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

Veille scientifique
en économie de la santé

Watch on Health Economics Literature

Décembre/December 2018

E-santé – Technologies médicales	*E-health – Medical Technologies*
Économie de la santé	*Health Economics*
État de santé	*Health Status*
Géographie de la santé	*Geography of Health*
Handicap	*Disability*
Hôpital	*Hospitals*
Inégalités de santé	*Health Inequalities*
Médicaments	*Pharmaceuticals*
Méthodologie – Statistique	*Methodology – Statistics*
Politique de santé	*Health Policy*
Politique publique	*Public Policy*
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Soins de santé primaires	*Primary Health Care*
Systèmes de santé	*Health Systems*
Travail et santé	*Occupational Health*
Vieillissement	*Aging*

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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Veille scientifique en économie de la santé / **Watch on Health Economics Literature**

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E-santé – Technologies médicales

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Les applications sur smartphones permettront-elles une généralisation de la télémédecine ?

ALLAERT F. A. ET QUANTIN C.

2018

Journal de gestion et d'économie médicales 36(2): 145-151.

Durant des années, la télémédecine n'a pas réussi à prendre sa véritable place dans notre système de santé alors qu'elle correspondait à un véritable besoin. Les raisons évoquées étaient les difficultés qu'elle suscitait sur le plan administratif et juridique ainsi que son manque de financement mais la véritable raison était que les conditions techniques ne permettaient pas d'être assez près du patient pour être véritablement efficace. Le développement des smartphones et leur généralisation constituent le chaînon manquant pour rendre la télémédecine efficace et lui permettre de se généraliser.

The Impact of Electronic Health Record Systems on Clinical Documentation Times: A Systematic Review

BAUMANN L. A., BAKER J. ET ELSHAUG A. G.

2018

Health Policy 122(8): 827-836.

Effective management of hospital staff time is crucial to quality patient care. Recent years have seen widespread implementation of electronic health record (EHR) systems but the effect of this on documentation time is unknown. This review compares time spent on documentation tasks by hospital staff (physicians, nurses and interns) before and after EHR implementation. A systematic search identified 8153 potentially relevant citations. Studies examining proportion of total workload spent on documentation with ≥40h of staff observation time were included. Meta-analysis was performed for physicians, nurses and interns comparing pre- and post-EHR results. Studies were weighted by person-hours observation time. Twenty-eight studies met selection criteria. Seventeen were pre-EHR, nine post-EHR and two examined both periods. With implementation of EHR, physicians' documentation time increased from 16% (95% confidence interval (CI) 11-22%) to 28% (95% CI 19-37%), nurses from 9% (95% CI 6-12%) to 23% (95% CI 15-32%) and interns from 20% (95% CI 7-32%) to 26% (95% CI 10-42%). There is a lack of long-term follow-up on the effects of EHR implementation. Initial adjustment to EHR appears to increase documentation time but there is some evidence that as staff become more familiar with the system, it may ultimately improve work flow.

De quoi l'écart d'âge est-il le nombre ? L'apport des big data à l'étude de la différence d'âge au sein des couples

BERGSTRÖM M.

2018

Revue française de sociologie 59(3): 395-422.

Dans la majorité des couples hétérosexuels, l'homme est plus âgé que la femme. Ce fait est étonnamment constant à travers le temps et les continents : dans la quasi-totalité des sociétés connues, l'époux est en moyenne plus âgé que son épouse. Si le fait est bien établi, les ressorts le sont beaucoup moins. Comment se produit cette asymétrie sexuée ? À cette problématique, relative aux rapports de genre, les enquêtes peinent à répondre. Parce qu'elles interrogent des personnes déjà en union, elles captent mal le processus de rencontre. Cet article propose une approche alternative, mobilisant des données issues d'un site de rencontres sur internet. Ces services – désormais largement utilisés en France – constituent un point d'observation original sur les attentes des acteurs et les logiques d'appariement des partenaires. Aussi donnent-ils des enseignements nouveaux. Alors que les données d'enquêtes indiquent que l'écart d'âge est surtout désiré par les femmes, les analyses du site montrent qu'il est aussi recherché par les hommes, notamment lors d'une remise en couple. Plus généralement, l'étude questionne la notion de « choix » du conjoint – chère aux sociologues du couple – montrant que les rencontres amoureuses et sexuelles reposent sur un arbitrage entre les aspirations féminines et masculines qui divergent plus souvent qu'elles ne concordent. Par l'exemple de l'écart d'âge, l'article se veut une illustration empirique de quelques-unes des opportunités offertes par lesdites « données massives ».

The Impact of Electronic Health Records on Healthcare Quality: A Systematic Review and Meta-Analysis

CAMPANELLA P., LOVATO E., MARONE C., *et al.*

2016

European Journal of Public Health 26(1): 60-64.

To assess the impact of electronic health record (EHR) on healthcare quality, we hence carried out a systematic review and meta-analysis of published studies on this topic. PubMed, Web of Knowledge, Scopus and Cochrane Library databases were searched to identify studies that investigated the association between the EHR implementation and process or outcome indicators. Of the 23 398 citations identified, 47 articles were included in the analysis. Meta-analysis showed an association between EHR use and a reduced documentation time with a difference in mean of –22.4% [95% confidence interval (CI) = –38.8 to –6.0%; P< 0.007]. EHR resulted also associated with a higher guideline adherence with a risk ratio (RR) of 1.33 (95% CI = 1.01 to 1.76; P = 0.049) and a lower number of medication errors with an overall RR of 0.46 (95% CI = 0.38 to 0.55; P < 0.001), and adverse drug effects (ADEs) with an overall RR of 0.66 (95% CI = 0.44 to 0.99; P = 0.045). No association with mortality was evident (P = 0.936). High heterogeneity among the studies was evident. Publication bias was not evident. EHR system, when properly implemented, can improve the quality of healthcare, increasing time efficiency and guideline adherence and reducing medication errors and ADEs. Strategies for EHR implementation should be therefore recommended and promoted.

Ce que le big data fait à l'analyse sociologique des textes. Un panorama critique des recherches contemporaines

COINTET J.-P. ET PARASIE S.

2018

Revue française de sociologie 59(3): 533-557.

Depuis les années 2000, de nouvelles techniques d'analyse textuelle font leur apparition au croisement des mondes informatiques, de l'intelligence artificielle et du traitement automatique de la langue. Bien qu'élaborées en dehors de toute préoccupation sociologique, ces techniques sont aujourd'hui mobilisées par des chercheurs – sociologues comme non-sociologues – dans le but de renouveler la connaissance du social en tirant parti du volume considérable de matériaux textuels aujourd'hui disponibles. En dressant un panorama des enquêtes sociologiques qui reposent sur la mise en données et le traitement quantitatif de corpus textuels, cet article identifie à quelles conditions ces approches peuvent constituer une ressource pour l'enquête sociologique. Les trois conditions qui émergent de notre analyse concernent : 1) la connaissance du contexte de production des inscriptions textuelles ; 2) l'intégration à l'enquête de données extérieures au texte lui-même ; 3) l'ajustement des algorithmes au raisonnement sociologique.

Plateforme, big data et recomposition du gouvernement urbain. Les effets de Waze sur les politiques de régulation du trafic

COURMONT A.

2018

Revue française de sociologie 59(3): 423-449.

Cet article adopte une perspective de sociologie de la donnée pour analyser les recompositions de la gouvernance urbaine liées à l'émergence d'un nouveau régime de quantification : le big data. À partir du cas des politiques de circulation routière et de l'application Waze, deux hypothèses sont poursuivies : 1) Le big data propose de nouvelles représentations de la ville qui troublent l'agencement stable et ordonné de la réalité porté par les institutions publiques. Cela permet à de nouveaux acteurs, les plateformes, de proposer des formes alternatives de régulation de l'espace urbain provoquant des tensions avec les autorités publiques locales. 2) Toutefois, l'analyse précise des modalités de production de ces nouvelles données met en évidence des modes d'accommodement entre la réalité établie par les institutions publiques et celle des plateformes de service numérique. Par la voie discrète des données émergent de nouvelles modalités de coordination entre acteurs publics et privés. Cet article illustre ainsi l'apport d'une sociologie de la donnée pour comprendre comment, à l'ère du big data, s'articulent différents types de régulation sur un territoire pour former de nouveaux modes de gouvernance urbaine.

Computerised Interventions Designed to Reduce Potentially Inappropriate Prescribing in Hospitalised Older Adults: A Systematic Review and Meta-Analysis

DALTON K., O'BRIEN G., O'MAHONY D., *et al.*

2018

Age and Ageing 47(5): 670-678.

Computerised interventions have been suggested as an effective strategy to reduce potentially inappropriate prescribing (PIP) for hospitalised older adults. This systematic review and meta-analysis examined the evidence for efficacy of computerised interventions designed to reduce PIP in this patient group. An electronic literature search was conducted using eight databases up to October 2017. Included studies were controlled trials of computerised interventions aiming to reduce PIP in hospitalised older adults (≥65 years). Risk of bias was assessed using Cochrane's Effective Practice and Organisation of Care criteria. This systematic review concludes that computerised interventions are capable of statistically significantly reducing PIMs in hospitalised older adults. Future interventions should strive to target both PIMs and PPOs, ideally demonstrating both cost-effectiveness data and clinically significant improvements in patient-related outcomes.

La protection sociale à l'heure du numérique : l'enjeu de l'affiliation et des cotisations patronales

GAURON A.

2018

Revue française des affaires sociales(2): 82-91.

Le dossier de ce numéro d'avril-juin 2018 de la RFAS traite du statut de la protection sociale dans l'économie collaborative, un sujet qui concerne de plus en plus de travailleurs mais qui fait l'objet d'un nombre encore réduit de travaux scientifiques, sans doute en raison d'une difficulté à en définir le périmètre. Coordonné par Stéphanie Laguérodie et Jean-Luc Outin, le dossier comprend des articles d'Olivia Montel, Joséphia Dirringer et Alexis Louvion, une synthèse réalisée par Nicolas Amar et Louis-Charles Viossat et deux points de vue, d'André Gauron et de Marie-Anne Dujarier. Il est suivi d'un article d'Olivier Cousin sur la tarification à l'activité à l'hôpital.

Le tout plutôt que la partie. Big data et pluralité des mesures de l'opinion sur le web

KOTRAS B.

2018

Revue française de sociologie 59(3): 451-474.

Sur les blogs, forums et sites de réseaux sociaux, l'abondance et la calculabilité de la parole des internautes permettrait d'accéder à une opinion spontanée, directement issue des traces de nos conversations ordinaires. Depuis les années 2000, un ensemble de start-ups et d'agences élaborent ainsi des méthodes humaines et algorithmiques visant à tirer parti de ce matériau foisonnant pour proposer une nouvelle mesure des opinions du grand public, voulue plus authentique que celle mesurée par les sondages traditionnels. À travers une sociohistoire du marché de l'opinion en ligne, cet article étudie la façon dont se recompose un nouveau régime de connaissance de l'opinion à partir de ses traces numériques, et souligne le caractère varié, contingent et situé des projets épistémiques qui se saisissent des big data. À partir d'entretiens et d'un travail ethnographique, nous montrons ainsi l'opposition entre des entreprises adeptes de l'échantillonnage des traces numériques, et d'autres, qui visent au contraire une captation la plus exhaustive possible des opinions du web social. Nous analysons en particulier les épreuves simultanément techniques et épistémiques auxquelles se confrontent les acteurs de l'opinion en ligne, qui mettent en échec les approches échantillonnées, et consacrent a contrario le projet d'une veille extensive et continue sur la conversation en ligne.

Économie de la santé
Health Economics

Financial Protection of Households Against Health Shocks in Greece During the Economic Crisis

CHANTZARAS A. E. ET YFANTOPOULOS J. N.

2018

Social Science & Medicine 211: 338-351.

Harsh funding cutbacks along with measures shifting cost to patients have been implemented in the Greek health system in recent years. Our objective was to investigate the evolution of financial protection of Greek households against out-of-pocket payments (OOPP) during the economic crisis. National representative data of 33,091 households were derived from the Household Budget Surveys for the period 2008–2015. Financial protection was assessed by applying the approaches of catastrophic (CHE) and impoverishing OOPP. The determinants of CHE and impoverishment were examined using binary logistic regressions. OOPP dropped by 23.5% in real values between 2008 and 2015, though their share in households' budget rose from 6.9% to 7.8%, with an increasing trend since 2012. These outcomes were driven by significant increases in medical products (20.2%) and inpatient (63%) OOPP, while outpatient expenses decreased considerably (–62%). Both incidence and overshoot of CHE were significantly exacerbated. The additional burden was distributed progressively, hence, financial risk inequalities decreased. Food poverty increased, but its incidence still remains at very low levels. Both incidence and intensity of relative poverty increased considerably in real terms. The poverty impact of OOPP is aggravating following 2012, and 1.9% of individuals were impoverished due to OOPP in 2015. Households of higher size, lower expenditure quintile, in urban areas, without disabled, elderly or young children members, and with younger or retired, better-educated breadwinners were significantly less vulnerable to CHE. Households in the lower-middle expenditure quintile, in rural regions, and with elderly members were facing higher risk, while wealthier families exhibited a considerable lower likelihood of impoverishment. The expansion of reliance of healthcare funding on OOPP has increased the financial risk and hardship of Greek households, which may disrupt their living conditions and create barriers to healthcare access. Cost-sharing policies should recognise the different social protection needs of households.

Tarification à l'activité, variation autour de la rationalité économique

COUSIN O.

2018

Revue française des affaires sociales(2): 111-129.

La tarification à l'activité impose aux médecins hospitaliers une rationalité économique qu'ils perçoivent spontanément comme envahissante et toute-puissante. L'économie est d'abord appréhendée comme un corps étranger, dénaturant le travail et les représentations que les acteurs s'en font. Toutefois, elle peut prendre d'autres sens et d'autres aspects quand elle est appréhendée comme un élément constitutif du travail, au même titre que le respect des normes, que les cadres déontologiques fixant les règles éthiques, ou les savoir-faire techniques acquis tout au long de la formation des médecins. En appréhendant ainsi l'économie, via la tarification à l'activité, comme une variable entrant dans la composition du travail, il est alors possible d'essayer de saisir la place qu'elle occupe dans l'accomplissement des activités, comment les acteurs parviennent à la neutraliser et à quelle condition elle acquiert de la légitimité.

Le Time Driven Activity Based Costing (TDABC), modèle de calcul de coût adapté au parcours de soins des maladies chroniques ? Cas du parcours de soins de l'accident vasculaire cérébral (AVC)

DOMINGO H., EGGRICKX A., NARO G., *et al.*

2018

Gestion et management public 6 / 3(1): 71-93.

Premier poste des dépenses de santé, les maladies chroniques nécessitent une prise en charge globale et transversale du patient via le parcours de soins, alors que la tarification à l'activité contribue à renforcer les cloisonnements. Une recherche intervention sur le parcours d'une maladie chronique, l'Accident Vasculaire Cérébral (AVC), 3e cause de décès en France, a pour objectif de vérifier l'applicabilité d'un calcul de coût par activité comme le Time Driven Activity Based Costing (TDABC). Selon les critères de simplicité et précision des méthodes d'évaluation de coûts, la littérature suggère que le TDABC est adapté aux approches transversales et au secteur de la santé.

Les résultats de la recherche restreinte à une partie du parcours, montrent l'applicabilité du TDABC et la prise en compte dans les équations de temps des variations de coûts liées à la diversité des parcours et aux évolutions des traitements. Malgré les limites de la méthode pour l'estimation du temps et du non chiffrable comme la valeur des soins, le TDABC présente plusieurs apports : simplification possible par la loi de Pareto, outil compréhensible par les professionnels de santé et suscitant le dialogue, simulation des « coûts cachés » de l'indisponibilité des ressources et des goulots d'étranglement.

Maîtrise de stage universitaire et paiement à la performance

HUMBERT X., RABIAZA A., BANSART M., *et al.*

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(4): 181-186.

Depuis la création de la filière universitaire de médecine générale en 2004, l'implication des médecins généralistes dans la formation des étudiants en médecine ne fait que croître. En parallèle depuis 2011, a été mise en place la rémunération sur objectif de santé publique (ROSP) pour les médecins généralistes, système de paiement à la performance inspiré du modèle anglo-saxon. Dans ce contexte, nous voulions savoir quelle est l'influence de la maîtrise de stage universitaire de médecine générale sur l'accomplissement de la ROSP. Pour cela, nous nous sommes appuyés sur l'expérience des médecins généralistes du département de l'Orne (Normandie, France). Entre 2014 et 2016, nous n'avons pas mis en évidence de différence sur les critères de la ROSP entre les médecins généralistes maîtres de stage universitaires (MSU) et les autres. Il s'agit du premier travail qui étudie spécifiquement le lien entre MSU et ROSP.

Impacts of Chronic Non-Communicable Diseases on Households' Out-Of-Pocket Healthcare Expenditures in Sri Lanka

PALLEGEDARA A.

2018

International Journal of Health Economics and Management 18(3): 301-319.

https://doi.org/10.1007/s10754-018-9235-2

This article examines the effects of chronic non-communicable diseases (NCDs) on households' out-of-pocket health expenditures in Sri Lanka. We explore the disease specific impacts on out-of-pocket health care expenses from chronic NCDs such as heart diseases, hypertension, cancer, diabetics and asthma. We use nationwide cross-sectional household income and expenditure survey 2012/2013 data compiled by the department of census and statistics of Sri Lanka. Employing propensity score matching method to account for selectivity bias, we find that chronic NCD affected households appear to spend significantly higher out-of-pocket health care expenditures and encounter grater economic burden than matched control group despite having universal public health care policy in Sri Lanka. The results also suggest that out-of-pocket expenses on medicines and other pharmaceutical products as well as expenses on medical laboratory tests and other ancillary services are particularly higher for households with chronic NCD patients. The findings underline the importance of protecting households against the financial burden due to NCDs.

Family Physician Remuneration Schemes and Specialist Referrals: Quasi-Experimental Evidence from Ontario, Canada

SARMA S., MEHTA N., DEVLIN R. A., *et al.*

2018

Health Economics 27(10): 1533-1549.

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3783

Understanding how family physicians respond to incentives from remuneration schemes is a central theme in the literature. One understudied aspect is referrals to specialists. Although the theoretical literature has suggested that capitation increases referrals to specialists, the empirical evidence is mixed. We push forward the empirical research on this question by studying family physicians who switched from blended fee-for-service to blended capitation in Ontario, Canada. Using several health administrative databases from 2005 to 2013, we rely on inverse probability weighting with fixed-effects regression models to account for observed and unobserved differences between the switchers and nonswitchers. Switching from blended fee-for-service to blended capitation increases referrals to specialists by about 5% to 7% per annum. The cost of specialist referrals is about 7 to 9% higher in the blended capitation model relative to the blended fee-for-service. These results are generally robust to a variety of alternative model specifications and matching techniques, suggesting that they are driven partly by the incen-

tive effect of remuneration. Policy makers need to consider the benefits of capitation payment scheme against the unintended consequences of higher referrals to specialists.

Consensus-Based Cross-European Recommendations for the Identification, Measurement and Valuation of Costs in Health Economic Evaluations: A European Delphi Study

VAN LIER L. I., BOSMANS J. E., VAN HOUT H. P. J., *et al.*

2018

The European Journal of Health Economics 19(7): 993-1008.

https://doi.org/10.1007/s10198-017-0947-x

Differences between country-specific guidelines for economic evaluations complicate the execution of international economic evaluations. The aim of this study was to develop cross-European recommendations for the identification, measurement and valuation of resource use and lost productivity in economic evaluations using a Delphi procedure.

Hospitals Using Bundled Payment Report Reducing Skilled Nursing Facility Use and Improving Care Integration

ZHU J. M., PATEL V., SHEA J. A., *et al.*

2018

Health Aff (Millwood) 37(8): 1282-1289.

A goal of Medicare's bundled payment models is to improve quality and control costs after hospital discharge. Little is known about how participating hospitals are focusing their efforts to achieve these objectives, particularly around the use of skilled nursing facilities (SNFs). To understand hospitals' approaches, we conducted semistructured interviews with an executive or administrator in each of twenty-two hospitals and health systems participating in Medicare's Comprehensive Care for Joint Replacement model or its Bundled Payments for Care Improvement initiative for lower extremity joint replacement episodes. We identified two major organizational responses. One principal strategy was to reduce SNF referrals, using risk-stratification tools, patient education, home care supports, and linkages with home health agencies to facilitate discharges to home. Another was to enhance integration with SNFs: fifteen hospitals or health systems in our sample had formed networks of preferred SNFs to exert influence over SNF quality and costs. Common coordination strategies included sharing access to electronic medical records, embedding providers across facilities, hiring dedicated care coordination staff, and creating platforms for data sharing. As hospitals presumably move toward home-based care and more selective SNF referrals, more evidence is needed to understand how these discharge practices affect the quality of care and patient outcomes.

État de santé
Health Status

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

GRISWOLD M.G., *et al.*

2018

The Lancet 392 (10152): 1015-1035.

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

Adolescents : psychotropes et/ou thérapies relationnelles, un équilibre sans cesse questionné

PRESCRIRE

2018

Revue Prescrire 38(417): 548-549.

Les manifestations des troubles psychiatriques des adolescents donnent souvent lieu à une prescription médicamenteuse dite de «sécurité», tant pour les adolescents eux-mêmes que pour les adultes autour d'eux. Mais d'autres thérapies pourraient être utilisées. Cet article rapporte l'expérience du service de psychiatrie de l'enfant et de l'adolescent du centre hospitalier de Moulins-Yzeure (Allier).

Global Cancer Statistics 2018: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries

BRAY F., FERLAY J., SOERJOMATARAM I., *et al.*

2018

CA: A Cancer Journal for Clinicians (0) : 1-31.

https://onlinelibrary.wiley.com/doi/abs/10.3322/caac.21492

This article provides a status report on the global burden of cancer worldwide using the GLOBOCAN 2018 estimates of cancer incidence and mortality produced by the International Agency for Research on Cancer, with a focus on geographic variability across 20 world regions. There will be an estimated 18.1 million new cancer cases (17.0 million excluding nonmelanoma skin cancer) and 9.6 million cancer deaths (9.5 million excluding nonmelanoma skin cancer) in 2018. In both sexes combined, lung cancer is the most commonly diagnosed cancer (11.6% of the total cases) and the leading cause of cancer death (18.4% of the total cancer deaths), closely followed by female breast cancer (11.6%), prostate cancer (7.1%), and colorectal cancer (6.1%) for incidence and colorectal cancer (9.2%), stomach cancer (8.2%), and liver cancer (8.2%) for mortality. Lung cancer is the most frequent cancer and the leading cause of cancer death among males, followed by prostate and colorectal cancer (for incidence) and liver and stomach cancer (for mortality). Among females, breast cancer is the most commonly diagnosed cancer and the leading cause of cancer death, followed by colorectal and lung cancer (for incidence), and vice versa (for mortality); cervical cancer ranks fourth for both incidence and mortality. The most frequently diagnosed cancer and the leading cause of cancer death, however, substantially vary across countries and within each country depending on the degree of economic development and associated social and life style factors. It is noteworthy that high-quality cancer registry data, the basis for planning and implementing evidence-based cancer control programs, are not available in most low- and middle-income countries. The Global Initiative for Cancer Registry Development is an international partnership that supports better estimation, as well as the collection and use of local data, to prioritize and evaluate national cancer control efforts.

Cancers Attributable to Tobacco Smoking in France in 2015

CAO B., HILL C., BONALDI C., *et al.*

2018

European Journal of Public Health 28(4): 707-712.

http://dx.doi.org/10.1093/eurpub/cky077

The evidence on the carcinogenicity of tobacco smoking has been well established. An assessment of the population-attributable fraction (PAF) of cancer due to smoking is needed for France, given its high smoking prevalence. We extracted age- and sex-specific national estimates of population and cancer incidence for France, and incidence rates of lung cancer among never smokers and relative risk (RR) estimates of smoking for various cancers from the American Cancer Prevention Study (CPS II). For active smoking, we applied a modified indirect method to estimate the PAF for lung and other tobacco smoking-related cancer sites. Using the RR estimates for second-hand smoking, the proportion of never smokers living with an ever-smoking partner derived from survey, and marital status data, we then estimated the PAF for lung cancer attributable to domestic passive smoking. Overall in France in 2015, 54 142 and 12 008 cancer cases in males and females, respectively, were attributable to active smoking, accounting for 28 and 8% of all cancer cases observed among adult (30+ years) males and females. Additionally, 36 and 142 lung cancer cases, respectively among male and female never smokers, were attributable to second-hand smoke resulting from their partner's active smoking, corresponding to 4.2 and 6.7% of lung cancer cases which occurred in never smoker males and females, respectively. Tobacco smoking is responsible for a significant number of potentially avoidable cancer cases in France in 2015. More effective tobacco control programmes are critical to reduce this cancer burden.

Amenable Mortality in the EU—Has the Crisis Changed Its Course?

KARANIKOLOS M., MACKENBACH J. P., NOLTE E., *et al.*

2018

European Journal of Public Health 28 (5) : 864–869

Did the global financial crisis and its aftermath impact upon the performance of health systems in Europe? We investigated trends in amenable and other mortality in the EU since 2000 across 28 EU countries. We use WHO detailed mortality files from 28 EU countries to calculate age-standardized deaths rates from amenable and other causes. We then use joinpoint regression to analyse trends in mortality before and after the onset of the economic crisis in Europe in 2008. Amenable and other mortality have declined in the EU since 2000, albeit faster for amenable mortality. We observed increases in amenable mortality following the global financial crisis for females in Estonia [from –4.53 annual percentage change (APC) in 2005–12 to 0.03 APC in 2012–14] and Slovenia (from –4.22 APC in 2000–13 to 0.73 in 2013–15) as well as males and females in Greece(males: from –2.93 APC in 2000–10 to 0.01 APC in 2010–13; females: from –3.48 APC in 2000–10 to 0.06 APC in 2010–13). Other mortality continued to decline for these populations. Increases in deaths from infectious diseases before and after the crisis played a substantial part in reversals in Estonia, Slovenia and Greece. There is evidence that amenable mortality rose in Greece and, among females in Estonia and Slovenia. However, in most countries, trends in amenable mortality rates appeared to be unaffected by the crisis.

Géographie de la santé
Geography of Health

Demand-Based Models and Market Failure in Health Care: Projecting Shortages and Surpluses in Doctors and Nurses

BIRCH S.

2018

Health Economics, Policy and Law [Ahead of Print]

Models for projecting the demand for and supply of health care workers are generally based on objectives of meeting demands for health care and assumptions of status quo in all but the demographic characteristics of populations. These models fail to recognise that public intervention in health care systems arises from market failure in health care and the absence of an independent demand for health care. Hence projections of demand perpetuate inefficiencies in the form of overutilisation of services on the one hand and unmet needs for care on the other. In this paper the problems with basing workforce policy on projected demand are identified and the consequences for health care system sustainability explored. Integrated needs-based models are offered as alternative approaches that relate directly to the goals of publicly funded health care systems and represent an important element of promoting sustainability in those systems.

Les déserts médicaux

FRÉLAUT M.

2018

Regards 53(1): 105-116.

La question des déserts médicaux et son impact sur l'accès aux soins de la population sont aujourd'hui au centre du débat public. Il s'agit d'abord d'un révélateur des difficultés d'accès aux soins liées aux évolutions de la répartition territoriale des professionnels de santé et notamment des médecins généralistes de premier recours. C'est également devenu progressivement un concept opérationnel, cadre de mise en œuvre des différentes politiques des pouvoirs publics (collectivités territoriales, État et Assurance Maladie). Enfin, c'est aujourd'hui une réalité perçue par les patients en recherche d'un médecin traitant et ayant des difficultés nouvelles d'accès aux soins. La situation du département de l'Orne, département rural et vaste est symptomatique de ces difficultés, comme en témoigne la récente mise en œuvre de la PFIDASS (Plate- Forme d'Intervention Départementale pour l'Accès aux Soins et à la Santé).

Developing an Openly Accessible Multi-Dimensional Small Area Index of 'Access to Healthy Assets and Hazards' for Great Britain, 2016

GREEN M. A., DARAS K., DAVIES A., *et al.*

2018

Health & Place 54: 11-19.

Health geographers have been long concerned with understanding how the accessibility of individuals to certain environmental features may influence health and wellbeing. Such insights are increasingly being adopted by policy makers for designing healthy neighbourhoods. To support and inform decision making, there is a need for small area national level data. This paper details the creation of a suite of open access health indicators, including a novel multidimensional index summarising 14 health-related features of neighbourhoods for Great Britain. We find no association of our overall index with physical health measures, but a significant association to mental wellbeing.

Rural - Urban Differences in Determinants of Patient Satisfaction with Primary Care

WEINHOLD I. ET GURTNER S.

2018

Social Science & Medicine 212: 76-85.

In light of the rising regional inequalities in primary care provider supply, to ensure equitable access is a pressing issue in health policy. Most policy approaches fall short in considering the patient perspective when defining shortage areas. As a consequence, implementations of new service delivery models might fail to be responsive to patients' expectations. To explore regional differences in the relative importance of structure and process attributes as drivers of patient satisfaction with local primary care, we collected data from residents of three objectively well-supplied urban and six objectively worse-supplied rural areas in Germany and tested a multi-group structural equation model.

The results suggest that the relative importance of care attributes is different among the regional conditions rural and urban. Regardless of regional constraints, the strongest determinants of satisfaction are not related to structural aspects but are concerned with the quality of the doctor-patient relationship. A lack of available choices and a higher tolerance in terms of distances provide possible explanations for the results. The high importance rural residents attribute to the interpersonal relation should not be neglected in the re-organization of traditional service delivery in rural areas.

Do Rural Incentives Payments Affect Entries and Exits of General Practitioners?

YONG J., SCOTT A., GRAVELLE H., *et al.*
2018
Social Science & Medicine 214: 197-205.

Many countries use financial incentive programs to attract physicians to work in rural areas. This paper examines the effectiveness of a policy reform in Australia that made some locations newly eligible for financial incentives and increased incentives for locations already eligible. The analysis uses panel data (2008–2014) on all Australian general practitioners (GPs) aggregated to small areas. We use a difference-in-differences approach to examine if the policy change affected GP entry or exit to the 755 newly eligible locations and the 787 always eligible locations relative to 2249 locations which were never eligible. The policy change increased the entry of newly-qualified GPs to newly eligible locations but had no effect on the entry and exit of other GPs. Our results suggest that location incentives should be targeted at newly qualified GPs.

Handicap
Disability

Risk of Pressure Ulcers in Tetraplegic People: A French Survey Crossing Regional Experience with a Long-Term Follow-Up

LE FORT M., ESPAGNACQ M., ALBERT T., *et al.*
2018
Eur J Public Health : [Ahead of print]
https://www.ncbi.nlm.nih.gov/pubmed/29873752

Pressure ulcer risk assessment provides an indicator of quality of care in French health establishments. The reliability and validity of assessment tools have been shown to be lower for people with spinal cord injury (SCI). We hypothesized that skin complications would be less frequent in people with traumatic SCI and tetraplegia (TSCIt), who were initially managed in French regions with a high level of specialized SCI rehabilitation experience. First, we used the most recent French territorial survey about SCI to determine a 'Level of Regional Experience (LRE) in Specialized Physical Medicine and Rehabilitation'. We then studied the individual variables reported in the Tetrafigap survey (which compiled a cohort of TSCIts people to assess their trajectory and life conditions following their return to community life by questionnaires) using univariate analysis according to these LREs (chi2 test using a significance threshold of $P < 0.05$). Finally, we performed a series of logistic regressions to determine the link between LREs and pressure ulcers. Management in high-LRE regions was linked with a lower declaration of pressure ulcers during early treatment and in the long term (on average, 8 years post-trauma). Conclusions: Using pressure ulcers as a marker, our study showed the protective element of regional experience in the early management of TSCIts patients. A dilution effect between SCI specialized units and more polyvalent physical medicine and rehabilitation departments should be prevented within each region within the scope of a regional organization that would link referral centres and local health care networks.

Hôpital
Hospitals

The Effect of the Hospital Readmissions Reduction Program on Readmission and Observation Stay Rates for Heart Failure

ALBRITTON J., BELNAP T. W. ET SAVITZ L. A.

2018

Health Aff (Millwood) 37(10): 1632-1639.

The Hospital Readmissions Reduction Program reduces Medicare prospective payments for hospitals with excess readmissions for selected diagnoses. By comparing data for patients who were readmitted or placed on observation status immediately before and immediately after the thirty-day cutoff for penalties, we sought to determine whether hospitals have responded to the program by shifting readmissions for heart failure to observation status. We used regression discontinuity, taking advantage of the cutoff to generate unbiased estimates of treatment effects. Overall, we found no evidence that the program has affected the use of observation stays. However, for nonpenalized hospitals, the use of observation status was 5.4 percent higher for patients returning to the hospital immediately before the thirty-day cutoff than for patients returning immediately after the cutoff, which suggests that some hospitals may have used observation status to help avoid penalties. Because differences in the cost-sharing rules may lead to higher out-of-pocket expenses for Medicare patients placed on observation status, the program could have an inequitable financial impact.

Successful Community Discharge Following Postacute Rehabilitation for Medicare Beneficiaries: Analysis of a Patient-Centered Quality Measure

CARY M. P., PRVU BETTGER J., JARVIS J. M., *et al.*

2018

Health Services Research 53(4): 2470-2482.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12796

The aim of this study is to determine the sociodemographic and clinical characteristics as well as health services use associated with successful community discharge. It is based on the Inpatient Rehabilitation Facility-Patient Assessment Instrument and Medicare Provider Analysis and Review files. We retrospectively examined 167,664 Medicare beneficiaries discharged from inpatient rehabilitation facilities (IRFs) in 2013 to determine the sociodemographic and clinical characteristics as well as health services use associated with successful community discharge. In the multivariable model, sociodemographic (younger age, no disability, social support), clinical (higher motor and cognitive functional status at admission), and health services use (fewer acute care days and longer IRF days) variables were associated with successful community discharge. Remaining in the community is an important patient-centered outcome that could complement other postacute rehabilitation quality measures.

Satisfaction of Physicians Working in Hospitals Within the European Union: State of the Evidence Based on Systematic Review

DOMAGAŁA A., BAŁA M. M., PEÑA-SÁNCHEZ J. N., *et al.*

2018

European Journal of Public Health: [Ahead of Print]

http://dx.doi.org/10.1093/eurpub/cky117

Despite the wide range of studies concerning physician satisfaction in different European countries, there is a lack of literature reviews synthesizing and analyzing current evidence evaluating satisfaction of physicians working in European hospitals. The goal of our research was to provide a general overview of the studies in this area and their results. We searched MEDLINE, Embase, PsycINFO, CINAHL and the Cochrane Library from January 2000 to January 2017 including both MESH/Emtree terms and free text words related to the subject with no language restrictions. The eligibility criteria included: (i) target population: physicians working in European hospitals, (ii) quantitative research aimed at assessing physician satisfaction and (iii) validated tools. Finally 61 studies were eligible for qualitative analysis. Included studies enrolled a total of 50 001 physicians from 17 countries. Sample sizes varied between 54 and 7090 participants (median: 336). According to our review 59% of physicians working in European hospitals are overall satisfied, 3.54 was the

mean satisfaction among studies reporting data on a scale from 1 to 5, 4.81 for studies with a scale from 1 to 7, 6.12 among studies reporting data on a scale from 1 to 10, and 59.65 among studies with a scale from 0 to 100.ConclusionsThe level of physician satisfaction in Europe is moderate. There is a large variety of tools and scales used to assess it.

Impact of Specialist Rehabilitation Services on Hospital Length of Stay and Associated Costs

DUARTE A., BOJKE C., CAYTON W., *et al.*

2018

The European Journal of Health Economics 19(7): 1027-1034.

https://doi.org/10.1007/s10198-017-0952-0

Provision of specialist rehabilitation services in North Yorkshire and Humberside may be suboptimal. Local commissioning bodies need to prioritise investments in health care, but previous studies provide limited evidence to inform the decision to expand existing services on the basis of cost-effectiveness. We examine the impact of specialist rehabilitation services in the subregion on hospital length of stay (LoS) and associated costs compared to routine care.

L'hôpital : dossier thématique

KEHR J. ET CHABROL F.

2018

Anthropologie & Santé(16).

https://journals.openedition.org/anthropologiesante/2997

Qu'est-ce qu'un hôpital ? À cette question très simple, il n'est pas aisé de répondre. L'hôpital est un échelon structurant de l'organisation des systèmes de santé, un lieu où se pratique la médecine et où de multiples professions médicales et non-médicales travaillent ensemble. Cette institution située au cœur de la biomédecine est devenue, depuis une vingtaine d'années, un terrain privilégié des chercheurs en anthropologie de la santé. Ces propositions pour une ethnographie hospitalière ont mis en avant l'hôpital comme miroir de la société et de sa culture, domaine dans lequel les valeurs se (re)définissent, un espace qui condense la vie et la mort. Cherchant à prendre une part active aux discussions sur, et aux conceptualisations de l'hôpital, ce dossier thématique d'Anthropologie & Santé réunit des articles ethnographiques, ancrées dans des approches « classiques » d'anthropologie médicale, tout en ouvrant de nouvelles pistes de recherche. Les auteurs abordent l'hôpital en reliant de manière originale le lieu hospitalier aux pratiques – médicales, infirmières, bureaucratiques et comptables – exercées en son sein. À mesure que le regard ethnographique s'éloigne des problématiques propres à la médecine hospitalière, l'on appréhende les productions et propriétés de l'hôpital en tant que tel.

Quality Changes After Implementation of an Episode of Care Model with Strict Criteria for Physical Therapy in Ontario's Long-Term Care Homes

MCARTHUR C., HIRDES J., CHAURASIA A., *et al.*

2018

Health Services Research 53(6): 4863-4885.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13020

The aim of this study is to describe the proportion of residents receiving rehabilitation in long-term care (LTC) homes, and scores on activities of daily living (ADL) and falls quality indicators (QIs) before and after change from fee-for-service to an episode of care model; and to evaluate the effect of the change on the QIs. The Secondary data were collected from all LTC homes in Ontario, Canada, between January 1, 2011 and March 31, 2015. Variables of interest were the proportion of residents per home receiving physical therapy (PT), and the scores on seven ADL and one falls QI. Study Design Retrospective, longitudinal study. All data were extracted from the Resident Assessment Instrument Minimum Data Set. Fewer residents received PT after the policy change (84.6 percent, 2011; 56.6 percent, 2015). The policy change was associated with improved performance on several ADL QIs. However, having a large proportion of residents receive no PT or little PT was associated with poorer performance on two of the QIs measuring improvement in ADLs [No PT: –0.029 (–0.043 to –0.014); –0.048 (–0.068 to –0.027). PT <45 minutes per week: –0.012 (–0.026 to –0.002); –0.026 (–0.045 to –0.007); p < .01]. While controversial, the policy and subsequent PT service delivery change appears to be associated with improved performance on several ADL QIs, except in homes where a large proportion of residents receive no PT and low time-intensive PT.

Optimal Timing of Physician Visits After Hospital Discharge to Reduce Readmission

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

2018

Health Services Research 53(6): 4682-4703.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12976

The aim 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.

Impact de la rééducation à la phase subaiguë d'un accident vasculaire cérébral en France en 2016

SCHNITZLER A., ERBAULT M., SOLOMIAC A., *et al.*

2018

Bulletin Épidémiologique Hebdomadaire(29): 595-601

À la phase subaiguë d'un accident vasculaire cérébral (AVC), la prise en charge rééducative multidisciplinaire vise à récupérer ou compenser des limitations d'activité. Le but de cette étude était de déterminer si son intensité avait un effet sur l'amélioration fonctionnelle. Les patients hospitalisés en soin de suite et de réadaptation (SSR) pour AVC (codes CIM10 I60 à I64, à l'exception d'I63.6) au cours des huit premiers mois de l'année 2016 ont été sélectionnés dans le PMSI-SSR. La durée quotidienne de rééducation et son impact fonctionnel ont été obtenus dans le PMSI-SSR. Trois analyses multivariées ont été réalisées pour analyser les facteurs liés à un meilleur pronostic (présentés sous la forme d'odds ratios -OR- avec intervalle de confiance -IC95. La population d'étude comptait 12 122 patients, d'âge médian 76 ans. La durée médiane (DM) du séjour était de 56 jours et la DM de rééducation par jour de 90 minutes. En analyse multivariée, une durée de rééducation entre 90 et 120 minutes par jour (contre moins de 30 minutes) conduisait à une probabilité plus grande de gain d'autonomie, de faible dépendance et de sortie à domicile à l'issue de l'hospitalisation (OR respectivement de 1,87 [1,56-2,22], 1,88 [1,51-2,33] et 2,02 [1,65-2,46]). Cette étude a montré le probable impact fonctionnel de l'intensité de la rééducation à la phase subaiguë d'un AVC. La portée de cette étude rétrospective reste limitée par le fait que les patients les plus enclins à progresser ont possiblement bénéficié d'une rééducation plus intense.

Soigner les maux de l'hôpital-usine : dossier

VINCENT S. ET DESRIAUX F.

2018

Santé & Travail(104): 25-40.

Même si la satisfaction de soigner et de sauver est toujours présente au quotidien chez les soignants, le mal-être s'est désormais installé. Le plan santé présenté le 18 septembre par Emmanuel Macron comporte 54 mesures susceptibles de desserrer l'étau qui malmène les soignants. Ce dossier fait le point sur les tensions insupportables qui existent à l'hôpital, résultats des dernières réformes hospitalières.

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

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

2018

Health Services Research 53(6): 4829-4847.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12861

The aim of this study is to evaluate the technical efficiency of acute inpatient care at the pan-Canadian

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

Inégalités de santé
Health Inequalities

▶ Renoncer aux soins périnataux : quelles conséquences sur l'état de santé du nourrisson ?

ANCELOT L., BONNAL L. ET DEPRET M.-H.

2018

Revue économique 69(3): 373-405.

De nombreuses études ont mis au jour les mécanismes intergénérationnels à l'œuvre dans la construction des inégalités de santé. Ces travaux convergent vers l'idée que l'état de santé d'un individu est en grande partie lié aux comportements adoptés par ses parents, parfois avant même sa naissance. Cette contribution vient compléter cette idée et ces études. Notre objectif est d'étudier l'impact du renoncement aux soins de la future mère sur l'état de santé de son nourrisson à la naissance. Pour ce faire, nous utilisons les données de l'Enquête nationale périnatale réalisée en 2010. Nous montrons que la probabilité qu'un nourrisson naisse avec un problème de santé augmente si sa mère a, durant sa grossesse, à la fois rencontré un problème de santé et renoncé à des soins.

▶ Un levier innovant de promotion de la santé et de réduction des inégalités sociales de santé

ANZIVINO L., MARTIN DE CHAMPS C., COLOM P., *et al.*

2018

Santé Publique S1(HS1): 63-67.

La ville de Villeurbanne, ville santé OMS, a fait le choix politique de réduire les inégalités sociales de santé. Le service santé- environnement à travers son contrat local de santé s'est engagé à la réalisation d'une évaluation d'impact en santé (EIS) documentant les liens entre urbanisme et santé. L'attention s'est portée sur un quartier de 6 000 habitants qui fait l'objet d'un plan de rénovation urbaine. Le bouleversement provoqué par cette opération de rénovation doit permettre d'évaluer les impacts potentiels sur la santé des habitants. Quartier montrant une certaine précarité, le taux d'adultes sous traitement antidiabétique est élevé. La médecine scolaire a de plus noté une forte proportion d'enfants en surpoids dans les écoles du quartier, plus important que dans l'ensemble des écoles de la ville. L'objectif de cette EIS est donc d'identifier l'influence potentielle du projet de rénovation sur la mobilité des enfants et d'émettre des recommandations afin de lutter contre leur sédentarité en favorisant la pratique spontanée d'activité physique. Elle doit également servir de levier de promotion de la santé et de

réduction des ISS. Même si certains aspects du projet montrent un impact positif sur la santé des habitants, d'autres ont un impact négatif sur la mobilité des enfants, le bien-être et le capital social des habitants. Au final, une trentaine de recommandations ont été co-construites et priorisées en fonction de leur portage politique et de leur faisabilité technico-économique et temporelle. L'EIS a créé une dynamique de travail transversale entre des secteurs autres que ceux de la santé et donné l'occasion de sensibiliser et d'informer les acteurs impliqués sur différents concepts et sur leurs rôles pour promouvoir les comportements favorables à la santé. L'EIS, comme levier de promotion de la santé, permet de mettre en œuvre des stratégies qui visent à transformer les conditions de vie à l'origine des inégalités sociales de santé.

Health Inequalities and Inequities by Age: Stability for the Health Utilities Index and Divergence for the Frailty Index

ASADA Y., HURLEY J., GRIGNON M., *et al.*
2018
SSM - Population Health 5: 17-32.

Successful aging is an important policy goal in an aging society. A key indicator of successful aging of a population is whether health inequalities (differences) and inequities (unfair differences) in the population increase or decrease with age. This study investigates how health inequalities and inequities differ across age groups in the Canadian population within the equity framework of equal opportunity for health, using two popular measures of health, the Health Utilities Index Mark 3 (HUI) and the Frailty Index (FI). We use the 2009-10 Canadian Health Measures Survey. We first quantify the degree of health inequality by calculating the Gini coefficient for the distributions of the HUI and the FI within three age groups (20–44, 45–64, and 65–79 years). We then identify sources of health inequality by using regression models and decomposing inequality into ethically acceptable and unacceptable components. We finally quantify the degree of health inequity by calculating the Gini coefficient for each health measure and each age group after standardizing for fairness. We find that the magnitudes of inequality and inequity in the HUI and the FI in each of the three age groups are policy relevant. The magnitude and age-related dynamics of health inequality and inequity depend on the choice of the health measures. In all three age groups, inequality and inequity in health measured by the HUI are larger than those measured by the FI. Across the three age groups, inequality and inequity are stable in the HUI but divergent in the FI. This study contributes to the methodological development to support policies for successful aging. Examination of alternative notions of health captured by the HUI and the FI contributes to the exploration of how the fair distribution of each aspect of health may characterize a successfully aging population.

A Multi-Criteria Decision Approach for Ranking Unmet Needs in Healthcare

CLEEMPUT I., DEVRIESE S., KOHN L., *et al.*
2018
Health Policy 122(8): 878-884.

Early temporary reimbursement (ETR) schemes for new interventions targeting high unmet needs are increasingly applied in pharmaceutical policy. Crucial for these schemes is the assessment of unmet healthcare needs of patients and society. This study develops and tests a multi-criteria decision approach (MCDA) for assessing therapeutic and societal needs. The Belgian unmet needs commission, responsible for creating a list of unmet needs for the ETR programme, has tested this methodology to assess the needs in eight health conditions. For therapeutic need, three criteria were included (impact of the condition on quality of life and on life expectancy and inconvenience of current treatment); for societal need two criteria (condition-related healthcare expenditures per patient, prevalence). The results show that the proposed MCDA is feasible and acceptable for the unmet needs commission. Clear definitions of the criteria and regular repetition of these is needed to avoid variable interpretation of the criteria by the commission members. Quality assessment of the evidence is desired. Rankings resulting from the application have face validity. Considering therapeutic need separately from societal need is considered appropriate. Policy makers should consider the use of MCDA in assessing healthcare needs. MCDA improves the transparency and accountability of the decision making processes and is practical and feasible.

Discriminations et accès aux soins des personnes en situation de précarité

CORNU PAUCHET M.

2018

Regards 53(1): 43-56.

Les discriminations sont définies comme des traitements différentiels (intentionnels ou non), illégitimes et produisant un résultat défavorable sur l'accès aux droits fondamentaux d'un individu ou d'un groupe d'individus. Directes, ou indirectes lorsqu'elles sont produites par les règles d'un système, elles sont génératrices d'inégalités. Or, l'accès aux soins est l'un des droits fondamentaux pour lesquels un principe d'égalité est préconstitué. Les discriminations en matière d'accès aux soins aujourd'hui objectivées font pourtant état de la pluralité des populations concernées : personnes en situation de handicap, en situation de précarité, personnes âgées, étrangers, individus atteints de pathologies graves... L'analyse qui suit est volontairement centrée sur les personnes en situation de précarité bénéficiaires de la couverture maladie universelle (CMU). Quel diagnostic peut-on faire aujourd'hui sur les situations de discriminations rencontrées par les bénéficiaires de la CMU, de la CMU-C ou de l'ACS lors de leur parcours d'accès aux soins ? Comment se traduisent concrètement ces discriminations ? Comment sont-elles objectivées ? S'agit-il de discrimination directe ou indirecte ? Quelles en sont les causes et les conséquences ? Cet article tente de répondre à ces questions.

Do the More Educated Utilize More Health Care Services? Evidence from Vietnam Using a Regression Discontinuity Design

DANG T.

2018

International Journal of Health Economics and Management 18(3): 277-299.

https://doi.org/10.1007/s10754-018-9233-4

In 1991, Vietnam implemented a compulsory primary schooling reform that provides this study a natural experiment to estimate the causal effect of education on health care utilization with a regression discontinuity design. This paper finds that education causes statistically significant impacts on health care utilization, although the signs of the impacts change with specific types of health care services examined. In particular, education increases the inpatient utilization of the public health sector, but it reduces the outpatient utilization of both the public and private health sectors. The estimates are strongly robust to various windows of the sample choice. The paper also discovers that the links between education and the probability of health insurance and income play essential roles as potential mechanisms to explain the causal impact of education on health care utilization in Vietnam.

Parcours de soins en situation de précarité : entre détermination et individualisation

DESPRÈS C.

2018

Santé Publique S1(HS1): 157-163.

L'article est une synthèse des principales logiques des parcours de soins pour des personnes en situation de précarité. Elle s'appuie sur les résultats d'une recherche anthropologique réalisée en 2011 et en 2012. Une quarantaine d'entretiens semi-directifs ont été réalisés dans le Nord et en Bourgogne (milieu rural) et visaient à recueillir le récit des parcours de soins dans le cadre de différents événements de santé au cours de l'existence, en les resituant dans une histoire individuelle, familiale et dans leur environnement (social, organisation des soins, etc.). Les résultats montrent différents types de déterminants. Les premiers concernent les normes et règles qui régissent l'accès aux droits et aux soins. Malgré les effets positifs de la CMUc et de l'ACS, les parcours continuent à être fortement contraints économiquement et notamment pour ceux qui sont au-dessus des seuils et n'ont pas de complémentaires santé. Nous avons par ailleurs repéré une culture de la privation acquise dans l'enfance qui continue à marquer les parcours à l'âge adulte. Enfin, des expériences subjectives de disqualification et de violence symbolique fréquemment relatées chez les personnes précaires, contribuent à un évitement des institutions sociales et/ou de soins afin de préserver une identité fragilisée. Malgré ces déterminations, chaque événement de santé apparait unique parce qu'inscrit dans une histoire de vie singulière et dans un contexte qui en renouvelle la signification. Les négociations identitaires sont au cœur de leurs conduites de soins.

Saint-Denis : des médiatrices en santé pour répondre aux besoins des habitants

PRESCRIRE

2018

Revue Prescrire 38(420): 777-779.

En France, à la fin des années 1980, des habitants d'un quartier socialement défavorisés de Saint-Denis accompagnaient bénévolement des voisins ou amis, souvent en difficulté, dans leurs démarches de santé ou d'accès aux droits. L'Association communautaire santé bien-être, implantée dans le quartier, a été à l'initiative d'une professionnalisation de ces personnes bénévoles. En 2016, cette association a créé un centre de santé associatif, «La Place Santé». Quatre médiatrices en santé y travaillent en 2018 et jouent un rôle facilitateur dans la relation avec les soignants, dans l'accès aux soins et aux droits des habitants du quartier.

Migration-Related Changes in Smoking Among Non-Western Immigrants in France

KHLAT M., LEGLEYE S. ET BRICARD D.

2018

Eur J Public Health [Ahead of print]

http://dx.doi.org/10.1093/eurpub/cky230

Migrants make up a growing share of European populations, and very little is known about the impact of migration on their smoking patterns. We develop a longitudinal analysis of smoking prevalence among native-born and immigrants in France based on retrospective data collected in the 2010 national Baromètre santé health survey. Analyses concerned 19 578 individuals aged 18–70 years and born in metropolitan France, in the Maghreb or in sub-Saharan Africa. Person-years with and without smoking were reconstructed using migration and smoking histories and analyzed with discrete-time regression models. Prior to migration, immigrants from both the Maghreb and sub-Saharan Africa had lower smoking prevalence than the native-born of similar birth cohort, age and education. After migration, the prevalence increased over time among Maghrebin men up to levels beyond those of the native-born (odds ratio: 1.54 [1.09–2.17] for 10 years of residence or more), while it remained much lower throughout among men from sub-Saharan Africa (odds ratio: 0.36 [0.19–0.68] for 10 years of residence or more). Starting at extremely low levels, the prevalence in both groups of women rose considerably after migration. Women from sub-Saharan Africa nearly caught up to the native-born (odds ratio: 0.70 [0.37–1.32] for 10 years of residence or more), but this was not the case for those from the Maghreb (odds ratio: 0.52 [0.33–0.81] for 10 years of residence or more). The findings uncover the low pre-migration prevalence and the diversity of post-migration trajectories. Tobacco control programs targeting recently arrived migrants would contribute to prevent unhealthy assimilation.

Health Insurance and Poverty in Trajectories of Out-Of-Pocket Expenditure Among Low-Income Middle-Aged Adults

KWON E., PARK S. ET MCBRIDE T. D.

2018

Health Services Research [Ahead of Print]

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12974

The aim of this study is to assess the effects of longitudinal patterns of health insurance and poverty on out-of-pocket expenditures among low-income late middle-aged adults. Six waves (2002–2012) of the Health and Retirement Study, in combination with RAND Center for the Study of Aging data, were used. A random coefficient regression analysis was conducted in a multilevel growth curve framework to estimate the impact of health insurance and poverty on out-of-pocket expenditures. At baseline, individuals with private insurance or unstable coverage were more likely to have out-of-pocket expenditures and financial burdens than public insurance holders. Over time, the poor who had no insurance, unstable coverage, or insurance type change had higher out-of-pocket expenditures; private coverage holders had higher odds of financial burden. Unstable insurance coverage had a discernible effect on the long-term, out-of-pocket expenditures among low-income adults. Findings have an important policy implication to protect poor late middle-aged population; as this population enters old age, the high financial burden it faces may exacerbate persistent socioeconomic health disparity among older people with unstable insurance coverage.

À quelle échelle appliquer l'approche universelle proportionnée pour lutter contre les inégalités sociales de santé ? Pour une approche contextualisée des actions de prévention et de promotion de la santé

PORCHERIE M., LE BIHAN-YOUINOU B. ET POMMIER J.

2018

Santé Publique S1(HS1): 25-32.

La lutte contre les inégalités sociales de santé constitue depuis 2009 l'un des axes fondateurs des politiques conduites par les Agences régionales de santé (ARS). Le présent article interroge deux cadres d'analyse mobilisés pour l'étude des actions de prévention et de promotion de la santé. À partir de l'exemple d'un dispositif hospitalier de prévention et de promotion de la santé, il démontre la nécessité de prendre en compte les contextes locaux, régionaux et nationaux dans lesquels s'inscrivent les actions menées afin d'en appréhender la portée sur les inégalités sociales et de santé. Une analyse qualitative de documents de programmation a été utilisée pour mener une analyse descriptive des effets attendus sur les inégalités sociales de santé selon la classification de Diderichsen et al. Le cadre d'application des mesures universelles proportionnées de Carey et al. a été utilisé pour analyser son action sur les inégalités sociales de santé dans une approche contextualisée au regard des politiques régionales et nationales. Le dispositif étudié, axé sur des actions ciblées mais ouvert sur le territoire, oscille entre stratégie de rattrapage des écarts et action sur le gradient pour agir sur les inégalités sociales de santé. En revanche, une analyse au prisme de l'approche universelle proportionnée réinterroge l'appréciation des effets d'une intervention sur les inégalités sociales de santé. La mise en œuvre d'interventions qui concourent à la réduction des inégalités sociales de santé reste un défi pour les institutions comme les Agences régionales de santé. Néanmoins, l'étude d'un dispositif hospitalier de prévention montre une vision contrastée de son effet possible sur le gradient de santé, selon qu'il est considéré de manière isolée ou globale. Cet article plaide pour une analyse contextualisée des dispositifs locaux qui visent la réduction des inégalités sociales de santé.

Les évolutions des modes d'action pour agir sur les inégalités sociales de santé dans les recommandations politiques à l'international et en France

PORCHERIE M., LE BIHAN-YOUINOU B. ET POMMIER J.

2018

Santé Publique S1(HS1): 33-46.

Cet article présente les évolutions des modes d'action politiques pour lutter contre les inégalités sociales de santé préconisées en France, au regard des textes de l'OMS et d'autres organismes internationaux. Une analyse de contenu des textes de recommandations politiques a permis d'identifier onze catégories de modes d'action et cinq types d'évolutions en fonction des populations cibles et des moyens à déployer. Les recommandations ont ainsi évolué d'une action pour l'accès aux soins primaires à une action sur les déterminants sociaux de la santé, du renforcement des capacités individuelles à l'empowerment global, de l'action sur des cibles populationnelles à l'inclusion sociale de tous, de la promotion des investissements pour la santé à une régulation financière accrue, d'une approche des politiques publiques favorables à la santé à une approche de santé dans toutes les politiques. En France, les modes d'action ont été multiples mais sont restés peu opérationnalisés. Ils ont évolué au cours du temps, faisant le plus souvent écho aux textes de référence mondiaux avec un certain décalage temporel. Les modes d'action préconisés au niveau international s'éloignent fortement des modes d'action centrés sur les capacités individuelles alors que la nouvelle loi de santé publique en France réintroduit des interventions ciblées sur les comportements. Ce constat soulève d'autres interrogations, notamment sur la manière dont la recherche sur les inégalités sociales de santé irrigue la décision publique, et sur le traitement institutionnel de la santé dans toutes les politiques.

Identifier les facteurs explicatifs du renoncement aux soins pour appréhender les différentes dimensions de l'accessibilité sanitaire

REVIL H.

2018

Regards 53(1): 29-41.

https://www.cairn.info/revue-regards-2018-1-page-29.htm

A Qualitative Study of Disengagement in Disadvantaged Areas of the UK: 'You Come Through Your Door and You Lock that Door'

ROMEO-VELILLA M., ELLIS N., HURST G., *et al.*

2018

Health & Place 52: 62-69.

Health inequalities are a major concern in the UK. Power imbalances are associated with health inequalities and should be challenged through health promotion and empowering strategies, enabling individuals who feel powerless to take control over their own life and act on the determinants of health (Green and Tones, 2010). This study aimed to explore resident expectations of a community engagement programme that intended to empower communities to take action on pre-identified priorities. The programme targeted communities in deprived areas of a mid-sized city in the UK. A qualitative design was implemented. In-depth semi-structured interviews were undertaken with 28 adult residents at the start of the programme. Transcripts were analysed using an inductive approach to thematic analysis. Resident expectations were explored from a constructivist epistemological perspective. The qualitative inductive approach allowed a second research question to develop which led this paper to focus on exploring how disempowerment was experienced by individuals before taking part in a community engagement programme. Analysis of interviews revealed a 'process of deterioration' that provided insight into how communities might become (more) disadvantaged through disempowerment. Five master themes were identified: external abandonment at the institutional-level (master theme 1); a resulting loss of sense of community (master theme 2); this negatively affected psychological wellbeing of residents (master theme 3); who adopted coping strategies (e.g., disengagement) to aid living in such challenging areas; (master theme 4); disengagement further perpetuated the deterioration of the area (master theme 5). Distrust was identified as a major barrier to participation in community engagement programmes. Overall, our data suggested that community engagement approaches must prioritise restoration of trust and be accompanied by supportive policies to mitigate feelings of abandonment in communities.

Maladies chroniques et inégalités sociales de santé en soins premiers. Partie 2

RYCHEN C., MALAZOVIC K., VANDERSNICKT G., *et al.*

2018

Médecine : De la Médecine Factuelle à nos Pratiques(14): 221-227.

Notre objectif était de décrire la relation entre des maladies chroniques (dépendance au tabac, mésusage d'alcool, maladies cardiovasculaires, HTA, maladies respiratoires, asthme) et des indicateurs socio- économiques, en médecine générale. Nous avons réalisé en 2015 une étude observationnelle transversale descriptive en Aquitaine, avec analyse par régression logistique multivariable. 473 patients ont été inclus. 46,8 % avait un probable mésusage d'alcool ; 41,9 % une probable dépendance au tabac ; 13,8 % étaient hypertendus ; 13,6 % déclaraient un asthme. En analyse multivariable, il existait une association entre la dépendance probable au tabac et certains indicateurs socio- économiques.

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

European Journal of 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 healthcare 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
Pharmaceuticals

Co-prescriptions d'antibiotiques et d'anti-inflammatoires par le médecin généraliste : données en pharmacie de ville et informations diagnostiques perçues par le patient

PRESCRIRE

2018

Revue Prescrire 14(5): 228-235

Les anti-inflammatoires sont rarement recommandés en pathologies infectieuses courantes, et de nombreuses études interrogent sur les risques éventuels liés à ces prescriptions en contexte infectieux, notamment en pathologie respiratoire haute, où les complications peuvent être graves. À partir d'un recueil de données de la CPAM de Lorraine en 2013, cet article étudie les pratiques de prescription des médecins généralistes dans ce domaine.

Médicaments en Questions : des résultats toujours aussi encourageants

PRESCRIRE

2018

Revue Prescrire 38(417): 543-544.

Depuis 2014, Prescrire propose Médicaments en Questions, un programme en ligne d'amélioration des pratiques professionnelles. L'objectif est d'aider les soignants à mieux prendre en compte dans leur pratique les effets indésirables des médicaments et à mieux y faire face, pour les réduire. Ce programme est basé sur une démarche réflexive : décrire, analyser, comparer sa pratique ; actualiser et approfondir ses connaissances ; échanger avec d'autres soignants. Cet article présente les résultats de la session 2016-2017, qui sont encourageants.

Médicaments et insuffisance rénale

ALOY B., DESPLANQUES P.-Y., GURGEL S., *et al.*

2018

Actualités Pharmaceutiques 57(572): 33-36.

Le vieillissement s'accompagne d'un déclin physiologique de la fonction rénale, pouvant entraîner une accumulation des médicaments, responsable d'une toxicité liée à un surdosage. Un site internet sur le bon usage clinique des médicaments propose des adaptations posologiques et des calculettes d'estimation de la fonction rénale. À l'officine, cet outil permet de sécuriser la délivrance chez le patient âgé.

Assessing Complexity in Interventions to Improve Appropriate Polypharmacy in Older People Using the Intervention Complexity Assessment Tool for Systematic Reviews

CADOGAN C., RANKIN A., LEWIN S., *et al.*

2018

Age and Ageing 47(suppl. 5): v13-v60.
http://dx.doi.org/10.1093/ageing/afy140.21

A key challenge in prescribing for older multimorbid populations is ensuring appropriate polypharmacy. Most previously evaluated interventions targeting appropriate polypharmacy have involved multiple components and been described as complex interventions. The intervention Complexity Assessment Tool for

Systematic Reviews (iCAT_SR) has been developed to facilitate detailed assessments of intervention complexity in systematic reviews. This study aimed to assess, using the iCAT_SR, the complexity of interventions aimed at improving appropriate polypharmacy in older people, as reported in studies (n = 20) included in the update of a Cochrane review.1

The Impact of Patient-Centered Medical Homes on Medication Adherence?

DAVID G., SAYNISCH P., LUSTER S., *et al.*

2018

Health Econ 27(11): 1805-1820.

Accreditation of providers helps resolve the pervasive information asymmetries in health care markets. However, meeting accreditation standards typically involves flexibility in implementation, leading to heterogeneity in performance. For example, the patient-centered medical home (PCMH) is a leading model for recognizing high-performing primary care practices. Flexibility in PCMH implementation allows for varying degrees of emphasis on processes designed to enhance medication adherence. To assess the impact of the PCMH on adherence, we combine 6 years of detailed patient claims data with a novel dataset containing detailed practice-level PCMH attributes. We study the effects of the number and configuration of adherence-relevant capabilities, using variation in the timing of PCMH adoption to estimate its impact. While PCMH adoption improved overall medication adherence, when combining claims data with the unique recognition data detailing what PCMH capabilities were adopted, we find that these gains are concentrated among patients in practices that adopted more adherence-relevant capabilities. Despite mixed evidence in the literature concerning costs and utilization, our results indicate that PCMH recognition improves medication adherence.

Comparison of Treatment Persistence with Dabigatran or Rivaroxaban Versus Vitamin K Antagonist Oral Anticoagulants in Atrial Fibrillation Patients: A Competing Risk Analysis in the French National Health Care Databases

MAURA G., BILLIONNET C., ALLA F., *et al.*

2018

Pharmacotherapy 38(1): 6-18.

https://www.ncbi.nlm.nih.gov/pubmed/29028119

Direct oral anticoagulants (DOACs) have been proposed as a more convenient alternative to vitamin K antagonists (VKAs), which are commonly associated with poor treatment persistence in non-valvular atrial fibrillation (nv-AF). Using data from the French national health care databases (Regime General, 50 million beneficiaries), a cohort study was conducted to compare the 1-year non-persistence rates in nv-AF patients initiating dabigatran (N = 11,141) or rivaroxaban (N = 11,126) versus VKA (N = 11,998). Treatment discontinuation was defined as a switch between oral anticoagulant (OAC) classes or a 60-day gap with no medication coverage, with the additional criterion of no reimbursement for international normalized ratio monitoring during this gap for VKA patients. Considering death as a competing risk, differences between 1-year discontinuation rates were used to compare each DOAC versus VKA. The 95% confidence intervals (CIs) were estimated via bootstrapping. Baseline patient characteristics were adjusted using inverse probability of treatment weighting. Consistent results were obtained when considering both switches between OAC classes and death as competing risks of treatment discontinuation. Results from this nationwide cohort study showed high non-persistence levels with all OACs and suggest that persistence with both dabigatran and rivaroxaban therapy is not better than persistence with VKA therapy. Hospitalizations for bleeding among non-persistent patients were unlikely to explain these high non-persistence rates.

Medication Adherence, Costs, and ER Visits of Nurse Practitioner and Primary Care Physician Patients: Evidence from Three Cohorts of Medicare Beneficiaries

MUENCH U., GUO C., THOMAS C., *et al.*

2018

Health Serv Res [Ahead of print]

The aim of this study is to compare medication adherence, cost, and utilization in Medicare beneficiaries attributed to nurse practitioners (NP) and primary care physicians (PCP). This analysis is based on Medicare Part A, B, and D claims and beneficiary summary file data, years 2009-2013. We used propensity score-weighted analyses combined with logistic regression and generalized estimating equations to test differences in good medication adherence (proportion of days covered (PDC >0.8); office-based and specialty care costs; and ER visits. Data extraction are related to beneficiaries with prescription claims for anti-diabetics, renin-angiotensin system antagonists (RASA), or statins. PRINCIPAL FINDINGS: There were no differences in good medication adherence (PDC >0.8) between NP and PCP attributed beneficiaries taking anti-diabetics or RASA. Beneficiaries taking statins had a slightly higher probability of good adherence when attributed to PCPs (74.6% vs 75.5%; P < 0.05). NP attributed beneficiaries had lower office-based and specialty care costs and were less likely to experience an ER visit across all three medication cohorts (P < 0.01). Examining the impact of NP and PCP provided care on outcomes beyond the primary care setting is important to the Medicare program in general but will also help practices seeking to meet benchmarks under alternative payment models that incentivize higher quality and lower costs.

German Healthcare Professionals' Perspective on Implementing Recommendations About Polypharmacy in General Practice: A Qualitative Study

STRASSNER C., STEINHÄUSER J., FREUND T., *et al.*

2018

Family Practice 35(4): 503-510.

http://dx.doi.org/10.1093/fampra/cmx127

Key recommendations for the management of patients with polypharmacy are structured medication counselling (SMC), medication lists and systematic medication reviews. The aim of this study was to identify determinants (hindering and facilitating factors) for the implementation of the recommendations in general practice. This study was linked to a tailored intervention aimed at improving the implementation of the recommendations in German general practice. Interviews and focus groups with different healthcare professionals were carried out in the design phase and after delivery of the intervention. The material from both data collections was analysed separately in a content analytical approach resulting in two sets of categories. For this study, the subcategories of both sets were assigned to the Tailoring Interventions for Chronic Diseases (TICD) checklist, a comprehensive framework of determinants of practice. Interviews with 24 general practitioners (GPs), 4 other medical specialists, 1 pharmacist, 3 nurses and 6 medical assistants as well as 2 mixed focus groups with 17 professionals were conducted. We identified 93 determinants: 29 referred to medication counselling, 21 to the use of medication lists, 20 to medications reviews and 23 to all recommendations. The determinants were related to all 7 main domains and to 25 of the 57 subdomains on the TICD checklist including guideline factors, patient factors, individual healthcare professional factors, social, political and legal factors, incentives and resources, and capacity for organizational change. While many interventions to improve polypharmacy focus on the provision of pharmacological knowledge, a much wider range of domains need to be addressed, such as communication skills, patient involvement and practice organization.

Méthodologie – Statistique
Methodology – Statistics

The Great Regression. Machine Learning, Econometrics, and the Future of Quantitative Social Sciences

BOELAERT J. ET OLLION É.

2018

Revue française de sociologie 59(3): 475-506.

Que peuvent faire les sciences sociales avec le machine learning, et que peut-il leur faire ? Cet article propose une introduction à cette classe de méthodes statistiques. Il détaille ses prémisses, sa logique, et les défis qu'elle pose pour les sciences (sociales). Il le fait au moyen d'une comparaison avec d'autres approches quantitative plus conventionnelles, les régressions paramétriques en premier lieu, et ce tant au niveau général qu'en pratique. Au-delà de l'exercice méthodologique, l'article se propose de revenir sur les débats houleux qui entourent le learning. Il revient pour se faire sur le rôle et les conséquences possibles de l'usage de l'apprentissage statistique. Il soutient que la révolution promise par beaucoup et crainte par d'autres ne se produira pas de sitôt, ou en tout cas pas dans les termes souvent mentionnés. Le changement de paradigme évoqué de manière prophétique n'aura pas lieu. Plutôt, une concurrence accrue entre différentes formes de quantification du monde social va se mettre en place. Contre toute attente, cette incertitude croissante pourrait être de bon augure pour la connaissance en général.

An Ethical Appraisal of Living-Anonymous Kidney Donation Using Adam Smith's Theory of Moral Sentiments

KHETPAL V. ET MOSSIALOS E.

2018

Health Policy 122(11) : 1212-1221

Ethical debates continue to shape organ transplant policies, particularly for kidneys. Facing organ shortages, governments have created incentives targeting prospective living-anonymous donors - socially and biologically unrelated to the recipient. However, these policies may transform altruistic exchanges of tissues into trades of commodities. We use Adam Smith's concept of sympathy to outline a new approach to transplantation ethics. This is accomplished using a case study analysis of six countries with established living-anonymous kidney donation practices - Iran, Israel, the Netherlands, Saudi Arabia, the United Kingdom, and the United States. An ethical test was also developed from ethnographies of donors and Smith's Theory of Moral Sentiments. The case study analysis considered the role of religious and historic norms, media campaigns, adherence to the 2008 Declaration of Istanbul guidelines for each case, and how each factor related to Smith's sympathy, categorizing the countries into four tiers of altruism. Iran occupied the least altruistic tier, followed by the Netherlands, the UK and the US, and Saudi Arabia and Israel. The ethical test identified a similar ranking. Our findings suggest that a highly-selected cohort of states with established living-anonymous kidney donation programs may already utilize a Smithian approach for recruiting donors, and that socially-valued government incentives can preserve altruism. The ethical test could become a useful instrument to assess the altruism of emerging incentive policies.

Appraising Qualitative Research for Evidence Syntheses: A Compendium of Quality Appraisal Tools

MAJID U. ET VANSTONE M.

2018

Qualitative Health Research 28(13):2115-2131

As the movement toward evidence-based health policy continues to emphasize the importance of including patient and public perspectives, syntheses of qualitative health research are becoming more common. In response to the focus on independent assessments of rigor in these knowledge products, over 100 appraisal tools for assessing the quality of qualitative research have been developed. The variety of appraisal tools exhibit diverse methods and purposes, reflecting the lack of consensus as to what constitutes appropriate quality criteria for qualitative research. It is a daunting task for those without deep familiarity of the field to choose the best appraisal tool for their purpose. This article provides a description of the structure, content, and objectives of existing appraisal tools for those wanting to evaluate primary qualitative research for a qualitative evidence synthesis. We then discuss

common features of appraisal tools and examine their implications for evidence synthesis.

L'analyse des opinions politiques sur Twitter. Défis et opportunités d'une approche multi-échelle

SEVERO M. ET LAMARCHE-PERRIN R.

2018

Revue française de sociologie 59(3): 507-532.

Des blogs et forums aux pages Facebook et comptes Twitter, le récent déluge des données numériques du web a fortement affecté la recherche en sciences sociales. Cette nouvelle catégorie d'information, utile à l'extraction des opinions politiques, se présente comme une alternative aux techniques traditionnelles telles que les sondages. Premièrement, en réalisant un état de l'art des études de l'opinion s'appuyant sur les données Twitter, cet article vise à mettre en relation les méthodes d'analyse utilisées dans ces études et les définitions de l'opinion politique qui y sont suggérées. Deuxièmement, cet article étudie la faisabilité de réaliser des analyses multi-échelles en sciences sociales concernant l'étude de l'opinion politique en exposant les mérites de plusieurs méthodes, allant des méthodes orientées contenus aux méthodes orientées interactions, de l'analyse statistique à l'analyse sémantique, des approches supervisées aux approches non supervisées. Le résultat de notre démarche est ainsi d'identifier les tendances futures de la recherche en sciences sociales concernant l'étude de l'opinion politique.

A quantile regression approach to panel data analysis of health-care expenditure in Organisation for Economic Co-operation and Development countries

TIAN F., GAO J. ET YANG K.

2018

Health Economics 27(12) : 1921-1944

This paper investigates the variation in the effects of various determinants on the per capita health-care expenditure. A total of 28 Organisation for Economic Co-operation and Development countries are studied over the period 1990–2012, employing an instrumental variable quantile regression method for a dynamic panel model with fixed effects. The results show that the determinants of per capita health-care expenditure growth, involving the growth of lagged health spending, of per capita gross domestic product (GDP), of physician density, of elderly population, of life expectancy, of urbanization, and of female labor force participation, do vary with the conditional distribution of the health-care expenditure growth, while the changing patterns are dissimilar. Moreover, we show that Baumol's model of "unbalanced growth' has a significantly positive effect on per capita health spending growth, and its effect is quite stable over the entire distribution. However, the correlation between the components (wage growth and labor productivity growth) of the "Baumol variable" and health expenditure growth is more varied. As a comparison, only the growth of lagged health spending, per capita GDP, and the Baumol variable (or its components) are found related to health spending growth in conditional mean regressions. The prediction results were also quite different between the quantile regression dynamic panel instrumental variable models and linear panel data models. More attention needs to be paid to the varying influence of determinants in health expenditure study.

Contrôle de cohérence actes-dispositifs médicaux

TOUBAL S., POREAUX A., MORELL M., *et al.*

2018

Journal de gestion et d'économie médicales 36(2): 123-136.

Le codage des actes médicaux doit être optimal d'autant plus qu'il s'agit de pose de dispositifs médicaux implantables (DMI).Un hôpital universitaire a conçu un contrôle (COHERENCE) permettant de vérifier la cohérence entre les données d'actes de pose de DMI et les données de traçabilité. L'objectif de ce travail est d'évaluer l'impact de ce contrôle : bilan quantitatif sur les séjours concernés, revalorisation des séjours contrôlés et des DMI en sus du GHS COHERENCE croise les données de codage des actes avec les données de traçabilité des DMI et repère automatiquement les séjours à contrôler. Ces séjours seront traités par le DIM pour vérification de la saisie des actes. En cas de problème de traçabilité, ces séjours seront traités par la Pharmacie. Pour le premier trimestre 2017, 151 séjours repérés par COHERENCE ont nécessité un contrôle. 48 % des contrôles portaient sur les DMI cardio-vasculaires ; 36 % sur les DMI orthopédiques. 38 % des séjours ont nécessité une correction d'acte contre 19 % qui relevaient d'un problème de traçabilité. La revalorisation des séjours contrôlés est estimée à + 261 667 €. La part de revalorisation considérée comme imputable à l'action de correction d'actes est estimée

à +119 019 € (+4 104 €/séjour). La rectification de la traçabilité par la Pharmacie a permis une revalorisation des DMI facturés en sus du GHS de +28 158 €. Les résultats obtenus, mettent en évidence l'intérêt financier et sanitaire de l'utilisation d'un programme automatique de contrôle de cohérence actes-dispositifs médicaux.

▶ Cross-Sector Collaboration in the High-Poverty Setting: Qualitative Results from a Community-Based Diabetes Intervention

TUNG E. L., GUNTER K. E., BERGERON N. Q., *et al.*
2018
Health Serv Res 53(5): 3416-3436.

The aim of this study is to characterize the motivations of stakeholders from diverse sectors who engaged in cross-sector collaboration with an academic medical center. Primary qualitative data (2014-2015) were collected from 22 organizations involved in a cross-sector diabetes intervention on the South Side of Chicago. In-depth, semistructured interviews; participants included leaders from all stakeholder organization types (e.g., businesses, community development, faith-based) involved in the intervention. All stakeholders described collaboration as an opportunity to promote community health in vulnerable populations. Among diverse motivations across organization types, stakeholders described collaboration as an opportunity for: financial support, brand enhancement, access to specialized skills or knowledge, professional networking, and health care system involvement in community-based efforts. Based on our findings, we propose a framework for implementing a working knowledge of stakeholder motivations to facilitate effective cross-sector collaboration. We identified several factors that motivated collaboration across diverse sectors with health care systems to promote health in a high-poverty, urban setting. Understanding these motivations will be foundational to optimizing meaningful cross-sector collaboration and improving diabetes outcomes in the nation's most vulnerable communities.

Politique de santé
Health Policy

▶ Le service sanitaire pour les étudiants en santé

BENSADON A. C., VAILLANT L., GICQUEL R., *et al.*
2018
Actualité et dossier en santé publique(103): 5-7.

Le service sanitaire pour les étudiants en santé s'inscrit dans le cadre de la Stratégie nationale de santé, dont le premier axe vise la prévention et la promotion des comportements favorables à la santé, et le deuxième axe la lutte contre les inégalités sociales et territoriales. Après une définition de ce service sanitaire, cet article décrit les propositions de mise en œuvre.

▶ Science réglementaire en santé publique : de quoi parle-t-on ?

CAMADRO M., BENAMOUZIG D., BAROUKI R., *et al.*
2018
Santé Publique 30(2): 187-196.

Cet article porte un éclairage sur un concept peu connu des acteurs de la santé publique en France : la science réglementaire ou regulatory science, utilisé pour décrire l'ensemble des activités scientifiques servant à produire les connaissances mobilisées pour appuyer, développer ou adapter les décisions en matière de politiques publiques. Il s'agit de comprendre comment l'expression apparue au milieu des années quatre-vingt et formalisée en un concept sociologique sous la plume de l'américaine Sheila Jasasnoff en 1990, s'est progressivement imposée au sein des agences de régulation américaines, japonaises puis européennes comme une nouvelle discipline scientifique. L'article examine l'évolution du concept et les différentes approches proposées pour définir la science réglementaire. Il met en évidence sa nature hybride et hétérogène soulignant ainsi les différentes caractéristiques que l'expression recouvre suivant l'institution qui la formule (FDA, EMA, PMDA) et le champ d'application qu'elle couvre. En s'appuyant sur des exemples concrets d'application des pratiques de science réglementaire dans trois grands domaines

du risque sanitaire (la toxicologie environnementale, les maladies infectieuses et la pharmacovigilance), l'article interroge surtout la place de la recherche dans le processus de décision en montrant comment l'apparition de nouvelles méthodes destinées à renforcer la capacité des régulateurs à exercer des fonctions de surveillance, de contrôle ou de réglementation, et le rôle des communautés académiques associées à cette démarche, contribuent au renforcement des politiques de santé publique en France, comme à l'échelle mondiale.

Accès aux soins : éléments de cadrage

CHAMBAUD L.

2018

Regards 53(1): 19-28.

La notion d'accès aux soins revient régulièrement dans les débats autour de notre santé. Elle est très souvent utilisée soit pour louer l'universalité de notre système, soit au contraire pour en dénoncer les insuffisances ou les dangers, et notamment les inégalités qu'il laisse perdurer ou se creuser. Cette notion d'accès aux soins n'est pas une préoccupation uniquement française. Sur le plan conceptuel, il est toutefois important de souligner dès cette introduction que ce sujet est devenu un axe majeur de la politique portée par l'Organisation mondiale de la santé (OMS) sous un terme différent : la couverture sanitaire universelle. En effet cet objectif a été lancé en 2013 dans le programme de développement de l'après 2015 et devient une référence constante dans les efforts internationaux pour améliorer la santé. La France est pleinement impliquée dans ce mouvement. Même si les deux termes ne se recoupent pas complétement, il est clair que « la couverture sanitaire universelle n'est pas possible sans accès universel ». Mais qu'entend-on par accès aux soins ? Quelles dimensions sont couvertes par ce terme ? Cet article propose quelques éléments de cadrage.

Community Participation in General Health Initiatives in High and Upper-Middle Income Countries: A Systematic Review Exploring the Nature of Participation, Use of Theories, Contextual Drivers and Power Relations in Community Participation

HOON CHUAH F. L., SRIVASTAVA A., SINGH S. R., *et al.*

2018

Social Science & Medicine 213: 106-122.

Community participation is commonly regarded as pivotal in enabling the success of many health initiatives. However, the theoretical constructs, and evidence about the contextual drivers and relational issues that shape participation is lacking. The aim of this systematic review was to examine the evidence for published academic literature on community participation in relation to general, non-disease specific health initiatives, including the use of theories to inform community participation, and the study of contextual drivers and relational issues that influence community participation, with a focus on high and upper-middle income countries. We searched multiple databases including Medline, Embase, Scopus, LILACs and Global Health from January 2000 to September 2016. Overall, our findings show that strategies to encourage community participation in health initiatives can be categorized along a continuum that varies from less to more participation and control among the community. Our analysis of reported outcomes demonstrates that community participation in general health initiatives can contribute to positive process, social and health outcomes. Social outcomes are more often associated with increasing community participation in our selection of papers. Overall, our findings reaffirm the understanding that community participation is a complex process that is strongly influenced by the context in which it occurs, and that social factors such as power relations must be carefully considered. There is a need for more robustly designed studies to improve the theorization of community participation, and to draw out a better understanding of how tangible and intangible elements such as power, influence community participation and its outcomes.

Potential Health Impact of Strong Tobacco Control Policies in 11 South Eastern WHO European Region Countries

LEVY D. T., WIJNHOVEN T. M. A., LEVY J., *et al.*
2018
European Journal of Public Health 28(4): 693-701.
http://dx.doi.org/10.1093/eurpub/cky028

While some WHO European Region countries are global tobacco control leaders, the South Eastern region of Europe has the highest tobacco smoking prevalence globally and a relatively low level of overall implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC). An abridged version of SimSmoke has been developed to project the health impact of implementing tobacco control policies in line with the WHO FCTC. Data on population size, smoking prevalence, policy-specific effect sizes and formulas were applied in 11 South Eastern WHO European Region countries [Albania, Bosnia and Herzegovina (the Federation of Bosnia and Herzegovina and the Republika Srpska), Bulgaria, Croatia, Israel, Montenegro, Republic of Moldova, Romania, Serbia, Slovenia and the former Yugoslav Republic of Macedonia] to project the relative reduction in smoking prevalence, number of smokers and number of smoking-attributable deaths resulting from implementing individual and/or combined six WHO FCTC measures. For all countries, an increase in excise cigarette taxes to 75% of price yields the largest relative reduction in smoking prevalence (range 8–28%). The projections show that within 15 years smoking prevalence can be reduced by at least 30% in all countries when all six tobacco control measures are fully implemented in line with the WHO FCTC. The projections show that large health effects can be achieved and the results can be used as an advocacy tool towards acceleration of the enforcement of tobacco control laws in WHO European Region countries.

Between Empowerment and Self-Discipline: Governing Patients' Conduct Through Technological Self-Care

PETRAKAKI D., HILBERG E. ET WARING J.
2018
Social Science & Medicine 213: 146-153.

Recent health policy renders patients increasingly responsible for managing their health via digital technology such as health apps and online patient platforms. This paper discusses underlying tensions between empowerment and self-discipline embodied in discourses of technological self-care. It presents findings from documentary analysis and interviews with key players in the English digital health context including policy makers, health designers and patient organisations. We show how discourses ascribe to patients an enterprising identity, which is inculcated with economic interests and engenders self-discipline. However, this reading does not capture all implications of technological self-care. A governmentality lens also shows that technological self-care opens up the potential for a de-centring of medical knowledge and its subsequent communalization. The paper contributes to Foucauldian healthcare scholarship by showing how technology could engender agential actions that operate at the margins of an enterprising discourse.

Politique publique
Public Policy

L'évaluation des politiques publiques. Les sciences sociales comme sciences de gouvernement

DURAN P.

2018

Idées économiques et sociales 193(3): 6-27.

La thématique de l'évaluation des politiques publiques occupe une bonne place depuis les années 1980 sur l'agenda de recherche comme sur l'agenda politique. Une telle observation est pourtant paradoxale, dans la mesure où tout le monde s'accorde sur le fait que la situation française est marquée par une institutionnalisation difficile de l'évaluation des politiques publiques qui fait de cette dernière une activité faiblement identifiée, insuffisamment systématisée et dont les résultats sont généralement sous-utilisés [1]. Le bilan des dernières années, en dépit d'un affichage ambitieux allant de la Révision générale des politiques publiques (RGPP) à la Modernisation de l'action publique (MAP), est plutôt mitigé, en tout cas « pas à la hauteur des ambitions », comme le notent des observateurs attentifs [2].

L'évaluation des politiques publiques. Les sciences sociales à l'épreuve

DURAN P., ERHEL C. ET GAUTIÉ J.

2018

Idées économiques et sociales 193(3): 4-5.

L'évaluation se situe aujourd'hui au cœur de la conduite des politiques publiques. Cependant, les débats méthodologiques restent nombreux, et surtout l'évaluation est souvent réduite, dans une optique trop strictement économique, à une évaluation d'impact. L'évaluation de mise en œuvre, qui analyse les logiques d'acteurs, est pourtant indispensable à la compréhension des mécanismes causaux, et par là à celle des conditions de généralisation. L'évaluation est un domaine où la complémentarité des regards disciplinaires (économie, sociologie et sciences politiques) s'avère particulièrement fructueuse.

Politique sociale
Social Policy

L'avenir du droit de la protection sociale dans un monde ubérisé

DIRRINGER J.

2018

Revue française des affaires sociales(2): 33-50.

Le lien entre emploi et protection sociale sur lequel s'est construit le système de protection sociale en France est aujourd'hui mis à l'épreuve. L'essor du capitalisme de plateforme a en effet mis en exergue le risque d'exclusion sociale des personnes participant à l'économie dite collaborative. Cette exclusion tient largement au cloisonnement des régimes de protection sociale. S'il convient certainement d'y remédier, il faut encore déterminer comment. Notamment comment assurer l'effectivité du droit à la protection sociale sans mettre en péril le système censé l'assurer ? Que l'on songe à redonner au droit social de nouvelles bases ou que l'on souhaite donner à l'individu les moyens d'assurer sa subsistance, les dispositifs juridiques censés réaliser ces desseins s'avèrent à l'étude plus ambivalents et les conceptions du monde social dont ils sont porteurs des plus variées. L'analyse des réformes et des propositions de réformes en atteste.

Approche économique de l'aide informelle. Analyse des comportements de prise en charge et de la place du soutien familial dans notre système de protection sociale

FONTAINE R.

2017

Dialogue 216(2): 67-80.

La mise en évidence de l'importance de l'aide informelle a conduit au développement de travaux économiques visant à mieux comprendre les déterminants, conséquences et mécanismes socio-économiques de la mobilisation familiale. Un premier axe d'analyse s'inscrit au niveau individuel et familial et vise à mieux comprendre les comportements d'aide. Il met en lumière l'importance de la dimension familiale encadrant les comportements individuels et les coûts indirects de l'aide informelle. Un deuxième axe s'inscrit au niveau collectif et s'interroge sur la place de l'aide informelle dans notre système de protection sociale, à côté des solidarités publiques et de la prévoyance individuelle. Si l'effet d'éviction des solidarités familiales par les solidarités publiques semble très limité, l'effet d'éviction de la demande d'assurance dépendance par l'aide informelle semble plus important.

Économie collaborative et protection sociale : mieux cibler les plateformes au cœur des enjeux

MONTEL O.

2018

Revue française des affaires sociales(2): 15-31.

L'essor de l'économie collaborative soulève des enjeux importants dans le champ de la protection sociale, aussi bien pour les travailleurs concernés, qui sont insuffisamment protégés, que pour les entreprises traditionnelles employant des salariés, qui dénoncent une concurrence déloyale. En France, ces enjeux ont relancé le débat posé par le développement des nouvelles formes de travail sur la création d'un statut intermédiaire entre salarié et travailleur indépendant et sur la mise en œuvre d'un statut de l'actif. La réflexion sur la protection sociale des travailleurs des plateformes bute toutefois sur le flou conceptuel qui entoure l'essor de ces nouveaux modèles productifs : il n'existe à ce jour aucune définition consensuelle et arrêtée de l'économie collaborative ou de l'économie des plateformes. Or, ces expressions regroupent une réalité extrêmement hétérogène, ce qui est un frein à l'élaboration de réglementations opérationnelles. Nous proposons donc, comme préalable à la réflexion sur la protection sociale des travailleurs des plateformes, de mieux appréhender cette diversité en analysant les différents modèles productifs et les relations de travail qui en découlent. Nous définissons des critères minimaux permettant d'apprécier la dépendance des travailleurs aux plateformes, dans le but de mieux cibler les plateformes au cœur des enjeux de protection sociale.

Prévention santé
Health Prevention

Universalisme proportionné : vers une « égalité réelle » de la prévention en France ?

AFFELTRANGER B., POTVIN L., FERRON C., *et al.*

2018

Santé Publique S1(HS1): 13-24.

Malgré une philosophie ou ambition souvent universalistes, les stratégies et actions de prévention ont fréquemment des effets différenciés, selon les publics ou territoires bénéficiaires. Cette différenciation procède, autant qu'elle l'alimente, d'un gradient (social, territorial…) d'accès et/ou de recours à l'offre de prévention, et d'effectivité de celle-ci. Cette différenciation peut renforcer les inégalités de santé et illustrer un décalage entre les principes des politiques publiques, et la réalité de leur mise en œuvre. Toutefois, l'analyse de la différenciation et la réflexivité des pratiques préventives permettent d'identifier des leviers d'adaptation de l'offre de prévention. La différenciation constitue, en cela, une ressource analytique pour déployer l'universalisme proportionné – principe pré-

senté par Sir Marmot comme levier de réduction des inégalités de santé, mais dont les modalités pratiques ont été, jusqu'à un passé récent, peu détaillées dans la littérature.

Inégalités sociales et soins préventifs : le cas du conseil en activité physique délivré par les généralistes

BLOY G., MOUSSARD PHILIPPON L. ET RIGAL L.

2018

Santé Publique S1(HS1): 81-87.

Les comportements favorables à la santé sont moins fréquents en bas de l'échelle sociale, ce qui contribue aux inégalités sociales de santé. Par leurs conseils préventifs, les médecins généralistes (MG) peuvent espérer agir sur cette tendance. Notre objectif était de décrire les inégalités sociales en matière d'activité physique (AP) dans les patientèles et de conseil en AP en consultation, et de mieux comprendre leur construction au niveau de la relation médecin/malade. Prev Quanti a étudié les différences sociales concernant l'AP des patients et le conseil en AP dispensé par leur MG parmi 3 640 patients tirés au sort dans la liste médecin-traitant de 52 MG maîtres de stage franciliens. Prev Quali a exploré la construction des « styles de pratique » pour ce conseil, sur la base de 99 entretiens réalisés avec des MG franciliens « tout-venant ». Résultats : Des gradients sociaux de conseil en AP défavorables au bas de la hiérarchie sociale, où la pratique d'une AP était aussi moins souvent déclarée par les patients, ont été observés. Les entretiens ont souligné une difficulté des MG à considérer en routine l'AP comme un soin médical pertinent , et une pratique peu systématique. Un processus discret de triage entre les patients avec lesquels « il est judicieux » d'aborder l'AP et les autres opère, ce qui produit une sélection sociale indirecte, sans conscience claire des gradients sociaux en la matière. Ne pas creuser les inégalités sociales lors de la promotion de l'AP est un défi pour les MG.

The Effect of Organized Breast Cancer Screening on Mammography Use: Evidence from France

BUCHMUELLER T. C. ET GOLDZAHL L.

2018

Health Economics 27(12):1963-1980.

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3813

Abstract In 2004, France introduced a national program of organized breast cancer screening. The national program built on preexisting local programs in some, but not all, départements. Using data from multiple waves of a nationally representative biennial survey of the French population, we estimate the effect of organized screening on the percentage of women obtaining a mammogram. The analysis uses difference-in-differences methods to exploit the fact that the program was targeted at women in a specific age group: 50 to 74 years old. We find that organized screening significantly raised mammography rates among women in the target age range. Just above the lower age threshold, the percentage of women reporting that they had a mammogram in the past 2 years increased by over 10 percentage points after the national program went into effect. Mammography rates increased even more among women in their 60s. Estimated effects are particularly large for women with less education and lower incomes, suggesting that France's organized screening program has reduced socioeconomic disparities in access to mammography.

Prévention et promotion de la santé : une responsabilité collective

CAMBON L., ALLA F., CHAUVIN F., *et al.*

2018

Actualité et dossier en santé publique(103): 8-58.

La santé est multidimensionnelle. Au-delà des approches, les stratégies et les interventions de la prévention se croisent et se complètent. Il existe des ressources documentaires validées et partagées et en amont, toute mesure envisagée devrait prendre en compte ses impacts sur la santé. Ce dossier aborde ces différentes problématiques.

Physician Assistant Involvement in Health Advocacy, Health Promotion and Disease Prevention: A Scoping Review

ELZIBAK O. H., DANG A. T., QUTOB M. S., *et al.*

2018

2018 1(1).

http://ojs.lib.umanitoba.ca/index.php/jcpa/article/view/611

Physician Assistants (PAs) have been integrated into the Canadian healthcare system to improve patient access and clinical efficiency. The CanMEDS-PA framework describes the PA as a health advocate, but the current extent of PA involvement in health advocacy has not been delineated. A scoping review was conducted to investigate PA participation in health advocacy, health promotion and disease prevention initiatives. An electronic literature search was conducted using Web of Science, PubMed, CINAHL, OVID (Embase and MEDLINE) and Cochrane databases. Broad eligibility criteria were used to include publications involving PAs or PA students who participated in health advocacy, health promotion and disease prevention initiatives globally. RESULTS: 297 records were identified; 14 met the inclusion criteria. Publications included cross-sectional studies, surveys, program evaluations, clinical framework development, and patient education handouts. Topics included cancer screening, chronic disease management, adolescent health promotion and stroke prevention. All records were published in the United States. Global research on PA involvement in health advocacy, health promotion and disease prevention is limited and focuses on a small subset of medicine (cancer screening) in one geographical area (United States). Data show that PAs are effective health advocates but more reporting is needed to guide expansion of the PA role and to inform policy in Canada and globally.

Education thérapeutique des patients et des proches

GIRAUDET A. S.

2018

Revue du praticien 68(8): 819-825.

L'éducation thérapeutique des patients est un acte thérapeutique, un soin, par opposition à l'éducation pour la santé (éducation sanitaire, promotion de la santé) qui se situe en amont de la maladie et lutte contre un comportement à risque. Mais c'est encore trop souvent un traitement orphelin en quête de reconnaissance.

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.

The increasing prevalence of type 2 diabetes has highlighted the importance of evidence-based guidelines for effective prevention, management and treatment. Diabetes self-management education (SME) produces positive effects on patient behaviours and health status. We analyzed the literature to identify (i) the level of integration between usual care and SME programs and (ii) any possible differences across them in terms of outcomes. Searches were made on three databases - PubMed, Scopus and Web of Science - to identify relevant publications on diabetes SME to 2015, which also describe the provider of usual care. In total, 49 studies met the inclusion criteria. We identified three levels of integration (high, medium and low) between usual care and SME programs based on the level of involvement of usual care professionals within the SME programs. In most cases, the primary care physician was responsible for the diabetes patients. Patient health behaviors and/or outcomes improve in most of the studies, independently from the level of integration. However, findings suggest that when patients/participants could perceive that usual care provider is highly involved in SME delivery, educational programs produced results that appear to be more positive.

Effect of Organised Mammography Screening on Breast Cancer Mortality: A Population-Based Cohort Study in Norway

MØLLER M. H., LOUSDAL M. L., KRISTIANSEN I. S., *et al.*

2018

International Journal of Cancer [Ahead of print]

https://onlinelibrary.wiley.com/doi/abs/10.1002/ijc.31832

We aimed to estimate the effect of organised mammography screening on incidence-based breast cancer mortality by comparing changes in mortality among women eligible for screening to concurrent changes in younger and older ineligible women. In a county-wise balanced, open-cohort study, we used birth cohorts (1896-1982) to construct three age groups in both the historical and screening period: women eligible for

screening, and younger or older women ineligible for screening. We included women diagnosed with breast cancer who died within the same age-period group during 1987-2010 (n = 4,903). We estimated relative incidence-based mortality rate ratios (relative MRR) comparing temporal changes in eligible women to concurrent changes in ineligible women. Additionally, we conducted analyses comparing the change in eligible women to younger, ineligible women with either continued accrual and follow-up period (eligible women only) or continued follow-up period. All three age groups experienced a reduction in mortality, but the decrease among eligible women was about the same among ineligible women (relative MRR = 1.05, 95% CI: (0.94-1.18)). Varying the definition of follow-up yielded similar results. Mammography screening was not associated with a larger breast cancer mortality reduction in women eligible relative to ineligible women. This article is protected by copyright. All rights reserved.

Applying a Prevention Framework to Address Homelessness as a Population Health Issue

NICHOLAS W. C. ET HENWOOD B. F.

2018

Journal of Public Health Policy 39(3): 283-293.

https://doi.org/10.1057/s41271-018-0137-9

This paper presents a population health framework for homelessness prevention. Rooted in the Los Angeles County Homeless Initiative, the framework includes strategies that affect social determinants of health that influence a broad range of health outcomes prevalent among the homeless. For each prevention level, we consider the purpose of prevention, the sub-population of interest, and evidence of the effectiveness of interventions in addressing factors that affect health and health outcomes. Our review highlights the importance of cross-cutting strategies and the limits of our knowledge about more targeted preventive interventions. We note that a prevention orientation requires attention to the social and physical environments that affect homelessness plus connections between the homelessness services sector and mainstream systems of care and support.

Colorectal Cancer Screening Participation: A Systematic Review

WOOLS A., DAPPER E. A. ET LEEUW J. R. J. D.

2016

European Journal of Public Health 26(1): 158-168.

http://dx.doi.org/10.1093/eurpub/ckv148

Colorectal cancer (CRC) is one of the most common cancers in men and women. CRC screening programmes have been implemented in various countries. However, the participation rate remains disappointingly low. For a screening method to be beneficial, high participation rates are essential. Therefore, understanding the factors that are associated with CRC screening and follow-up adherence is necessary. In this systematic review, factors studied in literature were identified that are associated with CRC screening adherence. A systematic search in PUBMED, EMBASE and COCHRANE was performed to identify barriers and facilitators for CRC screening adherence. Study characteristics were summarized and analysed. Seventy-seven papers met the inclusion criteria to be applicable for review. Female gender, younger participants, low level of education, lower income, ethnic minorities and not having a spouse were the most frequently reported barriers. Health provider characteristics, such as health insurance and a usual source of care were also frequently reported barriers in CRC screening adherence. Disparities were found in weight, employment status and self-perceived health status. Barriers and facilitators of CRC screening participation are frequently reported. Understanding these factors is the first step to possibly modify specific factors to increase CRC screening participation rate.

Prévision – Evaluation

Prevision - Evaluation

Une contribution de la sociologie de l'action publique à l'évaluation de processus. Le cas des « politiques d'organisation »

BERGERON H. ET HASSENTEUFEL P.

2018

Idées économiques et sociales 193(3): 42-50.

La sociologie de l'action publique, qui renvoie à des approches partagées entre sociologues et politistes, occupe une place marginale dans l'évaluation des politiques publiques en France. Les raisons de cette situation relèvent de dynamiques à la fois cognitives et institutionnelles. Pourtant, cette sociologie permet la réalisation d'évaluations de processus, dont l'objectif principal est de comprendre la dynamique des interactions entre acteurs et institutions dans le cadre de la mise en œuvre des politiques publiques. Une telle démarche, complémentaire notamment avec les évaluations expérimentales et les évaluations d'impact, apparaît pertinente du fait du développement de « politiques d'organisation » dont l'objectif central est de développer la coopération et la coordination entre acteurs et entre institutions, et de permettre ainsi la prise en charge d'enjeux transversaux d'action publique. À travers trois exemples d'évaluations de politiques publiques, il s'agit de montrer que l'évaluation des processus de mise en œuvre de ces politiques publiques d'organisation est de facto une évaluation de l'efficacité : une mesure du résultat qu'ont ces organisations, eu égard aux objectifs spécifiques qui leur ont été assignés (coordination et coopération).

Les méthodes d'évaluation des politiques publiques

BOZIO A.

2018

Idées économiques et sociales 193(3): 28-33.

L'évaluation des politiques publiques repose en grande partie sur une démarche scientifique visant à améliorer nos connaissances quant à l'impact des nombreuses variantes de politiques publiques. Cette démarche reconnaît comme point de départ l'étendue de notre ignorance en la matière – une chose pas forcément aisée à partager avec les responsables politiques – et ainsi la nécessité d'approfondir, par l'évaluation, nos connaissances quant aux meilleures façons d'atteindre les objectifs fixés par le débat démocratique.

Two Morbidity Indices Developed in a Nationwide Population Permitted Performant Outcome-Specific Severity Adjustment

CONSTANTINOU P., TUPPIN P., FAGOT-CAMPAGNA A., *et al.*

2018

J Clin Epidemiol 103: 60-70.

The objective of the study was to develop and validate two outcome-specific morbidity indices in a population-based setting: the Mortality-Related Morbidity Index (MRMI) predictive of all-cause mortality and the Expenditure-Related Morbidity Index (ERMI) predictive of health care expenditure. A cohort including all beneficiaries of the main French health insurance scheme aged 65 years or older on December 31, 2013 (N = 7,672,111), was randomly split into a development population for index elaboration and a validation population for predictive performance assessment. Age, gender, and selected lists of conditions identified through standard algorithms available in the French health insurance database (SNDS) were used as predictors for 2-year mortality and 2-year health care expenditure in separate models. Overall performance and calibration of the MRMI and ERMI were measured and compared to various versions of the Charlson Comorbidity Index (CCI). The MRMI included 16 conditions, was more discriminant than the age-adjusted CCI

(c-statistic: 0.825 [95% confidence interval: 0.824-0.826] vs. 0.800 [0.799-0.801]), and better calibrated. The ERMI included 19 conditions, explained more variance than the cost-adapted CCI (21.8% vs. 13.0%), and was better calibrated. The proposed MRMI and ERMI indices are performant tools to account for health-state severity according to outcomes of interest.

Les évaluations par assignation aléatoire. Apports et limites

JATTEAU A.

2018

Idées économiques et sociales 193(3): 34-41.

Les évaluations par assignation aléatoire, portées notamment par l'économiste Esther Duflo, constituent une méthode quantitative d'évaluation d'impact qui a connu un large succès ces dernières années. Quels en sont les fondements théoriques, les domaines d'application, les limites épistémologiques et méthodologiques ?

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

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

2018

Health Econ 27(11): 1670-1683.

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.

Smoking Cessation: A Comparison of Two Model Structures

PENNINGTON B., FILBY A., OWEN L., *et al.*

2018

PharmacoEconomics 36(9): 1101-1112.

https://doi.org/10.1007/s40273-018-0657-y

Most economic evaluations of smoking cessation interventions have used cohort state-transition models. Discrete event simulations (DESs) have been proposed as a superior approach.

Repères méthodologiques pour l'évaluation des Contrats Locaux de Santé et de leur capacité à réduire les inégalités sociales de santé

SCHAPMAN-SEGALIE S. ET LOMBRAIL P.

2018

Santé Publique S1(HS1): 47-61.

Les Contrats Locaux de Santé sont un des outils prometteurs de lutte contre les inégalités sociales et territoriales de santé. Ils donneront leur plein effet s'ils sont conçus pour mobiliser des ressources intersectorielles visant les déterminants proximaux et fondamentaux des inégalités. Nous proposons une « grille de lecture » de leurs capacités a priori d'atteindre le but recherché. Elle comporte deux parties : la première porte sur les buts et objectifs recherchés à travers la mise en place de chaque action (sur quoi veut-on agir pour quels résultats à quel terme ?) ; la seconde porte sur les stratégies et moyens d'action mis en œuvre et répond à la question du « comment agit-on ? ». Une application à l'analyse d'un échantillon de CLS franciliens de 1re génération est présentée à titre d'exemple. Elle montre l'importance accordée au système de santé par rapport aux conditions de vie des habitants. La discussion porte sur les nécessaires précautions d'emploi d'une grille de travail qui n'aborde pas les conditions de mise en œuvre des actions, ni leur territorialisation, ni leur gouvernance régionale.

Psychiatrie
Psychiatry

Continuity of Care Among People Experiencing Homelessness and Mental Illness: Does Community Follow-Up Reduce Rehospitalization?

CURRIE L. B., PATTERSON M. L., MONIRUZZAMAN A., *et al.*

2018

Health Serv Res 53(5): 3400-3415.

The aim of this study is to examine whether timely outpatient follow-up after hospital discharge reduces the risk of subsequent rehospitalization among people experiencing homelessness and mental illness. Comprehensive linked administrative data including hospital admissions, laboratory services, and community medical services. Participants were recruited to the Vancouver At Home study based on a-priori criteria for homelessness and mental illness (n = 497). Logistic regression analysis was used to assess the relationship between outpatient care within 7 days postdischarge and subsequent rehospitalization over a 1-year period. DATA EXTRACTION: Data were extracted for a consenting subsample of participants (n = 433) spanning 5 years prior to study enrollment. More than half of the eligible sample (53 percent; n = 128) were rehospitalized within 1 year following an index hospital discharge. Neither outpatient medical services nor laboratory services within 7 days following discharge were associated with a significantly reduced likelihood of rehospitalization within 2 months (AOR = 1.17 [CI = 0.94, 1.46]), 6 months (AOR = 1.00 [CI = 0.82, 1.23]) or 12 months (AOR = 1.24 [CI = 1.02, 1.52]). In contrast to evidence from nonhomeless samples, we found no association between timely outpatient follow-up and the likelihood of rehospitalization in our homeless, mentally ill cohort. Our findings indicate a need to address housing as an essential component of discharge planning alongside outpatient care.

Place for Being, Doing, Becoming and Belonging: A Meta-Synthesis Exploring the Role of Place in Mental Health Recovery

DOROUD N., FOSSEY E. ET FORTUNE T.

2018

Health & Place 52: 110-120.

The role of place in mental health recovery was investigated by synthesizing qualitative research on this topic. Using a meta-ethnographic approach, twelve research papers were selected, their data extracted, coded and synthesized. Findings Place for doing, being, becoming and belonging emerged as central mechanisms through which place impacts recovery. Several material, social, natural and temporal characteristics appear to enable or constrain the potential of places to support recovery. The impact of place on recovery is multi-faceted. The multidimensional interactions between people, place and recovery can inform recovery-oriented practice. Further research is required to uncover the role of place in offering opportunities for active engagement, social connection and community participation.

Availability and Use of Mental Health Services in European Countries: Influence on National Suicide Rates

KÖNIG D., FELLINGER M., PRUCKNER N., *et al.*

2018

Journal of Affective Disorders 239: 66-71.

Previous research suggests significant increases in suicide mortality rates in European countries following the economic crisis of 2008. However, the relationship between national differences in availability and use of mental health services and suicide rates has not been extensively examined yet. Data on mental health services and socioeconomic variables were derived from Eurostat for the years 2000–2013 for ten European countries. The national health care variables consisted of suicide mortality rate (SMR), average length of hospital stay and number of hospitalizations due to affective disorder or any psychiatric disorder, number of psychiatric beds and number of prescribed antidepressants. Economic variables included the gross

domestic product (GDP), the gross domestic product per 1000 inhabitants (Real GDP), the rate of unemployment and the GINI-coefficient as a measurement for the equality of wealth distribution. Mixed models were used to investigate the potential influence of the onset of the economic crisis in 2008 on each of the psychiatric variables. Multivariable regression analyses were used to assess the influence on suicide mortality rates. In this study, a significant change in slope starting from 2008 was revealed for the number of psychiatric beds, hospitalizations due to affective disorder or any psychiatric disorder and for prescribed antidepressants. Furthermore, a significant step change for hospitalizations due to affective disorder was observed in 2008. SMR exhibited a significant step change in 2008 for males and females as well as a significant change in slope from 2008 onwards for males only. Contrary to our hypothesis, most variables showed no statistically significant influence on SMR. Only a higher number of available psychiatric beds was significantly associated with higher suicide mortality rates. This effect, however, was only significant for females and did not remain significant after correcting for economic variables. Less than 10% of suicide mortality rate variability could be explained by a model including all variables, further corroborating the multifactorial etiology of suicide. Limitations Since administrative registry data was used, the results should be interpreted with caution. Results might not be applicable to countries not included. While significant changes in the psychiatric variables, as well as SMR, were observed, no statistically significant influence on SMR remained after correcting for country, time and economic variables. Our study suggests the necessity of a more comprehensive international data gathering effort. Further research is needed to identify populations at risk of suicide.

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.

Mental Health and the Jilted Generation: Using Age-Period-Cohort Analysis to Assess Differential Trends in Young People's Mental Health Following the Great Recession and Austerity in England

THOMSON R. M. ET KATIKIREDDI S. V.

2018

Social Science & Medicine 214: 133-143.

Those born in the United Kingdom post-1979 have been described as a 'jilted generation', materially disadvantaged by economic and social policy; however, it is unclear whether this resulted in their experiencing poorer mental health than previous cohorts. Following the 2008 recession, UK austerity reforms associated with worsening mental health also disproportionately impacted those of younger working-age. This study aimed to identify any historic cohort changes in population mental health, and whether austerity widened generational inequalities. Repeat cross-sectional data from the Health Survey for England (1991–2014) were used to calculate prevalence of psychopathology for those of younger and older working-age (16–30 and 31–64 years) and retirement-age (65+ years), measured by General Health Questionnaire-12 (GHQ) score ≥ 4 (caseness). Descriptive age-period-cohort analysis was performed for 15-year birth cohorts, including the jilted generation (born 1976-90). Logistic regression tested

differences in outcome between groups. Age-specific GHQ caseness between successive birth cohorts did not significantly change for men, and significantly improved between 2.8% (95% CI 0.1%–5.5%) and 4.4% (95% CI 2.2%–6.7%) for women. Secondary analysis adjusting for education partially explained this improvement. Following the recession, GHQ caseness worsened in men of younger and older working-age by 3.7% (95% CI 1.2%–6.2%) and 3.5% (95% CI 2.1%–5.0%) respectively before returning to baseline during austerity. All women experienced non-significant increases post-recession, but trends diverged during austerity with caseness worsening by 2.3% (95% CI 1.0%–3.6%) for older working-age women versus 3.7% (95% CI 1.3%–6.2%) for younger working-age women. Those of retirement-age experienced little change throughout. In summary, mental health has historically improved between successive cohorts, including for the jilted generation. However, the 2008 recession and subsequent austerity could be most impacting those of younger working-age, particularly women, to create a new cohort effect. Policymakers should consider the differential impact economic and social policy may have across society by age.

Soins de santé primaires
Primary Health Care

▶ Quels projets de santé pour les maisons de santé ?

PRESCRIRE

2018

Revue Prescrire 38(417): 539-542.

En France, en 2017, environ 800 maisons de santé et pôles de santé étaient en fonctionnement et 700 en projet. En 2012, un panorama d'une soixantaine de projets avait permis de montrer la diversité de ce type de regroupement de professionnels de santé. En 2017, une étude de 111 projets de santé donne un aperçu des actions de soins et de santé publique envisagées : meilleures coordinations des soins et accessibilité aux soins ; diversité des thématiques, avec des axes communs et des adaptations au contexte local.

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

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

2018

Health Econ 27(11): 1684-1698.

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.

▶ Les deux têtes du médecin

EVEN G.

2018

Paris : L'Harmattan

Qu'attend-on du médecin ? Quelle place notre médecine de plus en plus efficace et technicisée peut-elle faire à la personne malade ? L'idée directrice de cet ouvrage est que la médecine a atteint un seuil à partir duquel de profondes modifications sont nécessaires

pour que l'attention au sujet occupe la place qui lui revient. C'est à partir de rencontres avec des patients et d'événements ayant marqué l'itinéraire professionnel de l'auteur qu'il sera proposé au lecteur d'entrer dans cette réflexion sur la médecine actuelle et son devenir.

Comment les médecins généralistes favorisent-ils l'équité d'accès à l'éducation thérapeutique pour leurs patients ?

FOURNIER C., FRATTINI M.-O., NAIDITCH M., *et al.*

2018

Santé Publique S1(HS1): 69-80.

Notre recherche vise à comprendre de quelle manière et à quelles conditions les médecins généralistes contribuent à l'équité d'accès à l'éducation thérapeutique (ETP). Une enquête, se référant à la sociologie interactionniste, a été conduite à partir de récits de pratiques auprès d'un échantillon diversifié de 32 médecins. Ces derniers sont affiliés à des réseaux, maisons ou pôles de santé liés au Pôle de ressources en ETP d'Île-de-France, inscrivant notre étude dans un contexte a priori favorable à l'ETP, dont témoigne aussi le fait que plus de la moitié sont sensibilisés ou formés à l'ETP. En consultation, les médecins interrogés déclarent tous développer des pratiques éducatives plus ou moins structurées, mobilisant des outils qui relèvent toutefois rarement de l'ETP. L'orientation vers d'autres ressources éducatives – professionnels libéraux, programmes d'ETP et ressources d'accompagnement social – reste occasionnelle. Elle est motivée généralement par le souhait de résoudre une difficulté contingente au processus éducatif, avec la préoccupation prioritaire que la relation avec les patients ne soit pas altérée. Les médecins soulignent que leur investissement dans la relation thérapeutique ne dépend pas des caractéristiques psycho-sociales des patients. Néanmoins leurs pratiques éducatives semblent influencées par des anticipations liées notamment à ces caractéristiques. En les prenant en compte, certains médecins développent des pratiques en faveur d'une meilleure équité d'accès, facilitée par plusieurs dynamiques que nous décrivons. Les résultats de cette recherche ouvrent des pistes de réflexion dont peuvent s'emparer les professionnels exerçant en ambulatoire et les structures d'aide au développement de l'ETP pour faciliter l'accès à l'éducation de tous les patients.

Les centres de santé : une réforme importante, un enjeu pour les établissements de santé ?

GEY-COUÉ M.

2018

Gestions hospitalières(578): 477-478.

2018 est l'année de réforme pour les centres de santé. Confortés dans leur rôle de structures sanitaires de proximité dispensant des soins de premier recours, ils s'ouvrent davantage à l'extérieur. Le décloisonnement ville/hôpital est désormais affiché comme réciproque et la coordination de tous les acteurs n'a jamais été autant d'actualité. Quel lien tisser avec les établissements de santé ? Celui du partenariat en premier lieu, au titre de la coordination et du décloisonnement. Mais il ne faut pas oublier qu'un établissement de santé peut également être lui-même gestionnaire de centre de santé.

Revisiting Alma-Ata: What Is the Role of Primary Health Care in Achieving the Sustainable Development Goals?

HONE T., MACINKO J. ET MILLETT C.

2018

The Lancet 392(10156): 1461-1472.

The Sustainable Development Goals (SDGs) are now steering the global health and development agendas. Notably, the SDGs contain no mention of primary health care, reflecting the disappointing implementation of the Alma-Ata declaration of 1978 over the past four decades. The draft Astana declaration (Alma-Ata 2·0), released in June, 2018, restates the key principles of primary health care and renews these as driving forces for achieving the SDGs, emphasising universal health coverage. We use accumulating evidence to show that countries that reoriente their health systems towards primary care are better placed to achieve the SDGs than those with hospital-focused systems or low investment in health. We then argue that an even bolder approach, which fully embraces the Alma-Ata vision of primary health care, could deliver substantially greater SDG progress, by addressing the wider determinants of health, promoting equity and social justice throughout society, empowering communities, and being a catalyst for advancing and amplifying universal health coverage and synergies among SDGs.

Do Skilled Nursing Facilities Selected to Participate in Preferred Provider Networks Have Higher Quality and Lower Costs?

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

2018

Health Services Research : [Ahead of Print]

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13027

To determine whether skilled nursing facilities (SNFs) chosen by health systems to participate in preferred provider networks exhibited differences in quality, costs, and patient outcomes relative to other SNFs after accounting for differences in case mix. Medicare provider and claims data, 2012 and 2013. We compared SNFs included in preferred networks relative to other SNFs in the same market, prior to the establishment of preferred provider networks. We linked the SNFs in our sample to facility characteristics and quality data. We identified SNF admissions and hospitalizations in claims data and limited the analysis to patients discharged from the hospitals in our sample. We obtained patient characteristics from Medicare summary files and the preceding hospital stay. Preferred SNFs exhibited better performance across publicly reported quality measures. Patients admitted to preferred SNFs exhibited shorter stays, lower Medicare payments, and lower probability of SNF readmission relative to non-preferred SNFs. Our results imply that health systems selected SNFs with lower resource use and better performance on quality measures. Thus, the trend toward preferred provider networks could have implications for Medicare spending and patient health.

Repérer l'épisode dépressif caractérisé en médecine générale

JESTIN E., LAUNAY J., CESTERA P., *et al.*

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(4): 187-191.

Les médecins généralistes sont en première ligne pour la prise en charge de la dépression mais le repérage des patients concernés est parfois complexe. Le test à deux questions d'Arroll est recommandé pour ses très bonnes performances pour le repérage des épisodes dépressifs caractérisés (EDC) en soins premiers dans différents pays anglo-saxons. Mais ce test, dont l'utilisation était recommandée par l'Anaes dès 2002, n'a pas encore été validé en français. Son utilisation permettrait de mieux repérer les EDC, préalable à la mise en place de démarches diagnostique et thérapeutique adaptées. L'objectif de notre étude était de mesurer les qualités métrologiques du test à deux questions d'Arroll traduit en français, dans le repérage de l'EDC en médecine générale.

Healthcare Assistants in EU Member States: An Overview

KROEZEN M., SCHAFER W., SERMEUS W., *et al.*

2018

Health Policy 122(10):1109-1117

With many European countries facing health workforce shortages, especially in nursing, and an increasing demand for healthcare, the importance of healthcare assistants (HCAs) in modern healthcare systems is expected to grow. Yet HCAs' knowledge, skills, competences and education are largely unexplored. The study 'Support for the definition of core competences for healthcare assistants' (CC4HCA, 2015-2016) aimed to further the knowledge on HCAs across Europe. This paper presents an overview of the position of healthcare assistants in 27 EU Member States (MSs) and reflects on the emerging country differences. It is shown that most learning outcomes for HCAs across Europe are defined in terms of knowledge and skills, often at a basic instead of more specialized level, and much less so in terms of competences. While there are many differences between MSs, there also appears to be a common, core set of knowledge and skills-related learning outcomes which almost all HCAs across Europe possess. Country differences can to a large extent be explained by the regulatory and educational frameworks in which HCAs operate, influencing their current and future position in the healthcare system. Further investments should be made to explore a common understanding of HCAs, in order to feed discussions at policy and organisational levels, while simultaneously investments in the development and implementation of context-specific HCA workforce policies are needed.

Les spécificités des centres de santé au sein des formations continues en santé : revue de la littérature internationale

LEKFIF S., DULAC-MOSTEFAI Y., RAYMOND R., *et al.*

2018

Cahiers de Santé Publique et de Protection Sociale (Les)(28): 35-45.

L'objectif principal de cette étude était de lister les évaluations de programmes de formation continue en soins primaires publiées. Les objectifs secondaires étaient d'identifier les caractéristiques des centres de santé visées au sein de ces formations et de voir si l'impact des formations sur ces caractéristiques avait été évalué. Cette étude se base sur une revue de littérature internationale non exhaustive.

Task Shifting from Physicians to Nurses in Primary Care in 39 Countries: A Cross-Country Comparative Study

MAIER C. B. ET AIKEN L. H.

2016

European Journal of Public Health 26(6): 927-934.

http://dx.doi.org/10.1093/eurpub/ckw098

Primary care is in short supply in many countries. Task shifting from physicians to nurses is one strategy to improve access, but international research is scarce. We analysed the extent of task shifting in primary care and policy reforms in 39 countries. Cross-country comparative research, based on an international expert survey, plus literature scoping review were conducted. A total of 93 country experts participated, covering Europe, USA, Canada, Australia and New Zealand (response rate: 85.3%). Experts were selected according to pre-defined criteria. Survey responses were triangulated with the literature and analysed using policy, thematic and descriptive methods to assess developments in country-specific contexts. Results: Task shifting, where nurses take up advanced roles from physicians, was implemented in two-thirds of countries (N = 27, 69%), yet its extent varied. Three clusters emerged: 11 countries with extensive (Australia, Canada, England, Northern Ireland, Scotland, Wales, Finland, Ireland, Netherlands, New Zealand and USA), 16 countries with limited and 12 countries with no task shifting. The high number of policy, regulatory and educational reforms, such as on nurse prescribing, demonstrate an evolving trend internationally toward expanding nurses' scope-of-practice in primary care. Many countries have implemented task-shifting reforms to maximise workforce capacity. Reforms have focused on removing regulatory and to a lower extent, financial barriers, yet were often lengthy and controversial. Countries early on in the process are primarily reforming their education. From an international and particularly European Union perspective, developing standardised definitions, minimum educational and practice requirements would facilitate recognition procedures in increasingly connected labour markets.

L'adolescent, sa maladie chronique et son médecin généraliste : la transition pédiatrie/médecin adulte

MORSA M.

2018

Médecine : De la Médecine Factuelle à nos Pratiques 14(5): 206-210.

La transition pédiatrie- médecine adulte est une période critique pour le jeune vivant avec une maladie chronique. Les ruptures de suivi médical, les comportements de non- adhésion au traitement et le mal- être y sont plus fréquents chez ces patients. Le médecin généraliste est concerné. Il incarne un lien stable avec le système de santé pour le patient adolescent qui connaît des changements importants dans sa prise en charge. Il est aussi celui qui peut répondre à ses besoins de soins de santé primaires, incluant la prévention, et à ses attentes d'un suivi plus psychosocial, dans une démarche éducative.

Identification of Influencing Factors and Strategies to Improve Communication Between General Practitioners and Community Nurses: A Qualitative Focus Group Study

NIEUWBOER M. S., PERRY M., VAN DER SANDE R., *et al.*

2018

Family Practice 35(5): 619-625.

http://dx.doi.org/10.1093/fampra/cmy009

As the number of patients with complex healthcare needs grows, inter-professional collaboration between primary care professionals must be constantly optimized. General practitioners (GPs) and community nurses (CNs) are key professions in primary care; however, poor GP–CN communication is common, and research into the factors influencing its quality is lim-

ited. The aim of this study is to explore patient-related GP–CN communication and facilitating and hindering factors, and to identify strategies to enhance this communication. A qualitative focus group design was used to identify the facilitating and hindering factors and strategies for improvement. In a Dutch primary care setting, 6 mono-professional focus group interviews (3 meetings of 13 GPs; 3 meetings of 18 CNs) were organized between June 2015 and April 2016, recorded and transcribed verbatim. Two independent researchers performed the coding of these interviews, identifying their categories and themes. Results show that, despite the regular contact between GPs and CNs, communication was generally perceived as poor in effectiveness and efficiency by both professions. Mutual trust was considered the most important facilitating factor for effective communication. Profession-specific factors (e.g. differences in responsibility and profession-specific language) and organizational factors (e.g. lack of shared care plans, no in-person communication, lack of time) may be of influence on communication. Participants' suggestions for improvement included organizing well-structured and reimbursed team meetings and facilitating face-to-face contact. GP–CN patient-related communication benefits most from trusting inter-personal relationships. Inter-professional training programmes should address both professional and organizational factors and should be evaluated for their effect on quality of care.

Does the Primary Care Behavioral Health Model Reduce Emergency Department Visits?

SERRANO N., PRINCE R., FONDOW M., *et al.*

2018

Health Services Research [Ahead of Print]

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12862

The aim of this study is to examine the impact of integrating behavioral health services using the primary care behavioral health (PCBH) model on emergency department (ED) utilization. Data from three Dane County, Wisconsin hospitals and four primary care clinics from 2003 to 2011 were used. We used a retrospective, quasi-experimental, controlled, pre–post study design. Starting in 2007, two clinics began integrating behavioral health into their primary care practices with a third starting in 2010. A fourth, nonimplementing, community clinic served as control. Change in emergency department and primary care utilization (number of visits) for patients diagnosed with mood and anxiety disorders was the outcomes of interest. Retrospective data were obtained from electronic patient records from the three main area hospitals along with primary care data from participating clinics. Principal Findings : Following the introduction of the PCBH model, one clinic experienced a statistically significant ($p < .01$, 95 percent CI 6.3–16.3 percent), 11.3 percent decrease in the ratio of ED visits to primary care encounters, relative to a control site, but two other intervention clinics did not. Conclusions : The PCBH model may be associated with a reduction in ED utilization, but better-controlled studies are needed to confirm this result.

A Scoping Review of Facilitators of Multi-Professional Collaboration in Primary Care

SØRENSEN M., STENBERG U. ET GARNWEIDNER-HOLME L.

2018

International Journal of Integrated Care 18(3): 13.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC6137624/

Multi-professional collaboration (MPC) is essential for the delivery of effective and comprehensive care services. As in other European countries, primary care in Norway is challenged by altered patient values and the increased expectations of health administrations to participate in team-based care. This scoping review reports on the organisational, processual, relational and contextual facilitators of collaboration between general practitioners (GP) and other healthcare professionals (HCPs) in primary care. A systematic search in specialist and Scandinavian databases retrieved 707 citations. Following the inclusion criteria, nineteen studies were considered eligible and examined according to Arksey and O'Malley's methodological framework for scoping reviews. The retrieved literature was analysed employing a content analysis approach. Primary care research into MPC is immature and emerging in Norway. Our analysis showed that introducing common procedures for documentation and handling of patient data, knowledge sharing, and establishing local specialised multi-professional teams, facilitates MPC. The results indicate that advancements in work practices benefit from an initial system-level foundation with focus on local management and MPC leadership. Further, our results show that it is preferable to enhance collaborative skills before introducing new professional teams, roles and responsibilities. Investing

in professional relations could build trust, respect and continuity. In this respect, sufficient time must be allocated during the working day for professionals to share reflections and engage in mutual learning. There is a paucity of research concerning the application and management of MPC in Norwegian primary care. The work practices and relations between professionals, primary care institutions and stakeholders on a macro level is inadequate. Health care is a complex system in which HCPs need managerial support to harvest the untapped benefits of MPC in primary care. As international research demonstrates, local managers must be supported with infrastructure on a macro level to understand the embedding of practice and look at what professionals actually do and how they work.

California Nurse Practitioners Are Positioned to Fill the Primary Care Gap, but They Face Barriers to Practice

SPETZ J. ET MUENCH U.

2018

Health Aff (Millwood) 37(9): 1466-1474.

Nurse practitioners are well prepared to help fill care gaps arising from shortages of primary care physicians in California. This article reports findings from a survey of California nurse practitioners that examined their employment and practice barriers. The number of nurse practitioners per capita varies across California counties and is positively correlated with the number of physicians per capita. Hispanic and Filipino nurse practitioners are more likely to live in underserved areas. Nurse practitioners and their education programs are concentrated in the same counties that have high physician-to-population ratios. In these counties, recently graduated nurse practitioners are more likely to report that they plan to relocate to another state in the next five years. Expanding education programs in underserved areas, increasing the diversity of the nurse practitioner workforce, and ensuring that nurse practitioners feel empowered to fully use their skills are necessary to meet both current and future primary care needs.

Hours Worked by General Practitioners and Waiting Times for Primary Care

SWAMI M., GRAVELLE H., SCOTT A., *et al.*

2018

Health Economics 27(10): 1513-1532.

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3782

The decline in the working hours of general practitioners (GPs) is a key factor influencing access to health care in many countries. We investigate the effect of changes in hours worked by GPs on waiting times in primary care using the Medicine in Australia: Balancing Employment and Life longitudinal survey of Australian doctors. We estimate GP fixed effects models for waiting time and use family circumstances to instrument for GP's hours worked. We find that a 10% reduction in hours worked increases average patient waiting time by 12%. Our findings highlight the importance of GPs' labor supply at the intensive margin in determining the length of time patients must wait to see their doctor.

Do Medical Homes Improve Quality of Care for Persons with Multiple Chronic Conditions?

SWIETEK K. E., DOMINO M. E., BEADLES C., *et al.*

2018

Health Serv Res. [Ahead of print]

The aim of this study is to examine the association between medical home enrollment and receipt of recommended care for Medicaid beneficiaries with multiple chronic conditions (MCC). Secondary claims data from fiscal years 2008-2010. The sample included nonelderly Medicaid beneficiaries with at least two of eight target conditions (asthma, chronic obstructive pulmonary disease, diabetes, hypertension, hyperlipidemia, seizure disorder, major depressive disorder, and schizophrenia). We used linear probability models with person- and year-level fixed effects to examine the association between patient-centered medical home (PCMH) enrollment and nine disease-specific quality-of-care metrics, controlling for selection bias and time-invariant differences between enrollees. This study uses a dataset that links Medicaid claims with other administrative data sources. Patient-centered medical home enrollment was associated with an increased likelihood of receiving eight recommended mental and physical health services, including A1C testing for persons with diabetes, lipid profiles for persons with diabetes and/or hyperlipidemia, and psychotherapy for persons with major depression and

persons with schizophrenia. PCMH enrollment was associated with overuse of short-acting beta-agonists among beneficiaries with asthma. The PCMH model can improve quality of care for patients with multiple chronic conditions.

Integrated and Person-Centered Care for Community-Living Older Adults: A Cost-Effectiveness Study

UITTENBROEK R. J., VAN ASSELT A. D. I., SPOORENBERG S. L. W., *et al.*

2018

Health Serv Res 53(5): 3471-3494.

The aim of this study is to assess the cost-effectiveness of Embrace, an integrated primary care service for older adults. Care and support claims from health care insurers, long-term care administration, and municipalities for enrolled older adults between 2011 and 2013 were used. A total of 1,456 older adults, listed with 15 general practitioners practices in the Netherlands, were stratified into risk profiles ("Robust," "Frail," and "Complex care needs") and randomized to Embrace or care-as-usual groups. Incremental costs were calculated per quality-adjusted life year, per day able to age in place, and per percentage point risk profile improvement. Total average costs were higher for Embrace compared to care-as-usual. Differences in health-associated outcomes were small and not statistically significant. Probabilities that Embrace is cost-effective were below 80 percent, except for "risk profile improvements" within risk profile "Complex care needs." Complete case analysis resulted in smaller differences in total average costs across conditions and differences in health-associated outcomes remained small. According to current standards, Embrace is not considered cost effective after 12 months. However, it could be considered worthwhile in terms of "risk profile improvements" for older adults with "Complex care needs," if society is willing to invest substantially.

Systèmes de santé
Health Systems

Health Services and Delivery Research. In : Understanding new models of integrated care in developed countries: a systematic review

BAXTER S., JOHNSON M., CHAMBERS D., *et al.*

2018

Southampton : NIHR Journals Library

The NHS has been challenged to adopt new integrated models of service delivery that are tailored to local populations. Evidence from the international literature is needed to support the development and implementation of these new models of care. The study aimed to carry out a systematic review of international evidence to enhance understanding of the mechanisms whereby new models of service delivery have an impact on health-care outcomes. The study combined rigorous and systematic methods for identification of literature, together with innovative methods for synthesis and presentation of findings. Participants are patients receiving a health-care service and/or staff delivering services. Interventions concerned changes to service delivery that increase integration and co-ordination of health and health-related services. The findings detail the complex pathway from new models to impacts, with evidence regarding elements of new models of integrated care, targets for change, process change, influencing factors, service-level outcomes and system-wide impacts. A number of positive outcomes were reported in the literature, with stronger evidence of perceived increased patient satisfaction and improved quality of care and access to care. There was stronger UK-only evidence of reduced outpatient appointments and waiting times. Evidence was inconsistent regarding other outcomes and system-wide impacts such as levels of activity and costs. There is stronger evidence that new models of integrated care may enhance patient satisfaction and perceived quality and increase access; however, the evidence regarding other outcomes is unclear. The study recommends factors to be considered during the implementation of new models.

Regional Regulators in Health Care Service Under Quality Competition: A Game Theoretical Model

BISCEGLIA M., CELLINI R. ET GRILLI L.

2018

Health Economics 27(11) : 1821-1842

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3805

In several countries, health care services are provided by public and/or private subjects, and they are reimbursed by the government, on the basis of regulated prices (in most countries, diagnosis-related group). Providers take prices as given and compete on quality to attract patients. In some countries, regulated prices differ across regions. This paper focuses on the interdependence between regional regulators within a country: It studies how price setters of different regions interact, in a simple but realistic framework. Specifically, we model a circular city as divided in two administrative regions. Each region has two providers and one regulator, who sets the local price. Patients are mobile and make their choice on the basis of provider location and service quality. Interregional mobility occurs in the presence of asymmetries in providers' cost efficiency, regulated prices, and service quality. We show that the optimal regulated price is higher in the region with the more efficient providers; we also show that decentralisation of price regulation implies higher expenditure but higher patients' welfare.

Medicare Accountable Care Organizations of Diverse Structures Achieve Comparable Quality and Cost Performance

COMFORT L. N., SHORTELL S. M., RODRIGUEZ H. P., *et al.*

2018

Health Services Research 53(4): 2303-2323.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12829

This study aimed to examine whether an empirically derived taxonomy of Accountable Care Organizations (ACOs) is associated with quality and spending performance among patients of ACOs in the Medicare Shared Savings Program (MSSP). Three waves of the National Survey of ACOs and corresponding publicly available Centers for Medicare & Medicaid Services performance data for NSACO respondents participating in the MSSP (N = 204); SK&A Office Based Physicians Database from QuintilesIMS are used. We compare the performance of three ACO types (physician-led, integrated, and hybrid) for three domains: quality, spending, and likelihood of achieving savings. Sources of performance variation within and between ACO types are compared for each performance measure. Principal Findings There is greater heterogeneity within ACO types than between ACO types. There were no consistent differences in quality by ACO type, nor were there differences in likelihood of achieving savings or overall spending per-person-year. There was evidence for higher spending on physician services for physician-led ACOs. ACOs of diverse structures perform comparably on core MSSP quality and spending measures. CMS should maintain its flexibility and continue to support participation of diverse ACOs. Future research to identify modifiable organizational factors that account for performance variation within ACO types may provide insight as to how best to improve ACO performance based on organizational structure and ownership.

The Impact of the 2008/2009 Financial Crisis on Specialist Physician Activity in Canada

LAVERGNE M. R., HEDDEN L., LAW M. R., *et al.*

2018

Health Econ 27(11): 1859-1867.

Fee-for-service physicians are responsible for planning for their retirements, and there is no mandated retirement age. Changes in financial markets may influence how long they remain in practice and how much they choose to work. The 2008 crisis provides a natural experiment to analyze elasticity in physician service supply in response to dramatic financial market changes. We examined quarterly fee-for-service data for specialist physicians over the period from 1999/2000 to 2013/2014 in Canada. We used segmented regression to estimate changes in the number of physicians receiving payments, per-physician service counts, and per-physician payments following the 2008 financial crisis and explored whether patterns differed by physician age. The number of specialist physicians increased more rapidly in the period since 2008 than in earlier years, but increases were largest within the youngest age group, and we observed no evidence of delayed retirement among older physicians. Where changes in service volume and payments were observed, they occurred across all ages and not immediately following the 2008 financial crisis. We conclude that any response to the financial crisis was small compared with demographic shifts in the physi-

cian population and changes in payments per service over the same time period.

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

The aim of this study is 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.

Moving Organizational Culture from Volume to Value: A Qualitative Analysis of Private Sector Accountable Care Organization Development

MCALEARNEY A. S., WALKER D. M. ET HEFNER J. L.
2018
Health Services Research [Ahead of print]
https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13012

The concept of shifting from volume (i.e., billing for as many patients and services as possible) to value (i.e., reducing costs while improving quality) has been a key underpinning of the development of accountable care organizations (ACOs), yet the cultural change necessary to make this shift has been previously unexplored. Primary data collected through site visits to four private sector ACOs were used. Cross-sectional, semi-structured interview study with analysis were done at the ACO level to learn about ACO development. One hundred and forty-eight interviews recorded and transcribed verbatim followed by rigorous qualitative analysis using a grounded theory approach were conducted. The importance of shifting organizational culture from volume to value was emphasized across sites and interviewees, particularly when defining an ACO; describing the shift in organizational focus to value; and discussing how to create value by emphasizing quality over volume. Value was viewed as more than cost–benefit, but rather encapsulated a paradigmatic cultural change in the way care is provided. We found that moving from volume to value is central to the culture change required of an ACO. Our findings can inform future efforts that aim to create a more effective value-based health care system.

Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction: A Systematic Review and Meta-Analysis

PANAGIOTI M., GERAGHTY K., JOHNSON J., *et al.*
2018
JAMA Internal Medicine : 178(10):1317–1330

Physician burnout has taken the form of an epidemic that may affect core domains of health care delivery, including patient safety, quality of care, and patient satisfaction. However, this evidence has not been systematically quantified. The aim of this study is to examine whether physician burnout is associated with an increased risk of patient safety incidents, sub-

optimal care outcomes due to low professionalism, and lower patient satisfaction. MEDLINE, EMBASE, PsycInfo, and CINAHL databases were searched until October 22, 2017, using combinations of the key terms physicians, burnout, and patient care. This meta-analysis provides evidence that physician burnout may jeopardize patient care; reversal of this risk has to be viewed as a fundamental health care policy goal across the globe. Health care organizations are encouraged to invest in efforts to improve physician wellness, particularly for early-career physicians. The methods of recording patient care quality and safety outcomes require improvements to concisely capture the outcome of burnout on the performance of health care organizations.

L'accès aux soins aux États-Unis sous les mandatures de Barack Obama et Donald Trump

PAREL V.

2018

Journal de gestion et d'économie médicales 36(2): 91-108.

L'article propose une analyse économique portant sur l'évolution de l'accès aux soins aux Etats-Unis depuis 2010. Il s'appuie principalement sur les textes de lois et les réglementations débattues et adoptées sous les mandatures de Barack Obama et de Donald Trump et les données de la Kaiser Family Foundation. Une première partie fait valoir les acquis relatifs de la loi de 2010, soit l'extension de la couverture maladie à plus de 20 millions d'Américains, permis par la mise en place de l'obligation d'assurance, l'expansion de Medicaid, et la création de marchés réglementés. Toutefois, l'adoption récente des dernières réglementations de l'Administration Trump, notamment la suppression des pénalités relatives à l'obligation d'assurance, viennent s'opposer au moins partiellement à l'application de la loi de 2010. De nombreuses incertitudes demeurent aujourd'hui de ce point de vue, notamment sur l'évolution des marchés réglementés que la loi avait instaurés. Une deuxième partie aborde le contexte inflationniste dans lequel s'inscrivent ces évolutions. Elle rend compte de l'envolée des coûts médicaux, auquel est confronté le pays depuis l'effondrement économique du Managed care, à la fin des années 1990. Elle fait valoir l'obstacle majeur que représente cette hausse des coûts pour l'accès aux soins des Américains.

Travail et santé
Occupational Health

The Role of the General Practitioner in Return to Work After Cancer-A Systematic Review

DE JONG F., FRINGS-DRESEN M. H., DIJK N. V., *et al.*

2018

Fam Pract 35(5): 531-541.

The number of cancer patients and survivors of working age is increasing. General Practitioners (GPs) may have a significant role in psychosocial cancer care, including work-related concerns. Therefore, we performed a systematic literature review to identify the role of the GP in work-related concerns and integration/reintegration into work of cancer patients and/or survivors. Methods: We searched PubMed, Embase, Cinahl, PsycINFO and Cochrane Library, irrespective of study design. The Critical Appraisal Skills Programme tool was used to assess the methodological quality of included articles. We used narrative synthesis to describe the role of the GP. Results: We included four qualitative studies from

three countries. Two of these studies focused on the health care professionals' perspectives and two studies focused on patients' perspectives regarding the role of the GP. Lack of communication between health care professionals, lack of knowledge about work-related concerns and limited resources were recurring themes in these papers. Fully establishing the role of the GP is difficult given the small number of studies on work-related concerns in cancer patients in primary care. There is little evidence regarding the role of the general practitioner in cancer care and work guidance. Therefore, further research should focus on the role that is desired for GPs and on interventions to study the feasibility of GP involvement in the return to work of cancer patients and/or survivors.

Unemployment and Work Disability Due to Common Mental Disorders Among Young Adults: Selection or Causation?

HARKKO J., VIRTANEN M. ET KOUVONEN A.

2018

Eur J Public Health 28(5): 791-797.

Unemployment in early adulthood is associated with higher rate of disability due to common mental disorders (CMDs). We investigated to what extent the association between unemployment and sub-sequent long-term sickness absence due to CMDs is direct or whether it is dependent on accumulation of mental health problems and socioeconomic disadvantage. In this longitudinal study, a population-based 60% sample of Finnish young adults born between 1983 and 1985 (N=116 878) was followed up for the incidence of CMDs from 2006 to 2010. Sociodemographic and health-related covariates were identified using several nationwide registers. Hazard ratios (HRs) with 95% confidence intervals (CIs), and survival and cumulative hazard functions for CMD were calculated. A matching procedure was applied to account for the systematic differences in the distribution of the baseline characteristics. Using a causal approach, our study suggests that unemployment is consistently associated with an increased risk of work disability due to CMDs. Considering the young unemployed as a risk group may help in targeting interventions promoting mental health and improving educational and employment opportunities.

Crises and Mortality: Does the Level of Unemployment Matter?

LALIOTIS I. ET STAVROPOULOU C.

2018

Social Science & Medicine 214: 99-109.

The relationship between mortality and economic fluctuations has been a topic of long interest, which intensified following the 2008 global financial crisis. We study whether mortality responds non-linearly and asymmetrically to unemployment in the context of national economic crises. Although these assumptions have been challenged in other domains, they have been neglected in the mortality literature. Greece offers an ideal setting as unemployment was decreasing until mid-2008, but then it was sharply increased as a result of a severe economic crisis. We use quarterly data on regional unemployment and mortality from 1999 to 2013, giving a balanced panel of 780 observations. We find evidence of a countercyclical total mortality, especially for the older groups, and a further deteriorating crisis effect. We provide evidence that the relationship is non-linear and asymmetric, suggesting that the effect on death rates changes for very high values of unemployment and depends on its direction. Both non-linearity and asymmetry are mainly driven by those above 65 years old. The results suggest that the mechanisms explaining these effects are likely to vary across age groups. Our findings have important methodological implications and suggest that empirical investigations on fluctuations, recessions and mortality should not ignore possible non-linear and asymmetric behaviours, especially during turbulent times.

Unemployment Is Associated with High Cardiovascular Event Rate and Increased All-Cause Mortality in Middle-Aged Socially Privileged Individuals

MENETON P., KESSE-GUYOT E., MEJEAN C., *et al.*

2015

Int Arch Occup Environ Health 88(6): 707-716.

The aim of this study is to assess prospectively the association between employment status and cardiovascular health outcomes in socially privileged individuals. The incidence of fatal and non-fatal cardiovascular events and all-cause mortality rate were monitored during 12 years in a national sample of 5,852 French volunteers, aged 45-64 years, who were free of cardiovascular disease or other overt disease at baseline. The association between health outcomes and employment

status was tested using Cox proportional modelling with adjustment for confounding factors. Compared to randomly selected individuals, these volunteers were characterized by higher education level and socio-economic status and lower cardiovascular risk and mortality rate. A total of 242 cardiovascular events (3.5 events per 1,000 person-years) and 152 deaths from all causes (2.2 deaths per 1,000 person-years) occurred during follow-up. After adjustment for age and gender, both cardiovascular event risk [HR (95% CI) 1.84 (1.15-2.83), p = 0.01] and all-cause mortality [2.79 (1.66-4.47), p = 0.0002] were increased in unemployed individuals compared to workers. These poor health outcomes were observed to the same extent after further adjustment for clinical, behavioural and socio-demographic characteristics of individuals at baseline [HR (95% CI) 1.74 (1.07-2.72), p = 0.03 and 2.89 (1.70-4.69), p = 0.0002, respectively]. In contrast, neither cardiovascular event risk nor all-cause mortality was significantly increased in retired individuals compared to workers after adjustment for confounding factors. These results support the existence of a link between unemployment and poor cardiovascular health and suggest that this link is not mediated by conventional risk factors in middle-aged socially privileged individuals.

The Impact of Depressive Symptoms on Exit from Paid Employment in Europe: A Longitudinal Study with 4 Years Follow-Up

PORRU F., BURDORF A. ET ROBROEK S. J. W.

2018

European Journal of Public Health [Ahead of Print]

http://dx.doi.org/10.1093/eurpub/cky136

Mental health problems are a risk factor for loss of paid employment. This study investigates (i) the relation between depressive symptoms and different involuntary pathways of labour force exit and (ii) explores gender and geographical differences in this relation. The study population consisted of 5263 individuals in paid employment aged between 50 years and the country-specific retirement age from 11 European countries participating in the longitudinal Survey of Health, Ageing and Retirement in Europe (SHARE). Self-reported depressive symptoms at baseline were assessed using the EURO-D. Employment status was derived from interviews after 2 and 4 years. Cox proportional hazards regression analyses were used to investigate the association between depressive symptoms and labour force exit via disability benefit and unemployment. Population attributable fractions (PAFs) were calculated to estimate the contribution of depressive symptoms to these pathways of labour force exit. Both men and women with a EURO-D score ≥4 had a >2- increased risk of a disability benefit (HR: 2.46, 95%CI 1.68–3.60) after adjustment for demographics and work-related characteristics. Among men depressive symptoms elevated the risk of becoming unemployed at follow-up (HR 1.55; 95%CI: 0.94–2.57). The PAF was 0.18 for disability benefit and 0.04 for unemployment, and varied across European regions. Individuals with depressive symptoms are at increased risk of losing paid employment, which in turn may aggravate their symptoms. Targeting depressive symptoms with public health and occupational policies should be considered to reduce the burden of mental diseases in Europe.

The Buffering Role of the Family in the Relationship Between Job Loss and Self-Perceived Health: Longitudinal Results from Europe, 2004–2011

TATTARINI G., GROTTI R. ET SCHERER S.

2018

Health & Place 52: 55-61.

Unemployment has numerous negative consequences for health, but the family and the welfare state can mitigate these consequences. How the family supports its members and whether and to what extent this interacts with the broader context is still an open question. Our evidence show that job loss is causally linked to significant declines in health for men, but not for women. Yet, the increased risk of poor health is lower for coupled men, especially if the partner is employed. This suggests that both emotional and economic support play a role. Moreover, the family's mitigating role widely varies across different welfare regimes in Europe and it is particularly strong in Southern and Eastern regimes, characterized by "rudimentary" welfare systems and a more traditional family model.

Vieillissement
Aging

Palliative Care Experience in the Last 3 Months of Life: A Quantitative Comparison of Care Provided in Residential Hospices, Hospitals, and the Home from the Perspectives of Bereaved Caregivers

BAINBRIDGE D. ET SEOW H.

2018

The American Journal of Hospice & Palliative Care 35(3): 456-463.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5794103/

This study captured the end-of-life care experiences across various settings from bereaved caregivers of individuals who died in residential hospice. A retrospective, observational design using the CaregiverVoice survey with bereaved caregivers of patients in 22 hospices in Ontario, Canada. The survey assessed various dimensions of the patient's care experiences across multiple care settings in the last 3 months of life. A total of 1153 caregivers responded to the survey (44% response rate). In addition to hospice care, caregivers reported that 74% of patients received home care, 61% had a hospitalization, 42% received care at a cancer center, and 10% lived in a nursing home. Most caregivers (84%-89%) rated the addressing of each support domain (relief of physical pain, relief of other symptoms, spiritual support, and emotional support) by hospice as either "excellent" or "very good." These proportions were less favorable for home care (40%-47%), cancer center (46%-54%), and hospital (37%-48%). This is one of few quantitative examinations of the care experience of patients who accessed multiple care settings in the last months of life and died in a specialized setting such as residential hospice. These findings emphasize the importance of replicating the hospice approach in institutional and home settings, including greater attention to emotional and spiritual dimensions of care.

Effectiveness and Cost-Effectiveness of Proactive and Multidisciplinary Integrated Care for Older People with Complex Problems in General Practice: An Individual Participant Data Meta-Analysis

BLOM J. W., VAN DEN HOUT W. B., DEN ELZEN W. P. J., *et al.*

2018

Age and Ageing 47(5): 705-714.

http://dx.doi.org/10.1093/ageing/afy091

The aim of this study is to support older people with several healthcare needs in sustaining adequate functioning and independence, more proactive approaches are needed. This purpose of this study is to summarise the (cost-) effectiveness of proactive, multidisciplinary, integrated care programmes for older people in Dutch primary care. Individual patient data (IPD) meta-analysis of eight clinically controlled trials were used. Combination of (i) identification of older people with complex problems by means of screening, followed by (ii) a multidisciplinary integrated care programme for those identified. Main outcome activities of daily living, i.e. a change on modified Katz-15 scale between baseline and 1-year follow-up. Secondary outcomes quality of life (visual analogue scale 0–10), psychological (mental well-being scale Short Form Health Survey (SF)-36) and social well-being (single item, SF-36), quality-adjusted life years (Euroqol-5dimensions-3level (EQ-5D-3L)), healthcare utilisation and cost-effectiveness. No significant differences were found in the other patient outcomes or subgroup analyses. Compared to usual care, the probability of the intervention group to be cost-effective was less than 5%.Compared to usual care at 1-year follow-up, strategies for identification of frail older people in primary care combined with a proactive integrated care intervention are probably not (cost-) effective.

Is Frailty a Stable Predictor of Mortality Across Time? Evidence from the Cognitive Function and Ageing Studies

MOUSA A., SAVVA G. M., MITNITSKI A., *et al.*

2018

Age and Ageing 47(5): 721-727.

http://dx.doi.org/10.1093/ageing/afy077

Age-specific mortality reduction has been accompanied by a decrease in the prevalence of some diseases and an increase in others. Whether populations are becoming 'healthier' depends on which aspect of health is being considered. Frailty has been proposed as an integrative measure to quantify health status. The aim of this study is to investigate changes in the near-term lethality of frailty before and after a 20-year interval using the frailty index (FI), a summary of age-related health deficit accumulation. Baseline data from the Cognitive Function and Ageing Studies (CFAS) in 1991 (n = 7,635) and 2011 (n = 7,762were used. Three geographically distinct UK centres (Newcastle, Cambridgeshire and Nottingham) were followed. Individuals aged 65 and over (both institutionalised and community-living) were identified. 30-item frailty score was used, which includes morbidities, risk factors and subjective measures of disability. Missing items were imputed using multiple imputations by chained equations. Binomial regression was used to investigate the relationship between frailty, age, sex and cohort. Two-year mortality was modelled using logistic regression. Mean frailty was slightly higher in CFAS II (0.19, 95% confidence interval (CI): 0.19–0.20) than CFAS I (0.18, 95% CI: 0.17–0.18). Two-year mortality in CFAS I was higher than in CFAS II (odds ratio (OR) = 1.16, 95% CI: 1.03–1.30). The association between frailty and 2-year mortality was non-linear with an OR of ~1.6 for each 0.10 increment in the FI. The relationship between frailty and mortality did not significantly differ across the studies. Severe frailty as an indicator of mortality is shown to be a stable construct.

A Multilevel Analysis of the Determinants of Emergency Care Visits by the Elderly in France

OR Z. ET PENNEAU A.

2018

Health Policy 122(8): 908-914.

Rising numbers of visits to emergency departments (EDs), especially amongst the elderly, is a source of pressure on hospitals and on the healthcare system. This study aims to establish the determinants of ED visits in France at a territorial level with a focus on the impact of ambulatory care organisation on ED visits by older adults aged 65 years and over. We use multilevel regressions to analyse how the organisation of healthcare provision at municipal and wider 'department' levels impacts ED utilisation by the elderly while controlling for the local demographic, socioeconomic and health context of the area in which patients live. ED visits vary significantly by health context and economic level of municipalities. Controlling for demand-side factors, ED rates by the elderly are lower in areas where accessibility to primary care is high, measured as availability of primary care professionals, out-of-hours care and home visits in an area. Proximity (distance) and size of ED are drivers of ED use. High rates of ED visits are partly linked to inadequate accessibility of health services provided in ambulatory settings. Redesigning ambulatory care at local level, in particular by improving accessibility and continuity of primary and social care services for older adults could reduce ED visits and, therefore, improve the efficient use of available healthcare resources.

Frailty in Older-Age European Migrants: Cross-Sectional and Longitudinal Analyses of the Survey of Health, Aging and Retirement in Europe (SHARE)

WALKDEN G. J., ANDERSON E. L., VINK M. P., *et al.*

2018

Social Science & Medicine 213: 1-11.

Frailty correlates with morbidity and is superior to chronological age in predicting mortality. Frailty of older migrants has important implications for the demands placed on healthcare systems. Examining 95,635 Europeans in the Survey of Health, Aging and Retirement in Europe, we investigated cross-sectional and longitudinal associations between migration and frailty at ages >50 years. We examined whether associations differed by countries' level of healthcare coverage and access for migrants and tested mediation by home-ownership and citizenship. Cross-sectionally, first-generation migrants >50 years old were, on average, 16.4% (95% confidence interval [CI]: 14.6, 18.2%) frailer than non-migrants after confounder-adjustment. This decreased to 12.1% (95% CI: 10.1, 14.1%) after adjustment for citizenship. The strength of association between migrant status and frailty was greater in migrants from low-or-middle-income

countries, compared with migrants from high-income countries. Migrants into Northern, Western and Eastern Europe were 37.3% (95% CI: 33.2, 41.5%), 12.2% (95% CI: 10.0, 14.6%) and 5.0% (95% CI: 0.5, 9.6%) frailer than non-migrants, respectively, but migrants into Southern Europe were no frailer than non-migrants. The strength of association between migrant status and frailty was greater in countries with lower healthcare coverage and access for migrants. However, citizenship attenuated this difference. Longitudinally, migrants were frailer than non-migrants at 50 years old and trajectories converged over time until migrants and non-migrants were equally frail by 80–90 years. Our work finds no evidence of the 'healthy migrant effect' outside of Southern Europe in older migrants and suggests that acculturation is a key determinant of migrant health.

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