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

Juin 2023 / June 2023

Assurance maladie	*Health Insurance*
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Vieillissement	*Ageing*

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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www.irdes.fr/english/documentation/watch-on-health-economics-literature.html

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

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Health Insurance

Financial Transaction Costs Reduce Benefit Take-Up Evidence From Zero-Premium Health Insurance Plans in Colorado

DRAKE C., ANDERSON D., CAI S.-T., *et al.*

2023

Journal of Health Economics 89: 102752.

https://doi.org/10.1016/j.jhealeco.2023.102752

With the passage of the American Recovery Plan Act of 2021, roughly 12 million Americans are eligible to purchase zero-premium Health Insurance Marketplace plans. Millions more are eligible for generously subsidized health plans with small, positive premiums. What difference does a premium of zero make, relative to a slightly positive premium? Using a regression discontinuity design and administrative data from Colorado, we find that zero-premium plans increase coverage, primarily by helping low-income households begin coverage sooner. The main mechanism is eliminating the transaction costs of having to make on-time payments to begin coverage. Transaction costs may be a meaningful barrier to subsidized insurance coverage take-up, particularly for low-income families.

Private Health Insurance in the Universal Public Healthcare System: The Role of Healthcare Provision in Finland

LAVASTE K.

2023

Health Policy (Ahead of pub): 104820.

https://doi.org/10.1016/j.healthpol.2023.104820

Voluntary private health insurance (VPHI) has gained popularity in universal public healthcare systems. We studied how the local provision of healthcare services correlated with VPHI take-up in Finland. Nationwide register data from a Finnish insurance company was aggregated to the local level and augmented with high-quality data on public and private primary care providers' geographical closeness and fees. We found that the sociodemographic characteristics explained the VPHI take-up more than public or private healthcare provision. The VPHI take-up was negatively associated with distance to the nearest private clinic, while the associations with distance to public health stations were statistically weak. Fees and co-payments for healthcare services were not associated with insurance take-up, meaning that the geographical closeness of providers explained the take-up more than the price of services. On the other hand, we found that VPHI take-up was higher when local employment, income and education levels were higher.

Démographie

Demography

L'évolution démographique récente de la France. En région comme au niveau national, des comportements démographiques encore marqués par la Covid-19

BRETON D., BELLIOT N., BARBIERI M., *et al.*

2022

Population 77(4): 535-614.

https://www.cairn.info/revue-population-2022-4-page-535.htm

Le 1er janvier 2022, la France comptait 67,8 millions d'habitants soit 187 000 de plus qu'au 1er janvier 2021. Les nombres de naissances, d'IVG et de mariages en 2021 ont augmenté par comparaison à 2020, sans retrouver les niveaux observés avant la crise sanitaire. (2019). Il en est même pour les décès dont le nombre a diminué, mais reste encore supérieur à celui observé en 2019. En 2021, la France fait partie des 9 pays européens parmi les 27 dont le solde naturel est positif. Son solde migratoire l'est également et, en 2021, est supérieur au solde naturel. Au total, la population de la France continue d'augmenter, mais à un rythme plus faible qu'avant la pandémie. En 2020, les flux d'entrées

de personnes venant de pays tiers avec un titre de séjour ont très fortement diminué du fait de la crise sanitaire. Ce sont les titres pour raison professionnelle qui ont le plus baissé. Les demandes se concentrent en Île-de-France. En 2021, l'indice conjoncturel de fécondité augmente très légèrement (1,83 enfant par femme), principalement du fait de la hausse des taux entre 30 et 39 ans. Le profil par âge varie selon les régions. Le recours à l'avortement est plutôt stable entre 2020 et 2021, mais la part des IVG réalisées par la méthode médicamenteuse augmente d'année en année (77 % en 2021), surtout celles pratiquées en cabinet de ville. Cependant, on observe d'importantes différences territoriales, du fait d'une offre de soins inégale au niveau local. En 2021, le rattrapage des mariages qui n'ont pu être célébrés en 2020 n'a été que partiel. Pour la première fois en 2020, le nombre de pacs dépasse celui des mariages. Les mariages sont plus fréquents sur le flanc est du pays et les pacs sur la façade atlantique et dans le Sud-Ouest. Le nombre de décès reste important en 2021 malgré une amélioration par rapport à 2020. L'espérance de vie en 2021 reste inférieure de 4,6 mois pour les hommes par rapport à 2019, et de 1,4 mois pour les femmes. La surmortalité est estimée à 6,3 % en 2021 après avoir été de 7,5 % en 2020. Les régions les plus touchées ne sont pas nécessairement celles où la mortalité était initialement forte.

E-santé – Technologies médicales

E-health – Medical Technologies

The Credibility of Physician Rating Websites: A Systematic Literature Review

GUETZ B. ET BIDMON S.

2023

Health Policy (Ahead of pub): 104821.

https://doi.org/10.1016/j.healthpol.2023.104821

Increasingly, the credibility of online reviews is drawing critical attention due to the lack of control mechanisms, the constant debate about fake reviews and, last but not least, current developments in the field of artificial intelligence. For this reason, the aim of this study was to examine the extent to which assessments recorded on physician rating websites (PRWs) are credible, based on a comparison to other evaluation criteria. Methods Referring to the PRISMA guidelines, a comprehensive literature search was conducted across different scientific databases. Data were synthesized by comparing individual statistical outcomes, objectives and conclusions. Results The chosen search strategy led to a database of 36,755 studies of which 28 were ultimately included in the systematic review. The literature review yielded mixed results regarding the credibility of PRWs. While seven publications supported the credibility of PRWs, six publications found no correlation between PRWs and alternative datasets. 15 studies reported mixed results. Conclusions This study has shown that ratings on PRWs seem to be credible when relying primarily on patients' perception. However, these portals seem inadequate to represent alternative comparative values such as the medical quality of physicians. For health policy makers our results show that decisions based on patients' perceptions may be well supported by data from PRWs. For all other decisions, however, PRWs do not seem to contain sufficiently useful data.

Evaluation of a National E-Booking System For Medical Consultation in Primary Care in a Universal Health System

MOTULSKY A., BOSSON-RIEUTORT D., USHER S., *et al.*

2023

Health Policy (Ahead of pub): 104759.

https://doi.org/10.1016/j.healthpol.2023.104759

The Rendez-vous Santé Québec is a national online booking (e-booking) system of medical appointments in primary care rolled out in 2018 in Québec (Canada). The objectives of this study were to describe the adoption by targeted users, and analyze the facilitating and limiting factors at the technological, individual and organizational levels to inform policy makers. Methods A mixed methods evaluation was conducted involving interviews with key stakeholders (n = 40), audit logs of the system in 2019, and a population-based survey (n = 2 003). All data were combined to analyze facilitating and limiting factors, based on the DeLone

and McLean framework. Results The RVSQ e-booking system had a low adoption across the province mainly because it was poorly aligned with the diversity of organizational and professional practices. The other commercial e-booking systems already used by clinics seemed better adapted to interdisciplinary care, patient prioritization and advanced access. e-Booking system was appreciated by patients, but has implications for the performance of primary care organization that goes beyond scheduling management issues, with potential detrimental consequences for care continuity and appropriateness. Further research is needed to define how e-booking systems could support a better alignment between primary care innovative practices and improve the fit between patients' needs and resources availability in primary care.

Économie de la santé

Health Economics

Tiered Cost Sharing and Health Care Demand

ACKLEY C. A.

2022

Journal of Health Economics 85: 102663.

https://doi.org/10.1016/j.jhealeco.2022.102663

In this paper, I study tiered cost sharing, an innovative incentive structure designed to steer patients toward low-cost providers using large out-of-pocket price differentials. Using administrative data from New Hampshire, where two large insurers utilize tiered pricing programs, I estimate the effects of tiering on choices and spending for common gastrointestinal endoscopic procedures. I first conduct a difference-in-differences analysis using the rollout of one insurer's tiered option. I then develop and estimate a demand model to explicitly compare the tiered design with other common plans. Both the reduced form and structural models imply that the tiered plans are associated with 4.5%–6.3% less in mean per-episode spending than high-deductible and coinsurance-based plans, and do not affect the likelihood of seeking care. I find evidence that the savings is in part due to a salience or "simple pricing" effect whereby patients respond to tiered out-of-pocket prices but not to traditional deductibles or coinsurance rates.

Regional Differences in Healthcare Costs at the End of Life: An Observational Study Using Swiss Insurance Claims Data

BÄHLER C., RAPOLD R., SIGNORELL A., *et al.*

2020

International Journal of Public Health 65.

https://doi.org/10.1007/s00038-020-01428-w

We evaluated healthcare cost differences at the end of life (EOL) between language regions in Switzerland, accounting for a comprehensive set of variables, including treatment intensity. Methods We evaluated 9716 elderly who died in 2014 and were insured at Helsana Group, with data on final cause of death provided by the Swiss Federal Statistical Office. EOL healthcare costs and utilization, ≥ 1 ICU admission and 10 life-sustaining interventions (cardiac catheterization, cardiac assistance device implantation, pulmonary artery wedge monitoring, cardiopulmonary resuscitation, gastrostomy, blood transfusion, dialysis, mechanical ventilation, intravenous antibiotics, cancer chemotherapies) reimbursed by compulsory insurance were examined .Results Taking into consideration numerous variables, relative cost differences decreased from 1.27 (95% CI 1.19–1.34) to 1.06 (CI 1.02–1.11) between the French- and German-speaking regions, and from 1.12 (CI 1.03–1.22) to 1.08 (CI 1.02–1.14) between the Italian- and German-speaking regions, but standardized costs still differed. Contrary to individual factors, density of home-care nurses, treatment intensity, and length of inpatient stay explain a substantial part of these differences. Conclusions Both supply factors and health-service provision at the EOL vary between Swiss language regions and explain a substantial proportion of cost differences.

Do Urgent Care Centers Reduce Medicare Spending?

CURRIE J., KARPOVA A. ET ZELTZER D.

2023

Journal of Health Economics 89: 102753.
https://doi.org/10.1016/j.jhealeco.2023.102753

We ask how urgent care centers (UCCs) impact healthcare costs and utilization among nearby Medicare beneficiaries. When residents of a zip code are first served by a UCC, total Medicare spending rises while mortality remains flat. In the sixth year after entry, 4.2% of the Medicare beneficiaries in a zip code that is served use a UCC, and the average per-capita annual Medicare spending in the zip code increases by $268, implying an incremental spending increase of $6,335 for each new UCC user. UCC entry is also associated with a significant increase in hospital stays and increased hospital spending accounts for half of the total increase in annual spending. These results raise the possibility that, on balance, UCCs increase costs by steering patients to hospitals.

Discontinuation of Performance-Based Financing in Primary Health Care: Impact on Family Planning and Maternal and Child Health

EL-SHAL A., CUBI-MOLLA P. ET JOFRE-BONET M.

2023

International Journal of Health Economics and Management 23(1): 109-132.
https://doi.org/10.1007/s10754-022-09333-w

Performance-based financing (PBF) is advocated as an effective means to improve the quality of care by changing healthcare providers' behavior. However, there is limited evidence on its effectiveness in low- and middle-income countries and on its implementation in primary care settings. Evidence on the effect of discontinuing PBF is even more limited than that of introducing PBF schemes. We estimate the effects of discontinuing PBF in Egypt on family planning, maternal health, and child health outcomes. We use a difference-in-differences (DiD) model with fixed effects, exploiting a unique dataset of six waves of spatially constructed facility-level health outcomes. We find that discontinuing performance-based incentives to providers had a negative effect on the knowledge of contraceptive methods, iron supplementation during pregnancy, the prevalence of childhood acute respiratory infection, and, more importantly, under-five child mortality, all of which were indirectly targeted by the PBF scheme. No significant effects are reported for directly targeted outcomes. Our findings suggest that PBF can induce permanent changes in providers' behavior, but this may come at the expense of non-contracted outcomes.

Episode Payment Models and Provider Consolidation: Evidence From the Comprehensive Care For Joint Replacement Model

HE F.

2023

Medical Care Research and Review (Ahead of pub): 10775587231160912.
https://journals.sagepub.com/doi/abs/10.1177/10775587231160912

A possible unintended consequence of episode payment models is provider consolidation, which can, in turn, increase prices for commercially insured enrollees. We assess the effect of Medicare's Comprehensive Care for Joint Replacement (CJR) model on provider consolidation. Hospitals in randomly assigned metropolitan statistical areas were mandated to participate during the first 2 years of the model and a subset of hospitals were mandated for later years. We used a difference-in-differences approach to assess whether CJR affected consolidation, as measured by hospital ownership of practices, the number and size of practices, the Herfindahl–Hirschman Index, and the four-firm concentration ratio. Given limited sample sizes, our results are only suggestive that CJR was not associated with changes in consolidation. Our strongest results suggest null effects for changes in hospital ownership and practice size. These findings suggest that concerns regarding the role alternative payment models play in consolidation may have been overstated.

Climate Change, Health and Sustainable Healthcare: The Role of Health Economics

HENSHER M.

2023

Health Economics 32(5): 985-992.
https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4656

Healthcare systems around the world are responding with increasing urgency to rapidly evolving ecological crises, most notably climate change. This Perspective considers how health economics and health econo-

mists can best contribute to protecting health and building sustainable healthcare systems in the face of these challenges.

Facilitating and Inhibiting Factors in the Design, Implementation, and Applicability of Value-Based Payment Models: A Systematic Literature Review

LEAO D. L. L., CREMERS H.-P., VAN VEGHEL D., *et al.*

2023

Medical Care Research and Review (Ahead of pub).

https://journals.sagepub.com/doi/abs/10.1177/10775587231160920

Evidence on the potential for value-based payment models to improve quality of care and ensure more efficient outcomes is limited and mixed. We aim to identify the factors that enhance or inhibit the design, implementation, and application of these models through a systematic literature review. We used the PRISMA guidelines. The facilitating and inhibiting factors were divided into subcategories according to a theoretical framework. We included 143 publications, each reporting multiple factors. Facilitators on objectives and strategies, such as realistic/achievable targets, are reported in 56 studies. Barriers regarding dedicated time and resources (e.g., an excessive amount of time for improvements to manifest) are reported in 25 studies. Consensus within the network regarding objectives and strategies, trust, and good coordination is essential. Health care staff needs to be kept motivated, well-informed, and actively involved. In addition, stakeholders should manage expectations regarding when results are expected to be achieved.

The Effects of Patient Out-Of-Pocket Costs on Insulin Use Among People with Type 1 and Type 2 Diabetes with Medicare Advantage Insurance—2014–2018

MCADAM-MARX C., RUIZ-NEGRON N., SULLIVAN J. M., *et al.*

2023

Health Services Research (Ahead of pub).

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.14152

The objective of this paper is to identify the association between insulin out-of-pocket costs (OOPC) and adherence to insulin in Medicare Advantage (MA) patients. Data Sources and Study Setting The study is based on Optum Labs Data Warehouse, a longitudinal, real-world data asset with de-identified administrative claims and electronic health record data. Study Design Using descriptive and multivariable logistic regression analyses, we identified the likelihood of patients with diabetes having ≥60 consecutive days between an expected insulin fill date and the actual fill date (refill lapse) by OOPC, categorized by $0, >$0–$20 (reference), >$20–$35, >$35–$50, and > $50 per 30-day supply. Data Collection/Extraction Methods The study included MA enrollees with type 1 or type 2 diabetes and prescription claims for insulin between 2014 and 2018. Principal Findings Those with average insulin OOPC per 30-day supply >$35 or $0 were more likely to have an insulin refill lapse versus OOPC of >$0 to $20, with odds ratios ranging 1.18 (95% CI 1.13–1.22) to 1.74 (95% CI 1.66–1.83) depending on OOPC group and diabetes type. Conclusions Capping average insulin OOPC at $35 per 30-day supply may help avoid cost-related insulin non-adherence in MA patients; efforts to address non-cost barriers to medication adherence remain important.

Does Prospective Payment Influence Quality of Care? a Systematic Review of the Literature

POTT C., STARGARDT T. ET FREY S.

2023

Social Science & Medicine 323: 115812.

https://doi.org/10.1016/j.socscimed.2023.115812

In the light of rising health expenditures, the cost-efficient provision of high-quality inpatient care is on the agenda of policy-makers worldwide. In the last decades, prospective payment systems (PPS) for inpatient care were used as an instrument to contain costs and increase transparency of provided services. It is well documented in the literature that prospective payment has an impact on structure and processes of inpatient care. However, less is known about its effect on key outcome indicators of quality of care. In this systematic review, we synthesize evidence from studies investigating how financial incentives induced by PPS affect indicators of outcome quality domains of care, i.e. health status and user evaluation outcomes. We conduct a review of evidence published in English, German, French, Portuguese and Spanish language produced since 1983 and synthesize results of the studies narratively by comparing direction of effects and statistical significance of different PPS interventions. We included 64 studies, where 10 are of high, 18 of

moderate and 36 of low quality. The most commonly observed PPS intervention is the introduction of per-case payment with prospectively set reimbursement rates. Abstracting evidence on mortality, readmission, complications, discharge disposition and discharge destination, we find the evidence to be inconclusive. Thus, claims that PPS either cause great harm or significantly improve the quality of care are not supported by our findings. Further, the results suggest that reductions of length of stay and shifting treatment to post-acute care facilities may occur in the course of PPS implementations. Accordingly, decision-makers should avoid low capacity in this area.

Use Trends and Recent Expenditures For Cervical Cancer Screening–Associated Services in Medicare Fee-For-Service Beneficiaries Older than 65 Years

QIN J., HOLT H. K., RICHARDS T. B., *et al.*

2023

JAMA Internal Medicine 183(1): 11-20.

https://doi.org/10.1001/jamainternmed.2022.5261

Since 1996, the US Preventive Services Task Force has recommended against cervical cancer screening in average-risk women 65 years or older with adequate prior screening. Little is known about the use of cervical cancer screening–associated services in this age group. To examine annual use trends in cervical cancer screening–associated services, specifically cytology and human papillomavirus (HPV) tests, colposcopy, and cervical procedures (loop electrosurgical excision procedure, cone biopsy, and ablation) in Medicare fee-for-service beneficiaries during January 1, 1999, to December 31, 2019, and estimate expenditures for services performed in 2019.This population-based, cross-sectional analysis included health service use data across 21 years for women aged 65 to 114 years with Medicare fee-for-service coverage (15-16 million women per year). Data analysis was conducted between July 2021 and April 2022.Proportion of testing modalities (cytology alone, cytology plus HPV testing [cotesting], HPV testing alone); annual use rate per 100 000 women of cytology and HPV testing, colposcopy, and cervical procedures from 1999 to 2019; Medicare expenditure for these services in 2019.The results of this cross-sectional study suggest that while annual use of cervical cancer screening–associated services in the Medicare fee-for-service population older than 65 years has decreased during the last 2 decades, more than 1.3 million women received these services in 2019 at substantial costs.

Long-Term Projections of Health Care Funding, Bed Capacity and Workforce Needs

RACHET-JACQUET L., ROCKS S. ET CHARLESWORTH A.

2023

Health Policy (Ahead of pub): 104815.

https://doi.org/10.1016/j.healthpol.2023.104815

Changes in population structure and underlying health put a significant strain on health care system resources. In this context, projecting future health care needs can contribute to better health care system planning and resource allocation over the long term. This paper presents a model of future demand and costs of care to estimate long-term funding and resource needs up to 2030/31. Methods Using data from England, we first calculate health care utilisation rates by age, gender and comorbidity, where available, and multiply them by the projected future populations to estimate future demand for a wide range of service areas. We then cost this future demand using 2018/19 unit costs for each service area which we project by accounting for assumptions around future inflation and productivity. Results Our results indicate in the longer term, funding for the English NHS would need to increase by around 2.8% per year in real terms to meet these underlying funding pressures. Further, our projections imply that the number of general and acute care beds would need to grow by between 1.3 – 4.1% a year and the NHS workforce would need to grow by between 1.8 – 2.6% a year by 2030/31, depending on productivity assumptions. Conclusions Our projections of workforce and hospital beds illustrate the extent of underlying pressures from population ageing and changes in morbidity. Improvements in care emerge as crucial for meeting these pressures.

The Long-Term Effects of Hospitalization on Health Care Expenditures: An Empirical Analysis For the Young-Old Population in Lombardy

TORRINI I., LUCIFORA C. ET RUSSO A.

2023

Health Policy (Ahead of pub): 104803.

https://doi.org/10.1016/j.healthpol.2023.104803

As the burden of acute care on government budgets is mounting in many countries, documenting the evolution of health costs following patients' hospital admission is essential for assessing overall hospital-re-

lated costs. In this paper, we investigate the short- and long-term effects of hospitalization on different types of health care expenditures. We specify and estimate a dynamic DID model using register data of the entire population of individuals aged 50-70 residing in Milan, Italy, over the period 2008-2017. We find evidence of a large and persistent effect of hospitalization on total health care expenditures, with future medical expenses mostly accounted for by inpatient care. Considering all health treatments, the overall effect is sizable and is about twice the cost of a single hospital admission. We show that chronically ill and disabled individuals require greater post-discharge medical assistance, especially for inpatient care, and that cardiovascular and oncological diseases together account for more than half of expenditures on future hospitalizations. Alternative out-of-hospital management practices are discussed as a post-admission cost-containment measure.

État de santé

Health Status

Correlates of Weight Bias in Adults From the Nutrinet-Santé Study

BRANCHE O., BUSCAIL C., PÉNEAU S., *et al.*

2023

American Journal of Preventive Medicine.

https://doi.org/10.1016/j.amepre.2023.02.012

Explicit weight bias is an underlying cause of weight stigma, but its associations with individual characteristics are not well known. This study aimed to assess explicit weight bias in French adults and to explore the associations with weight status and sociodemographic characteristics.

Cervical Cancer Stage at Diagnosis and Survival Among Women ≥65 Years in California

COOLEY J. J. P., MAGUIRE F. B., MORRIS C. R., *et al.*

2023

Cancer Epidemiology, Biomarkers & Prevention 32(1): 91-97.

https://doi.org/10.1158/1055-9965.EPI-22-0793

Through adequate screening and follow-up, cervical cancer can be prevented or detected at early-stage (stage I), which is related to excellent survival. Current guidelines recommend discontinuing screening for women ≥65 years with history of normal Pap and/or HPV tests, potentially leaving this age group vulnerable. This study examined late-stage disease in a population-based cohort. Using California Cancer Registry data, we identified 12,442 patients ages ≥21 years with a first primary cervical cancer diagnosed during 2009–2018. Proportions of late-stage disease (stages II–IV) and early- and late-stage 5-year relative survival are presented by the age group. Among patients ages ≥65 years, multivariable logistic regression estimated associations of sociodemographic and clinical characteristics with late-stage cervical cancer. Nearly one fifth of patients (n = 2,171, 17.4%) were ≥65 years. More women ages ≥65 years (71%) presented with late-stage disease than younger women (48% in patients ages <65). Late-stage 5-year relative survival was lower for women ≥65 years (23.2%–36.8%) compared with patients <65 (41.5%–51.5%). Characteristics associated with late-stage cervical cancer in women ≥65 years included older age [odds ratio (OR), 1.02; 95% confidence interval (CI), 1.01–1.04; each year], non-adenocarcinoma histologic subtypes, and comorbidities (OR, 1.59; 95% CI, 1.21–2.08).There remains a significant burden of advanced cervical cancer in women ≥65.Efforts should be made to better understand how the current screening paradigm is failing women of 65 years and older. Future work should focus on determining past screening history, lapses in follow-up care, and non-invasive testing approaches.

The Question of the Human Mortality Plateau: Contrasting Insights By Longevity Pioneers

DANG L. H. K., CAMARDA C. G., MESLÉ F., *et al.*

2023

Demographic Research 48(11): 321-338.

https://www.demographic-research.org/volumes/vol48/11/
https://www.demographic-research.org/volumes/vol48/11/48-11.pdf

The debate about limits to the human life span is often based on outcomes from mortality at the oldest ages among longevity pioneers. To this day, scholars disagree on the existence of a late-life plateau in human mortality. Amid various statistical analysis frameworks, the parametric proportional hazards model is a simple and valuable approach to test the presence of a plateau by assuming different baseline hazard functions on individual-level data. Objective: We replicate and propose some improvements to the methods of Barbi et al. (2018) to explore whether death rates reach a plateau at later ages in the French population as it does for Italians in the original study. Methods : We use a large set of exceptionally reliable data covering the most recently extinct birth cohorts, 1883–1901, where all 3,789 members who were born and died in France, were followed from age 105 onward. Individual life trajectories are modeled by a proportional hazards model with fixed covariates (gender, birth cohort) and a Gompertz baseline hazard function. Results: In contrast with Barbi et al. (2018)'s results, our Gompertz slope parameter estimate is statistically different from zero across all model specifications, suggesting death rates continue to increase beyond 105 years old in the French population. In addition, we find no significant birth cohort effect but a significant male disadvantage in mortality after age 105. Conclusions: Using the best data currently available, we did not find any evidence of a mortality plateau in French individuals aged 105 and older. Contribution: The evidence for the existence of an extreme-age mortality plateau in recent Italian cohorts does not extend to recent French cohorts. Caution in generalizations is advised, and we encourage further studies on long-lived populations with high-quality data.

▶ Impact de Covid-19 sur le stade du cancer du sein à la découverte et le délai de traitement en Côte d'Or, France

FERON AGBO C., ASSOGBA E., BERTAUT A., *et al.*
2023
Revue d'Épidémiologie et de Santé Publique 71(1): 101575.
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En raison de la pandémie de Covid-19, et de l'engorgement du système de santé français qui en a résulté, la prise en charge des patients atteints de la Covid-19 a été privilégiée par rapport à celle des patients atteints d'autres pathologies, notamment de maladies chroniques. L'objectif de cette étude était d'étudier l'impact de la Covid-19 sur le stade de découverte des cancers diagnostiqués dans le cadre d'un programme de dépistage organisé du cancer du sein, ainsi que l'impact sur le délai de prise en charge. Matériel et méthodes Toutes les femmes âgées de 50 à 74 ans pour lesquelles un cancer a été diagnostiqué en Côte d'Or dans le cadre du programme national de dépistage organisé du cancer du sein (première ou deuxième lecture) du 1er janvier 2019 au 31 décembre 2020 ont été incluses dans cette étude. À partir des données des laboratoires d'anatomie pathologique, des centres cliniques et du registre des cancers du sein et gynécologiques de la Côte d'Or, en France, nous avons recueilli les données sociodémographiques, cliniques et de traitement de tous les patients. Nous avons comparé les données de l'année 2019 (avant Covid) avec celles de l'année 2020 (Covid). Résultats Dans cette étude, nous n'avons pas observé de changement dans le stade de découverte du cancer au moment du diagnostic, ni de changement dans la stratégie thérapeutique. Cependant, nous avons observé une augmentation significative des tumeurs infiltrées, une diminution des tumeurs in situ, et la découverte d'une plus grande taille clinique des tumeurs in situ après la pandémie de Covid. Conclusion Bien que ces résultats soient rassurants, une surveillance continue est nécessaire pour déterminer les effets postpandémie.

▶ Prevalence of Overweight and Obesity in France

FONTBONNE A., CURRIE A., TOUNIAN P., *et al.*
2023
Journal of Clinical Medicine 12(3): 925.
https://www.mdpi.com/2077-0383/12/3/925

Obepi-Roche 2020 by the "Ligue Contre l'Obésité" (League Against Obesity) estimated overweight and obesity prevalence in France. The adopted methodology was chosen to be as similar as possible to that of a series of quota-based surveys conducted every three years from 1997 to 2012 (Obepi-Roche studies). The 2020 survey was conducted online from 24th September to 5th October 2020 by the Odoxa polling institute on a sample of metropolitan French subjects aged 18 years or over. Participants (n = 9598) self-measured their height and weight according to detailed instructions. Prevalence estimates were produced for all categories of body mass index. The prev-

alence of excess weight was 47.3% (17.0% of subjects with obesity), with higher values in the north and east of France. When comparing these 2020 estimates to previous Obepi-Roche estimates in order to visualize trends since 1997, it appeared that overweight fluctuated around 30%, and obesity prevalence increased steadily at a rapid pace. The increase was even steeper in the youngest age groups and for severe and complex obesity. Given the slightly different methodologies between the 1997–2012 studies and the 2020 survey, the worrying trends in obesity prevalence since 1997 must be confirmed, calling for a reedition of the Obepi-Roche series.

▶ Top and Bottom Longevity of Nations: A Retrospective Analysis of the Age-At-Death Distribution Across 18 OECD Countries

VERGUET S., NIWA M. ET BOLONGAITA S.

2022

European Journal of Public Health 33(1): 114-120.

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Similar to the study of the distribution of income within countries, population-level health disparities can be examined by analyzing the distribution of age at death. We sourced period-specific death counts for 18 OECD countries over 1900–2020 from the Human Mortality Database. We studied the evolution of country-year-specific distributions of age at death, with an examination of the lower and upper tails of these distributions. For each country-year, we extracted the 1st, 5th, 10th, 90th, 95th and 99th percentiles of the age-at-death distribution. We then computed the corresponding shares of longevity—the sum of the ages weighted by the age-at-death distribution as a fraction of the sum of the ages weighted by the distribution—for each percentile. For example, for the 10th percentile, this would correspond to how much longevity accrues to the bottom 10% of the age-at-death distribution in a given country-year. We expose a characterization of the age-at-death distribution across populations with a focus on the lower and upper tails of the distribution. Our metrics, specifically the gap measures in age and share across the 10th and 90th percentiles of the distribution, enable a systematic comparison of national performances, which yields information supplementary to the cross-country differences commonly pointed by traditional indicators of life expectancy and coefficient of variation. Examining the tails of age-at-death distributions can help characterize the comparative situations of the better- and worse-off individuals across nations, similarly to depictions of income distributions in economics.

Géographie de la santé

Geography of Health

▶ Barriers, Facilitators, and Motives to Provide Distance Care, and the Consequences For Distance Caregivers: A Mixed-Methods Systematic Review

BEI E., MORRISON V., ZARZYCKI M., *et al.*

2023

Social Science & Medicine 321: 115782.

https://doi.org/10.1016/j.socscimed.2023.115782

Rationale Distance caregivers (DCGs) are a growing population with substantial contributions to informal care. While much is known about the provision of local informal care, evidence from the distance caregiving population is lacking. Objective: This mixed-method systematic review examines barriers and facilitators of distance caregiving, determinants of motivations and willingness to provide distance care, and the impact on caregiver outcomes. Methods A comprehensive search strategy was conducted in four electronic databases and grey literature to minimise potential publication bias. Thirty-four studies, including 15 quantitative, 15 qualitative, and 4 mixed-method studies were identified. Data synthesis involved a convergent integrated approach to integrate quantitative with qualitative findings, followed by thematic synthesis to identify key themes and subthemes. Results Barriers and facilitators of providing distance care included contextual and socioeconomic aspects of geographic distance, communication and information resources, and local support networks that shaped the distance caregiver role

and caregiver involvement. The main motives for caregiving given by DCGs were cultural values and beliefs, societal norms, and perceived expectations of caregiving encompassing the sociocultural context of the caregiving role. Interpersonal relationships and individual characteristics further shaped DCGs' motivations and willingness to care from a geographic distance. DCGs experienced both positive and negative outcomes as a result of their distance caretaking responsibilities including feelings of satisfaction, personal growth, and enhanced relationship with the care recipient but also high levels of caregiver burden, social isolation, emotional distress, and anxiety. Conclusions The reviewed evidence contributes toward novel understandings about the unique nature of distance care and have important implications for research, policy, healthcare, and social practice.

Recruitment and Retention of General Practitioners in European Medical Deserts: A Systematic Review

BES J. M., FLINTERMAN L. E., GONZALES A. I., *et al.*
2023
Rural and Remote Health 23(1): 11p.

Despite policies aiming at universal health coverage by ensuring availability and accessibility of general practitioners (GPs), medically underserved areas are still present in Europe. This systematic review aims to summarize and compare literature on interventions and their potential effectiveness of GP recruitment and retention in these underserved areas ('medical deserts') from 2011 onwards. Methods: PubMed and Embase were used to identify publications, applying a two-stage selection process. All types of study designs, published in the past 10 years, were included if they discussed a possible intervention for GP recruitment or retention covering an underserved area in an EU-27/EEA/EFTA country (part of the European Union, the European Economic Area or the European Free Trade Association). Exclusion criteria were abstracts or full text not available, conference abstracts, poster presentations, books or overlapping secondary literature. Identified interventions were classified into four categories: 'education', 'professional and personal support', 'financial incentives' and 'regulation'. Eligible articles were critically appraisal by two authors (JB, LF), independently, by using the Joanna Briggs Institute checklist. Results: Of the 294 publications initially retrieved, 25 publications were included. Of them, 14 (56%) described educational interventions, 13 (52%) professional and personal support, and 11 (40%) financial or regulatory interventions. Overlapping categories were often described (56%). The effectiveness of educational or supportive interventions has mainly been evaluated cross-sectionally, whereby causal inference on future GP availability cannot be implied. Few and mixed results were found for the effectiveness of financial and regulatory interventions, because period co-interventions were not taken into account during the study. Conclusion: In the past 10 years, educational and supportive interventions to improve GP recruitment and retention have been reported most frequently, but often overlapping strategies are seen. While multiple strategies have potential to be effective, their limited evaluation makes it difficult to provide suggestions for policymakers to adapt their GP recruitment and retention strategies aiming at a best-practice approach in European medical deserts.

Geographical Variation in the Use of Private Health Insurance in a Predominantly Publicly-Funded System

CAVAZZA M., VECCHIO M. D., FATTORE G., *et al.*
2023
Health Policy 130: 104720.
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We provide evidence of geographical variations in the use of private health insurance (PHI) in Italy. Our study offers an original contribution, using a 2016 dataset on the use of PHI amongst a population of more than 200,000 employees of a major company. The average claim per enrolee was €925, representing approximately 50% of public health expenditure per capita, primarily for dental care (27.2%), specialist outpatient services (26.3%) and inpatient care (25.2%). Residents in northern regions and metropolitan areas respectively claimed reimbursements for €164 and €483 more than those in southern regions and in non-metropolitan areas. Both supply and demand factors can explain these large geographical differences. The study suggests the urgency for policymakers to address the considerable disparities in the Italian healthcare system, revealing the overall social, cultural and economic conditions that shape the demand for healthcare.

Regional Variations in Multimorbidity Burden Among Office-Based Physicians in Germany

GEIGER I., FLEMMING R., SCHÜTTIG W., *et al.*
2023
European Journal of Public Health (Ahead of pub).
https://doi.org/10.1093/eurpub/ckad039

Multimorbidity is associated with higher utilization of healthcare services. However, many countries do not consider multimorbidity when estimating physician supply. The main aim of this study was to assess how regional multimorbidity levels can be integrated when estimating the need for office-based physician supply. Claims data were used to measure and compare the proportions of multimorbid patients of GPs, ophthalmologists, orthopaedic specialists and neurologists, and examine spatial variations through Bernoulli cluster analysis of regional multimorbidity levels. To explore the interrelationship between current capacities and spatial occurrence of high-rate clusters, clusters were compared with the current supply of physicians. About 17 239 488 individuals out of approximately 67 million records were classified as multimorbid. Multimorbidity levels varied greatly between physician disciplines (31.5–60.1%). Bernoulli cluster analysis demonstrated that many high-rate areas were found for all specialized physicians, but clusters varied partially by size and location. The comparison with current physician supply at cluster level showed that more than a third of clusters with a significantly higher share of morbid patients seeing a GP are met, on an average, by GP supply below targeted values. In turn, clusters with significantly higher multimorbidity levels of specialized physicians were met, on an average, by supply that exceeded targeted values. Our study offers an approach to how to include discipline-specific multimorbidity at area level when estimating physician supply and discusses its relevance. The outcomes of our article can be used by policymakers to advance current planning strategies and to improve the quality of office-based care.

Hôpital
Hospitals

Barriers and Facilitators to Implementing Priority Setting and Resource Allocation Tools in Hospital Decisions: A Systematic Review

AHUMADA-CANALE A., JEET V., BILGRAMI A., *et al.*
2023
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Health care budgets in high-income countries are having issues coping with unsustainable growth in demand, particularly in the hospital setting. Despite this, implementing tools systematising priority setting and resource allocation decisions has been challenging. This study answers two questions: (1) what are the barriers and facilitators to implementing priority setting tools in the hospital setting of high-income countries? and (2) what is their fidelity? A systematic review using the Cochrane methods was conducted including studies of hospital-related priority setting tools reporting barriers or facilitators for implementation, published after the year 2000. Barriers and facilitators were classified using the Consolidated Framework for Implementation Research (CFIR). Fidelity was assessed using priority setting tool's standards. Out of thirty studies, ten reported program budgeting and marginal analysis (PBMA), twelve multi-criteria decision analysis (MCDA), six health technology assessment (HTA) related frameworks, and two, an ad hoc tool. Barriers and facilitators were outlined across all CFIR domains. Implementation factors not frequently observed, such as 'evidence of previous successful tool application', 'knowledge and beliefs about the intervention' or 'external policy and incentives' were reported. Conversely, some constructs did not yield any barrier or facilitator including 'intervention source' or 'peer pressure'. PBMA studies satisfied the fidelity criteria between 86% and 100%, for MCDA it varied between 36% and 100%, and for HTA it was between 27% and 80%. However, fidelity was not related to implementation. This study is the first to use an implementation science approach. Results represent the starting point for organisations wishing to use priority setting tools in the hospital setting by providing an overview of barri-

ers and facilitators. These factors can be used to assess readiness for implementation or to serve as the foundation for process evaluations. Through our findings, we aim to improve the uptake of priority setting tools and support their sustainable use.

What Is Important For High Quality Rural Health Care? a Qualitative Study of Rural Community and Provider Views in Aotearoa New Zealand

ATMORE C., DOVEY S., GAULD R., *et al.*

2023

Rural and Remote Health 23(1)

While the general principles of healthcare quality are well articulated internationally, less has been written about applying these principles to rural contexts. Research exploring patient and provider views of healthcare quality in rural communities is limited. This study investigated what was important in healthcare quality particularly for hospital-level care for rural communities in Aotearoa New Zealand. Methods: A pragmatic qualitative study was undertaken in four diverse rural communities with access to rural hospitals. Data were gathered through eight community and indigenous (Māori) focus groups (75 participants) and 34 health provider interviews, and analysed thematically. Results: Two study sites had large Māori populations and high levels of socioeconomic deprivation, whereas the other two sites had much lower Māori populations and lower levels of socioeconomic deprivation, but further travel distances to urban facilities. Rural hospitals in the communities ranged from 12 to 80 beds and were both government and community trust owned. A theme of the principles of high quality rurally focused health services was developed. Nine principles were identified: (1) providing patient- and family-centred care that respected people's preferences for where treatment was provided; (2) providing services as close to home as could be done well; (3) quality was everybody's job; (4) consistent care across settings, with reduction on unwarranted variation; (5) team-based care across distance, with clear communication and processes between different facilities working together; (6) equitable health care particularly for Māori, and then for the whole rural community; (7) sustainable service models, particularly for workforce, as a counterbalance to 'closer to home'; (8) health networks to improve patient flow, and reduce waste; and (9) value was more than value for money, and including valuing respectful, timely care.

Le gouvernement de la santé à l'ère de l'audit : ce que nous enseigne l'étude de la certification des comptes sur la régulation hospitalière

AUBERT I. ET KLETZ F.

2023

Politiques & management public 1(1): 51-77.

https://www.cairn.info/revue-politiques-et-management-public-2023-1-page-51.htm

L'introduction de la certification des comptes dans les hôpitaux publics a souvent été analysée comme un dispositif de nature purement technique, destiné à fiabiliser le jugement porté par le régulateur sur la situation comptable et budgétaire des établissements. Pourtant, loin de se réduire à l'instauration d'un nouveau contrôle sur les hôpitaux, cette réforme s'inscrit dans un mouvement plus profond d'évolution des techniques de gouvernementalité (Foucault, 2004) de la santé. À partir d'une étude qualitative, le présent article analyse ce processus de transformation et met en lumière la consolidation d'une politique de régulation des hôpitaux de plus en plus distante, dé- spécifiée et médiatisée par des intermédiaires. Notre étude permet ainsi d'enrichir la grille d'analyse des régimes de gouvernementalité dans le champ hospitalier (Lenay, 2001, Cazin, 2017), et interroge les limites de ce modèle, notamment en termes d'équilibre et d'articulation entre les logiques de conformation et d'apprentissage.

Quelles caractéristiques des conditions de travail ont un impact sur la reconnaissance au travail ? Le cas d'un centre hospitalier universitaire français

BARET C., RECOTILLET I. ET KORNIG C.

2022

Journal de gestion et d'économie de la santé 5-6(5): 398-417.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2022-5-page-398.htm

En France, les personnels hospitaliers dénoncent depuis plusieurs années une dégradation de leurs conditions de travail dues aux restrictions budgétaires, aux sous effectifs et à l'accroissement des tâches administratives. Parallèlement, de nombreuses professions de santé réclament une meilleure reconnaissance de leur qualification et de la pénibilité de leur travail. Cela n'est pas nouveau, puisque ce sont en effet les

infirmières qui, les premières, ont revendiqué une meilleure reconnaissance au travail pour professionnaliser leur métier, et ce, dès 1988. Peut-on mettre en évidence des relations entre les conditions de travail et la reconnaissance ? En sciences de gestion, les travaux sur la reconnaissance ont principalement porté sur l'identification des pratiques de reconnaissance, ou de non-reconnaissance, et sur ses effets sur le comportement des salariés dans l'organisation. Peu de travaux traitent des facteurs qui ont une influence sur la reconnaissance. L'impact des transformations des conditions de travail est évoqué mais ne s'appuie pas sur des résultats empiriques. Dans cette recherche, nous retenons l'approche multidimensionnelle de la reconnaissance de Brun et Dugas pour tester cinq hypothèses sur les relations entre certaines caractéristiques des conditions de travail et certaines dimensions de la reconnaissance sur la base de l'exploitation de 26 entretiens semi-directifs et d'un questionnaire administré dans un centre hospitalier universitaire français en 2018. Les conditions de travail ont une influence quasi similaire sur toutes les dimensions de la reconnaissance. L'autonomie dans le travail, le soutien de la hiérarchie et les moyens disponibles pour réaliser son travail sont les caractéristiques des conditions de travail qui ont la plus forte influence sur la reconnaissance. Sur un plan plus descriptif, les résultats montrent que les médecins, les personnels soignants et les personnels médico-techniques sont ceux qui expriment le plus grand déficit de reconnaissance. Parmi les 4 dimensions de la reconnaissance, c'est principalement celle de l'investissement au travail qui fait défaut.

Les métiers invisibles à l'hôpital : A la découverte de la face cachée de la lune : Dossier

BARRICAULT C.

2023

Gestions Hospitalières(623): 90-124.

L'hôpital est une aventure humaine. Mille et une professions s'y côtoient, formant une nébuleuse qui s'étend à mesure qu'on l'observe. Vingt-quatre heures sur vingt-quatre, sept jours sur sept et durant les 365 jours de l'année, les agents des centres hospitaliers s'affairent, dans une rotation constante, à leurs tâches respectives. Si, gravitant autour du patient, les soignants et les médecins sont les astres qui scintillent le plus, l'équipe hospitalière est constituée d'éléments phares et de satellites aussi importants les uns que les autres pour en assurer l'équilibre. Électriciens, socio-esthéticiennes, vaguemestres ou orthoprothésistes..., dans les dédales de cet univers qu'est l'hôpital et que les élèves directrices et directeurs d'hôpital (EDH) explorent au cours de leur stage de découverte, les professions se révèlent et, avec elles, leurs constellations de singularité. Partant de cette expérience, les EDH de la promotion Marie-Marvingt (2022-2023) ont voulu mettre en lumière des acteurs méconnus de la galaxie hospitalière. À l'écoute de leur démarche, Gestions hospitalières leur a ouvert ses colonnes pour un dossier dédié aux métiers invisibles à l'hôpital. Avant toute chose, la notion de « métiers invisibles » à l'hôpital est à éclairer. Invisibles pour qui, pourquoi ?

Prevalence and Incidence of Cardiovascular and Renal Diseases in Type 1 Compared with Type 2 Diabetes: A Nationwide French Observational Study of Hospitalized Patients

DUCLUZEAU P. H., FAUCHIER G., HERBERT J., *et al.*

2023

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Type 1 diabetes mellitus (T1DM) and type 2 diabetes mellitus (T2DM) increase risks of cardiovascular (CV) and renal disease compared with diabetes-free populations. There are only a few studies comparing T1DM and T2DM for the relative risk of these clinical events. Methods All adult patients hospitalized in French hospitals in 2013 with at least 5 years of follow-up were identified and categorized by their diabetes status. A total of 50,623 patients with T1DM (age 61.4 ± 18.6, 53% male) and 425,207 patients with T2DM (age 68.6 ± 14.3, 55% male) were followed over a median period of 5.3 years (interquartile range: 2.8 - 5.8 years). Prevalence and event rates of myocardial infarction (MI), heart failure (HF), ischemic stroke, chronic kidney disease (CKD), all-cause death and CV death were assessed with age stratification of 10-year intervals. For clinical events during follow-up, we report hazard ratios (HRs) in T1DM relative to T2DM. Results The age and sex-adjusted prevalence of CV diseases was higher in T2DM for ages above 40 years whereas the prevalence of CKD was more common in T1DM between ages 18 and 70 years. During 2,033,239 person-years of follow-up, age and sex-adjusted HR event rates comparing T1DM, versus T2DM as reference, showed that MI and HF relative risks were increased above 60 years (1.2 and 1.4 -fold). HR of ischemic stroke did not markedly differ between T1DM and T2DM. Risk of incident

CKD was 2.4-fold higher in T1DM above 60 years. All-cause death HR risk was 1.1-fold higher in T1DM after 60 years and the CV death risk was 1.15-fold higher in T1DM between 60 and 69 years compared to T2DM. Conclusions Although the crude prevalent burden of CV diseases may be lower in T1DM than in T2DM, patients with T1DM may have a higher risk of incident MI, HF, all-cause death and CV death above 60 years of age, highlighting the need for improved prevention in this population.

Facteurs prédictifs du risque de réhospitalisation et de perte d'autonomie chez des personnes âgées admises aux urgences : une étude pilote

GANGNEUX C., CHARPIGNY M., PATRY C., *et al.*

2022

Recherche en soins infirmiers 151(4): 60-74.

https://www.cairn.info/revue-recherche-en-soins-infirmiers-2022-4-page-60.htm

Un nombre croissant de personnes âgées sont admises aux urgences chaque année, mais les contraintes temporelles et structurelles de ces services ne permettent pas de repérer de façon optimale les personnes à risque de réhospitalisation et de perte d'autonomie. Objectif : décrire la population des personnes de plus de 75 ans sortant des urgences sans indication d'hospitalisation, montrer la contribution d'une infirmière en pratique avancée (IPA) en regard des facteurs prédictifs de perte d'autonomie identifiés. Méthode : étude pilote, prospective, monocentrique, descriptive d'une cohorte de 67 patients, menée aux urgences. Résultats : l'étude a permis de décrire une population féminine, vieillissante et fragile. La réévaluation à six mois a permis d'observer un déclin fonctionnel pour 23 % des patients. Des facteurs prédictifs de perte d'autonomie, pour cette population d'étude, sont proposés. Discussion : ces résultats, cohérents avec ceux de la littérature, montrent la plus-value que pourrait avoir l'IPA en regard du déclin fonctionnel de cette population. Conclusion : la population âgée des urgences rentrant au domicile étant hétérogène, complexe et fragile, l'intervention d'une IPA a été mise en place pour améliorer la prise en soins des personnes et prévenir leur perte d'autonomie.

The Geography of Medicare's Hospital Value-Based Purchasing in Relation to Market Demographics

MCLAUGHLIN C. C. ET BOSCOE F. P.

2023

Health Services Research (Ahead of pub).

https://doi.org/10.1111/1475-6773.14141

The objective of this study is to illustrate the association between the sociodemographic characteristics of hospital markets and the geographic patterns of Medicare hospital value-based purchasing (HVBP) scores. Data Sources and Study Setting This is a secondary analysis of United States hospitals with a HVBP Total Performance Score (TPS) for 2019 in the Centers for Medicare and Medicaid Services (CMS) Hospital Compare database (4/2021 release) and American Community Survey (ACS) data for 2015–2019. Study Design This is a cross-sectional study using spatial multivariable autoregressive models with HVBP TPS and component domain scores as dependent variables and hospital market demographics as the independent variables. Data Collection/Extraction Methods We calculated hospital market demographics using ZIP code level data from the ACS, weighted the 2019 CMS inpatient Hospital Service Area file. Principal Findings Spatial autoregressive models using eight nearest neighbors with diversity index, race and ethnicity distribution, families in poverty, unemployment, and lack of health insurance among residents ages 19–64 years provided the best model fit. Diversity index had the highest statistically significant contribution to lower TPS ($\beta = -12.79$, $p < 0.0001$), followed by the percent of the population coded to "non-Hispanic, some other race" ($\beta = -2.59$, $p < 0.0023$), and the percent of families in poverty ($\beta = -0.26$, $p < 0.0001$). Percent of the population was non-Hispanic American Indian/Alaskan Native ($\beta = 0.35$, $p < 0.0001$) and percent non-Hispanic Asian ($\beta = 0.12$, $p < 0.02071$) were associated with higher TPS. Lower predicted TPS was observed in large urban cities throughout the US as well as in states throughout the Southeastern US. Similar geographic patterns were observed for the predicted Patient Safety, Person and Community Engagement, and Efficiency and Cost Reduction domain scores but are not for predicted Clinical Outcomes scores. Conclusions The lower predicted scores seen in cities and in the Southeastern region potentially reflect an inherent—that is, structural—association between market sociodemographics and HVBP scores.

Estimating the Health Impact of Delayed Elective Care During the Covid -19 Pandemic in the Netherlands

OOSTERHOFF M., KOUWENBERG L. H. J. A., ROTTEVEEL A. H., *et al.*

2023

Social Science & Medicine 320: 115658.

https://doi.org/10.1016/j.socscimed.2023.115658

The Covid-19 pandemic had a major impact on the continuity of healthcare provision. Appointments, treatments and surgeries for non-COVID patients were often delayed, with associated health losses for patients involved. Objective To develop a method to quantify the health impact of delayed elective care for non-COVID patients. Methods A model was developed that estimated the backlog of surgical procedures in 2020 and 2021 using hospital registry data. Quality-adjusted life years (QALYs) were obtained from the literature to estimate the non-generated QALYs related to the backlog. In sensitivity analyses QALY values were varied by type of patient prioritization. Scenario analyses for future increased surgical capacity were performed. Results In 2020 and 2021 an estimated total of 305,374 elective surgeries were delayed. These delays corresponded with 319,483 non-generated QALYs. In sensitivity analyses where QALYs varied by type of patient prioritization, non-generated QALYs amounted to 150,973 and 488,195 QALYs respectively. In scenario analyses for future increased surgical capacity in 2022–2026, the non-generated QALYs decreased to 311,220 (2% future capacity increase per year) and 300,710 (5% future capacity increase per year). Large differences exist in the extent to which different treatments contributed to the total health losses. Conclusions The method sheds light on the indirect harm related to the COVID-19 pandemic. The results can be used for policy evaluations of COVID-19 responses, in preparations for future waves or other pandemics and in prioritizing the allocation of resources for capacity increases.

Impact of the First Covid-19 Pandemic Wave on Hospitalizations and Deaths Caused By Geriatric Syndromes in France: A Nationwide Study

TORRES M. J., COSTE J., CANOUÏ-POITRINE F., *et al.*

2023

The Journals of Gerontology: Series A (Ahead of pub).

https://doi.org/10.1093/gerona/glad032

The fear of contracting Covid-19 and the preventive measures taken during the health crisis impacted both people's lifestyles and the health system. This nationwide study aimed to investigate the impact of the first wave of the Covid-19 pandemic on hospitalizations and mortality related to geriatric syndromes (GS) in older adults in France. The French National Health Data System was used to compare hospital admissions (excluding main diagnosis of Covid-19) and mortality rates (using multiple-cause and initial-cause analyses, and both including or excluding confirmed/probable Covid-19) related to 10 different GS (dementia, other cognitive disorders and symptoms, delirium/disorientation, depression, undernutrition/malnutrition, dehydration, pressure ulcer, incontinence, fall/injury and femoral neck fracture) from January to September 2020 to rates observed in previous years. Analyses were stratified by age, sex, place of residence or place of death, and region. Hospitalization rates for all GS decreased during the first lockdown compared to the same periods in 2017-2019 (from -59% for incontinence to -13% for femoral neck fractures). A dose-response relationship was observed between reduced hospitalizations and Covid-19-related mortality rates. Conversely, for almost all GS studied, excess mortality without Covid-19 was observed during this lockdown compared to 2015-2017 (from +74% for delirium/disorientation to +8% for fall/injury), especially in nursing homes and at home. In France, during the first lockdown, a substantial decrease in hospitalizations for GS was accompanied by excess mortality. This decline in use of services, which persisted beyond lockdown, may have a mid- and long-term impact on older adult's health.

Inégalités de santé

Health Inequalities

Assessing the Contribution of Migration Related Policies to Equity in Access to Healthcare in European Countries. a Multilevel Analysis

HÜBNER W., PHILLIMORE J., BRADBY H., *et al.*
2023
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Access to good healthcare and the conditions for good health is one of the central dimensions of immigrant integration. National health policies play a major role in equipping residents with the necessary entitlements to accessible and acceptable healthcare services. Rarely analysed so far is the contribution of migration-related health policies to equity in access to healthcare between immigrants and the general population. To address this gap, this study analysed whether the extent to which migration is considered within national health policies moderates the association between immigration status and subjectively perceived unmet medical need in Europe. Using data from the 2019 European Union Statistics on Income and Living Conditions (EU-SILC) survey in combination with the Migration Integration Policy Index (MIPEX) a multilevel analysis was carried out assessing the cross-level interaction between immigration status and MIPEX scores controlling for individual-level factors such as age, gender, education and employment status. While our results showed that immigrants are more likely to report unmet medical need than the general population (adjusted Odds Ratio (aOR) = 1.32; 95% confidence interval (CI) 1.22–1.43), the cross-level interaction indicated increased relative inequality in unmet medical need between immigrants and the general population in countries with high MIPEX scores compared to countries with low MIPEX scores (aOR = 1.39, 95% CI: 1.18–1.63). The main reason for this increase of inequality on the relative scale was the overall lower prevalence of unmet medical need in countries with high MIPEX scores. In conclusion, our findings indicate that even in countries with relatively migration-friendly health policies inequalities in access to healthcare between immigrants and the general population persist.

Unmet Health Care Needs During the Covid-19 Pandemic Among Adults: A Prospective Cohort Study in the Canadian Longitudinal Study on Aging

KHATTAR J., ANDERSON L. N., RUBEIS V. D., *et al.*
2023
CMAJ Open 11(1): E140-E151.
https://www.cmajopen.ca/content/cmajo/11/1/E140.full.pdf

The Covid-19 pandemic affected access to health care services in Canada; however, limited research examines the influence of the social determinants of health on unmet health care needs during the first year of the pandemic. The objectives of this study were to describe unmet health care needs during the first year of the pandemic and to investigate the association of unmet needs with the social determinants of health. Methods: We conducted a prospective cohort study of 23 972 adults participating in the Canadian Longitudinal Study on Aging (CLSA) Covid-19 Study (April–December 2020) to identify the social determinants of health associated with unmet health care needs during the pandemic. Using logistic regression, we assessed the association between several social determinants of health on the following 3 outcomes (separately): experiencing any challenges in accessing health care services, not going to a hospital or seeing a doctor when needed, and experiencing barriers to accessing testing for SARS-CoV-2 infection. Results: From September to December 2020, 25% of participants experienced challenges accessing health care services, 8% did not go to a hospital or see a doctor when needed and 4% faced barriers accessing testing for SARS-CoV-2 infection. The prevalence of all 3 unmet need outcomes was lower among older age groups. Differences were observed by sex, region, education, income and racial background. Immigrants (odds ratio [OR] 1.18, 95% confidence interval [CI] 1.09–1.27) or people with chronic conditions (OR 1.35, 95% CI 1.27–1.43) had higher odds of experiencing challenges accessing health care services and had higher odds of not going to a hospital or seeing a doctor (immigrants OR 1.26, 95% CI 1.11–1.43; chronic conditions OR 1.45, 95% CI 1.31–1.61). Prepandemic unmet health care needs were strongly associated with all 3 outcomes. Interpretation: Substantial unmet health care needs were reported by Canadian adults during the first year

of the pandemic. The results of this study have important implications for health equity.

Minimum Wages and Health: Evidence From European Countries

LEBIHAN L.

2023

International Journal of Health Economics and Management 23(1): 85-107.
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This study investigates the effects of minimum wage on health, well-being, and income security in European countries. The empirical strategy consists of exploiting variations in the minimum wage across European countries over time. We show that minimum wage increases improve individuals' self-reported health and income security. Minimum wage increases also improve life satisfaction and happiness. The effects are largest among women, employed individuals, married individuals, and those with less than a secondary education. Our results are robust to several robustness checks and consistent with existing evidence on the relationship between minimum wage and health.

Health Check-Ups For the French Under-Consuming Agricultural Population: A Pilot Evaluation of the Instants Santé MSA Program

MICHEL M., ARVIS SOUARÉ M., DINDORF C., *et al.*

2023

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The social protection scheme in charge of farmers and agricultural employees (MSA) in France has developed a two-step health promotion program with a nurse appointment followed by a consultation with a doctor of the participant's choosing to reach its under-consuming beneficiaries and enroll them back into a care pathway. Our objective was to carry out a pilot evaluation of this program. Methods The evaluation was carried out on the population invited during the second semester of 2017 using data from the program's service providers (date of invitation, of nurse appointment…), regional MSA bodies (consultation voucher), and reimbursement data (other care consumption). Participation rates were calculated overall and by participant characteristics. Medical needs were identified during the nurse appointment and new care pathways were assessed using reimbursement data. Multivariable regression models identified factors associated with participation. Results 2366 beneficiaries were included in the analysis. 1559 (65.89%) were men and mean age was 52.41 (standard deviation = 14.86). 409 (17.29%) attended the nurse appointment. There was a significant increase in participation with age, in farmers vs. employees (odds ratio = 1.905, 95% confidence interval = 1.393–2.604), and in people living in the most disadvantaged areas (odds ratio = 1.579, 95% confidence interval = 1.079–2.312). Participation to the consultation following the nurse appointment was high (62.35%–73.11%). 87.53% of participants had at least one medical need, and new care pathways were more frequent among those who had attended the nurse appointment (55.50% vs. 34.80%, $p < 0.0001$). Conclusions This pilot evaluation shows promising results which need to be confirmed with a national evaluation of the program and longer-term evidence.

Women's Health in Migrant Populations: A Qualitative Study in France

OUANHNON L., ASTRUC P., FREYENS A., *et al.*

2022

European Journal of Public Health 33(1): 99-105.
https://doi.org/10.1093/eurpub/ckac133

In 2019, there are 6.5 million migrants living in France. Numerous quantitative studies show inequalities in access and quality of care, in particular in women's health. This study aimed to explore migrant women's experience of gynaecological care. We conducted 17 semi-structured in-depth interviews with migrant women in Toulouse (France). We used a Grounded Theory approach to perform the analysis. Although migrant women were generally satisfied with the gynaecological care received, they also reported dysfunctions. Positive elements were the French health insurance system, the human qualities of the healthcare providers and the performance of the health system. Although reassuring, the structured framework was perceived to have little flexibility. This was sometimes felt as oppressive, paternalistic or discriminatory. These obstacles, amplified by the women's lifestyle instability and precariousness, the language barrier and the difficulty to understand a totally new healthcare system, made women's health care and, especially, preventive care, a difficult-to-achieve and low-priority objective for the women. Migrant women's overall satisfaction with the healthcare system con-

trasted with the known health inequalities in these populations. This is a good example of the concept of acculturation. Healthcare professionals need to make an introspective effort to prevent the emergence of stereotypes and of discriminatory and paternalistic behaviours. A better understanding and respect of the other person's culture is an indispensable condition for intercultural medicine, and thus for reducing the health inequalities that migrant women experience.

Promoting the Health of Vulnerable Populations: Three Steps Towards a Systems-Based Re-Orientation of Public Health Intervention Research

ROD M. H., ROD N. H., RUSSO F., *et al.*

2023

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This paper proposes a novel framework for the development of interventions in vulnerable populations. The framework combines a complex systems lens with syndemic theory. Whereas funding bodies, research organizations and reporting guidelines tend to encourage intervention research that (i) focuses on singular and predefined health outcomes, (ii) searches for generalizable cause-effect relationships, and (iii) aims to identify universally effective interventions, the paper suggests that a different direction is needed for addressing health inequities: We need to (i) start with exploratory analysis of population-level data, and (ii) invest in contextualized in-depth knowledge of the complex dynamics that produce health inequities in specific populations and settings, while we (iii) work with stakeholders at multiple levels to create change within systems.

Médicaments

Pharmaceuticals

Linkage Between Electronic Prescribing Data and Pharmacy Claims Records to Determine Primary Adherence: The Case of Antihypertensive Therapy in the Lisbon and Tagus Valley Region, Portugal

COELHO A.

2022

Family Practice 40(2): 248-254.

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Hypertension (HT) is highly prevalent and a major risk factor for cardiovascular disease. Over 42% of Portuguese adults have HT. Even though the benefits of antihypertensive (AHT) drugs have been demonstrated, HT control remains inadequate. One major reason is that patients often fail to take their medications as prescribed. This paper aims to determine primary adherence to AHT therapy in newly diagnosed and treated hypertensive patients in Primary Health Care (PHC) units of Lisbon and Tagus Valley Health Region. This study reports data from a population-based, retrospective, cohort study from patients diagnosed with HT in PHC units of Lisbon and Tagus Valley Region from 1 January to 31 March 2011, with no prior use of AHT drugs. Primary adherence rate was expressed as number of claims records/total number of prescriptions records. Data were collected from SIARS for each patient during a 2-year period. Overall primary adherence rate was 58.5%, increasing with age. Rates were higher for men, living in the Lisbon Metropolitan Area and diagnosed with uncomplicated HT. Drugs acting on the renin–angiotensin system had the highest rates, increasing for fixed-dose combinations and diminishing with the increase of cost for the patient. Overall, almost 1 out of 2 prescribed AHT drugs were not dispensed. Until this study, little was known in Portugal about primary adherence. Our findings imply that the potential benefits of AHT therapy cannot be fully realized in this population.

Potentially Inappropriate Medications and Polypharmacy in the Older Population: A Nationwide Cross-Sectional Study in France in 2019

DRUSCH S., ZUREIK M. ET HERR M.

2023

Therapies (Ahead of pub).

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The aim of this study is to assess the prevalence of potentially inappropriate medications (PIMs) and polypharmacy in adults aged 75 years and over in France in 2019 based on data from the French health insurance claims database, at the national level and by region. Methods.- We conducted a cross-sectional study in French adults aged 75 years or over in 2019. We assessed the prevalence of seventeen PIM criteria adapted from the 2015 Beers and STOPP lists, as well as cumulative polypharmacy. Polypharmacy (5 to 9 drugs) and hyper-polypharmacy (≥10 drugs) were defined as the average number of drugs dispensed per quarter. The regional analysis used the age- and sex-standardized prevalence. Results.- Of 6,707,897 older adults, 39.6% were exposed to at least one PIM in 2019, 46.7% were exposed to polypharmacy (5 to 9 drugs), and 25.2% to hyper-polypharmacy (≥10 drugs). Benzodiazepine PIMs were the most frequent (26.9%), followed by atropinic PIMs(8.3%), non-steroidal anti-inflammatory PIMs (7.8%), concomitant use of three or more central nervous system-active drugs (7.3%), and antihypertensive drugs PIMs (6.0%). There was a gradient in the level of exposure to PIMs according to the level of polypharmacy for every PIM category. We observed regional variations in PIM prevalence from 36.5% in Pays-de-la-Loire to 44.8% in Hauts-de-France in mainland France. Conclusion.- These results show that PIMs concerned more than one in three older adults after age 75 years in France in 2019and support the need to rationalize prescriptions in this population. The reasons for geographic variations in PIM prevalence should be investigated in further studies.

Evidence on the Effectiveness of Policies Promoting Price Transparency - a Systematic Review

JOOSSE I. R., TORDRUP D., GLANVILLE J., *et al.*

2022

Health Policy (Ahead of pub): 104681.

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Policies promoting price transparency may be an important approach to control medicine prices and achieve better access to medicines. As part of a wider review, we aimed to systematically determine whether policies promoting price transparency are effective in managing the prices of pharmaceutical products. We searched for studies published between January 1, 2004 and October 10, 2019, comparing policies promoting price transparency against other interventions or a counterfactual. Eligible study designs included randomized trials, and non-randomized or quasi-experimental studies such as interrupted time-series (ITS), repeated measures (RM), and controlled before-after studies. Studies were eligible if they included at least one of the following outcomes: price (or expenditure as a proxy for price and volume), volume, availability or affordability of pharmaceutical products. The quality of the evidence was assessed using the GRADE methodology. A total of 32011 records were retrieved, two of which were eligible for inclusion. Although based on evidence from a single study, public disclosure of medicine prices may be effective in reducing prices of medicines short-term, with benefits possibly sustained long-term. Evidence on the impact of a cost-feedback approach to prescribers was inconclusive. No evidence was found for impact on the outcomes volume, availability or affordability. The overall lack of evidence on policies promoting price transparency is a clear call for further research.

Éthique et médicament : faut-il s'indigner du prix de certains médicaments ?

LE COZ P. ET BOUVENOT G.

2023

Bulletin de l'Académie Nationale de Médecine (Ahead of pub).

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Le nombre de médicaments vendus sur le marché à des prix très élevés tend à s'accroître chaque année, suscitant des controverses en France comme partout ailleurs. Étant donné les contraintes budgétaires qui s'imposent aux États, une prise en charge optimale équitable de tous les patients concernés pourrait devenir hors de portée. Aussi la pratique des prix onéreux fait-elle planer le spectre du rationnement, avec des conséquences éthiques majeures. L'émotion du public est vive lorsque des laboratoires pharmaceutiques donnent le sentiment de prospérer sur la maladie, réalisant de confortables bénéfices pour un progrès thérapeutique de leurs produits parfois modeste. La question est suffisamment grave pour que des instances

éthiques s'en emparent et prennent position contre la pratique des prix abusifs, pointant le manque de transparence et les marges déraisonnables que s'octroient les industriels. Ces derniers s'en défendent, dénonçant la méconnaissance des investissements colossaux auxquels ils doivent consentir en amont, mais aussi les économies substantielles que représente l'amélioration de l'état de santé des individus pour la collectivité. De ce point de vue, l'indignation des profanes serait uniquement l'expression de leur ignorance économique. Pour clarifier les termes du débat et savoir si l'indignation est fondée ou non, il convient avant tout de s'entendre sur la manière de fixer le juste prix des médicaments. L'histoire de la philosophie morale montre qu'il existe trois principales manières de le déterminer. La conception déontologique qui met l'accent sur la moralité des protagonistes ; la conception essentialiste qui cherche le juste prix dans la valeur intrinsèque du produit ; la conception procédurale qui pense le cerner dans la régularité de la convention entre les parties. Misant sur le respect de clauses équitables et équilibrées, l'éthique procédurale semble s'imposer à une époque comme la nôtre où l'équation des coûts ne cesse de se complexifier. Cependant, l'expérience montre qu'une procédure apparemment équitable peut cacher des rapports de force subreptices et cautionner indirectement des choix sacrificiels. Cette limite de l'éthique procédurale doit nous conduire à une réhabilitation au moins partielle de la conception essentialiste.

Incentivizing Appropriate Prescribing in Primary Care: Development and First Results of an Electronic Health Record-Based Pay-For-Performance Scheme

RAMERMAN L., HEK K., CRAMER- VAN DER WELLE C., *et al.*

2022

Health Policy 126(10): 1010-1017.

https://doi.org/10.1016/j.healthpol.2022.07.004

Objective Part of the funding of Dutch General Practitioners (GPs) care is based on pay-for-performance, including an incentive for appropriate prescribing according to guidelines in national formularies. Aim of this paper is to describe the development of an indicator and an infrastructure based on prescription data from GP Electronic Health Records (EHR), to assess the level of adherence to formularies and the effects of the pay-for-performance scheme, thereby assessing the usefulness of the infrastructure and the indicator. Methods Adherence to formularies was calculated as the percentage of first prescriptions by the GP for medications that were included in one of the national formularies used by the GP, based on prescription data from EHRs. Adherence scores were collected quarterly for 2018 and 2019 and subsequently sent to health insurance companies for the pay-for-performance scheme. Adherence scores were used to monitor the effect of the pay-for-performance scheme. Results 75% (2018) and 83% (2019) of all GP practices participated. Adherence to formularies was around 85% or 95%, depending on the formulary used. Adherence improved significantly, especially for practices that scored lowest in 2018. Discussion We found high levels of adherence to national formularies, with small improvements after one year. The infrastructure will be used to further stimulate formulary-based prescribing by implementing more actionable and relevant indicators on adherence scores for GPs.

Méthodologie – Statistique

Methodology - Statistics

Les méthodes mixtes : vers une méthodologie 3.0 ?

AGUILERA T. ET CHEVALIER T.

2021

Revue française de science politique 71(3): 361-363.

https://www.cairn.info/revue-francaise-de-science-politique-2021-3-page-361.htm

Dédié à Guy Michelat (1933-2021), ce numéro s'intéresse aux méthodes mixtes, qualitatives et quantitatives, utilisées dans la recherche en science politique. Le dossier qui lui est consacré vient combler un manque criant dans la littérature, notamment francophone, sur une hybridation méthodologique qui est pourtant au cœur des pratiques scientifiques de nombreux politistes. Une chronique bibliographique portant sur la théorie politique complète cette livraison estivale.

Health Data Hub et interopérabilité du Système national des données de santé

BENDA L., CHARLES C., RIMAUD G., *et al.*

2023

Revue d'Épidémiologie et de Santé Publique 71: 101457.

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La France dispose d'une des bases de données médico-administratives les plus complètes et homogènes au monde : le Système national des données de santé (SNDS). Cette base de données, initialement destinée à la gestion financière de l'Assurance maladie, a longtemps été sous-exploitée pour la recherche en santé en raison de sa complexité. Pour faciliter sa réutilisation, une piste de travail est sa standardisation via l'utilisation de modèles de données communs. Méthodes Depuis 2020, le Health Data Hub (HDH) transforme le SNDS vers le modèle OMOP-CDM (« Observational Medical Outcomes Partnership - Common Data Model »). Cette transformation permet de créer un modèle relationnel centré sur une table "patient" et de facilement reconstruire les parcours de soins. A partir d'un extrait du SNDS couvrant la période 2019-2020 pour une population hospitalisée pour COVID (SNDS Fast-Track), un alignement des schémas de données et des terminologies ont été réalisés. Les scripts de transformation sont développés en Python et les validations sont effectuées via les logiciels du consortium OHDSI. Des travaux d'harmonisation ont été réalisés avec des partenaires institutionnels (AP-HP, BPE). Résultats Ce travail a permis de passer d'une base de données de plus de 180 tables à moins de 20 tables. Les alignements de terminologies ont été réalisés par des internes en médecine sur plusieurs milliers de codes de différentes nomenclatures (CCAM, NABM, CSARR, etc.) vers SNOMED-CT. L'ensemble est disponible via la documentation collaborative du SNDS. Des travaux sont menés pour élargir le périmètre temporel (2015-2021). Discussion/Conclusion La standardisation des bases de données de santé assure leur normalisation et interopérabilité, rendant leur exploitation croisée au niveau national et international plus efficace. L'utilisation de modèles de données communs accélère le partage de données, de documentation et de programmes. Plusieurs initiatives européennes sont actuellement en cours telles que l'action conjointe TEHDAS et le pilote EHDS2 mené par le HDH.

Mesurer la qualité d'un parcours de soins d'une maladie chronique dans le Système national des données de santé (SNDS) : exemple de la bronchopneumopathie chronique obstructive (BPCO)

COQUELIN A., ERBAULT M., GUEN N. L., *et al.*

2023

Revue d'Épidémiologie et de Santé Publique 71: 101488.

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Avec 15 millions de personnes atteintes en France, les maladies chroniques constituent un défi pour le système de santé (financement, organisation des soins). La Haute Autorité de santé (HAS) copilote avec la Cnam la définition de parcours de soins et la construction d'indicateurs de mesure de leur qualité. La BPCO est le pilote de ces travaux réalisés avec ARS et DRSM pour le déploiement en région. Méthodes La construction des indicateurs à partir du guide parcours de soins HAS : • Groupe de travail d'experts sans conflit d'intérêt avec le thème traité incluant : professionnels de santé pluri-disciplinaires, représentants d'usagers, producteurs, utilisateurs du SNDS ; • Définition : pertinence cli-

nique et objectifs d'amélioration ; • Conception de l'algorithme et traduction en langage de programmation ; • Production des résultats à partir du SNDS + étapes de contrôle ; • Analyse des résultats avec le GT. Résultats La BPCO est le premier parcours de soins pour lequel ont été développés sept indicateurs de qualité présentant des enjeux de qualité sur l'ensemble du parcours du dépistage au suivi au long cours, en ville comme en établissement de santé. Les mesures nationales et régionales dans le SNDS montrent des marges d'amélioration. Au niveau national les résultats des indicateurs présentent des taux de 20 à 70 % On observe une importante variabilité régionale, différence de 6,5 à 31,5 points selon les indicateurs. Discussion / conclusion Ces indicateurs n'ont pas un objectif épidémiologique mais mesurent la qualité de la prise en charge au sein des parcours, à partir du SNDS. Leur interprétation se fait au regard des organisations territoriales et des limites du SNDS. Une démarche d'amélioration de la qualité du parcours en ville comme en établissement santé nécessite la mise en œuvre d'organisation au niveau territorial, comme dans la région Hauts de France (ARS, DRSM, professionnels et usagers).

Impact of the EURO-PERISTAT Reports on Obstetric Management: A Difference-In-Regression-Discontinuity Analysis

DAALDEROP L. A., BEEN J. V., STEEGERS E. A. P., *et al.*

2023

European Journal of Public Health 33(2): 342-348.

https://doi.org/10.1093/eurpub/ckad013

Population health monitoring, such as perinatal mortality and morbidity rankings published by the European Perinatal Health (EURO-PERISTAT) reports may influence obstetric care providers' decision-making and professional behaviour. We investigated short-term changes in the obstetric management of singleton term deliveries in the Netherlands following publication of the EURO-PERISTAT reports in 2003, 2008 and 2013.We used a quasi-experimental difference-in-regression-discontinuity approach. National perinatal registry data (2001–15) was used to compare obstetric management at delivery in four time windows (1, 2, 3 and 5 months) surrounding publication of each EURO-PERISTAT report. The 2003 EURO-PERISTAT report was associated with higher relative risks (RRs) for an assisted vaginal delivery across all time windows [RR (95% CI): 1 month: 1.23 (1.05–1.45), 2 months: 1.15 (1.02–1.30), 3 months: 1.21 (1.09–1.33) and 5 months: 1.21 (1.11–1.31)]. The 2008 report was associated with lower RRs for an assisted vaginal delivery at the 3- and 5-month time windows [0.86 (0.77–0.96) and 0.88 (0.81–0.96)]. Publication of the 2013 report was associated with higher RRs for a planned caesarean section across all time windows [1 month: 1.23 (1.00–1.52), 2 months: 1.26 (1.09–1.45), 3 months: 1.26 (1.12–1.42) and 5 months: 1.19(1.09–1.31)] and lower RRs for an assisted vaginal delivery at the 2-, 3- and 5-month time windows [0.85 (0.73–0.98), 0.83 (0.74–0.94) and 0.88 (0.80–0.97)].This study showed that quasi-experimental study designs, such as the difference-in-regression-discontinuity approach, are useful to unravel the impact of population health monitoring on decision-making and professional behaviour of healthcare providers. A better understanding of the contribution of health monitoring to the behaviour of healthcare providers can help guide improvements within the (perinatal) healthcare chain.

Comparing the Descriptive Performance of EQ-5D 3L and 5L in the General Population in France

DE POUVOURVILLE G. ET ANDRADE L. F.

2022

Journal de gestion et d'économie de la santé 5-6(5) : 319-337.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2022-5-page-319.htm

Le but de cette étude était d'évaluer la performance descriptive des deux questionnaires EQ-5D, à trois et à cinq niveaux, à partir des données de l'étude de valorisation des états de santé de EQ-5D-5L Méthode : Les questionnaires EQ-5D-5L, EQ-5D-3L et EQ-VAS ont été collectés lors de l'étude de valorisation incluant 1 143 résidents français âgés de 18 ans et plus avec une base de sondage aléatoire stratifiée sur l'âge, le sexe et le statut socio-économique. L'analyse comparative des résultats a comporté la cohérence entre les états de santé 3L et 5L, les redistributions par dimension, le pouvoir discriminatoire avec l'indice de Shannon et l'indice d'uniformité. Les scores EVA collectés aux deux moments des entretiens ont été comparés, les différences analysées en référence aux paires d'états de santé 5L-3L incohérentes. Résultats : La cohérence globale était de 92,3 %. La fréquence globale des niveaux 1 a baissé de 6,8 %. Les changements importants vers des niveaux plus sévères concernaient la douleur et l'inconfort et l'anxiété et la dépression. L'indice de Shannon s'est amélioré de 55 % et l'indice d'uniformité de Shannon de 6 %. Aucun ou peu d'écart

n'a été observé entre l'EVA initiale et finale pour 76,9 % (879/1143) des paires. Conclusion : L'étude a confirmé les résultats des publications similaires : le questionnaire à 5 niveaux offre un meilleur système descriptif que le questionnaire à 3 niveaux. Les réponses aux deux questionnaires étaient très cohérentes. Les limites de notre étude sont le faible taux d'états de santé graves observés dans la population générale.

Performance des bases médico-administratives pour l'identification des individus atteints de sclérose en plaques

DUCATEL P., DEBOUVERIE M., SOUDANT M., *et al.*

2023

Revue d'Épidémiologie et de Santé Publique 71(1): 101572.

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Les bases médico- administratives (BMAs) représentent une alternative aux registres de maladies pour étudier la sclérose en plaques (SEP). Néanmoins, n'ayant pas été conçues initialement pour répondre à des objectifs de recherche, il apparait nécessaire d'évaluer leur performance. En Lorraine, nous disposons du « Registre Lorrain de la Sclérose en plaques » (ReLSEP) qui collecte de manière exhaustive l'ensemble des cas de SEP résidant dans la région. Notre objectif était d'évaluer la performance de la BMA française, comprenant les bases de données de l'Assurance maladie et des départements d'information médicale, pour identifier les patients atteints de SEP, en comparaison avec le ReLSEP. Matériel et méthodes Dans une étude de cohorte en population, nous avons relevé les individus résidant en Lorraine identifiés par le ReLSEP ou la BMA entre le 01/01/2011 et le 31/12/2016 comme atteints de SEP. En prenant le ReLSEP pour référence, les vrai positifs, faux positifs et faux négatifs ont été définis. Le reste de la population lorraine (vrais négatifs) était estimé grâce aux données de l'Institut national de la statistique et des études économiques (Insee). Conclusion Les BMAs, bien qu'utiles pour étudier la SEP, devraient être exploitées avec prudence. Notre étude montre l'avantage des registres régionaux qui permettent une identification plus fiable et plus rapide des cas. Bien que l'extrapolation à des BMAs différentes doive s'effectuer avec précaution, nos résultats sont dignes d'intérêt pour de plus larges applications.

Keeping an Eye on Cost: What Can Eye Tracking Tell Us About Attention to Cost Information in Discrete Choice Experiments?

GENIE M. G., RYAN M. ET KRUCIEN N.

2023

Health Economics (Ahead of pub).

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4658

Concern has been expressed about including a cost attribute within discrete choice experiments (DCEs) when individuals do not have to pay at the point of consumption. We use eye tracking to investigate attention to cost when valuing publicly financed health care. One-hundred and four individuals completed a DCE concerned with preferences for UK general practitioner appointments: 51 responded to a DCE with cost included and 53 to the same DCE without cost. Eye-movements were tracked whilst respondents completed the DCE. We assessed if respondents pay attention to cost. We then compare fixation time (FT) on attributes, eye movement patterns and mental effort across the experimental groups. Results are encouraging for the inclusion of cost in DCEs valuing publicly provided healthcare. Most respondents gave visual attention to the cost attribute most of the time. Average FT on multi-attribute tasks increased by 44% in the cost DCE, with attention to non-monetary attributes increasing by 22%. Including cost led to more structured decision-making and did not increase mental effort. Acceptability of the cost attribute and difficulty of choice tasks were predictors of cost information processing, highlighting the importance of both motivating the cost attribute and considering difficulty of the tasks when developing DCEs.

The Urgent Need For Valid Data on Access to Healthcare in Europe

GUIDI C. F. ET INGLEBY D.

2023

European Journal of Public Health 33(2): 176-178.

https://doi.org/10.1093/eurpub/ckad011

The probability of experiencing an unmet need for medical or dental care can be expressed either (a) as a proportion of the whole population studied or (b) as a proportion of those who had a need. Only (b) yields a valid measure of access to care. Using (a) combines access to care with state of health. Unfortunately, the main data source used by researchers (the European Union Survey of Income and Living Conditions, EU-SILC)

uses method (a), rendering the literature to date subject to unknown errors. The authors argue that there is an urgent need for Eurostat to publish data using method (b).

A Critical Review of Methodologies Used in Pharmaceutical Pricing Policy Analyses

JOOSSE I. R., TORDRUP D., BERO L., *et al.*

2022

Health Policy (Ahead of pub): 104576.

https://doi.org/10.1016/j.healthpol.2022.03.003

Robust evidence from health policy research has the potential to inform policy-making, but studies have suggested that methodological shortcomings are abundant. We aimed to identify common methodological weaknesses in pharmaceutical pricing policy analyses. A systematic review (SR) of studies examining pharmaceutical pricing policies served as basis for the present analysis. We selected all studies that were included in the SR (n = 56), and those that were excluded from the SR due to ineligible study designs only (n = 101). Risk of bias was assessed and specific study design issues were recorded to identify recurrent methodological issues. Sixty-one percent of studies with a study design eligible for the SR presented with a high risk of bias in at least one domain. Potential interference of co-interventions was a source of possible bias in 53% of interrupted time series studies. Failing to consider potential confounders was the primary cause for potential bias in difference-in-differences, regression, and panel data analyses. In 101 studies with a study design not eligible for the SR, 32% were uncontrolled before-after studies and 23% were studies without pre-intervention data. Some of the methodological issues encountered may be resolved during the design of a study. Awareness among researchers on methodological issues will help improve the rigor of health policy research in general.

Decreasing Survey Response Rates in the Time of COVID-19: Implications For Analyses of Population Health and Health Inequities

KRIEGER N., LEBLANC M., WATERMAN P. D., *et al.*

2023

American Journal of Public Health: e1-e4.

https://doi.org/10.2105/AJPH.2023.307267

The objectives of this paper is to examine whether, and if so how, US national and state survey response rates changed after the onset of the COVID-19 pandemic. Methods. We compared the change in response rates between 2020 and 2019 of 6 (3 social and economic, 3 health focused) major US national surveys (2 with state response rates). Results. All the ongoing surveys except 1 reported relative decreases (?29%) in response rates. For example, the household response rate to the US Census American Community Survey decreased from 86.0% in 2019 to 71.2% in 2020, and the response rate of the US National Health Interview Survey decreased from 60.0% to 42.7% from the first to the second quarter of 2020. For all surveys, the greatest decreases in response rates occurred among persons with lower income and lower education. Conclusions. Socially patterned decreases in response rates pose serious challenges and must be addressed explicitly in all studies relying on data obtained since the onset of the pandemic. Public Health Implications. Artifactual reduction of estimates of the magnitude of health inequities attributable to differential response rates could adversely affect efforts to reduce these inequities. (Am J Public Health. Published online ahead of print April 6, 2023:e1?e4. https://doi.org/10.2105/AJPH.2023.307267)

Selecting Qualitative Cases Using Sequence Analysis: A Mixed-Method For In-Depth Understanding of Life Course Trajectories

LE ROUX G., STUDER M., BRINGÉ A., *et al.*

2023

Advances in Life Course Research 56: 100530.

https://doi.org/10.1016/j.alcr.2023.100530

In this paper, we propose a sequence analysis-based method for selecting qualitative cases depending on quantitative results. Inspired by tools developed for cross-sectional analyses, we propose indicators suitable for longitudinal study of the life course in a holistic perspective and a set of corresponding analysis guidelines. Two complementary indicators are introduced, marginality and gain, that allows labeling observations according to both their typicality within their group and their illustrativeness of a given quantitative relationship. These indicators allow selecting a diversity of cases depending on their contributions to a quantitative relationship between trajectories and a covariate or a typology. The computation of the indicators is made available in the TraMineRextras R package. The method and its advantages are illustrated through an original study of the relationships between residential trajectories in the Paris region and residential

socialization during childhood. Using the Biographies et Entourage [Event history and entourage] survey and qualitative interviews conducted with a subsample of respondents, the analysis shows the contributions of the method not only to improve the understanding of statistical associations, but also to identify their limitations. Extension and generalization of the method are finally proposed to cover a wider scope of situations.

Using Machine-Learning Algorithms to Improve Imputation in the Medical Expenditure Panel Survey

MCCLELLAN C., MITCHELL E., ANDERSON J., *et al.*

2023

Health Services Research 58(2): 423-432.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.14115

The aim of this study is to assess the feasibility of applying machine learning (ML) methods to imputation in the Medical Expenditure Panel Survey (MEPS). Data Sources All data come from the 2016–2017 MEPS. Study Design Currently, expenditures for medical encounters in the MEPS are imputed with a predictive mean matching (PMM) algorithm in which a linear regression model is used to predict expenditures for events with (donors) and without (recipients) data. Recipient events and donor events are then matched based on the smallest distance between predicted expenditures, and the donor event's expenditures are used as the recipient event's imputation. We replace linear regression algorithm in the PMM framework with ML methods to predict expenditures. We examine five alternatives to linear regression: Gradient Boosting, Random Forests, Extreme Random Forests, Deep Neural Networks, and a Stacked Ensemble approach. Additionally, we introduce an alternative matching scheme, which matches on a vector of predicted expenditures by sources of payment instead of a single total expenditure prediction to generate potentially superior matches. Data Collection Study data is derived from a large federal survey. Principal Findings ML algorithms perform better at both prediction and matching imputation than Ordinary Least Squares (OLS), the most common prediction algorithm used in PMM. On average, the Stacked Ensemble approach that combines all the ML algorithms performs best, improving expenditure prediction R2 by 108% (0.156 points) and final imputation R2 by 227% (0.397 points). Matching on a prediction vector also improves alignment of sources of payments between donor and recipient events. Conclusions ML algorithms and an alternative matching scheme improve the overall quality of expenditure PMM imputation in the MEPS. These methods may have additional value in other national surveys that currently rely on PMM or similar methods for imputation.

Les parcours de soins de la maladie rénale chronique : apports des nouvelles données de financement au forfait

RAFFRAY M., COUCHOUD C., AUGÉ E., *et al.*

2023

Revue d'Épidémiologie et de Santé Publique 71: 101484.

https://doi.org/10.1016/j.respe.2023.101484

Afin d'améliorer la prise en charge de la maladie rénale chronique (MRC) de stade 4 et 5, une rémunération forfaitaire (forfait MRC) a été mise en place fin 2019 dans les établissements de santé. Ceci a nécessité un nouveau recueil de données. L'objectif était de décrire la file active de patients au niveau national, ses caractéristiques et son évolution entre 2020 et 2022. Méthodes Les données ont été mises à disposition par l'Agence technique de l'information sur l'hospitalisation (ATIH). Les années complètes 2020 et 2021 ainsi que le premier semestre 2022 ont été considérées. Les variables obligatoires du recueil ont été étudiées : caractéristiques démographiques et cliniques des patients et variables d'activité (consultations avec néphrologue, diététicien.ne, infirmier.ère). Résultats Au total, 137 289 patients ont été inclus, avec un âge médian de 75 ans, dont 39,6 % étaient des femmes. Parmi eux, 3,9 % sont sortis du forfait, car décédés. La file active de patients déclarés s'élevait à 72 127 en 2020, avec 46 328 nouveaux patients en 2021 et 18 834 en 2022. Le nombre d'établissements bénéficiaires était de 351 en 2020, 366 en 2021, 268 au premier semestre 2022. En 2021, la file active médiane déclarée par un site géographique était de 189 patients IIQ[69- 325]. La file active comprenait 75 % de patients au stade 4 (25 % stade 5), proportion stable entre les années. En 2021, 93 % des patients avaient bénéficié d'une consultation avec un néphrologue (96 % en 2020), 43 % avec un.e diététicien.ne (44 % en 2020) et 47 % avec infirmier.ère (49 % 2020). Discussion/Conclusion Cette étude offre un premier retour au niveau national d'un nouveau recueil de données de soins dans le cadre d'une nouvelle organisation de l'offre de soins. Un chaînage aux données du SNDS apparait important pour une vision complète du parcours des patients. Des questions demeurent notamment sur la réception et l'utilisation

du forfait au niveau local et la place des médecins généralistes au sein de cette nouvelle organisation. Mots-clés Forfait Maladie Rénale Chronique ; Système d'information ; Epidémiologie ; Parcours de soins Déclaration de liens d'intérêts Les auteurs déclarent ne pas avoir de liens d'intérêts.

Politique de santé

Health Policy

Support For Evidence-Based Alcohol Policy in Ireland: Results From a Representative Household Survey

CALNAN S., MILLAR S. R. ET MONGAN D.

2023

European Journal of Public Health 33(2): 323-330.

https://doi.org/10.1093/eurpub/ckad031

Alcohol use is a leading risk factor for death and disability and there is a need for evidence-based policy measures to tackle excess alcohol consumption and related harms. The aim of this study was to examine attitudes towards alcohol control measures among the general public in the context of significant reforms undertaken in the Irish alcohol policymaking landscape. A representative household survey was conducted among individuals aged 18+ years in Ireland. Descriptive and univariate analyses were used. A total of 1069 participants took part (48% male) and there was broad support (>50%) for evidence-based alcohol policies. Support was strongest for a ban on alcohol advertising near schools and creches (85.1%) and for warning labels (81.9%). Women were more likely than men to support alcohol control policy measures while participants with harmful alcohol use patterns were significantly less likely to support these measures. Respondents with a greater awareness of the health risks of alcohol showed higher levels of support, while those who had experienced harms due to other people's drinking showed lower support compared with those who had not experienced such harms. This study provides evidence of support for alcohol control policies in Ireland. However, notable differences were found in levels of support according to sociodemographic characteristics, alcohol consumption patterns, knowledge of health risks and harms experienced. Further research on reasons behind public support towards alcohol control measures would be worthwhile, given the importance of public opinion in the development of alcohol policy.

Management of the Sars-Cov2 Pandemic in France - Benefit-Risk Balance at the Collective Versus Individual Level Individual Scale in Children

CLAUDET I. ET BRÉHIN C.

2023

Ethique Santé 20(1): 39-46.

According to the precautionary principle and facing the initial uncertainty of the potential seriousness of Covid-19, France has adopted collective measures understood as acceptable despite the deprivation of liberty and the known risks of long confinement on mental health. Such measures should be applied proportionately and cause the least possible harm. Among these, the closure of schools was decided by declination of those appearing in response plans to viral pandemics where children play a major role in the transmission of the disease (e.g. flu). In an unprecedented way, measures and constraints have been taken against the interests of children and to protect a vulnerable group other than the children themselves. From the perspective of children's health, the relationship between health gains from these measures and negative consequences has been unbalanced. The reduction in instruction time has reduced overall academic performance and has had adverse consequences for the socialization and development of children. Confinement has generated more serious domestic accidents, an increase in intra-family violence and marked collateral effects in terms of the mental health of adolescents. Very early on, the various Covid19-related publications showed that children were not the driving force behind this pandemic - If the initial application of collective measures was legitimate, the adaptation of measures at the individual level was out of step with the already known repercussions followed by those observed on the health of the child.

Regulations on Palliative Sedation: An International Survey Across Eight European Countries

GARRALDA E., BUSA C., POZSGAI É., *et al.*

2022

European Journal of Public Health 33(1): 35-41.
https://doi.org/10.1093/eurpub/ckac153

Palliative sedation is a commonly accepted medical practice. This study aims to clarify how palliative sedation is regulated in various countries and whether this may impact its practice. An online survey requesting regulations on palliative sedation was conducted in Belgium, Germany, Hungary, Italy, The Netherlands, Spain, Romania and the UK. Purposive sampling strategy was used to identify clinicians from different medical fields and legal experts for each country. Regulations were analyzed using the principles of the European Association for Palliative Care Framework on palliative sedation. Country reports describing how palliative sedation is regulated were elaborated. One hundred and thirty-nine out of 223 (62%) participants identified 31 laws and other regulations affecting palliative sedation. In Spain, 12 regional laws recognize palliative sedation as a right of the patient at the end of life when there are refractory symptoms. In Italy, the law of informed consent and advance directives specifically recognizes the doctor can use deep sedation when there are refractory symptoms. There are also general medical laws that, while not explicitly referring to palliative sedation, regulate sedation-related principles: the obligation of doctors to honour advance directives, informed consent, the decision-making process and the obligation to document the whole process. In Germany, the Netherlands and the UK, palliative sedation is also regulated through professional guidelines that are binding as good practice with legal significance. Palliative sedation is considered in the general law of medical practice, in laws regarding the patient's autonomy, and through professional guidelines.

Alignment and Authority: Federalism, Social Policy, and COVID-19 Response

GREER S. L., DUBIN K. A., FALKENBACH M., *et al.*

2023

Health Policy 127: 12-18.
https://doi.org/10.1016/j.healthpol.2022.11.007

Effective pandemic response requires alignment of social policy and health policy. Federalism can create misalignment in health and social policy. More automatic and collaborative intergovernmental relations enabled alignment and effective pandemic response.

Le découplage de la GRH comme régulation du secteur sanitaire

MAINHAGU S.

2022

Journal de gestion et d'économie de la santé 5-6(5): 369-397.
https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2022-5-page-369.htm

Grâce à une revue de littérature systématique traitant des pratiques de Gestion des Ressources Humaines (GRH) depuis le début des années 1990 dans le secteur sanitaire, nous montrons la persistance des découplages avec les normes institutionnelles. Contrairement aux affirmations de chercheurs de la Théorie néo-institutionnaliste (TNI), les efforts de traduction ne les ont pas gommés. Les isomorphismes identifiés par la TNI portent davantage sur les décisions des dirigeants que les pratiques. L'application de grappes de pratiques de GRH associées à la logique institutionnaliste valorisant la performance individuelle rencontre l'opposition des professionnels de santé. Cette analyse de l'approche « critique » est contredite en apparence par celle que nous qualifions « d'optimiste » car même si des vertus sont trouvées dans l'application de ces normes, ces auteurs se plaignent du nombre encore trop réduit d'hôpitaux qui s'y conforment. Ainsi, le pouvoir des dirigeants semble limité comme celui des soignants, qui tentent d'imposer la régulation conforme à leur logique institutionnelle médicale. Ni les régulations de contrôle ni les régulations autonomes n'arrivent à s'imposer, restant durablement disjointes, tant les logiques institutionnelles s'opposent, alimentées par des évaluations des effets des normes de GRH sur les conditions de travail divergentes. Nous contribuons sur le plan théorique en considérant le découplage comme une forme de régulation duale qui est mise en tension par les dirigeants dans leur projet d'optimisation des ressources. Nos résultats questionnent au final le bien-fondé du managérialisme du Nouveau Management Public dans un contexte de pénurie de soignants.

Conseil national de la refondation en santé : une opportunité pour renforcer la démocratie en santé et initier une nouvelle gouvernance du système de santé ?

RUSCH E. ET DENIS F.

2022

Santé Publique 34(6): 757-760.

https://www.cairn.info/revue-sante-publique-2022-6-page-757.htm

Changes in the Health Systems and Policy Environment For Maternal and Newborn Health, 2008–2018: An Analysis of Data From 78 Low-Income and Middle-Income Countries

STIERMAN E. K., MALIQI B., MARY M., *et al.*

2023

Social Science & Medicine 321: 115765.

https://doi.org/10.1016/j.socscimed.2023.115765

Background Political, social, economic, and health system determinants play an important role in creating an enabling environment for maternal and newborn health. This study assesses changes in health systems and policy indicators for maternal and newborn health across 78 low- and middle-income countries (LMICs) during 2008–2018, and examines contextual factors associated with policy adoption and systems changes. Methods We compiled historical data from WHO, ILO, and UNICEF surveys and databases to track changes in ten maternal and newborn health systems and policy indicators prioritized for tracking by global partnerships. Logistic regression was used to examine the odds of systems and policy change based on indicators of economic growth, gender equality, and country governance with available data from 2008 to 2018. Results From 2008 to 2018, many LMICs (44/76; 57·9%) substantially strengthened systems and policies for maternal and newborn health. The most frequently adopted policies were national guidelines for kangaroo mother care, national guidelines for use of antenatal corticosteroids, national policies for maternal death notification and review, and the introduction of priority medicines in Essential Medicines Lists. The odds of policy adoption and systems investments were significantly greater in countries that experienced economic growth, had strong female labor participation, and had strong country governance (all $p < 0·05$). Conclusions The widespread adoption of priority policies over the past decade is a notable step in creating an environment supportive for maternal and newborn health, but continued leadership and resources are needed to ensure robust implementation that translates into improved health outcomes.

Rapport 23-05. Planification d'une politique en matière de périnatalité en France : organiser la continuité des soins est une nécessité et une urgence

VILLE Y., RUDIGOZ R. C. ET HASCOËT J. M.

2023

Bulletin de l'Académie Nationale de Médecine (Ahead of pub).

https://doi.org/10.1016/j.banm.2023.03.017

La mortalité néonatale en France n'a pas diminué depuis 20 ans et le dernier plan de périnatalité est arrivé à terme en 2007. Une crise démographique sans précédent touche toutes les professions de la périnatalité. Cette crise contribue à l'accélération des fermetures de maternités, en particulier au sein des établissements de soins privés. La couverture territoriale par les établissements de type 2 et 3, à l'exception de la Corse, est satisfaisante, mais ces établissements sont saturés et offrent des conditions de travail et d'accueil dégradées. Leur attractivité est particulièrement faible pour les sages-femmes et les infirmières, professions où les postes vacants sont nombreux. Les attentes de la population autour de la naissance ne sont satisfaites ni qualitativement ni en termes d'accès aux soins. La situation particulièrement préoccupante des départements et régions d'outre-mer doit faire l'objet d'une analyse qui n'a pas pu être réalisée dans ce rapport. La mise en œuvre d'une politique adaptée en matière de périnatalité devrait s'appuyer sur une réduction accrue du nombre de maternités. Celles-ci devraient être regroupées avec les établissements de type 2 et de type 3 d'un même territoire, dont les contraintes structurelles et de ressources humaines doivent garantir, à la fois, la sécurité et la satisfaction des usagers, tout en offrant des conditions de travail acceptables et pérennes.

Prévention santé

Health Prévention

New Recommendations For Cervical Cancer Screening in France

BARAQUIN A., PÉPIN L., FLOERCHINGER P., *et al.*

2022

Annales pharmaceutiques françaises(81) 2 :202-209

http://europepmc.org/abstract/MED/36150499

https://doi.org/10.1016/j.pharma.2022.09.006

In France, recent advances in cervical cancer screening include an organized cervical cancer-screening program and the introduction of HPV testing as a first-line test for women aged 30-65 years. The HPV test, performed on a cervical smear taken by a health professional, could also be performed on a vaginal self-sample in certain indications. The detection kits used to test for HPV should target high-risk HPV, be validated for screening and meet the performance requirements for this indication. Although no longer used as a first-line test in women aged 30-65 years, cytological examination of cervical cells remains important, particularly in the triage of HPV positive women. The interest of other biological techniques, such as HPV genotyping, viral load, cellular expression of p16/Ki-67 proteins and the methylation of cellular or viral genes, still needs to be clarified, but they could help to refine the triage strategy of HPV-positive women and limit the need for colposcopy and unnecessary stress for patients.

La prescription d'activité physique adaptée chez les adultes atteints de pathologies chroniques par les médecins généralistes, en France et à l'étranger : étude des freins et leviers. Une revue systématique de la littérature

CROQUIN M., GALUDEC P. M., MAGOT L., *et al.*

2023

Science & Sports (Ahead of pub).

https://doi.org/10.1016/j.scispo.2022.07.009

La sédentarité gagne du terrain dans la plupart des pays occidentaux et coûte des milliards d'euros à nos sociétés. La France n'est pas épargnée par cette tendance et a entrepris des actions de grande ampleur pour y remédier, en autorisant notamment les médecins généralistes à prescrire une activité physique adaptée à leurs patients en affection longue durée grâce à la loi de 2016. Cependant, cette possibilité est très peu exploitée par les praticiens. L'objectif principal de cette étude était de déterminer les freins à la prescription d'APA en France et à l'étranger et trouver des leviers pour que cette thérapeutique soit davantage prescrite à l'avenir. Méthodes Une revue systématique de la littérature a été effectuée selon le modèle PRISMA, en interrogeant 6 moteurs de recherche scientifiques et la littérature grise. La recherche a été réalisée entre le 5 et le 24 juin 2021, avec une veille bibliographique jusqu'au 11 février 2022. La sélection des articles s'est faite en double aveugle à l'aide de l'outil informatique Rayyan, en se basant d'abord sur le titre et le résumé, et ensuite sur le texte intégral. Nous recherchions un consensus en cas de désaccord à chaque étape de la sélection. Un total final de 58 articles a servi de base pour ce travail. Résultats Le manque de connaissances et de formation à l'APA, le manque de temps des médecins et des patients, le non- remboursement par la CPAM et la complexité de la prescription sont les freins qui sont le plus ressortis dans notre recherche. Conclusion L'amélioration de la formation des MG, de la communication et de l'information auprès des professionnels et de la population générale, ou encore la simplification de la prescription nous semblent nécessaires. Les questions de la prise en charge de l'APA par la CPAM et de la revalorisation de la consultation dédiée doivent être posées, afin que cette thérapeutique soit plus utilisée. Discipline médecine générale.

Barriers to Cervical Cancer and Breast Cancer Screening Uptake in Low- and Middle-Income Countries: A Systematic Review

SRINATH A., VAN MERODE F., RAO S. V., *et al.*

2022

Health Policy and Planning 38(4): 509-527.

https://doi.org/10.1093/heapol/czac104

There is an alarmingly high growth in breast and cervical cancers in low- and middle-income countries. Due to late presentation to doctors, there is a lower cure rate. The screening programmes in low- and middle-income countries are not comprehensive. In this paper, we systematically analyse the barriers to screening

through an accessibility framework. We performed a systematic literature search in PubMed, Mendeley and Google Scholar to retrieve all English language studies (quantitative, qualitative and mixed-methods) that contained information on breast and cervical cancer screening in low- and middle-income countries. We only considered publications published between 1 January 2016 and 31 May 2021. The review was guided by Preferred Reporting Items for Systematic Reviews and Meta-Analyses literature search extension (PRISMA-S), an extension to the PRISMA Statement for Reporting Literature Searches in Systematic Reviews. The search yielded a total of 67 articles from low- and middle-income countries in this review. We used a framework on accessibility known as the 5A framework, which distinguishes five aspects of access: approachability, acceptability, availability, affordability and appropriateness, to classify the screening barriers. We added two more aspects: awareness and angst, as they could explain other important barriers to screening. They confirmed how the lack of awareness, cost of the screening service and distance to the screening centre act as major impediments to screening. They also revealed how embarrassment and fear of screening and cultural factors such as lack of spousal or family support could be obstacles to screening. We conclude that more needs to be done by policymakers and governments to improve the confidence of the people in the health systems. Women should be made aware of the causes and risk factors of cancer through evidence-based strategies so that there is an increased adherence to screening.

▶ Le Plan européen de lutte contre le cancer : un modèle de stratégie internationale en santé publique

TRILLET-LENOIR V.

2023

Bulletin de l'Académie Nationale de Médecine (Ahead of pub).

https://doi.org/10.1016/j.banm.2023.03.002

Première cause de mortalité dans la plupart des pays européens, le cancer est un défi de santé publique aux multiples déterminants (comportementaux, environnementaux, sociétaux et commerciaux). Ses conséquences sanitaires, mais également financières et sociétales, sont considérables. Le Plan européen de lutte contre le cancer est guidé par le constat d'importantes disparités de santé géographiques et socioéconomiques. Considéré par les institutions européennes comme une priorité, ce programme d'actions poursuit des objectifs ambitieux de réduction de l'incidence et de la mortalité, en faisant de la lutte contre les inégalités un enjeu transversal. Il comporte des propositions d'actions législatives, d'incitations et de recommandations portant sur toutes les étapes de la maladie (prévention, accès aux soins, soutien aux patients) en s'appuyant sur les leviers de la recherche et du partage de connaissance et grâce à des financements diversifiés. Il constitue une étape majeure de la construction de l'Europe de la santé et propose un modèle d'organisation européenne de prise en charge des maladies non transmissibles.

Prévision – Evaluation

Prevision - Evaluation

▶ Évaluer les interventions en santé des populations : les apports de l'évaluation fondée sur la théorie

CAMBON L.

2023

Revue d'Épidémiologie et de Santé Publique 71(2): 101398.

https://doi.org/10.1016/j.respe.2022.08.006

La recherche interventionnelle en santé des populations a été définie comme l'utilisation de méthodes scientifiques pour produire des connaissances sur les interventions, politiques et programmes mis en œuvre dans le secteur de la santé ou en dehors de celui-ci et qui ont le potentiel d'avoir un impact sur la santé au niveau de la population. Ces solutions englobent en réalité une multitude d'interventions possibles de type, d'envergure, de cible et de mise en œuvre différentes, ce qui les rend complexes à appréhender. Cette complexité soulève des questions conceptuelles et méthodologiques majeures car la réalité est que nous n'évaluons jamais une intervention mais des éléments

interventionnels interagissant avec ceux d'un contexte dans lequel ils sont mis en œuvre. Ce sont ces interactions qui produisent des effets. On ne parle alors plus d'intervention mais de système interventionnel défini justement par ces interactions. Pour appréhender ce système, il est alors nécessaire de combiner les paradigmes et les approches en évaluation afin de saisir l'ensemble des ressorts mobilisés. Dans ce cadre, les évaluations fondées sur la théorie constituent une approche intéressante. Cet article se propose de présenter les grands principes de ce type d'évaluation à travers leur capacité à éclairer ce qui se joue dans la rencontre intervention/contexte et donc à proposer des conclusions transférables telles qu'attendues dans le domaine de la recherche en santé des populations.

A Comparison of Synthetic Control Approaches For the Evaluation of Policy Interventions Using Observational Data: Evaluating the Impact of Redesigning Urgent and Emergency Care in Northumberland

CLARKE G. M., STEVENTON A. ET O'NEILL S.

2023

Health Services Research 58(2): 445-457.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.14126

The objective of this paper is to compare the original synthetic control (OSC) method with alternative approaches (Generalized [GSC], Micro [MSC], and Bayesian [BSC] synthetic control methods) and re-evaluate the impact of a significant restructuring of urgent and emergency care in Northeast England, which included the opening of the UK's first purpose-built specialist emergency care hospital. Data Sources Simulations and data from Secondary Uses Service data, a single comprehensive repository for patient-level health care data in England. Study Design Hospital use of individuals exposed and unexposed to the restructuring is compared. We estimate the impact using OSC, MSC, BSC, and GSC applied at the general practice level. We contrast the estimation methods' performance in a Monte Carlo simulation study. Data Collection/Extraction Methods Hospital activity data from Secondary Uses Service for patients aged over 18 years registered at a general practice in England from April 2011 to March 2019. Principal Findings None of the methods dominated all simulation scenarios. GSC was generally preferred. In contrast to an earlier evaluation that used OSC, GSC reported a smaller impact of the opening of the hospital on Accident and Emergency (A&E) department (also known as emergency department or casualty) visits and no evidence for any impact on the proportion of A&E patients seen within 4 h. Conclusions The simulation study highlights cases where the considered methods may lead to biased estimates in health policy evaluations. GSC was found to be the most reliable method of those considered. Considering more disaggregated data over a longer time span and applying GSC indicates that the specialist emergency care hospitals in Northumbria had less impact on A&E visits and waiting times than suggested by the original evaluation which applied OSC to more aggregated data.

Does the Inclusion of Societal Costs Change the Economic Evaluations Recommendations? a Systematic Review For Multiple Sclerosis Disease

RODRÍGUEZ-SÁNCHEZ B., DAUGBJERG S., PEÑA-LONGOBARDO L. M., *et al.*

2023

The European Journal of Health Economics 24(2): 247-277.

https://doi.org/10.1007/s10198-022-01471-9

Multiple sclerosis imposes a heavy burden on the person who suffers from it and on the relatives, due to the caregiving load involved. The objective was to analyse whether the inclusion of social costs in economic evaluations of multiple sclerosis-related interventions changed results and/or conclusions.

Evaluation of the Effects of a Complex Intervention

SAILLOUR-GLÉNISSON F. ET SALMI L. R.

2023

Rev Epidemiol Sante Publique 71(2): 101377.

Appraising the effects of a complex intervention is one step in a more broadly based research process, from the construction or modelling of the intervention to its actual deployment. It consists in measuring the effectiveness or impact of the intervention, i.e. analyzing its capacity to produce change. The aim of this article is to obtain unbiased measurement of the average effects of an intervention, based on a panel of predetermined parameters and on the assumption of a causal link between the intervention and the measured result. This article is consequently devoted to evaluation of the

effects of a complex intervention and focuses on the methodological challenges of its three key stages : 1) modelling of the intervention and feasibility analysis, essential prerequisites ; 2) the choice of study design and of the effects to be measured, that is to say the methodological premises ; and 3) process analysis, carried out in parallel with the evaluation of effects, leading to an indispensable appraisal of the intervention implementation and of the context into which it is integrated. The article is illustrated by five intervention impact assessment projects. A specific objective when evaluating the effects of a complex intervention consists in (a) moving away from a simple search for causality involving the intervention and its effects and (b) toward understanding of the effectiveness mechanisms, once again taking into account the context and the actual conditions of implementation. The challenge is to embrace rather than limit the complexity of the intervention, this being an essential prerequisite for its successful deployment and eventual generalization.

Decision-Making Process and Evaluation of Public Health Interventions

SALMI L. R., NOËL L. ET SAILLOUR-GLÉNISSON F.

2023

Rev Epidemiol Santé Publique 71(2): 101384.

We have designed a methodological framework for experts involved in the support of decision-making in public health interventions. METHODS: The methodological framework consists of four elements: 1) A series of nine questions, formulated in non-technical terms, relevant to assessment of the usefulness of an intervention, at a given time in a given context; 2) Translation of these questions into concepts related to the evaluation of interventions (definition of the intervention, its target and objective, potential and actual effectiveness, safety, efficiency, and equity); 3) Logical organization of the information needed to address and answer the questions; and 4) An algorithm to translate the available information into recommendations on the real usefulness of the intervention in the context in which the questions were raised. RESULTS: Each step is illustrated by questions raised about road safety interventions, screening, blood transfusion and measures proposed during the COVID-19 pandemic. CONCLUSION: Decision-making can be facilitated if experts provide decision-makers with a formal summary of the strengths and weaknesses of existing knowledge, based on an analysis of all facets of an intervention's potential usefulness.

Population Health Intervention Research, Health Technology Assessment, Health Services Research and Intervention Implementation Research: Convergences and Singularities

STEVENS N. ET ALLA F.

2023

Rev Epidemiol Santé Publique 71(2): 101424.

In public health, intervention is an object of research and evaluation which, over time, has given rise to numerous approaches. The first part of the article proposes to reposition intervention research in population health and intervention evaluation on a continuum. Although the former has a more cognitive objective and the latter a more pragmatic objective, they are not mutually exclusive. The distinction between these two practices is based on the predominance of the following characteristics: the objectives pursued, the scope of the investigations, the regulatory constraints, the financing obtained, the ethical approaches taken, and the deliverables established. The second part of the article offers a glance different fields and approaches within the continuum between these two poles: Health Technology Assessment, Health Services Research and Implementation Research. While all of them have the study of health interventions at their core, but each has developed through specialisation in one or the other type of intervention, in a particular scope or context, in certain evaluation questions, or in specific approaches. all as gateways to the study of public health intervention, these different approaches are by no means mutually exclusive.

Recherche interventionnelle en santé des populations, évaluation des technologies de santé, recherche sur les services de santé et recherche sur la mise en œuvre des interventions : convergences et particularités

STEVENS N. ET ALLA F.

2023

Revue d'Épidémiologie et de Santé Publique 71(2): 101424.

https://doi.org/10.1016/j.respe.2023.101424

En santé publique, l'intervention, est un objet de recherche et d'évaluation qui au fil du temps a donné naissance à de nombreuses approches. La première partie de l'article propose de repositionner la recherche interventionnelle en santé des populations

et évaluation des interventions sur un continuum. Si l'on reconnait à la première un objectif plus cognitif et à la seconde un objectif davantage pragmatique, elles ne sont pas pour autant opposables l'une à l'autre. La distinction entre ces deux pratiques relève de la prédominance des caractéristiques en présence concernant : les objectifs poursuivis, la portée des investigations, les contraintes règlementaires, le financement obtenu, les démarches éthiques réalisées et les livrables établis. La seconde partie de l'article balaye différents champs et approches s'inscrivant au sein du continuum établi entre ces deux pôles : Health Technology Assessment, Health Services Research et Implementation Research. Tous ont pour noyau et point commun l'étude des interventions pour la santé mais chacun d'entre eux s'est développé par spécialisation sur l'une ou l'autre nature d'intervention, sur un périmètre ou un contexte d'insertion de l'intervention, sur certaines questions évaluatives ou sur des approches spécifiques. Ces différentes approches sont autant de portes d'entrée sur l'étude de l'intervention de santé publique, non exclusives l'une de l'autre.

Psychiatrie

Psychiatry

▶ Association of Health Literacy with Physical and Mental Health in People with Chronic Diseases

ARSENOVIĆ S., TRAJKOVIĆ G., PEKMEZOVIĆ T., *et al.*

2023

Revue d'Épidémiologie et de Santé Publique 71(1): 101419.

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L'objectif de cet article est d'étudier l'association des domaines de la littératie en santé avec la qualité de vie physique et mentale chez les personnes atteintes de certaines maladies chroniques. Méthodes Les personnes atteintes de maladies chroniques qui vivaient en résidences communautaires et qui devaient être vaccinées contre la grippe en 2017/2018 ont été incluses dans l'étude. Toutes les personnes non vaccinées et un nombre équivalent de personnes vaccinées sélectionnées au hasard et appariées sur la ville de résidence ont été incluses. Les données ont été recueillies au moyen d'un questionnaire sociodémographique, du Health Literacy Questionnaire (HLQ) et du Short Form-36 (SF-36). Les scores composites physiques et mentaux ainsi que leurs domaines ont été calculés. Résultats Au total, 295 personnes ont été recrutées. La régression logistique ajustée a montré que les scores composites physiques et mentaux étaient associés à tous les domaines du HLQ sauf 5) Évaluation des informations sur la santé. Un meilleur fonctionnement physique était associé à des scores plus élevés sur 1) Se sentir compris et soutenu par les professionnels de santé, 6) Capacité à s'engager activement avec les professionnels de santé, 7) Naviguer dans le système de santé et 8) Capacité à trouver les bonnes informations sur la santé. De meilleurs scores sur la vitalité, le fonctionnement social, le rôle émotionnel et la santé mentale étaient associés à des scores plus élevés sur tous les domaines du HLQ sauf 5) Évaluation des informations sur la santé. Conclusions La littératie en santé est importante pour la qualité de vie physique et mentale chez les personnes atteintes de maladies chroniques. Les professionnels de santé et les autres parties prenantes doivent travailler en permanence pour améliorer la littératie en santé de leurs patients.

▶ Évaluation de la participation des usagers et des aidants en santé mentale numérique dans le cadre des projets européens eMEN, IT4anxiety et PATH

BERG J., COSTA M. ET SEBBANE D.

2023

L'information psychiatrique 99(3): 145-155.

https://www.cairn.info/revue-l-information-psychiatrique-2023-3-page-145.htm

Le Centre collaborateur de l'OMS (CCOMS) pour la recherche et la formation en santé mentale de Lille est mandaté par l'OMS pour promouvoir le développement du numérique dans le champ de la santé mentale. Son action porte sur le développement des connaissances relatives à la participation des usagers et des aidants dans le développement de solutions innovantes. L'objectif est de dresser un état des lieux

des modalités d'implication des usagers et des aidants dans le développement des outils numériques en santé mentale. Méthode : il s'agissait d'une étude descriptive observationnelle transversale, conduite auprès de l'ensemble des partenaires européens impliqués dans chacun des projets européens du CCOMS en santé mentale numérique. Conclusion : la participation des usagers et des aidants aux projets relatifs à la santé mentale numérique rencontre les mêmes difficultés que celle concernant la santé mentale plus globalement. La création et la diffusion d'une boîte à outils qui permettrait aux partenaires des projets une meilleure prise en compte de la place des personnes concernées et de leurs proches dans le cadre des projets internationaux en e-santé mentale apparaissent être une piste intéressante.

Refugee Mental Health and the Role of Place in the Global North Countries: A Scoping Review

ERMANSONS G., KIENZLER H., ASIF Z., *et al.*

2023

Health & Place 79: 102964.

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Post-migration factors significantly influence refugee mental health. This scoping review looks at the role of place in refugee mental health. We included 34 studies in Global North high-income countries that elaborated on the place characteristics of facilities, neighbourhoods, urban and rural areas, and countries. While the role of place remains under-theorised, all studies reveal common characteristics that support a strong relationship between place of residence, refugee mental health and wellbeing outcomes in post-migration context. Given that refugees often have little or no choice of where they ultimately live, we suggest future research should focus on how characteristics of place co-constitute post-migration refugee mental health risks, protections, and outcomes.

Promouvoir la santé mentale des personnes âgées avec des incapacités physiques : revue systématique des interventions proposées à domicile et en établissement

MEYNET S., BEAUDOIN M. ET SMEDIG A.

2022

Recherche en soins infirmiers 151(4): 18-29.

https://www.cairn.info/revue-recherche-en-soins-infirmiers-2022-4-page-18.htm

La promotion de la santé mentale des personnes âgées et fragiles est une priorité de santé publique. Contexte : la majorité des interventions ciblant la santé mentale des personnes âgées ne sont pas toujours adaptées à une population qui présente plusieurs incapacités physiques. Objectifs : cet article souhaite fournir aux professionnels de la gérontologie un aperçu des interventions adaptées à leur lieu d'exercice (domicile ou établissement de longs séjours) et aux caractéristiques de leurs usagers (plus de 75 ans avec des incapacités physiques). Méthode : un examen systématique de la littérature a été effectué dans les bases de données PsycInfo, PubMed et Cochrane, entre 2001 et 2022. Toutes les interventions ciblant la santé mentale ont été incluses, quelle que soit leur méthodologie de recherche. Résultats : au total, 18 études ont été retenues pour cette revue systématique. Les limites méthodologiques de ces études viennent impacter négativement les possibilités de conclusion et de généralisation des résultats de la présente revue. Toutefois, les interventions sociales et de soutien psychologique semblent prometteuses. Discussion : un accompagnement personnalisé semble représenter un facteur important pour garantir le succès d'une intervention à domicile comme en établissement de longs séjours. Conclusion : d'autres études restent nécessaires pour fournir des preuves d'efficacité.

A New Case-Mix Based Payment System For the Psychiatric Day Care Sector in Switzerland: Proposed Methods For Developing the Tariff Structure

NOLL S., HAAG S., GUIDON R., *et al.*

2023

Health Policy 131: 104797.

https://doi.org/10.1016/j.healthpol.2023.104797

In many European countries, there has been a shift towards outpatient psychiatric care over the past decades, as it is more cost-effective and resources for health care are limited. Switzerland, however, still has a high number of inpatient psychiatric hospital beds and a comparatively high length of stay. The existence of differing remuneration systems between inpatient and outpatient settings creates a distortion of incentives regarding the choice of treatment setting and an inefficient allocation of resources. To address this issue, a new tariff structure for day care treatment is suggested, based on the development and evaluation

of the DRG-based inpatient remuneration system tariff psychiatry (TARPSY), using inpatient data from 2018, 2019, and 2021. The method involves three steps: estimating the day care treatment setting potential by delimiting cases from the inpatient patient data, adjusting the costs of this subset to approximate a day care treatment setting, and calculating daily cost weights based on the existing cost weights. The resulting reimbursements are about half of the inpatient reimbursements. To implement the tariff structure, this paper suggests that a number of framework conditions and regulations must be defined or modified. Additionally, subsequent cost data surveys from the day care setting can be incorporated into the calculation as part of a learning system. The remuneration system outlined in this paper could potentially be applied for day care psychiatry in other countries with DRG systems, especially in countries with conflicting remuneration systems in the inpatient and outpatient sector.

Efficacité et tolérance de l'électroconvulsivothérapie en psychiatrie, une mise au point

SAUVAGET A., BULTEAU S., GAILLARD R., *et al.*

2023

Bulletin de l'Académie Nationale de Médecine 207(4): 441-449.

https://doi.org/10.1016/j.banm.2023.02.005

L'électroconvulsivothérapie (ECT) est une technique de neuromodulation cérébrale utilisée en psychiatrie depuis plus de 80 ans. Sa pratique a considérablement évolué sur le plan technique et réglementaire. L'ECT se réalise au moyen d'un dispositif médical qui dispense, sous anesthésie générale de quelques minutes, un stimulus électrique, au niveau cérébral. Avec ses propriétés curatives et préventives, en situation d'urgence et à des stades résistants des troubles, l'ECT a deux indications principales : les troubles de l'humeur et les troubles du spectre de la schizophrénie. Ses effets indésirables de type mnésique doivent être pondérés au regard de ses effets procognitifs positifs, notamment sur les fonctions exécutives. L'ECT est une thérapeutique de choix pour la dépression très sévère du sujet âgé. Sa pratique au sein d'unités de neuromodulation en psychiatrie est une nécessité afin de pouvoir l'intégrer totalement dans l'offre de soins en psychiatrie.

Psychological Caring Climate at Work, Mental Health, Well-Being, and Work-Related Outcomes: Evidence From a Longitudinal Study and Health Insurance Data

WEZIAK-BIALOWOLSKA D., LEE M. T., COWDEN R. G., *et al.*

2023

Social Science & Medicine 323: 115841.

https://doi.org/10.1016/j.socscimed.2023.115841

Psychological climate for caring (PCC) is a psychosocial factor associated with individual work outcomes and employee well-being. Evidence on the impacts of various psychological climates at work is based mostly on self-reported health measures and cross-sectional data. We provide longitudinal evidence on the associations of PCC with subsequent diagnosed depression and anxiety, subjective well-being, and self-reported work outcomes. Employees of a US organization with a worker well-being program provided data for the analysis. Longitudinal survey data merged with data from personnel files and health insurance claims records comprising medical information on diagnosis of depression and anxiety were used to regress each outcome on PCC at baseline, adjusting for prior values of all outcomes and other covariates. PCC was found to be associated with lower odds of subsequent diagnosed depression, an increase in overall well-being, mental health, physical health, social connectedness, and financial security, as well as a decrease in distraction at work, an increase in productivity/engagement and possibly in job satisfaction. There was little evidence of associations between PCC and subsequent diagnosed anxiety, character strengths, and work-family conflict. Work policies focused on improving PCC may create a promising pathway to promoting employee health and well-being as well as improving work-related outcomes.

Medicaid Reimbursement For Psychiatric Services: Comparisons Across States and with Medicare

ZHU J. M., RENFRO S., WATSON K., *et al.*

2023

Health Affairs 42(4): 556-565.

https://doi.org/10.1377/hlthaff.2022.00805

Medicaid is characterized by low rates of provider participation, often attributed to reimbursement rates below those of commercial insurance or Medicare.

Understanding the extent to which Medicaid reimbursement for mental health services varies across states may help illuminate one lever for increasing Medicaid participation among psychiatrists. We used publicly available Medicaid fee-for-service schedules from state Medicaid agency websites in 2022 to construct two indices for a common set of mental health services provided by psychiatrists: a Medicaid-to-Medicare index to benchmark each state's Medicaid reimbursement with that of Medicare for the same set of services, and a state-to-national Medicaid index comparing each state's Medicaid reimbursement with an enrollment-weighted national average. On average, Medicaid paid psychiatrists at 81.0 percent of Medicare rates, and a majority of states had a Medicaid-to-Medicare index that was less than 1.0 (median, 0.76). State-to-national Medicaid indices for psychiatrists? mental health services ranged from 0.46 (Pennsylvania) to 2.34 (Nebraska) but did not correlate with the supply of Medicaid-participating psychiatrists. As policy makers look to reimbursement rates as one strategy to address ongoing mental health workforce shortages, comparing Medicaid payment across states may help benchmark ongoing state and federal proposals.

Sociologie

Sociology

▶ Le discours du soignant sur la relation de soin, vers un impact positif ? Une revue de la littérature

CRAQUELIN M., DELFOSSE C., IDOUX J., *et al.*

2023

Éthique & Santé 20(1): 30-38.

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La relation soigné-soignant anime la réflexion éthique depuis toujours et d'autant plus depuis la promulgation de la loi Kouchner, au regard de son implication majeure dans la qualité de la prise en charge délivrée aux patients. La place que tient le discours du soignant, élément fondateur de cette relation, questionne toujours depuis plus de 20 ans. Matériel et méthode Une revue de la littérature a été menée sur les dix dernières années afin de mettre en évidence l'impact du discours des soignants chez les patients, notamment en termes de vécu de la maladie et d'engagement dans la démarche thérapeutique. Résultats Sur les 1292 articles, 15 ont été inclus dans la revue. Ces derniers ont permis de souligner des attitudes de soin très variées allant d'une relation autoritaire souvent associée à un manque d'informations fournies aux patients, à la coopération thérapeutique. Conclusion Cette synthèse souligne que certains comportements paternalistes sont contre-productifs. À l'inverse une approche centrée sur le patient contribue à développer l'alliance thérapeutique et à favoriser l'empowerment chez ces derniers. Le discours du soignant apparaît ainsi comme un levier indispensable pour promouvoir la santé des patients.

Soins de santé primaires

Primary Health Care

The Local Roots of 'Health For All': Primary Health Care in Practices, 1950s–2000s

BEAUDEVIN C., GAUDILLIÈRE J.-P. ET GRADMANN C.
2023
Social Science & Medicine 319: 115321.
https://doi.org/10.1016/j.socscimed.2022.115321

We look at Universal Health Coverage (UHC) through a historical investigation of the "health for all by 2000" policy adopted by the WHO in 1978. Within contemporary debates on access to care, Alma Ata is usually considered as a brief moment of well-intentioned utopia, which buckled to global health's agenda of performance metrics and targeted diseases. Such visions of primary health care (PHC) are shared references in the debates about UHC. Aiming at a less geopolitical and more local approach of the strategy's roots than the existing historiography, the paper draws from historical and ethnographic work on health policies and practices in Tanzania, Oman and Kerala (India), in which PHC was not only envisioned, but constructed as the backbone of local health systems, often prior to Alma Ata. All three states were praised for their PHC achievements. Studying them allows for emphasizing the importance of national trajectories in PHC, as well as revealing shared core issues such as the importance of access and affordability, of the focus on rural centers and the mass training of non-medical personnel, and of the articulation of vertical programs and horizontal system building. It also reveals very different trajectories in terms of duration, priorities, outcomes and international visibility.

General Practice in the EU: Countries You See, Customs You Find

GARATTINI L., BADINELLA MARTINI M. ET NOBILI A.
2023
The European Journal of Health Economics 24(2): 153-156.
https://doi.org/10.1007/s10198-022-01549-4

General Practice (GP) is acknowledged as a medical specialisation with specific skills and tasks. In parallel, the pivotal role played by General Practitioners (GPs) within primary care has been historically consolidated [1]. However, over the last few years, primary care in Europe has been undergoing continuous changes in response to the increasing multi-morbidity and (both medical and social) complexity of patients, whilst funding constraints have been strengthened following the economic crisis. This has necessarily affected the role of GPs, which now urgently needs a change as radical as it is necessary to be abreast with the times [2]. Therefore, the specialty training programme in GP and the role of GPs in healthcare systems appear to be two crucial issues to deal with in the European health landscape. Despite the growing importance of these topics, the health literature on them in the main European countries is currently scarce [3]. Here we try to compare the basic features of the post-graduate GP specialty training programmes and the roles of GPs in the health systems of the four main countries in the European Union (EU), two with Bismarckian health systems (France and Germany) and two with Beveridgian health services (Italy and Spain). Finally, we depict a potential scenario for primary care in the EU.

Access to Outpatient Care in Manhattan and Paris: A Tale of Real Change in Two World Cities

GUSMANO M. K., WEISZ D., MERCIER G., *et al.*
2023
Health Policy 132: 104822.
https://doi.org/10.1016/j.healthpol.2023.104822

France's system of universal health insurance (UHI) offers more equitable access to outpatient care than the patchwork system in the U.S., which does not have a UHI system. We investigate the degree to which the implementation of the Patient Protection and Affordable Care Act (ACA) has narrowed the gap in access to outpatient care between France and the U.S. To do so, we update a previous comparison of access to outpatient care in Manhattan and Paris as measured by age-adjusted rates of hospital discharge for avoidable hospital conditions (AHCs). We compare these rates immediately before and after the implementation of the ACA in 2014. We find that AHC rates in Manhattan declined by about 25% and are now lower than those in Paris. Despite evidence that access to outpatient care in Manhattan has improved, Manhattanites continue to

experience greater residence-based neighborhood inequalities in AHC rates than Parisians. In Paris, there was a 3% increase in AHC rates and neighborhood-level inequalities increased significantly. Our analysis highlights the persistence of access barriers to outpatient care in Manhattan, particularly among racial and ethnic minorities, even following the expansion of health insurance coverage.

Physician Workforce Planning in Canada: The Importance of Accounting For Population Aging and Changing Physician Hours of Work

ISLAM R., KRALJ B. ET SWEETMAN A.

2023

Canadian Medical Association Journal 195(9): E335-E340.

https://www.cmaj.ca/content/cmaj/195/9/E335.full.pdf

Canada has long struggled to maintain an appropriately sized physician workforce. The recruitment of foreign-trained physicians over recent decades and, starting in the mid-2000s, increased domestic enrollments in medical schools has led to Canada currently having an historically high physician-to-population ratio. However, concerns about physician shortages and burnout, as well as limited access to physician care continue. Previous analyses of physician supply and demand have not adjusted for both population aging and evolving physician hours of work, despite discussions of these factors being quantitatively important. To provide insights into the aforementioned challenges — and to inform the profession, the public and governments in planning regarding the appropriate number of new physicians who should enter practice — we analyzed data from 1987 to 2020 to quantify increasing demand because of an aging population and changing service supply given declining physician self-reported hours of work.

Analyse de l'efficience des médecins généralistes coopérant avec des infirmières : l'expérimentation Asalée

LOUSSOUARN C.

2022

Journal de gestion et d'économie de la santé 5-6(5): 338-368.

https://www.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2022-5-page-338.htm

En France, la coopération entre les professionnels de santé exerçant dans les soins de premier recours peut servir de réponse face aux enjeux de l'inégale répartition géographique des médecins et de l'amélioration de la qualité et de la pertinence de la prise en charge des patients. Depuis 2004, Asalée, une expérimentation de coopération, offre aux infirmiers la possibilité d'effectuer certaines tâches substituables ou complémentaires à celles des médecins généralistes. Cet article évalue l'impact de cette expérimentation sur l'efficience technique de 1 152 médecins généralistes sur la période 2010- 2017 à partir de données d'activité et de pratique professionnelle du Système National des Données de Santé (SNDS). L'analyse stochastique des frontières de production dans un cadre multi- output, après un appariement entre un échantillon de 361 médecins généralistes participant à l'expérimentation et un groupe témoin de 791 médecins généralistes n'y participant pas, montre qu'il existe des différences initiales en faveur des futurs entrants dans l'expérimentation qui se maintiennent dans le temps, l'expérimentation n'améliorant pas significativement l'efficience technique des cas relativement aux témoins (68,70 % contre 66,50 % en moyenne pour le score d'efficience sur l'ensemble de la période). L'absence d'effet de l'expérimentation sur le score d'efficience technique pourrait être liée au nombre réduit d'actes pouvant être délégués à l'infirmière.

Work Like a Doc: A Comparison of Regulations on Residents' Working Hours in 14 High-Income Countries

MAOZ BREUER R., WAITZBERG R., BREUER A., *et al.*

2023

Health Policy 130: 104753.

https://doi.org/10.1016/j.healthpol.2023.104753

Medical residents work long, continuous hours. Working in conditions of extreme fatigue has adverse effects on the quality and safety of care, and on residents' quality of life. Many countries have attempted to regulate residents' work hours. Objectives We aimed to review residents' work hours regulations in different countries with an emphasis on night shifts. Methods Standardized qualitative data on residents' working hours were collected with the assistance of experts from 14 high-income countries through a questionnaire. An international comparative analysis was performed. Results All countries reviewed limit the weekly working hours; North-American countries limit to 60–80 h, European countries limit to 48 h. In

most countries, residents work 24 or 26 consecutive hours, but the number of long overnight shifts varies, ranging from two to ten. Many European countries face difficulties in complying with the weekly hour limit and allow opt-out contracts to exceed it. Conclusions In the countries analyzed, residents still work long hours. Attempts to limit the shift length or the weekly working hours resulted in modest improvements in residents' quality of life with mixed effects on quality of care and residents' education.

Occupational Role and Covid-19 Among Foreign-Born Healthcare Workers in Sweden: A Registry-Based Study

NWARU C., LI H., BONANDER C., *et al.*

2023

European Journal of Public Health 33(2): 202-208.

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Many studies report that foreign-born healthcare workers (HCWs) in high-income countries have an elevated risk of Covid-19. However, research has not yet specifically evaluated the distribution of Covid-19 among foreign-born workers in different healthcare work groups. We examined the risk of Covid-19 infection and hospitalization among foreign-born HCWs in different occupational roles in Sweden. We linked occupational data (2019) of 783950 employed foreign-born workers (20–65 years) to Covid-19 data registered between 1 January 2020 and 30 September 2021. We used Cox proportional hazards regression to estimate the hazard ratio (HR) with 95% confidence intervals (95% CIs) of Covid -19 infection and hospitalization in eight healthcare occupational groups vs. non-HCWs and assessed whether region of birth modified the association between healthcare occupations and Covid -19.All HCWs had a higher risk of COVID-19 outcomes than non-HCWs, but the risk differed by occupational role. Hospital-based assistant nurses had the highest risk (infection: HR 1.78; 95% CI 1.72–1.85; hospitalization: HR 1.79; 95% CI 1.52–2.11); allied HCWs had the lowest risk (infection: HR 1.22; 95% CI 1.10–1.35; hospitalization: HR 0.98; 95% CI 0.59–1.63). The relative hazard of the outcomes varied across foreign-born workers from different regions. For example, the relative risk of Covid-19 infection associated with being a physician compared to a non-HCW was 31% higher for African-born than European-born workers. The risk of CovidOVID-19 among foreign-born HCWs differed by occupational role and immigrant background. Public health efforts that target occupational exposures as well as incorporate culturally responsive measures may help reduce COVID-19 risk among foreign-born HCWs.

Equity in the Use of Physician Services in Canada's Universal Health System: A Longitudinal Analysis of Older Adults

PULOK M. H. ET HAJIZADEH M.

2022

Social Science & Medicine 307: 115186.

https://doi.org/10.1016/j.socscimed.2022.115186

This study presents longitudinal evidence on the trends and determinants of income-related inequities in general practitioner (GP), specialist, and any physician visits among older adults (aged 65+) in Canada. Using the Canadian National Population Health Survey between 1998/99 and 2010/11, random effect probit and negative binomial models were employed to model the probability of visit and the total number of visits, respectively. The concentration index-based horizontal inequity (HI) approach was used to measure income-related inequities in physician services. The decomposition technique was applied to explain the factors contributing to the observed inequities. The mobility index (MI) was also calculated to compare short-run and long-run estimates of inequities. The HI indices reveal significant pro-rich inequities in both the probability and the number of specialist visits. Inequities in the likelihood of GP visits and any physician visits were pro-rich but trivial in magnitude. The MI shows that upwardly income mobile individuals contribute to inequity in specialist visits in the long run. After income, education was the most important contributor to inequity in specialist visits, while unobserved heterogeneity explained most of the pro-rich inequity in the total number of GP and any physician visits. Although physician services are free at the point of the provision in Canada, this study demonstrates that poorer older adults utilized fewer specialist services than richer older adults for the same level of need. Specific policies are needed to ensure equity in specialist care use among the older adults in Canada.

Patient Factors Associated with Use of Adult Primary Care and Virtual Visits During the Covid-19 Pandemic

RITZWOLLER D. P., GOODRICH G. W., TAVEL H. M., *et al.*

2023

Medical Care 61: S12-S20.
https://doi.org/10.1097/mlr.0000000000001792

The delivery of adult primary care (APC) shifted from predominately in-person to modes of virtual care during the Covid-19 pandemic. It is unclear how these shifts impacted the likelihood of APC use during the pandemic, or how patient characteristics may be associated with the use of virtual care. Methods: A retrospective cohort study using person-month level datasets from 3 geographically disparate integrated health care systems was conducted for the observation period of January 1, 2020, through June 30, 2021. We estimated a 2-stage model, first adjusting for patient-level sociodemographic, clinical, and cost-sharing factors, using generalized estimating equations with a logit distribution, along with a second-stage multinomial generalized estimating equations model that included an inverse propensity score treatment weight to adjust for the likelihood of APC use. Factors associated with APC use and virtual care use were separately assessed for the 3 sites. Results: Included in the first-stage models were datasets with total person-months of 7,055,549, 11,014,430, and 4,176,934, respectively. Older age, female sex, greater comorbidity, and Black race and Hispanic ethnicity were associated with higher likelihood of any APC use in any month; measures of greater patient cost-sharing were associated with a lower likelihood. Conditional on APC use, older age, and adults identifying as Black, Asian, or Hispanic were less likely to use virtual care. Conclusions: As the transition in health care continues to evolve, our findings suggest that to ensure vulnerable patient groups receive high quality health care, outreach interventions to reduce barriers to virtual care use may be warranted.

Former plus de médecins pour demain ?

TOUZÉ E., BOCOGNANO A. ET BOURGUEIL Y.

2023

Les Tribunes de la santé 75(1): 71-89.
https://www.cairn.info/revue-les-tribunes-de-la-sante-2023-1-page-71.htm

La question du nombre de médecins à former est en France, comme dans de nombreux pays, au premier plan dans le débat public à l'heure où la notion de numerus clausus a disparu et où de nombreuses voix alertent les inégalités territoriales responsables de « déserts médicaux ». La régulation purement quantitative de la démographie médicale par le numerus clausus, durant plus de quarante ans, a échoué à obtenir un niveau d'équilibre entre l'offre et les besoins. Le nombre idéal de médecins qui permet l'accès de tous, sur tout le territoire, à des soins de qualité dépend de la démographie de la population, de la démographie médicale, mais aussi de la démographie des autres professionnels de santé, et de nombreux facteurs épidémiologiques, techniques, économiques et organisationnels, qui sont par essence instables dans le temps et propres à chaque population et système de santé. Avec la suppression du numerus clausus et l'instauration d'une programmation pluriannuelle du besoin en médecins, la réforme issue de la loi de 2019 relative à l'organisation et à la transformation du système de santé replace le processus de régulation dans le temps long. L'approche par objectifs nationaux pluriannuels a ainsi marqué un pas dans la réflexion. Les travaux préparatoires à la conférence nationale tenue en mars 2021 ont conclu à la nécessité de continuer à augmenter le nombre de médecins en formation, ce qui a été acté par les ministres en charge de la Santé et de l'Enseignement supérieur qui ont arrêté des objectifs pluriannuels de formation en augmentation de près de 20 %. Mais pour répondre à l'ambition de rapprocher les besoins en professionnels de santé des besoins de soins, il faut aller encore plus loin dans la prise en compte des déterminants du besoin en ressources humaines. Tirant leçon du passé, cet article propose des voies nouvelles pour sortir de l'unique question du nombre de médecins à former, prendre en compte davantage l'organisation du système de santé et mieux approcher la réponse aux besoins territoriaux de soins.

Examining the Influence of Physician Assistant/Associate Scope of Practice Reforms and Individual Characteristics on Wages

WHITE R. D.

2023

Medical Care Research and Review (Ahead of pub): 10775587231165351.

https://doi.org/10.1177/10775587231165351

High labor demand for physician assistants/associates (PA) has led to substantial PA workforce and wage growth. During this growth period, states have adopted reforms to reduce PA scope of practice restrictions and reports of significant gender and race wage disparities have emerged. This study examined data from the American Community Survey to investigate the influence of demographic characteristics, human capital, and scope of practice reforms on PA wages from 2008 to 2017. Using an ordinary least squares two-way fixed effects estimator, a significant association between reforms and PA wages could not be established. Rather, wages were found to be strongly associated with human capital and demographic characteristics. Gender and race wage disparities persist, with female PAs earning 7.5% lower wages than male PAs and White PAs earning 9.1% to 14.5% higher wages than racial and ethnic minority PAs. These findings suggest a minimal influence of prior scope of practice reforms on PA wages.

Community Pharmacists Are Also First Aid Actors. Results of the Survey on Unscheduled Care in Pharmacies in the Grand Est Region

WILCKE C., PARENTY L., ZAMOLO H., *et al.*

2023

Annales pharmaceutiques françaises 81(2): 380-388.

According to the Public Healthcare Code, contributing to primary care is one of the pharmacist's key missions. Accessibility without appointment and the territorial network of pharmacies make the pharmacist an essential player in the management of unscheduled care, which remains an important gateway for users into the primary care system. This type of requests, daily in pharmacies, has not been yet the subject of a qualitative or quantitative evaluation. The Grand- Est Region, regrouping nearly 8 % of French pharmacies, wanted to conduct a specific survey to quantify and assess the unscheduled care requests addressed to pharmacists on its territory.
Methods: The survey by URPS Pharmacists and ARS Grand- Est was conducted by Tous Pour la Santé over a period of 12months from November 2020 to November 2021. Participation in the study was on a voluntary basis. The main objective of this study was to define the typology of unscheduled care requests addressed to the Region pharmacies and to characterize the responses provided.
Results: One hundred and eighty- nine pharmacies (nearly 12 % of Grand Est pharmacies, the participation rate could certainly have been higher if the study had not been conducted during the Covid- 19 pandemic), representing 11,010 unscheduled care requests, took part in the survey. Despite the profession's massive desire to get involved in handling unscheduled care requests, the survey revealed a lack of specific training for pharmacists on this subject and an all- too- rare update from the AFGSU. User requests concern both daily healthcare needs and more specific chronic patients' needs. They evolve according to the profile of the applicant, the seasons, the days of the week and the type of pharmacy concerned. All ages are represented, including young adults. The average duration of care by the pharmacy team was 8minutes per request, even though in 20 % of cases this did not lead to any delivery of product and in 11 % of cases to no remuneration for the pharmacist.

Conclusion: This survey confirmed the role of the pharmacist in responding to unscheduled care requests as a first- line actor and referral agent in the health system. The implementation of shared multiprofessional protocols, including first and foremost general practionners, and the recognition of the contribution of pharmacy teams would allow to define a framework to optimize the patient's journey through the healthcare system.

Systèmes de santé

Health Systems

« L'ubérisation de notre système de santé, c'est le risque d'une véritable médecine à deux vitesses »

2023

Les Tribunes de la santé 75(1): 91-95.

https://www.cairn.info/revue-les-tribunes-de-la-sante-2023-1-page-91.htm

Urgentiste bien connu du grand public en raison d'une présence régulière sur les plateaux de télévision, Patrick Pelloux est un observateur critique de notre système de santé. Il porte sur ce système un regard sans concession tant pour le politique que pour nombre de ses confrères. Il a accordé aux Tribunes de la santé un entretien recueilli le 17 février 2023.Les Tribunes de la santé :Au Royaume-Uni, en Espagne, en France, et dans de nombreux autres pays, les systèmes de santé sont en crise, l'accès aux soins devient de plus en plus difficile, les vocations s'épuisent. Quel regard portez-vous sur ces crises profondes ? Cet article rapporte les échanges de cet entretien.

Does Devolution Influence the Choice and Quality of Public (Vs Private) Health Care?

COSTA-FONT J. ET FERRER-I-CARBONELL A.

2022

Journal of Economic Behavior & Organization 202: 632-653.

https://doi.org/10.1016/j.jebo.2022.08.022

Government decentralisation also called 'government devolution' (GD) can provide an alternative to the 'build in' accountability mechanism of markets by influencing both the choice as well as the perceived quality of public versus private health care. To test this hypothesis, this paper exploits the gradual decentralisation of the political stewardship of the Spanish National Health System (NHS) using a difference-in-differences design. We find that GD (abandoning centralised governance) increases the choice and quality of (measured by the preference for, perceptions of, and satisfaction with) public health care (NHS) compared to private health care. Consistently, we also find that the GD reduces the uptake of private health insurance among higher income and education groups. These effects are mainly driven by improvements in health care quality as well as policy innovation and diffusion.

Le système de santé espagnol : source d'inspiration pour la France

COURGEON T. ET MOINET A.

2023

Gestions Hospitalières(623): 79-81.

Le système national de santé espagnol, dans sa version contemporaine, est issu de la loi générale de santé de 1986. Celle-ci institue une prise en charge décentralisée, publique, universelle et gratuite des citoyens espagnols, qui repose donc presque exclusivement sur les 17 communautés autonomes du pays. Au sein de chacune de ces communautés, les centres de santé et les centres hospitaliers constituent les deux pierres angulaires de l'offre publique de soins. À la suite de leur stage extérieur – l'un à l'hôpital de La Paz, à Madrid, l'autre au ministère de la Santé espagnol – effectué dans le cadre de leur cursus d'élèves directeurs d'hôpital à l'Ehesp, les auteurs livrent ici quelques réflexions nées de leur expérience madrilène.

Lier parcours de vie et trajectoires de services pour améliorer la qualité des systèmes de santé

COUTURIER Y., MARTIN J. ET GUILLETTE M.

2022

Vie sociale 40(4): 173-182.

https://www.cairn.info/revue-vie-sociale-2022-4-page-173.htm

Un peu partout dans le monde, les efforts sont nombreux pour augmenter l'efficacité de l'organisation des systèmes de santé. Dans cette perspective, les appels à la collaboration interprofessionnelle et intersectorielle se multiplient et génèrent un grand nombre d'innovations visant à mieux prendre en considération les trajectoires de soins. L'article présente dans un premier temps des principes généraux qui orientent les efforts d'innovation en matière d'actualisation des systèmes de santé. Puis il expose les potentiels d'amélioration des services de santé qu'une telle perspective contient en les concevant sous l'angle des parcours de vie. Enfin, il conclut sur quelques pistes d'action afin

de lier parcours de vie et trajectoires de services en fonction d'une philosophie organisationnelle ancrant les services de santé dans une approche véritablement singularisante des soins.

Can Covid-19 Response Inform Future Health System Reforms? Lessons Learned From Finland

KARREINEN S., RAUTIAINEN P., KESKIMÄKI I., *et al.*

2023

Health Policy (Ahead of pub): 104802.

https://doi.org/10.1016/j.healthpol.2023.104802

The COVID-19 pandemic has plagued health systems in an unprecedented way and challenged the traditional ways to respond to epidemics. It has also revealed several vulnerabilities in countries' health systems and preparedness. In this paper we take the Finnish health system as an example to analyse how pre-Covid-19 preparedness plans, regulations, and health system governance were challenged by the pandemic and what lessons can be learned for the future. Our analysis draws on policy documents, grey literature, published research, and the Covid-19 Health System Response Monitor. The analysis shows how major public health crises often reveal weaknesses in health systems, also in countries which have been ranked highly in terms of crisis preparedness. In Finland, there were apparent regulative and structural problems which challenged the health system response, but in terms of epidemic control, the results appear to be relatively good. The pandemic may have long-term effects on the health system functioning and governance. In January 2023, an extensive health and social services reform has taken place in Finland. The new health system structure needs to be adjusted to take on board the legacy of the pandemic and a new regulatory frame for health security should be considered.

Analysing the Efficiency of Health Systems: A Systematic Review of the Literature

MBAU R., MUSIEGA A., NYAWIRA L., *et al.*

2023

Applied Health Economics and Health Policy 21(2): 205-224.

https://doi.org/10.1007/s40258-022-00785-2

Efficiency refers the use of resources in ways that optimise desired outcomes. Health system efficiency is a priority concern for policy makers globally as countries aim to achieve universal health coverage, and face the additional challenge of an aging population. Efficiency analysis in the health sector has typically focused on the efficiency of healthcare facilities (hospitals, primary healthcare facilities), with few studies focusing on system level (national or sub-national) efficiency. We carried out a thematic review of literature that assessed the efficiency of health systems at the national and sub-national level.

Health Systems Resilience: Is It Time to Revisit Resilience After Covid-19?

PASCHOALOTTO M. A. C., LAZZARI E. A., ROCHA R., *et al.*

2023

Social Science & Medicine 320: 115716.

https://doi.org/10.1016/j.socscimed.2023.115716

The concept of health system resilience has been challenged by the COVID-19 pandemic. Even well-established health systems, considered resilient, collapsed during the pandemic. To revisit the concept of resilience two years and a half after the initial impact of Covid-19, we conducted a qualitative study with 26 international experts in health systems to explore their views on concepts, stages, analytical frameworks, and implementation from a comparative perspective of high- and low-and-middle-income countries (HICs and LMICs). The interview guide was informed by a comprehensive literature review, and all interviewees had practice and academic expertise in some of the largest health systems in the world. Results show that the pandemic did modify experts' views on various aspects of health system resilience, which we summarize and propose as refinements to the current understanding of health systems resilience.

Travail et santé

Occupational Health

Does Paid Sick Leave Encourage Staying at Home? Evidence From the United States During a Pandemic

ANDERSEN M., MACLEAN J. C., PESKO M. F., *et al.*

2023

Health Economics (Ahead of pub).

https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4665

We study the impact of a temporary U.S. paid sick leave mandate that became effective April 1st, 2020 on self-quarantining, proxied by physical mobility behaviors gleaned from cellular devices. We study this policy using generalized difference-in-differences methods, leveraging pre-policy county-level heterogeneity in the share of workers likely eligible for paid sick leave benefits. We find that the policy leads to increased self-quarantining as proxied by staying home. We also find that COVID-19 confirmed cases decline post-policy.

Retraite, pénibilité, usure prématurée : rôle des professionnels et des médecins en santé au travail

DESCATHA A.

2023

Archives des Maladies Professionnelles et de l'Environnement 84(2): 101807.

https://doi.org/10.1016/j.admp.2023.101807

Alors qu'il est question pour des raisons économiques d'allonger la durée de cotisation des travaillants, il est nécessaire de rappeler qu'un allongement quantitatif du travail doit s'accompagner d'une amélioration qualitative du travail. Alors que l'Organisation mondiale de la santé et l'Organisation internationale du travail ont récemment montré que la durée hebdomadaire de travail excessive est la première source de morbi-mortalité d'origine professionnelle, qui est probablement liée à des comportements et des situations causées par un travail délétère. De plus, lorsque l'on regarde les autres causes de mortalité, on remarque des facteurs à contraintes physiques, chimiques, organisationnelles et qui expose à une usure prématurée de l'organisme pas forcément immédiatement visible. Ainsi, on pourrait dire « l'augmentation de la quantité du travail doit s'accompagner d'amélioration de la qualité du travail ». C'est dans ce contexte que les professionnels de santé au travail, médecins du travail spécialisés en santé accompagnés de leurs équipes pluriprofessionnelles au sein de services de prévention en santé au travail jouent un rôle majeur de santé au travail, de santé publique, de santé sociétale. Non seulement, ils sont capables par anticipation de dépister cette usure prématurée souvent visible que trop tardivement, mais surtout de la prévenir en conseillant employeurs, acteurs de l'entreprise, travaillants pour diminuer les facteurs de risque d'incidence d'origine professionnelle. Cela nécessite des moyens avec du temps - médical et d'action en milieu de travail - des capacités de traçabilité, d'analyse et d'utilisation d'outils d'aide à la décision, de moyens réglementaires et qui nécessitent d'être déployés en amont des difficultés.

Does Experience Rating Reduce Sickness and Disability Claims? Evidence From Policy Kinks

KYYRÄ T. ET PAUKKERI T.

2018

Journal of Health Economics 61: 178-192.

https://doi.org/10.1016/j.jhealeco.2018.07.007

We study whether the experience rating of employers' disability insurance premiums affects the inflow to disability benefits in Finland. To identify the causal effect of experience rating, we exploit kinks in the rule that specifies the degree of experience rating as a function of firm size. Using comprehensive matched employer–employee panel data, we estimate the effects of experience rating on the inflow to sickness and disability benefits. We find that experience rating has little or no effect on either of these outcomes.

The Impact of Paid Sick Leave Mandates on Women's Health

SLOPEN M.

2023

Social Science & Medicine 323: 115839.

https://doi.org/10.1016/j.socscimed.2023.115839

The United States does not have a national program to provide job-protected paid leave to workers when

they or a family member are ill or need to seek medical care. Many workers receive paid sick leave through their employers, but women, particularly parents, those without a college degree, and Latinas, are less likely than their counterparts to receive employer-provided paid sick leave (PSL). To address the shortfall in PSL coverage, several states and localities have passed laws mandating employers to provide PSL. I examine the impacts of three recent state-level paid sick leave policies on women's self-reported health using data from the Behavior Risk Factor Surveillance System. Using static and event-study difference-in-differences models, I find that PSL mandates decreased the proportion of women reporting fair or poor health by an average of 2.4 percentage points and reduced the number of days women reported their physical and mental health was not good by 0.68 days and 0.43 days in the past 30 days respectively. Effects were concentrated among parents, women without college degrees, and women of color. This study demonstrates that despite being a low-intensity policy, PSL improves women's health and well-being and that mandating workplace benefits may play a role in achieving health equity.

Analyse des trajectoires de retour au travail après un diagnostic de cancer du sein à partir des données de l'Echantillon généraliste des bénéficiaires (EGB)

VARNIER R., MOSKAL A., DIMA A. L., *et al.*

2023

Revue d'Épidémiologie et de Santé Publique 71: 101437.

https://doi.org/10.1016/j.respe.2023.101437

Le retour au travail (RT) est un enjeu important pour la qualité de vie des femmes touchées par un cancer du sein. Les données actuelles reposent principalement sur des indicateurs chiffrés ne prenant pas en compte la globalité des parcours. Cette étude exploratoire avait pour objectif d'identifier des trajectoires de RT pendant les trois années suivant un premier diagnostic de cancer du sein à partir des données de l'échantillon généraliste des bénéficiaires (EGB). Méthodes Nous avons mené une étude de cohorte rétrospective, incluant les femmes âgées de 25 à 55 ans, affiliées au régime général, ayant bénéficié d'au moins une indemnité journalière au décours d'un diagnostic de cancer du sein localisé entre 2013 et 2016 et suivies pendant trois ans au sein de l'EGB. Résultats Trois groupes de trajectoires ont été identifiés parmi les 317 patientes étudiées : « RT précoce » (49,5 %) avec un RT survenant la première année, « RT après reprise partielle » (37,5 %) avec un RT plus tardif et précédé d'une reprise à temps partiel, et « compensation continue » (13 %) sans RT. Les patientes du groupe « RT précoce » avaient été moins exposées que les autres patientes aux traitements adjuvants par radiothérapie, chimiothérapie ou thérapie ciblée, alors que les patientes du groupe « compensation continue » présentaient des facteurs sociaux défavorables (indice de défaveur élevé, couverture maladie universelle complémentaire). Discussion/Conclusion L'exploration des trajectoires de RT à partir des données de l'EGB a permis de distinguer des profils, permettant d'éclairer le développement d'interventions ciblées de prévention et d'accompagnement. Mots-clés EGB ; Cancer ; Retour au travail ; Trajectoires ; Séquences Déclaration de liens d'intérêts Les auteurs déclarent ne pas avoir de liens d'intérêts.

Vieillissement

Ageing

L'épargne-retraite : deux décennies de comportements des ménages français (1997-2018). Analyse à travers cinq vagues de l'enquête Patrimoine

ARRONDEL L., DELBOS J.-B., DURANT D., *et al.*

2022

Retraite et société 89(2): 165-192.

https://www.cairn.info/revue-retraite-et-societe-2022-2-page-165.htm

Cet article examine les comportements d'épargne et de placement des ménages français sur longue période, à travers cinq vagues de l'enquête Patrimoine de l'Insee, qui couvrent deux décennies (1997- 2018). Les enquêtes, conduites en 1997- 1998, 2003- 2004, 2009- 2010, 2014- 2015 et 2017- 2018, interrogent chacune entre 9 000 et 15 000 ménages de façon détaillée sur leur détention d'actifs financiers, immobiliers et professionnels, sur leur endettement et sur leurs revenus. Elles intègrent également des questions sur les caractéristiques sociodémographiques et le parcours professionnel des membres du ménage ; la dernière vague d'enquête (2017- 2018) a ainsi été renommée « Histoire de vie et Patrimoine ». Lorsque cela était nécessaire, les variables sociodémographiques et patrimoniales ont été harmonisées au travers des cinq vagues d'enquête. Sur l'ensemble de la période couverte (1997- 2018), la détention de produits d'épargne- retraite a été affectée par les réformes des régimes de retraite à partir de 1993, mais également, à partir de 2003, par de nombreux changements législatifs concernant l'épargne- retraite, les pouvoirs publics ayant accompagné la baisse future des droits à pension d'incitations à l'épargne individuelle. L'évolution des détentions d'épargne- retraite dépend également des rendements relatifs des produits et du rendement espéré de ces produits sur le cycle de vie. Enfin, l'évolution des revenus et la crise financière de 2007- 2008 ont modifié les intentions des ménages concernant l'épargne.

A Comparative Overview of Health and Social Care Policy For Older People in England and Scotland, United Kingdom (UK)

AUJLA N., FROST H., GUTHRIE B., *et al.*

2023

Health Policy (Ahead of pub): 104814.

https://www.sciencedirect.com/science/article/pii/S0168851023000994

Responsibility for health and social care was devolved to Scotland in 1999 with evidence of diverging policy and organisation of care compared to England. This paper provides a comparative overview of major health and social care policies in England and Scotland published between 2011-2023 relating to the care of older people. Methods We searched United Kingdom (UK) and Scotland government websites for macro-level policy documents between 2011-2023 relating to the health and social care of older people (aged 65+). Data were extracted and emergent themes were summarised according to Donabedian's structure-process-outcome model. Results We reviewed 27 policies in England and 28 in Scotland. Four main policy themes emerged that were common to both countries. Two related to the structure of care: integration of care and adult social care reform. Two related to service delivery/processes of care: prevention and supported self-management and improving mental health care. Cross-cutting themes included person-centred care, addressing health inequalities, promoting use of technology, and improving outcomes. Conclusion Despite differences in the structure of care, including more competition, financial incentivisation, and consumer-based care in England compared to Scotland, there are similarities in policy vision around delivery/processes of care (e.g. person-centred care) and performance and patient outcomes. Lack of UK-wide health and social care datasets hinders evaluation of policies and comparison of outcomes between both countries.

To Care For Them, We Need to Take Care of Ourselves: A Qualitative Study on the Health of Home Health Aides

CHO J., TOFFEY B., SILVA A. F., *et al.*

2023

Health Services Research (Ahead of pub).

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.14147

This objective of this study is to understand the perspectives of home health aides (HHAs) toward their own health and health behaviors, and how their job impacts both. Data Sources and Study Setting Interviews were conducted with 28 HHAs from 16 unique home care agencies from August 2021 to January 2022. The study was conducted in partnership with the 1199SEIU Training and Employment Fund, a labor-management fund of the largest health care union in the US. Study Design A qualitative study with English and Spanish-speaking HHAs. Interviews were conducted using a semi-structured topic guide, informed by Pender's Health Promotion Model and the National Institute for Occupational Safety and Health's Total Worker Health Model. To be eligible, HHAs had to be currently employed by a home care agency in New York, NY. Data Collection/Extraction Methods Interviews were recorded, professionally transcribed, and analyzed thematically. Principal Findings The 28 HHAs had a mean age of 47.6 years (SD 11.1), 39% were non-Hispanic Black, 43% were Hispanic, and they had a mean of 14.1 years (SD 7.8) of job experience. Five themes emerged; HHAs were: (1) Healthy enough to work, but were managing their own chronic conditions while working; (2) Motivated to be healthy, in part driven by their desire to care for others; (3) Worked closely with sick patients, which influenced their perceptions of health; (4) Experienced occupational and patient-level barriers to practicing healthy behaviors; (5) Sought support and resources to improve their health and wellbeing. Conclusions HHAs have numerous health challenges, many of which are influenced by their job. Culturally and occupationally tailored interventions may mitigate the barriers that HHAs experience to achieve optimal health.

Variation in End-Of-Life Trajectories in Persons Aged 70 Years and Older, Sweden, 2018–2020

EBELING M., MEYER A. C. ET MODIG K.

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The aim of this paper is to analyze variation in end-of-life trajectories with regard to elder care and medical care and how they relate to age, gender, and causes of death. Methods. We analyzed all deaths of persons at age 70 years and older between the years 2018 and 2020 in Sweden, using a linkage of population registers. We applied latent class analysis to identify distinct types of end-of-life trajectories. Results. We identified 6 different types of end-of-life trajectories. The types differed substantially in the amount of utilized elder care and medical care before death. Deaths characterized by high levels of elder care and medical care utilization become more common with age. The trajectory types show distinct cause-of-death profiles. Conclusions. Most deaths today do not comply with what is often referred to as a ?good? death (e.g., retaining control or requiring low levels of elder care). The results suggest that longer lifespans partly result from a prolonged dying process. Public Health Implications. The current modes of dying call for a discussion about how we want to die in an era of increasing lifespans and aging societies.

L'accumulation du patrimoine au cours du cycle de vie : une approche par microsimulation

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L'objectif de ce travail est de projeter des patrimoines individuels par microsimulation afin de pouvoir intégrer les produits de l'épargne dans le revenu disponible et calculer des niveaux de vie ajustés qui tiennent compte de ces revenus du patrimoine. Actifs et retraités diffèrent à cet égard en raison de leur position dans le cycle de vie. De plus, les premiers sont susceptibles d'hériter du patrimoine des seconds. Cette étude propose une méthodologie originale qui imbrique un modèle structurel stylisé de consommation et d'épargne au cours du cycle de vie

dans le modèle de microsimulation Destinie, projetant les pensions d'individus reliés entre eux sur les plans conjugaux et familiaux. Ce modèle, incluant l'héritage, intègre de ce fait une dimension intergénérationnelle. Cette approche mobilise les données de plusieurs enquêtes Patrimoine : d'une part, la vague 2010 sur laquelle Destinie s'appuie, et, d'autre part, les vagues 2015 et 2018, partiellement panélisées, qui constituent la première objectivation empirique de l'accumulation du patrimoine sur données françaises. La méthode retenue consiste à calibrer les paramètres du modèle de consommation et d'épargne au long du cycle de vie, et à estimer, puis à simuler, un modèle d'héritage. Finalement, cette approche permet de simuler des profils individuels d'épargne cohérents avec les profils agrégés observés et de calculer des indices de concentration, tenant compte des revenus du patrimoine. Ces derniers étant plus concentrés que les revenus du travail, la modélisation permet de quantifier l'importance de cet ajustement et d'améliorer la qualité des projections liées aux niveaux de vie des retraités.

Burden of Disease Among Older Adults in Europe—Trends in Mortality and Disability, 1990–2019

IBURG K. M., CHARALAMPOUS P., ALLEBECK P., *et al.*
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It is important to understand the effects of population ageing on disease burden and explore conditions that drive poor health in later life to prevent or manage these. We examined the development of disease burden and its components for major disease groups among older adults in Europe over the last 30 years. Using data from the Global Burden of Disease 2019 Study, we analyzed burden of disease trends between 1990 and 2019 measured by years of life lost (YLL), years lived with disability (YLD) and disability-adjusted life years (DALYs) among older adults (65+ years) in Western, Central and Eastern Europe using cause groups for diseases and injuries. Between 1990 and 2019, the crude numbers of DALYs for all causes increased substantially among older Western Europeans. In Eastern Europe, the absolute DALYs also increased from 1990 to 2005 but then decreased between 2006 and 2013. However, DALY rates declined for all European regions over time, with large differences in the magnitude by region and gender. Changes in the YLL rate were mainly driven by the contribution of cardiovascular diseases. This study found an increased overall absolute disease burden among older Europeans between 1990 and 2019. The demographic change that has taken place in Eastern European countries implies a potential problem of directed resource allocation to the health care sector. Furthermore, the findings highlight the potential health gains through directing resources to health promotion and treatment to reduce YLDs and to prevent YLLs, primarily from cardiovascular diseases.

Preferences of Older Adults For Healthcare Models Designed to Improve Care Coordination: Evidence From Western Switzerland

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Implementing innovations in care delivery in Switzerland is challenging due to the fragmented nature of the system and the specificities of the political process (i.e., direct democracy, decentralized decision-making). In this context, it is particularly important to account for population preferences when designing policies. We designed a discrete choice experiment to study population preferences for coordination-improving care models. Specifically, we assessed the relative importance of model characteristics (i.e., insurance premium, presence of care coordinator, access to specialists, use of EMR, cost-sharing for chronic patients, incentives for informal care), and predicted uptake under different policy scenarios. We accounted for heterogeneity in preferences for the status quo option using an error component logit model. Respondents attached the highest importance to the price attribute (i.e. insurance premium) (0.31, CI: 0.27- 0.36) and to the presence of a care coordinator (0.27, CI: 0.23 - 0.31). Policy scenarios showed for instance that gatekeeping would be preferred to free access to specialists if the model includes a GP or an interprofessional team as a care coordinator. Although attachment to the status quo is high in the studied population, there are potential ways to improve acceptance of alternative care models by implementation of positively valued innovations.

Les plateformes d'accompagnement et de répit pour les aidants de personnes en perte d'autonomie ou ayant une maladie neuro-évolutive

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Depuis les années 2000, le rôle important qu'ont les aidants dans la prise en charge des personnes en situation de handicap, malades ou en perte d'autonomie est davantage mis en évidence. La littérature scientifique s'intéresse notamment aux axes portant sur la santé des aidants, les possibles effets délétères de l'aide apportée ainsi que son impact sur les situations d'emploi des aidants. Il est prouvé que l'aide apportée peut être source d'épuisement particulièrement lorsqu'elle atteint de hauts niveaux d'intensité, et la nécessité de soutenir les aidants a donné un élan pour des expérimentations et interventions novatrices de professionnels des secteurs médico-sociaux. C'est notamment le cas dans le cadre du troisième plan Alzheimer (2008–2012), qui est à l'origine de la circulaire créant les Plateformes d'accompagnement et de répit pour les aidants. Elles sont en effet destinées à soutenir les aidants dans la durée en leur accordant des temps de répit, des informations sur leurs droits et le maintien à domicile, du soutien psychologique, des rencontres entre aidants ou des formations pour comprendre les troubles de leur proche et s'y ajuster au mieux. Nous présentons les différentes missions de ces Plateformes en montrant comment elles répondent aux multiples besoins des aidants dont le proche est atteint d'une maladie neuro-évolutive, en proposant l'exemple concret de ce qui est mis en place au sein des Plateformes du 94 Ouest de l'Association Delta 7.

Conceptual Framework For Integrating Family Caregivers into the Health Care Team: A Scoping Review

RAJ M., STEPHENSON A. L., DEPUCCIO M. J., *et al.*

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More than 80% of family care partners of older adults are responsible for coordinating care between and among providers; yet, their inclusion in the health care delivery process lacks recognition, coordination, and standardization. Despite efforts to include care partners (e.g., through informal or formal proxy access to their care recipient's patient portal), policies and procedures around care partner inclusion are complex and inconsistently implemented. We conducted a scoping review of peer-reviewed articles published from 2015 to 2021 and reviewed a final sample of 45 U.S.-based studies. Few articles specifically examine the inclusion of care partners in health care teams; those that do, do not define or measure care partner inclusion in a standardized way. Efforts to consider care partners as "partners" rather than "visitors" require further consideration of how to build health care teams inclusive of care partners. Incentives for health care organizations and providers to practice inclusive team-building may be required.

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