobility (life-space mobility; frequency, distance and need of assistance). We studied relationships between frailty and life-space mobility and perceived autonomy in participation outdoors among community-dwelling 75–90 years old people.Methods: longitudinal analyses of the 'Life-space mobility in old age' cohort study (n = 753). Life-space mobility (Life-Space Assessment, range 0–120) and perceived autonomy in participation outdoors (Impact on Participation and Autonomy subscale 'autonomy outdoors', range 0–20) were assessed at baseline and 2 years later. Baseline frailty indicators were unintentional weight loss (self-report), weakness (5 times chair rise), exhaustion (self-report), slowness (2.44 m walk) and low physical activity (self-report).Results: in total, 53% had no frailty, 43% pre-frailty (1–2 frailty indicators) and 4% frailty (≥3 indicators). Generalised estimation equation models showed that life-space mobility was lower among those with frailty and pre-frailty compared with those without frailty and, in addition, declined at a faster pace. Perceived autonomy in participation outdoors was more restricted among those with frailty and pre-frailty compared with those without frailty, but the rate of decline did not differ.Conclusion: frailty was associated with more restricted life-space mobility and poorer perceived autonomy in the decision-making concerning community mobility. Over the follow-up, frailty predicted a steeper decline in life-space mobility but not in perceived autonomy. Further study is warranted to determine whether compensation strategies or changes in the valuation of activities underlie this discrepancy.

Hôpital / Hospitals

Loirat, P., et al. (2016). "Should payment for performance depend on mortality?" BMJ **353**.
http://www.bmj.com/content/bmj/353/bmj.i3429.full.pdf

The introduction of the Hospital Value Based Purchasing (HVBP) programme, as shown recently by Jose F Figueroa and colleagues, did not improve 30 day mortality of Medicare beneficiaries admitted to US hospitals for three incentivised conditions. We agree with the authors' conclusion that an "appropriate mix of quality metrics and incentives to improve patient outcomes" has yet …

Nam, **Y. S., et al. "Greater continuity of care reduces hospital admissions in patients with hypertension: An analysis of nationwide health insurance data in Korea, 2011-2013."** Health Policy **120**(6): 604-611.
http://dx.doi.org/10.1016/j.healthpol.2016.04.012

We investigate the association between continuity of care and hospital admission.?Greater continuity of care will decrease risk of hospital admission in hypertension patients.?Increasing medication possession ratio will decrease risk of hospital admission.?We report the need for a healthcare delivery system that promotes continuity of care.

Sirven, N. et Rapp, T. (2016). "The Dynamics of Hospital Use among Older People Evidence for Europe Using SHARE Data." Health Serv Res: Ahead of print.
http://dx.doi.org/10.1111/1475-6773.12518

Objective Hospital services use, which is a major driver of total health expenditures, is expected to rise over the next decades in Europe, especially because of population aging. The purpose of this article is to better understand the dynamics of older people's demand for hospital care over time in a cross-country setting. Data source We used data from the Survey on Health, Ageing, and Retirement in Europe (SHARE), in 10 countries between 2004 and 2011. Study Design We estimated a dynamic panel model of hospital admission for respondents aged 50 years or more. Principal Findings Following prior research, we found evidence of state dependence in hospital use over time. We also found that rise in frailty—among other health covariates—is a strong predictor of increased hospital use. Progression by one point on the frailty scale [0;5] is associated with an additional risk of about 2.1 percent on average. Conclusions Our results support promotion of early detection of frailty in primary care, and improvement of coordination between actors within the health system, as potential strategies to reduce avoidable or unnecessary hospital use among frail elderly.

Inégalités de santé / Health Inequalities

Abdus, S., et al. (2015). "Racial and Ethnic Disparities in Services and the Patient Protection and Affordable Care Act." Am J Public Health **105 Suppl 5**: S668-675.

OBJECTIVES: We examined prereform patterns in insurance coverage, access to care, and preventive services use by race/ethnicity in adults targeted by the coverage expansions of the Patient Protection and Affordable Care Act (ACA). METHODS: We used pre-ACA household data from the Medical Expenditure Panel Survey to identify groups targeted by the coverage provisions of the Act (Medicaid expansions and subsidized Marketplace coverage). We examined racial/ethnic differences in coverage, access to care, and preventive service use, across and within ACA relevant subgroups from 2005 to 2010. The study took place at the Agency for Healthcare Research and Quality in Rockville, Maryland. RESULTS: Minorities were disproportionately represented among those targeted by the coverage provisions of the ACA. Targeted groups had lower rates of coverage, access to care, and preventive services use, and racial/ethnic disparities were, in some cases, widest within these targeted groups. CONCLUSIONS: Our findings highlighted the opportunity of the ACA to not only to improve coverage, access, and use for all racial/ethnic groups, but also to narrow racial/ethnic disparities in these outcomes. Our results might have particular importance for states that are deciding whether to implement the ACA Medicaid expansions.

Agrawal, P. et Venkatesh, A. K. (2016). "Refugee Resettlement Patterns and State-Level Health Care Insurance Access in the United States." Am J Public Health **106**(4): 662-663.

We sought to evaluate the relationship between state-level implementation of the Patient Protection and Affordable Care Act (ACA) and resettlement patterns among refugees. We linked federal refugee resettlement data to ACA expansion data and found that refugee resettlement rates are not significantly different according to state-level insurance expansion or cost. Forty percent of refugees have resettled to states without Medicaid expansion. The wide state-level variability in implementation of the ACA should be considered by federal agencies seeking to optimize access to health insurance coverage among refugees who have resettled to the United States.

Drewniak, D., et al. (2016). "The influence of patients' immigration background and residence permit status on treatment decisions in health care. Results of a factorial survey among general practitioners in Switzerland." Social Science & Medicine **161**: 64-73.

http://www.sciencedirect.com/science/article/pii/S0277953616302672

This study examines the influence of patients' immigration background and residence permit status on physicians' willingness to treat patients in due time. A factorial survey was conducted among 352 general practitioners with a background in internal medicine in a German-speaking region in Switzerland. Participants expressed their self-rating (SR) as well as the expected colleague-rating (CR) to provide immediate treatment to 12 fictive vignette patients. The effects of the vignette variables were analysed using random-effects models. The results show that SR as well as CR was not only

influenced by the medical condition or the physicians' time pressure, but also by social factors such as the ethnicity and migration history, the residence permit status, and the economic condition of the patients. Our findings can be useful for the development of adequate, practically relevant teaching and training materials with the ultimate aim to reduce unjustified discrimination or social rationing in health care.

García-Pérez, M. (2016). "Converging to American: Healthy Immigrant Effect in Children of Immigrants." American Economic Review **106**(5): 461-466.

We analyze children of immigrants' healthy immigrant effect using parental year of arrival and region of birth. Using data from Integrated National Health Interview Survey 2008-2014, we evaluate children of immigrants' health status by using obesity rates and the number of visits to the doctor versus their native counterparts. Consistent with their parents, children of immigrants' health status declines the longer their parents, remain in the United States. Meanwhile, there is an increase in the number of visits to the doctor the more years their parents, have resided in the country. The convergence rate differs by immigrant group.

Giannoni, M., et al. (2016). "Migrant integration policies and health inequalities in Europe." BMC Public Health **16**(1): 1-14.

http://dx.doi.org/10.1186/s12889-016-3095-9

Research on socio-economic determinants of migrant health inequalities has produced a large body of evidence. There is lack of evidence on the influence of structural factors on lives of fragile groups, frequently exposed to health inequalities. The role of poor socio-economic status and country level structural factors, such as migrant integration policies, in explaining migrant health inequalities is unclear. The objective of this paper is to examine the role of migrant socio-economic status and the impact of migrant integration policies on health inequalities during the recent economic crisis in Europe.

Han, K.-T., et al. "Unmet healthcare needs and community health center utilization among the low-income population based on a nationwide community health survey." Health Policy **120**(6): 630-637.

http://dx.doi.org/10.1016/j.healthpol.2016.04.004

?The low-income population had higher unmet needs and utilized community health centers (CHC) more frequently compared with the higher income groups.?The low-income population visited CHC for primary care and vaccinations.?The high-income population visited CHC for incidental purposes.

Hanssens, L. G. M., et al. (2016). "Access, treatment and outcomes of care: a study of ethnic minorities in Europe." International Journal of Public Health **61**(4): 443-454.

http://dx.doi.org/10.1007/s00038-016-0810-3

Recent research has shown that ethnic minorities still have less access to medical care and are less satisfied with the treatment they receive and the outcomes of the health care process. This article assesses how migrants in Europe experience access, treatment and outcomes in the European health care systems.

Médicaments / Pharmaceuticals

Elliott, R. A. et Lee, C. Y. (2016). "Poor uptake of interdisciplinary medicine reviews for older people is a barrier to deprescribing." BMJ **353**.

http://www.bmj.com/content/bmj/353/bmj.i3496.full.pdf

Rohan A Elliott, clinical senior lecturer and senior aged care pharmacist1 2, Cik Yin Lee, research fellow1 31Centre for Medicine Use and Safety, Monash University, Melbourne, Victoria, Australia2Pharmacy Department, Austin Health, Melbourne, Victoria, Australia3Royal District Nursing Service (RDNS) Institute, Melbourne, Victoria, Australiarohan.elliott{at}monash.eduIn their recent

article about deprescribing through shared decision making,1 Jansen and colleagues note that many of the triggers for deprescribing can be identified only by a medicine review and that this review can be triggered by important “life transitions.” …

Koulayev, S., et al. (2016). "Can Physicians Affect Patient Adherence With Medication?" Health Economics: n/a-n/a.
http://dx.doi.org/10.1002/hec.3357

Non-compliance with medication therapy remains an unsolved and expensive problem for healthcare systems around the world, yet we know little about the factors that affect a patient's decision to follow treatment recommendations. In particular, there is little evidence on the extent to which doctors can influence patient adherence behavior. This study uses a unique panel dataset comprising all prescription drug users, physicians, and all prescription drug sales in Denmark over 7 years to analyze the contributions of doctor-specific, patient-specific, and drug-specific factors to the adherence decision. We find that physicians exert substantial influence on patient compliance. Further, the quality of the match between a doctor and a patient accounts for a substantial portion of the variation in adherence outcomes. This suggests that the sorting of patients across doctors is an important mechanism that affects patient adherence beyond the effects of individual patient-specific and physician-specific factors. Copyright © 2016 John Wiley & Sons, Ltd.

Michel-Lepage, A. et Ventelou, B. (2016). "The true impact of the French pay-for-performance program on physicians’ benzodiazepines prescription behavior." The European Journal of Health Economics **17**(6): 723-732.
http://dx.doi.org/10.1007/s10198-015-0717-6

The French pay-for-performance (P4P) contract CAPI implemented by the national health insurance included a target-goal which aims at reducing benzodiazepines prescriptions. In this investigation, we would like to assess whether: (1) the general practitioners (GPs) having signed P4P contract obtain better results regarding the target-goal than non-signatories; (2) (part of) this progression is due to the CAPI contract itself (tentative measurement of a “causal effect”); (3) (part of) the money spent on this P4P incentive can be self-financed with the amount of pharmaceuticals saved.

Park, S. et Han, E. (2016). "Do Physicians Change Prescription Practice in Response to Financial Incentives?" International Journal of Health Services.
http://joh.sagepub.com/content/early/2016/05/18/0020731416649846.abstract

We assessed the impact on physician prescription behaviors of an outpatient prescription incentive program providing financial rewards to primary care physicians for saving prescription costs in South Korea. A 10% sample of clinics (N = 1,625) was randomly selected from all clinics in the National Health Insurance claims database for the years 2009–2012, and all claims with the primary diagnosis of peptic ulcer or gastro-esophageal reflux diseases were extracted from those clinics’ data. A clinic-level random-effects model was used. After the program, clinics in general medicine showed a lower prescription rate (by 0.8 percentage points), lower number of medicines prescribed (by 0.02), lower prescription duration (by 0.15 days), and lower drug expenditure per claim (by 740 won). Small clinics on the <25th percentile of a regional sum of monthly drug expenditure had shorter prescription duration (by 0.76 days), while large clinics on the ≥75th percentile and clinics in group practice had a higher prescription rate (by 1.5 and 2.5 percentage points, respectively) and a higher number of medicines prescribed (by 0.03 for group practice only) after the program. The outpatient prescription incentive program worked as intended only in certain subgroup clinics for the target medicines.

Méthodologie – Statistique / Methodology - Statistics

de Lagasnerie, G. (2016). "Assurance maladie obligatoire et demande de soins : une analyse par microsimulation." Revue économique **67**(4): 849-878.
http://www.cairn.info/revue-economique-2016-4-page-849.htm

a microsimulation a souvent été utilisée pour simuler les effets de réformes du remboursement des soins, mais le plus souvent dans un cadre statique sans modification des comportements des patients.

Geoffard et de Lagasnerie [2013] ont notamment suivi cette méthodologie pour examiner l'impact de l'instauration d'une franchise, d'un ticket modérateur unique et d'un plafond de reste à charge. Cet article prolonge ce travail en y introduisant des réactions comportementales calibrées à partir des conclusions des études empiriques mesurant l'élasticité-prix de la demande de soins, c'est-à-dire la variation de consommation de soins consécutive à une modification de la couverture des soins. En intégrant dans le modèle de microsimulation des réactions comportementales, cette étude montre que, jusqu'à une certaine valeur de la franchise (égale à environ 100 euros pour une élasticité-prix de la demande de soins fixée à – 0,2), l'effet de renchérissement du coût des soins du fait de la franchise et du ticket modérateur domine l'effet du plafonnement de reste à charge qui réduit le coût des soins pour certains assurés. Dans ces cas, il est possible de diminuer le plafond de reste à charge grâce au surplus engendré pour l'assurance maladie publique par la diminution de la consommation des assurés. À partir d'une franchise de 100 euros, l'effet s'inverse et il est alors nécessaire d'augmenter le plafond pour garder le même niveau de dépenses pour l'assurance maladie publique.

Doat, S., et al. (2016). "Estimation de l'incidence des cancers du sein, de la prostate et du côlon-rectum à partir des bases de l'assurance maladie" Revue d'Epidmiologie et de Santé Publique **64**(3): 145-152.

L'objectif de cette étude était de comparer l'incidence des cancers du sein, de la prostate et du côlon-rectum obtenue à partir d'algorithmes appliqués à un échantillon de la base de données médico-administratives de l'assurance maladie, à celle estimée à partir des données de registres du cancer.

Eggink, E., et al. (2016). "Forecasting the use of elderly care: a static micro-simulation model." The European Journal of Health Economics **17**(6): 681-691.
http://dx.doi.org/10.1007/s10198-015-0714-9

This paper describes a model suitable for forecasting the use of publicly funded long-term elderly care, taking into account both ageing and changes in the health status of the population. In addition, the impact of socioeconomic factors on care use is included in the forecasts. The model is also suitable for the simulation of possible implications of some specific policy measures. The model is a static micro-simulation model, consisting of an explanatory model and a population model. The explanatory model statistically relates care use to individual characteristics. The population model mimics the composition of the population at future points in time. The forecasts of care use are driven by changes in the composition of the population in terms of relevant characteristics instead of dynamics at the individual level. The results show that a further 37 % increase in the use of elderly care (from 7 to 9 % of the Dutch 30-plus population) between 2008 and 2030 can be expected due to a further ageing of the population. However, the use of care is expected to increase less than if it were based on the increasing number of elderly only (+70 %), due to decreasing disability levels and increasing levels of education. As an application of the model, we simulated the effects of restricting access to residential care to elderly people with severe physical disabilities. The result was a lower growth of residential care use (32 % instead of 57 %), but a somewhat faster growth in the use of home care (35 % instead of 32 %).

Semere, W., et al. (2016). "Challenges in Identifying Refugees in National Health Data Sets." Am J Public Health **106**(7): 1231-1232.

OBJECTIVES: To evaluate publicly available data sets to determine their utility for studying refugee health. METHODS: We searched for keywords describing refugees in data sets within the Society of General Internal Medicine Dataset Compendium and the Inter-University Consortium for Political and Social Research database. We included in our analysis US-based data sets with publicly available documentation and a self-defined, health-related focus that allowed for an examination of patient-level factors. RESULTS: Of the 68 data sets that met the study criteria, 37 (54%) registered keyword matches related to refugees, but only 2 uniquely identified refugees. CONCLUSIONS: Few health data sets identify refugee status among participants, presenting barriers to understanding refugees' health and health care needs. PUBLIC HEALTH IMPLICATIONS: Information about refugee status in national health surveys should include expanded demographic questions and focus on mental health and chronic disease.

Ntic - Technologies médicales / E-Health – Medical Technologies

Boire, J.-Y. (2016). "Quelles politiques publiques pour favoriser le développement de hautes technologies en santé ?" Revue française des affaires sociales **5**(1): 323-325.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-1-page-323.htm

Les hautes technologies sont des activités reposant sur l'innovation et sur des compétences élevées. Quatre types d'intervention doivent permettre d'une part de favoriser l'innovation dans ces secteurs et d'autre part de passer plus facilement à l'étape de la production et de la commercialisation, afin d'en faire un moteur de la croissance.

Postel-Vinay, G. (2016). "Santé et innovation." Revue française des affaires sociales **5**(1): 309-322.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-1-page-309.htm

La santé est, en France comme ailleurs, une priorité stratégique. En tant que demande sociétale, d'abord, où elle figure de façon stable dans le temps en seconde position dans les aspirations de la population (59 % de réponses positives), juste après la réduction du chômage. La santé est également un élément majeur de l'économie : les dépenses courantes de santé représentent 256,9 milliards d'euros...

Trinh-Duc, A., et al. (2016). "[The pharmaceutical record in an emergency department: Assessment of its accessibility and its impact on the level of knowledge of the patient's treatment]." Ann Pharm Fr **74**(4): 288-295.

Knowledge of the home medication list may impact therapeutic decisions made in the emergency department (ED). In France, the pharmaceutical record (PR) is a shared professional tool arising from the pharmacists lists of all drugs dispensed during the last 4 months. This PR is included in a microchip equipping a "Vitale" card detained by each beneficiary of health insurance benefits. Since 2011, the law authorises experimentally the consultation of the PR by some hospital doctors such as those working in emergency medicine. The purpose of this work is to assess the accessibility to this PR and to verify the hypothesis that its consultation increases the level of information concerning the treatment of patients admitted in an ED. A prospective, single-center, observational study was conducted during a 15-day period on all patients arriving at the Agen hospital emergency department. Of the 1046 patients enrolled in the study, 828 (79 %) presented a "Vitale" card in which a PR furnished with data was found in 45 % of the cases. The only paper source of information available was provided by the PR (25 %), a medical letter (6 %) or a prescription (3 %). A dual reconciliation between 2 of these sources was possible at a rate of about 4 % each whereas only 3 % of patients showed up with the 3 sources of available information. The consultation of PR by the ED staff is significantly possible. It improves quantitatively the level of information and thus optimizes medication assessment, the initial and critical step of the medical management of patients.

Politique de santé / Health Policy

Birch, S., et al. (2016). "Will the Need-Based Planning of Health Human Resources Currently Undertaken in Several Countries Lead to Excess Supply and Inefficiency? A Comment on Basu and Pak." Health Economics: Ahead of print.
http://dx.doi.org/10.1002/hec.3370

Basu and Pak (2014) argue that need-based workforce planning models would not maximize social welfare, and use of need-based models would result in inefficiency. They propose that planning be based on service utilization to incorporate preferences or other socioeconomic factors. We show that the analysis is based on inappropriate considerations of the nature of healthcare demand, a misrepresentation of need-based approaches and misunderstanding publicly funded healthcare system objectives. We explain how current levels of utilization emerge from workload and income

interests of providers that underlie utilization-based models and are incompatible with public goals of maximizing health gains. Copyright © 2016 John Wiley & Sons, Ltd.

Guiner, S. (2016). "De "la santé dans toutes les politiques" à "toutes les politiques dans la santé" : le régme de visibilité de la prise en compte de la santé dans les politiques de l'Union européenne. ." Santé Publique **34**(2): 71-79.

Politique publique / Public Policy

Blanchet, D., et al. (2016). "Évaluation des politiques publiques, ex post et ex ante : l'apport de la microsimulation. Introduction." Revue économique **67**(4): 685-696.

http://www.cairn.info/revue-economique-2016-4-page-685.htm

Deux approches sont actuellement très mobilisées pour l'évaluation quantitative des effets des politiques publiques. La première est l'approche expérimentale qui consiste à tester ces effets sur des échantillons d'individus sélectionnés aléatoirement, comme on le fait dans le domaine des essais cliniques. La seconde est l'approche pseudo-expérimentale : elle s'appuie sur la variabilité des politiques...

Smits, P., et al. (2016). "Prendre en compte la santé dans les politiques publiques :Etude d'un régime de gouvernementalité au Québec." Santé Publique **34**(2): 45-70.

Politique sociale / Social Policy

von Lennep, F. (2016). "Économie, croissance et protection sociale : comment améliorer le bien-être ?" Revue française des affaires sociales **5**(1): 301-307.

http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-1-page-301.htm

Le dossier de ce numéro de la Revue française des affaires sociales (RFAS) est né d'une volonté conjointe de la Direction de la recherche, des études, de l'évaluation et des statistiques (DREES), de Bruno Palier et du Centre pour la recherche économique et ses applications (CEPREMAP) d'animer une réflexion internationale sur les liens entre stratégies de croissance et protection sociale. Cet article définit quels sont les enjeux actuels de la protection sociale en France.

Prévention / Prevention

Bossard, C., et al. (2016). "Surveillance des suicides liés au travail en France : une étude exploratoire." Revue d'Epidmiologie et de Santé Publique **64**(3): 201-210.

Il n'existe à l'heure actuelle en France aucun système d'enregistrement permettant de dénombrer les suicides en lien avec le travail, ni même ceux survenant sur un lieu de travail. Une étude de faisabilité relative à la mise en place d'un système multi-sources de surveillance des suicides en lien avec le travail, à partir de données existantes, a été conduite par le département santé travail de l'Institut de veille sanitaire. L'objectif du système était de permettre le dénombrement et la description des suicides en lien avec le travail selon des variables sociodémographiques et professionnelles.

Freitag, S. et Schmidt, S. (2016). "Prevention of frailty through narrative intervention." Social Science & Medicine **160**: 120-127.

http://www.sciencedirect.com/science/article/pii/S0277953616302441

AbstractBackground Frailty is a syndrome of increased vulnerability with adverse outcomes, increasing with age for elderly people. So far, intervention programs have mainly addressed the physical components of frailty. As biographical writing approaches have shown positive effects on cognition

and health, the aim of this study is to investigate the effects of a biographical disclosure intervention on psychological frailty and health in older adults. Methods In total, 198 elderly people (mean age = 75.1 years) were recruited and randomly assigned to four disclosure conditions: oral biographical disclosure, written structured and unstructured biographical disclosure, daily diary and a control group. Frailty was measured with the Tilburg Frailty Indicator, and physical and mental health were assessed with the Short Form (12-item) Health Survey. Measurements were assessed pre- and post-intervention, and at a three month follow-up. Mixed design ANOVAs with repeated measures, correlations and Wilcoxon tests were calculated. Results The sample showed a frailty prevalence of 39.9% pre-intervention. Participants in the oral biographical disclosure, structured biographical writing, and daily diary groups showed improvements in their frailty and mental health, with small effect sizes. No effect for physical health was evident. People with high frailty symptoms and low mental health benefitted from the intervention. Frailty was negatively correlated with physical and mental health components. Conclusions The results of the intervention indicate a short-term positive effect on frailty and mental health in elderly people, who benefitted from the disclosure intervention in terms of improved mental health and lower frailty levels. Early frailty detection is therefore crucial in the treatment and care of older adults, and biographical disclosure approaches can help to maintain health at old age.

Prévision – Evaluation / Prevision - Evaluation

Shearer, J., et al. (2016). "Economic Evaluation of Mental Health Interventions: A Guide to Costing Approaches." PharmacoEconomics **34**(7): 651-664.
http://dx.doi.org/10.1007/s40273-016-0390-3

Costing approaches in the economic evaluation of mental health interventions are complicated by the broad societal impacts of mental health, and the multidisciplinary nature of mental health interventions. This paper aims to provide a practical guide to costing approaches across a wide range of care inputs and illness consequences relevant to the treatment of mental health. The resources needed to deliver mental health interventions are highly variable and depend on treatment settings (institutional, community), treatment providers (medical, non-medical) and formats (individual, group, electronic). Establishing the most appropriate perspective is crucial when assessing the costs associated with a particular mental health problem or when evaluating interventions to treat them. We identify five key cost categories (social care, informal care, production losses, crime and education) impacted by mental health and discuss contemporary issues in resource use measurement and valuation, including data sources and resource use instruments.

Psychiatrie / Psychiatry

Benamouzig, D. et Ulrich, V. (2016). "Numéro spécial sur la psychiatrie : Avant-propos." Revue française des affaires sociales **6**(2): 7-19.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-2-page-7.htm

Chambon, N. et Le Goff, G. (2016). "Enjeux et controverses de la prise en charge des migrants précaires en psychiatrie." Revue française des affaires sociales **6**(2): 123-140.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-2-page-123.htm

Cet article présente les problématiques d'accès au soin en santé mentale des migrants en situation de précarité. La psychiatrie est interpellée sur les questions où sont entremêlées des problématiques médicales, juridiques, administratives et politiques. La question de la légitimité de ces demandes est régulièrement interrogée, d'autant plus dans un contexte où les politiques dénoncent régulièrement le coût de l'aide médicale d'État. Les individus sont donc considérés comme des étrangers avant d'être des sujets malades ou en souffrance.

Après avoir exposé trois typologies – l'immigré, l'exilé, et le migrant précaire – à travers une lecture sociohistorique et leur appréhension en psychiatrie, les auteurs interrogent les demandes de soin en

santé mentale des migrants aujourd'hui. La diversité des demandes met en difficultés les professionnels et les institutions de droit commun. Pour les auteurs, il y a alors un enjeu de santé publique à penser le recalibrage de l'action publique afin de répondre aux problématiques de santé mentale des migrants en situation de précarité.

Coldefy, M. (2016). "Les soins en psychiatrie : organisation et évolutions législatives récentes." Revue française des affaires sociales **6**(2): 21-30.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-2-page-21.htm

Le système français de prise en charge des troubles psychiques se caractérise par une grande pluralité des acteurs, des organisations, des structures et des modalités d'accompagnement. Il fait également l'objet d'une organisation et d'une législation spécifiques par rapport au reste du champ sanitaire. Cette spécificité est liée à plusieurs dimensions : le caractère souvent durable et évolutif...

Coldefy, M., et al. (2016). "L'hospitalisation sans consentement en psychiatrie en 2010 : analyse et déterminants de la variabilité territoriale." Revue française des affaires sociales **6**(2): 253-273.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-2-page-253.htm

En France, 71 000 personnes ont été hospitalisées sans leur consentement en psychiatrie, en 2010. Le taux de recours à l'hospitalisation sans consentement varie fortement géographiquement, à la fois entre pays et à l'intérieur d'un pays. Si la contrainte aux soins est une exception psychiatrique, le soin librement consenti reste privilégié et majoritaire. Nécessaire dans certains cas, elle pose des questions en termes d'atteinte aux libertés des personnes et constitue une problématique majeure pour les équipes soignantes et les personnes concernées. A partir de l'exploitation des données du recueil d'informations médicalisées en psychiatrie, la présente étude propose de décrire cette population, de mesurer la variabilité géographique du recours aux soins sans consentement, et d'explorer le rôle de l'environnement géographique, socio-économique et sanitaire dans les disparités observées. Elle conclut au rôle prépondérant du contexte social et économique pour expliquer cette variabilité.

Gandré, C., et al. (2016). "Qualité des prises en charge et alternatives à l'hospitalisation à temps plein en psychiatrie. Étude de l'association entre la variabilité des critères illustrant la qualité des prises en charge et le niveau de développement des alternatives à l'hospitalisation à temps plein." Revue française des affaires sociales **6**(2): 227-252.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-2-page-227.htm

En France, le développement des alternatives à l'hospitalisation à temps plein (AHTP) en psychiatrie reste faible du fait d'une absence de consensus sur son bénéfice. Ce travail cherche à objectiver les variations des critères illustrant la qualité des prises en charge dans les secteurs français de psychiatrie générale et à mettre en évidence un lien éventuel entre ces variations et le niveau de développement des AHTP. Il s'agit d'une étude rétrospective, utilisant des données médico-administratives sur les prises en charge des patients en psychiatrie générale et des données d'enquêtes sur les établissements. Des variations importantes ont été observées pour les critères illustrant la qualité des prises en charge avec des coefficients de variation systématiquement supérieurs à 50 %. Les résultats suggèrent que le niveau de développement des AHTP est en partie lié à cette variabilité : il existe en particulier une diminution significative de la durée moyenne de séjour et du taux d'hospitalisation à temps plein des patients pris en charge par le secteur avec le développement des AHTP. Des études complémentaires sont maintenant nécessaires pour approfondir ces premiers résultats.

Hirsch, V. et Strizyk, A. (2016). "Du secteur au territoire : l'offre de soins ambulatoire au sein de la Communauté hospitalière de territoire pour la psychiatrie parisienne." Revue française des affaires sociales **6**(2): 275-280.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-2-page-275.htm

Lafaye, C. G. (2016). "L'hospitalisation sous contrainte, une source de conflits normatifs." Revue française des affaires sociales **6**(2): 35-55.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-2-page-35.htm

La psychiatrie est aujourd'hui à la croisée d'attentes normatives, issues à la fois des récentes réformes de la loi concernant l'hospitalisation sous contrainte et également des évolutions sociales, cherchant

auprès de la psychiatrie des solutions à tous les maux (mal-être, délinquance, souffrance sociale). Ces injonctions sont souvent incompatibles et placent les médecins, en particulier lorsqu'il est question de recourir à la contrainte, face à des conflits normatifs. Nous étudierons, en nous appuyant sur une enquête de sociologie qualitative, les procédés par lesquels les psychiatres trouvent une issue à ces conflits, qu'il s'agisse d'opérations de hiérarchisation de normes, d'arrangements normatifs avec la loi ou avec les principes de la déontologie médicale ou, enfin, de retour à l'interrogation, fondatrice en médecine, consistant à identifier la source véritable et légitime de la demande de soins.

Quantin, C., et al. (2016). "Étude des algorithmes de repérage de la dépression dans le SNIIRAM par le réseau REDSIAM." Revue française des affaires sociales **6**(2): 201-225.

http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-2-page-201.htm

Le Système national d'information interrégimes de l'assurance maladie (SNIIRAM) est une source de données médico-administrative de santé quasi exhaustive de la population française, réunissant les données de remboursement de soins de ville et d'hospitalisation. Compte tenu du nombre croissant d'utilisateurs des données du SNIIRAM à des fins d'études, de recherche et de surveillance épidémiologique, le réseau REDSIAM a pour objectif de favoriser l'interaction entre utilisateurs, de valider et de promouvoir les méthodes d'analyses issues des données. Au sein de ce réseau, le groupe de travail Troubles mentaux et du comportement (GT-TMC) s'est intéressé aux algorithmes d'identification de la dépression de l'adulte à partir des données du SNIIRAM. Il apparaît en effet que les pathologies psychiatriques, et notamment la dépression, ont été peu étudiées à partir des bases de données médico-administratives. La méthodologie s'est appuyée sur l'interview de dix experts ayant déjà travaillé sur le SNIIRAM, à partir de questionnaires validés.

La synthèse des entretiens montre que les algorithmes doivent s'adapter aux objectifs spécifiques poursuivis par les études et dépendent du type d'enquête réalisée, du type de dépression, du périmètre de données interrogées et de l'association ou non aux données de consommation médicamenteuse.

Soins de santé primaires / Primary Health Care

Agamaliyev, E., et al. (2016). "Les déterminants de l'opinion des médecins généralistes sur la délégation de tâches vers les infirmiers de leur cabinet." Revue française des affaires sociales **5**(1): 375-404.

http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-1-page-375.htm

Des nouvelles formes de coopération entre les médecins généralistes libéraux et les infirmiers se développent en France, souvent dans le cadre d'expérimentations. La vision des professionnels de santé sur les modalités de cette coopération n'est pas uniforme. À partir des résultats de deux enquêtes réalisées auprès du panel des médecins généralistes, cet article étudie les déterminants de la disposition à déléguer des médecins selon trois scénarios de financement de l'infirmier : la rémunération intégrale par l'assurance maladie, la rémunération mixte (50 % par l'assurance maladie et 50 % par les revenus du cabinet) et la rémunération intégrale par les revenus du cabinet. Tous scénarios confondus, un tiers des médecins généralistes seraient favorables à la délégation d'une ou plusieurs tâches vers un infirmier de leur cabinet. Néanmoins, ce résultat varie sensiblement selon le mode de financement de l'infirmier : les médecins seraient d'autant plus favorables au transfert d'activité que celui-ci est rémunéré par l'assurance maladie (60 % d'entre eux), alors que lorsque l'infirmier est intégralement rémunéré par les revenus du cabinet, seuls 17 % des avis seraient favorables. Nos analyses suggèrent également l'émergence de deux modèles de coopération entre les médecins généralistes libéraux et les infirmiers. Un premier modèle, pour lequel opte la majorité des médecins qui seraient favorables à la délégation, prévoit une délégation d'activités liées à l'accompagnement des patients et au suivi des maladies chroniques (éducation thérapeutique, accompagnement des patients lors de l'arrêt de la consommation de tabac, etc.). Un deuxième modèle beaucoup plus minoritaire semble aussi émerger de médecins favorables à une délégation plus large d'activités y compris des actes techniques (le frottis cervical) ou la prescription d'hémoglobine glyquée (HbA1c).

Ayanian, J. Z. et Hamel, M. B. (2016). "Transforming Primary Care — We Get What We Pay For." New England Journal of Medicine **374**(24): 2390-2392.
http://www.nejm.org/doi/full/10.1056/NEJMe1603778

Gulland, A. (2016). "Would Brexit stop the flow of doctors and patients between EU countries?" BMJ **353**.
http://www.bmj.com/content/bmj/353/bmj.i3138.full.pdf

Anne Gulland, journalist, London, UK agulland{at}bmj.com In the last of a series on the implications for health of the UK leaving the European Union, Anne Gulland examines the likely effects on freedom of movement Would British doctors no longer be able to work elsewhere in Europe? The European Union's Mutual Recognition of Professional Qualifications Directive passed into UK law in January this year. It is the key regulation allowing doctors to practise in other EU states, as well as in Norway, Iceland, and Liechtenstein, and promotes the automatic recognition of professional experience. The directive also allows European regulators to check applicants' language skills and includes an early warning system advising when a doctor is banned or has restrictions on their practise. The number of UK trained doctors practising in Europe is thought to be low, although nobody collects statistics. They can expect that any barriers the UK puts up if it leaves the EU will be matched by EU countries. Would European collaboration in medical research change? According …

Marchildon, G. P. et Hutchison, B. "Primary care in Ontario, Canada: New proposals after 15 years of reform." Health Policy **120**(7): 732-738.
http://dx.doi.org/10.1016/j.healthpol.2016.04.010

?In the past decade, Ontario has led the way in Canada in funding a suite of primary care practice models.?These reforms were accompanied by major new investments but recent funding constraints have led to increased conflict with physicians.?An advisory committee recently established by the Ontario government has recommended more radical changes in financing and governance.?In response, the provincial government is proposing significant changes in the delivery of primary health care but has not accepted the more radical changes in governance and financing suggested by its advisory committee.

Mayor, S. (2016). "Seven day GP service reduces hospital emergency visits, study finds." BMJ **353**.
http://www.bmj.com/content/bmj/353/bmj.i3419.full.pdf

Susan MayorLondonOpening general practices seven days a week reduced the number of visits to hospital accident and emergency departments by nearly 18% at weekends, an evaluation of a pilot scheme in London has estimated.1Researchers analysed patient level data from four general practices in central London that started piloting seven day opening at various times from April 2013, paid for by the Prime Minister's Challenge Fund. They compared emergency department visits as shown in secondary uses service data among patients at the pilot practices with patients from 30 practices in central London that didn't offer appointments across seven days.Results showed that, before …

Mazumdar, S., et al. (2016). "How useful are Primary Care Service Areas? Evaluating PCSAs as a tool for measuring Primary Care Practitioner access." Applied Geography **72**: 47-54.
http://www.sciencedirect.com/science/article/pii/S0143622816300765

The appropriate delivery of primary care services, an important policy imperative in many developed nations, is contingent on defining appropriate geographies to which these services are delivered. Primary Care Service Area (PCSA) geographies have been created in some countries to facilitate primary care policy making and have been utilized in a large body of research. In spite of their extensive use across rural and urban settings, the usefulness of PCSAs has not been evaluated. In this study, for the first time we put PCSAs to the test by comparing them to another small area geography - Postal Areas, and by exploring their usefulness in measuring relationships between Primary Care Practitioner supply and use. We find while PCSAs are better than Postal Areas in measuring relationships between General Practitioner supply and visits by patients, this relationship shows some heterogeneity across areas.

McWilliams, J. M., et al. (2016). "Early Performance of Accountable Care Organizations in

Medicare." New England Journal of Medicine **374**(24): 2357-2366.
http://www.nejm.org/doi/full/10.1056/NEJMsa1600142

Neil, A. L., et al. "The new Australian after-hours general practice incentive payment mechanism: equity for rural general practice?" Health Policy **120**(7): 809-817.
http://dx.doi.org/10.1016/j.healthpol.2016.05.005

?In July 2015, a general practice incentive funding mechanism was introduced in Australia to reward general practices for providing after-hours care.?The mechanism makes payments to practices on the basis of the (age-sex adjusted) number of patients seen by individual practices and service arrangements employed.?The mechanism favours large urban practices and does not take into account the necessity of around-the-clock care provided by small rural practices.?Insufficient consideration was given to regional specificity.

Schulz, M. (2016). "Do Gatekeeping Schemes Influence Health Care Utilization Behavior Among Patients With Different Educational Background? An Analysis of 13 European Countries." International Journal of Health Services.
http://joh.sagepub.com/content/early/2016/06/14/0020731416654663.abstract

Gatekeeping has been introduced to regulate health care demand and to decrease existing educational inequalities in specialist utilization. This article aims to test whether these policy intentions are met effectively. By pooling two waves of the Survey of Health, Ageing, and Retirement in Europe (SHARE), this study performs a cross-country comparison of the impact of two different types of gatekeeping—obligatory referral and skip-and-pay schemes—on absolute and relative general practitioner and specialist utilization levels as well as their moderating effect on inequalities in health care utilization according to education. Results imply that skip-and-pay gatekeeping schemes are not successful in decreasing specialist use and, moreover, aggravate inequalities in health care use, according to education. These findings question the role of choice in health care and call for instruments other than gatekeeping to make health care more efficient and to buffer existing educational inequalities in health care use.

Vernus, A. L., et al. "Maisons et pôles de santé pluriprofessionnels incluant des pharmaciens : un état des lieux." Annales Pharmaceutiques Françaises.
http://www.sciencedirect.com/science/article/pii/S0003450916000201

Résumé : Introduction La réorganisation actuelle des soins de santé primaire en France s'accompagne du développement des structures d'exercice coordonné et de nouvelles missions de santé pour les pharmaciens. Les objectifs de cette étude étaient d'identifier l'ensemble des maisons et pôles de santé pluriprofessionnels (MSP et PSP) en activité intégrant des pharmaciens et de décrire leur organisation et leur fonctionnement. Méthodes Cette étude a inclus les MSP et PSP métropolitains en activité au deuxième semestre 2013, intégrant un ou plusieurs pharmaciens. L'identification des MSP et PSP a été réalisée à partir des informations issues des ARS et de la Fédération française des maisons et pôles de santé (FFMPS). Les données ont été recueillies grâce à un questionnaire électronique. Résultats Au total, 60 structures, dont 35 MSP et 25 PSP, intégraient des pharmaciens. Les sociétés interprofessionnelles de soins ambulatoires (SISA) étaient la principale forme de société choisie pour ces structures. La majorité des MSP et des PSP avait bénéficié de financements publics, principalement des ARS, et les propriétaires des murs des MSP étaient le plus souvent les collectivités territoriales. Les pharmaciens étaient systématiquement conviés à des réunions interprofessionnelles dans les MSP et PSP, et il existait souvent des protocoles de soins transversaux. Les pharmaciens n'avaient jamais accès au secrétariat partagé en MSP et rarement en PSP, et ils avaient inconstamment accès aux dossiers des patients dans les MSP et PSP. Conclusion Les pharmaciens sont actuellement présents dans près d'un quart des MSP et PSP, mais leur intégration dans ces structures est encore partielle.

Systèmes de santé / Health Systems

Gulland, A. (2016). "What would the NHS look like if the UK left the EU?" BMJ **353**.
http://www.bmj.com/content/bmj/353/bmj.i3027.full.pdf

Anne Gulland, freelance journalistLondon, UKagulland{at}bmj.comAnne Gulland asks whether a post-Brexit NHS would look any differentWould there be more money in the NHS budget as a direct result of Brexit?The Conservative MP Boris Johnson has been touring the United Kingdom with his fellow Vote Leavers in a battle bus emblazoned with the words, “We send the EU £350m a week. Let’s fund our NHS instead.” Technically, that figure is correct, says the Institute for Fiscal Studies, but it does not take into account the rebate the UK receives from the European Union or money that doesn’t go through government departments, such as EU grants to universities. The UK’s net contribution to the EU will average £8bn a year over the next five years, the institute has calculated.1Brexit campaigners have also pointed to the potential drain on NHS resources presented by the large numbers of European migrants who may come to the UK in coming years, from Turkey, Macedonia, Albania, Serbia, and Montenegro, all of which want to join the EU.But NHS England’s chief executive, Simon Stevens, has sounded the alarm over the potential of …

Sutherland, J. M. et Busse, R. "Canada: Focus on a country's health system with provincial diversity." Health Policy **120**(7): 729-731.
http://dx.doi.org/10.1016/j.healthpol.2016.06.010

Travail et santé / Occupational Health

Barnay, T. (2016). "Health, work and working conditions: a review of the European economic literature." The European Journal of Health Economics **17**(6): 693-709.
http://dx.doi.org/10.1007/s10198-015-0715-8

Economists have traditionally been very cautious when studying the interaction between employment and health because of the two-way causal relationship between these two variables: health status influences the probability of being employed and, at the same time, working affects the health status. Because these two variables are determined simultaneously, researchers control endogeneity skews (e.g., reverse causality, omitted variables) when conducting empirical analysis. With these caveats in mind, the literature finds that a favourable work environment and high job security lead to better health conditions. Being employed with appropriate working conditions plays a protective role on physical health and psychiatric disorders. By contrast, non-employment and retirement are generally worse for mental health than employment, and overemployment has a negative effect on health. These findings stress the importance of employment and of adequate working conditions for the health of workers. In this context, it is a concern that a significant proportion of European workers (29 %) would like to work fewer hours because unwanted long hours are likely to signal a poor level of job satisfaction and inadequate working conditions, with detrimental effects on health. Thus, in Europe, labour-market policy has increasingly paid attention to job sustainability and job satisfaction. The literature clearly invites employers to take better account of the worker preferences when setting the number of hours worked. Overall, a specific “flexicurity” (combination of high employment protection, job satisfaction and active labour-market policies) is likely to have a positive effect on health.

Bossard, D., et al. (2016). "Surveillance des suicides liés au travail en France : une étude exploratoire." Revue d'Epidmiologie et de Santé Publique **64**(3): 201-209.

Curnock, E., et al. (2016). "The impact on health of employment and welfare transitions for those receiving out-of-work disability benefits in the UK." Soc Sci Med **162**: 1-10.

Employment status has a dynamic relationship with health and disability. There has been a striking increase in the working age population receiving out-of-work disability benefits in many countries, including the UK. In response, recent UK welfare reforms have tightened eligibility criteria and introduced new conditions for benefit receipt linked to participation in return-to-work activities. Positive and negative impacts have been suggested but there is a lack of high quality evidence of the health impact when those receiving disability benefits move towards labour market participation.

Using four waves of the UK's Understanding Society panel survey (2009-2013) three different types of employment and welfare transition were analysed in order to identify their impact on health. A difference-in-difference approach was used to compare change between treatment and control groups in mental and physical health using the SF-12. To strengthen causal inference, sensitivity checks for common trends used pre-baseline data and propensity score matching. Transitions from disability benefits to employment (n = 124) were associated on average with an improvement in the SF12 mental health score of 5.94 points (95% CI = 3.52-8.36), and an improvement in the physical health score of 2.83 points (95% CI = 0.85-4.81) compared with those remaining on disability benefits (n = 1545). Transitions to unemployed status (n = 153) were associated with a significant improvement in mental health (3.14, 95% CI = 1.17-5.11) but not physical health. No health differences were detected for those who moved on to the new out-of-work disability benefit. It remains rare for disability benefit recipients to return to the labour market, but our results indicate that for those that do, such transitions may improve health, particularly mental health. Understanding the mechanisms behind this relationship will be important for informing policies to ensure both work and welfare are 'good for health' for this group.

Heggebo, K. (2016). "Health Effects of Unemployment in Denmark, Norway and Sweden 2007-2010: Differing Economic Conditions, Differing Results?" Int J Health Serv **46**(3): 406-429.

This article investigates short-term health effects of unemployment for individuals in Denmark, Norway, and Sweden during an economic downturn (2007-2010) that hit the Scandinavian countries with diverging strength. The longitudinal part of the European Union Statistics on Income and Living Conditions (EU-SILC) data material is analyzed, and results from generalized least squares estimation indicate that Denmark is the only Scandinavian country in which health status deteriorated among the unemployed. The individual-level (and calendar year) fixed-effect results confirm the negative relationship between unemployment and health status in Denmark. This result is robust across different subsamples, model specifications, and changes in both the dependent and independent variable. Health status deteriorated especially among women and people in prime working age (30-59 years). There is, however, only scant evidence of short-term health effects among the recently unemployed in Norway and Sweden. The empirical findings are discussed in light of: (1) the adequacy of the unemployment insurance system, (2) the likelihood of re-employment for the displaced worker, and (3) selection patterns into and out of employment in the years preceding and during the economic downturn.

Murcia López, G., et al. (2016). "Has the Spanish economic crisis affected the duration of sickness absence episodes?" Social Science & Medicine **160**: 29-34.
http://www.sciencedirect.com/science/article/pii/S0277953616302209
The global economic crisis has had particularly intense effects on the Spanish labor market. We investigated whether the duration of non-work related sickness absence (SA) episodes in salaried workers had experienced any changes before and after the crisis started. This was a repeated cross-sectional analysis conducted in a dynamic cohort in 2006 and 2010. Database was provided by eight mutual insurance companies, covering 983,108 workers and 451,801 SA episodes. Descriptive analysis and crude, bivariate and multivariate analyses using Cox proportional hazards modeling were performed, to quantify the changes in duration of SA episodes between 2006 and 2010, stratified by sex. There was a higher number of episodes in 2010 for both sexes, but especially for women. Unadjusted median duration in men was similar for both years, while for women it was shorter in 2010. Final multivariate models show a greater risk of longer episode duration for men in 2010 (HR 0.95; 95% CI, 0.95–0.95), but a shorter one for women (HR 1.07; 95% CI, 1.07–1.07). Once the economic crisis started affecting the Spanish labor market, the number of SA episodes in women equalized with those in men. There was a decrease of episodes in the youngest age groups, in the construction and in temporary contracts. The relative ranking of leading diagnoses was similar in both years with an increase in infectious, nervous system and respiratory diseases and in mental disorder episodes for both sexes, but especially for women. The risk of longer episode duration was greater in 2010 among men, but smaller in women.

Skagen, K. et Collins, A. M. (2016). "The consequences of sickness presenteeism on health and

wellbeing over time: A systematic review." Social Science & Medicine **161**: 169-177.
http://www.sciencedirect.com/science/article/pii/S0277953616302866

AbstractRationale The association between sickness presenteeism, defined as going to work despite illness, and different health outcomes is increasingly being recognized as a significant and relevant area of research. However, the long term effects on future employee health are less well understood, and to date there has been no review of the empirical evidence. The aim of this systematic review was to present a summary of the sickness presenteeism evidence so far in relation to health and wellbeing over time. Methods Eight databases were searched for longitudinal studies that investigated the consequences of workplace sickness presenteeism, had a baseline and at least one follow-up point, and included at least one specific measure of sickness presenteeism. Of the 453 papers identified, 12 studies met the eligibility criteria and were included in the review. Findings We adopted a thematic approach to the analysis because of the heterogeneous nature of the sickness presenteeism research. The majority of studies found that sickness presenteeism at baseline is a risk factor for future sickness absence and decreased self-rated health. However, our findings highlight that a consensus has not yet been reached in terms of physical and mental health. This is because the longitudinal studies included in this review adopt a wide variety of approaches including the definition of sickness presenteeism, recall periods, measures used and different statistical approaches which is problematic if this research area is to advance. Future research directions are discussed.

Vieillissement / Ageing

Moberg, L., et al. (2016). "User choice in Swedish eldercare – conditions for informed choice and enhanced service quality." Journal of European Social Policy **26**(3): 281-295.
http://esp.sagepub.com/content/26/3/281.abstract

Proponents of user choice argue that this type of policy arrangement improves the quality of public social services since users are expected to select the most highly performing providers. In order for users to make informed choices, however, they need quality information about the services offered by different providers. In this article, we carry out a case study, investigating whether information about service quality was presented to users of home-based elderly care in Sweden. The analysis is based on unique data regarding the information of 223 providers in 10 municipalities. The results suggest that the information was poor and lacking in important quality dimensions. This indicates a lack of real user power since it is virtually impossible for users to make informed choices without relevant information. It also makes it less likely that the general quality level of home-based services will increase as a result of the user choice.